

GAO

Report to the Subcommittee on  
Personnel, Committee on Armed  
Services, U.S. Senate

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September 2004

# MILITARY PERSONNEL

## DOD Needs to Address Long-term Reserve Force Availability and Related Mobilization and Demobilization Issues



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Highlights of [GAO-04-1031](#), a report to the Subcommittee on Personnel, Committee on Armed Services, U.S. Senate

## Why GAO Did This Study

Over 335,000 reserve members have been involuntarily called to active duty since September 11, 2001, and the Department of Defense (DOD) expects future reserve usage to remain high. This report is the second in response to a request for GAO to review DOD's mobilization and demobilization process. This review specifically examined the extent to which (1) DOD's implementation of a key mobilization authority and personnel policies affect reserve force availability, (2) the Army was able to execute its mobilization and demobilization plans efficiently, and (3) DOD can manage the health of its mobilized reserve forces.

## What GAO Recommends

GAO recommends that DOD develop a strategic framework with personnel policies linked to human capital goals, update planning assumptions, determine the most efficient mobilization support options, update health guidance, set a timeline for submitting health assessments electronically, and improve medical oversight. Of eight recommendations, DOD agreed with five and partially agreed with three. DOD cited four documents that it says, along with associated personnel policies, constitute its strategic framework. GAO notes that DOD's policies were issued prior to these framework documents. DOD said oversight of Marine Corps health data would be difficult. GAO believes this oversight is needed to determine the medical readiness of reservists.

[www.gao.gov/cgi-bin/getrpt?GAO-04-1031](http://www.gao.gov/cgi-bin/getrpt?GAO-04-1031).

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

## MILITARY PERSONNEL

# DOD Needs to Address Long-term Reserve Force Availability and Related Mobilization and Demobilization Issues

## What GAO Found

DOD's implementation of a key mobilization authority to involuntarily call up reserve component members and personnel policies greatly affects the numbers of reserve members available to fill requirements. Involuntary mobilizations are currently limited to a cumulative total of 24 months under DOD's implementation of the partial mobilization authority. Faced with some critical shortages, DOD changed a number of its personnel policies to increase force availability. However, these changes addressed immediate needs and did not take place within a strategic framework that linked human capital goals with DOD's organizational goals to fight the Global War on Terrorism. DOD was also considering a change in its implementation of the partial mobilization authority that would have expanded its pool of available personnel. This policy revision would have authorized mobilizations of up to 24 consecutive months without limiting the number of times personnel could be mobilized, and thus provide an essentially unlimited flow of forces. In commenting on a draft of this report, DOD stated that it would retain its current cumulative approach, but DOD did not elaborate in its comments on how it expected to address its increased personnel requirements.

The Army was not able to efficiently execute its mobilization and demobilization plans, because the plans contained outdated assumptions concerning the availability of facilities and support personnel. For example, plans assumed that active forces would be deployed abroad, thus vacating facilities when reserves were mobilizing and demobilizing but reserve forces were used earlier and active forces had often not vacated the facilities. As a result, some units were diverted away from their planned mobilization sites, and disparities in housing accommodations existed between active and reserve forces. Efficiency was also lost when short notice hampered coordination efforts among planners, support personnel, and mobilizing or demobilizing reserve forces. To address shortages in housing and other facilities, the Army has embarked on several construction and renovation projects without updating its planning assumptions regarding the availability of facilities. As a result, the Army risks spending money inefficiently on projects that may not be located where the need is greatest. Further, the Army has not taken a coordinated approach evaluating all the support costs associated with mobilization and demobilization at alternative sites in order to determine the most efficient options for the Global War on Terrorism.

DOD's ability to effectively manage the health status of its reserve forces 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 pre-deployment 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 personnel had medical problems that had not been resolved for up to 18 months, but the full extent of this situation is unknown.

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## Abbreviations

AMSA	Army Medical Surveillance Activity
DOD	Department of Defense
GAO	Government Accountability Office
IMA	Installation Management Agency
IRR	Individual Ready Reserve
MEB	Medical Evaluation Board
OASD/RA	Office of the Assistant Secretary of Defense (Reserve Affairs)
OSD	Office of the Secretary of Defense
PEB	Physical Evaluation Board
TPFDD	Time-Phased Force and Deployment Data

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United States Government Accountability Office  
Washington, DC 20548

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September 15, 2004

The Honorable Saxby Chambliss  
Chairman  
The Honorable E. Benjamin Nelson  
Ranking Minority Member  
Subcommittee on Personnel  
Committee on Armed Services  
United States Senate

The Department of Defense (DOD) currently cannot meet its global commitments without sizeable participation from among its 1.2 million National Guard and Reserve members. Since September 11, 2001, more than 335,000 of DOD's reserve component<sup>1</sup> members have been involuntarily called to active duty—almost 234,000 from the Army, almost 56,000 from the Air Force, over 24,000 from the Marine Corps and over 21,000 from the Navy. Furthermore, thousands of reserve component members have volunteered for extended periods of active duty service, according to DOD officials. During this period, the Army has had more reserve component members mobilized than all the other services combined. Much of the Army's reserve component force has been organized, trained, and resourced as a strategic reserve that would receive personnel, training, and equipment as a later-deploying reserve force rather than an operational force designed for continued overseas deployments.

Reserve component members have been deployed around the world; some helping to maintain peace and security at home while others serve on the front lines in Iraq, Afghanistan, and the Balkans. According to DOD figures, over 195,000 of the mobilized reserve component members had been demobilized as of April 7, 2004. Since the pace of reserve operations is expected to remain high due to the Global War on Terrorism stretching

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<sup>1</sup>DOD's reserve components include the collective forces of the Army National Guard and the Air National Guard, as well as the forces from the Army Reserve, the Naval Reserve, the Marine Corps Reserve, and the Air Force Reserve. The Coast Guard Reserve also assists DOD in meeting its commitments. However, we did not cover the Coast Guard Reserve during this review because it accounts for about 1 percent of the total reserve force and comes under the day-to-day control of the Department of Homeland Security rather than DOD.

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indefinitely into the future, it is critical that the services mobilize and demobilize their reserve forces as efficiently as possible.<sup>2</sup> Furthermore, DOD has recognized that the treatment of these servicemembers is one of the keys to the retention of a quality force. In addition, the health and treatment of Guard and Reserve members when mobilized have been the subject of recent media reports and congressional hearings. Health data are important to determine reservists' deployability and to identify health trends for servicemembers, which could assist in the early identification of the causes of potential post-deployment health problems.

This is the second and final report responding to your Subcommittee's request that we review a wide range of issues related to mobilizations and demobilizations. Our first report, issued in August 2003, focused on reserve mobilization issues, including the mobilization approval process, visibility over the process, and DOD's limited use of the Individual Ready Reserve.<sup>3</sup> As agreed with your offices, this review specifically examined the extent to which (1) DOD's implementation of a key mobilization authority to involuntarily call up reserve component members and DOD's personnel policies affect reserve component force availability, (2) the Army was able to efficiently execute its mobilization and demobilization plans, and (3) DOD can effectively manage the health status of its mobilized reserve component members.

In addressing our objectives, we reviewed policies from the services and the Office of the Secretary of Defense (OSD) in light of the various mobilization authorities that are available to DOD and planned deployment rotations. We also visited sites where the services conduct mobilization and demobilization processing and interviewed responsible officials at those sites. Although we visited sites for all the services, we focused our review primarily on the Army's mobilization and demobilization processes, since more personnel from the Army have been and are expected to be mobilized than from all the other services combined. We analyzed personnel and facility data obtained during the

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<sup>2</sup> Mobilization is the process of assembling and organizing personnel and equipment, activating or federalizing units and members of the National Guard and Reserves for active duty, and bringing the armed forces to a state of readiness for war or other national emergency. Demobilization is the process necessary to release from active duty units and members of the National Guard and Reserve components who were ordered to active duty under various legislative authorities.

<sup>3</sup> GAO, *Military Personnel: DOD Actions Needed to Improve the Efficiency of Mobilizations for Reserve Forces*, [GAO-03-921](#) (Washington, D.C.: Aug. 21, 2003).

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site visits and held meetings with military and civilian officials from OSD, the Joint Chiefs of Staff, the service headquarters, reserve component headquarters, and support agencies. In addition, we examined the collection and processing of pre- and post-deployment health assessment information, and spoke to officials responsible for collecting and reviewing health assessment information at the mobilization and demobilization sites we visited. We also interviewed the officer in charge of the organization responsible for maintaining DOD's centralized health assessment database, and obtained and analyzed information from the database containing the health assessments of over 290,000 reserve component members who were mobilized or demobilized from November 2001 through March 2004. We also interviewed reserve component members with medical problems at the mobilization and demobilization sites we visited, and interviewed hospital commanders and their staffs, case managers and medical liaison officers, and officials from the service Surgeons General offices. Finally, we tracked and analyzed trends in service data concerning the numbers of personnel with medical problems, their locations, and the elapsed time since they had been diagnosed with their medical problems. Based on our review of databases we used, we determined that the DOD-provided data were reliable for the purposes of this report. We conducted our review from November 2003 through July 2004 in accordance with generally accepted government auditing standards. A more thorough description of our scope and methodology is provided in appendix I.

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## Results in Brief

DOD's implementation of a key mobilization authority and the department's personnel policies greatly affect the numbers of National Guard and Reserve personnel available to fill the increased requirements for the Global War on Terrorism.

- The manner in which DOD implements its mobilization authorities affects the number of reserve component members available. The partial mobilization authority limits involuntary mobilizations to not more than 1 million reserve component members at any one time, for not more than 24 consecutive months during a time of national emergency. Under DOD's current implementation of the authority, reserve component members can be involuntarily mobilized more than once, but involuntary mobilizations are limited to a cumulative total of 24 months. If DOD's implementation of the partial mobilization authority restricts the cumulative time that reserve component forces can be mobilized, then it is possible that DOD will run out of forces. Faced with critical shortages of some reserve component personnel,



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DOD considered a change in its implementation of the partial mobilization authority that would have expanded its pool of available personnel. Under such a revised implementation, DOD could have mobilized its reserve component forces for less than 24 consecutive months; sent them home for an unspecified period; and then remobilized them, repeating this cycle indefinitely and providing an essentially unlimited flow of forces.

- DOD's personnel policies also affect the availability of reserve component members. Many of DOD's policies that affect mobilized reserve component personnel were implemented in a piecemeal manner and were focused on the short-term requirements of the services and the needs of reserve component members rather than on long-term requirements and predictability. For example, DOD has sometimes implemented stop-loss policies, which are short-term measures that increase the availability of reserve component forces by retaining both active and reserve component members on active duty beyond the end of their obligated service. Overall, the policies reflect DOD's past use of the reserve component as a later-deploying reserve force rather than a force designed for continued overseas deployments. However, DOD's policies were not developed within the context of an overall strategic framework, which would set human capital goals concerning the availability of reserve forces and show how the policies work in conjunction with each other to meet the department's long-term requirements for the Global War on Terrorism. Consequently, the policies underwent numerous changes as DOD strove to increase the availability of the reserve components to meet current requirements. These policy changes created uncertainties for reserve component members concerning the likelihood of their mobilization, the length of their service commitments, the length of their overseas rotations, and the types of missions that they would be asked to perform. It remains to be seen how these uncertainties will affect recruiting, retention, and the long-term viability of the reserve components. There are already indications that some portions of the force are being stressed. For example, the Army National Guard failed to meet its recruiting goal during 14 of 20 months from October 2002 through May 2004, and ended fiscal year 2003 approximately 7,800 soldiers below its recruiting goal.
- Furthermore, it is unclear how DOD plans to meet its longer-term requirements for the Global War on Terrorism. In commenting on a draft of this report, DOD stated that it would retain its current implementation approach to the partial mobilization authority—limiting mobilizations to a cumulative total of 24 months. Policies that

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limit involuntary mobilizations based on cumulative service make it difficult for mobilization planners, who must keep track of prior mobilizations in order to determine which forces are available to meet future requirements. In June 2004, DOD had more than 150,000 reserve component members mobilized, and it projects that over the next 3 to 5 years, it will continuously have 100,000 to about 150,000 reserve component members mobilized. It also noted that about 30,000 reserve members had already been mobilized for 24 months. The availability of the reserve force will continue to play an important role in the success of DOD's missions. However, DOD's comments that said it would retain its current implementation approach to the partial mobilization authority did not elaborate on how it would address the increased requirements under this approach.

The Army was not able to efficiently execute its mobilization and demobilization plans because the plans contained outdated assumptions concerning the availability of facilities and support personnel. Specifically, the plans assumed (1) that active forces would deploy away from the mobilization and demobilization sites before the reserve forces arrived and (2) that specialized reserve component support units would remain available to support ongoing mobilizations and demobilizations. However, installation officials were not always able to prepare adequate facilities for the arrival of mobilizing and demobilizing reserve component forces because active forces had not deployed away from the mobilization and demobilization sites as plans had assumed. As a result, some reserve component units were diverted away from their planned mobilization sites, and disparities in housing accommodations arose between active and reserve component forces at the same installations. To address housing and other facilities shortages at mobilization and demobilization sites, the Army has embarked on a number of facility construction and renovation projects without updating its planning assumptions regarding the availability of facilities. In addition, installation officials faced uncertainties concerning the availability of specialized reserve component support units that provide much of the medical, training, logistics, and processing support during mobilization and demobilization. Faced with the prospect of mobilizing support personnel for more than 24 months, the Army began a series of initiatives to replace many of these specialized reserve component support personnel with civilians or contractors. These initiatives coupled with the facility construction and renovation projects are projected to run into the hundreds of millions of dollars. However, the Army did not take a coordinated approach to evaluate all the support costs associated with mobilization and demobilization at alternative sites—including both facility (construction, renovation, and maintenance) and

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support personnel (reserve component, civilian, contractor or a combination) costs—and determine the most efficient options.

DOD's ability to effectively manage the health status of its reserve component members is limited because (1) its centralized database has missing and incomplete health records and (2) it has not maintained full visibility over reserve component members with medical problems.

- First, not all of the required information collected from reserve component members has reached DOD's central data collection point. For example, the Marine Corps did not send servicemembers' pre-deployment health assessment forms to the centralized database as required.<sup>4</sup> Marine Corps officials told us that Marine Corps guidance did not require them to submit pre-deployment health assessments to the centralized database. The Marine Corps also lacks a mechanism for overseeing the submission of these forms to the database. Some records in DOD's centralized health assessment database did not include information that could be used to identify the causes of various medical problems, often because the forms were not submitted electronically. Even though all of the reserve components have the capability to submit the forms electronically—and such electronic submission would expedite the inclusion of key data for meaningful analysis, increase accuracy of the reported information, and lessen the burden of sites forwarding paper copies and the likelihood that information would be lost—DOD has not set a timeline for the services to electronically submit the health assessment forms to the centralized database. Despite some missing information in the database, we determined that over 90 percent of the more than 290,000 mobilized reserve component personnel rated their overall health as good to excellent. Despite the small percentages of mobilized personnel with medical problems, there are still thousands of reserve component personnel on active duty with medical problems, due to the large reserve component mobilizations.
- Second, DOD's ability to effectively manage the health of its reserve component members is limited because some of the reserve components could not adequately track personnel with medical issues. The Army previously lacked central visibility over its reserve

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<sup>4</sup> DOD policy requires that the services collect pre- and post-deployment health information from servicemembers, and submit copies of the forms that are used to collect this information to the Army Medical Surveillance Activity.

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component personnel with medical problems, and this contributed to housing and pay problems for the reserve component members, lost health care coverage for their dependents, and allegations that it was taking too long to get medical treatment. The Army has taken steps to address all of these problems and now has good visibility over its reserve component personnel who are on active duty with medical problems. However, the Air Force has visibility over only some of its personnel on active duty with medical problems because it lacks a mechanism for tracking reserve component members with health problems who are on voluntary active duty orders.<sup>5</sup> As a result, some air reserve component members have medical issues that may not have been resolved over long periods of time. For example, at one of the sites we visited, several reservists told us that they were currently on voluntary orders with medical problems, and one reservist who was currently on voluntary orders told us that his problem had lasted for 18 months and he did not expect resolution of his case anytime soon. The extent to which such a problem is commonplace is unknown, given the inability of the Air Force to track such personnel.

We are making eight recommendations in this report. We recommend that DOD develop a strategic framework that sets human capital goals concerning the availability of its reserve force to meet the longer-term requirements of the Global War on Terrorism and that DOD identify personnel policies that should be linked within the context of the strategic framework. We also recommend that DOD update the Army's mobilization- and demobilization-planning assumptions, evaluate all support costs associated with mobilization and demobilization at alternative Army sites to determine the most efficient options, update Marine Corps guidance concerning the submission of health assessments, improve Marine Corps oversight of the submission of health assessments, set a timeline for the military departments to electronically submit health assessments, and develop a mechanism for Air Force tracking of reserve component members on voluntary active duty orders with health problems.

In commenting on a draft of this report, DOD concurred with five of our eight recommendations and partially concurred with the other three. DOD stated that it has a strategic framework for setting human capital goals,

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<sup>5</sup> Reserve component members often switch to voluntary mobilization orders after the expiration of involuntary orders, but the Air Force has also used voluntary mobilizations in lieu of involuntary mobilizations under the current partial mobilization authority.

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which was established through a December 2002 force mix review, a January 2004 rebalancing report, and other planning and budgeting guidance. However, DOD agreed that it should review and, as appropriate, update its strategic framework. Although the documents cited by DOD lay some of the groundwork needed to develop a strategic framework, these documents do not specifically address how DOD will integrate and align its personnel policies to maximize its efficient usage of reserve component personnel in order to meet its overall organizational goals. DOD also stated that its September 20, 2001, personnel and pay policy and its July 19, 2002, addendum established personnel policies associated with this strategic framework and said that the department should review, and as appropriate, update the policies. However, the policies cited by DOD predate the 2004 report and the December 2002 review, which DOD cited as part of its strategic framework. The strategic framework should be established prior to the creation of personnel policies. Regarding our recommendation concerning Marine Corps oversight of health assessments, DOD stated that electronic submission might not be practical for every Marine Corps deployment. However, this recommendation was directed at the oversight of health assessments regardless of how the assessments are submitted—in paper or electric form. We continue to believe that the Marine Corps needs to establish a mechanism for overseeing the submission of its pre- and post-deployment health assessments.

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## Background

Mobilization is the process of assembling and organizing personnel and equipment, activating or federalizing units and members of the National Guard and Reserves for active duty, and bringing the armed forces to a state of readiness for war or other national emergency. It is a complex undertaking that requires constant and precise coordination between a number of commands and officials. Mobilization usually begins when the President invokes a mobilization authority and ends with the voluntary or involuntary mobilization of an individual Reserve or National Guard member. Demobilization<sup>6</sup> is the process necessary to release from active duty units and members of the National Guard and Reserve components who were ordered to active duty under various legislative authorities.

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<sup>6</sup> Some of the services use the term “deactivation” to describe the process for taking reserve component members off active duty and use the term “demobilization” to describe the broader processes that also include restoring equipment to its reserve status. We have used the more common “demobilization” term throughout this report even though the report is focused on personnel issues.

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Mobilization and demobilization times can vary from a matter of hours to months depending on a number of factors. For example, many air reserve component units are required to be available to mobilize within 72 hours while Army National Guard brigades may require months of training as part of their mobilizations. Reserve component members' usage of accrued leave can greatly affect demobilization times. Actual demobilization processing typically takes a matter of days once the member arrives back in the United States. However, since members earn 30 days of leave each year, they could have up to 60 days of leave available to them at the end of a 2-year mobilization.

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## Reserve Components and Categories

DOD has six reserve components: the Army Reserve, the Army National Guard, the Air Force Reserve, the Air National Guard, the Naval Reserve, and the Marine Corps Reserve. Reserve forces can be divided into three major categories: the Ready Reserve, the Standby Reserve, and the Retired Reserve. The Ready Reserve had approximately 1.2 million National Guard and Reserve members at the end of fiscal year 2003, and its members were the only reservists who were subject to involuntary mobilization under the partial mobilization declared by President Bush on September 14, 2001. Within the Ready Reserve, there are three subcategories: the Selected Reserve, the Individual Ready Reserve (IRR), and the Inactive National Guard. Members of all three subcategories are subject to mobilization under a partial mobilization.

- At the end of fiscal year 2003, DOD had 875,072 Selected Reserve members. The Selected Reserve's members included 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.
- At the end of fiscal year 2003, DOD had 274,199 IRR members. During a partial mobilization, these individuals—who were previously trained during periods of active duty service—can be mobilized to fill requirements. Each year, the services transfer thousands of personnel who have completed the active duty or Selected Reserve portions of their military contracts, but who have not reached the end of their military service obligations, to the IRR.<sup>7</sup> However, IRR members do not

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<sup>7</sup> While enlistment contracts can vary, a typical enlistee would incur an 8-year military service obligation, which could consist of a 4-year active duty obligation followed by a 4-year IRR obligation.

participate in any regularly scheduled training, and they are not paid for their membership in the IRR.<sup>8</sup>

- At the end of fiscal year 2003, the Inactive National Guard had 2,138 Army National Guard members. This subcategory contains individuals who are temporarily unable to participate in regular training but who wish to remain attached to their National Guard unit.

Appendix II contains additional information about end strengths within the various reserve components and different categories.

## Mobilization Authorities

Most reservists who were called to active duty for other than normal training after September 11, 2001, were mobilized under one of the three legislative authorities listed in table 1.

**Table 1: Authorities Used to Mobilize Reservists after September 11, 2001**

Title 10 U.S.C. section	Type of mobilization	Number of Ready Reservists that can be mobilized at any one time	Length of mobilizations
12304 (Presidential reserve call-up authority)	Involuntary	200,000 <sup>a</sup>	Not more than 270 days for any operational mission
12302 (Partial mobilization authority)	Involuntary	1,000,000	Not more than 24 consecutive months
12301 (d)	Voluntary	Unlimited	Unlimited

Source: GAO.

<sup>a</sup>Under this authority, DOD can mobilize members of the Selected Reserve and certain IRR members but it is limited to not more than 200,000 members at any one time, of whom not more than 30,000 may be members of the IRR.

<sup>8</sup> IRR members can request to participate in annual training or other operations, but most do not. Those who are activated are paid for their service. Also, there are small groups of IRR members who participate in unpaid training. The members of this last group are often in the IRR only for short periods while they are waiting to transfer to paid positions in the Selected Reserve. IRR members can receive retirement credit if they meet basic eligibility criteria through voluntary training or mobilizations.

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On September 14, 2001, President Bush declared that a national emergency existed as a result of the attacks on the World Trade Center in New York City, New York, and the Pentagon in Washington, D.C., and he invoked 10 U.S.C. § 12302, which is commonly referred to as the “partial mobilization authority.” On September 20, 2001, DOD issued mobilization guidance that, among a host of other things, directed the services as a matter of policy to specify in initial orders to Ready Reserve members that the period of active duty service under 10 U.S.C. § 12302 would not exceed 12 months. However, the guidance allowed the service secretaries to extend orders for an additional 12 months or remobilize reserve component members under the partial mobilization authority as long as an individual member’s cumulative service did not exceed 24 months under 10 U.S.C. § 12302. It further specified that “No member of the Ready Reserve called to involuntary active duty under 10 U.S.C. 12302 in support of the effective conduct of operations in response to the World Trade Center and Pentagon attacks, shall serve on active duty in excess of 24 months under that authority, including travel time to return the member to the residence from which he or she left when called to active duty and use of accrued leave.” The guidance also allowed the services to retain members on active duty after they had served 24 or fewer months under 10 U.S.C. § 12302 with the member’s consent if additional orders were authorized under 10 U.S.C. § 12301(d).<sup>9</sup>

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## Mobilization and Demobilization Roles and Responsibilities

Combatant commanders are principally responsible for the preparation and implementation of operation plans that specify the necessary level of mobilization of reserve component forces. The military services are the primary executors of mobilization. At the direction of the Secretary of Defense, the services prepare detailed mobilization plans to support the operation plans and provide forces and logistical support to the combatant commanders.

The Assistant Secretary of Defense for Reserve Affairs, who reports to the Under Secretary of Defense for Personnel and Readiness, is to provide policy, programs, and guidance for the mobilization and demobilization of the reserve components. The Chairman of the Joint Chiefs of Staff, after

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<sup>9</sup> According to DOD, this policy guidance is still in effect and the only major change to the policy has been to allow the Army to call up reserve component members for more than 12 months on their initial orders. However, DOD also noted that there have been multiple other documents published to augment the policy, provide more information, or implement legal requirements.



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coordination with the Assistant Secretary of Defense for Reserve Affairs, the secretaries of the military departments, and the commanders of the Unified Combatant Commands, is to advise the Secretary of Defense on the need to augment the active forces with members of the reserve components. The Chairman of the Joint Chiefs of Staff also has responsibility for recommending the period of service for units and members of the reserve components ordered to active duty. The service secretaries are to prepare plans for mobilization and demobilization and to periodically review and test the plans to ensure the services' capabilities to mobilize reserve forces and to assimilate them effectively into the active forces.

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## Reserve Component Approaches to Mobilization and Demobilization

Within the constraints of the existing mobilization authorities and DOD guidance, the services have flexibility as to how, where, and when they conduct mobilization and demobilization processing. Unit readiness also affects time frames. For example, air reserve component units, which must be ready to deploy on short notice, generally complete their mobilization processing much quicker than Army units that have been funded at low levels under the Army's tiered readiness concept. However, higher-priority units may take longer to complete demobilization processing because, at the end of the processing, they must be ready to deploy on short notice again.

The reserve components differ in their approaches to the mobilization and demobilization processes. The Army and Navy use centralized approaches, mobilizing and demobilizing their reserve component forces at a limited number of locations. The Army utilizes 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 and demobilizing.

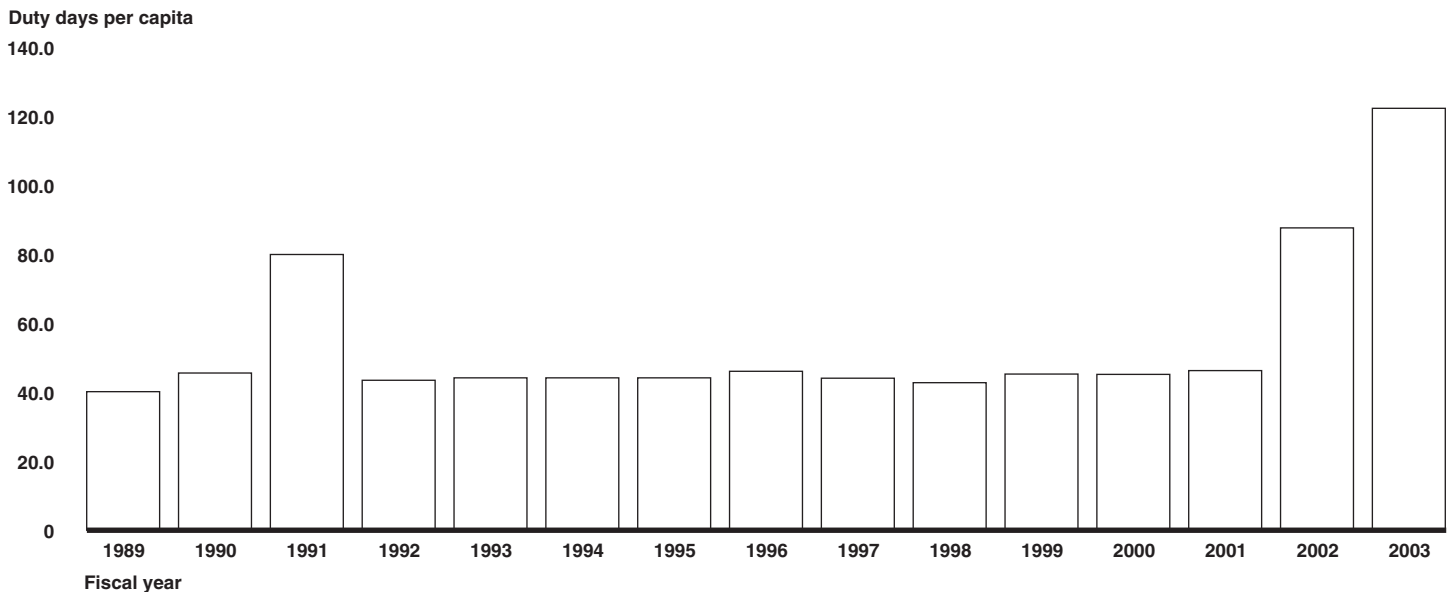
By contrast, the Air Force uses a decentralized approach, mobilizing and demobilizing its reserve component members at their home stations—135 for the Air Force Reserve and 90 for the Air National Guard. The Marine Corps uses a hybrid approach. It has five Mobilization Processing Centers to centrally 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 and then report to their gaining commands, such as the First or Second Marine Expeditionary

Force located at Camp Pendleton and Camp Lejeune, respectively. Individuals usually demobilize at the same location where they mobilized and units generally demobilize at Camp Pendleton or Camp Lejeune. See appendix III for a listing of the services' mobilization and demobilization sites.

### Service Usage of the Reserve Component since September 11, 2001

Figure 1 shows reserve component usage on a per capita basis since fiscal year 1989 and demonstrates the dramatic increase in usage that occurred after September 11, 2001. It shows that the ongoing usage—which includes support to operations Noble Eagle, Enduring Freedom, and Iraqi Freedom—exceeds the usage rates during the 1991 Persian Gulf War in both length and magnitude.<sup>10</sup>

**Figure 1: Average Days of Duty Performed by DOD's Reserve Component Forces, Fiscal Years 1989–2003**



Source: GAO analysis of OASD/RA data

Note: Duty days in figure 1 include training days as well as support for operational missions.

<sup>10</sup> Noble Eagle is the name for the domestic war on terrorism. Enduring Freedom is the name for the international war on terrorism, including operations in Afghanistan. Iraqi Freedom is the name for operations in and around Iraq.

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While reserve component usage increased significantly after September 11, 2001, an equally important shift occurred at the end of 2002. Following the events of September 11, 2001, the Air Force initially used the partial mobilization authority more than the other services. However, service usage shifted in 2002, and by the end of that year, the Army had more reserve component members mobilized than all the other services combined. Since that time, usage of the Army's reserve component members has continued to dominate DOD's figures. On June 30, 2004, the Army had about 131,000 reserve component members mobilized while the Air Force had about 12,000, the Marine Corps about 9,000, and the Navy about 3,000.

Under the current partial mobilization authority, DOD increased not only the numbers of reserve component members that it mobilized, but also the length of the members' mobilizations. The average mobilization for Operations Desert Shield and Desert Storm in 1990-91 was 156 days. However, by December 31, 2003, the average mobilization for operations Noble Eagle, Enduring Freedom, and Iraqi Freedom was 319 days, or double the length of mobilizations for Desert Shield and Desert Storm. By March 31, 2004, the average mobilization for the three ongoing operations had increased to 342 days, and that figure is expected to continue to rise.

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## DOD's Management of Reserve Component Health Issues

Section 1074f of Title 10, United States Code required 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, its territories, or its possessions as part of a contingency operation or combat operation. It further required 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 post-deployment medical examinations<sup>11</sup> and that recordkeeping requirements are met.

DOD policy requires that the services collect pre- and post-deployment health information from their members and submit copies of the forms that are used to collect this information to the Army Medical Surveillance

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<sup>11</sup> Physical examinations are not required but servicemembers may request physicals as part of their demobilization processing. Appendix IV shows the differences between required periodic physicals and optional demobilization physicals.

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Activity (AMSA).<sup>12</sup> 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 medical 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 health care providers in identifying health problems and providing needed medical care. The pre-deployment health assessment is generally administered at the service mobilization site or unit home station before deployment, and the post-deployment health assessment is completed either in theater before redeployment to the servicemember's home unit or shortly after redeployment.

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 servicemembers 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 servicemember's permanent medical record and a copy "immediately forwarded to AMSA."

Both the pre- and the post-deployment assessments were originally two-page forms, but on April 22, 2003, the post-deployment assessment was expanded to four pages "in response to national interest in the health of deployed personnel, combined with the timing and scope of current deployments." Both forms include demographic information about the servicemember, member-provided information about the member's general health, and information about referrals that are issued when service medical providers review the health assessments. The pre-deployment assessment also includes a final medical disposition that shows whether the member was deployable or not, and the post-deployment assessment contains additional information about the location where the member was deployed and things that the member might have been exposed to during the deployment. Compared with the two-page

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<sup>12</sup> AMSA operates the Defense Medical Surveillance System, which was established in 1997.

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post-deployment form, the four-page form captures more-detailed information on deployment locations, potentially hazardous exposures, and medical symptoms the servicemember might have experienced. It also asks a number of mental health questions. Examples of the forms can be found in appendix V.

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## GAO's Prior Report on DOD's Mobilization Process

Our August 2003 report found the following:

- DOD's process to mobilize reservists after September 11, 2001, had to be modified and contained numerous inefficiencies.
- DOD did not have visibility over the entire mobilization process primarily because it lacked adequate systems for tracking personnel and other resources.
- The services have used two primary approaches—predictable operating cycles and formal advance notification—to provide time for units and personnel to prepare for mobilizations and deployments.
- Mobilizations were hampered because one-quarter of the Ready Reserve was not readily available for mobilization or deployment. Over 70,000 reservists could not be mobilized because they had not completed training requirements, and the services lacked information needed to fully use the 300,000 previously trained IRR members.<sup>13</sup>

We made a number of recommendations in our report to enhance the efficiency of DOD's reserve component mobilizations. DOD generally concurred with the recommendations and has mobilization reengineering efforts under way to make the process more efficient. The Army has also taken steps to improve the information it maintains on IRR members.

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## Availability of Reserves Is Greatly Influenced by Mobilization Authorities and Personnel Policies

The availability of reserve component forces to meet future requirements is greatly influenced by DOD's implementation of the partial mobilization authority and by the department's personnel policies. Furthermore, many of DOD's policies that affect mobilized reserve component personnel were implemented in a piecemeal manner, and were focused on the short-term needs of the services and reserve component members rather than on long-term requirements and predictability. The availability of reserve component forces will continue to play an important role in the success of DOD's missions because requirements that increased significantly after

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<sup>13</sup> [GAO-03-921](#).

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September 11, 2001, are expected to remain high for the foreseeable future. As a result, there are early indicators that DOD may have trouble meeting predictable troop deployment and recruiting goals for some reserve components and occupational specialties.

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## DOD's Recent Use of Mobilization Authorities

On September 14, 2001, DOD broke with its previous pattern of invoking successive authorities by invoking a partial mobilization authority without a prior Presidential Reserve call-up. In addition, DOD was considering a change in its implementation of the partial mobilization authority. The manner in which DOD implements the mobilization authorities currently available can result in either an essentially unlimited supply of forces or running out of forces available for deployment, at least in the short term.

While DOD has consistently used two mobilization authorities to gain involuntary access to its reserve component forces since 1990, the methods of using the authorities has not remained constant. On August 22, 1990, the President invoked Title 10 U.S.C. Section 673b, allowing DOD to mobilize Selected Reserve members for Operation Desert Shield.<sup>14</sup> The provision was then commonly referred to as the Presidential Selected Reserve Call-up authority and is now called the Presidential Reserve Call-up authority.<sup>15</sup> This authority limits involuntary mobilizations to not more than 200,000 reserve component members at any one time, for not more than 270 days, for any operational mission. On January 18, 1991, the President invoked Title 10 U.S.C. Section 673, commonly referred to as the "partial mobilization authority," thus providing DOD with additional authority to respond to the continued threat posed by Iraq's invasion of Kuwait.<sup>16</sup> The partial mobilization authority limits involuntary mobilizations to not more than 1 million reserve component members at any one time, for not more than 24 consecutive months, during a time of national emergency. During the years between Operation Desert Shield and September 11, 2001, DOD invoked a number of separate mission-specific Presidential Reserve Call-ups for operations in Bosnia, Kosovo, Southwest Asia, and Haiti. The department did not seek a partial

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<sup>14</sup> The provision was renumbered 12304 in 1994. Pub. L. No. 103-337, §1662(e) (2) (1994).

<sup>15</sup> In 1990, the authority permitted the involuntary call-up of only members of the Selected Reserve. The statute was amended to permit the call-up of up to 30,000 members of the Individual Ready Reserve and is consequently now referred to as the Presidential Reserve Call-up authority. Pub. L. No. 105-85 § 511 (1997).

<sup>16</sup> This provision was renumbered 12302 in 1994. Pub. L. No. 103-337, §1662(e) (2) (1994).

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mobilization authority for any of these operations, and it continued to view the partial mobilization authority as the second step in a series of progressive measures to address escalating requirements during a time of national emergency.

Unlike the progressive use of mobilization authorities following Iraq's 1990 invasion of Kuwait, after the events of September 11, 2001, the President invoked the partial mobilization authority without a prior Presidential Reserve Call-up.<sup>17</sup> Since the partial mobilization for the Global War on Terrorism went into effect in 2001, DOD has used both the partial mobilization authority and the Presidential Reserve Call-up authority to involuntarily mobilize reserve component members for operations in the Balkans.

The manner in which DOD implements the partial mobilization authority affects the number of reserve component forces available for deployment. When DOD issued its initial guidance concerning the partial mobilization authority in 2001, it limited mobilization orders to 12 months but allowed the service secretaries to extend the orders for an additional 12 months or remobilize reserve component members, as long as an individual member's cumulative service under the partial mobilization authority did not exceed 24 months. Under this cumulative implementation approach, it is possible for DOD to run out of forces during an extended conflict such as the long-term Global War on Terrorism. During our review, DOD was already facing some critical personnel shortages. To expand its pool of available personnel, DOD was considering a policy shift that would have authorized mobilizations of up to 24 consecutive months under the partial mobilization authority with no limit on cumulative months. Under the considered approach, DOD would have been able to mobilize its forces for less than 24 months; send them home; and then remobilize them, repeating this cycle indefinitely and providing essentially an unlimited flow of forces.

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<sup>17</sup> In commenting on a draft of this report, DOD indicated that under its analysis of the applicable authorities at the time, DOD was not authorized to use Presidential Reserve Call-up authority in September 2001. DOD also noted that 10 U.S.C 12304(b) has since been changed to allow for the call-up of Reserve members in response to "...a terrorist attack or threatened terrorist attack...".

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Piecemeal Policies Did Not Address Long-term Requirements or Predictability

Many of DOD's policies that affect mobilized reserve component personnel were implemented in a piecemeal manner and were not linked within the context of a strategic framework to meet the organizational goals. Overall, the policies reflected DOD's past use of the reserve components as a strategic force rather than DOD's current use of the reserve component as an operational force to respond to the increased requirements of the Global War on Terrorism. Faced with some critical shortages, the policies focused on the short-term needs of the services and reserve component members rather than on long-term requirements and predictability. This approach was necessary because the department had not developed a strategic framework that identified DOD's human capital goals necessary to meet organizational requirements. Without a strategic framework, OSD and the services made several changes to their personnel policies to increase the availability of the reserve components for the longer-term requirements of the Global War on Terrorism, and predictability declined for reserve component members. Specifically, reserve component members have faced uncertainties concerning the likelihood of their mobilizations, the length of their service commitments, the length of their overseas rotations, and the types of missions that they would be asked to perform.

Volunteer and Individual Ready Reserve Policies

The partial mobilization authority allows DOD to involuntarily mobilize members of the Ready Reserve, including the IRR;<sup>18</sup> but after the President invoked the partial mobilization authority on September 14, 2001, DOD and service policies encouraged the use of volunteers and generally discouraged the involuntary mobilization of IRR members. DOD officials said that they could meet requirements without using the IRR and stated that they wanted to focus involuntary mobilizations on the paid, rather than unpaid members, of the reserve components. However, our August 2003 report documented the lack of predictability that resulted from the volunteer and IRR policies.<sup>19</sup> These policies were disruptive to the integrity of Army units because there was a steady flow of personnel among units. Personnel were transferred from nonmobilizing units to mobilizing units that were short of personnel, and when the units that had supplied the

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<sup>18</sup> The partial mobilization authority (10 U.S.C. § 12302) states that "To achieve fair treatment as between members in the Ready Reserve who are being considered for recall to duty without their consent, consideration shall be given to (1) the length and nature of previous service, to assure such sharing of exposure to hazards as the national security and military requirements will reasonably allow; (2) family responsibilities; and (3) employment necessary to maintain the national health, safety, or interest."

<sup>19</sup> [GAO-03-921](#).



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personnel were later mobilized, they in turn were short of personnel and had to draw personnel from still other units. Despite the DOD and Army reluctance to use the IRR, the Chief of the Army Reserve has advocated using the IRR to cut down on the disruptive cross-leveling and individual mobilizations that have been breaking Army units. From September 11, 2001 to May 15, 2004, the Army Reserve mobilized 110,000 of its reservists, but more than 27,000 of these reservists were cross-leveled and mobilized with units that they did not normally train with. Furthermore, because the IRR makes up almost one-quarter of the Ready Reserve, policies that discourage the use of the IRR will cause members of the Selected Reserve to share greater exposures to the hazards associated with national security and military requirements. Moreover, policies that discourage the use of the IRR could cause DOD's pool of available reserve component personnel to shrink by more than 200,000 personnel.

Since our August 2003 report, Navy and Air Force officials have stated that they still have not involuntarily mobilized any members of their IRRs. In our August 2003 report, we noted that the Air Force's reluctance to use any of its more than 44,000 IRR members resulted in unfilled requirements for more than 9,000 personnel to guard Air Force bases. However, the Army National Guard agreed to provide personnel from its Selected Reserve units to fill these requirements. Faced with critical personnel shortages, the Army recently changed its policy and now plans to make limited use of its IRR. To date, the Marine Corps has made the most extensive use of its IRR, capitalizing on the willingness of many members to voluntarily return to active duty.

## Stop-Loss Policies

At various times since September 2001, all of the services have had "stop-loss" policies in effect.<sup>20</sup> These policies are short-term measures that increase the availability of reserve component forces while decreasing predictability for reserve component members who are prevented from leaving the service at the end of their enlistment periods. Stop-loss policies are often implemented to retain personnel in critical or high-use occupational specialties. Appendix VI contains a summary of the services' stop-loss policies that have been in effect since September 2001.

The only stop-loss policy in effect when we ended our review was an Army policy that applied to units rather than individuals in critical occupations.

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<sup>20</sup> Stop-loss policies can affect active as well as reserve component personnel. The focus of our report was those policies affecting the reserves.

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Under that policy, Army reserve component personnel were not permitted to leave the service from the time their unit was alerted<sup>21</sup> until 90 days after the date when their unit was demobilized. Because many Army units undergo several months of training after being mobilized but before being deployed overseas for 12 months, stop-loss periods can reach 2 years or more.

According to Army officials, a substantial number of reserve component members have been affected by the changing stop-loss policies. As of June 30, 2004, the Army had over 130,000 reserve component members mobilized and thousands more alerted or demobilized less than 90 days. Because they have remaining service obligations, many of these reserve component members would not have been eligible to leave the Army even if stop-loss policies had not been in effect. However, from fiscal year 1993 through fiscal year 2001,<sup>22</sup> Army National Guard annual attrition rates exceeded 16 percent and Army Reserve rates exceeded 25 percent. Even a 16 percent attrition rate means that 20,800 of the mobilized 130,000 reserve component soldiers would have left their reserve component each year. If attrition rates exceed 16 percent or the thousands of personnel who are alerted or who have been demobilized for less than 90 days are included, the numbers of personnel affected by stop-loss policies would increase even more.<sup>23</sup> When the Army's stop-loss policies are eventually lifted, thousands of servicemembers could retire or leave the service all at once and the Army's reserve components could be confronted with a huge increase in recruiting requirements.

## Mobilization and Rotation Policies

Following DOD's issuance of guidance concerning the length of mobilizations in September 2001, the services initially limited most mobilizations to 12 months, and most services maintained their existing operational rotation policies to provide deployments of a predictable length that are preceded and followed by standard maintenance and training periods. However, the Air Force and the Army later increased the length of their rotations, and the Army increased the length of its mobilizations as well. These increases in the length of mobilizations and

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<sup>21</sup> The Army goal is to alert units at least 30 days prior to the units' mobilization date.

<sup>22</sup> Army stop-loss policies went into effect early in fiscal year 2002.

<sup>23</sup> Officials from the Office of the Assistant Secretary of the Army (Manpower and Reserve Affairs) estimated that recent stop-loss policies might have prevented more than 42,000 reserve component soldiers from leaving the service on the date when they would have been eligible if stop-loss policies had not been in effect.

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rotations increased the availability of reserve component forces but decreased predictability for individual reserve component members who were mobilized and deployed under one set of policies but later extended as a result of the policy changes.

The Air Force's operational concept prior to September 2001, was based on a rotation policy that made reserve component forces available for 3 out of every 15 months. After September 2001, the Air Force was not able to solely rely on its normal rotations and had to involuntarily mobilize large numbers of reserve component personnel. From September 11, 2001, to March 31, 2004, the Air National Guard mobilized more than 31,000 personnel, and the Air Force Reserve mobilized more than 24,000 personnel. Although most Air Force mobilizations were for 12 months or less, more than 10,000 air reserve component members had their mobilization orders extended to 24 months. Most of these personnel were in security-related occupations. Since September 2001, the Air Force has not been able to return to its normal operating cycle, and in June 2004, the Air Force Chief of Staff announced that Air Force rotations would be increased to 4 months beginning in September 2004.

Before September 2001, the Army mobilized its reserve component forces for up to 270 days under the Presidential Reserve Call-up authority, and it deployed these troops overseas for rotations that lasted about 6 months. When it began mobilizing forces under the partial mobilization authority in September 2001, the Army generally mobilized troops for 12 months. However, troops that were headed for duty in the Balkans continued to be mobilized under the Presidential Reserve Call-up authority. When worldwide requirements for both active and reserve component Army troops increased, the Army changed its Balkan rotation schedules. These schedules had been published years in advance to allow poorly resourced Guard and Reserve units time to train and prepare for the deployments. As a result of the changed schedules, some reserve component units did not have adequate time to prepare and train for Balkan rotations and then deploy for 6 months and still remain with the 270-day limit of the Presidential Reserve Call-up authority. Therefore, the Army mobilized some reserve component units under the partial mobilization authority so that they could undergo longer training periods prior to deploying for 6 months under the Presidential Reserve Call-up authority. The Army's initial deployments to Iraq and Afghanistan were scheduled for 6 months, just like the overseas rotations for the Balkans. Eventually, the Army increased the length of its rotations to Iraq and Afghanistan to 12 months. This increased the availability of reserve component forces, but it decreased predictability for members who were mobilized and deployed

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during the transition period when the policy changed. Because overseas rotations were extended to 12 months and mobilization periods must include mobilization and demobilization processing time, training time, and time for the reserve component members to take any leave that they earn, the change in rotation policy required a corresponding increase in the length of mobilizations.

### Cross-Training Policies

DOD has a number of training initiatives underway that will increase the availability of its reserve component forces to meet immediate needs. Servicemembers are receiving limited training—called “cross-training”—that enables them to perform missions that are outside their area of expertise. In the Army, field artillery and air defense artillery units have been trained to perform some military police duties. Air Force and Navy personnel received additional training and are providing the Army with additional transportation assets. DOD also has plans to permanently convert thousands of positions from low-use career fields to stressed career fields.

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### Early Indications That DOD May Have Trouble Meeting Its Rotation and Recruiting Goals Exist

While it remains to be seen how the uncertainty resulting from changing personnel policies will affect recruiting, retention, and the long-term viability of the reserve components, there are already indications that some portions of the force are being stressed. For example, the Army National Guard failed to meet its recruiting goal during 14 of 20 months and ended fiscal year 2003 approximately 7,800 soldiers below its recruiting goal. (Appendix VII contains additional information about reserve component recruiting results.)

The Secretary of Defense established a force-planning metric to limit involuntary mobilizations to “reasonable and sustainable rates” and has set the metric for such mobilizations at 1 year out of every 6. However, on the basis of current and projected usage, it appears that DOD may face difficulties achieving its goal within the Army’s reserve components in the near term. Since February 2003, the Army has continuously had between 20 and 29 percent of its Selected Reserve members mobilized. To illustrate, even if the Army were to maintain the lower 20 percent mobilization rate for Selected Reserve members, it would need to mobilize

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one-fifth of its selected reserve members each year.<sup>24</sup> DOD is aware that certain portions of the force are used much more highly than others, and it plans to address some of the imbalances by converting thousands of positions from lower- demand specialties into higher-demand specialties. However, these conversions will take place over several years and even when the positions are converted, it may take some time to recruit and train people for the new positions.

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### DOD Plans to Address Increased Personnel Requirements Are Unclear

It is unclear how DOD plans to address its longer-term personnel requirements for the Global War on Terrorism, given its current implementation of the partial mobilization authority. Requirements for reserve component forces increased dramatically after September 11, 2001, and are expected to remain high for the foreseeable future. In the initial months following September 11, 2001, the Air Force used the partial mobilization authority more than the other services, and it reached its peak with almost 38,000 reserve component members mobilized in April 2002. However, by July 2002, Army mobilizations surpassed those of the Air Force, and since December 2002, the Army has had more reserve component members mobilized than all the other services combined. Although many of the members who have been called to active duty under the partial mobilization authority have been demobilized, as of March 31, 2004, approximately 175,000 of DOD's reserve component members were still mobilized and serving on active duty. According to OASD/RA data, about 40 percent of DOD's Selected Reserve forces had been mobilized from September 11, 2001, to March 31, 2004.<sup>25</sup>

By June 30, 2004, the number of mobilized reserve component members had dropped to about 155,000—consisting of about 131,000 members from the Army, about 12,000 from the Air Force, about 9,000 from the Marine Corps, and about 3,000 from the Navy. However, the number of mobilized reserve component forces is projected to remain high for the foreseeable

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<sup>24</sup> Given the fiscal year 2003 attrition rates of 17 percent for the Army National Guard and 21 percent for the Army Reserve, it might be possible to achieve the one in six metric if attrition is concentrated in the population that has already been mobilized, and the Army is able to fully utilize its entire selected reserve population by mobilizing individual soldiers out of its reserve component units that have already been mobilized.

<sup>25</sup> This percentage does not take into account the more than 270,00 IRR members who can be mobilized under a partial mobilization authority. DOD officials said that IRR members make up less than 2 percent of the 343,020 reserve component members who were mobilized from September 11, 2001, to March 31, 2004.

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future. DOD projects that over the next 3 to 5 years, it will continuously have 100,000 to about 150,000 reserve component members mobilized, and the Army National Guard and Army Reserve will continue to supply most of these personnel.

While Army forces may face the greatest levels of involuntary mobilizations over the next few years, all the reserve components have career fields that have been highly stressed. For example, the Navy and Marine Corps have mobilized 60 and 100 percent of their enlisted law enforcement specialists and 48 and 100 percent of their intelligence officers, respectively. The Air National Guard and Air Force Reserve mobilized 64 and 93 percent of their enlisted law enforcement specialists and 71 and 86 percent of their installation security personnel, respectively.

- As noted earlier, during our review, DOD was considering changing its implementation of the partial mobilization authority from its current approach, which limits mobilizations to 24 cumulative months, to an approach that would have limited mobilizations to 24 consecutive months to expand its pool of available personnel. However, in commenting on a draft of this report, DOD stated that it would retain its current cumulative implementation approach. Policies that limit involuntary mobilizations on the basis of cumulative service make it difficult for mobilization planners, who must keep track of prior mobilizations in order to determine which forces are available to meet future requirements. This can be particularly difficult now, when many mobilizations involve individuals or small detachments rather than complete units.
- In June 2004, DOD noted that about 30,000 reserve members had already been mobilized for 24 months. Under DOD's cumulative approach, these personnel will not be available to meet future requirements. The shrinking pool of available personnel, along with the lack of a strategic plan to clarify goals regarding the reserve component force's availability, will present the department with additional short- and long-term challenges as it tries to fill requirements for mobilized reserve component forces. In its comments on a draft of our report, DOD did not elaborate on how it expected to address its increased personnel requirements.

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## The Army Was Not Able to Efficiently Execute Its Mobilization and Demobilization Plans

The Army was not able to efficiently execute its mobilization and demobilization plans, because mobilization and demobilization site officials faced uncertainties concerning demands for facilities, turnover among support personnel, and the arrival of reserve component forces. The efficiency of the mobilization and demobilization process depends on advanced planning and coordination. However, the Army's planning assumptions did not accurately portray the availability of installations and personnel needed to fully accommodate the high number of mobilizations and demobilizations. Moreover, officials did not always have adequate notice to prepare for arriving troops. The Army has several initiatives under way to improve facility and support personnel availability, but it has not taken a coordinated approach to evaluate all the support costs associated with mobilization and demobilization at alternative sites in order to determine the most efficient options under the operating environment for the Global War on Terrorism.

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## Advanced Planning and Coordination Are Key to Efficient Mobilizations and Demobilizations

The efficiency of the mobilization and demobilization processes depends largely on advanced planning in the form of facility preparation and coordination between installation planners, support personnel, and arriving reserve component units or individuals. The Army attempts to take the necessary planning steps to support efficient servicemember mobilization and demobilization. For example, installations that are responsible for mobilizing and demobilizing reserve component forces attempt to contact units or personnel prior to their arrival, so that both the reserve component forces and the supporting installations can be prepared to meet the Army's mobilization and demobilization requirements. During these contacts, reserve component forces are told what records, and equipment to bring to the mobilization and demobilization sites and installation officials obtain information—such as the number of arriving troops and the anticipated time of their arrival—that is necessary for them to efficiently prepare for the arrival of the reserve component forces. With this information, the installations can plan where they will house, feed, and train the troops; how they will transport the troops around the installation and to their final destinations; and when

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they will send the troops for medical and dental screenings and administrative processing.<sup>26</sup>

Army guidance, which states that units are to demobilize at the same installation where they mobilized, can add to the efficiency of the demobilization process. Efficiencies can be realized because many of records created during the mobilization process or copies of the records are kept at the installation and can be used to do advanced preparation before the demobilizing unit arrives at the installation. Army officials told us that since September 11, 2001, most units have demobilized at the same installation where they mobilized, but there have been some exceptions. For example, officials from the First U.S. Army told us that they had mobilized a unit for Operation Iraqi Freedom at Fort Rucker, Alabama, and were demobilizing the unit at Fort Benning, Georgia. They also told us that troops who had mobilized at Fort Stewart, Georgia, were going to be demobilizing at Fort Dix, New Jersey, after a deployment to Kosovo. To accommodate shifts in demobilization sites, the new sites must, among other things, obtain reserve component unit medical, dental, and personnel records and must coordinate the return of individual equipment, such as helmets, sleeping bags, packs, and canteens that were issued at the original mobilization site.<sup>27</sup> With adequate notice and planning, alternate demobilization sites can demobilize reserve component units without any major problems. However, officials at Fort Lewis, Washington, told us that their support personnel had to reconstruct dental records for 150 soldiers in an engineer unit that had originally mobilized at Fort Leonard Wood, Missouri. Because the Army's goal is to complete demobilization processing within 5 days of a unit's arrival at a demobilization site, the Fort Lewis personnel were not able to wait for the arrival of the dental records, which had been sent from Fort Leonard Wood via routine mail rather than overnight delivery.

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<sup>26</sup> Among other things, this administrative processing involves issuing identification cards; storing, retrieving, and checking pay and personnel records; processing travel vouchers; and providing numerous briefings on the reserve component members' rights and benefits, such as health care. At one site we visited, 17 different briefings were given to the reserve component members during mobilization processing and 13 different briefings during demobilization processing. The briefings cover topics such as health benefits, pay, and legal and mental health matters. Some briefings were given during both mobilization and demobilization processing; other briefings were applicable only one time.

<sup>27</sup> Body armor had been among the items that were returned to the sites where it had been issued, but during our visit to Fort Lewis in March 2004, officials told us that body armor was being managed in theater and not being returned to the demobilization sites.



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## Army Planning Assumptions Were Not Accurate

The Army's planning assumptions did not accurately portray the availability of installations and personnel needed to fully accommodate the high number of mobilizations and demobilizations. Specifically, planning assumptions regarding the availability of facilities for mobilization and demobilization were outdated, and did not anticipate the availability of specially designed reserve component support units to provide much of the medical, training, logistics, and processing support needed to mobilize and demobilize reserve component units and individuals.

## Assumptions for Availability of Facilities Were Outdated

The Army's planning assumptions regarding the availability of facilities for mobilization and demobilization were outdated. Consequently, installations sometimes lacked the support infrastructure needed to accommodate both active and reserve component mobilizing and demobilizing members in an equitable manner. The Army's mobilization and demobilization plans assumed that active forces would be deployed abroad, thus vacating installations when reserve component forces were mobilizing and often demobilizing. These assumptions are important because they served as a basis to help the Army determine which installations would have the necessary support facilities to serve as its primary and secondary mobilization sites.<sup>28</sup> Most of the Army's primary mobilization sites are installations that serve as home bases for large active Army units. For example, three of the Army's primary sites that we visited—Fort Lewis, Washington; Fort Stewart, Georgia; and Fort Hood, Texas—are home to two active combat brigades, an active combat division, and two active combat divisions, respectively, along with hosts of other active forces. Fort Hood alone has about 42,000 active troops assigned to the installation.

Under the Army's plans, reserve component units were assigned mobilization and demobilization sites so that units could plan in advance for their mobilizations. Units often developed relationships with the installations where they expected to mobilize and in many cases the units trained at these installations. However, because active units had not vacated many of the Army's major mobilization sites as planned, mobilizing reserve component forces were moved to sites where they had

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<sup>28</sup> The Army refers to its primary mobilization and demobilization sites as "power projection platforms" and its secondary sites as "power support platforms" and mobilizes most of its reserve component forces at these installations. However, the Army also uses a number of other installations to mobilize and demobilize small units or other troops that are slated to remain at or in the immediate vicinity of these other mobilizing installations.

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not trained and where they had not developed any relationships that could have increased the mobilizations' efficiency. As a result, transportation distances for personnel and equipment were increased, and extra coordination was required with the mobilization sites and sometimes even within units. For example, the 116<sup>th</sup> Cavalry Brigade from the Idaho Army National Guard, which had planned to mobilize at Fort Lewis, Washington, was mobilized at Fort Bliss, Texas, because, among other things, adequate housing facilities were not available at Fort Lewis. Another Army National Guard Brigade, which was mobilized at Fort Bragg, North Carolina, faced increased coordination challenges because one of its battalions was mobilized at Fort Drum, New York, and another at Fort Stewart, Georgia, because of a lack of available facilities at Fort Bragg.

At mobilization and demobilization sites where active forces remained on the installations while reserve component forces were mobilizing or demobilizing, competing demands sometimes led to housing inequities for the reserve members. For example, at the installations we visited, single active component personnel who were permanently assigned to the installation were generally housed in barracks where two to four people shared a room,<sup>29</sup> but mobilized reserve component personnel were often housed in open-bay barracks. At some installations, reserve component personnel were housed in tents, gymnasiums, or older buildings that were designed for short training periods rather than mobilization periods that could last several months. The presence of large active duty and reserve contingents on the same installations at the same time also strained training and medical facilities.<sup>30</sup> Fort Hood officials said that the scheduling and rescheduling of training ranges presented major challenges during 2003 when the installation was preparing to deploy both its active divisions and a large group of reserve component forces at the same time. To address these facility challenges, the Army has begun a number of housing and facility construction and renovation projects.

**Assumptions Did Not Account for Long-term Needs for Reserve Component Support Personnel under a Partial Mobilization Authority**

The Army did not anticipate that its reserve component units that support mobilizations and demobilizations would be needed beyond 24 months under a partial mobilization authority. When the Army created these units to provide much of the medical, training, logistics, and processing support to mobilizing and demobilizing units and individuals, it anticipated that the need for these units would be commensurate with the mobilization

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<sup>29</sup> Officers and senior enlisted personnel often had individual rooms.

<sup>30</sup> Medical facility issues are addressed in the next section of this report.

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authority in place at the time. However, the Army is now facing support requirements for a long-term Global War on Terrorism, while being limited to involuntary mobilizations of not more than 24 cumulative months under the department's implementation of the partial mobilization authority.

The underlying assumptions of the Army's mobilization and demobilization plans were that (1) only a small portion of these reserve component support personnel would be required to support the limited mobilizations associated with a Presidential reserve call-up and (2) all of the reserve component support personnel would be available for as long as needed to support the large mobilizations for long periods that are associated with full or total mobilizations. The Army's plans called for these support personnel to be among the first reserve component members mobilized and the last demobilized. Army officials assumed that, under a partial mobilization authority, these reserve component support forces would be able to support large mobilizations and demobilizations, or support mobilizations for long periods, but not large mobilizations for long periods.

As a result of the large requirements for the Army's reserve component forces, many pieces of the reserve component support units were mobilized for 12 months early in the Global War on Terrorism and then later extended. Some support personnel were mobilized for 24 months under the partial mobilization authority—which, under DOD's current implementation, limits involuntary mobilizations to 24 cumulative months—and then sent home. However, many others agreed to stay on active duty under voluntary mobilization orders after they had served 24 months under the partial mobilization authority. For example, from a 27-person support detachment that was mobilized for 12 months at Fort Hood, in October 2001, 13 people were later extended for a full 2 years, and 6 of these reserve component personnel accepted voluntary orders at the end of their mobilizations. At Fort Lewis, two reserve component support detachments—one with 59 personnel and the other with 17—were mobilized in September 2001. Both detachments served on active duty for 2 full years. In July 2004, more than 1,100 reserve component support personnel were on voluntary orders or mobilization extensions.

Even though some reserve component support personnel have voluntarily extended their orders, the Army is facing a shortage of mobilization and demobilization support personnel because the Global War on Terrorism is lasting beyond the time when most reserve component support personnel would reach their 24-month mobilization points. Consequently, the Army has begun hiring civilian and contractor replacement personnel to provide

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medical, training, logistics, and administrative support at its mobilization and demobilization sites.

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### Installation Planning and Support Officials Sometimes Lacked Adequate Notice to Prepare for Arriving Troops

Planners and the installations that mobilize and demobilize reserve component forces have not always had adequate notice to prepare for arriving troops. Without advanced notice, officials at these sites are forced to make last-minute adjustments that may result in the inefficient use of installation facilities and support personnel. Our prior report highlighted problems associated with the lack of advance notice in March 2003.<sup>31</sup> While officials at the installations we visited noted that the level of advance notice had improved significantly for mobilizing troops, they still faced some short-notice mobilizations. According to Army officials, the Army is currently providing 30 days' notice to all involuntarily mobilized troops. However, as of May 2004 some units that are being mobilized under the partial mobilization authority are still being mobilized with less than 30 days advance notice. According to Army Reserve officials, each member of these units signs a volunteer waiver stating that he or she agrees to be mobilized with less than 30 days advance notice. Therefore, the Army does not violate its policy concerning advance notice for involuntary mobilizations.

Installation planning officials told us that they typically receive shorter notice and less definitive information concerning the arrival of demobilizing troops. Typically, when an installation mobilizes a reserve component unit, the installation planner records the length of unit mobilization orders. Depending on the length of unit mobilization orders and the resulting time available for leave at the end of the orders, installation planners begin to anticipate the return of the unit up to several months before the unit's orders expire. The planners said that they use a variety of formal and informal means to try to ascertain the specific arrival dates and times for demobilizing troops but that the arrival dates and times are often uncertain right up until the time the troops arrive. This is because their different sources of information sometimes provide conflicting information.

The planners generally begin their search for information about units returning to their installation using the automated systems within DOD's Joint Operations Planning and Execution System. A primary source of

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<sup>31</sup> [GAO-03-921](#).

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information is the time-phased force and deployment data (TPFDD). Installation planning officials told us that the TPFDD is most valuable in providing them with information on large units with orders that have not changed and that return as complete units. However, the planners stated that it is not uncommon for the TPFDD to be incorrect or outdated because changes are constantly being made to redeployment schedules, particularly for small units or individuals.

One source of such last-minute changes stems from changes in travel arrangements. According to DOD officials, when there are empty seats available on planes departing the theater of operations, small units are often placed on the planes at the last minute to fill the empty seats. However, these changes are not always captured in the TPFDD or DOD's other automated systems. For example, while we were visiting Fort Lewis, planning officials were trying to determine which unit or units might be returning to Fort Lewis to go through demobilization processing along with the 502<sup>nd</sup> Transportation Company and 114<sup>th</sup> Chaplain detachment that were scheduled to arrive on March 1, 2004. Neither the TPFDD nor the other automated tracking systems that were available to planning officials at Fort Lewis provided definitive answers. As a result of contacts through informal channels, at 11:20 a.m. on March 1, 2004, Fort Lewis officials thought that 21 people from the 854<sup>th</sup> Quartermaster Unit were going to arrive at McChord Air Force Base—located adjacent to Fort Lewis, just south of Tacoma, Washington—40 minutes later. Due to the lack of reliable information, Fort Lewis officials could not finalize planning arrangements. For example, because they did not know whether to expect male or female soldiers, they could not finalize housing plans for the soldiers. Nor did they know whether the unit was bringing weapons with them or what types of weapons they might have, and thus transportation personnel and personnel in the arms room at Fort Lewis were placed on standby. A check with McChord officials at 11:50 a.m. revealed that there were no inbound flights. At 3:53 p.m. Fort Lewis officials had confirmation that the soldiers would be arriving at 9:35 p.m. and that there were 19 additional personnel from an unknown unit or units on the plane with the 21 soldiers from the 854<sup>th</sup> Quartermaster unit. By 4:12 p.m. on March 1, 2004, the Fort Lewis officials had canceled the scheduled demobilization processing times for the 854<sup>th</sup> because information showed that the unit would not arrive until 7:42 a.m. on the following day, March 2, 2004. Planning officials had to make several other adjustments to planned schedules before the Quartermaster unit finally arrived. Moreover, the 502<sup>nd</sup> Transportation Company and 114<sup>th</sup> Chaplain detachment, which had been visible through DOD's formal systems, also arrived later than the expected March 1 date.

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Sometimes, planning officials receive information from informal sources, such as family members of deployed personnel. During our visit to Fort Lewis, officials had begun tracking an inbound Army National Guard military police unit on the basis of information received from an informal information source. This unit became visible to the planning officials when the wife of one of the soldiers, who also served as the unit's family readiness coordinator, notified the officials that her husband and 11 other unit personnel had left Iraq, were in Germany, and were scheduled to fly to Washington state on a commercial airliner the next day. The coordinator also provided the Fort Lewis officials with the names and social security numbers for all 12 returning soldiers. According to Fort Lewis officials, in the past, 2 out of every 10 units have arrived at the site without notification. The demobilization planning officials at Fort Lewis summed up their visibility situation by stating, "Most valuable information on unit redeployment is not official, rather it is word of mouth."

Demobilization officials at other installations said that they also had good visibility over large units that returned as planned but said that it was difficult to plan for the arrival of small units and individuals. During our visit to Fort McCoy, Wisconsin, 28 soldiers—a 9-soldier unit, and a 19-soldier unit—arrived at the site unexpectedly. In addition, officials at Fort Hood said that they were able to track the evacuation of medical patients from the theater to stabilization hospitals, such as the Walter Reed Army Medical Center in Washington, D.C., or Brooke Army Medical Center in Texas, but that they often lost visibility of the patients during the last leg of their journey back to Fort Hood. They also said that visibility was sometimes a problem for individual soldiers who had reached the end of their enlistments or mobilization orders and were returning as individuals on "freedom flights" because the automated tracking systems were designed primarily to handle units and not individuals.

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**Army Facility Improvements Were Begun with Outdated Assumptions and Were Not Coordinated with Support Personnel Changes**

Without updating its planning assumptions regarding the availability of facilities for mobilization and demobilization, the Army has begun a number of costly short- and long-term efforts to address facility and support personnel shortfalls at individual mobilization and demobilization sites. Furthermore, the Army has not taken a coordinated approach to evaluate all the support costs associated with mobilization and demobilization at alternative sites in order to determine the most efficient options under the operating environment for the Global War on Terrorism. The use of civilian and contractor personnel to provide mobilization and demobilization support may not provide cost-effective alternatives to some reserve component support personnel.

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## Facility Construction and Renovation Projects Are Not Based on Updated Planning Assumptions

To address housing and other facilities shortages at mobilization and demobilization sites, the Army has embarked on a number of facility construction and renovation projects without updating its planning assumptions regarding the availability of facilities and personnel. As a result, the Army risks spending money inefficiently on projects that may not be located where the need is greatest. Until the Army updates its planning assumptions, it cannot determine whether the current primary and secondary mobilization sites are the best sites for future mobilizations and demobilizations.

The Army has a variety of individual construction and renovation plans under way. For example, Fort Hood has a \$5.1 million project to renovate its open-bay, cinder block barracks that have been used to house reserve component soldiers at North Fort Hood. Fort Stewart has a similar project under way to renovate National Guard barracks to current mobilization standards. Fort Stewart has also submitted plans to build a new facility to house its reserve component members with medical problems.

The Army also has developed a plan to construct several new buildings that would be used to house active and reserve component soldiers who are undergoing training. In addition, these facilities would be available for use when reserve component units were mobilizing and demobilizing. This project has not yet been funded or approved by Army leadership. However possible sites for these buildings include Fort Lewis, Washington; Fort Hood, Texas; Fort Bliss, Texas; Fort Carson, Colorado; Fort Polk, Louisiana; Fort Riley, Kansas; and Fort Stewart, Georgia. The construction of some of these facilities could begin as early as 2006. However, a recent GAO review found that DOD's efforts to improve facility conditions are likely to take longer than expected because of competing funding pressures. The review also found that without periodic reassessments of project prioritization, projects that are important to an installation's ability to accomplish its mission and improve servicemembers' quality of life could continually be deferred.<sup>32</sup>

The Army also has plans to make greater use of one of its secondary mobilization sites. The Army is planning to make greater use of Camp Shelby, Mississippi, a secondary mobilization site that is owned by the state of Mississippi. Because this site does not have active troops and has

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<sup>32</sup> GAO, *Defense Infrastructure: Long-term Challenges in Managing the Military Construction Program*, [GAO-04-288](#) (Washington D.C.: Feb. 24, 2004).

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Civilian and Contractor  
Personnel May Not Provide  
Cost-Effective Alternatives to  
Some Reserve Component  
Support Personnel

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a large housing capacity, the Army plans to use this site to relieve immediate pressures on its primary mobilization sites. However, Camp Shelby's facilities are not new, and they are in need of repairs. Housing units are made of cinder block, have no heating or air conditioning, and were not designed for year-round accommodations. According to officials from the U.S. Army Forces Command, Camp Shelby will require \$22 million in federal funding for renovations.

Key officials at the mobilization and demobilization sites we visited expressed a number of concerns about the availability of civilian or contractor personnel and the abilities of these personnel to provide capable, flexible replacements for the reserve component support personnel at a reasonable cost. In addition, the Army has not fully analyzed the costs of hiring these civilian and contractor personnel at its existing mobilization sites compared with the costs and feasibility of hiring support personnel at an alternative set of mobilization and demobilization sites.

At Fort Stewart, Georgia, officials said that there is a very small civilian population in the area from which to draw replacement personnel. They also noted that the rural nature of the area and lack of cultural amenities makes it difficult to attract physicians and other highly paid specialists who support the mobilization and demobilization process. Officials at Fort Lewis had already replaced many of their medical support personnel at the time of our visit but acknowledged that even with the large population of the Seattle-Tacoma area to draw upon, they were still facing challenges in the hiring of physician assistants and nurse practitioners. The commander of the hospital at Fort Hood said that the hospital had issued a contract to try to fill its nurse shortage, but the only result from the contract was that civilian nurses at the hospital left the hospital to work for a contractor that paid them more. Thus, the net result was that the hospital did not fill its shortages, and it kept the same nurses but paid the contractor more for their services.

Even when civilian or contractor personnel are available to replace reserve component personnel, the replacements may not be able to provide the same capability or flexibility as reserve component support personnel. During our visit to Fort Hood, officials told us that over the past 10 years, the Army had repeatedly looked at the option of using civilian or contractor medical evacuation teams to replace reserve component support personnel. However, the option has not been adopted because the civilians would not be able to fly into live-fire training areas or under blackout conditions without costly Army flight training. Fort Lewis



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officials raised similar concerns about the limited abilities of civilian helicopter rescue teams during our prior review.<sup>33</sup> In addition, officials at mobilization and demobilization sites said that reserve component support personnel provided them with great flexibility in dealing with the unexpected arrival of mobilizing or demobilizing soldiers. Reserve component personnel are technically available 24 hours per day, 7 days per week. Therefore, processing could be scheduled for any hour and any day without regard to overtime considerations. During our visits, we observed several cases where civilian personnel left their processing sites at the end of their scheduled workday but reserve component personnel stayed until all processing was completed.

In addition to the civilian replacements for reserve component medical support personnel, the Army is looking for replacements for the reserve component personnel who performed administrative processing, logistic, training, and other support functions within its garrison support units. The Army's Installation Management Agency (IMA) is working with the Army Contracting Agency to develop short- and long-term replacement solutions. The long-term solution is an "Indefinite Delivery/Indefinite Quantity" contract that will allow installation commanders to place task orders to hire or contract workers for particular support functions. According to contracting officials, this contract will be awarded on or about October 1, 2004. IMA is programmed to receive \$238 million for this contract in fiscal year 2005. By July 2004, IMA had received \$56 million and had allocated \$48.4 million to 12 different mobilization sites to cover the transition period until the long-term contract is in place. This interim funding can be used to expand existing installation support contracts or to hire temporary workers. In addition, the Army is also keeping over 1,100 reserve component members on active duty to help cover the transition period.<sup>34</sup>

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<sup>33</sup> [GAO-03-921](#).

<sup>34</sup> These personnel had not been mobilized for 24 months under the partial mobilization authority, or they had agreed to accept voluntary mobilization orders.

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## Ability to Effectively Manage Health of Servicemembers Is Limited

DOD's ability to effectively manage the health status of its reserve component members is limited because (1) its centralized database has missing and incomplete health records and (2) it has not maintained full visibility over reserve component members with medical issues.

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## DOD's Centralized Database Has Missing and Incomplete Health Records

During our review of health data collected at AMSA, DOD's central data collection point, we found that the database had missing and incomplete records. Not all of the required health information collected from reserve component members had reached AMSA. Furthermore, only some of the health assessment information that had reached AMSA had been entered into the centralized database.

## Required Health Assessments Have Not Reached DOD's Assessment Collection Point

DOD policy guidance issued in October 2001 directed the services to submit pre- and post-deployment health forms to AMSA,<sup>35</sup> but not all of the required health information collected from reserve component members during their mobilization and demobilization processing has reached DOD's central collection activity at AMSA. Table 2 compares the number of personnel who were mobilized from September 11, 2001, to March 30, 2004 with the number of pre-deployment health assessments submitted to AMSA from November 1, 2001—the first month when health assessments were required for all mobilizing and demobilizing reserve component members—to March 31, 2004. The differences between the mobilization numbers and the pre-deployment health assessment numbers provide indications that assessment forms may be missing for members of all six of DOD's reserve components. However, because the mobilization and health assessment data cover slightly different time periods and come from different sources, we could not determine the exact extent of the mismatch. When we investigated the cause of the large differences between Marine Corps numbers, officials told us that the Marine Corps' guidance did not require them to submit pre-deployment health assessments to AMSA.

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<sup>35</sup> The tracking system was established pursuant to 10 U.S.C. Section 1074f.

**Table 2: Mobilization and Pre-Deployment Assessment Numbers**

Reserve component	Mobilizations	Pre-deployment health assessments
	Sept. 11, 2001-Mar. 31, 2004	Nov. 1, 2001-Mar. 29, 2004
Army National Guard	138,345	120,664
Army Reserve	95,515	78,835
Air Force National Guard	31,383	22,225
Air Force Reserve	24,468	9,980
Marine Corps Reserve	24,468	2,104
Navy Reserve	21,328	5,786
<b>Total</b>	<b>335,507</b>	<b>239,594</b>

Source: GAO analysis of data from AMSA and OASD/RA.

Note: Pre-deployment health assessments became mandatory for all mobilized reserve component members on October 25, 2001.

The officials cited guidance, in the form of two Marine Corps administrative messages that directed responsible officials to submit post-deployment health assessments to AMSA. However, the administrative messages neglect to direct the officials to submit pre-deployment health assessments. Furthermore, no additional administrative messages have addressed the requirement for pre-deployment assessments. As a result, the AMSA database contained only 2,104 pre-deployment health assessments but 11,499 post-deployment health assessments for Marine Corps reservists.

Another possible reason why the Marine Corps has not submitted pre-deployment health assessments to AMSA is because the Marine Corps lacks a mechanism for overseeing the submission of these forms. There is no current Marine Corps requirement for tracking and reporting the submission of these forms in the Deployment Health Quality Assurance program. In a March 12, 2004, memorandum to the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness, the Marine Corps reported the number and percentage of post-deployment health assessments that were completed but did not report any information on pre-deployment assessments.

Officials at Camp Lejeune told us that they would begin submitting pre-deployment health assessments to AMSA after we raised the issue during a site visit in 2004 and the issuance of subsequent Navy Department guidance. Officials told us that the Marine Corps Medical Office had drafted new guidance to address this requirement, but the guidance had

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not been issued by the time we drafted our report in July 2004 and we were not able to determine the cause of the delay or to verify that new guidance would adequately address the submission of pre-deployment health assessments.

Navy health assessment submissions to AMSA also appear to be incomplete. According to Navy procedures, all mobilizing reservists are to complete their pre-deployment health assessment at their local reserve center before they report to their Navy Mobilization Processing Sites. In such cases, the reserve center is required to send the reservists' completed pre-deployment health assessment forms to AMSA. Therefore, Navy data collection is only done centrally at the Navy Mobilization Processing Stations in limited cases when a reservist arrives without a completed pre-deployment health assessment. We did not visit any individual Navy Reserve centers to verify the submission of pre-deployment health assessments. We did review Navy Quality Assurance program guidance and found that it does not address the submission of pre-deployment health assessments. However, the guidance specifies that a 90 percent submission rate is considered satisfactory for post-deployment health assessments.

In September 2003, we reported similar findings for the active forces.<sup>36</sup> Specifically, we found that DOD did not maintain a complete, centralized database of active servicemember 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 will not be available until February 2005, and it is too early to determine the extent to which the new quality assurance program will provide effective oversight to address data submission problems from each of the services and their reserve components.

While the services are not in complete compliance with the requirement to submit pre- and post-deployment assessments to AMSA, the number of assessments in the database has grown significantly. According to AMSA officials, the database contained about 140,000 assessments at the end of

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<sup>36</sup> GAO, *Defense Health Care: Quality Assurance Process Needed to Improve Force Health Protection and Surveillance*, [GAO-03-1041](#) (Washington, D.C.: Sept. 19, 2003).

1999, and grew to about 1 million assessments by May 2003, and 1,960,125 by June 2004.

**Data from Health Assessments Have Not Been Entered into DOD’s Centralized Database**

Not all the records in the AMSA database contained complete information, thus limiting the amount of meaningful analysis that can be conducted. Health assessment database records sometimes did not include information that could be used to identify the causes of various medical problems. Nonetheless, the available data indicate that the overall pre- and post-deployment health status of mobilized reserve component members was good.

**Some Database Records Missing Key Information**

Records in the health assessment database sometimes did not include key information or information that could be used to identify the causes of various medical problems. For example, records were sometimes missing information on the servicemember’s deployability and the specific types of medical referrals that were given to members with referrals.

Almost 6 percent of the nearly 240,000 pre-deployment health assessments we reviewed did not have the servicemember’s deployability status recorded in the AMSA database. As shown in table 3, the missing data ranged from less than 4 percent for the Army National Guard to almost 18 percent for the Naval Reserve.

**Table 3: Service Decisions Concerning Reserve Component Member Deployability**

Reserve component	Deployable	Nondeployable	Answer missing	Total	Percentage missing	Percentage nondeployable
Army Reserve	67,747	6,907	4,181	78,835	5.3%	9.3%
Army National Guard	108,237	7,891	4,536	120,664	3.8%	6.8%
Naval Reserve	4,704	63	1,019	5,786	17.6%	1.3%
Air Force Reserve	8,243	98	1,639	9,980	16.4%	1.2%
Marine Corps Reserve	1,752	18	334	2,104	15.9%	1.0%
Air National Guard	19,630	140	2,455	22,225	11.0%	0.7%
<b>Total</b>	<b>210,313</b>	<b>15,117</b>	<b>14,164</b>	<b>239,594</b>	<b>5.9%</b>	<b>6.7%</b>

Source: GAO analysis of AMSA data.

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For the remaining records with the deployability status recorded, 93 percent of the servicemembers were deployable. Nondeployable rates ranged from less than 1 percent in the Air National Guard to more than 9 percent in the Army Reserve. Other data showed that most of the nondeployable personnel had medical conditions that clearly made them nondeployable, and which did not require medical referrals. According to medical officials, some of these 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 them nondeployable at the time of their assessment.

Detailed referral information could assist the services in determining and addressing the factors that cause reserve component members to be nondeployable; however, these data were often missing in AMSA's database. About 99 percent of the pre- and post-deployment assessments we reviewed showed whether or not reserve component members had been given a medical referral, but less than 44 percent of the records with referrals contained detailed information about the type of referral that was given to the member (eye, ear, cardiac, mental health, etc.).

One reason for the incomplete health assessment records we found at AMSA at the time of our data draw in March 2004 is that some of the health assessments were entered into AMSA's database by hand. According to the officer in charge of AMSA, records in the database with detailed referral data had been submitted electronically rather than as paper copies, which the installations are required to forward to the centralized database. Generally, electronic data are sent to AMSA after being collected in one of two different ways: (1) from applications that are available at Army installations and over the Internet and (2) on stand-alone laptop computers and hand-held personal digital assistant units, which collect data in the theater and elsewhere. All electronic data are transmitted to AMSA and updated immediately upon receipt. Because of workload demands, when paper forms were received at AMSA, database personnel captured only a data element indicating if a referral was needed, not the specific type of referral indicated.<sup>37</sup> In addition, when there was a backlog of four page paper post-deployment health assessments to be

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<sup>37</sup> After summary data from the forms are entered into the database, AMSA scans an image of the complete health assessment forms, and additional data from the form can be entered into the database at a later date. Individual health assessments in the database can sometimes be linked to other detailed health records.

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entered into the database, data entry personnel were entering only the first and last pages of the form and not the middle two pages. Because of this, at various times the data that have been collected from servicemembers may not be available for analysis. However, as of June 2004, the officer in charge of AMSA said that AMSA had no backlog of paper forms to be entered into the centralized database and had 15 people working full-time to process pre- and post-deployment health assessment forms. Furthermore, he estimated that by the end of July 2004, they would be caught up with the entries of the middle pages of the post-deployment health assessments that had been skipped earlier. Still, there is a delay between receipt of the form and its entry into the database. The AMSA Chief said the paper forms take approximately 1 week for processing, scanning, and entering data.

All of the reserve components have the capability to submit the health assessments electronically, including detailed medical referral information. Many Army and Air Force servicemember health assessments are now transmitted electronically, and detailed information is captured into the database from those forms. The Army has been sending electronic health assessment data for active and reserve servicemembers to AMSA since July 2003. Although the Army is capable of transmitting all of its forms electronically, only about 52 percent of its forms submitted from January 1, 2003, to May 3, 2004, had been submitted electronically. The Air Force began sending electronic data to AMSA in June 2004. The Navy and Marine Corps have established a working group that is currently evaluating several options and developing an implementation plan.

DOD established a deployment health task force to make recommendations by late April 2004 on completing all pre- and post-deployment health assessments electronically. However, the Deployment Health Task Force is continuing its work to expedite and monitor progress toward the electronic capture of deployment health assessment forms. Even though electronic submission of the health assessment forms from the mobilization and demobilization sites to AMSA's centralized database would expedite the inclusion of key data for meaningful analysis, increase accuracy of the reported information, and lessen the burden of sites forwarding paper copies and the likelihood of lost information, DOD has not set a timeline for the services to electronically submit the health assessment forms to the centralized database.

Available Data Show Reserve Component Members Self-Reported Health Is Good

Table 4 shows that 98 percent of the reserve component members reported that they were in good to excellent health when they completed their pre-deployment health assessments. The Army Reserve had the

lowest number—97 percent—of servicemembers considering themselves in good to excellent health.<sup>38</sup>

**Table 4: Pre-Deployment Overall Health Status and Medical Referrals**

Reserve component	Overall health status		Medical referrals
	Good or excellent	Fair or poor	
Marine Corps Reserve	99%	1%	3%
Naval Reserve	99%	1%	4%
Air National Guard	99%	1%	1%
Air Force Reserve	99%	1%	2%
Army National Guard	98%	2%	5%
Army Reserve	97%	3%	6%
<b>Total</b>	<b>98%</b>	<b>2%</b>	<b>5%</b>

Source: GAO analysis of AMSA data.

Table 4 also shows that the total referral rate that resulted from the pre-deployment health assessments was 5 percent but ranged from 1 percent for the Air National Guard to 6 percent for the Army Reserve.

Table 5 shows that even after deployment, a high percentage of reserve component members thought they were in good to excellent health. However, a comparison of table 4 with table 5 shows that numbers had generally declined from pre-deployment levels. In particular, the percentage of personnel who rated their health as good to excellent declined from 98 percent to 93 percent. The Army Reserve had the lowest percentage of servicemembers who considered themselves in good to excellent health during their post-deployment assessments—89 percent—while the Air National Guard and Air Force Reserve had the highest percentage of servicemembers who considered themselves in good to excellent health after deployment—98 percent.

<sup>38</sup> The percentages do not necessarily mean that the servicemembers were in those categories when first mobilized. Because pre-deployment health assessments have to be completed within 30 days of deployment, thousands of reserve component members (primarily in the Army) who had long post-mobilization training periods completed two or more pre-deployment health assessments. Only the most recent pre-deployment health assessment is kept in the AMSA database.



**Table 5: Post-Deployment Overall Health Status and Medical Referrals**

Reserve component	Overall health status		Medical referrals
	Good or excellent	Fair or poor	
Marine Corps Reserve	90%	10%	24%
Naval Reserve	96%	4%	13%
Air National Guard	98%	2%	8%
Air Force Reserve	98%	2%	10%
Army National Guard	92%	8%	21%
Army Reserve	89%	11%	30%
<b>Total</b>	<b>93%</b>	<b>7%</b>	<b>21%</b>

Source: GAO analysis of AMSA data.

Moreover, the percentage of medical referrals jumped to 21 percent on the post-deployment health assessments. A comparison of tables 4 and 5 shows that the referral rate that resulted from post-deployment assessments was quadruple the 5 percent referral rate from pre-deployment assessments. There were also differences between the services, in that reserve component personnel from the Army and Marine Corps received higher referral rates, as would be expected for ground forces, than those in the Air Force and the Navy. The percentages ranged from 8 percent for the Air National Guard to 30 percent for the Army Reserve.

Table 6 shows that when reserve component members completed their post-deployment health assessments, almost half of them chose the same category to characterize their overall health as they had chosen on their pre-deployment health assessment. The table shows that almost 14 percent of the personnel who completed both pre- and post-deployment health surveys believed that their health had improved enough to warrant recharacterizations of their original assessments.

**Table 6: Comparison of Self-Reported Composite Health from Pre- and Post-Deployment Health Assessments**

Reserve component	Matching pre- and post-deployment health assessments	Health improved	Health stayed the same	Health declined
Marine Corps Reserve	871	9%	39%	52%
Naval Reserve	3,438	12%	52%	36%
Air National Guard	14,118	14%	58%	28%
Air Force Reserve	5,345	14%	57%	29%
Army National Guard	51,514	14%	46%	39%
Army Reserve	39,220	13%	44%	43%
<b>Total</b>	<b>114,506</b>	<b>14%</b>	<b>48%</b>	<b>39%</b>

Source: GAO analysis of AMSA data.

Note: DOD's health assessments ask servicemembers to categorize their general health into one of five categories: (1) excellent, (2) very good, (3) good, (4) fair, or (5) poor.

The table above also shows that 39 percent of the personnel who completed both the pre- and post-deployment health surveys reported that their health had declined between the assessments. Reserve component personnel from the Army and Marine Corps experienced larger declines than those of the Navy and Air Force.

### DOD Could Not Maintain Visibility over Reserve Component Personnel on Active Duty with Medical Issues

Some of the services could not maintain visibility over reserve component members with medical issues because they could not adequately track those personnel, which contributed to problems for those personnel. In the Army, the lack of tracking information for reserve component personnel with medical issues contributed to problems for those personnel. In the Army, the lack of visibility over reservists with medical issues resulted in housing and pay problems for some personnel. The Air Force has also lost visibility of some reservists with medical issues, which has resulted in lengthy periods of time without resolution to their medical issues.

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Reserve component personnel who have been involuntarily mobilized, along with members who are voluntarily serving on active duty, may experience medical problems for a variety of reasons. Some are injured during combat operations; others become injured or sick during the course of their training or routine duties; and others have problems that are identified during medical appointments, physicals, or health assessments and other medical screenings. Our review focused on reserve component members with medical problems that were expected to keep them from being returned to full duty or from being demobilized within 30 days. This group contained reserve component members with a wide variety of injuries and ailments. During our visits to mobilization and demobilization sites, we spoke with reserve component members who had suffered heart attacks or combat wounds, as well as to members with knee and ankle injuries, diabetes, chronic back pain, and mental health problems.

The services have used different policies and procedures to accommodate involuntarily mobilized reserve component personnel who have long-term medical problems. In some cases, the services have left the members on their original mobilization orders and then extended those orders as necessary. In other cases, the services have switched the members to voluntary orders or offered the members the option to leave active duty and have their medical conditions cared for through the Department of Veterans Affairs.<sup>39</sup>

## Army

The dramatic increase in the use of the reserve components has led to a dramatic increase in the numbers of reserve component members on active duty with medical problems. For example, our analysis of data from the more than 239,500 pre-deployment health assessments collected in the AMSA database from November 2001 through March 2004 showed that over 15,100 members, or almost 7 percent, were not deployable; almost 14,800 of these members came from the Army's reserve components.<sup>40</sup> Prior to a change in Army policy in October 2003, personnel who were mobilized and found to be non-deployable were kept on active duty until (1) their medical problems had been resolved and they were returned to full duty or (2) they had been referred to a medical board process and

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<sup>39</sup> DOD officials told us that very few members choose this option because they lose their active duty pay and some other benefits when they leave active duty.

<sup>40</sup> Over 14,100 records, or almost 6 percent, were missing information concerning the servicemembers' deployability status.

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discharged from the Army. (See appendix VIII for additional information on the services' medical evaluation boards.)

As a result of its October 2003 policy change, the Army was able to demobilize personnel who were found to be nondeployable within the first 25 days of their mobilizations. This policy change helped to reduce the inflow of reserve component personnel on active duty with medical problems who were identified during the pre-deployment health-screening process. However, the reserve component members who were already on active duty with medical problems that had been identified during the pre-deployment health-screening process were not demobilized when the policy changed. In addition, significant numbers of reserve component personnel continued to experience medical problems as a result of injuries or illnesses that occurred (1) after the members had been mobilized for 25 days and (2) as a result of problems that were identified during their post-deployment health assessments. As a result, on July 14, 2004, the Army still had over 4,000 reserve component personnel on active duty with medical problems.<sup>41</sup> Although Army officials said that the primary responsibility that these soldiers had was to go to their medical treatment so they could get well, many of the soldiers did not require daily medical treatment. As a result, these soldiers often do other work ranging from temporary details to maintain base facilities to longer-term jobs such as working at mobilization processing sites or working as mechanics in installation motor pools.

Initially, issues associated with the care of Army personnel with medical problems were usually dealt with at the Army installation where the servicemember was mobilized or demobilized and at nearby medical treatment facilities. As the numbers of reserve component personnel with medical problems increased, the Army found that it had difficulty maintaining visibility of such personnel, resulting in some housing, pay, and other problems for the personnel.

For example, at Fort Stewart, Georgia, reserve component soldiers with medical problems were being housed in open-bay, cinder block barracks that did not have heating or air conditioning. In addition, shower and bathroom facilities were in separate, nearby buildings. These facilities

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<sup>41</sup> The 4,000-plus personnel were in units that Army identifies as "medical hold" or "medical holdover," respectively, depending on whether the members are actually attached to a medical treatment facility or attached to an installation and are just receiving care at the medical treatment facility.

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normally housed National Guard personnel during their 2-week annual training periods. Following media attention to these conditions, the Under Secretary of Defense for Personnel and Readiness issued a memorandum that established housing standards for personnel with medical problems in October 2003. During our visit to Fort Stewart, in November 2003 we found that the soldiers with medical problems were being housed in accordance with the updated standards, which required climate-controlled quarters that included integrated bathroom facilities. The Army also created a servicewide medical-status tracking system during the summer of 2003. This system generates regular weekly reports on the numbers of reserve component members on active duty with medical problems, their locations, and the length of time that they have been receiving medical care.

Following up on allegations in 2003 that medical treatment was taking too long, and that soldiers were missing their scheduled medical appointments, investigators at Fort Stewart also found that case managers<sup>42</sup> were needed to track the care of the soldiers with medical problems and that a command structure was needed to manage the other needs and duties of these personnel. At the time of our visit, Fort Stewart had 15 case managers in place, and a new command and control structure had been set up to manage the soldiers with medical problems. However, officials told us that they still faced challenges with the management and care of these soldiers because the group was so large. On November 19, 2003, there were 661 reserve component members with medical problems at Fort Stewart; as of July 14, 2004, there were 349 members.

The lack of visibility and tracking also caused problems for members with medical problems at Fort Lewis, Washington. Army procedures called for reserve component members on involuntary mobilization orders to be switched over to voluntary active duty medical extension orders after a long-term medical problem had been identified. The administrative process for issuing these active duty medical extensions was cumbersome, and mechanisms were not in place to effectively track requests for these extensions, which had to be submitted from the units with servicemembers experiencing medical problems to a central office in the Pentagon. When we visited Fort Lewis in March 2004, we found that medical extension orders had expired for 19 of 84 personnel in the medical

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<sup>42</sup> The Army has been using nurses or administrative personnel who report to nurses to serve as case managers.

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hold unit. When a servicemember's orders expire, the member's pay stops and the member's dependents lose their health care coverage.<sup>43</sup> After our visit to Fort Lewis, the Army changed its policy concerning active duty medical extensions. On March 6, 2004, the Assistant Secretary of the Army for Manpower and Reserve Affairs issued a policy that provides installations with the ability to issue voluntary orders for up to 180 days for reserve component members with medical problems without going through the cumbersome active duty medical extension process. While the authority to issue these voluntary orders has been delegated to the installation level, the Army is still maintaining visibility over its reserve component personnel with medical problems because these personnel are assigned to units that must report their personnel numbers on a weekly basis.

## Air Force

In the Air Force, a lack of central visibility of some reserve component personnel with medical problems who are serving on active duty has resulted in delayed resolution to their medical problems. The Air Force does have central visibility over reserve component personnel with medical problems who remain on their original mobilization orders or receive extensions to those orders.<sup>44</sup> However, the Air Force also allows personnel with medical problems to switch over to voluntary orders.<sup>45</sup> These orders are issued by the Air Force's major commands. The Air Force can track the number of orders issued and the number of days covered by these orders, but it does not have a mechanism in place to track the numbers of personnel who have medical problems and are serving under these orders. As with many of the reserve component personnel in the Army's medical hold and holdover units, many of the air reserve component personnel with medical problems are still able to perform significant amounts of work while undergoing their medical treatment or medical discharge processing.

While the reservists experiencing medical problems who we interviewed did not identify any difficulties with their housing or their orders, they did identify problems with the amount of time it was taking to resolve their medical issues, much like the problems identified at Fort Stewart prior to

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<sup>43</sup> A number of GAO reports on pay problems are included in the list of related GAO products at the end of this report.

<sup>44</sup> On June 11, 2004, there were 219 personnel in these categories.

<sup>45</sup> The Air Force refers to these as military personnel appropriation (MPA) day orders.

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the deployment of case managers to that location. At one of the sites we visited, an Air Force reservist told us that he had been in a medical status on voluntary orders for 18 months and did not expect resolution of his case anytime soon. The extent to which such a problem is commonplace is unknown, given the inability of the Air Force to track such personnel.

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## Conclusions

As the Global War on Terrorism is entering its fourth year, DOD officials have made it clear that they do not expect the war to end anytime soon. Furthermore, indications exist that certain components and occupational specialties are being stressed and the long-term impact of this stress on recruiting and retention is unknown. Moreover, although DOD has a number of rebalancing efforts under way, these efforts will take years to implement. Because this war is expected to last a long time and requires far greater reserve component personnel resources than any of the smaller operations of the previous two decades, DOD can no longer afford policies that are developed piecemeal to maximize short-term benefits and must have an integrated set of policies that address both the long-term requirements for reserve component forces and individual reserve component members' needs for predictability.

For example, service rotation policies are directly tied to other personnel policies such as policies concerning the use of the IRR, and the extent of cross training. Policies to fully utilize the IRR would increase the pool of available servicemembers and would thus decrease the length of time each member would need to be deployed based on a static requirement. Policies that encourage the use of cross-training for lesser-utilized units could also increase the pool of available servicemembers and decrease the length of rotations. Until DOD addresses its personnel policies within the context of an overall strategic framework, it will not have clear visibility over the forces that are available to meet future requirements. In addition, it will be unable to provide reserve component members with clear expectations of their military obligations and the increased predictability, which DOD has recognized as a key factor in retaining reserve component members who are seeking to successfully balance their military commitments with family and civilian employment obligations.

The Army's mobilization and demobilization plans contained outdated assumptions about the location of active duty forces during reserve mobilizations and demobilizations. As a result, facilities were not always available to equitably support active and reserve component forces that were collocated on bases that serve as mobilization and demobilization sites. Until the Army updates the assumptions in its mobilization and

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demobilization plans and therefore recognizes that active and reserve component forces are likely to need simultaneous support at Army installations within the United States, it may not be able to adequately address the support needs of both its active and reserve component forces. The Army has a number of uncoordinated efforts under way to correct the facility infrastructure shortage that has developed. However, these projects are being conducted without considering the long-term requirements and associated costs. In addition, when the Army created medical, training, logistics, and administrative support units that relied heavily on reserve component members, it did not anticipate that it would have to support long-term mobilization requirements for a Global War on Terrorism under a partial mobilization authority. As a result, the reserve component force cannot continue to support mobilizations as DOD currently implements the partial mobilization authority and the Army is now planning to rely on civilians and contractors. However, the Army has not determined the costs and availability of these civilian and contractor personnel. Until the Army makes these determinations, it cannot plan to conduct future mobilizations and demobilizations in the most efficient manner.

DOD's ability to effectively manage the health status of reserve component members has been hampered by a lack of complete information and the inability to track servicemembers with health issues. For example, the AMSA database does not contain a large number of health assessment records for the Marine Corps and lacks complete information from some of the health assessment records that were submitted to the database in a nonelectronic format. Consequently, the deployability status and related health problems of some reserve component members were not discoverable. Until the Marine Corps addresses its data submission problems with updated guidance and a mechanism to oversee the submission of health assessments to the centralized database and until DOD establishes a timeline for the military departments to submit health assessments electronically, DOD and the services will continue to face difficulties in determining and addressing the factors that cause reserve component members to be nondeployable. Moreover, until the Air Force develops a mechanism to track its reserve component members who are on voluntary active duty orders with health problems, it cannot determine whether these personnel are having their health problems addressed in a timely manner. Furthermore, the treatment of the nation's reserve component members who have served their country and experienced medical problems while on active duty is an important issue for DOD to address. Until DOD gains visibility over the status of all of its reserve component personnel on active duty with medical problems, it cannot



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effectively oversee their situations and deploy, demobilize, or discharge them.

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## Recommendations for Executive Action

We recommend that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness, in concert with the service secretaries and Joint Staff, to take the following two actions:

- develop a strategic framework that sets human capital goals concerning the availability of its reserve component forces to meet the longer-term requirements of the Global War on Terrorism under various mobilization authorities and
- identify personnel policies that should be linked within the context of the strategic framework.

We recommend that the Secretary of Defense direct the Secretary of the Army to take, within the context of establishing DOD's strategic framework for force availability, the following two actions:

- update mobilization and demobilization planning assumptions to reflect the new operating environment for the Global War on Terrorism—long-term requirements for mobilization and demobilization support facilities and personnel and the likelihood that active forces will continue to rotate through U.S. bases while reserve component forces are mobilizing and demobilizing and
- develop a coordinated approach to evaluate all the support costs associated with mobilization and demobilization at alternative sites—including both facility (construction, renovation, and maintenance) and support personnel (reserve component, civilian, contractor, or a combination) costs—to determine the most efficient options; and then update the list of primary and secondary mobilization and demobilization sites as necessary.

We also recommend that the Secretary of Defense take the following four actions:

- direct the Commandant of the Marine Corps to issue updated mobilization guidance that specifically lists the requirement to submit pre-deployment health assessments to AMSA,
- direct the Commandant of the Marine Corps to establish a mechanism for overseeing submission of pre- and post-deployment assessments to the centralized database,
- direct the Under Secretary of Defense for Personnel and Readiness, in concert with the service secretaries, to set a timeline for the military

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departments to electronically submit pre-and post-deployment health assessments,

- direct the Secretary of the Air Force to develop a mechanism for tracking reserve component members who are on voluntary active duty orders with medical problems.

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## Agency Comments and Our Evaluation

In written comments on a draft of this report, DOD generally concurred with our recommendations. The Department specifically concurred with our recommendations to (1) update Army mobilization and demobilization planning assumptions to reflect the new operating environment for the Global War on Terrorism; (2) develop a coordinated approach to evaluate all the support costs associated with Army mobilizations and demobilizations at alternative sites—including both facility and support personnel costs—to determine the most efficient options, and then update the list of primary and secondary mobilization and demobilization sites as necessary; (3) issue updated Marine Corps mobilization guidance that specifically lists the requirement to submit pre-deployment health assessments to AMSA; (4) set a timeline for the military departments to electronically submit pre- and post-deployment health assessments; and (5) develop a mechanism for tracking Air Force reserve component members who are on voluntary active duty orders with medical problems.

DOD partially concurred with our other three recommendations. In partially concurring with our recommendation concerning the development of a strategic framework, DOD stated that it has a strategic framework for setting human capital goals, which was established through its December 2002 comprehensive review of active and reserve force mix, its January 2004 force rebalancing report, and other planning and budgeting guidance. However, DOD agreed that it should review and, as appropriate, update its strategic framework. Although the documents cited by DOD lay some of the groundwork needed to develop a strategic framework, these documents do not specifically address how DOD will integrate and align its personnel policies, such as its stop-loss and IRR policies, to maximize its efficient usage of reserve component personnel to meet its overall organizational goals.

In partially concurring with our recommendation to identify personnel policies that should be linked within the context of a strategic framework, DOD stated that its September 20, 2001, personnel and pay policy and its July 19, 2002, addendum established personnel policies associated with its strategic framework. DOD also stated that the department should review, and as appropriate, update these policies. We agree that the Office of the

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Secretary of Defense has issued personnel policies and various guidance and reports concerning its reserve components. However, the policies cited by DOD pre-date the 2002 comprehensive review and 2004 force rebalancing report that were cited as part of the department's strategic framework. The strategic framework should be established prior to the creation of personnel policies. We continue to believe that DOD's policies were implemented in a piecemeal manner and focused on short-term needs. For example, our report details service changes to policies concerning the use of the IRR, mobilization lengths, deployment lengths, and service obligations.

In partially concurring with our recommendation concerning oversight of the Marine Corps' pre- and post-deployment health assessments, DOD stated that system improvements are ongoing and that electronic submission of pre- and post-deployment health assessments is possible and highly desirable but may not be practical for every Marine Corps deployment. However, our recommendation was directed at oversight of health assessments regardless of how the assessments are submitted—in paper or electronic form. We continue to believe that the Marine Corps needs to establish a mechanism for overseeing the submission of its pre- and post-deployment health assessments. The other services have established such mechanisms as part of their quality assurance programs.

Finally, in commenting on a draft of this report, DOD stated that after reviewing its implementation of the partial mobilization authority, it decided to retain its "24-cumulative month" policy. DOD noted that it had identified significant problems with changing to a 24-consecutive-month approach but did not elaborate on those problems. The final decision concerning the implementation of the partial mobilization authority was not made until after our review ended, and the decision was counter to the decision expected by senior personnel we met with during the course of our review. As noted in our report, with a 24-cumulative-month interpretation of the partial mobilization authority, DOD risks running out of forces available for deployment, at least in the short term. Regardless of DOD's interpretation of the partial mobilization authority, the department needs to have a strategic framework to maximize the availability of its reserve component forces. For example, usage of the more than 250,000 IRR members can affect rotation policies because the use of these reservists would increase the size of the pool from which to draw mobilized reservists. Therefore, without a strategic framework setting human capital goals, how DOD will continue to meet its large requirements for the Global War on Terrorism remains to be seen. We

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have modified our report to recognize the decision that DOD made regarding its implementation of the partial mobilization authority.

DOD's comments on our recommendations are included in this report in appendix IX. DOD also provided other relevant comments on portions of the draft report and technical comments, which we incorporated as appropriate.

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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 have any questions concerning this report, please contact me at (202) 512-5559 or [stewartd@gao.gov](mailto:stewartd@gao.gov) or Brenda S. Farrell, Assistant Director, at (202) 512-3604 or [farrellb@gao.gov](mailto:farrellb@gao.gov). Others making significant contributions to this report are included in appendix X.



Derek B. Stewart  
Director, Defense Capabilities and Management

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# Appendix I: Scope and Methodology

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To determine how the Department of Defense's (DOD) implementation of the partial mobilization authority and its personnel policies affect reserve component force availability, we reviewed and analyzed the mobilization authorities that are available under current law, along with personnel policies from the services and Office of the Secretary of Defense. We also collected and analyzed data on DOD's historical usage of the reserve components and its usage of these forces since September 11, 2001. We analyzed usage trends since the 1991 Persian Gulf War and compared usage rates across services, reserve components, and occupational specialties. We also reviewed DOD documents that addressed the projected future use of reserve component forces and plans to mitigate the high usage of forces within certain occupational specialties. We analyzed the structure of the reserve component forces and evaluated the effects of utilizing or excluding members of the Individual Ready Reserve from involuntary call-ups. We discussed the implementation of mobilization authorities and the effects of various personnel policies with responsible officials from the

- Joint Chiefs of Staff, Washington, D.C.;
- Assistant Secretary of Defense for Reserve Affairs, Washington, D.C.;
- Assistant Secretary of the Army for Manpower and Reserve Affairs, Washington, D.C.;
- U.S. Army Forces Command, Fort McPherson, Georgia;
- Air Force Reserve Command, Robins Air Force Base, Georgia;
- Commandant, Marine Corps (Manpower, Plans, and Policy), Quantico Marine Corps Base, Virginia; and
- U.S. Army Reserve Command, Fort McPherson, Georgia.

During our visits to mobilization and demobilization sites, we also interviewed reserve component members concerning the length of their mobilizations, deployments, and service commitments.

To determine how efficiently the Army executed its mobilization and demobilization plans, we interviewed senior and key mobilization officials involved with the mobilization and demobilization processes to document their roles and responsibilities and collect data about the processes. We visited selected sites where the Army conducts mobilization and demobilization processing. At those sites, we observed mobilization and demobilization processing and interviewed responsible Army officials as well as soldiers being processed for mobilization and demobilization at those sites. We collected and analyzed cost data for facility renovation and construction projects. We also collected and analyzed available cost information on the contracts to replace reserve component members with

civilian and contractor personnel. Finally, we documented problems that the installations had tracking the arrival of mobilizing and demobilizing troops through their automated systems. We visited five mobilization and demobilization sites. These sites included four installations that supported both active and reserve component troops and one site that supported only reserve component troops. Four of the sites were among the largest in terms of the numbers of reserve component members mobilized and demobilized. One was among the smallest. Specifically we visited the following sites:

- Fort Stewart, Georgia;
- Fort Hood, Texas;
- Fort McCoy, Wisconsin;
- Fort Lewis, Washington; and
- Fort McPherson, Georgia.

We also interviewed Army officials from the following locations:

- U.S. Army Forces Command, Fort McPherson, Georgia;
- First U.S. Army, Fort Gillem, Georgia;
- Fifth U.S. Army, Fort Sam Houston, Texas;
- Army Installation Management Activity, Arlington, Virginia; and
- Army Contracting Agency, Fort McPherson, Georgia.

As requested, we also visited sites where the other services conducted mobilization and demobilization processing, but we did not report on the efficiency of the other services' processes because the numbers of reserve component members who were mobilizing and demobilizing through these sites were insufficient for us to draw any conclusions about the services' processes. Specifically, we interviewed responsible officials and observed ongoing mobilizations and demobilizations at the following sites:

- Quantico Marine Corps Base, Virginia;
- Camp Lejeune Marine Corps Base, North Carolina;
- Dobbins Air Reserve Base, Georgia;
- Dover Air Force Base, Delaware; and
- Navy Mobilization Processing Site Norfolk, Virginia.

At some of the demobilization locations, we observed reservists receiving medical, legal, and family support briefings, and interviewed some individuals who had been demobilized, including some on medical extensions. We also walked through and compared facilities used to house active and reserve component personnel, specifically focusing on the

facilities used to house personnel with medical problems. We interviewed appropriate officials about facility capacities, and gathered and analyzed information about facility renovations and new construction projects. We obtained and reviewed additional documentation such as mobilization orders, activation checklists, and demobilization processing checklists. We also collected and analyzed reserve component mobilization data, flowcharts, reports, plans, directives, manuals, instructions, and administrative guidance. We reviewed relevant GAO reports and contacted other audit and research organizations regarding their work in the area. We reviewed congressional testimony by Navy officials in which they described steps planned by the Navy to improve its demobilization process, and we followed up on the status of those planned steps with officials at the Navy Mobilization Processing Site Norfolk, Virginia.

To examine the extent to which DOD can effectively manage the health status of its mobilized reserve component members, we collected and analyzed data from a variety of sources throughout DOD. We tracked weekly data from the Office of the Assistant Secretary of Defense for Reserve Affairs (OASD/RA), which showed the numbers of Army, Navy, Air Force, and Marine Corps personnel on medical extensions, and the numbers of Army personnel in medical statuses. We also collected, tracked, and analyzed data from the Army's Office of the Surgeon General. These data showed the numbers of reserve component personnel in medical statuses by installation and by time spent in a medical status. We also reviewed the Army's projected medical status numbers, the Army's plans to mitigate future problems, and reports on the lessons that were learned from the medical-related problems that occurred at Fort Stewart during 2003. We also obtained and analyzed information from the Office of the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness, Deployment Health Support Directorate. We collected and reviewed the services' medical instructions, memoranda, and policies. In addition, we interviewed personnel responsible for the processing, reviewing, and collection of the deployment health assessments at the mobilization and demobilization sites visited. We compared information about the services' medical and physical evaluation board processes. We discussed these medical issues with responsible officials from

- Office of the Assistant Secretary of Defense for Reserve Affairs, Washington, D.C.;
- U.S. Army Medical Department, Army Medical Command, Washington, D.C.;
- U.S. Army Forces Command, Fort McPherson, Georgia;
- First U.S. Army, Fort Gillem, Georgia;

- Fifth U.S. Army, Fort Sam Houston, Texas;
- U.S. Army Medical Command, Fort Sam Houston, Texas;
- Walter Reed Army Medical Center, Washington, D.C.;
- Winn Army Community Hospital, Fort Stewart, Georgia;
- Darnall Army Community Hospital, Fort Hood, Texas;
- Madigan Army Medical Center, Fort Lewis, Washington;
- Fort McCoy, Wisconsin;
- Quantico Marine Corps Base, Virginia;
- Camp Lejeune Marine Corps Base, North Carolina;
- Navy Mobilization Processing Site, Norfolk, Virginia;
- Headquarters, United States Air Force Military Policy Division, Washington, D.C.;
- Air National Guard, Washington, D.C.;
- Air Force Medical Operations Agency, Washington, D.C.; and
- Dobbins Air Reserve Base, Georgia.

We also interviewed reserve component members who were in medical status at the mobilization and demobilization sites visited. We interviewed hospital commanders and their staff, case managers, medical liaison officers, and officials from the services' Surgeons General Offices.

We interviewed the Chief of the Army Medical Surveillance Activity (AMSA). We discussed the information in the consolidated health assessment database and obtained selected data from all the reserve component member pre- and post-deployment health assessments that were completed from October 25, 2001—when assessments became mandatory for all mobilized reserve component members through March 2004. The data we obtained contained health assessment records for 290,641 reserve component members. For 122,603 members, we obtained only pre-deployment health assessments, for 51,047 members we obtained only post-deployment health assessments, and for 116,991 members we obtained both pre- and post-deployment health assessments. We analyzed the data that we obtained to determine referral, deployability, and exposure rates. We also analyzed data on the self-reported general health of the reserve component members and compared the data from pre-deployment assessments with the data from post-deployment assessments. We also analyzed the month-by-month flow of forms to the AMSA to see if the services had been submitting the forms as required. We compared elapsed times between pre- and post-deployment assessments. We conducted cross tabulations of the data to identify relationships between various variables such as the overall health status, deployability, and referral variables. All of our analyses compared data across the reserve components to look for differences or trends.



We assessed the reliability of reserve component mobilization, demobilization, and general usage data supplied by OASD/RA by (1) reviewing existing information about the data and the systems that produced them and (2) interviewing agency officials knowledgeable about the data. We also compared the data with data supplied to us by the services. Our assessment of the AMSA data was even more rigorous and included the electronic testing of relevant data elements, and discussions with knowledgeable officials about not only the procedures for collecting the data but also the procedures for coding the data. As a result of our assessments, we determined that the data were sufficiently reliable for the purposes of this report.

We conducted our review from November 2003 through July 2004 in accordance with generally accepted government auditing standards.

# Appendix II: National Guard and Reserve End Strength Figures

Tables 7 and 8 show information about the Ready Reserve and its subcategories. Table 7 shows that the strength of the Ready Reserve has declined steadily from fiscal year 1993 to fiscal year 2003, but the strength of the Selected Reserve remained fairly steady from fiscal year 1998 to fiscal year 2003 after declining by more than 170,000 personnel from fiscal year 1993 to fiscal year 1998. The Selected Reserve is the portion of the Ready Reserve that participates in regular training. Table 8 shows the relative sizes of the reserve components at the end of fiscal year 2003. The Army's reserve components are larger than those of the other services and are expected to remain so for the foreseeable future.

**Table 7: Changes in Reserve Category End Strengths**

Category	Fiscal year										
	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Ready Reserve	1,840,650	1,779,436	1,633,497	1,522,451	1,437,722	1,340,557	1,276,190	1,238,715	1,211,264	1,186,388	1,154,140
Selected Reserve	1,057,676	998,330	945,852	920,371	902,216	881,491	870,917	865,242	867,422	874,326	875,072
Individual Ready Reserve	776,080	774,336	681,203	596,788	530,777	454,352	398,525	370,858	336,610	305,922	274,199
Inactive National Guard	6,894	6,770	6,442	5,292	4,729	4,714	4,590	4,212	4,049	3,142	2,138

Source: Defense Manpower Data Center data.

**Table 8: Fiscal Year 2003 End Strengths for Each of DOD's Six Reserve Components**

	Army National Guard	Army Reserve	Naval Reserve	Marine Corps Reserve	Air National Guard	Air Force Reserve	Department of Defense Total
Ready Reserve	353,227	329,295	152,855	98,868	108,137	111,758	<b>1,154,140</b>
Selected Reserve	351,089	211,890	88,156	41,046	108,137	74,754	<b>875,072</b>
Individual Ready Reserve		117,405	61,968	57,822		37,004	<b>274,199</b>
Inactive National Guard	2,138						<b>2,138</b>

Source: Defense Manpower Data Center data.

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# Appendix III: Service Mobilization and Demobilization Installations

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## Army

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### Power Projection Platforms

Fort Carson, Colorado.  
Fort Benning, Georgia.  
Fort Stewart, Georgia.  
Fort Riley, Kansas.  
Fort Campbell, Kentucky.  
Fort Polk, Louisiana.  
Fort Bragg, North Carolina.  
Fort Dix, New Jersey.  
Fort Drum, New York.  
Fort Sill, Oklahoma.  
Fort Bliss, Texas.  
Fort Hood, Texas.  
Fort Eustis, Virginia.  
Fort Lewis, Washington.  
Fort McCoy, Wisconsin.

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### Power Support Platforms

Fort Rucker, Alabama.  
Fort Huachuca, Arizona.  
Camp Roberts, California.  
Gowen Field, Idaho.  
Camp Atterbury, Indiana.  
Fort Knox, Kentucky.  
Aberdeen Proving Ground, Maryland.  
Camp Shelby, Mississippi.  
Fort Leonard Wood, Missouri.  
Fort Buchanan, Puerto Rico.  
Fort Jackson, South Carolina.  
Fort Lee, Virginia.

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## Navy

Navy Mobilization Processing Site New London, Connecticut.  
Navy Mobilization Processing Site Seattle, Washington.  
Navy Mobilization Processing Site Gulfport, Mississippi.  
Navy Mobilization Processing Site Jacksonville, Florida.  
Navy Mobilization Processing Site Norfolk, Virginia.  
Navy Mobilization Processing Site Pensacola, Florida.  
Navy Mobilization Processing Site Port Hueneme, California.  
Navy Mobilization Processing Site Washington, D.C.  
Navy Mobilization Processing Site Memphis, Tennessee.  
Navy Mobilization Processing Site London, United Kingdom.  
Navy Mobilization Processing Site Pearl Harbor, Hawaii.

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Navy Mobilization Processing Site San Diego, California.  
Navy Mobilization Processing Site Great Lakes, Illinois.  
Navy Mobilization Processing Site Camp Lejeune, North Carolina.  
Navy Mobilization Processing Site Camp Pendleton, California.

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## Marine Corps

Camp Pendleton, California (Used to mobilize and demobilize units and individuals for worldwide usage).

Camp Lejeune, North Carolina (Used to mobilize and demobilize units and individuals for worldwide usage).

Marine Corps Base Quantico, Virginia (Primarily used to mobilize and demobilize individual reservists for duty in the Washington, D.C. Metro area).

Marine Corps Air Station Miramar, California.<sup>1</sup>

Marine Corps Air Station Cherry Point, North Carolina.

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## Air Force

### United States Air Force Reserve Sites

Maxwell Air Force Base, Alabama.  
Little Rock Air Force Base, Arkansas.  
Davis-Monthan Air Force Base, Arizona.  
Luke Air Force Base, Arizona.  
Beale Air Force Base, California.  
March Air Reserve Base, California.  
Travis Air Force Base, California.  
Vandenberg Air Force Base, California.  
Peterson Air Force Base, Colorado.  
Schriever Air Force Base, Colorado.  
Dover Air Force Base, Delaware.  
Eglin Air Force Base, Florida.  
Homestead Air Reserve Base, Florida.  
MacDill Air Force Base, Florida.

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<sup>1</sup> Marine Corps Air Station Miramar, California, and Marine Corps Air Station Cherry Point, North Carolina, were both used as mobilization sites after September 11, 2001, but they were not being used when we visited Camp Lejeune and Quantico in the spring of 2004.

Patrick Air Force Base, Florida.  
Dobbins Air Reserve Base, Georgia.  
Robins Air Force Base, Georgia.  
Andersen Air Force Base, Guam.  
Scott Air Force Base, Illinois.  
Grissom Air Reserve Base, Indiana.  
McConnell Air Force Base, Kansas.  
Barksdale Air Force Base, Louisiana.  
New Orleans Air Reserve Station, Louisiana.  
Hanscom Air Force Base, Massachusetts.  
Westover Air Reserve Base, Massachusetts.  
Andrews Air Force Base, Maryland.  
Selfridge Air National Guard Base, Michigan.  
Minneapolis-Saint Paul International Airport Air Reserve Station,  
Minnesota.  
Whiteman Air Force Base, Missouri.  
Columbus Air Force Base, Mississippi.  
Keesler Air Force Base, Mississippi.  
Pope Air Force Base, North Carolina.  
Seymour Johnson Air Force Base, North Carolina.  
Offutt Air Force Base, Nebraska.  
McGuire Air Force Base, New Jersey.  
Kirtland Air Force Base, New Mexico.  
Fort Hamilton, New York.  
Niagara Falls International Airport Air Reserve Station, New York.  
Wright Patterson Air Force Base, Ohio.  
Youngstown Air Reserve Station, Ohio.  
Tinker Air Force Base, Oklahoma.  
Portland International Airport, Oregon.  
Pittsburgh International Airport Air Reserve Station, Pennsylvania.  
Willow Grove Air Reserve Station, Pennsylvania.  
Charleston Air Force Base, South Carolina.  
Shaw Air Force Base, South Carolina.  
Brooks Air Force Base, Texas.  
Fort Worth Naval Air Station Joint Reserve Base, Texas.  
Lackland Air Force Base, Texas.  
Laughlin Air Force Base, Texas.  
Randolph Air Force Base, Texas.  
Hill Air Force Base, Utah.  
Langley Air Force Base, Virginia.  
Norfolk Naval Air Station, Virginia.  
Fairchild Air Force Base, Washington.

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McChord Air Force Base, Washington.  
General Mitchell Air Reserve Base, Wisconsin.

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Air National Guard Sites

Eielson Air Force Base, Alaska.  
Kulis Air National Guard Base, Alaska.  
Birmingham International Airport, Alabama.  
Montgomery Regional Airport, Alabama.  
Fort Smith Regional Airport, Arkansas.  
Little Rock Air Force Base, Arkansas.  
Phoenix Sky Harbor International Airport, Arizona.  
Tucson International Airport, Arizona.  
Channel Islands Air National Guard Station, California.  
Fresno Air Terminal, California.  
March Air Reserve Base, California.  
Moffett Federal Airfield, California.  
Buckley Air Force Base, Colorado.  
Bradley Air National Guard Base, Connecticut.  
New Castle County Airport, Delaware.  
Jacksonville International Airport, Florida.  
Robins Air Force Base, Georgia.  
Savannah International Airport, Georgia.  
Andersen Air Force Base, Guam.  
Hickam Air Force Base, Hawaii.  
Des Moines International Airport, Iowa.  
Sioux City Airport, Iowa.  
Gowen Field, Idaho.  
Greater Peoria Airport, Illinois.  
Scott Air Force Base, Illinois.  
Springfield Capital Airport, Illinois.  
Fort Wayne International Airport, Indiana.  
Terre Haute International Airport, Indiana.  
Forbes Field, Kansas.  
McConnel Air Force Base, Kansas.  
Standiford Field, Kentucky.  
New Orleans Naval Air Station, Louisiana.  
Barnes Air National Guard Base, Massachusetts.  
Otis Air National Guard Base, Massachusetts.  
Andrews Air Force Base, Maryland.  
Martin State Airport, Maryland.  
Bangor International Airport, Maine.  
Selfridge Air National Guard Base, Michigan.  
W.K. Kellogg Airport, Michigan.

Duluth Air National Guard International Airport, Minnesota.  
Minneapolis-Saint Paul International Airport, Minnesota.  
Lambert-Saint Louis International Airport, Missouri.  
Rosecrans Memorial Airport, Missouri.  
Jackson International Airport, Mississippi.  
Key Field, Mississippi.  
Great Falls International Airport, Montana.  
Charlotte-Douglas International Airport, North Carolina.  
Hector International Airport, North Dakota.  
Lincoln Municipal Airport, Nebraska.  
Pease Air National Guard Base, New Hampshire.  
Atlantic City Municipal Airport, New Jersey.  
McGuire Air Force Base, New Jersey.  
Kirtland Air Force Base, New Mexico.  
Reno Cannon International Airport, Nevada.  
F.S. Gabreski Airport, New York.  
Hancock Field, New York.  
Niagara Falls International Airport, New York.  
Stewart Air National Guard Base, New York.  
Stratton Air National Guard Base, New York.  
Mansfield Lahm Airport, Ohio.  
Rickenbacker Air National Guard Base, Ohio.  
Springfield-Beckley Municipal Airport, Ohio.  
Toledo Express Airport, Ohio.  
Tulsa International Airport, Oklahoma.  
Will Rogers Air National Guard Base, Oklahoma.  
Klamath Falls International Airport, Oregon.  
Portland International Airport, Oregon.  
Harrisburg International Airport, Pennsylvania.  
Pittsburgh International Airport, Pennsylvania.  
Willow Grove Air Reserve Station, Pennsylvania.  
Luis Munoz Marin International Airport, Puerto Rico.  
Quonset State Airport, Rhode Island.  
McEntire Air National Guard Station, South Carolina.  
Joe Foss Field, South Dakota.  
McGhee Tyson Air National Guard Base, Tennessee.  
Memphis International Airport, Tennessee.  
Nashville International Airport, Tennessee.  
Ellington Field, Texas.  
Fort Worth Naval Air Station Joint Reserve Base, Texas.  
Kelly Air Force Base, Texas.  
Salt Lake City International Airport, Utah.  
Richmond International Airport, Virginia.  
Burlington International Airport, Vermont.

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**Appendix III: Service Mobilization and  
Demobilization Installations**

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Camp Murray, Washington.  
Fairchild Air Force Base, Washington.  
General B. Mitchell Air National Guard Base, Wisconsin.  
Truax Field, Wisconsin.  
Eastern West Virginia Regional Airport, West Virginia.  
Yeager Air National Guard Airport, West Virginia.  
Cheyenne Air National Guard, Wyoming.




# Appendix IV: Differences between Demobilization and Periodic Physicals for Reserve Component Members

**Table 9: Physical Requirements**


	Demobilization physical requirements	Periodic physical Requirements	Frequency
<b>Army</b>	<p>Screenings for all soldiers; referrals and treatment are based on screening.</p> <p>Limited physical examination at the request of the soldier; includes</p> <ul style="list-style-type: none"> <li>height, weight, blood pressure, pulse, and temperature;</li> <li>“hands on” clinical evaluation of head, face, scalp, nose, sinuses, mouth, throat, ears, eyes, heart, lungs, vascular system, abdomen, extremities, feet, spine, skin, neurologic exam, and breast/testicular exam; and</li> <li>focused laboratory work based on specific problems or physical findings.</li> </ul>	<p>Examination includes</p> <ul style="list-style-type: none"> <li>height, weight, blood pressure, pulse, temperature, vision, and hearing;</li> <li>clinical evaluation of head, face, scalp, nose, sinuses, mouth, throat, ears, eyes, heart, lungs, vascular system, abdomen, extremities, feet, spine, skin, neurologic exam, breast exam/testicular exam, neck, and anus;</li> <li>lab work includes urinalysis, HIV, and cholesterol testing;</li> </ul> <p>Age 40 and over exam includes prostate exam, rectal exam with stool, urine-specific tests (gravity and microscopic), test for intraocular pressure, and fasting blood sugar and fasting lipid profile.</p>	<p>Annual health screenings.</p> <p>Physical every 5 years beginning at age 30 and annually at age 60.</p> <p>Requirements and frequency vary on the basis of occupational specialty.</p>
<b>Air Force</b>	<p>All reservists get an assessment by a medical technician and are referred to a provider if needed.</p> <p>All members returning from austere locations see medical providers regardless of their physical condition.</p>	Same as the Army.	<p>Annual health assessment.</p> <p>Requirements and frequency vary on the basis of occupational specialty.</p>
<b>Navy/Marine Corps</b>	<p>Screenings for all sailors and Marines; physical examinations and specialty referrals are given as indicated on a patient-directed, symptom-driven basis.</p> <p>Physical examinations conducted if the periodic examination expired during the mobilization period.</p>	General examination requirements similar to the Army.	<p>Annual health certification.</p> <p>Full physical every 5 years through age 50, every 2 years through age 60, and annually after age 60.</p> <p>Requirements and frequency vary on the basis of occupational specialty.</p>

Source: GAO analysis of DOD instructions and regulations.

# Appendix V: Pre- and Post-Deployment Health Assessment Forms



## PRE-DEPLOYMENT Health Assessment



33823

Authority: 10 U.S.C. 136 Chapter 55. 1074f, 3013, 5013, 8013 and E.O. 9397

Principal Purpose: To assess your state of health before possible deployment outside the United States in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care to you.

Routine Use: To other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

Disclosure: **(Military personnel and DoD civilian Employees Only)** Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

**INSTRUCTIONS:** Please read each question completely and carefully before marking your selections. Provide a response for each question. If you do not understand a question, ask the administrator.

---

**Demographics**

<b>Last Name</b> <input type="text"/>	<b>Today's Date (dd/mm/yyyy)</b> <input type="text"/> / <input type="text"/> / <input type="text"/>
<b>First Name</b> <input type="text"/>	<b>Social Security Number</b> <input type="text"/> - <input type="text"/> - <input type="text"/>
<b>Deploying Unit</b> <input type="text"/>	<b>DOB (dd/mm/yyyy)</b> <input type="text"/> / <input type="text"/> / <input type="text"/>

<b>Gender</b> <input type="radio"/> Male <input type="radio"/> Female	<b>Service Branch</b> <input type="radio"/> Air Force <input type="radio"/> Army <input type="radio"/> Coast Guard <input type="radio"/> Marine Corps <input type="radio"/> Navy <input type="radio"/> Other	<b>Component</b> <input type="radio"/> Active Duty <input type="radio"/> National Guard <input type="radio"/> Reserves <input type="radio"/> Civilian Government Employee	<b>Pay Grade</b> <input type="radio"/> E1 <input type="radio"/> O1 <input type="radio"/> W1 <input type="radio"/> E2 <input type="radio"/> O2 <input type="radio"/> W2 <input type="radio"/> E3 <input type="radio"/> O3 <input type="radio"/> W3 <input type="radio"/> E4 <input type="radio"/> O4 <input type="radio"/> W4 <input type="radio"/> E5 <input type="radio"/> O5 <input type="radio"/> W5 <input type="radio"/> E6 <input type="radio"/> O6 <input type="radio"/> Other <input type="radio"/> E7 <input type="radio"/> O7 <input type="radio"/> E8 <input type="radio"/> O8 <input type="radio"/> E9 <input type="radio"/> O9 <input type="radio"/> O10
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**Location of Operation**

<input type="radio"/> Europe	<input type="radio"/> Australia
<input type="radio"/> SW Asia	<input type="radio"/> Africa
<input type="radio"/> SE Asia	<input type="radio"/> Central America
<input type="radio"/> Asia (Other)	<input type="radio"/> Unknown
<input type="radio"/> South America	

**Deployment Location (IF KNOWN) (CITY, TOWN, or BASE):**


**List country (IF KNOWN):**

**Name of Operation:**

**Administrator Use Only**


Indicate the status of each of the following:

Yes	No	N/A	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Medical threat briefing completed
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Medical information sheet distributed
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Serum for HIV drawn within 12 months
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Immunizations current
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> PPD screening within 24 months





DD FORM 2795, MAY 1999

ASD (HA) APPROVED SEPTEMBER 1998 Ver 1.3



**Appendix V: Pre- and Post-Deployment Health Assessment Forms**

 33823	PLEASE FILL IN SOCIAL SECURITY # <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> - <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> - <span style="border: 1px solid black; display: inline-block; width: 40px; height: 15px;"></span>			
<b>Health Assessment</b>				
1. Would you say your health in general is: <span style="float: right;"> <input type="radio"/> Excellent   <input type="radio"/> Very Good   <input type="radio"/> Good   <input type="radio"/> Fair   <input type="radio"/> Poor                 </span>				
2. Do you have any medical or dental problems? <span style="float: right;"> <input type="radio"/> Yes   <input type="radio"/> No                 </span>				
3. Are you currently on a profile, or light duty, or are you undergoing a medical board? <span style="float: right;"> <input type="radio"/> Yes   <input type="radio"/> No                 </span>				
4. Are you pregnant? (FEMALES ONLY) <span style="float: right;"> <input type="radio"/> Don't Know   <input type="radio"/> Yes   <input type="radio"/> No                 </span>				
5. Do you have a 90-day supply of your prescription medication or birth control pills? <span style="float: right;"> <input type="radio"/> N/A   <input type="radio"/> Yes   <input type="radio"/> No                 </span>				
6. Do you have two pairs of prescription glasses (if worn) and any other personal medical equipment? <span style="float: right;"> <input type="radio"/> N/A   <input type="radio"/> Yes   <input type="radio"/> No                 </span>				
7. During the past year, have you sought counseling or care for your mental health? <span style="float: right;"> <input type="radio"/> Yes   <input type="radio"/> No                 </span>				
8. Do you currently have any questions or concerns about your health? <span style="float: right;"> <input type="radio"/> Yes   <input type="radio"/> No                 </span>				
Please list your concerns: _____ _____				
Service Member Signature				
I certify that responses on this form are true. <span style="float: right; border: 1px solid black; display: inline-block; width: 200px; height: 20px;"></span>				
<b>Pre-Deployment Health Provider Review (For Health Provider Use Only)</b>				
After interview/exam of patient, the following problems were noted and categorized by Review of Systems. More than one may be noted for patients with multiple problems. Further documentation of problem to be placed in medical records.				
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <b>REFERRAL INDICATED</b>  <input type="radio"/> None  <input type="radio"/> Cardiac  <input type="radio"/> Combat / Operational Stress Reaction  <input type="radio"/> Dental  <input type="radio"/> Dermatologic  <input type="radio"/> ENT  <input type="radio"/> Eye  <input type="radio"/> Family Problems  <input type="radio"/> Fatigue, Malaise, Multisystem complaint                         </td> <td style="width: 50%; vertical-align: top;"> <input type="radio"/> GI  <input type="radio"/> GU  <input type="radio"/> GYN  <input type="radio"/> Mental Health  <input type="radio"/> Neurologic  <input type="radio"/> Orthopedic  <input type="radio"/> Pregnancy  <input type="radio"/> Pulmonary  <input type="radio"/> Other _____                         </td> </tr> </table>			<b>REFERRAL INDICATED</b> <input type="radio"/> None <input type="radio"/> Cardiac <input type="radio"/> Combat / Operational Stress Reaction <input type="radio"/> Dental <input type="radio"/> Dermatologic <input type="radio"/> ENT <input type="radio"/> Eye <input type="radio"/> Family Problems <input type="radio"/> Fatigue, Malaise, Multisystem complaint	<input type="radio"/> GI <input type="radio"/> GU <input type="radio"/> GYN <input type="radio"/> Mental Health <input type="radio"/> Neurologic <input type="radio"/> Orthopedic <input type="radio"/> Pregnancy <input type="radio"/> Pulmonary <input type="radio"/> Other _____
<b>REFERRAL INDICATED</b> <input type="radio"/> None <input type="radio"/> Cardiac <input type="radio"/> Combat / Operational Stress Reaction <input type="radio"/> Dental <input type="radio"/> Dermatologic <input type="radio"/> ENT <input type="radio"/> Eye <input type="radio"/> Family Problems <input type="radio"/> Fatigue, Malaise, Multisystem complaint	<input type="radio"/> GI <input type="radio"/> GU <input type="radio"/> GYN <input type="radio"/> Mental Health <input type="radio"/> Neurologic <input type="radio"/> Orthopedic <input type="radio"/> Pregnancy <input type="radio"/> Pulmonary <input type="radio"/> Other _____			
<b>FINAL MEDICAL DISPOSITION:</b> <span style="float: right;"> <input type="radio"/> Deployable   <input type="radio"/> Not Deployable                 </span>				
Comments: (If not deployable, explain) _____ _____ _____				
I certify that this review process has been completed. Provider's signature and stamp: <span style="float: right;">Date (dd/mm/yyyy)</span>				
		<span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 40px; height: 15px;"></span>		
<b>End of Health Review</b>				
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**Appendix V: Pre- and Post-Deployment Health Assessment Forms**



**POST-DEPLOYMENT Health Assessment**

Authority: 10 U.S.C. 136 Chapter 55. 1074f, 3013, 5013, 8013 and E.O. 9397

Principal Purpose: To assess your state of health after deployment outside the United States in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care to you.

Routine Use: To other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

Disclosure: (Military personnel and DoD civilian Employees Only) Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before marking your selections. Provide a response for each question. If you do not understand a question, ask the administrator.

**Demographics**

**Last Name**

**Today's Date (dd/mm/yyyy)**  
 /  /

**First Name** **MI**

**Social Security Number**  
 -  -

**Name of Your Unit or Ship during this Deployment**

**DOB (dd/mm/yyyy)**  
 /  /

<b>Gender</b>	<b>Service Branch</b>	<b>Component</b>
<input type="radio"/> Male	<input type="radio"/> Air Force	<input type="radio"/> Active Duty
<input type="radio"/> Female	<input type="radio"/> Army	<input type="radio"/> National Guard
	<input type="radio"/> Coast Guard	<input type="radio"/> Reserves
	<input type="radio"/> Marine Corps	<input type="radio"/> Civilian Government Employee
	<input type="radio"/> Navy	
	<input type="radio"/> Other	

**Date of arrival in theater (dd/mm/yyyy)**  
 /  /

**Date of departure from theater (dd/mm/yyyy)**  
 /  /

**Location of Operation**

<input type="radio"/> Europe	<input type="radio"/> Australia	<input type="radio"/> South America
<input type="radio"/> SW Asia	<input type="radio"/> Africa	<input type="radio"/> North America
<input type="radio"/> SE Asia	<input type="radio"/> Central America	<input type="radio"/> Other _____
<input type="radio"/> Asia (Other)	<input type="radio"/> Unknown	

**Pay Grade**

<input type="radio"/> E1	<input type="radio"/> 001	<input type="radio"/> W1
<input type="radio"/> E2	<input type="radio"/> 002	<input type="radio"/> W2
<input type="radio"/> E3	<input type="radio"/> 003	<input type="radio"/> W3
<input type="radio"/> E4	<input type="radio"/> 004	<input type="radio"/> W4
<input type="radio"/> E5	<input type="radio"/> 005	<input type="radio"/> W5
<input type="radio"/> E6	<input type="radio"/> 006	
<input type="radio"/> E7	<input type="radio"/> 007	<input type="radio"/> Other
<input type="radio"/> E8	<input type="radio"/> 008	
<input type="radio"/> E9	<input type="radio"/> 009	
	<input type="radio"/> 010	

**To what areas were you mainly deployed:**  
 (mark all that apply - list where/date arrived)

<input type="radio"/> Kuwait	_____	<input type="radio"/> Iraq	_____
<input type="radio"/> Qatar	_____	<input type="radio"/> Turkey	_____
<input type="radio"/> Afghanistan	_____	<input type="radio"/> Uzbekistan	_____
<input type="radio"/> Bosnia	_____	<input type="radio"/> Kosovo	_____
<input type="radio"/> On a ship	_____	<input type="radio"/> CONUS	_____
		<input type="radio"/> Other	_____

**Name of Operation:**

**Occupational specialty during this deployment (MOS, NEC or AFSC)**

**Combat specialty:** \_\_\_\_\_

**Administrator Use Only**

Indicate the status of each of the following:

Yes	No	N/A	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Medical threat debriefing completed
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Medical information sheet distributed
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Post Deployment serum specimen collected

**Appendix V: Pre- and Post-Deployment Health  
Assessment Forms**

*Please answer all questions in relation to THIS deployment*

1. Did your health change during this deployment?

- Health stayed about the same or got better
- Health got worse

2. How many times were you seen in sick call during this deployment?

--	--

No. of times

3. Did you have to spend one or more nights in a hospital as a patient during this deployment?

- No
- Yes, reason/dates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Did you receive any vaccinations just before or during this deployment?

- Smallpox (leaves a scar on the arm)
- Anthrax
- Botulism
- Typhoid
- Meningococcal
- Other, list: \_\_\_\_\_
- Don't know
- None

5. Did you take any of the following medications during this deployment?

- (mark all that apply)*
- PB (pyridostigmine bromide) nerve agent pill
  - Mark-1 antidote kit
  - Anti-malaria pills
  - Pills to stay awake, such as dexedrine
  - Other, please list \_\_\_\_\_
  - Don't know

6. Do you have any of these symptoms now or did you develop them anytime during this deployment?

No	Yes During	Yes Now	No	Yes During	Yes Now
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Chronic cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Chest pain or pressure
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Runny nose	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Dizziness, fainting, light headedness
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Difficulty breathing
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Weakness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Still feeling tired after sleeping
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Difficulty remembering
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Swollen, stiff or painful joints	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Diarrhea
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Frequent indigestion
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Muscle aches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Vomiting
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Numbness or tingling in hands or feet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Ringing of the ears
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Skin diseases or rashes			
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Redness of eyes with tearing			
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Dimming of vision, like the lights were going out			

7. Did you see anyone wounded, killed or dead during this deployment?

- (mark all that apply)*
- No
  - Yes - coalition
  - Yes - enemy
  - Yes - civilian

10. Are you currently interested in receiving help for a stress, emotional, alcohol or family problem?

- No
- Yes

8. Were you engaged in direct combat where you discharged your weapon?

- No
- Yes (  land  sea  air )

9. During this deployment, did you ever feel that you were in great danger of being killed?

- No
- Yes

11. Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?

- | None                  | Some                  | A Lot  |
|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Little interest or pleasure in doing things                                |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Feeling down, depressed, or hopeless                                       |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Thoughts that you would be better off dead or hurting yourself in some way |

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**Appendix V: Pre- and Post-Deployment Health Assessment Forms**

**12. Have you ever had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you ....**

<u>No</u>	<u>Yes</u>	
<input type="radio"/>	<input type="radio"/>	Have had any nightmares about it or thought about it when you did not want to?
<input type="radio"/>	<input type="radio"/>	Tried hard not to think about it or went out of your way to avoid situations that remind you of it?
<input type="radio"/>	<input type="radio"/>	Were constantly on guard, watchful, or easily startled?
<input type="radio"/>	<input type="radio"/>	Felt numb or detached from others, activities, or your surroundings?

**13. Are you having thoughts or concerns that ...**

<u>No</u>	<u>Yes</u>	<u>Unsure</u>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	You may have serious conflicts with your spouse, family members, or close friends?
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	You might hurt or lose control with someone?

**14. While you were deployed, were you exposed to:**  
*(mark all that apply)*

<u>No</u>	<u>Sometimes</u>	<u>Often</u>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	DEET insect repellent applied to skin
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pesticide-treated uniforms
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Environmental pesticides (like area fogging)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Flea or tick collars
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pesticide strips
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Smoke from oil fire
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Smoke from burning trash or feces
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Vehicle or truck exhaust fumes
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Tent heater smoke
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	JPB or other fuels
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Fog oils (smoke screen)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Solvents
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Paints
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Ionizing radiation
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Radar/microwaves
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lasers
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Loud noises
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Excessive vibration
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Industrial pollution
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sand/dust
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Depleted Uranium (If yes, explain) _____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other exposures _____

**15. On how many days did you wear your MOPP over garments?** 

--	--

  
No. of days

**16. How many times did you put on your gas mask because of alerts and NOT because of exercises?** 

--	--

  
No. of times

**17. Were you in or did you enter or closely inspect any destroyed military vehicles?**  
 No     Yes

**18. Do you think you were exposed to any chemical, biological, or radiological warfare agents during this deployment?**  
 No     Don't know  
 Yes, explain with date and location  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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**Appendix V: Pre- and Post-Deployment Health Assessment Forms**

**Health Care Provider Only**

SERVICE MEMBER'S SOCIAL SECURITY #     -   -

**Post-Deployment Health Care Provider Review, Interview, and Assessment**

**Interview**

1. Would you say your health in general is:  Excellent  Very Good  Good  Fair  Poor
2. Do you have any medical or dental problems that developed during this deployment?  Yes  No
3. Are you currently on a profile or light duty?  Yes  No
4. During this deployment have you sought, or do you now intend to seek, counseling or care for your mental health?  Yes  No
5. Do you have concerns about possible exposures or events during this deployment that you feel may affect your health?  Yes  No  
Please list concerns: \_\_\_\_\_
6. Do you currently have any questions or concerns about your health?  Yes  No  
Please list concerns: \_\_\_\_\_

**Health Assessment**

After my interview/exam of the service member and review of this form, there is a need for further evaluation as indicated below. (More than one may be noted for patients with multiple problems. Further documentation of the problem evaluation to be placed in the service member's medical record.)

**REFERRAL INDICATED FOR:**

- None
- Cardiac
- Combat/Operational Stress Reaction
- Dental
- Dermatologic
- ENT
- Eye
- Family Problems
- Fatigue, Malaise, Multisystem complaint
- Audiology

**EXPOSURE CONCERNS (During deployment):**

- GI
- GU
- GYN
- Mental Health
- Neurologic
- Orthopedic
- Pregnancy
- Pulmonary
- Other \_\_\_\_\_
- Environmental
- Occupational
- Combat or mission related
- None

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I certify that this review process has been completed.  
 Provider's signature and stamp:

This visit is coded by V70.5 \_\_ 6

Date (dd/mm/yyyy)   /   /

**End of Health Review**

DD FORM 2796, APR 2003

ASD(HA) APPROVED



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# Appendix VI: Service Stop-Loss Policies since September 11, 2001

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On September 14, 2001, the Secretary of Defense delegated his stop-loss authority to the service secretaries. This authority allows the services to retain both active and reserve component members on active duty beyond the end of their obligated service. Reserve component members who are affected by the order generally cannot retire or leave the service until authorized by competent authority. Each of the services has exercised its stop-loss authority on different occasions and for different military occupational specialties.

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## Army

The Army issued a stop-loss message on December 4, 2001, imposing stop-loss on several active component skill-based specialties. As the needs of the Army changed, the number of occupational specialties expanded and then contracted, and included the reserve components as well as the Army's active forces. The Army ended its specialty-based stop-loss on November 13, 2003. The Army's current stop-loss policy, which affects active and reserve component forces, is unit-based rather than occupational specialty driven. Significant stop-loss policy changes that affected the Army's reserve component forces are listed below.

- **January 2002.** The stop-loss policy already in effect for the active component is expanded to include soldiers in the Ready Reserve. Soldiers with 23 different occupational specialties, including special forces, civil affairs, psychological operations, certain aviation categories, mortuary affairs, and maintenance are affected.
- **February 2002.** The Army expands its stop-loss policy for the active and reserve components, adding 38 occupational specialties to the stop-loss program. The new categories include military police, military intelligence specialties and technicians, comptrollers, foreign area officers (Eurasia, Middle East/North Africa), contract and industrial management, additional aviator specialties, criminal investigators, and linguists.
- **June 2002.** The Army expands and retracts its stop-loss policy for the active and reserve components. New occupational specialties affected include information operations, strategic intelligence, various field artillery and air defense specialties, explosive ordnance disposal, and unmanned aerial vehicle operators. Soldiers in the foreign area officer (Eurasia) and select intelligence specialties were released from the stop-loss policy.



- **November 2002.** Army ends skill-based stop-loss policy for the Ready Reserve and Guard forces. The new stop-loss policy is unit based, beginning when the unit is alerted until 90 days after the end of the unit's mobilization.
- **February 2003.** Army expands stop-loss to include active component units identified for deployment in support of Operation Iraqi Freedom.
- **November 2003.** Army again issues unit stop-loss for active forces, and cancels occupational specialty stop losses that had been issued since February 2003. (There were several stop-loss changes issued between February 2003 and November 2003 but these changes were focused on active forces.) The unit stop-loss policies for reserve component forces have remained continuously in effect since they were instituted in 2002.

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## Navy

The Navy exercised its stop-loss authority on September 28, 2001, by imposing stop-loss on several occupational specialties. Unlike the Army, the Navy's initial stop-loss policy affected both active and reserve component forces. The Navy's significant stop-loss policy changes are listed below.

- **September 2001.** The Navy issues a stop-loss policy for a variety of officer and enlisted occupational specialties, and subspecialties to include personnel in special operations/special warfare, security, law enforcement, cryptology, and explosive ordnance disposal as well as selected physicians, nurses, and linguists.
- **March 2002.** The Navy modifies its existing stop-loss policy, adding new specialties and removing others. After the changes, selected linguists and personnel in security, law enforcement, and cryptology were subject to the stop-loss restriction.
- **August 2002.** The Navy ends its stop-loss policy.

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## Air Force

The Air Force exercises its stop-loss authority on September 22, 2001, by imposing a servicewide stop-loss on all Air Force personnel. Unlike the Army, the Air Force's initial policy affected active, reserve, and Air National Guard members. The Air Force's significant stop-loss policy changes are listed below.

- **September 2001.** The Air Force implements a servicewide, stop-loss policy.

- **January 2002.** The Air Force releases 64 occupational specialties from the general stop-loss. Specialties that still fall under the limitations of the stop-loss policy include selected pilots, navigators, intelligence specialists, weather specialists, security personnel, engineers, communications specialists, selected health care providers, lawyers, chaplains, aircrew operators, aircrew protection personnel, command and control specialists, fuel handlers, logisticians and supply specialists, selected maintenance providers, and investigators.
- **June 2002.** The Air Force exempts additional occupational specialties from the general stop-loss. Specialties that remain under the limitations of the stop-loss policy include selected pilots, navigators, security personnel, aircrew operators, command and control specialists, intelligence specialists, aircrew protection, and fuel handlers.
- **March 2003.** The Air Force announces that effective May 2, 2003, stop-loss will be expanded to cover a total of 99 occupational specialties. Specialties that are affected by the stop-loss policy include selected pilots, navigators, command and control specialists, intelligence specialists, security personnel, engineers, selected health care providers, investigators, aircrew operators, aircrew protection personnel, communications specialists, logisticians and supply specialists, and fuel handlers.
- **May 2003.** The Air Force modifies its stop-loss policy, releasing about half of the previously selected occupational specialties. The list of specialties still affected by the stop-loss includes selected pilots, navigators, intelligence specialists, security forces, special investigators, aircrew operators, fuel handlers, and maintenance personnel.
- **June 2003.** The Air Force ends its stop-loss policy.

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## Marine Corps

The Marine Corps exercised its stop-loss authority for selective active and reserve Marines in January 2002. Specific policies varied as to their applicability to active and reserve forces; however, expansion of stop-loss policy eventually covered all Marines. The Marine Corps' significant stop-loss policy changes are listed below.

- **January 2002.** The Marine Corps implements a specific stop-loss authority for Marines with C-130 specialties to assist in Operation Enduring Freedom. This stop-loss authority includes Marines in the reserve component.

- **January 2003.** The Marine Corps implements a general stop-loss policy for all Marines, regardless of component. Marine Corps reservists cannot be extended beyond the completion of 24 cumulative months of activated service. Furthermore, the first general officer in a Marine's chain of command can exempt Marines from the stop-loss policy.
- **May 2003.** The Marine Corps lifts its stop-loss policy.

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# Appendix VII: Reserve Component Recruiting Results, Fiscal Year 1993-2004

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The services use recruiting and retention strategies together to achieve their programmed end strengths. If retention is better than expected in a particular year, then the reserve components may achieve their desired end strengths without achieving their recruiting goals. While the services can effectively meet their yearly programmed end strengths through a wide range of recruiting and retention combinations, long-term overreliance on either recruiting or retention can eventually cause negative impacts for a service or service component.

A service or component that repeatedly misses its recruiting goals will need to retain a higher-than-planned percentage of its personnel each year. This will eventually lead to a force that is out of balance. Either too many people will be promoted and the component will end up with too many senior personnel and not enough junior personnel or promotion rates will decline. Decreased promotion rates tend to lead to increased attrition rates, which would lead to end strength problems if a component were already having problems meeting its recruiting goals.

Appendix VI showed that the services have employed a variety of stop-loss policies since September 11, 2001. Because these policies artificially inflate retention rates, recruiting figures rather than retention or end strength figures may be the best indicator of whether or not the components will face difficulties meeting their future programmed end strengths. Table 10 shows historical recruiting results. It shows that all the reserve components met their recruiting goals in fiscal year 2002. But it shows that the Army National Guard fell far short of its goal in fiscal year 2003 and was falling far short of its fiscal year 2004 monthly goals through May of 2004. This dramatic drop in recruiting results occurred as the Army was significantly increasing its involuntary mobilizations of Army National Guard combat forces. The improving job market in the United States may make it even more difficult for the Army National Guard to achieve its recruiting objectives over the next few years.

**Appendix VII: Reserve Component Recruiting  
Results, Fiscal Year 1993-2004**

**Table 10: Reserve Component Recruiting Figures**

<b>Fiscal year</b>	<b>Army National Guard</b>	<b>Army Reserve</b>	<b>Naval Reserve</b>	<b>Marine Corps Reserve</b>	<b>Air National Guard</b>	<b>Air Force Reserve</b>	<b>DOD total</b>
<b>Goal</b>							
1993	68,177	50,600	19,537	10,140	10,454	10,592	<b>169,500</b>
1994	69,710	46,500	13,144	11,122	10,325	10,434	<b>161,235</b>
1995	60,649	47,732	13,660	11,748	8,496	12,578	<b>154,863</b>
1996	61,793	50,179	16,850	10,388	11,000	7,090	<b>157,300</b>
1997	59,262	47,935	16,950	10,063	9,996	9,702	<b>153,908</b>
1998	56,638	47,940	15,329	10,174	8,004	10,874	<b>148,959</b>
1999	56,958	52,084	20,455	9,464	8,520	11,791	<b>159,272</b>
2000	54,034	48,461	18,410	9,341	10,080	9,624	<b>149,950</b>
2001	60,252	34,910	15,250	8,945	11,808	8,051	<b>139,216</b>
2002	60,504	38,857	15,000	9,835	9,570	6,080	<b>139,846</b>
2003	62,000	40,900	12,000	8,173	5,712	7,512	<b>136,297</b>
2004	56,002	34,782	10,500	7,960	8,842	7,997	<b>126,083</b>
2004 <sup>a</sup>	36,575	20,862	6,622	5,268	5,702	5,816	<b>80,845</b>
<b>Accessions</b>							
1993	67,360	50,255	18,367	10,216	9,163	10,908	<b>166,269</b>
1994	61,248	47,412	13,006	11,236	9,177	11,464	<b>153,543</b>
1995	56,711	48,098	13,701	12,043	8,351	9,757	<b>148,661</b>
1996	60,444	46,187	16,820	12,566	9,958	7,566	<b>153,541</b>
1997	63,495	47,153	17,106	10,744	9,986	8,383	<b>156,867</b>
1998	55,401	44,212	14,986	10,213	8,744	8,877	<b>142,433</b>
1999	57,090	41,784	15,715	9,565	8,398	7,518	<b>140,070</b>
2000	61,260	48,596	14,911	9,465	10,730	7,740	<b>152,702</b>
2001	61,956	35,622	15,344	9,117	10,258	8,826	<b>141,123</b>
2002	63,251	41,385	15,355	10,090	10,122	6,926	<b>147,129</b>
2003	54,202	41,851	12,772	8,222	8,471	7,557	<b>133,075</b>
2004 <sup>a</sup>	32,052	21,569	7,140	5,505	5,284	5,304	<b>76,854</b>
<b>Goal achievement</b>							
1993	98.8%	99.3%	94.0%	100.7%	87.7%	103.0%	<b>98.1%</b>
1994	87.9%	102.0%	99.0%	101.0%	88.9%	109.9%	<b>95.2%</b>
1995	93.5%	100.8%	100.3%	102.5%	98.3%	77.6%	<b>96.0%</b>
1996	97.8%	92.0%	99.8%	121.0%	90.5%	106.7%	<b>97.6%</b>
1997	107.1%	98.4%	100.9%	106.8%	99.9%	86.4%	<b>101.9%</b>
1998	97.8%	92.2%	97.8%	100.4%	109.2%	81.6%	<b>95.6%</b>
1999	100.2%	80.2%	76.8%	101.1%	98.6%	63.8%	<b>87.9%</b>

**Appendix VII: Reserve Component Recruiting  
Results, Fiscal Year 1993-2004**

<b>Fiscal year</b>	<b>Army National Guard</b>	<b>Army Reserve</b>	<b>Naval Reserve</b>	<b>Marine Corps Reserve</b>	<b>Air National Guard</b>	<b>Air Force Reserve</b>	<b>DOD total</b>
2000	113.4%	100.3%	81.0%	101.3%	106.4%	80.4%	<b>101.8%</b>
2001	102.8%	102.0%	100.6%	101.9%	86.9%	109.6%	<b>101.4%</b>
2002	104.5%	106.5%	102.4%	102.6%	105.8%	113.9%	<b>105.2%</b>
2003	87.4%	102.3%	106.4%	100.6%	148.3%	100.6%	<b>97.6%</b>
2004 <sup>a</sup>	87.6%	103.4%	107.8%	104.5%	92.7%	91.2%	<b>95.1%</b>

Source: Defense Manpower Data Center.

<sup>a</sup>Signifies fiscal year 2004 data through May.

# Appendix VIII: Service Medical and Physical Evaluation Board Processes

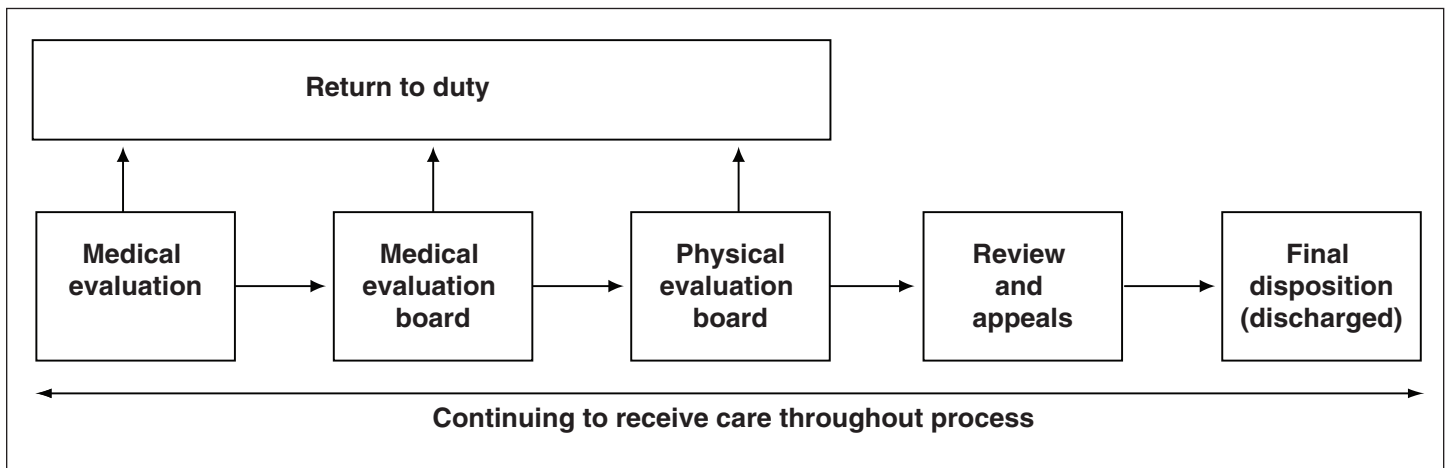
## Disabilities Evaluation System

DOD's Physical Disabilities Evaluation System consists of four main elements:

1. medical evaluation by Medical Evaluation Boards (MEBs),
2. physical disability evaluation by Physical Evaluation Boards (PEBs) to include appellate review,
3. servicemember counseling, and
4. final disposition by appropriate personnel authorities.

Figure 2 shows the steps of the disabilities evaluation system, which will eventually lead to one of two outcomes. Servicemembers will either be returned to duty or they will be discharged from their military service. Members who are discharged sometimes, but not always, receive disability compensation.

Figure 2: Steps of DOD's Disabilities Evaluation System



Source: GAO analysis of DOD regulations and instructions.

Reserve component personnel who have been involuntarily mobilized, along with members who are voluntarily serving on active duty, may end up with medical problems for a variety of reasons. Some are injured during combat operations; others become injured or sick during the course of their training or routine duties; and others have problems that are identified during medical appointments, physicals, or medical screenings. Servicemembers on active duty or in the Ready Reserve are eligible for referral into the Disability Evaluation System when they are

unable to reasonably perform the military duties of their office, grade, rank, or rating as a result of a diagnosed medical condition.

Servicemembers who have been diagnosed with medical conditions that may render them unfit for military service enter into medical treatment programs.

The initial stage of the process, when medical professionals are diagnosing servicemembers' problems, determining courses of treatment, and evaluating the effectiveness of the ongoing treatments is often the most time-consuming portion of the medical process. According to service officials, this initial phase is intentionally long to give servicemembers a good chance to get well and return to full duty. If, however, the servicemembers have not returned to full duty within 1 year of their diagnoses or if prior to a year they reach a point where they have achieved the maximum recovery expected, and additional treatment is not expected to materially affect their condition, their medical status and duty limitations will be documented and referred to a MEB.

The MEB documents full clinical information on all medical conditions and states whether each condition is cause for referral into the Disability Evaluation System. The duty-related impairment MEB package should include a medical history; records from physical examinations; records of medical tests and their results; and documentation of medical and surgical consultations, diagnoses, treatments and prognoses. If the servicemember meets retention standards, the disability processing ends with the MEB. If the MEB concludes that the servicemembers do not meet retention standards, the members' cases are referred to the PEB to determine fitness for duty and possible entitlement to benefits.

The first step in the PEB process is referral of the cases to informal PEBs that review documents from the MEB and other administrative documents without the presence of the servicemember. The informal PEB then issues its initial findings and recommendations. If servicemembers are found to be fit for duty, the disability processing ends with the informal PEB. If servicemembers are found to be unfit for duty, they may request to personally appear before the PEB during formal PEB hearings. Servicemembers who do not agree with the decisions of the Formal PEB have an additional opportunity to appeal the decisions.

When a physician initiates an MEB, the processing time should normally not exceed 30 days from the date the MEB report is initiated to the date it is received by the PEB. For cases where reserve component members are



referred for solely a fitness determination on a non-duty-related condition, processing time for conducting an MEB or physical examination should not exceed 90 days. And when the PEB receives the MEB or physical examination report, the processing time to the date of the final disposition of the reviewing authority should normally be no more than 40 days.

All servicemembers who enter the Disability Evaluation System receive counseling. Counselors inform the servicemembers of the sequence and nature of the steps in the process, statutory and regulatory rights, the effects of findings and recommendations, and the servicemember's recourse in the case of an unfavorable finding.

It is not within the mission of the military departments to retain members on active duty or in the Ready Reserve to provide prolonged, definitive medical care when it is unlikely the member will return to full military duty. Servicemembers should be referred into the Disability Evaluation System as soon as the probability that they will be unable to return to full duty is ascertained and optimal medical treatment benefits have been reached.

# Appendix IX: Comments from the Department of Defense



RESERVE AFFAIRS

ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, DC 20301-1500

AUG 27 2004

Mr. Derek B. Stewart  
Director, Defense Capabilities and Management  
U.S General Accountability Office  
Washington, DC 20548

Dear Mr. Stewart:

This is the Department of Defense response to the GAO draft report, "MILITARY PERSONNEL: DOD Needs to Address Long-Term Reserve Forces Availability and Related Mobilization and Demobilization Issues," dated August 12, 2004 (Code 350449/GAO-04-1031). The Department's response to the report is provided in three sections: 1) Responses to GAO's eight recommendations for executive action, 2) Other relevant comments on portions of the report, and 3) technical corrections. The response, which includes all three sections, is enclosed.

The point of contact for this office Mr. Daniel J. Kohner, OASD/RA (M&P), who can be reached at (703) 693-7479 or via e-mail at dan.kohner@osd.mil.

Sincerely,

A handwritten signature in black ink, appearing to read "John W. ...", written over a printed name.

T. F. Hall

Enclosure  
As stated

GAO DRAFT REPORT – DATED AUGUST 12, 2004  
GAO CODE 350449/GAO-04-1031

“MILITARY PERSONNEL: DoD Needs to Address Long-Term Reserve Forces Availability  
and Related Mobilization and Demobilization Issues”

DEPARTMENT OF DEFENSE COMMENTS  
TO THE RECOMMENDATIONS

**RECOMMENDATION 1:** The GAO recommended that the Secretary of Defense direct the Under Secretary of Personnel and Readiness, in concert with the Service Secretaries and Joint Staff, to develop a strategic framework that sets human capital goals concerning the availability of its reserve component forces to meet the long-term requirements of the Global War on Terrorism under various mobilization authorities. (Page 59/GAO Draft Report)

**DoD RESPONSE:** The Department partially concurs with the recommendation, though the recommendation would be more accurately stated if it proposed that the Department review and, as appropriate, update the current strategic framework for human capital goals specifically dealing with availability of its reserve component members. The recommendation implies that no strategic framework for setting human capital goals exists. The Department’s Strategic Planning Guidance, Contingency Planning Guidance, Comprehensive Review of Active/Reserve Force Mix, and Force Rebalancing Report, all establish the strategic framework for setting human capital goals, especially regarding the use of Reserve forces.

**RECOMMENDATION 2:** The GAO recommended that the Secretary of Defense direct the Under Secretary of Personnel and Readiness, in concert with the Service Secretaries and Joint Staff to identify personnel policies that should be linked within the context of the strategic framework. (Page 59/GAO Draft Report)

**DoD RESPONSE:** The Department partially concurs with the recommendation, though the recommendation would be more accurately stated if it proposed that the Department review and, as appropriate, update the personnel policies linked to the strategic framework for human capital goals specifically dealing with availability of its reserve component members. The recommendation implies that no personnel policies linked to the strategic framework for setting human capital goals exist, when, in fact, they do exist. And, the original personnel and pay policy published September 20, 2001, along with the 1<sup>st</sup> addendum to that policy, dated July 19, 2002, which establish those personnel policies associated with the strategic framework, and set specific guidelines regarding the use of Reserve forces for this mobilization, remain in effect today. Review and updating of policies is a continuous process in DoD to ensure proper adjustments to meet changing requirements. For example, the Secretary of Defense is currently reviewing the rules for deployment of troops – both Active and Reserve, the results of which will ensure a consistent application of policy.

Note: Page numbers in  
the draft report may differ  
from those in this report.

**RECOMMENDATION 3:** The GAO recommended that the Secretary of Defense direct the Secretary of the Army to take, within the context of establishing DoD's strategic framework for force availability, action to update mobilization and demobilization planning assumptions to reflect the new operating environment for the Global War on Terrorism—long-term requirements for mobilization and demobilization support facilities and personnel and the likelihood that active forces will continue to rotate through U.S. bases while reserve component forces are mobilizing and demobilizing. (Page 59/GAO Draft Report)

**DoD RESPONSE:** The Department concurs with the recommendation. The Secretary of Defense is currently reviewing the rules for deployment of troops. The follow-on extension of this will be for the Department of the Army, using the Secretary's guidelines, to update their planning assumptions and requirements for support personnel, medical personnel, and facilities that support the Reserve component mobilization and demobilization mission.

**RECOMMENDATION 4:** The GAO recommended that the Secretary of Defense direct the Secretary of Army to take, within the context of establishing DoD's strategic framework for force availability, action to develop a coordinated approach to evaluate all the support costs associated with mobilization and demobilization at alternative sites – including both facility (construction, renovation and maintenance) and the support personnel (reserve component, civilian, contractor or a combination) costs—to determine the most efficient options; and then update the list of primary and secondary mobilization and demobilization sites as necessary. (Page 59-60/GAO Draft Report)

**DoD RESPONSE:** The Department concurs with the recommendation. The Secretary of Defense is currently reviewing the rules for deployment of troops. The follow-on extension of this will be for the Department of the Army, using the Secretary's guidelines, to update their planning assumptions and requirements for support personnel, medical personnel, and facilities that support the Reserve component mobilization and demobilization mission.

**RECOMMENDATION 5:** The GAO recommended that the Secretary of Defense direct the Commandant of the Marine Corps to issue updated mobilization guidance that specifically lists the requirement to submit pre-deployment health assessments to the Army Medical Surveillance Activity. (Page 60/GAO Draft Report)

**DoD RESPONSE:** The DoD concurs with the recommendation. All Services, including the Marine Corps, support the requirements for collection and submission of pre- and post-deployment health data. Marine Corps units are working to resolve past problems with submission. Changes to the current Marine Corps Deployment Health QA Program policy memo clearly and specifically address pre- and post-deployment assessments, their submission, and development of programs to monitor compliance. The revised Marine Corps policy memo is currently in coordination with publication expected in the October 2004 to November 2004 timeframe.

**RECOMMENDATION 6:** The GAO recommended that the Secretary of Defense direct the Commandant of the Marine Corps to establish a mechanism for overseeing submission of pre- and post-deployment assessments to the centralized database. (Page 60/GAO Draft Report)

**DoD RESPONSE:** The DoD partially concurs with the recommendation. Electronic submission of the data is highly desirable and facilitates data analysis. Though electronic submission of DD Forms 2795 and 2796 is currently a possibility, given the nature of the Marine Corps mission, it may not currently be practical for every deployment. Information management system improvements are ongoing that will eventually enable such collection and transmission.

**RECOMMENDATION 7:** The GAO recommended that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness, in concert with the Service Secretaries, to set a timetable for the Military Departments to electronically submit pre- and post-deployment health assessments. (Page 60/GAO Draft Report)

**DoD RESPONSE:** The DoD concurs with the recommendation. As noted in the GAO report, the Assistant Secretary of Defense (Health Affairs) established a Deployment Health Task Force in February, 2004. ASD(HA) directed the Task Force to work with the Services to fully automate the collection of pre- and post-deployment health assessments.

The Services initially reported their progress on April 19, 2004 and provided a follow-up brief on June 14, 2004. Another update is scheduled for September 10, 2004. In an August 17<sup>th</sup> draft briefing provided to ASD(HA), the Army reported capturing over 80% of all pre- and post-deployment health assessments electronically. They plan to increase the use of automation in Iraq, Kuwait, and in CONUS while beginning the deployment of automated systems in Afghanistan. Timelines were to be incorporated by the September briefing.

For the immediate term the Air Force has implemented methods to capture both pre- and post-deployment assessments electronically and will issue formal guidance on electronic submission of pre-deployment assessments by September 2004. In the same August 17 draft briefing, the Air Force stated they will select an option for in-theater electronic collection by September 30, 2004 with the goal of being fully operational by March, 2005.

In a July 12, 2004 memorandum to the Surgeon General of the Navy, ASD(HA) re-emphasized his intent of achieving full electronic capture of pre- and post-deployment health assessments. The Navy is examining five options for the electronic collection of health assessments for both the Navy and Marine Corps and, in his July 21, 2004 reply to ASD(HA), the Navy Surgeon General advised a final decision on these plans would be forthcoming in the next few weeks.

**RECOMMENDATION 8:** The GAO recommended that the Secretary of Defense direct the Secretary of the Air Force to develop a tracking mechanism for tracking reserve component members who are on voluntary active duty orders with medical problems. (Page 60/GAO Draft Report)

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**Appendix IX: Comments from the Department  
of Defense**

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**DoD RESPONSE:** DoD concurs with the recommendation. The Air Force is aware of the tracking problem associated with certain reserve component members who are on voluntary active duty orders with medical problems, and has initiated action to address this issue.

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# Appendix X: GAO Contact and Staff Acknowledgments

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## GAO Contact

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## Acknowledgments

In addition to the individual named above Kenneth F. Daniell, Michael J. Ferren, Christopher R. Forys, Jim Melton, Kenneth E. Patton, Gary W. Phillips, Jennifer R. Popovic, Sharon L. Reid, Irene A. Robertson, Nicole Volchko, and Robert K. Wild also made significant contributions to the report.

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# Related GAO Products

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*Military Pay: Army Reserve Soldiers Mobilized to Active Duty Experienced Significant Pay Problems.* [GAO-04-990T](#). Washington, D.C.: July 20, 2004.

*Reserve Forces: Observations on Recent National Guard Use in Overseas and Homeland Missions and Future Challenges.* [GAO-04-670T](#). Washington, D.C.: April 29, 2004.

*Defense Infrastructure: Long-term Challenges in Managing the Military Construction Program.* [GAO-04-288](#). Washington, D.C.: February 24, 2004.

*Military Pay: Army National Guard Personnel Mobilized to Active Duty Experienced Significant Pay Problems.* [GAO-04-413T](#). Washington, D.C.: January 28, 2004.

*Military Pay: Army National Guard Personnel Mobilized to Active Duty Experienced Significant Pay Problems.* [GAO-04-89](#). Washington, D.C.: November 13, 2003.

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

*Military Personnel: DOD Needs More Data to Address Financial and Health Care Issues Affecting Reservists.* [GAO-03-1004](#). Washington, D.C.: September 10, 2003.

*Military Personnel: DOD Actions Needed to Improve the Efficiency of Mobilizations for Reserve Forces.* [GAO-03-921](#). Washington, D.C.: August 21, 2003.

*Homeland Defense: DOD Needs to Assess the Structure of U.S. Forces for Domestic Military Missions.* [GAO-03-670](#). Washington, D.C.: July 11, 2003.

*Defense Health Care: Army Has Not Consistently Assessed the Health Status of Early-Deploying Reservists.* [GAO-03-997T](#). Washington, D.C.: July 9, 2003.

*Defense Infrastructure: Changes in Funding Priorities and Management Processes Needed to Improve Condition and Reduce Costs of Guard and Reserve Facilities.* [GAO-03-516](#). Washington, D.C.: May 15, 2003.



*Homeland Defense: Preliminary Observations on How Overseas and Domestic Missions Impact DOD Forces.* [GAO-03-677T](#). Washington, D.C.: April 29, 2003.

*Defense Health Care: Army Needs to Assess the Health Status of All Early-Deploying Reservists.* [GAO-03-437](#). Washington, D.C.: April 15, 2003.

*Military Treatment Facilities: Eligibility Follow-up at Wilford Hall Air Force Medical Center.* [GAO-03-402R](#). Washington, D.C.: April 4, 2003.

*Military Personnel: Preliminary Observations Related to Income, Benefits, and Employer Support for Reservists during Mobilizations.* [GAO-03-549T](#). Washington, D.C.: March 19, 2003.

*Military Personnel: Preliminary Observations Related to Income, Benefits, and Employer Support for Reservists during Mobilizations.* [GAO-03-573T](#). Washington, D.C.: March 19, 2003.

*Defense Health Care: Most Reservists Have Civilian Health Coverage but More Assistance Is Needed When TRICARE Is Used.* [GAO-02-829](#). Washington, D.C.: September 6, 2002.

*Reserve Forces: DOD Actions Needed to Better Manage Relations between Reservists and Their Employers.* [GAO-02-608](#). Washington, D.C.: June 13, 2002.

*Wartime Medical Care: DOD Is Addressing Capability Shortfalls, but Challenges Remain.* [GAO/NSIAD-96-224](#). Washington, D.C.: September 25, 1996.

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

*Defense Health Care: Physical Exams and Dental Care Following the Persian Gulf War.* [GAO/HRD-93-5](#). Washington, D.C.: October 15, 1992.

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