A 3rd Infantry Division Soldier does pushups for an Army physical fitness test on Nov. 15, 2016, during Marne Week's Best Squad Competition at Fort Stewart, Georgia. The three-day event also features two ruck marches, a combat-related physical training event, and warrior task testing. (Photo by Staff Sgt. Candace Mundt)

Managing the Health of the Force: A Primer for Company Leaders

■ By Capt. Robert Klein, Capt. Josi Hall, and Capt. William Greenwood

Company commanders and first sergeants need to know how to manage the health of the force. Unfortunately, this topic is generally not discussed in Army schoolhouse programs of instruction, in leadership courses, or during initial counseling. Company leaders should understand profiles, the systems used for monitoring the health of the force, and the functions of health care providers.

Privacy Rules

It is important to understand what protected health information (PHI) a commander or first sergeant may be allowed to review. The main regulatory guidance that governs what can be disclosed is the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and the Department of Defense (DOD) Health Information Privacy Regulation (DOD 6025.18-R), which implements the HIPAA Privacy Rule within the Military Health System.

DOD 6025.18-R outlines what is often referred to as the "military command exception," which authorizes that "a covered entity (including a covered entity not part of or affiliated with the Department of Defense) may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission."

The level and amount of PHI that should be disclosed is often disputed among battalion physician assistants (PAs) and unit commanders. PAs try to disclose the least amount of information required, and commanders feel that they need the most information possible in order to make decisions, especially when determining deployability.

Commanders would benefit from discussing with their battalion PAs what information has traditionally been given to commanders and

through what medium (such as a commander's medical meeting or an email). If a commander has a battalion provider who is reluctant to give any information, the best course of action is to contact the brigade legal office and the HIPAA officer within the local military treatment facility to determine the standard.

The goal is to facilitate enough information to complete the mission. Upon receipt of PHI, commanders are tasked to safeguard information under the Privacy Act of 1974. They may be subject to fines and Uniform Code of Military Justice action if PHI is not appropriately safeguarded.

Profiles

Profiles are used by medical and behavioral health providers to notify leaders of a Soldier's functional limitations. Profiles are recommendations to leaders, and a provider's recommendation does not override a commander's decision. The only acceptable proof of profile for a Soldier to produce is a Department of the Army Form 3349, Physical Profile, not a sick call slip. The profile is honored only if the individual has the document on hand and can present it when asked.

When reviewing a Soldier's profile, a leader should first check the PULHES section (block 3). PULHES is an acronym for physical capacity/stamina (P), upper extremities (U), lower extremities (L), hearing and ears (H), eyes (E), and psychiatric (S).

PULHES includes numbers from one to four. For brevity, a code of 1 or 2 means that the Soldier can deploy, and a 3 or 4 means that the Soldier cannot deploy. However, leaders should be aware of whether a Soldier on a profile coded 2 can deploy to certain regional command theaters. For example, the U.S. Central Command will accept a Soldier on mood medications with a code 2, but the U.S. European Command will not.

Block 1 describes the medical condition that warranted the profile. Block 2 includes codes that describe the Soldier's capacity to deploy.

Section 4 says whether the Soldier has a permanent or temporary profile. It should be noted that Soldiers with a permanent 2 (P2) profile can be retained in the Army; however, Soldiers may need to change their military occupational specialties (MOSs) based on their physical limitations and duty requirements.

Sections 5 and 8 explain the Soldier's functional limitations and other comments. Leaders must know what the Soldier can and cannot do in the field and during physical training. For example, the profile may say that the Soldier cannot run, so a leader may have him ride a stationary bike to maintain cardiovascular fitness.

Block 7 says whether or not the Soldier on a permanent profile requires an MOS Administrative Retention Review (MAR2). The MAR2 process ensures that Soldiers who are issued a P3 or P4 profile have an administrative review to see if the physical limitations on their profiles prohibit them from performing their primary MOSs.

The Human Resources Command performs an administrative review of the MAR2 packet based on the limitations stated in the profile, the Soldier's statement, and the commander's statement. The packet allows the Human Resources Command to determine if the Soldier will be retained in his current MOS, reclassified to another MOS, or referred to a medical evaluation board (MEB).

Tracking the profile history of a Soldier is the responsibility of leaders, not medical care providers. Clinic personnel will record and report a Soldier's status; however, it is up to leaders to track their Soldier's medical status and path to recovery and to determine the way ahead.

It can be difficult for a commander or first sergeant to determine what a Soldier can do during the duty day because a profile is essentially a long list of what the individual should not do in order to fully recover. It is best to sit down with the PA and determine, based on the individual's injury or illness, projected recovery time, and MOS requirements, what the Soldier can do as opposed to what he should not do. This ensures that the Soldier is being fully employed while being given the opportunity to heal.

Leaders' Resources

Army Regulation 40-501, Standards of Medical Fitness, and the PA are the main resources for profile information or questions. The PA should be available to sit down with the commander and provide in-depth feedback about individuals within the formation. The PA should provide recommendations regarding the profile, recovery timeline, and possible future actions.

If the battalion PA is not providing enough information on a profile, a leader can request that the PA use the template function within the eProfile system. This function uses templates that incorporate rehabilitation guidance from Field Manual 7-22, Army Physical Readiness Training.

If a leader decides against the PA's recommendation in a profile, the Soldier may turn to the inspector general (IG) for support. It is a good idea for leaders to meet the IG representative early in their command or responsibility. This will alleviate friction later.

Another important person to meet early on is the legal representative for the battalion. It is smart to consult with the IG and legal representative when faced with complex issues.

Recovery and Readiness

Leaders should compare the profile history to the recovery timeline given by the provider. Once a leader determines whether or not a Soldier is within the recovery timeline, the leader can begin to look into the way ahead for the Soldier, such as a chapter, MEB, permanent profile, warrior transition battalion (WTB) assignment, MAR2, or rear detachment assignment.

It is important to develop a method to track how long and for what reason a Soldier is on profile. When tracking recovery timelines, leaders

Medical Readiness Categories (MRCs)	Time to Correct	Unit Status Report Available	Example of Condition
MRC 1	Meets standard	Yes	The Soldier does not have a medical condition.
MRC 2	< 72 hours	Yes	The Soldier has received evaluation for chronic lower back pain or chronic knee pain.
MRC 3A	< 30 days	No	The Soldier has acute lower back pain or ankle sprain.
MRC 3B	> 30 days	No	The Soldier is recovering from surgery.
MRC 4	Unknown	Yes	The Soldier is missing a current periodic health assessment or dental screening.

Figure 1. Medical readiness categories.

need to keep their training calendars and deployment dates in mind. Knowing the timeline for recovery allows leaders to forecast whether Soldiers will be available for a training center rotation or a deployment.

Leaders should know the difference between an elective surgery and a medically necessary surgery because a surgery can affect an expiration of term of service, permanent change of station, deployment, or training center rotation. An elective surgery still may be necessary for a Solider to be mission capable, and the leader should consult the PA to determine the surgery's necessity.

A Soldier's medical readiness category (MRC) is how readiness is tracked in the unit status report. (See figure 1.) During battalion and higher meetings, a leader will need to be able to discuss the Soldier's MRC and will hear others refer to the Soldier as being in a certain MRC.

Systems for Monitoring Health

Several tools, such as eProfile, the Commander's Dashboard, and the Medical Protection System (MEDPROS), are used to manage the health of a unit.

eProfile. The most important program to be aware of is eProfile. This program gives a leader access to all the profiles in the unit. A leader is typically given access to eProfile in the commander's or first sergeant's course. The program provides both current and past profiles so that a leader can look for trends such as recovery timelines or repetitive profiles (also known as "profile riding").

The Commander's Dashboard. The Commander's Dashboard allows leaders to view pertinent information that helps them to identify at-risk Soldiers and make decisions regarding them. Even though it is called the Commander's Dashboard, first sergeants have access to this program. Leaders can view a Soldier's personnel data (active flag information, deployment history, and PULHES) and risk history (positive urinalysis, blotter reports, and domestic violence cases).

Integrated Disability Evaluation System. Within the Commander's Dashboard, leaders will find the Integrated Disability Evaluation System (IDES). This system is used to evaluate Soldiers who have met a medical retention decision point within one year of being diagnosed with a medical condition and no further treatment would greatly improve the Soldier's condition to a retainable status.

Two very important parts of IDES are a MEB and a physical evaluation board (PEB). These are formally initiated by the medical provider; however, command involvement is important throughout the entire process. The MEB is an informal board that determines if the Soldier is unfit for duty and should not be retained in the Army or current MOS. If the MEB determines the Soldier is unfit, then the Soldier is referred to a PEB, which further delineates the Soldier's disposition.

The Command Management System (CMS). Within the Commander's Dashboard is CMS, a web-based application that shows commanders and first sergeants where a Soldier is in the MEB process, how many days have been spent in each of the steps in the process, and the goal number of days at each step.

CMS provides contact information for the PEB liaison officer, who guides each Soldier through the entire IDES process. Once Soldiers begin the IDES process, they are coded 9H for unit status reports and replacements can be requested.

MEDPROS. A final program to be aware of is MEDPROS. This program tracks medical and dental readiness. Every military post will approach access to this program differently.

Access is available to commanders and even platoon-level leaders, and it has to be obtained through the medical clinic. To obtain access to MEDPROS, leaders must complete online training and a three-day block of classroom instruction.

Health Care Providers

Prior to taking command or responsibility, a leader should meet the battalion PA and brigade psychologist to get an understanding of their roles in managing the health of the unit. These providers give recommendations on how to manage the health of the unit; their recommendations do not override the commander's decisions. In most units, only the PA is authorized to initiate a MEB, even if

it is for behavioral health reasons.

A leader should have frequent contact with the PA to discuss the health of the unit. Weekly meetings with the PA are recommended until the leader has a grasp of the health of the unit. After gaining an understanding the unit's health, the leader should meet with the PA monthly. This meeting should occur the week before the battalion's health of the force meeting so that the leader is prepared to brief battalion leaders.

Some initial topics to cover with the PA include the following:

- ☐ How to track profiles.
- ☐ Notifying leaders of a "profile rider."
- ☐ When a temporary profile should be changed to permanent.
- ☐ When a Soldier has reached a medical retention decision point and a MEB or MAR2 should be initiated.
- ☐ When a Soldier should go to a WTB and the differences between being assigned and attached to the WTB.
- ☐ What the PA's and leader's roles are in submitting and tracking a warrior transition unit packet.
- ☐ How the PA determines when a Soldier will be fully mission capable.

The brigade has an Army psychologist and an Army social worker. It also has an embedded behavioral health (EBH) clinic assigned to it. The primary role of the brigade psychologist is to be a consultant to commanders on behavioral health topics. The psychologist's secondary role is to assess, treat, and manage behavioral health issues.

The brigade psychologist and social worker do not do the same things, but the services they provide overlap. Only the brigade psychologist can perform psychological testing, evaluate security clearances, write profiles without requiring a co-signature, and diagnose personality disorders. Both providers can do command-directed mental health evaluations (CDMHEs) and evaluations for school attendance.

Leaders should consult with the brigade psychologist if they feel that a Soldier should be separated from the Army for behavioral health reasons. The psychologist will determine whether or not separation is warranted and explain the reasoning behind this decision. It is common to involve the Soldier's EBH clinic provider to determine what is needed for separation.

The EBH clinic belongs to the hospital and is located within the brigade's footprint. It is staffed by civilian psychologists, social workers, and providers who can prescribe medication (typically nurse practitioners). The primary role of these providers is to treat behavioral health issues, and their secondary role is to serve as consultants to commanders.

The typical EBH clinic assigns one of its providers to be a consultant for each battalion in the brigade. One difference between the brigade's organic behavioral health assets and the EBH clinic is that the organic assets are available 24/7 while the civilians in the EBH clinic work specific hours. A second difference is that the organic assets will deploy with the unit while the EBH clinic continues to treat Soldiers at home station.

CDMHE

Leaders need to know about CDMHEs. This type of evaluation can be initiated by a commander or a designated senior enlisted service member when a Soldier demonstrates behavior that is considered a threat to unit readiness, a threat to self, or a threat to others.

When receiving feedback on the evaluation from a behavioral health provider, leaders should be aware that research has shown that not all providers have adequate training in all aspects of suicidality (including prevention, assessment, management, and treatment).

Research has also shown that clinical experience does not equate to clinical competency. For example, one study found that clinicians with years of experience in assessing suicidality were no more knowledgeable of suicidality than graduate students.

Leaders typically take a behavioral health provider's word because suicide prevention is not a leader's specialty. But leaders should use the behavioral health provider's recommendations and opinions only as a single data point for reducing a Soldier's risk.

Leaders should take a multidisciplinary approach to developing a Soldier's risk reduction strategy. For example, leaders should consider recommendations and opinions from the unit's PA, the chaplain, and the Soldier's family members in addition to the leader's own perspective. The at-risk Soldier is likely to present differently to each person.

The purpose of this article is to educate company-level leaders on how to manage the health of the force. The need to efficiently manage the health of the force has recently been brought to the forefront because of the drawdown and the Army's mandate to reduce its nondeployability rate to 5 percent. The topics covered in this article should provide company leaders with a basic understanding of the systems used for monitoring the health of the force and the functions of health care providers at the company level.

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