Strength and Recovery: Reconditioning Our Army

by COL Charles Masaracchia, CSM Daniel T. Hendrex, CPT Jason Cirolia, SFC Charles M. Meecham and SPC Aura E. Sklenicka

Sergeant Major of the Army Daniel A. Dailey has highlighted the largest problem facing the Army today: the lack of available Soldiers who are ready to deploy. Dailey spoke at the Command and General Staff College Nov. 19, 2015, stating there are about 50,000 non-deployable Soldiers at the moment. To put that into perspective, that would be three out of 10 divisions within the Army.

Musculoskeletal injuries are the leading cause of all medical disabilities, accounting for 40 percent to 75 percent of all claims, according to Marlene E. Gubata et al.[1] It is also important to note that lower-extremity overuse injuries are listed as the No. 1 cause of lost and limited duty days across the U.S. military.[2] This has resulted in more than 3.8 million lost duty days per year as well as 10 million limited-duty days due to physical profiles.

The initial observation from within our brigade – 2nd Armored Brigade Combat Team (ABCT), 1st Armored Division, Fort Bliss, TX – was that 60 percent of all chapters in the preceding years (2013-2014) were Army Body Composition Program and Army Physical Fitness Training (APFT) failures, and 12 percent were non-available due in large part to injuries.

The nation's ability to fight and win wars is greatly affected by this lack of able-bodied Soldiers. However, simply removing all non-available service members from the force is not the answer. It costs the Army time and money to train each Soldier. As leaders, it is incumbent on us to work with what we have been given, training our Soldiers how to take care of themselves and getting those injured back into the fight.

Therefore, we decided to dramatically rework our brigade physical-training program with a wholly new Reconditioning Physical Readiness Training (RPRT) program at its center. This approach would dramatically change the brigade's readiness for the better, create healthier and stronger Soldiers, and create a model we hope other units are able to use as well.

Holistic approach to fitness

Our unit created a cross-functional team known as the Brigade Tactical Athlete Committee (BTAC) in September 2014. This committee convened quarterly to discuss the current trends and future of physical fitness within the unit.

The BTAC is composed of brigade and battalion command teams, master-fitness and master-resiliency trainers (MFTs/MRTs), the brigade surgeon, a physical therapist, executive-wellness noncommissioned officers (NCOs), the dining-facility manager, brigade executive officer and other subject-matter experts from across the brigade and installation. These meetings are an opportunity for open communication about what is and is not working and are a catalyst for creating a cultural shift surrounding health, fitness and nutrition within the brigade.

We formed the BTAC to address how to serve Soldiers and enhance their interest in increasing their levels of physical fitness and readiness across the brigade. Through the experience, expertise and leadership of our command teams and the combination of Fort Bliss' fitness knowledge, our unit began implementing a holistic approach to fitness, attempting to make it a way of life for Soldiers.

In an effort to demonstrate the focus on physical-readiness training (PRT), the BTAC decided to extend PRT hours from 6:30 a.m. to 8 a.m. This allowed Soldiers and leaders the time to fully benefit from preparation, conditioning, military movement, runs and recovery drills without the pressure of attempting to complete everything in one hour. We also directed that no other activity took precedence during that time, enabling leaders to focus their attention on improving their teams and preparing them physically for combat.

Also, to better integrate wartime mission preparation, we initiated the "march and shoot" program, which combines the requirements of carrying a rucksack and the ability to qualify with assigned weapons. Soldiers conducted foot movement to the range, qualified on their assigned weapon system and conducted a foot movement back.

Figure 1. Participants in the 2nd ABCT, 1st Armored Division, Strike Hard or Go Home Obstacle Course complete a tire sprint up the hill June 11, 2015, at Strike Field, Fort Bliss, TX. Readiness within the unit has improved through a holistic approach to fitness for all Soldiers. (*Photo by SPC Aura E. Sklenicka*)

Furthermore, the brigade also purchased and began using total-resistance exercise (TRX) deployable tactical-training boxes. The TRX boxes maintain a presence on Strike Physical Training Field while in garrison and are transported to every field exercise down to the battalion level to ensure Soldiers are given the opportunity to maintain their physical-fitness levels.

Finally, the brigade and individual battalions held physical-fitness competitions, optimal-performance rodeos and organizational events, encouraging all Soldiers to participate and allowing them to see fitness as being fun rather than a required task. Many brigade and battalion physical-fitness events included family participation to promote healthy lifestyles and develop healthy habits. Soldiers are educated and informed on the components of the performance triad as well as the physical and mental aspects of fitness, movement and mechanics, nutrition, sleep and energy management.

Figure 2. Participants in the 2nd ABCT, 1st Armored Division, Little Strike Obstacle Course complete the hill obstacle June 11, 2015, at Strike Field, Fort Bliss, TX. Many brigade and battalion physical-fitness events include family participation to promote healthy lifestyles and develop healthy habits. (*Photo by SPC Aura E. Sklenicka*)

Reconditioning program

Despite the success of all the previously mentioned initiatives, we still had a significant problem with non-available Soldiers due to medical profiles. Lengthening PRT, doing “march and shoots” and holding PRT competitions only addressed those Soldiers healthy enough to participate. Compounding the problem, our brigade’s original RPRT programs had not proven successful in readily recovering injured Soldiers. Additional analysis of the physical

readiness within our brigade illustrated a shortage of experienced MFTs, while battalion RPRT programs varied in focus and effectiveness. Many programs were being led by NCO cadre who themselves had profiles and in turn couldn't perform required exercises. Finally, the cadre showed little interest in the Soldier and the Soldier's ability to recover.

These factors translated into injured Soldiers not being motivated to recover and other Soldiers returning to their units without verification that they were recovered and ready for the intensity of unit PRT. In addition to the Soldiers' lack of motivation, units across the brigade took little effort toward encouraging the Soldier to take personal ownership of their recovery.

Although many commanders are aware of Field Manual (FM) 7-22, there is often little understanding or awareness of the RPRT program outlined in Chapter 6. Many units attempt their own form of profile physical training with mixed results, but often with little to no oversight and accountability. There are many pitfalls identified for these types of programs. Some common problem areas encountered are the variety of profiles and effected body parts; the issue of malingering and minimal effort toward recovery; lengthy profile times; deconditioning while on profile; and injury reoccurrence upon return to the unit's regular PRT.

As a result of all these challenges, we developed and implemented a brigade-led and battalion-executed RPRT program with the intent for each Soldier to have a stake in the rate of their recovery and physical-fitness timeline, increasing their capabilities to test out and add to the number of available Soldiers.

We identified four lines of effort (LoE) within the RPRT to aid a Soldier in getting back into the fight: accountability, execution, progress and education. Each LoE is interconnected, and combined allow the reconditioning program to run efficiently and effectively.

Accountability LoE. The accountability LoE begins when the battalion medical officer identifies personnel requiring RPRT based off profiles. The roster generated is given to company-command teams, the battalion MFT and battalion command sergeant major to track attendance. The accountability formation was also moved to the end of the PRT hours to ensure presence for the entirety of the prescribed time. The battalion physician assistants are also able to see why a Soldier is not making progress if they aren't attending.

Also, we recognized that holding RPRT at a centralized location allows 100 percent attention and observation on each battalion conducting their RPRT program. Our brigade commander and command sergeant major begin and end their morning PRT on Strike PT Field, reinforcing the concept that fitness is a high priority within the unit.

Execution LoE. The execution LoE begins with an MFT assigned by the battalion, who provides guidance to the cadre on the field leading the reconditioning program. The cadre include the reconditioning program leader (RPL) and the assistant reconditioning program leaders (ARPL). Daily the RPL and ARPL conduct RPRT with their formations to ensure profile guidance is being kept while also providing a challenging experience for the Soldier.

Progress LoE. The progress LoE focuses on each Soldier's improvements throughout their assignment to the program. From their first day in the program, Soldiers are monitored and tested against the entry and exit criteria outlined in FM 7-22, Chapter 6. With open communication among battalion physician assistants, physical therapists and occupational therapists, the RPL and MFT are able to ensure that daily maintenance and progress is being made by each Soldier. With progress tracked by the RPL, Soldiers are better able to progress through the program and back to their units.

As a part of the progress LoE, the Soldier's motivation is tracked to go beyond the maintenance phase of recovery and return to their unit. This communication and the unique factor of tracking Soldier motivation has reduced malingering among this group. Creating a chain of communication and trust among the trainers, the command team and the unit's medical staff has also enhanced profile management and effective courses of treatment. The RPRT program can only be successful with the cohesive efforts of the unit's MFT, medical personnel and command teams.

Education LoE. Continuing education for this program is essential as the last LoE. With the collaboration of physical therapists and MFTs throughout the brigade, cadre are trained in directing and executing the phases of the RPRT program. As new cadre are rotated in the RPRT program, these training events ensure they understand the goals, methods and processes involved. This communication has allowed medical personnel and RPRT cadre to fine-tune

the program based on what is, or is not, effective for Soldiers in reconditioning. Soldiers who are in the reconditioning program are also recipients of education pertaining to the performance triad, as one or more of these components may be affected by their recent injury. The education LoE also reinforces the importance of why taking ownership of their health is essential for their recovery.

In addition to creating a better organizational structure to the RPRT, we also paid significant attention to its content as well. Simply walking or performing whatever exercises the Soldier felt like while under a medical profile is not the intention of the reconditioning program. Since Soldiers in the RPRT program are already at a disadvantage compared to their healthy counterparts, the intent is to have these groups challenge themselves even more to surpass a maintenance phase of fitness – so they can match Soldiers within their units. They have the burden of maintaining their fitness levels while simultaneously aggressively seeking to return to full mission capability. Thus, we established a two-phase plan to move Soldiers from injured to healthy with gated criteria to move from one phase to the next.

Figure 3. Participants in the 2nd ABCT, 1st Armored Division, Strike Hard or Go Home Obstacle Course plunge into an ice bath June 11, 2015, at Strike Field, Fort Bliss, TX. The RPRT program's intent is to have groups in the program challenge themselves to surpass a maintenance phase of fitness. (*Photo by SPC Aura E. Sklenicka*)

Phase I is traditionally a gym-based program. Its purpose is to maximize what Soldiers are doing with their occupational and physical therapists while maintaining their fitness during early stages of recovery. Although our brigade does not use the installation gym, using the schedule outlined in FM 7-22, our brigade replicated the exercises using physical-therapist therabands. To uphold the goals of this phase, we developed strength and endurance routines, with a catered focus on mobility and stability according to the medical provider's specifications and limitations for the Soldiers. It is important to mention that pain is not conducive to recovery and the mantra "No pain, no gain" is both harmful and ineffective when managing recovery from injuries.

Once Soldiers are tested for entry into Phase II, we are able to implement alternate versions of traditional PRT exercises. At this point, the medical team has cleared a Soldier to perform other functional movements, depending on the specific injury and their ability to bear weight. Our aim is to bridge the gap of basic movement without pain, conditioning and a Soldier's capability to become fully functioning for unit PRT.

Each week the MFTs inform Soldiers of the coming week's test-out day for their phase and provide the names of those who are projected to test out or if their profile will be expiring so they can meet with their medical provider. Testing-out criteria are in accordance with FM 7-22.

Observations

For the program to continue to work effectively, command emphasis from company to brigade is essential.

Also, the brigade learned that even with initial hesitation about a centrally located program, the battalion's individual programs improved. Shared knowledge among MFTs, ARPLs and medical personnel enabled best practices to be shared more readily.

With increased leader focus on RPRT, we were able to quickly identify which Soldiers lacked motivation to continue their recovery. This enabled command teams and health-care providers to decide how to proceed with their Soldiers in the Medical Evaluation Board and Military Medical Review Board process.

Also, the MFTs began seeing systemic trends in injuries and recovery times. This enabled MFTs to supplement exercises Soldiers conducted during their physical-therapist appointments. With this free communication, many Soldiers were able to recover on an accelerated timeline without risk of reinjury. The possibility to accelerate testing out of a phase is not identified or discussed in FM 7-22. In our brigade, if a Soldier on profile is capable of performing the exercises required to test out, they are able to request, through their MFT, a test-out date. The MFT will communicate with the physician's assistant and receive an answer generally within 24 hours after their review. Establishing a good working relationship between the MFT and physician's assistant is imperative. This trust is necessary as the MFT makes recommendations for progress and test-outs from the program.

Intuitively, the brigade learned that Soldiers are motivated again to get back in the fight through challenging RPRT exercises that are tailored to them. Soldiers being motivated and taking ownership are clear indicators of rapid recovery.

Also, commanders need to give time for MFTs and ARPLs to conduct PRT on their own so they can give their attention to their formations during reconditioning. Cadre can quickly lose their effectiveness by becoming out of shape in support of this program.

Cadre observed the lack of strength to perform PRT climbing drills even though no injury precluded it. Phase II of RPRT has focused on making Soldiers more capable of executing these climbing drills, and after testing out, these Soldiers are more capable than their non-injured counterparts. We extended this focus throughout the brigade for all Soldiers to focus and better themselves in this area of PRT.

Conclusion

To demonstrate the program's effectiveness, in just a few short months our brigade went from 12 percent non-available Soldiers to below 7.5 percent non-available Soldiers – with numbers continuing to improve. The brigade started with 652 Soldiers assigned to the reconditioning program and is currently at about half of that (330 Soldiers). The Soldiers who have been assigned and tested out of the program have also shown to be less likely to reinjure themselves as shown in the Medical Readiness Assessment Tool.

With the identification of the Army's issue of non-available Soldiers within the brigade, specifically toward physical readiness, the brigade took a holistic approach. Command emphasis, in conjunction with the inception of the BTAC, led to improved physical readiness throughout the brigade. The unique RPRT program that our brigade conducts remains a pillar of this holistic approach.

The approach to ensuring an effective and meaningful RPRT program involves team cohesion, command support, proper training and accountability measures. Although initially it was labor intensive, the program is now self-sustaining with minimal oversight.

This article is not to detail the only way in approaching this population but to outline a way that has been successful and congruent with the commander's expectations. In general, the most important asset we have is our Soldiers, and they should be supported and encouraged to take ownership of their recovery. Through leadership involvement, effective communication and personal motivation, Soldiers participating in an effective reconditioning program are better prepared to return to their unit and accomplish their wartime mission.

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CSM Daniel Hendrex is command sergeant major of 2nd ABCT, 1st Armored Division, Fort Bliss. Previous assignments include military fellow, Chief of Staff of the Army's Strategic Studies Group, Arlington, VA; operational adviser, troop sergeant major and squadron command sergeant major, Asymmetric Warfare Group, Fort Meade, MD; first sergeant, 3rd Armored Cavalry Regiment, Fort Carson, CO; and master gunner, 1st Armored Division, Bad Kreuznach, Germany. His military education includes Primary Leadership Development Course, Basic Noncommissioned Officer Course, M1A1 Armor Master Gunner School, Advanced Noncommissioned Officer Course and U.S. Army Sergeants Major Academy. His awards include Legion of Merit, Bronze Star Medal with V device and OLC, Meritorious Service Medal with OLC and Combat Action Badge.

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Notes

[1] Marlene E. Gubata, M.R.B., David N. Cowan, Ricardford R. Connor, Janice K. Gary, Vanessa J. Grinblat-Moglin, Alexis A. Oetting, Elizabeth R. Backnett, Vielka C. Rivera, Nadia Urban and Bin Yi, Accession Medical Standards Analysis and Research Activity, 2013 annual report.

[2] Bruce A. Ruscio, B.H.J., Steven H. Bullock, Bruce R. Burnham, Michelle Canham-Chervak, Christopher P. Rennix, Timothy S. Wells and Jack W. Smith, "A Process to Identify Military Injury Prevention Priorities Based on Injury Type and Limited Duty Days," ***American Journal of Preventive Medicine***, Vol. 38, 2010; David W. Niebuhr, M.E.G., Li Yuanzhang, David N. Cowan, Janice K. Gary, Vanessa J. Grinblat-Moglin, Alexis A. Oetting, Elizabeth R. Packnett, Vielka C. Rivera, Nadia Urban and Bin Yi, Accession Medical Standards Analysis and Research Activity, 2010 annual report; K.G. Hauret, J.B., S.H. Bullock, M. Canham-Chervak and S. Canada, "Musculoskeletal injuries description of an under-recognized injury problem among military personnel, ***American Journal of Preventive Medicine***, 38(1), 2010.