UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

JUN 09 2008

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510-6050

Dear Mr. Chairman:

This letter provides the 2008 Annual Report to Congress for the Department of Defense on health status and medical readiness of members of the Armed Forces. The enclosed report is based on the Comprehensive Medical Readiness Plan developed by the Joint Medical Readiness Oversight Committee (JMROC) as required by Section 731 of the Ronald W. Reagan National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2005.

The initial Comprehensive Medical Readiness Plan identified 10 objectives and 22 action items for concentrated action, including the necessary measures of success. The 2007 report reflected completion of 20 of 22 action items. JMROC expanded the Plan to include readiness actions mandated by NDAA for FY 2006 and 2007. The current plan reflects 16 action items of which 14 are complete.

Thank you for your continued support of the Military Health System.

Sincerely,

David S. C. Chu

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

JUN 09 2008

The Honorable Ben Nelson
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510-6050

Dear Mr. Chairman:

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cc:
The Honorable Lindsey O. Graham
Ranking Member

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WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

JUN 09 2008

The Honorable Ike Skelton
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515-6035

Dear Mr. Chairman:

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Enclosure:
As stated

cc:
The Honorable Duncan Hunter
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

JUN 09 2008

The Honorable Susan Davis
Chairwoman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515-6035

Dear Madam Chairwoman:

This letter provides the 2008 Annual Report to Congress for the Department of Defense on health status and medical readiness of members of the Armed Forces. The enclosed report is based on the Comprehensive Medical Readiness Plan developed by the Joint Medical Readiness Oversight Committee (JMROC) as required by Section 731 of the Ronald W. Reagan National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2005.

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Enclosure:
As stated

cc:
The Honorable John M. McHugh
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

JUN 09 2008

The Honorable Robert C. Byrd
Chairman, Committee on Appropriations
United States Senate
Washington, DC 20510-6025

Dear Mr. Chairman:

This letter provides the 2008 Annual Report to Congress for the Department of Defense on health status and medical readiness of members of the Armed Forces. The enclosed report is based on the Comprehensive Medical Readiness Plan developed by the Joint Medical Readiness Oversight Committee (JMROC) as required by Section 731 of the Ronald W. Reagan National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2005.

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Enclosure:
As stated

cc:
The Honorable Thad Cochran
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

JUN 09 2008

The Honorable Daniel K. Inouye
Chairman, Subcommittee on Defense
Committee on Appropriations
United States Senate
Washington, DC 20510-6028

Dear Mr. Chairman:

This letter provides the 2008 Annual Report to Congress for the Department of Defense on health status and medical readiness of members of the Armed Forces. The enclosed report is based on the Comprehensive Medical Readiness Plan developed by the Joint Medical Readiness Oversight Committee (JMROC) as required by Section 731 of the Ronald W. Reagan National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2005.

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cc:
The Honorable Ted Stevens
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

JUN 09 2008

The Honorable David R. Obey
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515-6015

Dear Mr. Chairman:

This letter provides the 2008 Annual Report to Congress for the Department of Defense on health status and medical readiness of members of the Armed Forces. The enclosed report is based on the Comprehensive Medical Readiness Plan developed by the Joint Medical Readiness Oversight Committee (JMROC) as required by Section 731 of the Ronald W. Reagan National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2005.

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The Honorable Jerry Lewis
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

JUN 09 2008

The Honorable John P. Murtha
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515-6018

Dear Mr. Chairman:

This letter provides the 2008 Annual Report to Congress for the Department of Defense on health status and medical readiness of members of the Armed Forces. The enclosed report is based on the Comprehensive Medical Readiness Plan developed by the Joint Medical Readiness Oversight Committee (JMROC) as required by Section 731 of the Ronald W. Reagan National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2005.

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Enclosure:
As stated

cc:
The Honorable C. W. Bill Young
Ranking Member

Joint Medical Readiness Oversight Committee

Annual Report to Congress
On the
Health Status and Medical Readiness of Members of the Armed Forces
May 2008




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Background:

The 2005 Comprehensive Medical Readiness Plan was established with the goal of improving medical readiness throughout the Department of Defense (DoD) and enhancing Service member health status tracking before, during, and after military operations. The 2005 plan specifically addressed requirements of the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005 (NDAA 05) and other legal requirements, and identified ten objectives consisting of 22 plans for concentrated action. As of the last report to Congress, 20 of 22 (90 percent) of the action plans were complete.

Action 1, NDAA 05, Section 731(a) – Comprehensive Medical Readiness Plan Update

This section requires DoD to develop a comprehensive plan to improve medical readiness and tracking of health status throughout service in the Armed Forces, and to strengthen medical readiness and tracking before, during, and after deployment overseas.

To maintain the currency of the Comprehensive Medical Readiness Plan, the Joint Medical Readiness Oversight Committee (JMROC) updated the 2005 plan. The 2007 plan includes not only the remaining and recurring actions from NDAA 05, but also new requirements from the National Defense Authorization Act for Fiscal Year 2006 (NDAA 06) and the John Warner National Defense Authorization Act for Fiscal Year 2007 (NDAA 07). The resulting plan yielded 16 actions, of which 14 are now complete.

Action 2, NDAA 05, Section 731(c) – Annual Report on the Health Status and Medical Readiness of Members of the Armed Forces

This section requires that JMROC prepare and submit a report annually to the Secretary of Defense and to the Senate and House Armed Services Committees (reviewed by veterans and military health advocacy organizations) on the health status and medical readiness of members of the Armed Forces, including members of reserve components, based on the comprehensive plan and compliance with DoD policies on medical readiness tracking and health surveillance.

In addition to coordination within the Department of Defense, this year's report has been coordinated with the following military health advocacy organizations:

- Air Force Association;
- American Legion;
- American Veterans (AMVETS);
- Association of the United States Army;

- Commissioned Officer Association of the U.S. Public Health Service;
- Disabled American Veterans;
- Enlisted Association of the National Guard of the United States;
- Fleet Reserve Association;
- Jewish War Veterans;
- Marine Corps Association;
- Military Officers Association of America;
- National Association for Uniformed Services;
- National Guard Association of the United States;
- National Military Family Association;
- Naval Reserve Association;
- Non-Commission Officers Association;
- Paralyzed Veterans of America;
- Reserve Officers Association;
- Veterans of Foreign Wars; and
- Vietnam Veterans of America.

In addition, the Department of Health and Human Services and the Department of Veterans Affairs reviewed the report.

Summary of Comments
No comments were received from the military health advocacy organizations.

Action 3, NDAA 05, Section 733 – Baseline Health Data Collection Program

This section requires the Secretary of Defense to implement a program to collect baseline health data for all persons entering the armed forces at the time of entry, and provide computerized compilation and maintenance of the baseline data.

There are two components to baseline health data collection in DoD. The first involves routine processing examinations accomplished at the Military Entrance Processing Stations (MEPS) for enlisted recruits and for new officers as part of DoD Medical Examination Review Board (DoDMERB) process. These two examinations provide the earliest collection of baseline health information from new military applicants. Recruits bring a paper copy of their initial MEPS health record with them to initial training. The U.S. Military Enlistment Processing Command is developing a standardized electronic data collection system that will link to AHLTA, the Military Health System's electronic health record, allowing incorporation of the information into the service member's longitudinal electronic health record. However, this linkage will not be complete until after 2010.

In the meantime, DoD has focused on developing a parallel baseline health information collection tool, the Health Assessment Review Tool-Accession (HART-A). This self-reporting tool collects demographic, medical, psychosocial (including depression and post-traumatic stress disorder (PTSD) scales that are not part of the MEPS/DoDMERB tools), occupational, and other health risk data. A paper-based process was piloted at several recruit sites in the past. On October 1, 2007, the Military Health System launched a viable technical solution that provides a web-enabled version of the HART-A for recruits to complete from any computer terminal with Internet access, as long as they are registered in Defense Enrollment Eligibility Reporting System (DEERS) and have a valid Common Access Card (CAC).

Action 4, NDAA 05, Section 738 – Full Implementation of Medical Readiness Tracking and Health Surveillance Program and Force Health Protection and Readiness Program

This section requires the Secretary of Defense and the Secretaries of the military departments to take actions as necessary to ensure the Army, Navy, Air Force, and Marine Corps fully implement the Medical Readiness Tracking and Health Surveillance Program and the DoD program of Force Health Protection and Readiness (relating to the prevention of injury and illness, and the reduction of disease and non-combat injury threats). Through the USD (P&R), JMROC oversees the development and monitors implementation of the Medical Readiness Tracking and Health Surveillance Program, and the DoD program of Force Health Protection and Readiness.

JMROC decided to measure individual medical readiness using two complementary metrics. The first metric is the percent of the Armed Forces without any deployment limiting medical condition. It is calculated by selecting only those Service members who have a current medical and dental evaluation and determining the percentage of these Service members who do not have a chronic or prolonged deployment limiting medical condition or a significant dental condition in need of treatment. It provides senior leaders with an estimate of the percentage of their units that would be medically available to deploy. Performance goals also were established as follows: FY07 – greater than 87 percent; FY08 – greater than 90 percent; FY09 – greater than 92 percent.

The second metric complements the first in that it defines the completeness of the first medical readiness estimate. It is the percent of Armed Forces whose medical readiness status is indeterminate. This metric is calculated by determining all personnel who are not current on their medical or dental evaluation and then expressing this as a percentage of all of the deployable Armed Forces. Performance goals are as follows: FY07 – less than 25 percent; FY08 – less than 15 percent; and FY09 – less than 10 percent.

Over the last year, individual medical readiness has improved significantly, but the DoD did not meet all of its goals. The indeterminate status decreased from 30 percent to 24 percent, exceeding the goal of 25 percent. The medically ready status, however, only increased from 84 percent to 85 percent, missing the goal of 87 percent. When broken out by components, all of the active duty components met the medically ready goal of 87 percent. However, the Navy and the Marine Corps failed to meet the goal of an indeterminate rate below 25 percent. The Navy Reserve met its goals, but other Reserve Components, especially the Army Reserve and the Army Guard, did not meet the goals for individual medical readiness. A Reserve Component Work Group will address medical readiness within the reserves.

The DoD Instruction on Force Health Protection Quality Assurance (FHPQA), published on February 16, 2007, implements policy, assigns responsibilities, and prescribes procedures by establishing a comprehensive DoD FHPQA program. It addresses comprehensive military health surveillance by including FHP elements from the full range of military activities and operations, and expands deployment health quality assurance activities, deployment health surveillance activities, and occupational and environmental health surveillance activities by applying FHPQA to key elements throughout the entire period of an individual's military service. The Force Health Protection Quality Assurance Program is actively and fully supported by Services.

In June 2007, the Government Accountability Office (GAO), published, "DEFENSE HEALTH CARE: Comprehensive Oversight Framework Needed to Help Ensure Effective Implementation of Deployment Health Quality Assurance Program. In it, GAO found that DoD had established a deployment health quality assurance program as part of its medical tracking system, but did not have a comprehensive oversight framework to help ensure effective implementation of the program. Thus, DoD does not have the information it needs to evaluate the effectiveness and efficiency of its deployment health quality assurance program.

Consistent with the GAO recommendation and DoD Instruction 6000.05, the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness (DASD (FHP&R)), in conjunction with the Force Health Protection Council, assumed the lead to approve key FHP elements and measures of success for quality assurance monitoring and reporting purposes. As a result, military Service Quality Assurance Program representatives met in November 2007 to discuss common core issues, Service-specific systems, and operational and definition differences. Service discussions related to program implementation, process measures, outcomes, and compliance. The representatives have proposed to develop performance specific measures, definitions, target methodologies, and data sources to present to the Force Health Protection Council for decision.

In addition, the Military Departments are providing DASD (FHP&R) quarterly Quality Assurance reports that identify monitoring activities, outline Service specific quality improvement efforts, document site visits, and show performance measures that are consistent with the deployment and pre-deployment health requirements as outlined in the Health Affairs policy 04-001, "Policy for Department of Defense Deployment Health Quality Assurance Program."

Action 5, NDAA 05, Section 739 – Force Health Protection Quality Assurance Program

This section requires the DoD to report annually on its FHPQA program including serum repository results, status of pre- and post-deployment health assessments, an analysis of the actions taken to respond to health concerns expressed by Service members returning from deployment, an analysis of actions taken to evaluate or treat members of the Armed Forces who are confirmed to have been exposed to deployment occupational or environmental hazards potentially deleterious to their health, and compliance with applicable law and policies of the recording of health assessment data in military health records.

The Department submitted the 2007 Quality Assurance report on August 28, 2007. It reported that 94 percent of Service members who returned from deployments in 2006 rated their overall health from good to excellent. Additionally, 56 percent indicated no health concerns at the time of their post-deployment health assessment. These rates represent moderate, but tangible improvements over those identified in last year's report (at 92 and 55 percent, respectively).

The report addressed specific FHPQA activities during calendar year 2006. These activities included deployment health quality assurance (DHQA) visits to military installations, and the associated reviews of over 600 medical records of Service members for deployment-related health documentation, such as health assessments, referrals, and immunizations. The report also provided information on DHQA data maintained in the central database of the Defense Medical Surveillance System, and described highlights from the military Services' DHQA programs in 2006. In addition, data and analyses on post-deployment health concerns of over 190,000 Service members were included, along with synopses of deployment-related occupational and environmental exposure events, details on 425 operational health risk assessment reports, and information on the more than 2,000 Service members monitored under the DoD Depleted Uranium Bioassay Program.

Action 6, NDAA 06, Section 731 – Study Relating to Pre-deployment and Post-deployment Medical Exams of Certain Members of the Armed Forces

This section requires a study of the effectiveness of self-administered assessments included in pre-deployment and post-deployment medical exams, including the mental health portion of the surveys.

The Department submitted an interim report to the Congressional defense committees on November 8, 2006, and a final report is currently in coordination. Almost all Service members (97 percent) rated their general health as at least "good" immediately before deployment to Operation Iraqi freedom or Operation Enduring Freedom. The vast majority of Service members (81 percent) reported their health as at least "good" following return from deployment. Not surprisingly, self-reports from Service members who encountered combat events were more negative than those who did not, and Service members with more combat experiences were more negative that those who encountered fewer actual combat experiences. All respondents reported a high degree of satisfaction with the deployment health assessment process, with endorsement rates of 85 percent or higher for most aspects of the process.

Action 7, NDAA 06, Section 737– Report on Adverse Health Events Associated with Use of Anti-malarial Drugs

This section requires DoD to conduct appropriate studies of adverse health events that may be associated with use of anti-malarial drugs, including mefloquine. The methodology was to ensure the participation in the study of epidemiological and clinical researchers of the Federal Government outside DoD, and of epidemiological and clinical researchers outside the federal government.

In the United States, there are five approved drugs available for malaria chemoprophylaxis: mefloquine, doxycycline, atovaquone-proguanil (Malarone), chloroquine, and hydroxychloroquine sulfate. Of these, mefloquine, chloroquine, and hydroxychloroquine sulfate have sufficiently long half-lives to permit weekly dosing. Weekly dosing enhances compliance with prophylactic dosing regimens. Resistance of malaria parasites to chloroquine and hydroxychloroquine sulfate has also become extremely widespread. Consequently, the most commonly used drugs for malaria prophylaxis are mefloquine, doxycycline, and atovaquone-proguanil. Of these, mefloquine is preferred because it can be administered weekly. Malarone and doycycline are appropriate alternatives but require daily administration. Some individuals poorly tolerate Doxcycline, and Malarone is very expensive. Mefloquine is a very efficacious drug that reliably prevents malaria.

In an interim report submitted to Congress on February 2, 2007, the Department reported the methodology to accomplish the study. To do so, the Department proceeded with four deliberate activities, three of which were complete at the time of the interim report. First, the Armed Forces Epidemiology Board recommended a design for the study. Second, the Deployment Health Research Center studied the health outcomes after Mefloquine use among U.S. Service members. Finally, the Department commissioned two studies by the Armed Forces Institute of Pathology. The first study, which is complete, addressed suicides in deployed and recently deployed Service members. The second is a larger case-control epidemiological study to understand better the myriad of potential attributable risk factors associated with military suicides, including anti-malarials. Use of Mefloquine is one of the factors assessed in this study. The project is on-going, and the Department will submit a final report to the Committees after it is finished.

Action 8, NDAA 07, Section 720 – Report on Distribution of Hemostatic Agents for Use in the Field

This section requires the Secretary to submit to the congressional defense committees a report on the distribution of hemostatic agents.

The Department submitted this report on February 14, 2007. In it, we reported that each Service has adopted hemostatic agents for treating severe traumatic hemorrhage. The Navy, Marines, and Air Force selected QuikClot™. The Army chose a chitosan dressing for the individual soldier, combat lifesavers, and combat medics, and it limits distribution of QuikClot™ to medically trained individuals. Hemostatic agents are fully integrated into the medical supply chain process, and we know of no problems with providing supplies to the units in the field.

Action 9, NDAA 07, Section 733 – Report on Uniform Standards for the Access to Health Care for Wounded, Injured, or Ill Members of the Armed Forces

This section requires the Secretary of Defense to submit to the Committees on Armed Services of the Senate and the House of Representatives a report on uniform standards for the access of wounded, injured, or ill members of the Armed Forces to health care services in the United States following return from a combat zone. The report was to describe, in detail, policies on:

1) The access of wounded, injured, or ill members of the Armed Forces to emergency care;
2) The access of such members to surgical services;

3) Waiting times for referrals and consultations of such members by medical personnel, dental personnel, mental health specialists, and rehabilitative service specialists, including personnel and specialists with expertise in prosthetics and in the treatment of head, vision, and spinal cord injuries; and
4) Waiting times of such members for acute care and for routine follow-up care.

The Department submitted its report on March 7, 2007. The Code of Federal Regulations, 32 CFR 199.17, and the Assistant Secretary of Defense for Health Affairs Policy 06-007, February 21, 2006, "TRICARE Policy for Access to Care and Prime Service Area Standards" incorporate the standards for access to care. All military health care beneficiaries have the right to access emergency services when and where the need arises. For an urgent medical condition, care is to be provided within 24 hours. Waiting time for treatment of a routine condition must not exceed one week. Waiting time for access to specialty care including surgical, medical, dental, mental health, and rehabilitative services will not exceed four weeks after receiving a referral. Health Affairs Policy 06-007 provides that active duty Service members who cannot be accommodated in the direct care medical treatment facility system within the established access to care standards must be offered a referral for care within the civilian network or authorization to seek care outside the network.

In June 2007, the DoD Task Force on Mental Health recommended improvement for access to mental health care throughout the TRICARE system. One response was the Assistant Secretary of Defense for Health Affairs' Policy 07-022, "TRICARE Prime Access Standards for Mental Health Care." These standards have always applied to all health care needs, but there has been some perception that the standards were not followed for mental health concerns. This policy re-emphasizes the 24-hour standard for urgent care and one-week standard for routine care.

Action 10, NDAA 07, Section 733 – Report on the Department's Tracking System Established to Monitor the Access to Health Care Services

This section requires that the Secretary report on the Department's tracking system established to monitor the access to health care services for wounded, injured, or ill service members returning to the United States from a combat zone.

The Department contracted with a health policy research and consulting firm to develop a consistent methodology to monitor the access to health care services, and produce a quarterly report of the results. The Department maintains a list of all members who return from overseas deployments. In the tracking system, the Department of Defense first identifies the injured, ill, and wounded members of the Armed Forces who have returned to the United States following return from a combat zone in three primary

ways. The U.S. Transportation Command Regulating And Command and Control Evacuation System (TRAC^{2}ES) identifies members of the Armed Forces who have been medically evacuated from theater for injuries, illnesses, or war wounds. Next, the Department identifies ill, injured, or wounded members by questioning members who return from deployments outside the United States about their medical care needs. This is done through the Post Deployment Health Assessment (PDHA), which uses the DD Form 2796 as an assessment tool. The PDHA contains questions that allow the identification of ill, injured, or wounded members.

In addition, DoD also uses a third method to identify the injured, ill, or wounded– the Post Deployment Health Reassessment (PDHRA), which uses the DD Form 2900 as an assessment tool. The PDHRA is administered to Service members who returned from deployment 90-180 days previously, and is designed to assess the medical status of returning members and their need for services at that time. Like the PDHA, the PDHRA identifies returning members who need a referral to a medical care provider for evaluation and follow-up.

The Department's tracking system uses all three of these sources (TRAC^{2}ES, PDHA, and PHDRA) to identify the injured, ill, or wounded who have returned from a combat zone to the United States. Because members return to the United States in different ways (medical air transport or other), and because some symptoms are not evident when a member returns to the United States, no one method is sufficient. Consequently, the Department's tracking system uses all three sources to identify the injured, ill, or wounded.

The Department submitted a report to Congress on the Tracking System on June 11, 2007.

Action 11, NDAA 07, Section 733 – Report on the Performance of the Uniform System for Tracking the Performance of the Military Health Care System in Meeting the Requirements for Access of Wounded, Injured, or Ill Members of the Armed Forces to Health Care Services

This section requires the Secretary to report on the system established to provide a uniform system for tracking the performance of the military health care system in meeting the requirements for access of wounded, injured, or ill members of the Armed Forces to health care services described.

The Department submitted a report on October 16, 2007. The Department of Defense tracking system uses five sources (medical evacuations, Post-deployment Health Assessments, Post-deployment Health Reassessments, military medical treatment facility (MTF) and civilian claims data, and active duty referrals to the Department of Veterans Affairs (VA)) to identify the ill, injured, or wounded who have returned from a combat

zone to the United States. This report measured the access-to-care results for individuals who returned to the United States during the July to September 2006 quarter.

The 9,759 individuals who had MTF care that required a referral received 40,476 unique referrals for care (about 4.1 referrals per person). Across all referrals that could be compared with the standards, about 85 percent met DoD's access-to-care standards for time between the referral and the initial appointment. This percentage varied widely by type of referral. For example, 62 percent of the 876 initial referral appointments for urgent care met DoD's one-day standard, and 73 percent of the 350 referrals for routine care met DoD's seven-day standard. On the other hand, out of 36,669 initial referral appointments for specialty care, 85 percent met DoD's 28-day standard and 99 percent of the 161 referrals for wellness care met DoD's 28-day standard.

The study also analyzed the degree to which the access standards were met for the individuals who had MTF care that did not require a referral. Of the 203,032 MTF appointments that did not require a referral, 42,608 appointments are available for comparison against DoD's access-to-care standards that measure the time between the date the appointment was scheduled and when it occurred. About 84 percent of these visits met DoD's access-to-care standards. Meeting standards ranged from 64 percent for routine care to 90 percent for wellness care. The most common type of appointment was for specialty care; 86 percent of these appointments were completed within DoD's 28-day standard.

For both types of appointments combined, DoD's access-to-care standards were met in 84 percent of the cases for these ill, injured, or wounded members receiving MTF care. For urgent care, specialty care, and wellness care referrals and appointments in the MTF, the percentage of referrals and appointments that met DoD's access-to-care standards ranged from 85 to 91 percent.

Action 12, NDAA 07, Section 738 – Enhanced Mental Health Screening and Services in the Pre- and Post-deployment Health Assessments

This section requires the pre-deployment and post-deployment medical assessment of a member of the armed forces to include: 1) An assessment of the current treatment of the member and any use of psychotropic medications by the member for a mental health condition or disorder; and 2) An assessment of traumatic brain injury.

Since 1998, DoD has been doing a pre-deployment health assessment that includes questions such as whether a Service member has received mental health care in the past year, what medications are currently taken by the member, and whether the member has any other medical concerns. The pre-deployment health assessment does not include questions about traumatic brain injury (TBI), but questions for TBI on the annual

Periodic Health Assessment will be part of the medical record reviewed at the time of deployment. The post-deployment health assessment (PDHA) and the post-deployment health reassessment (PDHRA) contain several psychosocial questions relating to relevant mental health concerns a Service member may be experiencing.

Action 13, NDAA 07, Section 738 – Development of Criteria for Referral for Evaluations for Mental Health Screening and Services

This section requires development of criteria for referral for further evaluations including: 1) development of clinical practice guidelines to be utilized by healthcare providers in determining whether to refer a member of the armed forces for further evaluation relating to mental health (including traumatic brain injury); 2) mechanisms to ensure that healthcare providers are trained in the application of such clinical practice guidelines; and 3) mechanisms for oversight to ensure that healthcare providers apply such guidelines consistently.

The Department, working in concert with the VA, has developed and fielded evidence-based and professional consensus-based Clinical Practice Guidelines (CPGs) to identify standards of care, and to facilitate effective clinical decision-making according to published algorithms. There are CPGs for Post-deployment Health Evaluation and Management, Acute Stress Disorder, PTSD, Major Depressive Disorder, Substance Abuse Disorder, and Medically Unexplained Symptoms. In addition, the Defense and Veterans Brain Injury Center developed a CPG for TBI in August 2006. These CPGs are well designed for individual provider study. They are maintained, along with various other training materials, on the Deployment Health Clinical Center website at http://www.pdhealth.mil/.

Action 14, NDAA 07, Section 738 – Minimum Standards for Mental Health for the Eligibility of a Service Member to Deploy to a Combat Operation or a Contingency Operation.

This section requires the Secretary to prescribe in regulations minimum standards for mental health for the eligibility of a member of the armed forces for deployment to a combat operation or contingency operation. The standards will include:

1) A specification of the mental health conditions, treatment for such conditions, and receipt of psychotropic medications for such conditions that preclude deployment of a member of the armed forces to a combat operation or contingency operation, or to a specified type of such operation; and
2) Guidelines for the deployability and treatment of members of the armed forces diagnosed with a severe mental illness or post-traumatic stress disorder.

On November 7, 2006, the Assistant Secretary of Defense for Health Affairs issued "Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications" on the minimum mental health standards for deployment, including post-traumatic stress disorder (www.ha.osd.mil/policies/2006/061107_deployment-limiting_psych_conditions_meds.pdf).

Action 15, NDAA 07, Section 738 – Improvement of the Quality Assurance Program

The section requires the Secretary to ensure that the quality assurance program will include the following:

1) The types of healthcare providers conducting post-deployment health assessments;
2) The training received by such providers applicable to the conduct of such assessments, including training on assessments and referrals relating to mental health;
3) The guidance available to such providers on how to apply the clinical practice guidelines developed in determining whether to make a referral for further evaluation of a member of the armed forces relating to mental health;
4) The effectiveness of the tracking mechanisms required in ensuring that members who receive referrals for further evaluations relating to mental health receive such evaluations and obtain such care and services as are warranted; and
5) Programs established for monitoring the mental health of each member who, after deployment to a combat operation or contingency operation, is known to have a mental health condition or disorder; or to be receiving treatment, including psychotropic medications, for a mental health condition or disorder.

The Department has established a variety of quality assurance programs that address deployment health-related elements and requirements to ensure that Service members' health needs are met appropriately and effectively. The DoD Military Health System National Quality Management Program encompasses focused reviews and special studies on pertinent topics such as provider training, clinical practice guidelines, and PTSD, as well as post-deployment health evaluation, treatment, and management. The Assistant Secretary of Defense for Health Affairs Memorandum, "Policy for Department of Defense Deployment Health Quality Assurance Program," January 9, 2004, implemented a program that monitors Service implementation of DoD deployment health policies and helps ensure compliance with pre-, during, and post-deployment health requirements. The DoD Force Health Protection Quality Assurance Program (DoD Instruction 6200.05, February 16, 2007) expands the focus of the Deployment Health Quality Assurance Program to the full spectrum of military activities throughout a Service member's career.

Action 16, NDAA 07, Section 738 – Report on Actions Taken to Enhance Mental Health Screening and Services

The section requires the Secretary of Defense to submit to the Committees on Armed Services of the Senate and the House of Representatives a report on the actions taken to implement the requirements of this section.

The Department submitted this report on July 26, 2007. The Department of Defense (DoD) has made several significant changes in health care policy to enhance its ability to detect and treat mental health problems. Service members are assessed for mental health disorders including post-traumatic stress disorder and the use of psychotropic medications before they deploy, immediately following the deployment, and 3-6 months after returning home from a deployment. Two questions will be added to post-deployment assessments to screen for exposure to explosions, blasts, motor vehicle accidents, or any other event that caused a blow to the head or whiplash. In addition, a new DoD subject-matter expert panel will develop tools and clinical practice guidelines for assessment and treatment of traumatic brain injury (TBI) at the time of the injury, as well as on an annual basis for all service members.

Our FHPQA program will continue to add metrics evaluating the implementation of newer programs, such as criteria for mental health referral and TBI evaluation, and referral, as data for these programs accumulate.