2008 REPORT TO CONGRESS
ON DEPARTMENT OF DEFENSE
FORCE HEALTH PROTECTION QUALITY
ASSURANCE PROGRAM

JUNE 2009
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BACKGROUND

The Department of Defense (DoD) reports annually to Congress on Force Health Protection Quality Assurance program, as provided for in Section 739 of the National Defense Authorization Act for Fiscal Year 2005. Topics include maintenance of deployment health assessment information in the Armed Forces Health Surveillance Center (AFHSC), immunization data, and health assessment data in deployment military medical records, as well as actions taken in response to post-deployment health concerns and deployment related exposures to occupational or environmental hazards. This is the DoD's 2009 report, which covers Calendar Year (CY) 2008 force health protection quality assurance (FHPQA) activities.

DEPLOYMENT HEALTH QUALITY ASSURANCE PROGRAM

DoD published Health Affairs (HA) Policy 04-001, "Deployment Health Quality Assurance Program," in January 2004. This policy directed the implementation of a DoD Deployment Health Quality Assurance Program under the direction of the Deputy Assistant Secretary of Defense (DASD) for Force Health Protection and Readiness (FHP&R). In February 2007, DoD issued, DoD Directive (DoDD) 6200.05, "Force Health Protection Quality Assurance (FHPQA) Program," as an enhancement to HA Policy 04-001. The enhancement broadened comprehensive military health surveillance by applying agreed-upon quality assurance measures relevant to military health, deployment, and occupational and environmental health surveillance activities throughout the entire period of an individual's military service. These measures incorporate high risk, problem prone or high volume health issues faced by deployed individuals.

As specified in DoDD 6490.02E, "Comprehensive Health Surveillance," and DoDD 6493.04, "Deployment Health," the Assistant Secretary of Defense for Health Affairs has both the authority and the responsibility for all aspects of comprehensive military health surveillance and documentation related to force health protection and surveillance implementation. These include longitudinal health monitoring, epidemic and outbreak prevention, and detection and response activities, as well as deployment health surveillance monitoring of environmental and occupational health hazards, assessment of disease and injury prevention and control, and health care system evaluation and planning. DoDD 6200.05 provides guidance to focus on those important activities under the three pillars of DoD force health protection, which are: (1) proving and sustaining a healthy and fit force; (2) preventing illness and injury; and (3) providing medical and rehabilitative care to the sick and injured.

Effective Implementation of Deployment Health Quality Assurance Program,' dated June 22, 2007, (GAO Code 350897) recommended that FHP&R perform an independent verification to ensure the information provided is both accurate and complete.

The DASD (FHP&R), in conjunction with the Force Health Protection Council (FHPC) (members include the Services' Surgeons General and the Joint Staff Surgeon), oversees the FHPQA program, to include selection of key elements for monitoring and reporting. This collaborative effort demonstrates the commitment to force health protection among the Services. The CY 2008 Force Health Protection (FHP) measures were the following:

- Individual Medical Readiness Rate;
- Overdue Health/Dental Assessment Rate;
- Deployment Health Assessments;
- Orthopedic Injuries in Theater;
- Heat/Cold Injuries in Theater;
- Influenza-like Illness in Theater;
- Behavioral Health Encounters in Theater; and
- Mental Health Theater Evacuation Rate.

For CY 2008, the FHPQA program performed the following activities:

- visited military installations to assess compliance with force health protection policy and procedures;
- collected quarterly reports from the Services on their specific force health protection quality assurance programs;
- documented and reported to the FHPC deployment health assessment trends;
- analyzed data comparing AFHSC and Service data; and
- wrote the annual report to Congress.

REPORT OF FHPQA VISITS TO MILITARY INSTALLATIONS

In CY 2008, staff from FHP&R and the Services' medical departments jointly planned, coordinated, and conducted the following FHPQA visits to military installations.

- Army (January 2008)
  - Fort Carson Colorado
  - Evan Army Community Hospital
  - Soldier Readiness Center
- Marine Corps (July 2008)
  Third Marine Expeditionary Force (Okinawa and Hawaii)
  - Camp Courtney Third Marine Expeditionary Force Command Element
  - Camp Schwab Combat Assault Battalion
amp Han

n Fifth Air Naval Gunfire Liaison Company
a alpital Okinawa
Kaneohe Bay Logi"es
Marine Aircraft Group
- Third Marine Division
Third Marine Regiment
- Fourth Marine Division

- Air Force (OCTOBER 20
8) Dover Air Force
Base
- Dover Air Medical Command
- Air Force Reserve 57th Aerospace Medical Squadron

- Navy October 2
8)
Naval Base Ventura County
- Port Hueneme Command First Naval Construction Division
Port Hueneme Naval Reserve Center
- Navy Mobilization Processing Site Port Hueneme

The purpose of the visits was to assess deployment health policy compliance and effectively directed by DoDI 6200.05. These visits generally included briefings with commanders and senior medical leaders, discussions of deployment health processing activities and reviews of individual medical records for documentation of deployment health-related information (including required pre- and post-deployment health-related information. These visits generally included briefings with commanders and senior medical leaders, discussions of deployment health processing activities and reviews of individual medical records for documentation of deployment health-related information (including required pre- and post-deployment health-related information.

In preparation for each visit, the FHPQA program collaborated with each Service to collect deployment-related data. Available enterprise-wide documentation of both pre- and post-deployment health assessments and serum specimens were pre-populated onto a FHPQA data collection tool and reviewed. This facilitated the identification of individuals who had recently deployed and returned from deployment and had the required post-deployment assessment forms.

The GAO in the report titled DEFENSE HEALTH CARE: Oversight of Military Service Post-Deployment Health Reassessment Completion Rates Is Limited (GAO-01-102SR) reported that AFHSC’s monthly reports to DoD A program should also include the total number of Service members who returned from deployment and had completed PDHRA for the QA program to accurately assess and report. During the installation visits, the QA program staff’s authenticate the accuracy of the data provided from the AFHSC, review for data transfer integrity and document deployment processing practices. Data transfer or integrity concerns are reported to AFHSC for further investigation.
Findings from the 2008 FHPQA Service visits included percentage of deployment medical records consistent with centralized database. Active and Reserve records/reports and findings were combined.

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<th>2008 FORCE HEALTH PROTECTION QUALITY ASSURANCE INSTALLATION VISITS</th>
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<td>DD Form 2795 on file and in record</td>
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<tr>
<td>94%</td>
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<tr>
<td>DD Form 2796 on file and in record</td>
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<tr>
<td>90%</td>
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<tr>
<td>DD Form 2900 on file and in record</td>
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<tr>
<td>98%</td>
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<tr>
<td>Mental Health Care received or sought in theater</td>
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<td>Positive responses to Traumatic Brain Injury on DD Form 2796</td>
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<tr>
<td>Major concerns identified by provider DD Form 2900</td>
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<td>0%</td>
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<tr>
<td>Referrals indicated by provider DD Form 2900</td>
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</table>

*DD Form 2796 was revised March 2008 after the Army visit, therefore, information was not collected.

The following were observations associated with the FHPQA installation visits conducted in 2008:

- Fort Carson has a traumatic brain injury (TBI) program available to support those who are preparing to deploy and have returned from deployment. This program includes a questionnaire-screening tool, notarized affidavit of blast occurrences, and related interventions. According to the official on site, additional emphasis and resources have been placed on documenting those Service members' responses, completing an injury affidavit, and reviewing the Injury Questionnaire Screening Tool.

- The reviewers reported to AFHSC evidence of multiple pre-deployment assessments (2795s) without a deployment tied to the assessment. AFHSC was able to reset pre-deployment numbers for only those individuals who deployed rather those who submitted the forms for reasons other than deployment.

- The Marine Corps Third Expeditionary Force (MEF) staff explained and demonstrated the neurocognitive assessment test administration. Staff explained that a computer-based tool was designed to detect speed and accuracy of attention, memory, and thinking ability.
• The Marine Corps have assigned a regimental psychiatrist to the MEF to provide training and education for staff and independent duty corpsmen that deploy with Service members.

• The Marine Corps have combined aid station and deployment readiness units, noting that providers who deploy with their units maintain the continuity of pre- and post-deployment health care.

• The compliance of the Air Force and Air Force Reserves with Periodic Health Assessments was commendable including the Adult Preventive and Chronic Care flow sheet.

• Dover Air Force Base has assigned one provider to be responsible for reviewing any positive responses to TBI or post-traumatic stress disorder (PTSD) questions on the deployment health assessments. Any affirmative response, even a single "yes" out of the four PTSD questions, resulted in an outreach and a referral for further assessment.

• The airman's primary care provider typically completed his/her post deployment reassessment evaluation and annual periodic health assessment.

• Dover Air Force Base has assigned one provider as the direct liaison between the medical staff and line commanders. Commanders identify those Service members projected for deployment to facilitate the pre-deployment medical assessments. Collaborative processes with mental health, family advocacy, and alcohol and drug programs occur simultaneously.

• Port Hueneme Naval Command has implemented a referral tracking and medical follow-up policy that includes placement of information into medical records. Evidence of its effectiveness was evident in the deployment medical records.

• Port Hueneme Naval Command has assigned one provider as the direct liaison between the medical staff and line commanders. Commanders identify those Service members projected for deployment to facilitate the pre-deployment medical assessments and review.

• Navy Reserve Component has implemented Family Readiness Days that provide family deployment activities.

Following are overall electronic review observations and recommendations during the visits in 2008:

• Documentation of required immunizations was quite good, with significant improvement noted in both Reserve components in comparison to previous years.
• Some providers were unaware of the established Post-Deployment Health Clinical Practice Guideline requirement as outlined in Department of Defense Instruction (DoDI), 6490.03, "Deployment Health.

• We recommended that service review the interpretation of DoD 6490.03 partially in regard to those who deploy to "at risk locations" for less than 30 days. In some instances, those individuals require deployment health assessment.

• We recommended a practice of internal peer review to discuss, educate, and validate deployment health clinical practice guidelines; targeting deployment health assessment and standards of practice that would support development of policy or training for providers.

• The U.S. Army completes the post-deployment health assessment once it individual returns home from deployment.

R E F O R C E S H E A L T H S U R V E I L L A N C E C E N T E R R E P O R T

Established in 2008, AFHC receives data feeds from the Army's Medical Repository the Air Force Preventive Health Assessment Individual Medical Readiness Tracking System, the Marine Corps Medical Readiness Reporting System, and the Navy Ironemental Health Center. The AFHS also receives copies of the monthly contingency Tracking System (TTS) report that is prepared by Defense Manpower Data Center and includes information (provided by the Services) on all Service members who have deployed. AFHC operates and maintains the Defense Medical Surveillance System which contains enterprise-wide data on diseases, medical events, and data on personnel and deployment. AFHSC provides data and reports to the Service, the MIPQA program, and other supporting agencies for review. Additionally, AFHSC prepares the Medical Surveillance Monthly Report, publishes it monthly, and makes it available online at http://www.atshc.mil.

The following report is based on specific deployment criteria and should not be compared with the total number of completed forms submitted by the Service. The chart attempts to address GAO's concerns outlined in the report title, 'DEFENSE HEALTH CARE: Oversight of Military Service Post-Deployment Health Reassessment.'

Completion Rate Limited. DoD ability to provide these data is dependent on the Service continued take in upporting the ongoing efforts to resolve deployment data. The contingency reporting is improving deployment data and accuracy. Data source reported as collected from the Defense Medical Surveillance System (DMSS), as of April 1, 2009.

Many factors should be considered when reviewing these reports, such as deployment rotation, Service policy changes throughout the reporting year, and multiple deployments within a calendar year.
he following table were de veloped to demonstrate how data may support c ompliance reporting. Although time lag between efense Manpower Data Center MD and CT ro ter reporting may ac onnt for some data discrepancies, it is also impo unt to note the reporting time parameter.

### DEFENSE MEDICAL RVEILL CE SYSTEM REPORT 2008

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5 completed within the 90 day prior to the end of the deployment.
90 day prior to the end of the deployment.
30 day after the end of the deployment.
60 day after the end of the deployment.
90 day after the end of the deployment.
End and output time is within 180 days of DD2906 date.
## MARINE CORPS DEPLOYMENT QUALITY ASSURANCE REPORT

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<th>Pq-Ass Deploy Era***</th>
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DD 795 completed within 90 days prior to 30 day after the start of deployment.
DD 796 completed from 60 days prior to the end of the deployment to 90 days after.
*DD2900 completed from 60 days prior to the end of the deployment to 60 days after the end of deployment.
** Urns drawn from 30 days prior to the end of the deployment to 90 days after the end of deployment.
*** Urns drawn from 30 days prior to the end of the deployment to 90 days after the end of deployment.

## II. ITARY SERVICES QUALITY ASSURANCE PROGRAM REPORT

The service continue to provide adequate support by conducting deployment health quality assurance efforts that are tailored in scope, focus, and methodology to their organization and environment.

Common program elements are reported through a variety of health surveillance and administrative procedures from the service to the FHPQA program.

Following are the highlights from the service’s 2008 report as follows:

### S. ARMY

- The Surgeon General of the U. S. Army tasked the U.S. Army Center for Health Promotion and Preventive Medicine with the development of a Q Program for Deployment Health. The Army reported that its Deployment Health Quality Assurance (DHQA) program provides a capacity for on-site review as well as a system for accountability (compliance with standards) QA and process improvement. The Department of the U. S. Army Personnel Policy Guidance (Chapter 7), DoD I6490.03m Deployment Health, August 11, 2006, and DoDI
• In an effort to provide a sense of importance and oversight for deployment health program, the Army DHQ team created a Community of Practice Web site located on Army Knowledge Online. This Web site contains links to resources, discussion forum, and information pertaining to Army Lean Six Sigma project related to the soldier readiness processing.

• The U.S. Army DHQA program noted that one root cause for inconsistent compliance in reporting was the apparent lag between the contingency tracking system and the Defense Medical Surveillance system and the need to track the e data over time. The Army outlined data differences in the same period from July-September 2008. Update of the data were requested about 60 days later.

• Noting the increase in the number of Soldiers who returned from deployment the marked improvement in compliance for the DD 2795s for the Reserve and Guard and the marked improvement for the DD 2900 and medical visits for all three components reassessments, post deployment serum ample and post-deployment referrals indicated and completed the Army plan to continue to track quarterly metrics for at least three consecutive quarters to allow the system to compensate for the apparent lag between the T and the DM.

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<tr>
<th>ARMY REVIEW OF AFHS QA DATA REPORT</th>
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<td>Previous (3rd Quarter 2008)</td>
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<tr>
<td></td>
<td>Jul-Sep 30, 2008</td>
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<tr>
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<tr>
<td></td>
<td>% DD2795</td>
</tr>
<tr>
<td>Active Duty</td>
<td>28,125</td>
</tr>
<tr>
<td>Reserve</td>
<td>2,375</td>
</tr>
<tr>
<td>Guard</td>
<td>4,049</td>
</tr>
</tbody>
</table>
S. NAVY

- The Commander, U.S. Fleet Forces Command reported that units were meeting compliance standards to the best of their ability and will maintain a Post-Deployment Health Assessment QA system to track performance.

- The Navy reported that the number of Post-Deployment Health Assessments (PDHA) submitted by U.S. Navy personnel would continue to decrease because DoDI 6490.03 no longer mandates PDHA assessment for routine shipboard operations.

- The U.S. Navy has reported that it has become difficult for operational units to comply with PDHRA completion because returning individuals may have detached from that unit or departed military service.

- During 2008, the U.S. Navy reported the following QA activity data.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unics reporting %</td>
<td>27</td>
<td>24</td>
<td>27</td>
<td>27</td>
</tr>
<tr>
<td>Personnel deployed</td>
<td>2,109</td>
<td>1,067</td>
<td>1,427</td>
<td>2,494</td>
</tr>
<tr>
<td>Personnel returned</td>
<td>2,109</td>
<td>1,056</td>
<td>1,243</td>
<td>5,023</td>
</tr>
<tr>
<td>DD2796(PDHA)</td>
<td>2,132</td>
<td>1,054</td>
<td>1,235</td>
<td>1,741</td>
</tr>
<tr>
<td>Personnel requiring referral post-PDHA</td>
<td>83</td>
<td>108</td>
<td>52</td>
<td>62</td>
</tr>
<tr>
<td>Personnel completing referral post-DD2796</td>
<td>82</td>
<td>79</td>
<td>50</td>
<td>48</td>
</tr>
<tr>
<td>D02900(PDHRA)</td>
<td>574</td>
<td>229</td>
<td>935</td>
<td>882</td>
</tr>
<tr>
<td>Personnel requiring referral post-PDHRA</td>
<td>Not Repted</td>
<td>Not Repted</td>
<td>48</td>
<td>72</td>
</tr>
<tr>
<td>Personnel completing referral post-DD2900</td>
<td></td>
<td></td>
<td>100</td>
<td>72</td>
</tr>
<tr>
<td>Number of DD 2796 Forms to AFHSC</td>
<td>2,101</td>
<td>1,052</td>
<td>1,231</td>
<td>1,332</td>
</tr>
<tr>
<td>Number of DD 2900 Forms to AFHSC</td>
<td>274</td>
<td>274</td>
<td>904</td>
<td>97</td>
</tr>
<tr>
<td>Post-Deployment Sera</td>
<td>2,103</td>
<td>229</td>
<td>1,162</td>
<td>920</td>
</tr>
</tbody>
</table>

Three units included in the count from the 2nd quarter. The total number of forms was (92), which was about seven percent of the total.

S. AIR FORCE

- During 2008, the U.S. Air Force identified, reported, and resolved recurring data quality issues with the denominator data received from Defense Manpower Data Center (DMDC).

- The U.S. Air Force increased its compliance rate from 77 percent to more than 78 percent for both pre- and post-deployment requirements. Limitations of the military personnel data system to identify all
individuals in deployment status, maybe part of the cause that these percentages are low. Air Force continues to reconcile and track data from its personnel systems versus the DMDC-reported number of deployers to assure accurate reporting.

- The U.S. Air Force implemented a monthly installation QA meeting. This meeting is now an inspectable item in the 2008 Health Services Inspection guide.

### U.S. AIR FORCE 2008 DEPLOYMENT HEALTH DATA*

<table>
<thead>
<tr>
<th>Centralized Data</th>
<th>1st QUARTER</th>
<th>2nd QUARTER</th>
<th>3rd QUARTER</th>
<th>4th QUARTER</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel deployed (DCAPES)</td>
<td>14,285</td>
<td>17,242</td>
<td>19,417</td>
<td>10,998</td>
<td>N/A</td>
</tr>
<tr>
<td>DD2795 Pre-deployment assessment forms</td>
<td>11,781</td>
<td>14,034</td>
<td>16,310</td>
<td>84</td>
<td>9,173</td>
</tr>
<tr>
<td>Personnel deployed</td>
<td>15,885</td>
<td>19,361</td>
<td>19,441</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD2795(DHA)</td>
<td>13,086</td>
<td>16,351</td>
<td>16,490</td>
<td>85</td>
<td>12,850</td>
</tr>
<tr>
<td>Personnel requiring referral post PDHA</td>
<td>1,437</td>
<td>2,167</td>
<td>1,759</td>
<td>34</td>
<td>445</td>
</tr>
<tr>
<td>Individuals completing referral post D02796</td>
<td>646</td>
<td>656</td>
<td>590</td>
<td>34</td>
<td>445</td>
</tr>
<tr>
<td>Number of personnel retired from deployment since March 2004</td>
<td>50,326</td>
<td>N/A</td>
<td>51,825</td>
<td>42,374</td>
<td>51,357</td>
</tr>
<tr>
<td>Number of personnel completed D02900(DHRA)</td>
<td>42,720</td>
<td>85</td>
<td>42,374</td>
<td>82</td>
<td>42,473</td>
</tr>
<tr>
<td>Pre-Deployment Sera</td>
<td>10,022</td>
<td>9,642</td>
<td>14,148</td>
<td>73</td>
<td>8,478</td>
</tr>
<tr>
<td>Post-Deployment Sera</td>
<td>12,603</td>
<td>14,095</td>
<td>13,714</td>
<td>71</td>
<td>10,169</td>
</tr>
</tbody>
</table>

*The table above summarizes completion rates of key pre- and post-deployment requirements for all personnel identified in a deployment status for duration of 30 or more days during each reporting period.

### S. MARINE CORPS

- The U.S. Marine Corps reported that the following annual data on the Marine Corps Deployment Health Assessment Quality Assurance (DHA QA) programs were obtained from AFHSC, the U.S. Marine Corps Operational Data Store Enterprise, and MRRS. The following chart is an annual comparison of the noted reporting systems.

- The U.S. Marine Corps reported throughout the year that there were discrepancies between number deployed and number of DD 2795s. A few data discrepancies may be explained in part by unanticipated extensions of short deployments beyond 30 days.

- The U.S. Marine Corps also identified that MRRS list where the Marine is officially assigned as opposed to a temporary assignment does not currently result in a MRRS notation or change resulting in personnel remaining listed in their parent unit. In the report below, the U.S. Marine Corps combined the entire Corps.
• The U.S. Marine Corps is reporting that "Referrals completed" do not capture referrals if completed in a Battalion Aid Station without access to the military's electronic health record, chaplain's office or a community service such as Military One Source and the U.S. Marine Corp community services. One recommendation that the U.S. Marine Corps has made to the AFHSC QA report is to add a question to the DD 2900 to ask the member if referrals from the DD 2796, if any, were completed.

• Negative numbers for referrals on the chart below indicate that the U.S. Marine Corps data is inaccurate for QA purposes, perhaps because of the way the capture required data. Therefore, for future reports, the U.S. Marine Corps plans to use the AFHS report because the AFHS report has a more definite data history.

• The U.S. Marine Corps Data Management Health Assessment Quality Assurance (DHA QA) program collected and compared data from the operation and medical information system for the 4th quarter 2008. The results received are reported above:

<table>
<thead>
<tr>
<th>Criterion Tracked</th>
<th>MC Datum Source</th>
<th>Reported by AFHSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-deployment Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD 2795 to AFHSC</td>
<td>MRRS</td>
<td>4511</td>
</tr>
<tr>
<td>Total deployed</td>
<td>ODSE</td>
<td>Not reported</td>
</tr>
<tr>
<td>Post-deployment Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total returned from deployment</td>
<td>ODSE</td>
<td>6,522</td>
</tr>
<tr>
<td>DD2796 to AFHSC</td>
<td>AFHS</td>
<td>4,859</td>
</tr>
<tr>
<td>Sera obtained</td>
<td>AFHS</td>
<td>5,318</td>
</tr>
<tr>
<td>Referral indicated</td>
<td>AFHS</td>
<td>676</td>
</tr>
<tr>
<td>Referral completed</td>
<td>AFHS</td>
<td>323</td>
</tr>
<tr>
<td>PDHRA Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90-180 days since redeploy</td>
<td>MRRS</td>
<td>Not reported</td>
</tr>
<tr>
<td>DD2900 completed</td>
<td>AFHS</td>
<td>358***</td>
</tr>
</tbody>
</table>

Unavailable data lost, not retrievable from the system.

Includes those currently deployed plus those deployed during the period and having returned during the reporting period.

**Calculated arithmetically from reports (Post-tk phunianm-alllllnie and DD 2900 reports) provided by AFHSC.

*** Does not include "catch up," i.e., 0 02 no 1llllpkld d ler due date.

ARMED FORCES HEALTH SURVEY A.C.E.: TEM REPORTING

During CY 2008, the DoD perio d called for the questions and associated data collection and analysis processes to maintain the health protection goal of maintaining a fit and healthy force. AFHSC provided deployment health assessment data weekly to the FI IPQ program. The following article titled, "Update: Deployment Health Surveillance" was published in U.S. Armed Forces, December
2008," provides the total number of mental health assessments and reassessment forms and Service mem "related concerns. Unlike compliance reporting that only includes forms that are completed within a certain timeframe; the following charts and analysis include all reported during January-December 2008.
Update: Deployment Health Assessments, U.S. Armed Forces, January 2009

The force health protection strategy of the U.S. Armed Forces is designed to deploy healthy, fit, and medically ready forces, to minimize illnesses and injuries during deployments, and to evaluate and treat physical and psychological problems (and deployment-related health concerns) following deployment.

In 1998, the Department of Defense initiated health assessments of all deployers prior to and after serving in major operations outside of the United States. In March 2005, the Post-Deployment Health Reassessment (PDHRA) program was begun to identify and respond to health concerns that persisted until or emerged within three to six months after returning from deployment.

This report summarizes responses to selected questions on deployment health assessments completed since 2003. In addition, it documents the nature and frequencies of changes in responses from pre-deployment to post-deployment.

Methods

Completed deployment health assessment forms are transmitted to the Defense Medical Surveillance Center (DMSS), where they are incorporated into the Defense Medical Surveillance System (DMSS). In the DMSS, data recorded on health assessment forms are integrated with data that document demographic and military characteriscs and medical encounters at base military and other (contracted care) medical facilities of the Military Health System. For this analysis, DMSS was searched to identify all pre (DD2795) and post-deployment health assessment forms completed since January 2003 and all post-deployment health reassessments (DD2900) forms completed since July 2005.

Results

During the 12-month period from February 2008 to January 2009, there were 400,458 pre-deployment health assessments, 360,500 post-deployment health assessments, and 306,829 post-deployment health reassessments completed per month. In Figure 1, the number of post-deployment health reassessments (DD2900) completed per month has averaged in a range between approximately 16,000 and 36,000 (Figure 1, Table 1).

From January to December 2008, nearly 64% of returned deployers rated their health as excellent or very good during pre-deployment assessments (58.5%) and post-deployment reassessments (53.9%). There were increases in the proportions of deployers who rated their health as "fair" or "poor" from pre-deployment to post-deployment.

Source: Medical Surveillance Monthly Report, January 2009
Table 1. Deployment-related health assessment forms, by month, U.S. Armed Forces, February 2008-January 2009

<table>
<thead>
<tr>
<th>Month</th>
<th>Pre-deployment assessment (DD2795)</th>
<th>Post-deployment assessment (DD2798)</th>
<th>Post-deployment reassessment (DD2900)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>460,458 100</td>
<td>360,500 100</td>
<td>306,829 100</td>
</tr>
</tbody>
</table>

- **February 2008**
  - Pre-deployment: 40,883 10.2
  - Post-deployment: 21,033 5.8
  - Post-reassessment: 32,719 10.7

- **March 2008**
  - Pre-deployment: 31,788 7.9
  - Post-deployment: 28,246 7.8
  - Post-reassessment: 27,768 9.0

- **April 2008**
  - Pre-deployment: 34,870 8.7
  - Post-deployment: 33,196 9.2
  - Post-reassessment: 33,658 11.0

- **May 2008**
  - Pre-deployment: 24,786 6.2
  - Post-deployment: 39,513 11.0
  - Post-reassessment: 25,001 8.1

- **June 2008**
  - Pre-deployment: 26,074 6.5
  - Post-deployment: 23,885 6.6
  - Post-reassessment: 21,062 6.9

- **July 2008**
  - Pre-deployment: 33,715 8.4
  - Post-deployment: 21,386 5.9
  - Post-reassessment: 29,921 9.8

- **August 2008**
  - Pre-deployment: 30,164 9.8
  - Post-deployment: 32,374 9.5
  - Post-reassessment: 25,663 8.4

- **September 2008**
  - Pre-deployment: 38,437 9.6
  - Post-deployment: 34,335 9.1
  - Post-reassessment: 25,949 8.5

- **October 2008**
  - Pre-deployment: 28,091 7.6
  - Post-deployment: 33,329 9.2
  - Post-reassessment: 22,867 7.5

- **November 2008**
  - Pre-deployment: 35,749 8.9
  - Post-deployment: 35,565 9.9
  - Post-reassessment: 19,927 6.5

- **December 2008**
  - Pre-deployment: 38,808 9.7
  - Post-deployment: 23,951 6.0
  - Post-reassessment: 20,971 6.8

In the past 12 months, the proportion of deployers who assessed their general health as "fair" or "poor" was consistently low before deployment (mean, by month: 2.6%), highest 3-6 months after return from deployment (mean, by month: 13.0%) (Figure 3). There was relatively little variability in the proportions of deployers who rated their health as "fair" or "poor" on pre-deployment and post-deployment reassessment questionnaires (Figure 4). However, the proportion of deployers who rated their health as "fair" or "poor" on the post-deployment questionnaire increased during the year from less than 6% in February 2008 to nearly 11% in November 2008 (Figure 1). Of deployers who completed health assessments both prior to and 3-6 months after returning from deployment, nearly one of 6 (15.6%) indicated significant declines (i.e., change of 2 or more categories on a 5-category scale) in their perceived general health status between these assessments (Figure 4).

In general, on pre-deployment and reassessment, deployees in the Army and in Reserve components were more likely than their respective counterparts to report health and exposure-related concerns. Among Reserve component members of the Army and Marine Corps, health and exposure-related concerns and indications for referrals were much greater 3-6 months after return from deployment (DD2900) than at the time of return (DD2795). Of note, at the time of return, active component soldiers were the most likely of all deployers to receive mental health referrals; however, 3-6 months after returning, Reserve component members of the Army and

**Source:** Medical Surveillance Monthly Report, January 2009

1S
Marine Corps were the most likely of all deployers to receive mental health referrals (Table 2, Figures 5, 6).

Finally, in general, soldiers and Reserve component members were more likely to report exposure concerns 3-6 months after returning from deployment compared to the time of returning from deployment itself (Table 2, Figures 5, 6).}

Another consistent finding of deployment-related health assessments is that deployers rate their general health worse when they return from deployment compared to before deploying, regardless of the Service or component. Deployments are inherently physically and mentally demanding; and there are more, and medically significant threats to the physical and mental health of service members when they are conducting combat operations in hostile environments compared to when living in their civilian communities (Reserv component).

Another consistent finding of deployment-related health assessments is that service members rate their general health worse and are more likely to report exposure concerns 3-6 months after returning from deployment compared to the time of returning from deployment. Among U.S. veterans of combat duty in Iraq and Afghanistan, mental health problems tend to return after deployment. Amn British veterans of the war zone PTDS illness is a more common among Reserve component members who served in Iraq and Afghanistan. PTDS illness is a more common among Reserve component members who served in Iraq and Afghanistan.

**Figure 3.** Proportion of deployment health assessment forms with self-assessed health status as "fair" or "poor", U.S. Armed Forces, February 2008-January 2009

**Figure 4.** Proportion of service members whose self-assessed health status improved (better) or declined ("worse") by 2 or more categories on 5-category scale from pre-deployment to reassessment, by month, U.S. Armed Forces, February 2008-January 2009

**Source:** Medical Surveillance Monthly Report, January 2009
Table 2. Percentage of service members who endorsed selected questions/received referrals on health assessment forms, U.S. Armed Forces, February 2008-January 2009

Figure 5. Percent of deployers with mental or behavioral health referrals, by Service and component by urging of health assessment.

Source: Medical Surveillance Monthly Report, January 2009
Figure 6. Ratio of percents of deployers who endorse selected questions. Reserve versus active component, on pre-deployment health assessments (D0 2795) and post-deployment health reassessments (D02900), U.S. Armed Forces, February 2008 - January 2009

Figure 7. Proportion of service members who endorse exposure concerns on post-deployment health assessments, U.S. Armed Forces, January 2004 - January 2009

Reference


2. Assistant Secretary of Defense (Health Affairs). Memo and for the Assistant Secretaries of the Army (M&RA), Navy (M&RA), and Air Force (M&RA), subject: Post-deployment health reassessment (HA policy: 05-011), dated 10 March 2005. Washington, DC.


Source: Medical Surveillance Monthly Report, January 2009
Extenшion of health surveillance during the period of Operation Iraqi Freedom (OIF) occupation and current incident investigation and analysis performed in laboratories where the bulk of the samples were collected from January 1, 2003, to December 31, 2004. In the period they antilyzed more than 11,000 samples, of which the majority were taken at more than 275 locations in the Iraq latcs entral region and USCENTCOM area.

Concerning health effects durinQ the period, there were no significant findings indicating a small number of illness attributable to sulfur fire exposure and chronic lung disease during the period of interest. However, the results did not rule out the possibility of an association between the occurrence of respiratory problems and exposure to sulfur fire smoke. The association was not statistically significant, but there are sufficient data to suggest a possible increased risk of respiratory illness.

The health implications of sulfur fire smoke on personnel deployed in the Iraq region are still under investigation. The results of this study will be used to improve health surveillance and to identify potential risks to deployed personnel.
United States Air National Guard was continued to collect additional airborne monitoring data. The Air National Guard continued to collect additional air monitoring data and working with other federal health organisms to determine whether airborne particulate pollutants increased risk.

In 2001, Dr. Quade of the National Health Council (R) to review the studies and the National Center for Interim data collection, studies, and medical surveillance. The comprehensive timeline for this project included an interim NRC report at the end of 2009.

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Other exam pl k im lud La _007 in :: lent thtn n, all cd in a smt II group r - r'vice member e po ed during...eXps unecs to chlor ine un:-, that ha've occasionally occurred yowLUcd... 2001 IIa, b'en r· Int. I l·mall in number and ill' hcd a limited number f... IIlili,l' pt:rmn I h se inc, u'li'I'i rm o'h ing III re than 10 reported injuries w·'r'ntIIII d t'cm:my engagem III (e.g., impr)psc i plotics device exploded al rind'gird ·chlorine ga ·<, lind ·rs) or uni11Lential releases near occupied locations. For tho':...f...l, ice mem ber who recen I'd medical treatmen!:... all returned to duty. The e exposure incidentals... all the i, available im: iden t data arc archiv d in the USACHPP II cpiu ment O - II a ta Port II J. fll l'utun: rckrence.
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ProvLittiv 1$vkc1in1 t-am c nd H1 d a health sun 1 of .S. erv1c e
members \ h ere curious for th ci illia11 c n tmc rt. Suh:-eqm:ntl , it was dl:tem111ed that appr ximat 1250
U.S. Ser vic e membcr1:. \ h po prnv ide d 1:LCurit at tile Qarmat Ali
plant o u ld have bcl'n ex:OSL'd lo low-k cl cocnc 1i wrins of hexavalent
chromium in the s jel and in air. Ext br i, cell\ in nmental sampling for

\
hexavalent chromium and comprehensive medical e‘m1lat1t>11,,LIL’ accomplished to include whole blood chromium tc:db 011 thL’ I \ personnel who were assigned at that locatio n. OnJy IllIFr. tlL-11pur.11 health effects, such as bloody noses, were identifie<l in :-nnL‘ individuals. These minor effects could not be dircl.:II’.attihull’d 11, chromium exposures because acute effects u uall y requirL’c,pt,...uL-11.111 much higher levels over longer duratio ns than existed at thL'<m111.11\ li faci 1ity. It was more likely that these minor health cflLct, "1..L- rL-ludL’to existing medical conditio ns or exposures LOdesc,t t hL'al.,and du-¡t. and wind. Because the duration of the possible expo ulV",\ ,.,L, L'n short, the overall risk for occuJTe nce of long-te rm hca llh clll xh ,.,,i, considered negligible. The other factor considered "' hexal ullllllllthL: possible for any long-term health effects was the absence or, cL lu\ levels of chromium found in the blood of the exposed s1'n1u: III:L-0llL, Extensive environmental monitoring and the health e xalIlillilillllh including blood chromium levels, indicated no sig ni licarll L'pu..III L” to hexavalent chromium. The Defense Health Board upon theful1 inull LI; tI\ of the environmental monitoring and medical exami nalHIh n:....111h validated the findings and conclusions of the U.S. Army i>rL!, L'ltL’L Medicine team. Following 2008 Congressional hear ing,. Illldllll’d L’ll reports pertaining to allegations raised by KBR employl'L:, th.Ith'll parent company did not adequate ly protect them from c pu,urL'111 tile sod ium dichromate, additi onal concerns arose on the part ol ...aillL-1S. personnel who were previously assigned to the Qannat Illfociilt. along with their corresponding State's National Guard (Indiana, West Virginia, South Carolina, Oregon). In LllL2th11 thL DoD’s Health Board reviewed the Amy’s environmL11nt im e, L111l1lllland medical response and concluded that the "field im c ,i a fdl\,. completed in an exemplary fashion and lhail its conclu..10thl . recommendations, and interventions were sound and appwpri.itl’... FORCE HEALTH PROTECTION QA PROGRAM SUMMAR,

In 2008, the Services and the FHP&R QA program agreed to add;:-;., d1111 ilL: 11ly and operational issues related to identifying deployment rosters. Vcrlkat1011 Of’ deployment rosters between the Services systems, AFHSC. and DM DC is llcL;:-; airy duL' to a policy change in Department of Defense Instruction (Do D1), 6490.03. ‘-‘kpr111111111 Health" that no longer mandates health assessments for certain routine operat111111’ L III! Services, AFHSC, DMDC and additional agenc ies continue to coordinlatL’ th_d lll t

The FHPQA program through activities and vis its will conti n imL'to <1L‘lk.ind evaluate potential measures as guided by the FHPC.
The Honorable David R. Obey  
Chairman, Committee on Appropriations  
U.S. House of Representatives  
Washington, DC 20515

Dear Mr. Chairman:

Enclosed is the annual report to Congress on the Department of Defense (DoD) Force Health Protection Quality Assurance program, as required by Section 739 of the National Defense Authorization Act for Fiscal Year 2005.

This report addresses specific quality assurance activities during Calendar Year 2008, including deployment health quality assurance visits to military installations, review of more than 400 deployment medical records of Service members who have returned from deployment, information maintained in the central DoD database, and the Services' force health protection measures. In addition, it provides information on compliance in recording health assessment data in military personnel records, as required by Section 739.

The Department is committed to providing the highest quality of care before, during, and after deployment for our Service members and their families. Our quality assurance programs are key contributors and validate that level of accomplishment.

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

Sincerely,

Ellen P. Embrey  
Performing the Duties of the  
Assistant Secretary of Defense  
(Health Affairs)

Enclosure:  
As stated

cc:  
The Honorable Jerry Lewis  
Ranking Member
The Honorable Daniel K. Inouye  
Chairman, Subcommittee on Defense  
Committee on Appropriations  
United States Senate  
Washington, DC  20510

Dear Mr. Chairman:

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Sincerely,

Performing the Duties of the  
Assistant Secretary of Defense  
(Health Affairs)

Enclosure:  
As stated

cc:  
The Honorable Thad Cochran  
Vice Chairman
Dear Mr. Chairman:

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Ellen P. Embrey
Performing the Duties of the Assistant Secretary of Defense (Health Affairs)

Enclosure:
As stated

cc:
The Honorable Thad Cochran
Vice Chairman
The Honorable Susan Davis  
Chairwoman, Subcommittee on Military Personnel  
Committee on Armed Services  
U.S. House of Representatives  
Washington, DC  20515

Dear Madam Chairwoman:

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Perfoming the Duties of the  
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(Heallth Affairs)

Enclosure:  
As stated

cc:  
The Honorable Joe Wilson  
Ranking Member
Dear Mr. Chairman:

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Performing the Duties of the
Assistant Secretary of Defense
(Health Affairs)

Enclosure:
As stated

cc:
The Honorable Lindsey O. Graham
Ranking Member
Dear Mr. Chairman:

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Performing the Duties of the Assistant Secretary of Defense (Health Affairs)

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member
The Honorable Ike Skelton  
Chairman, Committee on Armed Services  
U.S. House of Representatives  
Washington, DC 20515

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Performing the Duties of the  
Assistant Secretary of Defense  
(Health Affairs)

Enclosure:  
As stated

cc:  
The Honorable Howard P. "Buck" McKean  
Ranking Member
Dear Mr. Chairman:

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- P.

Ellen P. Embrey
Performing the Duties of the Assistant Secretary of Defense (Health Affairs)

Enclosure:
As stated

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