Prepared Statement

of

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on

Force Health Protection

Before the

House of Representatives Armed Services Committee

Mr. Chairman and members of this distinguished committee, thank you for the opportunity to be here today to discuss the Department of Defense's force health protection programs. Today, we have more than 253 thousand service men and women deployed in support of our nation's defenses, including those serving in Afghanistan and Iraq. DoD is firmly committed to protecting the health of our service members, before, during and after deployments.

Protecting our forces is a primary mission of the Military Health System. As part of our Force Health Protection program, our objectives are to recruit and maintain a healthy and fit force, to prevent disease and injury, and to provide medical and rehabilitative care to those who become ill or injured.

The rigorous medical requirements of the Armed Forces entrance physical examination and our periodic physical examinations, HIV screenings, annual dental examinations, physical fitness training and testing, immunizations and regular medical record reviews contribute to maintaining a healthy force. One of our most recently developed DoD policies require all deployable forces to achieve a new Individual Medical Readiness (IMR) standard. The IMR is now used as the measure for the services' preparation of service members to deploy and execute the mission. The services are now using a common set of individual medical readiness standards to monitor the collective readiness of the force. For a service member to be fully medically ready, all immunizations must be current and they must be in dental class 1 or 2. They must have all medical readiness lab tests done, including HIV tests, have no deployment-limiting medical conditions, have completed a current health assessment, and have all the medical equipment they need, including ear plugs, eyeglasses and mask inserts. By tracking the individual medical readiness against this standard, commanders can monitor the percentage of personnel who meet each of the criteria. This is an important new commander's tool.

Our post-deployment health assessments gather information from deployed service members to help medical personnel evaluate health concerns or problems that may be related to deployment. Face-to-face health assessments with licensed health care providers determine referrals for appropriate medical follow-up. Blood samples are taken within 30 days and are archived. Pre- and post-deployment health assessments and deployment health records are maintained in the individual's permanent health record, which is available to the VA upon the service member's separation from the military.

In January, I published written policy establishing the DoD deployment health quality assurance program as directed by the Congress and recommended by the GAO. A key element of this program is the Defense Medical Surveillance System, (DMSS), which provides periodic reports on centralized pre- and post-deployment health assessments. The quality assurance program also requires periodic reports on service-specific deployment health quality assurance programs, periodic visits to military installations to assess deployment health programs and an annual report on the DoD-wide program. DMSS retains copies of, and maintains centralized databases for, deployment health assessments. Army Medical Surveillance Activity (AMSA) provides me with weekly reports on post-deployment health assessments and monthly reports on pre- and post-deployment health assessments. The post-deployment reports include data on service members' health status, medical problems, mental health and exposure concerns, blood samples, and referrals for post-deployment care. Since January 2003, more than 90 percent of the 300,000 service members returning from deployment have reported their health status as good, very good, or excellent.

In theater, deployed Army, Navy and Air Force preventative medicine units are performing comprehensive occupational and environmental health surveillance in support of

Operation Iraqi Freedom and Operation Enduring Freedom. All reports are archived centrally at the U.S. Army Center for Health Promotion and Preventative Medicine, (USACHPPM). USACHPPM deployed and maintained a forward liaison and a specialized preventative medicine augmentation team to perform in-theater surveillance and facilitate support. When an environmental exposure is identified, DoD records the names of all service members possibly exposed and the samples are identified with a date/time and location that could potentially be linked to personnel present.

We continue to protect our deploying troops with appropriate vaccines against potential biological weapons. The Department has succeeded in protecting many hundreds of thousands of service members from two deadly infections--anthrax and smallpox. DoD led the nation in collecting and sharing information about safely administering smallpox vaccinations. We protected more than 580,000 people against smallpox in a sophisticated program of education, screening, and follow-up. We achieved safety levels similar to or superior to those seen with smallpox vaccine used in previous decades. Military healthcare workers repeatedly were asked to help our civilian colleagues in improving the preparedness efforts of the communities in which we live.

Our Anthrax Vaccine Immunization Program has now protected over a million service members. Despite the current high operations tempo, we have delivered 82 percent of those doses on time and are working diligently to improve this rate even further. The supply of anthrax vaccine increases steadily.

And we are delighted to say we now have one site in the Vaccine Healthcare Center Network, a network of specialty clinics to provide the best possible care in rare situations where serious adverse events follow vaccination. In all our vaccination efforts, we focus on keeping

individual service members healthy, so they can return home safely to their families and loved ones. The Institute of Medicine, in a congressionally mandated report, concluded that anthrax vaccine is an effective vaccine to protect humans against all forms of anthrax, including inhalational. They also concluded that the vaccine is safe. It is fairly common for people to experience some local discomforts, such as redness, itching or swelling, but these are comparable to those observed with other vaccines given to adults. On December 30, 2003 the Food and Drug Administration issued a final rule and order concluding, "the licensed anthrax vaccine is safe and effective for the prevention of anthrax disease, regardless of the route of exposure."

Like the anthrax vaccine, the smallpox vaccine is fully licensed by the FDA and is considered safe and effective, however it is known to carry risks for a very small percentage of individuals. By carefully screening recipients with known risk factors, we have been able to keep serious adverse effects well below what was anticipated when the vaccination program began. The Centers for Disease Control and Prevention tracks possible reactions to these and other vaccines through the Vaccine Adverse Event Reporting System, or VAERS, which is co-sponsored with FDA. DoD encourages all service members to report any reactions to VAERS. Like all vaccines, most adverse events with these two are minor and temporary. Serious events, such as those requiring hospitalization, are extremely rare.

In terms of casualty care in today's military, medical care is usually available within minutes after injury and is saving lives. Based on current analysis, more than 98 percent of those wounded have survived and one third have returned to their units for duty within 72 hours. Irrespective of the cause of a military member's illness or injury, our focus is to provide the care needed and whenever possible, to return that person to duty. Clearly some injuries are much more serious than others, but it is also clear that military medicine, improved personal protection

devices, and operational risk management techniques are saving lives. For Operation Iraqi Freedom, the rate of non-combat disease or injury is lower than in any previous U.S. conflict. Cumulative data through February 5, 2004, shows that four out of 100 deployed personnel sought clinical care in theater for a health concern or complaint each week At home, the usual rate of clinic visits for active duty military personnel is at least twelve out of 100 per week.

As of February 5, 2004, data from the Transportation Command shows 11,200 total evacuations out of theater. Service members were transported from the theater of operations for a wide variety of medical conditions and very few were life threatening. With our smaller, more flexible healthcare capabilities in theater, we can expect to evacuate many routine cases. The vast majority of medical evacuations – 87 percent – were routine medical care that couldn't be provided in theater. The remaining 13 percent were urgent or high priority medical care. We are moving toward implementing fully automated patient care systems, and we are working with the service surgeons general to establish a trauma registry that will capture information from the point of care.

Of course, physical trauma isn't the only kind of injury that deployed service members can face. Behavioral health issues, from combat stress to post traumatic stress disorder, threaten our troops and we've made a great deal of progress in the areas of prevention, identification, and care of these potential risks. General Peake, the Army Surgeon General, will be able to give you details of that progress.

At the request of the Operation Iraqi Freedom leadership, General Peake sent a 12-person Mental Health Advisory Team into Iraq and Kuwait from August to October 2003 to assess mental health issues and behavioral health care for OIF soldiers. The advisory team's recommendations include adapting current garrison-based Army suicide prevention initiatives to

the OIF deployed force. The team briefed its findings and recommendations to the coalition forces Commander and the commander of the joint task force.

While we monitor stress casualties, we have a renewed focus on suicide prevention during this deployment. The Office of the Armed Forces Medical Examiner has classified 21 soldiers' deaths as suicide for soldiers deployed to Iraq and Kuwait during 2003. There are additional Army deaths during this period for which the manner of death is pending final determination. The 21 confirmed Army suicides during Operation Iraqi Freedom represent an annualized rate of 15.8 suicides per 100,000 soldiers per year. This rate compares with a rate of 9.1 to 14.8 per 100,000 in the army between 1995 and 2002. In the overall U.S. male population, when age-matched with the Army, the rate is 20.5 per 100,000. While every suicide is a tragic loss, the suicide rate for soldiers deployed to OIF is not significantly different from the range of recent annual Army suicide rates. Nonetheless, the Human Resources Policy Directorate is funding additional Applied Suicide Intervention Skills Training for personnel in units preparing for OIF deployment.

We continue to deploy troops to areas where malaria is an endemic hazard. In 2003, we had 80 cases in Liberia, 44 between Afghanistan and Iraq, and 10 in South Korea. These were the areas most associated with malaria in US personnel. Studies have shown that troops need constant reminders and reinforcement to keep up their guard against the biting insects that transact disease. Preventive measures include use of uniforms impregnated with repellent, applying skin repellant several times a day, using bed nets and taking preventive medications as prescribed.

The preventive medications for malaria most often used by the US military are chloroquine, doxycycline, primaquine and mefloquine, also called Larium. All of these are

FDA-approved drugs. As with any medication, precautions in prescribing and taking the medication must be taken. Investigation has not identified mefloquine as a cause in murders or suicides as the media have implied. However, according to the FDC, mefloquine should not be prescribed for persons with active depression, a recent history of depression, generalized anxiety disorder, psychosis, or schizophrenia or other major psychiatric disorders, or with a history of convulsions. DoD follows FDA guidelines on the use of mephloquine, and it is DoD's policy that every service member who receives this medication also receives information about possible adverse effects.

I have directed a study to assess the rate of adverse events, to include suicide and neuropsychiatric outcomes, associated with antimalarial medications, particularly mefloquine, prescribed to deployed service members. DoD will appoint a panel of the experts in malaria and malaria medications that can articulate the most scientifically valid approaches and provide guidance on the methods of the study.

The Baltimore Veterans Affairs hospital is continuing the DoD/VA Depleted Uranium Medical Follow-up Program for those individuals who were in or on armored vehicles that were struck with depleted uranium munitions in friendly fire incidents during the Gulf War. Some 70 individuals have volunteered to participate in this program. To date, no medical consequences have been found as a result of those exposures. About a quarter of the individuals being followed have very small fragments of depleted uranium still in their bodies and have high levels of depleted uranium in their urine.

On the research side, the Army Center for Health Promotion and Preventive Medicine is conducting a health risk assessment for exposure to depleted uranium oxide created when the munition penetrates armor. Extensive data on concentration, duration and resuspension of this

oxide were collected during the CAPSTONE study done last year and those data are being used to produce the health risk assessment. The results are anticipated within six months.

On a practical level, deployed service members receive training in the common sense steps they should take to avoid potentially harmful exposures. DoD also has a program to identify and test individuals who were possibly exposed to depleted uranium oxide at levels that could theoretically have health effects. Current policy calls for the services to identify and track the service members most highly exposed to DU, perform DU bioassays and invite them to join the medical follow-up evaluation program. To date, more than 500 military members have been tested for DU exposure. So far, none of them has registered levels of DU in their bodies that are of concern. DoD continues to monitor exposures to depleted uranium.

After service members return from deployments, military and VA providers use the jointly developed Post-Deployment Health Clinical Practice Guideline to give health care focused on post-deployment problems and concerns. The guideline, established in 2002, provides a structure for the evaluation and care of service members and veterans with deployment-related concerns. The Deployment Health Clinical Center (DHCC) provides health care professionals access to expert clinical support for patients with difficult symptoms and illnesses, as well as deployment-related information.

We monitor the health status of active duty troops after deployments, staying alert for trends that might reflect deployment-related health issues. Currently we do not have full visibility of the health care obtained by veterans or deactivated reserve component members post-deployment. I have recently assembled a task force whose job it is to put systems in place that allow us to better monitor the health status of veterans after they have left DoD. The extended period of eligibility for TRICARE following separation, for up to six months, and the

eligibility for service through the VA for two years, provide an excellent way for us to capture information and follow up medical concerns.

After deployment, our goal for injured or ill service members is to effect a seamless transition of care from DoD to the VA health care system. An injured service member's ability to return to full duty is based on a careful health evaluation by a physician. If a member is found to be unfit for continued active duty by their attending physician, the service member is referred to a Physical Evaluation Board where it is determined if the individual is fit to perform duties. All members referred to a Physical Evaluation Board must attend Disability Transition Assistance Program training. During this training, a counselor from the VA informs members of VA benefits, disability ratings and how to file a claim. Prior to separation, members with disabilities are required to file or refuse to file a claim with the VA for compensation, pension or hospitalization.

Active duty members voluntarily separating from the service and not referred to the Physical Evaluation Board, are required to receive mandatory pre-separation counseling through the Transition Assistance Management Program (TAMP). Separating members are required to fill out a Pre-separation Counseling Checklist, including a briefing on VA benefits and health care services.

The Federal Health Information Exchange transfers electronic health information on separating Service members to the VA. Currently, DoD sends VA laboratory results, outpatient military treatment facility pharmacy data, radiology results, discharge summaries, demographic information and admission, disposition and transfer information, allergy information and consult results. DoD and the VA have created integration points that will permit VA to access the

Defense Enrollment and Eligibility Reporting System – DEERS - in real time by the end of 2005.

As you can see, DoD has made tremendous progress in force health protection and surveillance since the Gulf War, and quite a bit since the beginning of Operation Iraqi Freedom. The groundwork has been laid for even greater progress in the near future and I am firmly committed to continued improvement in protection for the health of our service members. The medical personnel of our combined services have my heartfelt appreciation and full support for the outstanding work they are doing to develop and implement the force health protection programs necessary to field the most fit and healthy force in the world.