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

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TABLE OF CONTENTS

BACKGROUND 1
DEPLOYMENT HEALTH QUALITY ASSURANCE PROGRAM 1
REPORT OF FHPQA VISITS TO MILITARY INSTALLATIONS 2
ARMED FORCES HEALTH SURVEILLANCE CENTER REPORT 6
MILITARY SERVICES' QUALITY ASSURANCE PROGRAM REPORT SUMMARY 8
U.S. ARMY 8
U.S. NAVY 10
U.S. AIR FORCE 10
U.S. MARINE CORPS 11
ARMED FORCES HEALTH SURVEILLANCE SYSTEM REPORTING 12
OCCUPATIONAL AND ENVIRONMENTAL HEALTH DEPLOYMENT SURVEILLANCE REPORTING 19
FORCE HEALTH PROTECTION QA PROGRAM SUMMARY 22

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

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) promoting and sustaining a healthy and fit force; (2) preventing illness and injury; and (3) providing medical and rehabilitative care to the sick and injured.

The Government Accountability Office (GAO) in the report titled, "DEFENSE HEALTH CARE: Comprehensive Oversight Framework Needed to Help Ensure

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

- Camp Hansen Fifth Air Naval Gunfire Liaison Company
- Naval Hospital Okinawa
- Kaneohe Bay Logistics
- Marine Aircraft Group
- Third Marine Division
- Third Marine Regiment
- Fourth Marine Division

- Air Force (October 2008)

  Dover Air Force Base
  - Dover Air Medical Command
  - Air Force Reserve, 512th Aerospace Medical Squadron

- Navy (October 2008)

  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 effectiveness as directed by DoDI 6200.05. These visits generally included briefings with commanders and senior medical leaders, discussions of deployment health processing activities and issues, 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 and AFHSC 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 review 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 Services' Post-Deployment Health Reassessment Completion Rates Is Limited," September 4, 2008, (GAO Code 08-1025R) reported that AFHSC's monthly reports to DoD's QA program should also include the total number of Service members who returned from deployment and should have completed PDHRA for the QA program to accurately assess and report. During the installation visits, the QA program staffs authenticate the accuracy of the data provided from the AFHSC, review for data transfer inconsistency, and discuss deployment processing practices. Data transfer or inconsistency 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.

2008 FORCE HEALTH PROTECTION QUALITY ASSURANCE INSTALLATION VISITS				
AUDIT ITEMS	**ARMY**	**AIR FORCE AND AIR FORCE RESERVE**	**NAVY AND NAVY RESERVE**	**MARINE CORPS**
Number of Records	110	184	41	110
Immunization rates	97%	64%	76%	75%
DD Form 2795 on file and in record	94%	47%	92%	80%
DD Form 2796 on file and in record	90%	48%	97%	87%
DD Form 2900 on file and in record	98%	25%	0%	74%
Mental Health Care received or sought in theater	7%	1%	0%	33%
Positive responses to Traumatic Brain Injury on DD Form 2796	*	2%	0%	11%
Major concerns identified by provider DD Form 2900	0%	10%	6%	13%
Referrals indicated by provider DD Form 2900	5%	6%	0%	12%

*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 requirements as outlined in Department of Defense Instruction (DoDI), 6490.03, "Deployment Health."
- We recommended that Services review the interpretation of DoD 6490.03, especially in regards to those who deploy to "at risk locations" for less than 30 days. In some instances, those individuals require deployment health assessments.
- We recommended a practice of internal peer review to discuss, educate, and validate deployment health clinical practice guidelines; targeting deployment health assessments, and standards of practice that would support the development of policy or training for providers.
- The U.S. Army completes the post-deployment health assessment once its individuals return home from deployment.

ARMED FORCES HEALTH SURVEILLANCE CENTER REPORT

Established in 2008, AFHSC receives data feeds from the Army's Medical Protection System, the Air Force's Preventive Health Assessment Individual Medical Readiness System, the Marine Corps Medical Readiness Reporting System and the Navy Environmental Health Center. The AFHSC also receives copies of the monthly Contingency Tracking System (CTS), a roster that is prepared by Defense Manpower Data Center and includes information (provided by the Services) on all Service members who have deployed. AFHSC operates and maintains the Defense Medical Surveillance System, which contains enterprise-wide data on diseases, medical events, and data on personnel and deployments. AFHSC provides data and reports to the Services, the FHPQA program and other supporting agencies for review. Additionally, AFHSC prepares the Medical Surveillance Monthly Report, publishes it monthly, and makes it is available online at http:www.afhsc.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 Services. The chart attempts to address GAO's concerns outlined in the report title, "DEFENSE HEALTH CARE: Oversight of Military Services' Post-Deployment Health Reassessment Completion Rates Is Limited." DoD's ability to provide these data is dependent on the Services continued stake in supporting the ongoing efforts to resolve deployment data roster discrepancies, thus improving deployment data 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 rotations, Service policy changes throughout the report year and multiple deployments within a calendar year.

The following tables were developed to demonstrate how data may support compliance reporting. Although time lags between Defense Manpower Data Center DMDC and CTS roster reporting may account for some data discrepancies, it is also important to note the reporting time parameters.

DEFENSE MEDICAL SURVEILLANCE SYSTEM REPORT 2008

ARMY DEPLOYMENT QUALITY ASSURANCE REPORT

Deployment End Date	Component	Number returned from deployment	DD2795*		DD2796**		DD2900***		Post Deploy Sera****		Referral On DD2796		Medical Visit After Referral*****	
			Num	%	Num	%	Num	%	Num	%	Num	%	Num	%
1-01-08 - 3-31-08	Active	28,453	23,190	82	23,069	81	16,703	58	21,415	75	8,245	36	6,066	74
1-01-08 - 3-31-08	Reserve	2,814	2,296	82	2,072	74	1,361	48	2,065	74	847	41	533	63
1-01-08 - 3-31-08	Guard	7,490	5,781	77	5,157	69	3,511	47	5,345	72	1,447	28	1,186	82
4-01-08 - 6-30-08	Active	32,761	26,610	81	26,112	80	19,848	61	2,6471	81	11,031	42	9,302	84
4-01-08 - 6-30-08	Reserve	6,007	5,429	90	5,051	84	3,575	60	5,002	83	2,127	42	1,301	61
4-01-08 - 6-30-08	Guard	15,246	12,158	80	14,210	93	9,887	65	14,004	92	6,026	42	4,690	78
7-01-08 - 9-30-08	Active	27,806	21,043	76	21,366	77	16,150	58	21.018	76	8,769	41	7,802	89
7-01-08 - 9-30-08	Reserve	2,329	1,614	69	1,182	51	803	35	1,119	48	615	52	461	75
7-01-08 - 9-30-08	Guard	3,883	2,820	73	2,836	73	2,226	57	2,840	73	1,141	40	941	83
10-01-08 - 12-31-08	Active	42,962	36.026	84	38,384	89	19,964	47	38,292	89	15,329	40	12,945	85
10-01-08 - 12-31-08	Reserve	3,021	2,389	79	2,490	82	1,124	37	2,425	80	1,182	47	923	78
10-01-08 - 12-31-08	Guard	16,541	15,529	94	14,413	87	6,467	39	14,418	87	6,802	47	6,086	90

AIR FORCE DEPLOYMENT QUALITY ASSURANCE REPORT

1-01-08 - 3-31-08	Active	17,360	15,029	87	13,988	81	12,370	71	15,556	90	1,322	10	1,171	89
1-01-08 - 3-31-08	Reserve	1,907	593	31	727	38	178	9	793	42	168	23	111	66
1-01-08 - 3-31-08	Guard	3,755	2,715	72	2,538	68	2,147	57	2,578	69	316	13	179	57
4-01-08 - 6-30-08	Active	16,450	14,008	85	13,909	85	11,249	68	14,284	87	1,784	13	1,663	93
4-01-08 - 6-30-08	Reserve	2,160	812	38	1,154	53	652	29	1,317	61	246	21	160	65
4-01-08 - 6-30-08	Guard	3,041	2,463	81	2,460	81	1,999	66	1971	65	333	14	216	65
7-01-08 - 9-30-08	Active	14,595	12,586	86	12,131	83	1,039	71	12,548	86	1,323	11	1,255	95
7-01-08 - 9-30-08	Reserve	2,475	1,049	42	1321	53	638	26	1,314	53	205	16	135	66
7-01-08 - 9-30-08	Guard	3,769	2,862	76	2,855	76	2,393	64	2,559	68	293	10	161	55
10-01-08 - 12-31-08	Active	11,992	10,252	86	9,850	82	5,729	48	9,855	82	1,241	13	1,155	93
10-01-08 - 12-31-08	Reserve	1,937	607	31	580	30	221	11	638	33	126	22	93	74
10-01-08 - 12-31-08	Guard	2,736	1,865	68	1,864	68	787	29	1,665	61	205	11	94	46

*DD2795 completed within the 90 days prior to 30 days after the start of deployment
**DD2796 completed from 60 days prior to the end of the deployment to 60 day after
***DD2900 completed from 60-210 days after the end of the deployment.
****Serum drawn from 30 days prior to the end of the deployment to 60 days after the end of deployment.
*****Inpatient and outpatient visits within 180 days of DD2796 date.

NAVY DEPLOYMENT QUALITY ASSURANCE REPORT														
Deployment End Date	Component	Number returned from Deployment	DD2795*		DD2796**		DD2900***		Post Deploy Sera****		Referral On DD2796		Medical Visit After Referral*****	
			Num	%	Num	%	Num	%	Num	%	Num	%	Num	%
1-01-08 - 3-31-08	Active	8,691	2,035	23	1,770	20	1,445	17	3,443	40	338	19	306	91
1-01-08 - 3-31-08	Reserve	1,680	731	44	780	46	605	36	1,245	74	220	28	206	94
4-01-08 - 6-30-08	Active	15,163	2,225	15	2,259	15	1739	12	3,696	25	457	20	388	85
4-01-08 - 6-30-08	Reserve	1,798	683	38	974	54	586	33	1,241	69	253	26	242	96
7-01-08 - 9-30-08	Active	9,649	2,238	23	2,463	26	1125	12	2,790	29	731	30	660	90
7-01-08 - 9-30-08	Reserve	1,526	358	24	994	65	437	29	964	63	342	34	322	94
10-01-08 - 12-31-08	Active	17,960	2,374	13	2,854	16	854	5	4,428	25	840	30	662	79
10-01-08 - 12-31-08	Reserve	1,283	290	23	845	66	150	12	861	67	240	28	193	80
MARINE CORPS DEPLOYMENT QUALITY ASSURANCE REPORT														
1-01-08 - 3-31-08	Active	14,313	7,474	52	7,283	51	6,830	48	11,768	82	1,199	17	878	73
1-01-08 - 3-31-08	Reserve	1,487	612	41	1,049	71	600	40	1,326	89	363	35	227	63
4-01-08 - 6-30-08	Active	12,935	6,839	53	8,006	62	6,022	47	9,591	74	1,374	17	936	68
4-01-08 - 6-30-08	Reserve	2,139	1,062	50	1,682	79	1,275	60	1,835	86	661	39	433	66
7-01-08 - 9-30-08	Active	8,168	5,139	63	5,514	68	2,506	31	5,805	71	1,374	25	977	71
7-01-08 - 9-30-08	Reserve	1,527	1,132	74	1,349	88	735	48	1,355	89	583	43	325	56
10-01-08 - 12-31-08	Active	12,312	6,994	57	7,627	62	3,319	27	8,489	69	1,806	24	1,101	61
10-01-08 - 12-31-08	Reserve	1,438	515	36	766	54	387	27	1,068	74	149	20	89	60

*DD2795 completed within the 90 days prior to 30 days after the start of deployment
**DD2796 completed from 60 days prior to the end of the deployment to 60 day after
***DD2900 completed from 60-210 days after the end of the deployment.
****Serum drawn from 30 days prior to the end of the deployment to 60 days after the end of deployment.
*****Inpatient and outpatient visits within 180 days of DD2796 date.

MILITARY SERVICES' QUALITY ASSURANCE PROGRAM REPORT SUMMARY

The Services continue to provide steadfast support by conducting deployment health quality assurance efforts that are tailored in scope, focus, and methodology to their organizational structure, the environment, and mission.

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

Following are the highlights from the Services' 2008 reports are as follows:

U.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 QA Program for Deployment Health. The Army reported that its Deployment Health Quality Assurance (DHQA) program provides a capacity for on-site reviews, 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), DoDI 6490.03m Deployment Health, August 11, 2006, and DoDI

6200.05, Force Health Protection QA Program, February 16, 2007, serve as references for guidance, measures, and reporting requirements related to deployment health activities.

- In an effort to provide assistance and oversight for deployment health programs, the Army DHQA team created a Community of Practice Web site located on Army Knowledge Online. This Web site contains links to resources, a discussion forum, and information pertaining to Army Lean Six Sigma projects related to the soldier readiness processing.

- The U.S. Army DHQA program noted that one root cause for inconsistent compliance reporting was the apparent lag between the Contingency Tracking System and the Defense Medical Surveillance System and the need to track these data over time. The Army outlined data differences in the same period, from July–September 2008. Updates of these 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 2900s and medical visits for all three components' reassessments, post-deployment serum samples and post-deployment referrals indicated and completed, the Army plans to continue to track quarterly metrics for at least three consecutive quarters to allow the system to compensate for the apparent lag between the CTS and the DMSS.

ARMY REVIEW OF AFHSC QA DATA REPORT

Previous (3rd Quarter 2008) Deployment end date July 1-September 30, 2008	Number Returned From Deployment	% DD2795	% DD2796	% DD2900	% Post Deployment Sera	% Referrals On DD2796	%Post Deployment Medical Visit
Active Duty	22,067	77	81	19	80	32	78
Reserve	1,590	10	48	10	45	22	61
Guard	2,458	2	75	14	74	23	77
Updated report Deployment end date July 1-September 30, 2008							
Active Duty	28,125	76	76	50	75	39	95
Reserve	2,375	69	49	21	47	44	83
Guard	4,049	73	73	44	73	37	87

U.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.

U.S. NAVY 2008 DEPLOYMENT HEALTH QUALITY ASSURANCE DATA								
Centralized Data	**1st Quarter 2008**		**2nd Quarter 2008**		**3rd Quarter 2008**		**4th Quarter 2008**	
Units reporting		%	27	%	24	%	27	%
Personnel deployed	2,109		1,067		1,427		2,494	
Personnel returned	2,109		1,056		1,243		3,023	
DD2796(PDHA)	2,132		1,054	99.8	1,235*	87	1,741	57.6
Personnel requiring referral post-PDHA	83	3.9	108	10	52	4.2	62	3.6
Personnel completing referral post-DD2796	82	3.7	79	73	50	96	48	77.4
DD2900 (PDHRA)	574	2.7	229	22	935	75	882	
Personnel requiring referral post-PDHRA	Not Reported		Not reported		48	5	72	8.2
Personnel completing referral post-DD2900					48	100	72	100
Number of DD 2796 Forms DD to AFHSC	2,101	99.5	1,052	99.5	1,231	99	1,332	76.5
Number of DD 2900 Forms to AFHSC	274	1.3	274		904	97		
Post-Deployment Sera	2,103	99.7	229	100	1,162	94	920	52.8

*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.

U.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*								
Centralized Data	**1st QUARTER**		**2ndQUARTER**		**3rd QUARTER**		**4th QUARTER**	
Criterion		%		%		%		%
Personnel deployed (DCAPES)	14,285		17,242		19,417		10,998	N/A
DD2795 Pre-deployment assessment forms	11,781	82	14,034	81	16,310	84	9,173	83
Personnel deployed	15,885		19,361		19,441			
DD2796(PDHA)	13,086	82	16,351	84	16,490	85	12,850	85
Personnel requiring referral post PDHA	1,437	11	2,167	13	1,759	11	1,577	12
Individuals completing referral post DD2796	646	45	656	30	590	34	445	28
Number of personnel returned from deployment since March 2004	50,326	N/A	51,825	42,374	51,357	N/A	48,704	N/A
Number of personnel completed DD2900 (PDHRA)	42,720	85	42,374	82	42,473	83	42,802	86
Pre-Deployment Sera	10,022	70	9,642	73	14,148	73	8,478	77
Post-Deployment Sera	12,603	79	14,095	73	13,714	71	10,169	67

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

U.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 Entrise, 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 currently completed in a Battalion Aid Station without access to AHLTA (the military's electronic health record), a chaplain's office, or non-medical counseling such as Military One Source and the U.S. Marine Corps 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 source is inaccurate for QA purposes, perhaps because of the way the system captures required data. Therefore, for future reports, the U.S. Marine Corps plans to use the AFHSC report because the AFHSC is the data repository.

- The U.S. Marine Corps Deployment Health Assessment Quality Assurance (DHA QA) program obtained and compared data from the operation and medical reporting systems for the 4th quarter 2008. The results received are reported below:

Criterion Tracked	Total for all USMC	USMC Datum Source	Reported by AFHSC
Pre-deployment Data			
DD 2795 to AFHSC	Unavailable	MRRS	4511
Total deployed	14,970*	ODSE	Not reported
Post-deployment Data			
Total returned from deployment	10,636*	ODSE	6,522
DD2796 to AFHSC	15,584**	AFHSC	4,859
Sera obtained	15,782**	AFHSC	5,318
Referral indicated	-45**	AFHSC	676
Referral completed	-391**	AFHSC	323
PDHRA Data			
90-180 days since redeploy	3,954	MRRS	Not reported
DD2900 completed	5,644**	AFHSC	358***

Unavailable=data lost, not retrievable from source

* Includes those currently deployed plus those deployed at the beginning of the period and having returned during reporting period

**Calculated arithmetically from reports (Post-deployment summaries and DD 2900 reports) provided by AFHSC.

*** Does not include "catch up, i.e., DD2900 completed after due date.

ARMED FORCES HEALTH SURVEILLANCE SYSTEM REPORTING

During CY 2008, the DoD periodically reviewed the questions and associated data collection and analysis processes to ensure that the questionnaires were meeting the DoD force health protection goal of maintaining a fit and healthy force. AFHSC provided deployment health assessment data weekly to the FHPQA program. The following article titled, "Update: Deployment Health Assessment, U.S. Armed Forces, December

2008," provides the total number of submitted deployment health assessments and reassessment forms and Service members self-reported concerns. Unlike compliance reporting that only includes forms that are received within a certain timeframe; the following charts and analysis include all reports received 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.[1] 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.[2]

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

Methods:

Completed deployment health assessment forms are transmitted to the Armed Forces Health Surveillance Center (AFHSC) where they are incorporated into the Defense Medical Surveillance System (DMSS).[3] In the DMSS, data recorded on health assessment forms are integrated with data that document demographic and military characteristics and medical encounters (e.g. hospitalizations, ambulatory visits) at fixed 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 (DD2796) deployment health assessment forms completed since 1 January 2003 and all post-deployment health reassessment (DD2900) forms completed since 1 August 2005.

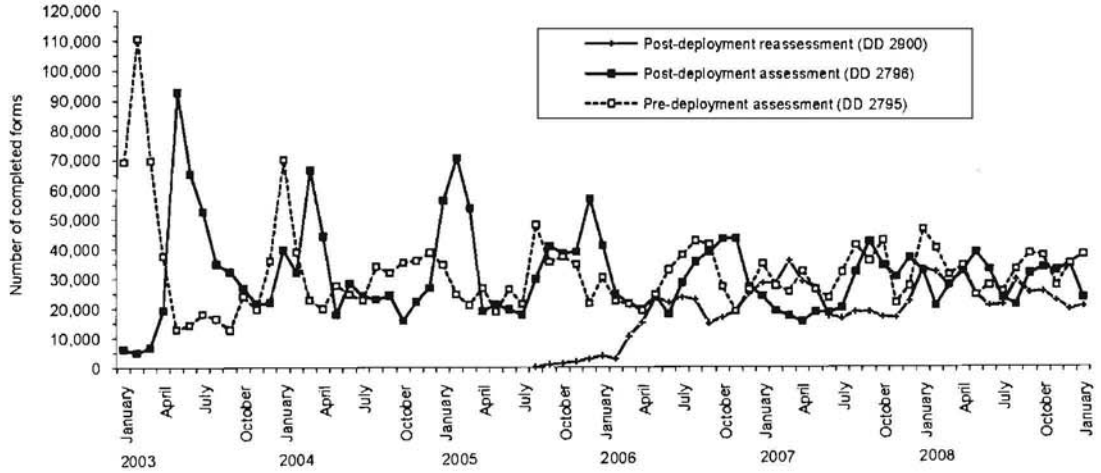
Results:

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 at field sites, forwarded to the Armed Forces Health Surveillance Center, and archived in the Defense Medical Surveillance System **(Table 1)**.

Between January 2003 and January 2009, there were peaks and troughs in the numbers of pre-deployment and post-deployment health assessments that generally corresponded to times of departure and return of large numbers of deployers **(Figure 1)**. Since April 2006, the numbers of post-deployment health reassessments (PDHRA) completed per month have fluctuated in a range between approximately 16,000 and 36,000 **(Figure 1, Table 1)**.

From January to December 2008, nearly three-fourths (72.8%) of deployers rated their "health in general" as "excellent" or "very good" during pre-deployment health assessments. Smaller proportions of returned deployers rated their health as "excellent" or "very good" during post-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 and from

Figure 1. Total deployment health assessment and reassessment forms, by month, U.S. Armed Forces, February 2003-January 2009



Source: Medical Surveillance Monthly Report, January 2009

Table 1. Deployment-related health assessment forms, by month, U.S. Armed Forces, February 2008-January 2009

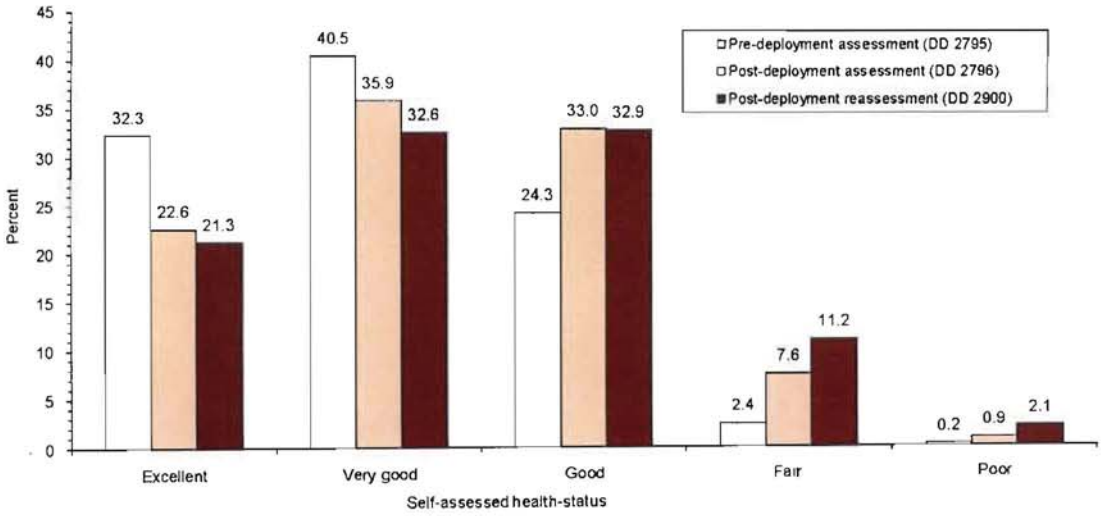
	Pre-deployment assessment DD2795		Post-deployment assessment DD2796		Post-deployment reassessment DD2900	
	No.	%	No.	%	No.	%
Total	400,458	100	360,500	100	306,829	100
2008						
February	40,883	10.2	21,033	5.8	32,719	10.7
March	31,788	7.9	28,246	7.8	27,768	9.0
April	34,870	8.7	33,196	9.2	33,658	11.0
May	24,786	6.2	39,513	11.0	25,001	8.1
June	28,093	7.0	33,687	9.3	21,062	6.9
July	26,074	6.5	23,885	6.6	21,323	6.9
August	33,715	8.4	21,386	5.9	29,921	9.8
September	39,164	9.8	32,374	9.0	25,663	8.4
October	38,437	9.6	34,335	9.5	25,949	8.5
November	28,091	7.0	33,329	9.2	22,867	7.5
December	35,749	8.9	35,565	9.9	19,927	6.5
2009						
January	38,808	9.7	23,951	6.6	20,971	6.8

immediate post-deployment to 3-6 months after returning. For example, prior to deploying, less than one of 40 (2.6%) deployers rated their health as "fair" or "poor"; upon returning from deployment, one of 14 (8.5%) deployers rated their health as "fair" or "poor"; and 3-6 months after returning, one of 7 (13.3%) deployers rated their health as "fair" or "poor" **(Figure 2)**.

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%), higher at return from deployment (mean, by month: 8.3%), and 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 3)**. However, the proportions of deployers who rated their health as "fair" or "poor" on the post-deployment questionnaire generally increased during the year from less then 6% in February 2008 to nearly 11% in November 2008 **(Figure 3)**. 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 states between the assessments **(Figure 4)**.

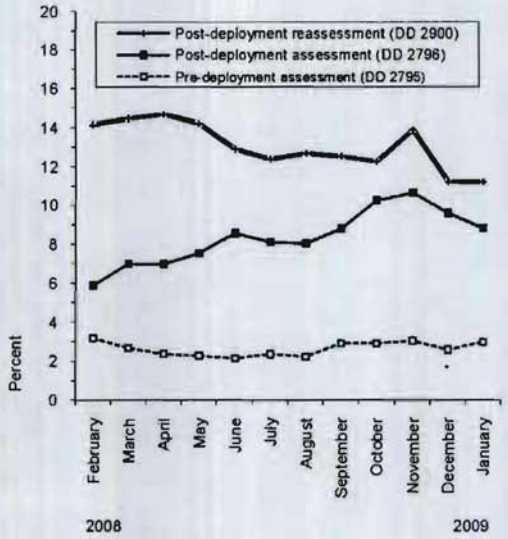
In general, on post-deployment assessments and reassessments, deployers in the Army and in Reserve components were more likely than their respective counterparts to report health and exposure-related concerns. Among Reserve component members of the Army and Marine Corps, health and exposure-related concerns and indications for referrals were much greater 3-6 months after return from deployment (DD2900) than at the time of return deployment (DD2796). 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

Figure 2. Percent distributions of self-assessed health status as reported on deployment health assesment forms, U.S. Armed Forces, February 2008-January 2009



Source: Medical Surveillance Monthly Report, January 2009

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



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

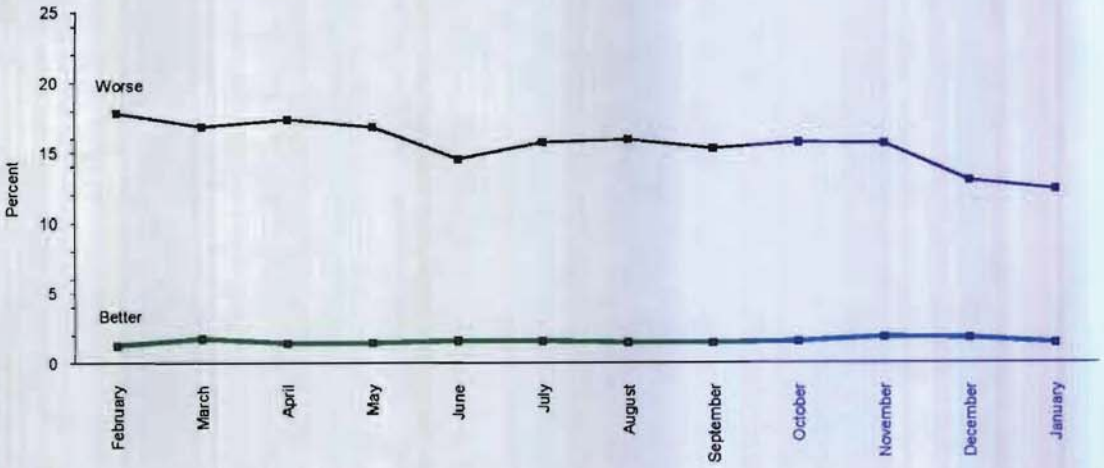
Finally, in general, soldiers and Reserve component members were more likely than their respective counterparts to report "exposure concerns"; and both active and Reserve component members were more likely to report "exposure concerns" 3-6 months after compared to the time of return from deployment **(Table 2, Figures 6,7).**

Editorial comment:

A 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 psychologically demanding; and there are more – and more significant – threats to the physical and mental health of service members when they are conducting combat operations away from their families in hostile environments compared to when serving at their permanent duty stations (active component) or when living in their civilian communities (Reserve component).

Another consistent finding of deployment-related health surveillance is that, as a group, returned 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 return. Symptoms of post deployment stress disorder (PTSD) may emerge or worsen within several months after a life threatening experience (such as military service in a war zone). PTSD among U.S. veterans of combat duty in Iraq has been associated with higher rates of physical health problems after return from deployment.[4] Among British veterans of the Iraq war, Reservists reported more "ill health" than their active counterparts. Roles, traumatic experiences, and unit cohesion while deployed were associated with medical outcomes after

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



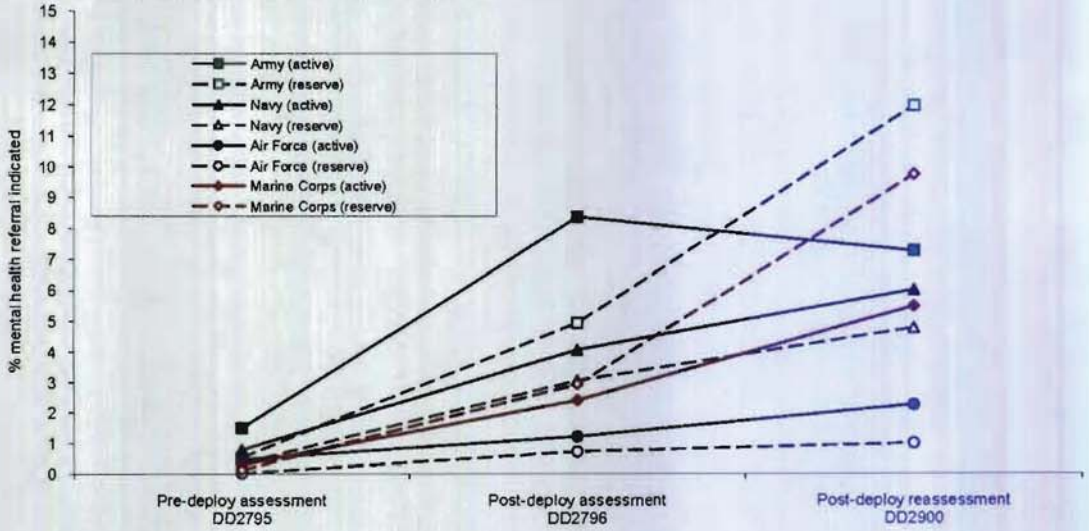
Source: Medical Surveillance Monthly Report, January 2009

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

	Army			Navy			Air Force			Marine Corps			All service members		
	Pre-deploy DD2795	Post-deploy DD2796	Reassess DD2900	Pre-deploy DD2795	Post-deploy DD2796	Reassess DD2900	Pre-deploy DD2795	Post-deploy DD2796	Reassess DD2900	Pre-deploy DD2795	Post-deploy DD2796	Reassess DD2900	Pre-deploy DD2795	Post-deploy DD2796	Reassess DD2900
Active component	n= 134,919 %	n= 124,778 %	n= 94,595 %	n= 16,043 %	n= 11,914 %	n= 8,285 %	n= 58,589 %	n= 51,268 %	n= 50,759 %	n= 30,930 %	n= 27,307 %	n= 40,743 %	n= 240,481 %	n= 215,265 %	n= 194,382 %
General health "fair" or "poor"	4.3	10.7	16.5	1.5	4.8	6.6	0.5	3.4	4.4	1.9	5.9	9.6	3.0	7.8	11.8
Health concerns, not wound or injury	12.5	24.9	33.3	4.7	13.9	16.1	1.8	7.3	12.9	3.5	12.9	23.1	8.6	18.1	25.5
Health worse now than before deployed	na	6.5	28.4	na	0.8	14.1	na	1.9	9.4	na	1.0	19.3	na	4.1	21.4
Exposure concerns	na	19.6	24.3	na	14.5	15.0	na	10.3	15.8	na	10.3	19.6	na	15.6	20.9
PTSD symptoms (2 or more)	na	12.1	17.6	na	4.7	7.9	na	2.7	3.1	na	4.3	10.2	na	8.1	12.2
Depression symptoms (any)	na	9.2	37.5	na	1.3	26.0	na	2.0	15.5	na	2.2	32.9	na	5.8	30.7
Referral indicated by provider (any)	5.5	32.9	24.0	5.6	22.0	16.7	1.5	11.7	8.3	4.3	20.1	25.3	4.4	25.1	20.1
Mental health referral indicated*	1.5	8.4	7.3	0.8	4.1	6.0	0.5	1.2	2.3	0.3	2.4	5.5	1.1	5.4	5.7
Medical visit following referral†	98.4	98.1	97.1	90.0	76.0	92.5	78.5	94.7	96.6	67.0	69.3	73.3	90.9	93.0	90.5
	Army			Navy			Air Force			Marine Corps			All service members		
	Pre-deploy DD2795	Post-deploy DD2796	Reassess DD2900	Pre-deploy DD2795	Post-deploy DD2796	Reassess DD2900	Pre-deploy DD2795	Post-deploy DD2796	Reassess DD2900	Pre-deploy DD2795	Post-deploy DD2796	Reassess DD2900	Pre-deploy DD2795	Post-deploy DD2796	Reassess DD2900
Reserve component	n= 67,781 %	n= 50,870 %	n= 75,284 %	n= 3,836 %	n= 3,980 %	n= 4,724 %	n= 15,113 %	n= 14,152 %	n= 14,003 %	n= 2,731 %	n= 3,137 %	n= 3,155 %	n= 89,461 %	n= 72,139 %	n= 97,166 %
General health "fair" or "poor"	2.1	10.8	19.3	0.5	7.9	9.5	0.3	4.4	4.8	0.6	8.5	9.7	1.7	9.4	15.6
Health concerns, not wound or injury	13.1	36.8	51.2	3.1	27.2	30.9	0.9	11.6	13.7	2.9	24.1	35.9	10.5	31.3	42.5
Health worse now than before deployed	na	12.7	37.6	na	3.4	23.1	na	2.6	10.1	na	2.9	24.7	na	9.9	31.1
Exposure concerns	na	25.4	36.3	na	34.2	27.7	na	15.7	20.5	na	19.1	29.0	na	23.9	32.6
PTSD symptoms (2 or more)	na	11.3	25.0	na	5.1	11.2	na	2.0	2.6	na	4.7	13.9	na	9.0	19.5
Depression symptoms (any)	na	12.3	40.0	na	3.0	26.3	na	1.7	13.9	na	4.8	32.4	na	9.6	34.1
Referral indicated by provider (any)	4.5	32.8	34.0	3.3	28.8	18.3	0.7	14.2	5.8	5.6	35.5	30.8	3.9	29.6	27.9
Mental health referral indicated*	0.5	4.9	12.0	0.3	3.1	4.8	0.0	0.7	1.0	0.1	2.9	9.8	0.4	4.0	9.5
Medical visit following referral†	96.2	98.0	29.5	88.6	86.5	36.1	59.1	61.7	40.2	81.1	59.7	29.7	94.4	90.1	30.0

*Includes behavioral health, combat stress and substance abuse referrals.
†Record of inpatient or outpatient visit within 6 months after referral

Figure 5. Percent of deployers with mental or behavioral health referrals, by Service and component, by timing of health assessment, U.S. Armed Forces, February 2008-January 2009



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 (DD2795) and post-deployment health reassessments (DD2900), U.S. Armed Forces, February 2008-January 2009

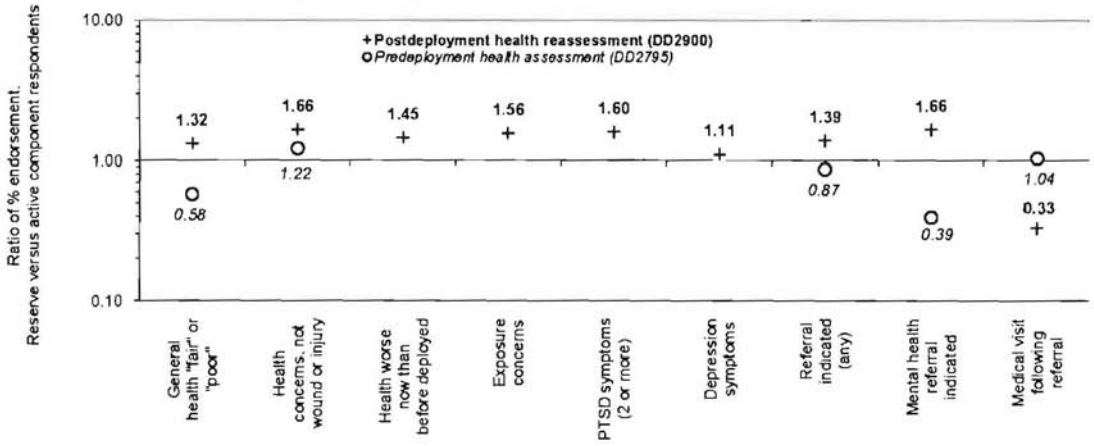
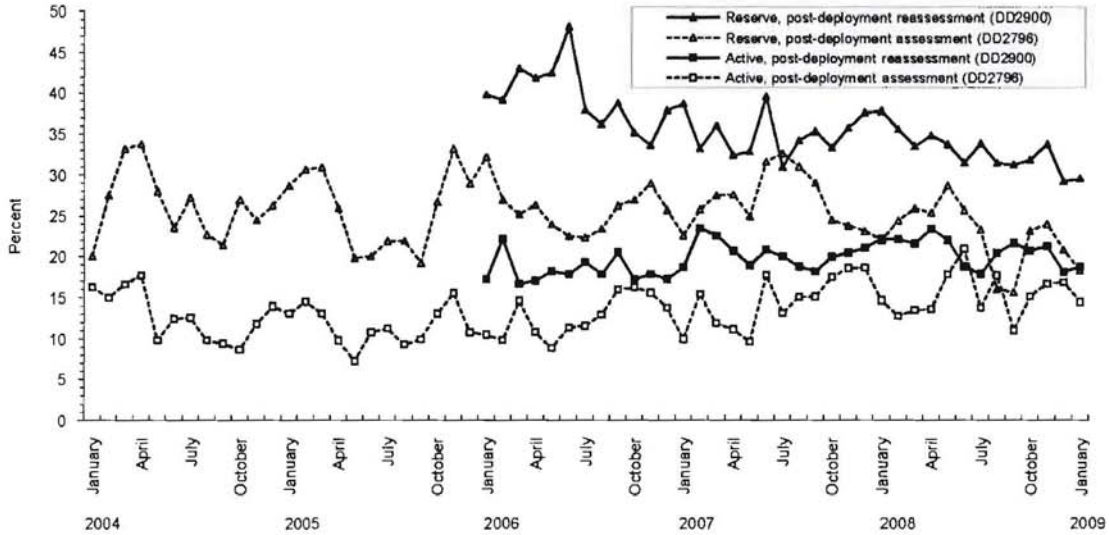


Figure 7. Proportion of service members who endorse exposure concerns on post-deployment health assessments, U.S. Armed Forces, January 2004-January 2009



returning; however, PTSD symptoms were more associated with problems at home (e.g., reintegration into family, work, and other aspects of civilian life) than with events in Iraq.[5]

References:

1. Undersecretary of Defense for Personnel and Readiness. Department of Defense Instruction (DODI) No. 6490.3, subject: Deployment health, dated 11 August 2006. Washington, DC.
2. Assistant Secretary of Defense (Health Affairs). Memorandum 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.
3. Rubertone MV, Brundage JF. The Defense Medical Surveillance System and the Department of Defense serum repository: glimpses of the future of public health surveillance. *Am J Public Health*. 2002 Dec;92(12):1900-4.
4. Hoge CW, Terhakopian A, Castro CA, Messer SC, Engel CC. Association of posttraumatic stress disorder with somatic symptoms, health care visits, and absenteeism among Iraq war veterans. *Am J Psychiatry*. 2007 Jan,164(1):150-3.
5. Browne T, Hull L, Horn O, et al. Explanations for the increase in mental health problems in UK reserve forces who have served in Iraq. *Br J Psychiatry*. 2007 Jun;190:484-489.

Source: Medical Surveillance Monthly Report, January 2009

OCCUPATIONAL AND ENVIRONMENTAL HEALTH DEPLOYMENT SURVEILLANCE REPORTING

Extensive deployment occupational and environmental health (OEH) surveillance continued during this period to prevent hazardous exposure whenever possible and to document exposures to hazardous agents whenever they occurred. The U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) recently completed a summary report of Operation Iraqi Freedom (OEF) and Operation Enduring Freedom (OIF) occupational and environmental media analyses performed by its laboratory (where the bulk of the samples are analyzed) from January 1, 2003, to December 31, 2008. For this period, they analyzed more than 11,000 environmental media samples taken at more than 275 locations in the United States Central Command (USCENTCOM) area of responsibility. This included 6,780 air samples, 2,070 water samples, and 2,136 soil samples.

Previous Force Health Protection Quality Assurance Reports discussed various deployment OEH exposure monitoring results and reports of specific incidents that were investigated and documented. Evaluations especially focused on whether incident exposures had the potential to cause long-term health implications or require follow-up medical surveillance.

Concern involving possible exposures to combustion products associated with the 2003 Mishraq sulfur fire was first reported in the 2005 and 2006 Force Health Protection Quality Assurance report to Congress. This fire started in June 2003 at the Al-Mishraq State Sulfur Plant located near Mosul, Iraq, and burned from June 24 to July 21, 2003. The resulting smoke plume contained atmospheric pollutants, such as hydrogen sulfide (H_2S), and sulfur dioxide (SO_2). A number of Service members near the plume reported acute health effects during the incident. In 2006, USACHPPM undertook a formal epidemiological investigation involving the review of medical data of thousands of personnel to determine whether anyone potentially exposed to the combustion products was at an increased risk of illness. This analysis did not show a definitive link between sulfur fire exposure and chronic or recurring respiratory diseases. However, the results did not rule out the possibility of such an association, and the Army continues to look at the possible health outcomes associated with this incident. Apart from the possible respiratory health effects associated with exposure to the sulfur fire smoke, a separate, yet significant, finding indicates that a small sample of all returning OIF and OEF veterans (regardless of any exposure to sulfur fire) appear to have experienced more respiratory problems post-deployment than before deployment. While the findings are statistically significant, there are still too many variables to distinguish a single quantified estimate of any increased risk.

The health implications of exposures to the fine sand and dust identified throughout the theater, which are routinely much higher than most locations within the

United States, are still not well understood. The Department of Defense (DoD) has continued to collect additional airborne monitoring data and is working with other Federal health organizations to determine whether the elevated airborne particulate levels pose a health risk. In May 2009, DoD requested the National Research Council (NRC) to review its studies and the extensive deployment particulate matter data and provide an external expert assessment and any recommendations for future data collection, studies, and medical surveillance. The estimated timelines for this project include an interim NRC report at the end of 2009.

Other exposure incidents, to include exposures to chlorine gas, that have occasionally occurred since 2006 have been relatively small in number and involved a limited number of U.S. military personnel. Those incidents involving more than 10 reported injuries were often due to enemy engagement (e.g., improvised explosive devices exploded alongside chlorine gas cylinders) or unintentional releases near U.S. occupied locations. For those Service members who received medical treatment, all returned to duty. For these exposure incidents, all the available incident data are archived in the USACHPPM Deployment OEH Data Portals for future reference.

Other examples include a 2007 incident that resulted in a small group of Service members exposed during site reconnaissance activities to a chemical warfare blister agent from old leaking Iraqi munitions. A small number of personnel were treated for acute symptoms. Others who did not demonstrate adverse effects were later confirmed to have been exposed. The personnel returned to the United States through Madigan Army Medical Center at Fortt Lewis, Washington, where the pulmonary physician was informed of the details of the exposure incident for follow-up purposes. Other site-specific exposures are the unique industrial emissions at Kuwait's Shuaiba Sea Port of Debarkation/ Embarkation. Past Force Health Protection Quality Assurance Reports noted occasional releases of toxic industrial compounds at the site that have resulted in reports of odors and eye and throat irritation. Air monitoring and risk communication activities continue at this location.

Other environmental exposures examined over the past few years include exposures associated with military waste burn pits, especially the burn pit at Joint Base Balad, Iraq, and the reported exposures to sodium dichromate (hexavalent chromium) at the Qarmat Ali water treatment plant in Southern Iraq that occurred in 2003. Summaries for these two exposure incidents follow.

- Burn pits are used at many of the forward operating bases in USCENTCOM for solid waste disposal, often because other more desirable options are not available. Until wartime conditions abated with an accompanying reduction in the force protection threats, it was risky for personnel to transport wastes away from bases to other locations. Unfortunately, burn pits generate a great amount of

disagreeably smelling smoke that often drifts over the life support areas of our camps. Because of health concerns associated with the smoke, in 2008 USCENTCOM completed a health risk assessment of the burn pit smoke at Joint Base Balad, the largest burn pit in Iraq. The health risk assessment included an analysis of more than 160 air samples. Each sample was analyzed for approximately 25 different substances or characteristics resulting in more than 4,000 data points. Following the completion of the Joint Base Balad Health Risk Assessment, the Defense Health Board, a Federal Advisory Committee serving the Department, reviewed the risk assessment. This Board of medical experts, including university professors and renowned scientists in the fields of epidemiology, preventive medicine, and toxicology determined that the health risk assessment provided an accurate evaluation of airborne exposure levels for deployed Service members and confirmed that all toxic substances detected were within acceptable health standards and that no long-term health effects, including cancer, were expected. USCENTCOM has made significant strides in installing incinerators and implementing other measures to reduce the need to burn wastes, such as the use of landfills and recycling operations. They also are relocating some burn pits to more suitable locations (e.g., downwind and further from the life support areas). There are now 25 solid waste incinerators in Iraq that are operational, ranging in size up to 64 tons. In addition, USCENTCOM is embarking on a waste disposal strategy for Afghanistan that will rely more heavily on the use of incinerators and incorporate other waste disposal lessons learned from Iraq.

- In April 2003, the U.S. initiated operations to restore the Qarmat Ali Industrial Water Treatment Plant and provide industrial quality water for oil production. Kellogg Brown & Root (KBR) was the designated contractor for this operation, with military forces providing security. Shortly after their arrival, KBR employees expressed concerns about exposures to what turned out to sodium dichromate (containing hexavalent chromium, a carcinogen) that had been spilled in and around the plant. In mid-August 2003, the KBR Health, Safety, and Environment personnel collected air and soil samples and conducted medical surveillance of its contractors. In October, a U.S. Army Preventive Medicine team conducted a health survey of U.S. Service members who were currently providing security for the civilian contractors. Subsequently, it was determined that approximately 250 U.S. Service members who provided security at the Qarmat Ali plant could have been exposed to low-level concentrations of hexavalent chromium in the soil and in air. Extensive environmental sampling for

hexavalent chromium and comprehensive medical examinations were accomplished to include whole blood chromium tests on the U.S. personnel who were assigned at that location. Only minor, temporary health effects, such as bloody noses, were identified in some individuals. These minor effects could not be directly attributed to chromium exposures because acute effects usually require exposures at much higher levels over longer durations than existed at the Qarmat Ali facility. It was more likely that these minor health effects were related to existing medical conditions or exposures to desert heat, sand, dust, and wind. Because the duration of the possible exposures was very short, the overall risk for occurrence of long-term health effects was considered negligible. The other factor considered when evaluating the possible for any long-term health effects was the absence or very low levels of chromium found in the blood of the exposed Service members. Extensive environmental monitoring and the health examinations, including blood chromium levels, indicated no significant exposures to hexavalent chromium. The Defense Health Board upon their full review of the environmental monitoring and medical examinations results validated the findings and conclusions of the U.S. Army Preventive Medicine team. Following 2008 Congressional hearings and media reports pertaining to allegations raised by KBR employees that their parent company did not adequately protect them from exposure to the sodium dichromate, additional concerns arose on the part of some U.S. personnel who were previously assigned to the Qarmat Ali facility, along with their corresponding State's National Guard Headquarters (Indiana, West Virginia, South Carolina, Oregon). In late 2008, the DoD's Health Board reviewed the Army's environment investigation and medical response and concluded that the "field investigation was completed in an exemplary fashion and that its conclusions, recommendations, and interventions were sound and appropriate."

FORCE HEALTH PROTECTION QA PROGRAM SUMMARY

In 2008, the Services and the FHP&R QA program agreed to address data integrity and operational issues related to identifying deployment rosters. Verification of deployment rosters between the Services systems, AFHSC, and DMDC is necessary due to a policy change in Department of Defense Instruction (DoDI), 6490.03, "Deployment Health" that no longer mandates health assessments for certain routine operations. The Services, AFHSC, DMDC and additional agencies continue to coordinate this effort.

The FHPQA program through activities and visits will continue to seek and evaluate potential measures as guided by the FHPC.

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG 24 2009

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

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

Enclosure:
As stated

cc:
The Honorable Jerry Lewis
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

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

AUG 24 2009

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

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

Enclosure:
As stated

cc:
The Honorable Thad Cochran
Vice Chairman

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG 24 2009

The Honorable Daniel K. Inouye
Chairman, Committee on Appropriations
United States Senate
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Enclosure:
As stated

cc:
The Honorable Thad Cochran
Vice Chairman

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG 24 2009

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

Dear Madam Chairwoman:

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.

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Sincerely,

Ellen P. Embrey

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

Enclosure:
As stated

cc:
The Honorable Joe Wilson
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG 24 2009

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

Dear Mr. Chairman:

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Sincerely,

Ellen P. Embrey

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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

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG 24 2009

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

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

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG 24 2009

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

Dear Mr. Chairman:

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Sincerely,

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

Enclosure:
As stated

cc:
The Honorable Howard P. "Buck" McKeon
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG 24 2009

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

Dear Mr. Chairman:

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The Honorable C. W. Bill Young
Ranking Member