OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

APR 21 2009

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

Dear Mr. Chairman:

This letter provides the 2009 Annual Report to Congress for the Department of Defense on health status and medical readiness of members of the Armed Forces. The enclosed report is based on the Comprehensive Medical Readiness Plan developed by the Joint Medical Readiness Oversight Committee as required by Section 731 of the Ronald W. Reagan National Defense Authorization Act (NDAA) for Fiscal Year 2005.

The initial Comprehensive Medical Readiness Plan identified 10 objectives and 22 action items for concentrated action, including the necessary measures of success, of which 20 were completed the first year. The Committee revised the Comprehensive Medical Readiness Plan each year to include remaining actions from the previous year's plan and added new readiness actions mandated by NDAAs for subsequent fiscal years. The enclosed report is based on the plan approved in 2008.

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

Sincerely,

Gail H. McGinn
Performing the Duties of
the Under Secretary of Defense
(Personnel and Readiness)

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

OFFICE OF THE UNDER SECRETARY OF DEFENSE
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WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

APR 21 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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The Honorable Lindsey O. Graham
Ranking Member

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WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

APR 21 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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The Honorable John M. McHugh
Ranking Member

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4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

APR 21 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:

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The Honorable Joe Wilson
Ranking Member

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WASHINGTON, D.C. 20301-4000

PERSONNEL AND READINESS

APR 21 2009

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

Dear Mr. Chairman:

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Enclosure:
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cc:
The Honorable Thad Cochran
Vice Chairman

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PERSONNEL AND
READINESS

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

APR 21 2009

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Ranking Member

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PERSONNEL AND READINESS

APR 21 2009

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

Dear Mr. Chairman:

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Performing the Duties of
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Enclosure:
As stated

cc:
The Honorable Jerry Lewis
Ranking Member

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WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

APR 21 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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Enclosure:
As stated

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

DRAFT

Joint Medical Readiness Oversight Committee

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

January 2009

DRAFT

DRAFT

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Annual Report to Congress On the Health Status and Medical Readiness of Members of the Armed Forces January 2009

Background:

The 2005 Comprehensive Medical Readiness Plan (CMRP) was established with the goal of improving medical readiness throughout the Department of Defense (DoD) and enhancing Service member health status tracking before, during, and after military operations. The 2005 plan specifically addressed requirements of the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005 (NDAA 05) and other legal requirements. DoD has updated the CMRP annually to reflect new requirements and completion of previous actions.

Action 1, National Defense Authorization Act For Fiscal Year 2005 (NDAA 05), Section 731(a) – Comprehensive Medical Readiness Plan Update

Requirement:

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

Response:

This action is complete for 2008, but is an annual requirement. To maintain the currency of the Comprehensive Medical Readiness Plan, the Joint Medical Readiness Oversight Committee (JMROC) updated the plan. The JMROC approved the 2008 plan on October 28, 2008. It includes not only the remaining and recurring actions from 2007, but also new requirements from the National Defense Authorization Act for Fiscal Year 2008 (NDAA 08). The resulting plan yielded seven actions, of which six are complete.

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

Requirement:

The JMROC will prepare and submit a report annually to the Secretary of Defense and to the Senate and House Armed Services Committees (reviewed by veterans and military health advocacy organizations) on the health status and medical readiness of members of the Armed Forces, including members of reserve components, based on the

comprehensive plan and compliance with DoD policies on medical readiness tracking and health surveillance.

Response:

This action is complete for 2008, hut is an annual requirement. DoD submitted the 2008 report to Congress covering the events of 2007 on June 9, 2008. In addition to coordination within the Department of Defense, the 2008 report was coordinated with the following military health advocacy organizations:

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

The Department of Health and Human Services and the Department of Veterans Affairs also reviewed the report.

Summary of Comments

No commcnts were received from the military health advocacy organizations.

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

Requirement:

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

Response:

This action is complete. There are two components to baseline health data collection in DoD. The first involves routine processing examinations accomplished at the Military Entrance Processing Stations (MEPS) for enlisted recruits and for new officers as part of DoD Medical Examination Review Board (DoDMERB) process. Recruits bring a paper copy of their MEPS health record with them to initial training. The U.S. Military Enlistment Processing Command is developing a standardized electronic data collection system that will link to AHLTA, the Military Health System's electronic health record, allowing incorporation of the information into the Service member's longitudinal electronic health record. In the interim, the paper records are scanned and added to the electronic medical record.

The second component is self-reported medical information. DoD developed a baseline health information collection tool, the Health Assessment Review Tool (HART). This self-reporting tool collects demographic, medical, psychosocial (including depression and post-traumatic stress disorder scales that are not part of the MEPS/DoDMERB tools), occupational, and other health risk data. On October 1, 2007, the Military Health System launched a web-enabled version of the HART for recruits to complete from any computer terminal with Internet access, as long as they are registered in Defense Enrollment Eligibility Reporting System and have a valid Common Access Card. Each of the Services has developed its own version of the HART, which is used during the annual preventive health assessment. This is first accomplished within one year following basic training.

Action 4, NDAA 06, Section 731 – Study Relating to Pre-deployment and Post-deployment Medical Exams of Certain Members of the Armed Forces

Requirement:

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

Response:

DoD submitted a report to Congress on January 4, 2008, which reported key findings related to the effectiveness and performance of the Department of Defense assessments.

In summary, almost all Service members (97 percent) rated their general health as at least "good" immediately before deployment to Operation Iraqi Freedom or Operation Enduring Freedom. The vast majority of Service members (81 percent) reported their health as at least "good" following return from deployment. Not surprisingly, self-reports from Service members were more negative among those who encountered combat events than those who did not, and Service members with more combat experiences were more negative than those who encountered fewer actual combat experiences. All respondents reported a high degree of satisfaction with the deployment health assessment process, with endorsement rates of 85 percent or higher for most aspects of the process.

Action 5, NDAA 08, Section 714 – Report On Medical Physical Examinations of Members of the Armed Forces Before their Deployment:

Requirement:

1. Compares the policies of the military departments concerning medical physical examinations of members of the Armed Forces before their deployment, including an identification of instances in which a member (including a member of a Reserve component) may be required to undergo multiple physical examinations, from the time of notification of an upcoming deployment through the period of preparation for deployment.

2. Provides an assessment of the current policies related to, as well as the feasibility of, a single pre-deployment physical examination for members of the Armed Forces before their deployment and a single system for tracking electronically the results of examinations that can be shared among the military departments to eliminate redundancy of medical physical examinations before deployment.

Response:

On September 15, 2008, the Assistant Secretary of Defense for Health Affairs a report to Congress, which reported DoD's efforts to assure medical assessments of members of the Armed Forces before their deployment. In summary, DoD has policies that govern pre-deployment processing, e.g., DoD Instruction (DoDI) 6490.03, "Deployment Health," was published August 11, 2006. Each Service, the Joint Staff, and many of the Combatant Commands have instructions on pre-deployment processing that

implement this DoDI. Because they are tied to the DoDI, there is little variance in the policies among the Services.

Service members must be prepared to deploy at any time; this requirement was documented in DoDI 6025.19, "Individual Medical Readiness (IMR)," which was published on January 3, 2006. The instruction requires each Service and component to repeatedly measure and report the readiness of individual members, and requires that the results of all Periodic Health Assessments be included in the IMR calculations. All Services are performing annual Periodic Health Assessments.

Within 30 days before deployment, Service members are evaluated with a pre-deployment health assessment. Reserve Component (RC) units activated to deploy follow the same process as do Active Duty members except that they receive an additional evaluation by their Reserve medical personnel before activation to ensure deployability following activation.

DoD has a computerized medical record system, AHLTA, for capturing and archiving medical information. This system captures the medical information on all Active Component personnel. Plans are in progress to have AHLTA available to all RC units. Each of the Services has a system for recording medical readiness data. The Army uses the Medical Protection System, the Navy uses the Medical Readiness Reporting System (MRRS), and the Air Force uses the Preventive Health Assessment and Individual Medical Readiness System. The Marines and the Coast Guard use the Navy's MRRS. RC medical readiness is tracked using the Service medical readiness systems, so that, there is visibility of readiness information.

DoD is working to make the medical pre-deployment process more efficient with several initiatives. One is the Consolidated Health (Self-) Assessment Review Tool (CHART) initiative. CHART's goal is to consolidate all self-assessment tools into one large database of self-assessment questions and then individualize the assessment for each Service member.

In addition, each Service is working on information technology solutions to build bidirectional interfaces between AHLTA and the Service system. DoD is installing solutions to allow access to AHLTA by each RC unit to allow better access to healthcare data and better visibility of the medical care that RC members receive before activation.

Action 6, NDAA 08, Section 715 – Report and Study on Multiple Vaccinations of Members of the Armed Forces

Requirement: This section requires a report on the policies of the Department of Defense for administering and evaluating the vaccination of members of the Armed Forces including:

1. An assessment of the Department's policies governing the administration of multiple vaccinations in a 24-hour period, including the procedures providing for a full review of an individual's medical history prior to the administration of multiple vaccinations, and whether such policies and procedures differ for members of the Armed Forces on active duty and members of Reserve Components.

2. An assessment of how the Department's policies on multiple vaccinations in a 24-hour period conform to current regulations of the Food and Drug Administration and research performed or being performed by the Centers for Disease Control, other non-military Federal agencies, and non-Federal institutions on multiple vaccinations in a 24-hour period.

3. An assessment of the Department's procedures for initiating investigations of deaths of members of the Armed Forces in which vaccinations may have played a role, including whether such investigations can be requested by family members of the deceased individuals.

4. The number of deaths of members of the Armed Forces since May 18, 1998, that the Department has investigated for the potential role of vaccine administration, including both the number of deaths investigated that was alleged to have involved more than one vaccine administered in a given 24-hour period and the number of deaths investigated that was determined to have involved more than one vaccine administered in a given 24-hour period.

5. An assessment of the procedures for providing the Adjutants General of the various States and territories with up-to-date information on the effectiveness and potential allergic reactions and side effects of vaccines required to be taken by National Guard members.

6. An assessment of whether procedures are in place to provide that the Adjutants General of the various States and territories retain updated medical records of each National Guard member called up for active duty.

Response: DoD submitted an interim report to Congress in May 30, 2008 and a final report on September 4, 2008, which reported the policies of the Department of Defense

for administering and evaluating the vaccination of members of the Armed Forces. The following summarizes the report:

DoD Policies Governing Administration Of Multiple Near-Concurrent Vaccinations

The policies and procedures for all military immunization practices are outlined in DoD Joint Regulation, "Immunization and Chemoprophylaxis," updated and published September 2006 (http://www.vaccines.mil/documents/969r40_562.pdf). This joint regulation applies to all active duty, National Guard, and reserve members of the Army, Navy, Air Force, Marine Corps, and Coast Guard, as well as nonmilitary persons under military jurisdiction; selected Federal employees; selected employees of DoD contractors; and family members and other health care beneficiaries eligible for care within the military health care system.

DoD maintains a robust global vaccine monitoring system for the health care of its members. The Army, as Executive Agent for the Military Immunization Program and in cooperation with the military Services, manages the Military Vaccine Agency (MILVAX) and operates the Vaccine Healthcare Centers (VHC) Network to provide the military Services with a coordinated source for information and education of vaccine–related activities.

The Vaccine Adverse Event Reporting System (VAERS) is a joint post-marketing safety surveillance program of the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration. All DoD vaccine providers record a detailed account of severe adverse events after administering immunizing agents or other medications. VAERS accepts all reports of real or suspected adverse events occurring after the administration of any vaccine by any interested party. All DoD health care beneficiaries are eligible to file claims.

Before administration of any vaccine, all Active and Reserve Component members (individually or collectively) are asked about general food and drug allergies, health status, previous adverse events before immunization, and allergy to any specific component of the vaccine or its packaging and provided an opportunity to ask questions about potential contraindications. Each vaccine recipient is provided Vaccine Information Statements, produced by the CDC, about benefits and risks associated with each pending immunization. This information is culturally appropriate and at an appropriate age level.

DoD studies on multiple, near-concurrent vaccinations

An extensive 2004 review by the Armed Forces Epidemiological Board (AFEB, now the Defense Health Board) and a 2007 study published by the CDC Vaccine Analytic

Unit of multiple near-concurrent immunizations administered to DoD Service members concluded there is no evidence of increased risk of adverse events for those receiving multiple near-concurrent vaccinations.

DoD vaccination policies for Active and Reserve Component members

The DoD policies, procedures, and standards of care for delivery of military vaccines are provided in the DoD Joint "Immunization and Chemoprophylaxis" regulation and are the same for all Active and Reserve Component members, including National Guard, and Reserve members of the uniformed Departments of the Army, Navy, Air Force, Marine Corps, and Coast Guard. Military Services abide by these standards in routine immunization delivery.

Conformance Of DoD Policies On Multiple Near-Concurrent Vaccinations To Federal And Non-Federally Acceptable Standards

The U.S. nationally accepted standards for administering all single, multiple, or multiple near-concurrent vaccinations are determined by the CDC and the Advisory Committee on Immunization Practices (ACIP). It is DoD policy (DoD Joint Regulation, "Immunization and Chemoprophylaxis", Chapter 2.1) to follow the recommendations of the CDC and the ACIP for administering all single, multiple, or multiple near-concurrent vaccinations for its Active and Reserve Component members, unless there is a militarily relevant reason to do otherwise.

DoD Procedures For Initiating Death Investigations In Which Vaccinations May Have Played A Role

The Armed Forces Medical Examiners (AFME) System, under the Armed Forces Institute of Pathology, investigates all DoD Service member deaths and maintains the DoD Medical Mortality Registry. Each Military Department maintains a Service casualty office serving as the primary liaisons for families concerning personnel recovery and accounting. The death of a Reserve Component member while not in a military status or not on a military installation is under the purview of civilian authority. Once a unit is informed of the death, the Reserve Component chain of command is notified of the member's death. If the civilian authorities, the military command, or the family feel that there is any possible connection to military service, there is a subsequent investigation.

The AFME System is governed by Sections 176, 1565a, 1471, and 2012 of Title 10, United States Code and DoD Instruction 5154.30 ("Armed Forces Institute of Pathology Operations," March 18, 2003), which specifically refer to forensic pathology investigations. The AFME may conduct a forensic pathology investigation

to determine the cause or manner of death of a deceased person if such an investigation is determined to be justified. It is sometimes learned during an investigation that the deceased had recently received vaccination(s) but this is not routinely queried. Any autopsy finding of myocarditis, however, always targets vaccines as a causative element. If a Service member's death may be vaccine-related, the VHC Network vaccination databases are queried.

Family member access to death investigations

Family members of deceased active duty personnel can always get a copy of an autopsy report if one is performed by a DoD pathologist. Since 2001, over 3,200 autopsy results have been given to family members including detailed reports, pictures, etc.

Service member deaths investigated by DoD since May 18, 1998, for the potential role of vaccine administration, including those deaths alleged or determined to have involved more than one vaccine administered in a given 24-hour period

More than 2 million members of the Armed Forces have been vaccinated against anthrax, and more than 1.5 million have been vaccinated against smallpox. It is not possible to identify the number of deaths of members of the Armed Forces since May 18, 1998, whose deaths may have involved more than one vaccine administered within 24 hours, but there have been four extensive investigations for deaths possibly related to vaccination. Among the four cases, investigation concluded that vaccination may have contributed to an illness that led to death in one case. The review of the other three cases found no causal association with vaccination.

Determining causality between vaccination and adverse events

According to the National Network for Immunization Information (NNii) at http://www.immunizationinfo.org/vaccine_safety_detail.cfv?id=67, most adverse events following immunization (AEFIs) are not unique clinical illnesses or syndromes (i.e., AEFIs also occur in people who do not receive the vaccine). When large populations are vaccinated, some serious events will be observed coincidentally following vaccination. However, epidemiologic studies cannot absolutely prove coincidence (reject causation) because there can always be very rare occurrences that were not detected in the study population, or because the vaccine only accounted for a very small proportion of the adverse events. When the risk for vaccinated personnel cannot be distinguished from the risk for unvaccinated personnel, the strongest interpretation that can be made is that the evidence favors rejection of causation.

DoD Procedures For Providing Adjutants General (AGs) With Vaccine Information

The DoD does not have a procedure specifically in place to provide the Adjutants General (AGs) of the various states with vaccine-related up-to-date information on the effectiveness and potential allergic reactions and side effects. However, the DoD does provide this information to all DoD Active and Reserve Components, including the Army National Guard of the United States, Army Reserve, Air National Guard of the United States, Air Force Reserve, Naval Reserve, Marine Corps Reserve, and Coast Guard Reserve.

Procedures allowing Adjutants General to retain updated medical records

All Reserve Components have automated (electronic) health readiness records, which are permanent archives available at any time during the members' service and are retained beyond separation, retirement, and death. As an example, the Army National Guard's health readiness records have data uploaded from the Army MEDPROS that provides reporting and tracking information for dental and medical readiness and includes a soldier's permanent or temporary medical profiles (i.e., soldier's physical limitations), line of duty determinations, and individual immunization status. All immunization data is entered directly into MEDPROS at the point of service or within 24 hours. The health readiness records are always available to the AGs and their staffs.

Action 7, NDAA 08, Section 1673 – Improvement of Medical Tracking System for Members of the Armed Forces Deployed Overseas

Requirement:
This section requires a protocol for the pre-deployment assessment and documentation of the cognitive (including memory) functioning of a member who is deployed outside the United States in order to facilitate the assessment of the post-deployment cognitive (including memory) functioning of the member. The protocol will include appropriate mechanisms to permit the differential diagnosis of traumatic brain injury in members returning from deployment in a combat zone.
The section also requires conducting up to three pilot projects to evaluate various mechanisms for use in the protocol. One of the mechanisms to be so evaluated will be a computer-based assessment tool to include administration of computer-based neurocognitive assessment and pre-deployment assessments to establish a neurocognitive baseline for members of the Armed Forces for future treatment.

Response: On May 28, 2008, the Assistant Secretary of Defense for Health Affairs published interim guidance to the Services directing them to administer automated

baseline neurocognitive assessments for all Service members before deployment. As of November 30, 2008, DoD has assessed more than 117,000 Service members.

The decision to accomplish baseline pre-deployment cognitive assessments was based on existing evidence that DoD does not consider sufficient to convert the interim guidance to permanent policy. Efforts to obtain such evidence include several studies, most notably the head-to-head comparison study by the Defense and Veteran's Brain Injury Center to compare the available automated neuropsychological instruments. This study will provide a scientific basis to support DoD in selecting the best tool to institutionalize, if the evidence supports implementing population-based assessments. The instruments included in the head-to-head study include the Automated Nueropsychological Assessment Metrics, CSI (Cognitive Stability Index) Head Minders; ImPact Concussion Management Software, CNS Vital Signs, and CogState Research. To date, there have been no independent comparisons of these instruments.

The study will include a variety of head injury populations, including an in-theater component, to assess their use in combat and blast injuries. To assure that this study is designed and analyzed in a meaningful, valid, and impartial manner, the National Academy of Neuropsychology agreed to establish an unbiased panel of experts to assist in study design and analysis. In addition, a traumatic brain injury subcommittee the Defense Health Board, a panel of civilian experts appointed to advise the Secretary of Defense on matters of TBI policy, approved the design and plan.

We will submit another interim report to Congress in December 2009 to inform on the progress of the study. As a result, this action remains open.