



DEPARTMENT OF THE NAVY
NAVY ENVIRONMENTAL HEALTH CENTER
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03 AUG 2004

From: Executive Secretary, Navy Epidemiology Board
To: Commanding Officer, Navy Environmental Health Center
Via: President, Navy Epidemiology Board

Subj: MINUTES OF THE NAVY EPIDEMIOLOGY BOARD (NEB) MEETING OF 09-11
JUNE, 2004

Ref: (a) NAVENVIRHLTHCENINST 6220.1F

- Encl:
- (1) List of Attendees
 - (2) Navy Epidemiology Board Meeting Agenda
 - (3) EPI-RAP 04-001 Bloodborne Pathogen Protocol for Operational Forces
 - (4) EPI-RAP 04-002 Reducing Hand Transmittable Illness in the United States Navy and Marine Corps
 - (5) EPI-RAP 04-003 Guideline for the Prevention and Management of community-acquired Methicillin-resistant *Staphylococcus aureus* (MRSA) in the United States Navy and Marine Corps
 - (6) EPI-RAP 04-004 Structure of the Navy Epidemiology Board (NEB)
 - (7) EPI-RAP 04-005 Preventive Medicine Officer Workload Standards, in regards to the Clinical Efficiency and Effectiveness IPT/Workgroup
 - (8) EPI-RAP 04-006 Mandatory use of the Electronic HRA (e-HRA) Tool prior to completing the annual Preventive Health Assessment (PHA)
 - (9) EPI-RAP 04-007 Expedited Formalized Guidance from BUMED
 - (10) EPI-RAP 04-008 Centralization of Medical Event Reporting

1. The subject meeting was held at the Little Creek Conference Center, Naval Amphibious Base, Little Creek, Virginia Beach, VA on June 9-11, 2004, in accordance with reference (a). CAPT (sel) LaMar welcomed the attendees (listed in enclosure (1)) and the Minutes from the previous meeting were reviewed. CAPT Hiland, NEHC Commanding Officer, addressed the NEB members, and discussed programs to promote Wellness and Fitness for everyone who serves the U.S. Navy including active duty, families, and civilian personnel. CAPT Hiland asked the board members to come up with 10 action items designed to help keep Navy personnel fit and within weight standards. CAPT Hiland also discussed pre and post deployment health assessments (PDHA) and introduced the topic of the "Navy in Motion" program.

2. **Old Business** (Previous EPI-RAPs still pending)

a. **EPI-RAP 03-003: Turnover of SERT Responsibilities to the NEPMUs**

NEB Recommendation: CAPT Kilbane made a motion recommending that the current status of the SERT teams remain the same and to close the EPI-RAP for further action, which the board unanimously approved the motion.

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Action required: None. SERT teams are chartered independent of the authority of the NEB and NEHC.

Status: Closed

3. New Business

a. EPI-RAP 04-001 Bloodborne Pathogen Protocol for Operational Forces

NEB Recommendation: The board recommends that an HIV Needle stick exposure advisory be created for use by operational forces as guidance. CAPT Rudolf stated that the NEHC Occupational and Environmental Medicine (OEM) directorate would take this for action.

Action required: Recommend to CO NEHC that he direct the OEM directorate to draft an HIV Needle stick exposure advisory to be posted on the NEHC website and shared with all echelon four activities for wide dissemination. NEB requests that CAPT Rudolf report on status of HIV protocol for operational forces at the next NEB meeting.

Status: Open

b. EPI-RAP 04-002 Reducing Hand Transmittable Illness in the United Navy and Marine Corps

NEB Recommendation: Whereas the board recognizes that hand hygiene is an important force readiness issue in prevention of multiple infectious diseases, we recommend that the Commanding Officer of NEHC recommend to BUMED the chartering of a multi-disciplinary team to develop a public health intervention plan and program directed at improving hand washing of operational force personnel.

Action required: Recommend to CO NEHC that he request BUMED to charter a multi-disciplinary team to develop a public health intervention program directed at improving hand washing of operational force personnel. The NEB requests that a member of the team, if chartered, report to the board on progress at the next meeting.

Status: Open

c. EPI-RAP 04-003 Guideline for the Prevention and Management of community acquired Methicillin-resistant *Staphylococcus aureus* (MRSA) in the United States Navy and Marine Corps

NEB Recommendation: Board made motion for NEPMU5, NEPMU6, and NEHC clinical epidemiology staff and a Marine Corps representative to form an ad hoc committee to edit the draft MRSA clinical practice advisory for prevention and management for NEB endorsement. It should be submitted for review to the Director of Population Health at NEHC by August 1, 2004. Once in final form it will be placed on the NEHC website and disseminated to the NEPMUs.

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Action required: NEB Secretary will forward draft MRSA clinical practice advisory presented to LCDR Howe, NEPMU5; CAPT Hayashi, NEPMU6; LCDR Von Thun, NEHC; and LCDR Suraj, MARFORLANT for their review and comments. The NEB Secretary will incorporate these comments and submit the resulting MRSA clinical practice advisory to the NEHC Population Health Director for review, endorsement and posting on NEHC and NMO websites and dissemination to the NEPMUs.

Status: Open

d. EPI-RAP 04-004 Structure of the Navy Epidemiology Board (NEB)

NEB Recommendation: The board recommended the EPI-RAP be tabled until further information can be presented to the NEB by the originator, CAPT Hooker. The current NEB instruction, NAVENVIRHLTHCENINST 6220.1F, requires a clinical epidemiologist is to be assigned as a permanent member. The currently appointed clinical epidemiologist representative is CAPT Robert Brawley, NMC Portsmouth.

Action required: CAPT Hooker can present further information on his recommendation at the next NEB meeting.

Status: Open

e. EPI-RAP 04-005 Preventive Medicine Officer Workload Standards, in regards to the Clinical Efficiency and Effectiveness IPT/Workgroup

NEB Recommendation: CAPT Rudolf presented the experience of Occupational Medicine in defining workload standards for their specialty. The board has no recommendations at this time. The President will further research the matter and report back at the next meeting.

Action required: CAPT (sel) LaMar will continue to research workload standards for the Preventive Medicine specialty and present findings at the next NEB meeting.

Status: Open

f. EPI-RAP 04-006 Mandatory use of the Electronic HRA (e-HRA) Tool prior to completing the annual Preventive Health Assessment (PHA)

NEB Recommendation: There is a current Department of Defense-Health Affairs chartered Integrated Process Team (IPT) that is developing a Health Risk Assessment (HRA) tool for use by all military services. The NEB voted to table this EPI-RAP and address it after the HRA IPT has completed its task.

Action required: LCDR Von Thun is a member of the HRA IPT, and will brief the board on progress at the next meeting.

Status: Open

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g. EPI-RAP 04-007 Expedited Formalized Guidance from BUMED

NEB Recommendation: The board would like to encourage BUMED to create an online forum via Navy Medicine Online. Captain Kilbane agreed to research the matter further and report to the board at the next meeting.

Action required: CAPT Kilbane will report findings of his inquiries at the next NEB meeting.

Status: Open

h. EPI-RAP 04-008 Centralization of Medical Event Reporting (MER)

NEB Recommendation: The NEB recommended that the presentation made by Ms. Lea Gilchrist of NEHC be made into an EPI-RAP and recommend its implementation to the CO, NEHC.

Action required: Recommend to CO NEHC that a message be sent to all reporting entities using NDRS to report MERS to (1), Request that MERS be reported directly to NEHC using file transfer protocol (FTP), and (2), Provide instruction on how to put into operation reporting using FTP.

Status: Open

4. Administrative Business

a. Presentations to the Board

1) CAPT Kilbane, MC, USN, briefed BUMED M3F4/JPMPG issues:

- There is a recent Government Accounting Office report that is very critical of the use of “plume modeling” to assess chemical exposures during Desert Storm.
- The new Rabies instruction is out and includes the new DD2341 reporting form.
- All services do HIV testing at different intervals and BUMED has an official tasker to get it changed to every two years.
- The PDHA that the Navy uses is not a valid survey tool and while they must be done, they provide little useful information.
- The Armed Forces Epidemiology Board mefloquine descriptive study is almost done.
- A total rewrite of the TB control instruction is in progress.

2) CDR McMillan, MC, USN briefed Headquarters, United States Marine Corps issues:

- There is a “Cultural Inertia” in the Marine Corps, which is results in training-related injuries, problems from poor hygiene, and medical recommendations and protective equipment to prevent them.
- There is a technology solution request to look into newer technology to get rid of old latrines.

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- The Sports Medicine Injury Prevention (SMIP) program includes “Semper Fit”, Athletic Trainer Certified (ATC), funding, data collection and analysis in order to improve physical readiness.
- There is a large-scale implementation of a new eye protection system to lessen facial blast injuries.
- The new self-opening permethrin treated bednets are being ordered.
- 3) CAPT (sel) Henderson, MSC, USN briefed FDPMU issues:
- The FD-PMU platform is striving to meet CNO guidance on meeting enhanced medical surveillance needs in support of Seapower 21.
- An overview of the modular components of the PD-PMU platforms was presented.
- Three FD-PMUs were deployed to OIF.
- Two teams are currently deployed to OIF II-1.
- Two additional teams are being readied to back fill for OIF II-2.
- Two teams will be required for OIF III at approximately the February 2005 time frame.

4) Ms. Lea Gilchrist from NEHC Population Health discussed Completeness of Reporting of reportable medical events (RMEs):

- Medical Event Reporting (MER) submissions have been negatively impacted by OIF deployments and increasing use of attachment-blocking email filters in DON networks. \
- For the period of 01 Jan 2004 to 15 May 2004, overall reporting is down 38% from the same period last year.
- Because of the success in using FTP to avoid attachment-stripping email virus filters, it is recommended that a message be sent to all MTFs and ships using NDRS to submit directly to NEHC via FTP.
- Users should be encouraged to submit daily, and no less frequently than weekly.

5) Mr. Charles Raney from SPAWARS gave a presentation on the SAMS Communicator:

- The SAMS Communicator allows users to enter data into SAMS as usual.
- The Communicator captures all data events in SAMS and publishes them to a directory.
- The Communicator monitors SAMS data changes and configured intervals and processes for transmission.
- The process is completely transparent to the user and there is a minimal impact on the computer network.
- The Communicator does not require hardware, operating system or network configuration changes.

6) NEPMU Presentations:

- CAPT (sel) LaMar, NEPMU2:
 - Priorities for the Unit are PM-MMART and FD-PMU readiness.
 - There is an FD-PMU deployment to Iraq in March with LCDR Jim Herbst as the Team Leader.

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- From March to the present, the Unit has been supporting the FD-PMU team in Iraq and training of the second team to replace them with CDR Mark Malakooti as the Team Leader.
- In May, Unit personnel visited Marine Corps Recruit District, Parris Island to investigate cases of MRSA in the recruits.
- Fleet Readiness personnel have been emphasizing quick response to deploying ships and answering questions on bloodborne pathogens.
- CAPT Hayashi, NEPMU6:
 - Deployed a FD-PMU team with an Entomologist in support of the 1FSSG, IMEF.
 - The Unit participated in the PACOM-CBRNE in a Pacific Exercise with Reserve Units from Portland, Oregon.
 - Other activities include updating force protection guidelines and attending the DOD International HIV/AIDS Board of Directors Meeting.
- LCDR Buff, NEPMU7:
 - The Unit is performing many environmental and health threat assessments in countries such as Djibouti, Sao Tome, Liberia, and Spain.
 - DNBI analysis of the sixth fleet is ongoing. Unit participated in MAREUR Exercise Clean Hunter and provided food and water sanitation, medical planning, and Force Health Protection support.
- LCDR Howe, NEPMU5:
 - The Unit deployed 4 members lead by and Entomologist from DVECC, JAX to CJTF Haiti to perform environmental assessments, disease surveillance, and vector/rodent control.
 - One PMT deployed to Naval Hospital Guantanamo Bay, Cuba for 6 months in support of JTF-Gitmo.
 - Recent outbreak investigations include one at the School of Infantry (SOI) Camp Pendleton regarding GAS pneumonia/pharyngitis, and Marine Corps Recruit Depot San Diego for gastroenteritis/Norovirus infections.
 - The Unit developed “ActiveLink”, a relational database system using Microsoft Access and shared on the internal network.
 - The system collects information on customers, services rendered, and specifics on work performed.
 - The Partnership staff was involved in all stages of design, testing, and the implementation process.

7) CAPT Bohnker, MC, USN discussed current initiatives in the NEHC Population Health Directorate:

- NEHC reorganization now includes development of Readiness Support Teams, use of Executive Directors, and a focus on a prioritized budget list, and ties to products and services ongoing.
- Clinical Epidemiology is working on the implementation of the Population Health Navigator, including briefs on status to the BUMED Flag ESC and new SG.

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- Population Health Benchmarks for Branch Clinic Oceana and a method to improve the care of high utilizers of services are being followed and studied.
- The “Get Moving Navy” pilot test study at Oceana for improving fitness and reducing obesity, which ends in December 2004 was discussed.
- A “Leader’s Guide to Handling Personnel in Stress” CD/web-based information guide by CDR Gaskins (HQMC) and Dr. Long (NEHC) is due out by 01 October 2004.
- CDR Martschinske and CAPT Bohnker completed a study entitled “Preliminary Analysis of Post Deployment Health Assessment Forms for Navy and Marine Personnel”, which involved an analysis of all post deployment forms filled out between 01 January 2003 and 31 March 2004 and included data from OEF, OIF, Bosnia, SWA and all other deployments.

8) LCDR Zinderman, MC, USN, provided an update on MRSA:

- Since 2001, MRSA outbreaks have been noted on surface ships, submarines, aircraft carriers, Marine Corps Recruit Depot-Parris Island (MCRD-PI), Basic Underwater Demolition School (BUDs) and Naval Aviation Training Center at Pensacola.
- Community-acquired MRSA often occurs in otherwise healthy persons who do not have the traditional risk factors associated with MRSA.
- It is now estimated that 2-3% of the general population may be colonized with MRSA, and up to 5% in populations in communal living situations, such as military barracks or prisons.
- MRSA is primarily transmitted from person to person by direct contact, usually from the hands of an infected or colonized person.
- The sharing of clothing, personal hygiene items, or training equipment may also transmit MRSA.
- In the military, prolonged close contact between personnel combined with lapses in personal hygiene result in ideal conditions for MRSA transmission.

9) LCDR Howe, MC, USN provided a briefing on the BIONET program:

- The BioNet Program is a one-year “pilot project” in San Diego involving collaboration of multiple military and civilian public health organizations.
- Its goal is to perform public health and environmental monitoring to quickly identify and provide information to help manage a potential Biological Warfare attack.
- Objectives are: develop interoperable concepts of military and civilian operation, integrate military and civilian capabilities to detect and characterize a biological event, and to provide common situational awareness to ensure timely, effective, and consistent response actions.

10) CAPT (sel) LaMar led a forum discussion, per request of the CO, NEHC, to develop a list of 10 Action Items to improve the fitness of Sailors. The NEB deliberated on ideas for Action Items, and prioritized the TOP TEN (the two action items ranked 5 were tied):

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Rank	Action Item (total score)	Implementation Entity
1.	Fitness Culture - Allow PT time during workday (50)	CNO/CFFC/COs
2.	Provide better vending machine choices (41)	NavSupp/MWR/NEX
3.	Enforce PRT instruction (35)	CNO/CFFC/COs
4.	Salad bar in every food court (31)	NavSupp/MWR/NEX
5.	Fitness Mentors (30) CNO/BUPERS/CFFC/COs	
6.	Remove fast food counters from ships (28) (candies, sodas, Pizza Hut-like items)	NavSupp/CFFC
7.	Unit BMI report card tied to CO evaluation (28)	CNO/BUPERS/COs
8.	Fat tax on poor food choices (27) (subsidize good food choices)	NavSupp/MWR/NEX
9.	Good food-choice coupons (24)	NavSupp/MWR/NEX
10.	Weekly unit mandatory PT program (23)	CNO/CFFC/COs

Other action items that were brought up during the discussion:

11.	Weight Watcher approach at galleys (22)	SG/MWR/NEX
12.	Implement the PHA (21)	SG
13.	Designated "no eating" spaces (20)	CNO/CFFC/COs
14.	Employ patient based prevention counseling (19)	SG
15.	Correlate BMI and military bearing (19)	CNO/BUPERS/COs
16.	Validate HRA tool (helps drive P-BPC) (6)	SG
17.	Mandatory diet for overweight cases (6)	CNO/CFFC/SG/COs
18.	Don't sell XXL sizes except for maternity (4)	MWR/NEX
19.	Health promotion programs (2)	SG
20.	Enhance and improve FEP programs (1)	CNO/COs
21.	Electronic BMI displays at the food court (1)	MWR/NEX
22.	Liposuction/Bariatric surgery for recalcitrant cases (0)	SG

5. Next Meeting. The next meeting is tentatively scheduled for December 1-3, 2004.

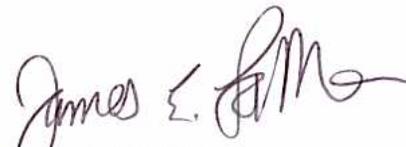


G. E. TETREAULT
LCDR, MSC, USN
Executive Secretary

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Minutes reviewed and approved by President, Navy Epidemiology Board.

Date: 29 JUNE 2004


J. E. LAMAR
CDR, MC, USN

Minutes reviewed by Commanding Officer, NAVENVIRHLTHCEN

Comments:

Approved / Disapproved

Date: 7/19/07


D. A. HILAND

**NAVY EPIDEMIOLOGY BOARD
NAVY ENVIRONMENTAL HEALTH CENTER
PORTSMOUTH, VA**

LIST OF ATTENDEES FOR NAVY EPIDEMIOLOGY BOARD
MEETING OF 09-11 JUNE, 2004

MEMBERS PRESENT

CAPT (sel) J. LaMar, MC, USN (**President**/NEPMU2)
CAPT B. Bohnker, MC, USN (NEHC PH)
CAPT E. Kilbane, MC, USN (BUMED M3F4/JPMPG)
CAPT K. Hayashi, MC, USN (NEPMU6)
CAPT G. Rudolf, MC, USN (NEHC OEM)
CDR D. McMillan, MC, USN, (HQMC)
CDR M. Malakooti, MC, USN, (**Vice President**/NEHC PH)
LCDR C. McCannon, MC, USN (II MEF)
LCDR J. Howe, MC, USN, (NEPMU5)
LCDR A. Buff, MC, USN, (NEPMU7)
LCDR B. Conner, MC, USN, (NEPMU2)
LCDR G. Tetreault, MSC, USN (**Executive Secretary**/NEHC PH)

GUESTS

CAPT D. Hiland, MC, USN, (NEHC CO)
CAPT (sel) M. Henderson, MSC, USN, (NEHC PO)
LCDR T. Luke, MC, USN, (USHS)
LCDR F. Litow, MC, USN, (NEHC OEM)
LCDR C. Zinderman, MC, USN, (NEPMU2)
LCDR A. VonThun, MC, USN (NEHC PH)
LCDR J. Martin (SPAWARS)
HMC Totales (SPAWARS)
Mr. C. Raney, (SPAWARS)
Mr. T. Freese (SPAWARS)
Ms. L. Gilchrist, (NEHC PH)

MEMBERS ABSENT

CAPT Robert Brawley, MC, USN (NMCP)
CAPT M. McCarthy, MC, USN, (NMRC)
COL K. Cox, MC, USAF REP
CDR T. Robinson, MC, USN, (I MEF)
MAJ S. Jang, MC, USA REP
LT B. Killenbeck, MSC, USN (NEHC EH)

AGENDA
NAVY EPIDEMIOLOGY BOARD MEETING
9-11 JUNE 2004

Wednesday, 9 June 2004

- 0800 – 0810 Welcome & Opening Remarks – CAPT (Sel) LaMar
0810 – 0830 Commanding Officer Remarks – CAPT Hiland
0830 – 0900 BUMED M3F4 / JPMPG – Captain Kilbane
Break
0910 – 0950 HQ USMC PM –CDR McMillan
0950 – 1030 FDP MU – update status/doctrine/Instruction and future plans – CDR Henderson
1030 – 1100 Completeness of Reporting RMEs – Ms. Lea Gilchrist
1100 – 1200 SAMS Communicator Brief – Mr. Charles Raney, SPAWARS

1200 – 1330 Lunch

- 1330 – 1445 NEPMUs 15-min Briefs
Break
1500 – 1630: EPI-RAP 04-001 Bloodborne Pathogen SOPs for Operational Forces – LCDR Litow, LCDR Luke

Thursday, 10 June 2004

- 0800 – 0805 Opening Remarks – CAPT (Sel) LaMar
0805 – 0835 NEHC Population Health Directorate – CAPT Bohnker
0835 – 0915 **Old Business (Review Previous Open EPI-RAPS)**
EPI-RAP 03-003: Turnover of SERT Responsibilities to the NEPMUs
Break
0930 – 1130 **New EPI-Raps**
MRSA Update: LCDR Zinderman/CDR Malakooti
EPI-RAP 04-002: Reducing Hand Transmittable Illness in the United States Navy and Marine Corps
EPI-RAP 04-003: Guideline for the Prevention and Management of community-acquired Methicillin-resistant Staphylococcus aureus (MRSA) infections in the United States Navy and Marine Corps

1130–1300 Lunch

- 1300 – 1500 **New EPI-RAPS (cont.)**
EPI RAP 04-004: The Structure of the Navy Epidemiology Board (NEB)
EPI-RAP 04-005: Preventive Medicine Officer Workload Standards, in regards to the Clinical Efficiency and Effectiveness IPT/Workgroup
EPI-RAP 04-006: Mandatory use of the Fleet HRA Tool prior to completing the Annual Preventive Health Assessment
Break
1515 – 1600 EPI-RAP 04-007 Expedited Formalized Guidance from BUMED

Friday, 11 June 2004

0800 – 0805 Opening Remarks – CAPT (Sel) LaMar

0805 – 0830 NEB Administrative Issues

0830 – 0850 BioNet Program Brief – LCDR Howe

0850 – 1010 New EPI-RAPS (cont.)

1010 – 1030 Break

1030 - 1100 Selection of Date for Next Meeting /Unfinished Business and Closing remarks

1100 **Adjourn**

**NAVY EPIDEMIOLOGY BOARD
REQUEST FOR ACTION PAPER (Epi-RAP)**

Epi-RAP 04-001

TITLE

Bloodborne Pathogen Protocol for Operational Forces.

ISSUE/PROBLEM STATEMENT

No established Navy instruction or message on the subject of bloodborne pathogen exposure (needle-stick Post-Exposure Protocol) in deployed forces, that includes prophylactic anti-HIV drugs to be stocked and used in the event of a needle stick while underway/deployed

PRIORITY

Important.

BACKGROUND

NEPMU2 has received a couple of calls recently from Atlantic Fleet ships and deploying Marine Units seeking policy on possible bloodborne pathogens exposure as a result of needle stick injury received in the course of providing medical care. We found that there is no established Navy instruction or message regarding prophylactic anti-HIV drugs to be used in the event of a needle stick while underway/deployed.

NEPMU2 (LCDR Thomas Luke, Preventive Medicine Resident, USUHS; CDR James LaMar, Preventive Medicine Officer, NEPMU2) and Occupational and Environmental Medicine, NEHC (LCDR Francesca Litow, Occupational Medicine Officer, NEHC) have collaborated in authoring two Bloodborne Pathogen Protocols or standard operating procedures (SOPs). One is for afloat forces, the other for deployed land-based forces.

ACTION NEEDED

Review, edit and endorse attached bloodborne pathogen exposure protocols for CO, NEHC to submit to BUMED for adoption as guidelines for deployed Naval forces.

ISSUE ORIGINATOR

LCDR Thomas C. Luke, MC, USN
LCDR James LaMar, MC, USN

PERTINENT REFERENCES

JOINT Instruction 6000.1H

Navy message (R 131551Z SEP 01 ZYB PSN 189681I33), sets Navy policy for
needlestick/bloodborne pathogens

ASD letter of 21 Jun 2001; mandates use of OSHA 29 CFR 1910.1030 Bloodborne Pathogen
standard

OSHA 29 CFR 1910.1030 Bloodborne Pathogen standard

PERTINENT PERSONNEL

EPMUs
NEHC
BUMED
HQMC

**NAVY EPIDEMIOLOGY BOARD
REQUEST FOR ACTION PAPER (Epi-RAP)**

Epi-RAP 04-002

TITLE

Reducing Hand Transmittable Illness in the United States Navy and Marine Corps

ISSUE/PROBLEM STATEMENT

Historical and recent outbreaks of hand transmitted pathogens causing URI, gastroenteritis, MRSA skin infections and other diseases within training commands, naval vessels, and deployed forces have caused significant morbidity and loss of readiness. A program is needed to reduce hand-transmitted illness in the United States Navy and the Marine Corps. It is conceivable that a successful program can result in a 50% reduction in URIs and gastroenteritis rates.

PRIORITY

Important.

BACKGROUND

Certain behaviors by US military members are ingrained, predictable and enforced – saluting and grooming are two of many such actions that are “military virtues”. Because hand washing after defecation, urination, before eating and at other appropriate times is not a “military virtue”, high rates of hand transmitted diseases and epidemics will continue to occur in the Navy and the Marine Corps. This is unfortunate as the majority of published hand washing studies demonstrate that hand washing programs effectively reduce disease. Such hand hygiene studies include a 50% decrease in URIs at a Navy recruit depot and significant reductions and/or elimination of MRSA, URIs and gastroenteritis and other pathogens in a variety of civilian institutions.

Education alone without enforcement is generally ineffective in modifying individual and organizational behavior. A successful hand-washing program to compel service member and unit compliance will require support from the senior officer and enlisted leadership of the Navy and the Marine Corps. However, data of efficacy in military operational forces, ships and stations is lacking. What is needed is a research and development study to conclusively demonstrate disease reduction, feasible implementation, and the cost of a successful hand-washing program in the operational/training setting.

A 50% reduction in URIs and other hand transmitted diseases in the US Navy and Marine Corps is potentially achievable within a few years, and would have a major impact on reducing health care costs, improving individual health, and enhancing combat effectiveness. Given post-911 commitments and increased operational tempo, the individual health of every service member is paramount. The prevention of epidemics within Naval units and operational forces is

directly related to hygiene practices and is a critical, if yet unrecognized, component of the Navy's strategic operational doctrine Sea Power 21.

This doctrine calls for sharp reductions in crew size by reconfiguring current vessels and constructing new platforms with a variety of high technology and automation features. As such, the contribution required from each crewmember to the ship's overall combat effectiveness is increased while reducing the ability of the ship to replace DNBI losses organically. Epidemic disease outbreaks on board ships are distressingly frequent, always disruptive to ship operations, and may, given reductions in ship crew personnel, be more disabling in the future.

It is of interest that the Chief of Naval Operations has recently directed that the SG develop plans to reduce patient demand for Navy Medicine services. Prevention of illness is the logical endpoint to meet this goal, and the prevention of acute diseases for which vaccines are not available is likely to have the greatest immediate impact. The preventive medicine personnel of the United States Navy are able to meet this challenge by initiating research and proposing workable solutions to drastically reduce hand transmittable illness in the Navy and the Marine Corps.

ACTION NEEDED

We recommend that a hand hygiene committee or working group headed by a senior preventive medicine officer be established on orders. The committee should draft any necessary research protocols, determine outcome objectives, and identify a lead agent command to conduct the study, secure funding sources, and coordinate operational line and BUMED support for the research program. Upon completion of the study, determine if reductions in illness are significant on a population-based level.

If a hand hygiene program is recommended, the lead agency should coordinate implementation of Navy and Marine Corps program with surveillance mechanisms and adequate metrics to measure on-going compliance.

ISSUE ORIGINATOR

LCDR Thomas C. Luke, MC, USN
LCDR Craig Zinderman, MC, USN

PERTINENT REFERENCES

Preliminary Report: Ongoing MRSA outbreak MCRD-PI. LCDR Luke and LCDR Zinderman.

MMWR: Guideline for Hand Hygiene in Health-Care Settings. Recommendations and Reports October 25, 2002.

Ryan MA, Christian RS, Wohlrabe J. Handwashing and respiratory illness among young adults in military training. Am J Prev Med. 2001 Aug;21(2):79-83.

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White C, Kolble R, Carlson R, Lipson N, Dolan M, Ali Y, Cline M. The effect of hand hygiene on illness rate among students in university residence halls. *Am J Infect Control*. 2003 Oct; 31(6):364-70.

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PERTINENT PERSONNEL

EPMU2
NEHC
BUMED
HQMC
GEIS
NHRC
CDC
NMRCD

**NAVY EPIDEMIOLOGY BOARD
REQUEST FOR ACTION PAPER (Epi-RAP)**

Epi-RAP 04-003

TITLE

Guideline for the Prevention and Management of community-acquired Methicillin-resistant *Staphylococcus aureus* (MRSA) infections in the United States Navy and Marine Corps

ISSUE/PROBLEM STATEMENT

Community-acquired MRSA cases in the United States have increased dramatically in the past few years. Navy and Marine Corps service-members and beneficiaries have been equally affected by this emerging pathogen. Since 2001, outbreaks have been noted on several surface ships, submarines and aircraft carriers, Marine Corps recruit Depot-Parris Island (MCRD-PI), Basic Underwater Demolition School (BUDs), and the Naval Aviation Training Center at Pensacola. A guideline is needed to provide military health care providers with a standardized regimen for preventing, treating, reporting, and responding to MRSA cases within their units.

PRIORITY

Routine.

BACKGROUND

MCRD-PI has experienced an on-going seasonal outbreak of MRSA cases among recruits since 2001. An extensive investigation by Navy Environmental Health Center (NEHC) detailed the outbreak and led to recommendations to help curtail the spread of infections. Between August 2002 and December 2002, a total 235 MRSA cases occurred among trainees. A total of 542 cases were diagnosed in 2003, with the majority occurring between May and November. Preventive measures were put in place last year to including increased hygiene, education and culturing of lesions.

As the 2004 warm season approaches and rates of community-acquired MRSA cases increase, it is important to continue to implement and reinforce these measures. Similar measures have been recommended for outbreaks at other Navy facilities and operational platforms. NEPMU2 has worked in collaboration with NEHC, infectious disease specialists, and MRSA experts at the Centers for Disease Control, to provide military units experiencing MRSA cases with the most effective known treatment and control measures. Based on this experience and an extensive review of the available literature for treating and preventing MRSA cases, NEPMU2 has developed the accompanying guideline to assist Military providers in responding to cases.

ACTION NEEDED

Recommend that the NEB review and endorse the accompanying document: "GUIDELINE FOR THE MANAGEMENT OF COMMUNITY-ACQUIRED METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA) INFECTIONS IN THE US NAVY & MARINE CORPS".

ISSUE ORIGINATOR

LCDR Craig Zinderman, MC, USN

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PERTINENT PERSONNEL

EPMU2
NEHC
BUMED
HQMC

**NAVY EPIDEMIOLOGY BOARD
REQUEST FOR ACTION PAPER (EPI-RAP)**

DATE: 1 May 04
EPI-RAP# 04-004

TITLE

Structure of the Navy Epidemiology Board (NEB)

ISSUE/PROBLEM STATEMENT

The functioning of the NEB may be improved by the addition of sub-committees representative of the major issues within the preventive medicine community.

PRIORITY

Routine

BACKGROUND

Continual evaluation and improvement should be a part of the policy of every board. There may be ways in which the NEB can improve its efficiency and effectiveness. Determining and implementing an optimal structure will facilitate improvement.

ACTION NEEDED

Using the Armed Forces Epidemiology Board (AFEB) as a model, consider establishing permanent sub-committees to meet for a day independent of the NEB, at large, during regularly scheduled meetings and to work between meetings to produce products and services of value to our customers. This may, also, mean considering alterations in the NEB's membership. Areas to consider for sub-committees include infectious diseases, operational medicine, clinical epidemiology, evidence-based health care, research and GEIS, and medical informatics; as well as others. The membership would probably support up to four sub-committees.

ISSUE ORIGINATOR

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**NAVY EPIDEMIOLOGY BOARD
REQUEST FOR ACTION PAPER (Epi-RAP)**

Epi-RAP 04-005

TITLE Preventive Medicine Officer Workload Standards, in regards to the Clinical Efficiency and Effectiveness IPT/Workgroup

ISSUE/PROBLEM STATEMENT

The Clinical Efficiency and Effectiveness IPT/Workgroup, chartered by BUMED and chaired by RDML Thomas Burkhard, is seeking to improve clinical efficiency and effectiveness by establishing minimum workload productivity standards for all credentialed providers. CAPT Bohnker, Director, Population Health, NEHC noted that Preventive Medicine Officers have no standards addressed in the "Minimum Benchmarked Workload Standards" or the Direct Clinical Support Staffing Standards" listed in Enclosure 1), which was delivered with Enclosure 2), "IPT Milestone 1 Brief, on March 30, 2004. In due course, standards will have to be addressed for the Preventive Medicine Specialty, and the Navy Epidemiology Board should take the lead.

PRIORITY

Urgent.

BACKGROUND

The purpose of the Clinical Efficiency and Effectiveness IPT/Workgroup is to improve clinical efficiency and effectiveness by establishing minimum workload productivity standards for all credentialed providers. To do this, it is developing minimum benchmarked workload standards for all credentialed clinical providers along with direct clinical support staffing standards and establish administrative discounts for clinical full time equivalents (adjustments for department heads and directors to capture time spent in administrative duties). It is also developing a user-friendly database that provides absolute and relative comparisons of clinical productivity, and exploring incentives to increase clinical efficiency and effectiveness. The completion date is planned to be no later than 30 June 2004

ACTION NEEDED

The NEB should develop a set of "Minimum Benchmarked Workload Standards" in the style used by the IPT. The NEB will then provide them to the PM Specialty leader who can forward them to the IPT as soon as possible for consideration.

ISSUE ORIGINATOR

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Enclosure (7)

PERTINENT REFERENCES

- 1) Spreadsheet, "Summary Benchmark Final Clinical Standards - Rev 1"
- 2) Presentation, "IPT Milestone 1 Brief"

PERTINENT PERSONNEL

Not applicable

**NAVY EPIDEMIOLOGY BOARD
REQUEST FOR ACTION PAPER (EPI-RAP)**

DATE: 9JUN04
EPI-RAP# 04-006

TITLE

Mandatory use of the Electronic HRA (e-HRA) Tool prior to completing the annual Preventive Health Assessment (PHA).

ISSUE/PROBLEM STATEMENT

Currently there is no standard method of collecting behavioral risk data on the annual PHA. Identifying pertinent health risk behaviors in an individual is a lengthy and time consuming process, requiring 20-30 minutes of face-time with a highly skilled provider. Yet this is exactly what is required to complete the behavioral counseling section of the annual Preventive Health Assessment (PHA). Often this process is skipped over or eliminated entirely during the PHA. To get the most value out of the PHA, health risk behaviors must be identified using a standard tool. This will decrease variation in the PHA process thus providing a standard method of Program Evaluation and Outcome measures.

PRIORITY

Routine

BACKGROUND

An important but under emphasized component of the annual PHA includes individual focused counseling of identified health risk behaviors. The problem arises in trying to identify which health risk behaviors are a concern for the individual. This is in itself time consuming and highly sensitive. Most providers are either not allotted the proper time needed or are not trained to identify certain risky behaviors. In some instances the PHA program is being implemented and managed at the lowest level with lack of ownership by the senior members of the Primary Care Team. What tends to occur is the PHA becomes merely a checklist for individual medical readiness, immunizations and various preventive maintenance exams. The counseling component to the PHA tends to be neglected or overlooked.

The e-HRA tool is an excellent tool for assessing high-risk behaviors among individuals and entire groups of people. It is quick, easy to complete and confidential. After completing the on-line questionnaire the patient can print their results and share them with their provider during their annual PHA.

The e-HRA is aligned with the Leading Health Indicators (LHIs). Mandatory use of the e-HRA provides standard data collection, minimal process variation and an excellent metric for Program Evaluation and Outcome measure. The Commanding Officer and necessary Population Health experts can view combined unit data for the purposes of focused high-risk behavioral training.

ACTION NEEDED

The NEB should endorse the e-HRA as a mandatory component of the annual PHA. The OPNAVINST 6120.3 must be rewritten, not only to include the e-HRA requirement, but also to clearly outline Areas of Responsibility among Health Care Providers. The ownership and responsibility of the PHA/e-HRA is on the Primary Care Teams as a component of the individual Clinical Preventive Services.

ISSUE ORIGINATOR

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PERTINENT REFERENCES

OPNAVINST 6120.3 Preventive Health Assessment

PERTINENT PERSONNEL

BUMED
N931 OPNAV

**NAVY EPIDEMIOLOGY BOARD
REQUEST FOR ACTION PAPER (EPI-RAP)**

May 27, 2004
EPI-RAP04-007

TITLE

Expedited Formalized Guidance from BUMED

ISSUE/PROBLEM STATEMENT

1. The preparation, approval and dissemination process for instructions can take months to years.
- 2.
3. Various topics in preventive medicine, particularly for infectious diseases, require agile, timely dissemination of standardized direction that internal and external customers can use easily.

PRIORITY

Routine

BACKGROUND

Avian influenza and SARS protective procedures, the latest requirements for anti-retrovirals in the case of needlesticks, the use of primaquine for primary malaria chemoprophylaxis, higher dose primaquine for terminal malaria chemoprophylaxis, and other issues have emerged that stimulated questions from the field.

While the CDC and WHO have prepared suitable guidelines in the context of civilian medicine, their recommendations may not address circumstances that military commands may face – e.g. the prescribing of the CDC-endorsed higher levels (30mg/day) of primaquine for terminal malaria chemoprophylaxis. This variance from the FDA label-approved guidance led to multiple, duplicative questions to NEPMUs, NEHC and BUMED.

ACTION NEEDED

The NEB endorse BUMED's use of an electronic mechanism to provide real-time guidance on preventive medicine and public health issues. An electronic "Memo to Providers", developed to provide guidance on short-fuse and new development issues, would be one alternative. BUMED could take advantage of the increasing availability of electronic mail to obtain inputs and review of memo content prior to dissemination. The memos would be especially useful for issues not warranting rewriting instructions, and could provide interim guidance for issues requiring incorporation into future instructions.

ISSUE ORIGINATOR

Submitted by CAPT Konrad E. Hayashi, NEPMU-6, Pearl Harbor, Hawaii, 96860-4477, (808) 473-0555, Hayashi@nepmu6.med.navy.mil

PERTINENT REFERENCES

Include the CDC Health Information for International Travel and the package insert for Primaquine.

PERTINENT PERSONNEL

The BUMED and HQMC Preventive Medicine Officers input, in addition to NEHC, will be critical in providing perspective and input on this issue.

**NAVY EPIDEMIOLOGY BOARD
REQUEST FOR ACTION PAPER (Epi-RAP)**

Epi-RAP: 04-008

TITLE:

Centralization of Medical Event Reporting

DESCRIPTION:

Medical Event Report (MER) submissions have been severely impacted by OIF deployments and increasing use of attachment-blocking email filters in DON networks. For the period of 01 JAN 2004 to 15 May 2004, overall reporting is down 38% from the same period last year. Breakdown by unit: NEPMU2- down 48%; NEPMU5- down 23.5%; NEPMU6- down 68%; and NEPMU7- up 5.9%.

BACKGROUND:

MERs are required IAW BUMED 6220.12A to electronically report significant medical conditions and communicable illnesses. The current instruction directs MTFs & ships to report to one of the four worldwide Navy Environmental Preventive Medicine Units (NEPMUs), who aggregate data under each respective AOR for reporting to NEHC. NEHC submits this data to the Army Medical Surveillance Activity (AMSA), the DoD Tri-Service data repository.

Data can be submitted via electronic mail, File Transfer Protocol (FTP), fax, paper, or Navy Message. If sent by fax or paper format, the NEPMU has to enter the data electronically for the reporting site. The Privacy Act of 1974 and HIPAA Act of 1996 require any Social Security numbers and personally-identifiable healthcare data be protected against unauthorized disclosure. One mechanism for this was the use of password-protected zip files. Unfortunately, the recent proliferation of virus and mass-mailing worms have caused the majority of networks to filter out any attachment with a password. By far the area of greatest data loss is the leg between the MTFs and the cognizant NEMPU.

One mechanism used to provide backup and redundancy for email is the FTP process. Although FTP is sent in clear text, the password embedded in the MER data file makes the transmission also Privacy Act/HIPAA compliant. A secure FTP server has been set up at NEHC and has been used in the past to allow data transfer for those few sites affected by attachment stripping email filters. The complexity of setting up a secure FTP server precludes this being done at each unit.

Technical Issues (of which we have no control):

- A. Requirement to report
- B. ZIP file stripping/email virus filters
- C. No standard configuration service-wide
- D. Increased frequency and sustainment of deployments
- E. Schedule of reporting to AMSA (1st vs. 15th)

Action Needed:

Because of the success in using FTP to avoid attachment-stripping email virus filters, it's recommended that instructions be given for all MTFs and ships using NDRS to submit directly to NEHC via FTP. Users will be encouraged to submit daily, and no less frequently than weekly. All data will be assimilated into the master database, and queries will be run for reports, sorted by NEPMU. A zip file containing all reports under a NEPMU's AOR will be sent daily from NEHC to the respective NEPMU for examination then import into their local database.

Discussion:

The recommended change in reporting will hopefully reverse this trend of decreasing reporting. NDRSi is based on a concept of centralized reporting that is not routed through the NEPMUs, therefore; any information reported through NDRSi will not be seen in the local database. All data sources are integrated into one main database housed at NEHC.

Deployments from the NEPMUs are much more frequent, and often there is a data system 'SME' for reporting. When that person is deployed, medical event reporting breaks down. Centralized reporting has several advantages.

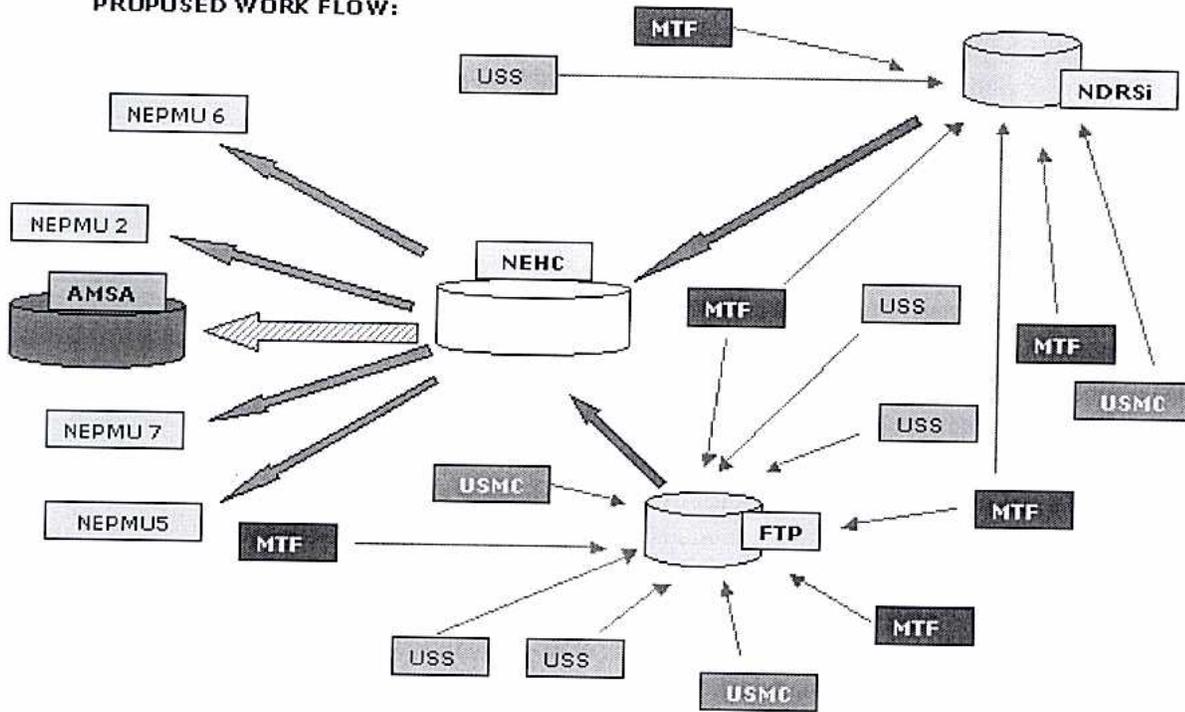
The 'big win' in this change will be the prevention of data loss inherent in the first two legs of the current process. NEHC can frequently receive data that the NEPMUs can't, and inclusion of this in the daily report will more completely inform that NEPMU of what's happening in their AOR. Another benefit of this change is that the NEPMUs would be relieved of data processing work. Instead of dealing with multiple reports from several MTFs, they would have to only assimilate one file from NEHC. NEHC would continue support to the NEPMUs for all tech issues.

At NEHC, submitted data files are updated daily, and incidents of interest brought to the attention of staff epidemiologists for investigation. This change will enhance reporting as data submitted will be much more timely.

Best of all, this requires no additional expenditure or training. The only change is the method of transmission and frequency data is requested.

PROs	CONS
Data gets to NEHC much quicker (daily vs. 45 days)	NEPMUs see the data in 24 hrs
Data flow directly to NEHC is reviewed daily	
NEPMUs don't have to process data: greatly reducing the PMT workload	
NEPMUs see all data under their AOR	
No additional training or expense	
Provide better continuity for reporting: uniform process service-wide	
Eliminates database inconsistencies [NEHC vs. NEPMU vs. MTF]	
Provides for centralized data backup	
Reporting synchronized with AMSA	
Complete database is available for analysis	

PROPOSED WORK FLOW:



Proposed SOP:

Effective 1 JUL 2004, all sites reporting MERs via NDRS 3.0 are instructed to change the preferred method of transmission from email to FTP. This change is made in the Program Setup section, and can be easily made by the user.

Open NDRS.

A. In the Program Configuration window, change method of transmission from email to FTP.

B. Under the FTP button, enter the following account information:

IP address: 164.167.141.27
User name: nuser
Password: ne25hc10
Account: NEHC FTP SITE

Continue to enter reports and process reportable medical events as before. This change will route data records via FTP to NEHC instead of email to the NEPMUs. (This is HIPAA/ASDHA complaint for the protection of PHI/sensitive data.) Urgent reportables should be followed-up with a telephone call to the NEPMU in addition to being reported via NDRS/SAMS.

C. Users are urged to export reports as they are entered, daily if entered daily, but no less frequently than weekly for non-urgent reportables. This will increase timeliness of reporting and relieve the reporting unit of having to designate someone to oversee the reporting process. If whoever enters the data exports that data at the end of their shift, there will not be such a burden of reporting to meet a deadline.

D. Once daily, reports from all units will be aggregated and pulled into the main MER database at NEHC. Queries will be run for reports under each NEPMU and that report will be sent to the EPI dept at each respective NEPMU. With very little manipulation (at datasheet level) this data file can be imported into the NEPMUs' database.

E. All MERs submitted will be reported back to the cognizant NEPMU, not just those confirmed cases.

E. A backup file of the current NDRS database will be posted on the NEHC FTP site, and is available to any NEPMU wanting to perform further analysis.