

6220
Ser PM/

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
04-06 DECEMBER, 2002

Ref: (a) NAVENVIRHLTHCENINST 6220.1F

Encl: (1) List of Attendees
(2) Navy Epidemiology Board Meeting Agenda
(3) EPI-RAP 02-007 Elimination of Military Labor Sheets - CAPT Hayashi
(4) EPI-RAP 02-008 Unplanned Pregnancy Survey - CAPT Hayashi
(5) EPI-RAP 02-009 Outcome Measures of Navy Health Promotion Programs – CAPT Hayashi
(6) EPI-RAP 02-010 Updating the Navy Reportable Medical Events List – Ms. Riegodedios
(7) EPI-RAP 02-011 Review/Revise Metrics Used at NEHC BOD Meetings - CAPT Hayashi
(8) EPI-RAP 02-012 Hands –On CBRE Training - CAPT Hayashi

1. The subject meeting was held at the Navy Environmental Health Center, 04-06 December, 2002, in accordance with reference (a). CDR Sherman welcomed the attendees (listed in enclosure (1)); the Minutes from the previous meeting were reviewed. CAPT Sack, NEHC Commanding Officer, addressed the NEB members, and discussed the Surgeon General's continued emphasis on Population Health improvement. Challenge is to demonstrate our worth using useful measures of effectiveness and impact of prevention activities.

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

a. EPI-RAP 02-003: Validation of Medical Event Reports

NEB Recommendation: NEHC PM should continue the pilot study for validation of MERs, wherein MTF laboratories reportable dz lab reports are compared with the MERs submitted to the NDRS. In the future, may include in the MER Instruction the requirement for MER QA and validation by MTFs.

Action required: Ms. Riegodedios and NEHC PM to draft SOP for validation of MERs, and complete pilot study.

Status: Closed

Subj: MINUTES OF THE NEB MEETING OF 04-06 DECEMBER, 2002

b. EPI-RAP 02-004: PH Surveillance Using Lab and Pharmacy Data

NEB Recommendation: Endorses concept of making reporting of reportable diseases mandatory for MTF laboratories.

Action required: NEHC PM will include concept in revision of BUMED Instruction 6220.12A Medical Event Reports

Status: Closed

c. EPI-RAP 02-005: TST Competency and Refresher Training

NEB Recommendation: Enclosure (1) of the BUMED TB Instruction states that the SMDR must document that personnel are qualified to perform TST. NEB endorses having more detailed requirements for personnel who administer and read TSTs.

Action required: CAPT Hayashi will take lead on developing appropriate guidelines, and submitting them to BUMED Prev Med.

Status: Closed.

d. EPI-RAP 02-006: Notifying Gaining Commands of TST Reactors and TB Patients on Treatment

NEB Recommendation: If medical personnel executed the TB program as currently instructed, LTBI and active TB patients would not be lost from the program during PCS moves. Patient tracking may improve by adding to the TB Instruction that relevant TST and INH treatment information must be thoroughly documented on the DD 2766 Adult Preventive and Chronic Care Flowsheet.

Action required: CAPT Hayashi will take lead on drafting appropriate input for BUMEDINST 6224.8, and submitting to BUMED Prev Med. NEPMU's Fleet Liaison personnel to encourage fleet medical personnel to properly carry out the Navy TB/INH program.

Status: Closed.

3. New Business

a. EPI-RAP 02-007: Elimination of Military Labor Sheets

NEB Recommendation: A letter had been submitted from a NEPMU to the CO, NEHC, recommending elimination of Military Labor Sheets. The NEB was shown a copy of the letter of reply from the CO, NEHC, explaining need for and instructing continued completion of monthly labor reports.

Subj: MINUTES OF THE NEB MEETING OF 04-06 DECEMBER, 2002

Action required: None

Status: Closed

b. EPI-RAP 02-008: Unplanned Pregnancy Survey

NEB Recommendation: To help reduce the impact of pregnancies on operational units, accurate data is needed regarding circumstances leading to pregnancies in shipboard sailors, and Marines. An anonymous survey sampling from ship's crews, and Marines, may provide data to better guide pregnancy prevention strategies.

Action required: CAPT Hayashi to discuss/research feasibility with BUMED Prev Med and Women's Health contacts, and report to the Board at the next meeting.

Status: Open

c. EPI-RAP 02-009: Outcome Measures of Navy Health Promotion Programs

NEB Recommendation: The HRAs and HEARS performed at commands, even annually, do not accurately follow behavior changes in the population, and cannot measure the effects of Navy Health Promotion programs on individuals, due to the frequently changing populations of Navy commands. A new DODI on Health Promotion is expected soon, to align with and exceed Healthy People 2020 goals – outcome measures should be built into the recommendations.

Action required: NEHC Health Promotion work with BUMED and BUPERS to measure the impact of our various programs that aim for behavior change

Status: Closed

d. EPI-RAP 02-010: Updating the Navy Reportable Medical Events List

NEB Recommendation: There is no clear process for updating the Triservice Reportable Medical Event list, and adopting it for the Navy. There are arguments for and against adding conditions, whether or not they require traditional public health response. Recommendations to add West Nile, JEV, and Community-Acquired MRSA to the Navy list, and delete Viral Meningitis. The Board voted to continue to maintain a separate Navy list, rather than just adopt the Triservice list.

Action required: NEHC Prev Med to suggest changes to the Navy RME list in the draft of the new Medical Event Reports Instruction, and changes will be considered during the Instruction review process.

Status: Closed.

Subj: MINUTES OF THE NEB MEETING OF 04-06 DECEMBER, 2002

e. EPI-RAP 02-011: Review/Revise Metrics Used at NEHC BOD Meetings

NEB Recommendation: Consensus was that current metrics used are not useful. Various alternate measures were discussed, including (speed of) response to consultations, numbers of consults per month, events such as deployments and outbreak investigations, rates of RMEs, etc.

Action required: Specific recommendations should be discussed by NEB members and forwarded to NEHC for consideration.

Status: Open

f. EPI-RAP 02-012: Hands-On CBRE Training

NEB Recommendation: Though it takes much time from NEPMU members who teach the 3-day course, they benefit by becoming experts on the material. Students repeatedly ask for hands-on exercises as part of the course.

Action required: NEHC should pursue facilitating hands-on training as part of the CBRE course – referred to NEHC Plans and Ops for action.

Status: Closed

4. Administrative Business

a. Presentations to the Board.

1) CDR Landro, MC, USN, discussed the BUMED realignment and issues related to M3F4. Current challenges include pressure to press ahead with the Smallpox vaccine program. An Individual Medical Readiness working group was formed to report on IMR measures to the SecDef. Also, the Navy IG has said that that BUMED should conduct a self-assessment for Preventive Medicine, “to establish and prioritize POA&Ms to address areas for improvement.” Members of working group to tackle the Self-Assessment will include personnel from the NEB, NEHB, PMTs and other pertinent communities. CDR Landro has for M3F4 action.

2) CAPT Schor, MC, USN, briefed HQ- USMC issues. The SMIP (sports medicine and injury prevention) program has high level visibility and support, currently is in the Transitional Task Force phase, aim to deploy software to all 6 MC entry-level schools by APR03. PM-AMAL review is ongoing. Demands for reporting up of anthrax vaccine and DNBI data from the field are challenging, due to computer constraints, difficulty getting SAMS in the field, and operational priorities.

Subj: MINUTES OF THE NEB MEETING OF 04-06 DECEMBER, 2002

3) Ms. Riegodedios, MPH briefed on completeness of RME reporting. The AMSA reported Navy medicine as having 13% completeness for CY-2001, but NEHC PM evaluation found the figure to actually be 42%. Heat injuries and varicella are the most underreported. Will continue to address specific data loss problems, and pursue change in reporting system to web-based.

4) Ms. Suesz presented NEHC data from the NDRS. CDR Sherman suggested that it would be more useful to also present denominators and rates of reportable events.

5) CDR Michael McCarthy, MC, USN, XO of NMRC, updated the Board on Navy medical research issues. Anthrax/BW/CBRE, research and training. Blood substitute ready for field trial; skin grafting; tx of DCS; 'agile vaccinology' with rapid development and deployment of vaccines.

6) NEPMU presentations: 2 consumed by FDP MU issues; MRSA at MCRD-Parris Island. 5 acting as IMEF PMO due to gravidity of incumbent. Just-in-time training for big contingency deployments; MRSA issues at BUDS and MCRD-SD. 6 with large CBRE training burden for 3-day course, as have all NEPMUs. Lymphoma in two crewmembers of a Cruiser, ALL on Guam. 7 funded for 3-yr diarrhea study at Incirlik. High deployment tempo; DNBI from 5th Fleet, not 6th; GI problems on ships inchopping to AOR

7) LCDR Conner, MC, USN and LT Zinderman, MC, USN presented updated information on the CA-MRSA outbreak at MCRD-PI

8) LTCOL Grayson, MC, USAF, from AFIERA gave update on Air Force epidemiology. Working on DOD Mortality Registry, 30k death certificates coded, 100k left to do. ESSENCE monitoring. Discussed RME system (AFRESS), for fixed MTFs, and data from GEMS rolled in from deployed sites.

b. Selection of new NEB President.

Because there was not a quorum of members present, the election of a new NEB President was deferred until the next meeting.

5. Next Meeting. The next meeting is scheduled for 04-06 June, 2003.

(signed)
M. A. MALAKOOTI
CDR, MC, USN

Minutes reviewed and approved by President, Navy Epidemiology Board.

Date: 08 JAN 2003

(signed)
S. S. SHERMAN
CDR, MC, USN

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

**LIST OF ATTENDEES FOR NAVY EPIDEMIOLOGY BOARD
MEETING OF 04-06 DECEMBER, 2002**

MEMBERS PRESENT

CDR S. Sherman, MC, USN (**President**/NEPMU-5)
CAPT B. Bohnker, MC, USN (NEHC)
CAPT E. Kilbane, MC, USN (NEPMU7)
CAPT K. Hayashi, MC, USN (NEPMU-6)
CAPT K. Schor, MC, USN (HQUSMC)
CDR J. LaMar, MC, USN (NEPMU-2)
CDR F. Landro, MC, USN (BUMED M3F4)
CDR M. Malakooti, MC, USN (**Executive Secretary**/NEHC)

GUESTS

LTCOL Grayson, MC, USAF (AFIERA)
CDR A. Philippi, MC, USNR (NEHC)
LCDR K. Hanley (TelCon from III MEF)
Dr. J. Muller (NEHC)
Ms. Lea Gilchrist (NEHC)
Ms. Asha Riegodedios (NEHC)
Ms. Wendi Suesz (NEHC)

MEMBERS ABSENT

CAPT R Thomas, MC, USN (NEHC)
CAPT J. Beddard, MSC, USN (NEHC)
CDR M. McCarthy, MC, USN (NMRC)
CDR B. Hendrick, MC, USN (II MEF)
LCDR J. Howe, MC, USN (I MEF)

AGENDA
NAVY EPIDEMIOLOGY BOARD MEETING
04-06 DECEMBER 2002

Wednesday, 04 December 2002

0800-0810 Welcome & Opening Remarks - CDR Sherman
0810-0830 Commanding Officer Remarks - CAPT Sack
0830-0900 BUMED M3F4 / JPMPG - CDR Landro
Break
0910-0950 HQ USMC PM - CAPT Schor
0950-1030 FDPMU - update status/doctrine/Instruction and future plans - CDR Sherman, CAPT Schor
1030-1100 Completeness of Reporting RMEs - Ms. Riegodedios
1100-1130 NDRS etc. Update - Ms. Gilchrist, Ms. Suesz
1130 - 1300 Lunch
1300-1400 NEPMUs 15-min Briefs
Break
1410-1610 R&D Update: WMD, Combat Casualty Care and FHP - CDR McCarthy

Thursday, 05 December 2002

0800-0805 Presidential Remarks - CDR Sherman
0805-0830 Draft DODDir 6200.AA Emergency Health Powers on Military Installations - CAPT Schor
0830-0915 NEHC Population Health Directorate - CAPT Bohnker
Break
0925-1130 **Old Business (Review Previous Open EPI-RAPS)**
EPI-RAP 01-007 PM Physician Billets - Changing the Infrastructure - CAPT Brawley- previously closed, but CO comments this could be NEB item?
EPI-RAP 02-003 Validation of Medical Event Reports - Ms. Riegodedios
EPI-RAP 02-004 PH Surveillance Using Laboratory and Pharmacy Data - Ms. Riegodedios, Ms. Ajene
EPI-RAP 02-005 TST Competency and Refresher Training - CAPT Hayashi
EPI-RAP 02-006 Notifying Gaining Commands of TST Reactors and TB Patients On Treatment - CAPT Hayashi
1130-1300 Lunch
1300-1520 **New EPI-RAPS**
EPI-RAP 02-007 Recommend Elimination of Military Labor Sheets - CAPT Hayashi
EPI-RAP 02-008 Unplanned Pregnancy Survey - CAPT Hayashi
EPI-RAP 02-009 Outcome Measures of Navy Health Promotion Programs - CAPT Hayashi
EPI-RAP 02-010 Updating the Navy Reportable Medical Events List - Ms. Riegodedios
EPI-RAP 02-011 Review/Revise Metrics Used at NEHC BOD Meetings - CAPT Hayashi
EPI-RAP 02-012 Hands-On CBRE Training - CAPT Hayashi
Break
1530-1615 USAF Epi update - LtCol Grayson

Friday, 06 December 2002

0800-0805 Opening Remarks - CDR Sherman
0805-0930 MRSA at Parris Island, SC - LCDR Conner, LT Zinderman
0930-0940 Break
0940-1000 NEB Membership Issues - Great Lakes PMO for At-Large position; Army guest rep
1000-1030 Selection of New NEB President and officers
1030-1100 Selection of Date for Next Meeting/Unfinished Business and Closing Remarks
1100 **Adjourn**

Enclosure (2)

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

DATE: 11/26/02
EPI-RAP# 02-007

Recommend Elimination of Military Labor Sheets

Background: All personnel at NEPMU6, and other Claimancy XVIII echelon four units are required to fill out and submit, weekly, labor sheets. The process requires substantial labor hours, and there is no feedback mechanism, validation process, or evidence of changes in staffing that have resulted from the use of labor sheets.

Discussion: This service member asked multiple members of the command from the Acting Officer In Charge to the Comptroller what the utility of the labor sheets is. The universal consensus is that the unit would be better off if we did not have to fill them out, allowing more time to be concentrated on mission support. An analogy to the use of the labor sheets is the obtaining of laboratory tests; tests should be ordered when there is a specific need, when the information will be provided in a timely manner to allow the submitter to make a change in their activities (i.e. alter treatment procedures or another aspect of care), when the tests are determined to be accurate, and when the test is deemed cost-effective for the condition being evaluated. None of these criteria appear to be met by the submission of labor sheets. Specifically, there is no process to validate the submitted data, there is no direct feedback mechanism to the providers, there is no change in staffing available as a result of inputs, and the requirement for completion is universal vice dependent on accurate sampling. The NEPMUs do not provide routine patient care procedures that are reimbursed by outside agencies, and hence there is no reimbursable product line. In addition, it would be myopic to cut staffing of operation-supporting military commands based on labor reports as the staffing needed to support combat and disaster contingencies exceeds routinely reported activities. In contrast to this command, operational commands at the 0-4 command to the four star level do not submit labor sheets. In addition, there are inherent biases in the current process requirements that guarantee incorporating gross, systemic reporting errors. These include the failure to include as many labor hours as are actually performed (the maximum is eight), and failure to count physical exercise, mandated for optimal military performance, as work.

Alternatives:

- A. Eliminate the requirement for routine submission of labor sheets.
- B. Continue requirement as is. No change.

Recommendation: A. Eliminate the requirement for routine submission of labor sheets. If specific reasons justification arises for tracking labor accurately the use of scientifically determined samplings should be used. Example: Randomly select two-week periods from a random selection of submitting commands and track the hourly activities of each labor sheet submitter. Provide on-site trainer evaluators advise how to complete the forms accurately, and to go over the forms after submission with completers. Use validated information to extrapolate as needed, and provide the feedback to submitting commands. Continuing the current system belies credence that Navy Medicine seeks to make decisions based on metrics.

Enclosure (3)

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

DATE: 11/27/02
EPI-RAP# 02-008

Unplanned Pregnancy Survey

Issue: The rate of unplanned pregnancies in the Navy reportedly does not differ significantly from those in the civilian sector, but the impact on operational commands remains notable for both the Navy and Marine Corps. Unplanned pregnancies in single Sailors are more likely to result in single parent families with attendant stresses and increased risk of attrition, lower educational completion, and significant stresses. In addition, the lifelong impact of increased poverty for single parents outside the military (most Sailors not completing a career) compared with dual parental unit families is a significant socioeconomic problem. Prior surveys filled out by Sailors asking about whether pregnancies were planned or unplanned reflected use of standard survey instruments and may not have reflected actual opinion. The “right” answer has been that a pregnancy was unplanned, and not that the intent was to get out of a deployment. An anonymous survey focusing more on the issue of pregnancy planning could provide useful information.

Background-Discussion: The nature of pregnancies (unplanned vice planned) alters how the Navy should deal with preventing adverse impact of pregnancy in the military, both on operations and on the Sailor and any children. Determining whether pregnancies have been “initiated” to avoid deployment has not been rigorously evaluated. If a substantial percentage of “unplanned” pregnancies turn out to actually have been planned, then this would significantly alter the educational materials and programs needed by Sailors. As the male partner of most shipboard pregnancies is another Sailor assigned to the command, the survey results could alter educational efforts directed toward males to increase responsibility. To avoid the potential stigma of reporting the answers that personnel believe military surveys want to hear requires assurance of anonymity.

Options:

A. NEHC request BUMED work with BUPERS to prepare and conduct anonymous surveys of all personnel assigned to a sampling of mixed-gender ships and USMC units asking questions which may include: number of years and months in the service, whether they have experienced a pregnancy during the past three years (probable maximum tour length), marital status, if they have had an opposite sex sexual partner assigned to the same command / at another military command, if the pregnancy was planned, if the timing of that planning interfered with their eligibility for a scheduled deployment, ship or shore assignment, if the pregnancy caused the individual to miss a deployment, if the impact of the pregnancy was likely to increase the Sailor’s plans to end military service. There may be a number of questions the Special Assistant to the Surgeon General for Women’s Health and others (e.g. CAPT Mike Hughey, MC, USNR (Ret), The Alan Guttmacher Institute in Seattle, the Army’s CHPPM) could add that would have great utility. Any survey instrument should be provided to the Sailor so they may complete it and mail it from off the ship if desired with participants being assured that the military will not have access to personal identifiers linking response to any particular individual. Surveys should ask male partners who have been the initiator of a pregnancy in a command Sailor their level of responsibility in providing support. It will be important to work with the appropriate Area and Type Commanders, public affairs officers, legal officers, and their Command Surgeons and N1s to assure buy in for conducting the surveys. The results should be reported to NEHC and the line so that Navy Medicine and the line can maintain or modify course as optimal.

Enclosure (4)

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

11 October 2002
EPI-RAP# 02-009

Validating Navy Health Promotion Programs

Issue: The Navy Preventive Medicine community has not received feedback in our population on the long-term impact of many Navy Health Promotion programs. These include tobacco cessation, injury prevention, sexual health and responsibility, the Right Spirit program, etc.. At the same time, we have offered Health Risk Assessments (HRA) and are increasingly requiring the Health Enrollment Assessment Review (HEAR).

Background: Having the metrics on the changes in HRA and HEAR results on a sample population would provide Navy Medicine with outcome based measures on program impact, and should help us to either stay or change course. Navy Medicine has increasingly offered health promotion programs to personnel in both the operational and support arenas. HRAs and HEARs have been administered with increasing frequency to personnel, but there has been no reporting of the results of serial HRAs and HEARs on the *same* population of active duty personnel. HRAs have been administered for at least five years in the surface navy. HEAR result reporting has had large problems due to depending on TRICARE contractors. Physical Readiness testing results are routinely provided to BUPERS, and thus provide serial information on specific physical accomplishments, even as point systems have changed for categories of accomplishment (e.g. satisfactory, outstanding, high satisfactory). The Navy Environmental Health Center (NEHC) offers awards to commands that include criteria based on the behavior of their population. However, operational commands typically rotate approximately a third of their personnel each year. Thus, trend data on a specific command does not necessarily reflect the behavior of the personnel who were aboard at the time of prior annual reviews. The effect of command programs and unique initiatives can be falsely evaluated unless the population aboard during the period of intervention is monitored as opposed to the total population at the beginning of the intervention and the population present at the time of evaluation. Impacts can be falsely elevated or diminished. To provide a proper evaluation of the impact of programs over an extended period of time requires a prospective review. To gain a reasonable idea of the impact of programs, and thus provide an information source to those who should be deciding how to manage Navy resources, would require the evaluation of a sample of personnel to see how their behavior and health outcomes have changed over time.

Options/Considerations

A. NEHC work with BUPERS to obtain a sample of personnel who have been in the Navy for at least three years and analyze, with the help of BUMED/NEHC the results of their HRAs and HEARs (when available) from both early and subsequent years. Report results of behavior changes and health outcomes along with trends in running times, situps, and pushups, percentages of body fat. Hospitalizations could also be evaluated looking at injuries and illnesses.

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

DATE: 11/26/02
EPI-RAP# 02-010

TITLE

Reportable Medical Events (RME) List and Required Minimal Data Elements

ISSUE/PROBLEM STATEMENT

Per BUMED INSTR 6220.12A, over 80 medical events are reportable through the Navy medical event surveillance system. This list does not match the Triservice Reportable Events list of 70 events. In addition, the minimal data elements required per BUMEDINST 6220.12A are different than those outlined by the Triservice agreement.

PRIORITY

Routine

BACKGROUND

The Triservice Reportable Events Guidelines and Case Definitions document was created through a forum of Preventive Medicine professionals from all three services. This forum agreed on a list of reportable events applicable to all services, case definitions for those events, and a list of required data elements. Each service may add more medical events and required elements to create its own service specific reportable events guidelines. However, it is unclear as to the current relevance of the additional medical events on the Navy RME list. Furthermore, the minimal data elements identified by the Navy are not consistently listed in the BUMEDINST and do not contribute to conducting surveillance based on sound epidemiologic methodologies.

ACTION NEEDED

- (1) Review enclosure 1 and discuss the relevance of those medical events not on the Triservice list.
- (2) Support the deletion of medical events that are no longer relevant to Medical Event Surveillance in the Navy.
- (3) Review Enclosure 2 of required minimal data elements for RMEs and ensure any Navy additions are consistent with Triservice guidance.

ISSUE ORIGINATOR

Asha Riegodedios, MSPH
Preventive Medicine Directorate
Navy Environmental Health Center
620 John Paul Jones Circle Ste 1100
Portsmouth, VA 23708-2103
(757) 953-0708; DSN 377-0708

PERTINENT REFERENCES

1. BUMED INST 6220.12A
2. Tri-Service Reportable Events Guidelines and Case Definitions.
Version 1.0. July 1998.

PERTINENT PERSONNEL

None

Enclosure (6)

Enclosure 1. REPORTABLE MEDICAL EVENTS

1. Amebiasis*006
2. Anthrax*022
3. Biological warfare agent expE997.1
4. Botulism*005.1
5. Brucellosis023
6. Campylobacteriosis*008.43
7. Carbon Monoxide poisoning*986
8. Chlamydia099.41
9. Cholera001
10. Coccidioidomycosis114
11. Cryptosporidiosis*136.8
12. Cyclospora*007.8
13. Dengue fever (specify type)*061
14. Diphtheria032
15. E. Coli 0157:H7 infection*008.09
16. Ehrlichiosis083.8
17. Encephalitis (specify type)*
 - a. California subgroup062.5
 - b. Eastern equine062.2
 - c. Japanese062.0
 - d. St. Louis062.3
18. Filariasis (specify type)125.0
19. Giardiasis007.1
20. Gonorrhoea098
21. Haemophilus influenza, type b038.41
22. Hantavirus infection (specify type)* 079.81
23. Hemorrhagic fever (specify type)* 065 (includes Lassa fever, Ebola & Marburg viral diseases, Crimean fever, and Adrenaviral disease)
24. Hepatitis, A (acute, sym only)070.1
25. Hepatitis, B (acute, sym only)070.3
26. Hepatitis, C (acute, sym only)070.51
27. Influenza (confirmed)487
28. Legionellosis*482.8
29. Leishmaniasis (specify type)085
30. Leprosy (Hansen's disease)030
31. Leptospirosis*100
32. Listeriosis027.0
33. Lyme Disease088.81
34. Malaria (specify type)*¹
 - a. Malaria, falciparum084.0
 - b. Malaria, malariae084.2
 - c. Malaria, ovale084.3
 - d. Malaria, unspecified084.6
 - e. Malaria, vivax084.1
35. Measles*055
36. Meningitis (bacterial other than Meningococcus)*320
37. Meningitis (aseptic, viral)321.2
38. Meningococcal disease*
 - a. Meningitis036
 - b. Septicemia036.2
39. Mumps072
40. Onchocerciasis125.3
41. Pertussis*033

- Not on Triservice RME list
42. Plague*020
43. Pneumococcal pneumonia481
44. Poliomyelitis*045
45. Psittacosis (Ornithosis)073
46. Q Fever*083.0
47. Rabies, clinical human*071
48. Relapsing fever087
49. Rift Valley fever066.3
50. Rocky-Mountain spotted fever082.0

51. Rubella*056
52. Salmonellosis*003
53. Schistosomiasis (specify type)120
54. Shigellosis*004
55. Smallpox*050
56. Streptococcal disease, Group A Invasive
 a. (including necrotizing fasciitis)038.0
 b. pneumonia481
 c. Rheumatic fever, acute390
57. Syphilis-specify stage
 a. Syphilis, primary/secondary091
 b. Syphilis, latent096
 c. Syphilis, tertiary095
 d. Syphilis, congenital090
58. Tetanus037.0
59. Toxic shock syndrome785.59
60. Trichinosis124
61. Trypanosomiasis (specify type)086
62. Tuberculosis, pulmonary active (specify type)*011
63. Tularemia*021
64. Typhoid fever*002.0
65. Typhus (specify type)*080
66. Urethritis (non gonococcal)099.40
67. Varicella (**Active Duty only**)052
68. Yellow fever*060
69. Any unusual condition not listed799.8
70. Bites, rabies vaccine/rabies IG V01.5
71. Bites, venomous animalE905.0
72. Chemical warfare agent exposure989
73. Cold injuries (include outside temp)
 a. Frostbite991.3
 b. Hypothermia991.6
 c. Immersion type991.4
 d. Unspecified991.9
74. Heat injuries (specify type, include WBGT and dry bulb temp)
 a. Heat exhaustion992.3
 b. Heat stroke992.0
75. Lead poisoning984
76. Occ exposure to b-b Pathogens883.0
77. Vaccine related adverse event979.9
78. Food/Water associated illness*005
79. Respiratory Illness519.8

Enclosure 2. Required Minimal Data Elements

1. Date of Report
2. Reporting command's UIC/Point of Contact
3. Patient's First/Last Name
4. Patient's SSN/FMP
5. Patient's Branch of Service
6. Patient's UIC
7. Patient's Race/Ethnicity
8. Patient's Sex
9. Patient's Date of Birth
10. Diagnosis (ICD-9 code)
11. Diagnosis Suspected or Confirmed
12. Method of Confirmation
13. Date of Onset of Symptoms
14. Travel History (for certain Medical Events)
15. Comments

Proposed additions

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

DATE: 11/26/02
EPI-RAP# 02-011

DRAFT COMMENTS - NEHC METRICS

Background: Metrics are considered critical to determine organizational effectiveness in measuring, and supporting the Navy's mission. The line has had long experience with metrics, and has increased the priority on measuring outcomes, vice process measures, as part of the CNO's emphasis on decreasing taskings on personnel during the Inter-Deployment Training Cycle (IDTC). Organizations, familiar with process measures (e.g., number of patient visits) often have difficulty changing their measurement focus (e.g., % of patients with a positive PPD skin test who complete their INH).

Discussion: NEHC's metrics, presented to the WWVTC, cover a spectrum of areas, but do not necessarily reflect outcome measures. In addition, the measures are subject to multiple influences that may not be apparent to the examiner (e.g. deployment to areas with disease-carrying vectors, OPTEMPO). Small numbers can have a disproportionate influence on the observed rates and incidence, and thereby provide a false impression of improvement, or decline, in the metric measures. An organization which spends time focusing on unsuitable metrics expends resources that are much better committed to other areas. The following criticisms are provided to foster a change in the measures used. Each topic is followed by discussion of the specific limitations of that measure, and recommendations.

A. DIP2: Monitor and reduce injuries and illness in Navy and Marine Corps personnel through active prevention partnerships.
Metric B: AD vector-borne disease occurrence.

This presupposes that the deployment of personnel throughout the Navy and Marine Corps remains at static levels across quarters, and that the number of AD personnel remains static. The small numbers involved are subject to great variance from quarter to quarter, and may reflect reporting artifact vice occurrence in that quarter. In addition, there is no provision for separating out those personnel who acquire dengue or malaria while on vacation, vice deployment. On top of this, it presumes that each deployment is to areas where risks are endemic for the diseases of interest. This has been a factor in the past (e.g., Somalia, Liberia, Haiti) and is likely to become a factor again as non-occupational travel resumes prior 9-11 levels.

Recommendation: Do not brief this metric during BOD VTCs. Change the metric to: Rates of vector-borne disease, per thousand personnel per month, during named deployments ashore to region where diseases of interest are endemic.

General comment: It is evident that reporting artifact causes disease occurrence to "rise" during quarters Q2 to Q4 for multiple diseases. Without rate standardizing this reporting may be best be provided in separate graphics to show the "ramping up" of surveillance reporting.

B. DIP2: Monitor and reduce injuries and illness in Navy and Marine Corps personnel through active prevention partnerships. Metrics C and D: AD USN STD occurrence.

This metric does not account for rates during times of varying numbers of personnel, and doesn't provide any indication of different pay grade, ethnicities and racial acquisition rates.

Recommendation: Do not brief this metric during BOD VTCs. Show rates. Providing separate pay grade, ethnic and racial rates may help to provide more effective marshalling of preventive medicine educational and testing resources.

C. DIP2: Monitor and reduce injuries and illness in Navy and Marine Corps personnel through active prevention partnerships. Metric E: AD TB occurrence

Does not account for rates during times of varying numbers of personnel. Unduly affected by variation.

Recommendation: Do not brief this metric during BOD VTCs. Show rates. A better metric would be to actively review a percentage of records to determine the percentage of randomly selected charts of PPD reactors reviewed, which are placed on INH, where the patient is documented to have completed their prescribed course of medication.

DIP2: Monitor and reduce injuries and illness in Navy and Marine Corps personnel through active prevention partnerships. Metric F: % significant threshold shifts (AD/Civil Service)

This metric also fails to account for rates, and implies that program initiatives taken today, or even during the last several years, will significantly impact the percentages within a year or two. STSS show the effect of many years of exposure, and are thus not a valid reflection of activities taken by commands over a briefer period of time.

Recommendation: Do not brief this slide during BOD VTCs.

DIP2: Monitor and reduce injuries and illness in Navy and

Marine Corps personnel through active prevention partnerships.
Metric G: # of Preventive Medicine Partnership visits

Process vice outcome focus. Assumes commands all have the same number of partnership commands to visit, and that number of deployers which can be contacted by OCONUS commands remains static across quarters and year to year.

Recommendation: Do not brief the metric during BOD VTCs. An active satisfaction survey of supported Commanding Officers and their medical department heads could provide a more useful metric, along with soliciting valued suggestions to provide the best support to operational commands.

HP: Reduce the number of behavioral risk factors of Navy and Marine Corps personnel. Metric: % AD who use tobacco, exercise <3x/wk, BMI >25, BMI>30, waived from PRT, failed PRT

Percentage waived from PRT is subject to influence by pregnancy. Implying that a waiver is an indication of any sort of problem that needs to be improved logically implies pregnancy is a "failure" of the medical system. Lumps all tobacco use together. Lumps services together.

Recommendation: Delete inclusion of this metric in an otherwise excellent metric. Break out the % of AD who use spitting tobacco from the % of AD who use smoking tobacco. Break out USN and USMC percentages. Working on the % of unintentional pregnancies would be a far more useful metric, and attacking that problem would help commands, service members, and their progeny.

Summary: Briefing the current metrics is, overall, not a useful tool to encourage "course corrections". In addition, increasing the emphasis on current metrics can lead to mis-marshalling of scarce resources to please "headquarters" instead of focusing on areas that will improve the health of supported command personnel.

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

DATE: 10/26/02
EPI-RAP# 02-012

"Hands -On" CBRE Training

Issue: Feedback from medical providers who have attended training provided by the NEPMUs has called for "Hands-On" Chemical Biological and Environmental (CBRE) training. Current programs within Navy medicine provide limited support for this need. Adding the requirement to be conducted by NEPMUs would dissipates availability to best prepare for contingencies, with the current training requirements already taxing the NEPMUs..

Background: CBRE training program content varies widely across the military services, with the preeminent "Hands-On" courses for health care providers conducted by the Army at Aberdeen, Maryland. The NEPMUs conduct both one-day familiarization, and more robust three-day courses, the latter leading to presentation of a certificate, though there is no DoD submission of who has obtained certification. Neither provides opportunities to work with detection papers and equipment, decontamination gear, or drilling. The courses are currently conducted by physicians, entomologists, and other Medical Service Corps personnel who have attended training at Aberdeen and Fort Detrick from the Army, along with attending one of the CBRE three-day courses at one of the NEPMUs, along with the training provided within a two week period by Batelle Corporation. General consensus among NEPMU course instructors is that there is little presented in the courses that logically requires that the instructor be an *active duty* provider, or even that the instructor be in the military (NEPMU5 has a civilian instructor/coordinator with notable military experience.) There is special value of military instructors in providing frames of reference based on experience both shipboard, and in the field. Instructing the course, as with membership on the MMART is not a primary duty, but typically comprises in excess of 25% of instructors' time (preparation, training, travel, revising, admin, exercises, etc.), requiring those remaining at the NEPMU when courses are conducted be less robustly staffed. This added tasking decreases the ability of NEPMU staff involved with CBRE training to optimally prepare for other contingency concerns. Aboard ship, CBRE response, with the exception of provision of medical treatment, is considered a function of damage control personnel. The training is likewise a damage control function. The use of medical personnel for "Hands-on" training, with the exception of assisting with care, breaks with the standard operational forces model.

Options/Considerations:

- A. NEHC work with BUMED to advise the damage control leaders of the line in development of standardized "Hands-On" training for the management of CBRE exposures and decontamination procedures. NEHC recommend to BUMED a baseline review of training requirements (in conjunction with CNET) to assess who is best suited to provide CBRE training, and if training continuity and efficacy would be better served through joint service and/or increased civilian (with military experience) training staffs. NEHC urge BUMED work with the other uniformed services to increase jointness of CBRE training.
- B. Continue training as currently done.

Action Needed: The NEB recommend to Commanding Officer, NEHC, options contained in A be discussed with BUMED for evaluation and action as appropriate. The adoption of the considerations set forth in A. would bring CBRE training more in accord with the operational forces conduct of training, potentially improve continuity, increase the joint perspective on CBRE, and improve the ability of NEPMU personnel to respond to contingencies while permitting greater participation in well established NEPMU functions.

Issue Originator: Captain K. E. Hayashi, NEPMU6 Epidemiology, 1215 North Road, Pearl Harbor, HI 96860-4477, Hayashi@NEPMU6.Med.Navy.Mil .

Pertinent References: Government Accounting Office -GAO-02-219T Chemical and Biological Defense - DoD Should Clarify Expectations for Medical Readiness, November 7, 2001, CBRE Training Materials prepared by NEHC.

Pertinent Personnel: NEPMU CBRE instructor staff, NEHC Plans and Operations, BUMED Operations, CNET.