

Running Head: Overseas Screening

Overseas Medical Screening

LT Stephen C. Elgin, MSC, USN
Administrative Resident
United States Naval Hospital
Naples, Italy

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14. ABSTRACT This study analyzes the performance of the Navy's Overseas Medical Screening process in regards to the European Theater. The data reviewed are from personel early returned due to a medical condition, repetitive medivacs for the same condition, and medical board proceedings to determine whether personel and their dependants are transferring with conditions which existed prior to transfer and would have normally caused their transfer not to occur. The time periods for this study are various between the years 1999 and 2002 due to data availability, and are from U.S. Naval Hospital's Rota, Spain and Naples, Italy. The overseas medical screening process for all three military services are also reviewed as USNH Naples is the primary MTF for the NATO Command, AFSOUTH, which has all three services represented. Literature research was also conducted to determine whether GS CONUS-hired employees must be medically screened prior to transfer overseas. The data collected during the study also determined whether a negative impact on overseas MTFs is occurring by the quality of GS employee medical screening being conducted.					
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Conditions which prompted this study

Within the European Theater, mostly concentrated in the areas of Naples, Italy; Sigonella, Sicily, Italy; and, Rota, Spain, there is a large population of U.S. Navy active duty members, many of whom are accompanied by their family members. Each service member and family member is required to undergo a medical screening within 30 days of receipt of Permanent Change of Station (PCS) orders to an overseas duty station. During Fiscal Year 2001, 655 requests for determination of overseas duty suitability of a service member or family member were sent to receiving military Medical Treatment Facilities (MTF). Of those 655, 134 were denied suitability for transfer. Despite this screening, some active duty personnel or their family members who have medical conditions that make them unsuitable for duty in a certain area do indeed transfer and, subsequently, must be returned to the Continental United States (CONUS) to ensure their health care needs are met. Within the last year, approximately 36 people were processed for return to CONUS from the European Theater due to medical conditions. Because many of these people were on accompanied tours, the actual number of people returned to CONUS is much larger. To move each one of these individuals and their family members from outside of CONUS (OCONUS) back to CONUS incurs a cost to the U.S. Government, specifically the Department of Defense (DoD). A cost of “doing business” perhaps, but still an expense, which can, and should, be kept at a minimal cost.

In a 20-month time period, January 2000 to August 2001, for United States Naval Hospital (USNH) Naples, 36 patients were aeromedically evacuated (MEDEVAC) two or more times for routine appointments for the same condition. For USNH Rota, this number was 45 patients for the same 20-month time period September 2000 through April 2002. These medical evacuations also require a great deal of resources in manpower to execute the flight, the actual

operational cost of the plane, and the per diem expense of the patient. If these medical evacuations occurred for pre-existing conditions which may have prohibited their transfer overseas, then they could have been avoided with proper screening.

In addition, the Armed Forces South (NATO) command is located in the Naples area. At this command, there are approximately 1,783 U.S. Army and Air Force service and family members. Both the Army and the Air Force have their own Overseas Screening programs, which are different from that of the Navy's. Because USNH Naples is the only U.S. MTF in the local area, this facility is entrusted with their healthcare needs. Thus, USNH Naples is at the mercy of each individual service's overseas screening policy. At the conception of this study, a family member of an Army officer was returned to CONUS early due to a condition, which should have been screened out prior to transfer. Unfortunately, this family member never received a screening.

Finally, not all functions performed by the military or on the behalf of the military are performed by active duty service personnel, but by General Schedule (GS) and contract employees. It is believed that GS employees and their family members, as well as contract employees and their family members, are not undergoing any form of medical screening prior to transfer overseas to Naples, Rota, or Sigonella. Because both groups have private insurance coverage, they are not limited to care at American military treatment facilities. But, because of the disparate level of care between the American, Spanish, and Italian healthcare systems, the majority of this population pursues their healthcare from the USNH's Naples, Rota, and Sigonella. Because MTF's are reimbursed for care provided to GS and contract employees, this is not necessarily financially onerous. But, because OCONUS MTF's are not equipped and manned as large, tertiary CONUS MTF's are, the health of these employees and their family

members could be thought of as unnecessarily endangered if they have medical conditions not screened that OCONUS MTF's are not able to provide care for. This necessitates medical evacuations to CONUS and OCONUS MTF's for therapy, medication adjustments, and consultations.

Problem Statement

How many personnel were returned to CONUS or required more than one MEDEVAC for the same condition in order to manage the condition, which should have prohibited their transfer overseas had they been adequately screened?

Is there a difference in the processes that the Army, Navy, and Air Force use to determine the suitability of a service member and their family members? If so, is there a problem being created because of the separate processes?

Finally, is there a requirement that GS and contract employees undergo a medical suitability screening prior to transfer overseas? And, is there evidence, based on MEDEVAC and early return data, that this screening, or the possible lack thereof, results in Navy civilian employees being early returned to CONUS or requiring repetitive medical evacuations in order to manage illnesses not identified prior to transfer OCONUS?

Literature Review

Military overseas screening is a subject not widely studied. There have been three studies regarding the effectiveness of the screening. The first was conducted in 1974, and while not located, was alluded to in the second study. The second was conducted in 1980 by the System Development Corporation in Santa Monica, California, and entitled, "Determination of the Impact of Revised Screening for Overseas Assignment." Its premise is to reenact the 1974 study in order to determine whether the screening process is having a positive impact on the

number of personnel being returned to CONUS prematurely from OCONUS tours. The 1980 study focuses solely on active duty personnel and not focus specifically on health screening, but all aspects of overseas screening to include discipline, job performance, and financial screens. Overall, the study determined that the screening process has had a positive impact, but also notes that there still remains room for improvement. No recommendations were made in regards to improving the medical screening process. Students of the Naval Postgraduate School in Monterey, California conducted the third study entitled, “An Analysis of the Navy’s Overseas Screening Policy” in 1990. It too focuses solely upon the active duty population. All of these studies are also global in nature in that they focus on all personnel serving overseas in all locations. In addition, they examine data that is not case specific, but aggregated.

Purpose Statement

The purpose of this study is to determine the number of returned personnel to CONUS for preexisting medical conditions, which should have made them ineligible for transfer overseas. In addition, the purpose is to determine whether those personnel who required repetitive medical evacuations for the same condition had the condition prior to their transfer OCONUS, thus pointing to the supposition that an improper screen has occurred. An additional purpose will be to delineate the processes incumbent in the separate overseas screening programs for the three services. The final purpose is to determine whether a problem exists due to the current policies, or the lack thereof, regarding medical suitability of GS and contract employees serving overseas.

Method And Procedures

As mentioned previously, within the European Theater, there are three major Navy activities, each of whom have their own Naval hospitals: Naval Air Station, Rota, Spain; Naval

Support Activity, Naples, Italy; and, Naval Air Station, Sigonella, Sicily, Italy. This study will use data from only Naples and Rota. The most intensive and detailed portion of this study is the capture of data for those patients who required multiple medical evacuations for the same condition. While it is preferable to have been able to include Sigonella within the study, the unavailability of its MEDEVAC data made this impossible. Both Naples and Rota aeromedically evacuated and received 1277 and 874 patients respectively, within the time periods examined. Each site had large files of MEDEVAC paperwork, but fortunately the basic information for each and every patient medically evacuated was entered into a database of one form or another. This allowed for relatively quick determination of who required multiple medical evacuations; the first step in this research. This database was not available at Sigonella, making this first step an almost impossible one. In the end, the result would have been the same. Both hospitals at Rota and Sigonella are very similar in size, beneficiary type, and skill set. They both, as does Naples, rely upon U.S. Army Regional Medical Center, Landstuhl, Germany (LRMC) for their tertiary care needs; and, all three are required to participate in the Navy's Overseas Screening Program.

The Screening Methodologies of the Three Services

In order to determine the processes for overseas screening for each of the three major services, the instructions governing the processes will be determined, collected, and absorbed. In addition, subject matter experts, i.e., those who coordinate the screening for the individual services will be interviewed. The differences between the three processes will be noted while discussing the merit of the differences in relation to Navy process.

Early Returns to CONUS

When the researchers in the previous three studies of overseas screening conducted their research, it was done from afar, capturing data which had already been reported to higher authority, or the researchers made calculated assumptions about the data reported. Because of the size of the studies, the researchers were not able to examine in detail the actual overseas screening file on each patient or the specific instance of care provided. For example, in the 1990 study, it is assumed that if a service member is medical evacuated from OCONUS to CONUS in an inpatient status, he or she will not return to his or her parent command. The service member is, in effect, assumed to have been early returned to CONUS. This study does not make such an assumption. As files are kept locally for each of the patients that were early returned for medical reasons, the files will be examined. These files contain the letter from the hospital command to the sponsor's command recommending that the patient be early returned to CONUS and why. Additionally, often there will be copies of medical forms, such as the Standard Form (SF) 600, that provide additional information for the return. The reason for the return will be captured along with any pertinent information detailed in the file, such as specific comments from the physician that would explain the etiology of the condition. The next step will be to review the individual overseas screening file to determine whether the condition was reported during the screening. In the event the individual screening file cannot be found and specific language regarding the condition's etiology reveals whether the condition did or did not exist prior to transfer, this will be accepted as evidence. Even if this revealing etiology is found within the early return paperwork, the overseas screening paperwork will be reviewed, if possible, to determine whether there were circumstances that would further clarify the etiology. Interviewing the recommending physician, if he or she is still onboard, may capture additional

information about the returned patients. Finally, if the recommending physician is not available, then a senior medical officer with extensive experience conducting overseas screens will be interviewed to determine if the condition is one that would have ordinarily been screened out, or is one that would have had a sudden etiology.

The time period for this portion of the study will be the calendar years 1999, 2000, and 2001 for both USNH's Naples and Rota. The early return of a patient to CONUS, while a serious matter, is fortunately not a common one. For this reason, a number of years' worth of cases were required in order to have an appropriate population size. Additionally, if one year, or even two were selected, there remains a chance that a spike or trough in occurrences might skew the data. The third year allows a more appropriate variability of data to be examined.

Only civilian employees or contractors, their dependents, or the dependents of active duty service members can be early returned to CONUS. This status does not apply to active duty service members. This is not to say that an active duty service member can never be considered as having been inadequately screened prior to transfer overseas. Inadequate screening of them, can and does, occur. For a service member to be returned to CONUS early for medical reasons, they must first undergo a medical board, which limits their specific duty status (LIMDU) or a medical board, which determines whether the service member can continue active service within the military. The Navy calls this latter board a Physical Examination Board or PEB.

Whether a service member undergoes a LIMDU or PEB, their ability to do their job is compromised; thus, their parent command cannot fully utilize them within their particular skill set. Service members serving overseas are considered forward deployed and must be fully capable to do their particular skill set. Given the fact that the number of billets overseas is limited, instances when a sailor may be the only one with his or her particular skill set on-site

become more common. Unlike CONUS commands, quite often there is not someone in the next command with the critical skill just lost who can be taken to fill the gap. Additionally, when a service member must be transferred to the European Theater to fill the skill set gap, the delay can be substantial. For these reasons, a sailor who undergoes LIMDU or PEB proceedings can essentially be considered as early returned to CONUS due to the fact that the skill set is lost to the command. If the Sailor had the medical board condition prior to transfer overseas, then this constitutes an avoidable gap in skill set or manpower.

For both Naples and Rota, the time period examined for medical boards will be January 2001 to April 2002. This time period does not match the same time periods examined for the early returned population due to the fact that the LIMDU and PEB data for Naples is not available prior to January 2001. The individual sailor's medical board files will be reviewed to determine the condition for which the medical board was written; further clarifying comments by the physician will be taken into consideration. Medical boards for orthopedic conditions will not be reviewed in detail, as the nature of the specialty is to repair fractured bones and torn ligaments and tendons. These are conditions that by their nature would have spontaneously occurred in theater; the sailor absolutely would never have been transferred overseas with the condition existing. However, medical boards for back conditions will be examined in detail as these conditions are normally chronic in nature; and, the potential for sailors with back conditions to be transferred overseas does exist. Once the condition for which the board was conducted is determined, a review of the individual overseas screening record, if available, will be reviewed to determine whether the condition existed prior to transfer overseas. Any clarifying remarks within the medical board regarding the etiology of the condition will be considered. Finally, if

the physician who recommended the board is still onboard, then he or she will be interviewed to determine in their opinion whether the condition existed prior to transfer.

Repetitive Medical Evacuations

Whenever a MEDEVAC is recommended for a patient, the requesting physician must fill out a MEDEVAC request form. This form provides information such as where the patient is to be sent; the clinical service under which the MEDEVAC is to occur; the top three, if applicable, medical reasons for the MEDEVAC; further clarifying comments from the provider such as why the MEDEVAC is requested or the specific test or consultation requested; and, finally, whether a medical or non-medical attendant is requested to accompany the patient and who he or she is. From this, a MEDEVAC clerk will enter the particular medical information into an Air Force program called TRAC2ES, which generates a Patient Movement Request. Additionally, when a patient is medically evacuated by the U.S. Air Force aeromedical transportation services, an Air Force (AF) form 3899, Aeromedical Evacuation Patient Record, is completed for each patient. This form details where the patient is going or coming from, the reason for the MEDEVAC, and pertinent details such as how the specific condition is tolerated during flight. For each leg of the flight, this form is updated until the final destination is reached. The fact that the patient has reached the final destination is documented by date and additional clarifying documentation.

From these three documents, a researcher can accurately determine the reason for the MEDEVAC, when the patient left the originating facility and when they returned, and whether there was an attendant for the patient, and who he or she was. Once this information is gathered, the next step will be to review the overseas screening record, if available, to determine whether or not the patient's condition for the MEDEVAC existed prior to transfer to OCONUS, and whether there are any extenuating circumstances regarding the condition. If there are any

comments regarding the etiology of the patient's MEDEVAC condition, this will also suffice for evidence, or the lack thereof, of whether the condition did or did not exist prior to the transfer overseas. An example of this would be if there were a comment that the patient status is post motor vehicle accident which occurred in Naples, Italy. Finally, if a determination as to whether the condition was one that should have been previously screened out cannot be made, then a senior medical officer will be interviewed to assist in making a determination, if possible.

The dates examined for repetitive medical evacuations for Rota and Naples are dissimilar. For Naples, the time period was January 2000 through August 2001. This period was chosen as it encompassed a reasonably recent period in history ending when the research began initially. Twenty months was thought to, and did, provide an acceptable sample size, and these dates were included in Naples' MEDEVAC database. The same dates were initially chosen for Rota in order to maintain continuity within the research; but this was not possible as Rota's database did not begin until September 2000. In order to maintain the desired continuity, a twenty-month period was chosen beginning in September 2000 but now ending in April 2002. The length of the time period for both areas is the same. More importantly, this is not a comparison study between Naples and Rota, but a determination as to whether or not there are patients who require repetitive medical evacuations for conditions which existed prior to their transfer overseas and, perhaps, should have caused them to be declared unsuitable for transfer overseas.

Civilian and Contract Employees

In regards to GS and contract employees, during the early returned patient and repetitive MEDEVAC data collection, the service and status of each patient will be noted. This will reveal whether the patient was a GS or contract employee. This data will be examined to look for the

existence of a trend that this population is incurring a high number of early returned patients or repetitive medical evacuations. The actual screening process, or the lack of a process, will be confirmed by reviewing all available instructions and interviewing appropriate Human Resources Office (HRO) personnel.

Expected Findings And Utility Of Results

Early Return to CONUS, Repetitive Medical Evacuations, and Medical Board Proceedings

The expected findings are that many of the Navy personnel that were early returned, required repetitive medical evacuations, or were subject to medical board proceedings had conditions that would have led to them not transferring overseas had they been properly screened. If so, then the overseas screening system is not appropriately screening out those it should, and, subsequently, monies spent to transfer these personnel were ill-spent and lost manpower is needlessly being inflicted upon overseas commands.

GS and Contract Employees

Additionally, it is expected that many GS and contract employees or their family members do indeed transfer overseas when they have medical conditions that would have led to them not being allowed to transfer. It is not expected that a change would be immediately effected by the Office of Civilian Personnel Management, but, at minimum, a case can be made for arguing for medical screening of GS and contract employees. Additionally, the actual process, if a requirement for screening exists, by which a GS or contract employee is medically screened will be determined. This will provide military medical personnel an understanding of what is and is not required. If the process is not working appropriately, then the appropriate personnel may address this.

The Screening Methodologies of the Three Services

Finally, it is expected that the three services do have different overseas screening policies. As service members will increasingly find themselves receiving care from MTF's that are not of their own service, it is appropriate that our sister services begin to further understand their respective differences. Such an understanding can only provide greater coordination and understanding between the services.

Results

Early Returns

Neither facility overall is experiencing a drastic problem in regards to family members being transferred overseas with conditions that should have been screened out. Based on the cases studied, beneficiaries, transferring to the Naples and Rota areas respectively, have a 0.1 and 0.05 percent chance of doing so with a condition which existed prior to the transfer and ultimately will be recommended for transfer back to the CONUS for the condition.

Table 1

Early Returns

	Appropriate Screen	Inappropriate Screen	Indeterminate Data	Total
Naples	18	4	4	26
Rota	7	2	0	9

Repetitive Medical Evacuations

While there is evidence that supports the theory that members or their family members are transferring overseas with conditions, which ordinarily would not have been screened out but

present a problem once on station requiring repetitive medical evacuations, this is not occurring in significant numbers. Overall, overseas medical screening is performing adequately.

Table 2

Repetitive Medical Evacuations

	Acceptable Screen	Unacceptable Screen	Indeterminate Data	Retirees	Total
Naples	27	4	0	5	36
Rota	13	1	5	22	44

Active Duty with Medical Board Proceedings

Neither Naples nor Rota is having an overall problem with active duty personnel transferring to the area with conditions when they should not have transferred. Naples and Rota each had one service member who should not have transferred to the area. This is not significant in comparison to the total number of service members (67) who underwent medical board proceedings during the study period.

Table 3

Medical Board Proceedings

	Acceptable Screen	Unacceptable Screen	Orthopedic Condition	Indeterminate Data	Total
Naples	16	1	25	0	42
Rota	12	1	11	2	26

Note: 68 boards are listed with one service member undergoing both a LIMDU and PEB

Civilian and Contract Employees

The expected results as discussed previously were not supported. On the supposition of whether or not a burden upon USNH's Naples or Rota exists due to the fact that GS and contract

employees are not being screened prior to transfer overseas to Naples or Rota, there is not data to support this claim. In the time period examined, for the Naples area, there was only one civilian patient who was early returned for a medical condition. In this particular instance, the recommendation for early return was made for a condition, which did not exist prior to transfer overseas. In regards to civilian employees who required repetitive medical evacuations from Naples, there was only one, and it was for a condition which existed prior to transfer but a condition which is not normally life-threatening but only life-discomforting. USNH Rota did have one civilian patient who required repetitive medical evacuations. The patient had complications of a condition, which ordinarily would not have precluded them from transfer to Rota. There were no civilian patients at Rota who received an early return recommendation during the time period reviewed.

In regards to whether civilian employees must be medically screened prior to transfer overseas, CONUS-hired civilian employees must receive a medical examination prior to transfer overseas. In regards to this same question as it relates to contract employees, no instruction could be identified mandating that this category of employee must be medically screened prior to transfer overseas.

The Screening Methodologies of the Three Services

As expected, the three services do have their own process for screening its active duty service members and their families. The methodologies are similar yet distinct in their own way. As to whether the different methodologies are having an adverse impact on USNH's Naples or Rota, overall, the answer is no. There is evidence that perhaps a breakdown in communication between the Army and Navy is occurring in regards to personnel and their families who have transferred to Naples.

Discussion

Early Returns

USNH Rota, over the three-year study period, as shown in Table 1, had a total of nine patients recommended for early return to CONUS; this includes 1999, during which no patients were recommended for early return. Two of these nine had screening discrepancies meaning that they should never have transferred to the area. An additional two were returned for conditions, which existed prior to transfer but were approved for transfer. During their tours at Rota, their conditions worsened to the point where USNH Rota could no longer render appropriate care. The remaining five had conditions of spontaneous etiology, which were beyond appropriate care by USNH Rota. If one subtracts out the five patients with conditions of spontaneous etiology, this leaves, for the study time period, an average of 1.33 patients per year who arrive in Rota who perhaps should not have. Given a beneficiary population of approximately 8,000 that transfer on an average of every three years, 1.3 patients for a transferring population of 2,667 provides a 0.05 percent chance that a beneficiary may receive an improper screen and will need to transfer back to CONUS early.

USNH Naples, over the three-year study period, also as shown in Table 1, had a total of 26 patients recommended for early return to CONUS. Four of these were transferred overseas with conditions which should have precluded their transfer, four other cases did not have enough information to make a determination of the quality of the screening, and the remaining 18 received acceptable screens or had an unavoidable spontaneous on set of their conditions.

Five of the patients returned and not considered to be screening failures were new babies born with conditions for which USNH Naples could not appropriately treat or manage. One patient, the spouse of a civilian employee, was returned due to a pregnancy complication.

Another patient was one who was in a consecutive overseas tour with the previous tour being one in an area more remote than Naples without any complications. Her conditions were closely examined prior to transfer and based on the previous history was medically approved for transfer. Finally, one patient, a young boy, had a condition, which would have ordinarily been screened out but due to the boy's young age when the transfer occurred would have never been detected. The remaining eight patients who are not considered to be screening failures had conditions of unavoidable spontaneous onset.

One of the patients considered to have had an unacceptable screen was a young boy who was transferred to the Naples area with pre-existing conditions; these conditions were screened. Despite this, the boy was allowed to transfer, as it was believed transferring him to where his biological father was would be of therapeutic benefit. This is considered a screening failure, but given the fact that the transfer occurred for therapeutic effect can only be lauded versus derided.

If one assumes that the four patients early returned from Naples did indeed have an improper screen thus adding to four who were determined to have an improper screen and should have never transferred to the local area, then these eight patients over the three-year study period averages to 2.67 patients transferred to the Naples area who should not have. If one further considers the fact that USNH Naples has an approximate beneficiary population of 16,000 transferring an average of every three years, then the average beneficiary transferring to the Naples area has a 0.1 percent chance of having a condition which should have been screened out and will subsequently transfer back to CONUS early.

Repetitive Medical Evacuations

For the study time period, USNH Naples had 36 patients, as shown in Table 2, who required a MEDEVAC two or more times for the same condition. Of these, five are military

retirees who have retired in the local area. Because of their status, they are not subject to the requirement that they be medically screened prior to transfer. Of the remaining 31 patients, only four had conditions which should have warranted them not being transferred to Naples.

A recommendation that someone not transfer to a particular duty station because of a health condition is just that—a recommendation—and because it is merely a recommendation, it may not be accepted. One of the four patients, who should not have transferred to Naples based on her condition, did receive from USNH Naples a recommendation not to transfer to the local area, yet it was the sponsor's command that overrode the recommendation based on the abilities and work ethic of the sponsor. The command was willing to accept the per diem expense of sending the patient for follow-up appointments at LRMC in order to have the service member be permanently assigned to their command. Fortunately, the sponsor was never required to travel with the family member during the MEDEVAC, so the loss of manpower to the command never became an issue. In another such case, the family member of an Army service member who had a condition, which existed prior to transfer to Naples and should have never been transferred, received a subsequent regularly scheduled transfer to another overseas duty station. The family member was not medically recommended for transferred but was authorized for transfer by higher authority. The family member has subsequently been early returned to CONUS for a transplant made necessary by the medical condition.

Based on the number of patients who should not have transferred to the Naples area and required subsequent medical evacuations to manage their care, the average beneficiary transferring to Naples has a 0.05 percent chance of transferring with a condition that will require multiple medical evacuations in order to manage it. This figure is determined by dividing four by 20 months to determine the monthly average of 0.2. This figure is subsequently multiplied by

12 for the number of months in a year to derive the yearly average. This figure is further divided by the yearly average number of beneficiaries transferring to the Naples area based on the USNH Naples beneficiary population of 16,000 transferring every three years.

During the study time period, USNH Rota had a total of 44 patients, also as shown in Table 2, who had repetitive medical evacuations for the same condition. Of this number, 22 were military retirees living in the local community. Of the remaining 22, a reason for the MEDEVAC could not be determined for five of the patients with another three with conditions that the etiology could not be determined due to unavailability of data. Finally, of the remaining 14, only one had a condition, which existed prior to transfer and should have precluded the transfer. All others had conditions of unavoidable spontaneous etiology.

The one patient who required repetitive medical evacuations and categorized as having the condition prior to transfer required the MEDEVAC for rulings in conjunction with his PEB. This was a young Seaman who transferred from boot camp. While at boot camp, he experienced difficulty passing the Physical Readiness Test (PRT) due to the condition. He received additional physical training until he was physically capable of passing the PRT and was subsequently cleared for transfer overseas. Upon arrival in the Rota area, he continued to fail the PRT and eventually recommended for a PEB, which ruled him fit to continue on active duty.

Active Duty with Medical Board Proceedings

During the study period, as shown in Table 3, USNH Naples processed 42 separate LIMDU or PEB medical board proceedings for 41 separate patients. Of the 42 boards, 25 were for orthopedic conditions that were not reviewed under the assumption that they were due to spontaneous onset and would not have existed prior to transfer to Naples. Of the remaining 17, one was an inadequate screen, and 11 were for a spontaneous onset of a condition or an insidious

condition that most likely would not have been screened out. The remaining seven boards were sailors who had psychiatric conditions in which traits had previously been exhibited but a screenable diagnosis could not be made until the condition further manifested itself. Such conditions would not likely have been screened out because none of the patients had been treated for the condition while on active duty. If the condition existed prior to enlistment or commissioning, then a waiver would have been granted or ruled acceptable for active duty service. Thus, the fact that the condition had not been treated while on active duty in combination with the waiver would have made the likelihood that the condition would have been screened out improbable.

USNH Rota processed 26 patients, also as shown in Table 3, for LIMDU or PEB medical proceedings within the time period examined. Of these, 11 were for orthopedic conditions that were not reviewed for the reasons mentioned above. Of the remaining 15, only one can be classified as having had an inappropriate screen and is the patient described in the above repetitive MEDEVAC discussion. Two other sailors who had medical boards did not have enough information available to make a determination. All others received proper screens or had conditions of spontaneous etiology.

Civilian and Contract Employees

Department of the Navy (DON) Office of Civilian Personnel Management (OCPM) Instruction 12301.1, paragraph II.C.8.a., states “all persons appointed to an overseas assignment with DON must successfully pass a medical examination.” In regards to whether a CONUS-hired civilian employee’s dependents must be screened, paragraph II.C.8.d. states “It is not mandatory that dependents have a medical examination, but dependents who have known medical problems should be made aware of the possible ramifications of an overseas tour.” This,

on the surface, contradicts the guidance provided in DoD regulation 1010.13-R Chapter 5.2. which states “The children of a civilian selectee for an overseas position shall be screened for the presence of disabilities immediately AFTER the selectee has been notified of his or her selection.” In fact, the children are screened, yet it is the prospective employee only certifying, in the form of a Statement of Suitability, that the child has no medical conditions that would be counter indicative of a tour in the area to which they are transferring. Exhibit T of OCPM Instruction 12301.1 is an example of such Statement.

As mentioned above, a civilian employee is only medically screened for the position after being selected for the position. The gaining command provides to the HRO in the area where the employee has been hired the local environmental and physical factors the employee will experience in the position. These factors are annotated on a Standard Form (SF) 78, Certificate of Medical Examination, and the selected employee undergoes a complete physical examination by an authorized physician. If there are any adverse findings as determined by standards in the FPM Supplement 339-31, then these are reported to the gaining command via HRO. The suitability of the prospective employee is verified by the local gaining MTF. If a finding of unsuitability is determined, the gaining command may then decide as to whether or not the offer of employment will be withdrawn. If not withdrawn, the employee is briefed on the adverse findings and their implications for the local overseas area in regards to available health care and may make a decision as to whether to accept transfer to the command. If the employee decides to accept the position despite the possible limitations, then he or she is required to sign a medical disengagement informing them of the implications of their decision in regards to their health care overseas.

The Screening Methodologies of the Three Services

Navy

The Navy requires each and every one of its Sailors and Marines as well as their family members, if transferring, to undergo the same formal overseas medical screening process. This process is dictated by Chief of Naval Operations instruction 1300.14C with specific instructions for medical screening promulgated by Bureau of Medicine and Surgery instruction 1300.2. Each service member and family member must complete a Medical, Dental, and Educational Suitability Screening Checklist and Worksheet (NAVMED 1300/2), Medical, Dental, and Educational Suitability Screening for Service and Family Members (NAVMED 1300/1), and a Report of Medical History (SF 93). Each member of the family is to present these forms to a military medical provider at their treatment facility. In addition, the veracity of what has been reported on these forms should be confirmed by reviewing each individual's health record, any narrative summaries of inpatient admissions, as well as reviewing the individual patient data available in the Composite Health Care System (CHCS) such as medical requirements, dispensed medications, and radiology and laboratory results. If discrepancies are noted, then the NAVMED 1300/1 should be updated.

On the NAVMED 1300/1 are shaded blocks, which, if checked, denote areas of concern. These areas of concern are to be reported to the gaining MTF for determination of whether the MTF can provide the required support or whether the condition is one that could be further exacerbated by local environmental factors to the point, which exceeds the gaining MTF's capabilities. The screening is not complete until a response is received by the gaining MTF, either positive or negative. If the response is negative, then the member may decide to accept the orders but in an unaccompanied status. Or, the member may request the assignment of a

different geographic location where the condition(s) may be appropriately monitored or treated. If positive, then, barring any other difficulties, the transfer proceeds per appropriate Navy military personnel actions.

Army

When a member of the U.S. Army is notified that they have orders pending transferring them overseas, they too receive a form of formal medical screening. Army regulation AR600-811 paragraph 4.2 specifies, “soldiers who are being reassigned overseas must be medically and dentally qualified for assignment.” Soldiers are directed to the Personnel Assignment office who provides a Department of the Army (DA) Form 4036-R, Medical and Dental Preparation for Overseas Movement worksheet. The soldier is informed that a review will occur of his or her medical and dental records during a personal interview by a medical or dental provider at the local MTF. He or she is also advised that this will also occur for any accompanying family members. In addition, the soldier is advised to resolve any and all temporary medical problems of him or herself to include those of accompanying family members. From this time, the soldier has 21 calendar days to complete the required screening for him or herself as well as those of accompanying family members.

Per AR 40-501, all “members of any component of the U.S. Army throughout their military service, whether or not on active duty” is subject to the physical profile system. The physical profile system is a six-factor profiling system. The six factors are physical capacity or stamina, upper extremities, lower extremities, hearing and ears, eyes, and psychiatric. Each of the factors has four numerical designations, which denote the functional capacity of the individual in each of the six factors. The four designations are one through four, with one indicating a functional area having a high level of medical fitness and four indicating that one or

more medical conditions or physical defects exist that are of such severity the individual's ability to perform military duty is drastically limited. This designation does not automatically denote whether or not a soldier is deployable or not or has any restrictions on their assignment, but in combination with the six factors certain profiles have further code designations which represent certain combinations of physical limitation or assignment guidance.

The screening of the medical and dental records, in combination with the physical profile, determines whether a soldier is suitable for transfer overseas. If the soldier is found to be suitable for transfer, then the appropriate personnel action required to execute the transfer occurs. If the soldier is found to be unsuitable for transfer, then the orders are deleted or deferred.

The Army does put a considerable amount of effort in ensuring that a soldier's family is healthy enough to live overseas. Within the Military Healthcare System, there exists the Exceptional Family Member Program (EFMP). EFMP was specifically established to aid service members in ensuring that the special educational and medical needs of their family members are available where the service member is stationed. This includes ensuring that the services needed are available at the duty station to which the service member is transferring. If not, then transfer of family members is not authorized.

For the Army, as directed by AR 608-75, the EFMP also acts as the screening tool for all family members regardless if there exists an EFM condition or not prior to their transfer overseas. In this regard, when a soldier is provided orders to the European Theater and desires transfer in an accompanied status, they must contact their local military medical treatment facility (MTF) and make an appointment for EFMP screening. The soldier complete Part A of the DA Form 5888-R, Family Member Deployment Screening Sheet, and all of the DA Form 7246-R, Exceptional Family Member Program (EFMP) Screening Questionnaire, prior to the

appointment. These forms as well as the family members' health records are reviewed at the appointment. If enrollment in EFMP is warranted, then the DA Form 5862-R, Army Exceptional Family Member Program Medical Summary, and DD Form 2792, Exceptional Family Member Medical and Educational Summary, are completed to include the service member or spouse signing them. Additionally, if educational requirements exist, then the school completes the DA Form 5291-R, Army Exceptional Family Member Program Education Summary. All of these forms are coded and then entered into a program called PERNET, which provides a printout that is placed in the health record. All of the aforementioned forms are then forwarded to 1st PERSCOM for processing. The European Regional Medical Command (ERMC) in Heidelberg, Germany serves as the coordinator for ensuring that the family member(s) have been appropriately medically screened and recommends the geographic areas the family member may be transferred to in theater that has the capabilities the family needs. All previously mentioned steps are completed prior to the orders having been issued to ensure that an unapproved family member is not unwittingly transferred overseas.

Once 1st PERSCOM has approved the transfer of all of the family members and a gaining command has been selected, a message is sent to the soldier's losing command authorizing the transfer. Soldiers are not always transferred to an area where an Army MTF is the primary treatment facility, as is the case with the soldiers stationed at AFSOUTH. In these cases, ERMC coordinates with the other services to ensure the required services are available and the service provider is able to handle the care coordination. While there is evidence that there has been coordination in the past between ERMC and Naples in the care provided to Army personnel and their families (11% of the Soldiers currently members of the Army Element at AFSOUTH had screening files), unfortunately, for the 5 cases where a repetitive MEDEVAC or early return has

occurred for Army families, no overseas screening paperwork could be located. Indeed, as previously mentioned, one of the family members of these soldiers who was early returned had a condition so serious that no American military treatment facility within the European Theater had the capability to treat the condition, and she was returned the same week she arrived in theater. This statement is in no way meant to disparage the quality of screening the Army does, but to elucidate how seriously overseas screening should be taken by all parties involved. The screening is meant to potentially help save lives, and in this instance, a tragedy could have occurred. Finally, while researching the Army screening process, it was discovered that the contact information ERMC has for USNH Naples is incorrect and has been out of date for over two years.

Air Force

When an active duty member of the Air Force is to transfer overseas, they are notified before their orders are promulgated. At that point, their unit orderly will coordinate the actions that must be taken prior to the orders being officially issued. When an airman goes for their medical screening, a PCS checklist is provided and the member's health record, immunizations, and general health status is checked.

This information is compared with for accuracy and general update of the PHA. As all Air Force personnel are required under an annual preventive health assessment with the results of the assessment being entered into the Air Force's Preventive Health Assessment (PHA) program. The PHA categorizes each service member into one of four categories based on the member's military skill set as dictated by Air Force Instruction (AFI) 48-123, Medical Examinations and Standards. Category 1 through 3 is considered worldwide suitable with category 1 recipients considered to have no medical limitations, category 2 has some limitations which do not require

correction in order to transfer, and category 3 has some limitations which require correction prior to transfer. Members with a category 4 determination are not considered worldwide suitable and must remain in the CONUS. Once the category 3 limitation is corrected, it is the screening medical officer that determines whether or not the airman is medically suitable for transfer.

As previously mentioned, the AFI 48-123 lists the acceptable or not acceptable medical conditions, by military skill set, which would limit the airman's ability to perform his or her job. No condition is considered based on environmental hazards or the ability of the local military MTF; if the member is worldwide suitable, then they may transfer anywhere their skill set is needed. If a condition develops while on station overseas either due to environmental exacerbations or cannot be appropriately supported by the local MTF, then a Medical Evaluation Board is conducted to determine whether the airmen can remain on station. Because those personnel declared as worldwide suitable are declared so based on the physical requirements of their particular skill set and not on local environmental conditions or the abilities of the local MTF, no coordination with other services is conducted for active duty members as they are considered worldwide suitable.

Per AFI 36-3020, Family Member Travel, family members of active duty Air Force personnel do receive a formal screening prior to their transfer overseas. Each family member has an Air Force (AF) Form 1466, Request for Family Member's Medical and Education Clearance for Travel form, completed. A screening physician reviews the AF Form 1466 in addition to the family member's health record with the family member present. A representative from the EFM program is present during the screening interview in case any EFM-type issues are raised. Once the screening is complete, the screening physician makes a recommendation of either "approved" or "delayed." This AF 1466 is forwarded to the screening clinic's Senior Medical Officer. This

medical officer reviews the screening and provides final approval authority. If there are not any medical issues, which warrant concern, approval is granted. If there are concerning issues, then the form is placed into a delayed status until additional clarifying information can be provided. Once the clarifying information is collected, the medical officer will make another determination. If there still remains for issues of concern, then the paperwork is sent to the gaining MTF to make a suitability determination. Once the suitability determination is made and is positive, then the screening paperwork is sent to the Personnel Flight who does the additional personnel actions to affect the transfer. If the determination is negative, then the member may choose to transfer in an unaccompanied status or request new orders.

Air Force personnel do transfer to AFSOUTH and there is evidence that some coordination occurs between the Air Force and the Navy in regards to the screening of Air Force personnel family members. Eighteen of 255 service members currently members of the Air Force Element at AFSOUTH had screening records located in which areas of medical concern were reviewed prior to transfer to the area. In addition, of the five years worth of overseas screening files reviewed, many other Air Force screening requests were noted in which transfer to Naples was not recommended and the service member was not a member of the Element at AFSOUTH.

Of the three services' overseas screening programs for active duty, the Air Force's is the most dissimilar to the Navy's. The Army's is also different with its physical profiling system but overall is fairly similar to the Navy's program. Overall, they work for the individual service and need not be questioned. In regards to the screening of family members, the Navy's program is most dissimilar from that of the Army and Air Force program. This is due to the fact that both the Army and the Air Force require that either EFMP either conduct the screening or a

representative of EFMP be present during the screening. The Navy's program only requires that the case be forwarded to the EFMP if it is suspected that an EFM condition exists. On the surface, it could be assumed that the Navy's method in regards to EFMP provides for the potential that a screening error could occur in that it depends upon the screener's familiarity with EFMP; an inexperienced screener may inadvertently overlook a condition that should be referred to EFMP. In fact, this is not the case as the screeners are educated in what the EFMP's mission. They are trained that it is better to be proactive than inactive, and that a board the EFMP convenes makes the decision as to whether a family member does or does not have a condition, which warrants enrollment.

Conclusions and Recommendations

Overall, USNH Naples is not being negatively affected by the differences in the three services' overseas screening programs. That being said, it is recommended that the USNH Naples Patient Administration Officer as well as Naples' Overseas Coordinator make personal contact with the Overseas Coordinators located at ERMC to ensure continued appropriate communication. This action should occur every time the USNH Patient Administration Officer or the Overseas Screener is relieved. Also, it is recommended that these same personnel make contact with the Air Force Element staff at AFSOUTH to also ensure continued communication about the importance of appropriate overseas screening.

Navy overseas medical screening is working appropriately as examined by this study. That being said, complaints by overseas MTF staff, and overseas line commands in general, about the quality of the screening that is occurring are expected to continue and will continue so long as personnel continue to transfer overseas with their families to bases that are not as fully equipped as CONUS facilities. The medical criteria that determine whether someone is suitable

for transfer to an overseas location are based on the abilities of local MTF and its staff as well as the local environmental conditions.

These criteria can neither be too stringent nor too lax; there must be a position taken on every screening where personnel have conditions that raise some concern. If the screening criteria are too tight, then commands may discover themselves with gaps in personnel manning or extending those they already onboard until an appropriate replacement arrives. If personnel are extended, then morale could be negatively affected thus possibly reducing retention. Or, further, personnel may be required to transfer overseas without their family members, thus possibly continuing to negatively affect retention. The aforementioned complaints will continue until it is realized that sailors who transfer overseas are not perfect specimens of health and the recommendation that someone not transfer overseas is just a recommendation. The "line" commands, which require the skills these sailors are trained in, sometimes will make concessions just to have a particular skill set on board. For overseas medical screening to be completely effective, the recommendation by medical personnel that someone not transfer overseas will need to no longer be a recommendation, but an absolute declaration that someone not transfer to the location requested and that declaration be upheld.

Based on the evidence of this study, overseas medical screening is performing appropriately. If personnel are transferring overseas with conditions when they should not be, then they are arriving on station and performing their jobs. If anything, this is a testament of the abilities and care of the medical personnel stationed overseas who are working diligently to ensure the health and well being of our service members and their families overseas.

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