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**Execution of MEDCOM Operational Order 15-74
(Improving Readiness through Reduction of
Unintentional Injuries), August 2016–December 2017**

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The twenty-four installation Injury Prevention (IP) Teams and their Team Leads that executed FRAGO 1 to MEDCOM OPORD 15-74 (Improving Readiness through Reduction of Unintentional Injuries) made great strides toward addressing injuries, a leading barrier to medical readiness of Soldiers and productivity of Civilian personnel. Despite challenges, they moved toward organizing local medical injury prevention subject matter experts to advise their installation or regional Community Health Promotion Council, using data as a foundation for planning and decision-making. Future iterations of OPORD execution will benefit from their dedication, building on the documented work that was done, so that consistent progress is made toward addressing this leading military health and readiness issue.

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14. ABSTRACT Injuries are a leading Army medical and readiness issue. This report summarizes activities related to U.S. Army Medical Command (MEDCOM) Operational Order (OPORD) 15-74 (Improving Readiness through Reduction of Unintentional Injuries), August 2016 to December 2017. <i>Execution:</i> Twenty-four installations participated in execution of Fragmentary Order (FRAGO) 1 to MEDCOM OPORD 15-74, establishing installation-level Injury Prevention Teams at 17 additional installations that were not part of the OPORD pilot phase. Team Lead surveys indicated that 64% of teams were led by Preventive Medicine, with an average team size of 6 members (± 4) and most teams met 3 times (± 1.4) during the 6-month execution period. Fourteen OPORD Working Group meetings were held, enabling distribution of centralized injury data summaries and monitoring tools and coordination between installations. Teams queried additional data systems and summarized all available data. <i>Products:</i> In July 2017, 16 installations (67%) produced reports summarizing data, reviewing existing programs, and providing short and long-term installation-specific injury prevention recommendations for their respective Community Health Promotion Council (CHPC) Physical Health Working Group (PHWG). Injury was introduced to CHPC or PHWG strategic plans at 8 installations. Recommendations and lessons learned were collected from Team Leads and incorporated into FRAGO 2. <i>Conclusion:</i> OPORD execution developed links between Army injury prevention partners across the medical and public health enterprise and provided injury data necessary to inform decision making, optimize use of medical and public health resources, and facilitate information exchange and access to installation-level injury data. FRAGOs reflect continuous improvement, with modifications based on participant input and lessons learned each year. Year 3 execution will begin with publication of FRAGO 2, which will maintain and enhance Army medical support for installation injury prevention.				
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of Unintentional Injuries), August 2016–December 2017**

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Public Health Report No. S.0047776-17
Execution of MEDCOM Operational Order 15-74 (Improving Readiness through
Reduction of Unintentional Injuries)
August 2016–December 2017

1 Summary

1.1 Purpose

To summarize the pilot phase and Fragmentary Order (FRAGO) 1 execution of U.S. Army Medical Command (MEDCOM) Operation Order (OPORD) 15-74 (Improving Readiness through Reduction of Unintentional Injuries).

1.2 Pilot Phase of MEDCOM OPORD 15-74 (Improving Readiness through Reduction of Unintentional Injuries)

MEDCOM OPORD 15-74 (Improving Readiness through Prevention of Unintentional Injuries) was developed to address a leading Army medical and readiness issue, and support 2017 Army Medicine Campaign objectives through operationalization of medical injury prevention (IP) support to the Community Health Promotion Councils (CHPCs), as described in Army Regulation (AR) 600-63 (Army Health Promotion) Section 5-3 (Injury Prevention) (Department of the Army Headquarters 2015). The OPORD coordinates installation-level medical input on injuries and enables data-driven installation medical IP program planning, reporting, and monitoring. The OPORD pilot phase was conducted from November 2015 through July 2016 with seven pilot sites from across the four Regional Health Commands (RHCs). Recommendations and lessons learned were collected from pilot phase participants and incorporated into a FRAGO. The most significant change, recommended by all pilot sites, was the requirement of participation from specific medical disciplines in order to create a team, rather than one point of contact, to fulfill installation IP support needs.

1.3 FRAGO 1 to MEDCOM OPORD 15-74 Execution

In October 2016, FRAGO 1 to MEDCOM OPORD 15-74 was published, in response to the recognition of a continued need for a systematic approach to establishing Army medical and public health support for injury prevention at the installation level. Twenty-four installations executed the FRAGO during Year 2, establishing Unintentional IP Teams with representation from preventive medicine, occupational medicine, physical or occupational therapy, medical (hospital) safety, health promotion, and a health analyst. The Teams reviewed available data, compiled relevant local data, and produced short and long-term installation-specific IP recommendations summarized in reports for their respective CHPC Physical Health Working Group in July 2017. Recommendations and lessons learned were collected from Team Leads and incorporated into FRAGO 2 to MEDCOM OPORD 15-74, which outlines Year 3 (2018) execution of the OPORD.

1.4 Conclusion

From August 2016 through December 2017, lessons learned from the pilot phase of MEDCOM OPORD 15-74 were summarized, incorporated into a FRAGO, and executed by 24 installations during Year 2. The OPORD provided data necessary for informed decision making and developed links between Army IP partners across the medical and public health enterprise, enabling optimized use of medical and public health resources, information exchange, and access to data on installation-level injuries. FRAGOs reflect continuous improvement, with modifications based on participant input and lessons learned from each year. Year 3 execution will begin with publication

of FRAGO 2, which will continue a systematic approach to establishing and maintaining injury prevention support at Army installations.

2 References

See Appendix A for a list of references used within this report.

3 Authority

The U.S. Army Public Health Center (APHC) supports the 2017 Army Medicine Campaign Plan (AMCP) Readiness and Health objectives to (1) Optimize Soldier protection in all environments and (2) Improve healthy behaviors, communities, and environments (U.S. Army Medical Command 2016). The OPORD and FRAGO contribute to these objectives through operationalization of AR 600-63 (Health Promotion) Section 5-3 (Injury Prevention), which consists of support to Community Health Promotion Councils and unit commanders through a review of available injury data and coordinated, data-driven installation IP program planning and monitoring.

4 Background

With a growing recognition of the contribution of injuries to Army health and readiness, MEDCOM OPORD 15-74 development was initiated in 2013 as part of the Army Medicine 2020 Campaign Injury and Violence Free Living Program (Canham-Chervak et al. 2017). To address a problem as large and complex as injuries, a systematic approach was needed. The OPORD utilizes the public health approach to IP (Jones et al. 2010), incorporating activities related to surveillance, program evaluation, and dissemination of IP knowledge. MEDCOM staffing and external reviews were completed and the OPORD was published in September 2015. A pilot phase followed from November 2015 through June 2016, with participation from seven installations from across the four RHCs. The OPORD development and pilot phase, March 2013–July 2016, are described in detail in a prior report (Canham-Chervak et al. 2017).

The intent of both the OPORD and FRAGO 1 to MEDCOM OPORD 15-74 is to execute a systematic, coordinated approach to IP, aligning MEDCOM IP resources in support of CHPCs and unit commanders, as outlined in AR 600-63 (Army Health Promotion) Section 5-3 (Injury Prevention). The OPORD and FRAGO also align with the 44th Army Surgeon General's Campaign Plan, as noted in the Authority section above.

5 Execution

5.1 Pilot Phase Summary

The OPORD pilot phase was conducted over a 9-month period, November 2015 through July 2016. Development of the OPORD has been described previously (Canham-Chervak et al. 2016). This section provides a summary of pilot phase activities and results.

Each RHC identified pilot sites in November and December 2015, as specified in MEDCOM OPORD 15-74. With the exception of RHC-Pacific, each region identified two installations to serve as pilot sites. The pilot sites were as follows: Fort Lee (RHC-Atlantic), Fort Rucker (RHC-Atlantic), Fort Carson (RHC-Central), Fort Leonard Wood (RHC-Central), U.S. Army Garrison (USAG) Rheinland-Pfalz (RHC-Europe), USAG Bavaria (RHC-Europe), and U.S. Army Region (USAR) Hawaii (RHC-Pacific).

An installation IP Lead was appointed at each pilot site, also as specified in the OPORD. The Lead was responsible for completion of the following tasks:

- Identification of MEDCOM IP partners at the installation with subject matter experts (SMEs) in Active Duty Army musculoskeletal injuries, Civilian injuries, and safety.
- Coordination with appropriate offices to schedule CHPC Physical Working Group (PWG) briefing(s) summarizing existing installation-level injury data for Active Duty Army injury-related medical encounters, Civilian injuries, and Safety reports.
- Production of a baseline annual installation report containing interpretations of this data, installation prevention priorities, and descriptions of existing programs and evaluation plans.
- Provision of input and recommendations for a FRAGO describing full execution at Army installations with a CHPC.

APHC IP Division was tasked to plan and execute monthly meetings from November 2015 through July 2016. Meetings were held for each RHC, and included the RHC representative and all installation IP Team Leads within the RHC. The meetings provided guidance regarding OPORD execution, assistance with interpretation of installation-specific Active Duty and Civilian data summaries provided by APHC, examples and use of unit-level data available in the Medical Readiness Assessment Tool (MRAT), results of, review of the report template, and opportunities to discuss emerging questions and concerns. APHC IP Division also pursued *ad hoc* analyses of medical encounter data requested by the Leads.

During the last two meetings, each RHC and its installation Leads contributed input to an assessment of the strengths, weaknesses, opportunities, and threats (SWOT) related to 1) the pilot phase OPORD process and tasks, and 2) utility of available data and data monitoring tools. Pilot sites suggested retaining the required CHPC PWG coordination, APHC-lead monthly coordination meetings, APHC installation data summaries, availability of *ad hoc* installation injury analyses in partnership with APHC, MRAT training, and the annual report requirement. All pilot sites recommended appointment of specific team members to fulfill SME needs. Challenges for the installation IP Teams included vacant Health Promotion Officer Positions, CHPCs without a PWG, limited or no participation from installation IP stakeholders outside of MEDCOM without a formal tasking, and limited staffing or command support. Appendix B summarizes all comments received.

Most importantly, as recommended by all pilot sites, FRAGO 1 to MEDCOM OPORD 15-74 required representation on the installation IP Teams from each of the following medical specialties:

- Preventive medicine physician or public health nurse.
- Occupational medicine physician or occupational health nurse.
- Physical or Occupational therapy.
- Safety.
- Health promotion.
- Health analyst/Health information systems specialist.

Also, as recommended by pilot sites, it retained the review of data, MRAT training, and the annual report requirement. FRAGO 1 was reviewed by pilot site representatives and completed MEDCOM review and staffing prior to publication.

5.2 FRAGO 1 Execution

FRAGO 1 to MEDCOM OPORD 15-74 was published on 6 October 2016. As outlined in FRAGO 1, key tasks were as follows:

- Coordinate installation medical IP support.
- Standardize the approach to unintentional injury reporting and prevention planning.
- Provide data to inform decision-making and routine review of a leading medical readiness issue.
- Establish links across the public health enterprise to optimize medical personnel resources and skills.

Responsibilities for the APHC, RHCs, and Military Treatment Facilities (MTFs) were as follows: APHC provided guidance and oversight of FRAGO execution, monthly and quarterly installation injury metrics, and annual summaries of installation-level Active Duty, Civilian workers' compensation, and safety data from centralized data sources. RHCs provided oversight, guidance, and input as needed. Execution was limited to installations with a CHPC and CHPC facilitator (Appendix C). At these installations, MTFs were responsible for assembling an installation IP Team with representation from each of the following medical specialties:

- Preventive medicine.
- Occupational medicine.
- Physical or Occupational therapy.
- Safety.
- Health promotion.
- Health analyst/Health information systems specialist.

The IP Team Lead was responsible for the following:

- Maintaining contact and coordinating with RHC and APHC IP Division including attending OPORD Working Group meetings.
- Assisting with identification of medical IP SMEs on Active Duty Army musculoskeletal injury-related medical encounters, Army Civilian injuries, and Safety injury reports to serve on the installation IP Team.
- Assessing installation data provided by APHC and leading efforts to obtain and integrate installation data from the MRAT.
- Scheduling CHPC PWG briefing(s).
- Producing a report for the CHPC PWG summarizing installation injury data, IP initiatives, and next steps based on the data.

Twenty-four installations were identified to execute FRAGO 1. OPORD Working Group meetings began in February 2017. Of the seven installations that participated in the pilot phase of OPORD 15-74, all seven installations participated in FRAGO 1 execution (i.e., Year 2) as well. Given the additional year of execution, data for these sites are presented separately and are hereafter referred to as Pilot sites. The 17 installations in their first year of execution with participation in FRAGO 1 are hereafter referred to as Year 2 sites. Table 1 lists all installations.

Table 1. Installations and Regions Participating in Year 2: Execution of FRAGO 1 to MEDCOM OPORD 15-74

RHC-Atlantic (n=9)	RHC-Central (n=8)	RHC-Europe (n=3)	RHC-Pacific (n=4)
Fort Benning, GA	Fort Bliss, TX	U.S. Army Garrison (USAG) Rheinland-Pfalz*	U.S. Army Region (USAR) Hawaii*
Fort Campbell, KY	Fort Carson, CO*	USAG Bavaria*	Fort Wainwright, AK
Fort Gordon, GA	Fort Hood, TX	USAG Stuttgart	Camp Zama, Japan
Fort Knox, KY	Fort Huachuca, AZ		Korea-Area 2 (Yongsan) & Korea-Area 3 (Camp Humphreys)
Fort Lee, VA*	Fort Leonard Wood, MO*		
Fort Meade, MD	Fort Leavenworth, KS		
Fort Rucker, AL*	Fort Riley, KS		
Fort Stewart, GA	Joint Base San Antonio		
Joint Base Myer-Henderson Hall			

Note:

*Pilot phase participant.

5.2.1 FRAGO coordination and meetings

APHC IP Division led 14 meetings with OPORD Working Groups between January 2017 and June 2017. To facilitate group discussion and manage varying time zones, meetings were typically held separately by RHC. The meetings provided the opportunity for discussion and collaboration between installation IP Teams. Team Leads reported on progress, challenges, and strategies for successful completion of OPORD tasks. APHC IP Division and RHC representatives provided further guidance and ongoing consultation. Appendix D displays meeting details (dates/times and agenda topics). In addition, information briefings were provided to key stakeholders and stakeholder groups in preventive medicine, public health nursing, and health promotion throughout this period. Appendix D also lists these briefings.

5.2.2 Team Lead Survey

Surveys of installation IP Team Leads were used to collect information on the following elements of the OPORD process:

- Existence and activities of the installation Community Health Promotion Council.
- Existence and activities of a PWG or other PWG-like workgroup(s).
- IP Team Members and their area(s) of expertise.
- Team activities and data utilization.
- Existing IP programs at the installation.

The surveys were administered electronically using the Verint Enterprise Feedback Management System™ at two points in time: near the start of Year 2 (March/April 2017) and again at the end of Year 2 (September 2017). Appendices E and F presents the questions and response options on each survey.

Among the 24 installations that executed FRAGO 1 to MEDCOM OPORD 15-74, 75% (n=18) completed the initial survey and 92% (n=22) completed a follow-up survey at the conclusion of Year 2 (September 2017). Seventy-one percent (n=5) of the pilot sites responded to both the initial and follow-up surveys, and of 17 installations that participated in Year 2 only, 71% (n=12) completed both the initial and follow-up surveys. In this report, results from the follow-up survey only and from those who completed both an initial and follow-up survey are reported.

5.2.3 Installation-level infrastructure to support OPORD execution

A viable CHPC infrastructure and support such as a CHPC Facilitator are essential elements for success of the OPORD process. Among the 22 installations with a follow-up Team Lead survey, 20 reported having a functioning CHPC during execution of FRAGO 1 (Table 2). Most CHPCs (85%) met quarterly. All installations with a CHPC also had a PWG in place and 65% of PWGs had monthly meetings. Nearly all (95%) also had a CHPC Facilitator or Health Promotion Officer during the course of FRAGO 1 execution. Approximately half (53%) of CHPC Facilitators had been at their installation more than 12 months and 61% of CHPC Facilitators participated on the installation IP Team.

Paragraph 6, Products and Tools summarizes additional follow-up Team Lead survey results.

Table 2. CHPC Activity, Structure, and Support during Year 2 Execution of MEDCOM OPORD 15-74*

		Pilot sites with CHPC (n=5)	Year 2 sites with CHPC* (n=15)	Total with CHPC (n=20)
Characteristic		n (%)	n (%)	n (%)
Frequency of CHPC meetings	Quarterly	5 (0)	12 (80)	17 (85)
	Other	0 (0)	3 (20)	3 (15)
PWG in place	Yes	5 (0)	15 (100)	20 (100)
	No	0 (0)	0 (0)	0 (0)
Frequency of PWG meetings	Monthly	4 (80)	9 (60)	13 (65)
	Quarterly	0 (0)	2 (13)	2 (10)
	Other	1 (20)	4 (27)	5 (25)
Had CHPC Facilitator	Yes	5 (100)	14 (93)	19 (95)
	No	0 (0)	1 (7)	1 (5)
How long CHPC Facilitator has been at installation	1-6 months	1 (25)	3 (27)	4 (27)
	6-12 months	1 (25)	2 (18)	3 (20)
	More than 12 months	2 (50)	6 (54)	8 (53)
	Missing/Unknown	1 (-)	4 (-)	5 (-)

CHPC Facilitator part of installation Injury Prevention Team	Yes	4 (80)	7 (53)	11 (61)
	No	1 (20)	6 (46)	7 (39)
	Missing	0 (-)	2 (-)	2 (-)

Note: *Data on installations with a follow-up survey that reported having a functional installation or regional CHPC (n=20).

5.2.4 Assessment of injury rate change

Interrupted time series (ITS) analysis was conducted to assess effects of OPORD participation on injury rates. It has been suggested that it is beneficial to use ITS for public health intervention research (Biglan et al. 2000), especially in conjunction with control charts (Fretheim and Tomic 2015). The focus was on Pilot sites, given that the first year of OPORD execution primarily involves team formation and data review, and typically does not incorporate implementation of interventions, policies, programs, or initiatives that would begin to influence injury rates. Since they were in their second year of OPORD execution, pilot sites had the opportunity to move beyond this first year and begin program implementation.

The implementation period, or the period during which action to reduce injury was expected, was after the start of the pilot phase and through FRAGO 1 execution, or January 2016 to June 2017. Rates and trends from this period were compared to the same period of time (18 months) prior to the pilot phase, or July 2014 to December 2015. Statistical differences in injury rates before the pilot phase and after pilot phase at each Pilot site were determined using the rate comparison tool in Open Epi (www.openepi.com). The slope of linear trends in injury rates before and after the pilot phase for each Pilot site were calculated using Minitab 17.1.0.

Appendix G provides analysis results for each Pilot site. Five of seven (71%) pilot sites had promising changes in injury trends (i.e., decreasing rates) following participation, though only one of seven (15%) had an injury rate at the end of the evaluation period (June 2017) that was lower than the injury rate at the start of pilot phase participation (December 2015). However, affecting rates of public health outcomes is complicated and is likely to require multiple interventions (Sleet and Moffett 2009). As installation teams participate in subsequent iterations of the OPORD and continue to implement interventions and monitor effects, it is more likely that they will begin to see injury rate reductions. More data is typically needed to observe effects; prior assessments of effects of IP policies have used 10–12 year evaluation periods ((Lipscomb et al. 2003)–10 years, (Crofts et al. 2016, Bernal et al. 2017)–12 years).

Also of note, in initial stages of monitoring, it is possible that injury rates may increase due to increased reporting resulting from OPORD participation and increased awareness among leadership and IP personnel (Craib et al. 2007). Some injury interventions addressing improvements to access to care will result in injury rate increases; therefore, monitoring of additional outcomes may be necessary. Seasonal trends in military injury rates are also expected, independent of interventions, with higher rates common in the summer and lower rates frequently observed in winter months (Jones et al. 2008). Furthermore, we have no data about what interventions are implemented at nonparticipating installations, so conclusions cannot be drawn about trends in injury rates at those installations.

Future reports will continue to assess trends at multiple installations and will benefit from an additional years of data.

6 Products and Tools

6.1 Formal Link across the Public Health Enterprise

Each level of public health (Senior Enterprise, Regional, and Installation) contributed to FRAGO 1 execution. The APHC (Senior Enterprise level) plans and leads OPORD Working Group meetings, provides summaries of installation injury data available from existing centralized data systems for Army Active Duty and Civilian personnel, and conducts *ad hoc* analyses of installation data upon request from Installation IP Team Leads. OTSG Innovative Clinical Analytics (Senior Enterprise level) provides MRAT training and consultation to facilitate the integration of MRAT data into annual IP reports. RHC representatives participate in OPORD Working Group meetings, along with their Installation IP Team Leads. Installation IP Teams serve as the link to the CHPCs, unit commanders, and other installation leadership who can affect change through implementation of injury prevention programs and policies. The communication established through OPORD Working Group meetings establishes a routine link across the Army Public Health Enterprise, from Senior to Installation level.

6.2 Installation Injury Prevention (IP) Teams

Installation IP Teams serve as the link to the CHPCs and execute the majority of tasks outlined in MEDCOM OPORD 15-74. As described previously, they are designed to have a variety of disciplines represented, and thus a variety of expertise in elements of IP, from interpretation of population-based data to program development to evaluation. Team Lead follow-up surveys indicated that 64% of installation IP Teams were led by Preventive Medicine personnel (67% of pilot installations, 63% of Year 2 installations), followed by Public Health Nursing and Physical Therapy (Table 3). On average, IP Teams consisted of six team members (± 4). The teams achieved representation across a variety of disciplines, with Public Health Nursing, Preventive Medicine, and Safety being the most common disciplines represented (Table 3).

On the Team Lead survey, it was reported that most teams met an average of three times in the 6-month FRAGO 1 implementation period. Among the pilot phase installations, the average number of team meetings in 6 months was 3 ± 1.6 meetings (range: 1–5). Among the Year 2 installations, the average number of team meetings in 6 months was 3 ± 1.2 meetings (range: 2–5). In communications with their teams, email was used by 70% ($n=12$) of Team Leads, though often in combination with meetings or phone calls. It was reported that, given the breadth of team membership, meetings were not always possible. Also, it was expressed that personal visits often facilitated buy-in and participation.

Table 3. Installation Injury Prevention (IP) Team Characteristics*

Characteristic		Pilot sites with survey (n=6)	Year 2 sites with survey (n=16)	Total with survey (n=22)
		n (%)	n (%)	n (%)
Installation IP Team Lead discipline	Preventive Medicine	4 (67)	10 (63)	14 (64)
	Public Health Nursing	1 (17)	2 (13)	3 (14)
	Physical Therapy	1 (17)	2 (13)	2 (9)
	Other**	0 (0)	2 (13)	3 (14)
Team Member disciplines	Public Health Nursing	4 (67)	13 (81)	17 (77)
	Preventive Medicine	3 (50)	12 (75)	15 (68)
	Safety	4 (67)	9 (56)	13 (59)
	Occupation Health Nurse or Physician	3 (50)	8 (50)	11 (50)
	Health Promotion	4 (67)	7 (44)	11 (50)
	Nutritionist/Dietitian	2 (33)	4 (25)	6 (27)
	Athletic Trainer/Fitness Specialist	2 (33)	3 (19)	5 (23)
	Health analyst/health information specialist	1 (17)	2 (13)	3 (14)
	Physical Therapy	4 (67)	13 (8)	2 (12)
	Occupational Therapy	0 (0)	2 (13)	2 (9)
	Other medical	2 (33)	3 (29)	5 (23)
	Other non-medical	2 (33)	2 (13)	4 (18)

Notes:

* Data on installations with a follow-up survey (n=22).

**Other disciplines included: Chief Nutrition Care, Director of Army Wellness Center

6.3 CHPC Support

Operationalizing medical IP responsibilities to the CHPCs, as described in Army Regulation 600-63 (Army Health Promotion), is a primary goal of MEDCOM OPORD 15-74. In the OPORD, installation IP Teams were tasked to collect and review installation injury data, and communicate their interpretation and recommendations in a report and briefing to the CHPC PWG. Through this process, the installation IP Teams provided data to inform decision-making and routine review of injuries, a leading medical readiness issue.

6.3.1 Briefings to the CHPC PWG

The Team Lead survey collected information on CHPC reporting. On the initial survey during FRAGO 1 execution, the following question was asked: "Within the last 12 months, have you or the IP Team provided a briefing on injuries to the CHPC or PWG?" Of the pilot sites, 80% (n=4) had provided a briefing in the past 12 months, consistent with expectations for the pilot phase (Table 4). Among Year 2 installations who were just beginning execution, 50% (n=6) reported briefing the

CHPC or PWG in the prior year, indicating that some CHPCs were obtaining medical input on injuries at their installation prior to OPORD execution. On the follow-up survey, Team Leads were asked “Within the last 6 months, have you or the IP Team provided a briefing on injuries to the CHPC?” and “Within the last 6 months, have you or the IP Team provided a briefing on injuries to the Physical Health Working Group?”. For those installations without a currently active CHPC, Team Leads could report if the IP Team had provided a briefing to an alternate group that was currently coordinating health and wellness activities across the installation. Among pilot sites, 100% (n=5) had briefed their CHPC, alternate CHPC, or PWG again during FRAGO 1 execution and 58% (n=8) of Year 2 installations had briefed their CHPC, alternate CHPC, or PWG (Table 4, follow-up survey results). IP teams presented to their CHPC, alternate CHPC, or PWG, on average 2.5 times (± 1.7) during the 6-month execution period.

Each CHPC is tasked to have a strategic plan based on installation health needs identified through systematic data collection (Courie et al. 2014). On the follow-up survey, Team Leads were asked if injury had been introduced to the strategic plan of the CHPC or PWG during the 6 months of OPORD execution. Two pilot sites and six Year 2 sites reported that IP had been added. Both pilot installations that added injury reported that the plan was established based on data provided by the Installation IP Team. Four out of the six (67%) Year 2 installations that added IP to CHPC or PWG action plans reported that population-based data provided by the Installation IP Team was used to establish IP priorities.

Regarding use of data in IP program evaluations, there were slight increases in collection of metrics among pilot sites, with all locations that completed the follow-up survey reporting that metrics were collected for some IP programs, but not all. Among Year 2 sites, 9 out of 12 (75%) were collecting metrics on injury programs at the end of Year 2 execution, compared to 2 out of 12 (17%) reporting metric collection on the initial survey ($p < 0.001$).

Table 4. Process Metrics for Pilot and Year 2 Sites as Reported on Team Lead Surveys*

		Pilot site with both surveys (n=5)		Year 2 site with both surveys (n=12)	
		Initial survey n (%)	Follow-up survey n (%)	Initial survey n (%)	Follow-up survey n (%)
Briefing to CHPC, Alternate CHPC, or CHPC Physical Work Group	Yes	4 (80)	5 (100)	6 (50)	8 (66)
	No	1 (20)	0 (0)	6 (50)	4 (33)
	Missing	-	-	-	-
Injury introduced to strategic plan of CHPC or PWG in past 6 months	Yes	n/a	2 (50)	n/a	6 (54)
	No	n/a	2 (50)	n/a	5 (45)
	I do not know	n/a	0 (0)	n/a	1 (9)
	Missing	n/a	1	n/a	0
CHPC or PWG injury priorities in Strategic Plan established using data	Yes	n/a	2 (67)	n/a	4 (67)
	No	n/a	0 (0)	n/a	0 (0)
	I was not involved	n/a	1 (33)	n/a	2 (33)
	Missing	n/a	2	n/a	6

		Pilot site with both surveys (n=5)		Year 2 site with both surveys (n=12)	
		Initial survey n (%)	Follow-up survey n (%)	Initial survey n (%)	Follow-up survey n (%)
Variable	Variable level				
Number of injury prevention programs with metrics in place	1	2 (50)	3 (60)	1 (50)	4 (44)
	2	2 (50)	2 (40)	1 (50)	2 (22)
	3 or more	0 (0)	0 (0)	0 (0)	3 (33)
	Missing	1	--	10	3

Note: *Data for sites that completed both the initial and follow-up surveys (pilot sites: n=5, 71%; Year 2 sites: n=12, 71%).

6.3.2 Annual IP Report for CHPC PWG

Of the installations that had been pilot sites, 71% (n=5) produced a 2016 Annual Injury Report and 65% (n=11) of Year 2 installations produced a 2016 Annual Injury Report. Installations did not complete a report for a variety of reasons, including deployment of the Team Lead, Team Lead transition, and Team Lead medical leave. The intent of the annual IP Reports was to document the current environment (installation mission and population, CHPC status) and IP Team Members, review available data, outline existing IP programs, and provide long- and short-term recommendations based on the data review. In times of transition, the report serves as documentation of the status of the Team's work, so progress and established partnerships are not lost. Efforts will be made during Year 3 to ensure report completion.

6.3.2.1 Review of installation injury data

On the follow-up survey at the conclusion of Year 2 (September 2017), an average of 2 ± 2 personnel from pilot installations had been trained on MRAT (range: 0-6 personnel) and an average of 2 ± 1.5 personnel (range: 0-4 personnel) were trained on MRAT at Year 2 installations. All annual reports provided a review of data. Data from the MRAT was reported in 73% of installation annual reports, Force Risk Reduction (FR2) was reported in 53%, and Public Health 360 (PH360) was reported in 40%. Some installations reported data obtained from installation data sources, for example Installation Injury Compensation Specialist reports, hospital or unit safety reports, and TRICARE Composite Health Care System reports.

6.3.2.2 Inventory of installation IP initiatives

The annual installation IP reports captured brief descriptions of existing IP interventions at each installation, recording the IP goal, location, population, program description, evaluation methods, current status, and next steps for each intervention. Forty-seven total programs were reported; metrics were tracked for 55%. Programs were varied and included both primary and secondary prevention efforts, i.e., initiatives that aimed to prevent injury before it occurred and those that aimed to lessen the impact of injury after its occurrence. Examples included educational interventions to train incoming company commanders, rehabilitation programs to reduce Soldier return to duty time, and civilian programs with worksite visits and ergonomic assessments. Appendix K contains a complete list of programs by installation.

6.4 Installation Injury Data Summaries

A key task of MEDCOM OPORD 15-74 was to standardize the approach to unintentional injury reporting and prevention planning. One step toward achieving this goal was to provide standardized installation injury data summaries containing data available from existing centralized data systems for Active Duty and Civilian staff assigned to or working on an Army installation or Joint Base (Appendices H, I, J). APHC IP Division, with assistance from Defense Health Agency Army Satellite staff, prepared the data slides. The data summaries provide a population-level “injury picture” for each installation. The APHC IP Division prepared summaries for distribution to the installation IP Teams, CHPC, and others (upon request) at each installation. The data were intended to be used together and alongside other data available at the installation level. Interpreting this data provides insights about injuries at each installation (e.g., trends, causes) and assists leadership with prioritizing IP efforts to focus scarce resources on the leading causes, occupations, age groups, and/or workplaces. Army data were also provided for comparison. Summaries included Active Duty injury medical encounter data, Civilian workers’ compensation data, and safety report data.

6.4.1 Active Duty Army injury medical encounters

Appendix H provides an example of an installation summary of Active Duty Army injury medical encounters. Installation Active Duty injury summaries combined data displayed in the Public Health 360 (U.S. Army Public Health Center 2016a) and Strategic Management System (SMS) injury dashboards (Department of the Army 2015). Charts specific to each installation included:

- Relative burden of injury and diseases, past calendar year.
- Injury rates and training-related lower extremity overuse injury rates, past 7 years.
- Injury rates by age and year, past 7 years.
- Injury rates by gender and age, past calendar year.
- Top five causes of unintentional injuries.
- Quarterly injury rates with control limits.

To characterize the relative burden of injury and diseases, conditions were grouped into diagnostic categories adapted from the World Health Organization Global Burden of Disease Study (Armed Forces Health Surveillance Center 2014) and consistent with Army surveillance reporting (Marshall et al. 2013, U.S. Army Public Health Center 2014, U.S. Army Public Health Center 2016b). Methods for categorizing noninjury related diagnostic categories mirrored that used in AFHSB’s April 2014 Medical Surveillance Monthly Report, which summarized the Department of Defense annual morbidity burden (Armed Forces Health Surveillance Center 2014). Injury rate data were reported using the definition described in Section 5.2.1. Causes of unintentional injury were identified from International Classification of Disease external cause of injury codes entered during Soldiers’ outpatient visits for each incident injury.

6.4.2 Civilian workers’ compensation

Appendix I provides an example of an installation summary of data obtained from Civilian workers’ compensation records. Installation Civilian injury summaries included the following:

- Overview of the current Civilian population.
- Rates of Civilian lost time each fiscal quarter, past 5 years.
- Top causes of Civilian lost time, previous fiscal year.
- Top occupations with Civilian lost time, previous fiscal year.
- Costs related to Civilian compensation claims, previous calendar year.

Overview and lost time data were obtained from the Force Risk Reduction System (Office of the Secretary of Defense Personnel and Readiness 2016). The number of lost-time cases and lost days were determined from workers' compensation claims submitted via the Electronic Data Interchange and the Safety First Event Reporting (SaFER) system and from Continuation of Pay and Leave without Pay data from the Defense Finance Accounting System pay files. Monetary lost time and medical treatment costs associated with claims were obtained from the Defense Injury and Unemployment Compensation System (DIUCS) (Department of Defense 2016). DIUCS reports all claims for injury unemployment compensation and the total dollar amount paid out for each claim (sometimes \$0, if the claim was denied or no payments have been made yet). Accruing claim costs are assigned to the original claim date, and payments are made only after the claim is submitted, approved, and processed, so a lag in data is probable.

6.4.3 Army accident reports

Appendix J provides an example of installation safety report data. Accidents involving Army Civilians and Active Duty Army Soldiers were reported to the Army Safety/Combat Readiness Center (AS/CRC) as described in DA Pam 385-40 (Department of the Army 2009) and entered into the AS/CRC Risk Management Information System (RMIS). RMIS is queried for ground accidents occurring at that installation (aviation-related incidents are not included in the summary), and data summaries were produced for the following (most recent calendar year):

- Active Duty Army accident and nonfatal injury counts and rates by age and gender.
- Active Duty Army accident and nonfatal injury counts by accident classification, duty status, accident type, and activity.
- Fatal injury counts by age, gender, accident classification, duty status, accident type, and activity.
- Cost information by accident classification, duty status, and accident type.

6.5 Control Charts for Monitoring of Installation Injuries

Contributing to the OPORD key tasks of standardizing the approach to unintentional injury reporting and providing data to inform decision-making, an additional data tool, statistical process control charts, were developed. Statistical process control (SPC) charts for monitoring injury rates provide a unique visualization and strategic management tool for leadership and installation IP teams. The charts provide “signals” of statistically significant departures from baseline rates, facilitating monitoring of trends and progress toward injury reduction goals. SPC charts identify the negative implications (i.e., increasing injury rates) of recent changes such as new training requirements, weather-related factors, and shifts in Soldier demographics. Increasing injury rates can also represent positive effects of an intervention to improve access to injury medical care. Statistically significant decreases identified in SPC charts can provide leaders and IP stakeholders with important information about the effectiveness of prior and ongoing IP strategies. This information becomes an integral part of an ongoing continuous improvement feedback loop as new IP strategies are applied.

Control charts are maintained for each Army installation with an Active Duty population greater than 500 Soldiers and are displayed in the Army's SMS (<https://www.sms.army.mil>). Details of the development, methodology, and use of these charts are described elsewhere (Canham-Chervak et al. 2017; Schuh et al. 2017). During FRAGO 1 execution, accelerated reporting of injury rate data was implemented in response to requests for data that were closer to real-time. Monthly data are now reported with only a 3-month delay, the minimum lag required based on data source limitations (Defense Medical Surveillance System); quarterly data subsequently experience a one-quarter lag.

A limitation of this new methodology is that injury counts (and therefore injury rates) may not be entirely complete at the time of initial reporting because inpatient and purchased care encounters are known to take longer to enter the system than outpatient treatment received at military treatment facilities. In spite of this limitation, this methodology offers an improvement over the previous reporting lag time of 6 months (two quarters).

7 Conclusions and Recommendations

From August 2016 to December 2017, 24 installations participated in execution of FRAGO 1 to MEDCOM OPORD 15-74, establishing installation-level IP Teams at 17 additional installations that were not part of the OPORD pilot phase. Team Lead surveys indicated that 64% of teams were led by Preventive Medicine, with an average team size of six members (± 4) and most teams met three times (± 1.4) during the 6-month execution period. Fourteen OPORD Working Group meetings were held, enabling distribution of centralized injury data summaries and monitoring tools and coordination between installations. Teams queried additional data systems such as the MRAT. Sixteen installations (67%) produced reports summarizing the data, existing programs, and providing short and long-term installation-specific IP recommendations for their respective CHPC Physical Health Working Group. Twelve IP Teams (50%; or 71% of installations completing the follow-up survey) also reported briefing their CHPC or PWG. Injury was introduced to CHPC or PWG strategic plans at eight installations during the 6-month FRAGO 1 execution period. Recommendations and lessons learned were collected from Team Leads and incorporated into FRAGO 2, which outlines Year 3 execution of the OPORD.

FRAGO 1 to MEDCOM OPORD 15-74 continued the development of links between IP partners across the Army medical and public health enterprise. Data necessary to support informed IP planning were provided as part of OPORD activities, enabling optimized use of medical resources, information exchange, and standardized information. Metrics and tools developed during the pilot phase were maintained and enhanced for installation injury data monitoring. Installation IP Team strength was increased, with required representation from multiple medical specialties with expertise in elements of IP, from population-based data interpretation to program development to evaluation.

FRAGOs to MEDCOM OPORD 15-74 reflect continuous improvement, with modifications based on participant input and lessons learned each year. Year 3 will build on progress made thus far by involving additional installations, continuing to improve existing monitoring tools and installation access to data, and building partnerships with assets such as the Army Wellness Centers to facilitate IP program development at the installation level. Year 3 execution will begin with publication of FRAGO 2 in February 2018.

8 Point of Contact

The APHC IP Division is the point of contact for this project, e-mail usarmy.apg.medcom-aphc.mbx.injuryprevention@mail.mil, or phone number 410-436-4655, DSN 584-4655. Specific questions may be directed to authors listed at the front of this report.

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Appendix A

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Appendix B

Pilot Phase Strengths, Weaknesses, Opportunities, and Threats (SWOT) Assessment Summary

Table B-1. OPORD Process and Tasks

<p style="text-align: center;">Strengths</p> <ul style="list-style-type: none"> • APHC Lead provides visibility at strategic level and standardization (communication, process, data) across MEDCOM. • Having RHC representative enabled RHC understanding of installation challenges. • Monthly meeting interval during pilot phase helped provide direction and necessary feedback; other phases may be different. • Meetings facilitated discussions offline between installation leads. • Eight months for report development was enough time. • At some installations, good occupational health contacts were found and useful local data obtained. • Good support from CHPCs and PWGs at each installation. • Annual report was worthwhile to provide CHPC and PWG visibility. Sharing of annual reports could inspire new reporting and analyses. 	<p style="text-align: center;">Weaknesses</p> <ul style="list-style-type: none"> • Limited public health resources/expertise at some installations. Could not do more than an annual report due to staffing. • Difficult to get participation from installation staff that were not under the same command and/or tasked to participate. • OPORD should specify the types of expertise needed for the team (physical and occupational therapy, preventive and occupational medicine, safety, health promotion) and mandate participation. Best installation lead is not clear, but need multiple participants from different offices. Requiring a team would help with identification of installation expertise. • RHC lead in Clinical Operations would be effective; they could delegate down. • Tasker from RHC is needed, but was not done in all Regions. • RHC likely not aware of local installation nonMEDCOM resources. • Multi-disciplinary RHC support team, like a process action team, might be beneficial but may not be feasible due to RHC resources. • Objectives could not be accomplished if CHPC and/or PWG were not operational.
<p style="text-align: center;">Opportunities</p> <ul style="list-style-type: none"> • Provides model for communication across the Public Health Enterprise. • Partnerships and coordination with others at installation involved in aspects of injury prevention, including safety officers. • As per AR 600-63, CHPC PWG is tasked with overseeing injury prevention activities. • Report facilitates annual review of a leading readiness issue. • Creation of CHPC action plan also helps. • Health promotion officer assisted with PWG and CHPC coordination/scheduling. There were no issues obtaining this assistance. • Partnership with the Physical Performance Service Line. 	<p style="text-align: center;">Threats</p> <ul style="list-style-type: none"> • Integration with Forces Command (FORSCOM) is needed. Coming from MEDCOM is not enough. • Command may not support level of participation needed for participation of subject matter experts and effective OPORD execution. • Competing responsibilities for team members. • Competing priorities of CHPC PWG. • No official PWG injury sub-group. • Continued funding of installation health promotion officer, an integral member of the team. • RHCs may lack personnel or expertise needed to support installations. • Potential conflict of interest between patient care priorities of RHC. • Overseas hiring process is extremely limited.

Legend: APHC=U.S. Army Public Health Center; CHPC=Community Health Promotion Council;
MEDCOM=Medical Command; OPORD=Operational Order; PWG=Physical Working Group;
RHC=Regional Health Command.

Table B-2. Data and Data Monitoring Tools

Strengths	Weaknesses
<ul style="list-style-type: none"> • Summaries of available data enable data-driven injury prevention planning. • APHC summaries of centrally-available data allowed installation Team Leads to focus on building teams, analyzing local data. • APHC data summaries were an informative overview and were used as the basis of reports. • Administrative data source (medical encounters) used by APHC is more complete than other sources and uses injury definition recommended for military injury monitoring. • Reviewed both active duty and civilian data. • Display of medical encounters for injury and disease showed importance of injury relative to other health conditions. • Charts available in the Strategic Management System were presented to CHPC and provide installation-specific thresholds to identify increasing and decreasing injury rates. • Strategic Management System charts updated quarterly. • Civilian workers' compensation data provided information (unit, occupation, causes) valuable for targeting interventions. • Workers' compensation cost data was important for commanders; type of injury by cost was of interest. • Learning MRAT was worthwhile, user-friendly, useful for comparing units and identifying units with highest rates. • MRAT use aligned with other installation requirements. • <i>Ad hoc</i> APHC-assisted analyses were not widely used, but liked the idea; suggested keeping this service. • Online data sources (FR2, PH360, RMIS) were not utilized since this information was provided by APHC. 	<ul style="list-style-type: none"> • Unable to access Reserve data. Recommend removing this requirement. • Cause coding is not completed for all medical encounter data. • Need local assistance to define reasons for fluctuations in rates. • APHC summaries available for installation only; should be supplemented with local or MRAT unit-level data. • MRAT use difficult due to challenge of obtaining unit identifier codes (UICs) and time needed to learn the system. • Strategic Management System charts not available in Europe CPHC PWG nodes yet. • Strategic Management System charts subject to data lag due to administrative data sources on which they depend. • Civilian data source defines installations differently than active duty data source. • Civilian workers' compensation numbers may be low, giving the impression there is no need for action. • APHC <i>ad hoc</i> cause of injury analysis was useful, but did not ultimately carry a lot of weight due to small sample size (n=544 overexertion injuries at USAG Hawaii). • Did not recommend pursuing <i>ad hoc</i> medical records data analysis at the local level.

CONTINUED ON NEXT PAGE

Opportunities	Threats
<ul style="list-style-type: none">• Installation level data offers opportunity for action and monitoring at CHPCs.• APHC support provides continuity of data with shifting, unknown local resources.	<ul style="list-style-type: none">• Lack of funding for local analytic support• APHC data summaries require DHA support for data pulls; fulfillment of requests are subject to their workload.• Incomplete cause coding of medical encounter data limits medical and commanders' ability to focus prevention efforts.• MRAT continuation and funding determined by the Office of the Surgeon General.

Legend: APHC=U.S. Army Public Health Center; CHPC=Community Health Promotion Council; DHA=Defense Health Agency; FR2=Force Risk Reduction System; PH360=Public Health 360 system; RMIS=Risk Management Information System (Army Combat Readiness/Safety Center); MRAT=Medical Readiness Assessment Tool; PWG=Physical Working Group.

Appendix C

Installations with a Community Health Promotion Council (CHPC) and CHPC Facilitator, as of May 2016 (Appendix 7 of FRAGO 1 to MEDCOM OPORD 15-74)

1	Aberdeen Proving Ground, MD
2	ARNORTH/Fort Sam Houston, TX
3	Camp Zama, Japan
4	Carlisle Barracks, PA
5	Detroit Arsenal, MI
6	Fort Belvoir, VA
7	Fort Benning, GA
8	Fort Bliss, TX
9	Fort Bragg, NC
10	Fort Campbell, KY
11	Fort Carson, CO
12	Fort Drum, NY
13	Fort Eustis, VA
14	Fort Gordon, GA
15	Fort Hood, TX
16	Fort Huachuca, AZ
17	Fort Irwin, CA
18	Fort Jackson, SC
19	Fort Knox, KY
20	Fort Leavenworth, KS
21	Fort Lee, VA
22	Fort Leonard Wood, MO
23	Fort Lewis, WA
24	Fort Meade, MD
25	Fort Polk, LA
26	Fort Richardson, AK
27	Fort Riley, KS
28	Fort Rucker, AL
29	Fort Sill, OK
30	Fort Stewart, GA
31	Fort Wainwright, AK
32	Joint Base Myer-Henderson Hall
33	Korea-Area 1 Camp Red Cloud
34	Korea-Area 2 Yongsan
35	Korea-Area 3 Camp Humphreys
36	Korea-Area 4 Camp Walker
37	Presidio of Monterey, CA
38	Redstone Arsenal, AL
39	Rock Island Arsenal, IL
40	US Army Hawaii-25 ID
41	USAG Bavaria/Grafenwoehr
42	USAG Benelux
43	USAG Franconia/Ansbach
44	USAG Rheinland-Pfalz/Kaiserslautern
45	USAG Stuttgart

Appendix D

OPORD Working Group Meetings and Other Coordination, Aug 2016–Dec 2017

Meeting Number	Dates and times	Agenda
1	RHC-A: 09 Jan 2017, 1000-1100 Eastern RHC-C: 06 Feb 2017, 0900-1000 Eastern RHC-E: 09 Jan 2017, 0800-0900 Eastern RHC-P: 02 Feb 2017, 1600-1700 Eastern	<ul style="list-style-type: none"> • Introductions • Background (APHC) <ul style="list-style-type: none"> – Army injury surveillance data – Army Medicine Campaign 2017 • MEDCOM OPORD 15-74 (APHC) <ul style="list-style-type: none"> – History, Intent, Products, Impact – Responsibilities/deadlines • APHC injury surveillance summaries (APHC) • Installation updates (progress, questions) (Installation Leads) • POCs, Next meeting (APHC)
2	RHC-A & RHC-E: 13 Feb 2017, 1000-1100 Eastern RHC-P & RHC-C: 09 Mar 2017, 1600-1700 Eastern	<ul style="list-style-type: none"> • MRAT analysis presentation (PPSL) • Additional data & other information from APHC (APHC) • Team member roles (APHC) • Installation updates (APHC/Installation Leads) • Next meeting (APHC)
3	RHC-A: 11 Apr 2017, 1000-1130 Eastern RHC-C: 26 Apr 2017, 1000-1130 Eastern RHC-E: 17 Apr 2017, 0830-1000 Eastern RHC-P: 03 May 2017, 2200-2330 Eastern	<ul style="list-style-type: none"> • Report template review (APHC) • Installation updates (Installation Leads) • SWOT assessments (APHC/Installation Leads) • APHC comments, next meeting (APHC)
4	RHC-A: 01 Jun 2017, 0930-1100 Eastern RHC-C: 14 Jun 2017, 1000-1130 Eastern RHC-E: 02 Jun 2017, 0800-0930 Eastern RHC-P: 21 Jun 2017, 2200-2330 Eastern	<ul style="list-style-type: none"> • Roll call (APHC) • Installation updates & Report questions (Installation Leads) • SWOT assessments (APHC/Installation Leads) <ul style="list-style-type: none"> –Data & data collection tools –OPORD process • APHC comments (APHC)
<i>Special topic:</i> New MRAT metrics	22 Aug 2017, 0900-1000 Eastern 30 Aug 2017, 1600-1700 Eastern	<ul style="list-style-type: none"> • Review of Active Duty data sources introduced during Injury OPORD meetings (APHC) • Presentation from Physical Performance Service Line on new injury metrics (PPSL)

Legend: APHC=U.S. Army Public Health Center, Injury Prevention Division
PPSL= Physical Performance Service Line, Office of the Surgeon General

OPORD Information Briefings (Summary of MEDCOM OPORD 15-74 Activities)

- 8 Dec 2016, Public Health Enterprise Review and Analysis Meeting
- 23 Aug 2017, APHC Public Health Service Line Lead
- 24 Aug 2017, Training and Doctrine Command (TRADOC) Health Promotion Council Executive Committee (Chair: TRADOC Deputy Chief of Staff)

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- 12 Sep 2017, Army Public Health Nursing Consultant
- 3 Oct 2017, TRADOC Health Promotion Council (Chair: TRADOC Deputy Commanding General)

Appendix E

Initial OPOD 15-74 Team Lead Survey (March 2017)

Note: Not an actual representation of the survey, which was administered electronically and utilized skip patterns as noted in the text below.

To the installation Injury Prevention Team Leads:

This survey will provide details necessary to describe factors affecting execution of MEDCOM OPOD 15-74 (Improving Readiness through Prevention of Unintentional Injuries) at your installation or in your area of responsibility (AOR). Please provide as much detail as possible.

Your full name (rank (if applicable), first name, last name):

Installation or USAG:

The first set of questions provides background information on the Community Health Promotion Council on your installation or in your AOR (area of responsibility).

1. Is there a Community Health Promotion Council (CHPC) at your installation or in your AOR? Y/N
 - a. If no, is there an alternate group where you will present the data provided to you as part of MEDCOM OPOD 15-74? Y/N
 - i. If yes, enter name of group.
 - ii. If yes, within the last 12 months, have you or the Injury Prevention Team provided a briefing on injuries to this alternate group? Y/N
 - iii. If yes, please enter the number of times you or the Injury Prevention Team have briefed injury to this group. (Sliding scale, Range 0 to 12)
 - iv. If yes, how many of these briefings included injury data (such as installation injury statistics or injury prevention program outcomes). (Sliding scale, Range 0 to 12)
 1. If >0, please describe the data that were included in the briefing.
 - b. If yes, how often does the CHPC meet? Quarterly/Other (Enter frequency)
 - c. If yes, who facilitates the installation's CHPC process? Health Promotion Officer (HPO)/Community Readiness & Resiliency Integrator (CR2I)/Other (Please specify)/We do not currently have a CHPC Facilitator/I do not know
 - i. If select HPO/CR2I/Other, approximately how long has the CHPC Facilitator been working with your CHPC? (less than 1 month, 1-6 months, 6-12 months, more than 12 months, I do not know)
 - ii. If select HPO/CR2I/Other, is the CHPC Facilitator part of your Injury Prevention Team? (Y/N).
 - iii. If CR2I/Other/We do not currently have a CHPC Facilitator/I do not know, was a Health Promotion Officer previously assigned to work with the CHPC? (Y/N/I do not know)
 1. If yes, approximately how long had the HPO worked with your CHPC? (less than 1 month, 1-6 months, 6-12 months, more than 12 months, I do not know)
 - d. If yes, is injury prevention currently part of the installation CHPC's Strategic Plan or Health Improvement Plan? Y/N/I do not know
 - i. If yes, were injury prevention priorities in the CHPC Strategic Plan established after a review of population-based data (such as surveillance summaries from U.S. Army Public Health Center or installation data sources)? Y/N/ I was not involved in development of the Strategic Plan
 1. If yes, please briefly describe the data that were used.

- ii. If yes, were injury prevention priorities in the CHPC Strategic Plan established using a systematic, criteria-based process? Y/N/I was not involved in development of the Strategic Plan.
 1. If yes, please briefly describe the process that was used.
2. Does your CHPC have a working group that oversees and coordinates installation Physical Health activities (e.g., physical fitness, injury prevention, oral health, nutrition)? These working groups are often called the Physical Working Group or Physical Health Working Group, consistent with language used in AR 600-63 (Army Health Promotion). (Y/N)
 - a. If no, is there an alternate group where you will present the data provided to you as part of MEDCOM OPORD 15-74? Y/N
 - i. If yes, enter name of group.
 - ii. If yes, within the last 12 months, have you or the Injury Prevention Team provided a briefing on injuries to this alternate group? Y/N
 - iii. If yes, please enter the number of times you or the Injury Prevention Team have briefed injury to this group. (Sliding scale, Range 0 to 12)
 - iv. If yes, how many of these briefings included injury data (such as installation injury statistics or injury prevention program outcomes). (Sliding scale, Range 0 to 12)
 1. If >0, please describe the data that were included in the briefing.
 - b. If yes, how often does the CHPC Physical Health Working Group meet?
Monthly/Quarterly/Other (Enter frequency)/I do not know
 - c. If yes, is injury prevention currently part of the Physical Health Working Group's Action Plan? Y/N/I do not know
 - i. If yes, were injury prevention priorities in the Physical Health Working Group's Action Plan established after review of data (such as surveillance summaries from U.S. Army Public Health Center or installation POCs)? Y/N/ I was not involved in development of the Action Plan
 1. If yes, please briefly describe the data that were used.
 - ii. If yes, were injury prevention priorities in the Physical Health Working Group's Action Plan established using a formal, systematic process? Y/N/I was not involved in development of the Action Plan.
 1. If yes, please briefly describe the process that was used.
 - iii. If no, were injury prevention priorities a part of another CHPC working group?
 1. If yes, enter name of group.
3. If CHPC has PWG (or similar working group), within the last 12 months, have you or the Injury Prevention Team provided a briefing on injuries to the CHPC or Physical Health Working Group? Y/N
 - a. If yes, please enter the number of times you or the Injury Prevention Team have briefed injury to the CHPC. (Sliding scale, Range 0 to 12)
 - b. If yes, please enter the number of times you or the Injury Prevention Team have briefed injury to the physical health working group within the last 12 months. (Sliding scale, Range 0 to 12)
 - c. If yes, how many of these briefings included injury data (such as installation injury statistics or injury prevention program outcomes). (Sliding scale, Range 0 to 12)
 - i. If >0, Please describe the data that were included in the briefing.
4. Please enter any additional details about your installation's CHPC and PWG.

This second set of questions provides details on the Injury Prevention Team that you have organized to represent your installation or AOR in support of execution of MEDCOM OPORD 15-74.

5. How many team members are currently on your Injury Prevention Team? (Enter number)
6. What disciplines are represented on the Team? (Select all that apply)
 - a. Preventive Medicine
 - b. Public Health Nurse/Community Health Nurse
 - c. Occupational Health Nurse or Physician

- d. Physical Therapy
 - e. Occupational Therapy
 - f. Safety
 - g. Health Promotion
 - h. Health analyst/health information systems specialist
 - i. Nutritionist or Dietician
 - j. Athletic Trainer/Fitness Specialist
 - k. Other medical (Please describe)
 - l. Other non-medical (Please describe)
7. What data or data sources have you reviewed to understand and describe injuries at your installation or in your AOR? (*Select all that apply*)
- a. U.S. Army Public Health Center (APHC) Active Duty installation injury summary slides
 - b. Active Duty installation injury rate control charts (<https://www.sms.army.mil/cms/>)
 - c. Defense Health Agency installation injury reports (<http://www.health.mil/Military-Health-Topics/Health-Readiness/Armed-Forces-Health-Surveillance-Branch/Reports-and-Publications/Installation-Injury-Reports>)
 - d. Medical Readiness Assessment Tool (MRAT) (<https://cms.mods.army.mil/cms/>)
 - e. Public Health 360 (PH360) (<https://pasba.army.mil/MEDCOM360/Dashboard/Map/PH360>)
 - f. U.S. Army Public Health Center (APHC) Civilian installation injury summary slides
 - g. Force Risk Reduction (FR2) (<https://fr2.safety.army.mil/>)
 - h. Defense Injury and Unemployment Compensation System (DUICS) (<https://dodhrinfo.cpms.osd.mil/Directorates/HROPS/Benefits-and-Worklife/Injury-and-Unemployment-Compensation/Pages/Home1.aspx>)
 - i. Safety data (RMIS) (<https://safety.army.mil/>)
 - j. Installation data sources (Please describe)
 - k. Other data sources (Please describe)
 - l. Do not currently use any of the above sources
8. Please enter any additional details (comments, challenges, opportunities) about your Injury Prevention Team.
9. Are you aware of injury prevention programs on your installation or in your AOR? Y/N
- a. Please enter the number of ongoing injury prevention programs of which you are aware. (Enter number)
 - b. How many of these programs involve partnerships with non-MEDCOM units? (Enter number).
 - c. How many of these programs are supported by Injury Prevention Team members? (Enter number).
 - d. Do you know how many programs have metrics in place to evaluate program effects? Y/N
 - i. If yes, Please enter the number of ongoing injury prevention programs that have metrics in place to evaluate program effects. (Enter number)
 - e. Do you know how many programs have a requirement or plan to disseminate and inform others of their results? Y/N
 - i. If yes, Please enter the number of ongoing injury prevention programs that have a requirement or plan to disseminate and inform others of their results. (Enter number)
 - 1. If ≥ 1 , where will program results be reported? (Please describe)
10. Please enter any additional details about injury prevention programs on your installation or in your AOR.

Appendix F

Follow-Up OPORD 15-74 Team Lead Survey (September 2017)

Note: Not an actual representation of the survey, which was administered electronically and utilized skip patterns as noted in the text below.

To the installation Injury Prevention Team Leads:

This survey will provide details necessary to describe factors affecting execution of MEDCOM OPORD 15-74 (Improving Readiness through Prevention of Unintentional Injuries) at your installation or in your area of responsibility (AOR). Please provide as much detail as possible.

Installation or USAG:

The first set of questions provides background information on the Community Health Promotion Council on your installation or in your AOR (area of responsibility).

1. Over the past 6 months, has there been a Community Health Promotion Council (CHPC) at your installation or in your AOR? Y/N
 - a. If no: Has there been an alternate group coordinating community health and wellness activities across installation/USAG units? (Y/N)
 - i. If yes: Enter name of group.
 - ii. If yes: Within the last 6 months, have you or the Injury Prevention Team provided a briefing on injuries to this alternate group? (Y/N)
 - iii. If yes: Please enter the number of times you or the Injury Prevention Team have briefed injury to this group in the past 6 months. (Sliding scale, Range 0 to 6)
 - iv. If yes: How many of these briefings included injury data (such as installation injury statistics or injury prevention program outcomes). (Sliding scale, Range 0 to 6)
 - v. Over the past 6 months, was injury prevention introduced as part of this group's strategic plan or goals? (Y/N)
 - vi. Please add any additional comments or details about your work with this group.
 - b. If yes: How often has the CHPC met? (Quarterly/Other (Enter frequency))
 - i. Within the last 6 months, have you or the Injury Prevention Team provided a briefing on injuries to the CHPC? (Y/N)
 - ii. Please enter the number of times you or the Injury Prevention Team have briefed injury to this group. (Sliding scale, Range 0 to 6)
 - iii. How many of these briefings included injury data (such as installation injury statistics or injury prevention program outcomes). (Sliding scale, Range 0 to 6)
 - c. If yes: Who facilitated the CHPC process? Health Promotion Officer (HPO)/Community Readiness & Resiliency Integrator (CR2I)/Other (Please specify)/We do not currently have a CHPC Facilitator
 - i. If selected HPO/CR2I/Other: Approximately how long has the CHPC Facilitator been working with your CHPC? (less than 1 month, 1-6 months, 6-12 months, more than 12 months, I do not know)
 - ii. If selected HPO/CR2I/Other: Is the CHPC Facilitator part of your Injury Prevention Team? (Y/N)
 - d. If yes: Over the past 6 months, was injury prevention introduced as part of the CHPC's Strategic Plan or Health Improvement Plan? (Y/N)
 - i. If yes: Were injury prevention priorities in the CHPC Strategic Plan established after a review of population-based data provided by the Installation Injury Prevention Team? (Y/N/I was not involved in development of the Strategic Plan)
 1. If yes: Please briefly describe the data that were used.

- ii. If yes: Were injury prevention priorities in the CHPC Strategic Plan established using a systematic, criteria-based process? (Y/N/I was not involved in development of the Strategic Plan)
 - 1. If yes: Please briefly describe the process that was used.
- 2. Over the past 6 months, has your CHPC had a working group that oversees and coordinates installation Physical Health activities (e.g., physical fitness, injury prevention, oral health, nutrition)? This group is often called the Physical Working Group or Physical Health Working Group, consistent with language used in AR 600-63 (Army Health Promotion). (Y/N)
 - a. If no: Over the past 5 months, was there an alternate group where you presented the injury data provided to you as part of MEDCOM OPORD 15-74? (Y/N)
 - i. If yes: Enter name of group.
 - ii. If yes: Within the last 5 months, have you or the Injury Prevention Team provided a briefing on injuries to this alternate group? (Y/N)
 - iii. If yes: Please enter the number of times you or the Injury Prevention Team have briefed injury to this group. (Sliding scale, Range 0 to 6)
 - iv. If yes: How many of these briefings included injury data (such as installation injury statistics or injury prevention program outcomes). (Sliding scale, Range 0 to 6)
 - b. If yes: Over the past 6 months, how often did the Physical Health Working Group meet? (Monthly/Quarterly/Other (Enter frequency))
 - i. Within the last 5 months, have you or the Injury Prevention Team provided a briefing on injuries to the Physical Health Working Group? (Y/N)
 - ii. Please enter the number of times you or the Injury Prevention Team have briefed injury to the Physical Health Working Group. (Sliding scale, Range 0 to 6)
 - iii. How many of these briefings included injury data (such as installation injury statistics or injury prevention program outcomes). (Sliding scale, Range 0 to 6)
 - c. If yes: Does the Physical Health Working Group have an action plan or objectives? (Y/N)
 - i. If yes: Does the Physical Health Working Group's action plan or objectives include injury? (Y/N/I don't know)
 - ii. If yes: Over the past 6 months, were injury prevention objectives added to the Physical Health Working Group's action plan or goals? (Y/N)
 - 1. If yes: Were injury prevention priorities in the Physical Health Working Group's action plan established after review of population-based data provided by the Installation Injury Prevention Team? (Y/N/I was not involved in development of the Strategic Plan)
 - a. If yes: please briefly describe the data that were used.
 - 2. If yes: Were injury prevention priorities in the Physical Health Working Group's action plan established using a formal, systematic process? (Y/N/I was not involved in development of the action plan)
 - a. If yes: please briefly describe the process that was used.
 - iii. If no: Were injury prevention priorities a part of another CHPC working group?
 - a. If yes: enter name of group.
- 3. Please enter any additional details about your installation's CHPC and PWG.

This second set of questions provides details on the Injury Prevention Team that you have organized to represent your installation or AOR in support of MEDCOM OPORD 15-74.

- 4. How many team members are currently on your Injury Prevention Team? (Enter number)
- 5. What disciplines are represented on the Team? (Select all that apply)
 - a. Preventive Medicine
 - b. Public Health Nurse/Community Health Nurse
 - c. Occupational Health Nurse or Physician
 - d. Physical Therapy

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- e. Occupational Therapy
 - f. MEDCOM safety officer
 - g. Garrison safety officer
 - h. Health Promotion
 - i. Health analyst/health information systems specialist
 - j. Nutritionist or Dietician
 - k. Athletic Trainer/Fitness Specialist
 - l. Other medical (Please describe)
 - m. Other non-medical (Please describe)
- 6. Over the past 6 months, how many of your Injury Prevention Team members completed the Medical Readiness Assessment Tool (MRAT) training? (Enter number)
 - 7. Over the past 6 months, please describe your access to workers' compensation data (did not pursue, pursued but unable to obtain, pursued and obtained)
 - 8. Please rank your need for cost data on workers' compensation claims (greatly needed/needed/would use, but not necessary/not needed)
 - 9. Over the last 5 months, how many meetings have been held with your Injury Prevention Team? (Enter number)
 - 10. Please describe your primary method(s) of communication with the Team.

Final questions and input.

- 11. Please describe the greatest challenge(s) or barrier(s) faced during execution of this OPORD, January-July 2017.
- 12. Please describe the greatest accomplishment(s) during execution of this OPORD, January-July 2017.
- 13. What advice do you have for future Installation Injury Prevention Team Leads?
- 14. What recommendations do you have for the RHC or APHC Leads?
- 15. Please provide any additional feedback here.

Your input will be used to determine next steps. Thank you again for your feedback, time, and effort in executing MEDCOM OPORD 15-74.

Appendix G

Interrupted Time Series (ITS) Analyses for 2016 (Pilot) Participants

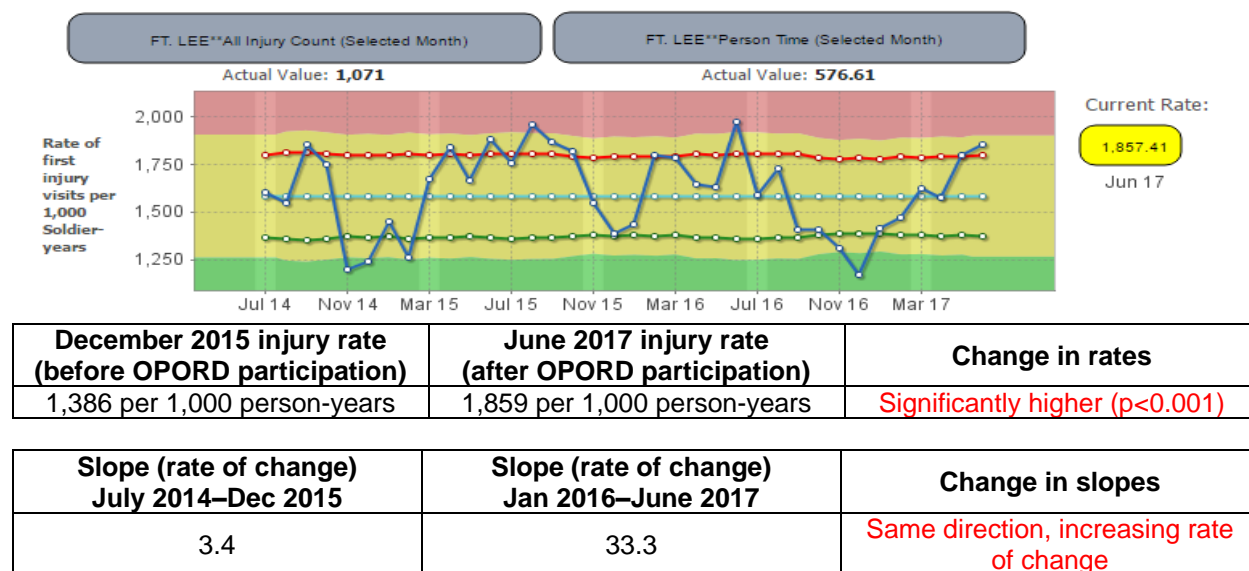


Figure G-1. RHC-A, Fort Lee

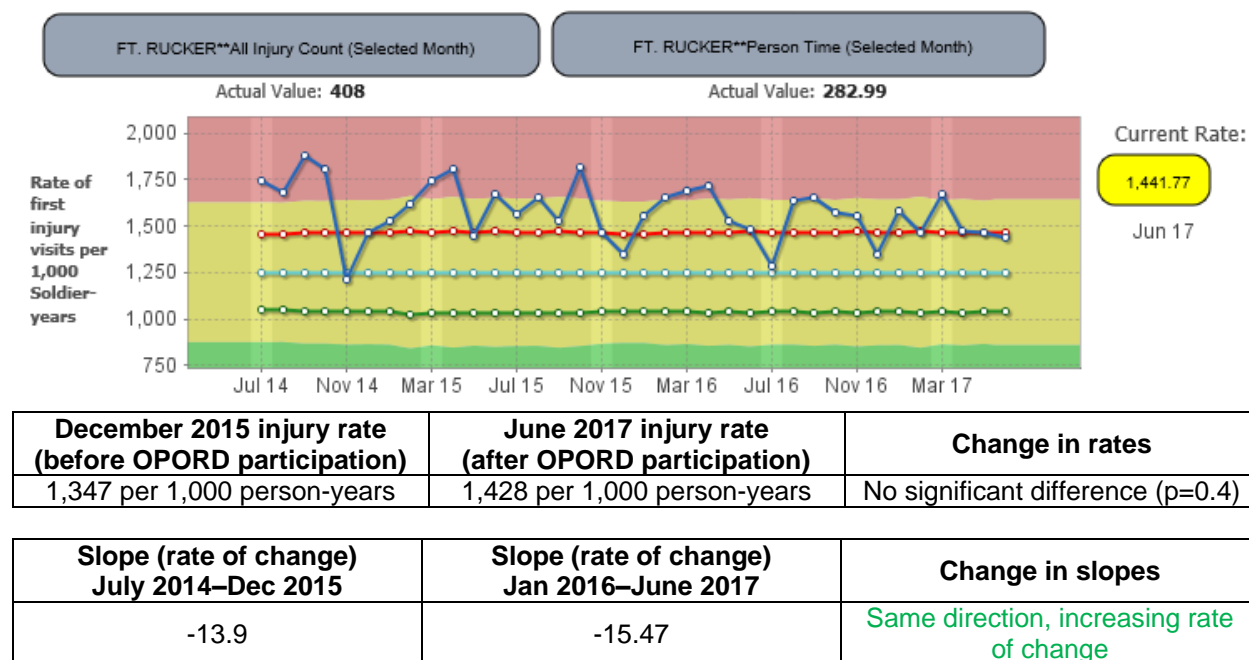


Figure G-2. RHC-A, Fort Rucker

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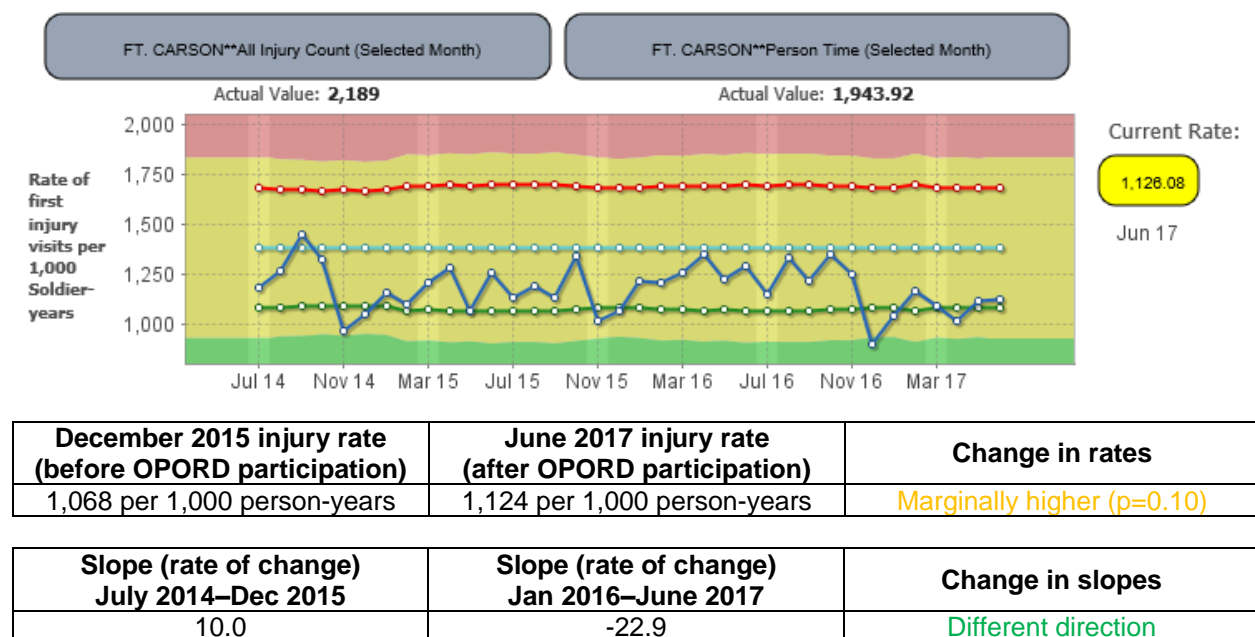


Figure G-3. RHC-C, Fort Carson

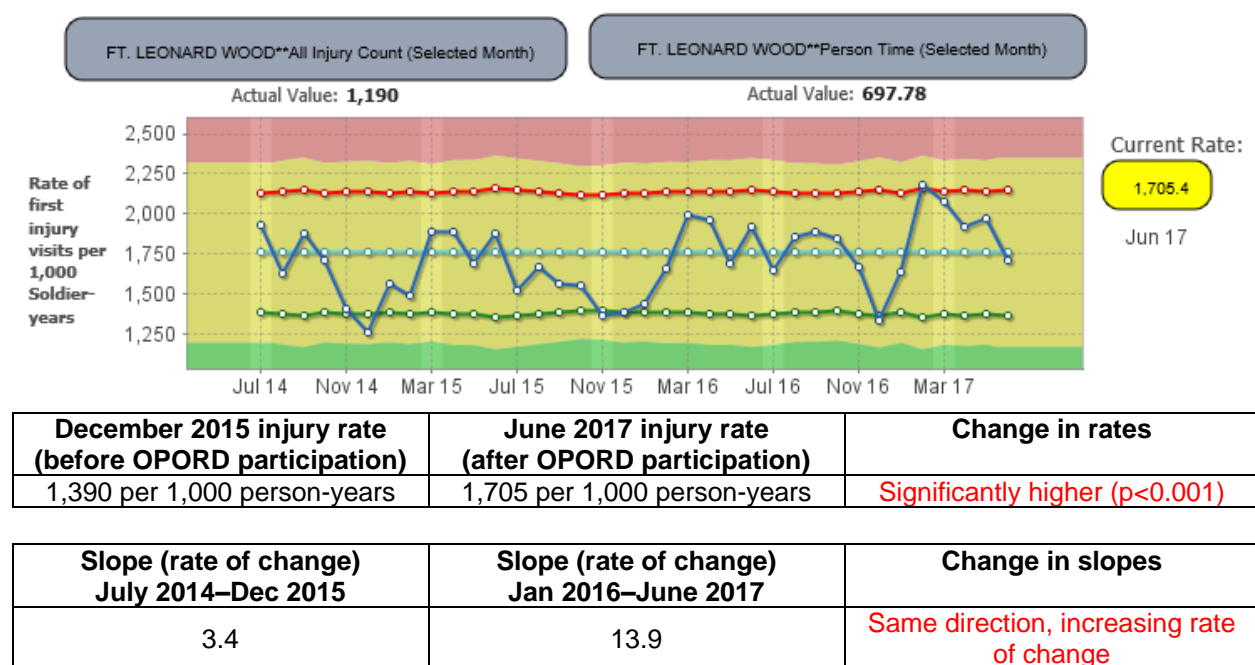


Figure G-4. RHC-C, Fort Leonard Wood

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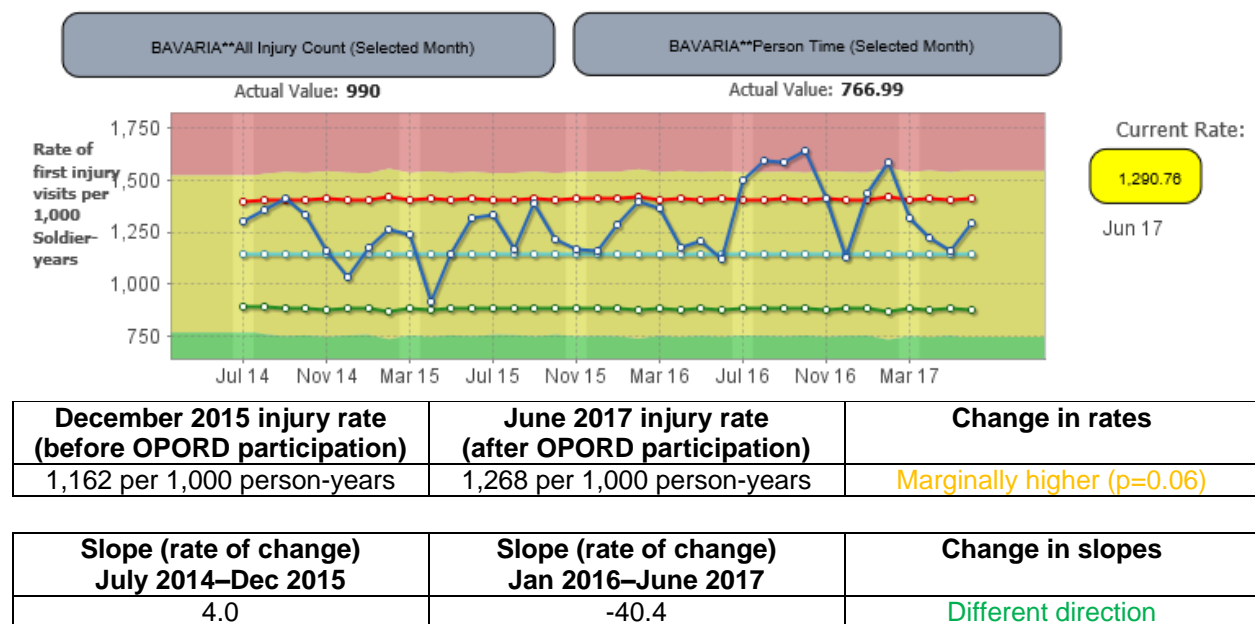


Figure G-5. RHC-E, Bavaria

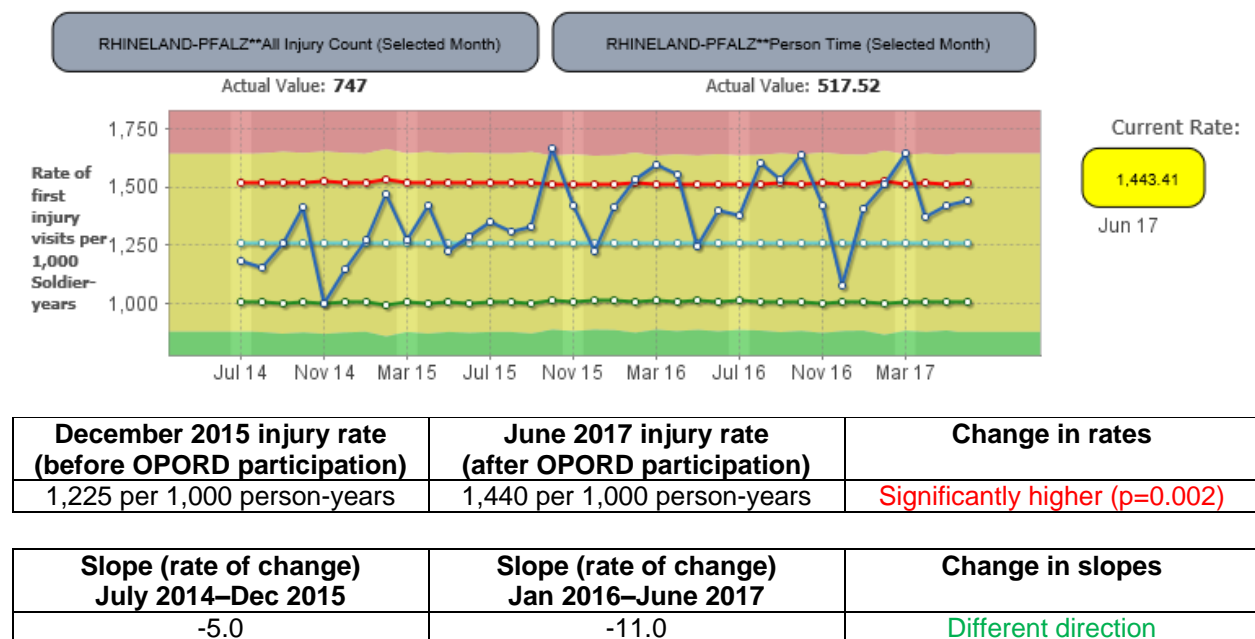


Figure G-6. RHC-E, Rheinland-Pfalz

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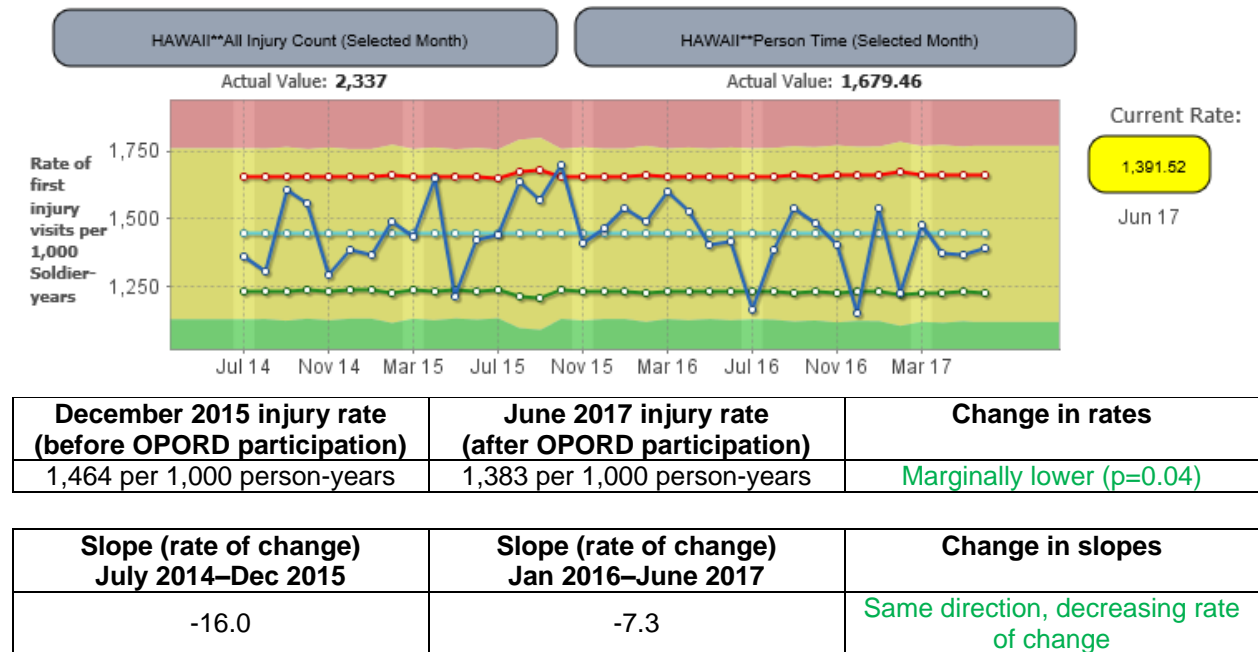


Figure G-7. RHC-P, Hawaii

Appendix H

Example Installation Active Duty Injury Medical Encounter Data Summary

Prepared by APHC Injury Prevention Division

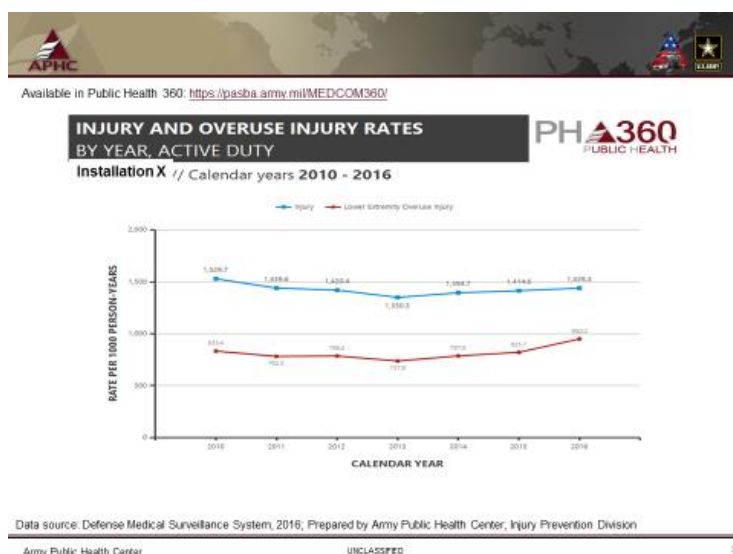


Figure H-1. Injury and Overuse Injury Rates Among Active Duty Army Soldiers, by Year, 2010-2016

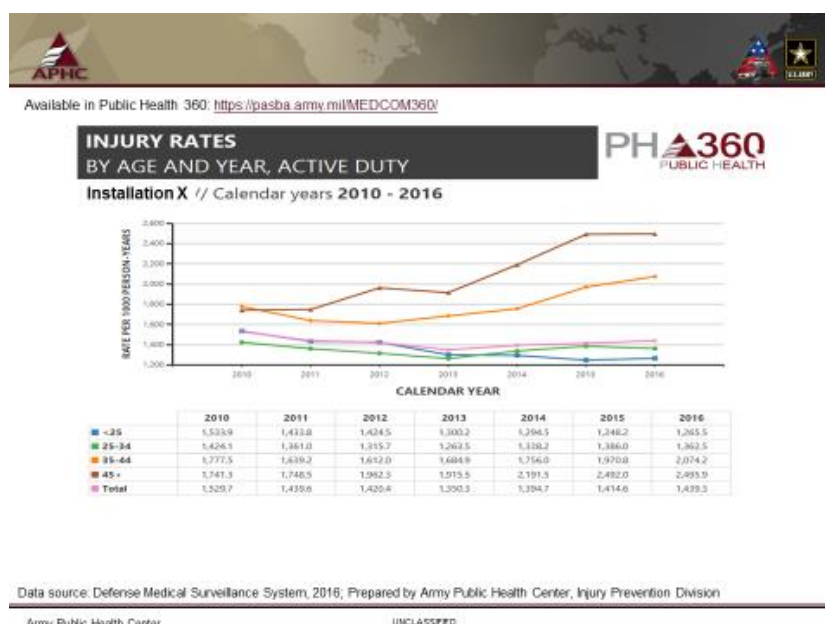


Figure H-2. Injury Rates Among Active Duty Army Soldiers, by Age Group and Year, 2010-2016



Figure H-3. Injury Rates Among Active Duty Army Soldiers, by Gender and Age Group, 2016

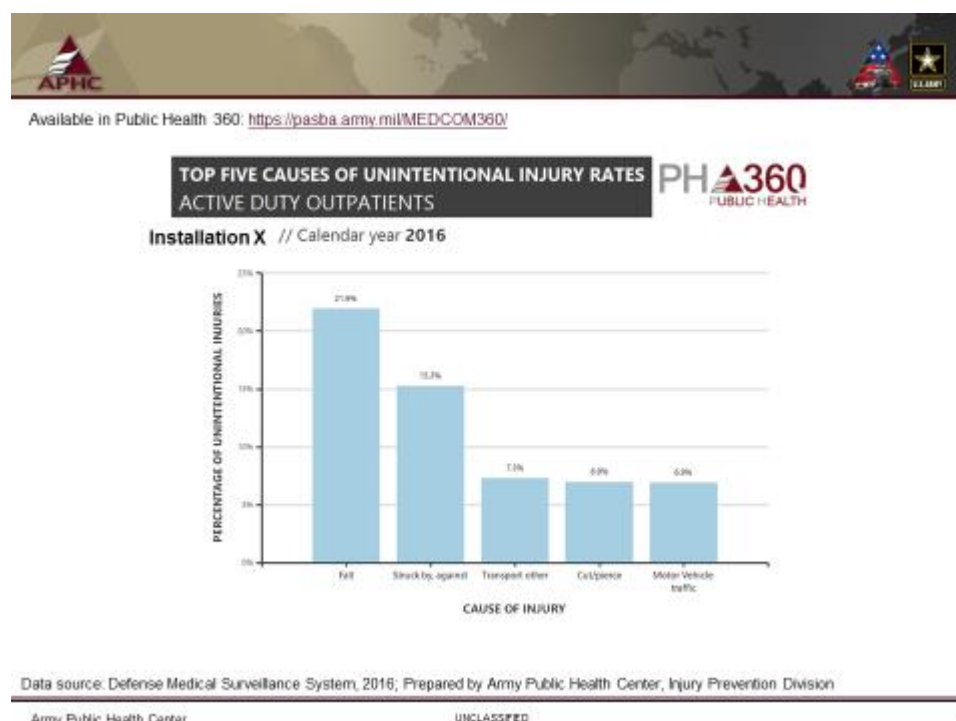


Figure H-4. Top five Causes of Unintentional Injury Rates Among Active Duty Outpatient Soldiers, 2016

Appendix I

Example Installation Army Civilian Workers' Compensation Data Summary

Prepared by APHC Injury Prevention Division

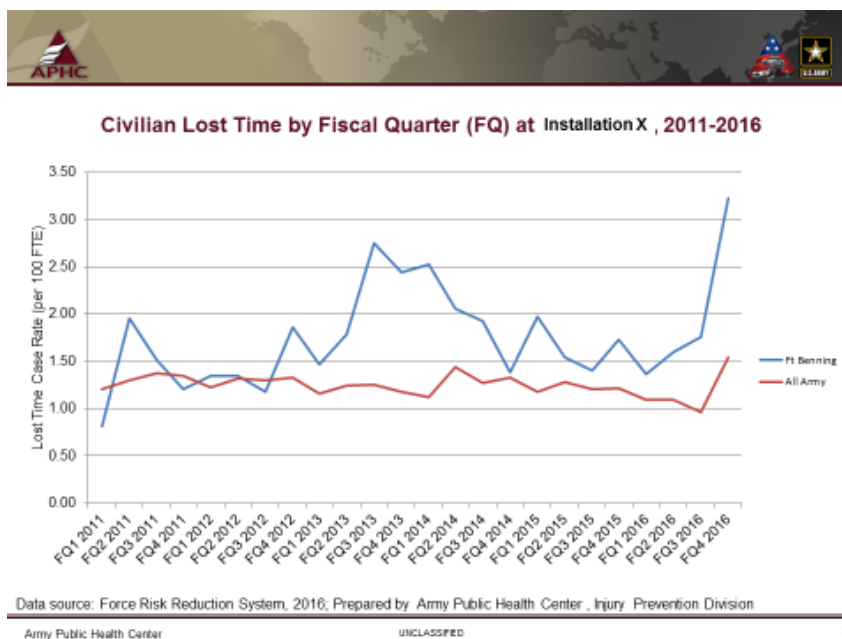


Figure I-1. Civilian Lost Time by Fiscal Quarter at an Army installation, 2011-2016

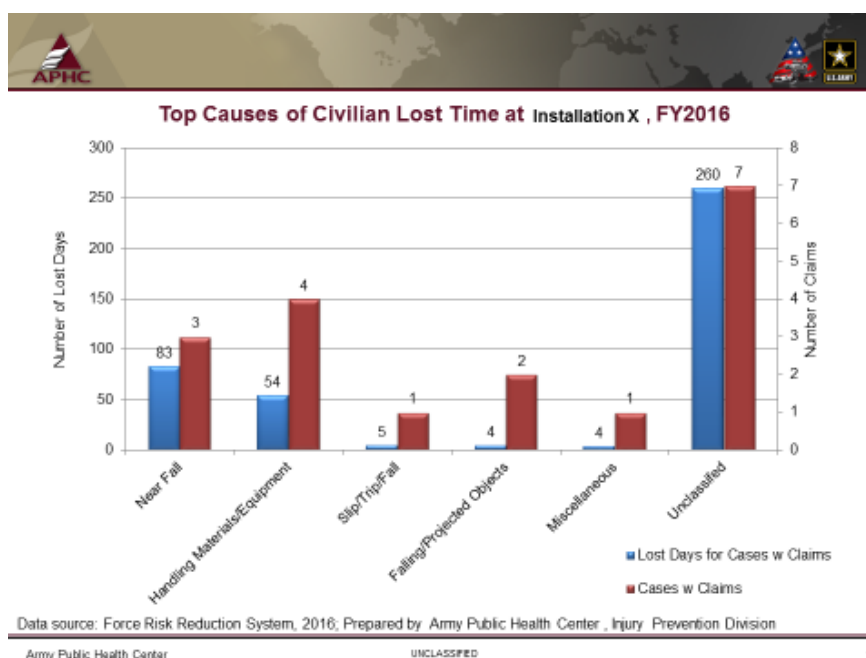


Figure I-2. Top Causes of Civilian Lost Time at an Army Installation, 2016

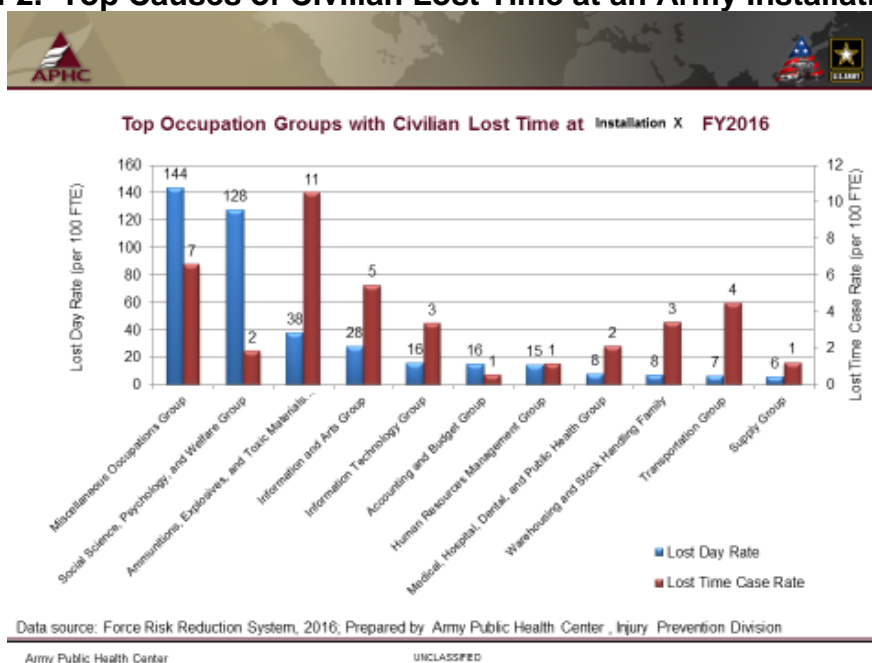


Figure I-3. Top Occupations with Civilian Lost Time at an Army Installation, 2016

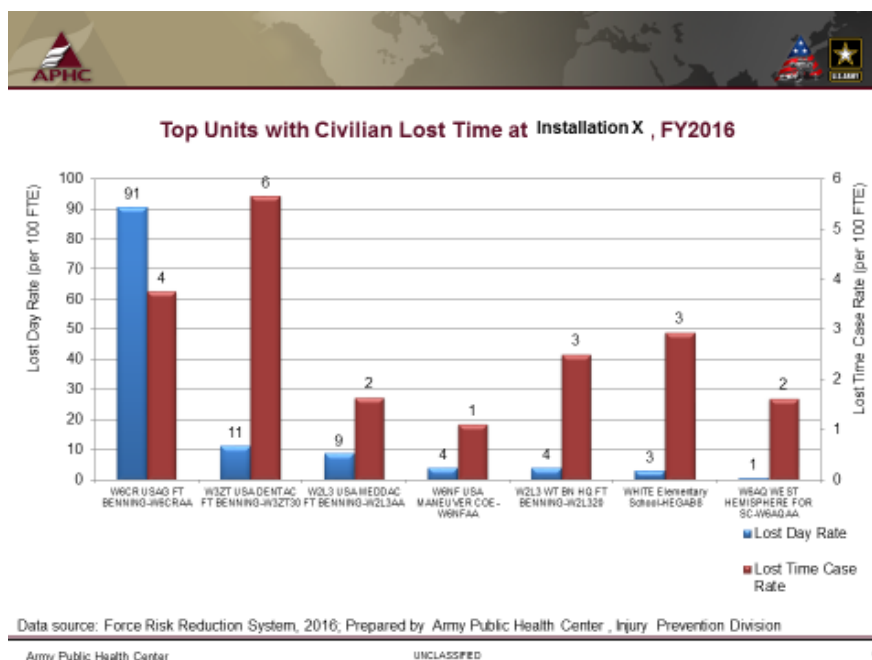


Figure I-4. Top Units with Civilian Lost Time at an Army Installation, 2016

Appendix J

Example Installation Safety Report Data Summary

Prepared by APHC Injury Prevention Division



Age*	Accident Occurrences** n (%)	Rate per 1,000	Fatality Count* n (%)
<25	51 (55)	5.4	1 (100)
25 to 34	31 (37)	4.8	0
35 to 44	6 (7)	2.3	0
45+	2 (2)	4.0	0
Not Evaluated	2 (2)	--	0
TOTAL	92	4.8	1

*Army Military Personnel Only

**This report contains occurrence counts which are not accident counts. Each accident may have multiple occurrence counts

Data source: Army Risk Management Information System, accessed 9JAN17, Prepared by APHC, Injury Prevention Division

U.S. Army Public Health Center

FOUO

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Figure J-1. Ground Accident Occurrence by Age at an Army Installation, 2016



Gender*	Accident Occurrences** n (%)	Rate per 1,000	Fatality Count* n (%)
Male	79 (81)	4.4	1 (100)
Female	19 (19)	16.5	0
TOTAL	98	4.8	1

*Army Military Personnel Only

**This report contains occurrence counts which are not accident counts. Each accident may have multiple occurrence counts

Data source: Army Risk Management Information System, accessed 9JAN17, Prepared by APHC, Injury Prevention Division

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Figure J-2. Ground Accident Occurrence by Gender at an Army Installation, 2016

Installation, 2016



Accident Classification	Accident Count** n (%)	Injury Count*		Cost**		
		Fatal n (%)	Non-Fatal*** n (%)	Damage	Injury	Total
A	1 (1)	1 (100)	0	\$0	\$395,000	\$395,000
C	64 (48)	0	48 (50)	\$5,000	\$439,646	\$444,646
D	67 (51)	0	48 (50)	\$0	\$120,840	\$120,840
TOTAL	132	1	96	\$5,000	\$955,486	\$960,486

*Army Military Personnel Only

** Represents all incidents involving Army or non-Army personnel and/or damage to Army or non-Army property as a result of Army operations.

*** Non-Fatal Injuries include Permanent Total Disability, Permanent Partial Disability, Days Away From Work/Training (Hospitalized, Quarters, Convalescent Leave, etc.), restricted work activities to include permanent or temporary transfer to another job, medical treatment greater than first aid, first aid, needle stick injuries and cuts from sharps that are contaminated from another person's blood or other potentially infectious material, medical removal under medical surveillance requirements of an OSHA standard, occupational hearing loss, or a work-related tuberculosis case or loss of consciousness.

Data source: Army Risk Management Information System, accessed 9JAN17; Prepared by APHC, Injury Prevention Division

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Figure J-3. Ground Accidents by Accident Classification, Injury Count, and Cost at an Army Installation, 2016



Duty Status	Accident Count** n (%)	Injury Count*		Cost**		
		Fatal n (%)	Non-Fatal*** n (%)	Damage	Injury	Total
Off Duty	5 (4)	0	5 (5)	\$0	\$20,355	\$20,355
On Duty	127 (96)	1 (100)	91 (95)	\$5,000	\$935,131	\$940,131
TOTAL	132	1	96	\$5,000	\$955,486	\$960,486

*Army Military Personnel Only

** Represents all incidents involving Army or non-Army personnel and/or damage to Army or non-Army property as a result of Army operations.

*** Non-Fatal Injuries include Permanent Total Disability, Permanent Partial Disability, Days Away From Work/Training (Hospitalized, Quarters, Convalescent Leave, etc.), restricted work activities to include permanent or temporary transfer to another job, medical treatment greater than first aid, first aid, needle stick injuries and cuts from sharps that are contaminated from another person's blood or other potentially infectious material, medical removal under medical surveillance requirements of an OSHA standard, occupational hearing loss, or a work-related tuberculosis case or loss of consciousness.

Data source: Army Risk Management Information System, accessed 9JAN17; Prepared by APHC, Injury Prevention Division

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Figure J-4. Ground Accidents by Duty Station, Injury Count, and Cost at an Army Installation, 2016

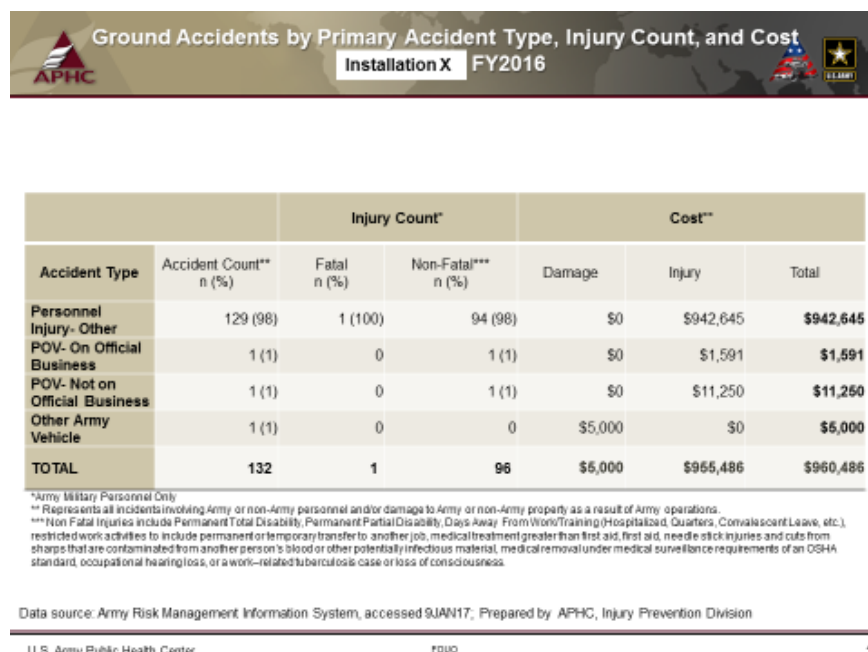


Figure J-5. Ground Accidents by Primary Accident Type, Injury Count, and Cost at an Army Installation, 2016

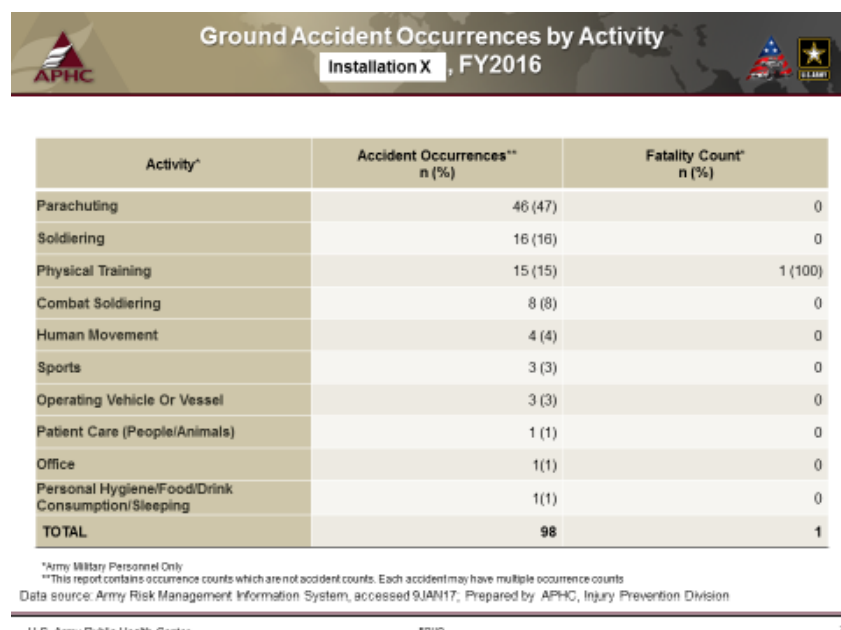


Figure J-6. Ground Accident Occurrences by Activity at an Army Installation, 2016

Appendix K. Inventory of Injury Prevention Interventions Reported in Installation FY16 Unintentional Injury Prevention Reports

Installation	Reported ongoing injury prevention programs (n)	Brief description of program(s)	Programs with evaluation metrics (n)	Brief description of evaluation metrics	Programs with dissemination plan (n)	Where program results will be reported
RHC-A						
Fort Benning, GA	2	1. Hearing Program: Goal is to reduce incidence of new permanent hearing loss in AD Soldiers and DoD Civilians on FBGA by examining available data collected by the hearing program as a core function, and compared between units by MOS as described above 2. Heat Injury Mitigation and Prevention: Goal is to reduce incidence of serious heat injury by increased awareness and implemented a policy mandating that all trainees with minor illnesses be profiled for seven days against training events requiring maximal physical effort (i.e., timed pass/fail endurance runs, ruck marches, and APFT)	2	1. Continued monitoring of hearing injury incidence 2. Monitoring of heat stroke rates, activity performed at time of injury, and climatic conditions. Heat stroke definition is more consistent and cases are more consistently detected by available data capture methods, and present the most serious risk for permanent injury to those affected.		
Fort Campbell, KY	1	Reconditioning Physical Readiness Training: Goal to improve medical readiness and effectively recondition injured Soldiers (fully recovered and performed in a shorter amount of time) the 101st Airborne Division by implementing a reconditioning physical readiness training program	1	Formal evaluation conducted by U.S. Army Public Health Center		
Fort Gordon, GA	7	1. AIT Student Injury Prevention and Healthcare Utilization: Goal to increase AIT graduation rates, assist trainees with seeking medical care, assist AIT Cadre with profile communication, and prevent musculoskeletal injuries to AIT trainees by briefing common injuries seen in the IET/AIT environment, injury prevention techniques and appropriate exercise prescription for the training environment. 2. Pregnancy Postpartum Physical Training (P3T): Goal is to provide standardized physical training that is safe and effective during pregnancy and postpartum by participating daily during PT and once a week during the education portion 3. Quarterly injury prevention briefings: Goal is to provide training to the new Commanders and their new 1SGTs about the P3 and HIV Program Management to maximize their personal health and of the Soldiers under their command. 4. Health Fair participation: Goal is to participate in the community events on anything that is related to health maintenance and disease prevention activities 5. Move to Health: Goal is to empower health care teams and patients to activate their own self-healing mechanisms which will result in prevention of injury/chronic illnesses and enhance their health	4	2. Soldiers are to complete a Pregnant Soldier Survey (Pregnant Soldier Survey) and a Postpartum Soldier Survey (Postpartum Soldier Survey). The Survey is not received at installation level; it is received by higher headquarters. 5. Surveys, quantitative and qualitative data 6. Primary: track number of profiles on installation; Secondary: track musculoskeletal related injuries due to overuse 7. pre and posttest on subjects addressed; longitudinal ROI studies; improved PT scores; measurement of decreased incidence of duty limiting injuries		

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Installation	Reported ongoing injury prevention programs (n)	Brief description of program(s)	Programs with evaluation metrics (n)	Brief description of evaluation metrics	Programs with dissemination plan (n)	Where program results will be reported
		<p>readiness</p> <p>6. Army Wellness Center: Goal is to provide evidence based program designed to help improve soldiers' physical fitness and readiness while also reducing injury risk</p> <p>7. USAF Airman Resiliency Team, Physical Medicine Comprehensive: Goal is to significantly decrease incidence of musculoskeletal injuries causing duty limitations or duty restrictions to 50% baseline of 691 significant injuries/1100 personnel/year = 0.63 acute and overuse musculoskeletal injuries/Airman/year</p>				
Fort Knox, KY	1	Reduction of low back pain by individual education on how to prevent injuries conducted by Physical Therapy at IRAHC.	1	Track number of ergonomic assessments conducted; compare future reports to baseline metrics collected; track M2 reports for indication of decrease/change in low back injuries at Fort Knox	1	Safety POCs
RHC-C						
Fort Bliss, TX	1	FORSCOM Soldier Readiness Test Pilot Program: Goal is to compare the effects of unit-specific functional fitness training program on a Soldier Readiness Test (SRT) Performance and Medical Readiness within three different functional Brigade Combat Teams (BCT); Armor (ABCT), Infantry (IBCT), Stryker (SBCT) and a Multi-Functional Brigade (Sustainment Brigade, DIVARTY/Fires Brigade, or Engineer Brigade)	1	<p>MOE 1: % Soldiers w/passing SRT scores increases.</p> <p>MOE 2: % Soldiers w/passing SRT event scores increases.</p> <p>MOE 3: % Soldiers w/passing APFT scores increases</p> <p>MOE 4: % Soldiers w/passing APFT event scores increases</p> <p>MOE 5: % Soldiers flagged for Army Body Comp Program decreases.</p> <p>MOE 6: % Soldiers on temp MSK profile >90 days in last 6 months decreases.</p> <p>MOE 7: % Soldiers on temp MSK profile >30 days in last 6 months.</p> <p>MOE 8: # of days on temp MSK profile per 100 Soldiers per month decreases.</p> <p>MOE 9: % Soldiers on MRC-3 for MSK decreases.</p>		
Fort Carson, CO	4	1. 4th Infantry Division Human Performance Optimization Program (HPOP): Goal is to provide education and training that optimizes the physical/mental development of the Soldier by implementing a trifold plan, which includes education, training implementation, and assessments with the main emphasis on training the trainer and creating PRT force multipliers across the division	2	<p>1. We conduct the following fitness evaluations, by appointment only: Functional Movement Screening (Flexibility), Power (Broad Jump), Strength (Deadlift, Pull-up), Agility (Davies test)</p> <p>4. All participants at Fort Carson are issued FITBITS to be utilized during the program. In</p>		

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		<p>2. Performance Team Initiative: Goal is to educate Master Fitness Trainers, devise a schedule for conducting MFT classes, and conduct performance enhancement and skill development training</p> <p>3. Reconditioning PRT: Goal is to prevent profiled soldiers from further injury, maintain or improve their conditioning, and return them to full duty as quickly as possible by making suggestions on the proper execution of a RPRT program, training RPRT cadre members to administer RPRT in accordance with 4ID RPRT standards, and ensuring provider use of PRT specific profiles</p> <p>4. Fort Carson Fit for Performance Course: Goal is to assist flagged Soldiers lose weight and meet Army standards by creating a 6 week voluntary program using the Fit for Performance material, but adding a Performance Triad (Sleep, Exercise, Nutrition) emphasis</p>		collaboration with the Wellness Center, all Soldiers get pre and post BODPODs (body composition assessments), in addition to weekly weights. Soldiers are also assessed on dietary habits pre and post.		
Fort Hood, TX	6	<p>1. Company Commander/First Sergeant Pre-Command Course Injury Prevention Briefing: Goal is to educate the incoming company commanders and first sergeants on best practices to help reduce injuries in regard to unit physical training by utilizing multimedia format to educate incoming Company Commanders and First Sergeants on how to prevent injuries in their unit physical training formations</p> <p>2. CRDAMC Army Safety and Health Management System (ASHMS): Goal is to increase available end strength, which positively affects force readiness; improve employee morale & worksite productivity; increase understanding of safety & health requirements, providing supervisors & employees with focus & direction; improve lines of communication, which provide better opportunities for feedback; reduce lost time injuries resulting in cost savings</p> <p>3. Soldier Peak-Performance and Advanced Reconditioning for the Tactical Athlete (SPARTA): Goal is to Provide early access to definitive diagnostic/therapeutic treatment for acute musculoskeletal injuries; improve return to duty rates for acute injuries; decrease MRC3 rates; improve Ortho number of cases to surgery/ number of referrals; improve Primary Care Access to Care by off-loading MSK injuries; integrate available resources to maximize potential gains</p> <p>4. Worksite Visits: Goal is to observe the physical, environmental, toxic and other hazards of our DA Civilian work force by verbal and written recommendations on engineering controls, administrative controls and Personal Protective Equipment (PPE) to protect the work force</p> <p>5. Pre-Placement and Annual Medical Surveillance Exams: Goal is to identify DA civilian employees, who because of pre-existing conditions,</p>	4	<p>1. After Action Reviews</p> <p>2. The organization uses the Environment of Care (EOC) committee to assess established management plan objectives and status through review of Safety, Security, Utilities, and Medical Equipment performance indicators. Areas requiring improvement are then worked out through the Risk Assessment Working Group to mitigate hazards and provide correct action through the Hierarchy of Controls. This provides an overall reflection of the worksite safety program. Annual Assessments are provided to higher headquarters and OSHA on our accident data and is reviewed by leadership prior to submission</p> <p>3. Need for continued profile, time to get into treatment, return to duty timeframes, and MRC3 rates</p> <p>5. Monthly review of the numbers, types and completeness of OH exams.</p>		

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		may be more likely to become injured due to the physical duties and environmental factors of the position by exams tailored to the known and expected hazards for each workplace and duty position 6. Ergonomic Assessments: Goal is to reduce number of cumulative trauma disorder injuries by conducting worksite ergonomic assessments for employees experiencing injury symptoms from their workplaces by a multi-disciplinary Ergonomics team made up of at least two disciplines (Safety, Industrial Hygiene, and Occupational Health) will visit the workplace at the request of an employee or the employee's supervisor				
Fort Huachuca, AZ	9	1. Reconditioning Physical Readiness Training: Goal is to manage injury risk effectively by embedded Physical Therapy (PT) staff in high risk units can demonstrate and assist Soldiers with preventive strategies to mitigate further injury 2. Pregnancy Postpartum Physical Training Program: Goal is to utilize safe exercises for pregnant females along with trained exercise leaders to maintain Soldiers fitness levels during pregnancy and after pregnancy 3. Embedded Physical Therapy assets in the MI Student Clinic and Soldier Centered Clinic: Goal is to limit second and third order effects of initial injuries by embedding PT assets 4. Environmental modifications: Goal is to create of a multi-use path to increase pedestrian and bicyclist safety 5. Bike and walk to work and school campaigns: Goal is to increased MP presence and increased educational awareness training regarding sharing the road 6. Motorcycle Mentorship Program: Goal is to reduce motorcycle accidents and injuries by developing an annual training calendar, an MMP Operator's Packet and a TASKORD for the 20 OCT 2017 safety awareness ride 7. Move Towards Health: Goal is to assess physical activity, diet and personal health goals by an intensive 16 week program available to AD Soldiers, family members, beneficiaries and retirees 8. Performance Triad– Enhancement training: Goal is to gain a basic understanding of progressive training to prevent and treat musculoskeletal injuries and obtain a baseline Functional Fitness Assessment to move forward in their fitness goals by an elective for the Warrant Officer Advanced Course 9. Civilian Fitness Policy: Goal is to improve readiness, resilience, and	1	2. percentage of Soldiers who pass the APFT and meet height/weight standards NLT 6 months postpartum as well as the percentage of Soldiers who require an additional profile while pregnant or postpartum		

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		health by influencing optimal performance through positive sleep, activity, and nutrition behaviors; and supporting healthy working environments.				
Fort Leonard Wood, MO	3	<p>1. Ergonomic Injury Prevention via “Train the Trainer” Program: Goal is to decrease overuse injuries among civilian workers and military personnel if working in the same areas by Office/workstation “Train the Trainer” classes provided by Industrial Hygiene to the unit or directorate ergonomics officer</p> <p>2. Increasing Compliance of Completing Accident Reports: Goal is to decrease number of accidents on the installation by having complete and reliable data to analyze</p> <p>3. Occupational Health Worksite Visits and Industrial Hygiene Completion of Surveys in High Risk Worksites: Goal is to ensure evaluations are being conducted by Occupational Health RNs in order to survey high risk work environments that have seen the highest number of worker’s compensation claims as well as high risk shops identified by IH by increased number and frequency of worksite visits and IH shop surveys.</p>	2	<p>1. Worker’s Compensation Claims, Injury/Illness reporting in OSHA 300 logs. Determine if there was utilization for the classes offered by Industrial Hygiene.</p> <p>3. SMS Metric- Percentage of High Risk Work Places with IH Surveys. Occupational Health timecard entries in DHMRSi will determine whether approximately 30% of all hours logged by eligible providers are spent on worksite visits.</p>	2	<p>1. Hospital staff (as part of the Health Promotion Team Education Series)</p> <p>2. Chief of Industrial Hygiene</p>
RHC-E						
USAG Bavaria/US AG Ansbach (AOR: Bavaria, Ansbach, Grafenwoehr, Vilseck, Hohenfels)	1	Using the Functional Movement System (FMS) Testing Program to identify soldiers who would benefit from a physical therapy referral for corrective movement education and exercises, and see if this reduces the incidence of injury-related medical encounters within the units	1	MRAT measures for Musculoskeletal Problems and Population with Temporary Profiles examined before each testing session. Qualitative information collected through short interviews with Soldiers, Command teams and Testing staff during and after each testing session.		
USAG Rheinland-Pfalz/Landstuhl RMC (AOR: R-P, Kaiserslautern (civ),	1	Landstuhl Regional Medical Center was given the specific task of developing training material highlighting the DOD/VA Low Back Pain Clinical Practice Guideline	1	Tracking training completion via SWANK Health, an online distributed learning solution.		

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Benelux, Vicenza, Weisbaden)						
USAG Stuttgart	3	<p>1. Running gait and shoe analysis clinic/Physical Therapy Clinic: Goal is to improve understanding of the mechanics of running, reduce pain and repeated injury by each participant undergoing a personal foot imprint, a video of their run from front-back and sides, analysis of running gait and shoes by physical therapist and a detailed running, exercise, and shoe recommendation consult</p> <p>2. POSE Running clinic/Physical Therapy Clinic: Goal is to prevent of overuse injury due to poor running form by teaching the POSE method of running to improve form and minimize injury and pain</p> <p>3. Functional Recovery Program Lite/Physical Therapy Clinic: Goal is to improve understanding of injury, pain and repeated injury by 6-week program using the Landstuhl template in abbreviated form</p>	2	<p>1. Participants are followed up with at the 6 week mark to ascertain outcomes.</p> <p>3. Participants are followed up with throughout the 6 week mark to ascertain progress.</p>		
RHC-P						
Fort Wainwright, AK	3	<p>1. Unintentional Injury Prevention-MEDDAC-AK: Goal is to improve MEDDAC-AK unit readiness to 90% or better by reducing the number of musculoskeletal injuries (per MRAT Readiness Data) and profiles for musculoskeletal injuries (per E-Profile data) by a 60 minute class</p> <p>2. 2. Reconditioning PRT-MEDDAC-AK: Goal is to allow injured Soldiers to recover quickly from injuries and maintain fitness while on a limited duty profile by Reconditioning PRT</p> <p>3. Injured Reserve Physical Training Train-the-Trainer (1-25 SBCT): Goal is to Improve overall Readiness of the 1st Stryker Brigade through a more thorough understanding of Exercise Programing, Rehabilitation, and the Human Performance Triad. Improve unit readiness to 95% or better by reducing the number of musculoskeletal injuries (per MRAT Readiness Data) and profiles for musculoskeletal injuries (per E-Profile data) by a week-long training class.</p>	3	<p>1. Assess # of MSK profiles per month (per E-Profile data), # of MSKI injuries (per MRAT data), and APFT scores (during semi-annual APFT).</p> <p>2. 2. # of MSK profiles per month (per E-Profile data)</p> <p>3. 3. Using the MRAT to follow days on profile, tracking days to graduate from IRPT Program as listed on their counseling form, and the readiness rates per battalions who have a functioning IRPT program as compared to those who do not. Furthermore, we will assess # of MSK profiles per month (per E-Profile data), # of MSKI injuries (per MRAT data), and APFT scores (upon graduation from the IRPT Program).</p>		

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US Army Hawaii	6	<ol style="list-style-type: none"> 1. Soldier Performance Improvement/Mentorship initiative: Goal is to decrease unintentional injuries with regard to APFT improvement/remedial physical training 2. Reconditioning PRT with 25th ID: Goal is to improve mission readiness by improving Reconditioning PRT 3. 2BCT Bridge Programs: Goal is to reduce rates of re-injury and educate Soldiers on proper progression of activities by brigade physical therapist creates individualized run/ruck progression for Soldiers and works on technique for efficiency 4. Stability Mobility and Breathing Class: Goal is to reduce rates of re-injury, encouraging activity and movement for Soldiers with higher levels of functional disability by a one hour class once a week 5. 130th Engineer Brigade Yoga: Goal is to add mobility and active rest to Soldiers recovering from injury 6. RIPPED (Reducing Injury, Improving Personal Performance. Every Day.) Newsletter: Goal is to create an avenue for MFT's to continue to develop this specific skill and provide quality training and education to the unit they serve in 	1	2. 25th ID was tracking profile information with data being presented at the CHPC		