Navy and Marine Corps Public Health Center
Technical Manual NMCPHC-TM 6220.12

# Medical Surveillance and Reporting

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NMCPHC Technical Manual TM-6220.12, *Medical Surveillance and Reporting* dated July 2012, is hereby cancelled.

This manual may be accessed through the NMCPHC website:
http://www.med.navy.mil/sites/nmcphc/program-and-policy-support/disease-surveillance/Pages/default.aspx

Reviewed and approved by:

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## TABLE OF ISSUANCE AND REVISIONS/CHANGES

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## Appendices

# 1. Introduction

a. Under current doctrine, commanders at all levels are expected to maximize readiness by taking every reasonable measure to protect their personnel from disease and injury (D&I). To meet these expectations, Navy Medical Department personnel provide commanders with health risk assessments, force health protection (FHP) recommendations and FHP programs. The provision of this kind of support requires not only medical intelligence information about known health threats but also information about the current health of the unit/force. The Navy Medical Department's medical surveillance systems (people, policies, procedures, hardware/software, etc.) provide this support by aggregating surveillance information into data warehouses that make it available to both Command Surgeons and Navy Medicine Public Health experts who have additional analytical and response capability.

b. Medical Surveillance, for the purpose of this manual, is defined by Department of Defense (DoD) Directive 6490.02E. It includes the Navy Medical Department's efforts to capture/collect individual and population health status indicators, disease and injury data, and medical interventions (such as immunizations, treatments, and medications) to permit analysis, interpretation, and reporting of population-based information. This is done to identify, characterize, and counter threats to the Navy population's health, well-being, and performance.

**2. Purpose.** This manual provides basic medical surveillance procedures and reporting requirements for all Navy Medical Department personnel at the tactical/unit level to enable them to execute their basic regulatory duties as defined in chapters 2 and 22 of NAVMED P117, Manual of the Medical Department. There are two types of surveillance and reporting covered in this manual: a) reportable medical event (RME) surveillance and reporting and b) syndromic and categorical injury surveillance and reporting. Each type will be described separately below.

**3. Reportable Medical Events.** RMEs are events, usually disease or etiologic agent specific, which may pose an inherent, significant threat to public health and military operations. They have the potential to affect large numbers of people, to be widely transmitted within a population, to have severe/life threatening clinical manifestations, and/or to disrupt military training and deployment. In addition, actions exist to prevent or limit their occurrence. Specific RMEs were chosen from the Centers for Disease Control and Prevention (CDC) and the Council of State and Territorial Epidemiologists (CSTE) list of national notifiable diseases by a Tri-Service consensus. Military public health experts have also identified additional diseases which potentially pose a significant threat to military forces. The Armed Forces Health Surveillance Center (AFHSC) publishes the agreed upon RME list along with specific case definitions as the *Armed Forces Reportable Medical Events Guidelines & Case Definitions.* Reports of these events are commonly referred to as Medical Event Reports (MERs).

***a. Navy Medical Event Reporting Requirements***. Per BUMEDINST 6220.12 (series), any medical event that meets the case definition of a reportable event, as defined in the Armed Forces Reportable Medical Events Guidelines, must be reported. Any case(s) of novel influenza, as defined in Appendix A of this manual, must also be reported. The RMEs are to be reported by the medical officer, command surgeon, or their designated staff responsible for the health care/treatment of that individual. In instances where preliminary MERs are submitted while the health care team is waiting for more definitive information about the RME, the MERs shall be finalized once that information is available. Also, when submitting MERs of outbreaks or disease clusters, reporters need not include identifying information about individual patients or file a MER for each individual case unless instructed otherwise by the supporting Navy Environmental and Preventive Medicine Unit (NEPMU). See Appendix B for a description of information to include in outbreak reports.

***b. Medical Event Report Deadlines.*** Reports can be either urgent or routine. Urgent reports are required within 24 hours for some events as identified in Appendix C. Submit routine reports for all non-urgent events no later than seven calendar days after their identification.

***c. Medical Event Reporting Methods.*** The Disease Reporting System Internet (DRSi) is the Navy's official system to submit, view and track MERs. All shore based military treatment facilities (MTF) and all operational units where a Preventive Medicine Technician has been permanently assigned should use it. To obtain a DRSi account, contact the Navy DRSi helpdesk at NDRS@nmcphc.med.navy.mil, COMM: 757-953-0954, DSN: (312) 377-0954 or follow the detailed instructions available at NMCPHC's web site, http://www.med.navy.mil/sites/nmcphc/program-and-policy-support/drsi/Pages/default.aspx. All others may submit MERs by DRSi, phone, naval message, or e-mail to their nearest NEPMU. Appendix D contains a list of basic information to include in any MER submitted by means other than the use of DRSi. Note that reporters must protect sensitive information, including personal health information (PHI) and personally identifiable information (PII), in MERs from unauthorized access and disclosures as is required by DoD and Navy directives. Use only government furnished equipment and software when protected health information is to be transmitted electronically. When internet connectivity is limited, reporters may use the seven day reporting window for non-urgent MERs and wait for improved connectivity. If affected by connectivity limitations, MERs may be made by phone, naval message, or e-mail to their nearest NEPMU as described above. Operational units in a command-directed communications condition that prohibits all external communications may delay reports until the condition is lifted.

***d. State and Local Reporting Requirements.*** Regulations promulgated by the Chief, Bureau of Medicine and Surgery in the Navy's Manual of the Medical Department

mandate that all Navy Medical Officers will cooperate with the Public Health Service and other Federal, State, and local agencies for the prevention of disease and reporting of communicable diseases. Therefore, Senior Medical Officers or heads of unit medical departments must ensure that their unit has processes in place to report medical events deemed reportable by the laws of the State where their unit is based or home ported. Ships and other deployable units are generally exempt from their home State's reporting requirements while deployed unless there is a public health reason to report.

***e. International Reporting Requirements.*** In areas outside the United States and its territories, U.S. military units rarely report directly to host nation militaries or foreign governments. Routine medical event reporting to foreign governments or militaries shall be consistent with the requirements of applicable formal agreements with foreign governments, or allied forces.

## 4. Syndromic and Categorical Injury Surveillance.

This type of surveillance involves monitoring the incidence of specific pre-diagnostic syndromes and injuries occurring in specific populations to identify important clusters of disease/injury at the earliest time possible. Such events may be indicative of a biological weapon attack, a natural disease outbreak, or a force health protection breakdown. This surveillance is also known as disease and non-battle injury (DNBI) surveillance. New guidance refers to it simply as D&I surveillance. D&I surveillance is performed either electronically or manually depending on a unit's ability to complete and transmit healthcare encounter records to central Military Health System (MHS) data repositories.

### *a. Disease and Injury Surveillance and Reporting Methods.*

**(1) Electronic.** This preferred method involves the analysis and monitoring of D&I related information stored in MHS data repositories with the aid of analytic systems such as the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE), the Joint Medical Workstation, or the Theater Medical Data Store web interface. Installation Public Health Emergency Officers and MTF-based public health staff typically monitor ESSENCE. Technical guidance on the use of this system is provided separately by the NMCPHC on its website http://www.med.navy.mil/sites/nmcphc/program-and-policy-support/essence/Pages/default.aspx.

**(2) Manual.** As identified in BUMEDINST 6220.12(series), a limited number of remaining unit Medical Officers, Command Surgeons, and Senior Medical Department representatives assigned to operational units may still need to compile and submit manual reports of their unit's D&I information to the NMCPHC. Current procedures for this require the use of

unit-type specific Microsoft (MS) Excel spreadsheet templates. Those who still need to submit reports in this way shall:

(a) Obtain and use the latest D&I Spreadsheet templates for their unit type. They are available at http://www.med.navy.mil/sites/nmcphc/program-and-policy-support/disease-and-injury-reports/Pages/default.aspx.

(b) Use a unique MS Excel spreadsheet for each unit and do not include multiple unit reports in a single MS Excel file.

(c) Record and define, by syndrome or injury category, every new patient encounter resulting in an official visit. Syndrome and categorical injury definitions appear in Appendix E. Do not include administrative visits for immunizations, screenings, dental exams, physical exams, periodic health assessments (PHAs), or deployment health screenings/check-ups in the reports.

(d) Ensure that weekly D&I reports identify the entire unit's population at risk during the report week to enable the calculation of rates.

(e) Name the MS Excel spreadsheet file as follows before submitting your weekly report: "**unitname.xls**." Omit "USS" in front of the unit name, if applicable; for example, the USS ALASKA should name their MS Excel file "Alaska.xls".

(f) Submit completed D&I reports via e-mail to: dnbi-unclas@nehc.mar.med.navy.mil by close of business on Monday following the end of the report week.

## 5. Disease and Injury Report Analysis.

D&I incidence rates for each syndrome or injury category are calculated automatically within the spread sheets as data are entered, and the sheets indicate automatically when the rates have exceeded predetermined action levels. Reporters should use the decision instrument in Appendix F to answer important epidemiological questions when action levels are exceeded. This instrument should guide the reporter's comments in the D&I report and guide whether or not to complete a formal medical event report per guidance in paragraph 3 of this manual.

## 6. Classification of Medical Event and Disease and Injury Reports.

In general, these reports are "unclassified" unless an officer with appropriate authority has classified one. Reporters who are concerned that a report from their unit might have an adverse impact on their unit's operational security or our national security should consult their information security/commanding officer for a classification decision before releasing the report.

However, all MER and D&I reports contain sensitive medical information, so all reports made through email should be signed (digitally) and encrypted.

## 7. Consultation.

See Appendix G for contact information for your nearest NEPMU. The NEPMUs are the Navy's primary consultative resource for:

- Disease/outbreak confirmation and response assistance including implementation of prevention and control measures
- Reporting assistance
- Public health lab support, sample collection, etc
- Epidemiological study designs
- Disease surveillance and response training

# Appendix A

## Case Definition for Influenza A, Novel

### Clinical Description

An illness compatible with influenza virus infection (fever >100 degrees Fahrenheit, with cough and/or sore throat).

### Laboratory Criteria for Diagnosis

A human case of infection with an influenza A virus subtype that is different from currently circulating human influenza H1 and H3 viruses. Novel subtypes include, but are not limited to, H2, H5, H7, and H9 subtypes. Influenza H1 and H3 subtypes originating from a non-human species or from genetic reassortment between animal and human viruses are also novel subtypes. Novel subtypes will be detected with methods available for detection of currently circulating human influenza viruses at state and military public health laboratories (e.g., real-time reverse transcriptase polymerase chain reaction [RT-PCR]). Confirmation that influenza A virus represents a novel virus will be performed by CDC's influenza laboratory. Once a novel virus has been identified by CDC, confirmation may be made by public health laboratories following CDC-approved protocols for that specific virus, or by laboratories using an FDA-authorized test specific for detection of that novel influenza virus.

### Exposure

Criteria for epidemiologic linkage:

- The patient has had contact with one or more persons who either have or had the disease, AND
- Transmission of the agent by the usual modes of transmission is plausible. A case may be considered epidemiologically linked to a laboratory-confirmed case if at least one case in the chain of transmission is laboratory confirmed. Laboratory testing for the purposes of case classification should use methods mutually agreed upon by CDC and the CSTE. Currently, only viral isolation, RT-PCR, gene sequencing, or a 4-fold rise in strain-specific serum antibody titers are considered confirmatory.

### Case Classification

#### Suspected

A case meeting the clinical criteria, pending laboratory confirmation. Any case of human infection with an influenza A virus that is different from currently circulating human influenza H1 and H3 viruses is classified as a suspected case until the confirmation process is complete.

#### Probable

A case meeting the clinical criteria and epidemiologically linked to a confirmed case, but for which no confirmatory laboratory testing for influenza virus infection has been performed or test results are inconclusive for a novel influenza A virus infection.

#### Confirmed

A case of human infection with a novel influenza A virus confirmed by CDC's influenza laboratory or using methods agreed upon by CDC and CSTE as noted in Laboratory Criteria, above.

## Appendix B

### Medical Event Report Elements for Disease Outbreak/Cluster Reports

1. Date of onset**:**
   a. Date of first case:
   b. Date of onset of last case:
2. Reporting command:
3. Name of reporter:
4. Reporter's telephone number (include commercial and DSN, as applicable):
5. Reporter's e-mail address:
6. Reporting command's unit identification code (UIC):
7. Diagnosis/Etiologic Agent:
8. Diagnosis/outbreak status (suspected, probable or lab confirmed):
9. Type of outbreak: foodborne, waterborne, vector-borne GI-infectious, respiratory, dermatologic, neurologic, or unknown/other.
10. Number of people affected**:**
    a. Number of cases lab confirmed:
    b. Number of probable/suspect cases:
11. Affected population's geographic location:
    a. City:
    b. State:
    c. Country:
12. Narrative:
    a. Case definition (include specific patient criteria (signs/symptoms) or epidemiological criteria used:
    b. If the RME status is "lab confirmed," describe the test(s) and sample(s) tested to include the sample(s) specific types and source(s):
    c. Investigation description. Describe epidemiologic studies (patient exposure histories/surveys, food/water exposure history attack rate comparisons, travel histories, etc.) and environmental evaluations of, for example, food and water production, used to identify a common source or important risk factors. Include lists of specific questions used in surveys/questionnaires:
    d. List specific preventive measures taken (i.e. prophylaxis, immunization, patient cohorting, isolation, quarantine, hand washing protocols, food service protocols, environmental cleaning, space closures, work limitations, pesticide applications, etc.):
13. Additional Comments (optional):

# Appendix C

## Reportable Medical Events List

| | |
|---|---|
| | AMEBIASIS |
| ! | ANTHRAX |
| ! | BOTULISM |
| | BRUCELLOSIS |
| | CAMPYLOBACTER INFECTION |
| | CHLAMYDIA TRACHOMATIS, GENITAL INFECTIONS |
| | CHOLERA |
| | COCCIDIOIDOMYCOSIS |
| | COLD WEATHER INJURIES |
| | CRYPTOSPORIDIOSIS |
| | CYCLOSPORA INFECTION |
| | DENGUE FEVER |
| ! | DIPHTHERIA |
| | E. COLI, SHIGA TOXIN-PRODUCING (INCLUDES O157:H7) |
| | EHRLICHIOSIS / ANAPLASMOSIS |
| | ENCEPHALITIS, ARBOVIRAL |
| | FILARIASIS |
| | GIARDIASIS |
| | GONORRHEA |
| | HAEMOPHILUS INFLUENZAE, INVASIVE DISEASE |
| | HANTAVIRUS DISEASE |
| | HEAT ILLNESS |
| ! | HEMORRHAGIC FEVER |
| | HEPATITIS A |
| | HEPATITIS B, ACUTE & CHRONIC |
| | HEPATITIS C |
| | INFLUENZA-ASSOCIATED HOSPITALIZATION |
| !* | INFLUENZA A, NOVEL |
| | LEGIONELLOSIS |
| | LEISHMANIASIS |
| | LEPROSY |
| | LEPTOSPIROSIS |
| | LISTERIOSIS |
| | LYME DISEASE |
| ! | MALARIA (ALL) |
| ! | MEASLES (Rubeola) |
| ! | MENINGOCOCCAL DISEASE |
| | MUMPS |
| | NOROVIRUS |
| ! | OUTBREAK or DISEASE CLUSTER |
| | PERTUSSIS (Whooping Cough) |
| ! | PLAGUE |
| ! | POLIOMYELITIS |
| | Q FEVER |
| ! | RABIES, HUMAN |
| | RELAPSING FEVER |
| | RHEUMATIC FEVER (ACUTE) |
| | RIFT VALLEY FEVER |
| | ROCKY MOUNTAIN SPOTTED FEVER (*Rickettsia rickettsii*) |
| | RUBELLA (German measles) |
| | SALMONELLOSIS (*Salmonella* spp.) |
| | SCHISTOSOMIASIS |
| ! | SEVERE ACUTE RESPIRATORY SYNDROME (SARS) |
| | SHIGELLOSIS (*Shigella* spp.) |
| ! | SMALLPOX |
| | STREPTOCOCCUS, GROUP A, INVASIVE |
| | SYPHILIS |
| | TETANUS |
| | TOXIC SHOCK SYNDROME |
| | TRICHINOSIS |
| | TRYPANOSOMIASIS |
| ! | TUBERCULOSIS, PULMONARY |
| ! | TULAREMIA |
| | TYPHOID FEVER |
| | TYPHUS FEVER |
| | VARICELLA (Chickenpox) |
| | YELLOW FEVER |

! = Report within 24 hours

!* Case definition for Influenza A, Novel appears in Appendix A. Report within 24 hours.

## Appendix D

### Medical Event Report Format: Minimum Elements (Message, Mail, & Phone)

Note: This is not a form for entering data. These data elements can be provided in absence of the DRSi and must be handled and protected in accordance with DOD 6025.18-R. SECNAVINST 5211.5E and applicable DON Privacy Program regulations. The Privacy Act System of Records Notice for DRSi is N06150-2.

1. Today's date**:**
2. Reporting command and unit identification code (UIC):
3. Name of reporter:
4. Telephone of reporter (include commercial and DSN, as applicable):
5. E-mail address of reporter:
4. Patient's first and last name:
5. Patient's gender:
6. Patient's date of birth:
7. Patient's family member prefix/sponsor's SSN:
8. Sponsor's duty status (active, reserve, midshipmen, civilian, etc.):
9. Sponsor's rank/grade:
10. Sponsor's duty station and unit identification code:
11. Sponsor's Command and unit identification code (UIC):
12. Sponsor's Branch of Service:
13. Diagnosis:
14. Diagnosis status (suspected, probable or confirmed):
15. Disposition:
16. Additional Comments (if applicable, include vaccination status and pertinent travel):

# Appendix E

## Definitions of Syndromes and Injury categories: Manual D&I Surveillance

**Fever, Unexplalined:** New (incident). Oral temperature ≥ 100.5°F (38°C) for 24 hours or a history of fever with chills but no clear diagnosis. Such fevers cannot be explained by other inflammatory/infectious processes such as respiratory infections, heat and overexertion. INCLUDES septicemia and viremia. EXCLUDE cases where diagnoses allow more appropriate categorization (i.e. Influenza-like illness, neurological, or gastrointestinal illness syndrome). Targeted conditions – tropical diseases such as malaria, dengue, yellow fever, and typhoid fever.

**Influenza-like Illness**: New (incident). Illness characterized by fever (oral temperature > 100.0F° or 37.8C°) AND either cough or sore throat. Targeted conditions - influenza, adenovirus, pulmonary anthrax, tularemia, pneumonic plague, or emerging febrile respiratory infections (e.g., SARS).

**Lower Respiratory Illness**: Any new (incident) diagnosis of the lower respiratory tract, such as bronchitis, pneumonia, emphysema, reactive airway disease, and pleurisy.

**Rash:** New (incident). Acute condition of unclear etiology that may be consistent with smallpox (macules, papules, or vesicles predominantly on the face, arms, and legs). INCLUDES specific diagnoses such as chicken pox or smallpox and non-specific diagnoses such as viral exanthems. EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheic dermatitis, rosacea, rash not otherwise specified, rash due to poison ivy, sunburn, and eczema. Targeted conditions – smallpox, weapons of mass destruction, blister agent.

**Localized Cutaneous Lesion**: New (incident). Localized edema and/or cutaneous lesion (vesicle, ulcer, or eschar) that might be consistent with cutaneous anthrax or tularemia. INCLUDES insect bites. EXCLUDES generalized rashes, diabetic ulcers or ulcers associated with peripheral vascular disease. Targeted conditions – cutaneous anthrax, tularemia, or diseases like cutaneous leishmaniasis.

**GI – Infectious**: New (incident). Gastrointestinal, Infectious. All new (incident) diagnoses consistent with infection of the intestinal tract. Includes any type of diarrhea, gastroenteritis, “stomach flu”, nausea/vomiting, hepatitis, etc. EXCLUDES non-infectious intestinal diagnoses such as hemorrhoids, ulcers, irritable bowel syndrome, etc.

**Botulism-like**: Acute paralytic conditions consistent with botulism: CN VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, medial rectus palsy; acute descending motor paralysis (including muscles of respiration); or acute symptoms such as diplopia, dry mouth, dysphagia, difficulty focusing on a near point. Targeted condition - botulism.

**Neurological**: New (incident). Acute infection or intoxication of the central nervous system. INCLUDES meningitis, encephalitis, or encephalopathy and acute non-specific symptoms such as meningismus and delirium. EXCLUDES alcohol intoxication or any chronic, hereditary, or degenerative conditions of the CNS such as obstructive

hydrocephalus, Parkinson's. Targeted conditions – pneumococcal or meningococcal meningitis, viral encephalitides, rabies, toxic material/chemical exposures, etc.

**Psychiatric, Mental Disorders**: New (incident). Debilitating mental behavioral or somatic symptoms that meet diagnostic criteria for or have been previously diagnosed as a psychiatric/mental disorder including Post Traumatic Stress Disorder and adjustment disorders. EXCLUDES symptoms due to identified physical disease or injury, or symptoms better explained as a transient combat/operational stress reaction.

**Heat/Cold Injuries**: Heat/Cold Injuries. New (incident) Climatic injuries, including heat stroke, heat exhaustion, heat cramps, dehydration, hypothermia, frostbite, trench foot, immersion foot, and chilblain.

**Injury, Rec. /Sports**: Injuries, Recreational/Sports. Any new (incident) injury occurring as a direct consequence of the pursuit of personal and/or group fitness, excluding formal training.

**Injury, MVA**: Injuries, Motor Vehicle Accidents. Any new (incident) injury occurring as a direct consequence of a motor vehicle accident.

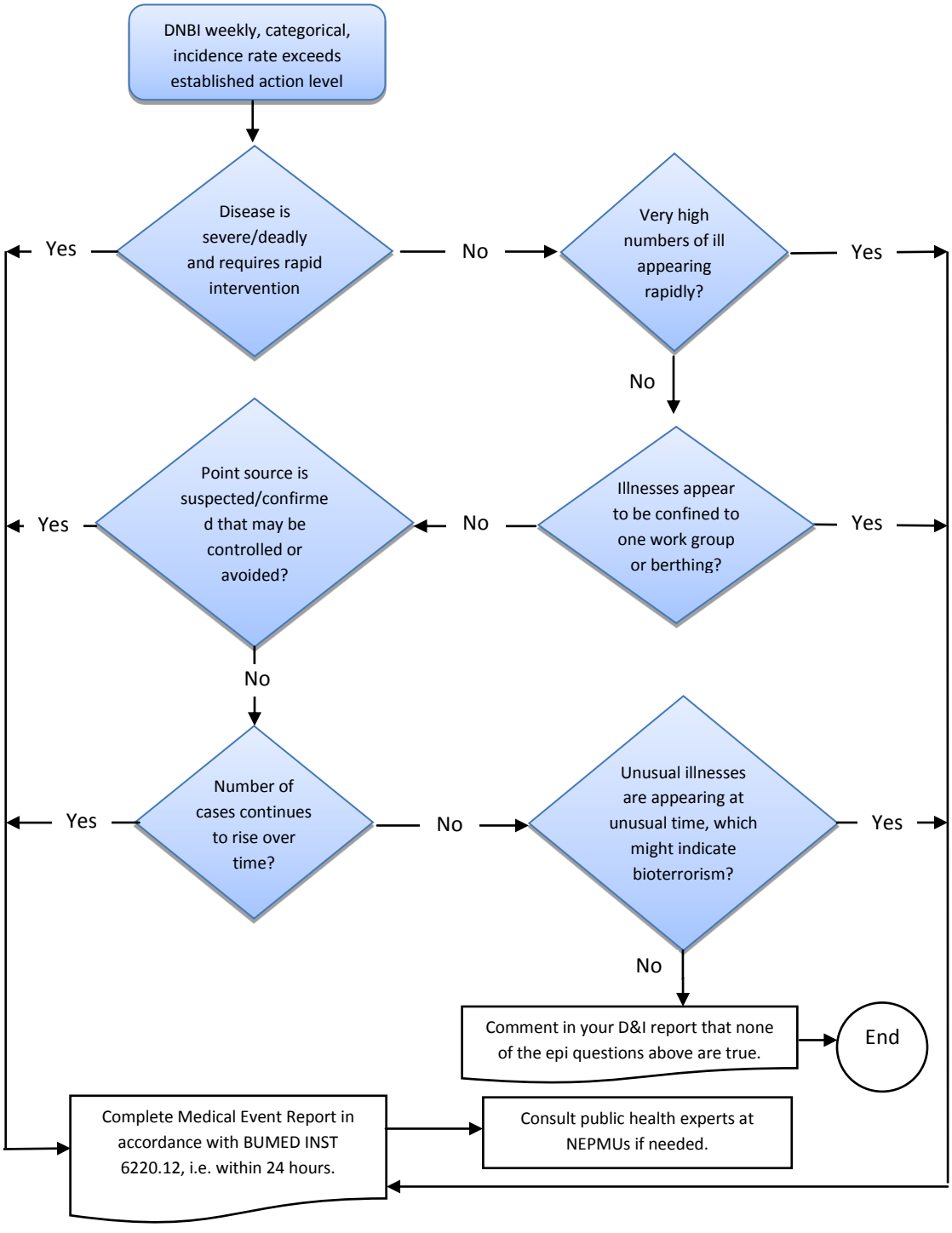
**Injury, Work/Training**: Injury, Work/Training. Any new (incident) injury occurring as a direct consequence of military operations/duties or of an activity carried out as part of formal military training, to include organized runs and physical fitness programs.

**Injury, Other**: Injury, Other. Any new (incident) injury not included in the previously defined injury categories.

**All Other**: Category. EXCLUDES all administrative/screening visits and exams.

# Appendix F

## Decision Instrument for Investigation of Elevated D&I Incidence Rates[1]




1. Not applicable to all injuries, psychiatric visits, or visits for combat or operational stress.

# Appendix G

## Navy Environmental and Preventive Medicine Unit Contact Information

Officer in Charge
Navy Environmental and Preventive Medicine Unit TWO
1285 West D Street, Bldg. U-238
Naval Station Norfolk, VA 23511-3394
Com: (757) 953-6600; DSN (312) 377-6600; Fax (757) 953-7212
E-mail : NEPMU2NorfolkThreatAssessment@med.navy.mil
PLA: NAVENPVNTMEDU TWO NORFOLK VA

Officer in Charge
Navy Environmental and Preventive Medicine Unit FIVE
3235 Albacore Alley
San Diego, CA 92136-5199
Com: (619) 556-7070; DSN (312) 526-7070; Fax (619)556-7071
Secure Telephone (STU-III): (619) 556-9694: DSN 526-9694
E-mail: ThreatAssessment@med.navy.mil
PLA: NAVENPVNTMEDU FIVE SAN DIEGO CA

Officer in Charge
Navy Environmental and Preventive Medicine Unit SIX
385 South Ave Bldg. 618
Joint Base Pearl Harbor-Hickam, HI 96860
Com: (808) 471-0237; DSN (315) 471-0237; Fax: (808) 471-0157
E-mail: NEPMU6ThreatAssessment@med.navy.mil
PLA: NAVENPVNTMEDU SIX PEARL HARBOR HI

Commanding Officer
Navy and Marine Corps Public Health Center
620 John Paul Jones Circle, Suite 1100
Portsmouth, VA 23708-2103
Com: (757) 953-0697; DSN (312) 377-0697; Fax: (757) 953-0685
E-mail: NMCPHCPTS-ThreatAssessment@med.navy.mil
PLA: NAVMCPUBHLTHCEN PORTSMOUTH VA

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