NORTH

NORTHERN REGIONAL MEDICAL COMMAND

VOLUME FIVE | WINTER 2012

COMMAND TEAM CHARTS COURSE FOR THE NEW YEAR

REGION REDUCING MEDICAL EVALUATION PROCESSING TIME

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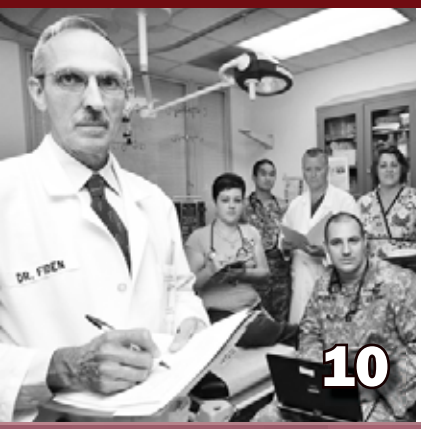

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ON THE COVER: Brig. Gen. Joseph Caravalho, Jr. and Command Sgt. Maj. Benjamin Scott stand in front of the new Northern Regional Medical Command headquarters building at Fort Belvoir, Va. Photo: Kevin Gonzales

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ARMY MEDICINE
Serving To Heal...Honored To Serve

NORTH

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A MESSAGE FROM NRMC LEADERSHIP

Brig. Gen. Joseph Caravalho, Jr.

Command Sgt. Maj. Benjamin Scott

Welcome to the Winter edition of NORTH, the first of 2012. NORTH tells the story of the dedicated professionals, both uniformed and civilian, of the Northern Regional Medical Command, who take on the monumental task of caring for America's Army and Army Families across a vast area of the country, providing the highest caliber healthcare available anywhere.

This issue illustrates that point. You will find stories of our commitment to effective healthcare delivery, like the article from Fort Bragg, N.C., on the patient-centered changes to healthcare coming to Womack Army Medical Center.

Our support to our Nation's warfighters is illustrated by the decline in both the number of days it takes Soldiers to complete the initial medical evaluation and the more formal medical evaluation board process, helping our Soldiers to either return to active duty or resume successful civilian lives.

NRMC develops leaders. The proof is in the accolades received by our military and civilian staff members. A McDonald Army Health Center sergeant was recently selected as the Fort Eustis, Va ., Noncommissioned Officer of the Year.

A commitment to medical innovation is a constant theme across the region. Womack Army Medical Center recently held its first nuclear medicine conference, bringing leaders in the field together for the advancement of patient care.

You will find these and other stories in these pages. The common elements are expertise, care and a commitment to take Army Medicine into the future. Enjoy.

Brig. Gen. Joseph Caravalho, Jr.
Commanding General
Northern Regional Medical Command

Command Sgt. Maj. Benjamin Scott
Command Sergeant Major
Northern Regional Medical Command

REGION MAKES GAINS IN REDUCING MEDICAL EVALUATION PROCESSING TIME

Story by Gail Cureton

Erin Frost-Tate, Health Systems Specialist, Physical Evaluation Board Liaison Office, Fort Drum, N.Y., explains the Integrated Disability Evaluation System (IDES) process to Spc. Jacob Pennell, C Company, 2nd Brigade Special Troops Battalion, 10th Mountain Division (LI), as he begins the Medical Board process. Photo: Kate Agresti

A collaborative Department of Defense/Department of Veterans Affairs program designed to streamline the disability evaluation process is realizing success within the Northern Regional Medical Command (NRMC).

Since January 2011, NRMC has seen a decline in both the number of days it takes service members to complete the initial medical evaluation and the more formal medical evaluation board processing. The evaluation stage now takes on average 70 days versus the 79 days of a year ago while the more comprehensive board processing time has been reduced by 31 days from 162 to 131 days.

The Army medical evaluation is the first part in a multi-phased process called Integrated Disability Evaluation System (IDES). IDES, launched as a pilot program in 2007 with Army-wide implementation in 2011, is a seamless, transparent disability evaluation system administered jointly by the Departments of Defense and Veterans Affairs to make disability evaluations for wounded, ill or injured service members and veterans, simple and seamless.

IDES was created to address what was described by many Soldiers, their Families and members of Congress to be a complex, disjointed and lengthy process in which both the DoD and the VA maintained separate evaluation systems.

Colonel Nathaniel Todd, NRMC IDES project manager, attributes the reduction to the lessons learned during the pilot phase of the IDES program. Military hospitals within the National Capital Region, which included the former Walter Reed Army Medical Center and Dewitt Army Community Hospital, were among the first DoD facilities to implement IDES.

"Many of our personnel are very familiar with the coordination and collaboration that are needed to make this process work for our wounded, ill and injured Soldiers. Some of our MTFs (medical treatment facilities) have been working this for 18 months, so we have a very mature process in place," he said. "We were able to take what we learned during the pilot and use that at MTFs throughout the region."

Two of those MTFs, Womack Army Medical Center at Fort Bragg, N.C., and Guthrie Army Health Clinic at Fort Drum, N.Y., are both well on their way toward meeting or exceeding the DoD goals of 35 days for MEB phase and 100 days for completion of the entire MEB process. Fort Drum has reduced the number of days it takes to begin an MEB from 69 to 31 days, a decrease of 44 percent. Fort Bragg has decreased its MEB stage days from 52 to 45 despite having more IDES cases to manage.

"We are trending downward," Todd said. "Over the next 120 to 180 days all of our facilities will be meeting the standards set by guidance and regulation. The staffs at our MTFs are doing great work in support of IDES implementation. They understand the importance of this effort."

Brig. Gen. Joseph Caravalho, Jr., NRMC commanding general, said the objective is not simply to meet or exceed standards because there is a policy in place requiring us to do so.

"Righting a process that was not working well and doing everything we can to provide the appropriate resources to support the end goal are among this region's highest priorities. Our Soldiers and their Families deserve a well-coordinated, well-managed transition process. This is about taking care of Soldiers."

NEW COMMAND SERGEANT MAJOR ASSUMES RESPONSIBILITY

Story by Gail Cureton Photos: Theresa Roman

Brig. Gen. Joseph Caravalho, Jr. passes the NCO sword to Command Sgt. Maj. Benjamin Scott at the change of responsibility ceremony Dec. 9, 2011, held in Wood Theater at Fort Belvoir, Va.

Command Sgt. Maj. Benjamin Scott accepted the ceremonial noncommissioned officers sword from outgoing Command Sgt. Maj. Frances Rivera signifying his assumption of authority as the Northern Regional Medical Command's senior enlisted leader Dec. 9 during a ceremony on Fort Belvoir.

Rivera, who retired after 31 years of service, thanked the command leadership for their support and left a leadership charge to those who follow her. "I ask that each sergeant major here today remember that we are the standard bearers. You have a legacy to live for and to leave to your Soldiers. It is never about you. It is about the (Army) values. It is about the NCO Creed. It is about being the most professional Soldier you can be."

Brigadier Gen. Joseph Caravalho Jr., NRMC commanding general, commended Rivera on her leadership during a time of significant change in the region as the result of the Base Realignment and Closure. "Command Sergeant Major Rivera led our medics, officers and DA Civilians through the process, while ensuring we continued to deliver the caliber of care this region is known to provide.

"Command Sergeant Major Rivera was the kind of leader our NCO Corps needed at a time of trying transition, and I, for one, am grateful for the opportunity to experience her professionalism first-hand," the general said.

Scott confirmed his responsibility as the new NRMC command sergeant major by stressing the importance of leading by example not by perfection. "I believe God will keep perfection for himself. Excellence we can all do and that is what we should do, what we must do," he said.

He concluded his remarks with a quote made famous by the Army Chief of Staff: "The strength of our nation is our Army. The strength of our Army is our Soldiers. The strength of our Soldiers is our Families. That is what makes us Army strong. That is what makes us NRMC strong."

A Charleston, S.C., native, Scott has served in a wide variety of leadership roles throughout his more than 27 years in the United States Army, specializing in dentistry. He most recently served as the Command Sergeant Major for the Warrior Transition Command (WTC). As the senior enlisted advisor to the WTC Commander, he was charged with advising the WTC Commander on the Army's Warrior Care and Transition Program and support for wounded, ill, and injured Soldiers.

Other senior leadership assignments included command sergeant major for Landstuhl (Germany) Regional Medical Center, where he worked closely with Soldiers medically evacuated from the combat theater in Iraq and Afghanistan. Immediately prior to arriving at Landstuhl, Scott was the command sergeant major for the U.S. Army Medical Activity at Fort Irwin, Calif., where he helped start a unit specializing in the care of severely injured Soldiers and Soldiers with traumatic brain injuries.

Command Sgt. Maj. Benjamin Scott speaks during the change of responsiblity ceremony.

His awards include Bronze Star Medal, Meritorious Service Medal with five oak leaf clusters , Army Commendation Medal with five oak leaf clusters, Army Achievement Medal with seven oak leaf clusters, Army Good Conduct Medal with seven oak leaf clusters, National Defense Service Medal with bronze star, Korean Defense Service Medal, Iraq Campaign Medal, Global War on Terrorism Expeditionary Medal, Global War on Terrorism Service Medal, NCO Professional Development Ribbon with numeral 4, Army Service Ribbon, Overseas Service Ribbon with numeral 3, Meritorious Unit Citation with one oak leaf cluster, and one overseas service bar. He earned the Expert Field Medical Badge, German Marksmanship Award (Schuetzenschnur), and is a member of the prestigious Sergeant Morale and Sergeant Audie Murphy Clubs and a recipient of the Order of Military Medical Merit.

KENNER ARMY HEALTH CLINIC HONORS NAMESAKE

Story by Tereasa Wade

Photo courtesty of Kenner Army Health Clinic

In the Army, buildings are often named after past leaders in recognition of their great accomplishments and contributions. In keeping with that tradition, Kenner Army Health Clinic, Fort Lee, Va., was named for Maj. Gen. Albert Walton Kenner, who served with distinction as an Army doctor for 33 years.

The clinic paid tribute to Kenner with a ceremony marking his 122nd birthday Dec. 15.

"Celebrating our Kenner namesake on the 122nd anniversary of his birth seems like the right thing to do," said Col. Joseph S. Pina, Kenner Army Health Clinic commander. "Team Kenner is proud to honor Maj. Gen. Kenner, and we hope to emulate his professionalism as we carry on providing quality health care in his name."

Members of Kenner's family will attend the ceremony, which also marks nearly 50 years since April 12, 1962, when Army Surgeon General Lt. Gen. Leonard D. Heaton dedicated the Fort Lee hospital as Kenner Army Hospital. The new Kenner Army Hospital replaced the previous facility that had been in operation since 1941.

"I am honored to be able to celebrate this auspicious occasion honoring Maj. Gen. Kenner and his many achievements and contributions to Army medicine," said Lt. Col. Paula Davis-Bonner, chief, Active Duty Clinic, who was born at Kenner the same month and year as the building was dedicated. "Kenner is a great facility, and I have truly enjoyed my two assignments here," said Davis-Bonner.

Kenner was born in Holyoke, Mass., on Dec. 15, 1889, and received his Ph.D. and M.D. degrees from George Washington University in 1910 and 1915, respectively.

"In paying tribute to Maj. Gen. Kenner and his career, and reflecting on the man that he was, certain things come to mind," said Pina. "Maj. Gen. Kenner was definitely an important figure in medical history, a great Soldier and a natural leader. We as Team Kenner pay tribute to Maj. Gen. Kenner and are glad to have the opportunity to fondly remember this great leader's passion for life, and to share why he was the inspiration for the name of this hospital and clinic."

Relatives visit clinic, bring living history of Rodney Conner, for whom the clinic is named

Story and photo by Kate Agresti

Pamela Chatterton-Purdy shares stories about letters home that her uncle "Rod" sent his mother during World War II, and a framed sampling, which she presented to Guthrie Army Health Clinic leaders, Command Sgt. Maj. Timothy J. Sprunger (center) and Col. Mark W. Thompson.

How many times do we walk into a building on a military installation and realize the name affixed to it pays tribute to deceased Army military and civilian personnel with records of outstanding and honorable service, under the Army Memorial Program?

Such is the case with the Conner Troop Medical Clinic (CTMC), Fort Drum, N.Y. named in honor of Technician Fifth Grade William Rodney Conner, who as a medic of the 87th Mountain Infantry Regiment, 10th Mountain Division, was awarded the Silver Star posthumously for gallantry in action on March 3, 1945, during an attack near Cimon Della Tiella, Italy.

Most times, we walk in - we walk out - having accomplished our business at hand, without a second thought. However, when you receive word that family members of the individual for whom a building is named are planning a visit, all that changes. The 'name' behind the building becomes a living history, as shared by those who knew the individual in life.

Last fall, Guthrie Army Health Clinic and CTMC leadership, and a handful of military and civilian staff, hosted a visit from Ms. Pamela Chatterton-Purdy, Conner's niece, and her husband, Rev. Dr. David A. Purdy, at CTMC. The couple had been in Utica the day prior, and felt it would be the perfect opportunity to visit Fort Drum to see the clinic named after Rodney Conner, as well as present MEDDAC command and leadership with photos, letters, and medals for display on-site.

For the family, the significance of entering the facility for the first time and speaking with command and leadership was immense.

"When my husband and I arrived at the Conner Troop Medical Clinic on Sunday, Oct. 16, we were so impressed. The day was gorgeous, the sky bright blue, the trees in full color. We were greeted and received with such a warm welcome that it brought tears to my eyes," said Chatterton-Purdy. "Any one of the young men who welcomed us could have been my 23-year-old uncle Rod, or one of our own sons!"

Ms. Chatterton-Purdy, who is a Massachusetts artist, had lovingly and artistically, framed a sampling of Conner's "Dear Mom" letters written from the war, as well as photos, which she proudly presented to Commander Col. Mark W. Thompson, and Command Sgt. Maj. Timothy J. Sprunger.

"Even though Rod was my uncle, (I was only 4 when he was killed) I had come to feel as if I was his mother," she said. "I had read so many of his letters addressed to 'Dear Mom,' and felt the caring tenor of his writing with the underlying (I am OK Mom, please don't worry).

"…My Uncle Rodney Conner did not die in vain, especially as he gave his life as a medic in an attempt to save the life of one of his comrades. We are so proud to have the clinic named after him!

"Rod's Purple Heart and Silver Star are now in a place of honor and living history, The Conner Clinic! Rod would be so proud. To think that he is a part of such a healing institution means the world to me and my family.

But not only did the visit impact those directly on site, it had a profound effect on another cousin veteran who could not attend.

"My Cousin Ronald Donahue, now 80 years old and a medic himself during the Korean War, was so touched that he cried as I shared with him our visit to the clinic," Chatterton-Purdy said. "Rod was like a brother to him and [he] was devastated when Rodney was killed."

In the near future, the items depicting Rodney Conner's military service will be placed in a prominent location at CTMC for all to see. This includes an on-the-wall collection of framed photos, letters and artifacts, bringing a bit of Rodney Conner history to today's active force.

In closing, Chatterton-Purdy said, "To all the Soldiers we met that day and those who pass through the doors of the Conner Clinic, we bless you and your families for your service! May you all be safe and be returned to your loving families."

MEDDAC SOLDIER EARNS JOINT BASE LANGLEY-EUSTIS NCO OF THE YEAR HONOR

Sgt. Jacquelyn Waddell repairs a piece of medical equipment in her lab. Photo: Staff Sgt. Ashley Hawkins

Sgt. Jacquelyn Waddell doesn't back down from a challenge. And, she lives by the NCO Creed and by the U.S. Army's values every day.

She proved her mettle recently by getting the highest score on the NCO of the Year Board, securing her title of Army Support Activity-Fort Eustis' Noncommissioned Officer of the Year for 2011.

Waddell competed at boards with other NCOs of the Quarter in 2011, solidifying her win after fourth-quarter oral finals in front of a board of sergeants major and first sergeants in November. If you win a monthly board, you are eligible to take the quarter boards at your unit level. If you win a quarter board at your unit level, you're eligible to compete on the post for NCO of the Quarter. And, if you win one of those, you can go on to compete for the post's NCO of the Year.

Waddell, who is in charge of fixing all medical equipment at the McDonald Army Health Center clinics, Joint Base Langley-Eustis (JBLE) and at Fort Story, Va. said the boards aren't just about answering questions. It's also about your work with your Soldiers and in the community.

"It's important to seek self-improvement and to look after my Soldiers and to make sure they're developing as well," Waddell, with USA MEDDAC Fort Eustis, said.

Waddell is involved in Kids Move – a program at the health center's pediatric department helping overweight children get more active and healthier, the NCO Call, where other NCOs voice concerns and issues once a month, and with encouraging those who need a push to pass their physical fitness tests.

The Fayetteville, N.C., native joined the Army in March 2005 and has been stationed at JBLE for almost two years. She's married to Jacob Waddell, former Army human resources specialist, and they have a son, Brett, 14.

As the shop foreman at the medical center with four Soldiers who answer to her, Waddell faces challenges every day. They fix everything from examination beds or chairs to defibrillators, X-ray machines and blood-pressure monitors.

"I'm not scared to take a challenge," Waddell said. "I'm very motivated and I think honor and respect is important."

She's not stopping there.

Waddell is finishing her associate's degree online in arts and plans to earn her bachelor's degree in biomedical equipment technology – a degree that will help her in the field she's in now.

She wants to take the Advanced Leadership Course in San Antonio, Texas to help her reach the rank of staff sergeant. She sees sergeant major in her future with the Army, and maybe a master's and doctorate degree.

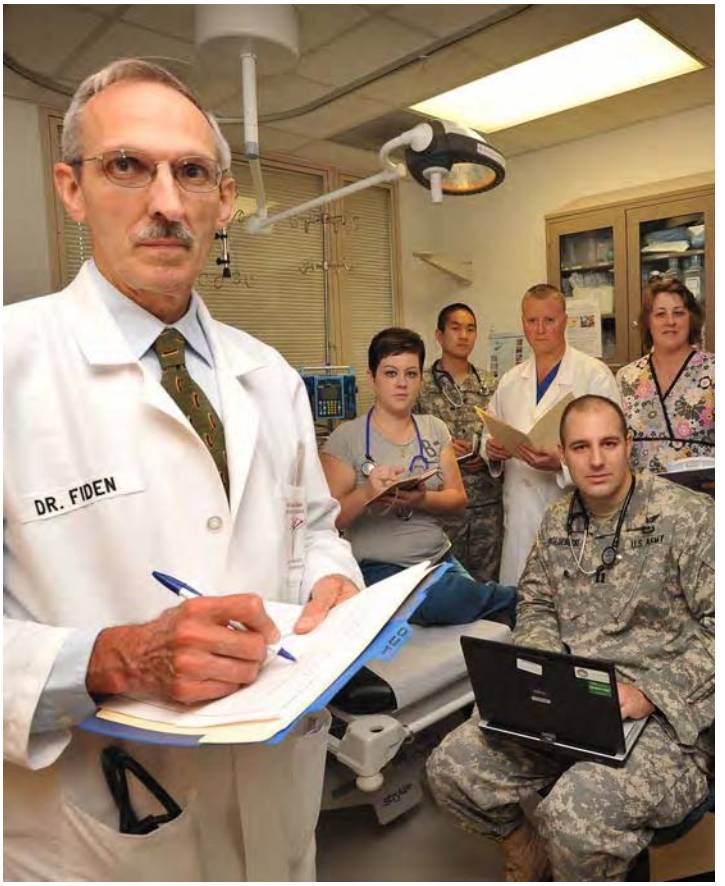
"I love school; I love learning and continuing as far as I can," she said.

Womack implements MEDCOM initiative:

PATIENT-CENTERED CARE

Story by Shannon Lynch

Womack Army Medical Center, Fort Bragg, N.C., has begun to make the necessary infrastructure and staffing changes in order to provide more accessible, personalized, and comprehensive care to its Army healthcare beneficiaries.



Dr. William Fiden, M.D. meets with staff members Heather Ferguson, LPN; Lt. Phung Phan, medical student; Lt. Col. (Dr.) John Osborn; Stephanie Bielli, LPN; and Capt. Kyle Hodebecke, M.D. Photo: Cindy

Army Medical Home (AMH), the Army's take on the Patient-Centered Medical Home (PCMH) concept is being implemented across Army Medical Treatment Facilities, and will be adopted Army-wide by 2015.

Facilities that work within a PCMH model promote a more visible team-centered approach to addressing patient needs when they have urgent needs, as well as before they get sick, through preventive measures. In addition to traditional face-to-face visits, PCMH promotes the use of non-traditional means, such as secure e-mail between patients and providers, and group visits for patients. All members of the clinic are challenged to work at the top of their training and experience to deliver the best care possible. Physicians, registered nurses, licensed practical nurses, pharmacists, and behavioral health specialists work as an integrated team to look ahead to patient needs.

"The patient-centered family medicine concept is not new to Womack or the Army. We implemented many aspects of this model at our clinics years ago," said Col. (Dr.) Niel Johnson, director, of Community-Based Medical Homes at Womack. "WAMC leadership began investing in this model because of its proven track record of success in the civilian community. Although it requires more staffing with a higher ratio of nursing to physicians, this concept allows healthcare providers to spend more time with their patients and allows the nursing staff to be more proactive with preventive care and care coordination." Johnson said.

Army Medical Command leaders expect that when PCMH is fully implemented across the Army in 2015, that patients will realize a new norm in excellence in delivering primary care. Better, more proactive management of patients with chronic medical conditions, for example, will result from establishing relationships with a synchronized healthcare team focused on earlier intervention and enhanced access.

"When fully implemented at their clinic, patients can expect better access to their Primary Care Manager (PCM) and their healthcare team," Johnson said.

Fiscal year 2015 is when all of the military treatment facilities need to be nationally certified as PCMH centers. "This prestigious certification represents an industry standard and the Army has chosen to adopt that certification across MEDCOM," said Dr. Johnson.

"This certification is similar to the Joint Commission and WAMC meets half of the standards now for certification. The majority of standards that we have not yet met are in the clinic space and utilization and future hiring actions," said Col. (Dr.) Frank Christopher, deputy commander for Clinical Services at Womack Army Medical Center.

"Family Medicine staff members are excited to be a part of this transition to a better environment of providing primary care," added Johnson. "This is a hospital-wide mission that will benefit our patients at Fort Bragg for years to come."

SOLDIERS LEADERS CIVILIANS FAMILIES

Take 5

Safety Begins at Home

- Leave three feet of space around space heaters
- Check electrical outlets for frayed wires or loose-fitting plugs
- Inspect fireplace flues and chimneys for leaks and blockages
- Keep a multi-purpose fire extinguisher handy
- Lock up medicines and household chemicals
- Keep hallways clutter-free and clear of obstacles

Oral and Maxillofacial surgery residency program: a vital component for educating future doctors in the Army

Story by Shannon Lynch

Womack Army Medical Center (WAMC) Oral & Maxillofacial Surgery Services provides full Scope facial trauma for the emergency its staff provides triage, diagnosis and treatment daily for all forms of facial trauma and life threatening infections. This service is provided 24 hours per day.

"For our active duty Soldiers this service means that we are able to provide facial surgery support from start to finish for injuries from overseas contingency operations," said Col. Jeffrey Almony, DDS, MD, Oral and Maxillofacial Surgery Program director. "Having a full-scope oral and maxillofacial surgery service offers active duty Soldiers and all eligible beneficiaries both dental and surgical treatment that includes dentoalveolar surgery, reconstructive surgery (both soft tissue and hard tissue) orthognathic surgery and a limited amount of facial cosmetic surgery."

Postdoctoral education Oral and Maxillofacial Surgery was established at Womack Army Medical Center, Fort Bragg, North Carolina in 2001, under the direction of the Office of the Surgeon General and The Chief of the Army Dental Corps.

The WAMC Oral and Maxillofacial Surgery Residency Training Program is a four-year program accredited for two residents per year. To date, 12 oral and maxillofacial surgery candidates have graduated successfully from the residency program. All graduates must successfully complete a written and oral certification process with a score of one hundred percent board certification with the American Board of Oral and Maxillofacial Surgery.

Residents typically work 80 hours per week. At 5:00 a.m. the pre-rounds begin and they perform surgery on Tuesdays, Wednesday and Thursdays. Monday is grand rounds where they see 60-80 patients. On Thursdays, they also conduct implant surgery and orthonathic surgery boards to also include craniofacial growth and development. On Fridays they conduct academics, journal club and general surgical evaluations and workups.

The support team provided by U.S. Army Dental Activity (DENTAC USA) to WAMC also includes an oral pathologist, periodontist, prosthodontist, orthodontist and pediatric dentist. These specialists provide adjunctive support to the Oral & Maxillofacial Surgery Residency.

"The Womack Army Medical Center and DENTAC's vision for residency training is a vital component for educating future doctors in the Army Medical Department. Womack Army Medical Center and the Fort Bragg Dental commands team effort have resulted in outstanding accreditation reviews by the Commission on Dental Accreditation of the American Dental Association.

Womack Army Medical Center celebrates Nuclear Medicine Week with inaugural conference

Story by Shannon Lynch

In recognition of Nuclear Medicine Week, Anthony G. Chavonne, mayor of Fayetteville, N.C., visited Womack Army Medical Center (WAMC) Oct. 5 to kick off WAMC's inaugural Nuclear Medicine Week Conference, at Fort Bragg which ended Oct. 6.

Chavonne, whose long association with the Fort Bragg, N.C., honorary membership in the 82nd Airborne Association, read a proclamation calling on the Fayetteville community to support WAMC in its efforts to educate the public about nuclear medicine. He cited the tremendous impact on the quality of healthcare over the past 40 years.

Dr. Vimal Sodhi and the Womack nuclear medicine department, including Sergeants Derek B. Riggle, Stephen Raya and Shaun Pochel, worked a year to bring the conference to reality with the support of Col. Brian T. Canfield, WAMC commander, and Col. Frank L. Christopher, his deputy commander for clinical services.

"Over 300 hours of Continuing Medical Education hours were granted by the American Association and the Society of Nuclear Medicine, and registrants attended from the entire Southeastern United States," Sodhi said. Participants witnessed six presentations by leaders in the nuclear medicine field.

Nuclear medicine specialists use safe, painless and cost-effective methods to see the body efficiently and treat disease in unique ways. The ability to see both the structures and functions unobtrusively by the use of very small amounts of radioactive materials, in most cases equal to the amount of radiation received during a regular x-ray exam.

Riggle, WAMC's nuclear medicine clinic noncommissioned officer-in-charge, said nuclear medicine offers the opportunity to diagnose many conditions far earlier than otherwise possible. "Soldiers' health is improved significantly by allowing the early detection of stress fractures, a very common injury for our Airborne Soldiers," he said. "Should these fractures remain undiagnosed, they may become so severe that they permanently impair the health of the Soldier and have the potential to end their career." Other uses include the diagnosis and staging of coronary artery blockage, as well as the differentiation of repairable cardiac muscle tissue from non-repairable tissue.

Riggle said the nuclear medicine clinic at WAMC has improved access to care, including appointments as late as 8 p.m. on weekdays and inpatient studies on weekends.

SOLDIERS LEADERS CIVILIANS FAMILIES

Take 5

Walkin' in a Winter Wonderland

- Alcohol use was reported in 48 percent of pedestrian fatalities in 2010
- High vehicle speeds contribute to pedestrian accidents
- Each year, about 5,900 pedestrians are killed and another 85,000 are injured in privately owned motor vehicle accidents
- Be alert when crossing the street; look left, right, then left again

KENNER NURSE EARNS TOP STATE LPN AWARD

Story and photo: Amy Perry, Fort Lee Traveler

Jane Blue, Kenner Army Health Clinic Preventative Medicine Department, second from left, was named the Virginia Licensed Practical Nurse of the Year during an awards ceremony Nov. 12. Pictured above, fellow KAHC members join Blue after she received her award.

A Kenner Army Health Clinic, Fort Lee, Va., staff member received a nursing award recently from the Virginia March of Dimes.

Jane Blue was named the Virginia Licensed Practical Nurse of the Year during a Nov. 12 awards ceremony in Richmond. Blue currently works in the preventative medicine department.

Blue said she was surprised to be selected for the award.

"When they announcing the awards, they said 'the 2011 LPN of the year is' and I thought they said my name, but I wasn't sure and just sat there," Blue said. "Then my husband said 'Aren't you going to go up there?' All of the sudden it hit me that they called my name."

Throughout her career, Blue has helped patients with their health concerns, encouraging them to reduce their cholesterol and quit smoking. She's served as a nurse since 1982 and started working at Kenner in 1989.

"For me, it made me feel that my hard work for 29 years has paid off," Blue said.

Nurses were nominated for the award after March of Dimes requested candidates, said Lt. Col. Michelle Munroe, deputy commander of nursing at KAHC. Seven KAHC nurses were finalists.

Munroe said she was excited one of her nurses earned the award.

"It was phenomenal - I was very proud to be part of the ceremony and to be asked to be there with Mrs. Blue," she said. "LPN of the Year is a big honor for her.

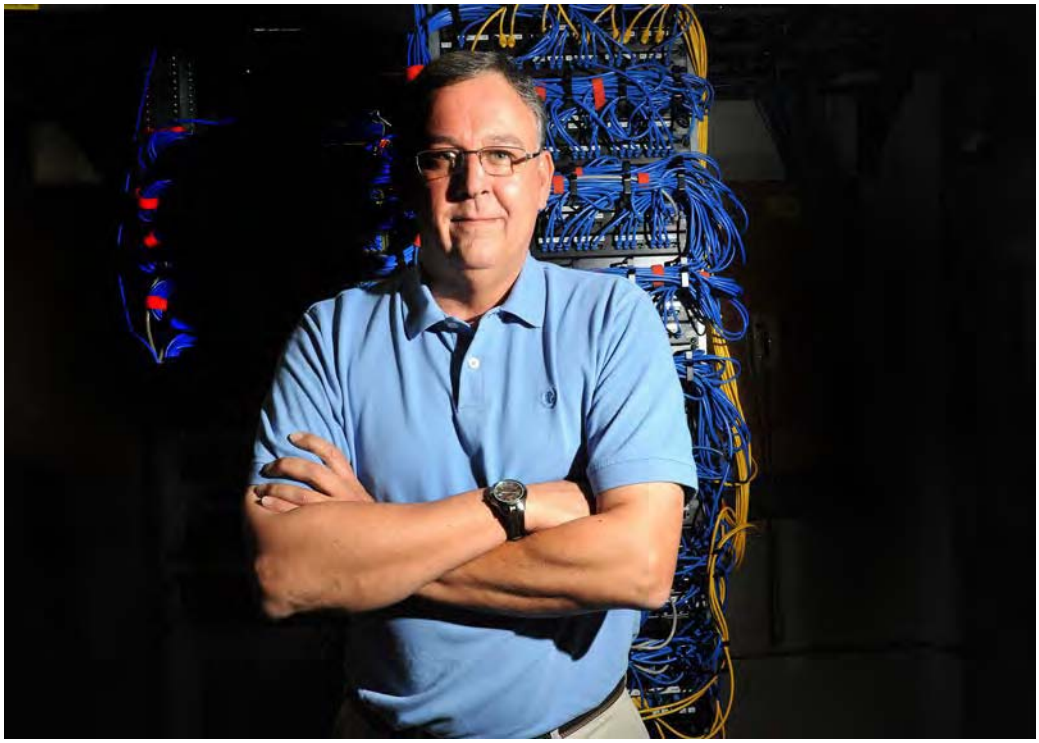
"The nice thing about this ceremony was that the March of Dimes recognized that nursing is the backbone to health care," Munroe continued. "They said they wanted to recognize the nursing staff because of the hard work they do - nurses are the unsung heroes, the ones who do a lot of hard work."

Blue will also be recognized by Col. Joseph Pina, KAHC commander, in the near future.

WOMACK ARMY MEDICAL CENTER SELECTED AS A TOP WIRED HOSPITAL IN UNITED STATES FOR 2011

Story by Shannon Lynch

Womack Army Medical Center (WAMC), Fort Bragg, N.C., is a facility that is using information technology to enhance and improve patient care. As part of the selection process Womack was evaluated in its use of technology in several categories to include: infrastructure, clinical application, various types of technology, how do we dispense medication, clinical quality and safety, medical imaging, electronic medical record, do we proactive evidenced based medication, and how do we deliver bedside treatment? "This award allows our patients to know that Womack is constantly looking at ways to advance the services we offer to them through technology," said Lt. Col. David Broyhill, the former Chief Information Officer (CIO) at Womack. Womack was one of four Department of Defense (DOD) medical facilities to win this award, 13 Veteran's Affairs (VA) and three other Army medical facilities won this award in 2011.



Roy Arne, information specialist, is a member of the team that enabled Womack Army Medical Center to be selected as one of the nation's Top 100 Wired Hospitals. Photo: Cindy Burnham, Fayetteville Observer

Womack is on the cutting edge with technology to better serve our patient population. Womack was chosen to test a new product titled, "Vocera," which allows Emergency Department staff, ancillary staff, radiology, laboratory as well as the medical ward the opportunity to communicate with an integrated communication system. The Vocera badge is worn around their neck and it eliminates the interruption of patient care. The badges serve as a phone, pager and a recorder all in one. The badges are docked at night and can be used on the wards for patient transition from one provider to another on different shifts. The system is Federal Information Processing Standard (FIPS) 140-2 compliant which means all the information transmitted over the badges is secure and encrypted.

Womack also uses the MEDCOM AHLTA Provider Satisfaction (MAPS). This is a collection of tools to help the clinical staff. Dragon Naturally Speaking is voice recognition program. The provider dictates the notes into a computer and it is a lot faster than typing. Many providers can dictate in one third of the time.

Womack also purchased computer tablets for the providers to use in multiple exam rooms. This cuts the time of logging in to multiple computers which are time consuming for the provider and the patient. The providers have the ability to walk from exam room to exam with their wireless tablets and document patient care, as required.

Womack Army Medical Center is also testing a Womack Appointment Text and/or email Reminder (WATER) system. Patients can fill out a form online or at the clinic and if they complete the form, Womack will send a 24 hour reminder to the patient via text or e-mail. The pilot program will start with psychiatry, Robinson Health Clinic, and physical therapy. After the trial, Womack will make a decision on whether to implement the program hospital wide.

"We hope this will decrease the number of no shows for the appointments at the primary care and specialty clinics," said Col. (Dr.) Frank Christopher, Deputy Commander for Clinical Services. "Our patients have asked for this service and we found a way to use technology to better serve our patients, Christopher added.

WELLNESS PROMOTER

PROVIDING ARMY MEDICINE & HEALTHCARE

STORY BY BRIAN O'SHEA
MILITARY MEDICAL TECHNOLOGY

Brig. Gen. Joseph Caravalho, Jr. stands in front of the new Northern Regional Medical Command headquarters building at Fort Belvoir, Va. Photo: Kevin Gonzales

On July 29, 2011, Brig. Gen. (Doctor) Joseph Caravalho, Jr., became the second commanding general of the U.S. Army Medical Command's recently reorganized Northern Regional Medical Command (NRMC), one of three commands within the continental U.S., extending from North Carolina to Maine, and from the Atlantic Coast west to Wisconsin. The region includes seven major Army medical treatment facilities, eight Warrior Transition Units, two battalion level troop commands, three Community-Based Warrior Transition Units, and their headquarters element. Additionally, Caravalho is the Army Service Component Commander for the Joint Task Force National Capital Region Medical and has administrative control over all Army staff working in the Walter Reed National Military Medical Center and the Fort Belvoir Community Hospital. His last assignment was as the commanding general of Southern Regional Medical Command and Brooke Army Medical Center in San Antonio from 2009 to 2011.

Caravalho was born and raised in Kaneohe, Hawaii, and is a 1975 alumnus of St. Louis High School in Honolulu. In 1979, he graduated magna cum laude with a Bachelor of Arts in mathematics from Gonzaga University in Spokane, Wash. Designated an Army ROTC Distinguished Military Graduate, Caravalho was first commissioned as a second lieutenant in the Medical Service Corps. He went on to the Uniformed Services University of the Health Sciences School of Medicine in Bethesda, Md., where he received his medical doctorate and was commissioned a Medical Corps Regular Army Captain in 1983.

Caravalho's post-graduate medical training included a transitional internship, internal medicine residency, and both nuclear medicine and cardiology fellowships. His military training includes the Command and Service Support School at Fort Leavenworth, Kan. He is a graduate of the Command and General Staff College and the Army War College, the latter from which he received a Master of Strategic Studies.

Clinically, Caravalho served as staff internist, nuclear medicine physician, and cardiologist. He served as chief of cardiology at Tripler Army Medical Center in Honolulu, and as deputy commander for clinical services at Womack Army Medical Center at Fort Bragg, N.C. His operational medical experience includes

Retired Lt. Gen. Eric Schoomaker, former Army Surgeon General, passes the Northern Regional Medical Command flag to Brig. Gen. Joseph Caravalho Jr., commanding general of the Northern Regional Medical Command, at the change of command ceremony held in the Rose Garden on the Walter Reed Army Medical Center, July 29, 2011. Photo: Joshua L. Wick

assignments as surgeon, 1st Battalion, 1st Special Forces Group (Airborne), Okinawa, Japan; physician augmentee, Joint Special Operations Command, Fort Bragg; surgeon, 75th Ranger Regiment, Fort Benning, Ga.; deputy chief of staff, surgeon, U.S. Army Special Operations Command, Fort Bragg; and most recently as the assistant chief of staff, health affairs, XVIII Airborne Corps, Fort Bragg. He also commanded the 28th Combat Support Hospital and the 44th Medical Command (Rear) (Provisional), both at Fort Bragg. He has two deployments in support of Operation Iraqi Freedom. As an AMEDD general officer, Caravalho served in Iraq as the surgeon for both Multi-National Force-Iraq and Multi-National Corps-Iraq. Following his last deployment, he served as commanding general for both Southern Regional Medical Command and Brooke Army Medical Center, both at Fort Sam Houston, Texas.

Caravalho earned the special forces and Ranger tabs and was awarded the Expert Field Medical Badge. He completed the Army Airborne and Flight Surgeon schools, as well as the Navy Dive Medical Officer and SCUBA courses. His individual awards include the Distinguished Service Medal, Legion of Merit with oak leaf cluster, Bronze Star Medal, Defense Meritorious Service Medal, Army Meritorious Service Medal with six oak leaf clusters, Joint and Army Commendation Medals, and the Army Achievement Medal with three oak leaf clusters. He is a recipient of the Order of Military Medical Merit. He holds current certification in nuclear cardiology.

Q: Can you describe your mission and responsibilities at your new position?

A: I have responsibility for Army medicine and the health care it provides to our Soldiers, Families and other beneficiaries within the region of the United States extending from North Carolina to Maine, and from the Atlantic Coast to Wisconsin. I'm also responsible for Soldier readiness issues within the region.

Q: What are your top priorities in assuming your new role as the commanding general of the Northern Regional Medical Command?

A: I want to ensure we promote wellness, prevent disease and deliver high-quality health care to those who serve our nation. Our relevance to our Soldiers and Families, to the warfighters, to the Department of Defense and, indeed, to the American public, is contingent on our ability to provide high-value services. At the individual level, this means we provide a memorable health experience to each patient. To the warfighter, this means we train our medics and clinicians to the highest standard, while preparing Soldiers well for their deployments. To the Department of Defense, this means we provide the very best care possible for the large population of military beneficiaries. Through it all, we must be standardized in our approach, yet compassionate with each human interaction.

Q: How do you plan on developing leaders "at all levels" to take Army medicine forward?

A: Within Army medicine, we have a valuable workforce that includes officers, noncommissioned officers, Soldiers, Department of the Army civilians, contractors and volunteers. The difference we have over university and community medical institutions is that we get to serve those who serve our nation. To ensure Army medicine continues to progress well into the future, we have to develop leaders within our workforce to take us forward. I thoroughly enjoy this aspect of our job.

In my mind, every officer is a future Army Surgeon General, every soldier is a future Command Sergeant Major of the Army Medical Command, and every Army civilian is a future Chief of the Army Medical Command's Civilian Corps. In essence, we are going to allow each individual to work within the full scope of their training and authority. We will introduce processional challenges at every level to expand everyone's knowledge and experiences. While maintaining standardization where appropriate, we will welcome innovation limited only by law, ethics and morality. Everyone in this organization is a leader, and we will give everyone an opportunity to excel for the benefit of the Army and the nation it serves.

Q: What are the major differences in being in command of the Southern Regional Medical Command to the Northern Regional Medical Command?

A: At the Southern Regional Medical Command, we focused initially on the Army Medical Command reorganization that brought together the Great Plains and Southeastern Regional Medical

Commands. This past year I dedicated much effort to the Base Realignment and Closure [BRAC] Commission-directed realignment of inpatients from Wilford Hall Medical Center to Brooke Army Medical Center, creating the San Antonio Military Medical Center in its place. I enjoyed working with the Air Force on this BRAC initiative. Here at the Northern Regional Medical Command, my initial focus has been on the closure of Walter Reed Army Medical Center and the Walter Reed installation. At this time, the Army officers and Soldiers at both the new Walter Reed National Military Medical Center and the Fort Belvoir Community Hospital are under the operational control of the Joint Task Force National Capital Region Medical, referred to as JTF CapMed. However, I remain the Army service component commander for the Joint Task Force National Capital Region Medical and have administrative control for all Army personnel assigned to the Army Service Elements at Walter Reed National Military Medical Center and the Fort Belvoir Community Hospital.

Outside of the San Antonio and National Capital Region, the Southern Regional Medical Command and the Northern Regional Medical Command are quite similar. They both have military treatment facilities that range in size and scope. Both regions have a mixture of Army Forces Command, Army Training and Doctrine Command and Army Installation Management Command forces to support.

Q: What lessons learned from the Southern Regional Medical Command are you bringing with you to the Northern Regional Medical Command?

A: I think experiences gained at the Southern Regional Medical Command are largely transferrable to the Northern Regional Medical Command. Adjusting for variations expected within this part of the country, I should be able to adapt the best of both regional medical commands. For one, we had a highly developed readiness division at the Southern Regional Medical Command as much of its staff came from the Southeastern Regional Medical Command headquarters. I will be able to incorporate much of these processes to the Northern Regional Medical Command. On the other hand, I believe the Warrior Transition Brigade here is functioning at an extremely high level. I also like that my headquarters building also houses my regional counterparts within the Dental and Public Health Commands. I expect large synergies to be gained by this collocation.

Q: Can you speak to the transformation to the patient-centered health care delivery model?

A: The Patient-Centered Medical Home provides a standardized, consistent and continuous relationship between the patient and his/her primary care manager and support staff. It will deliver care using the whole-person concept, coordinately and integrating evidence-based primary, specialty and wellness/preventative care in a comprehensive care plan process with the goal of customizing care to the unique needs of each individual patient.

We see one of the advantages being improved communication between the patient and care team, including traditional face-to-face interaction as well as virtual/ remote interface via telephone, video and emerging technologies such as a secure email messaging, improving care through enhanced, timely two-way communication between care team and patient.

Q: What is happening with the electronic health record effort and why is it important?

A: Army medicine has long been a leader in recognizing and using our electronic health record to transform the Army Medical Command into a knowledge-driven, evidence-based organization. Given the challenges with our current electronic health record, Army led the way in developing an information management/ information technology strategy, and securing funding for acquisition of a modernized electronic health record. The resulting effort was the 'Electronic Health Record Way Ahead' started in December 2009.

In 2010, the Department of Defense and Veterans Affairs agreed to pursue a joint, common platform enabled through appropriate governance for the future electronic health record. The goal is to allow a seamless transition of a service member's medical information between the military health care system into the VA health care system.

Both departments have already identified many synergies and common business processes, including common data standards and data center consolidation, common clinical applications and a common user interface.

Caravalho speaks to medical professionals during Patient-Centered Medical Home Training at Fort Belvoir's Barden Education Center. Photo: 1st Lt. Matthew Korth

Creating a single electronic health record will make information sharing between the two departments a better way to securely transfer patient data, which is very important in supporting our warfighters as they make the transition from the DoD system of care to the VA.

Q: How do the regional medical commands work together to fulfill the Army Medical Command's mission?

Caravalho recognizes the outstanding work of Staff Sgt. Glen Cassady in front of the Keller Army Health Clinic noncommissioned officers.

Photo: 1st Lt. Matthew Korth

A: There are five regional medical commands across the globe, three of which cover the continental United States. Of these three, we are aligned regionally with our TRICARE partners. Whether its health care or readiness, we are aligned under the direction of the Army Medical Command commanding general to provide standardized care across the force. As the Installations Command is accomplishing across its footprint, the Army Medical Command is building trust among its beneficiaries by providing efficient, appropriate, high-quality and standardized care, regardless of where it is delivered.

The Army Medical Command commanding general uses regular meetings for the regional medical commands to demonstrate this alignment, whether in its clinical or business operations, readiness plans or warrior transition programs. We use the balanced scorecard as a measure of progress in keeping with the commanding general's vision and end state.

Q: How have the Base Realignment and Closure Commission recommendations impacted the hospitals and clinics under your command?

A: The 2005 Base Realignment and Closure Act is more ambitious than previous restructuring efforts because it focuses on transforming military operations, not just improving efficiency. The most significant changes within the Northern Regional Medical Command include the August 2011 closing of the Army's flagship medical facility—Walter Reed Army Medical Center. We said goodbye to a 102-year-old institution renowned for its health care delivery, medical training and support, and are watching it transition into a state-of-the art joint DoD medical center located on the campus of the former National Naval Medical center in Bethesda, Md. Another hospital opened at Fort Belvoir to replace the Dewitt Army Community Hospital.

Of the seven remaining health service areas within the Northern Regional Medical Command, five of them will have BRAC-related changes requiring relocation of staff and/or restructured facilities and services.

The Army's pledge to each warrior, retiree and family member is that they will receive the same high-level care and support throughout this transition of Army medical facilities.

Q: What programs do you think play a role in supporting the health care needs of warfighters?

A: Taking care of our warriors is the highest calling we have as caregivers. It is a sacred trust. First, we provide enhanced access to care for our warriors in transition. Secondly, each wounded, ill or injured warrior has a team of supporting staff and cadre to help them and their families in their recovery, rehabilitation and reintegration process. Third, we provide options for our warriors to conduct this process either on the installation with us or at home, in proximity to their family support systems.

My goal is to provide a consolidated infrastructure of collocated services that can address any number of processes that may impact our warriors simultaneously: pain management, physical and occupational therapy, auditory and visual care, traumatic brain injury care, behavioral health care for the warrior and his/her family, spiritual support, and treatment for drug dependence. I think this will provide the most efficient care for our warriors, many of whom have a complex set of simultaneous processes.

We are instituting a similar system of collocated DoD and VA services to better facilitate the Integrated Disability Evaluation System process for our soldiers. We owe them an efficient process that maintains their dignity and respect, whether they return to duty or reintegrate into society as an Army veteran.

"Taking care of our Warriors is the highest calling we have as caregivers. It is a sacred trust."

-Brig. Gen. Joseph Caravalho, Jr.

Q: Are you planning any significant changes in the near future?

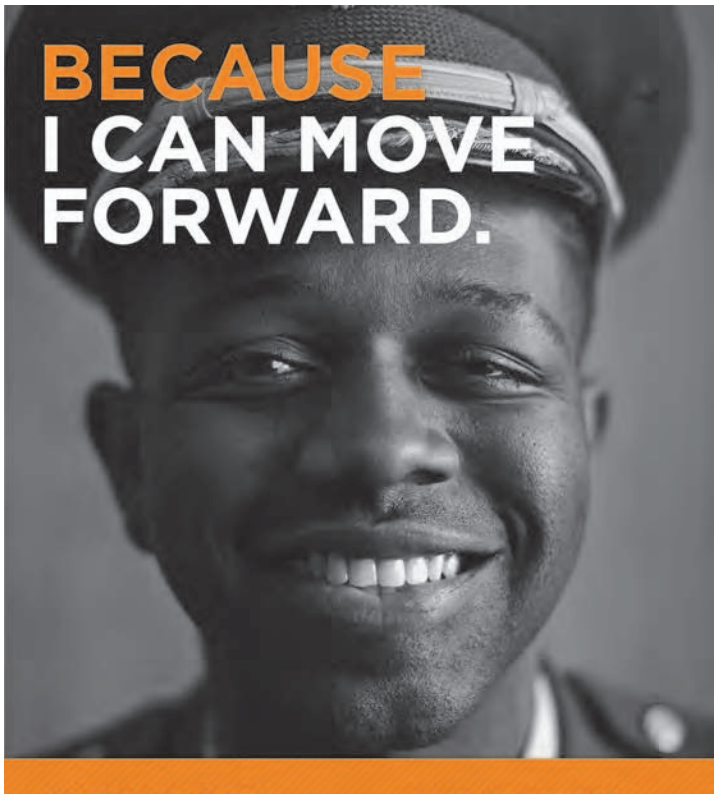
A: This is an exceptionally fine organization handed to me by Major General [Dr.] Carla Hawley-Bowland. The men and women assigned to this command are absolutely wonderful. I couldn't have asked for a better team to have joined. I don't see much that I would change in the near future.

I can tell you we will work feverishly to improve upon our Integrated Disability Evaluation System and Traumatic Brain Injury/Behavioral Health programs. In both cases, the answer lies in collocation of adequate resources. Our soldiers should be able to have issues addressed in parallel, rather than sequentially. I am excited to move forward in this direction.

Check out photos and learn more about Brig. Gen. Caravalho, visit the NRMC Facebook page at Facebook.com/ArmyNRMC.

COMMAND EXCEEDS COMBINED FEDERAL CAMPAIGN $10K GOAL

Story by Terry J. Goodman Illustrations courtesy of Combined Federal Campaign NCA



Northern Regional Medical Command staff members opened its wallets and hearts during the 2011 Combined Federal Campaign, which closed Dec. 31, by collecting more than $34K besting the target by 242 percent.

This is the first time that NRMC supported the CFC campaign from its new headquarters at Fort Belvoir, Va.

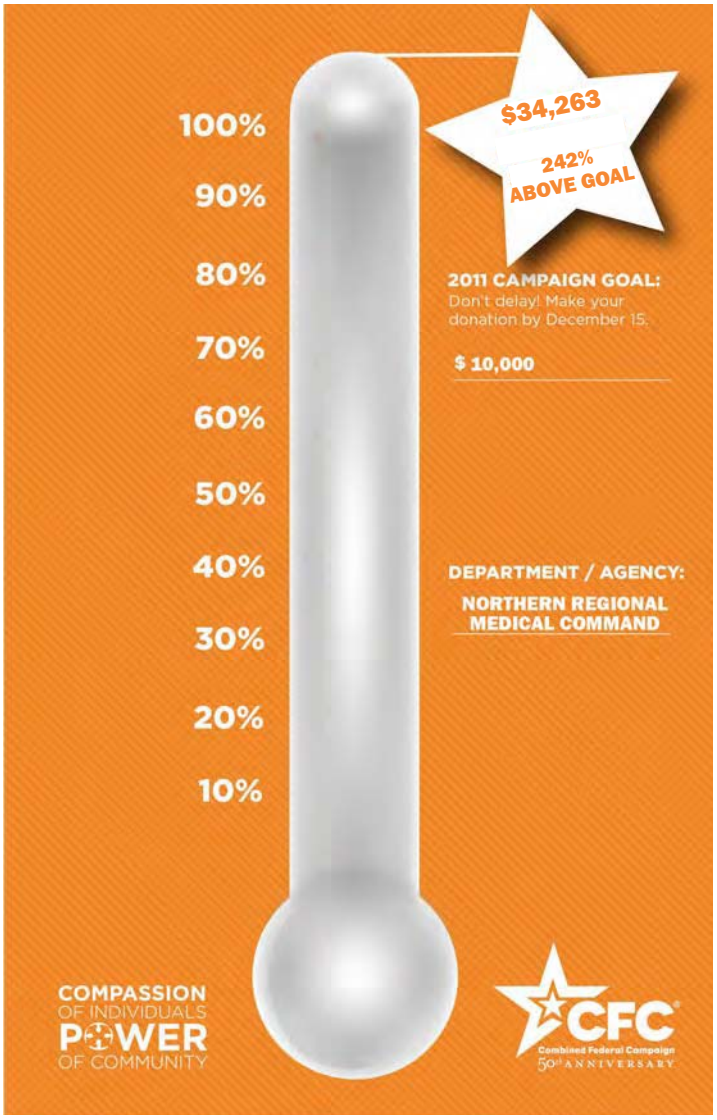
Mr. Russell Miller, Fort Belvoir's CFC campaign manager, commended NRMC's campaign team for exceeding their goals but also helping the installation collect more donations than it did during the 2010 campaign.

"Although Northern Regional Medical Command did not get its campaign going until December, they bested their goal by more than twenty four thousand dollars, that's impressive," Miller said. They did an incredible job.

CFC is the world's largest and most successful annual workplace charity campaign. Since being established in 1961 by President John F. Kennedy, the CFC has raised nearly $7 billion.

Brig. Gen. Joseph Caravalho Jr., NRMC commanding general, commended the CFC team for their efforts and those of his staff who chose to donate through the CFC.

"You (CFC team) were the boots on the ground, providing materials to your teammates, answering questions and collecting donations … outstanding work," Caravalho wrote. "It is indeed a pleasure to lead such an outstanding and giving organization. Again, thanks to all of you for choosing to help others, you are truly making a difference in the world."



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ACT

You are my brother, my sister, my fellow Soldier. It is my duty to stand up for you, no matter the time or place. I will take **ACTION**. I will do what's right. I will prevent Sexual Harassment and Assault. I will not tolerate sexually offensive behavior. I will **ACT**.

MOTIVATE

We are American Soldiers, **MOTIVATED** to keep our fellow Soldiers safe. It is our mission to prevent Sexual Harassment and Assault. We will denounce sexual misconduct. As Soldiers, we are all **MOTIVATED** to take action. We are strongest…together.

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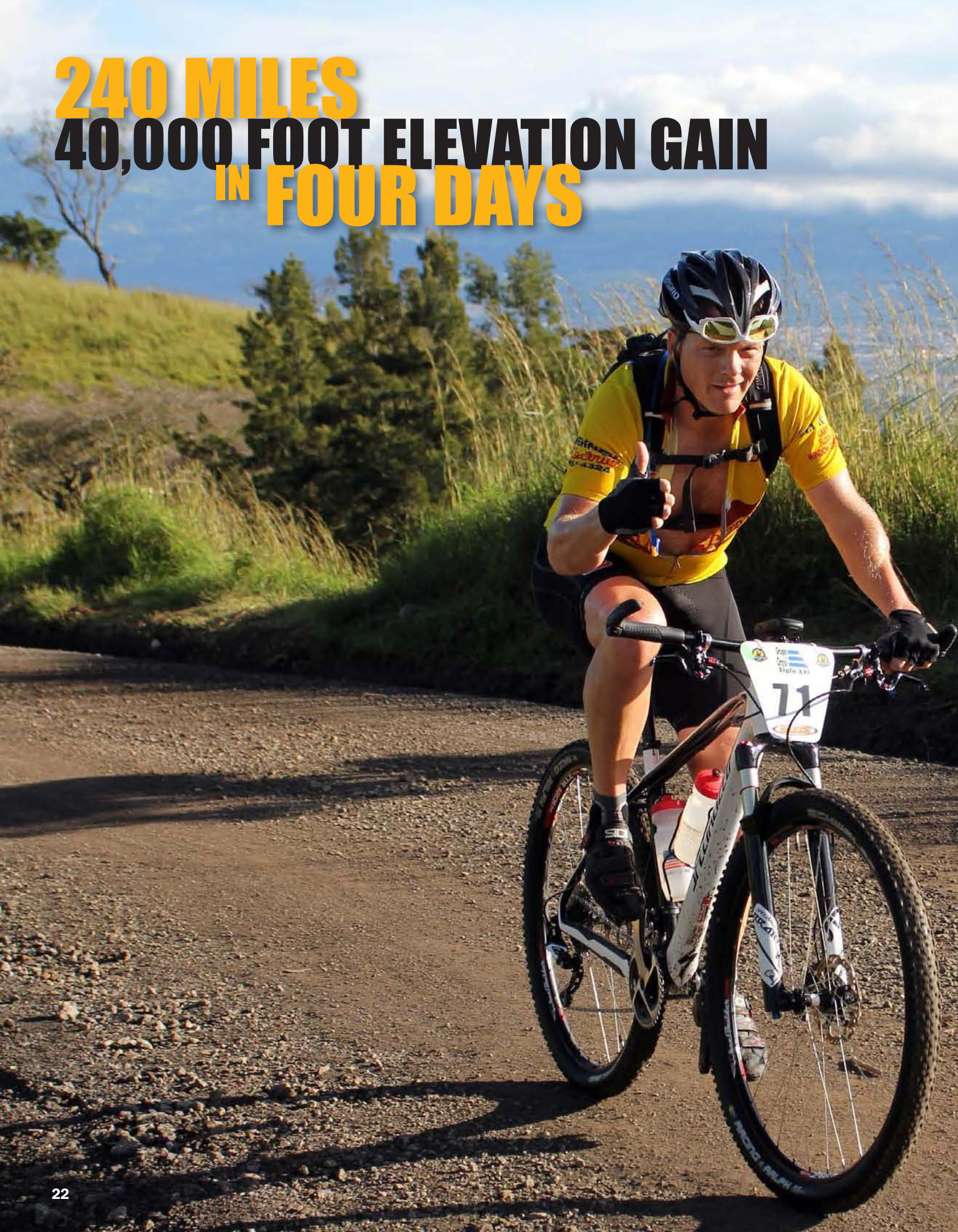


WELCOME TO LA RUTA

Lt. Col. David Haines was seriously injured in Iraq in 2006 but recently completed

"THE TOUGHEST MOUNTAIN BIKE RACE IN THE WORLD."

Story by Lt. Col. David Haines Photos by Luis Castro, Fotica.com

Lt. Col. David Haines, WTB Commander, Ireland Army Community Hospital, Fort Knox, Ky., rides through rough terrain during the La Ruta de los Conquistadores mountain bike race in Costa Rica.

La Ruta de los Conquistadores. I don't remember how I first heard of this race, whether it was a magazine article or it seeped into my consciousness over time. I have always known its reputation as the toughest mountain bike race in the world. Before I was wounded, La Ruta was always one of those events that I thought would be great to do, but I never took a serious interest in the steps to do it. I was perfectly happy riding my local trails, riding my road bike with friends, and racing on the weekends. I was passionate about cycling before my injuries.

In October 2006, I was seriously wounded by an Explosively Formed Projectile (EFP) IED while on a mounted patrol in Baghdad, Iraq. I took shrapnel injuries to my right side, right leg, right hand and arm and my left arm. The worst injuries were shattered bones in my right hand, segmented ulnar nerve and ulna bone in my left arm, and a non-union fracture to my right femur. Even with all that I consider myself lucky. My counterpart, Maj. David Taylor, was killed and the rest of the crew lost limbs in the IED strike. I was conscious the entire time. I can remember sitting in the HMMWV after we were hit in a state of shock. As I tried to figure out what had just happened I examined my injuries. Fingers on my gloved right hand were dangling off and I assumed that they would be lost. My left hand was locked back from the tendons that were cut by the piece of shrapnel embedded in my wrist. At first, I did not even realize I had broken my leg, until I tried to move and felt the intense pain. The buttstock of my M4, broken from the shrapnel passing through the vehicle flopped over my right. I knew I was going to be out of the fight. I can remember looking at the gunner lying next to me in a heap on the HMMWV floor. He was conscious, but it was hard to tell exactly what his injuries were. He had been knocked out of his hatch and lost both his legs below the knee. The driver was able to get out of the HMMWV and open my door in spite of his own serious leg injury. As I sat in the HMMWV, stuck because of my broken leg and tangled metal at my feet, I thought "God, I hope to get home and see my family again". As ridiculous as it may sound, my next thought was "I hope I will be able to ride a bicycle again".

I was evacced to Landstuhl. One of my doctors there asked what my recovery goals were, which forced me to think about where I really wanted to go as I fought to recover and rehabilitate. It didn't take me long: I wanted to stay in the Army, I wanted to ride a bicycle again, and I wanted to ride my motorcycle again. As improbable as those goals may have appeared, he made no judgment on them. Returning to cycling became my focal point that was going to enable me to achieve my other big goal of staying in the Army.

Today, after years of hard fought recovery, about 30 surgeries, four different attempts to repair my fractured leg, the last one successful, I have attained two of my three goals. I was found fit to return to duty, and I am finishing 2011 having completed over 6,000 miles of cycling. Cycling has allowed me to get in better condition than when I was five years younger; represent the Army at the 2011 Warrior Games, winning a silver medal; ride with President Bush and Lance Armstrong; ride from Ground Zero in New York City to Shanksville, Pa. and the Pentagon over eight days on the tenth anniversary of those horrible attacks; and complete the toughest mountain bike race in the world as a 46-year-old wounded warrior.

My road to La Ruta started this way. During my recovery, I had tried to mountain bike, but had a number of serious crashes due to my injuries. I do not have full mobility or function in either of my hands, so it was difficult for me to hold on to the handlebars. So, I focused on riding my road bike. Over time I slowly got stronger. I was offered the opportunity by the nonprofit Ride2Recovery to participate with 13 other wounded warriors in a mountain bike ride, the W100, with President George Bush at Big Bend National Park. I had not ridden a mountain bike in over a year, but the opportunity to ride with President Bush was enough motivation to get me back on the trails. After all, how hard could it be? It's in the middle of the Texas desert, which I mistakenly assumed was flat, and it would be led by a 64 year-old man. It was not easy. The area around Big Bend is rugged and beautiful. President Bush is a monster on a mountain bike. I survived with only one good crash to my credit. This ride also linked me up with a number of inspirational fellow wounded warriors. I had known Marc Hoffmeister since 2005 when we both attended CGSC/ILE at Fort Leaven-

worth, Kan. I knew he was an accomplished adventure sport athlete participating in everything from Eco-Challenges to serious mountain climbing.

The experience with President Bush boosted my confidence. The other wounded warriors I met inspired me to push myself a little further. I started thinking about taking on La Ruta. At first I thought about just doing it myself, but I figured I should fully commit and get other people involved. Pride would prevent me from talking myself out of it.

As I sat in the HMMWV, stuck because of my broken leg and tangled metal at my feet, I thought "God, I hope to get home and see my family again". As ridiculous as it may sound, my next thought was "I hope I will be able to ride a bicycle again."

-Lt. Col. David Haines

I knew that the train-up would be demanding. The race is 240 miles and climbs over 40,000 feet in just four days across the entire country of Costa Rica. The climate and terrain ranges from sea level, hot and humid, to 10,000 feet, cool and rainy. I had no illusions about keeping up with the professional mountain bikers contending for podium spots. My goal was simply to finish, which would put me in pretty elite company. In 19 years, less than 6,000 people have finished the race successfully. By the end of my training, I was riding 80-100 mile rides on my mountain bike and climbing 5,000 feet of elevation in one day.

Marc and I travelled to Costa Rica a few days ahead of time to get a feel for the weather and the terrain. One thing became clear from the begining - Costa Rica is a truly beautiful country with friendly people.

DAY ONE. I woke up early and mistook the pounding of the surf as thunder. Nerves prevented me from eating as good a breakfast as I should have. By the time I came to the starting line it seemed as if everyone was already going through their pre-ride rituals. I spent most of my time riding around to loosen up my legs.

As the race started, my advice to myself to go easily was quickly disregarded as the mountain bike peloton sped into the foothills of the mountains. As the ride went on, the trail narrowed and became steeper, gravel giving away to dirt, that gave away to mud and stream crossings and hike-a-bike sections climbing steep muddy slopes and jumping over deep ravines washed out by the water running down hill. My heart rate was running in the 160's and 170's and I knew I would not be able to maintain this for long but did not listen to my body. Marc was having a little easier time of it. His experience as an adventure racer and mountain climber was showing as he led me through the tougher climbs and sections where we had to carry our bikes. I was overheated and exhausted within the first 20 miles, and still had another 50 or so to go. I stopped in streams to cool my body and slow my heart rate. I wasn't going to quit; it was way too early.

At the first checkpoint I caught up with Marc and tried to eat and rehydrate, but I had already put my body in a serious deficit. The rest of the day was a struggle just to keep going. Marc waited for me at checkpoints. He was determined not to let his battle buddy fail. At the last check point of the day the close out time at the finish line was looming, so I told Marc to go so he could make cutoff and remain an official competitor. I would drag myself in. I continued to ride in misery. As I closed in on San Jose the roads became paved, but the hills were still long and steep. At points I had to get off my bike and walk the hills because I had no power left in my body to pedal. I reached the outskirts of San Jose as it was getting dark. I only had a few miles to go and knew that making cutoff for the first day was going to be close. As I rode through the city I mustered all my strength to finish as quickly as I could.

I rolled into the finish line and was relieved that the day was finally over. I thought I had come up short on the cutoff time and would no longer be an official competitor, which meant I would be allowed to start the next day, but would be classified as a DNF (did not finish) at the end of the race. I was disappointed, but after the pain of the first day, doubted I would be able to carry on for another three days like this. As I sat at the finish line totally exhausted and oblivious to everything going on around me, one of the race organizers came up and said "Congratulations! You made cutoff by four minutes". I honestly had mixed feelings. I just didn't know if I would be able to get up the next day and do this to myself all over again.

DAY TWO. I woke up and went to breakfast with Marc. I was still dealing with the toll inflicted on my body from the first day. It was hard to eat breakfast; my system was disrupted from the previous day's effort. Marc was doing better. Today was another tough day on the bike. He sensed the difficulty I was having and his encouragement convinced me to get on the bike and start the race. I had serious doubts in myself. Getting outside and feeling the fresh air improved my mood. My strategy for day two was simply to survive. The race started and I rolled out, ready for the hills that would hit us within the first few miles. I worked on keeping my breathing controlled and was able to engage in conversation with other riders as we slowly climbed the steep hills. As I reached the first big peak of the day, I fought to stay on my bike and not walk. At one point the hill became too steep. I unclipped from my pedals. The sudden loss of momentum and the steepness of the hill made me lose my balance as I straddled my bike. I started to hop on my left foot to maintain my balance. I was able to get my right leg off my bike as I hopped, but as I did, my left foot hit the edge of a concrete culvert on the side of the road. My feet went out from under me and I did a belly flop in the culvert and slid down hill

ten feet with an audience of about ten other riders. Besides the normal questions to make sure I was all right, a number of riders chimed in to tell me they were both amused and impressed with the acrobatics they had just witnessed. I good-naturedly asked "Where's a video camera when you need one?"

The remainder of day two is a blur. Marc and I had decided early that we would ride our own race today. I would occasionally close in on him and then fall back. The only real memories I have from the day are being struck once again by the beauty of Costa Rica and the friendliness of the people. At points during the race I would be lost in my thoughts and noticed giant blue butterflies. At first, they were so big I thought I was hallucinating, but I determined they were real and amazingly beautiful. If I had to pick a place to suffer on the bike, I had made the right choice.

I ended the second day making the cutoff time for the stage with time to spare. Marc had come in about 20 minutes ahead of me and was still going strong. I was excited to have the extra time to get cleaned up, eat, and relax. Perhaps the best feeling was that my appetite had returned. I wolfed down everything they put on my plate and was looking for more. The thought that I was able to comfortably put food in my body and had finished well boosted my confidence for tomorrow.

DAY THREE. While I did not know it yet, this day was to play more to my training compared to the other days and would be the best day of the race for me. Instead of the sharp climbs of the previous days, this day would be a long steady climb to 10,000 feet up the side of the Irazu Volcano, and a screaming descent on rocky gravel and paved roads. This day made it clear how important this race is to the Costa Ricans. This is their mountain bike Tour de France. The difference is not only the professional cyclists are the heroes; the any-man riders like me were getting the same enthusiastic cheers along the route. We came to a steep cobbled section that was lined by spectators yelling and cheering all the riders. Their encouragement pushed the riders to do their best to stay on the bike despite the steepness of the hill. Most had to give up and walk, but the people continued to yell. They seemed to recognize the Americans in the group and would shout encouragement in English. One fan in particular was especially enthusiastic, yelling "I love you!" as American riders passed by. As I passed by, the fan repeated "I love you!" I looked in the direction it came from and winked. The crowd erupted in laughter as I continued to push my bike up the hill.

The checkpoints came a little faster and easier than they had on the first two stages. We climbed higher, the weather cooled, and the clouds closed in. This was a welcome change, allowing me to exert myself a little more comfortably as we gained altitude. Eventually I had to put on a vest to keep warm and prepare for the descent down the other side of the mountain. One welcome discovery at the checkpoints was Agua Dulce, hot tea made from sugar cane. It felt great at the high altitude checkpoints.

Marc and I arrived at the final checkpoint before the big descent into Turriabla together. It had started to rain a little bit. There were still hard core spectators at the checkpoint that wanted to help the racers, which I was not used to. They were interested in our bikes, equipment, and clothing. They asked for pictures as if they were standing next to big stars. As we prepared to depart I was having trouble getting my gloves on my damaged hands, and the people were right there trying to help me get myself back together and on my way. We started off down the long descent. Talk of the rocky, steep descent with baby-head-sized rocks and limited visibility had us a little concerned about what lay ahead. Both of us were glad to have the descent, but the technicality of the terrain would place significant demand on our upper body and injured arms. We agreed to go somewhat cautiously and not get too separated in case one of us crashed. Like many things in life, the rumor and stories were not as bad as reality. We gained confidence and speed as we got a better feel for the rocky terrain. Occasionally Marc or I had to stop to give our arms a break. We continued until we hit pavement and cleared the bad weather.

At this point we began what was, for me, one of the more flat-out fun sections of the entire ride. We were still miles from the finish line, but it was nice pavement on a long descent along a mountain road. Marc and I instantly opened up the speed to finish strong. It seemed to go on for miles as we gathered speed, easily exceeding 40 miles per hour and passing buses and cars as we plummeted towards town. After so much time climbing steep hills and going down rocky or muddy hills, it was nice to just go fast, testing the ability of our tires to hold on to the road as we leaned through the corners tucked for aerodynamic advantage. At some points we were leaning into the corners so far it felt as if we were riding sport motorcycles. We eventually hit the flats and time trialed into the finish. Another day in the books – time to clean up and eat.

DAY FOUR. Day four began a little later than the previous three days. It was a good thing as the cumulative fatigue of three days of hard mountain bike riding were definitely evident as I woke up and began moving around. The weariness was balanced with excitement as I believed the worst was over for me. Day four was going to be long, at around 70 miles, and hot, but it was going to be flat for most of the way to Port Limon on the Atlantic Coast. While not overconfident, I fought the thought in my head saying "I got this!"

The final stage started with the peloton moving through town together. This was the only day that all the riders were able to stay with the pro's as the riders moved to the final short, sharp climbs of the last stage. We moved through town together escorted by dirt bikes, all-terrain vehicles, and four wheelers. As the group started hitting the beginning of the climbs, the stronger riders began to separate themselves from the pack. Vehicles following the riders became interspersed as we made the last steep paved climbs and descents of La Ruta.

The next challenge La Ruta threw at us was the infamous railroad tracks - over 20 kilometers of riding in the middle of these tracks. I did not handle this too well to start. The spacing and the depth of the gravel between the ties were not consistent, and within 100 yards of getting on the track, I caught my front wheel and was thrown violently over the handlebars onto the ground. My helmet saved me from serious injury, but part of my handlebar broke in the fall. Everything else was OK. Marc caught up to me. We con-

Marc Hoffmeister (Left) and Lt. Col. David Haines coast down a dirt trail during the La Ruta de los Conquistadores mountain bike race in Costa Rica.

tinued, passing through small villages and traversing the railroad bridges along the route. The bridges required riders to hike-a-bike across the spans. Some of the bridges were at least 30 feet over fast moving water. What made it even more interesting was that the railroad ties were not evenly spaced; some would be only a foot apart while others were almost four feet apart. The heat was becoming more of a challenge as we approached the coast. Both Marc and I took advantage once again of cooling down when we came to river crossings. It seemed like forever as we went from railroad tracks, to road, back to railroad tracks, to sandy trail.

Finally, we broke away from the railroad tracks and could see the ocean! In the distance we could see a point sticking out into the Atlantic Ocean. With guarded optimism I said that that must be Port Limon. It seemed like we had gone a long way, but we had not yet seen the final checkpoint.

We reached the last checkpoint, topped off our water and moved out for the finish. As we got closer to town, we started to see more people and houses. Eventually we hit the pavement and city traffic. By this point I was exhausted and overheated and ready to cross the finish line. We climbed one final little hill and rolled to the last left turn into the finish area. As we got closer you could hear the music, the announcer, and the cheers of the crowd. We descended some steps sandbagged to smooth the ride, were handed our medals, and were congratulated for our accomplishment.

I had a rush of feelings as I stood in the sand. I was exhausted from the effort over the last four days and relieved it was over. I was elated and proud that I was able to call myself a "conquistador" - one of few that had accomplished the hardest mountain bike race in the world. I think I was a little sad that this experience was coming to an end. Marc and I jokingly discussed what our next mountain biking epic adventure would be - Continental Divide? The Trans-Rockies? Or something else? Perhaps La Ruta 2012. In any case, the demands of, and triumph over, La Ruta de los Conquistadores gave both Marc and I the desire to find another epic event to challenge ourselves in the future.

IRELAND ARMY COMMUNITY HOSPITAL HOSTS FIRST "VIRTUAL BIRTH" FOR DEPLOYED DAD

Story and photo by Kristen Marquez

Casey Gessner, with newborn son Lincoln, ushered in IRACH's new Skype system. By having a dedicated Skype camera in the delivery room, the hospital will be able to connect deployed fathers with moms in labor, and allow both to be participants during birth.

Ireland Army Community Hospital, Fort Knox, Ky. celebrates births just about every day, but one birth here on Sept. 28 marked the beginning of a new service for families welcoming those bundles of joy.

Casey and Adam Gessner were able to welcome son Lincoln to the world, from thousands of miles apart. With little Lincoln's arrival, welcome to the era of "virtual births" being offered at Fort Knox.

For dads who may be deployed when their child is making an entrance to the world, IRACH is now able to offer birth via Skype, a software service that allows for video chats. The service has been successfully implemented at other military treatment facilities, and staff at Fort Knox decided it was something that should be offered to families here, too.

"In this world of technology, everyone is connected by the press of a button," said Capt. Adina Sippel, assistant officer-in-charge of Labor and Delivery. "We wanted to bring this technology into the labor and delivery unit to link our deployed Soldiers to their Families in a monumental and exciting life event. Not only can we provide family support to the laboring mom by having dad on live feed, we can provide support to that fighting dad by giving him the opportunity to experience the birth of his child."

For the Gessners, Casey said it was a relief to have Adam, currently deployed to Afghanistan, available via computer when it was time to welcome Lincoln to their family, which includes older siblings Addyson, 4, and Parker, 21 months.

"They first offered this to me when I was around 37 weeks," Casey said. "I was really hoping to have Adam home for it, but since that was not possible, this was the next best thing. All along I kept saying "I want to Skype! I want to Skype!"

During the labor and delivery, Adam was able to talk to Casey over the computer, comforting her, and see much of what was going on.

"He said he could see me clear as day and I could see him," she said. "If I couldn't hear him it probably would have been 10 times worse." Seeing the birth of his son even while halfway around the world meant the world to Adam, she said.

"He was very emotional. It was bittersweet. He got to see him, but he didn't get to hold him."Casey's mom, Beverly Leighton, was here for the birth and got the job of moving the camera around during the nearly 3 hours they were able to connect.

"This was a great experience for me," Ms. Leighton said. "This is her last baby. It was wonderful to see her, and see how happy he was to see his baby. Skype is a beautiful thing."

Casey and her mom agreed that this service is great for families here, and encourage others to utilize it. Casey also said she had tried using Skype on her phone, but the connection is difficult to get from within the hospital. That's why IRACH has a dedicated computer system just for the Skype service, which ensures a fast connection and clear picture.

"It was awesome – do it!" Casey said. "I highly recommend it. It's awesome and so clear."

The project has been in the planning stages since February, according to Sippel.

"Seeing the emotion from the family right after a delivery is extremely gratifying as a health care professional," Sippel said.

Labor and Delivery Nurse Dee Valdivia agreed that this first virtual birth for Fort Knox families was a very special occasion.

"It was amazing, it really was," she said. "When the baby was born, you could see (Adam) crying. It was very emotional for everyone. Being a military wife, it hits home."

Mrs. Valdivia pointed out that many of the wives delivering babies here are not only separated from their deployed husbands, but their families as well.

"I think this service will continue on," she said. "I still get teary eyed just thinking about his face."

FUTURE ARMY LEADERS MAKING A DIFFERENCE FOR SOLDIERS TODAY

Story and photo: Britney Walker

United States Military Academy Superintendent Lt. Gen. David Huntoon, USMA Dean of Academics Brig. Gen. Timothy Trainor, and Keller Army Community Hospital Commander Col. Beverly Land give Cadet Zack Langhans a little morale boost as he donates blood.

Keller Army Community Hospital, West Point, N.Y., kicked off its support of the annual Armed Services Blood Drive Jan. 9, at Eisenhower Hall at the U.S. Military Academy at West Point, N.Y., where all Cadets are encouraged to donate blood.

This blood drive, scheduled Jan. 9-12, from 8 a.m. to 6 p.m., is one of many across the country that helps provide quality blood products for service members and their families in both peace and war times. As a joint operation among the military services, the Armed Services Blood Program, or ASBP, has many components working together to collect, process, store, distribute and transfuse blood worldwide.

"We are proud to support this effort," said United States Military Academy Superintendent, Lt. Gen. David Huntoon. "It is critical to the success of our forces around the world and or veterans."

The U.S. Corps of Cadets is comprised of more than 4,400 men and women pursuing an undergraduate education and commission into the U.S. Army.

With the common bond of pride in their country and a strong belief in its founding principles of duty and honor, cadets are expected to participate in large numbers to donate blood to their fellow Soldiers.

"I usually come out and give blood every time we have a blood drive," said Zach Langhans, U.S. Military Academy Cadet. "This simple act really makes a difference in Soldiers' lives around the world. I'm glad I can help."

"Our nation's Soldiers deploy into combat worldwide to accomplish a myriad of mission, and unfortunately, sometimes are severely wounded and need blood products," said Col. Beverly Land, Keller Army Community Hospital commander. "With that said, it is only right that we, the Army community, do our part to insure there is an adequate supply of blood available for those injured in battle."

Due to many service members being ineligible to donate because of overseas deployment, the ASBP is limited to collecting blood only on military installations, ships, Reserve Officer Training Corps programs or other federal locations. As a result, a bulk of their blood supply comes from the Cadet corps, according to Armed Service Blood Program representative.

> "This simple act really makes a difference in Soldiers' lives around the world."
>
> -Zach Langhans, U.S. Military Academy Cadet

"This is one of the biggest blood drives we have here at the United States Military Academy," said Mary Mandia, Keller Army Community Hospital Blood Drive coordinator. "We had the highest blood donation on record since March 2003."

In 2011, cadets donated 2,194 units of blood. Of this number, 845 units were shipped to Iraq and Afghanistan, and 1,055 units were sent to military and Veterans Administration hospitals, according to Mandia.

Once all blood donations are collected, the donations are transported by aircraft to Fort Gordon, Ga., for processing. The blood donations are then tested and shipped to theater and military hospitals within two days for sick and injured service members and their families.

For more information about the blood drive or ways to donate, visit the national website at www.militaryblood.dod.mil.

CDC Vitalsigns™

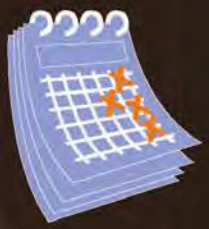
January 2012

Binge Drinking

Nationwide Problem, Local Solutions

1 in 6

More than 38 million US adults binge drink.



4X

Binge drinkers do so about 4 times a month.

8

The largest number of drinks per binge is on average 8.

New estimates show that binge drinking* is a bigger problem than previously thought. More than 38 million US adults binge drink, about 4 times a month, and the largest number of drinks per binge is on average 8. This behavior greatly increases the chances of getting hurt or hurting others due to car crashes, violence, and suicide. Drinking too much, including binge drinking, causes 80,000 deaths in the US each year and in 2006 cost the economy $223.5 billion. Binge drinking is a problem in all states, even in states with fewer binge drinkers, because they are binging more often and in larger amounts.

*Binge drinking means men drinking 5 or more alcoholic drinks within a short period of time or women drinking 4 or more drinks within a short period of time.

Learn what your community can do to reduce binge drinking.

Want to learn more? Visit

www http://www.cdc.gov/vitalsigns

National Center for Chronic Disease Prevention and Health Promotion
Division of Adult and Community Health

What Can Be Done

Everyone can help prevent binge drinking.

US Government can

- Collaborate with states and communities to support effective community strategies to prevent binge drinking strategies such as those recommended by the Community Guide.*
- Assist states and communities in tracking how many people binge drink, how often, and how much they drink when they binge.
- Help states and communities track and understand the laws and regulations that control the marketing and sale of alcohol.
- Work with states and communities to determine whether prevention strategies are working.

States and communities can

- Implement effective community strategies to prevent binge drinking such as those recommended by the Community Guide.*
- Routinely track and report how many people binge drink, how often, and how much they drink when they binge.
- Develop community coalitions that build partnerships among schools, community- and faith-based organizations, law enforcement, health care, and public health agencies to reduce binge drinking.

For more information, please contact
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Web: www.cdc.gov
Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Publication date: 1/10/2012

www http://www.cdc.gov/vitalsigns

Doctors, nurses and other providers can

- Recognize that drinking too much causes 80,000 deaths in the US each year and contributes to over 54 different injuries and diseases.
- Recognize that most binge drinkers are not alcohol dependent or alcoholics.
- Support effective community strategies to prevent binge drinking such as those recommended by the Community Guide.*
- Screen patients for binge drinking and advise those who do to reduce their use. More information can be found at http://www.uspreventiveservicestaskforce.org/uspstf/uspsdrin.htm.

People can

- Choose not to binge drink themselves and help others not to do it.
- Drink in moderation if they do drink. The US Dietary Guidelines on alcohol consumption recommend no more than 1 drink per day for women and no more than 2 drinks per day for men. Pregnant women and underage youth should not drink alcohol.
- Support effective community strategies to prevent binge drinking, such as those recommended by the Community Guide.*
- Support local control of the marketing and sale of alcohol.
- Support the minimum legal drinking age of 21.

* The Community Guide recommendations can be found at http://www.thecommunityguide.org/alcohol.

NORTHERN REGIONAL MEDICAL COMMAND

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Guthrie Army Health Clinic, Fort Drum, N.Y.
Keller Army Community Hospital, West Point, N.Y.
Kimbrough Ambulatory Care Center, Fort Meade, Md.
Kenner Army Health Clinic, Fort Lee, Va.
McDonald Army Health Center, Joint Base Langley-Eustis, Va.
Ireland Army Community Hospital, Fort Knox, Ky.
Womack Army Medical Center, Fort Bragg, N.C.

Community Based Warrior in Transition Units located at:
Massachusetts, Virginia, Illinois

Task Force NRMC, Fort Jackson, S.C.
Troop Command-South, Fort Belvoir, Va.
Troop Command-North, Bethesda, Md.
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