FINAL

STATEMENT BY

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Mr. Chairman and distinguished members of the committee, it is an honor and a great privilege to speak before you today on behalf of the nearly 40,000 Active component, Reserve component and National Guard officers, non-commissioned officers, enlisted and civilians that represent Army Nursing. It has been your continued tremendous support that has enabled Army Nursing, in support of Army Medicine, to provide the highest quality care for those who are entrusted to our care.

Last year I promised you an update on the Army Nurse Corps Campaign Plan that we began in October 2008. It became evident that our efforts to transform Army Nursing mirrored the desire of national nursing organizations and their leaders to improve nursing practice in support of the healthcare reform initiative. Today I will share with you some of Army Nursing's accomplishments that are leading national nursing initiatives as well as some of the challenges that we will face in the years ahead.

Leader Development: *Build our Bench*

The first priority for Army Nursing is to develop full spectrum Army nurse leaders. Considering our Nation's continuous engagement in overseas contingency operations and the complex clinical challenges our nurse officers face both home and abroad, I challenged my senior leaders to develop training platforms that will prepare our nurses to succeed in any contingency–based operation around the world.

Identifying the need for a clinical transition program for new graduate Army Nurses, the Army Medical Command (MEDCOM) formally fielded the BG (R) Anna Mae Hayes Clinical Transition Program (CTP), named in honor of our 13th Corps Chief, across nine medical centers beginning in October 2008. During Fiscal Year (FY) 2009, 364 new graduate Army Nurses completed this program. Throughout the year, the

program was standardized to decrease the variance among the nine program sites. Thus far in FY2010, over 270 nurses have graduated from the program. Their enthusiastic endorsement of the program usually ends with the question “when can I deploy?”

Our nurses take great pride in wearing the cloth of our nation. After graduating from the Officer Basic Leader Course, the new nurse officer enters the Leader Academy via the CTP. This program is based on the Army leader development strategy that articulates the characteristics we desire in our Army leaders as they progress through their careers. The CTP is a 25.5 week program designed to bridge the baccalaureate education and professional practice of the New Graduate Army Nurse (NGAN). It consists of three formal phases (orientation, preceptorship, and clinical immersion) developed to foster critical thinking, communication, and deployment skills. Incorporated into the phases are a five-hour monthly didactic seminar, journal club, and research review with a focus on leadership, professional role development, and improvement of patient outcomes. The CTP is congruent with the National College of State Boards of Nursing’s intent to require residency programs for new nurses.

Initial review of survey data collected during FY 2009 reveals NGAN positive responses to the following domains of new graduate nurse satisfaction: intent to stay, confidence levels in individual practice, and enthusiasm for the practice of nursing. The responses of the NGANs were similar to the published survey results from civilian clinical nurse transition programs. With the key elements of this program standardized, outcome variables related to risk management (such as medication errors, patient falls, and failure to rescue) can now be evaluated in FY 2010.

The first course that we realigned in support of the Campaign Plan was the Head Nurse Course. It has been renamed the Clinical OIC and NCOIC Clinical Leader Development Course. The renaming is a result of acknowledgement of the critical relationship that exists between the Clinical Nurse, OIC (Officer in Charge) and their clinical right arm - the NCOIC (Non-Commissioned Officer in Charge). As an integrated training platform, this course has had very positive results. It provides our mid-level managers the opportunity to learn the critical skills needed for working as a team, and to master those skills in a simulated environment. This allows participants the opportunity to hone tactics and to learn techniques and procedures and decision-making skills that are used in the clinical environment. The training received in this course promotes cognitive competency and teamwork, and metrics are being developed to examine the program's impact on patient outcomes. Twelve clinical NCOICs from across Army Medicine attended the Head Nurse Leader Development Course as a pilot test October 2009. Due to the success of this pilot test, full attendance of Clinical NCOICs at this course is in the approval process. Both the CTP and the clinical leader development course are designed to prepare clinical leaders to be experts at navigating the complexities of care delivery in any environment.

Through the past year we have leveraged the experience and expertise of our clinical Sergeants Major, as the senior enlisted advisors and subject matter experts on NCO and enlisted issues. They are our primary advisors on policies and regulatory guidance. Their voice and ideals have brought us a "results-based leadership" that has allowed us to excel in our imperatives and adopt a "new paradigm," or view of the world. These NCOs could not accomplish their mission without the hard work and dedication of

the men and women of the Army Medical Department (AMEDD) Enlisted Corps. It's through their unrelenting compassion to save and heal, despite hardships and dangers to life and limb that makes them "angels on the battlefield."

We are committed to the growth and development of our NCOs and Soldiers. Therefore, starting in FY 2011 we will fund two senior NCOs to obtain their Masters in Healthcare Administration which will ensure a continuous capability to meet the needs of the 21st Century. In addition, we are developing an Intensive Care Unit course for our Licensed Practical Nurses (LPN); this additional capability will allow commanders the flexibility to use LPNs for transport of critical patients, improve patient outcomes, and expand practice opportunities.

Finally, the Leader Academy facilitates enhanced career-long development of adaptive full spectrum Army Nurse Corps leaders through the level of Regional Nurse Executive (RNE). We adopted the American Organization of Nurse Executive competencies that include skills such as healthcare economics, and healthcare policy management as well as abilities in outcomes measurement and change management in order to ensure the RNEs have the knowledge, skills and behaviors to help manage the regions system of health. We leveraged George Mason University's "Nursing Administrative Leadership Academy" into our own leader academy as a training platform for our RNEs. We are sending three of our RNEs to the program this summer. We are also selectively using AMEDD courses such as the Interagency Federal Executive and the Executive Skills Course to hone and refine the RNE's abilities as influencers of the delivery of health. We believe the Army Nursing Leader Academy is

setting the standard nationally for how nurse leaders are prepared to have an active and influential voice in healthcare, AMEDD, and national nursing policy.

Warrior Care: *Back to Basics*

Our second strategic imperative is to standardize nursing care delivery systems in order to perfect nursing care at the bedside. We created a Patient and Family centered System of Nursing Care (SOC) that has as its cornerstone standardized nursing practice. This SOC will not only enable The Surgeon General's intent to improve and standardize care from the point of injury through evaluation and inpatient treatment and then return to duty, but will also enable, for the first time, comprehensive measurement and subsequent improvement of nurse-sensitive patient outcomes.

We piloted elements of this SOC at Blanchfield Army Community Hospital, Fort Campbell, Kentucky, in January 2009. After six months of monitoring we identified notable improvements in care such that nurse sensitive errors declined, while compliance with quality initiatives increased. During the six month pilot period, we found a 44% decrease in nursing medication errors and a 100% decrease in risk management events. Additionally, patient pain reassessment improved from 90% to 99% and reporting of critical laboratory values improved from 92% to 100%. We realized several "quick wins" such as the marked improvement in how nursing staff communicate with patients and physicians. Unexpectedly, we noted improvement in nurse retention metrics including a 24% increase in nurses' opinions that they are rewarded for a job well done, and a 23% increase in nurses' opinions that nurses are seen as important leaders in their organizations. Overall, nurses reported that they believed that they

were being heard, and their opinions valued. One nurse at Blanchfield said “Now I feel like I have a voice in the organization.”

Using the data from the Blanchfield pilot, we fully conceptualized the SOC as a three-sided pyramid with one side delineating clinical practice elements, another professional practice elements, and another business practice elements. The pyramid is anchored by the Army nursing triad; Army nurses, NCOs, and enlisted and civilians comprise its base. Next month, select elements of care are being implemented at three medical centers: Walter Reed Army Medical Center, Washington, DC; Brooke Army Medical Center, Fort Sam Houston, Texas; and Madigan Army Medical Center, Fort Lewis, Washington. For one element of the professional practice side of the pyramid, we are implementing an Army nursing creed – it is our nursing ethos and codifies who we are as nurses by articulating what we believe in and value as nurses; it is the heart of nursing practice. It includes Army values and the American Nurses Association Standards of Practice that allow us to define a standard level of nursing care common to all nurses and a standard level of behavior in the professional role.

In April, at the same three hospitals, we are implementing nursing peer review that aligns a business strategy with clinical practice. Peer review is a best clinical business practice that enables us to retain the very best nurses who provide quality care as measured against our professional standards of practice. Peer review is a talent management tool that provides real time, constructive feedback to clinicians to assist with their professional growth which leads to good patient outcomes.

In May, we will implement the Army Nurse Corps Practice Council along with unit-specific governance councils to support the clinical practice side of the pyramid.

Governance councils will facilitate decentralized joint decision making by nursing leaders and staff nurses at the frontline of care – the patient/nurse interface. These unit councils will collaborate with the Army Nurse Corps Practice Council to identify best practices relative to nursing tactics, techniques, and process, and then codify these practices for standard use across Army Nursing. Army Nursing identified two best practices that were incorporated into the SOC. At Tripler Army Medical Center (TAMC), nurses modified environmental and staff behavior factors to tailor inpatient care to provide "Healing Hours." The restorative importance of sleep is well documented, but hospitalized patients report many factors including noise, pain anxiety, light, and interruptions by hospital staff as sleep disruptors. To validate the most common sleep disruptors, TAMC nurses requested input from 227 patients over a 6 week period and received 135 responses. 71% of patients reported averaging less than 4 hours of sleep a night during their hospitalization. 62% reported their sleep being interrupted by a nurse or provider. With the information gathered, TAMC initiated the Healing Hours concept. Healing Hours are individualized based on diagnosis and requirement for hands-on care. The overall purpose of Healing Hours is to promote rest through consolidation of patient care activities. Ancillary services aligned their services to support this initiative. Pharmacy adjusted routine medication times to coincide with established rest hours. Routine laboratory service rounds do not begin before 0600 hours. Signs are posted on each patient's door to remind all staff of requested Healing Hours. Patients are provided information during pre-admission activities to encourage them to bring comfort items from home; i.e. earplugs, earphones, and eye masks.

At Walter Reed Army Medical Center, senior nursing leadership examined hourly nursing rounds as a measure to improve patient and staff outcomes. A total of 11 intensive, medical, surgical, and same day surgery units participated in the project, where we simultaneously measured outcomes such as patient satisfaction, staff satisfaction, falls, medication errors, and call light use. We compared pre and post intervention efficacy of hourly nursing rounds and found that within four months of the implementation of hourly rounds, patient outcomes, such as the use of call lights and patient falls decreased while patient satisfaction increased.

In order to ensure implementation of innovative ways to deliver care to the inpatient, outpatient, and deployed environment, we are also moving forward with implementing team nursing, comprised of RN, LPN, and medics. This aspect of the SOC aligns with The Surgeon General's (TSG) "Come Home to Army Medicine" campaign. This community based primary care will bring health care closer to home, standardize business practices, and develop the model for patient centered medical home.

As we begin implementation of the SOC, our nurse researchers have begun the transformation of a geographically disparate one to three person research cells into the Offices of Nursing Science and Clinical Inquiry (NSCI). The NSCI will combine the resources of Research PhD Scientists, Nurse Methods Analysts, Clinical Nurse Specialists, and the new DNP (Doctorate of Nursing Practice) with a robust mission that will provide decision support, evidence-based practice, and research. These NSCIs at each regional medical center will promote a shared vision across Army nursing using shared and capitalizing on shared resources and infrastructure. This change will shift

emphasis in focus to capitalize on integration of evidence-based research into practice, improve warrior care, enable leader development and maximize human capital while addressing Army nursing priorities. This fundamental shift will transform Army nursing from an expert based practice to system based care and will provide the impetus to move toward a culture and workforce with the ability to develop research agendas and translate evidence into practice at the bedside. Currently the Army Nurse Corps has an inventory of 33 ANC Research Scientists and two civilian nurse scientists with doctoral degrees. Twenty-one of these are actively working in research assignments.

In 2008, we initiated a comprehensive review of all Army nurse business and clinical processes and associated training and education. The gap analysis revealed a requirement for more advanced degree experienced nurses at patients' bedsides to influence nursing care; specifically, to direct nursing care within a systems-based care delivery model that decreased nursing care variance across the Army Medical Department in order to measure and improve patient outcomes. To that end, we expanded our review to examine the new Doctor of Nursing Practice (DNP) role as a modality for closing the gap. After this review was completed, we recognized the value of placing select DNP's within our NSCIs and the ANC is in the process of making this infrastructure change. This will provide clinical leadership, create a partnership with nurse PhD's and Nurse Method Analysts, and facilitate practical application of evidence-based research at the patient bedside to ensure evidence-based nursing care.

According to the American Nursing Association (ANA), one of the most significant shifts in health policy is represented in a measure to expand the involvement and authority of advance practice nurses. Army Nursing is also working closely with

national nursing organizations such as the American Academy of Colleges of Nursing (AACN) in leading national efforts to conceptualize a value-add role for DNPs as well as the new innovative clinical nurse leader role.

The Army nursing SOC will require new capabilities while allowing us to better leverage current nursing capabilities. For example, nursing case management is increasingly being recognized as an essential component of health care delivery. Case managers provide added value to the multidisciplinary healthcare team. Case managers in Warrior Transition Units (WTUs) are providing care to over 9000 Soldiers and have facilitated the transfer of over 8500 Soldiers back to duty or on to become productive Veterans. Warrior satisfaction with case management services has remained at or above 92% throughout the year.

The Army Nurse Case Management Course was fielded in December 2008. This course was designed to better prepare case managers in their role, facilitate the successful completion of national certification, and standardize case management services across WTUs, to ensure case managers are effectively trained to perform their mission. Over 300 nurse case managers participated in this web-based program that utilizes adult learning principles that enhance the Army NCM's understanding of case management theory. Students learn about best practices across military and civilian settings, thus gaining knowledge of principles and tools utilized in case management.

Army nursing case management is improving care in primary care settings as well as in our WTUs. Nurses across the country espouse success stories where case management has had a positive impact on patient care. In Alaska, NCMs were working with a 28 year old infantry Soldier undergoing the Medical Evaluation Board process for

moderate Post-Traumatic Stress Disorder (PTSD). During one of their sessions they talked about his mother who died at age 34 with colon cancer. Because the case managers had developed a good rapport with the Soldier, he felt comfortable mentioning that he had some rectal bleeding. He was immediately evaluated, determined to have metastatic colon cancer, and underwent a colectomy. The operation saved his life. Subsequently, he was able to medically retire as a healthy, productive veteran.

The strategic end state of this SOC is optimized nursing care delivery systems that wrap capability around AMEDD goals and priorities to achieve the best patient outcomes possible. This capability and functional structure is designed to leverage proliferation of evidence-based care and best practices to support TSG's strategic objectives.

Evidence-based Practice: *Optimize Performance*

Our third strategic imperative is to optimize Army Nursing performance using evidence-based management and evidence-based clinical practice. Evidence-based clinical practice aims to merge best practices from both clinical care and business practices to produce optimal outcomes. These goals are achieved through scientific analysis, data management, and system redesign to support the everyday performance of all our nurses. For example, the Workload Management System for Nursing (WMSN) is a tool that ANC has been using for accurately measuring patient acuity in order to establish manpower requirements in our inpatient care settings. This past year, we initiated the most dramatic update to our WMSN since 1985. Led by talented Army Nurses, the WMSN Refresh and Optimization project will enable us to upgrade our

WMSN operating system, integrate and migrate all previously separate servers, update the clinical classification and acuity measures, and develop a software interface for real time reporting tools. This milestone business process improvement will afford our nursing leadership the necessary data to support current and future resourcing decisions.

Another example is the Clinical Information System (CIS) that was developed with input from our clinical and nursing informatics experts that has played a major role in modernizing our electronic health record. This past year included tremendous expansion of the CIS inpatient health record throughout the MEDCOM. The CIS is designed to help nurses and other health care personnel collect, record, store and access patient data, as well as data from medical instrumentation and physiologic monitors from a centralized computer system. The impact of a standardized inpatient nursing documentation system cannot be minimized as it not only provides standardized documentation of the patient's history, but allows, through its requirement to enter data fields, standardization of how nurses practice.

Another evidence-based initiative is our collaboration with the Veteran's Health Administration (VHA) on Clinical Terminology Standardization that has resulted in the development of over 2,236 standardized clinical terms. The development of Systematized Nomenclature of Medicine - Clinical Terms and Logical Observation Identifiers Names and Codes will allow for intra-operable standardized clinical vocabulary to assist both the providers, and the clinical researchers. Future collaboration will allow for a seamless process to add, review, and map new terminology and integrate this into DOD inpatient documentation systems.

Given the magnitude of investment and the substantial military health care renovation and construction projects in the National Capitol Region (NCR), it is important to examine the relationship between environmental evidence-based design (EBD) features and patient and staff outcomes. COL Petra Goodman, an Army Nurse (AN), has collaborated with investigators from numerous agencies, to include our sister services, military treatment facilities in the NCR and the DOD Patient Safety Center, to develop research protocols in EBD principles and their specific outcomes, including falls, work-related injuries, and hospital acquired infections. There series of studies will provide critical baseline information for future research in EBD.

Implementing 2005 BRAC Law, Army Nurses have been involved from "Day One" in creating the new 1.23 million square foot Fort Belvoir Community Hospital ensuring that the project delivers on its mission to create a World Class Military Health Care facility. DeWitt Army Community Hospital (DACH) nurses, both uniformed and civilian, have provided critical input in the design, development, and implementation phases of this project which includes numerous EBD features such as single bed rooms with family zones, maximized use of natural light, healing gardens and positive distractions, increased HEPA filtration, ceiling mounted patient lifts, walled rather than cubicle spaces, and the use of reduced noise sources and sound absorbing materials. MAJ LaShanda Cobbs, AN, serving as Transition Director for the hospital project until July 2009, provided key leadership in coordinating design concept of operations workgroups, guiding utilization of EBD principles, and developing manning determinations for this state-of-the-art inpatient and ambulatory care center. Looking to the future, DACH nurses will continue to play pivotal roles in implementing integrated

bedside IT solutions, the Vocera hands-free nurse call system, creating patient controlled environments utilizing Smart Room Technology, and myriad other operational solutions to maximize EBD features to minimize hospital acquired infections and increase patient safety.

Never before have we relied so heavily on nursing research to infuse nursing practice with evidence-based science. In February 2009, the Triservice Nursing Research Program (TSNRP) invited nurse scientists from all services to meet in order to determine new priorities for TSNRP. Not surprisingly, Force Health Protection was recognized as the number one priority. Deployment research is designed to ask critical questions that cannot be answered other than on the battlefield providing medical care for our service members. Army nurses have led the way with deployment research relative to their strong presence in field environments. There have been 34 nursing led protocols, 27 of those are from ANC researchers and one joint Army/Air Force protocol. A breakdown of these protocols includes a total of 20 protocols on warrior care, including five on Soldier Health, three on Trauma care, and one on Behavioral Health and a total of 14 protocols to study the impact of compassion fatigue and stress on nursing and healthcare professionals. Post Traumatic Stress Disorder (PTSD) is a focal point for many of the studies. COL Kathy Gaylord at the Army's Institute of Surgical Research is conducting three studies to evaluate alternative therapies for treatment of PTSD or PTSD symptoms in burn patients. "Gradual Virtual Reality exposure therapy and D-Cycloserine (a learning enhancer pill) treatment for combat-related PTSD" is a pilot study to determine the effectiveness of virtual reality therapy for service members who have sustained a burn injury requiring multiple dressing changes as a distraction to

reduce their pain during these dressing changes. “Cranial Electrotherapy Stimulation (CES) on PTSD Symptoms in Burned Outpatients” is a double-blind randomized control research study is to determine if CES given to service members who have sustained a burn injury and meet PTSD criteria will be effective to reduce their PTSD symptoms and other deployment-related symptoms. ANC research scientists also continue to collaborate with the other DOD agencies, the Department of Veterans Affairs, and universities in support of the congressionally funded studies for research. In the Pacific region, Army nurses established a clinical-academic research partnership between Pacific Regional Medical Command (PRMC) and the University of Hawaii. This first formal academic-clinical nursing research partnership between Tripler Army Medical Center and the University of Hawaii creates a joint vision for the future of nursing and health care. This partnership provides the resources and structure that will allow Pacific Regional Medical Command (PRMC)-based nurses and University of Hawaii (UH)-based nurses to ask and answer the clinically relevant military healthcare questions.

Army Nurses, like MAJ Rebecca Terwilliger, are leading the way with an innovative best clinical practice pilot to improve nursing care. She won a $17,532 grant from the March of Dimes to establish a Centering Pregnancy Program for antepartum patients. Participants enroll into a stable group that begins meeting at 16 weeks followed by monthly meetings until 32 weeks, then every other week for the remainder of the pregnancy. The group meets for 2 hours each session and is led by a certified nurse midwife. Benefits of the program include the development of a socialization and support network system while providing 2 hours of education on topics related to pregnancy, childbirth and newborn care. Evidence has shown that the program

increases patient satisfaction, increases continuity with a provider and decreases preterm birth rate; for those that deliver prematurely, delivery occurs in gestation and the newborn is at a higher birth weight.

Research is also supporting evidence-based business practices. For example, we used data to evaluate our accession portals and make timely changes on how we recruit, retain, and incentivize nursing personnel to remain a part of our nursing team. The Army Nurse Corps was very successful in recruiting and retaining Army Nurses in 2009. Research, like that being done by LTC Breckenridge-Sproat, AN, titled “Factors Associated with Retention of Army, Air Force, and Navy Nurses" will survey Active Duty Army, Navy and Air Force nurses to explore factors influencing decisions to maintain their active duty status. In the history of military nursing research, there has never been a retention survey using a validated instrument conducted across all three services. Considering the changing market for registered nurses in the US and the complex factors that influence decisions to remain on active duty, it is important to obtain data to support appropriate strategies to retain military nurses in the Army, Navy and Air Force. The results of this multi-service study will provide the Corps Chiefs from the Army, Navy, and Air Force with a better understanding of factors impacting nurses' intent to stay in the military. The findings should allow administrators to capitalize on specific factors that positively influence nurses to stay in the military and implement changes to ameliorate factors that are influencing nurses to leave the military.

Research is also helping us develop new recruiting strategies, called precision recruiting, whereby we are recruiting experienced medical-surgical and specialty trained nurses. This strategy will provide us with a balanced force of new nurse graduates with

more experienced clinical nurses. Leveraging data allowed us to determine the need for precision recruiting, i.e., targeted recruiting of critical low densities. As a result, we increased our recruitment of Nurse Anesthetists, Behavioral Health Nurse Practitioners, Family Health Nurse Practitioners, and critical skills such as Emergency Room and Critical Care trained nursing personnel. These skills are especially in high demand with our nation's continued involvement in overseas contingency operations. Working closely with Accessions Command, we are formulating a recruitment strategy that ensures a consistent pipeline of ROTC, Army Enlisted Commissioning Program (AECP), and Federal Nurse Commissioning Program graduates, balanced with direct accessions of experienced nursing personnel.

Evidence-based processes also allow us to look at who, when, and where we have the greatest attrition and how attrition is impacting the care we provide for our beneficiaries. Incentives, such as Incentive Special Pay, critical skills bonuses, and hiring bonuses have not only allowed us to conduct precision hiring of civilian nurses, but also allowed us to compete with the recruitment market for experienced and well qualified nursing personnel. I want to thank the committee for supporting these initiatives in the past and look forward to your continuing support in the future. In addition we raised and then codified minimum standards for entry into the AECP based on the quality of the nurses this program produces. In the past we have had as high as 14% non-completions in the AECP. Data analysis revealed an antiquated admission criteria resulting in candidates who were not adequately prepared to sustain the rigors of the Bachelor's of Science program. The change in admission standards has vastly

improved the quality of candidates in the program and will ultimately impact the quality of care we will provide to our warriors and their families.

Human Capital: *Portfolio of Talent*

People are our organizations' most valuable asset and remain one of my top priorities. Success toward our strategic initiatives has been possible only because of the commitment and extraordinary work by the triad of nursing; Active and Reserve component officers, non-commissioned officers, and civilians. Our efforts over the past year in both recruitment and retention of active duty and civilian nurses have positively impacted Army Nursing. Investing in human capital requires a strategic approach to managing the recruited and retained talent so patient outcomes are optimized throughout the organization. Subsequently, our fourth imperative is optimizing human capital talent through talent management and succession management planning. One of the ways we are managing talent is by leveraging nursing capability in new ways. A great example of this is the "curbside nursing" concept that clinical nurse midwives implemented at Fort Campbell, KY. In 2009, it became strategically imperative that some type of new Soldiers' health initiative for women's gynecological intervention and engagement was needed to address the backlog of gynecologic appointments. Several Certified Nurse Midwives (CNM) services have actively engaged in leaving the confines of the hospitals and entered what normally has been recognized as a Soldier's clinic. This medical model approach to women's wellness has received laudatory comments noted in Army Provider Level Satisfaction Survey reports across several installations.

To support TSG's strategic priority of implementing a comprehensive behavioral health system of care, BG Steve Jones, Commander, Pacific Regional Medical

Command, and I worked together to implement a program to assess the effectiveness of connecting behavioral health resources with soldiers in a virtual encounter. Nursing resources were engaged in validation of the assessment tool as well as serving as a force multiplier through the integration of NCM and 68X, Mental Health Technicians, in the virtual program. Partnered with behavioral health (BH) providers, NCM screen for "at risk" Soldiers face-to-face and virtually with the intent to provide access to BH in remote or isolated locations. Many Soldiers returning from deployment do not need the complex services of the Warrior Transition Unit (WTU), but they do have significant concerns that could impact successful reintegration with families and non-combat environments. Coordinating care and support through the NCM, Soldiers and families are guided to financial, emotional, and physical care to support reintegration. The NCM effort in this Comprehensive Behavioral Health System, led by Amy Earle, RN, mitigates stressors to the Soldier and family by connecting them to services within the community.

At Europe Regional Medical Command, the Maternal Child Nursing section uses a Perinatal Clinical Nurse Specialist to track high risk patients, which resulted in significantly increasing the number of infants that were immunized against Hepatitis-B at birth or prior to discharge as recommended by the Centers for Disease Control. In 2009, LTC Sherri Franklin, Chief of Nurse Midwifery, started a new midwifery program with 3 active duty CNMs at Ft. Benning, Georgia. Due to the increased demand for low risk obstetrical care and the size of the post increasing, this planned service will be stabilized at Benning. Planned for 2011, an additional 6 new CNM graduates from accredited mastered prepared programs across the United States will be welcomed as new clinicians.

This year, for the first time in our history, two of the deployed Combat Support Hospitals will be commanded by Army Nurse Corps officers. In 2009, 333 active duty Army Nurses were deployed in support of Operation Iraqi Freedom and Operation Enduring Freedom. This represented a total of 70,589 deployed man days. In 2009, the 6 month (180 days) PROFIS deployment policy was successfully implemented, considerably reducing the adverse affects of long deployments on our nursing personnel. Through the expert coordination of our nursing leaders, nursing staff were rotated at six month intervals with no adverse impacts in patient care. However, our low density nurse specialists, to include nurse anesthetists, nurse practitioners, critical care, perioperative and emergency nursing are still experiencing frequent deployments with some nurses completing their second and third deployments. We are conducting an in-depth force structure analysis to determine our objective force structure for the future years.

Our Budgeted End Strength is projected to increase from 3515 in FY 2010 to 3580 in FY 2011. In addition, 80 Army Nurse Corps officer authorizations are projected as a part of the Grow the Army strategy. We are modeling for the optimal number of critical care nurses, emergency room nurses and behavioral health nurses needed to ensure sufficient staffing in our CONUS based medical treatment facilities and to continue the theater support that has supported the 93% survival rate of our service members injured in our combat theaters. We recognized that many of our specialty nurses transition to advanced practice roles as nurse anesthetists or nurse practitioners but their “loss” from the specialty role was not included in our previous models. Using innovative analytical processes we have identified shortfalls in our training requirements

that, when corrected, will increase the available strength of these critical low density nurse specialists. With increased numbers, the adverse impact of frequent repeat deployments will be mitigated. The Army Nurse Corps has always been committed to advanced education as an essential element of quality healthcare. As we face the continuing behavioral health challenges, we are increasing our number of nurses selected for behavioral health nurse practitioner programs. Of note, only the Psychiatrist and the Behavioral Health Nurse Practitioner has prescriptive authority as Behavioral Health providers. We have recognized that this level of Behavioral Health providers is critical in both garrison and deployed settings to facilitate optimal behavioral healthcare. This year, we will select 5 nurses for attendance in the Psychiatric/Mental health NP program at Uniformed Services University (USU) to start in 2011. In addition, as we transition our advanced practice nurse roles to the future DNP, we will be sending one nurse for a DNP program as a Psychiatric/ Mental Health NP.

We rely on the USU Graduate School of Nursing as the strongest educational platform to develop critical talent to provide nursing capability across Army Medicine. A good example of how USU is helping us build new nursing capabilities is the perioperative nursing program. COL (R) Wanzer and LCDR Conrardy, USU nursing faculty, developed a perioperative CNS program marketing brochure and designed a marketing poster for presentation at the 11th Annual Tri-Service Perioperative Symposium in Chicago in March 2009, and along with her fellow researchers Cole Hawker and D. Moultrie, were awarded the 2009 Association of Perioperative Registered Nurses National Research Excellence Award for their research titled: “Factors Associated with Multidrug Resistant (MDR) Acinetobacter Transmission

Occurring in Traumatic War Injuries". COL (R) Wanzer was also invited to address Congress during hearings on health care reform and presented "The Role of Clinical Nurse Specialist in Health Care Delivery: Today and in the Future." The Psychiatric Mental Health-Nurse Practitioner (PMH-NP) Program was evaluated for its academic content, testing, and overall effectiveness. Changes have been made to the course structure in order to ensure students integrate and apply their knowledge in context of the goals of the program. In addition the Graduate School has signed eleven new memorandums of understandings with new clinical sites. In October 2008, USU chartered a task force to examine implementation of a DNP curriculum to be in line with the American Association of Colleges of Nursing decision to move the current level of preparation necessary for advanced practice nursing from the master's to doctoral level by the year 2015. The results of eight months of study revealed that USU should take the steps necessary to implement a USU DNP program. This further expands USU's strength as an education platform for Army Nursing so that we can apply a practical application of evidence-based research at the patient bedside to ensure evidence-based nursing care.

Over 60% of our organization is our civilian work force, so our retention efforts continue to be focused on this group. We continue to have unprecedented success in our civilian nurse loan repayment program, with over 41% of total Army student loan repayments going to nurses. For fiscal year 2010, 314 applicants were selected to participate in the nurse loan repayment program, the largest number since the program started in 2006. We also recognize that our talented civilian health care professionals have unique issues and challenges. To provide support to our civilian nurse workforce,

the Civilian Nurse Task Force was chartered in March 2009 to provide a forum for specific discussion on issues related to recruitment, retention, and career progression. This group's hard work resulted in the adoption of a civilian RN career pathway that remains in a working phase today. From this task force, a Nurse Consortium was established, in November 2009, and each medical treatment facility has a civilian nurse representative. This consortium works on key issues affecting satisfaction of the civilian nurse workforce. Current working issues include improving the relationship between civilian and military nurses, recruitment of civilian new graduate nurses, and civilian nurses in senior leadership positions in medical treatment facilities. Our first step to leverage civilian nurse talent at the senior executive level was the selection of Dr. Patricia Wilhem as a member of the Army Nurse Corps Executive Board of Directors. In addition, the "Civilian Connection" link was established on our new, innovative ANC website and is used to post links and information pertaining to civilian nurses. It facilitates a sharing of information not only between civilian nurses but also between civilian and military nurses to enhance professional relationships.

Finally we continue to leverage our retired ANC officers to serve as nurse role models, mentors and subject matter experts and ambassadors for the ANC. COL (R) Jeri Graham, president of the Army Nurse Corps Association (ANCA) in partnership with the ANC conducted the pilot Veteran's Resiliency Program in May 2009. There were sixteen participants with eleven active component combat veteran nurses and five Vietnam veteran nurses. The program was designed to address the issues that returning warrior nurses have after deployment that impact retention. The program was

received favorably and with many positive comments to sustain the program in the future.

Conclusion

There has been great momentum since I introduced the Army Nurse Corps Campaign Plan to you last year. Our success has been the result of compassion, commitment, and dedication from all members of the triad of nursing. They have inspired me with their pride, enthusiasm, and openness to change. We continue to experience amazing progress in each of our strategic imperatives and we are ensuring that the ANC remains relevant and a force multiplier for Army Medicine.

I continue to envision an Army Nurse Corps in 2012 that will leave its mark on military nursing and will be a leader of nursing practice reform at the national level. The implementation of the standardized Patient & Family Centered System of Care is revolutionizing nursing care in the ANC and ensures that we optimize patient outcomes at every point of care delivery, both home and abroad. It reminds us that our priorities remain the patients and their families. Our common purpose is to support and maintain a system of health. In order to achieve this common purpose, we will let nothing hinder those who wear the cloth of our Nation or those who took an oath to forever save, protect, care, and heal.