MERCURY

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Maj. Gen. Patricia D. Horoho receives the U.S. Army Medical Command colors from Gen. Raymond T. Odierno, Army Chief of Staff, at the MEDCOM Change of Command Ceremony in the Blesse Auditorium on Fort Sam Houston, Texas, Dec. 5. Horoho is the first woman and first nurse to command the Army's largest medical organization. She succeeds Lt. Gen. Eric B. Schoomaker (far right), commander since December 2007. (Photo by Edward Dixon and Douglas Meyer)

Horoho assumes command of MEDCOM

By Shannon Carabajal
Mercury Editor

When Army Chief of Staff Gen. Raymond T. Odierno passed the U.S. Army Medical Command flag to Maj. Gen. Patricia D. Horoho during a ceremony at Fort Sam Houston Dec. 5, the moment marked two historic firsts for the command.

Horoho became the first woman and first nurse to command the Army's largest medical organization. The MEDCOM is organized into five major Subordinate Commands (MSCs) and five Regional Medical Commands (RMCs), all united under the MEDCOM Commander. The command is comprised of eight Army medical centers, 27 medical department activities, numerous clinics in the U.S., Europe, Korea, and Japan, and 10 subordinate Army Medical Department commands and agencies. She succeeds Lt. Gen. Eric B. Schoomaker, commander since December 2007, who will retire in January.

Medical Command is one of 11 Direct Reporting Units in the Army. It manages over a $12.8 billion budget and provides medical care for more than 3.95 million eligible beneficiaries worldwide — active duty service members, retirees, and their Family members. The command also oversees graduate medical education, health professional education, medical research and training of all combat medics.

See HOROHO P4

THE MERCURY

U.S. Army Medical Command

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INSIDE THE BUBBLES: Understanding the balanced scorecard

Throughout the Mercury, our readers will notice interactive bubbles connecting issues and topics to the Army Medicine Balanced Scorecard. The BSC communicates the mission, strategic vision and goals of AMEDD. The bubbles are the strategic objectives - the “means” and “ways” to accomplish the “ends.” For more information, visit **armymedicine.mil/about/BalancedScorecard.pdf.**

MERCURY Comment

TRICARE Young Adult from a beneficiary's perspective

By Josh Nosalik
Guest commentary

FORT GORDON, Ga. – Young adults of military parents now have a new option when it comes to health insurance with the TRICARE Young Adult program.

I turned 23 in December 2009, and with that I lost my TRICARE coverage. At the time as a college student, I could not afford health insurance. But I never gave that a second thought. I was healthy and only had to seek medical care for minor issues on a rare occasion.

Flash forward to April 21 of this year. I was playing ice hockey and during a fast breakaway, I collided with another player. This sent me feet first at full speed into the boards.

At the point of impact, I felt the worst pain I had ever felt. I looked down to see my left foot pointing 90 degrees to the left and I quickly realized that I had broken something. After the initial shock of the injury passed, the next thing that popped into my mind was the fact that I did not have health insurance. All I could think about was how much the medical bills were going to be and how I was going to pay for them.

An ambulance ride, emergency room visit, x-rays, and orthopedic consult later, my diagnosis was a fractured fibula, dislocated foot, and torn ligaments. The fracture required surgery and I was hospitalized for four days.

After my release from the hospital, I started to receive bills from the various physicians that had taken care of me throughout my emergency room visit and hospitalization. All in all, my medical bills totaled a staggering $65,000 - all of which I would have had to pay for out of pocket if it was not for the TRICARE Young Adult program.

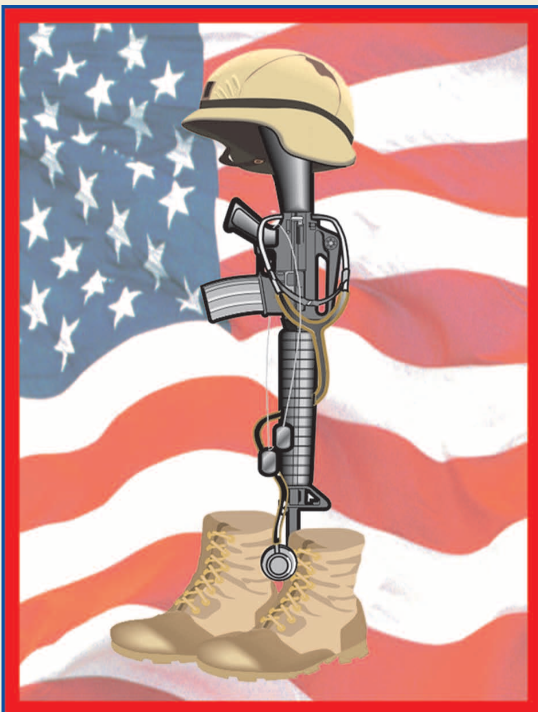
This new program went into effect on May 1, 2011 and was designed to offer coverage for young people whose regular TRICARE benefits had expired.

To qualify for this program, a beneficiary must be a dependant of an eligible uniformed service sponsor, unmarried, at least 21 years old but not yet 26, ineligible to enroll in an employer-sponsored health plan, and otherwise ineligible for TRICARE program coverage. Monthly premiums for TRICARE Young Adult for 2011 are $186.

When TRICARE Young Adult was first announced, for a short amount of time it initially allowed for purchase of retroactive coverage. In my case, the injury occurred prior to the start of the program but thankfully I was able to purchase insurance coverage retroactively by paying the premiums for the months I was uninsured.

It's been a little over five months since my accident and my recovery is progressing well. Dealing with billing and claims was overwhelming and a challenge at first. Since TRICARE Young Adult was still a new program, there were some initial problems. However, the TRICARE Service Center representatives at Eisenhower Army Medical Center have been extremely helpful and have gone out of their way to assist with resolving these issues. They ensured all providers involved in my care were contacted and educated on how to file claims and kept me up-to-date on the status of these claims and any deductibles I owed.

For more information about TRICARE Young Adult, visit the TRICARE website at **www.tricare.mil/tya**.



The last, full measure of devotion

SSG Keith F. Rudd, 68W, Sept. 9, 2011, Company C, 3rd Battalion, 82nd Combat Aviation Brigade, 82nd Airborne Division

SPC James A. Butz, 68W, Sept. 28, 2011, HHC, 1st Battalion, 505th Parachute Infantry Regiment, 3rd Brigade Combat Team, 82nd Airborne Division

SSG Robert B. Cowdrey, 68W, Oct. 13, 2011, Company C, 3rd Battalion, 82nd Combat Aviation Brigade, 82nd Airborne Division

1LT Ashley I. White, 70B, Oct. 21, 2011, 230th Brigade Support Battalion, 30th Heavy BCT, North Carolina National Guard

LTC David E. Cabrera, 73A, Oct. 29, 2011, Uniformed Services University of Health Sciences

SSG Christopher R. Newman, 68X, Oct. 29, 2011, Medical Company A, Tripler Army Medical Center

Brock assumes MEDCOM CSM responsibilities

By Shannon Carabajal
Mercury Editor

Command Sgt. Maj. Donna Brock assumed responsibility for the U.S. Army Medical command during a Change of Responsibilities Ceremony Dec. 5 in the Blesse Auditorium on Fort Sam Houston, Texas.

Brock assumed the duties of Command Sergeant Major, U.S. Army Medical Command Senior Enlisted Advisor.

A graduate of Class 50 of the U.S. Army Sergeants Major Academy and the Command Sergeants Major Course, Brock has served in leadership and staff positions as various levels, including assignments as the Command Sergeant Major, Southeast Regional Medical Command/Dwight D. Eisenhower Army Medical Center, and Command Sergeant Major, Darnall Army Community Hospital, Fort Hood, Texas

Command Sgt. Maj. Donna Brock

The Los Angeles native has earned many military and civilian accolades. Her military awards and decorations include the Bronze Star Medal; the Meritorious Service Medal with five oak leaf clusters; the Army Commendation Medal with four oak leaf clusters; the Army Achievement Medal with four oak leaf clusters; eight awards of the Good Conduct Medal; the National Defense Medal with one star; the Global War On Terrorism Expeditionary Medal; the Global War on Terrorism Service Medal; the Korean Defense Service Medal; the NCO Professional Development Ribbon (numeral 4); the Army Service Ribbon; the Overseas Service Ribbon (numeral 2); the Drill Sergeant Identification Badge; and the Air Assault Badge.

Brock was inducted into the Order of Military Medical Merit in 1996 and was selected to be a member of the Honorable Order of Kentucky Colonels in 1999.

HOROHO from P1

On Dec. 7, Horoho will be promoted to the rank of lieutenant general and sworn in as the Army 43rd Surgeon General. In that capacity, she will serve as the medical expert on the Army staff, advising the Secretary of the Army, Army Chief of Staff and other Army leaders and providing guidance to field units.

The general said she is honored by the confidence Army leaders have placed on her to serve as the 43rd Surgeon General. “I am very excited about being able to serve with and serve for a team of professionals who are internationally renowned,” she said.

She is also proud about joining a long lineage of past surgeon generals, going back to 1775. “In every conflict the US Army has fought, Army Medicine has stood shoulder to shoulder with our fighting forces, supporting those who are putting their lives on the line to defend our freedom. It is my honor to be able to serve in this position and carry on the strong tradition.”

Though she feels the unique personal and professional skills she brings to the position are more important than her gender or career field, she recognizes the significance of her assuming the position and the potential impact it can have in encouraging professional growth across Army Medicine.

“Some say that I am cracking the glass ceiling. I would submit that I am just the next person that is passing through the crack that has been opened by pioneers, leaders that came before me, regardless of gender, culture, race, or creed. What I bring to the job is not my gender, nor my clinical discipline but my 28 years of experience and education in the field of healthcare.

As Horoho looks forward to the next four years, there is much to do. The past ten years have presented the Army Medical Department with a myriad of challenges, encompassing support of a two-front war while simultaneously delivering healthcare to beneficiaries across the continuum. She plans to build on the strong platform that LTG Schoomaker and the Army Medicine team established. “There are challenges in front of us; but those challenges present windows of opportunities, and this team has the talent, drive and the passion to shape the future landscape that we have the honor to deliver care,” says Horoho.

Horoho was previously dual-hatted as the U.S. Army Deputy Surgeon General and 23rd Chief of the U.S. Army Nurse Corps. She has commanded Western Regional Medical Command, Joint Base Lewis-McChord, Wash.; Madigan Army Medical Center, Joint Base Lewis-McChord, Wash.; Walter Reed Health Care System, Washington D.C.; and DeWitt Health Care Network, Fort Belvoir, Va.

The general holds a Bachelor of Science in Nursing from the University of North Carolina Chapel Hill, and a Master of Science in Nursing as a Clinical Trauma Specialist from the University of Pittsburgh. She is also a resident graduate of the Army’s Command and General Staff College and the Industrial College of the Armed Forces where she earned a second Masters of Science degree in National Resource Strategy.

She has earned many awards and recognitions throughout her career. In 1993, she was selected by “The Great 100” as one of the top one hundred nurses in the State of North Carolina. In December 2001, she was honored in Time Life publications for her actions at the Pentagon during the terrorist attacks of Sept. 11, 2001. In September 2002, she was honored as one of 15 nurses selected by the American Red Cross and Nursing Spectrum to receive national recognition as a “nurse hero.” In 2007, she was honored as a University of Pittsburgh Legacy Laureate. In April 2009, she was selected as the USO’s “Woman of the Year.” Most recently, on 30 November 2011, University of North Carolina School of Nursing selected her as the “Alumna of the Year.”

Her military awards and decorations include the Distinguished Service Medal, Legion of Merit (with two oak leaf clusters), the Bronze Star Medal, Meritorious Service Medal (with six oak leaf clusters), the Army Commendation Medal (with three oak leaf clusters), the Army Achievement Medal (with oak leaf cluster), the Afghanistan Campaign Medal, the Armed Forces Expeditionary Medal, and various service and unit awards.

Secretary of Defense Leon Panetta, center, is joined by civic and military leaders as he cuts the ribbon during the dedication ceremony for the new Walter Reed National Military Medical Center. The 2.4 million-square-foot facility is the world's largest military hospital and will provide state-of-the-art care for about a million beneficiaries per year. (U.S. Navy photo by Sean Brennan)

Panetta dedicates Walter Reed National Military Medical Center

By Jim Garamone
American Forces Press Service

"If our military can be judged on how well we fight our nation's wars then our national character can be judged by how well we treat those who fight for us."

- Leon Panetta
Secretary of Defense

BETHESDA, Md. – Defense Secretary Leon Panetta presided over the opening of what he called "a 21st-century place of miracles" Nov. 10.

Panetta cut the ribbon of the new Walter Reed National Military Medical Center. The hospital is the result of the merging of the now-closed Walter Reed Army Medical Center in Washington, D.C., and the Bethesda National Naval Medical Center.

"This place performs miracles, it saves lives," Panetta said of the Bethesda medical facility. "And it renews life for the future."

The hospital honors Army Maj. Walter Reed, a pioneering bacteriologist and one of the men who found that mosquitoes were the disease vector for yellow fever. It also continues the world-class care that the Bethesda Naval facility has provided since it was founded during World War II.

The combined hospital is a place of healing and miracles, Panetta said. It will service more than 1 million patients from those severely wounded in the nation's wars, to military Families to retirees.

Military personnel deserve a health care system second to none, the secretary said.

"Since 9/11, nearly 47,000 Americans have been wounded in action," Panetta said. "Many have been dealing bravely with many grievous injuries. At the same time, their brothers and sisters in arms have also been battling cancer, degenerative diseases of one kind or another, psychological challenges of one kind or another.

"Our nation's wounded, our nation's ill, our nation's injured show remarkable fortitude and strength in the face of some huge obstacles, he continued.

"They want nothing more ... than to recover and rejoin their units and chart a new path of life in service to this country. In their spirit, we see the very best our country has to offer."

Since the terrorist attacks on America a decade ago, military medicine has "modernized and expanded," Panetta said, and in some cases "established innovative new capabilities for those in need."

The new Walter Reed hospital, he said, has the latest equipment, the best facilities and some of the most-innovative treatments. But it is the people, he added, who tend to those suffering, make the diagnoses, formulate the care plans, maintain the physical plant, cook the food, dispense the drugs and all the other things that make buildings places of healing that are most important.

The secretary said he knows that all will do their best for those who deserve so much.

"If our military can be judged on how well we fight our nation's wars then our national character can be judged by how well we treat those who fight for us," he said.

The 2005 Base Realignment and Closure Act mandated the merging of the hospitals. The facility in Bethesda is a tri-service facility staffed by Army, Navy and Air Force personnel.

The commander is Navy Dr. (Rear Adm.) Alton L. Stocks.

The Warrior Transition Battalion at Joint Base Lewis-McChord, Wash., is taking part in a one-year pilot program for hydrogen-fueled vehicles by adding a hydrogen bus to its fleet.

WTB goes green with new hydrogen bus

Story and photo by Suzanne Ovel
Warrior Transition Battalion Public Affairs

JOINT BASE LEWIS-MCCHORD, Wash. – From the outside, and, well, from the inside too, it looks like almost any other city bus with bright designs, individual passenger seats, and handicapped-accessible features.

But the Warrior Transition Battalion's newest bus is remarkable in what makes it run -- an electric battery whose life is extended by a hydrogen fuel cell.

In other words, the WTB is getting a lot more environmentally-friendly by using an alternatively-fueled bus, as part of Joint Base Lewis-McChord's partnership with the Defense Logistics Agency for the Hydrogen Demonstration Project.

"It shows the Warrior Transition Battalion is a leader in trying to go green," said Chip Townsend, the WTB's transportation coordinator.

Going green is something the federal government has been looking at for quite a while, according to Lou Fernandez, who is a national fuel cell bus consultant for partners with Signature Transportation Parts and Service, Inc.

The resident expert and liaison for the one-year pilot program at JBLM, which also includes 19 hydrogen-fueled forklifts, helped build the alternative-fueled bus.

The hydrogen bus fits into JBLM's goal of reducing air emissions; the hydrogen bus simply emits water from the combination of hydrogen and oxygen, as opposed to a diesel bus which emits particulates, soot and noxious fumes.

The heart of the vehicle's power source is the six-pack bank of batteries under the bus. Normally, after every 40 miles the battery pack would need to recharge, said Fernandez.

Add on the hydrogen fuel cell extender, and the bus can travel for 268-308 miles without refueling.

Because hydrogen gas is known to be flammable, the designers put redundant safety measures in place, said Fernandez.

The hydrogen tank is located atop the bus; the bus can automatically lock down and seal off the tank if needed; and if need be, the whole vehicle will shut down.

"It's smart enough, she knows she doesn't have to run anymore," said Fernandez.

With a top speed of 58 miles per hour, the hydrogen bus is meant for city driving, he said.

This is a good fit for driving on base, where the average speed limit is 30-45 miles per hour, said Townsend.

At $1.4 million, the hydrogen bus is roughly twice as costly as its diesel counterparts, but comparing costs can be tricky. The hydrogen bus does need regular oil changes and filter replacements, and it's expected to last four years longer than diesel buses.

Also, the initial hydrogen bus price includes research and development costs, said Fernandez. He said that some rethinking is needed in going green.

"We have to change our minds that we are trying to change the environment for our kids and grandkids," he said.

R 1.0 Optimize Resources and Value

Programs like this pilot help create this change by refining the development of hydrogen fuel. The pilot will measure the range, performance and safety of the bus, as well as gauge the technology itself and how to improve it.

Goals of the pilot program include to advance the technology of reforming waste digester gas (which here means converting methane to hydrogen) and the commercialization of hydrogen gas use, said Terry Austin, the base's pollution prevention program manager.

Soldiers compete for Army's best medic title

By Michelle Tan
Army Times

CAMP BULLIS, Texas – The two-man team representing 3rd Battalion, 75th Ranger Regiment, won the inaugural Command Sgt. Maj. Jack L. Clark Jr. Best Medic Competition Nov. 6.

The Soldiers, Sgt. 1st Class John Maitha and Staff Sgt. Christopher Whitaker, bested 30 other two-Soldier teams from across the Army during the grueling 72-hour competition.

CS 3.0 Responsive Battlefield Medical Force

"Throughout the entire course we had no idea how we were doing, we had no idea where we placed, so we just kept going as fast as we could," said Maitha, who is the senior medic for 3rd Battalion.

The pair, who have 14 combat tours between them, said they were surprised when they were named the winning team. Maitha and Whitaker received the Meritorious Service Medal, the combat medic statue and other gifts for winning the competition.

In second place was the team from the 160th Special Operations Aviation Regiment, represented by Staff Sgt. Gabriel Mendoza and Staff Sgt. Gabriel Valdez. Mendoza and Valdez received the Army Commendation Medal.

Spc. Austin Kreutzfeld and Spc. Allen Klingsporn, from the 82nd Airborne Division, came in third and received the Army Achievement Medal.

The Best Medic Competition kicked off Nov. 4 and tested the competitors with back-to-back events including a physical fitness challenge, M-9 and M-4 stress shoots, land navigation, day and night combat medic lanes, an obstacle course, a written test and a buddy run while carrying a 180-pound casualty on a litter.

The competition used to be known as the Expert Field Medical Challenge, and this was the first time the event has taken on its current form and its new name.

The competition was named for Clark, who served as the top enlisted Soldier for Medical Command beginning in February 2003 and was later diagnosed with brain cancer.

Sgt. 1st Class Ricardo Gutierrez, representing the Army Medical Department Center and School, approaches the tactical M-4 stress shoot area after a six-kilometer foot march.

Clark died June 17, 2004. He was 51.

"It's a terrific honor to the Family," Clark's father, Jack Clark Sr., said when he visited Camp Bullis to observe the competition Nov. 4. "He was a very special person to us. It makes us proud of the fact that he's still thought of. We're very proud of him, his accomplishments and his service."

To compete in the Best Medic competition, enlisted Soldiers must be in a medical military occupational specialty, officers must have a medical area of concentration or be a medevac pilot, said Capt. David Vise, officer in charge of the Expert Field Medical Badge Test Control Office at the Army Medical Department Center and School.

Competitors also must have earned the Combat Medic Badge or the Expert Field Medical Badge, he said.

Every Soldier who competed earned their spot in the competition, said Col. William LaChance, commander of the 32nd Medical Brigade, which designed the three-day event.

"They're all competitors, otherwise they wouldn't be here," he said. "What I hope they get from this is knowing they were challenged to the highest possible level physically, mentally … and the persons who win are the Army's best medics, because that's what they are."

(Reprinted with permission from Army Times)

Staff Sgt. Christopher Whitaker and Sgt. 1st Class John Maitha, representing the 3rd Battalion, 75th Ranger Regiment, Fort Benning, Ga., drag a 180-pound casualty during the M-9 stress shoot lane Nov. 4 at Camp Bullis, Texas. Whitaker and Maitha finished first in the competition securing the title of the Army's best combat medic team. (Photos by Lori Newman)

Officials cut the ribbon celebrating the opening of the new $1 billion Fort Belvoir Community Hospital. Built using Evidence-Based Design principles, the new, world-class hospital is the only one of its kind in the Department of Defense, and was built as a result of the 2005 Base Realignment and Closure program. (Department of Defense photo by Marc Barnes)

New Belvoir hospital cuts ribbon, celebrates project

By Kristin Ellis
Fort Belvoir Community Hospital

FORT BELVOIR, Va. – After five years of complex interagency and interservice collaboration, Fort Belvoir Community Hospital officially cut the ribbon today to celebrate completion of one of the largest and most involved medical BRAC projects.

Staff breathed life into the project with their unwavering commitment, leveraging cutting edge technology with evidence-based design to enhance clinical operations for military service members, retirees and their Families, said Vice Adm. John M. Mateczun, commander of Joint Task Force National Capital Region Medical.

For the last year, the Belvoir Hospital team maintained operations at Dewitt Army Community Hospital with a patient satisfaction survey of greater than 90 percent, while simultaneously planning, training, rehearsing, and executing transition operations for the new $1.03 billion facility. Within days of opening, medical staff "adjusted fire" to meet the challenges of a joint occupancy as well as the curveballs mother nature delivered to include an earthquake, hurricane, and regional flooding.

IP 11.0 Synchronize Army Medicine to Support Army Stationing and BRAC

"This transition was a herculean effort fueled by innovation, adaptability, and motivation unlike any I have experienced in my 30 years of service," noted Col. Susan Annicelli, commander of Fort Belvoir Community Hospital.

About four years ago, officials broke ground for the new facility, which was constructed in just over three years -- half the time it normally takes to build a facility of its magnitude.

"This is America's newest, most extraordinary, most technically advanced facility, and we are proud to have it in the military health system," said Mateczun.

Construction crews removed some 200,000 cubic yards of soil, and used 85,800 tons of concrete and 5,300 tons of steel to construct the building. Roughly 92 percent of the waste materials were recycled, and two trees were transplanted for every tree that was removed from the site to accommodate the project.

"This truly is a landmark facility for military medicine," Mateczun said. "They accomplished something many people thought couldn't be done, and did it by doing things that had never been done before. You never missed a beat, always keeping patient care as your number one priority."

New medic course pays big dividends for Afghan police

By Air Force Master Sgt. Paul Hughes
NATO Training Mission Afghanistan

An Afghan Border Policeman demonstrates the proper way to apply a tourniquet during the Trauma Assistance Medic Course at the Joint Regional Afghan National Police Center in Kandahar, Afghanistan. The eight-week course includes 31 modules, seven quizzes, 20 hands-on skills assessments, a final exam and a final practical.

KANDAHAR, Afghanistan – Sgt. Maj. Norman McAfee, Health Services adviser for the Joint Regional Afghan National Police Center, saw a problem last November that needed to be fixed. "Wounded Afghan National Patrolmen were dying of wounds before they could receive any medical attention," said McAfee.

Patrolmen weren't able to help their wounded buddies because they didn't know how, McAfee said. "The police have not had any formal medical training except for a few sporadic individual unit medics teaching versions of combat lifesaver courses."

So McAfee and other senior coalition medical officials brainstormed and created a plan to teach Afghan National Police patrolmen the basics of providing care for their wounded comrades, and named it the Trauma Assistance Medic Course.

"After coming to a consensus on what topics to cover, length of course, and who should instruct, the information was packaged and presented to Brig. Gen. Qhandahr Shinwari the ANP surgeon general. [Shinwari] approved the course and asked us to set up a pilot course," said McAfee

The pilot course was conducted at nearby Camp Nathan Smith, and the program of instruction was approved in February.

In May, the JRAC hosted its first TAM course with 18 Students. The course is eight weeks in length with 31 modules, seven quizzes, 20 hands-on skills assessments, a final exam and a final practical.

"You can take a test any time you want," said McAfee, "but they'll be judged by how well they perform out in the field."

Students learn how to pack aid bags, conduct patient surveys, treat casualties, and conduct casualty evacuations. But the TAM course is more than a combat medic course.

"They can work in a clinic or a field environment. Combat Lifesaver is the last portion of the course," said McAfee.

Graduating students can then go back to their units and teach CLS techniques. "Police officers were dying of their wounds before they could be treated; that's why CLS is so important," said McAfee

"The ANP are heavily engaged in the fight on a daily basis in RC-South and take a great number of battle injuries," said Air Force Maj. Ian Diaz, regional adviser for Regional Commands South and Southwest. "They're the ones coming into more contact with the Taliban."

The students come from ANP kondaks -- the equivalent of battalions or squadrons. Kondak leaders are asked to select men from their ranks who have at least third-grade literacy levels. "The average for the students in the course is something from 10th- to 12th-grade," McAfee said.

The students with lower literacy skills struggle, but in the end, McAfee said, they benefit the most. "They learn a skill and become literate at the same time."

The course is paying dividends at the JRAC. Diaz says six of the Afghan National Civil Order Police graduates are now working for the Zone Regional Surgeon, Dr. Nahzatullah Wardak. "He's helping them integrate into the clinic, so they can apply what they've learned and become confident in their abilities."

IP 8.0 Build Relationships and Enhance Partnerships

It's a win-win-win situation said Air Force Lt. Col. Mark Duffy, team chief adviser, Regional Surgeon for Regional Commands Sough and Southwest. "We build cooperation between the ANCOP and [Afghan Uniform Police], they use what they learn and they bolster the clinic's ability."

TAM students are taught simultaneously in both the Dari and Pashtu languages. They're also given English terms so they can more easily communicate with International Security Assistance Force personnel.

Training continues for some students. "Ten of the best and brightest from previous classes will go to the physician assistant's course at the [Afghan National Army] compound at Camp Hero. It's a great opportunity for the ANA and ANP to come together towards the goal of [Afghan National Security Forces] healthcare. Those students will provide the single most important impact to the ANSF and therefore ANP healthcare system," Diaz said.

The course has been taught by Afghans while members of the coalition have provided administrative support, such as taking care of the building, obtaining supplies, grading exams and maintaining grades and reports.

The coalition will continue to provide that administrative support for the remainder of the year. "Our goal is for the course to be Afghan controlled by the time Course Five rolls around which begins in January 2012," said Duffy.

Duffy said the course is already providing positive results

"The Afghan National Police are in the middle of the fight in RC-S and take heavy casualties," Duff said. "The skills learned by these medics-to-be are being utilized in the field already and being taught by graduates of this program to other policemen in the field. These medics are true lifesavers and force multipliers."

Army expanding successful behavioral health program

By Shannon Carabajal
Mercury Editor

> ***"There are so many good parts to the program. In previous years, we had to go through the hospital and we saw different physicians every time. Now, our Soldiers have greater access to (behavioral healthcare professionals) and we see the same provider routinely."***
>
> **- Maj. James Wiles**
> *2nd BCT, 4th ID rear commander*

After a successful pilot program aimed at reducing the emotional stress facing Soldiers and their Families by embedding behavioral health providers in units at Fort Carson, Colo., the Army is expanding the program to seven additional installations in fiscal year 2012.

The EBH program has had a tremendous impact on Fort Carson. Redeploying units showed significant reductions in multiple areas, including acute psychiatric admissions, spouse abuse, sexually transmitted diseases, suicide attempts, child abuse and positive drug screens.

According to Maj. Christopher Ivany, psychiatrist, Evans Army Community Hospital, the program started after Fort Carson leadership identified a gap between Soldiers who required behavioral health care and the availability of behavioral health care providers. Senior leaders believed that gap may have contributed to a high rate of violent incidents amongst Fort Carson Soldiers in 2008, so efforts began to make behavioral care more accessible, beginning with the 4th Brigade Combat Team (BCT), 4th Infantry Division, and expanded to all BCT's over the following 18 months.

IP 5.0 Maximize Physical and Psychological Health Promotion and Prevention

The 2nd BCT was the first to receive behavioral health support in the embedded model through a complete Army Force Generation cycle. From their redeployment in mid-2009 to deployment in June 2011, the BCT received embedded behavioral health support from a dedicated medical team that provided care from a clinic in the BCT's area of operation.

Mental health providers were aligned with each battalion so each battalion commander had a readily accessible behavioral health subject matter expert to evaluate and treat their Soldiers and assist them in optimizing mission readiness and safety.

The program improved access to care, improved continuity of care, enhanced BH provider communication with commanders, decreased inpatient hospitalizations, decreased referrals to the TRICARE network for behavioral health care and garnered high rates of commander and Soldier satisfaction. Additionally, compared to the unit's last deployment before the embedded program was implemented, 2nd BCT had 96 fewer Soldiers left on rear-detachment for a behavioral health reason after receiving a complete cycle of embedded behavioral health support.

Ivany said those results are significant, as the BCT was more prepared to accomplish their mission downrange and a greater percentage of Soldiers who were unable to deploy were identified and treated or transferred to nondeploying units, such as the Warrior Transition Battalion.

Each embedded team includes seven credentialed BH providers, usually three psychologists, three social workers and a psychiatrist or psychiatric nurse practitioner. A nurse case manager, two social service assistants (BH technicians), two front desk personnel and a licensed practical nurse provide critical support. The teams include both civilian and military personnel.

The program has made it easier and more convenient for Soldiers to seek help. Soldiers don't need an appointment to be seen and EBH services and contact information are widely advertised throughout the unit.

The teams work with the units to proactively identify and manage behavioral health risks before they become a serious problem. This approach to care maximizes diagnostic accuracy, removes barriers to care and improves treatment outcomes largely due to patient trust and consistency in care.

Ivany said Soldiers are more apt to seek help from providers embedded with their unit because the team is closer and Soldiers are likely to know someone who has sought treatment.

"The Soldier sees the same BH provider rather than multiple providers. Barriers are removed because brigade and battalion commanders are supportive of EBH and word gets around that (the team) knows what they are doing," he added.

Maj. James Wiles, 2nd BCT, 4th ID rear detachment commander, said the impact on the unit has been immeasurable.

"There are so many good parts to the program. In previous years, we had to go through the hospital and we saw different BH providers every time. Now, our Soldiers have greater access to (behavior healthcare professionals) and we see the same provider routinely," he said.

Wiles said the providers understand the challenges Soldiers face and interact weekly with leadership to help mitigate the high-risk cases.

"The stigma of seeking help has gone away. (The providers) are truly a combat enabler."

EBH is a key component of the Behavioral Health System of Care Campaign Plan that is intended to further standardize and optimize the vast array of behavioral health policies and procedures across Army Medical Command. The campaign aims to ensure seamless continuity of care to better identify, prevent, treat and track behavioral health issues that affect Soldiers and Families during every phase of the Army Force Generation cycle.

Based on the success at Fort Carson, the Army began expanding the program this fiscal year. EBH teams are currently supporting 4th Brigade, 1st Cavalry Division, at Fort Hood, Texas. The embedded model of care is also under development by key leaders at Fort Stewart, Ga.; Schofield Barracks, Hawaii; Fort Bragg, N.C.; Fort Bliss, Texas; Fort Drum, N.Y.; and Fort Knox, Ky.

Michael Perkins, instructor and trainer in the department of Behavioral Health Sciences at the Army Medical Department Center and School, Fort Sam Houston, Texas, left, conducts interviews with company grade officers and senior noncommissioned officers assigned to 1st Brigade Combat Team, 4th Infantry Division, about their experiences with military behavioral health professionals during deployment.

Leaders share views on combat stress

By Spc. Andrew Ingram
4th Infantry Division Public Affairs

FORT CARSON, Colo. – During deployment, service members can undergo a massive amount of stress. The military deploys combat stress teams and behavioral health professionals with military units to help these Soldiers work through the emotional problems they face and keep them in the fight.

Instructors from the Department of Behavioral Health Sciences at the Army Medical Department Center and School at Fort Sam Houston, Texas, recently traveled to Fort Carson to interview experienced company commanders and senior noncommissioned officers assigned to the 4th Infantry Division about their experiences with behavioral health professionals during a combat tour.

After compiling the interviews, the instructors plan to share them with every Combat Stress Team before it deploys, said Michael Perkins, a behavioral health instructor who interviewed the Fort Carson Soldiers.

"We will use this video during training with combat operational stress control personnel, so they know what is needed of them when they go downrange," Perkins said. "What is really special and important about these interviews is that the information is coming from combat leaders coming back from recent deployments who are telling us this is what we saw with combat stress, and this is what we really need from them."

Perkins said the Fort Sam Houston team chose to pull leaders from the 4th Inf. Div.'s 1st and 3rd brigade combat teams to get a cross section of experiences from leaders who had Soldiers undergo behavioral health assistance on large forward operating bases in Iraq or tiny platoon-sized fire bases in Afghanistan.

One of the most important things a behavioral health specialist must do is take the time to build the trust of the Soldiers they serve, said Master Sgt. Maurice Turner, noncommissioned officer-in-charge for operations, 1st Battalion, 8th Infantry Regiment, 3rd BCT, 4th Inf. Div.

"This is no joke; Soldiers need this assistance," said Turner, who served as a company first sergeant during his deployment to southern Iraq. "This is a stepping stone for something better in the future. I would like to see a better combat stress operating environment, where providers will not only find a problem, but also work with the Soldier and give him advice to make it better."

While Army behavioral health programs have improved in recent years, there are still a few changes leaders on the ground would like to see, said Capt. Ian Pitkin, commander, Headquarters and Headquarters Company, 1st Bn., 22nd Inf. Regiment, 1st BCT, 4th Inf. Div.

"The expectation for behavioral health, for commanders, is that they are able to keep our guys in the fight as much as possible while caring for them and giving them the help that they need," Pitkin said. "Operationally, it seems that (behavioral health professionals) can understand some of the stresses and triggers that (our Soldiers face) if they are able to circulate the battlefield and come out to some of the more austere locations, see how our guys are living, interact with the Soldiers and communicate with their command teams."

Perkins said he hopes the senior NCOs' and officers' insights and experiences would make a positive impression on behavioral health Soldiers gearing up for deployment.

"We are trying to narrow the difference between what is needed and what is actually going on. When a behavioral health or combat stress Soldier is at his best, he isn't just counseling Soldiers for an hour at a time -- that is just one piece of (his) mission. He should be out with the Soldiers, learning their needs and teaching commanders how to identify problems and warning signs."

Military Surgeons Association names MC4 top IT team

FORT DETRICK, Md. – The Army's Medical Communications for Combat Casualty Care (MC4) program was recognized by the Association of Military Surgeons of the United States as the 2011 top information technology team last week.

The AMSUS IT Team Award honors organizations that have made significant contributions in IT, specifically those that improve the effectiveness and cohesiveness of federal health care initiatives. In 2010, MC4 helped field the rapid expansion of technology used to remotely connect Soldiers with mental health physicians in the combat zone.

The Army's MC4 program trains, fields and supports IT systems that allow deployable medical staff to document and track patient care, digitally manage medical supplies and conduct health surveillance in the combat zone.

In addition to fielding new technology, last year MC4 launched new training initiatives to improve electronic medical record-keeping on the battlefield. In return, MC4 users have realized faster set-up times and easier use of the medical records system, while combatant commanders have gained better data integrity and a clearer picture of population health.

"By redirecting our resources away from classroom training and engaging users in garrison and in field exercises, deployed medical staff are now better prepared to use MC4 systems down range," said MC4 Product Manager Lt. Col. William Geesey.

In addition to improving end-user proficiency, MC4's involvement in the Army's Tele-behavioral Health Initiative is helping to connect at-risk Soldiers with mental health providers.

"Virtual consultations with Soldiers are allowing medical staff to recognize and treat post-traumatic stress disorder symptoms and other mental health issues faster," Lt. Col. Geesey said. "Health care providers don't have to wait until they arrive at the Soldier's location to meet with them. Now they can chat virtually when both their schedules allow."

Lt. Col. Rafael G. Semidei, Sr. (on screen), psychiatrist with the 883rd Medical Detachment (Combat Stress Control), and Sgt. Marie Swieta (right), NCO in charge with the 547th Area Support Medical Company (Combat Stress Control), demonstrate the Tele-behavioral Health System in Baghdad, Iraq.

Initial data indicates that more than 70 percent of the Soldiers seen through this capability likely would not have received services otherwise. The technology also reduces the frequency with which specialists must travel to remote outposts to meet with patients. The initial capability was implemented in October 2010 and completed within six weeks of requirement identification. The Army has endorsed this solution and has directed rapid expansion of the technology and capability throughout Afghanistan.

MC4 received the award on Nov. 9 at the Annual Awards Banquet in San Antonio.

Paying tribute

Family members of the namesakes were on hand as Fort Campbell, Ky., and 101st Airborne Division (Air Assault) leadership recently unveiled the new Adkins and Byrd Clinics on post.

The clinics were dedicated to Sgt. Dustin M. Adkins, Group Support Battalion, 5th Special Forces Group and Spc. Jordan M. Byrd, Alpha Company, 1st Battalion, 506th Infantry Regiment, 4th Brigade Combat Team, 101st Airborne Division.

Adkins, a dental specialist, died from injuries suffered after the Marine Corps helicopter he was riding in had to make an emergency water landing in western Al-Anbar Province, Iraq.

Byrd was killed while on patrol when his unit came under intense small arms fire, rocket-propelled grenades and mortar fire. (Photo by Glen Paddie)

Nurse Corps officers attend leadership course

By Lt. Col. Nancy A. Cantrell
Army Nurse Corps Historian

The Army Nurse Corps held the 20th annual Colonel C.J. Reddy Leadership Short Course in Washington D.C. last month for select junior officers. For the first time, senior nursing leaders were also invited to the course which is designed to immerse promising junior officers who have been selected by a rigorous board process into leadership principles.

With the presence of senior leaders at the conference, junior officers experienced the kind of mentoring that retired Col. C.J. Reddy is renowned and honored for each year. It was a valuable opportunity for junior officers and future leaders of the corps to learn from the experiences and discussions of senior leadership.

The first day included presentations from senior leaders regarding campaign planning, capability management, talent management, the impact of nursing on the future of healthcare, and quality management.

Subsequent days included a presentation by then Chief of the Army Nurse Corps and Deputy Surgeon General Maj. Gen. Patricia Horoho; Col. Susanne Clark, Army Nurse Corps deputy chief; and Sgt. Maj. Richard Brewer, Army Nurse Corps senior clinical enlisted adviser, regarding the Army Nursing Campaign Plan. Vital issues such as warrior care, evidenced-based practice, accessions, and human capital were addressed, as well as critical initiatives like the Patient Caring Touch system, advanced trauma training and the 66T program inception.

During the overview of Army Nurse Corps initiatives, Clark emphasized the “flexibility and adaptability” that the corps requires in the vast array of specialties and job functions available. She discussed the case management system and the “lean forward” in continuing the drive toward wellness, and warrior care as the continued need for “continuity of care across the spectrum, from community health to the battlefield.”

Talent management discussions centered on capabilities-based assignments. EBP, or evidenced-based practice, was explained as optimized business practices and cost capabilities through its analysis, measuring, and re-designing into daily practice. Clark discussed human capital and the optimization of the Army Nurse Corps footprint through validation of priorities and force structure in the reposturing for conditions-based capability and capacity.

Col. Linda Connelly, Army Nurse Corps deputy chief individual mobilized augmentee, presented a comprehensive update on the Reserve Component of the nurse corps and discussed challenges such as geographic constraints and communication needs, funding, as well as strengths of the Army Reserves and the wealth of experience and talent available. Other senior leaders discussed various topics including the Patient Caring Touch System, Warrior Transition Command, enroute care mission, U.S. Army Africa, and precision recruiting and accessions.

During the course, awards of excellence were presented to Capt. Jason Simmons, a clinical nurse officer in charge assigned to a 17-bed post anesthesia care unit at Walter Reed Army Medical Center; and Capt. Vernon Grier, currently assigned to the 48th Combat Support Hospital at Fort Meade, Md.

Simmons was honored for using his critical care knowledge and experience to educate and mentor 34 active duty and civilian staff in developing and strengthening their critical thinking skills and clinical judgment in treating severely wounded warriors and high acuity surgical patients. Grier earned recognition for being instrumental in the establishment of an in-house health care specialist sustainment program for the combat support hospital and directing the construction of the landing zone for the MEDEVAC helicopters at the units 2011 Warrior Exercise at Fort Hunter Liggett, Calif.

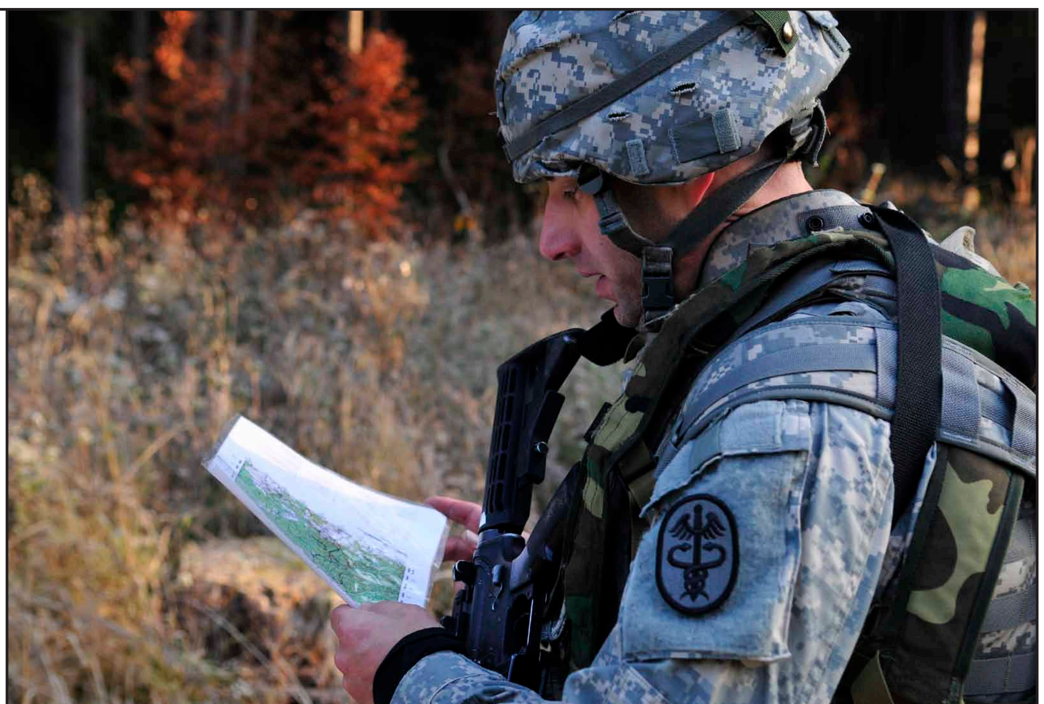
Closing remarks and farewells by Horoho wrapped up the sessions. The moments were nostalgic, as the 23rd Chief of the Army Nurse Corps bid farewell before assuming office as the 43rd Surgeon General of the United States Army.

Map check

Capt. Jeremy Brooks, representing the Landstuhl Regional Medical Center, navigates to a point during the night to day land navigation course as a part of the first annual U.S. Army Europe Best Junior Officer Competition Nov. 16.

Company grade officers from units throughout USAREUR competed in the competition at the Joint Multinational Training Center.

The competition included pistol and rifle qualifications, two marches totaling 25 kilometers, a land navigation course conducted both in day and night, as well as several situational training exercises. (Photo by Master Sgt. Robert Hyatt)



FSTE tests medical support, ground forces together

Story and photo by Denver Makle
7th Army Joint Multinational Public Affairs

GRAFENWOEHR, Germany – In rhythmic cadence a doctor barked orders, "There's no change. Give shock. Administer CPR. The patient is not breathing."

The tent was full of onlookers, the room was quiet. Nurses, doctors and medics rushed to find instruments and equipment to save the patient, a life-sized, computer-monitored mannequin connected to a power and fluid supply. He simulated breathing and his eyes even fluttered as he fought for air.

The Joint Multinational Training Command provides a challenging training environment and all the training aids and devices needed ensure the medical staff from the 30th Medical Command are trained, while supporting the 173rd Airborne Brigade Combat Team's Full-Spectrum Training Environment, or FSTE, rotation, hosted at Hohenfels Training Area.

"This is maximizing the training value for the U.S. Army in Europe," said Col. William D. Jones, chief of the Joint Multinational Simulations Center. "The JMSC has developed a list of events and activities to stimulate the environment, while enlarging the play to enhance training scenarios to accommodate the large-scale mission of the 30th MEDCOM. For example, a mass-casualty event will happen during the exercise to allow the hospital staff to fully exercise the staff."

A doctor treats a simulated causality, a mannequin capable of breathing and bleeding, during the 173rd Airborne Brigade Combat Team's Full-Spectrum Training Environment rotation at Grafenwoehr Training Area, Germany.

In its entirety the 30th MEDCOM would support an area the size of Afghanistan. Their involvement with the 173rd Airborne Brigade brought unique challenges in addition to the scripted scenarios.

"This training is valuable because you're not supporting an imaginary brigade," said Jones. "It's a better training event for the 30th MEDCOM, and we can do it for other multifunctional units in Europe."

CS 3.0 Responsive Battlefield Medical Force

At the Grafenwoehr Training Area's Camp Aachen, the 84-bed combat support hospital is a complex tent structure with multiple, interconnected additions that provide life-saving services.

On the inside it looks like any hospital. There is an intensive-care ward that hosts up to 60 patients; a supply section that houses enough supplies to lasts several days on site; an intensive care unit with up to 24 beds; a laboratory for blood analysis and storage; a radiology department and an operating room. The massive structure is constructed inside a fenced cantonment area away from the boots-on-the-ground training, but connected by technology.

"It's all about information. We use a master events list to drive the medical care and support," said Jones. "There is live-and-scripted casualty play."

During the FSTE the hospital staff is tested on how well they execute command and control of their brigade, as well as their theater-level support and casualty health support, which includes medical evacuation practices -- air and ground.

The FSTE rotation highlights strong partnerships among the ground troops, such as the Polish, Slovakian, and Slovenian forces as they assume roles as friendly and opposing forces. Soldiers from the United Kingdom and Germany are providing exercise and real-world medical support. In total, there are 918 multinational participants. Staff from the United Kingdom are also providing physical therapy expertise, while the German Army is providing combat-mental health services.

Further, the 212th Combat Support Hospital and the 421st Multifunctional Medical Battalion is augmented by their counterparts in the Air Force.

Training together, provides multinational and Soldiers common standards and objectives for treating the sick and wounded, said Maj. Tanner Roy, the 30th MEDCOM Plans and Exercises officer.

During contingency operations, the 30th MEDCOM manages multiple field hospitals and its own supply and logistics infrastructure to support the field medical staff. During the FSTE the simulations center developed additional events and activities to stimulate the environment, and enlarge the play to enhance the scenarios to accommodate the large-scale mission.

Doctors and nurses are treating patients while logistical staff ensure treatment supplies are delivered and available when needed, despite the austere environment.

"We want our Soldiers to be confident they can operate in a full-spectrum threat environment, and use their know-how anywhere and in all types of operations," said Roy. "We will provide medical support at all phases of the operation, from the beginning to the stability operations at the end."

There are approximately 750 medical personnel on the ground participating in the exercise.

The Grafenwoehr Training Area provides an enhanced training environment using simulations to stimulate the environment, while the 173rd engages the enemy simultaneously at the Hohenfel's Training Area. Because of its proximity to European, African and Asian nations, the training areas in central Europe regularly train U.S. forces with multinational partners.

"You can't do that kind of training stateside because those folks just aren't available," said Maj. Gen. James C. Boozer, the deputy commanding general of the U.S. Army in Europe and senior trainer of the FSTE. "But, here we are able to partner with all of our NATO partners and some of our non-NATO partners to conduct these large-scale training events."

There are partners serving in Afghanistan today because of the Army in Europe's training, and its unique ability to work with nations in Europe, Africa and Asia, he said.

"If we didn't do that we would be putting more brigade combat teams in Afghanistan than we do today."

Coping with deployment separation

By James W. Cartwright, Ph.D.
U.S. Army Public Health Command

Separation from a loved one who is deployed can be an emotionally difficult time for all Family members. The emotions can vary from low energy levels, feelings of sadness, anger, excitement, restlessness, tension, frustration, resentment and depression. Additionally, there are many challenges for military Families to overcome during deployments. It is important to recognize and understand these challenges in order to effectively cope with the separation during deployment.

An important challenge for Soldiers and Family members is to avoid the pitfalls often associated with deployments. A common pitfall is arguments prior to deployment. These arguments are generally the result of distress due to the upcoming separation. Realize this distress and try not to take these arguments too seriously.

Another pitfall is failure to discuss expectations regarding child-rearing, financial management, or intimacy concerns—these issues sometimes can be a source of misperception, distortion and hurt later during deployment. Soldiers and spouses attempting to resolve these major pitfalls via long distance are often not successful.

Listening to or spreading rumors can also be harmful. It is best not to repeat the rumor. Because of rapid communication, rumors can spread unchecked. For example, one Family Readiness Group member passing on allegations of infidelity about another group member can cause a great deal of psychological damage to individuals identified in the rumor. Such rumors also cause harm to Soldiers, Family members, FRG members and unit cohesion. Avoiding these pitfalls will ensure that the stress related to deployment separation will be much more manageable.

Another challenge is to recognize the deployment-related stressors that will impact the Soldier and Family during separation and then develop strategies to cope with these stressors. To help minimize the impact of deployment-related stress, the Soldier and Family member(s) can do the following.

Tips for couples

- Discuss expectations for managing finances, children and personal conduct before deployment.
- Expect changes in departure and return dates.
- Accept growth and change in all Family members.
- Reserve disagreements for face-to-face encounters with your spouse.
- Put existing and unresolved marital issues on hold until the Soldier returns home.
- Communicate regularly and creatively with your Soldier. End communications on a positive note.
- Keep the Soldier's parents informed and give mutual support.

Tips for parents

- Establish and maintain support that help the Family cope.
- Plan for Family stress relievers like fun outings and get-togethers.
- Plan opportunities for the at-home parent to get breaks from the children to revive emotionally and physically.
- Encourage Family members to share feelings and give assurances.
- Honestly discuss the Soldier's deployment. Share information about the Soldier's work and what the parent is doing for our country
- Answer questions openly and honestly, using words your children can understand.
- Provide a calendar or some measure to help your child count the days the parent has been deployed.
- Maintain a structured and safe emotional and physical environment for your children.
- Make sure the deployed parent is part of everyday conversations.
- Help children sort out what they hear and see in news reports
- Find out what your children know and understand and talk with them about their feelings. Follow your child's lead. Give a small piece of information at a time and see how your child responds before deciding what to do next.
- Provide your children with a method to communicate to the deployed parent, such as letter writing or e-mail access. Make it creative and fun.
- Maintain Family routines and traditions during the other parent's absence.
- Keep children involved with outside activities and maintain communications with schools.

The bottom line is that the Soldiers and Family members need to remain calm, go slow, stay informed and stay involved to cope during these challenges. An excellent source of help during this time is the unit's Family Readiness Group.

Marathon couple

Col. John Teyhen and his wife Lt. Col. Deydre Teyhen celebrate after completing the ING Hartford Marathon in Connecticut. With the completion of that race, the couple accomplished their ambitious goal of running a marathon in all 50 states. Col. Teyhen is the director of the Center for Health Education and Training at the Army Medical Department Center and School. Lt. Col. Teyhen is the Public Health Command Region-South commander. (Courtesy photo)

Plan ahead for safe and sober celebrating

By Julie Shelley
U.S. Army Combat Readiness/Safety Center

The fall and winter seasons are full of opportunities for celebrating. Football games, holidays and extended vacations from work all offer ample time for fun, food and fellowship. And for many people, tailgates and parties wouldn't be the same without a splash or two of their favorite alcoholic beverages.

While social gatherings offer a perfect opportunity to let loose, Soldiers, Family members and Civilians must be extra vigilant and have a plan if they choose to drink, regardless of the time of year. But when you factor in other variables unique to winter, including adverse weather conditions like ice and snow, prior planning becomes even more important.

"Planning ahead is especially important for Soldiers trying to get home on leave or pass to enjoy the holidays with Family and friends," said Walt Beckman, loss prevention program manager with the U.S. Army Combat Readiness/Safety Center's Driving Task Force. "Couple limited time with inclement weather, add alcohol and fatigue and you have a recipe for accidents and injuries, some fatal."

Accident reports show drinking and driving are a lethal combination for Soldiers year round. Between the start of fiscal 2010 and through the third quarter of fiscal 2011, at least 59 Soldiers died and 67 were injured in vehicle crashes where alcohol use was confirmed. Statistics also prove the dangers of alcohol impairment do not stop at driving — walking while drunk can be just as deadly. On average, the Army loses approximately two Soldiers every year to alcohol-related pedestrian accidents.

"Walking versus driving sounds like a good plan, but an intoxicated pedestrian is at tremendous risk," Beckman said. "A plan is only as good as the planner. If your thoughts are clouded by the effects of alcohol, you might not have planned for every challenge."

According to Beckman, both party hosts and their guests have special responsibilities to ensure everyone makes it home safely.

For hosts

- Collect car keys from guests as they arrive and return them to only those guests who are not impaired.
- Offer alcohol-free beverages and plenty of food so guests have alternatives to alcohol.
- Ensure guests leave sober or with a sober designated driver, and call a cab for guests without a ride.
- Keep alcoholic beverages off limits to all guests under the age of 21.

For guests

- Make a plan. Designate a nondrinking buddy and give him or her the keys, prearrange a taxi service or have the numbers for local cab companies programmed in your cellphone.
- Use the buddy system. Rotate designated driver responsibilities and, if no one else volunteers, speak up and offer to stay sober.
- Be honest with yourself and remember that even a slight "buzz" can significantly weaken your perceptions and abilities. If you are out on your own and know you are impaired, stay with the host until you are sober or call a friend or taxi for a ride.

Perhaps the most important thing to remember when celebrating these next few months is that no matter the situation, drinking and driving is never the right answer. Engagement on all fronts — Leaders, Soldiers, Family members and Civilians — is critical to ensuring everyone in the Army Family understands the dangers of impaired driving.

"Risk taking often ends in needless fatalities," Beckman said. "Our Army needs each and every one of our Soldiers. We must continue teaching our Soldiers to think about their decisions and the consequences of risky behavior."

For more information on impaired driving and POV safety, visit **https://safety.army.mil**.

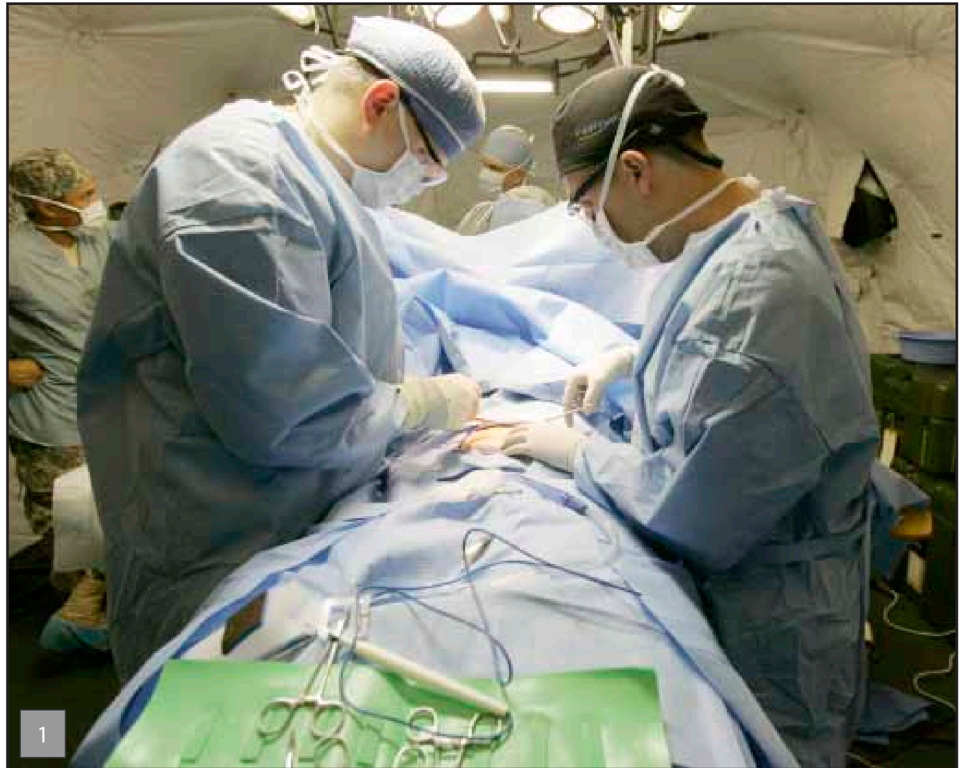
AROUND ARMY MEDICINE

1. Capt. Nathan Zwintscher, left, and Capt. Jacob Swann, 62nd Medical Brigade's 250th Field Surgical Team, performs surgery on Staff. Sgt. Mathew Horton, 2-1 Inf., during a live hands-on field exercise in a mobile field surgery operating room at Joint Base Lewis-McChord, Wash. (Photo by Jim Bryant)

2. First Lt. Allison Sweet, Nutrition Care Division at General Leonard Wood Army Community Hospital, Mo., holds the 2011 Margaret Simko Award for Excellence at Clinical Poster Sessions she received during the American Dietetic Association's Food and Nutrition Conference and Expo in San Diego. Sweet works in the Nutrition Care Division at General Leonard Wood Army Community Hospital, Mo. (Photo by Lt. Col. Lori Sigrist)

3. Sean Leyva pins Air Assault wings on his father, Staff Sgt. Juan Leyva, NCO in charge at Carl R. Darnall Army Medical Center's Thomas Moore Health Clinic, during a graduation ceremony at Fort Hood. Leyva was one of nine CRDAMC Soldiers out of 241 candidates to earn wings at Fort Hood's first air assault class. (Photo by Patricia Deal)

4. Brig. Gen. Nadja West, the Europe Regional Medical Command commanding general (wearing ACUs), competes alongside Warrior Transition Battalion-Europe Soldiers, cadre, and Army Morale Welfare and Recreation staff, during a game of seated volleyball during an adaptive sports clinic at the Kleber Gym and Fitness Center in Kaiserslautern, Germany. (Photo by Sgt. 1st Class Christopher Fincham)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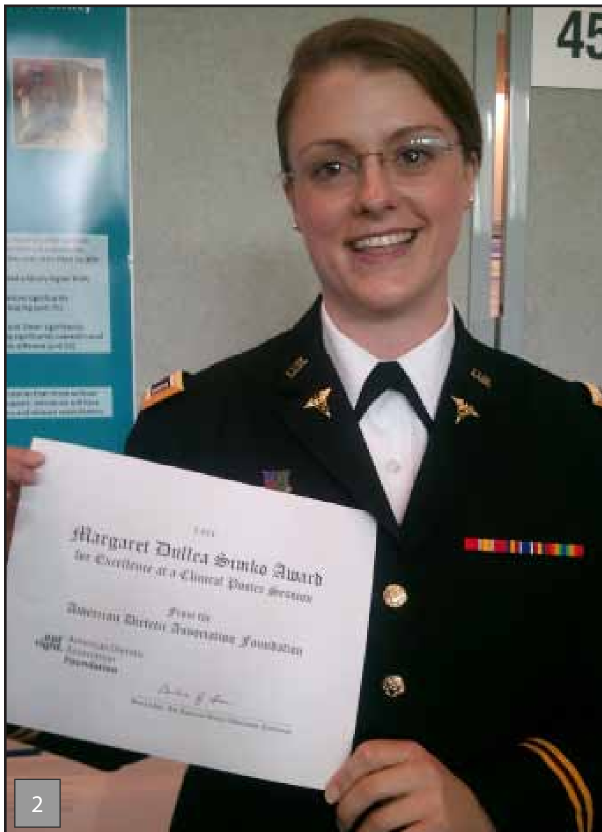

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