ARMY MEDICINE
Bringing Value...Inspiring Trust

MERCURY

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New clinics provide care for Army Families close to home

LTG Eric B. Schoomaker, Army Surgeon General and Commander of Medical Command, speaks at the ribbon-cutting ceremony for the first Community Based Medical Home Clinic, now open at Fort Campbell, Ky. This is the first of 17 such clinics that will provide primary care for Army Families close to where they live.(Photo provided by Fort Campbell MEDDAC)

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Community Based Medical Home Clinics

MERCURY Comment

Command corner

Army Medicine has big plans for 2011

by LTG Eric B. Schoomaker
Army Surgeon General and Commander of Medical Command

I hope everyone had an opportunity to enjoy the holiday season. Our operational tempo has been high and remains so, but it is important to take some time for yourself and your Family, let a little of the steam out of the kettle, and preserve our most valuable assets.

As we begin 2011, we continue to be part of an Army at war, while also supporting the ARFORGEN cycle and providing care for our Families and retirees. The missions are challenging, and we can expect to be facing them with some pressure on our budgets. I want everyone to keep five avenues of action foremost as we meet these challenges.

The Comprehensive Medical Management Center (MMC) Pilot Program will help us better manage non-deployable Soldiers and expedite their recovery and return to duty status. The MMC Pilot sites are located at Winn Army Community Hospital, Fort Stewart, Ga., and Ireland Army Community Hospital, Fort Knox, Ky. MTF Commanders have Command and Control. MMC is entering a Soldiers' health-care partnership with unit commanders to ensure we provide the necessary care to the injured, ill and wounded. This MMC Pilot Program will help the Army maintain readiness by ensuring rear detachment and unit commanders of injured, ill and wounded Soldiers have the support they need to manage Medically Not Ready (MNR) Soldiers.

The Comprehensive Behavioral Health System of Care Campaign Plan (CBHSOC-CP) establishes and standardizes MEDCOM policies and procedures for providing behavioral health care and support to Soldiers during every phase of the ARFORGEN Cycle. The CBHSOC-CP has five lines of effort: Standardize Behavioral Health Support Requirements; Synchronize Behavioral Health Programs; Standardize and Resource AMEDD Behavioral Health Support; Assess the Effectiveness of the CHBSOC-CP; and Strategic Communication.

MEDCOM has begun implementing recommendations of the Pain Management Task Force as part of the MEDCOM Comprehensive Pain Management Campaign Plan (CPMCP). The CPMCP creates system-wide care standards for pain management, appropriate to setting and professional roles. The objective is to ensure pain care is provided in an appropriately timely, regular and consistent manner along the continuum of care from acute to chronic pain in all settings.

Army Medicine is implementing the Patient Centered Medical Home (PCMH), a proven model of longitudinal health-care delivery that improves continuity of care and enhances access through patient-centered care and effective patient-provider communication. Soldiers, retirees, and their Families enrolled in PCMH will have a consistent relationship with their health-care provider and team who deliver first contact, continuous, and comprehensive care. Studies of the PCMH model show that it improves patient satisfaction and clinical outcomes. It also lowers health care costs by improving care coordination and communication between primary-care physicians and their patients. A major goal of the program is to better manage patient care, reducing unnecessary tests, drug prescriptions, doctor visits, and avoidable hospital admissions and emergency department visits.

We have consciously committed to building a Culture of Trust in Army Medicine. Every initiative aimed at improving patient's health-care experiences, outcomes, the health of our people and readiness of our Soldiers, and the environment for our staff, will be founded on a Culture of Trust. Trust is the critical element in our relationship with each other, our stakeholders, customers, patients. The Culture of Trust initiative is an Army Medicine enduring effort; it is an organizational change that will support Army Medicine well into the 21st Century.

Army Medicine: Building Value – Inspiring Trust.

Spouse prepares for reintegration

by Brittany Carlson

This week is my husband's last week in Afghanistan. It's been a year.

Thinking about it gives me an excited — but nervous — feeling in my gut.

I've been making arrangements for weeks for his return, from cleaning the house to making a meal plan with all of his favorite foods. I've gotten a haircut, bought new clothes and purchased a welcome-home banner.

However, I know what matters the most will be how we interact with each other, especially after the "honeymoon" phase wears off, about 45 to 60 days from now. I want to do everything I can to help us adjust and prepare for anything that may happen in the future.

So, I met with a chaplain to talk about reintegration.

The first thing he told me was that I was already ahead of the game simply by coming and requesting information. He said it's often the couples who think "It couldn't happen to us" who end up having reintegration issues down the road, frequently because they are unprepared.

Many redeploying Soldiers may have trouble completely relaxing for the first few months because their minds have not had a break in so long, he said; he called it "nervous energy." His advice to me was to keep a relaxed schedule, especially during block leave, to help my husband unwind.

He also suggested focusing on the positive and, instead of thinking of all of the things my husband and I missed in each other's lives during the past 12 months, work on creating new memories together.

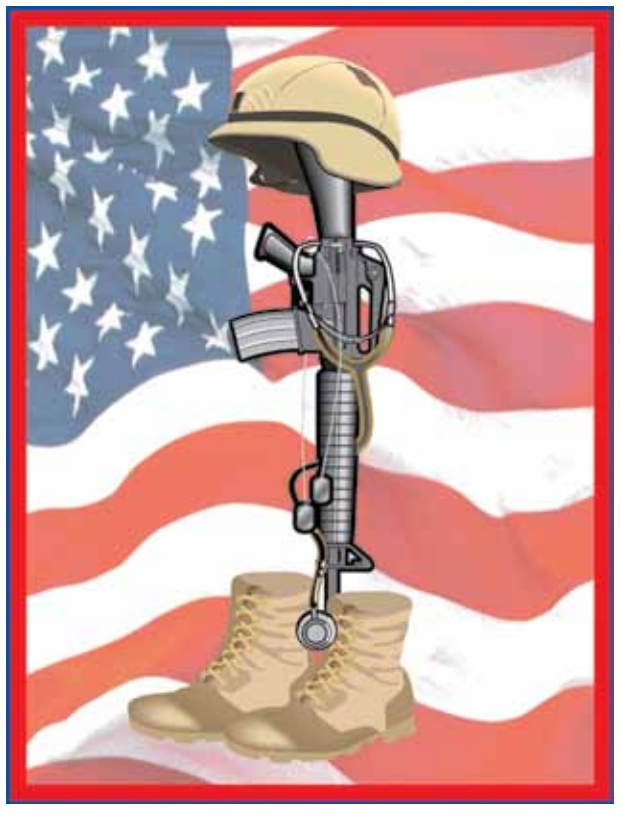
My worries were put into perspective when I said them out loud to someone who truly understood. It was also helpful to hear from a Soldier who had been downrange, like my husband, and remembered how it felt to return home.

His best advice to me was probably "Be yourself." While time budgeting and staying positive are both important after deployments, Soldiers just want to be with their spouse and Family, the chaplain said.

So, instead of getting myself worked up and trying to be the "perfect spouse" for my returning husband, I think I'll take the chaplain's advice and relax.

I know that by preparing myself, I can be ready to deflect potential problems and turn them into opportunities for my husband and me to grow closer.

It's also comforting to know that, should there be any problems that we can't solve on our own, there are people in my community who can help. (USAG Stuttgart)



The last, full measure of devotion

SPC Shannon Chihuahua, 68W, Nov. 13, 2010, 1st-327th Infantry

Mercury

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Patient Centered Medical Home opens

by Alexandra Hemmerly-Brown

The first of 17 planned off-base Army medical clinics is open outside Fort Campbell, Ky.

The concept for community-based medical home clinics began when the Army realized it will need to provide health-care access to an increasing number of Soldiers and their Families who are being relocated as part of Base Realignment and Closure (BRAC).

"At many of our Army installations, we have limited space, and military construction takes a considerable amount of time. We don't have the four-to-five years that it takes to complete a military construction project to adequately take care of the patients," said LTC Bradley Lieurance, program manager for the community-based primary-care clinic initiative.

The medical home clinic is a good solution to providing care for more beneficiaries without overloading Army hospitals, Lieurance said.

The clinics, which will each be able to accommodate about 8,100 enrolled patients, are for the Families of Soldiers, said Lieurance. He explained that many Army Families live off base, and traveling onto an installation for a medical appointment can be an inconvenience.

Better access

The in-town clinics will present a more accessible location for some Families while providing them with more personalized care.

Lieurance said Families in-processing at new participating installations will be given the option to make one of the clinics rather than the installation's medical treatment facility their medical "home base." However, he said, the clinics are focused on primary care, so Families will visit the base for specialists.

The clinics will be standardized, so no matter where Families are stationed in the future, their medical treatment process will be familiar.

"Every one of these clinics will look exactly the same. That was important for The Surgeon General, because he wanted to provide a common patient experience whether you are at Fort Benning or Fort Bragg," said Lieurance.

Each clinic will have 35 staff members: seven doctors or physician assistants, one behavioral-health practitioner, four registered nurses, 16 licensed practical nurses, three administrative personnel, one pharmacist, one pharmacy technician and two lab technicians.

Consistent care

The clinics are also created using a "patient-centered" approach, with the goal of patients seeing the same primary-care provider on each visit. This approach is described as both "revolutionary and old-fashioned" on Medical Command's Website.

"It's a team approach to health care where patients see the same providers every time," Lieurance said.

The program will also be cost-effective for the Army, as MEDCOM will be leasing the clinic space and tailoring it to meet the medical home model, rather than building new facilities. Clinics will be housed in spaces ranging from office buildings to strip malls, said Lieurance.

"This is going to improve the access and quality of our health care potentially for all of our Active Duty beneficiaries because of the impact it will have to military treatment facilities as well," Lieurance explained.

Maj. Chad Rodarmer, who also works on the project, said the most beneficial part of the program is the convenience of access it will provide to Family members.

Families like it

He said the Army Families who were asked what they thought about the program responded very positively.

"The feedback has been really tremendous. The Families are really excited," Rodarmer said.

Medical Command is so optimistic about the program, they might not stop at 17 clinics, said Lieurance, who explained the Army is considering expanding the program to 20 or 23 clinics.

Currently, clinics are planned to be opened at Forts Sill, Okla.; Bragg, N.C.; Stewart, Ga.; Sam Houston, Texas; Hood, Texas; Shafter, Hawaii; Lewis, Wash.; Leonard Wood, Mo.; and Benning, Ga. Several installations will have more than one community-based clinic, which are all planned to be opened by April. (Army News Service)

"This is going to improve the access and quality of our health care potentially for all of our Active Duty beneficiaries because of the impact it will have to military treatment facilities as well." — LTC Bradley Lieurance

Adolescents get comprehensive, holistic care at Madigan clinic

by Tawny M. Dotson

The events surrounding America's latest wars have affected not only service members, but also their Families. The secondary effects of prolonged stress from war on military Families and children are being recognized at Madigan Healthcare System on Joint Base Lewis-McChord, Wash.

One of the ways Madigan is caring for Soldiers' teens is by transitioning to a medical home environment within the adolescent specialty clinic. A medical home is characterized by comprehensive, holistic care within the department. The concept involves having the adolescent meet with a team in one location for all health care related matters.

Screening

The staff in the adolescent clinic no longer just performs physical check-ups. When adolescents come into the clinic they are screened from a whole-person perspective. They monitor not only height and weight, but also relationships, grades, behavior and feelings.

Triage nurses are learning to create a relationship with patients and assist with identifying when a teen may need more than a check of vital signs. In many cases, patients can meet with Dr. David DeWine, a pediatric psychologist, if they are identified as needing possible help with behavioral or emotional issues.

"The way that you assess risk and emotional concerns in adolescents is by developing a relationship with them. And if you see a different person every time you come in you are never going to develop that relationship," said MAJ Keith Lemmon, chief of the division of adolescent medicine. "The idea is to form an environment where they feel comfortable talking with you about some of the emotional issues they are experiencing."

"Only through feeling comfortable is it possible for the teens to feel like they can talk about depression, substance abuse and sexuality issues they might be facing," Lemmon said. "The whole concept of the adolescent clinic is that there is probably something going on in an adolescent's life that is a bigger threat to their health than whatever they came in for. So they may have come in for their sprained ankle, but there may be more serious issues affecting them like are they sexually active? Are they depressed? Are they cutting themselves?"

The benefit of having DeWine in the adolescent clinic means that the teens, which have opened up, won't be waiting for a referral before they speak to someone. The teen may be led to someone right there in the clinic.

Primary care

In addition, the primary-care physicians in the Adolescent Clinic are being trained to recognize when physical symptoms are really a sign of an emotional or behavioral issue.

"People don't go straight to their psychologist or psychiatrist; they come to their primary-care doctor with headaches or stomach aches or chest pain. A lot of physical symptoms in kids are a manifestation of emotional and behavior issues; most kids are healthy. They don't generally have organic causes for headaches," Lemmon said.

As a part of the medical home model the clinic is training doctors to recognize common symptoms which are factors in behavioral and emotional issues. When those are presented and serious health issues are ruled out, physicians can turn to therapies which will help to identify the issues at hand. This can lead to the adolescent being taught coping mechanisms with a doctor they are comfortable with early on before problems become too large. (Madigan)

Profiles going electronic

by Jerry Harben

The Army is using a new computer-based system to provide more consistent care for Soldiers needing profiles.

The program, called e-Profile, is replacing the practice of hand-written profiles for Soldiers. A profile lets commanders know about Soldiers' functional limitations due to medical conditions. An e-Profile accomplishes this electronically through the Medical Protection System, known as MEDPROS, the Army's medical database.

Medical personnel can immediately review a Soldier's profile history through the electronic system. The profile can be routed to an approving authority. It doesn't get lost as a paper profile can.

"A Soldier's profile can be written in e-Profile and routed automatically to his or her commander. In addition, the Soldier's MEDPROS profile updates automatically," said LTC Timothy Caffrey, primary-care staff officer at Medical Command Headquarters and a member of the e-Profile implementation team.

He said e-Profiles are available in AKO (Army Knowledge Online) so a Soldier can see them anytime he or she wants.

Medical Command OPORD 10-75, issued Sept. 10, 2010, directed all Army medical treatment facilities to begin using e-Profiles by Jan. 31. Caffrey said existing profiles will not have to be redone, but should be entered in e-Profile when they come up for review.

Resources to help implement e-Profiles may be found on the MEDPROS Website, http://www.mods.army.mil/.

In addition to making profile information more accessible to health providers, Soldiers and commanders, Caffrey said there will be benefits for researchers and planners.

"This will provide data on profiles as an Army and allow us to better manage readiness issues. You can do it with paper but not as efficiently or effectively," he said. (Army News Service contributed to this report.)

Patient records same as theater

Garrison aid stations use MC4

by Ray Steen and Bill Snethen

Fifty-seven battalion aid stations in garrison now use Medical Communications for Combat Casualty Care (MC4) systems to digitally chart patient care. The 2nd Brigade Combat Team (BCT), 4th Infantry Division (ID) at Fort Carson, Colo., and the 159th Combat Aviation Brigade (CAB), 101st Airborne Division at Fort Campbell, Ky., are the latest to join the growing list of units using MC4 outside of Southwest Asia.

From 2008 to 2009, 37 battalion aid stations in garrison transitioned from paper records to MC4, once a battlefield-only system. The 82nd Airborne Division at Fort Bragg, N.C., 3rd ID at Fort Stewart, Ga., 2nd ID in South Korea and 7th Army in Europe installed MC4 to fill a need for electronic medical recording (EMR). The system also supports their adoption of the Army's "train as you fight" model. To date, garrison aid stations have captured 53,000 patient encounters and transmitted countless medical supply orders electronically.

Preparing for deployment

Preparing for Southwest Asia, MAJ Theodore Stefani, 2nd BCT, 4th ID brigade surgeon, initiated the use of MC4 systems for outpatient care (AHLTA-T) in the brigade's six battalion aid stations. The unit uses MC4 hardware to connect to Evans Army Community Hospital at Fort Carson via Enterprise Remote Access (ERA), a virtual private network connection. The tool allows them to order X-rays and lab tests, as well as view inpatient care notes.

"The combination of MC4 and ERA allows us to move away from paper records and prepare for theater requirements," Stefani said. "My medics tested the network and charted 10 encounters the first day the systems were in place. Now, we electronically capture 25 patient notes daily. We offer a seamless transition of medical documentation for Soldier care, helping them when they move to new duty stations and eventually leave the military."

MAJ Roby Randall, Fort Carson MEDDAC chief information officer, previously deployed to Iraq as the health information systems officer with the 10th Combat Support Hospital (CSH). He understands the benefits the technical staff will reap by supporting MC4 at Fort Carson.

"Before the 10th CSH deployed in 2009, my team was not familiar with MC4 systems," Randall said. "In the beginning, we didn't understand all of the support requirements and we experienced a steep learning curve. Supporting the systems on a daily basis will help the unit-level administrators avoid those same struggles."

Stefani will include the systems in field exercises.

"The technical team gets the opportunity to practice setting up the systems in case the unit arrives in theater and does not fall in on an established network," Stefani said. "I'll also have the opportunity to review patient data for medical surveillance requirements."

Bring it home

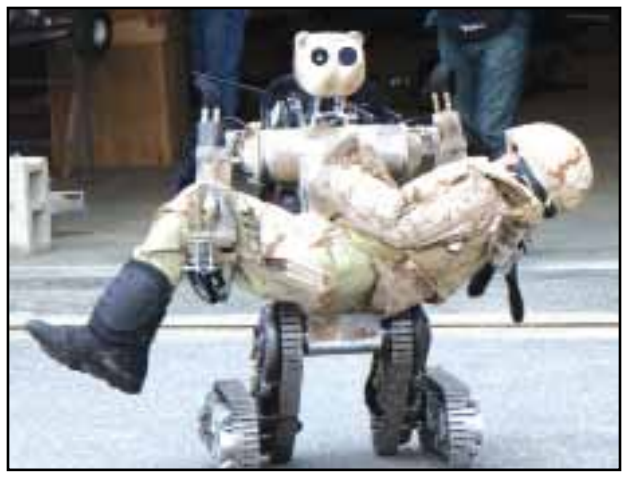
While Stefani's unit prepares for MC4 use in theater, SFC Shayne Henricksen, medical platoon sergeant and noncommissioned officer in charge of the 563rd Aviation Support Battalion, 159th CAB, 101st Airborne Division, readies his unit for MC4 in the states.

"Instead of the equipment being locked away in a CONEX until the next mission, we're using the MC4 systems like we did in Afghanistan," Henricksen said. "Daily use of the same system can only help the user."

In May, the 159th CAB installed 17 MC4 systems in their 12 battalion aid stations and the brigade medical supply office at Fort Campbell. In one month, the unit digitally documented 400 patient encounters and ordered approximately 20 items of medical supplies each week via MC4.

Henricksen believes his staff will be better prepared to build on lessons learned with MC4 in garrison.

"For our next mission, we'll have a database of our Soldiers on our computers. We'll spend less time entering demographic data and be ready to use the systems as soon as we hit the ground. We're able to build upon our experiences and provide a complete medical picture," he said. (MC4)



The BEAR all-terrain search-and-rescue robot can lift and carry up to 500 pounds, yet can grasp fragile objects without damaging them. (Photo by TATRC)

TATRC searches for high-tech solutions

by Barb Ruppert

The Army Medical Research and Materiel Command's Telemedicine and Advanced Technology Research Center (TATRC) is providing funding and guidance for projects using groundbreaking technology to benefit Soldiers.

The BEAR (Battlefield Extraction-Assist Robot), may be used to recover a wounded Soldier and bring him or her back to where a combat medic could safely conduct an initial assessment. A motion-capture glove or specially equipped rifle grip would allow a warfighter to control the robot remotely while still carrying out his or her other tasks. These technologies have been tested together over the past year by Soldiers at the Army Infantry Center Maneuver Battle Lab at Fort Benning, Ga.

A team from Florida State University and the University of Pittsburgh began experiments this year to design instruments for an electric-powered wheelchair to automatically detect hazardous terrain and implement safe driving strategies while avoiding wheel slip, sinkage or vehicle tipping.

The BEAR can reach out with its hydraulic arms to lift and carry up to 500 pounds; complete fine motor tasks with its hands and fingers; maneuver with a dual-track system; stand up and balance; and use cameras and sensors.

A computer simulation of the BEAR was created in 2009 and tested in the Battle Lab's OneSAF (One Semi-Autonomous Forces) combat operations simulator. In June 2010, the BEAR and controllers underwent live characterization studies with Soldiers observing their capabilities in both urban and wooded terrain.

"If robots could be used in the face of threats such as urban combat, booby-trapped IEDs, and chemical and biological weapons, it could save medics' and fellow Soldiers' lives," said Dr. Gary Gilbert, who manages TATRC's medical robotics portfolio.

Adapting automatic terrain-sensing controls for wheelchairs is a project of Florida State's Center for Intelligent Systems, Control and Robotics, which has worked with control and guidance of autonomous vehicles, and Pittsburgh's Human Engineering Research Laboratories, which has developed several assistive technologies already in use.

"This technology will provide electric-powered wheelchair users with an increased degree of independence that may significantly increase their ability to participate in recreational and functional activities," said MAJ Kevin Fitzpatrick, director of the wheelchair clinic at Walter Reed Army Medical Center. (TATRC)

CAPSULES

Fort Stewart

Officials broke ground for a new barracks for the warrior transition battalion at Fort Stewart, Ga. The building, with 240 rooms, should be completed by the end of 2012.

Fort Hood

The West Fort Hood clinic has been dedicated in memory of SGT Russell Lee Collier, a combat medic with 1st Battalion, 206th Field Artillery Regiment, who was killed Oct. 3, 2004 in Taji, Iraq, while rendering medical aid to a Soldier who was wounded by small-arms fire. He was posthumously awarded the Silver Star and Purple Heart.

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Building 36001, which houses administrative and clinic operations for Darnall Army Medical Center, has been renovated with new windows, roof, fire alarm and sprinkler system, ramps and elevator, and mechanical and electrical systems. It is now rated a Leadership in Energy and Environmental Design (LEED) silver building.

ATTC

The classroom used by Soldiers training at the Army Trauma Training Center in Miami, Fla., has been named in honor of SSG Ronald J. Spino, a medic of the 274th Forward Surgical Team who was killed in Afghanistan in 2009

Saudi Arabia

The office of the program manager for the Saudi Arabian National Guard has collaborated in fielding a disease surveillance system in hospitals of the Saudi National Guard. COL Fredric Plotkin and COL Michael Talley were instrumental in establishing necessary relationships between various agencies and acquiring automation equipment to support the system. The first phase of the system will track health care-associated infections; future phases will track additional conditions.

Lewis-McChord

Madigan Army Medical Center at Joint Base Lewis-McChord, Wash., has inaugurated a critical care emergency nurse course, featuring clinical rotations at Tacoma General Hospital and Mary Bridge Hospital. The 14-week course prepares nurses to function in the emergency room.

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Madigan Soldiers created a mobile training platform consisting of a trailer containing a casualty mannequin that speaks, breathes and bleeds. The trailer is used to train Soldiers in use of the Improved First Aid Kit. 1SG Kristopher Rick said by identifying unused resources they were able to create the platform for $2,000, while purchasing new equipment would have cost $250,000.

AMEDD Center and School

The medical materiel and system division at the AMEDD Center and School will conduct a MEDLOG Class VII Handling Workshop Feb. 28-March 4 to determine capabilities and gaps of medical logistics companies and medical logistics management centers. More information is available at (210) 221-1827.

Short Shots

The **463rd Veterinary Detachment** activated at Fort Benning, preparatory to deploying to Afghanistan in the summer…Scientists at the **Army Research Institute of Environmental Medicine** have been awarded a patent on technology to regulate a microclimate cooling garment using sensors that measure skin temperature.

The International Course on Current Concepts and Doctrine of the Israeli Medical Corps will be held May 24-June 6 in Israel. AMEDD officers may attend, but will not be centrally funded. Registration deadline is Jan. 30. More information is available at 972-3-7379237/8 or med.course@gmail.com

CW2 Sean Johnson, CW2 Eric Wells, SGT William Ebel and **SPC Todd Matthews** of the 5th Battalion, 158th Aviation Regiment received the Distinguished Flying Cross for the MEDEVAC of eight German soldiers under fire near Konduz, Afghanistan, on April 2, 2010.

SGT Kevin Faust, assistant NCOIC of the laboratory at **Rader Health Clinic**, and **SGT David Howell**, training NCO at Rader, were named Soldier of the Year and NCO of the Year, respectively, at Joint Base Myer-Henderson Hall…The medical evaluation board outreach counsel office of **Darnall Army Medical Center** was named one of the top service providers on Fort Hood for the fourth quarter of 2010…The flag football team of **Winn Army Community Hospital** won the championship of Fort Stewart.

CPT Jennifer Wissemann of **Madigan Army Medical Center** was selected as the Association of Women's Health, Obstetric and Neonatal Nurses Armed Forces Section Army Junior Nurse of the Year...At the 2010 Armed Forces District Meeting residents and fellows of **Madigan Army Medical Center** earned the following awards: Founder's Award to **CPT Kristen Bunch**, Chairman's Award to **CPT Bruce Pier**, Resident Award to **CPT Kyle Tobler** and **CPT Samuel Han**, and Fellow Award to **MAJ Brad Dolinsky.**

Upcoming Events

Feb. 1-28: National Patient Recognition Month

Feb. 2: 110th anniversary of the Army Nurse Corps

Feb. 21: Presidents Day

March 1-31: National Brain Injury Awareness Month

March 1: 124th anniversary of the Enlisted Corps

March 3: 100th anniversary of the Dental Corps

March 18-25: Armed Forces Public Health Conference, Hampton, Va. Information: https://usaphcapps.amedd.army.mil/afphc/ Contact AFPHC@amedd.army.mil

Snow off

A medical evacuation helicopter lands at Fort Wainwright, Alaska, during a training exercise by medics of H Company, 3rd Battalion, 21st Infantry Regiment. Training covered everything from calling for MEDEVAC support by radio to loading and unloading patients.

"It has long been known that the best chance for survival is within that first hour that a person's life is on the line," said SFC Jeramie Laughlin.

"When you're out there, everything seems so realistic, and to know that you have a life that's depending on you is the ultimate feeling," said PFC Jordan Smith. (Photo by Andreka Johnson/U.S. Army Alaska)

New Darnall promises increased access

by Patricia Deal and Christie Vanover

Officials have broken ground for Carl R. Darnall Army Medical Center's new hospital, signaling the start of a $534 million project that will consolidate services and enhance access to medical care for thousands of Soldiers, Family members and retirees at Fort Hood, Texas.

Construction of the 947,000 square-foot facility is slated to begin in April just south of the current medical center. It is expected to be open for patients in late summer 2015.

"We're excited to see the project begin as it brings us one step closer to providing increased access to care and more health-care services in line with the 21st century warfighter," said COL Steven Braverman, Darnall commander.

The new medical center will be nearly 60 percent larger than the current facility and will include a six-story hospital, three out-patient clinic buildings and three parking garages.

An important feature of the new hospital is the approximately 100,000 square feet dedicated for behavioral health services, said Braverman, which will enable the hospital to provide additional mental and physical care.

This area on the third floor will include an outpatient component, a resilience and restoration center, department of social work and hospital and administrative psychiatry. It will be connected through the concourse to the in-patient component of the psychiatric unit, which will also feature an exterior basketball court.

Artist's concept shows the new Darnall Army Medical Center due to open in 2015. (Darnall graphic)

Since the Wars in Iraq and Afghanistan began, military hospitals have seen an increase in the number of Soldiers needing treatment for physical injuries, traumatic brain injury and post-traumatic stress disorder. More than 4,200 wounded and ill Soldiers evacuated from Iraq and Afghanistan have been treated at Darnall.

The fourth floor of the new medical center will be devoted to women's services. It will include nine labor-delivery-recovery rooms, two C-section units, a 12-bed neo-natal intensive care unit and a 28-bed mother/baby unit.

Up one level, the pediatric unit will have 10 beds and the medical-surgery unit is designed to accommodate 30 beds.

Darnall will continue to provide additional services throughout the facility, such as emergency medicine, physical therapy, family medicine, internal medicine, and more. (Darnall)

Wellness centers provide holistic health care

Story and photo by Jane Gervasoni

The newly opened wellness center at Fort Bragg, N.C., exemplifies the capabilities of Public Health Command (Provisional)'s Army Wellness Center Program. It offers the standardized programs that PHC (Prov) hopes to develop at major installations.

The wellness center strengthens the Army Family Covenant's promises of improved, more holistic health care and service, as well as the Army Surgeon General's commitment to a focus on prevention and sustaining good health.

BG Timothy K. Adams, commander of PHC (Prov), said that Medical Command is "moving from a system that is reactionary and treatment-focused — a 'sick-care system' so to speak — to one that is proactive and focused on prevention, health promotion and wellness. This system for health will be enhanced by the Army Wellness Centers."

When all 38 planned sites are completed, the Army will have a standardized system in place to help keep its people healthy, he added.

The centers focus on health assessment, physical fitness, healthy nutrition, stress management, general wellness education and tobacco education. All programs are free for Soldiers, retirees, Family members and Department of Defense civilians.

The Fort Bragg center was developed after the model of the five similar centers existing in Europe.

"The AWCs will have tactical relevance and will integrate health promotion and wellness to enhance the military community," explained Kym Ocasio, program manager for health promotion operations at PHC (Prov).

The center at Fort Bragg has state-of-the-art equipment to ensure that fitness and wellness can be assessed, according to Todd Hoover, director of Army Wellness Centers–Europe, who coordinated the new AWC.

The services offered — including body fat measurement, metabolic testing and measurement of the volume of oxygen consumed while exercising — would cost as much as $3,000 per customer from private sources, according to Hoover.

The center saves money for the Army through reduction or prevention of such things as duty days lost to injury or illness, reduction or mitigation of chronic health conditions caused by lifestyle choices such as smoking and obesity, and stress reduction.

"This is a good idea for the Army — the cost benefit of preventing illness or disease rather than treating someone after they develop a problem is substantial," according to COL Jeffrey L. Kingsbury, chief of preventive medicine at Womack Army Medical Center.

Womack's commander agreed.

"This is an important, well-needed resource for the hospital. We need to get into a preventive medicine mode, and I am encouraging the physicians at [Womack] to visit the center and see what it offers and then to make referrals for patients who could use the AWC services," said COL Brian T. Canfield, hospital commander. (Public Health Command (Provisional))

Sarah Fewell and Sarah Guin, health educators at the Fort Bragg Army Wellness Center, demonstrate the Bod Pod, which measures the ratio of lean muscle mass to fat in five minutes, rather than 45 minutes needed for hydrostatic measuring.

Fort Hood honors heroes of shooting

Fort Hood, Texas, held a ceremony on the anniversary of the shooting in which 12 Soldiers and a civilian died and more than 30 people were wounded last year, both in memorial to the fallen and to honor those who helped bring the incident under control and care for the injured. Officials including Secretary of the Army John McHugh and Army Chief of Staff GEN George Casey spoke at the event.

"Today, we gather to pay tribute to those people who heard the call, and who, like so many before them, answered with neither hesitation nor reservation," McHugh said.

Among those receiving the Meritorious Service Medal were LTC Lawrence Masullo, MAJ Sean Lankford, MAJ Paulette Smith-Kimble, MSG Sheri Dubois, SFC Alwood Mangum, SSG Aaron Puckett, SGT Monique Archuletta and SPC Ryan Walton, all of Darnall Army Medical Center; as well as SSG Zackary Filip, a combat medic with the 2nd Brigade Combat Team of the 1st Cavalry Division, and SSG Shanett Robinson, a medic instructor with the III Corps NCO Academy.

Filip, who provided immediate aid to wounded at the site of the incident, said the best part of the ceremony was "seeing some of the people I worked on and meeting the Families of those I provided aid to."

Sandra Brown and Diana White of Darnall received the Superior Civilian Service Award.

Presented the Soldier's Medal were MAJ Steven Richter, 1LT Veronica Pacheco, SFC Maria Guerra, SGT Jean Alvarado, SPC Daniel Butler and SPC Francisco De La Serna, all of Darnall; and SGT Roland Murray of the 1207th U.S. Army Reserve Hospital.

Guerra was noncommissioned officer in charge of the building where the shooting took place, and barricaded the doors to prevent the gunman from reentering the building.

"NCO mode kicked in right away," she said. "The first thing I thought about was my Soldiers."

"I couldn't have asked for better people and resources to help treat the injured," said Richter, a medical logistics officer who provided aid to injured at the site.

CPT John Gaffaney, who was one of the casualties of the day after throwing a chair at the gunman, received the Soldier's Medal posthumously. Gaffaney was a psychiatric nurse with the 1908th Medical Detachment.

The emergency department at Darnall also received a plaque presented by the Fort Hood Chapter of the Military Order of the World Wars.

"Those of us who were on Fort Hood Nov. 5 will always remember," said COL Steven Braverman, commander of Darnall. "We will remember the loss of our friends. We will remember the adrenaline that helped us care for patients all through the night. We will remember the dreams of the wounded and continue to help them reach the highest heights." (Compiled from reports by Darnall, Fort Hood and Eighth Army.)

Stress detachment reacts to tragedy

by SFC Gail Braymen

Ironically, some of the Soldiers most deeply affected by the shooting at Fort Hood, Texas, Nov. 5, 2009, knew the most about recovering from shock and grief.

Soldiers of the 467th Combat Stress Control Detachment arrived in Texas Nov. 4 for post-mobilization training with First Army Division West. By the afternoon of the following day, three members of the unit were dead and several others wounded, shot as they waited to complete their deployment processing.

Deployed on schedule

It was exactly the type of situation the unit's psychologists and behavioral health specialists are trained to deal with. A few weeks later, after completing their training on schedule, every one of the remaining Soldiers of the 467th — except those whose injuries made them medically non-deployable — boarded the plane for Afghanistan.

Army Chief of Staff GEN George W. Casey Jr. visited members of the 467th during their overseas tour. During a remembrance ceremony at Fort Hood, Casey said he was impressed with their resilience.

"I watched members of the 467th Combat Stress Control Detachment — specialists charged with helping others deal with tragedy — as they coped themselves with the loss of three of their own," Casey said. "They were working hard to come to grips with what happened here, even as they poured themselves into helping other Soldiers deal with the stresses of combat. They helped in clinics that they had named for their fallen comrades."

The deployment was actually helpful for a lot of the Soldiers in the unit, said SGT Garry Cole, a behavioral health specialist with the 467th.

"It allowed us to kind of take that burden off our shoulders for a time," Cole said. "Our pace was so fast during the deployment that it was difficult to really have to stop and think about that and cope with what we were dealing with. In a way, helping other people is one of those things that makes your coping easier."

Cole said he drew from his personal experience at Fort Hood "all the time" to help Soldiers in Afghanistan.

"It was much easier for me to relate," Cole said. "Obviously, I would have rather not have gone through something like that ... but you might as well use it for something positive, instead of dwelling on something negative."

Cole, who is engaged to be married next April, said a survey at his forward operating base showed that more Soldiers there suffered from "homefront" issues such as marital problems than combat stress.

Although the 467th Soldiers are doing well, Cole said, it's good for them to get home.

"I think, for everyone in the military that gets deployed, the cure for all their symptoms is just to go home," Cole said. "Being with Family is an extremely important bonding experience and an important healer, as well."

Safe return

All of the 467th Soldiers who deployed to Afghanistan safely returned to the United States in late October, a fact the unit's senior enlisted leader, 1SG James McLeod, is very proud of. Although individual Soldiers could have decided not to deploy with the unit after the shooting, "they all said, 'Yes,' unanimously," McLeod said. "No one wanted to be left behind."

Once the unit arrived in Afghanistan, the 467th Soldiers focused on other Soldiers who needed their help, McLeod said.

"Violence is definitely a bad thing, but you have to accept it sometimes. You have to push forward, even though you don't want to, and our Soldiers were able to do that," McLeod said. "Going through that incident made our Soldiers much stronger and able to support the Soldiers who are dealing with any type of issue." (First Army Division West)

Stewart personnel safely dealt with hostage taker

Story and photo by SGT Joseph McAtee

Fort Stewart, Ga., MEDDAC honored those who prevented a hostage situation from escalating into a disastrous tragedy.

The incident took place Sept. 6, when a recently-discharged Soldier working at Fort Stewart as a civilian entered the hospital armed and took three hostages, demanding behavioral treatment from the thin overnight staff.

MAJ Sabon Shelton, the night supervisor at Winn Army Community Hospital, was one of those three hostages. Earlier in his career, Shelton was a psychiatric nurse who had completed training in deescalating such situations.

"I've had a lot of training with [Soldiers with post-traumatic stress disorder]," he said. "I have dealt with many Soldiers like [the one that night], I just hadn't dealt with one with a gun."

BG Jeffrey Phillips, deputy commanding general of the 3rd Infantry Division, pointed to a single feature in the people who made sure that no one was harmed in the process.

"It was the professionalism of everyone involved," he said. "That professionalism included valor, courage, skill, and most importantly, the internalization of the warrior ethos."

"The men and women within this facility are committed to providing quality patient care at all risks," said CSM Thomas Wrighton, the MEDDAC's acting command sergeant major. "No one can ask for more than that, and I'm damn proud to be on their team."

"They put their own lives at risk, and that made all the difference," said U.S. Representative Jack Kingston. "Knowing what to do is training. Doing it is bravery." (3rd Infantry Division)

SPC Nicholas Anderson (right) is congratulated by BG Jeffrey Phillips, deputy commanding general of the 3rd Infantry Division, during recognition of Winn Army Medical Center personnel who helped defuse a hostage situation at the hospital.

Fit to bite

CPT Bianco Bernardo and SGT Christie Botello, both of Charlie Company, 27th Brigade Support Battalion, clean the teeth of a U.S. Soldier in the troop medical center at Contingency Operating Base Marez, Iraq. The TMC serves a wide range of patients for a variety of ailments during deployment. (Photo by SPC Brandon Bolick/Joint Combat Camera Center Iraq)

Get on the move to reach weight loss goal

by LTC Patricia McKinney

Do you struggle with maintaining a normal weight? You are not alone. The proportion of overweight Americans has increased over the last decade and the proportion of those who are obese has doubled.

Just as the nation struggles with the obesity epidemic, so does the military community. Data analyzed from the Clinical Data Repository (patient height and weight records) in February 2009 showed that 68 percent of active-duty Family members, retirees and retiree Family members ages 17 and older are overweight, as defined by a body mass index (BMI) of 25–29.9 kilograms per square meter (kg/m2) or obese, defined as BMI greater than 30 kg/m2.

Obesity places an immense burden on the health and well-being of individuals, communities and health-care systems. Your health and your weight are connected. It is well established that being overweight or obese increases an individual's risk of health conditions such as type 2 diabetes, high blood pressure and heart disease.

The good news is that these risks can be prevented and controlled by making positive lifestyle changes such as healthy eating and moving more.

Army MOVE! is a weight management program to help you lose weight, keep it off, and improve your health. It is designed to help you discover nutrition and physical activity strategies that will get you started on your "weigh to success." The program offers real-time sessions online using the computer or face-to-face in a medical treatment facility or wellness center, coached by registered dietitians and other health-care providers. In addition, participants have access to self-management tools to include a customized, individualized report identifying obstacles to weight management.

With an Army Knowledge Online (AKO) account, Soldiers, retirees, Family members and DoD civilians can all access *Army MOVE!* The direct URL is https://www.us.army.mil/suite/page/248187.

Make an *Army MOVE!* to a healthier you — register today. (Public Health Command (Provisional))

Consolidating student loans can be good move

by Timothy R. Bowles

If you attended an institute of higher learning, you are probably one of the millions of people who carry student loan debt. Unfortunately, making the monthly payments on student loans can be crippling. Many people find that loan consolidation is a helpful way to lower monthly payments.

Visiting http://loanconsolidation.ed.gov is a great first step toward getting student loan debt under control. It is important to understand the types of loans that qualify as well as eligibility requirements for consolidation. According to information found on http://studentaid.ed.gov/, most federally-backed student loans are eligible for consolidation, including: subsidized and unsubsidized Direct, and Federal Family Education Loan (FFEL) program, Stafford Loans, Direct and FFEL PLUS Loans, Supplemental Loans for Students (SLS), Federal Perkins Loans, Federal Nursing Loans, and Health Education Assistance Loans. Private loans (which are not guaranteed by the federal government) are not included.

Why consolidate multiple loans into one? If several student loans are scattered among different lenders, varying interest rates, terms of duration and/or lenders may be involved. With consolidation, all loans are managed in one account, with one interest loan rate, one term of duration, and only one lender to pay.

One of the main points to consider is your objective for loan consolidation. If the objective is to reduce high monthly loan payments, depending upon the interest rates of the existing loans, it may be best to consolidate all loans with the lowest interest rate loan. If a lower interest rate is available in the marketplace, consolidating with a new loan may be best.

It is important to note that though payments may be low, the length of the loan affects the total amount paid in the end. In the case of a $30,000 30-year loan at 5.5 percent (monthly payment around $170), the total loan payoff amount would be about $61,319. Conversely, the same loan amount at 6.5 percent interest over 10 years (monthly payment around $340) results in a total payoff about $40,877. While low payments might sound enticing, 187 percent more would be paid in total interest over the course of the repayment plan, as well as double the original loan amount.

If your objective is to pay off your loans sooner or just simplify your finances by paying a single lender, loan consolidation may be a viable option as well. Though slashing loan payments from many to one may prove valuable for some, it may not be right for everyone. Interest rate discounts, loan cancellation benefits, or principal rebates could be lost when consolidating student loans, so do your homework to determine if you really save over the long run.

Once you have made the decision to consolidate your student loans, it is important to stay alert. It is easy to fall victim to the many marketers and lenders out there who are trying to take advantage of borrowers looking for relief.

Besides flashy advertisements promising "Low monthly payments" and "Lower your interest rate today," lenders may attempt to lure prospective borrowers by "scaring" them into believing interest rates may go up. Interest rates go up only if you have a variable rate interest on your loans. With fixed interest loans, there is no pressure for you to consolidate your loans. However, if you have variable rate loans (the Department of Education releases new variable rates July 1 each year), these rates will affect the loans you carry.

Before beginning the process of applying for a Direct Consolidation Loan, there are a few things to keep in mind. You are only eligible for the loan if you have already graduated from school, have left school, or your enrollment has dropped to less than half time. If you have defaulted on education loans in the past, you may still be eligible for loan consolidation if you have agreed to a loan repayment schedule with the lender or you agree to pay your new loan under the Income Based Repayment Plan or the Income Contingent Repayment Plan.

Consolidating student loans is an excellent opportunity for many people burdened by student loan debt. It is up to each individual to do the research and determine whether it is the right decision for him or her. (MEDCOM office of the staff judge advocate)

First class graduates from METC joint training campus

by Steve Elliott

It might have been a small group of airmen graduating at the Medical Education and Training Campus (METC), but they made a huge historical impact as the first class to complete training at the billion-dollar joint training campus that opened in June at Fort Sam Houston, Texas.

METC is an integrated campus under a single university-style administration, with more than 100 courses taught there.

The quartet of Air Force staff sergeants attended a two-week pharmacy craftsman course, which is required for advancement to 7-level Air Force supervisory training in Air Force Specialty Code 4P0X1, and also for promotion to technical sergeant.

The course had previously been given at Sheppard Air Force Base in Wichita Falls, Texas, and has now moved to METC where it will be a joint-service course.

"These four Airmen training with us have provided a model for others to follow," said Navy Rear Admiral William R. Kiser, METC commandant. "They were trained not only by Air Force, but by Army and Navy faculty as well. That will be the norm here at METC. This is the future of military medicine."

"There's something special about people who do something for the first time," said Kiser. "There will be thousands and thousands of people that will graduate from here in the future. Only a few can be the first, so it's an honor for me to stop and reflect on this with you."

"The course helped with our managerial skills and fine-tuned what we already knew," said SSG Tamika Isaacs-Powell. "I was expecting it to be a million of us fighting for attention, fighting for an opportunity to share what we do at our base. As the class continued, we really formed a bond and we were always talking and sharing knowledge."

"Here we can learn with real drugs in the outpatient clinic, not just by using Skittles or M&Ms like we used at Sheppard," said SSG Andrea Stein. "In the IV room, they have the same equipment we would use at a deployed location. To be able to practice on that was really awesome."

"Learning in this environment is unique because not only do students get the same course they would have gotten at Sheppard, but they get to experience it in a joint service climate," said Navy Lieutenant Commander Chris Lynch, program director for pharmacy training at METC. "It's not only what students learn in the classroom, but what they share between classes, just talking to each other about their experiences at their home bases." (Fort Sam Houston News Leader)

Protoype Caiman MRAP ambulance. (Photo courtesy BAE Systems)

Team developing new ambulance

A Pentagon team, Medical Command and BAE Systems are developing a new Caiman Mine-Resistant Ambush-Protected (MRAP) Ambulance that will have more space to treat patients, more on-board electrical power for medical equipment and additional protection for patients and crew members.

Built on a Caiman MRAP chassis, the prototype ambulance offers the latest medical technologies.

"The vehicle's versatility provides life-saving treatment or management procedures, vital-sign-monitoring and airway management with continuous oxygen delivery," said Kerry Riese, assistant program manager for the Caiman Vehicle Team, MRAP Joint Program Office.

"The Caiman Ambulance has the ability to transport four litter casualties or six ambulatory casualties or two litter casualties and three ambulatory casualties," said Riese. (Army News Service)

Medical Capabilities Integration Center

Center has far-reaching impact on medical care

by Steve Elliott

If it has anything to do with medical battlefield tactics, techniques, personnel, organizational structures or equipment, then the Medical Capabilities Integration Center of the AMEDD Center and School has had something to do with it.

"Our responsibilities range from developing the overall operational concept for a theater of operations down to developing the detailed doctrine, tactics, techniques and procedures manuals," said Hershell Moody, deputy chief of the center at Fort Sam Houston, Texas.

Five directorates

The MCIC oversees five diverse and far-ranging directorates that do everything from looking at lessons learned from theaters of operation, to creating databases that track battle injuries, to developing textbooks for military medicine, to testing and evaluating medical equipment and much more.

For example, the directorate of combat and doctrine development develops concepts, organizations, materiel, and doctrine for force health protection to the Army and identifies operational and clinical capabilities and develops requirement solutions.

Meanwhile, the Center for AMEDD Strategic Studies plans, programs, performs, and publishes complex, organized analytic assessments and evaluations in support of decision- and policy-making, management, and administration of Army medicine.

Data

The MCIC produces the data to envision, design and train a premier military medical force for full spectrum operations in support of the nation.

"Depending on changes in the operational concept, it may lead us to see how we design a combat field hospital, along with all the support activities, and also look at the patient workload," Moody said. "Did we put the right amount of air ground ambulances in a certain unit? Will it accomplish that workload?"

One valuable resource for military medical personnel is the AMEDD Lessons Learned Office that collects, analyzes, maintains, and disseminates unit observations and experiences from the Combat Training Centers, unit deployments and operational exercises. The office is supported by a content-heavy Website at http://lessonslearned.amedd.army.mil.

"When Army medical people get back from a theater of operation, they can enter what lessons they learned from being in that area. We take a look at this and see if it prompts any changes in doctrine, changes in the organizational structure of how that unit was built, or if the structure needs to be changed by adding people or additional equipment," Moody said.

"Are there changes or deficiencies in the medical equipment being used? Are there deficiencies in training or leadership?" Moody added. "Lessons learned provides a continuous playback loop to us."

"The question is, are we making a temporary fix for that particular theater of operation or is it going to be a permanent fix?" Moody added. "Right now, we are in a counterinsurgency type of operation. It's not a major combat operation we are fighting. There are things that are unique about this particular theater of operation. Each theater you go into is going to be different," Moody said.

Continuous

"Looking at the lessons learned is a continuous process," he added. "looking to ensure our structure, our doctrine, our leadership, our materiel, our training, is what it should be and if there are any deficiencies, how can we address them?"

While analyzing the present and the past can help in the design of the medical arm of the Army, it can also help to predict the future of military medicine.

First aid kit

"We looked around and saw the number one killer on the battlefield is bleeding out from wounds. Troops have made all kinds of jury-rigged tourniquets, but what we needed was a real good one, and at the same time we need a better bandage to put on the wound," Moody said. "What we came up with was the IFAK, the Improved First Aid Kit."

The IFAK contains a tourniquet, gauze, gloves, bandages, surgical tape and a nasopharyngeal airway, which relieves upper airway obstruction.

"We also found out recently the combat lifesaver is being trained to start an intravenous line," Moody said. "He was taking all this time to start an IV, while his primary job was just to keep the guy breathing and keep them from bleeding to death. The IFAK, which weighs about a pound and fits in an ammo pouch, was created to achieve just that." (Fort Sam Houston News Leader)

Army gathers awards at AMSUS meeting

A number of Army medical personnel were honored with annual awards during the 2010 meeting of the Association of Medical Surgeons of the United States (AMSUS), at Phoenix, Ariz.

MAJ Kevin Chung, medical director of the burn intensive care unit at the Army Institute of Surgical Research, received the Rising Star Award, presented to a successful young professional clearly on the path to executive leadership.

Chung's work in continuous renal replacement therapy has led to a $3 million multicenter trial under his leadership. He also has played a notable role in the Indirect Source Review Rule of 10 to minimize morbidity associated with over-resuscitation of combat burn casualties, and in use of robotic telepresence to bring medical expertise to bedside at any time and place.

The Nursing Award was presented to COL Bruce Schoneboom, associate dean for academic affairs at the Uniformed Services University of the Health Sciences Graduate School of Nursing. He monitors academic procedures, participates in curriculum design and promotes faculty enrichment.

Landstuhl Regional Medical Center came away with three awards — the Operational Medicine Award, Facility Based Healthcare Award, and the Physician Award, won by Air Force LTC Raymond Fang, who is LRMC trauma medical director.

"The awards are a testament to the hard work and dedication of all personnel within the LRMC footprint on behalf of wounded warriors returning from Afghanistan and Iraq," commented COL John M. Cho, LRMC commander. "These injured receive nothing short of world-class care as they are medically evacuated from battlefield en route to definitive and long-term care in the United States. Our Army, Navy, Air Force, Marine and civilian staff will tell you that it is reward enough to provide care for our sick and injured heroes. The additional recognition that these prestigious awards bring further validates the significant contributions that Landstuhl and its personnel are making not only for military medicine, but medicine worldwide."

COL Richard Petri, chief of physical medicine and rehabilitation services at William Beaumont Army Medical Center, received the Richard A. Kern Lecture Award, and delivered a lecture on "Why Alternative Medicine: A New World Practice."

"The goal in the practice of medicine is to assist the patient in healing," Petri said. "My belief is that integrative health and healing places the patient in the driver's seat to manage their health."

He stated medicine is shifting from reactive, disease-based medicine to "care in which the physician demonstrates his ability to listen, adapt and respond in an integrative manner."

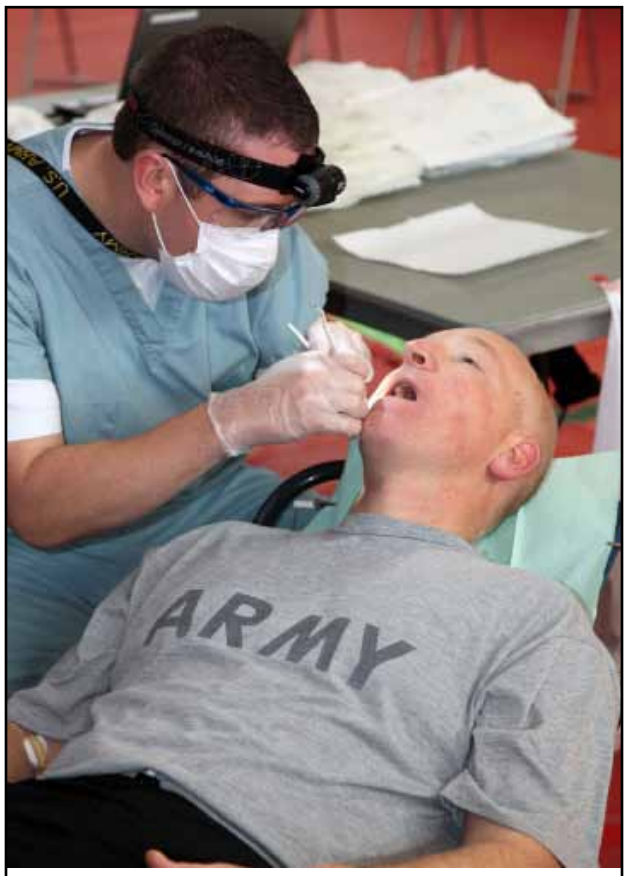
COL Kris Peterson, chief of psychiatry at Madigan Army Medical Center and consultant to The Surgeon General for child and adolescent psychiatry, delivered the William C. Porter Lecture, which honors an outstanding contribution to psychiatry.

MAJ Andrew Schoenfeld, director of research for the orthopedic residency at William Beaumont, received the History of Military Medicine Award for his work entitled, "The History of Combat Orthopedic Surgery."

"A lot of the advancements in terms of orthopedic care have always been derived from experiences in times of war," Schoenfeld told the *El Paso Times*. "So what our military practitioners are providing to the Soldiers currently in terms of novel approaches to limb salvage, fracture treatment in the setting of very significant soft tissue loss, et cetera, will likely be applied in the civilian setting in the future."

CPT Amy Bray, CPT Kylee Foy and Mayra Castillo of the Army Institute of Surgical Research won first place among research posters for a poster demonstrating how an aggressive education campaign to improve oral care can significantly reduce ventilator-associated pneumonia in burn intensive-care patients.

MAJ David Allen, MAJ Elizabeth Mann and LTC Maria Serio-Melvin of ISR received third place in the federal nursing poster session for a poster on "Clinical Satisfaction with Computer Decision Support in the Burn Intensive Care Unit." (William Beaumont, ISR, Landstuhl and the El Paso Times contributed to this report.)



Ready to go

LTC David Mundfrom, commander of the 774th Civil Support Team, receives a dental examination during the 7th Civil Support Command's annual Servicemember Readiness Program (SRP) at Kleber Kaserne, Germany. More than 200 Soldiers were checked for medical or dental conditions that could affect the ability to deploy.

"Only one Soldier in a 19-person or less unit can cause the whole unit to go red for not completing an annual dental screening," said MAJ Thomas Hrabal, officer in charge of the 7th's office of the surgeon.

Blood tests, immunizations and dental exams were among the services provided. (Photo by SPC Glenn M. Anderson/221st Public Affairs Detachment)

Mechanical mommy

CPT Kelly Langan performs a forceps-assisted delivery as part of a simulated emergency in the labor and delivery ward of Madigan Army Medical Center.

The "patient" is a simulator designed by LTC Shad Deering of the Charles Anderson Simulation Center at Madigan. The device can show maternal and fetal vital signs and simulate the most common obstetric emergencies.

Residents are not allowed to perform deliveries on human patients when emergencies occur, so the simulator provides hands-on practice for real-life situations. (Photo by Lorin T. Smith/Madigan)

Multinational MASCAL

SGT Michael Crain, a medic with Task Force Mustang, 4th Combat Aviation Brigade gives aid to a German soldier portraying a casualty during a mass casualty exercise at Camp Marmal, Afghanistan.

The exercise involved both U.S. and German forces.

One of the goals of the exercise was to validate the standard operating procedure in place, improve upon it and make it more applicable to a multinational environment. (Photo by SPC Jeanita C. Pisachubbe/4th CAB)

Intense effort vaccinates 9,000 at Gordon

by Chris Orose

The seasonal influenza vaccination campaign is a cornerstone of military medical readiness, and that was on display at Fort Gordon, Ga., as more than 9,000 Soldiers, sailors, Marines and civilians were screened and immunized against seasonal influenza within 10 hours.

When all was said and done, Fort Gordon had gone from an influenza-vaccination compliance rate of 17 percent to 78 percent.

With the help of registered nurses as initial screeners, 50 immunizers, four physicians and a dozen clerks documenting immunizations into medical records, the first Soldiers walked through the door at 5:00 a.m. to receive the mandatory influenza vaccination, be exempted if they had contraindications, or document a vaccination they previously received at another location.

In order to hold such a massive event and to ensure it went smoothly, all service members

Soldiers line up for influenza vaccinations at Fort Gordon. (Fort Gordon photo)

were screened first to determine if they were eligible to receive the vaccine (42 people had temporary or permanent exemptions, and some 300 had already received this year's flu vaccination). After eligibility was determined, those attending were directed to one of 10 tables where the vaccine was administered. Eight of those tables were giving FluMist, a live-virus intranasal vaccine licensed for those ages 2-49. For those who could not receive FluMist, two tables were set up to give injectable vaccine.

Since documentation of immunization is crucial, 14 people were charged with keeping track of vaccine lot numbers, vaccinees' personal information and who administered the vaccine. Every immunization given or received prior to the event was accurately documented in the appropriate service's immunization tracking system by noon on that same day.

Immunization teams later took immunizations to Fort Gordon units that could not attend the program (approximately 2,100 personnel, including National Guard and Reserve units).

It is because of efforts like this, and others modeled after it around the world, that the Department of Defense mandatory flu vaccination policy has been so effective at preventing illness and preserving readiness, and why DoD's compliance rate has steadily increased, becoming the highest ever last year. (MILVAX)

Scientists battle 'superbugs' in military hospitals

by Cheryl Pellerin

The military has been a leader in recognizing and protecting against the spread of multidrug-resistant organisms, commonly known as "superbugs," Department of Defense officials told members of Congress.

"DoD has been actively engaged in measures to screen, surveil, prevent and control infection in military treatment facilities at home and on the battlefield," said Dr. Jack Smith, the acting deputy assistant secretary for clinical and program policy in the Office of the Assistant Secretary of Defense for Health Affairs.

Superbugs can cause infections anywhere but are especially dangerous when they arise and spread among hospital patients, Smith said.

In hospital settings, the infections are most likely to contaminate surfaces and equipment like ventilators and dialysis machines; the hands of health-care workers, visitors and Family members; and the respiratory, urinary, skin and gastrointestinal tracts and wounds of hospitalized patients, he said.

"Health care-associated infections, including those from multidrug-resistant organisms, are a serious problem for the military and represent a growing problem in health-care facilities across the nation," Smith added. "These disease-causing organisms that are predominantly bacteria have increased the length of hospital stays and mortality rates."

Drug resistance is the ability of some microorganisms to withstand attack by antimicrobials, including antibiotics, according to the World Health Organization (WHO). It can come from the overuse and misuse of antibiotics and from the spread of resistant strains.

Common threats

According to the U.S. Centers for Disease Control and Prevention (CDC), some common drug-resistant organisms include:

— Methicillin-resistant Staphylococcus aureus, called MRSA, is a kind of bacteria that is resistant to methicillin, penicillin and other antibiotics. It was first recognized in the 1960s and now is a growing problem.

— Vancomycin-resistant enterococci, called VRE, are bacteria present in the human intestine. Resistance developed because of the misuse of antibiotics like vancomycin and the strain can spread from person to person.

— Multidrug-resistant Mycobacterium tuberculosis, called MDR-TB, is an infectious bacterial strain that arose from improper use of first-line or standard anti-TB drugs. Extensively drug-resistant (XDR) TB arises when second-line or less-effective TB drugs are misused, WHO says, creating a strain for which treatment options are seriously limited.

"The Infectious Disease Society of America, the Institute of Medicine and the World Health Organization all have identified resistant infectious agents as major public health threats for which a coordinated global effort is urgently needed," said Navy Captain Gregory Martin, the Navy surgeon general's specialty leader for infectious diseases and a practicing infectious disease physician.

Health professionals and researchers are concerned that if bacteria develop resistance to all antibiotics, no treatment options will exist for infected patients.

Smith said military health system efforts include a quality assurance program implemented in all military treatment facilities that establishes policies, procedures and training programs to minimize the risk of infection to patients and staff. In fiscal 2010, DOD spent $13.6 million on these efforts.

"We've established an infection prevention and control panel with service subject-matter experts as a subcommittee of our military health system quality forum," he said, and the Defense Department's Global Emerging Infection Surveillance and Response System gathers data from participating military laboratories and hospitals worldwide to monitor potential disease outbreaks.

The surveillance system, established by presidential directive in 1996, is a network of U.S. and overseas laboratories whose work helps the military health system prevent, monitor and respond to infectious diseases that threaten military personnel and Families and U.S. national security.

Military network

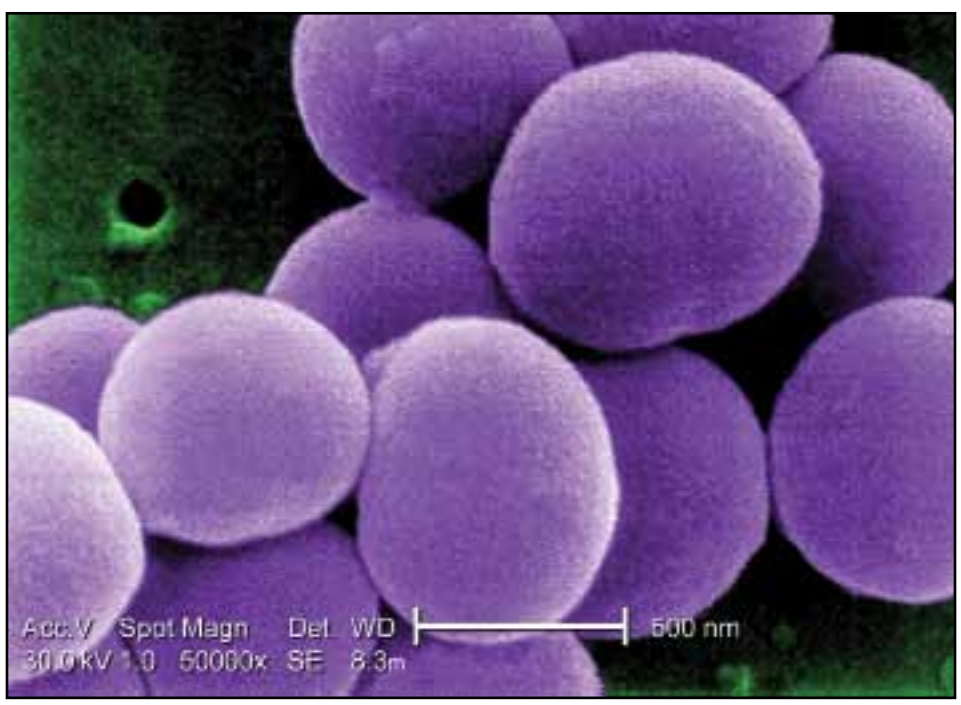
In the United States, the DoD surveillance system includes the Army Public Health Command (Provisional) and the Army Medical Research Institute of Infectious Diseases in Maryland, the Naval Health Research Center in California, the Naval Environmental Health Center in Virginia and the Air Force Global Surveillance Office in Texas.

The system has established working relationships with the CDC and international health agencies, including WHO. Overseas, military laboratories in Egypt, Indonesia, Kenya, Peru and Thailand work with each country's health ministry on disease research and surveillance.

Since December 2008, 33 military treatment facilities have participated in CDC's National Health Care Safety Network, a voluntary, secure, Internet-based surveillance system that integrates patient and health-care personnel safety surveillance systems managed by CDC.

DoD also has partnered with the Department of Veterans Affairs and the CDC to address the challenge of drug-resistant organisms.

"The DoD," Martin said, "has been a national leader in identifying and addressing the [multidrug-resistant organism] challenge." (American Forces Press Service)



Antibiotic-resistant Staphylococcus aureus bacteria, magnified 50,000 times. (Photo by Dr. Matthew J. Arduino/CDC)

Soldiers and Families of Warrior Transition Battalion-Europe cross the Trevere River in front of the Castel Sant' Angelo in Rome. (Photo by Barbaro Romano/ERMC)

Rome trip teaches resilience

Standing at ground level, raising their eyes up to the hard stone and cold brick of the Coliseum in Rome, Italy, SPC Jonathan Locke and his wife Ashley were not exactly thinking about architecture. Their thoughts, instead, turned to the thousands of Christians that had been slain in ancient times virtually at their feet. Their resolve to overcome their own difficulties grew.

The Lockes were two among nearly 50 warriors, their Families and cadre members of the Warrior Transition Battalion-Europe who volunteered for a weeklong retreat to Rome and the Vatican City.

The trip focused on building spiritual strength. During the four-day stay, the participants visited a number of sites where members of the early Christian church faced torture or death.

The trip was sponsored by the WTB-E chaplain and supported by the Vicenza garrison and Europe Regional Medical Command chaplains.

"Standing here, thinking about the places we've seen, I understand truly that when you come through something like what the early Christians did, you build something," Locke said.

"If you come to a WTU, you come to heal," said SPC Carlos Mendoza. "You make formations, you make your appointments, you do what you are able to do. That's your job. That's your focus. If you get assigned to a WTU and try to milk the system, try to stay in it as long as you can, you'll fail. I've seen it happen, and I think a lot of Soldiers see the few malingerers and think everyone in a WTU is like that."

Mendoza said that he was going to go back from the retreat even more dedicated to returning to duty.

"I want to stay in the Army. The Army has invested a lot in my training, and I think I can still be valuable," Mendoza said.

"Your ability to change a group's way of thinking is done through leadership," Locke said. "I want to become one of those leaders who help others, help them heal, help them change. I understand what Soldiers go through. I think I can help. This trip has made me more certain of that." (ERMC)

New Website helps wounded warriors

The Army Warrior Transition Command (WTC) launched a new Website, www.WTC.army.mil, a comprehensive source of information on Army warrior care for more than 16,000 wounded, ill and injured Soldiers and veterans.

Wounded, ill and injured Soldiers requiring at least six months of complex medical care are assigned to warrior transition units (WTU), where they have one mission — to heal and transition. WTU Soldiers surveyed indicated that having a single, comprehensive Website was among their most pressing information needs. Soldiers requested assistance "navigating benefits and access to resources" and "getting correct information in a timely manner."

"The Army is listening to our wounded warriors and this new Website is another example of the Army's commitment to provide them and their Families with the tools necessary for their long-term success," said COL Darryl Williams, commander of Warrior Transition Command. "The site was designed to clearly outline each step of the way for wounded warriors and their Families, covering administrative processes, benefits and resources."

The new site contains information on the primary concerns reported by wounded warriors, including:

Army Physical Disability Evaluation System, including an overview of the Medical Evaluation Board and Physical Evaluation Board process.

Army Wounded Warrior Program (AW2), the official Army program that provides personalized support for the severely wounded, ill and injured. More information on AW2 is available at www.AW2.army.mil.

Comprehensive Transition Plan, a six-part recovery and transition process for all wounded warriors that includes a personalized transition plan that the Soldier builds for him/herself.

Career and Education, including career and education training options that the Soldier may use during recovery.

Resources for Families and caregivers, including ways to contact community organizations and administrative resources. (WTC)

Optometrists must watch for TBI-related injuries

by Jerry Harben

MAJ Jinjong Chung is on a mission to improve the vision of Soldiers who have suffered traumatic brain injuries (TBI).

Chung, an optometrist with the rehabilitation and reintegration division in the Office of The Army Surgeon General, said such injuries can cause visual problems including focusing problems, sensitivity to light, double vision, difficulty reading, aching eyes, headaches, loss of visual field, comprehension difficulty, attention and concentration difficulty and memory difficulty.

According to published research, between 10 and 50 percent of TBI patients have visual symptoms, Chung said.

"It may be a functional problem, not just the clarity of letters. It's how the eyes work together and to relay information to the brain," Chung said.

"In mild TBI cases vision problems usually are temporary," he added.

Chung has organized a working group for an initiative he hopes will accomplish four objectives:

* Standardize TBI visual care across the Army.

* Improve providers' knowledge regarding TBI and visual impairments associated with TBI.

* Foster a multidisciplinary approach to vision rehabilitation.

* Provide resources to improve patient care.

"We want to get people looking for vision problems in TBI patients," he said.

The plan includes a standard TBI vision examination, with a template in the electronic health record system; hiring rehabilitation optometrists at large hospitals, possibly with telehealth connections; and creating a standardized vision rehabilitation toolkit for everyone who treats TBI patients.

TBI clinics need to collaborate more closely with vision providers to identify and treat vision problems resulting from TBI, Chung said. He is targeting primary-care providers, optometrists, occupational therapists, physical therapists and speech pathologists with educational information about these injuries.

Education will be provided at conferences and clinical courses. Eventually, Chung would like to see the development of a rehab optometry residency program and to integrate this care into the Patient Centered Medical Home Model that is the new standard for Army clinics.

Funding has been approved to hire rehab optometrists at Fort Bragg, N.C., and Landstuhl Regional Medical Center in Germany. The working group is working with Fort Bragg and Walter Reed Medical Center occupational health and vision specialists to develop a model for other installations. A draft of the toolkit is being reviewed by experts.

"It must be done as soon as possible," Chung commented.

He says the Army also must work with the Department of Veterans Affairs to create a seamless patient care experience both clinically and administratively.

"Soldiers will benefit because their daily visual function will improve. For instance, if they are having difficulty with reading then they will work with eye care providers and rehab providers to increase their reading skills and have an understanding for the basis for their symptoms." Chung concluded.