JOINT TASK FORCE NATIONAL CAPITAL REGION MEDICAL (JTF CAPMED)

The VOICE

456 days to a new era in Military Regional Healthcare

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LEADERSHIP

VADM MATECZUN
Commander

BG JONES
Deputy Commander

Col EDWARD
Chief of Staff

CSM BROCK
Command Senior Enlisted Leader

Military Workforce Notification Guidance

Rhonda M. Baxter, J1

Mission success at the future Walter Reed National Military Medical Center and Fort Belvoir Community Hospital will depend upon the seamless integration of current civilian and military workforces. The initial step of the integration process is to ensure the effective placement and notification of the permanent civilian workforce. Following the release of civilian notifications, the next step will entail a review of projected military workforce placements in preparation for coordinated actions with the Services to stabilize and assign military members.

The focus of the military review is to ensure the continuity of health care operations within the NCR, while supporting Service training and deployment requirements. The Military Workforce Placement Review will provide recommendations for stabilization and other transitional requirements, as appropriate, to support departmental missions within the two future Joint MTFs. The JTF Deputy Commander, JTF Chief of Staff, and Command Senior Enlisted Leader along with Deputy Commanders for Integration and Transition will participate in this essential review.

Beginning in late summer of 2010, JTF CapMed will collaborate with the Components and Services to develop notifications for military members. Working with the respective Component Commanders and Service assignment offices, JTF CapMed will request stabilization and support assignment actions to produce placement notifications for military members.

JTF CapMed is committed to keeping all employees informed about progress during workforce integration. Future developments will be available through newsletters, articles, and the webpage at http://www.jtfcapmed.mil.

JTF to Communicate Reassignment of Beneficiaries

LT Eric Polonsky
Ms. Anneliese Strumpell, J3

With a little over a year away from the much anticipated opening of the Walter Reed National Military Medical Center at Bethesda (WRNMMC) and the Fort Belvoir Community Hospital (FBCH), great work continues between JTF CapMed staff and subject matter experts from TRICARE Regional Office North (TRO-N), Healthnet Federal Services (HNFS), and Military Treatment Facilities (MTFs) of the Joint Operating Area (JOA) to ensure beneficiaries are enrolled to a site that meets health care needs and patient preference.

Beneficiaries affected by potential changes to enrollment will receive communication in Summer 2010. Specifically, those currently enrolled in TRICARE PRIME or TRICARE PLUS at National Naval Medical Center (NNMC) and Walter Reed Army Medical Center (WRAMC) will receive a message announcing a projected enrollment site for the time of integration in Summer/Fall 2011. If the projected enrollment site does not coincide with the beneficiary's preference, a process will be outlined to share feedback that can lead to a change. Families who wish to enroll

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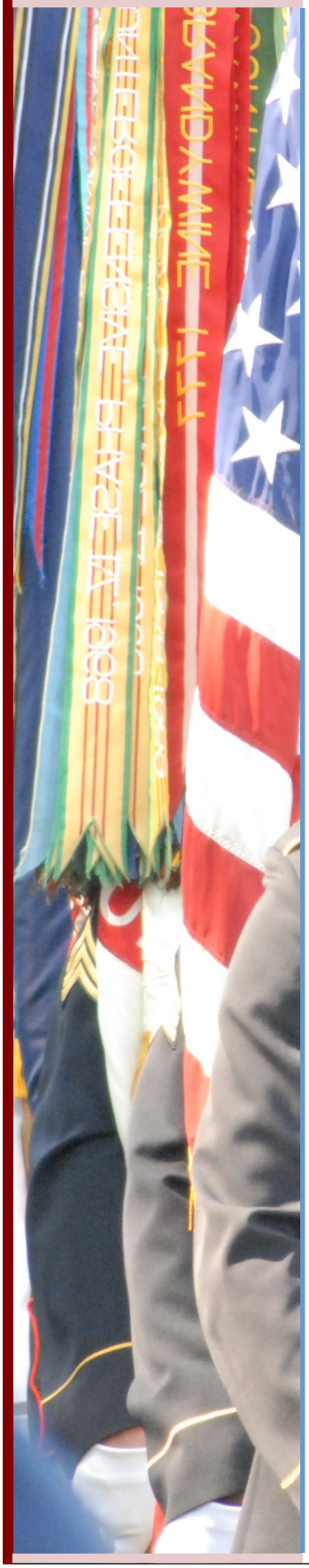

COMMAND SENIOR ENLISTED LEADER'S PERSPECTIVE

'CHANGE is sometimes difficult'

CSM Donna Brock

Official notifications of future job and position assignments for our military and civilian personnel working in the National Capital Region is just around the corner, and to say this is NOT business as usual is an understatement. The success of the future Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH) depends on the seamless integration of our current and future workforce.

So this month, I'm prompted to ask the question – **"How are YOU doing? How do YOU feel? Are you excited about the changes that are going to occur? Are you apprehensive about the upcoming changes/ moves?".....**

We've been watching in amazement and witnessing the massive construction being completed at the two hospital sites: WRNMMC and FBCH. There's a lot of excitement about the 'world class' facilities currently under construction and renovation for our patient population that deserves the absolute best we can give them. We're witnessing history as we establish the **first** two joint military hospitals in the DoD. These are exciting times and we all are a part of it.

However, sometimes we tend to take for granted the feelings and emotional welfare of our staff members. The tendency is to 'assume' that everyone is okay or that everyone will 'be' okay. I want to address the 'human dimension' of this new paradigm we are entering. This is a CHANGE in culture. This is NOT business as usual. We all need to take the very real feelings and anxieties of our staff into perspective. CHANGE is never easy. Sometimes we think that everyone will be on board with change because it's for the benefit of making things better. But not everyone feels that way. We must acknowledge and consider the feelings and emotions of our staff. Acceptance sometimes has a timetable or a clock of its own.

One thing that may help is if you express your feelings, thoughts and opinions out in the open so the people around you can express what they are feeling too. You may hear or see the changes in a different way by listening to others. As leaders, we must be open to discussion and be able to work through whatever the concerns are (or at least understand them).

We care about each and every one of our military and civilian members! If it weren't for our awesome staffs, we could not function in the superb manner that we do. Each and every one of you is a critical and important member of our team. Our soldiers, sailors, airmen, marines, coast-guardsmen, family members, and retirees depend on the caring, professional leadership you bring each and every day.

We need to know and understand your needs. We will do everything in our power to ensure that this transition is as smooth as possible. We know that things will not be perfect and that some of our staff will not be happy with the changes that are coming, but we are committed to do everything we can to work through these issues. I'm confident that you can expect this level of commitment from your leaders.

My Mission: A Response

Lt Col Mary Carlisle, RN, MS, CCRN, CCNS
Chief Nurse, Chief of Education and Training
US Air Force, Malcolm Grow Medical Center

I was pleased to read the article "Don't Be Afraid to Seek Help" by CSM Donna Brock in the May, 2010 JTF CapMed Voice Newsletter. She encourages service members to get help immediately for issues affecting their mental health and encourages leaders to ensure service members get the help they need, and work toward ending the stigma associated with mental health treatment.

I deployed to the Air Force Theater Hospital at Balad Air Base, Iraq in 2007 as the night-shift leader in the intensive care unit. We treated injuries from IEDs, gunshot wounds and burns. This wasn't my first deployment, and I felt confident in my years as a critical care nurse. I didn't think psychological health issues would affect me. I was wrong. This deployment was different because we had so many terrible casualties. I worked nights when the majority of the incidents came in. After I returned home, I thought I was managing my stress, but I became withdrawn. I realized I couldn't win the battle alone, and I reached out for help. Since then, I'm much happier and have advanced in my career.

It's now my mission to encourage my fellow service members to understand that resources are available, they work, and getting treatment doesn't mean the end of a military career. I've volunteered for the Real Warriors Campaign, a public education initiative that's combating the stigma associated with seeking treatment for psychological health concerns and Traumatic Brain Injury. Since volunteering for the campaign and filming my video profile, I've heard from service members worldwide that this campaign, and those who are sharing their stories are making a real difference.

Lt Col Mary Carlisle in the Air Force Theater Hospital, Intensive Care Unit, Balad AB, Iraq, 2007. Photo: Lt Col Carlisle

The message I and my fellow Real Warriors have for service members is this: You are not alone. Everyone experiences some deployment stress, and talking about it helps. Getting necessary treatment does not mean the end of a military career. As CSM Brock states, being mentally healthy ensures we are "One Team."

Real Warriors

Lt. Col Mary Carlisle's video can be found at: http://realwarriors.net/multimedia/profiles/carlisle.php/

"THIS WASN'T MY FIRST DEPLOYMENT, AND I FELT CONFIDENT IN MY YEARS AS A CRITICAL CARE NURSE. I DIDN'T THINK PSYCHOLOGICAL HEALTH ISSUES WOULD AFFECT ME. I WAS WRONG."

Civilian Workforce Transitional Notifications

Rhonda M. Baxter, J1

As directed by the Deputy Secretary of Defense, the new Walter Reed National Military Medical Center (WRNMMC) at Bethesda and the Community Hospital at Ft. Belvoir will be fully operational by September 2011. Employees from Dewitt Army Community Hospital (DACH), National Naval Medical Center (NNMC), and Walter Reed Army Medical Center (WRAMC) will integrate to provide 'World Class' patient care in the two new Joint Hospitals, and the distribution of the civilian initial placement notification letters are only days away.

By June 15, 2010 the permanent civilian employees of DACH, NNMC, and WRAMC will have received their initial placement notice for either the new WRNMMC at Bethesda or the Community Hospital at Ft. Belvoir. Department Transitional Chiefs for each Military Treatment Facility and appropriate supervisory representatives will receive and personally deliver all initial notification letters to permanent civilian employees.

The written notification will identify the employee's organization and location selected during the integration processes according to established business rules. Civilian employees will then have an opportunity to accept the posi-

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6/15/2010

Date Permanent Civilian Employees will Receive their initial placement notification

JILL BOLTE TAYLOR

studied her own stroke as it happened and has become a powerful voice for brain recovery. http://www.ted.com/speakers/jill_bolte_taylor.html

"THE PURPOSE OF THE CONFERENCE IS TO FOSTER INTERAGENCY COORDINATION AND COLLABORATION."

18

The Number of competitors in the Robert Allen Philips Competition.

Task Force Hosts Emergency Management Conference

Louise Cooper, PAO

The task force held an Emergency Management Conference for military and civilian emergency managers, public health emergency officers, and other medical professionals April 29 on the campus of Uniformed Services University for the Health Services, Bethesda, Md. The fourth in a series of emergency management conferences sponsored by JTF CapMed since December 2008, this conference focused on the integrated response to all-hazard incidents within the National Capitol Region by organizations across all levels of government and the private sector. The six speakers, all knowledgeable subject matter experts with several years of experience, covered a range of riveting topics from "It's Always 9-11: Managing Catastrophic Casualty Events," and "Interagency Coordination: The Rest of the Iceberg" to "Community Surge Planning." The audience engaged the speakers with a series of questions that developed into a lively dialogue during the presentations. "The purpose of the conference is to foster interagency coordination and collaboration between emergency managers, public health emergency officers, and other medical professionals from federal, state, and local departments and agencies and private sector healthcare on all hazards that could potentially affect the National Capitol Region," said Bruce Thompson, Deputy Chief, J5 Plans Division, JTF CapMed, and the event organizer.

(left) Charlie Gletchenhaus, International Monetary Fund, Jim Remik, Admiral Security, and George Nunez, George Washington University, Office of Emergency Management, greet members of the audience

Mr. Bruce A. Thompson (right), Deputy Chief, J5 Plans Division, JTF CAPMED welcomes guest speaker (left) CDR Darrell LaRoche, PE, USPHS, Director, Emergency Services, Indian Health Service. Photo: L. Cooper

Winners of 2nd NCR Military Research Competition Receive Robert Allen Philips Award

Dr. Marina Borovok, Head of Research Education, Clinical Investigation Dept, NNMC

The 2nd Joint National Capital Regional Military Research Competition (NCRMRC) was held during research week April 12, 14, 15, and 16 at NNMC, Bethesda. Hosted by the National Naval Medical Center and Walter Reed Army Medical Center, the competition featured the Bailey K Ashford Award in Clinical and Laboratory research and the Robert A Phillips (RAP) Award. *Captain Robert Allan Phillips MD* (1906-1976), distinguished scientist and dedicated physician, is famous for his enormous contribution to the understanding of the mechanism of death in cholera, and the development of a life-saving method of treating it.

As a result of his field studies, Dr. Phillips concluded that the

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chief killing element in cholera is the dehydration of the victim. He devised a method of replacing the body's fluids, salts, and electrolytes to bring the body chemistry back into balance. This life-saving therapy is so simple that it can be successfully administered in the field, even under the most elementary conditions, and even by relatively unskilled personnel. Dr. Phillips's research and leadership are responsible for the reduction in cholera from a death rate of over 60 percent in formerly untreated cases to a death rate of less than 1 percent in cases treated by his method. Dr. Phillips devoted his life to training others, both on an individual and nationwide scale.

The NNMC Oral Competition was held April 16, 2010 in Memorial Auditorium at NNMC and was very special due to the visit of family members of Dr. Phillips, as well as some of his colleagues.

Eighteen researchers competed for the RAP Award. They were introduced by Associate Program Directors. Presentations were evaluated by four judges: RADM Brian P. Monahan, MC, USN, The Attending Physician of the United States Congress and the United States Supreme Court; COL Renata J. M. Engler, MC, USA, the Director of the Vaccine Healthcare Centers Network; COL Kent E. Kester, MC, USA, Commander, Walter Reed Army Institute of Research; and Frederic G. Sanford, Former Executive Director of the Association of Military Surgeons of the United States (AMSUS), RADM, MC, US Navy (Ret).

The NNMC Oral Competition winners were as follows: for the Resident Category there was a tie, and the winners were CPT Frederick O'Brien, MC, USA (Orthopaedic) for "Heterotopic Ossification Formation in Complex Orthopedic Combat Wounds: Quantification and Characterization of Mesenchymal Stem/Progenitor Cell Activity in Traumatized Muscle" and CPT Joshua Mitchell, MC, USA (Internal Medicine) for "Venous Thromboembolism Prophylaxis Rates in Specific Patient Groups Using an Electronic Reminder Designed to Improve Compliance with ACCP Guidelines."

For the Staff/Fellow Category there was a tie again, and the winners were CAPT Brooks Cash, MC, USN (Gastroenterology) for "CTC in a Medicare Population: Implications for National Coverage" and MAJ Julie Ake, MC, USA (Infectious Disease) for "A Potential Source of Gram Negative Multidrug-Resistant Organism Outbreak in U.S. Military Healthcare Facilities: Host Nation Patient Colonization/Infection Is Linked to Environmental Contamination." All four winners will receive a cash award of $750, a RAP plaque, a RAP Coin, and a military award.

The following two individuals moved on to the Navy-Wide Research Competition in Naval Medical Center San Diego, CA for their CIP projects: Resident: CPT Frederick O'Brien, MC, USA CIP Project NNMC.2006.0064 and Staff: CAPT(sel) Brooks Cash, MC, USN CIP Project NNMC.2009.0009
On May 14th of 2010, CPT Frederick O'Brien won the first place award for Approved Clinical Investigation Program (CIP) Research Resident at the 25th annual Academic Research Competition in San Diego.
He is the third resident working with Regenerative Medicine to have won this award in the last four years and is the latest proponent of a collaborative research effort which focuses not only on advancing the care of patients, but fostering the development of future surgical scientists. Under the direct supervision of Dr. Thomas Davis, Dr. O'Brien and his colleagues have isolated progenitor cells from wounded warriors that demonstrate a proclivity for bone formation in those patients that develop heterotopic ossification - growth of bone material in the soft tissues of the body - which causes severe pain to the patient. This key finding may set the way to develop prognostic assays and new therapeutic strategies to treat this difficult disease process. Thanks to everyone who support research!

CAPT FREDERICK O'BRIEN

CDR BROOKS CASH

Beneficiaries

(Continued from page 1)

together will be able to do so. A special webpage is being developed and will be regularly updated to share the latest information on primary care enrollment in the JOA.

All TRICARE PRIME and PLUS beneficiaries will have continued opportunity to enroll within the JOA. Regardless of the primary care enrollment site, each is a "doorway" to the medical and health resources of this system. We aim to help match all our beneficiaries with Primary Care Managers close to where they live with access to specialty care when it is needed.

Public Health Emergencies and Children

Col John S. Murray, J7

How prepared is the United States to assist children during a public health emergency? The nonprofit organization Save the Children reported in June that only seven states—Arkansas, Mary land, Hawaii, New Hampshire, Massachusetts, Alabama, and Vermont—"are meeting crucial minimum standards to ensure that schools and child -care facilities are prepared to respond to the needs of children during a disaster." The terror attacks of September 11, 2001, Hurricane Katrina, and other worldwide calamities such as floods, earthquakes, and tsunamis have made it clear that nurses and other health care providers must be prepared to care for children during public health emergencies. Children are one of the most vulnerable groups during disasters or terrorist attacks, yet most health care facilities don't have pediatric emergency care plans in place, and many schools lack comprehensive procedures. Recent guidelines from the Agency for Healthcare Research and Quality (AHRQ) address the needs of children during these events, emphasizing their vulnerability and supplying health care providers with the tools they need to create emergency care plans designed specifically for this population.

Alison Schaefer, four, plays with her doll in a park near her home in Cape Girardeau, Missouri, on March 27, 2008, 10 days after the area was struck by severe storms and flooding. A child this age is extremely vulnerable during a natural disaster and may be unable to fully comprehend the event.

A VULNERABLE POPULATION

Distinctive physiologic, anatomic, developmental, and psychosocial considerations help to determine a child's vulnerability to injury and response to disasters. Physiologic and anatomic differences put children at greater risk for exposure to biological and chemical agents, and to dust particles from collapsed structures. Their increased respiratory rate means they may inhale larger amounts of potentially lethal toxins. Their small size and subsequent proximity to the ground puts them closer to where deadly gases such as sarin (an extremely toxic chemical weapon used as a lethal nerve gas) and chlorine, which are heavier than oxygen, build up. Children have less connective tissue flexibility and less adipose tissue than adults, and their abdominal organs are closer to the thoracic cavity, factors that place them at greater risk for multi-organ system injury as a result of blasts, flying debris from hurricanes and tornados, or falling rubble from earth quakes. Internal abdominal injuries can go unrecognized in children, with detection occurring only when their health has significantly declined.

Cognitive development plays a critical role in how children respond to a disaster. A toddler who's separated from her or his caretaker during an emergency will be unable to understand what's happening and may respond fearfully by crying, fussing, or becoming irritable. Older children will be better able to understand the implications and complexity of the situation.

Children's psychosocial needs are frequently overlooked during and after a disaster. Treating children appropriately is especially challenging because children can have varied reactions to emergencies. A child's response is contingent on a number of factors, including the type and severity of the disaster, the child's exposure to the event itself and resultant media cover age, the child's personality, and the degree to which parents and other adult caretakers are affected.

CHILDREN ARE ONE OF THE MOST VULNERABLE GROUPS DURING DISASTERS OR TERRORIST ATTACKS, YET MOST HEALTH CARE FACILITIES DON'T HAVE PEDIATRIC EMERGENCY CARE PLANS IN PLACE.

331

Number of people who died during the 2004 school hostage crisis in Beslan, Russia

2,526

Number of families reunited after Hurricane Katrina

20

Number of school systems used to create the detailed guide for creating a comprehensive school emergency response plan

40%

Estimated percentage of child casualties during the December 26th Tsunami in South/Southeast Asia

Moreover, adults may not recognize the intensity of a child's distress in response to a disaster. This may be because the adult assumes the child can handle the situation or because the adults themselves are having difficulty coping. Preschoolers may respond to a disaster by regressing, displaying extreme forms of helplessness, or by developing persistent fears; adolescents, on the other hand, may react by acting out and engaging in risk-taking behaviors.

URGENT NEED FOR PLANNING

The world has experienced several public health emergencies since the attacks of September 11, all of which have significantly affected children. According to the United Nations Children's Fund in the Russian Federation, of the 331 people who died during the 2004 school hostage crisis in Beslan, Russia, 186 were children. Just three months later, the December 26 earthquake and ensuing tsunami that affected South and Southeast Asia killed more than 220,000 people and displaced another 1.5 million; it's estimated that up to 40% of the casualties were children. In the aftermath of Hurricane Katrina, which struck on August 29, 2005, the National Center for Missing and Exploited Children reported that it had reunited 2,526 families who were separated during that public health emergency. Dolan and Krug point out that caring for hospitalized pediatric patients in the New Orleans area—which was difficult because of the extensive damage caused by the storm—was further hindered by inadequate disaster planning that led, for example, to mandatory evacuations of structurally intact hospitals.

A young boy in a life vest is lifted from a rescue boat by a first responder in Kingfisher, Oklahoma, on August 18, 2007, the first day Tropical Storm Erin hit Texas and Oklahoma, causing severe storms, flooding, and tornadoes. The intensity of a child's response to a public health emergency is partly contingent on the child's exposure to the event. Photo by Patrick Brach / FEMA.

Simply modifying disaster-response protocols developed for adults would be ineffective and inappropriate, considering the many physical, developmental, and psychosocial differences between adults and children. Clinicians and researchers have identified a critical need for a framework to improve the care delivered to children during public health emergencies.

SCHOOL- AND HOSPITAL-BASED GUIDELINES

In March, the AHRQ announced the release of two highly anticipated publications aimed at providing guidance on sheltering and caring for children who are attending school or hospitalized during a public health emergency.

School-Based Emergency Preparedness: A National Analysis and Recommended Protocol fills a major gap in disaster preparedness for children by providing a national model for public health preparedness in our schools. Created by researchers at the Center for Biopreparedness, part of the Division of Emergency Medicine at Children's Hospital Boston, this protocol provides an overview of an emergency response plan for school systems. One key feature is a detailed guide to creating a comprehensive school emergency response plan based on the best practices of approximately 20 school systems across the country. The Center for Biopreparedness solicited copies of the emergency response plans used by these systems, analyzed them, and developed a response plan specifically for the Brookline, Massachusetts, school system, which was used as a pilot testing site. School nurses were educated and trained in the principles of school-based emergency preparedness, and an emergency response manual was developed.

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Around the JOA

The Virtual You and a Second Life for Your Records

CAPT Kevin Berry, Special Projects

You can Print your airline boarding pass from home...so why can't the DoD and VA take care of your records electronically?

There you were… getting out of the military, planning for your last military move, excited about the future. You can think of nothing but the important decisions you are making about career, school, your new home, your family's adjustment, and your new life outside the service.

But then you think about the multitude of documents and DoD records you need to make sure you have as you exit. You also begin to consider what new records are being created, especially the new medical records the Veterans Administration is making for you to assure you receive the benefits you are entitled for your service. Do you have the records you need? How many copies will you need?

You are set to go, you are getting your DoD discharge physical and maybe another one at the VA. You also know they will want you to have additional tests – blood work, EKGs and what not. Should you be getting copies of the records and test results? Which ones? All? You have asked for medical record copies before and know it's not easy and not fast. Will you ever get through it?

And then you think about the discharge personnel paperwork. Who at the VA needs what paperwork? At about this point you are thinking your friend is right, you will need multiple copies of every scrap of paper and a rolling-file to haul them around in. It seems he and your father were right, save and copy everything!!

But wait, aren't we a modern society? You can get cash 24/7 at almost any ATM, online bank and even shop online. You can print your airline boarding pass from home as well, so why can't the DoD and VA take care of your records electronically?

Well, the answer is they can, and are! DoD and the VA are going virtual. This change in approach for many has not come soon enough.

On April 9, 2010, President Barack Obama, with Secretaries of Defense Robert Gates and Veterans Affairs GEN (Ret) Eric Shinseki standing at his side announced plans to create the virtual lifetime electronic record – VLER for short. When finished VLER should be the way you, the DoD and the VA move and use your medical, personnel and benefit records.

The president was direct, "When a member of the armed forces separates from the military, he or she will no longer have to walk paperwork from a [Defense Department] duty station to a local VA health center," Obama explained. "Their electronic records will transition along with them and remain with them forever."

Obama heard too many stories from active duty and veterans who found it nearly impossible to get the benefits they earned because of record foul-ups. "Without a comprehensive record plan to streamline the transition of records between the two departments, the president said, "And that results in extraordinary hardship for an awful lot of veterans who end up finding their records lost [or] unable to get their benefits processed in a timely fashion."

On March 9, 2010 the DoD and VA announced its phase 1a VLER community of Hampton Roads, Virginia, where the two departments will prototype and test the exchange of data between DoD and civilian TRICARE providers across the emerging nationwide health information network (NHIN). The phase 1b VLER community, San Diego, California was the prototype for sharing between the VA and Kaiser.

About medical record exchange, Dr. Steve Ondra, the senior policy advisor for the VA, said at the Health IT Day conference held at Bethesda, Maryland, on 6 April 2010, "VLER is not an acquisition program. The VLER is a strategy of standard-based health information exchange."

At the same conference, Norma St. Claire, director of information management at the office of the undersecretary of defense for readiness and personnel said, "We are building the VLER cautiously and in small steps."

One of the many huddles to overcome is positively identifying individuals listed in the many DoD and VA system. Ms. St. Claire said, "We have a problem in making sure that 'Joseph Smith' in this system, and 'Joe Smith' over there, and 'J. Smith' over there, are the same person. We try not to use Social Security

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Children

(*Continued from page 6)*

The result is a compilation of best practices that U.S. school systems can use to develop extensive emergency response plans in their districts. These guidelines are evidence based, but are also informed by lessons learned in the field during public health emergencies. For more information, go to www.ahrq.gov/prep/schoolprep. Pediatric Hospital Surge Capacity in Public Health Emergencies, developed by the Center for Biopreparedness at Children's Hospital Boston and the Department of Emergency Medicine at the University of Massachusetts Medical Center, Worcester, Massachusetts, addresses the special medical needs of children as well as pediatric hospital systems during a mass casualty incident. It responds to the long-standing concerns about hospitals' preparedness to care for large numbers of children during a public health emergency and aims to assist hospital EDs in the development of plans to care for an influx of pediatric mass casualties.

These guidelines include advice on how to expand day-to-day operations in pediatric hospitals from standard operating capacity to a larger "surge capacity" that can handle mass casualties during outbreaks of communicable airborne and food-borne illnesses. They outline how facilities can activate a surge capacity plan, including delineating the role and responsibilities of the ED as well as of all other units and departments within the hospital system. Since a stress-management plan is also recommended for personnel involved in a disaster response, the guidelines address the potential special needs of the health care personnel caring for large numbers of pediatric patients. Stress reactions such as anxiety and difficulty sleeping are common following a disaster. To encourage healthy adjustment and stress reduction among personnel, it's recommended that meetings or debriefings occur soon after the event, and that participants be encouraged to share their feelings about the outbreak or disaster. For more information, go to www.ahrq.gov/prep/pedhospital.

Nurses working with children and families during a public health crisis must have the appropriate tools to care for these vulnerable populations. All nurses should become familiar with the AHRQ guidelines and work with their facilities or employers to incorporate them into practice. These guidelines can also be used to help create emergency response checklists to be used during a disaster. They offer an unprecedented opportunity to improve our schools' and hospitals' emergency preparedness response and to better meet the needs of the pediatric population. *Article reprinted with permission from the American Journal of Nursing: Murray, JS. AJN 2009; 109(12):28-31. All rights reserved.*

Virtual You and a Second Life for Your Records, cont.

(*Continued from page 8)*

numbers too much. We are challenged in identity management." Despite the challenges and the need for a small-step strategy, wounded, ill and injured case managers at Walter Reed and National Naval can't wait for the day records are virtually available on the VLER 'second life' file room of the future.

What does all of this mean for you? Well, it means that DoD, the JTF and the VA are currently working together to develop an electronic health record concept and process that transitions both the current VLER and will work together with the DoD to accurately record and transfer data, making sure that each veterans records are consistent and available to a care provider anywhere the warrior, or veteran goes to receive his care. It will be timely, accurate and available to the provider and the veteran.

VLER and NHIN are new acronyms for most of us but knowing that the VA and DoD are working to make records virtual is a big deal, one that should make the DoD to VA transition for every service member a better experience.

MHS Features JTF

Military Health System Social Media Division views JTF CapMed as a valued source for expert information. Every twelve Podcasts MHS does has JTF CapMed as the featured organization in DoD to support medical related initiatives and topics for the benefit of our beneficiaries.

LTC Rebecca Porter recently talked about mental health resources available in the National Capital Region with MHS. Her interview is located on the MHS DotMil Docs 113 (TRICARE) page at www.health.mil/dotmildocs.

Mr. Bruce Thompson, deputy chief of the J5 Plans Division, discussed emergency preparedness in the National Capital Region at Dot Mil Docs 113. Capt. George McKenna discussed H1N1 influenza and the vaccine to protect you at Dot Mil Docs 74.

Substance Misuse Symposium Future Programs

An air of anticipation could be felt as VADM John Mateczun (Commander, Joint Task Force National Capital Region Medical) provided opening remarks on May 18th, when the JTF CapMed convened its first Substance Misuse Symposium at the Uniformed Services University of the Health Sciences (USUHS). The objective of the two day meeting on May 18th and 19th was to bring together clinicians and substance abuse preventionists in the Joint Operations Area to raise awareness of increasing substance abuse among service members, and how that is related to deployments, PTSD, suicide, and chronic pain management. Additionally, participants learned about the differences among the Services in how their substance abuse and prevention programs are administered. The Symposium enabled participants to network and learn how to collaborate toward implementation of an integrated healthcare delivery system. There were approximately 115 people registered for the Symposium.

BG (Ret) William Bester, Acting President Uniform Services University, speaks with attendees.

The curriculum for the symposium was planned by a committee that included representatives from the Army, Navy, Air Force, and USUHS and the disciplines of psychiatry, psychology, anesthesiology, nursing, and social work. Speakers came from the civilian sector, Department of Defense, Veterans Affairs, Indian Health System, and National Institutes of Health and provided both clinical and policy perspectives on the subject of substance misuse. Participants were excited about the array of presentations, and many asked if the JTF CAPMED is planning a similar symposium for next year. The symposium culminated with closing remarks by BG(R) William Bester, the acting President at USUHS, who said, "This is a topic that touches all of us, personally and professionally." Indeed, indications are that such a symposium would be well received in the future, as we continue to move forward toward an integrated delivery system for military healthcare.

(left) Dr. John Allen and Dr. Michael DeFalco, guest speakers and attendees at the Substance Misuse Symposium.

Civilian Notices

(Continued from page 1)

tion, request a change, or refuse the placement. The response should be noted, signed, and returned to the Civilian Personnel Advisory Center (CPAC) and Human Resources Office (HRO) no later than June 30, 2010. The options and directions will be clearly defined in the initial notification letters. JTF CapMed appreciates the time and efforts of all integration participants from all the Military Treatment Facilities. Through the collaboration of all participants, the initial placements for integrating the workforces from DACH, NNMC, and WRAMC into the two new Joint Hospitals will be a success.

A World-Class region, anchored by a world-Class Medical Center.

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J8 (Resources)……..	301.295.4583

JTF CapMed was established in September of 2007 as a fully functional Standing Joint Task Force reporting directly to the Secretary of Defense through the Deputy Secretary of Defense. The JTF is charged with leading the way for the effective and efficient realignment and enhancement of military healthcare in the NCR.

"A healthcare task force in the NCR capitalizes on the unique multi-Service military healthcare market in the region and provides the DoD with the opportunity to create a system that improves patient care through an integrated delivery system that promises world-class healthcare for beneficiaries. America's Military Health System is a unique partnership of medical educators, researchers, healthcare providers, and their worldwide personnel support." ~VADM Matezcun

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Note from the Editor: Change

Change seems to be the catch-word for this summer as the JTF and our partners move forward on many issues and projects we have been working on. A lot of work has been done with a lot more to go, but what was promised in this round of BRAC is coming close to fruition and a reality for many people.

What does this mean for you, our reader. It may mean many things, it certainly means something different for each of us, but it most certainly means for all of us that we are getting closer building on a long tradition of delivering the best healthcare available in the NCR through the use of new world class facilities.

It all starts with the grand opening ceremony for the National Intrepid Center of Excellence (NICoE) this month. Although the NICoE is a private venture, it is a centerpiece of our future healthcare needs and plan for the future providing the best in research and treatment for traumatic brain injuries (TBI) for our wounded, ill, and injured.

The opening of the NICoE is followed by the completion of buildings A and B on the current NNMC campus with more to follow in the near future. It means the construction of office and clinic space, the ordering of furniture and in 2011, the movement of employees from WRAMC and the installation of equipment to begin delivering health care in two beautifully constructed facilities with a world class staff.

Look for more on the progress being made in future editions of the JTF CapMed newsletter, "The Voice" as we continue striving to deliver the best for wounded, ill, and injured.

Our copy deadline is the 10th of the month. Please remove all copy editing symbols before emailing; also if you are providing photos, please provide captions.

Email your submission to
Craig.Ratcliff@med.navy.mil
louise.cooper@med.navy.mil

Thank you.
The Editor