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Winter 2009

# MEDICAL CORPS EXAMINER

A Newsletter of the United States Air Force Medical Corps

## Step Up and Lead

### Brigadier General (Dr.) Daniel O. Wyman

*Brigadier General (Dr.) Daniel O. Wyman serves as the Commander, 81st Medical Group, Keesler AFB, MS, and is the Medical Corps Chief*

At this year's AF/SG Summit in Leesburg, Lt Gen Green introduced us to the concept of the "**Air Force Medical Home**." This concept focuses on patient-centered care with a foundation of proactive preventive health care and an ultimate goal of continuity throughout all patient care settings. I'm sure we will hear much more about this important concept but as your Medical Corps Chief, I want to focus now on one of the keystones of this system – the "**physician-led team**." I believe that physician leadership is absolutely critical to the success of our AFMS (and quite frankly, key to the success of all federal health care). Let me expound.

I believe that "leadership" is the ability to influence others to make good decisions/do the right thing through mentorship, support, trust and respect. It is not dominance through fear, intimidation, or position. Leadership mandates serving others…subordinates, peers, and superiors…with your talents, attention, guidance, and heart. Thus, a true leader can lead from any position/situation in an organization as a servant leader. And in a patient-centered healthcare system, physicians should be prepared to lead. I am not disparaging the other Corps…we all have worked with many great non-physician leaders, and outstanding healthcare is delivered only via a robust, diverse team. However, our education/our training/our lives are dedicated to patient care…we are uniquely qualified.

So, my challenge to you is "step up and lead!" Lead your team, lead your clinic, lead your flight, lead your squadron, lead your medical group. Lead effective and efficient patient care. Lead smart change and innovation. Lead academic excellence. Lead operational execution. Lead – serve, support, mentor, respect, guide – technicians, coworkers, and superiors!

We particularly need you to step up to the challenges of the two Medical Corps leadership positions at every MTF—Chief of Medical Staff (SGH) and Chief of Aerospace Medicine (SGP). Raise your hand…yes, it will be hard work but the rewards for your patients, your medical staff, and your wing mission are incredible! As the recent Air Force advertisement said, "We've been waiting for you!" You can make a difference…you are uniquely qualified and we have the tools to prepare you for these future challenges…STEP UP!

I stand ready to assist you in any way I can. And I Thank you for your service…to our patients, our Air Force, and our nation!

Respectfully, dw

## INSIDE THIS ISSUE



## SPECIAL POINTS OF INTEREST

# Message from the Medical Corps Director
## Colonel (Dr.) Arnyce R. Pock

Seasons Greetings from Rosslyn, Virginia and warmest congratulations to our newest cadre of Medical Corps Majors, Lieutenant Colonels, Colonels, as well as to those who were recently identified for promotion to Brigadier General (Col Kory Cornum) and Major General (Brig Gen Carol Lee)!

Over the past few months, the majority of the Surgeon General's staff completed its relocation from the Maisey Building on Bolling AFB, DC, to a high rise office complex in Rosslyn, VA. While the move marks the end of one era, it heralds the beginning of another, as our current location is intended to serve as a "swing" space until all three Services have their SG Headquarters co-located in a single location, in the National Capital Region (NCR). It is for this reason that many of our phone numbers and mailing addresses have recently changed, although e-mail addresses have generally remained the same.

The last few months have been exceedingly busy in other ways too, with a flurry of activity taking place in support of our AF Medical Service. First, was the annual AFMS Senior Leadership Conference (Leesburg) that took place towards the end of October. This year's conference focused on "*Building Skills and Currency… Bridging the Gap and Shaping Our Future*," and was designed to serve as a working meeting, addressing many of the challenges facing the AFMS in general and the Medical Corps in particular.

Although there were a number of different work groups taking place simultaneously, Lt Col Janice Langer and I had an opportunity to lead a work group focusing on the topic of Faculty Development. In this regard we were assisted by fellow team members: Col Todd Boleman, Col Randy Zernzach, Lt Col Brian Crownover, Lt Col William (Bo) Hannah, Lt Col Tammy Lindsay, Lt Col Jessica Servey, Lt Col Robert Thaxton, Lt Col (ret) Barb Erickson, and our new SG1M Fellow, Maj Michelle Milner.

A number of key initiatives & recommendations emerged from the Faculty Development work group—among them was a proposal to develop a three tiered, military specific faculty development program. Tier 1, would be a week long, entry level form of faculty development, that would ideally be offered on-site (for example at USU) within the first 90 days of assignment to a full time teaching position. This could later be followed by a more advanced, Tier 2 level faculty development, which would be accomplished in an incremental/part time fashion, over a 6-12 month time period. Lastly, Tier 3 faculty development would be reserved for those individuals who had demonstrated a proven commitment to medical education & training. This would be a 1-2 year full time fellowship opportunity, competitively selected via the Joint Service GME Selection Board process. Full details are currently under development, so more to follow in subsequent issues of this newsletter!

Leesburg was closely followed by the 115th meeting of the Association of Military Surgeons of the United States (AMSUS), which was held in St. Louis, MO. Among the wide range of awards, presentations, and Federal and International panel discussions, was a session chaired by Ms. Ellen Embrey, in her role as Acting Assistant Secretary of Defense for Health Affairs (ASD/HA). Assisted by myself and an Army colleague, Col Cathy Nace, we presented the results of a ASD(HA) chartered work group that was specifically tasked with identifying "out-of-the-box" ideas that might make military medical service more attractive to female health professionals. Although the original impetus focused on means of attracting and retaining more female health professionals in the military, it quickly expanded to focus on health professionals of both genders.

Among some of the suggested proposals were cultivating opportunities for "on" & "off" ramps to military service. It was, for example, readily acknowledged that its fairly easy for a member to "exit" military service (especially once an ADSC is fully served), but it can be a long and difficult process for individuals to return to active duty service. Hence, the need to develop a means for individuals to take short term 'military sabbaticals' when unique personal or family situations arise. Other provisions included a need to extend child care provisions to accommodate the needs of individuals working non-traditional and/or extended hours. Also suggested was the need to more actively explore alternate work schedules and perhaps even cultivate provisions for certain forms of job-sharing! While no decisions were made, the fact that such discussions took place—and were so positively received—heralds a new era for the military "system!"

Shortly after AMSUS, was the annual meeting of the Joint Service Graduate Medical Education Selection Board (JSGMESB). The JSGMESB is traditionally conducted during the first full week of December and is where applications for graduate medical education are reviewed and scored in a competitive, Tri-service forum. As with most other competitive processes, the top scoring individuals are generally matched to the Internship, Residency, and/or Fellowship of their choice. This year we had 540 applicants competing for over 100 different types of sponsored (funded) and deferred (non-funded) training opportunities, ranging from categorical training Internal Medicine, Family Medicine, Pediatrics, Surgery, OB-GYN and Aerospace Medicine, to highly specialized areas such as Ophthalmologic Fellowships in Pediatric Strabismus, Forensic Psychiatry, and Microvascular Plastic Surgery!

Finally, immediately following the JSGMESB, we had our annual CSPAR (Clinical Systems Program Assessment Review) Conference, which is the annual meeting of all of the AF Surgeon General's Consultants. Coordinated by Lt Col Leslie Wilson, this year's meeting addressed a wide range of issues—starting with a series of consultant driven recommendations for the coming years' POM (manning requirements). The conference concluded with a series of multifaceted discussions ranging from a review of the International Health Specialist program which leverages medical education and the delivery of healthcare to enhance global and regional stability, to some of the different ways in which Medical Acupuncture can be effective in ameliorating some of the otherwise refractory pain syndromes experienced by some of our more severely wounded warriors.

All in all, the last few months have been more than busy, but as the many different programs and initiatives reflected in this current newsletter will portray, your entire AFMS leadership team is dedicated to making the AF Medical Service overall, and the AF Medical Corps in particular, stronger and even more resilient than ever before…So, with that in mind, I'll close for now and wish each of you a truly happy, healthy, safe & joyous holiday season.

—A.P.

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**Please include a proposed title for the article and identify complete names and ranks of any individuals within photographs*

## Medical Corps Coins

Show your support for the Medical Corps by purchasing a MC coin. **Coins are now only $8 each (includes shipping).**

Send check or money order to:

**"MC Coin Fund"**
**HQ USAF/SG1M**
**Attn: Maj Christie Barton**
**1500 Wilson Blvd, Ste 1400**
**Arlington, VA 22209**

*New Address!*

# Message from the Editor: Holidays in the White House...Take Two

## Major (Dr.) Christie L. Barton, USAF, BSC

It's my second year to serve in a little known unique extra duty opportunity called the White House Military Social Aide Program. White House Social Aides (WHSAs) support the President and First Lady throughout the year in their roles as official host and hostess of the United States. WHSAs assist the White House Social Secretary in facilitating and executing White House events—anything from bill signings to ceremonies to sports champion receptions to special concerts to Congressional and Governor's Balls...and yes, even the recent State Dinner with the now infamous "party crashers."

*The official 2009 White House Christmas Tree—a 18.5 ft. Douglas Fir from West Virginia*

The holidays are a busy but very special time to serve in the White House. With 27 Christmas trees, 68 wreaths, 2700 yards of ribbon, and 500 stems of dried hydrangea, the interior is a sight to behold. During December, hundreds of pounds of asparagus, gallons of eggnog, and thousands of holiday cookies (some in the shape of Bo, the "First Dog") are among the delectable treats served during 28 open houses, holiday receptions, and dinners.

*The famous "Lansdowne" portrait in the East Room*

The holiday spirit definitely comes alive within the walls and I often imagine how previous First Families and so many other great Americans have cherished their holidays here over the last 209 years. It's awe-inspiring to walk these halls.

This year's White House holiday theme, chosen by the First Lady, is "Reflect, Rejoice, and Renew"—a time to *reflect* on our many blessings, to *rejoice* in the pleasure of spending time with our family and our friends, and to *renew* our commitment to one another and to the causes that we believe in.

Happy holidays from the White House and I sincerely thank you for your service to the nation and to our Air Force! Reflect, rejoice, renew...

## Mark Your Calendar

- **MedXellence Course: 10-15 Jan 10, Honolulu, HI**
  **http://medxellence.usuhs.mil**
- **MHS Conference: 25-28 Jan 10, National Harbor, MD (DC Area)**
  **www.health.mil/mhsconference**
- **MC Developmental Team Meeting: 8-12 Feb 10, Randolph AFB, TX**
  **Don't forget to update your Airmen Development Plan (ADP)!**
- **Intermediate Executive Skills (IES) Course: 26 Apr-01 May 10, San Antonio, TX https://kx.afms.mil/ies**
- **SGH/QSPAR Symposium: 3-7 May 10, San Antonio, TX**

# Medical Corps Deputy Director Update

## Lieutenant Colonel (Dr.) Janice M. Langer

This summer, the Military Health System (MHS) announced a new award to recognize female physician leaders serving in the Armed Forces. We solicited nominations for the *Building Stronger Physician Leaders Award* from across the AFMS with high hopes for a good response from the field—and we were not disappointed! Although the MHS only selected one Colonel from amongst the Services and one mid-level physician (Captain through Lieutenant Colonel) from each of the services, we wanted to share the list of nominees. These are women who were recognized by their MTF leadership, peers, and subordinates as outstanding clinicians and leaders.

***Col Deborah Burgess***—Nephrology; Chief, Medical Modernization Division, HQ AETC, Director, Air Force Medical Modeling and Simulation Program, SG Consultant for Nephrology

***Col Linda Lawrence***—Emergency Medicine; Emergency Medicine Squadron Commander and SG Consultant for Emergency Medicine, Lackland AFB

***Col Margaret Matarese***—Aerospace Medicine/Family Medicine; HQ AETC Command Surgeon, Randolph AFB

***Col Mary Pelszynski***—Pediatrics; Maternal Child Care Squadron Commander and Chair, Pediatric Department of the San Antonio Military Medical Center

***Col Kimberly Slawinski***—Aerospace Medicine/Ophthalmology; Commander, 88th Medical Group, Wright-Patterson AFB

***Lt Col Lidia Ilcus***—Aerospace Medicine/Internal Medicine; Commander, 377th Medical Operations Squadron, Kirtland AFB

***Lt Col Linda Browne***—Internal Medicine; Chief, Internal Medicine Clinic, Aviano AB

***Lt Col Heather Callum***—Pediatrics; Clinical Medicine Flight Commander, Eielson AFB

***Lt Col Cassandra Howard***—Internal Medicine/Pediatrics; Commander, 164th Medical Group, Tennessee ANG

***Lt Col Cheryl Lowry***—Aerospace Medicine/Family Medicine; Chief of Physical Standards Policy Development, HQ USAF/SG

***Lt Col Susan Moran***—Pediatrics; Chief, Clinical Services, HQ PACAF, Hickam AFB

***Lt Col Heather Pickett***—Family Medicine; Family Medicine Residency Flight Commander, Nellis AFB

***Lt Col Rechell Rodriguez***—Internal Medicine; Deputy Clerkship Director, USUHS Internal Medicine Clerkships, Lackland AFB

***Lt Col Valerie Pruitt***—General Surgery/Trauma Surgery/Surgical Critical Care; General Surgery Residency Program Director, Keesler AFB

***Lt Col Stephanie Schaefer***—Dermatology; Staff Dermatologist, SAUSHEC

***Lt Col Pam Smith***—Aerospace Medicine; Commander, 437th Aerospace Medicine Squadron, Charleston AFB

***Lt Col Leigh Swanson***—Aerospace Medicine/Family Medicine; Chief, Aeromedical Services and PRP, HQ AFSPC, Peterson AFB

***Lt Col Carolyn Wild***—Hematology/Oncology; Chief, Hematology/Oncology, Travis AFB

***Lt Col Pam Williams***—Family Medicine; Associate Program Director, Family Medicine Residency, Travis AFB

***Lt Col Catherine Witkop***—Preventive Medicine/Obstetrics and Gynecology; Director, Trainee (Student) Health Program, USAFA

***Maj Nicole Dobson***—Neonatology; Critical Care Director, Craig Joint Theatre Hospital, Bagram AB

***Maj Mary Anne Kiel***—Pediatrics; Primary Care Flight Commander, D.E. Warren AFB

***Maj Colleen McBratney***—Orthopedic Surgery; Chief, Orthopedic Surgery, USAFA

***Maj Jessica McMichael***—Orthopedic Surgery; Chief, Orthopedics Clinic, Osan AB

***Maj Patricia Pankey***—Aerospace Medicine/Family Medicine; Flight Medicine Flight Commander, Hill AFB

***Maj Angela Pansera***—Radiology; Deputy Flight Commander Diagnostic Imaging and Chief of Women's Imaging, Andrews AFB

***Maj Sarah Page***—Obstetrics and Gynecology; Director of Simulation Education in OB/Gyn, SAUSHEC

***Maj Melissa Tyree***—Neonatology; Director Extracorporeal Membrane Oxygenation and Neonatal Critical Care Transport Services, Lackland AFB

***Maj Kirsten Vitrikas***—Family Medicine; Deputy Flight Commander and Assistant Clinical Professor, Scott AFB/St Louis University Family Medicine Residency, Scott AFB

***Capt Tracy Bozung***—Family Medicine; Family Medicine Element Leader, Davis Monthan AFB

Among the outstanding nominees, ***Lt Col Lidia Ilcus*** was selected as the winner in the mid-level AF physician category. She will be honored at the upcoming MHS Conference in Washington, DC in January.

Many thanks to the leaders and peers who expended the energy to make these nominations. We continue to have outstanding physicians in our midst all around the globe. I remain proud to serve with you and am humbled by your dedication to our patients, our Air Force and our country. Wishing you peace this holiday season,—JML

**New Squadron Commanders Announced**—HQ AFPC/DPA and HQ USAF/SG are pleased to announce the following Medical Corps officers selected for squadron commander assignments to fill CY10 vacancies: ***Lt Col Lynn Berry*** (87 AMDS, McGuire AFB), ***Lt Col Teresa Bisnett*** (579 MDOS, Bolling AFB), ***Lt Col David Blocker*** (23 AMDS, Moody AFB), ***Lt Col Naili Chen*** (45 ADOS, Patrick AFB), ***Lt Col (s) Scott Cummis*** (435 AMDS, Dover AFB), ***Lt Col Earl Ferguson*** (59 SSS, Lackland AFB), ***Lt Col Jeffrey Freeland*** (22 AMDS, McConnell AFB), ***Lt Col Duncan Hughes*** (4 AMDS, Seymour Johnson AFB), ***Lt Col Chetan Kharod*** (1 SOAMDS, Hurlburt Field), ***Lt Col Walter Matthews*** (92 AMDS, Fairchild AFB), ***Lt Col Andrew Moore*** (21 ADOS, Peterson AFB), ***Lt Col Mark Nassir*** (31 AMDS, Aviano AB), ***Lt Col Scott Price*** (366 MDOS, Mountain Home AFB), ***Lt Col David Rogers*** (7 AMDS, Dyess AFB), ***Lt Col Melinda Screws*** (8 MDOS, Kunsan AB), ***Lt Col Michael Tall*** (59 RSQ, Lackland AFB), ***Lt Col Anthony Waldroup*** (12 AMDS, Randolph AFB), ***Lt Col Michael Wood*** (15 ADS, Hickam AFB)

# Perspectives from the Medical Force Management Fellow

## Major (Dr.) Michelle R. Milner, Rosslyn, VA

Wow, remember in medical school when you felt like you were trying to sip from a fire hose? Since beginning the Medical Force Management Fellowship, I have experienced a bit of déjà vu. So much to learn, so few hours in the day. Our office, AF/SG1M, is responsible for all aspects of Force Development for the AFMS. We assist with doctrine development, force sculpting and shaping initiatives, AF Graduate Medical Education, recognition programs (e.g.: Medical Service awards), physician pay, and the Medical Corps Development Team (DT) just to name a few areas.

Let me share what I've learned so far. First, keep your Airman Development Plan (ADP) up to date. Your ADP is a way to communicate your vision of your Air Force career to the Medical Corps DT. The DT membership includes your specialty consultant, the medical center SGHs, inpatient and outpatient SGHs, representatives from overseas bases as well as the Medical Corps Chief, Brigadier General Daniel Wyman, and the Medical Corps Director, Colonel Arnyce Pock. Updating your ADP sends your message to some very knowledgeable and influential people.

Second, complete your rank-appropriate Professional Military Education (PME). This can be one of the distinguishing factors when you are being considered for your next assignment or opportunity. I'm studying the Air Command and Staff College curriculum currently! I have already seen the completion of Air War College as a discriminating factor for several exciting assignments in the past few months.

***"...Keep your Airman Development Plan (ADP) up to date. Your ADP is a way to communicate your vision of your Air Force career to the Medical Corps DT."***

Finally, I have learned that there is a job out there for any physician in the Air Force, no matter what you want to do. If you desire to remain clinical your entire career, we can help you do that. If command is your cup of tea, we can help you do that too. Have a knack for teaching? We really want to get you into a program where your skills can be put to good use! Talk with your specialty consultant, complete your ADP, and let the Medical Corps know where you see yourself over the next few years!

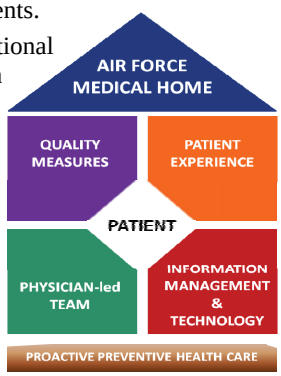
I would like to maximize my efforts this year by ensuring you hear about exciting opportunities when they become available. Please keep your consultants up to date on your desires, complete your ADP, and read anything that has my name on it… correspondence from me is usually regarding an exciting opportunity! Feel free to contact me if you should have any questions: michelle.milner@pentagon.af.mil.

# The Family Health Initiative (FHI) as a Patient Centered Medical Home

## Colonel (Dr.) Andrew W. Tice, AFMSA, Rosslyn, VA

The United States Air Force Medical Service (AFMS), as with the nation, has been buffeted by the crisis in primary care medicine. The Air Force Surgeon General has recognized that there is dissatisfaction with the practice of primary care medicine in the AFMS. The ability to train and retain adequate numbers of primary care providers in the Air Force is becoming an increasing concern as one in four practice positions go unfilled. Exit interviews and ongoing discussion with active practitioners have shown their desire for continuity of care with their patients and to forge an ongoing and continuous relationship with these patients.

AFMS leadership is looking at national efforts at health reform to model changes in the delivery of healthcare to better serve the interests of patients and providers. As the number of primary care providers in active practice and those seeking GME programs in that field decline, these reforms take on real urgency. Nationally, primary care medicine's efforts to address these healthcare delivery concerns have given rise to the patient-centered medical home (PCMH).




The American Academy of Family Practice, along with other primary medical care national organizations, has proposed several principles that define a patient-centered medical home. In a PCMH, patients have an ongoing relationship with a personal physician who directs a team of individuals that has responsibility for the ongoing care of the patient. That personal physician is responsible for all the patient's healthcare needs across all stages of life or arranges care with other qualified healthcare professionals. Care is coordinated across all elements of the healthcare system and continued through to the patient's community. Facilitation of this care is ensured by registries, information technology, and health information exchange so that patients get indicated care when and where they need and want it.

Quality and safety are emphasized throughout the PCMH with practices that advocate for the attainment of optimal patient-centered outcomes. These outcomes are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family. Physicians in the medical home accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. Such a practice would pursue a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model. These practices strive toward evidence-based medicine and use clinical deci-

*Continued on page 6*

# The Family Health Initiative *(continued from page 5)*

sion-support tools to guide decision making.

Patients enrolled in these practices actively participate in decision-making and feedback is sought to ensure patients' expectations are being met. Information technology is leveraged to attain optimal patient care, performance measurement, patient education, and enhanced communication. The utilization of 21st century communication tools will facilitate patient care and should improve access to care as has been seen with Geisinger Health Systems. In sum, patient-centeredness expresses the philosophy that the needs of the patient come first, "nothing about me without me," and every patient is the only patient.

The AFMS has chosen to move toward the PCMH and dubbed that program the Family Health Initiative (FHI). This program seeks to create an enjoyable and productive practice environment that promotes and delivers quality, evidence-based care with a focus on prevention. The FHI should encourage retention of current staff and facilitate recruiting military and civilian providers by providing consistent support staff as well as a reasonable patient panel size to enable the practice of quality medicine with adequate access to care

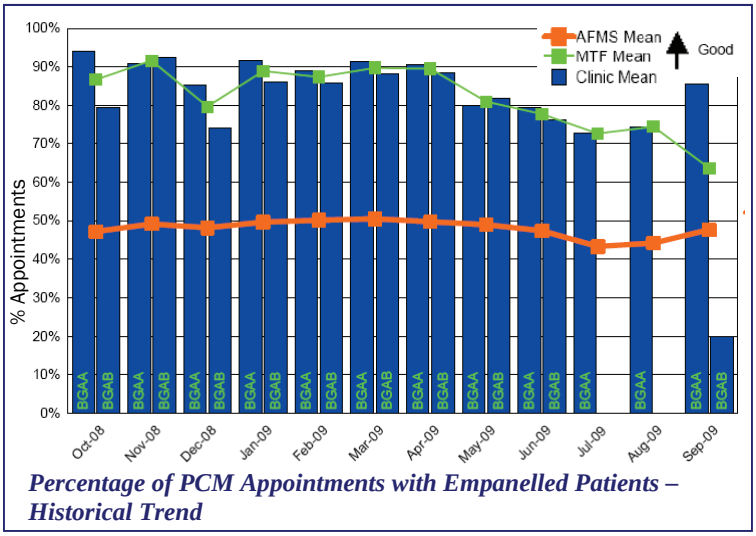
This initiative represents a major commitment of resources to ensure the success of the program. The FHI "Team" will consist of a board certified physician and another provider, most likely a physician assistant, but possibly a family nurse practitioner, general medical officer, or even another board certified family physician, supported by four technicians and a registered nurse. Disease management of the team's patient population will be the responsibility of a second nurse specifically trained in that aspect of medical management. The Team enrollment will be limited to 2500 patients to allow adequate population health interventions and assure necessary access to care. Additionally, facilities will be encouraged to balance the acuity of teams to ensure access and workload is balanced.. Access to care is enhanced by ensuring a minimum number of appointments are retained for the population assigned to the Team. These appointments will be centrally managed to reduce the Team nurse's administrative burden and will be available 30 days out for patients assigned to the Team.

***"This [Family Health Initiative] program seeks to create an enjoyable and productive practice environment that promotes and delivers quality, evidence-based care with a focus on prevention."***

From the start of this initiative, it was obvious that measures of success were necessary and would have to be tailored toward the desired outcomes of the project. In that light, metrics were designed to capture data regarding continuity, productivity, quality, and satisfaction. Metrics were obtained both on an individual provider level and at the military treatment facility (MTF) level. Continuity measurements were designed to show how often patients see their assigned provider and conversely how often providers see patients assigned to them. Technician continuity is also assessed by measuring the availability of the same technician(s) is in the clinic with his/her assigned provider. Productivity is measured by assessing a base of 250 RVUs per provider per month and the availability of the 90 centrally booked appointments per provider per week.

Patient satisfaction with the Family Health Team will be assessed with telephonic survey post-visit. A satisfaction survey of the staff is ongoing to capture pre and post implementation data. Healthcare Effectiveness Data and Information Set (HEDIS) measurements will be employed to capture quality of the care provided in this initiative. Providers will not be held to HEDIS standards for patients that may be enrolled but not seen in the facility.

A representative metric for FHI continuity is shown below:




***Percentage of PCM Appointments with Empanelled Patients – Historical Trend***

AFMS leadership feels that the FHI incorporates key components of the PCMH in that it focuses on building relationships between patients and providers based on continuity of care and ease of access. The Family Health Team is a true team that strives for participatory patient care with continuity at all levels. It is anticipated that by using the evidence based outcome measures and clinical decision support tools embedded in the DoD electronic medical record, quality and safety will be enhanced. The measures of success created will confirm our belief in the validity of the initiative or conversely create opportunities for change as the process matures.

As this effort moves forward several challenges have been identified and work is progressing to work through these. Specifically, two way secure communication between patient and provider remains problematic as the needs of military communication security can conflict with the ability to access secure patient-provider e-mail. AFMS leadership is fully aware that promises for staffing are easy to make and hard to ensure. The commitment to make this initiative a success remains firm and resources are pledged to assure that end.

For additional information and the latest briefings on the FHI, see https://kx.afms.mil/fhi.

# *In Memoriam*

The Air Force mourns the loss of two Air Force physicians.

**Lieutenant Colonel (Dr.) Thomas (T.J.) McBride** passed away on 25 October 2009. He was born in El Paso, Texas on 10 September 1955. He entered the Navy as an enlisted corpsman in 1978 and separated in 1989. He then completed his medical degree from the Loma Linda University School of Medicine and was commissioned into the Air Force in 1994. His first assignment was as a Family Practice resident at David Grant Medical Center, Travis AFB, CA. Upon completing the residency in July 1997, Dr. McBride began serving as Chief of Family Practice at Grand Forks AFB, ND. In 1999 he moved to Osan AFB, Korea where he served as the Medical Director of Emergency Services. His next assignment was in 2000 to Lakenheath, UK as a Staff Physician of Emergency Services. He returned to the states in 2003 as a Staff Physician in Emergency Services then Family Practice at MacDill AFB, FL. In 2006, he became the Chief of the Medical Staff at Offutt AFB, NE. He is survived by his wife, Deborah and three children, Katelyn, Nicholas and Christopher.

**Lieutenant Colonel (Dr.) H. Robert Prager** passed away on 17 June 2009. He was born and raised in upstate New York and earned his Bachelor of Science degree at Cornell University. He attended Chicago Medical School, graduating in 1994 with honors. Following a year of internal medicine training at the Mayo Clinic in Rochester, Minnesota, Dr. Prager completed a four-year residency in obstetrics and gynecology, also at Mayo, in 1999. His first assignment was in OB/Gyn services at Luke AFB, AZ. He went on to become medical director and eventually element chief in that department. Dr. Prager's interest in operational medicine grew after an F-16 incentive flight and when the obstetrical department at Luke AFB closed in 2001, he earned his flight surgeon's wings and continued his career at Luke as Medical Director of the 56th Aerospace Medicine Squadron. He moved to Ramstein AB, Germany in 2003, where he served as the theater validating flight surgeon. From there, he moved to Nellis AFB, NV and served as a flight surgeon. Dr. Prager is survived by his wife, Lisa, daughter, Rebecca, and son, Joseph.

# STARS-P Program Unveiled

## Colonel (Dr.) Dan R. Hansen, Director, AFMESI

In the fall edition of the Medical Corps Examiner, I discussed C-STARS, a program supported by Air Force Expeditionary Medical Skills Institute (AFEMSI), as one means to sharpen clinical skills. Each of the three C-STARS programs includes an episodic, several-week clinical immersion at civilian Level I trauma centers located either in Baltimore, Cincinnati, or Saint Louis. Within the last month, a fourth C-STARS platform, specific to Critical Care Air Transport Training, has been established at Wilford Hall Medical Center. All sites provide just-in-time training. Skills learned at C-STARS are difficult to maintain long term without ongoing clinical exposure to high-acuity patients. The vast majority of Air Force medical facilities lack this patient population.

To gain access to high-acuity trauma and intensive care unit patients, multiple Air Force medical facilities have developed, or are in the process of developing, alliances with local Level I civilian trauma hospitals. Deployable providers, nurses and technicians who may be assigned to critical care or trauma-associated teams will care for patients at the civilian trauma hospitals no less than two days per month or one week every three months. Participation must be regular and consistent throughout the year except if on leave, deployed or TDY.

The goal of the STARS-P (**S**ustainment of **T**rauma **a**nd **R**esuscitation **S**kills **P**rogram) is to provide the same training and experiences as C-STARS. Some of the training will be computer-based, covering topics with nuances unique to deployment medicine such as that found in burn management and blood transfusions. In cases where rotations do not meet specific requirements, simulators are used to fill the gaps.

Current sites approved for STARS-P implementation are: Luke AFB, Nellis AFB, Wright-Patterson AFB and Travis AFB. San Antonio Military Medical Center personnel are also approved for STARS-P participation but their program differs in one key respect - participants rotate within their own facility. A physician whose practice is primarily outpatient would rotate through the ICU or ER.

***"STARS-P is an excellent opportunity to maintain skills needed for current and future contingency operations and clinical practice."***

Check out AFEMSI's STARS-P website on the Knowledge Exchange at https://kx.afms.mil/starsp. You can find additional information on the program, the goals for training, and tracking forms for training.

STARS-P is an excellent opportunity to maintain skills needed for current and future contingency operations and clinical practice. The consistent, on-going trauma and resuscitation training tied to STARS-P ensures we are ready when just-in-time training is not feasible.

AFEMSI staff will be happy to help you address questions on either C-STARS or STARS-P. Our phone number is (210) 536-2383 or DSN 240-2383.

# DGMC's SimCenter Hosts Joint Conference

## Captain (Dr.) Bradley Williams, Travis AFB, CA

The 60th Medical Group's Simulation Center hosted a combined conference on team strategies and tools to enhance performance, patient safety, and simulation in healthcare on 21-25 Sept 09 at the David Grant Medical Center (DGMC), Travis AFB, CA. Participants were trained to become TeamSTEPPS instructors, and the conference included a simulation session demonstrating how TeamSTEPPS concepts could be applied to various clinical scenarios.

Colonel Deborah Burgess, Air Education Training Command's chief of medical modernization, presented the Air Force Medical Service's vision for simulation training. Clinical simulation can be used for readiness skills verification currency training, graduate medical education programs, and patient safety improvements for clinical team training. The 1999 Institute for Medicine's report, *"To Err Is Human"* recommended that clinical simulation efforts be used to train clinical staff in skills, communication and teamwork necessary to improve patient safety.

Army Colonel Peter Napolitano, a maternal fetal medicine physician at Madigan Army Medical Center, presented in-theatre clinical benefits from investing in training staff to follow TeamSTEPPS principles. Representatives from METI™ and Laerdal™, manufacturers of high-fidelity mannequins, demonstrated their products' capabilities and functions.

The 60th Medical Group's SimCenter staff described infrastructure and policy necessary to provide the multidisciplinary clinical simulations needed to train TeamSTEPPS principles, such a forming a simulation advisory committee, tracking participant performance, and reporting simulation center strategic objectives to the hospital executive committee.

DGMC's Patient Safety staff explained how simulation can be used to address incident reports. Simulation staff taught how to design clinical scenarios and gave participants a chance to write and run their own clinical scenarios.

"At first, the surgical staff was resistant to training," explained Col Napolitano. "That was until they discovered how the use of TeamSTEPPS principles dramatically strengthened and focused the phone calls they received from surgical ward nurses."

***Participants engage in clinical simulation as part of TeamSTEPPS training at the Stimulation Center at David Grant Medical Center, Travis AFB, CA***

The DGMC program has been accredited to award American Medical Association Category 1 Continuing Medical Education for conducting TeamSTEPPS clinical simulation training and has found that the team scenario debrief is where the majority of learning transpires. Conference participants had the opportunity to conduct the team pre-briefs and debriefs utilizing video of their clinical team performance.

After experiencing the training as both a participant and an observer, participants expressed a strong appreciation for the benefit of team training.

"DGMC looks forward to hosting similar events in the future," said Lt Col (Dr.) Christopher G. Scharenbrock, 60 MDG Chief of Medical Staff. "DGMC has been selected as an Air Force simulation 'Center of Excellence' and a TRICARE Management Agency Team Learning Resource Center for TeamSTEPPS. We're honored to have those designations."

For more information, contact Capt Bradley Williams at 707-423-3078.

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8-11 Sep 09

Szia (hello) from Hungary! I recently had the opportunity to attend and present at the 17th Annual American-Hungarian Defense Forces Military Medical Conference held in Budapest, Hungary from 8-11 Sept 2009. I discussed how to initially assess and treat the critically injured pediatric patient. I also distributed my pediatric trauma reference materials...medication calculators, pediatric equipment sizing references, vital signs references, and trauma mnemonic [as printed in the Fall 2009 Medical Corps Examiner https://kx.afms.mil/kxweb/dotmil/file/web/ctb_124200.pdf to the Hungarian Defense Forces for use at home and at their base in Afghanistan. "We fight together, we cure together," said Hungarian physician, Dr. Zsuza Szilágyi, in the opinion of whom there is always a need for development and exchange of views. Viszontlátásra!


Group photo in front of St Anthony's church in Budapest Hungary


DANIEL B. BRUZZINI
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Center for Sustainment of Trauma & Readiness Skills (C-STARS) Director, Pediatric Intensive & Emergency Medicine, St. Louis, MO

# Gotta Have HARRT!

## Colonel (Dr.) Wayne M. Pritt, Command Surgeon, 13 AF

Two events galvanized the resolve in the US Air Force to focus on medical Humanitarian Assistance/Disaster Response (HA/DR) and the formation of the Humanitarian Assistance Rapid Response Team (HARRT). The first event on 26 December 2004 was a 9.3 magnitude earthquake off the coast of Sumatra (Indonesia) which drove a devastating tsunami creating up to 100 foot waves and resulting in 230,000 people killed in 11 countries. The second event on 8 October 2005 was the Kashmir earthquake in remote northern Pakistan which left 80,000 dead and 8 million people directly affected.

Common to both events was that the Air Force's desire to send medical aid was greatly hampered by failure to have a plausible, executable medical capability with integrated base operating support (BOS). The EMEDS construct, though revolutionary and still in front of sister service efforts to be light, lean, and transportable, has an "Achilles heel" in that it was designed to lay into an airbase on top of already existing BOS. It is completely dependent on this support for power, water, food, billeting, and command, control, and communication. Last minute, late-to-need, crisis planning in an attempt to cobble together these BOS requirements to support an EMEDS based disaster response is inefficient and dramatically impedes execution of the mission. Our tepid ability to respond medically to these two disasters highlighted this problem.

In response, on 12 December 2006, then Chief of Staff of the Air Force, Gen T. Michael Mosely, issued the Humanitarian Relief Operations Operational Capabilities Package (HUMRO-OCP) letter directly to the COCOMs. The letter described a new stand alone capability based on an EMEDS+25 with integrated BOS focused on disaster and humanitarian response. Now the Air Force had a package designed and poised for execution that was crafted specifically for medical HA/DR.

On the leading edge of this initiative, 13 AF was the first (and currently only) to test this capability in an exercise. In January 2008, Pacific Lifeline (PLL) pulled together an EMEDS +25 from Elmendorf AFB, combined with the Contingency Response Group (CRG) from Andersen AB and a Base Expeditionary Airfield Resources (BEAR) package from Kadena AB to put through the paces this idea of medics with required BOS being the "pointy end of the spear" in regards to a contingency. The exercise proved that you could indeed field a self-supporting medical capability focused on HA/DR and supported by BOS. By all measures, PLL and the HUMRO-OCP concept was a success.

But successful concepts can always be, and in fact should be improved. A review highlighted a few shortcomings. First, execution of the HUMRO-OCP in PACOM relied on incorporating units from vastly geographically separated bases. This scattering of resources would complicate and slow the logistics. A means needed to be found to co-locate the people and equipment. Second, the HUMRO-OCP was a behemoth. A full eleven C-17s were required to airlift its 345 short tons, 225 people, and all its components. The sheer size of this package, the airlifting costs, and the logistics of finding eleven available C-17s made it extremely doubtful that a COCOM would ever execute this package short of presidential mandate. A viable way forward demanded a package with a smaller airlift requirement. Third, to enable rapid deployment, the concept would require establishment of a pre-developed, formalized force package to include a canned Time Phased Force Deployment Data.

Work began immediately on these points of improvement. The target was defined as creating a package that provided the smallest possible credible medical ensemble with required BOS and C3 that conformed to key assumptions and goals, which included: (1) all must fit on 2 C-17s (with alternate C-130 plan) (2) wheels up within 24 hours of EXORD (3) 5 days unresupplied (4) through put of 350 patients/day (12 hr day), 500 patients/day surge (18 hr day) (5) establish medical Full Operational Capability (FOC) within 6 hours of site arrival.

*Right: The first HARRT patient is examined in the South Pacific island state of Chuuk; Left: A deworming operation commences*

Through the planning, the criticism, and the fire of command review, the HARRT came into being as a CRG led expeditionary force with a modified EMEDS Basic at its core. This led to the selection of the in-garrison location of the HARRT to be Andersen AFB, the home of PACAF's CRG. The modifications to the EMEDS were predominantly on the personnel side with heavy emphasis on primary care physicians and IDMT extenders (8 total providers). Cross functionality was also a basic tenant and drove the designation of the EMEDS commander as a physician. Total medical personnel on the HARRT were trimmed to 23. Equipment modifications to the standard EMEDS table of allowances keyed on the defined five day period of engagement and simplicity to drive a "thinning" of equipment items from the standard set. Also built into the plan were optional augmentation packages to provide pediatric, obstetrics and surgical capability as dictated by the specifics of the disaster. The CRG brought to the plan 31 personnel with expertise in communications, fork lift operations, finance and contracting, security forces, aircraft off load operations, and mission command. The total number of HARRT personnel, without optional packages was designated as just 54:

| Total Pax | C-17 Chalk 1 | C-17 Chalk 2 |
|---|---|---|
| ***23 Medical*** | 23 Med Pax | 0 Med Pax |
| ***31 BOS*** | 25 BOS Pax | 6 BOS Pax |
| ***54 Total Pax*** | 48 Total Pax | 6 BOS Pax |

With the concept, construct, and plan developed, the next step was to execute an Operational Utility Evaluation (OUE)—basically a dry run of the concept. The OUE was conducted exactly like a deployment with complete marshalling of the pallets and processing of personnel. A two day exercise complete with mock patients capped the event. Building on the lessons learned and experience of the OUE, the next event was the Validation Exercise (ValEx) on the South Pacific island state of Chuuk (may be more familiar to you by its old name Truk).

During the ValEx we deployed the HARRT as a full-up round via two C-17s with the intent of using a humanitarian medical

*(Continued on page 10)*

# Gotta Have HARRT! *(continued from page 9)*

mission as a surrogate for an actual disaster. The first day involved getting the docs and IDMTs accustomed to the practice and pace of humanitarian operations as well as ironing out the flow of patients through the facility. A mass deworming event also commenced in order to mimic a population immunization event. This activity was notable in that it exemplified the principles of augmenting the local medical community, as well as working with Non-Governmental Organizations, in this case the Chuuk Women's Council, who organized and ran the deworming with IDMT support. In all, 894 Chuukese people were aided by the HARRT on day one alone.

On day two the wheels came off of the carefully structured plan and the resiliency, adaptability, and resolve of the HARRT deployers was tested when rain returned with a vengeance. The downpour continued throughout the day and despite efforts to pump, divert and drain the standing water, by 1400, the HARRT EMEDS was awash in 10 to 12 inches of water.

Despite this horrendous set of circumstances, by utilizing the billeting tents as an alternate medical facility medical care continued through to the end of the day. That night, the rain stopped and the next morning dawned bright and sunny. By 0800, the EMEDS was up and running again. By the end of the week, the HARRT had proven that it could deploy to an austere location and provide needed medical care despite harsh and inhospitable local conditions. In total, between the deworming and the primary care, the HARRT in Chuuk provided direct care to over 4000 people. Analysis of the deployment confirmed that the HARRT was a viable concept and ready to deploy to meet disaster challenges in the Pacific.

The HARRT members wouldn't have long to rest on their laurels. Just 22 days after redeploying from Chuuk, Indonesia suffered a 7.6 magnitude earthquake. The HARRT got the nod from PACOM to deploy to provide medical disaster relief. Compounding the response were the concurrent disasters in the Philippines caused by a recent typhoon, the US FEMA response to a tsunami in American Samoa, and an additional typhoon bearing down on Guam. Given that an earthquake was the cause of this disaster response, the surgical option for the HARRT was exercised. Once in country, the HARRT experienced its first big hurdle of the mission: the site selected for the HARRT was over 14 miles from the airport. The Defense Attaches Office of the US Embassy had stated that they could provide vehicles for that ground transport leg. True to their word, they arrived at the airport with a series of pickup truck sized vehicles–totally unsuitable for the movement of palletized cargo. Realizing there was no time to lose in getting the HARRT up and running, the mission commander decided to unpack and hand-load all the equipment and supplies onto the available transportation; speed and adaptability are the keys to HA/DR success! Ten hours later, the HARRT opened its doors. Co-located with the Djmal Hospital which had lost its outpatient facility, the HARRT plugged in as the hospital's outpatient clinic.

Impressed with the speed of execution of the effort, the U.S. Deputy Charge de Affairs in Indonesia remarked, "The people in the U.S. are very dedicated in helping the Indonesians as soon as possible in response to the terrible earthquake."

***HARRT team members treat earthquake victims in Indonesia***

Over the next eight days, HARRT members worked 14-16 hour days providing care to an average of 243 patients daily, performing 36 minor surgical and orthopedic procedures, and filling almost 3,600 prescriptions. HARRT surgeons also assisted Indonesian surgeons allowing the exhausted local physicians some rest and respite.

While the medics cared for the ill, the CRG members ensured the facility ran flawlessly and managed the patient waiting area adjacent to the facility, taking time to hand out candy and engaging the children with games to keep them occupied. The mix of patients in the beginning revealed about 65 to 70 percent injuries directly related to the earthquake. Over the week, this proportion of quake injuries decreased to about 15-20 percent on the last day of operations. It's important, however, to realize that while injury and illness directly related to the earthquake rapidly trailed off, the HARRT provided a vital service for the stricken community as one of the few fully functioning outpatient medical facilities.

Rear Adm. Richard Landolt, the Joint Task Force Commander for the overall Indonesian response, put it this way, "HARRT helps bring psychological normalcy to the people here. Knowing they have care, an island of stability is replaced." The Indonesian political leaders and medical community were extremely grateful for the assistance and the treatment provided for 1,945 citizens of Padang. The HARRT ceased operations on 14 October and redeployed.

Lessons learned and opportunities for improvement from the deployments to both Chuuk and Indonesia are being evaluated in a focused effort to further refine the concept, manning, and equipment used with the HARRT. The ongoing collaborative efforts between Air Combat Command (the MAJCOM responsible for ground medical ensembles) and 13 AF will evaluate tents that are faster to assemble, better containers to ship, store and secure medical supplies, and blister-pac packaging of high volume medications for speed of distribution. These initiatives and others will continue to improve the HARRT concept of rapid, capable medical disaster relief. HARRT is a perfect example of the cutting edge applicability of our Air Force to the mission execution requirements of the Department of Defense and the United States of America. It's been immensely gratifying to have been involved with this extremely important project.

***The HARRT team sets up shop in Indonesia following an earthquake***

# A Physician's Experience in the International Health Program

## Major (Dr.) Welsey D. Palmer, US Africa Command

I have been asked to write an article describing what it is like for a Medical Corps officer to be an International Health Specialists (IHS). There are many MC officers who are serving as International Health Specialists, and each likely will have a different experience than mine. What I would like to share in this forum is my story, and why I think it is important for MC officers to be part of this program.

I am often asked, what does it take to be an "IHSer"? There is a formal process to be awarded a Special Experience Identifier (SEI) to one's AFSC. However, the most important attribute is the ability and capability to interface with foreign national counterparts in a culturally sensitive manner. Basically, anyone can be an IHSer if they can quickly adapt to environments that are often unfamiliar or foreign and work with their counterparts to improve and enhance health care. Foreign language skills are exceptionally helpful but not always required.

My background is that I am a Family Physician, who is also trained in Flight Medicine. Any specialty can be an IHSer, but it helps to have a strong knowledge of/or interest in public and community health. So why should a doctor, highly trained in clinical and operational medicine, move out of the clinic into the global health roles that IHSers play?

First, poor health infrastructure in the world is a national security issue. The crucial role of human security can be seen in the following quote from National Defense Strategy:

> *"In collaboration with interagency and international partners we will assist vulnerable states and local populations as they seek to ameliorate the conditions that foster extremism and dismantle the structures that support and allow extremist groups to grow.....The best way to achieve security is to prevent war when possible and encourage peaceful change within the international system. Our strategy emphasizes building the capacities of a broad spectrum of partners as the basis for long-term security." – 2008 National Defense Strategy*

It is impossible for a society to fully achieve stability and security if the population is ravaged by disease and the lack of health.[1] The US military has worked with civilian and military counterparts for many years in small health related programs. Historically, these were in the form of Medical Civic Action Projects (MEDCAPS), where US personnel went into an area and delivered care to a needy population. However, though it may seem that this direct delivery of care is a good thing by providing a standard of medical care to those who wouldn't otherwise have it, and winning the 'hearts and minds' of the population; the unintended consequences are that local care providers can be discredited, the local care delivery system is disrupted, and the services provided are not sustained after US personnel leave, resulting in a medical vacuum.

The challenge presented then, is how to create programs and efforts that demonstrate U.S. goodwill, while simultaneously increasing host-nation medical capacity in a sustainable manner? The International Health Specialist is uniquely suited to identify, create, and implement such health engagement initiatives.

I attained my IHS Special Experience Identifier while I was assigned at the MTF level. I utilized my IHS skills on a Joint POW/MIA Accounting Command (JPAC) deployment to Laos, and later as a flight surgeon assigned to the 36th Contingency Response Group (CRG) in Guam. While assigned at the tactical level with the CRG, I participated in both the tsunami relief and Philippine mudslide relief both in planning and response roles.

During the Philippine mudslide relief, we called upon the full time PACAF IHS team to augment the response and provide civil-military coordination in regards to the health aspects of the relief effort. During the actual mudslide disaster, an entire village was engulfed in mud and about 1500 people instantly perished. Only a handful of people miraculously survived. One of those survivors was a 17 year-old girl, who suffered a complete laceration of the facial nerve, leaving the left side of her face completely paralyzed. The IHS member, Col John Cinco, utilized his knowledge and skills of the Philippine medical community and the military medical community and mobilized a true international civil-military effort to ensure this girl received the referral care she needed.[2] I became involved as the attending physician in her transport from the disaster area to Manila. The Armed Forces of the Philippines provided the en-route transportation, and the Philippine Red Cross provided for her hospital and follow-up care in Manilla in conjunction with the Philippine Ministry of Health. I am happy to say that the young victim of this tragedy was able to regain motor function of her face following neurosurgery, and will graduate from the University next spring!


ຫົວໜ້າກົມເສນາທິການຕ້ອນຮັບ
ຄະນະວິຊາການແພດທະຫານອເມລິກາ

ໃນຕອນແລງວັນທີ 6 ເມ ... ສາ 2009 ນີ້, ... ກົມເສນາທິການໃຫຍ່ພະລາທິ ... ກົມພົວພັນຕ່າງປະເທດກະຊວງ ... ການກອງທັບໄດ້ໃຫ້ກຽດຕ້ອນ ... ປ້ອງກັນປະເທດ, ທ່ານ ພັນເອກ ... ຮັບການ (ອ່ານຕໍ່ໜ້າ 7)

***Newspaper clipping from 7 April 2009, Kongthap Pasaxon Lao, Daily Newspaper, describing that the Ministry of National Defense Surgeon, Col (Dr.) Bountheun Bandavong met with Maj Wesley Palmer, 13th AF IHS***

Following my assignment in Guam, I was fortunate to become a full time member of the Pacific IHS team, now part of the 13th AF SG's office. At this level, we worked to develop and implement health engagement programs that met the Theater Security Cooperation objectives of the Combatant Command (COCOM), which was the US Pacific Command (US PACOM), and also of our MAJCOM, Pacific Air Forces (PACAF).

During my tenure with the 13th AF IHS team, we worked hard to develop programs that met the goals of transforming military health engagement into improving capacity in a sustainable manner. My duties were delineated both geographically and functionally. My profile geographically included part of South East Asia and functionally included aeromedical programs, along with primary care and public/community health.

Some of the programs I was involved with included developing a medical disaster response capability for 13th AF (now called the Humanitarian Assistance Rapid Response Team (HARRT), pan-

*(Continued on page 12)*

# International Health Program *(continued from page 11)*

demic preparedness with foreign nation's militaries and health departments, emergency medical response and disaster preparedness with foreign counterparts, and building partnership capacity in aerospace medicine and aeromedical evacuation.

In particular, I am very proud of the work we have done in Laos, in furthering US-Lao military to military cooperation through health engagement. Health engagement was one of the first bilateral initiatives welcomed by the Lao military after many years of minimal exchanges with U.S. DoD. Currently, we are working with the Lao Military Medical Department and the Lao Ministry of Health to enhance the disease surveillance capability within the Lao Military Medical department. We have teamed up with the Armed Forces Health Research Center (AFHRC)/DoD GEIS; the Army's Armed Forces Research Institute of Medical Sciences (AFRIMS) in Bangkok, Thailand; and the Lao National Emerging Infectious Diseases Coordinating Office (NEIDCO) to develop this capacity with the Lao Military Medical Department. The program is designed to be a 4-5 year project that develops influenza surveillance, along with other emerging infectious diseases surveillance, out to the provincial and district levels. Thus, health authorities are provided actionable information earlier in the course of an outbreak.

I recently moved to the Combatant Command (COCOM) level of IHS team at US Africa Command. The role I will have at the COCOM is to develop health engagement strategy and policy for the region to which I am assigned. In collaboration with other U.S. Government agencies, the COCOM will develop a 'whole of government' approach to enhancing stability and security within Africa. Health is certainly a key dimension to achieving human security on the African continent.

In all of these levels, tactical, operational, and strategic, it has been essential that an IHS MC officer engage with counterparts in other countries. As a member of the Medical Corps, a high level of credibility and trust is often afforded, even at the earliest of encounters. In addition, the knowledge that a MC officer brings to shaping and designing health engagement is crucial to ensuring viability and success of programs.

If you have an interest in IHS, please consider applying for the SEI. If you know of someone who would make a great candidate, please let them know about this unique program within the AFMS. For more information on the IHS program, please go to the IHS website at: https://kx.afms.mil/afihs or contact the IHS regional team for the COCOM with which you have a specialty or interest. You can also contact me at DSN 314-421-4629 or wesley.palmer@africom.mil. Lt Col Mylene Huynh, Director, Air Force International Health Specialist Program (AFMSA/SGXI) is also available to answer questions at DSN 425-7129 or mylene.huyhn@pentagon.af.mil.

1. For more information on the role of health and security please see the following articles: IOM (Institute of Medicine). 2009. *The U.S. Commitment to Global Health: Recommendations for the New Administration.* Washington, DC: The National Academies Press. And Bonventre, Eugene V. , Hicks, Kathleen H. , Okutani, Stacy M. 2009. **U**.S. National Security and Global Health An Analysis of Global Health Engagement by the U.S. Department of Defense A Report of the CSIS Global Health Policy Center—Working Draft

2. For more information on the Philippine mud slide relief and IHS involvement see: http://www.stripes.com/article.asp?section=104&article=36005

# Yoga Nidra (iRest): A "New Twist" on Treatment for Post Traumatic Stress Disorder (Part I)

## Major (Dr.) Nisha Money, AFHSC/GEIS

How does having mental armor or "mental fitness gear" to treat and possibly prevent PTSD sound? As members of the Armed Forces, we're very aware of the paramount importance of physical fitness in meeting the needs and duties of accomplishing the mission. In a similar fashion, psychological hardiness is the armamentarium that empowers our US military service member to optimize human performance and cope with psychological trauma. How would it be if we could cultivate the emotional and mental dexterity to access a full spectrum of internal resources to activate optimum health and well-being?

An estimated 300,000 US service members have returned from the OEF/ OIF wars with PTSD (Rand, 2008). PTSD is more prevalent in military personnel than in the general population, particularly in war veterans. More than 17% of soldiers returning from the wars in Iraq and Afghanistan suffer from PTSD, and nearly 40% report stress-related symptoms and dysfunction that significantly prevent reintegration into a full and productive life. Within this population, only 13-27% reported having received mental health care in the past year. Additionally, there is a growing concern over the increasing number of suicides, homicides, divorces, and homelessness associated with military service, which may appear long after the conclusion of active duty service. The service members with the greatest distress and PTSD symptoms at the time of return from the war zone reported mistrust of mental health professionals, concerns about being stigmatized, and doubts about the effectiveness of mental health treatments. The prevalence of PTSD and other trauma-linked disorders increases significantly throughout the first post deployment year. Efficacious, evidence-based early interventions are available, but many military personnel are reluctant to access services provided in specialty mental health care settings.

Current standards of care for PTSD include psychotherapies and pharmacotherapy (e.g. cognitive behavioral therapy, exposure therapy, selective serotonin reuptake inhibitors, etc). Studies show that these conventional therapies may not be maximally effective in addressing the full complexity and overlapping comorbidities. The most prevalent diagnoses associated with PTSD include mood disorders (e.g., depression and anxiety), pain, drug/ opiod desensitization (with abuse potential), and somatic (sleep, appetite, sexual, and energy) dysfunction. The data highlights a lack of non-stigmatizing, evidence-based early interventions for military personnel and veterans with PTSD. There is a pressing need for efficacious, self-management for recently returned OIF/ OEF veterans who do not have access, refuse, delay, lack confidence or feel stigmatized with standard treatments.

*(Continued on page 13)*

# Yoga Nidra (iRest) *(continued from page 12)*

The Defense Centers of Excellence (DCoE) has seen a growing interest and demand for effective, innovative Complementary and Alternative Medicine (CAM) treatments. CAM modalities include natural products, dietary supplements, chiropractic manipulation, massage, guided imagery, and mind-body practices, such as yoga and meditation. Yoga Nidra is one such CAM modality that has been found to be particularly effective amongst military personnel. In 2006, The Department of Defense Deployment Health Clinical Center (DHCC) conducted a feasibility study, funded by Samuelli Institute, on the use of Yoga Nidra, as an adjunctive therapy to treat symptoms of PTSD in soldiers returning from battle. On the basis of these initial findings, DHCC has, for over 3 years, successfully incorporated the modality into the Specialized Care Program, a multi-disciplinary treatment program for active duty soldiers with PTSD and Medically Unexplained Physical Symptom.

***Yoga participants practice the Savasana (corpse) asana (pose)***

Having recently served as the Chief of Fitness Policy at HQ USAF, my duties entailed developing regulations and instructions on keeping our forces physically fit. The position increased my awareness about the importance of overall physical and mental fitness, which includes promoting and instilling wellness across the many dimensions of health. This mind-body connection explains why psychological resilience can motivate and sustain physical fitness and enhance performance in challenging environments. With an interest in using an integrative approach to fitness, I was impressed with the potential benefits of Yoga Nidra for our service members. A team of us from DHCC, the Uniformed Services University of Health Sciences (USUHS) Preventive Medicine Department, the Integrative Restoration Center, and Samueli Institute created a protocol to further study the effectiveness of Yoga Nidra as an adjunctive therapy for PTSD. The Yoga Nidra protocol has been tailored specifically for a military setting and is now re-contextualized as Integrative Restoration (iRest).

**WHAT IS YOGA?**

*Yoga* is a set of principles, which for thousands of years, have shown to foster a clear mind and healthy body. Experts are quick to point out that yoga is not a religion, but rather a system of practices to assist people in leading more purposeful, healthy, and fulfilling lives. On the physical level, yoga postures, called *asanas*, are designed to tone, strengthen, and align the body. On the mental level, yoga uses breathing techniques and meditation to quiet, clarify, and discipline the mind in developing psychological resiliency and proficiency when presented with challenging life events. Given the wide variety of personality and body types, many types and forms of Yoga exist.

**WHAT IS YOGA NIDRA (aka Integrative Restoration (iRest))?**

The iRest military program, based on the ancient practice of Yoga Nidra, is designed to systematically reduce physical, emotional, mental, and even subconscious tension that characterizes PTSD. Participants are taught to manage disturbing moods and memories with a skill set that enables them to objectively respond to intense emotional experiences through conscious choices rather than unconscious reactions. The simple techniques can also be used in all aspects of daily life to feel more mentally and emotionally balanced when encountering difficult situations. A sense of emotional mastery is developed. These techniques are presumed to cause a relaxation response through a multi-faceted approach of psycho-physiological mechanisms to activate the parasympathetic nervous system and innate healing capacities of the mind-body complex.

The protocol is a synthesis of modern psychology and ancient yogic wisdom. It teaches progressive relaxation, breathing, stress reduction, cognitive and meditation techniques aimed at raising awareness and healing various aspects of the mental, emotional, and physical relationship. Its approach is non-dogmatic and secular, which does not conflict with personal religious beliefs. Regular practice enables participants to activate their potential to live more fully aware, accepting and welcoming of each moment and situation they encounter. This in turn strengthens participants' abilities to respond rather than react to life's changing and challenging circumstances. Supportive evidence shows the intervention leads to transformative and sustainable psychological changes.

**WHAT IS THE iRest PROTOCOL?**

The iRest protocol is composed of 10- steps, which can be used in their entirety or in segments. Once the knowledge and skills are acquired through participation in group classes, it is practiced independently using a self-practice CD. An emotional bank account is cultivated, to withdraw from, when a sense of safety, comfort and control is needed in daily life. The objective is to restore a sense of wholeness.

The series of techniques include body scanning, cognitive and emotional restructuring, visual imagery, deep breathing, systematic desensitization, reciprocal inhibition and habituation. The protocol consists of a series of 25-45 minute sessions where participants are:

1. Guided through a meditation sequence that releases negative body sensations, emotions, thoughts, images and beliefs.

2. Taught non-resistance training techniques to experience, welcome, and accept changing phenomena of emotional states, in order to relinquish the extremes of seeking pleasure and resistance to discomfort.

3. Trained to develop an internal locus of control, in order to modulate and control their responses to internal triggers

4. Empowered, through a foundation of psychological hardiness, with a skill set to cultivate the ability to release the grip of internal conflicts secondary to anxiety, fear, mental or emotional suffering.

***Editor's Note: This is the first of a two part series on Yoga Nidra and the iRest program. Part two will continue to discuss the iRest protocol, how it is being used in the military, and the future of the program. In the interim, those who seek further information on iRest programs or are interested in incorporating iRest protocols or research into their facilities or treatment centers may find further details at www.irest.us or may contact Maj Nisha Money directly at nisha.money@us.army.mil.***

# The Summer Experience of H1N1 at the USAF Academy

## Colonel (Dr.) Kenneth K. Knight, USAFA, CO

***Editor's Note: Colonel (Dr.) Kenneth Knight serves as the Commander, 10 MDG, and is the USAFA/SG***

If you read nothing else, here are the key takeaways from our experience:

1 – Disease first and foremost impacts daily life—get your line leadership involved, and do it early!
2 – It is a team approach – utilize all the tools available to you.
3 - Think beyond the here and now – What can you do now that would help others?

By now, everyone has been faced with what to do to respond to H1N1 at your location. What I want to do is to bring you back in time, back to July 2009, and get you to think of "What would I do?" July 2009 was not too long after initial reports from Mexico showed thousands infected and hundreds dying from H1N1. The vaccine was not available and the general public was still quite wary about H1N1. Is it deadly? Do I need to wear a mask? Should I send my kids to school? These and many more questions were out there.

Our scenario: Over 1500 new cadets arrived to the US Air Force Academy on 25 June 09 for basic training. They came from all over the world and were medically screened during in-processing day as well as prior to arrival. So we had a typical military population, 17-21 year-old, healthy, male and female cadets. For the first ten days, we had no unusual amount or presentation of illnesses or injuries. Then, on 6 July, we saw a spike of almost 40 cadets presenting with influenza- like illness, up from less than 10 every other day. We saw another 30 the following day.

Let me pause here. What would you do? What would be the questions running through your mind? What are you most concerned about? The characterization of H1N1 being typically mild had not been established as we were the one of the initial locations to document that fact.

*USAF Academy cadets from the Class of 2013 and their cadet cadre instructors march to Jacks Valley as part of Cadet Basic Training (U.S. Air Force photo/Dave Ahlschwede)*

**1 – Disease first and foremost impacts daily life—get your line leadership involved, and do it early!**

The non-medical issues: the TRUE test of leadership. If ever you think/have thought that the Disease Containment Plan is mostly medical, read The Great Influenza by John M Barry. As every base is unique, I had the distinct uniqueness of having each of my 4,500 enrolled population (the cadets) with a direct link to their congressman (all cadets must have a nomination by their congressman, Vice President, or President to enter) as well as having many direct links to AF senior leaders (aka, parents who are called "General" or "Doctor" or "Nurse"). In addition, my line leadership, just as yours, has to balance what mission can continue and what should be curtailed. Just a few of the questions they had to answer: What can a cadet miss during basic training and still meet the requirements? Where should we house the ill cadets? Do we continue with "Doolie Day Out" where off-base sponsor families host cadets for a day? What information do we need to get out and how?

The key: our job is risk characterization. The line needs to make the Operational Risk Management decisions and they rely on us to provide them with the medical aspect of the risk. For President Woodrow Wilson, the decision he faced was how to balance the risk of spreading the 1917 flu with the political imperative to support World War I.

**2 — It is a team approach–utilize all the tools available to you.**

The issues relating to the pure medical aspect were numerous, but in general, not too cosmic or difficult to figure out. Adaptive planning, just like the DoD uses, is critical. Starting off with a solid Disease Containment Plan and Medical Contingency Response Plan allowed us to have a starting point for discussion. We then formed the right team to come together to develop the guidance/plan for what we were going to do. This team included representatives from the line as many of our recommendations directly impacted them. As time went on, flexibility was huge… just as with all decision models, the team adapted its composition and the guidance as new information came in. This iterative process of acquiring new information and adjusting our guidance/actions occurred several times throughout the day, depending upon the amount and significance of the information.

One final point: don't do it "solo"… solo as an individual or a MDG. We relied heavily upon the Centers for Disease Control and Air Staff as we were in contact with them daily. In addition, we had the epidemiological team from the School of Aerospace Medicine as well as two AF SG experts come to our location to help in addressing our outbreak.

So how did we do? I think pretty well. Within a week, the outbreak was well contained and the mission went on.

**3 — Think beyond the here and now—what can you do now that would help others?**

As the senior leaders, thinking strategically and looking forward is our job. In our scenario, we were answering several questions: who else could benefit from what is happening here? Our answer: the local health department, other DoD entities nearby, other service Academies, other training bases, and Air Staff. What could we do to help to advance our medical knowledge? We had the ability and resources to collect viral shedding data over time… this helped characterize the period of contagiousness. In addition, we had patients cough/sneeze on a counter surface and collected samples to help characterize the viability of the virus on inanimate objects.

All in all, our experience was quite exciting and exhausting, but very rewarding. This will truly be one of those "once in a lifetime" experiences that we will be able to tell stories about for the rest of our lives… so, don't hesitate to ask us about it!

# Much Has Changed, Much Hasn't in the Kingdom of Saudi Arabia

## Lieutenant Colonel (Dr.) Daniel B. Bruzzini, C-STARS, St. Louis

***Editor's Note: Lt Col (Dr.) Dan Bruzzini is the Director of Pediatric Intensive & Emergency Medicine at the Center for Sustainment of Trauma and Readiness Skills (C-STARS), St. Louis University Health Sciences Center.***

Much has changed and much hasn't in the Kingdom of Saudi Arabia since I was a flight surgeon for the U-2, Dragonlady, in Taif, the EF-111, Raven, in Dhahran, and the F-16, Viper, in al-Kharj. These Operation Southern Watch aircraft have left for the boneyard and/or have continued service in Iraq and Afghanistan. There are new flight surgeons and new aircraft and unmanned aerial vehicles helping to carry the torch of freedom these days.

When I left the Kingdom of the two holiest mosques (Makkah and Medinah) in 1998 to pursue pediatric training at Wright-Patterson AFB, the Saudi medical system was in transition and the average inflation adjusted price for a barrel of oil was $15.77. The Saudi Arabian government decided to rely less upon third country nationals to provide their medical care, and increased funding to train talented Saudi citizenry in Britain, Canada, and the United States. Saudi Arabian Ministries of Health, Education, and Defense were all involved in improving the "people power" of their independent and often collocated medical systems. .

With three of my colleagues from the Society of Critical Care Medicine, I recently returned to the Kingdom of Saudi Arabia to teach pediatric critical care at King Saud University and King Khalid University Hospital. We were welcomed to the Kingdom with the traditional Arabian coffee and dates. I made sure to have an odd number of cups (three to be exact) in keeping with the Islamic cultural preference for odd numbers based upon their belief of only being one (an odd number) God. Soles of the feet down, no use of the left hand, no shaking of a lady's hand unless she offers first, no O.K. signs, gesturing with all my fingers not just with one, were mannerisms I recalled from the past, but my Arabic was very weak.

Fortunately, on the plane over, I sat next to a talkative Saudi gentleman. He took me on as a student and taught me key Arabic words and phrases over the next twelve hours at 37,000 feet. He imparted to me a respectable repertoire of Arabic but mildly imprinted with a Jeddah (Western province) accent. My rudimentary Arabic was appreciated by our Saudi hosts but not absolutely necessary. English is the lingua franca spoken amongst medical personnel. Coming from a family of fast speakers, with lots of information to convey in a short time, I was able to speak at full speed and not worry at all about audience English comprehension…kind of like Saudi speed limits being that of one's automobile limits instead of the numbers posted on speed limit signs.

Speaking of numbers, the four of us trained 100 physicians and nurses predominantly in the fields of pediatric intensive, pediatric cardiology, and pediatric emergency medicine. We mentored twelve new instructors so as to promote future self-sufficiency and continued training throughout the country and then throughout the Gulf region. We also conducted Pediatric Intensive Care Unit (PICU) Site Visits at six of the seven pediatric ICU's in Riyadh, offering advice on equipment purchases, simulation purchases, placement, and training program implementation, as well as in-patient consultation on challenging patient cases.

The Saudi's are confronting similar challenges as we face in terms of medical care delivery, maintenance of skills, quality improvement, and transitioning to a new PICU. We were glad to exchange ideas with an interactive dialogue on how would you solve a certain problem and why. I was impressed by the diversity of their staff and how they used ideas from all over the world to formulate their medical practice and administration. With no predominant training center for their medical and nursing staff, the perils of program in-breeding are assiduously avoided. With similar training backgrounds, concerns, and goals, we interacted not as Americans and Saudis but as colleagues soliciting and offering each other advice for our mutual benefit.

*Lt Col Daniel Bruzzini (2nd row, 4th from the right), with team members and pediatric critical care course attendees in Riyadh, Kingdom of Saudi Arabia*

No 7,500 mile trip would be complete without the evening cultural exchange program. Our Saudi hosts were extremely gracious and amply proved their assertion of the Kingdom of the two holiest mosques is also the Kingdom of Hospitality —from only pouring a little Arabian coffee into our cups, so as to allow them more opportunities to fill it, to ensuring the welfare of our lone female instructor. Our hosts made sure to include her as much as custom and circumstances would allow and were very solicitous to her needs.

Great food and cultural exchange occurred over many glasses of Saudi champagne—apple juice, seltzer water, and mint. Comingled stories of their time in the States or Canada, our experience in Riyadh, discussion of loosening the prohibition against women driving, eating habits, current events, medical developments, course debriefs, and laughter all merged and competed with each other resulting in many fabulous nights, but very late bedtimes. Serious moments were had in discussing the global economy, role of oil, the Islamic Republic of Iran, medical misadventures, transition to electronic medical records, and end of life care decisions for those who follow the five pillars of Islam.

All in all, much has changed, and much hasn't in the Kingdom of Saudi Arabia. Wait a minute! Just maybe, what has most changed is the eyes of the person viewing it after the intervening years—Captain to Lieutenant Colonel, flight surgeon to neonatologist, husband to father, twenty-something to forty-something. I am just grateful to have helped play my small role in passing along pediatric critical care information to those similarly dedicated to improving the lives of critically ill children. For me, this was ample compensation for the mandatory hard work and long nights. However, in doing so, I was additionally rewarded with a great cultural exchange and new friends thereby proving (Im'shallah – God willing) sometimes a good deed does go unpunished. Shukran Jazillan! -- Thank you very much!

# Headlines from the 13th AF Internat'l Health Specialist (IHS) Team

## *Colonel (Dr.) Craig Castillo, Hickam AFB, HI*

**LT COL JOHN WAITE IN THE PHILIPPINES—**Lt Col John Waite (13 AF) led the medical portion of a multi-national, inter-agency humanitarian assistance/disaster response exercise in the Republic of Philippines (RP) from 1-15 May 09. The Indonesian military deployed a field hospital and multiple ASEAN and Asian countries provided medical providers and assistance in conducting large scale MEDCAPS at two locations in and around C. Luzon, RP. Multiple thousands of patients were cared for and increased multilateral exposure in humanitarian and disaster response was gained.

**PACIFIC ANGEL INDONESIA/TIMOR LESTE A HUGE SUCCESS —** 13th AF conducted joint/combined PACIFIC ANGEL Humanitarian Assistance missions concurrently in both Indonesia (Kupang, West Timor) and East Timor (Dili and the island of Atauro) from 15-20 July. PACIFIC ANGEL 09-02 was a PACOM funded mission where the Alaskan National Guard provided airlift for the humanitarian operation with a KC-135 and C-130 humanitarian assistance (HA) airlift operation. The HA team consisted of host nation, Active Duty, Guard and Reserve members who provided primary care, optometry, and dental services at multiple sites as well as conducted a casualty evacuation SMEE and several public health-related civil engineering projects. The team treated 6,451 patients in Indonesia and 4,093 patients in East Timor.

**PACOM CO-HOSTS NURSING SYMPOSIUM IN HANOI, VIETNAM—**The U. S. Pacific Command and the Vietnam People's Army co-hosted more than 200 Army, Navy and Air Force senior leaders and nurses/medics from Australia, Cambodia, People's Republic of China, India, Indonesia, Japan, the Republic of Korea, Laos, Malaysia, the Philippines, Singapore, Thailand, the United States, and Vietnam during the third annual Asia-Pacific Military Nursing Symposium (APMNS) in Hanoi, Vietnam from 3-7 August 09. Maj Chung Lee (13 AF/IHS) was one of the primary organizers of the event. The theme for the symposium was "Promoting Global Military Nursing Cooperation." The APMNS provides a forum for nurses and medical technicians to exchange knowledge, share latest information on nursing advancement and capitalize on the prospect for increased collaboration and cooperation on military nursing issues.

Brigadier General Catherine Lutz stated, "The symposium fostered an informative, as well as collaborative, environment to share and acquire knowledge from our international colleagues. Although culturally we have many differences, we realize we have much in common. It provided an opportunity to showcase advances in nursing and promote global military nursing cooperation."

**PACIFIC ANGEL VIETNAM KEY IN THAWING OF US-VIETNAMESE RELATIONS—**After a 25 year absence, the US military returned to Quang Tri Province in Central Vietnam. From 15-25 September 09, 13 AF led a 26 person medical team in conducting a PACIFIC ANGEL humanitarian assistance mission in Cam Thuy commune, 15 km south of the old DMZ that separated north from south Vietnam. Over the span of the mission, the team saw over 5,000 patients.

***Maj (Dr.) Joanne Balintona examines a patient with a congenital nevus during PACIFIC ANGEL Vietnam. The patient asked if Dr. Balintona thought she was beautiful, to which Dr. Balintona replied with an emphatic, "Yes!" She continued, "I will remember you not because of your 'birthmark' but because of your wonderful smile."***

13 AF teamed with two NGOs in order to extend the scope of services and also to provide a long-term medical relationship with this community. East Meets West Foundation, an in-country NGO, provided dental equipment and Vietnamese personnel allowing for a comprehensive dental services from cleanings, extraction to restoration. 13 AF also partnered with Project HOPE to establish a comprehensive women's health clinic. Bringing expertise and material to compliment the 13 AF team, Project HOPE will use this mission as a starting point for a long-term capacity building relationship with the Cam Thuy clinic. The success of the mission in building relationships with the Vietnamese has been impressive. 13 AF was the first US military mission to be allowed to wear uniforms in the conduct of the event since 1975. The Vietnamese also asked 13 AF to return in 2010 to conduct another PACIFC ANGEL.

**Congratulations to the following individuals who were recently selected as a GME Program Director or Director of Medical Education (DME):**

**San Antonio Uniformed Services Health Education Consortium**
***Col Woodson Scott Jones***, Director of Medical Education
***Lt Col Dale Ahrendt***, Adolescent Medicine Fellowship
***Lt Col Michael Tankersley***, Allergy/Immunology
***Lt Col David Bush***, Clinical Research Fellowship
***Lt Col Erika Struble***, Hematology Oncology Fellowship
***Lt Col Warren Kadrmas***, Orthopedics Residency
***Lt Col Vinod Gidvani-Diaz***, Pediatric Residency
***Lt Col Paul Sherman,*** Radiology Residency

**David Grant Medical Center**
***Major John Baron***, Transitional Year Residency

**National Capital Consortium**
***Lt Col John Fischer***, Obstetrics & Gynecology Residency Program
***Lt Col Jay Kerecman***, Neonatology Fellowship

**Wright Patterson/Wright State**
***Lt Col Erik Nelson***, Director of Medical Education
***Lt Col Jeffrey Weiser,*** Psychiatry
***Major Richard Dagrosa***, Emergency Medicine

**Madigan Army Medical Center**
***Lt Col Christine Erdie Lalena***, Developmental and Behavioral Pediatric Fellowship

# Defense Institute for Medical Operations (DIMO) News

## DIMO Takes Trauma Training to Tajikistan

### Captain (Dr.) Heather Hancock, Lackland AFB, TX

DIMO, a unit of the U.S. Air Force School of Aerospace Medicine (USAFSAM) currently based at Brooks City-Base, San Antonio, TX, presented medical professionals in the Central Asian country of Tajikistan a training course focused on regional trauma and disaster response in August 2009. The course was presented in conjunction with a U. S. Central Command (CENTCOM) large regional exercise in Tajikistan entitled "REGIONAL COOPERATION 2009."

The DIMO team, led by Lt Col W. Tracey Jones, presented DIMO's *"Leadership Course in Regional Disaster Response and Trauma Systems Management"* to 26 senior-level physicians representing Kyrgyzstan, Kazakhstan, and Tajikistan. Among the senior participants was Colonel Mirzomiddin, the chief of all Tajikistan military physicians.

***DIMO members participating in the training mission in Tajikistan included (from left): Lt Col Barry Thomas, Capt Heather Hancock, Mr. Nusratullo Salimov, Tajikistan Minister of Health, Capt Francis Obuseh, and Lt Col W. Tracey Jones***

The trauma and disaster course included presentations covering initial principles for the approach to the trauma patient, environmental health impact and management after natural disasters, public health and preventive medicine in disasters, introduction to disaster planning, and setting up a regional trauma system, to name a few. Break-out groups, designed to allow trainees to practice application of newly-learned skills, garnered wide approval from the participants. Russian translators facilitated the exchange of information. Class sessions often extended after hours when informal question-and-answer sessions provided an opportunity for trainees to share their experiences.

In the post-Soviet era of civil war, the health care system of Tajikistan had deteriorated with the loss of many Russian doctors. Insufficient funding left the country and the areas around it at high risk for natural disasters and disease outbreaks. With recent political stability in Tajikistan and increased wages for health care workers, the current Ministry of Defense has renewed focus on rebuilding the health care infrastructure—reinforcing the fact that this DIMO course could not have been provided at a more opportune time.

In keeping with the spirit of cooperation, the governments of Kyrgyzstan and Kazakhstan agreed to move towards a regional health care program. Many individuals expressed an enlightened opinion of their fellow physicians and of their American instructors as well, and all three nations articulated a desire that this course be offered in their country. A Kazakhstani representative was specifically tasked to incorporate the knowledge learned at the course into an immediate plan for enhancement of his region's trauma/disaster response capabilities.

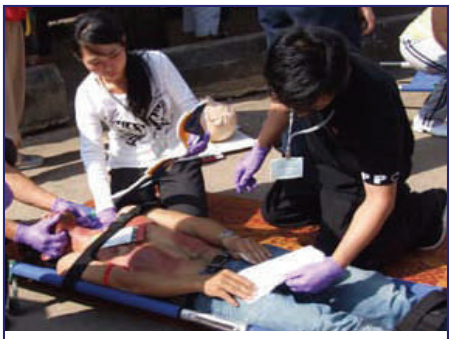
The importance of Central Asia within the current world climate cannot be overstated. Through medical information-sharing missions such as those DIMO provides, the U.S. seeks to establish strong and long-lasting bonds that are constructive for everyone involved.

DIMO, established in 2002, utilizes volunteer instructors from a vast pool of U.S. Government organizations including, but not limited to, the Department of Defense, the Federal Emergency Management Agency, and the U. S. Public Health Service. DIMO instructional teams help partner nations improve their medical capabilities and build healthcare capacity. Courses range from basic first responder training to health systems management.

## Mass Casualty Response Course in Laos a Success

### Major Kimberly Reed, Chief of Clinical Operations, DIMO

The Defense Institute for Medical Operations (DIMO) traveled to Vientiane, Laos with a five-member AF medical team from San Antonio, Texas, to conduct a *"Mass Casualty Response for Primary Care Providers"* course from 26-30 October 2009. This was in preparation for the South East Asian (SEA) Games to be held in December 2009 when 11 countries will participate in 28 various sporting events. A joint effort by the US Embassy, US Pacific Air Forces International Health Services, and DIMO, this training will contribute to the preparedness of the Lao Ministry of Health and Vientiane civilian and military hospitals in advance of the SEA games.



***Lao primary care providers participate in a mass casualty exercise in Vientiane, Laos***

The five-day course was attended by 25 Lao military and civilian physicians and nurses. Topics included patient assessment, resuscitation, management of musculoskeletal trauma, traumatic brain injury, thoracic and abdominal trauma, as well as, trauma in the pregnant patient. Day 4 training covered topics on mass casualty response such as command and control, triage, treatment teams, supplies, and safety. The course concluded on day 5 with an all encompassing mass casualty exercise, with a simulated tour bus crashing into a restaurant creating more than 20 casualties. The exercise required all course participants to implement the skills and training learned throughout the week.

If you are interested in our courses or would like to be an instructor, please visit our website at https://ks.afms.mil/dimo or http://airforcemedicine.afms.mil/dimo, or email us at brooks.dimo@brooks.af.mil.

# Special Experience Identifiers Awarded

The ME and MF Special Experience Identifiers (SEI) are awarded on a semi-annual basis by the Medical Corps Developmental Team (DT). These designators are designed to officially recognize our academic and/or clinical "Grand Masters" (**ME** SEI) as well as those who have demonstrated sustained excellence in clinical and/or academic teaching (**MF** SEI). To learn more about the SEI criteria and award process and to view the entire list of SEI designees, visit the SEI link on the Medical Corps Force Management website: https://kx.afms.mil/mc

At the fall DT meeting, 38 candidates were awarded an SEI. The Medical Corps DT proudly congratulates the latest SEI awardees:

**ME — Clinical or Academic Grand Master**

**AETC:** Lt Col Mark Boston (Otolaryngology—Head & Neck Surgery)
Lt Col M. Bardett Fausett (Obstetrics & Gynecology)

**MF—Excellence in Clinical or Academic Teaching**

**ACC:** Lt Col Roger Piepenbrink (Internal Medicine)

**AETC:** Col Timothy Cassidy (Gastroenterology)
Col Leon Kundrotas (Gastroenterology & Internal Medicine)
Lt Col M. Bardett Fausett (Maternal-Fetal Medicine)
Lt Col Earl Ferguson (Plastic Surgery)
Lt Col W. Tracey Jones (General Surgery)
Lt Col Warren Kadrmas (Orthopedic Surgery)
Lt Col Forrest Littlebird (Preventive Medicine)
Lt Col Thomas Newton (Pediatrics)
Lt Col Dawn Peredo (Pediatrics)
Lt Col Blaine Tuft (Pediatrics)
Lt Col Mark True (Internal Medicine)
Maj Robert Elwood (Pediatrics)
Maj Brian Faux (Pediatrics)
Maj David Jones (Pediatrics)
Maj John Lin (Pediatrics)
Maj Kaustubh Joshi (Psychiatry)
Maj Charles Puls (Anesthesiology)
Maj Cecelia Schmalbach (Otolaryngology—Head & Neck Surgery)
Maj Kevin Steel (Internal Medicine)
Maj Melissa Tyree (Neonatology)
Maj Erik Weitzel (Otolaryngology—Head & Neck Surgery)

**AFMC:** Col Paula Corrigan (Aerospace Medicine)
Col Robert Michaelson (Aerospace Medicine)
Col William Butler (Aerospace Medicine)
Maj Rebecca Short (Dermatology)

**AMC:** Lt Col Lyrad Riley (Family Medicine)
Maj Robert Jesinger (Diagnostic Radiology)

**HQ AFIA:** Col Roger Hesselbrock (Neurology)

**USAFE:** Lt Col Molinda Chartrand (Pediatrics)
Lt Col Lee Williames (Pediatrics)

**USUHS:** Lt Col Daniel Burnett (Public Health/Gen. Preventive Medicine)
Lt Col Jessica Servey (Family Medicine)
Maj Kirk Jensen (Pediatrics)
Maj Christopher Kieling (Pediatrics)

# SG Clinical Consultants

## Lieutenant Colonel (Dr.) Leslie Wilson

### *Maternal Child & Pediatric Consultant to the SG*

The Air Force Consultant Program is run out of AFMOA in San Antonio, Texas. The Consultants division at AFMOA is home to the four core Medical Corps consultants: Maternal Child/Pediatric, Family Medicine, Internal Medicine, and Surgical Consultants. We have an additional 54 MC consultants spread out all over the world.

The consultants are ambassadors to their specialty. They promote the Surgeon General's priorities and provide on-site observations and recommendations. They participate in development of manpower standards and AF training requirements. Consultants work with the SGX, the MAJCOMs and MTFs to ensure the deployer priority list is acceptable and fair.

The consultants are often asked to be subject matter experts in their field and may assist in the development and coordination of Air Force policy. Consultants are also asked to oversee the quality of medical care provided by their particular specialty and may assist in facility Root Cause Analysis events, Medical Incident Investigation teams and review of malpractice claims and adverse actions. Disseminating lessons learned from these events to the field is also the consultant's responsibility.

Perhaps most important, consultants serve as mentors to the individuals in the specialty they represent. They give input to the Corps Development Team on vectoring individuals and work on fostering the retention of existing and emerging specialty members as well as the recruitment of physicians to join the AF. They provide assistance with assignments, SEI determination, and assist in recommendation for career broadening opportunities.

Each Air Force physician should know their consultant. If you don't, please send them an email, tell them a little about yourself to include your short and long term goals, and allow the consultant a chance to help you meet your goals. A listing of all consultants with contact information can be found at https://kx.afms.mil/kxweb/dotmil/kj.do?functionalArea=SGConsultants.

We would like to recognize the new AF SG Medical Corps Consultants for 2009:

Col Roger Hesselbrock—Aerospace Medicine, Neurology

Col Timothy Sowin—Aerospace Psychiatry

Col Charles Webb—Allergy & Immunology

Lt Col Steven Ritter—Dermatology

Col Brian McCrary—Hyperbaric Medicine

Lt Col Samuel Jones—Internal Medicine, Cardiology

Col Timothy Cassidy—Internal Medicine, Gastroenterology

Lt Col Erika Struble—Internal Medicine, Hematology-Oncology

Lt Col Laveta McDowell—Internal Medicine, Nephrology

Lt Col James Phalen—Developmental & Behavioral Pediatrics

Lt Col Michael Rajnik—Pediatric Infectious Disease

Lt Col Catherine Bobenrieth—Psychiatry

Lt Col Warren Kadrmas—Orthopedic Surgery

# Special Recognition

*The AFMS congratulates Colonel (Dr.) Kory Cornum, ACC/SG, on his recent selection for promotion to Brigadier General & Brigadier General (Dr.) Carol Lee, IMA to the AF/SG, on her recent selection for promotion to Major General!*

*Professional accolades go to Brigadier General (Dr.) Mark Ediger, Commander of the Air Force Medical Operations Agency (AFMOA), who was the recipient of the Association of Military Surgeons of the United States' John D. Chase award for Executive Excellence!*

*An exceptionally skilled emergency room physician & Chief of Medical Toxicology at the 59th Medical Wing, Wilford Hall Medical Center, Maj (Dr.) Vikhyat Bebarta was recently recognized as this year's winner of the Association of Military Surgeons of the United States' Donald F. Hagen Young Physician award!*

*Transforming the practice of Family Medicine is Col (Dr.) Lori Heim (ret), who became President of the American Academy of Family Physicians, on 14 Oct 09! Dr. Heim is a 1986 graduate of the Uniformed Services University of the Health Sciences (USUHS) and currently represents more than 94,600 physicians and medical students from across the nation!*

*Another Air Force member serving in an executive capacity is 2nd LT Brooke Sciuto, a 4th year Medical Student at USUHS who was recently elected to the AAFP's Board of Directors! A 2003 graduate of the USAF Academy, Brooke will serve a 1-year term before graduating from USUHS in May 2010.*

*Warmest congratulations go to Col (Dr.) Matt Dolan (ret), who was recently identified as a Master in the American College of Physicians (ACP)! This prestigious award will be bestowed upon Matt during the Internal Medicine 2010 conference in Toronto, Canada, in April 2010 and makes Dr. Dolan the third Air Force ACP Master!*

*Exceptional kudos are extended to Lt Col (Dr.) William (Bo) Hannah, Program Director of the Internal Medicine Residency Program at Wilford Hall Medical Center, who was recently awarded the Air Force Association's 2009 Paul W. Myers award. The award honors Dr. Hannah's exemplary commitment to military medicine as well as his dedicated efforts in helping re-establish the Internal Medicine training program at Keesler AFB, in the aftermath of Hurricane Katrina.*

*"Novel Influenza A (H1N1) Outbreak at the U.S. Air Force Academy" is the title of a timely article written by Lt Col (Dr.) Cathy Witkop (lead author) and Col (Dr.) Ken Knight, along with colleagues from the USAFSAM Epidemiology Consult Service. The article appeared in the Oct '09 issue of the Am J Prev Med.*

*An analysis of the transfusion, surgical & ICU requirements associated with an explosive event was reflected in an article titled, "Surgical Response to Multiple Casualty Incidents Following Single Explosive Events" that was published in the August 2009 edition of the Annals of Surgery. The authors represent a diverse cadre of AF Surgeons and included: Capt (Dr.) Brandon Propper (Resident), Lt Col (Dr.) Todd Rasmussen, Lt Col (Dr.) Scott Davidson, Ms. Sheri VandenBerg, RN, Lt Col (Dr.) W. Darrin Clouse, Capt (Dr.) Gabe Burkhardt (Resident), Capt (Dr.) Shaun Gifford (Resident), and Col (Dr.) Jay Johannigman.*

*Professional accolades go to Col (Dr.) Brian Reamy, Professor & Chair of the Department of Family Medicine at USUHS who was recently selected to serve as the University's Associate Dean for Faculty!*

*Col (Dr.) Jay Neubauer, the Command Surgeon for NORTHCOM, was recently selected to attend the Harvard University's John F. Kennedy School of Government "National Preparedness Leadership Initiative" program. This two part program trains senior leaders from across the country in areas related to homeland security and emergency preparedness.*

*Capt (Dr.) Shannon Brodersen, a 3rd year Family Medicine Resident at Eglin AFB, FL, received special recognition from the Southern Medical Association who presented her their Young Physician Leadership award!*

*A trio of senior AF Family Physicians, Col (Dr.) Brian Reamy, Lt Col (Dr.) Pamela Williams, and Lt Col (Dr.) Tammy Lindsay, authored an informative review article on "Henoch-Schonlein Purpura", which was published in the October 1, 2009 issue of the American Family Physician, pp 697-704. Drs. Reamy & Williams are currently assigned to the USUHS, while Dr. Lindsay is the Program Director for the St. Louis University Family Medicine Residency associated with Scott AFB, IL.*

*"Prescription for Progress?" was the title of an Air Force Times article reflecting an interview with Lt Col (Dr.) Tim Kosmatka, our AF/SG Consultant for Family Medicine, regarding the new Family Health Initiative (FHI). Patterned after the concept of a Medical Home, the FHI is in the process of being implemented Air Force wide.*

*Continued on page 20*

# Special Recognition *(continued from page 19)*

*International recognition goes to the following AFMS Surgeons who presented professional papers at the October 2009 meeting of the 38th World Congress on Military Medicine in Kuala Lumpur, Malaysia! They are:*

*Col (Dr.) David Smith—Chair, Dept of Surgery, WHMC*

*Lt Col (Dr.) Todd Rasmussen—Senior Vascular Surgeon, WHMC*

*Capt (Dr.) Joseph M. White—Surgical Resident, WHMC*

*Capt Gabriel E. Burkhardt—Surgical Resident, WHMC*

*Also featured (in action) in the 5 Oct 09 Air Force Times article was Maj (Dr.) Cecelia Ficek, Director of the Family Medicine clinic at Ellsworth AFB, South Dakota, who commented on the benefits of "knowing her patients and working with the same nurses and medical technicians."*

*Maj (Dr.) Dustin Stevenson, Medical Director of the Bone Marrow Transplant service at Wilford Hall made DoD history on Sept 10th, when he became the first physician to perform a stem cell transplant involving a matching, unrelated donor in a DoD hospital! Dr. Stevenson & his patient were featured in a SG News Story which can be viewed at http://www.sg.af.mil/news/story.asp?id=123169936.*

*A review of the "Suicide Burden in the U.S. Air Force: 1990-2004," was authored by Col (Dr.) Grover Yamane & Ms. Jenny Butler, MS and published in the October 2009 issue of Military Medicine, pp1019-1023. Dr. Yamane is a member of the USAF School of Aerospace Medicine's Epidemiology Consult Service.*

*Congratulations to Col (Dr.) Dianne Ritter, who was selected to serve as the Air University SG (AU/SG) at Maxwell AFB, following her return from an extended deployment, early next year!*

*"Readdressing the Need for Consensus in Preclinical Education," was the title of an article focusing on the means by which clinical skills are taught to 1st and/or 2nd year medical students. Published in the October 2009 issue of Military Medicine, Capt (Dr.) Jeffrey LaRochelle was the lead author, while Lt Col (Dr.) John Poremba and Maj (Dr.) Steven Durning (Ret) helped co-author this review.*

*Col (Dr.) Jeffrey Bailey, a senior Surgeon and Director of the St Louis University based Center for Sustainment of Trauma & Readiness Skills (CSTARS) program, was recently cited by the St Louis Business Journal as one of their three physician "Health Care Heroes!"*

*Lt Col (Dr.) Dan Bruzzini made a KSDK- TV debut during the filming of the Cardinal Glennon Children's Medical Center Disaster Drill! A 12 minute clip of the exercise can be viewed at: http://www.ksdk.com/video/default.aspx?maven_playerId=articleplayer&maven_referralPlaylistId=playlist&maven_referralObject=1255821532&maven_referrer=staf*

*"Combined Flexion and Extension Cervical Spine Fractures with Vascular Injury," was the topic of an unusual case report described by Col (Dr) Chris Lisanti (Ret) and CPT Christopher Hartness, MC, USA. Their report can be found on pp1105-1107, in the October 2009 issue of Military Medicine.*

*Another unusual case—one involving the embolization of an IED fragment to the left posterior cerebral artery, was described in a recent issue of Military Medicine (Radiology Case #40). The case was co-authored by Capt (Dr.) Vincent Timpone, Maj (Dr.) Robert Jesinger, Maj (Dr.) Todd Johnson and Col (Dr.) Peter Palka. Details of the case can also be seen at: http://rad.usuhs.mil/amsus.html.*

*Col (Dr.) Linda Lawrence, our AF/SG Consultant for Emergency Medicine, has also become a key advocate for patient safety & Team-STEPPS, and was invited to deliver a presentation with Dr. Anthony Slonim, at the November 2009 meeting of the American College of Physician Executives (ACPE).*

*Congratulations go to one of our newest ACPE Certified Physician Executives: Lt Col (Dr.) Richard J. Bean, Chief of Medical Staff at Spangdahlem AB, Germany.*

*Capt (Dr.) Kristine Andrews and Col (Dr.) Les Folio, were two of the authors describing a case in which an AK-47 round penetrated a patient's leg where it subsequently embolized to the patient's pulmonary artery! For full details see pp iv-v in the September 2009 issue of Military Medicine!*

*Maj (Dr.) Kristen Wyrick and Capt (Dr.) Amy Davis co-authored an article on "Exercise for the Management of Cancer-Related Fatigue" which appeared in the October 1, 2009 issue of the American Family Physician. Dr. Wyrick is currently assigned to the 355th Medical Group at Davis-Monthan AFB, Arizona, while Dr. Davis is assigned to the 60th Medical Group at Travis AFB, California.*