



Medics Forward

“Any mission, Anywhere!”

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September 2004



German-American partnership training event

By Sgt. Joe M. Battle
Landstuhl Regional Medical Center
Public Affairs Office

Members of the German Regional Medical Command II had the opportunity to train with members of the Landstuhl Regional Medical Center (LRMC) staff during the German-American Partnership Training Event held Aug. 12 at LRMC.

“It is important that we keep a good, working relationship with our German counterparts,” said U.S. Army Capt. Jalaluddin A. Malik, Europe Regional Medical Command Soldier Medic Program Manager for Europe. “This is only the beginning of a path leading to the close cooperation between the two nations.”

The training was designed to show German military forces how medical procedures on the battlefield are accomplished by American medics, said Malik. Future training events held by the German military will show American forces how they handle battlefield casualties.

“The German-American Partnership Training Event was composed of three scenarios that involved controlling bleeding and shock, treating a gunshot wound to the chest with a leg fracture and perform CPR on a casualty who has inhaled a poisonous gas,” said Malik. These three scenarios are the most probable battlefield casualties that either countries military would come across.

“This is the first time training like this has ever taken place here,” said Malik. “It gives us an ability to give the Germans an introduction to the procedures we use and we get the opportunity to have an outside opin-



Photo by Sgt. Joe Battle, LRMC Public Affairs Office

U.S. Army Sgt. Chi L. Truong and Staff Sgt. Keith A. Gwyn, medics at LRMC instruct two members of the German Regional Medical Command II on how to treat a simulated casualty during the German-American Partnership Training Event at LRMC Aug. 12.

ion on our training to help us fix anything that seems wrong.”

“We are very happy to be a part of this event,” said Timothy E. Koenig, coordinator for the Medical Simulation Center here. “This gives us the opportunity to demonstrate the different medical procedures that each country uses and helps develop a common understanding between soldiers on the battlefield.”

“Communication is essential on the battlefield,” said Staff Sgt. Keith A. Gwyn, instructor for the German-American Partnership Training Event. “It is better to learn how to communicate with our German counterparts here than to be on the battlefield and have no way to communicate with each other.”

“Medicine is a common language,” said Brig. Gen. Carla Hawley-Bowland, commander, Europe Re-

gional Medical Command. “If we cannot speak to each other, we can still use sign language or even pictures to get the message across which is what this training is teaching us. “I am looking forward to learning from each other, growing closer to our German counterparts and becoming friends,” said Hawley-Bowland.

“This training was amazing,” said Brig. Gen. Volker Schwamborn, commander of the German Regional Medical II. “I have never seen training conducted in the outstanding way it was held here.”

“The training was set in a high-stress environment just like it would be on the battlefield by using real war sounds and low lighting,” said Schwamborn. “With this training between Germans and Americans, we can be confident that you can help us and we can help you.”

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Veterinary Detachment change of command.

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Operation Iraqi Freedom & Operation Enduring Freedom as of Sept. 14, 2004

Clinical Operations

- OIF patients 15,400
- OEF patients 2,773

USAMMCE

- Line items 226K
- DoD customers 841
- \$184.6 million

ERMC



“Caring for our nation’s best” Medics Forward ... Any Mission, Anywhere!

Europe senior NCO conference combines training with history

**By Staff Sgt. Kelly Bridgwater
Europe Regional Medical Command
Public Affairs**

Senior Noncommissioned Officers (NCOs), active duty and reserve, from a variety of units throughout the Army Medical Command, to include Heidelberg, Germany, and Fort Sam Houston Texas, recently gathered together to attend the Europe Senior NCO short course in Sonthofen, Germany August 15 – 19.

Set against the backdrop of the Alpine Mountain foothills more than 150 NCOs were briefed the latest information on critical Army issues such as the transformation to units of action, senior enlisted promotions and the 91 whiskey (Army healthcare specialist) program.

The course also offered educational leisure activities that included a trip to Dachau.



Command Sgt. Maj. U.S. Army Medical Command (MEDCOM) Sandra K. Townsend (left), greets Europe Regional Medical Command, commanding general, Brig. Gen. Carla G. Hawley-Bowland. Townsend, the former MEDCOM senior enlisted advisor retired August 2004.



A day trip to Dachau offered conference attendees the chance to experience history first hand. This picture shows the reconstructed sleeping quarters used by prisoners. Tour guide Diethard Bendlin, standing, presented the grim details of the camp with a calm yet vivid historical description.

Guest speakers were on hand to discuss a number of critical topics with the NCOs that included Equal Opportunity; Force Health Protection; the Army Medical Department Noncommissioned Officer’s Academy; 30th Medical Brigade overview; German / American Partnership and the transition and sustainment update of the 91 Whiskey program.



100th Medical Detachment change of command



US Army photo by Carl Burnett

Col. Michael B. Cates turned over command of the 100th Medical Detachment, Veterinary Service Headquarters, to Col. Michael A. Buley, former commander, Southern Europe Veterinary Detachment, Vicenza, Italy, during an Aug. 17 ceremony held at Nachrichten Kaserne, Heidelberg, Germany. The presiding official was Col. David A. Rubenstein, Commander, 30th Medical Brigade and V Corps Surgeon. Left to right, Rubenstein, Cates and Buley.

Buley previously commanded the Southern Europe Veterinary Detachment located in Vicenza, Italy. The outgoing 100th Medical Detachment Commander, Cates, has been nominated by the President for promotion to Brigadier General, with assignments as the next Chief, Army Veterinary Corps and Commanding General, US Army Center for Health Promotion and Preventive Medicine, Aberdeen Proving Ground, Maryland.

Col. David A. Rubenstein, Commander, 30th Medical Brigade and V Corps Surgeon, passes the guidon to Col. Michael A. Buley, incoming commander, 100th Medical Detachment, Veterinary Service Headquarters, during a change of command ceremony at Nachrichten Kaserne, Heidelberg, Germany.

US Army Photo by Carl Burnett



**100th
Medical
Detachment
(VS)**



H-MEDDAC



Mission:

To ensure medical readiness while providing quality, integrated healthcare.

Vision:

To be the most compassionate healthcare team, committed and responsive to the needs of the community.

Access to care remains good during time of large redeployments

By Charles Ward
H-MEDDAC Public Affairs

Heidelberg, Germany – With many of the long-awaited Soldiers and units back in central, southern Germany, one would anticipate greater difficulties for patients trying to access medical help at their local health care facilities.

Unlike half a year ago where many of our units were deployed abroad and our posts were quieter due to their absence, the redeployments have created a larger patient population with all of the military units back in garrison. Factor to this the newly arriving Soldiers, civilians, and families, and it is a mix for possible problematic access to health care. Thankfully, this is not the case.

Lt. Col. Robert Smith, Mannheim Health Clinic Commander, is quick to point out that, “While the overall health care picture, in terms of access, is good, it does vary depending on the community. We are staffed real well here now, but communities like Friedberg, at the moment, need some extra help. So we send out help to other clinics to cover the need.”

Capt. Jonathan Taylor, Buedingen Health Clinic Commander emphasized, “When our troops deployed, they took medical assets with them. In our case, we lost the PA (Physician’s Assistant) that assists with active duty sick call. Combine that with an ETS of the other physician assigned at Buedingen, and things get busy. The good news is that the PA and the replacement physician should be working just after Labor Day.”

What has helped is that not all units redeployed to Germany at the same time. Some communities like Mannheim are “doing fine in this period of post-redeployment,” said Smith. “Most Mannheim Soldiers returned last winter.” So now is a time of stability.

Capt. Jeremy Johnson, Coleman Health Clinic Commander, added,

“When troops returned in October and February, there was a higher patient load. We had to send overflow to Heidelberg or Mannheim. Things are okay for us now that our other (assigned) doctor is back from Iraq.”

“Our community’s soldiers returned in February and March,” commented Lt. Col. Carolyn Tiffany, Hanau Health Clinic Commander. “So our surge occurred then. But our medical providers who were also deployed did not return then. What helped is that the 1st Armored Division’s own medical assets redeployed to Germany with them in March and February. Their return did not cause as much of a drain on our resources.”

Despite the overall end-of-summer stability that the clinics are experiencing, not all U.S. military community members in Germany receive their health care directly at an on-post U.S. medical facility. For those unable to use direct access to a U.S. health care facility due to work status, type of health insurance, or beneficiary status, there are patient liaison representatives at each clinic who provide the necessary directions and assistance for the Preferred Provider Network (PPN) of Germany’s local health care providers.

This is available regardless of where one lives in Germany. These patient liaisons work in the clinic’s TRICARE Service Center. The patient liaisons link Americans directly with qualified German health care providers.

Clinic commanders had positive words to say about the German physicians who see Americans in the local communities. “Our relationship has been great,” emphasized Smith. “It has always been so. They like us, and we like them.” Johnson added, “I have heard nothing but praise for the German providers.”

Tiffany emphasized that, “I ob-

serve, over time, most (of our patients) are very happy and become very comfortable with their local care provider. They like the idea of a routine, regular provider who is not as subject to job changes or rotations (as is the active duty military health care provider). There is more continuity for the patient.”

“Remember, these care providers and physicians are just as well trained as our American medical professionals,” commented Reginald Underwood, Hanau Clinic’s Chief of TRICARE. “They speak English. That is a requirement to be in the PPN. And we have over 80 providers in our PPN right here in the Hanau area.”

“Their standards are as high as ours, and they practice medicine just as good as any U.S. physician,” added Tiffany. All Germany’s clinics and hospitals have similar, long lists of local German providers.

It is very clear; a patient’s comfort level with access to health care in Germany is directly linked to being well informed. For most people, in-processing when first arriving in country just goes too quickly. It is not possible to digest all of the information that is presented.

For those getting settled for the first time in Germany after a summer PCS or for those redeploying here, the place to turn is the local TRICARE Service Center. To find the one nearest you see <http://www.tricare.osd.mil/overseas/>

It is great to have our troops finally back from the long deployments. It is even better to report that the anticipated “summer surge” has not greatly impacted patient access to care. However, one positive surge in patient care the clinics hope to see is that of “pregnancies and babies for delivery, come about the Christmas period,” according to Smith. “That is what we tentatively anticipate,

Former therapist returns to visit hospital

By 1st Lt. Nicole Pressler
US Army Hospital, Wuerzburg

Europe was in the midst of great transformation at the end of World War II when Hildegard Erk began working at Wuerzburg Army Hospital. She arrived a few years after the US Army first occupied the building in 1945.

July 15 Erk revisited Wuerzburg Hospital. She had a special interest in the physical therapy department because at one time she had been chief of physio-therapy from 1948 to 1960.

Erk was raised in Germany but spent several years in America after her family lost three houses in bombings during the war. She speaks fluent English, with only a hint of an accent.

After earning a physical therapy degree from a German university, Erk worked in local hotels that had been converted into hospitals during the war. She was employed by the Army at Wuerzburg Hospital after American Soldiers approached her in one of the hotels. "It seemed like the right thing to do," she said.

While employed by the hospital, Erk met her now-deceased husband, a doctor of internal medicine. She has a daughter who is a pharmacist, and two grandchildren who are studying pharmacology in college.

As chief of physio-therapy, Erk had three to four Soldiers working for her.

"I remember Germans asking me to get them cigarettes from my Soldiers," she said.

She has many awards and certificates for her work treating soldiers.

During her recent visit, Erk reminisced about the work she performed.

"I was impressed with the new physical therapy room, and the equipment now being used for therapy. They've come a long way," she said. She talked about the machines she used and about whirlpool therapy. Current physical therapy chief, Maj. Roger Behrman, gave Erk a tour



Photo by 1st Lt. Nicole Pressler, US Army Hospital, Wuerzburg

Hildegard Erk visits Wuerzburg Army Hospital's physical therapy clinic. She was head of the department from 1948-1960.

of the clinic and explained how new equipment is used. "We no longer do whirlpool therapy, but many new forms of therapy are up and coming," Behrman said to her.

After the visiting the clinic, Erk toured the newer side of the hospital and visited the location of her physio-therapy department, which now serves as the hospital dental clinic.

Erk was impressed by changes the hospital has made since her departure.

"The hospital has changed so much since I've been here. It is nice to see how it has changed with times," she said.

The Army will celebrate the 60th anniversary of its occupation of Wuerzburg hospital next year. Erk said she is looking forward to coming back for the celebration.

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Europe Regional Dental Command's vision for Army dentistry in Europe

**By Maj. Michael Beatty
Europe Regional Dental Command**

The command teams of the Heidelberg, Landstuhl, and Wuerzburg Dental Activities met Aug. 26 for an Executive Board of Directors meeting to outline the Europe Regional Dental Commander's (ERDC) vision and develop a mission statement and a mission essential task list. The new ERDC commander, Col. Mike Cuenin, started the session with

a briefing to outline his vision for Army Dentistry in Europe. He stated his vision to the group.

"Together we are three DENTACs with one single mission," he said. "Our mission is the execution of Army dental care. Our business is dentistry. Together we will execute the mission compassionately, efficiently and productively."

The working group then developed a mission statement in line with the DENCOM mission. The purpose, 'To ensure dental readiness, promote dental health, and provide dental care for America's Army in Europe.'

The group, as seen in the photo, discussed the interface between MEDPROS and the Dental Clinic Office Management software titled Corporate Dental Application. Army Regulation 40-3 dictates that Soldier and unit dental readiness are the primary mission for the dental treat-



Photo courtesy US Army

Dental Activities service members discuss a new vision for Army dentistry in Europe.

ment facilities in Europe.

After discussions the group developed the mission essential task listing as follows:

- Quality - to provide quality and timely comprehensive dental care (preventive and interceptive).
- Dental Readiness - to maintain the readiness of the beneficiaries assigned to our supported units.
- Unit Readiness - to ensure the overall soldier readiness of the unit DENTAC Officers, non-commissioned officers, and junior enlisted Soldiers.
- Satisfaction - to maximize both

internal (staff) and external (patient and customer) satisfaction.

Cuenin's DENTAC centric approach will enable the Dental Activities and their subordinate clinic commands to work more efficiently with collocated medical treatment facilities.

Ongoing initiatives with USAMMCE as well as the Civilian Human Resource Management Agency

Europe are now planned to expedite solid business practices in dental sup-

ply procurement and civilian hiring efficiencies. This is particularly so in the difficult to recruit series of both chair side dental assistants and dental laboratory technicians.

As energized members of the AMEDD team in Europe, the new command teams reviewed current business practices and will make this business review a quarterly event to maximize mission effectiveness.

Using other health insurance

Article submitted by TRICARE-Europe

Many TRICARE beneficiaries have other health insurance through their employer, through a national health system outside of the U.S., or through a privately purchased insurance program. If you have public or private health insurance in addition to TRICARE, there are a few rules you need to know in order to ensure your medical claims are properly processed. OHI First, TRICARE Second By law, TRICARE is always the secondary payer for beneficiaries who have Other Health Insurance (OHI).

If you have OHI, you typically must file your claims with the other insurer first and with TRICARE second, if any balance remains. The are two main exceptions to this rule: you may file your claim with TRICARE first if you have OHI administered under the Social Security Medicaid Act, or supplemental coverage (see reverse) designed to cover TRICARE deductibles, coinsurance and cost shares. Double Coverage for claims that involve double coverage (when a beneficiary has OHI in addition to TRICARE), TRICARE benefits may not be extended until the other insurer processed the claim. Double coverage can be any of the following:

An insurance Plan: Any insurance plan or program that provides compensation for expenses incurred by a beneficiary for medical services/supplies.

A medical service or health plan: Any plan or program of an organized health care group which provides professional and institutional care to a premium-paying beneficiary.

Care from a Host Nation Provider If you have OHI and are referred to a Host Nation provider, that provider is not obligated to file your claim with your primary (OHI) insurance. In some cases, they might ask you for payment up front. In this case, you must send your claim to your primary insurer. Once the claim has been processed by your OHI, send a copy of the Explanation of Benefits you receive (even if the claim was denied), a copy of the bill and a DD 2642 claim form (available from your TRICARE Service Center), to the overseas TRICARE claims processor (see reverse). On your claim form, make sure to indicate the name and policy number of your primary insurer.

Completing a Claim Form

For all TRICARE Europe beneficiaries, claims may be submitted on a

CHAMPUS Claim Form (**DD Form 2642**). **This is the claim form used by TRICARE Europe** for overseas care. You may obtain claim forms from your local TRICARE Service Center. You may also download forms from www.europe.tricare.osd.mil (click on the "Beneficiaries" button).

Send Your Claim to WPS

The TRICARE Europe claims processor is Wisconsin Physician Services (WPS), located in Madison, Wisconsin. Please use your overseas (APO) address on claim forms.

A third party payer: Insurance that is provided by a medical service, insurance, or health plan by contract or agreement to include automobile liability insurance, a no-fault carrier and worker's compensation plan, or any other plan designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services or supplies.

www.europe.tricare.osd.mil claims in Europe, there are different box numbers for Active Duty and all other TRICARE eligible beneficiary claims:

Active Duty Civilian Care Claims: Send ALL Active Duty claims to your servicing Military Treatment Facility. **Active Duty Family Member Civilian Care Claims:** The claims processor handles ALL claims for active duty family members enrolled in TRICARE Europe Prime.

TRICARE Standard – Overseas Care

Individuals residing overseas covered by TRICARE Standard (including eligible retirees, their family members and Active Duty Family Members who have chosen not to enroll in Prime) should submit all TRICARE claims to the address above (WPS-Claims Processing) if the care was rendered overseas. Claims for CONUS care must be submitted to the claims processor of region where the care was rendered.

Prescriptions and OHI

If you need medication that is not covered under your primary health insurance plan, but is covered under TRICARE, you must submit your Explanation of Benefits (denial statement) from your OHI to the TRICARE overseas claims processor.

If you are covered by other health insurance (OHI) with a pharmacy benefit, you may not use TRICARE Mail Order Pharmacy Program (TMOP), unless the other insurer does not cover the medication needed or you have exceeded the dollar limit of coverage under that other plan. If the medication needed is not covered by OHI, submit the prescription and the

Explanation of Benefits from the OHI to Express Scripts. If the drug is covered by TMOP, Express Scripts will fill the prescription. If you reach your OHI's benefit cap, submit a copy of the cap notice to Express Scripts with your prescription. If the drug is covered by TMOP, Express Scripts will fill the prescription until your OHI pharmacy benefit is renewed. More information is available at www.tricare.osd.mil/pharmacy/tmop.cfm.

All prescription claims require the name of the patient; the name, strength, and quantity of each drug; the name and address of the pharmacy; and the name and address of the prescribing physician. Billing statements showing only total charges, reminders, cancelled checks, or cash register and similar receipts are not acceptable as itemized statements.

Supplemental Insurance Vs. OHI

Supplemental insurance is specifically designed to supplement TRICARE Standard costs. Unlike OHI, which pays for health care services first, supplemental policies are always secondary payers on TRICARE claims. Supplemental plans are frequently available from military associations and other private organizations and firms. Each TRICARE supplemental policy has its own rules concerning pre-existing conditions, eligibility requirements, deductibles, and mental health limitations, so you should carefully consider which plan is best suited to your individual needs before you buy any supplemental policy. More information is available at www.tricare.osd.mil/supplementalinsurance.

You Must Report Your OHI status

Failure to disclose your other health insurance information could result in your claim being delayed or denied. To report your other health insurance for the first time, complete **DD form 2569**, Third Party Collection Program-Record of Other Insurance, available at www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2569.pdf.

In addition to this formal notification, you must also identify that you have other insurance on every claim that you send to TRICARE. Lastly, you must notify the overseas claims processor (WPS) if you cancel your OHI. To do this, send WPS a letter from your OHI stating that your membership has been terminated with effective dates of the cancellation.

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europe.tricare.osd.mil

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ARNEWS



Army eliminates senior rater profile on company-grade OERs

By Joe Burlas
Army News Service

WASHINGTON (Army News Service, Aug. 16, 2004) -- Senior raters evaluating lieutenants, captains and warrant officers 1 and 2 will change the way they compare the rated officer with his or her peers in the active Army after Oct. 1.

Specifically, the change eliminates the use of block 7b of the Officer Evaluation Report, Department of the Army Form 67-9, for company grade officers and warrant officers 1 and 2.

The current senior rater profiling contains four ratings: above center of mass, center of mass, below center of mass retain and below center of mass do not retain. With Human Resources Command input, it reflects where the senior rater has rated other officers of equal rank in the past and where the senior leader thinks the rated officer falls in a direct peer-to-peer comparison.

Senior rater profiling will be retained for use in rating majors and above, and warrant officers 3 and above.

"We're getting away from that competitive peer-to-peer comparison at the company grade and lower warrant officer level to allow more leader focus on developing leaders and fostering closer unit cohesion," said Maj Gen Dorian T. Anderson, Human Resources Command commanding general.

Along with the end of peer-to-peer comparison at the company level, the Army will also expand developmental plans and counseling requirements beyond junior officers to include captains and warrant officers 2 in the active Army effective Oct. 1. Future version of DA Form 67-9-1a, Junior Officer Developmental Support Form, will have the word "junior," deleted to reflect the inclusion of more senior officers and warrants.

The OER enhancements will eventually be made in the Army Reserve and National Guard, but each has its own unique requirements and timeline, officials said. "Evaluations have to do two things: pro-

vide good solid feedback to the rated individual for development and it has to provide information for the system to use to select those qualified individuals for promotion to the next higher grade," Anderson said.

"The challenge is to find the balance between feedback for individual development and the information promotion boards need for selections. The enhancements of eliminating senior rater profiling, and at the same time requiring more senior involvement by raters in counseling and mentoring process, allows company grade officers to get more useable feedback about how they are doing in their job."

Company grade officers identified the lack of useful and ongoing feedback via OER requirements, and a "zero-defects" environment perception fostered by the OER process as major concerns during an extensive look at the Army's methods of growing and developing leaders. The Officer Army Training and Leader Development Panel results that identified those concerns were released in May 2001.

In 2002, the Army moved to mask, or remove to the restricted file, all lieutenant OERs once the officer reached the rank of captain in order to address part of the panel's findings.

The decision to mask those OERs at the rank of captain was to allow junior officers more room to grow, ease the zero-defects perception and effectively remove comments from a junior officer's file that may be a reflection of an initial learning curve, said George Piccirilli, Evaluation Systems chief.

As far as the last OER enhancements go, Piccirilli said they are "in keeping with the Army's spirit of transformation -- we are truly focusing on leader development."

To those who might think that the elimination of senior rater profiling is a ploy to retain more company grade officers in the Army, Anderson said that assumption couldn't be further from the truth as pro-

motion selection rates are the highest they have been in decades. The selection rate of captain promotion board over the past six years has been consistently more than 90 percent. The selection rate of the last captain board, held last fall, was 92.3 percent.

"There is a perception among officers in the field that they can make no mistakes - that if they do, they will get a senior leader middle box check and that means they're not going to be promoted," Anderson said. "The truth is that the promotion system picks up plenty of officers with center-of-mass ratings. The current enhancements allow for more interactive and ongoing discussions between the rated officer and rater about how the officer is doing and allows for timely correction of errors along the way."

The enhancements will also bring deeper depth of experience and knowledge into the mentoring process, as brigade commanders will have to review the development plans battalion commanders create for their captains, Anderson said. Under the current junior officer development system, company commanders create plans for their lieutenants and battalion commanders review them.

"The OER enhancements that we are talking about -- expanding the requirements of the use of the developmental support form for company grade officers and WO2s, as well as eliminating the block check requirement for company grade officers and WO1s and WO2s -- allows for leaders to focus on the real development of their junior officers," said Anderson. "What we want to do here is ensure that our junior leaders are given the opportunity to be sufficiently mentored as future joint and expeditionary leaders and warriors."

Officers can provide feedback on this subject via e-mail to arnews@hqda.army.mil.

For more information on the OER enhancements, visit www.perscomonline.army.mil/tagd/msd/



Photo by Maj. Barbara Jones, TFMF

A transfer of authority takes place Aug. 19 at Camp Bondsteel, Kosovo for members of Task Force Med Falcon.

Task Force Med Falcon conducts transfer of authority

**Article by Capt. Ellen Coddington
Task Force Med Falcon**

Camp Bondsteel, Kosovo - Aug. 19 was the date for the Transfer of Authority for medical support personnel working within the United States sector of Kosovo.

The transfer was conducted between the outgoing Medical Task Force commander, Col. Donald Harris, 330th Medical Brigade and the incoming commander Col. Stanley L.K. Flemming as-

signed to the 139th Medical Infantry Division. Group.

For the last time, the colors of the departing brigade were encased as the new colors of the 139th Medical Group from Independence, Mo., were unfurled for the first time signifying the official assumption of command.

The reviewing officer for the ceremony was Brig. Gen. Rick Erlandson, commander, Multi-National Brigade (East) Task Force Falcon, 34th

Task Force Medical Falcon X is comprised of Soldiers from the 139th Medical Group, Independence, Mo., the 18th Field Hospital, Virginia Beach, Va., the 422nd Medical Detachment (Vet), Rockville, Md., the 180th PM Detachment, Beloit, Wis., the 388th Medical Logistics Detachment, Hayes, Kan., the 237th Forward Support Battalion (GA), Columbus, Ohio and the 146th Aviation CO, Williamstown, W. Va.

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LRMC



New patient process

By Sgt. Joe M. Battle
Landstuhl Regional Medical Center
Public Affairs Office

Beginning at 6 a.m. Oct. 1st The Department of Emergency Medicine (TDEM) at Landstuhl Regional Medical Center will begin a new process of receiving, treating and releasing patients to help cut their length of stay at the hospital.

“We are excited about this new way of doing business, which was started with an idea initiated by Capt. Sharon Scott who arrived here from Keesler Air Force Base,” said Maj. Stephen E. Fecura, nurse manager for LRMC’s Department of Emergency Medicine.

“She implemented plans for the patient process by adapting practices and taking the lessons she learned from the Emergency Nurses Association’s Emergency Severity Index Five Level Triage. The new method, which was adopted at Keesler in October 2002, is used by only ten percent of ERs worldwide,” Fecura said.

“Our ‘KMC’ family can expect to see a whole new way we handle patients who visit the Emergency Room,” said Fecura. “The first person you will see will be a registered nurse, who will conduct a quick assessment and give the patient a quick questionnaire.”

Depending on the number of people simultaneously arriving at the E.R. at the same time as the patient, he will be directed to the waiting room or directly to a primary vital sign assessment area where vital signs will be checked and the ques-



Photo by Spc. Todd Goodman, LRMC Public Affairs Office

Capt. MaryAnn Borrelli, a triage nurse at LRMC, receives paperwork from a Soldier before he is seen by medical staff. The new patient process will reduce the wait time in the E.R. to patients who have more severe illnesses or injuries.

tionnaire reviewed. Once the assessment is completed, patients will be separated into triage categories ranging from three through five.

Triage categories one and two are reserved for the patients who come in requiring immediate lifesaving procedures. Categories two and three will be seen with a targeted wait time of no more than a 30-60 minutes.

“All the great changes to give patients better care couldn’t have been done without the help of Master Sgt. John Cronin, DEM NCO-in-charge, Maj. Scott Metzel, assistant nurse manager for the DEM, Ms. Melanie Hungate, a RN for the DEM and Staff Sgt. Martin Jensen, an experienced Independent Duty Medical Technician,” said Fecura. “Also, along with the help from the medical clerks, nursing staff

and providers, this process will be worthwhile to the patients of LRMC.”

New nursing documentation and assessment forms were adapted for our use by Capt. Susan Frisbie, an Army nurse for the DEM. Forms were created from samples taken from various ‘Best Practice’ ER documents from the top 100 state-side health care centers.

“We are excited to benchmark this new process for the European Theater,” said Fecura. “Also, with the support to our new DEM Chief, Col. Fredric Plotkin, we predict an improvement in our patient’s satisfaction, reduction in our patient’s length of stay and a significant reduction in patients who leave without being seen.”

Buffering the impact of a heavy workload

Article submitted by **USAMRU-E**

A recent study conducted by researchers at the U.S. Army Medical Research Unit-Europe, an overseas laboratory of the Walter Reed Army Institute of Research, identified two key factors that, when used in combination, can help military personnel weather the stress of high job demands.

The two factors examined in the study were the belief in one's ability to perform a particular task (commonly referred to as *self-efficacy*) and clarity regarding what is expected in a particular job or Military Occupational Specialty (commonly referred to as *role clarity*).

Surveys were collected from 2,403 U.S. Reserve Office Train-

ing Candidate cadets attending a 32-day National Advanced Leadership Camp. Self-efficacy was measured at day three of the training. Demands, role clarity, psychological health and morale were measured at day 22.

Analysis revealed that self-efficacy only buffered the impact of job demands on health and morale when it was coupled with high role clarity. That is, under a heavy workload, an individual with a great degree of confidence in his or her own ability to perform (high self-efficacy) but without clear ideas about what needs to be done to be successful (low role clarity) is virtually indistinguishable from an individual with low self-efficacy.

Health and morale scores drop in both cases compared to low workload conditions. However, if that

same individual is provided clear guidelines about his or her role then health and morale scores, remain strong regardless of workload.

This is the first occupational stress study to examine the link between self-efficacy and role clarity and is also one of the few studies to use a longitudinal design. This design is important because the results imply that if self-efficacy can be developed through training, the effects of self-efficacy will endure for some time.

In terms of practical significance, the evidence suggests military leaders can protect individuals from the negative effects of work stressors by the combination of one, providing more specific job training to enhance self-efficacy and two, creating work situations that are well-defined.

The paper provides empirical evidence that leaders can use both of these management tools to support the ability of their Soldiers to cope under conditions of high job demands.

The paper, *Self-efficacy and the Stress-Health Relationship: A Temporal Investigation*, was written by Maj. Paul Bliese, Capt. Jeffrey Thomas, and Dr. Kathleen Wright. It was presented at the American Psychological Association annual meeting in Honolulu, Hawaii in August 2004.



Photo courtesy Department of Defense

Cadet Lindsey Rowland, University of Hawaii, throws a grenade during a Reserve Officers Training Corps (ROTC) competition at Andersen Air Force Base, Guam. ROTC Units from Alaska, Hawaii, and Guam participated in the contest.

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Designing an ergonomic workspace

By Maj. David Gibson
U.S. Army Medical Materiel Command

Every year numerous employees experience difficulty, pain and sometimes injury while trying to perform operations in their work environments. In fact, in a study performed by the Occupational Safety and Health Administration (OSHA), researchers found that manual materials handling injuries accounted for 25 percent of all industrial injuries and resulted in 12 million lost workdays per year.

Furthermore, about 50 percent of all back injuries occur while lifting objects and another 15 percent occur while pushing, pulling, holding or carrying items. To put things in perspective, another study performed in 1990 stated that the average cost of a back injury was over \$180,000.

From July 1994 to June 1995, the US Army paid more than \$590,000 per workday in costs associated with civilian injuries and illnesses. The bottom line is failure to implement and practice sound ergonomic principles not only results in injured employees, these injuries cost organizations time, money, and productivity. Adopting ergonomic practices can reduce the risk of Work-Related Musculoskeletal Disorders (WMSDs), decrease fatigue and errors, increase safety, and improve the overall quality of work.

Implementing ergonomic work practices involves the application

of knowledge about human capacities and limitations to the design of the workplace. Implementing these practices can avoid unnecessary injuries, improve worker efficiency and enhance an organization's overall operational level of productivity.

Additionally, applying sound ergonomic work principles is something that everyone should

and allows the worker to move the items up, down, or laterally as needed. This allows the worker to place the materiel on a carrying device or work surface without straining and stretching. This intervention guards against the primary cause of back and wrist injuries and limits fatiguing the operator.

Although these examples are obvious, there are countless other initiatives that can produce positive results. Some of the other modifications Poole implemented include, a tilting work surface to limit workers bending over to reach and place items; adding adjustable wrist rests to guard against carpal tunnel injuries; and the use of anti-fatigue mats to reduce muscle tension and increase blood flow.



Photo courtesy of USAMMCE

Joachim Dauth uses a compressed air lift to move a medical set.

do at home and work in order to reduce common stresses on their body and mitigate the risk of injury. At the United States Army Medical Materiel Center, Europe (USAMMCE), Robert Poole has adopted this philosophy and made it a part of everyday operations. The whole idea behind ergonomic initiatives is to make the workspace fit the worker- not the other way around.

Since first receiving a class in September 2003, Poole has implemented several changes. For example, there are differences between a worker who picks up supplies to build medical sets and a worker who uses a compressed-air lift.

The lift attaches to the materiel

Finally, Poole has implemented a robust training and education plan to teach workers how to analyze their work conditions and implement ergonomic ideas that result in less stress on their bodies. Often times, we simply don't recognize the negative impact things such as improper posture, in-appropriate computer screen sighting or other common habits have on ourselves or our co-workers.

To find out more about ergonomic training and initiatives see the National Institute for Occupational Safety and Health (NIOSH) website at <http://www.cdc.gov/niosh/homepage.html> or <http://chppm-www.apgea.mil/ergowg2/>

Medical assessment success in Qara Tapa

**By Master Sgt. Mike Welsh
30th Brigade Combat Team,
1st Infantry Division,
Public Affairs Office**

Forward Operating Base Cobra, Iraq -

The serials of military vehicles from the Multi National Forces (MNF), 30th Brigade Combat Team (BCT), rolled deliberately into a small village near the town of Qara Tapa in northeastern Iraq. Children lined the streets as the Soldiers on a planned medical assessment mission poured into the austere trade's school carrying cases of medical supplies, clinical equipment, and good will intentions.

Their mission, to determine the condition of the children, evaluate health care needs, and offer clinical treatment for local residents, and asses the overall needs of this community.

"Our objective today was to bring some of the MNF medical resources and medical personnel to this area," said Maj. Michael Campbell, a medical doctor from the Virginia Army National Guard assigned to C Company, 230th Forward Support Battalion (FSB).

"We saw approximately 150-200 patients today. That included everything from environmental problems to more serious chronic illnesses such as asthma", continued Campbell.

Adding to the ranks of the MNF was a group of three Iraqi nurses from the local hospital in Qara Tapa. "The Iraqi nurses rotated around from physician to physician. They joined in on some of the assessments and they did some special needs projects," added Campbell.

Support for the mission was pulled from a variety of MNF resources within the 30th BCT. The cast included a Physician Assistant, Medics, and one medical doctor from C Company, 230th

FSB, Specialist from the 415th Civil Affairs (CA) Battalion, Tactical Psyop Team from the 7th Psyops Battalion, and security from C Company, 252nd Armor Battalion.

Who plans and coordinates such an undertaking like this, going into a remote community that speaks a different language, and setting up an instant medical clinic? The answer is Capt. Timothy Dukeman, 415th CA Battalion, attached to the 30th BCT.

"Predominately, Civil Affairs is the planning cell in the military for these types of projects", said Dukeman. Dukeman had to coordinate this effort with MNF assets located at several Forward Operating Base locations. However it appears it paid off very well.

"There are 700 - 1,000 people living in this village. Seeing 200 patients today is a significant part of the population," stated Dukeman. "We also donated an ambulance to Qara Tapa about a week ago. I'm already looking forward to going back to this area," continued Dukeman.

Using a building that serves as a trade school, the MNF quickly moved in and organized the medical assessment screening process.

"We had two adult stations, one pediatric station, and a makeshift pharmacy," said Maj. Kenneth Shedarowich, C Company, 230th FSB. Shedarowich is a Physician Assistant attached to the 30th BCT from E Company, 540th Main Support Battalion, California Army National Guard.

"I worked in the pediatric area and saw approximately 20-30 children with various illnesses ranging from basic anemia to moderate to severe malnutrition," added Shedarowich.

It would seem like divine fate that this team of medical professionals was in this village on this particu-

lar day.

"The very last patient that came in was a young boy that was very ill, severely dehydrated," continued Shedarowich. After a rapid assessment, IV fluids were started and antibiotics administered as the medical team facilitated the translators to obtain medical history information from the boy's mother.

The totality of the boy's medical history and what appeared to be septic shock prompted Shedarowich and Campbell to start the rapid process for a Medical Evacuation (MEDEVAC) aircraft. A hospital with a higher level of care was needed. Without the MEDEVAC the medical team did not expect the young boy in septic shock to survive.

"The 31st CASH (Combat Area Surgical Hospital) in Baghdad received the young boy and he was transferred to the ICU. The next day he was still in the ICU and stable," added Shedarowich.

Towards the end of the medical assessment, after the last Iraqi civilian was seen by the medical team, an assortment of packaged food supplies was generously passed out to the Iraqi people. Additionally, the remaining medical supplies not expended were taken to the medical clinic in Qara Tapa for eventual use by the local Iraqi citizens.

The future of Iraq is going to be determined ultimately by its own people. As progress continues to spread across Iraq, the opportunity for the MNF to switch from kinetic actions to humanitarian and infrastructure support will be intensified.

"I think we need to be here, we are making a difference. Improvements in Iraq are not going to all happen overnight. In time they (Iraqis) will eventually be able to sustain themselves. What we are doing here is well worth it," concluded Shedarowich.

1st Infantry

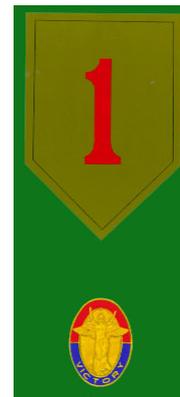


Photo by
Master Sgt. Mike Welsh

**Sgt. Jerard Thomas,
Headquarters and
Headquarters Com-
pany, 1st Battalion,
252nd Armor, escorts
a local boy from
Qara Tapa, Iraq at a
medical assessment
service provided by
Multi National
Forces.**



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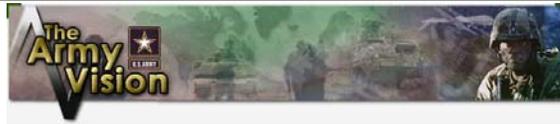
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**Text and photo by Roger Teel
Wuerzburg Army Hospital
Public Affairs Office**

As a kid growing up, Doug Pratt watched the Ironman Triathlon World Championship on television. “I always thought it would be an amazing thing to do,” he said, undaunted by the grueling physical challenge.

On Oct. 16, at the 26th annual Ironman Triathlon World Championship at Kailua Kona, Hawaii, the 31-year-old Army dentist from Illesheim will have his chance at this amazing event. Pratt finished 67th out of 1,961 competitors at the July 25 U.S. qualifying triathlon at Lake Placid, N.Y. He competes in the men’s 30-34 age group and qualified by being in the top 15 of his group.

Soldiers achieve success at PLDC

Wuerzburg Army Hospital Public Affairs

Two U.S. Army Hospital, Wuerzburg, Soldiers were recognized Aug. 27 during Primary Leadership Development Course graduation ceremonies at the 7th Army Non-commissioned Officer Academy at Grafenwoehr.

Leading all graduates was Sgt. Craig Landau, a radiology technician at Illesheim Health Clinic. Landau was named recipient of the Gen. George S. Patton award for being the distinguished honor graduate for class #08-04.

Also graduating was Cpl. Hamidah Abdullah, a laboratory technician at the Katterbach Health Clinic.

The US Army Europe Regional Medical Command was activated on Oct. 16, 1994, under the command and control of the US Army Medical Command, headquartered at Fort Sam Houston, Texas. The command was originally designated the European Health Service Support Area, one of seven Army health service support regions throughout the world. To clarify beneficiary recognition of their mission, all health service support areas were re-designated regional medical commands in July 1996.

To meet the European challenge of the ever changing medical environment and the military force, Europe Regional Medical Command oversees and maintains the successful operation of the Army’s 28 healthcare facilities in Germany, Italy and Belgium.