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News in Brief

WEB SITE UPDATES HELP VETERANS AFTER DEPLOYMENT

FALLS CHURCH, Va. Ñ Since launching Aug. 5, 2008, Afterdeployment.org has grown to provide more information and resources for service members returning from deployment - as well as for their families.

"It's a free resource that can be very helpful for veteranstransitioning back from their deployment," said Army Maj. Gen. Elder Granger, deputy director for TRICARE Management Activity.

The site provides change strategies and educational materials that address combat stress and triggers; conflict at work; re-connecting with family and friends; depression; anger; sleep problems; substance abuse; stress management; kids and deployment; spiritual guidance; living with physical injuries; and health and wellness.

The updated Web site at http://www.afterdeployment.org features workshops in the "Improving Relationships" program. These workshops provide service members with valuable tools for overcoming the tendency to isolate from friends and family, building relationship skills and reconnecting with partners following a deployment.

Afterdeployment.org also added self-help workshops and activities in the ÒHelping Kids Deal with Deployment," "Seeking Spiritual Fitness," and "Controlling Drugs and Alcohol" sections of the Web site.

"The diversity of registered users on Afterdeployment.org is a testimony to how wonderful the site is. Users report very positive feelings about the usefulness and quality of information available on Afterdeployment.org," said Granger. "We've received great feedback, and we expect the Website to offer even more assistance to families and veterans," Granger added.

"Statistics indicate that there is a balance of families, providers, veterans, and active duty service members registered on the site."

The "Explore the Site" box on the top right of the page is a gateway to the site's many materials. Anonymous registration is required only for the workshops.

For transition behavioral health help, go to http://www.afterdeployment.org.

For info on how TRICARE can help behavioral health, go to http://www.tricare.mil.

Medicine rewired at detainee combat hospital

By Capt. Ken Sturtz

CAMP BUCCA, Iraq — Checkpoints, concertina wire and guard towers canvas the horizon at the largest internment facility throughout the U.S. Central Command - Camp Bucca, Iraq.

Three miles of newly entrenched fiber-optic cables, though, have lifted the spirits of doctors and nurses at Camp Bucca, because it saves them hours of work at the end of their 12-hour shifts.

Spanning one square mile and located at the southern border of Iraq, Camp Bucca encompasses 29 independent compounds that can hold as many as 15,000 detainees at once. Since the beginning of Operation Iraqi Freedom, more than 100,000 detainees have been held at this location.

Spc. Victoria Krause, Cpl. Sheri Simpson and Pfc. Amanda Johnson, patient administration personnel with the 115th CSH, use the MC4 system to review patient data at Camp Bucca, Iraq.

Not apparent from its formidable surroundings, Camp Bucca houses a state-of-the-art medical facility, the 115th Combat Support Hospital, which provides the highest level of care on a non-stop basis to a diverse detainee population.

"Our patients usually do not speak English, so we have to utilize the services of translators so we can communicate with each other," said Sgt. 1st Class Robert Callahan, noncommissioned officer in charge of wire medicine for the 115th CSH.

"Our patients are escorted by guards and they also have primary care medical issues. It's not the typical mission our medics are trained to support before they arrive here."

Atypical is an understatement, given the location's layout and history. Each of the 29 compounds has its own primary care facility, known as a compound treatment room. In each of these rooms, medics and primary care providers perform "wire medicine" around the clock.

The term "wire medicine" was originally coined to describe the medical care administered to insurgents, which included a wire fence separating medical personnel and patients. While a fence no longer exists between patient and medical personnel, additional barriers have made care difficult.

Evolution from paper to electronic records

Originally, wire medicine at

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Flight paramedic invents new tool to document Medevac care

SGT Michael Ferguson dedicated 50 hours to create a new form that captures medevac patient care information while in transit. Upon arrival at the next level of care, the tool is used in concert with the MC4 system to ensure the transit care becomes part of Service membersÕ lifelong medical records.

The data is used to generate surveillance reports, providing insight to the missions medevacs conduct and the care they administer.

Additionally, the information can also be used to develop the next generation of equipment and life-saving techniques to help save lives on the battlefield.

Gateway: Why did you develop the new template to help document information during medevac missions?

Ferguson: While my unit attended MC4 training at our mobilization site at Fort Sill, Okla., we found that the MC4 handheld devices and laptops are not user friendly for pre-hospital use. They are geared to the clinical environment.

I have nearly 10 years of pre-hospital experience as a firefighter paramedic in one of the busiest medical systems in the U.S.Ñ the region surrounding Sacramento, Calif. I understand that if I effectively capture my procedures and the patientÕs conditions, the awaiting medical staff will have a solid foundation to efficiently continue care.

I believed that MC4 could be used to support our mission and also electronically chart patient information. This way, the information would be part of Service membersÕ permanent medical record.

Gateway: What were some of the issues that you saw with the MC4 system?

SGT Michael Ferguson is a flight paramedic with C Company, 1-168th Aviation Regiment. At right, he prepares for a medical evacuation mission in Afghanistan.

Ferguson: At first, we thought that the handhelds would be appropriate for our needs, but we found that the information collected on the electronic field medical cards (DD 1380s) was too simplistic.

As flight medics, we chart a lot of advanced, critical procedures that is beyond the level of detail on the 1380s. WeÕre doing more than applying a tourniquet, giving patients morphine and taking them to the next facility.

The problem with the outpatient software on the laptop, AHLTA-T, is that it wants us to enter information that is too detailed for our mission. This is great in a clinic setting for doctors, but it doesnÕt work well for flight medics. An unwritten rule for flight medics and pre-hospital providers is that we are not supposed to make a diagnosis of a patientÕs condition. You just document what you see and offer a differential diagnosis, or what you think is wrong with the person.

For example, if a patient experiences chest pain and I try to enter this into AHLTA-T, the system wants me to enter ÒchestpainwithcardiacoriginÓ or other specific chest problems. Flight medics do not determine the origin of a pain or injury. I only want to enter Òchest pain.Ó

For pre-hospital care, just about everything we do is based off of a primary and secondary survey, a narrative and then a timeline with the medications and treatments given at specific times. It was important to have a template with standardized steps that best match the symptoms we see and our protocols. It was important that the processes be as basic as possible.

Gateway: What steps did you take to develop the patient care record (PCR) form?

Ferguson: While we were at Fort Sill, I looked around MC4Õs online helpdesk for similar documents or templates to help with our mission. I found the trauma nursing note and modified it to meet our needs.

I am also the systems administrator for the unit, so I had access to one of the laptops. I set it up and worked with AHLTA-T to see how I could populate the new form based upon the information the application prompts clinical personnel. The creation and formatting of the form involved a lot of trial and error.

Throughout my testing, I had generated approximately 40 test encounters. When I finished, I reimaged the laptop so that the test data would not transfer to central databases, the Theater Medical Data Store (TMDS) and the Joint Medical Workstation (JMeWS). After approximately 50 hours and many revisions, the PCR form was complete.

The template has the standardized diagnoses we use. The nomenclature is not exactly what we would like to have, but it is the closest to the information we want to track. Primarily, this was done so that we would have the ability to generate surveillance reports in JMeWS to track the history of our patients and the care we provide.

Gateway: How do you use the PCR with the MC4 systems?

Ferguson: We transcribe the patient information and our treatments to the form while weÕre en route to the hospital. When we arrive at the treatment facility, we give the facility staff a verbal report based off our paper forms.

Our standard is that medevac personnel are to enter the data from the PCR into MC4 within 24 hours from patient contact. Typically, the information is entered after the flight medicÕs shift. He creates a new patient encounter in AHLTA-T and then attaches the electronic version of the PCR to the record.

Because of the efficiency of the hospital staff, it is not uncommon for the patient to be on a plane bound for Germany for additional care as the information from the PCR is entered into MC4.

Our documentation might not be available electronically when the doctors and nurses in Afghanistan begin treating the patient, but we want to make sure that when the wounded warrior arrives in Germany, the medical staff has the full medical picture and can see what the flight medics did and observed.

Gateway: What benefits have you seen since utilizing the PCR?

Ferguson: My unit has flight crews in four locations utilizing the PCR and entering the data into MC4 systems. We have electronically documented every flight mission conducted since we arrived in theater in mid-December 2008. Each location has one MC4 laptop, and each computer has a separate unit identification code, so we have the ability to run reports by location using JMeWS.

Because we have used the PCR and MC4 for a short time, it is a little early to determine trends. To date, we chart approximately 150 calls per month. As we run future medevac missions and enter more patient data, weÕll be able to generate thorough reports on our efforts. When the weather gets warmer and ground forces conduct more missions, we can potentially chart as many as 250 calls on a monthly basis.

We are also working to bring additional locations online where flight medics are located. Our standardization instructor travels throughout Afghanistan to help bring those locations online. Once this is complete, we will be able to provide additional information about our efforts.

Our brigade surgeon, MAJ Laura Kaster, knows about efforts with the PCR and she is very happy with the document. The form displays in JMeWS as a rich text format document. MAJ Kaster and others perform a random sample of our reports by clicking the document and viewing specific PCRs.

Gateway: Why did you feel that it was important to track your missions and generate reports with JMeWS?

Ferguson: I felt that it is important to bring visibility to the level of care being offered by medevac crews. The effort and level of care put forth by this unit on a daily basis is way beyond the common perception of medevacs. I think that many people believe that a

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High-tech mobile hospital trains to save lives in combat

FORT BRAGG, N.C. Ñ ÒMascal! Mascal! Mascal!Ó someone shouted as Soldiers ran out of tents towards a 15-passenger van, horn beeping loudly. Medical personnel whistled loudly to get everyoneÕs attention focused on the latest casualties coming into the area Feb. 12.

A doctor ran to the van and started assessing which wounded personnel were the most critical as medics stood at the ready with wheeled stretchers and all-terrain vehicles to take the patients into the emergency medical treatment area.

ÒThis looks like chaos but itÕs truly not,Ó said Lt. Col. Carlotta Head, 28th Combat Support Hospital. The mass casualty exercise is one of the many exercises planned to train the doctors, nurses, technicians and medics of the 28th CSH. ÒControlled chaos,Ó added Col. Bruce McVeigh, 28th CSH commander.

The hospital conducted a 20-day exercise near Normandy Drop Zone. The Soldiers of the 28th CSH constructed a 44-bed hospital complete with dining facility, EMT, operating room, laboratory, radiology, chapel, motor pool and laundry as well as living facilities for the staff.

ÒThe main reason we came up with this exercise was to get set up, to put the hospital through stressors and (as) realistic functions as we could,Ó said McVeigh.

Some of the activities planned were live surgeries, mannequin training, medical evacuations and field hospital setup. After setup, the CSH was validated by Womack Army Medicine Center, according to McVeigh.

Medics set up an area in front of the EMT to fill in-patient information and assign them to medical teams as fast as they could.

In the EMT, mock patients writhe in various degrees of pain on tables as a staff comprised of a doctor, a nurse and two medics quickly cut clothes off to see the nature of their patientÕs injuries. ÒThose people who need immediate care will be brought in first,Ó said Head.

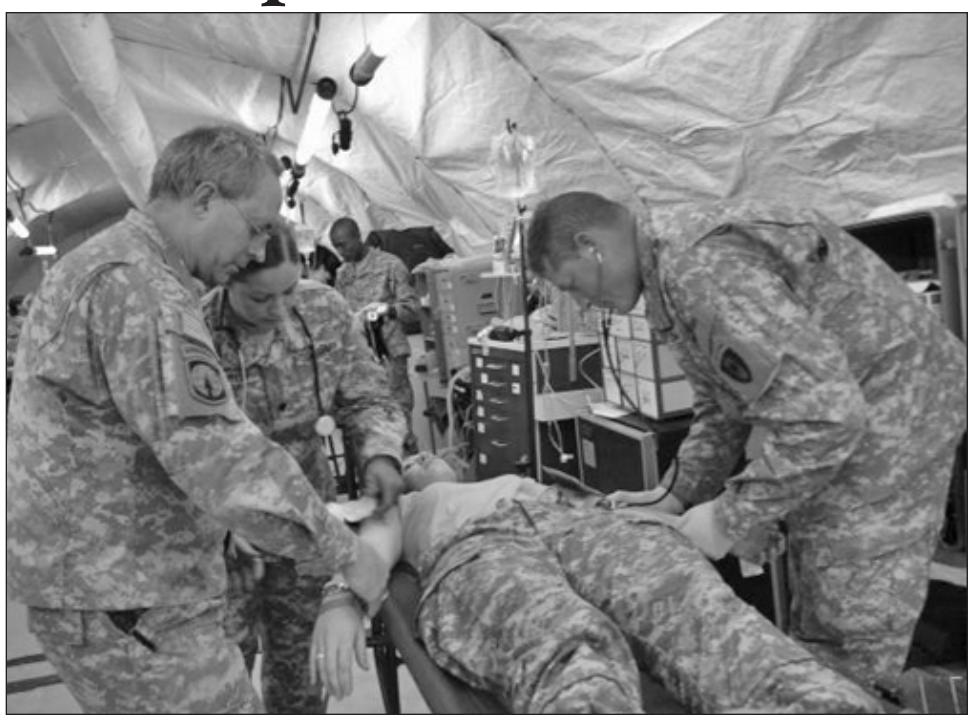
ÒThey do a secondary triage once they get inside. They get clothes off, they get a better look so even if this doc says ÒThis is a delay, it can wait,Õ this doc gets a better look and can elevate that person.Ó

Capt. Lindsay Colburn, one of the Òpatients Ólies on a table while a medical team works on her Òinjury.Ó She volunteered to help train the medical staff at the hospital. ÒIt helps us to prepare for real world mass casualties,Ó she said.

At another table, a medic cut the clothes off a patient. ÒDonÕt let me leave,Óhe screamed out.

ÒIÕm right here,Ósaid one of the chaplains at the hospital.

ÒChaplains generally respond when the hospital gets patients in the EMT to offer whatever support they can give to patients,Ó said Col. Ruth Lee, 28th CSH chief nurse. ÒSometimes if itÕs a mascal, they even help cut clothes, whatever they can do to offer assistance to us.Ó



Dawn Elizabeth Pandoliano photo

Capt. Billie Matthews, Spc. Lauren Bentley and Spc. Sean Whisner check vital signs on Capt. Nicole Bettinger, a "mock patient" during a mass casualty exercise in the emergency medical treatment area at the 28th Combat Support Hospital. The EMT carries the same equipment as a civilian emergency room but is designed for airdrop capabilities.

Chaplains who deploy are also taught Muslim rites for host nation casualties. The commander finds having two chaplains assigned to the hospital very helpful.

ÒThey need someone to talk to after seeing carnage or trauma,Ó said McVeigh.

When the hospitalÕs staff is overburdened by casualties, the rest of the team is ready.

ÒWe pull nurses from the intensive care units and have them assume command of the beds. They follow the patients to other areas of the hospital,Ó said Lee. ÒWe try to cross-train our nurses so they can work at more than one area of the hospital in the event that we do get overwhelmed. When weÕre overseas, we donÕt have a nursing pool to call in and say, ÔHey, we need more nurses today.ÕWe make do with what we have.Ó

Once patients are stabilized, they can go to ICUs or straight to surgery. The 28th CSH has two ICUs with a staff made up of medics and nurses; both registered and licensed practical.

ÒWe take care of patients that are coalition forces, contractors, host nation civilians, enemy combatants, we take care of everything,Ó said Maj. Crystal House, 28th CSH nurse.

One of the tools military medical personnel use from the EMT to ICU to other parts of the hospital is the Medical Combat Casualty Care System. MC4, a computer system, is used in Iraq, Afghanistan and stateside.

ÒItÕs a wonderful tool that we can utilize to document patient care and be able to utilize that system to send the information to other folks. They can actually sit in remote areas so they can re-transfer a patient to the next level of care. They have the ability to go in and see what weÕve been doing at our level and get a background history on that patient so it is an invaluable asset for us to be able to track and maintain patients and provide quality medical care,Ósaid House.

Another wealth of knowledge the hospital can use is the professional fillers system deployment system. Run by the Army Medical Department, the system identifies medical personnel with certain skills to be able to deploy wherever theyÕre needed.

ÒWe brought in 30 of what we call professional fillers from 10 different (hospitals) from as far as Hawaii and as close as Womack,Ó said McVeigh. ÒWhen we go to war, weÕll have about 200 or so professional fillers go with us. What they bring is expertise. They are our docs, our surgeons, our anesthesiologists, more nurses and more technicians. We couldnÕt have done what we did in this exercise and where weÕre going without those folks coming around with us. TheyÕve been critical to success for us.Ó

Capt. Angela Rosario, a nurse in the ICU is a PROFIS flight nurse, from Hawaii. If a patient has a head injury, or needs further help, flight nurses, along with a flight medic, travel by helicopter to a larger medical center.

ÒWhen we transfer patients on flights, the nurses are very responsible for the patients,Ó said Rosario. ÒWe take care of everything. We have all the life support measures that we need. We monitor them and give them drugs that they would need in order for them to survive.Ó

The hospital also has an operating room with two operating tables. The patient first comes to preoperative area. Beyond the red line, everyone must wear headgear, masks and gloves to keep a sterile environment according to Capt. John Avery. After the surgery, the team walks to the decontamination area to sterilize equipment for the next surgery.

The OR at the CSH can accommodate surgeries from appendectomies to life-saving surgeries according to Lee. ÒAny type of surgery that saves a SoldierÕs life,Óshe said. Once a patient is stabilized but needs more intensive surgeries, the 28th CSH sends them out of theater, said Lee.

While patients are being treated from the EMT to the OR, lab and X-ray technicians are busy with patientsÕtests and images.

Technicians in the lab can receive blood, urine and body fluids to test for a myriad of conditions. With most casualties coming in needing pints of blood, they receive O negative, the universal donor blood type in the EMT. Once a patient is stabilized, the lab techs can type their blood so they give them the right type and also save the O negative for other trauma patients. The lab is also a storage area for blood products.

The X-ray department has both a stationary and mobile X-ray machine for immobile patients as well as a computerized tomography scanner. Like every other department in the CSH, they also use the MC4.

ÒWe can send images to anywhere. So if something happens in Iraq, we can X-ray the patient and the images will be there before they arrive,Ó said Cpl. Mark Gichuru, X-ray tech.

The hospital also has a pharmacy stocked with supplies. The pharmacists can print a prescription label straight from the MC4 system and have the medicine ready for pickup.

Once a patient is resting at the hospital, they can look forward to three hot meals cooked by a health care nutritionist specialist according to Lee.

Last but not least is laundry. In one of four self-contained mobile systems in the world, laundry specialists give hospital linens and clothe a very thorough cleaning.

The water gets filtered three different times through three different filters, which take out any biotoxins left behind. The water goes through the boiler at 140 degrees Fahrenheit and comes back into the tank then goes into the next cycle according to Spc. Jason Sprague, 28th CSH. Clothes and linens are dried and folded for pickup.

McVeigh said he and his staff wanted to make sure the field hospital exercise was as real as possible so they would

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Medical genetics lab earns two-year accreditation

By Steve Pivnick
81st Medical Group Public Affairs

KEESLER AIR FORCE BASE, BILOXI, MISS. -- The Air Force Medical Genetics Laboratory at Keesler Medical Center has been awarded two-year accreditation by the Commission on Laboratory Accreditation of the College of American Pathologists.

The 81st Medical Operations Squadron flight received official notification Feb. 13. The genetics flight commander, Capt. Mona Nelson, was congratulated for the Òexcellence of the services being provided.Ó The laboratory is one of more than 6,000 CAP-accredited laboratories nationwide.

Captain Nelson said a three-person team arrived unannounced and inspected the genetics laboratory in early December.

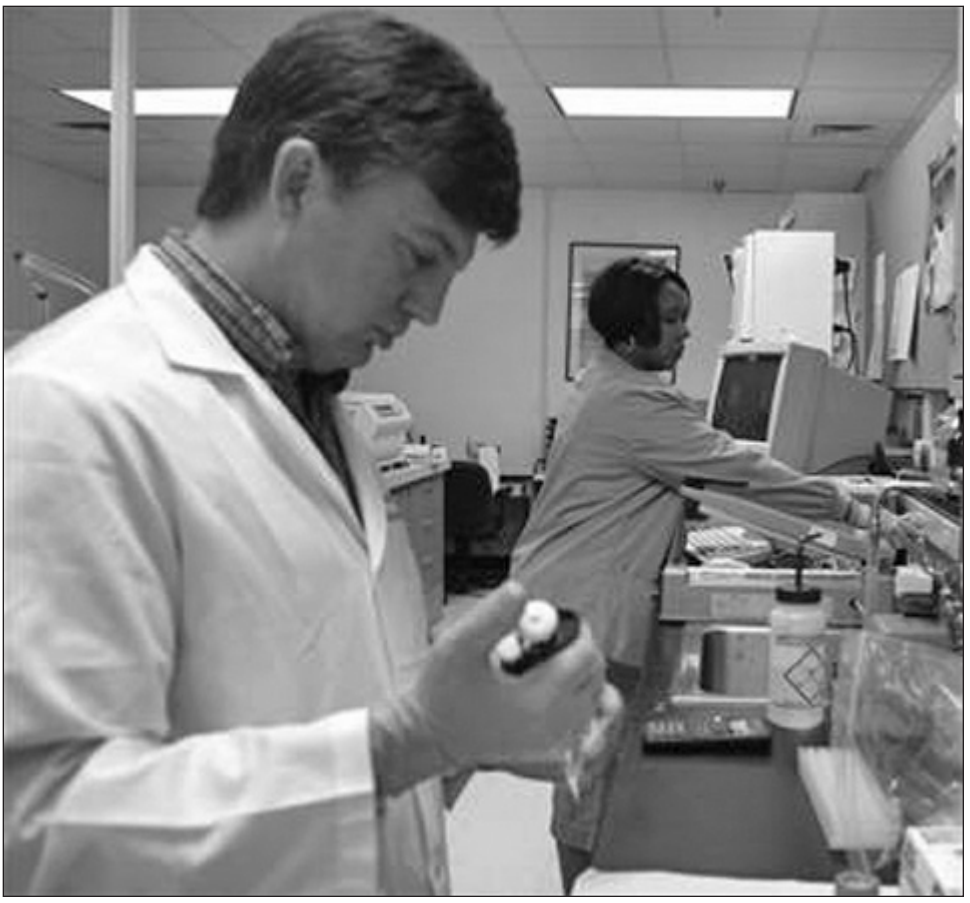
ÒThe summation meeting went extremely well and the whole team had nothing but high praise for the facility and its crew,Ó Capt. Nelson pointed out. ÒEveryone in genetics worked very hard to make the inspection an overwhelming success. Dr. David Rigdon, our medical director, played a pivotal role in this entire process.Ó

She added, ÒSecuring reaccreditation ensures continuing quality genetic testing services for more than120 military treatment facilities worldwide. This translates to approximately $2 million in annual savings for the Department of Defense. This figure will continue to trend upwards given our ongoing service expansion.Ó

Col. (Dr.) Kathleen Elmer, 81st MDOS commander, credits Captain Nelson with the centerÕs aggressive move forward in expanding services.

ÒIt is through her innovative leadership and the hard work of the entire genetics department that we have established Army, Navy and Veterans Affairs agreements for services that have propelled us to the forefront of genetics testing,Ó Colonel Elmer remarked. ÒWeÕve added a genetic counselor to our staff, which allows us to provide an expanded spectrum of genetics counseling and laboratory testing.Ó

The CAP laboratory accreditation program, begun in the early 1960s, is recognized by the federal government as equal to or more stringent than the governmentÕs own inspection program. During the CAP accreditation process, inspectors examine the laboratoryÕs records and quality control of procedures for the preceding two years. CAP inspectors also examine the entire staffÕs qualifications, the laboratoryÕs equipment, facilities, overall management and safety program and record. This stringent inspection program is designed to ensure the highest standard of care for the laboratoryÕs patients.



(U.S. Air Force photo by Steve Pivnick)

Michael Hart uses a pipette to place DNA samples into a microfuge tube as Bridgette Parks prepares reagents for DNA testing. Both are molecular genetics technologists in the medical genetics laboratory

★Combat

Continued from page 3

be ready for a deployment in the fall.

ÒThe focus is every one of these kids being ready to give the best care they can to AmericaÕs sons and daughters because thatÕs what weÕre going to ask them to do. In some form or fashion to include the host nation weÕre supporting,Óhe said.

LeeÕs reason is more personal.

Ò I entered the Air Force during the end of the Vietnam era. I heard about the war but didnÕt really live in it. But now having done it a few times, at least my attitude has changed,Ósaid Lee.

The 36-year veteran paused to steel her emotions.

ÒMy intensity has changed because I feel like we really have to get them ready to be over there. Because even one medic who doesnÕt know his job can really impact saving someoneÕs life.Ó

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Anzac Day

In the early hours of April 25, at various Shrines of Remembrance, cenotaphs and war memorials everywhere in Australia and New Zealand, there is a gathering of the men and women who have gone to war and returned, and with their families and friends gather for a dawn service that heralds the start of another Anzac Day.

This is a day of remembrance Ñ of the deaths and sufferings in war, the valor of fighting men and women, and the ever-present hope for the peoples of the world to live together in harmony and lasting peace.

And, as every Anzac Day service recalls, Òat the going down of the sun and in the evening we will remember them.Ó

End of innocence

Anzac Day, a public holiday in Australia and New Zealand, commemorates the landing at Gallipoli in 1915 of the two countriesÕfighting men, the Australian and New Zealand Army Corps, during World War I.

This was the war that was impossible to win and marked the end of AustraliaÕs age of innocence as Australians and New Zealanders alike witnessed and heard reports of the distant booming guns and the cries of the dying.

All in all, in the Gallipoli Campaign which ultimately ended in defeat, more than 8700 Australians and between 2400 and 2721 New Zealanders were killed. In relation to the two countriesÕ population at the time, this was a massive loss of lives Ñ a sacrifice remembered deeply on Anzac Day.

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Nurses

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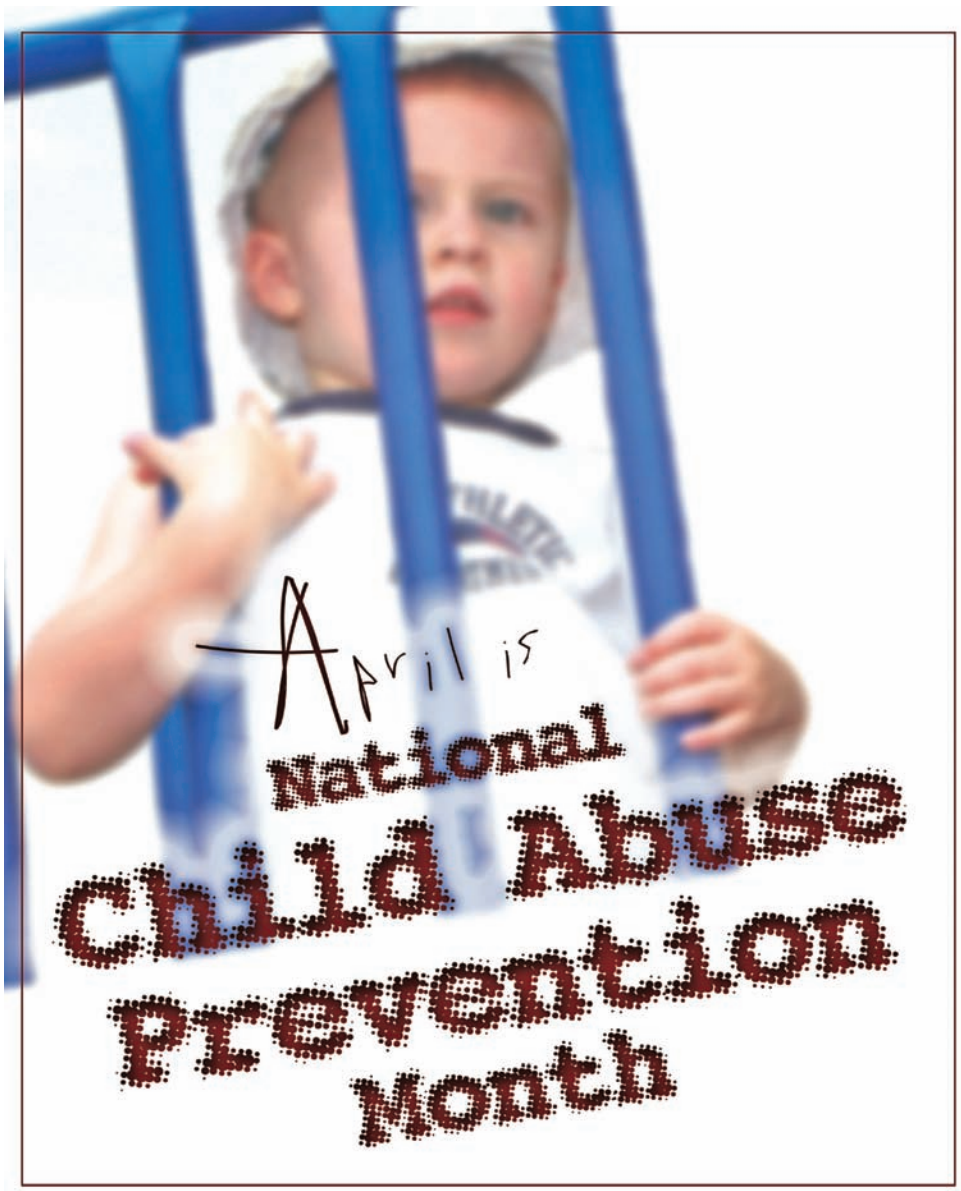

Therapists

Keesler neonatal ICU reclassified as a special care nursery

Neonatal intensive care nurses Susan Givens, left and Capt. Mickaelle Germain examine 3-day-old Riley Fredenburg in the Keesler Medical Center NICU March 11. They are members of the 81st Inpatient Operations Squadron. Keesler Medical Center Neonatal intensive care nurses Susan Givens, left and Capt. Mickaelle Germain examine 3-day-old Riley Fredenburg in the Keesler Medical Center NICU March 11. They are members of the 81st Inpatient Operations Squadron. Keesler Medical Center reclassified its Neonatal Intensive Care Unit to a Special Care Nursery April 1. RileyÕs parents are Navy Petty Officer 3rd Class Drew and Suzanne Fredenburg. Petty Officer Fredenburg is assigned to NMCB7 at the Gulfport, Miss., Combat Battalion Center. its Neonatal Intensive Care Unit to a Special Care Nursery April 1. RileyÕs parents are Navy Petty Officer 3rd Class Drew and Suzanne Fredenburg. Petty Officer Fredenburg is assigned to NMCB7 at the Gulfport, Miss., Combat Battalion Center.

KEESLER AFB, MISS. -- Keesler Medical Center has reclassified its Neonatal Intensive Care Unit to a Special Care Nursery April 1.

According to Lt. Col. Jeannine Ryder, 81st Inpatient Operations Squadron deputy commander, loss of the NICU is the result of a decrease in admissions and patient population. A Special Care Nursery opened as a unit for infants who are delivered at 35 weeks or more, newborns with respiratory difficulty needing short-term antibiotic therapy and/or additional minor delivery complications.

"The Special Care Nursery will be manned to assist the Family Birthing Center nursing staff and allow general pediatricians to upgrade their skills in transitioning newborns with complications at delivery," Colonel Ryder explained.

The two neonatologists presently affiliated with the NICU are expected to be reassigned to other Air Force medical facilities by midsummer. At that time, the Special Care Nursery will close and Keesler Medical Center will no longer provide long-term neonatal intensive care.

"When the Special Care Nursery closes, all women will have to be over 36 weeks and have an uncomplicated pregnancy to deliver at Keesler Medical Center," Colonel Ryder said. "If a woman comes to the medical center with active pre-term labor or pregnancy complications, she will be transferred to a facility in either Mobile, Ala., or New Orleans. All transfers will be dependent on the condition of the mother and coordinated between the military and civilian providers."

Colonel Ryder said, "Our facility has working relationships with neonatal intensive care units in both Mobile and New Orleans. A specialized team will come and transport these infants for further care at their facilities."

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Physicians

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Physicians

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Physicians

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Physicians

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Physicians

The Physician Foundation at California Pacific Medical Center (PFCPMC) is a group of over 100 physicians and a Sutter Health affiliate. PFCPMC delivers medical services to patients through our affiliated medical groups, Physician Foundation Medical Associates (PFMA) and Marin Headlands Medical Group (MHMG). We provide our physician members with an infrastructure for administrative and operational support, allowing them to focus on the practice of medicine. The San Francisco Bay Area is a wonderful place to work and a vibrant place to live. It is rich with culture, diversity and corporate strength. We are currently looking for a physician with experience in internal medicine for a position in the San Francisco Bay area. For more information about this opportunity, please call 415-600-4250 or email.

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Physicians

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Physicians

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Background Check:
A background review and reference checks will be completed on candidates, including State and Federal Criminal Records, Child and Dependent Adult Abuse Registries, Sexual Offender Registry and National Practitioners Data Bank

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The annual salary range for this position is up to $201,281.60, dependent upon qualifications and experience, and the successful candidate will enjoy an excellent benefit package inclusive of insurance, vacation/holidays, deferred compensation and retirement plans.
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'Pinwheels for Prevention' intended to build community awareness of child abuse

By Paula Tracy
81st Medical Operations Squadron

KEESLER AIR FORCE BASE, Miss. Ñ Child abuse, in any form, has been determined to be a consistent factor in predicting a childÕs future potential for poor academic performance, the abuse of alcohol or drugs, engaging in high-risk behavior or illegal activity, and repeating the same cycle of abuse with their own children.

Concerned adults want to leave todayÕs kids a legacy of nurturing homes and schools, safe neighborhoods and myriad opportunities for success. To do this everyone must play a part in community awareness and prevention. Only by working together can we begin to make a lasting impact in the lives of our children.

KeeslerÕs Family Advocacy staff has used ÒPinwheels for PreventionÓ since 2007 to remind the base population that child abuse and neglect is everyoneÕs business and problem. Keesler was the first in the state to use this colorful display for this purpose.

This year, ÒPinwheels for PreventionÓ again will be set up in front of Keesler Medical Center during April. It is a bright, colorful display of 961 twirling pinwheels. Each pinwheel represents a case of child abuse, neglect and exploitation confirmed in 2007 by the Mississippi Department of Human Services in Hancock, Harrison and Jackson counties. There were 1,833 reported cases in 2007; about one half of the reported cases were ultimately substantiated.

But anyone working in child protection will tell you that the reported cases are only the tip of the iceberg. As we stand and gaze at the beautiful pinwheels, we need to keep in mind that what we are seeing is but a glimpse of the complete picture. Therefore, we use the display as a dramatic yet enjoyable medium remind everyone of the need to end child abuse in our communities.

ÒPinwheels for PreventionÓ is a national campaign begun by Prevent Child Abuse America. Through this campaign, they hope to change the publicÕs beliefs and behaviors regarding the prevention of child abuse and neglect. This goes beyond just making Americans aware of the issue Ð it extends to motivating them to take an active role in prevention and in their community.

Genetic counseling available again

By Steve Pivnick
81st Medical Group Public Affairs

KEESLER AIR FORCE BASE, BILOXI, MISS. Ñ The Air Force Medical Genetics Center at Keesler Medical Center is again offering a service unavailable since Hurricane Katrina with the addition of genetic counselor Kathleen Bet to the staff.

Ms. Bet, who earned her masterÕs degree in the field from the University of South Carolina in Columbia, recently arrived from Charleston, S.C., where she worked as a pediatric genetic counselor.

Ò I talk with patients about genetic disorders they may have or that are present in their families,Óshe explained. ÒWe discuss the chances that they could develop or pass on a disorder. Options available include genetic testing and counseling on any psycho-social aspects that might affect them.Ó

Capt. Mona Nelson, 81st Medical Operations Squadron genetics flight commander, said, ÒIt was quite a challenge to find a qualified candidate for this position and we are very excited to have Ms. Bet join the Ôgene team.ÕÓ

Ms. Bet sees patients by referral only.

Providers may refer patients to the medical genetics clinic with a known genetic disorder who need more information about the disorder or risks to family members. Genetic counseling also is available to patients with a family history of a specific genetic disorder who want additional information about their risks of inheriting it or passing the disease on to their children. She also counsels women age 35 or older who are pregnant or desire pregnancy, and pregnant women at any age who have concerns about possible risks to a baby. Patients with cancer and/or a strong family history of cancer (generally defined as more than one first-degree relative with cancer at a young age) who want to learn more about their own cancer risk or the risk to their children may also be referred.

Genetics also welcomes referrals for children with an unexplained combination of developmental delay, birth defects, learning problems and/or distinct physical features to determine if there might be a genetic explanation.

Ms. Bet, a Pennsylvania native, is a member of a relatively small field of about 2,000 professionals in the U.S.

★ Paramedic

Continued from page 2

medevac consists of putting injured personnel on a helicopter, the pilots fly very fast to the hospital and little care is given en route.

This misconception might also stem from the difference between unit locations in Iraq and Afghanistan. In Iraq, there are many medical assets and forward operating bases in close proximity that the average flight times are five minutes. In Afghanistan, due to the remote locations where missions are conducted and the location of treatment facilities, flight times can range from 20 to 60 minutes.

During the long flights, we are performing and documenting advanced, critical procedures. Pushing medications needs to be documented in the Service memberÕs permanent file to have a future impact.

Recently, we had a patient that needed to be sedated and put on a ventilator en route to a hospital. Our actions were credits for saving the wounded warriorÕs life because of the massive bleeding that was taking place in the airway.

WeÕre trying to capture enough information and generate comprehensive documentation so that a future study can be performed regarding the role of medevac and what direction it needs to go.

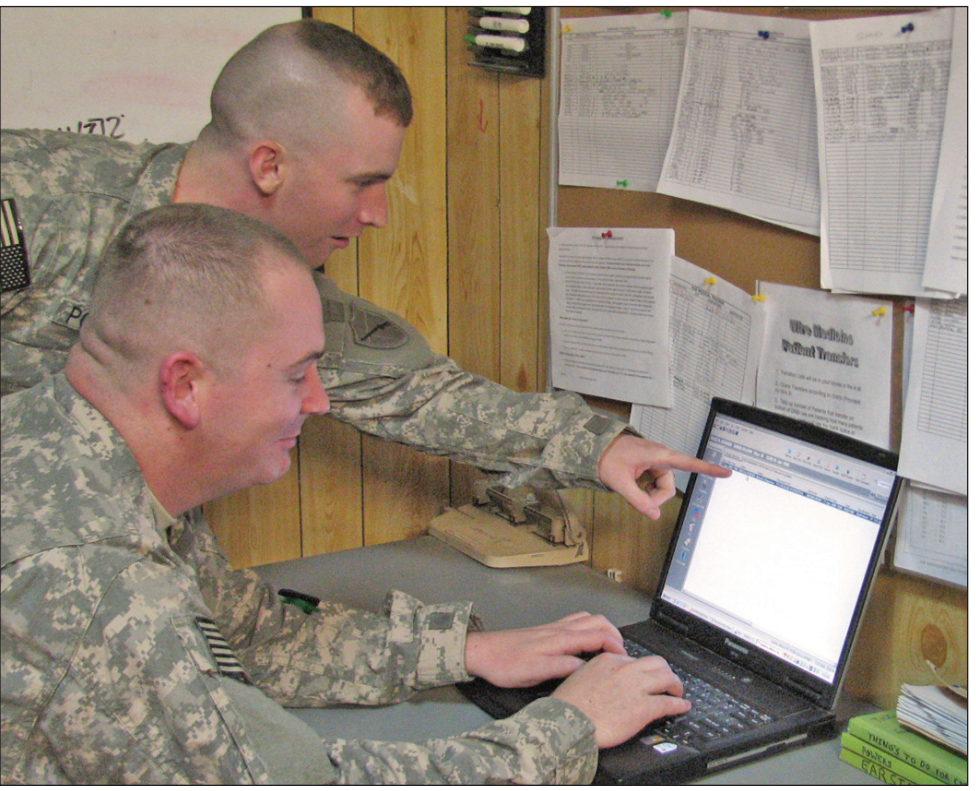
In our short time in theater, different groups have come into our hanger to collect information about what we do, including the ArmyÕs Institute for Surgical Research. Instead of showing them the data collected in the MC4 systems, we point them to JMeWS so they can review all of the information for themselves.

I believe that the documentation we produce will help to shine more light on the activities of medevac missions, so that future changes and enhancements can be made. As a result, more lives will be saved.

Gateway: Will the unit that replaces you continue to use the PCR and MC4 systems to document the care performed in transit?

Ferguson: This is actually one of our concerns. We do not know if the next unit will continue to use MC4 to document their medevac missions the same way we have done. This is a command decision. Since many of us have experience with electronic charting, we know that the information can be used to provide accurate reports and provide visibility about our efforts.

We are trying to incorporate our process into every medevac team and make it mandatory. Our medical officers are onboard with this and are working to make it happen. It is unknown whether the system will take hold and if others will embrace it like we have.



Spc. Jeffrey Powers (sitting) and Spc. Mark Lefevres, medics with the 115th CSH, electronically record patient data via MC4 at Camp Bucca, Iraq.

Spc. James Scott, signal officer (S6) with the 115th CSH, services an MC4 laptop in one of the 29 treatment rooms at Camp Bucca, Iraq.

★ Detainee

Continued from page 1

Camp Bucca was captured on field medical cards-the same paper forms that were first used on the battlefield during World War II. The problem with any paper medical record, regardless if the patient is a detainee or servicemember, is that the information can easily be lost while an individual is in transit to another facility for additional care.

The lack of information delays the healthcare process, requiring staff to conduct repeated tests and procedures to determine a patientÕs malady.

To eliminate this delay, the 31st CSH, the medical unit that immediately preceded the 115th CSH at Camp Bucca from 2007 to 2008, took the first step in moving their medical recording practice into the 21st century. The first solution involved installing laptop computers in the main hospital facility.

Regardless of who was receiving care, a commitment was made to digitally document patient data using the same system used to chart medical information for U.S. servicemembers in combat, the ArmyÕs Medical Communications for Combat Casualty Care, or MC4 system.

This permitted medics to transcribe hand-written encounter notes onto computers at the end of their shifts. However, adding yet another step for providers, who traverse half-mile walkways from treatment rooms to hospitals several times a day, did not win over new users.

To lighten the workload, MC4 handheld devices were introduced, reducing the amount of typing required by the medical staff. Instead, medics could record information into their PDA and sync it with an MC4 laptop, transferring records into a centrally available location.

To enhance the data transfer from the hand-held devices to the MC4 network, the 31st CSH established wireless access points throughout the internment facility to every treatment room. The wireless network then allowed medical personnel to upload the patient data from the 29 different compounds, collected via hand-held devices immediately following patient care.

ÒWhen we took over the mission at Camp Bucca, we used more than 100 hand-held devices to capture and upload thousands of patient encounters within a few months of our arrival,Ó said Spc. Robert Callahan Jr., medic with the 115th CSH. ÒWe really liked the handhelds. TheyÕre easy to use. We were able to enter the information quickly and our young Soldiers were familiar with them since the devices are similar to handheld organizers used in CONUS.Ó

Shift from wireless network to fiber

While the use of MC4 handhelds in a wireless network setting bridged the change from paper to computers, the network could not handle the workload and handhelds posed unforeseen challenges.

The 115th CSH accounts for about 20 percent of all digital patient encounters (7,000 per month) captured via MC4 in CENTCOM, making it one of the busiest treatment facilities in theater. As such, a growing patient population coupled with a taxed network meant the need for change, yet again.

The network was not robust enough to transmit patient encounter tasks in an efficient manner, thus causing delays in detainee care. The hand-held devices would not allow providers to co-sign notes initiated by medics. Additionally, at the end of a long shift, medical personnel were unable to determine if every encounter had transmitted to the network.

The 115th CSH realized that the use of the hand-helds and transferring data via the wireless network was not making the grade. The infrastructure needed to be upgraded.

After months of planning and hundreds of hours of hard work, more than three miles of fiber-optic cable was added to the network infrastructure. The 115th CSH coordinated permission to dig and run the cable throughout the internment facility, after procuring, configuring and installing more than 30 fiber switches so that the new network could efficiently carry patient data throughout the facility.

Ultimately, a large portion of the data that traveled over the NIPR network at Camp Bucca was transitioned over to the MC4 network, improving the overall performance of the network.

Upon switching to a fiber-optic network, the hand-held devices were removed from the compound treatment rooms and replaced with new MC4 laptops. Today, medical personnel throughout Camp Bucca have access to the full suite of medical applications on the MC4 systems without the concern of bandwidth restrictions.

ÒTechnology played a central role in the evolution of health care at Camp Bucca,Ó said Lt. Col. Stephen Wooldridge, deputy commander for administration for Task Force 115 South. ÒUnder the direction of our commander, Col. John McGrath, we have transitioned our efforts from paper documentation to electronic records. We took on this role from the moment we assumed this mission.Ó

Replacing hand-helds with more MC4 laptops has since provided medical personnel with an unexpected benefit. The 115th CSH is able to track the medical care detainees receive as they move throughout the numerous compounds, as well as at other medical facilities for follow-on care. By using laptops instead of hand-helds, users have a type of patient visibility not possible with the hand-helds.

ÒIt is critical to be able to view the health care administered to our patients, regardless of the location,Ó said Capt. Sara Wilson, chief of patient administration with Task Force 115 South. ÒMC4Õs interface with the Theater Medical Data Store allows each treatment room and internment facility to electronically view patient encounters. Providers can track the medical progress of their patients, as well as the efficacy of the medications dispensed in near-real time. This is an incredibly difficult task to accomplish without the advantage of a robust medical network.Ó

The 115th CSH has overcome a number of changes since taking on the mission at Camp Bucca and, in the process, significantly improved the network infrastructure used to collect patient data. As a result of their efforts, they have enabled the medical team to rapidly treat and diagnose thousands of detainees every month, improving the level of care administered at Camp Bucca.

For more information on how medical information is being captured and shared on the battlefield, visit www.mc4.army.mil.

(Capt. Ken Sturtz serves as the information management officer, 115th Combat Support Hospital, Camp Bucca, Iraq.)