US Army
Physician Assistant
Handbook

Second Edition

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US Army Medical Center of Excellence
Fort Sam Houston, Texas

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United States Army
Falls Church, Virginia

2021

"All Gave Some, Some Gave All"

In Memoriam to Our Fallen Physician Assistants . . .

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. . . From the Line, For the Line.



Officer Candidate Jessica Martin, an Interservice Physician Assistant Program (IPAP) Phase 2 student from William Beaumont Army Medical Center, Fort Bliss, Texas, participates in a suture and wound closure training at WBAMC's Simulation Center on March 9, 2018. Photo by March Sanchez. https://www.dvidshub.net/image/4241463/revamped-curricula-wbamcs-sim-center-aims-increase-safety-readiness

Lieutenant Colonel Avery Carney, the IPAP Phase 2 Clinical Coordinator at Evans Army Community Hospital, Fort Carson, Colorado, gives Captain Nelson Liuzzo his diploma during their graduation on October 5, 2018. Photo by Alexandra Shea. https://www.fortcarsonmountaineer.com/2018/10/ipap-graduation/





First Lieutenant Jamie Mueller treats a patient at Forward Operating Base Spin Boldak, Afghanistan, on April 30, 2014. US Army photo. https://archive.defense.gov/news/newsarticle.aspx?id=122192



Colonel (Retired) Louis H. Smith, III, the third Chief of the PA Section from 1998 to 2002, congratulates Colonel John Balser during COL Balser's swearing in ceremony as the 19th Army Medical Specialist (SP) Corps Chief on March 30, 2017. COL Balser is the first PA selected as the SP Corps Chief and he was the Chief of the PA Section from 2010 to 2014. Photo courtesy of Colonel Jeffrey Oliver.



Lieutenant Colonel John F. Detro, the incoming commander of the 187th Medical Battalion, accepts the guideon from Colonel Scott Drennon, commander of the US Medical Department Center and School Academy Brigade (P), while Lieutenant Colonel Jodi Dugai, the outgoing commander, looks on; September 12, 2016. Photo courtesy of MEDCoE PAO.



Captain Christine Cabal, 2nd Cavalry Regiment, Vilseck, Germany, takes care of a patient during a training exercise in September 2019. Photo by Wesley Elliott. https://www.dvidshub.net/image/5790944/army-physician-assistants-embrace-continued-front-line-roles-midst-transitions

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We dedicate this handbook to past Physician Assistants who forged the path that shaped our current environment. This second edition commemorates their legacy and achievements; may they never be forgotten. This handbook is also dedicated to the Physician Assistants stationed worldwide who are currently serving our nation.

The handbook propagates the illustrious narrative of the US Army Physician Assistant. Our hope is that this handbook will be worn and tattered from use, displayed prominently, and esteemed as a useful resource. We are honored to have had the pleasure and privilege to lead this literary effort, and we look forward to what the future generation of Physician Assistants will produce for the follow-on editions of the handbook.

"From the Line . . . for the Line."

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Foreword

The Army's priorities have expanded and are comprised of people, readiness, modernization, and reform. Accordingly, the Military Health System transformation is a critical time for Army Medicine to ensure there are no gaps or decreases in the quality of healthcare provided to our Soldiers, Families, Civilians, and Soldiers for Life—because people matter. Army Physician Assistants (PAs) are key enablers of Army Medicine's provision of sustained health services at home and in combat operations, and as such, are inevitably present from the "Foxhole to Fixed Facility." Army PAs serve in operational units on the front lines with our troops in every country our forces are deployed. They work in our clinics to provide the full spectrum of care for patients, spearhead preventive healthcare and performance optimization initiatives, and are pivotal in the design and transformation of the Military Health System. PAs command our clinics and field hospitals, and serve as senior staff in all of our formations.

The history of the modern PA profession is rooted in military tradition. In 1965, Dr. Eugene Stead announced the Nation's first "physician assistant program" at Duke University and accepted four Vietnam Veteran Navy Medical Corpsmen to the inaugural class. In 1971, the Army began the Medical Field Service Physician Assistant Program at Fort Sam Houston, Texas—and to this day, Army PA candidates selected primarily from currently serving Soldiers are educated through rigorous graduate-level programs such as the Interservice Physician Assistant Program (IPAP) at the Medical Center of Excellence.

It is with tremendous honor that I present the second edition of the *US Army Physician Assistant Handbook*. The second edition not only updates content from the previous edition, but also expands upon the information available to the Army PA. This handbook is the collaboration of PAs past and present and enhances shared understanding, learning, and decision-making; a sharing of knowledge.

Army PAs are the face of the Army Medicine provider to the line and will continue to serve as members of our cohesive team taking care of Soldiers. Army PAs are agile, adaptable, versatile, and innovative in their ability to meet the ever-changing challenges of today and

tomorrow. I'm proud of Army PAs and their work to take care of the Nation's greatest treasure: the men and women of the Armed Services, their Families, and our retirees.

Army Medicine is Army Strong!

TSG 45

VR

R. SCOTT DINGLE
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Commanding General, USAMEDCOM

Preface

The US military is approaching a milestone no one predicted when America was attacked on September 11, 2001. As the 20-year mark of the Nation's longest war nears, one of the most commendable achievements is the extraordinary care our medical teams have provided Soldiers, Marines, Sailors, and Airmen, on and off the battlefield. While our education and training, advanced technology, and enhanced techniques certainly factor in, it's the devotion of our medical teams that is the foundation of our improved outcomes. Physician Assistants have never served a more important role on those teams.

Deploying as a general surgeon in the Kosovo, Iraq, and Afghanistan theaters, I've had hundreds of experiences with casualties, most of them Soldiers and Marines wounded in combat and in need of surgical intervention. There's no doubt in my mind we have the highest survival rates and limb salvage rates in history because of our medics and corpsmen on the battlefield. They're the best in the world. The largely untold story is why they're so good.

The truth of the matter is, the best medics came from units with the best PAs. And the best PAs were not only superb practitioners, they were also great teachers; attentive to their responsibility to provide sustainment training for their medics. I saw it over and over again. When a Soldier or Marine came in with devastating injuries, those that had the best chance for survival almost invariably were treated by medics who had done everything right. They had the best chance of returning home to their families because the PAs in those units were always helping their medics. We owe nothing less to our warfighters, the best America has to offer.

I saw the extraordinary partners PAs were to all of the doctors, and in particular the surgeons, when I was the Chief of Surgery then Deputy Commander of Landstuhl Regional Medical Center early in the Afghanistan and Iraq wars. This was never more obvious than when casualties markedly increased patient loads. The general practice PAs were the combat multipliers of the MTF, treating everything from anxiety disorder to gastroenteritis. Specialty PAs were the physician extenders we needed, providing a significant amount of direct patient care, freeing up physicians to be where we needed them the most; carrying out the evaluations and procedures only they could perform.

I've served with hundreds of PAs during my 30+ years as an Army surgeon. As a former Military Medical Treatment Facility Commander, Regional Commander, and now as the Director of the Defense Health Agency, I appreciate the competence, commitment, and compassion you bring to the military medical profession. For these reasons and so many more, I'm extremely grateful for the privilege to present the second edition of the *US Army Physician Assistant Handbook*. Thanks for your continuing service to the men and women of our Armed Forces, and the Families who support them!

RONALD J. PLACE, MD
Lieutenant General, US Army
Director, Defense Health Agency

Prologue

The medical readiness of the force now and in the future is paramount. The US Army Medical Center of Excellence (MEDCoE) is responsible for envisioning and designing the responsive Army Medicine capabilities and structure that support the fielded force and the future force. As one of the US Army Training and Doctrine Command (TRADOC)'s ten Centers of Excellence, MEDCoE trains, educates, and inspires medical personnel to conduct medical operations in unified land operations and the multi-domain operational design of the future. Battle-focused training is the most crucial activity MEDCoE Soldiers and trainees do to achieve readiness. US Army physician assistants (PAs) have played an essential role in ensuring readiness since they first began serving in the 1970s. The PA initially met a need for healthcare providers which greatly expanded during the Iraq and Afghanistan conflicts of the 21st century. As the PA profession continued to grow, a need for a mentorship program developed, which led a group of PAs to write the first *US Army Physician Assistant Handbook*.

This second edition of the *US Army Physician Assistant Handbook* takes into account the changes in military medicine since the first edition was published in 2018. A comprehensive transformation occurred with the move of Army medical training to TRADOC, the transition of military medical treatment facilities to the Defense Health Agency, and research activities aligning with Army Futures Command. Army PAs are essential in this time of transition, using their clinical, educational, research, leadership, and management skills to maintain the highest quality of medical training as the command structure changes.

Today, Army PAs are integral to training activity in numerous positions and roles at MEDCoE: Interservice PA Program Director/ Associate professors, combat medicine training instructors, and commanders of training companies and battalions. Army PAs are contributing to readiness of the force by training Soldiers in tactical and technical competencies to build and sustain operational capabilities. Army PAs are critical to Army Medicine's ability to ensure the health of the maneuver element during competition, preserve Soldier lethality in conflict, and facilitate a return to competition. By leading their

profession in meeting the changing mission and training demands in the 21st century and beyond, Army PAs are a true embodiment of their motto, “From the Line … For the Line.”

DENNIS P. LEMASTER
Major General, US Army
Commanding

19th Army Medical Specialist Corps Chief Message

This second edition is an expansion on a very successful first edition launch of a handbook that, while intended as a guide for Physician Assistants, has touched on many aspects of Army Medicine. We will see significant changes when the Defense Health Agency (DHA) fully assumes the role of managing all the military medical treatment facilities, but PAs and the Specialist Corps will continue as the backbone of soldiers' medical care.

As Corps Chief, my job was to ensure that all components of the Corps (Occupational Therapists, Physical Therapists, Dietitians, and Physician Assistants) deliver the capabilities that the Army expects from these experts. The newest initiative is the Specialist Corps-driven Holistic Health and Fitness (H2F) program. These H2F providers are assigned to maneuver units working alongside the Physician Assistants already embedded in these units. This marriage shows what can be accomplished when the strength of the entire Corps works together. Working with the line as a collective group maintains the significant fighting strength the Army needs in any operational theater.

What about the future? Physician Assistants are popular and will continue to be a vital component of operational units. The DHA is the way forward, and as time goes by, we will likely see more collaboration between the various branches of the military, cementing our place in operational medicine. Likewise, many talented individuals have opened the door for leadership opportunities and proved that a PA is a capable leader at all echelons of command. There will always be a need for leaders in our various medical units, and this is a place where all those coming up through the ranks can take advantage of previous efforts and excel where others have paved the way. Rank opportunities have increased, and so it is up to those future individuals to carry the torch and forge new frontiers.

We are in an exciting time, and the future script is unwritten. I hope that the time and effort that has gone into this handbook is helpful and appreciated. Feel free to share it with others in the medical community because initiatives like this set us apart. Keep the machine moving!

Colonel John Balser, PA-C, MPAS, MSS
19th Army Medical Specialist Corps Chief

20th Army Medical Specialist Corps Chief Message

"Reading is to the mind what exercise is to the body." – Joseph Addison

The mission of the Army Medical Specialist (SP) Corps is to develop Corps leaders who enhance Soldier health and readiness in garrison and throughout multi-domain operations (MDOs). The Army PA Handbook, now in its second edition, provides an amazing resource to help our Corps reach our vision: to lead the advancement of Soldier health and readiness.

As the 20th Army Medical Specialist Corps Chief, I am honored and humbled to have witnessed the impact of Army PAs on the health and readiness of the force. Since joining the SP Corps in 1992, PAs have enhanced Corps capabilities in support of the total force. I have been fortunate to have worked with our best PAs in garrison and in deployed settings. This second edition of the PA Handbook highlights the value of Army PAs, which I have had the luxury of experiencing firsthand.

Gustave Flaubert stated, "The art of writing is the art of discovering what you believe." The Army PA serves a fundamental role in supporting Army Medicine's priorities in taking care of our people, enhancing battlefield medicine, and streamlining early identification and treatment of illness and injuries. Army PAs leverage their clinical, research, and force development expertise in ensuring the SP Corps delivers solutions in garrison, across MDOs, and in large-scale combat operations; in writing this handbook, they have shown the breadth and depth of their mission. Benjamin Franklin once stated, "Either write something worth reading or do something worth writing." This handbook exemplifies both. The number of Army PAs who leveraged their experiences to contribute is impressive and clearly demonstrates their tradition of sharing the roles and responsibilities of Army PAs. This edition has been expanded to include collaborative efforts with Compos 2 and 3, new roles, and lessons learned and tips for success. Additionally, our Army PAs have proven themselves at strategic, operational, and tactical environments; this second edition highlights the holistic impact of the Army's PAs on readiness. As the table of contents shows, this handbook is not just for Army PAs; it is also worth reading by anyone interested in military professional and personal development.

I am proud of our team's collaboration. The future of Army PAs remains bright. Stay fit!

Colonel Deydre S. Teyhen, DPT, PhD
20th Army Medical Specialist Corps Chief

Introduction and Acknowledgements

For almost 50 years, Army Physician Assistants (PAs) have supported the US Army by ensuring the military force is both ready to fight today and prepared for the challenges of tomorrow. Since the inception of the PA profession, military PAs have demonstrated that they are versatile and adaptable force multipliers, performing essential work in a variety of environments ranging from combat outposts to clinics and command suites. The role of the Army PA has evolved since the early 1990s when they first became commissioned officers. Over the years, the PA position has been tailored according to changing needs of the Army. Army PAs provide a wide range of care at each level, or echelon, of care, from emergency and life-saving treatment at the point of injury, to routine care or wellness visits, to specialty services such as orthopedics, emergency medicine, general surgery, and behavioral health, as well as serving in staff roles at various levels and organizations throughout the Department of Defense. Vast changes in the role of the PA, and in the opportunities for PA development, necessitated a dedicated resource; hence the initiation of a handbook to guide PAs: the *US Army Physician Assistant Handbook*.

The Borden Institute published the first edition of the *US Army Physician Assistant Handbook* in May 2018. The first edition originated from the need to understand the diverse positions and roles of the Army PA and prescribed PA-specific guidance for career development. This second edition of the handbook continues the legacy of the first edition in providing information on career development, current opportunities, and important lessons learned. The second edition also incorporates new roles and topics of interest that have emerged since 2015. It has been a "labor of love" to showcase PA foundations and recognize the advancements of the PA profession. This handbook serves as a chronological time capsule; a portrait in space and time. It depicts a thriving Army PA, a ready medical force multiplier who stands prepared to answer the call, whenever and where ever the nation has a need.

A literary work such as this handbook is no small feat. It requires extraordinary effort on the part of a dedicated and faithful team of collaborators. We are sincerely grateful for the contributions of so many of our colleagues and leaders in support of the second edition of the *US Army Physician Assistant Handbook*.

This handbook exists due to the support of the Borden Institute staff, namely Mr. Ed Lindeke (Director), Ms. Joan Redding (Senior Production Editor), Dr. Lisa O'Brien (Editor), Mr. Robert Dredden (Illustrator), and Mr. Ernest Barner (Public Affairs). We are forever indebted to them for their coaching and guidance in the arduous process of charting the path to produce the PA Handbook.

The PA Handbook working group was instrumental in ushering the completion of this project. We would like to thank COL Johnny Paul and MAJ Paul (Jason) Auchincloss for performing first draft chapter reviews, and MAJ Timothy Pekari and CPT Robert Gipson for their administrative support. This endeavor was made possible due to their devotion and commitment.

To the numerous contributing authors who dedicated their time and energy in sharing their knowledge and experience, we wholeheartedly thank you. These authors took precious time to capture and portray their expertise to ensure that others may benefit from their lessons learned and tips for success.

To the military and civilian leaders, thank you for your mentorship and confidence in PAs. Your trust and faith have enabled us to contribute to a medically ready force and a ready medical force. Army Medicine is Army Strong!

Amelia M. Duran-Stanton, PA-C, PhD, DSc, MPAS
Amy L. Jackson, PA-C, MPAS

Chapter 1

FROM VIETNAM TO AFGHANISTAN: THE HISTORY OF THE ARMY PHYSICIAN ASSISTANT

John F. Detro, APA-C, MPAS, MSS, MEd; John E. Balser, PA-C, MPAS, MSS; David W. Broussard, PA-C, MPAS; Amelia M. Duran-Stanton, PA-C, PhD, DSc, MPAS; Pauline V. Gross, PA-C, MPH; Robert S. Heath, APA-C, MPAS; Amy L. Jackson, PA-C, MPAS; James J. Jones, PA-C, PhD, MPAS; Jimmie E. Keller, PA-C, MPH; and Sarah E. Scott, BA

> As the face of the AMEDD [Army Medical Department] provider to the line, Army PAs [physician assistants] will continue to serve as a key healthcare link between the Warfighter and the AMEDD. Army PAs fulfill the mission and vision of being agile, adaptable, versatile, and innovative to meet the ever-changing challenges of today and tomorrow. Army PAs are proud to take care of the Nation's greatest treasure: the men and women in uniformed service, their Families and beneficiaries. Army PAs are truly part of "One Team. One Purpose! Conserving the Fighting Strength!"
>
> *—Lieutenant General Nadja West*
> *The Surgeon General & Commanding General,*
> *Office of The Surgeon General/US Army Medical Command, 2016–2019*
> *2016 National Physician Assistant Week Email Message*

Introduction

The physician assistant (PA) community and the US military have been connected since the founding of the PA profession. Currently, National PA Week is celebrated annually from October 6 to 12. Initially, National PA Day was celebrated once a year, on October 6. This date is significant for two reasons: (1) it is the date three former Vietnam-era Navy corpsmen graduated from Duke University's PA program in 1967, and (2) it is the birthday of Dr Eugene Stead Jr, the founding father of this prestigious program and of the PA profession.[1]

The 1960s: Origins of the Profession

The PA profession's past can be traced to an article written in 1961 by Dr Charles L. Hudson. Titled "Expansion of Medical Professional Services with Nonprofessional Personnel," it was published in the *Journal of the American Medical Association*.[2] Due to a shortage of physicians and allied health care professionals, Dr Hudson's vision was to create two new groups of providers to assist doctors in performing supervised primary care support to the public.[3] During the 1961 American Medical Association (AMA) conference, he described the two groups.[4] The first group would be interns who lacked formal medical education but would undergo on-the-job training like physicians of the past, and would serve in medical and surgical inpatient settings, including operating and emergency rooms. The second group was to be called externs. These individuals were to undergo formalized medical training somewhere between the level of a physician and that of a technician. The graduates would then work as primary care physician extenders. For this group, Dr Hudson proposed a 2-year college program followed by a 2-year clinical rotation leading to a Bachelor of Science in Medicine (BSM) degree. He felt that these "assistants to doctors" could be employed to handle routine care, allowing doctors to manage more complex procedures and care for increased patient populations.[2]

Three physicians took Dr Hudson's vision to heart. Dr Eugene Stead Jr, at Duke University, Dr Richard Smith from the University of Washington, and Dr Hu C. Myers at Alderson Broaddus College all bought into the idea of creating a program to address the national primary care physician shortage and began to develop the curricula.[3] Dr Stead and Dr Smith were aware of the plight faced by discharged medics after serving in the Vietnam conflict. These individuals had developed exceptional medical skills while serving in the military, but much of their training failed to translate into civilian education or health care professions. Both physicians felt that these former military medics could be trained to meet the primary care void.[4]

As early as 1964, Dr Stead and others used the term "physician assistant" to describe this new health care provider.[4] In 1965, Dr Stead was the first to create a PA program. Originally, he had hoped to convince the nursing community that his development of a nurse clinician program was a worthy cause. Unfortunately, the National League for Nursing, on three separate occasions, declined to accredit

the program. Disillusioned by their rejection of his proposal, Dr Stead enlisted former Navy corpsmen into his PA program. His idea was to develop a curriculum based on clinical versus didactic training, an approach that would produce results much more quickly than traditional academic programs.[5] The PA medical training model ultimately utilized was similar to a program developed during World War II that fast-tracked the training of physicians.[4]

This was not a totally new concept even during World War II. Peter the Great introduced a group of medical assistants called "fel'dshers" into the Russian army around 1721.[6] By the 1790s, over 500,000 fel'dshers were providing care in rural areas of Russia. "Loblolly boys" were used by the British and US navies to assist surgeons as early as the 1800s.[6] Their job description was "to do anything and everything that was required—from sweeping and washing the deck and saying 'amen' to the chaplain, down to cleaning the guns and helping the surgeons to make pills and plasters and to mix medicine."[6] Loblolly boys were predecessors of today's Navy corpsmen.[6]

According to Dr James Mau, first administrator of the Duke PA Program, he and Dr Stead traveled to Fort Bragg, North Carolina, to observe the Army Special Forces medic training program in 1965. The physicians noted that these medics were trained well beyond the level of Navy corpsmen. The Special Forces medics were equipped to operate independently, supporting units in austere environments without the presence of a physician. Dr Stead was impressed by this course, and the experience influenced his development of the PA program at Duke University.[5]

Though it was not easy to implement, Dr Hudson's original 1961 proposal to train former military medics as PAs made sense as a cost-efficient way to meet the growing health care needs of the country and to employ veterans returning from Vietnam.[3] To further help cover the costs of the PA program, Dr Stead tied the educational curriculum into an existing grant for training hyperbaric chamber specialists.[7]

In 1965 Dr Mau also visited with Dr Amos Johnson in Garland, North Carolina. Dr Johnson regularly interacted with the Duke University medical community.[5] In the 1940s Dr Johnson had employed a young African American man, Henry Lee "Buddy" Treadwell, who he trained as his assistant. Treadwell performed physical exams, made diagnoses, and treated patients. By 1960, Treadwell was traveling regularly with patients to Duke University Medical Center and interacting with

students and physicians. This was significant given the South remained segregated into the late 1960s. His role in the medical community was well known and respected. On the recommendation of Dr Mau, Duke eventually made Treadwell an honorary PA.[8]

During this period, Dr Smith, who had made a separate visit to Fort Bragg's Special Forces medic course, started his "MEDEX" (medicine extension) model, focusing on development and employment of graduates in medically underserved communities around the world, with 14 former military medics making up the first cohort. This program was not about creating a new health profession, but rather constituted a strategy to transform health care. Both Dr Stead and Dr Smith were greatly influenced by the Special Forces medic curriculum in creating their programs.[9]

On October 6, 1967, three of the four original Duke students graduated from the PA program with certificates of completion. These men were Victor H. Germino, Kenneth F. Ferrell, and Richard J. Scheele. Due to the fledgling nature of the profession, all three were hired by and remained at the Duke University Medical Center.[10]

Dr Myers disagreed in part with the educational philosophy of his counterparts Dr Stead and Dr Smith. Dr Myers believed that a degree was necessary to confer a sense of professionalism on this new career field. In 1968, he established the first baccalaureate degree-producing program at then Alderson Broaddus College (now a university) in Philippi, West Virginia. It quickly became clear that the federal government favored degree-producing schools, and the majority of new programs followed Dr Myers' lead.[3]

From 1968 to 1972, Duke hosted the first of four conferences to promote the PA profession, develop and standardize the curricula, and promote related legislation. The first graduates of Duke University's PA program established the American Academy of Physician Assistants (AAPA) in 1968 and incorporated the organization in North Carolina.[7] Its purpose was to serve as a national professional society to represent PAs in all areas of practice and promote the profession.[7] AAPA is now headquartered in the Carlyle area near Old Town Alexandria, Virginia.[7]

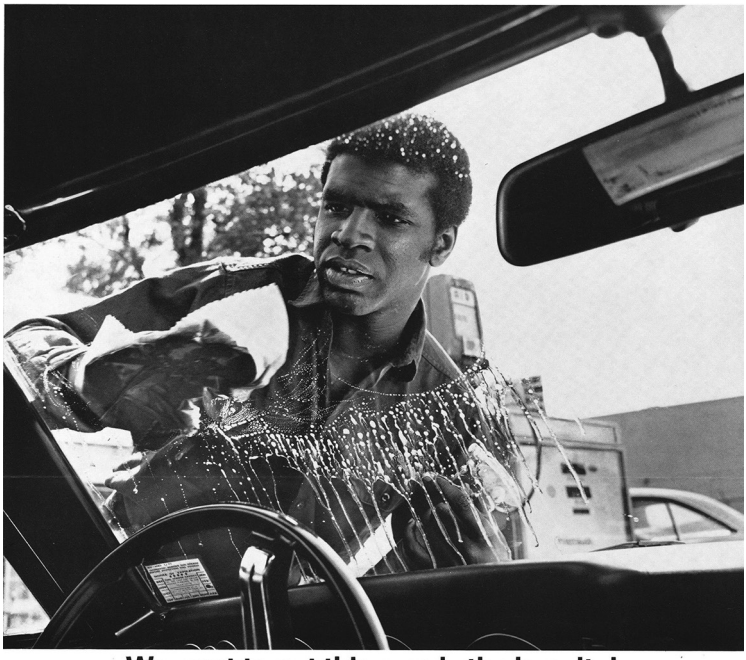
The 1970s: Beginnings

In 1971, the AMA passed a resolution to recognize PAs and began to develop national certification standards.[3] The same year, Dr Marvin

Gliedman, Dr Richard Rosen, and Clara Vanderbilt, Registered Physician Assistant–Certified (PA-C), established the first postgraduate residency in general surgery at Montefiore Medical Center, Bronx, New York. Later that year, Congress passed the Comprehensive Health Manpower Training Act of 1971, which included $4 million to establish PA educational programs.[7] At the same time, cartoonist Dick Moores' popular comic strip *Gasoline Alley* first introduced PAs to the public when leading character and former Vietnam-era Navy corpsman Chipper Wallet decided to become a PA.[11]

To garner support for the program, Dr Stead collaborated with AMA to develop an advertisement that ran in the July 30, 1971, issue of *Life Magazine* (Figure 1-1). Showing a young African American Vietnam veteran washing a car's windshield, the copy read: "This man belongs in a hospital. Or a doctor's office. Working alongside doctors, helping to care for patients." The advertisement copy related how for 2 years, this man was the first one on the battlefield to make decisions that could save the arms, legs, and lives of wounded service members in action. After serving his country, he could not get a job in medicine, like others with his skills. Not only did the advertisement describe the story of military medics, but it also informed the public of PA educational opportunities. The publicity effort was a powerful reminder to members of Congress about the sacrifices of America's medics, and led to support for educational funding of PA programs.

Also in 1971, Colonel Dwight F. Morse Jr wrote his US Army War College research paper on the initiation of an Army PA program. He based his concepts on the civilian programs, recognizing the shortage of physicians within the nation and military: "During recent years, the Army Medical Department has been progressively plagued with increasing losses of career medical officers by resignation or retirement."[12] His article described the impetus for the first military PA class, which was scheduled to begin the following year. At the time, Lieutenant Colonel Henry A. Robinson Jr, Medical Corps, was the acting program manager of the former Medical Field Service School at Fort Sam Houston, Texas (now the Medical Center of Excellence). Lieutenant Colonel Robinson led efforts to develop student prerequisites, curriculum, and utilization tours for those who graduated from the PA program. According to Morse, the PA was meant to fill a need to provide medical care to soldiers in their respective field units and to allow nurses to continue providing care within military medical treatment facilities (MTFs),



We want to put this man in the hospital.

This man belongs in a hospital. Or in a doctor's office. Working alongside doctors, helping to care for patients.

For two years, he was a medic in Vietnam (volunteered for the duty because he was always interested in medicine). For two years he was the first one to the wounded on the battlefield. The first one to make the decisions that could save an arm, a leg—or a life.

That happens to be pretty good experience for a career in medicine.

But back in civilian life, he's pumping gas. Nothing wrong with that, of course. Except for the terrible waste of his training.

But now there's a way to put people like this into hospitals and doctors' offices. Programs developed by the American Medical Association are now putting qualified people into patient care work. So they can apply their skills as "physician's assistants."

These "physician's assistants" are men and women who in a relatively short time can be trained to perform certain kinds of medicine (under a doctor's supervision, of course). They can do everything from taking blood pressure to giving shots, to saving lives in emergencies.

They're arriving on the scene just in time.

You see, there's a shortage of doctors today. And with the growth in population (a population that is living longer), and with the surge in demand for medical care, doctors need help now.

These "physician's assistants" are one very good answer to this grave problem. They're virtually an extra right hand for the doctor. And that's very good news for the doctor's patients.

For information on the "Physician's Assistant" programs, write: Box P, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

America's Doctors of Medicine

Figure 1-1. *Life Magazine* advertisement, July 30, 1971.
©American Medical Association [July 30, 1971]. All rights reserved/Courtesy of AMA Archives.

stating, "No plans exist at present for the assignment of the Army PA to duties in a hospital setting."[12] He concluded his paper by providing six recommendations to Army medical leaders:

(1) continual monitoring of civilian PA programs;
(2) involving all hospital staff at inpatient medical facilities in the education requirements of the Army PA program to maximize benefits;
(3) developing a marketing plan to ensure all involved understood the importance of PAs to Army medicine;
(4) urging physicians to utilize PAs in appropriate roles based on training and patient populations;
(5) developing further studies on the role of PAs within Army medicine; and
(6) conducting recurrent reviews to determine future extensions in the PA scope of practice.[12]

Up to this point, all the work of development and training in the profession had been conducted through universities with former US Army and Navy personnel. In 1971, the Air Force, under the direction of its surgeon general, Lieutenant General Alonzo A. Towner, was the first service to create a military PA program. Towner realized that the Air Force was not meeting medical needs in general and family medicine, and shortages could not be addressed through physician recruitment alone. To look into possible solutions to this problem, Towner created the Air Force Medical Services Health Manpower Utilization Study Committee. For the first time since 1966, the Air Force submitted a request to draft 150 medical professionals to cover this gap in active duty officers. Towner then requested that the committee establish a curriculum to train PAs to help fill the acute shortage in family medicine (email from John Heitz, US Air Force Medical Services History Office, Houston, TX, September 17, 2016).

The Navy and Army quickly followed suit. In 1973, the first Army PA class graduated (Figure 1-2), and its students became warrant officers. This initial class of Army PAs consisted of fifty-eight men and two women. Upon assignment, these graduates were designated "battalion surgeons" because of the lack of military physicians (general medical officers) within these units, therefore becoming first-line medical officers. Through their expertise, proximity to the troops, and respect earned within garrison and operational environments, they earned the affectionate designation of "doc."[5] Sergeant First Class Louis Rocco was a member of this first class. Rocco had gained fame in Vietnam while participating in a medevac mission as an Army medic. During



Warrant officer candidates attending the first class of the Physicians' Assistant Course, staff and faculty members include (from left, front) Dr. William G. Toland, Dean, Graduate School, Baylor University; Major General Kenneth D. Orr, Commanding General of Brooke Army Medical Center and Superintendent of AHSUSA; WOC's James O. Tanner, Benjamin N. Stewart, Dennis J. McCullough, De Leon Gunter, Roy D. Arian, Ray Barger Jr., Vincent Tenorio, David H. Jenkins, (second row) Hugh P. Hughes, Richard L. Curtis, Harold E. Slusher, Gerald E. Hults, Robert G. Hood, Joseph E. Swarts, Arthur Kyliavas, Harold B. Tyler Jr., William D. Long, Gary R. Herron, (third row) Daryl D. Butler, Harold W. Ward, David F. Duncan, James F. Madison, Louis R. Rocco, Harry M. Matthews Jr., Phillip O. Kerns, Ramona F. Deliz, George G. Strickler, Marvin H. Bruce, Milton Johnson, (fourth row) Don A. Johnson, Lawrence R. Williams Jr., Truman O. Thompson, Gilbert W. Coates, Howard L. Wells, Alvin R. Baccus, William H. Reinkins, Darvin D. Thomas, Jerry A. Massa and James L. Mountcastle; (fifth row) CPT Jerry J. Noren; WOC's John W. Hunt, Gordon E. Greentree, Clarence L. Thomas, Marshall E. Walker, Jo Ann E. Nick, Donald L. Edwards, Donald L. Spidel, Ernest C. Chastain, Walter E. Schofield, Johnny M. Brown Jr. and Joseph G. Obermire; CPT Joseph M. Long; CPT John Geesbreght; (back row) MAJ John Craig; MAJ Roger L. Christian; MAJ Dean Smith; CPT Peter B. Engber; Dr. Alton B. Lee, Baylor University; COL Henry A. Robinson Jr., Chief, Physicians' Assistant Branch, Medicine and Surgery Division, AHSUSA; COL Thomas C. Birk Jr.; LTC Joseph McNaney; CPT Stephen R. Uhlin; CPT Charles P. Cole; CPT Mark Langenfeld; MAJ George K. McMullan and CPT Henry S. Eden. Not shown is WOC Kurt M. Wyson.

Figure 1-2. Warrant officer candidates attending the first class of the Physician Assistant Course pose along with staff and faculty members. The photo appears to have been taken on the northern steps of the causeway between Willis and Aabel Halls.
US Army photo courtesy of the Medical Center of Excellence History Office.

a casualty evacuation mission, the UH-1H "Huey" helicopter Rocco was traveling in was shot down. Despite a fractured wrist, severe burns to his hands and body, and a badly injured hip and back, he carried several wounded crewmembers to safety while under enemy fire and was credited with saving their lives. For his bravery, Sergeant First Class Rocco received the Medal of Honor.[13]

In April 1972, the National Board of Medical Examiners (NBME) agreed to oversee development of the examination to certify PAs at the national level. The same year, the National Commission on Certification of Physician Assistants (NCCPA) was founded by 14 national health

care organizations to oversee eligibility and standards for the NBME examination. Formally recognized as a nonprofit group, NCCPA's purpose was and continues to be providing certifying examinations for new PA graduates and recertifying examinations for licensed PAs. The NBME appointed an advisory committee and task force to construct a blueprint for test committees, which eventually became the examination administered by the NCCPA.[14] During early versions of the testing, the candidate was required to perform hands-on testing in addition to a challenging written exam. PA programs varied in recognition from awarding certificates to conferring college degrees. The first civilian PAs to receive baccalaureate degrees graduated in 1972.[15] The first Army PAs graduated in 1973, earning certificates, and in 1985 the first Army PAs received baccalaureate degrees from University of Oklahoma Health Science Center.

In 1975, the Army determined that enough PAs were on active duty to fulfill primary care requirements and terminated its program. Within 3 years, another shortage ensued, and the Army surgeon general ordered the program restarted. Due to a lack of funding, however, the Army contracted with the Air Force to send students to Sheppard Air Force Base, Texas, for training. In September 1979, the Army resumed its program at Fort Sam Houston.[15]

In 1976, a group of former Army PAs stationed at Fort Hood, Texas, started a civilian organization to represent Army PAs. The first recorded meeting for the Society of Army Physician Assistants (SAPA) was held on September 24, 1976. In 1980, the first annual SAPA PA refresher course was held in Fayetteville, North Carolina. The annual conference continues to be held in Fayetteville, and today the organization has an average active membership of around 466.[16]

The 1980s: Combat Tested and Valued Members of the Army Medical Team

In 1980 and 1981, the Army began specialty programs for PAs in orthopedics, cardiovascular perfusion, emergency medicine, occupational medicine, and aviation medicine.[5] These programs continue today, with the addition of general surgery training. The first Army PAs deployed into combat with the 82nd Airborne Division (ABN DIV) and the 1st and 2nd Ranger battalions, proving their worth during fierce fighting in support of Operation Urgent Fury. Though operations

in Grenada were brief, several medical units that included PAs provided critical care to soldiers and civilians, treating their wounds and getting them safely away from the battlefield (email from Major [Retired] Jimmie E. Keller, former PA consultant to the Army surgeon general, Highlands Ranch, CO, November 17, 2015).



Figure 1-3. Chief Warrant Officer 2 Pauline Gross deployed to Palmerola Air Force Base in Honduras with the Joint Task Force-Bravo Medical Element as a physician assistant and surgical technician. As of this writing, now Colonel (Retired) Gross is the longest serving PA in the US Army Medical Department. She was appointed the Army Installation Management Command Surgeon in 2015. Photograph courtesy of Colonel (Retired) Pauline Gross.

On Mother's Day in 1986, Chief Warrant Officer 2 Pauline Gross (Figure 1-3) was deployed to Palmerola Air Force Base in Honduras to support Operation Golden Pheasant with the Joint Task Force (JTF)-Bravo Medical Element. The purpose of this operation was to disrupt the Contra supply chain during the Iran-Contra affair. The JTF-Bravo Medical Element included veterinarians, dentists, public health nurses, force protection officers, orthopedic surgeons, general surgeons, and family practice/internal medicine physicians, who traveled to different villages, providing sick call and sexually transmitted disease clinics for the troops as well as providing care for the local population outside the gates. Because of her prior operating room experience, PA Gross also worked in the surgical suite assisting the surgeons with emergency procedures. She previously served in the Women's Army Corps. In 2018 Colonel Gross retired as the Installation Management Command surgeon (Figure 1-4), earning the distinction of being the longest serving active duty PA in the Army,



Figure 1-4. On June 15, 2018, Colonel Pauline Gross celebrated her retirement with fellow female Army physician assistants (left to right): Lieutenant Colonel (Retired) Rhonda Wynder, Lieutenant Colonel Sharon Denson, Lieutenant Colonel Amelia Duran-Stanton, Lieutenant Colonel Lauris Trimble, Colonel (Retired) Pauline Gross, Colonel (Retired) Sherry Morrey, Major Lakeshia Logan, Major Adhana McCarthy, and Colonel Dawn Orta.
Photograph courtesy of Lieutenant Colonel Amelia Duran-Stanton.

having served as an enlisted soldier, noncommissioned officer, warrant officer, and commissioned officer.

In 1984, Major (then Chief Warrant Officer 3) Jimmie Keller (Figure 1-5) became the first Army PA assigned to the White House Medical Unit. During his 4-year tour, he traveled to 35 states and 22 foreign countries to prepare for and support presidential and vice presidential travels. This included the travel of families, staff, Secret Service, and the traveling press corps. Military PAs remain the primary care providers within the White House clinic and support the staff and government workers in the White House compound (see Chapter 60 for information on the White House Medical Unit). Major Keller said his most memorable event was planning for and supporting the summits between President Ronald Reagan and Soviet General Secretary Mikhail Gorbachev in Geneva, Iceland, Moscow, and Washington, DC (email from Major [Retired] Jim E. Keller, PA-C, former PA consultant to the Army surgeon general, Highlands Ranch, CO, November 20, 2015).

In December 1989, in support of Operation Just Cause, several PAs deployed once again with the 82nd ABN DIV and the 75th Ranger Regiment to Panama in order to remove General Manuel Noriega from power. They parachuted into a hot Panamanian swamp in the middle of the night a few kilometers from the target, Torrijos International Airport, which was held by the Panamanian Defense Forces. While parachuting and upon landing, the paratroopers could see green tracer rounds coming at them from three different directions. Working through the marsh, then Chief Warrant Officer 3 Bob Oyler, PA-C, of the 82nd ABN DIV, finally hit solid ground and crawled out onto dry land. Under the light of a half-moon, he saw a fence. Reaching underneath, he found an 18-inch gap. Sliding his rucksack through the hole, Oyler began to crawl under the fence. Unfortunately, he had forgotten to remove his pistol belt, and his ammunition pouches got caught in the fence. As he struggled to get free, he heard voices speaking Spanish right above him. With the enemy virtually standing over him, Oyler managed to undo his belt and pull his weapon. The enemy failed to notice him and talked for a few moments but moved away in the other direction, and into a Ranger ambush. Oyler freed himself and proceeded to the assembly area. He was the first medic to arrive on the scene, and it had taken him 93 minutes to get there (email from Captain [Retired] Robert J. Oyler, PA-C, Headquarters

Company, 307th Medical Battalion, 82nd Airborne Division, Saint Pauls, NC, December 21, 2015).

The 1990s: Finally Commissioned

Though one of the first services to produce graduates from PA training, the Army was the last to commission them. Air Force PAs were first



Figure 1-5. Then-Major Jimmie Keller, first Army physician assistant assigned to White House Medical Unit.
Photograph courtesy of Major (Retired) Jimmie Keller.

commissioned in 1978 and Navy graduates were commissioned in 1989.[17] A 1984 study found that PAs provided care to 79% of patients seen by primary care physicians at half the cost. The Defense Audit Task Force on Non-Physician Health Care Providers recommended to Congress that all military PAs be commissioned officers.[17] The SAPA was critical to the lobbying effort for commissioning. Despite Congress' desire to commission Army PAs, it was not until 1990 that a proposal to do so was approved by the Army chief of staff. A year later the defense authorization bill included funding for commissioning PAs, authorized the inclusion of Army PAs in the Army Medical Specialist Corps (AMSC), and created a fourth assistant chief of the AMSC to supervise the PA section.[18]

Through diligent staff work, SAPA and AAPA involvement, and congressional influence, senior PA leadership garnered the support of Lieutenant General (Retired) Frank Ledford, the Army surgeon general, for PA commissioning (Figure 1-6). Ledford and others (including PA consultant Major [Retired] Jimmie Keller) convinced key Army leaders, including the chief of staff of the Army, General Carl Vuono, future chief of staff General Gordon Sullivan, and the deputy chief of staff for personnel, Al Ono, to persuade Secretary of the Army Michael P.W. Stone to commission Army PAs. Despite ongoing officer force reductions, given the need for midlevel providers to support readiness of the force, the first Army PA commissioning ceremony occurred on February 4, 1992.[18] Across the globe, the Army commissioned 257 PAs, changing their rank from warrant officers to second lieutenant through major. In 2007, the US Public Health Service was the first, and remains the only, federal service organization to promote PAs to the rank of flag officer with the promotion of Captain Michael Milner to the rank of rear admiral.[19]

In December 1990, during Operation Desert Storm, eight physicians and four PAs were attached to the regimental clearing station for the 2nd Armored Cavalry Regiment (ACR). The job of the 2nd ACR was to spearhead the VII Corps' end-run deep into the Iraqi Republican Guard's Tawakalna Division, which ended with US forces decimating the Iraqis in the famed Battle of 73 Easting. The operation required quick movement and a mobile facility to treat casualties. The PAs also needed options for evacuating casualties from the battlefield. With air evacuation and ground options unsupported, medical staff had to be creative. Medics acquired two old Saudi National Guard buses and,



Figure 1-6. Lieutenant General (Retired) Frank F. Ledford Jr, 37th surgeon general of the US Army. Lieutenant General Ledford died on May 15, 2019.

with the help of maintenance troops and some scrap metal, converted these buses into mobile MTFs that would, supposedly, follow the battle and treat and remove casualties as needed. The buses were named the *Comfortless* and the *Merciless* after the Navy's medical ships, the USS *Comfort* and USS *Mercy*. On February 24, 1991, the buses

crossed into Iraq. Unfortunately, just a few miles across the border, the brake line ruptured on the *Merciless* and it had to be abandoned. The *Comfortless* continued on, and in the course of the next 4 days, PAs treated approximately 60 wounded soldiers and civilians as the bus made its way across the desert. On February 28, the day the cease-fire went into effect, the *Comfortless* crossed the border back into Kuwait. Ingenuity and teamwork made this mission a success (Figure 1-7).[20]

Chief Warrant Officer 2 Thomas F. Haigler, who was assigned to the 2nd ACR, stated that the biggest concern early on was the estimated casualty count. "It was estimated that 220 casualties would come from a squadron of 1,200, including 40 men who were expected to die. We were expecting to lose one of our tanks for every four of theirs. We faced not only conventional weapons but also the very real threat of chemical weapons."[21] However, there were few American or coalition casualties during the conflict, and the 2nd ACR (like the majority of US medical personnel) spent most of its efforts treating enemy prisoners of war.[21]

In support of Operations Desert Shield and Desert Storm, over 230 PAs saw action in 1991; of these, 12 were women, and they deployed



Figure 1-7. The *Comfortless*, in the Kuwaiti desert, 1991.
Photograph courtesy of Colonel John Balser.

across the battlefield. Chief Warrant Officer Karen K. Kelso deployed with the 3rd ACR. At the time, she was a 49-year-old grandmother; her second grandchild was born during her deployment. About a career spent supporting soldiers, Kelso remarked, "I fell in love with soldiers . . . It was amazing to me that they were willing to give their lives."[22] To meet the large number of PAs needed to support these operations, the Army recalled retired PAs to active duty for the first time, including Vietnam veteran Chief Warrant Officer 2 Louis Rocco.[13]

PAs continued serving with distinction throughout the 1990s. Chief Warrant Officer 3 William "Doc" Donovan was a legend in both the PA and Special Operations communities. In 1980, Donovan served as chief medic during the failed attempt to rescue the hostages in Iran. Among the hostages was Don Hohman, an Army medic on the embassy staff, who later went on to graduate from the PA program in 1984 (personal communication, Chief Warrant Officer 3 [Retired], William "Doc" Donovan, Atlanta, GA, August 25, 2015).

In 1991, Chief Warrant Officer 3 Louis "Lou" Smith III (Figure 1-8) was assigned to the 5th Special Forces Group when the 1st Battalion, 75th Ranger Regiment, conducted a combat parachute training mission into Kuwait. According to Smith, during high winds, the unit "evacuated some 40 guys off the drop zone." Two days later, "Doc" Donovan hobbled into Smith's aid station with a broken foot. Donovan had been blown off course during the jump and walked over 20 miles on his injured foot (personal communication, Colonel [Retired] Louis H. Smith III, Andrew Rader US Army Health Clinic, Fort Myer, VA, January 5, 2016).

In 1992, Donovan earned the Soldier's Medal for Heroism after he and two others rowed a Zodiac boat continuously for 4 hours in near-freezing weather to save fellow Rangers from drowning after a helicopter crash during a training mission in Utah. In 1999, Donovan, who had served in Vietnam and as well as multiple operations including Eagle Claw, Urgent Fury, Just Cause, Desert Storm, and Restore Hope, became the first PA to be inducted into the US Army Ranger Hall of Fame.[23]

After the Gulf War, the federal government began mandatory force reductions, which led to the consolidation of the military's PA programs. In 1995, the Army PA program was renamed and reflagged as the Interservice PA Program (IPAP), based at Fort Sam Houston, with an effective date of May 1996. Today, this program matriculates



Figure 1-8. Colonel Louis H. Smith III, the third physician assistant chief, and son then-First Lieutenant Chris Smith at former Iraqi President Saddam Hussein's palace in Baghdad, Iraq. Chris was serving as a field artillery officer and Louis was present to promote him to captain. Then-Captain Chris Smith later also became a physician assistant through the Interservice Physician Assistant Program.
Photograph courtesy of Major Chris Smith.

students from the Army, Air Force, Navy, and Coast Guard, with the majority of IPAP students being Army active duty, Reserve, and National Guard. Recently the program was lengthened from 24 to 29 months. Currently, students attend a 16-month didactic phase (Phase 1) followed by a 13-month clinical phase (Phase 2) at one of 23 military MTFs (see Chapter 38 for more information on IPAP). The program's vision is "to be recognized as the world-class leader in physician assistant education,"[24] and in 2019 the IPAP was ranked 10th out of 170 US PA programs by *US News and World Report*.[25]

On October 2, 1995, Sergeant First Class Robert Howes, who was attending the Special Forces Advanced Noncommissioned Officer Course, helped prevent further deaths during a dawn sniper attack at Fort Bragg that resulted in the death of one officer and wounding of 18 soldiers. Sergeant First Class Howes, along with three other Special

Forces noncommissioned officers, was doing a physical training run nearby and heard the shots. They diverted to help subdue the shooter, and Howes was wounded in the foot. While at Womack Army Hospital, he was visited by the Fort Bragg senior PA, Major Michael Robertson, and asked what he wanted to do in the Army. Howes stated he wanted to go to PA school. He applied and was admitted to the IPAP, and served as a PA in the 1st Battalion, 36th Infantry Regiment, in Friedberg, Germany, and in Iraq, then attended training to become an orthopedic PA. He retired from military service at Brooke Army Medical Center (BAMC), on November 10, 2011, culminating his military career as the Army orthopedic PA residency director, and retired from BAMC as a civilian orthopedic PA in 2016 (email from Lieutenant Colonel David L. Hamilton, commander, Public Health Command District–Fort Bragg, Fort Bragg, NC, November 20, 2015, and personal conversation, Lieutenant Colonel Amelia Duran-Stanton, deputy chief, Thermal and Mountain Medicine Division, Natick, MA, October 4, 2016).

Early 21st Century: Battle Hardened

Army PAs remain the backbone of soldier readiness and frontline care. Following the attacks of September 11, 2001, and the beginning of the conflicts in Iraq and Afghanistan, Army PAs found themselves overworked and understrength. The Army PA became the most deployed AMEDD officer. Demand for the total force of PAs continues to outstrip inventory. Today, the Army has 778 active duty PA authorizations with an inventory of 683 active duty PAs, including those in the process of retiring and those attending graduate-level education. The significant delta in inventory versus authorizations is being addressed with a multipronged approach including mentorship, use of talent management principles, increased active duty accessions, increased IPAP starts, and reinstitution of the health professions officer retention bonus. The Army's PA total force also includes 393 Reserve 65Ds (the PA area of concentration), 942 National Guard 65Ds, and 352 civilian PAs. With the active duty force, this totals 2,461 PAs serving the nation. Collectively, Army PAs have conducted 1,129 combat tours for a total of 9,278 months. The average combat tour is 12 months. Individually, Army PAs averaged 21.6 months, or 1.75 combat tours per PA. Many PAs in these conflicts have been deployed for a total of 3 to 4 years (email communication, Major Nicholas Bradley, PA-C,

65D assignment officer, Human Resource Command, Fort Knox, KY, February 9, 2017).

In February 2001, Lieutenant Colonel (Retired) Donald Parsons, a retired Army PA (Figure 1-9) and combat medical specialist training instructor at AMEDD Center and School, became concerned that Regular Army units were not following the guidance developed by the Committee on Tactical Combat Casualty Care (CoTCCC) on the training of first responders and Army medics despite the success of this training and implementation seen within the special operations community. Before the establishment of CoTCCC, military medicine had employed training doctrine that was more in line with care of



Figure 1-9. Lieutenant Colonel (Retired) Donald Parsons. Photograph courtesy of Don Parsons.

civilian trauma patients. This doctrine failed to fully recognize the unique challenges of providing care within austere environments, with medical personnel caring for injured at night or under enemy fire, while moving patients through long evacuation corridors. Parsons participated in numerous discussions with special operations medical personnel and became a member of the Committee on Tactical Combat Casualty Care (CoTCCC). The CoTCCC had been established in 2001 as a US Special Operations Command biomedical research effort to ensure that emerging technology and information is incorporated into the TCCC guidelines on an ongoing basis. The membership of the CoTCCC includes combat medics, corpsmen, pararescue jumpers, physicians, and PAs.[26]

As a former 18D (Special Forces medic), Parsons understood the training of Special Operations medics and was intrigued by the 75th Ranger Regiment's success at treating combat injuries, including a successful bleeding (hemorrhage) control kit that was attached to every Ranger's body armor. The kit was developed by a team that included then-Captain John F. Detro, an Army Ranger PA, who provided an example of the kit to Parsons. The original Ranger kit included a tourniquet, trauma dressing, a nasopharyngeal airway, a 14-gauge catheter for needle decompression, an oral antibiotic/analgesic pill pack, an intravenous starter kit, surgical tape, and gloves. This kit evolved into today's Individual First Aid Kit (IFAK), which has been issued to every soldier during Operation Enduring Freedom, Operation Iraqi Freedom, and other overseas contingency operations. The IFAK's contents, like the Ranger's kit, are focused on the three leading causes of preventable death: airway compromise, tension pneumothorax, and extremity exsanguination (personal conversation, Lieutenant Colonel John F. Detro, physician assistant consultant to the surgeon general, Falls Church, VA, January 5, 2016).

In 2003, Captain James Rice and fellow PAs developed a rough draft for a predeployment trauma course designed to prepare frontline PAs for combat. Eventually called the Tactical Combat Medical Care (TCMC) Course, the training was developed using principles of Tactical Combat Casualty Care to teach PAs the techniques required to treat preventable causes of battlefield death. The TCMC gained the Army surgeon general's approval and was first offered in April 2004. Shortly afterward, other medical providers began to attend the course. Today, the priority for attendance includes providers deploying to Roles 1 and 2 combat assignments.[27]

The United States again invaded Iraq in 2003, commencing Operation Iraqi Freedom. Many PAs stationed at military MTFs across the United States were deployed to support operations in theater, and many of these facilities were left without critical support. To provide adequate coverage for dependents, retired PAs were recalled to active duty for the second time. Recall was restricted to those still actively practicing medicine and included fill for 30 to 60 positions, with plans to recall more if the situation deteriorated (email from Major [Retired] Jim E. Keller, former PA consultant to the Army surgeon general, Highlands Ranch, CO, November 20, 2015).

On March 4, 2005, the first Army PA was killed in combat. Six months after Captain Sean Grimes deployed to Iraq, an improvised explosive device detonated near his convoy outside Ramadi, killing Grimes and three others. Grimes was the first PA killed on the battlefield in Iraq. At Fort Campbell, his home post, a training center at Blanchfield Army Community Hospital has been named for Grimes. His family used part of Grimes' life insurance money to establish an educational scholarship award through SAPA (email from Major Shawn Lockett, deputy division surgeon, 2nd Infantry Division, Beijing, China, September 27, 2016). SAPA provides three annual $1,000 Grimes scholarships to SAPA members and their beneficiaries (Figure 1-10).

In 2006, then-Major Leonard Gruppo, director of the Army's emergency medicine PA (EMPA) residency program, proposed a doctorate-level clinical training program for specialty PAs. The goal was to produce specialized PAs with a substantially higher level of clinical competency. This increased capability could then be forward deployed with units on the battlefield. The EMPA program, which had started in July 2005, was expanded from 12 to 18 months, and the first class graduated with a Doctor of Science in Physician Assistant Studies–Emergency Medicine from Baylor University on December 15, 2007. These PAs became the first in the nation to earn clinical doctorate degrees. Since this first graduation, the Army has developed similar doctorate programs in clinical orthopedics and clinical general surgery/intensivist.[28]

As the US footprint in Afghanistan began downsizing in 2009, Combat Outpost (COP) Keating was one of many forward operating bases being closed. The enemy was anticipating the closure, and on October 3, 400 Taliban troops launched a brutal attack on COP



Figure 1-10. Captain Sean Grimes.

Keating. Intense fighting continued for more than 12 hours. A team of medics, led by PA Captain Christopher Cordova, Headquarters Troop, 3rd Squadron, 61st Cavalry Regiment, 4th Brigade Combat Team, 4th Infantry Division, cared for the injured and helped defend the COP. Under heavy fire and with medevac support unavailable, Cordova and his team treated traumatic battle wounds and evacuated 16 Afghan soldiers and US personnel while providing aid to another 27 "walking wounded." In an event that continued for 84 hours, Cordova successfully led his team and provided continuous medical support to soldiers at the base. In recognition of his actions over those long days, Cordova earned the Silver Star for gallantry in action against an armed enemy (Figure 1-11).[29]



Figure 1-11. Then-Captain Christopher Cordova meeting with President Barack Obama.
Photograph courtesy of Major (Retired) Christopher Cordova.

Continuing Progress

In 2015, Major Saibatu Mansaray-Knight, PA-C, was designated as the Army military aide to the vice president of the United States (Figure 1-12). "This prestigious position is usually held by a line officer, such as an infantry officer or pilot," said Lieutenant Colonel James J. Jones, PhD, PA-C, deputy director and chief of protective medicine, White House Medical Unit. "It's not a medical role at all—which makes her appointment unique."[30] Another historic first was when Colonel John Balser (Figure 1-13) became the first PA to be selected as chief of the AMSC (email from Colonel Nikki Butler, Human Resources Command, Fort Knox, KY, January 19, 2016).

Many assignments traditionally limited to male PAs have now been opened to women. Several women have served in civil affairs units: Major Charisse Gonzalez served as the company commander for the Joint Special Operations Medical Training Center, and recently Major Katrina Monti became the senior PA, 1st Special Forces Group (email from Lieutenant Colonel John Elliott, US Special Operations Command, Fort Bragg, NC, March 15, 2020).



Figure 1-12. Then-Major Saibatu Mansaray-Knight during her tenure as Vice President Biden's Army military aide.
Photograph courtesy of Major (Retired) Saibatu Mansaray-Knight.

Currently, there are five PAs serving in brigade-level commands, eight in battalion-level commands, and one as a forward surgical team (FST) commander. There are two PAs who formerly served in brigade-level commands, eleven in battalion-level commands, and eight as FST commanders. In April 2019, Colonel Amy L. Jackson became the first PA to be promoted to colonel "below the zone," and on July 20, 2020, with the change of command ceremony at Keller Army Community Hospital, West Point, New York (Figure 1-14), she became the first female PA to command a level-1 military MTF.[31] "Below the zone" refers to early promotion, before the usual, expected time for consideration. These promotions "are intended to provide officers of exceptional ability an opportunity to advance quickly to more responsible positions, help retain high-quality officers, and give officers an incentive to perform at their highest potential."[32 (p19)]



Figure 1-13. Colonel John Balser, Army Medical Specialist Corps chief. Photograph courtesy of Colonel John Balser.

On February 26, 2020, the Centers for Disease Control and Prevention reported the first case of the spread of the novel coronavirus disease (COVID-19) within the United States. The disease was first recognized in Wuhan, China, and the first US patient had recently returned from China. The ensuing global pandemic led to the activation of active and reserve military forces to support civilian authorities to battle COVID-19. Several Army PAs were instrumental in the early efforts, including Colonel David Hamilton, commander of the 9th Hospital Center, which was set up within New York City's Javits Center to take on non-COVID patients to decrease pressure on the city's health care system (Figure 1-15). Within a few days, the team began and continues



Figure 1-14. Colonel Amy L. Jackson's change of command ceremony at Keller Army Community Hospital, West Point, New York, on July 10, 2020. Brigadier General Paula C. Lodi (right), commanding general, Regional Health Command–Atlantic, passes the Medical Activity West Point flag to Colonel Amy L. Jackson, signifying the change of command from Colonel Brett H. Venable to Colonel Jackson. Photo by John Pellino/USMA PAO.
Reproduced from: Lanier RK. WPHSA, CACH welcomes new commander. *Pointer View.* Published July 23, 2020. Accessed August 4, 2020. http://www.pointerview.com/2020/07/23/wphsa-kach-welcomes-new-commander/

to take on COVID-19 patients (email from Colonel David Hamilton, April 14, 2020). As of July 30, 2020, the global number of infections was 17,067,754 cases, with 667,935 deaths. Within the United States, there were 4,431,399 infected and 150,765 deaths.[33] As the fight to contain the virus attests, military PAs have been and will continue to be at the forefront of military medicine, whether supporting combat or humanitarian missions.



Figure 1-15. Captain Alex Merkle providing medical care to COVID-19 patients at the Javits Center, New York City.
Photograph courtesy of Lieutenant Colonel Terry "Lee" Clark.

Conclusion

Today's Army PA is not only a clinician, but also a leader. Several PAs have served in command roles, senior clinical positions, and administrative leadership roles throughout Army and military medicine. Army PAs are seasoned veterans with years of service. By drawing on their experiences, PAs can lead in both tactical and clinical settings. Today's soldiers continue to pave the way for future Army PA and AMSC leaders. The future of the Army PA is bright, and the potential is limitless. As Colonel John Balser frequently states, "PAs are the chameleons of the AMEDD, able to adjust to any mission, anywhere, at any time" (email from Colonel John E. Balser, Command Surgeon, US Army Reserve Headquarters, Fort Bragg, NC, January 20, 2016).

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Chapter 2

THE COUNCIL OF JUNIOR PHYSICIAN ASSISTANTS

P. Jason E.E. Auchincloss, APA-C, MPAS, and Amelia M. Duran-Stanton, PA-C, PhD, DSc, MPAS

Introduction

The Council of Junior Physician Assistants (CJPA) originated as a team of accomplished junior Army physician assistants (PAs), eager to focus awareness on current and potential future challenges and provide relevant feedback from the field to senior leaders. This team of PAs was hand-selected by senior mentors to provide time-sensitive input regarding a host of matters affecting Army medicine. Army PAs continue to serve as the "tip of the spear" to ensure readiness and increase lethality, while also supporting Army medicine's lines of effort, ensuring that forces are ready to fight today and prepared for the challenges of tomorrow. Army PAs remain front runners in the Army's ready medical force, and serve tirelessly to promote a medically ready force. Army PAs serve throughout the military, from the battalion aid station to the corps headquarters, from the Pentagon to the White House, spanning the full spectrum of warfighting from the tactical to the strategic level. Because Army PAs often function in remote operational locations, and regularly perform duties independently, mentoring them can be a challenge. Many senior leaders provide mentorship to promote the success of the Army PA; however, sustained face-to-face interactions are infrequent due to geographical separation and autonomy.

Literature Review

There is a reported gap in mentorship between senior and junior PAs—work often gets in the way of professional guidance and mentoring, and as a result junior PAs feel they are often left to seek out mentoring opportunities on their own. Junior PAs may feel they need to "pull"

knowledge from leaders, rather than having guidance routinely "pushed" from above. Recently, more emphasis has been placed on advising junior PAs to seek out a mentor and establish the mentor-mentee relationship early in their careers. Ideal mentor-mentee relationships span an extended period and require a significant time commitment by both parties.[1,2] Studies have shown that mentees initiate the most successful mentorship relationships,[3,4] and that mentorship improves the success and productivity of individuals and organizations as a whole.[5–8] The Army advocates mentorship because "mentoring develops great leaders to lead great soldiers"[9]; however, junior PAs may not know what they do not know in terms of mentorship, and how to reach out to their senior leaders.

Background

Lieutenant Colonel Amelia Duran-Stanton created the CJPA in 2017 as an informal group of junior PAs who showed initiative and drive in accomplishing projects outside the scope of their regular duties and responsibilities. The original group provided "boots on the ground" feedback on regulation updates, offered junior-level feedback to senior leaders, and processed strategic-level information and products from the Department of Defense, Department of the Army, Medical Command, Medical Specialist Corps, and civilian organizations that were then prioritized and disseminated to the PA community. The group was later formalized in 2018 with the approval of the PA consultant (then Colonel John F. Detro), and CJPA membership was extended to recipients of awards or recognitions such as the Surgeon General Physician Assistant Recognition Award (TSG-PARA), Iron Majors Week attendance, and the Junior Leadership Course attendance. Senior PA leaders identified their stellar junior PAs for inclusion. The inaugural director of the CJPA is Major P. Jason E.E. Auchincloss, the 2016 TSG-PARA.

Selection

Personnel selected informally by the PA leadership comprise the CJPA until a formal process is established. In addition to the award winners discussed above, other selectees are leaders within the organization, including brigade and division PAs, who are making great strides in the advancement of medicine within the military. Additionally, with the

establishment of new 65D (Army PA) committees in 2020, the senior PA leadership in each corps (I, III, and XVIII) will identify a group of outstanding junior PAs as selectees. To date, the CJPA team has been divided among committees, as follows:

- **Senior Executive Committee**. Composed of selected colonels and their deputies, acts as the board of directors, receives and reviews the work of other committees, and coordinates strategic action.
- **Committee on Recruitment and Retention**. Includes leaders from Human Resources Command, Recruiting Command, Forces Command, Medical Center of Excellence, and corps and division leadership. Focus is on junior officer outreach and mentorship, PA recognition (awards), career and talent management, bonuses, and other recruitment and retention tools.
- **Committee on Professional Policy and Modernization**. Concentrates on regulatory policy and guidance, synergizing medical organization initiatives for modified table of organization and equipment (MTOE) changes, personnel and equipment, Defense Health Agency transformation, and privileges and credentials.
- **Committee on Combat Medicine and Medical Readiness/ Sustainment**. Applies to individual critical task lists, the postprofessional short course program, 5-year long-term health education and training plans, continuing medical education, and force generation management.

Activities

The CJPA is frequently called upon by PA senior leaders to provide timely feedback for policy revision, updates to regulations and procedures, and bottom-up input for projects that affect the medical force. Many of these tasks garner high-level visibility within the Medical Command, Medical Specialist Corps, Office of the Surgeon General, Defense Health Agency, Pentagon, and the Joint Staff. Input from the field is critical to maintaining a ready and relevant medical force, and information is also often disseminated through the CJPA to the line elements. Much of the knowledge passed to the unit medical teams is time-sensitive and carries essential policy updates and messaging. Additionally, these activities inherently provide senior leadership availability, exposure, and mentorship to CJPA members.

Roles and Responsibilities

The CJPA group is responsible for providing timely feedback based on their current location and expertise. The varied experience of each CJPA member, whether coming from their area of concentration or military occupational specialty before becoming an Army PA, or from their current duty station, must be utilized in providing diverse and comprehensive feedback and communication, both within the group and to senior leaders. CJPA members are encouraged to provide candid feedback about products and other subjects of discussions that otherwise would not have reached the PA leadership. This communication offers visibility to senior leaders working at operational and strategic levels, separated from the tactical "boots on the ground" experience. CJPA members should take personal responsibility for their careers, initiate installation-level mentorship, leverage available modern technology, seek and provide products available for continuous updates and reviews, and improve current methods of communication.

Desired Skills and Attributes

Desired skills and attributes of a PA selected for the CJPA include:

- being current in all PA skills mandated by the individual critical task lists;
- operational experience;
- the rank of captain or junior major;
- outstanding written and oral communication skills and a willingness to provide meaningful input on short notice; and
- being outspoken and eager to bring about change within the organization.

The following attributes are helpful for success:

- operational medical experience within a variety of units (eg, infantry, artillery, aviation), with a minimum of Role 1 deployment experience preferred;
- readiness experience and understanding of the tactical and operational environments;

- ability to work well with both military and civilian personnel and organizations; and
- willingness to provide honest feedback to senior Army leaders.

Training

No additional training is required for the position other than the standard credentials requirements and those expected in Department of Defense Instruction 1322.24, *Medical Readiness Training*,[10] and by the Army. However, junior PAs are encouraged to seek training availability such as Lean Six Sigma, continuing medical education, and at least one Army Training Requirements and Resource System (ATRRS) readiness course annually.

Recommended Certifications

Beyond those required for credentialing, recommended certifications include Advanced Life Support and Lean Six Sigma courses such as Lean Leader, Green Belt, Black Belt, and Master Black Belt (see Chapter 66).

Opportunities and Experiences

The CJPA provides input into medical personnel management, equipment acquisition, training, and development of a ready medical force. Through the council, opportunities exist to provide real-time modifications to regulatory guidance that affect not only the Army Medical Department but also its beneficiaries. The CJPA is keenly aware of the positive impacts it has on enabling change within the organization.

Tips for Success

Members of CJPA should:

- identify challenges within the operational environment, document these challenges, and develop ideas and ways to improve systems and processes;

- not only look for areas to improve, but also provide solutions and alternative courses of action to bring about change;
- seek self-improvement and steward the profession at every opportunity (publishing or participating in research projects are great ways to develop critical thinking and writing skills); and
- become a subject matter expert in their organization and the medical capabilities it possesses.

Conclusion

Working behind the scenes with equity holders to improve the delivery of medicine, CJPA members are groomed for further service by exposure to the experience of executive leadership. The privileges and responsibilities of elite junior PAs in the CJPA require additional work beyond daily duties; however, the rewards of influencing tomorrow's medical force, and enhancing the readiness of the military, are immeasurable to the Army readiness posture.

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Chapter 3

THE ROLE OF THE PHYSICIAN ASSISTANT AS THE SPECIALIST AND VETERINARY CORPS EDUCATION BRANCH CHIEF

Benjamin K. Kocher, PA-C, DSc, MPAS

Introduction

The education branch chief (EBC) for the Specialist (SP) and Veterinary Corps (VC) is an SP Corps immaterial officer (65X) who is assigned to the Professional Education and Training Department (PETD), US Army Medical Center of Excellence (MEDCoE), Joint Base San Antonio–Fort Sam Houston, Texas. This officer is essential to synchronizing key strategic education and training initiatives for the SP and VC. The EBC also serves as the co-chair of the SP Corps education committee. The position is essential for execution of the long-term health education and training (LTHET) programs and the post-professional short course program (PPSCP). The EBC facilitates the administrative and budgetary requirements of these programs in collaboration with the organization's resource management office and corps leadership.

Organizational Functions

PETD serves multiple roles that influence Army Medical Department (AMEDD) officers on a daily basis. The functions of the department include the following:

- Serves as the proponent and principle advisor for Army Regulation 351-3, *Professional Education and Training Programs of the Army Medical Department*; LTHET; PPSCP; and professional certification (or licensure) maintenance and supporting policies.[1]

- Coordinates AMEDD, MEDCoE, Defense Health Agency, and Department of Defense professional education initiatives with corps leadership, including the graduate education manager, area of concentration (AOC) consultants to the surgeon general, corps-specific branch proponent officers (CSBPO), and corps chiefs.
- Facilitates SP and VC corps programs—LTHET, training with industry (TWI), and PPSCP.
- Validates military training agreements and education service agreements with institutions that support LTHET and PPSCPs.

Unit Structure

The EBC is rated by the department director and senior-rated by the assistant commandant. The department was historically task-organized under the Directorate of Training and Academic Affairs. However, since the 2019 restructuring and the transition to the MEDCoE, the department is under the assistant commandant's office. The department works closely with the Office of the Surgeon General (OTSG), Army Medicine Proponency Office, AMEDD Personnel Proponent Directorate, Capability Development Integration Directorate, MEDCoE Resource Management, Department of Graduate Education (MEDCoE Graduate School), and Human Resources Command to perform its routine functions.

Program Management

Program Development and Implementation

Each program must undergo an annual multidepartment analysis. For the SP Corps, the process starts with providing a proof of concept to the education committee for review. The education committee serves as the executive body responsible for providing strategic oversight to education and training initiatives. The proof of concept must evaluate the components of doctrine, organization, training, materiel, leadership and education, personnel, facilities, and policy as follows:

- identify capability gap or requirement;
- identify training platforms capable of providing required education;
- evaluate program compliance in accordance with policies and doctrine;

- evaluate AOC and trainee, transient, holdee, and student inventory;
- identify and approve utilization tours (designated as "97" on the modified table of organization and equipment or the table of distribution and allowances);
- execute a costs and business case analysis; and
- evaluate selection processes and prerequisites for the program (eg, grade point requirements, civilian education level, military education level, and Graduate Record Examination scores).

Once reviewed, the education committee provides its recommendation to the corps chief. If approved, the packet is sent to PETD for inclusion on the board. Once a program is validated, it may be included in future boards without resubmission through the education committee. The VC has a similar process and staffs the product through executive leaders, but without a specific committee to fulfill the function.

Types of Long-Term Health Education and Training Programs

The types of programs determine the funding sources and governing policies and regulations. Three programs cover all training opportunities.

School of Choice Programs. These degree-granting programs or professional residencies matriculate at a civilian institution. PETD manages the funding requirements of these programs in conjunction with Central Training Branch. Each student has historically been authorized a $1,000 book stipend annually, and a $200 to $500 stipend with completion of a program requiring a thesis or dissertation. Temporary duty costs, candidacy fees, and board certification fees are reimbursed only if they are program and corps requirements. Board certification fees are typically reimbursed only if certification is required for the AOC designation and occurs within the contracted LTHET period. Examples include Doctor of Philosophy (PhD), Masters in Public Health (MPH), and Masters in Health Administration (MHA).

Federal Programs. A Department of Defense institution sponsors these degree-granting, professional residencies or fellowships. Typically, each program's host organization supports funding requirements in

accordance with MEDCoE agreements generated by the office of Assistant Chief of Staff for Resource Management. Examples include the following:

- Laboratory Animal Medicine Programs
- Uniformed Services University of the Health Sciences
- US Army Medical Research Institute of Infectious Diseases
- Walter Reed Army Institute of Research
- DOD Veterinary Pathology Residency (DODVPR), Joint Pathology Center
- US Army–Baylor/MEDCoE Graduate School Programs
- Doctor of Science in Occupational Therapy
- Doctor of Science in Physical Therapy
- Doctor of Science in Physician Assistant Studies
- Fellowships
- Test and Evaluation Fellowship, AMEDD Board
- Point-of-Care Ultrasound Fellowship (Brooke Army Medical Center and Madigan Army Medical Center)

Training With Industry. Civilian internships, residencies, or fellowships sponsored and managed by the Department of the Army are separate from the LTHET offerings. However, they are included as part of the AMEDD LTHET validation board to fulfill Army requirements. The Department of the Army has quotas for these programs, and the corps must provide an order-of-merit list if they are requesting multiple training-with-industry positions. The sponsoring civilian organization typically funds program requirements. Offerings include:

- American Academy of Physician Assistants
- National Commission on Certification of Physician Assistants
- National Registry of Emergency Medical Technicians

Validation Process

After the SP and VC populate their program information into the annual program and position requirements worksheet (PPRW), PETD reviews the products to ensure compliance with governing policies and regulations. The Army Medicine Proponency Office then holds an electronic voting board using the automated PPRW to staff the annual

LTHET offerings for the AMEDD. Historically, the corps chief delegates the duty of voting and corps representation on the electronic board to the CSBPO. PETD summarizes the results and forwards them to the surgeon general through the MEDCoE commander for final approval. The surgeon general retains Title 10 authority over education and training of AMEDD officers under the reorganization.

Physician Assistant Planning Cycle

It is imperative that all PAs understand the validation process for LTHET and PPSCP. The process for LTHET programs occurs approximately 2 years prior to execution, whereas the PPSCP process occurs approximately 1 year prior to execution. With this in mind, PAs should coordinate emerging requirements and new courses approximately 3 years in advance to provide ample time for the required staffing and implementation. In preparation for the annual board, the graduate education manager, AOC consultant, CSBPO, and EBC work together to populate the key staff products. This primarily involves creating the PPRW for LTHET and TWI offerings, along with submitting the course administrative data sheets for the PPSCPs.

LTHET and TWI Planning Cycles

• October–November	LTHET military personnel (MILPER) message releases
• November–January	Applications submitted to, and staffed by, Human Resources Command
• January–February	Application waiver review and disposition
• February–March	PPRW input, TWI memo, and course administration datasheet generation
• April	LTHET / TWI / PPSCP validation board and selection panel
• June–July	LTHET results released
• August–September	Application and MILPER message revision

Skills and Attributes

The PETD position requires an experienced officer with a background in academia who collaborates effectively with multiple entities and senior AMEDD leaders. This officer advises and ensures that education and training requirements are incorporated into life-cycle management and integrated into all changes to doctrine, organization, training, materiel, leadership and education, personnel, facilities, and policy decisions affecting corps officers.

At PETD, a major or lieutenant colonel with the following experience historically serves as the EBC:

- knowledge of military and deployed medicine readiness requirements;
- experience in graduate professional education across multiple professions;
- prior academic leadership and program budget management;
- prior experience as a project officer for a PPSCP, functional course, or continuing education unit or continuing medical education activity;
- knowledge of national professional certification and license maintenance requirements for multiple disciplines;
- knowledge of personnel database systems such as the Force Management System website, Medical Operational Data System, and Total Officer Personnel Management Information System;
- effective verbal and written communication skills, including the ability to produce cogent staff materials designed for diverse audiences; and
- completion of Intermediate Level Education (recommended).

Duties and Responsibilities

On a daily basis, the EBC has many routine requirements, including the following:

- coordinating student tuition and associated program costs with Central Training Branch,
- validating and processing execution costs for PPSCPs,
- participating in briefing corps leadership on education and training activities, and

- analyzing AMEDD initiatives to provide input or recommendations to corps office staffing functions.

Routinely, the EBC is engaged in the following activities:

- speaking at junior officer mentorship programs (Basic Officer Leader Course, Captains Career Course, professional conferences, and graduate school programs),
- conducting SP Corps education committee (monthly),
- briefing the SP corps chief update (quarterly) and VC leadership upon request,
- submitting articles to the SP *Corps Connection* newsletter (quarterly),
- briefing the SP Corps Strategic Advisory Board (biannually) on education and training initiatives,
- co-authoring the SP corps handbook (annually),
- facilitating tuition waiver requirements (January–March),
- conducting LTHET student in-briefs (April–May),
- facilitating program validation and PPRW submission (April–May), and
- facilitating MILPER and LTHET application updates (August–September).

Lessons Learned

The EBC position may be challenging for individuals without a diverse background in academics, resource management, or the US Department of Education infrastructure. Each of the managed programs and courses have specific friction points that the EBC must be aware of to mitigate potential issues. This is complicated by managing two separate corps, because the officer requires familiarization with ten different AOCs and their associated education offerings and roles within the AMEDD. Early communication and research with AOC consultants and the CSBPO is essential to success. Familiarization with commonly used regulatory guidance is a vital step to professional success as the EBC.

Conclusion

The EBC provides a broadening opportunity for a field-grade officer to serve in a job that influences multiple disciplines of the AMEDD. The

individual holding the position will gain key knowledge of AMEDD planning processes and will work collaboratively with multiple organizations and agencies throughout the Department of Defense. PAs are well suited for this position with their diverse understanding of multidisciplinary care in the deployed environment and military medical treatment facilities. The position provides officers with the potential to affect long-term AMEDD initiatives and shape multiple professions.

As of 2020, and as part of the MEDCoE reorganization, this authorization will be repurposed to the Directorate of Training and Doctrine. In this new role, the officer will be acting as the subject matter expert for the SP Corps and be working to develop education and training platforms for the MEDCoE across operational, institutional, and self-development (OISD) domains.

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Chapter 4

ACADEMIC LEADERSHIP ROLES, PROFESSIONAL EDUCATION, AND TRAINING OPPORTUNITIES FOR PHYSICIAN ASSISTANTS

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Introduction

As Army medicine continues to evolve to meet the needs of the warfighter, physician assistants (PAs) are more essential than ever in meeting the Army and Army Medical Department (AMEDD) mission. Army medicine's professional education programs are integral to developing future leaders and providing qualified officers to man the generating and operational force.[1] These professional education programs are also vital to the continuum of care for service members and their families by expanding access to emergent and surgical services. This chapter reviews the roles and relationships of officers involved in professional education and discusses broadening opportunities available to the military PA. The attachment at the end of the chapter provides additional operational, medical, predeployment, and leadership training resources.

Education and Training Support Structure

Professional education initiatives specific to PAs are the responsibility of the Specialist Corps (SP) Office and are primarily managed by the PA consultant. The PA consultant leverages corps and PA academic leadership to perform these duties and manage the programs on a routine

basis. The following key academic leaders influence PA education: corps-specific branch proponent officer (CSBPO) and personnel proponent officer, Army Medicine Personnel Proponent Directorate (APPD); education branch chief (EBC), Professional Education and Training Department (PETD); PA capability manager, Capability Development Integration Directorate (CDID); graduate education manager (GEM), an additional duty historically assigned to a US Army Medical Center of Excellence (MEDCoE) officer; associate dean, MEDCoE Graduate School; and program chairpersons and directors of PA education. These leaders synergize PA educational initiatives through multiple working groups and committees, including the SP Strategic Advisory Board, SP Education Committee, SP Research Committee, PA Senior Executive Committee, and PA Committee on Combat Medicine and Medical Readiness/Sustainment.

All programs go through an annual validation process that includes the review and approval of the six AMEDD Corps proponent offices. Secondary to the reorganization of the MEDCoE under US Army Training and Doctrine Command (TRADOC) in 2019, training and education program service quota validation will be transitioned to the MEDCoE Training Programs Management Division of the Directorate of Training/Doctrine (DOTD), using the Army Program for Individual Training model described in Army Regulation 350-1, *Army Training and Leader Development*,[2] and the TRADOC Training Requirements Analysis System methodology, including the structure manning decision review (SMDR) and training resource arbitration panel (TRAP) processes. Services request training requirements 3 years out (reevaluated at 2 years) through the SMDR, then the TRAP determines what is supportable based on resources and priorities for the execution year.

Roles and Responsibilities of Academic Leaders

This section provides an overview on the different roles and responsibilities, command and control relationships, and support structures of the education programs for PAs. Figures 4-1 and 4-2 show the relationships of these leaders within the education structure. Figures 4-3 through 4-5 represent the annual planning cycles discussed in this section.

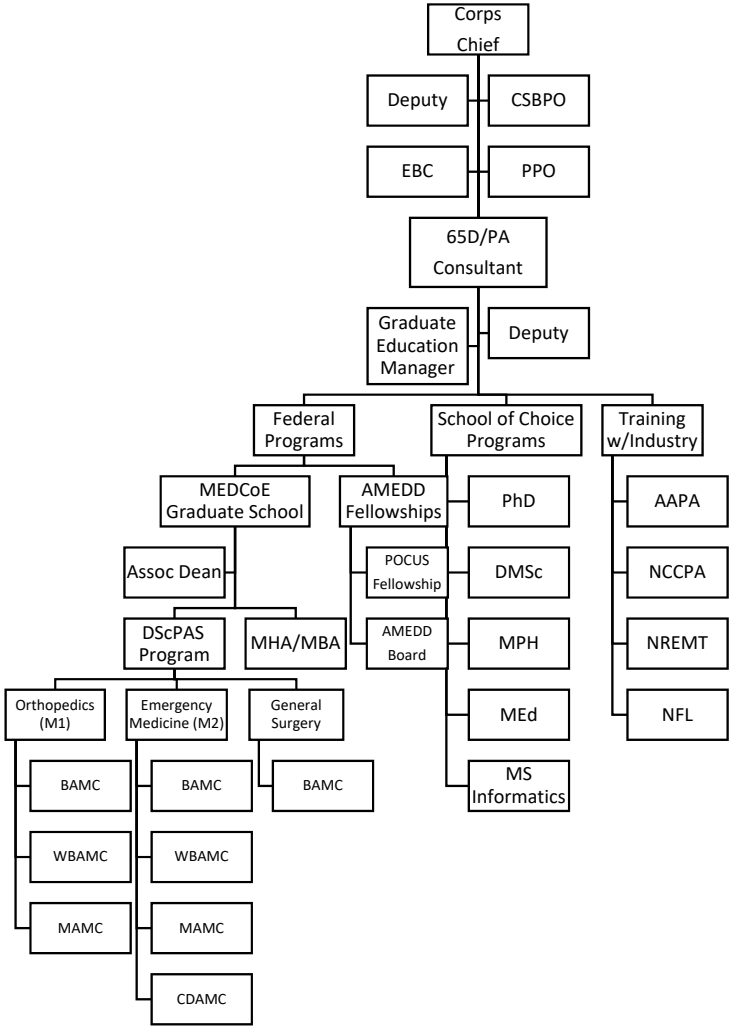


Figure 4-1. The education infrastructure for physician assistant postgraduate education programs and US Army Specialist Corps leadership.

AAPA: American Academy of Physician Assistants; AMEDD: Army Medical Department; BAMC: Brooke Army Medical Center; CDAMC: Carl R. Darnall Army Medical Center; CSBPO: corps-specific branch proponent officer; EBC: education branch chief; MAMC: Madigan Army Medical Center; MEDCoE: Medical Center of Excellence; NCCPA: National Commission on Certification of Physician Assistants; NFL: National Football League; NREMT: National Registry for Emergency Medicine Technicians; POCUS: Point-of-Care Ultrasound; PPO: personnel proponent officer; WBAMC: William Beaumont Army Medical Center

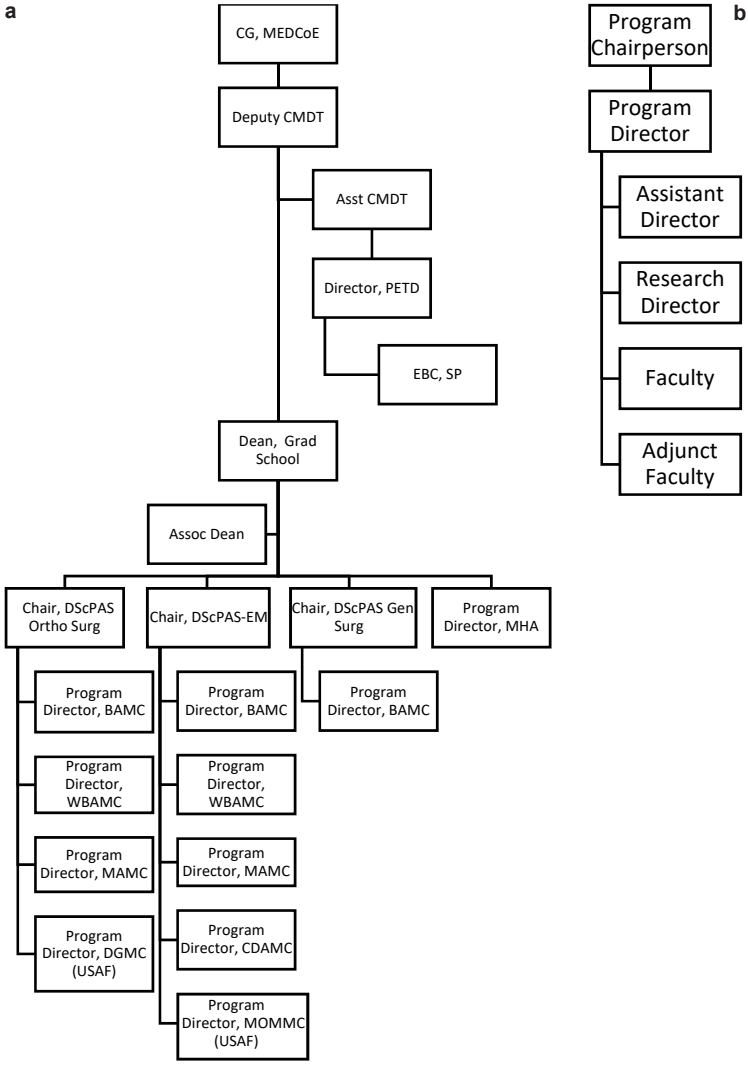


Figure 4-2. (a) The academic infrastructure for federal programs that reside under the Medical Center of Excellence Graduate School; **(b)** DScPAS program infrastructure and faculty organization.

BAMC: Brooke Army Medical Center; CG: commanding general; CDAMC: Carl R. Darnall Army Medical Center; CMDT: commandant; DGMC: David Grant Medical Center; EBC: education branch chief; EM: Emergency Medicine; MAMC: Madigan Army Medical Center; MOMMC: Mike O'Callaghan Military Medical Center; PETD: Professional Education and Training Department; Ortho: Orthopedic Surgery; Surg: General Surgery; USAF: US Air Force

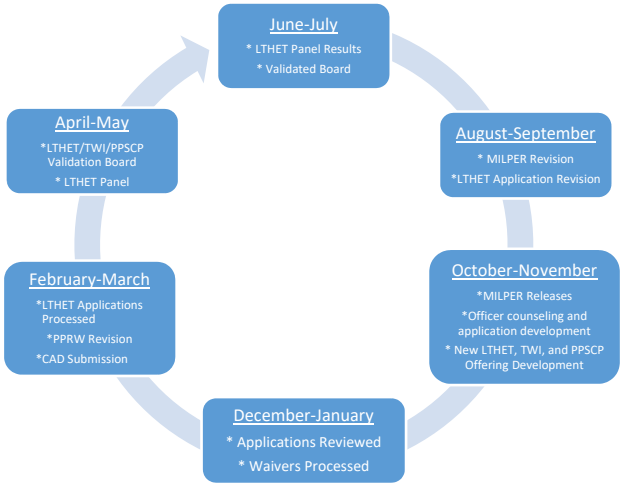


Figure 4-3. Professional Education and Training annual planning cycle.
CAD: course administrative data sheet; LTHET: long-term health education and training; MILPER: military personnel; PA: physician assistant; PPRW: program and positions requirement worksheet; PPSCP: post-professional short course program; TWI: training with industry

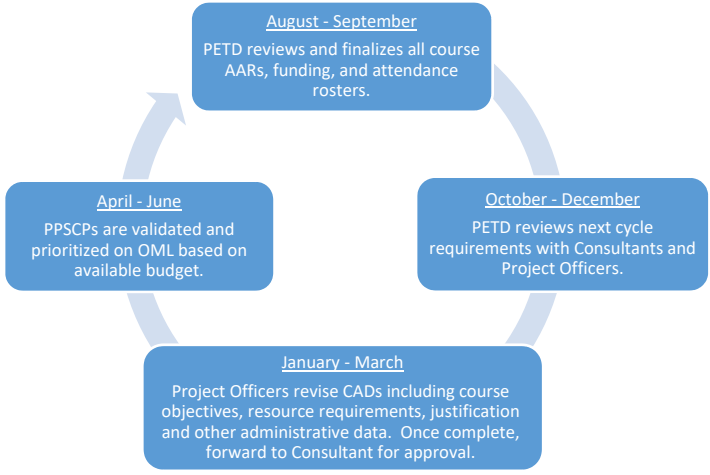


Figure 4-4. Post-professional short course program annual planning cycle.
AAR: after-action review; CAD: course administrative data sheet; LTHET: long-term health education and training; OML: order-of-merit list; PA: physician assistant; PETD: Professional Education and Training Department; PPRW: program and positions requirement worksheet; TWI: training with industry

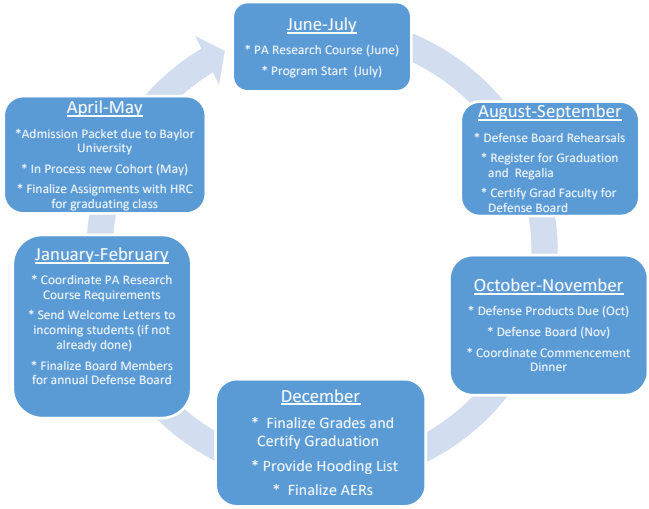


Figure 4-5. DScPAS program annual planning cycle.
AER: academic evaluation report; GEM: graduate education manager; HRC: Human Resources Command; LTHET: long-term health education and training; PA: physician assistant; PPRW: program and positions requirement worksheet

PA Consultant

The SP chief and PA consultant are ultimately responsible for coordinating, validating, and executing education for PAs. The consultant serves the following management roles in professional education:

- Coordinates and provides justification of new courses and programs, facilitated by the SP Education Committee. Each new program must undergo a multi-department analysis that identifies: capability requirement, training platform with a training agreement (PETD), and a validated utilization tour (APPD). This typically occurs during late fall and must be finalized prior to populating the program and position requirements worksheet (PPRW) and the annual validation cycle.
- Validates program and course offerings on an annual basis and provides updated program justification, narrative, and funding requirements on the PPRW.

- Provides academic oversight, validation of graduation requirements, and program accountability for officers enrolled in long-term health education and training (LTHET), training with industry (TWI), and the post-professional short course program (PPSCP).
- Reviews LTHET applications and provides consultation to the SP chief for officer waivers.

Education Branch Chief

The EBC is a 65X (branch immaterial) position responsible for coordinating all staff functions of professional education for the SP Corps. Multiple PAs have served in this role, most recently Lieutenant Colonel (Retired) Pamela Roof and Lieutenant Colonel Ben Kocher. This position has been repurposed under DOTD in 2020 with the reorganization of the AMEDD Center and School into the MEDCoE. Significant duties and responsibilities include:

- Coordinates AMEDD and DOD professional education initiatives with corps leadership including the GEM, consultants to the surgeon general, CSBPO, Human Resources Command (HRC), and SP Chief.
- Serves as vice-chair of the SP Education Committee, managing agenda and staffing products for the CSBPO (the committee chair). In conjunction with the consultant and GEM, provides updates to students enrolled in education programs such as LTHET and PPSCP. Coordinates new program requirements for presentations at board meetings.
- Assists the PA consultant and GEM in providing academic oversight to education programs through reviewing degree plans and coordinating student actions with program leadership.
- Validates graduation and funding requirements with the consultant and the GEM.
- Processes documentation that directs payment of tuition and execution fees. Also processes officer reimbursement requests with MEDCoE G8 (budget) staff.
- Facilitates staffing requirements of the annual validation process with key stakeholders. Reviews PPRWs with the CSBPO, PA consultant, GEM, APPD, and PETD director to ensure an accurate and comprehensive staffing product. Provides training to new leaders as required.

- Markets and recruits LTHET programs during junior officer leadership programs (Basic Officer Leader Course and Captains Career Course), professional conferences, and graduate school officer professional development events.

Graduation Education Manager

The GEM is the linchpin that synergizes PA education by interfacing with all key stakeholders and coordinating programmatic requirements at the direction of the PA consultant. This role is an additional duty. The GEM is appointed by the SP Corps office, with endorsement by the PA consultant, to serve as the consultant's principal advisor on PA education and training programs. It has historically been assigned to either a previous program chair or director of one of the Doctor of Science in Physician Assistant Studies (DScPAS) programs at Brooke Army Medical Center ("DSc" is used as the degree designation in signature blocks). The SP established the additional duty in 2006 due to the expansion of programs and increased requirements for student oversight. Previous officers filling this role include Colonel Rick Villarreal, Major (Retired) Paul Allen, Lieutenant Colonel Sharon Rosser, Colonel Brian Burk, Lieutenant Colonel Ben Kocher, Lieutenant Colonel James Jones, and Major Kerri Van Arnem. Significant duties and responsibilities include:

- Coordinates with CDID and APPD to project force management requirements to inform the annual validation board. Publishes the 5-year plan based on these projected requirements to synchronize program starts and utilization requirements.
- Member of the SP Education Committee, SP Research Committee, and PA Committee on Combat Medicine and Medical Readiness/ Sustainment.
- Appointed to the graduate faculty of MEDCoE graduate programs. Eligible to serve as chair or member of doctoral defense boards for the DScPAS program.
- Assists in developing the annual LTHET guidance by advising on issues such as numbers needed to train and necessary selection qualifications of PAs for postgraduate training.
- Responsible for managing the LTHET application process for PAs, including recruitment, the application process, and post-selection placement, working closely with PETD, HRC, and SP leadership throughout the application and selection process.

- Provides updates to the SP Research Committee on research efforts within the postgraduate programs; works closely with the program directors to align research efforts and track scholarly and research activities.
- Advises the PA consultant on student actions. If a student in a postgraduate program does not meet standards and requires discipline, remediation, probation, or release from the program, the GEM works closely with program leadership and the SP Education Committee to ensure the student receives due process.

Requirements for the GEM additional duty include:

- Terminal (professional or research) doctorate degree.
- Rank of lieutenant colonel (preferred).
- Intermediate Level Education graduate.
- Must meet requirements to be appointed to the graduate faculty of MEDCoE Graduate School affiliated universities.

Desired skills and attributes for the GEM additional duty include:

- Prior experience in an academic leadership position in a graduate program.
- Must be an excellent role model with the desire to mentor others.
- Comprehensive leadership, administrative, and academic skills.
- Strategic vision for future education and training requirements.

Associate Dean, Graduate School

The associate dean is a 65D (PA) position serving as the principal advisor to the dean on hospital-based training programs, which include all branch programs under the MEDCoE Graduate School. Specifically for PAs, these programs include Doctor of Science degrees and Phase 2 (hospital-based/clinical phase) of the Interservice Physician Assistant Program (IPAP). Previous officers filling this role include Lieutenant Colonel Sharon Rosser, Lieutenant Colonel Randolph "Scott" Harrison, and Lieutenant Colonel Matthew Douglas. Significant duties and responsibilities include:

- Manages accreditation requirements for programs under the Graduate School; primary liaison to the supporting institution's Office of Institutional Effectiveness.

- Responsible for providing organizational oversight and program standardization of DScPAS programs and other hospital-based training programs.
- Coordinates admissions process and other student in-processing requirements with the degree-granting university programs.
- Coordinates graduate faculty, professorial rank, and adjunct faculty appointments. Publishes the standard operating procedure for the process and ensures standardization of appointments.
- Coordinates graduate activities including student in-processing, faculty development, football events, and commencement activities.
- Manages graduation certification and filing requirements. Maintains student records in accordance with accreditation standards.
- Appointed graduate faculty for affiliated institutions. Eligible to serve as a chairperson or member of defense boards for the DScPAS program.
- Member of the SP Education Committee, SP Research Committee, and PA Committee on Combat Medicine and Medical Readiness/ Sustainment.

Requirements for the associate dean include:

- Terminal (professional or research) doctorate degree.
- Rank of lieutenant colonel.
- Intermediate Level Education graduate.
- Must meet requirements to be appointed graduate faculty of MEDCoE Graduate School affiliated universities.

Desired skills and attributes for the associate dean include:

- Prior experience in an academic leadership position in a graduate program.
- Must be an excellent role model with the desire to mentor others.
- Solid leadership, administrative, and academic skills; strategic vision for future education and training requirements.

Duty Descriptions for the Doctor of Science Programs

The positions below (program chairperson, program director, assistant program director, research director, and Specialized Interservice

Physician Assistant Program Instructor) apply to DSc programs for orthopedic surgery (see Chapter 5), emergency medicine (see Chapter 6), and general surgery (see Chapter 7), with similar roles and responsibilities. All PAs in these positions must be appointed in a professorial rank of assistant professor and above, maintain appointment to the graduate faculty of the degree-granting university, and serve as staff providers for their discipline.

Program Chairperson

Each discipline (orthopedic surgery, emergency medicine, and general surgery) has a program chairperson who is responsible for synergizing and orchestrating the training within their program across all training sites. The chairperson manages the accreditation requirements of the program and ensures standardization for the program and discipline. They are the primary liaison for the program with Army leadership, including the MEDCoE Graduate School, SP Office, PA consultant, and collaborative specialty consultants. Additionally, they serve the following functions:

- Provides academic leadership and oversight to the program directors by ensuring the entrusted professional attributes, program milestones, and procedural competencies are assessed and validated at each training site in accordance with governing policies and regulations. Ensures training is relevant to possible future capability gaps across the Department of Defense (DOD).
- Publishes and revises their program manual, policies, faculty handbook, and resident handbook to provide guidance to program faculty and matriculating students.
- Recommends faculty appointments in accordance with Graduate School policy and provides professional development and mentorship to program staff.
- Principal advisor to the specialty consultant to the Army surgeon general, the PA consultant to the Army surgeon general, and the SP chief. Responsible for identifying capability gaps within the specialty and providing recommendations on the use and placement of PAs within the profession throughout the services. Synchronizes education and research initiatives with the SP Education Committee, SP Research Committee, and other executive steering committees.

Program Directors (Site-Specific)

Each discipline assigns a program director for each training site. The directors are responsible for managing the program's accreditation requirements and ensuring compliance at their site. They are the primary liaison between the program and their site. They interface regularly with supporting Accreditation Council for Graduate Medical Education (ACGME) programs and other graduate professional education programs. Additionally, they serve the following functions:

- Serves as graduate faculty at the degree-granting university, responsible for managing all grade reporting, rotation evaluations, and doctoral defense preparation and coordination with the MEDCoE Graduate School.
- Ensures all programmatic policies are followed and objectives achieved by the matriculating officers.
- Responsible for managing the degree plan, coordinating medical-related rotations and training affiliation agreements. Also performs didactic instruction and mentors residents in clinical research.
- Coordinates academic requirements and student actions with the supporting graduate medical education committee or the institution's executive committee that governs professional education.
- Manages research initiatives and performance improvement projects for the programs, which includes performing research approved by the institutional review board (IRB), as well as assigning it to students and faculty and assisting them in completing it. Ensures that research initiatives support the SP Corps lines of research.
- Coordinates institutional support and serves as a preceptor for other graduate professional education programs such as the Uniformed Services University of the Health Sciences, IPAP, and nurse practitioner programs.

Assistant Program Director (Site-Specific)

Each site director assigns an assistant to support the residency site. The assistant directors are responsible for helping the director manage the accreditation requirements of the program and ensure compliance at their individual site. They are the alternative liaison between the program and their site. Assistant program directors interface regularly

with supporting ACGME programs and other graduate professional education programs. Additionally, the assistant program director has the following functions:

- Serves as program director in their absence or when required.
- May be assigned additional administrative duties, including as research director.
- Ensures all faculty members are compliant with productivity requirements based on duty description and additional duties.
- May serve as an IPAP Phase 2 coordinator.

Program Research Director

Each program assigns a research director to coordinate research activities and synchronize efforts for the students and faculty. The assigned faculty member will align efforts with the SP research program. Additionally, the research director serves the following functions:

- Responsible for tracking and assisting ongoing research efforts including publications, podium presentations in front of an audience, and poster presentations. Coordinates with the SP Education and Research Committee and with the program chairperson to establish a collaborative research effort within the SP.
- Ensures that all IRB-approved research projects are tracked and reported to the program chairperson, directors, the GEM, and the SP Education and Research Committee.
- Maintains a list of preproposal research projects within the established lines of research and task areas and provides immediate coordination of proposal ideas to collaborators within the SP Corps.
- Ensures that each student's research question has scientific merit (is novel and relevant) and is feasible to answer during the DSc program.
- Assists students in developing their protocol (study design as well as the IRB process) and makes sure the students follow the research timeline and submit quarterly counseling comments to the program director at each residency site.
- Conducts individual written performance counseling as needed.
- Monitors the participation of staff mentors in students' research; intervenes as needed to ensure ongoing mentorship.

- Reviews or coordinates mentor review for all students' manuscripts and offers comments.
- Organizes and conducts the defense of doctoral research projects and arranges practice for the defense. Performs as the main point of contact for DSc site program research.
- Serves as a 0.50 FTE (full-time equivalent) clinical provider.
- May serve as an IPAP Phase 2 coordinator.
- May be assigned additional administrative duties.

Specialized Interservice Physician Assistant Program Instructor

The IPAP (refer to Chapter 38 in this handbook) instructors for emergency medicine, orthopedics, and general surgery serve as associate professors for the Master of Science in Physician Assistant Studies (MPAS) program and as their specialty expert for the IPAP at the MEDCoE. They also serve as guest providers in their specialty, maintaining a minimum of 40 patient care hours per year, along with additional requirements by the credentialing and privileging facility. The specialized PA (in either emergency medicine, orthopedics, or general surgery) assigned to IPAP:

- is responsible for providing over 80 hours of instruction to Department of Defense PA students in their specialty;
- provides didactic instruction on anatomy and physiology, differential diagnosis, emergent evaluation and stabilization, appropriate ancillary studies, and patient management in their specialty;
- provides clinical practicums on their specialty's procedures, point-of-care stabilization, wound care and suturing, and bedside clinical and trauma procedures in accordance with specialized guidelines;
- updates IPAP curriculum and policy as a key member of program committees;
- directly mentors Phase 1 (didactic phase) IPAP students through routine and situational counseling, master's thesis development, and professional development activities;
- performs or assists in IRB-approved research and performance improvement projects; and
- educates and trains consulting providers, PAs, nurses, and medics in the management and appropriate disposition of their specialty-care patients.

Corps-Specific Education and Training Opportunities

There are three basic types of LTHET programs for SP officers. Each type is administered and funded differently, so it is important for PAs to understand how the programs are organized. The three types are:

- **School-of-choice programs**. Degree-granting or professional residencies sponsored by a civilian institution, including any of the programs conducted at an academic institution outside of the military. These programs typically result in master's degrees in public health (MPH), education (MEd), health administration (MHA), and informatics, as well as professional doctorates (DMSc) and research doctorates (DSc and PhD). Officers in these programs are assigned to the AMEDD Student Detachment (ASD) and funded through MEDCoE.
- **Federal programs.** Degree-granting, professional residencies or fellowships sponsored by the DOD or other government institution. Officers in these programs are assigned to their respective training academic medical centers and funded through their supporting organization. Examples include:
  - US Army MEDCoE Graduate School programs
    - MHA
    - DScPAS with specializations in:
      - Orthopedics (additional skill identifier [ASI] M1)
      - Emergency medicine (ASI M2)
      - General surgery and trauma (ASI M4-pending)
  - Federal training internships and fellowships
    - Point-of-Care Ultrasound Fellowship
    - Training and Evaluation Internship (with the AMEDD Board)
- **Training with industry.** Internships, residencies, or fellowships that are detailed to a civilian organization and sponsored by the Army (unlike LTHET offerings). However, AMEDD boards these programs as part of the LTHET validation process to fulfill Army requirements. There are quotas for these programs, and the SP Corps must provide an order-of-merit list if they request multiple TWI positions. Program requirements are typically funded through the civilian organization sponsoring the collaboration. Officers in these programs are assigned to the ASD and, if not funded by the sponsoring agency, the officer

may seek financial support through MEDCoE, based on availability of funds. The following are the programs that fall under TWI:
- American Academy of Physician Assistants
- NCCPA
- National Football League
- National Registry for Emergency Medicine Technicians

Qualifications

Qualifications for LTHET applicants are published in an annual military personnel (MILPER) message and are subject to change. Currently, prospective LTHET applicants must meet the following qualifications to be considered for an offering (all waiverable unless otherwise specified):

- be active duty, in the rank of captain to lieutenant colonel;
- be a graduate of the rank-appropriate military education level;
- have 5 to 13 years of active federal commissioned service, or be prior service and have less than 17 years active federal service;
- have completed 36 months of time on station (or 24 months with an HRC waiver) for stateside assignments prior to the start of the program;
- if assigned overseas, have completed the entire overseas tour, including any extension, without curtailment prior to the start of the program;
- be eligible for promotion (must not be in a non-select status);
- have not previously attended a funded equivalent-level LTHET degree program (if the applicant has completed a different degree at the level of the requested LTHET program, they must have completed the previous active duty service obligation prior to the start of the current program);
- have 3 years of clinical experience (2 years with an HRC waiver) at the start of the course[3];
- have received a general subjects GRE score greater than 300 combined for all degree-granting programs (note: individual universities determine the qualifying GRE scores for school-of-choice programs, and essay component is university- and program-dependent); and

- have completed 40 clinical-shadowing hours in the desired specialty or DSc program-approved alternative (if a PA desires to apply to more than one DSc program, they must complete shadowing for all programs they are applying for; the shadowing form is typically included with the application).[3]

Application Information

All PAs who want to participate in LTHET must be selected by the HRC LTHET panel. The digital application is posted on the HRC LTHET portal[3] and annual application guidance is published through a MILPER message posted on the portal in October or November. An applicant checklist is also posted, containing specific directions, deadlines, and the GEM's contact information.

In addition to the documents listed above, applicants need to review and update their individual Army military human resource record and officer record brief (ORB). The final application submission deadline is given in the annual MILPER message, usually in mid-February. Once the applicant receives the application with HRC, PA consultant, and corps endorsement from the GEM, the applicant must submit the completed checklist, LTHET application, DA Form 3838, official (degree-conferring) school transcripts (if not already posted on the military human resource record), and official GRE scores to the LTHET team according to the date and directions provided in the MILPER message.

Annual Planning Cycle

Prospective applicants should review the LTHET MILPER for the previous cycle to their projected application (1 year in advance). Although there may be some changes in the future checklist, a year will provide adequate preparation time to meet any application requirements, such as the GRE and clinical shadowing. Once eligible, applicants must review the current application guidelines in the annual MILPER message, usually no later than early December. LTHET selection panel results are generally published in June or July, approximately 1 year prior to the program start dates. For example, applications received in February 2021 will have selection panel results published in June or July 2021 for programs starting in summer 2022.

Utilization Tours

Each LTHET program must have an identified use, otherwise known as utilization tours. These are dependent on the program of completion, and are predetermined as part of the validation process. Before applying for training, prospective applicants should discuss utilization tours with the current GEM, previously trained PAs in the desired specialty, and the PA consultant.

Post-Professional Short Course Program

The PPSCP was developed to address military-unique medical training requirements and certification maintenance for AMEDD officers. These training opportunities were designed to align with deployment readiness requirements and later revised to train PAs on individual critical task lists. Due to the MEDCoE reorganization and alignment with TRADOC processes, responsibility for maintaining readiness has moved from the institutional to operational domains, and these programs have lost funding. However, some courses remain relevant and will continue to be sponsored.

Annual Planning Cycle

The PPSCP annual planning cycle mirrors the LTHET planning cycle. Each PPSCP has a course administrative data (CAD) document that is used to provide administrative information, course objectives, staffing requirements, funding requirements, and other resourcing information. Similar to LTHET, all new requests for training and courses occur in the late fall (October or November) and are due at the same time as the PPRW and populated in early spring. The PA consultant is responsible for assigning a project officer (course director) to each PPSCP offering to coordinate and execute the course. The project officer is responsible for development and coordination of the course's curriculum and required resources, and should be familiar with the PPSCP planning cycle, course curriculum, continuing medical education (CME) accrediting processes, and budgetary management.

PPSCPs are evaluated by the AMEDD corps offices using force development, health care delivery, and health readiness as key factors. Based on these factors, the courses are then prioritized on a four-point scale:

- Priority (highest). A program that meets regulatory requirements, such as training required for graduate professional education, GME, or dental graduate education. Programs that meet requirements for attaining an area of concentration or ASI are also considered priority.
- High priority. Programs that are directly tied to the surgeon general's priorities and lines of effort and have AMEDD relevance. Courses that maintain certification or licensure fall in this category as well.
- Moderate priority. Officer and leader development programs or training that provides education otherwise available at civilian institutions. The most common PPSCPs in this category are the Junior Leadership Course and Iron Majors Week Course.
- Low priority. Generalized institutional courses designed for federal employees and all service members.

Once prioritized, these courses are sequenced on an order-of-merit list and resourced based on available funding for the program.

Additional Educational Opportunities

A multitude of additional professional development opportunities, in both medicine and officer professional education, are offered by centralized and decentralized programs. All education that improves an officer's fund of knowledge and increases capability from the tactical to strategic roles of the AMEDD is encouraged. With exceptions as identified by DOD instructions, Army regulations, or annual programs not aligned with AMEDD, PAs are recommended to pursue all available education that improves their ability to support soldiers and the AMEDD. The National War College education system and the Army War College (aligned with Army University) offer strategic course matter that may also improve the ability to expand into joint operational force management.

Defense Strategy Course (Army War College)

A foundational military education course from the Army War College is the Defense Strategy Course, a 4-month nonresident/distant learning course offered twice a year.[4] The course is intended to improve officers' understanding of the DOD's role in the development of the national security strategy, and the strategy's role in the international

environment.[4] The course is recommended for majors and lieutenant colonels, and enrollment is limited to 50 active duty, 25 reserve, and 25 National Guard officers.[4] The course is highly competitive and strongly recommended for senior PAs for several reasons: the training helps leaders develop critical thinking skills required for strategic-level decision-making; it presents the opportunity to attend various fellowships; and it provides an ASI (6Z) per DA Pamphlet 611-21, *Personnel Selection and Classification: Military Occupational Classification and Structure*.[5]

To be eligible, applicants must have credit for military education level 4, and they must not be enrolled in or have completed a Senior Service College program. Enrollment information is as follows:

- Review the course curriculum at https://dde.carlisle.army.mil/curriculum.cfm.[4]
- Notify your assignment manager of your interest in attending the course.
- Submit a DA Form 3838 to your assignment manager.
- In the Army Training Requirements and Resources System (ATRRS), the school code is 217 and the course number is DSC.[6]

The Defense Strategy Course is divided into four sections with 13 lessons each. Each lesson requires approximately 7 to 10 hours to complete. As described on the course website, the sections are as follows:

Section 1, Introduction: introduces the student to the online format of the course and critical thinking concepts.
Section 2, Strategic and Military Theory: examines classical thinking about strategic theory, the military schools of strategic thought, the international system, strategy formulation frameworks, and states and strategy.[4]
Section 3, The Department of Defense: reviews the roles of the DOD, civil control of defense, the interagency framework, and homeland security.
Section 4, Policy Development and Security Environment: examines policy making, globalization and economic development, the current strategic environment based on both opportunities and

threats, cultural relations and dimensions, multinational operations, centers of gravity analysis, and strategy at the combatant command level.[4]

Graduates receive an Army War College certificate signed by the college's commandant. Although the course awards an ASI, recorded in the ORB under military education, it does not award a formal military education level, nor does it provide college course credits. There is no formal academic evaluation report, although PAs can apply CME (continuing medical education) category 2 credits for professional development to support their credentialing requirements (see Chapter 10, Maintaining Certification and the CME Categories, for further details). Graduates should provide the course completion certificate to their assignment officer to have the course and 6Z ASI added to their ORB.[4]

Additional Professional Military Education

Upon completion of the Defense Strategy Course, additional professional military education (PME) opportunities are available to PAs. The Defense Planners Course is a distant learning course focused on joint planning. The Army Force Management School has multiple course offerings in capability development and force management, including the "How the Army Runs" course (results in a 3R ASI). The US Navy has a robust online PME program; for example, the US Naval War College's College of Distance Education accepts applications from Army majors and above, as well as civilians in grades GS-11 and above, for some of its courses.[7] Additional offerings can be found through distance learning offered by the Air War College, the senior school in the Air Force PME system. The college's 44-week course for lieutenant colonels trains senior leaders for strategic-level employment of air, space, and cyberspace forces. The curriculum emphasizes coalition warfighting and national security, and includes seminars, simulation exercises, electives, international travel, and a national security symposium (contact the Air War College registrar directly for enrollment procedures).[8] The Joint Knowledge Online website also has multiple courses such as acute care provider modules and Military Health System course modules.[9]

Conclusion

Professional education is a key component for PAs to maintain critical wartime skills and meet the demands of future engagements. Understanding the roles of strategic academic leaders, professional education programs, and broadening training opportunities will assist PAs in managing their career and ensuring they are prepared for future deployments.

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Attachment: Long-Term Health Education and Training/Training with Industry (LTHET/TWI) Program Descriptions

This attachment lists additional courses that PAs may attend to enhance their operational readiness, prepare for upcoming positions and new duties, and gain CME credit. Follow the directions below for the Army Training and Requirements Resources System (ATTRS) and Defense Medical Readiness Training Institute (DMRTI) courses:

- ATTRS (https://www.atrrs.army.mil/): Click on "Course Catalog" at the right of the screen and insert the course number into the search engine. This will bring up the course. Double click on the course, and the dates and locations, scope, and points of contact for the course will be shown. (To enroll, apply through your operations office or directly to the course point of contact.)
- DMRTI (http://www.dmrti.army.mil/): Click on "Courses" at the top of the screen. Tabs will appear for all DMRTI courses, providing contacts, dates, CME credits, training focus, and requirements for who can attend.

Doctor of Science in Physician Assistant Studies (DScPAS) with specialization in Orthopedics

Program Length: 1.5 years **ADSO**: 3.5 years

Program Narrative
The Doctor of Science of Physician Assistant Studies in Orthopedics (DScPAS-O) is an 18-month program of subspecialty rotations, formal didactic instruction, and clinical research. This graduate program prepares physician assistants (PAs) with the knowledge and expertise to provide perioperative care to a full spectrum of musculoskeletal injuries and conditions. Students matriculate at one of four academic medical centers: San Antonio Military Medical Center, Joint Base San Antonio–Fort Sam Houston, Texas; Madigan Army Medical Center, Joint Base Lewis-McChord, Washington; William Beaumont Army Medical Center, Fort Bliss, Texas; and David Grant Medical Center, Travis Air Force Base, California. Current graduates serve in expeditionary surgical teams and combat surgical hospitals to provide

stabilizing measures for battlefield injuries. This program results in a research doctorate degree and an M1 additional skill identifier.

Doctor of Science in Physician Assistant Studies (DScPAS) with specialization in Emergency Medicine

Program Length: 1.5 years **ADSO**: 3.5 years

Program Narrative
The Doctor of Science of Physician Assistant Studies in Emergency Medicine (DScPAS-EM) Residency is an 18-month program that incorporates a variety of clinical rotations, formal didactic instruction, and research. The Doctor of Science program is modeled after the 3-year Emergency Medicine Physician Residency and prepares the EMPA to perform clinical research and to evaluate, diagnose, and stabilize critically ill or injured patients. The overall mission is to produce postprofessional, emergency medicine-trained PAs who provide Military Health System (MHS) beneficiaries state-of-the-art, advanced care in emergency situations. This program provides a structured environment to facilitate learning, ensure competency, practice evidence-based medicine, and conduct clinical research to benefit the warfighter, MHS beneficiaries, the US Army Medical Department, and the PA profession.

Doctor of Science in Physician Assistant Studies (DScPAS) with specialization in General Surgery

Program Length: 1.5 years **ADSO**: 3.5 years

Program Narrative
The Doctor of Science Physician Assistant Studies in General Surgery (DScPAS-GS) is an 18-month program consisting of formal academic requirements, postprofessional research, and structured clinical and surgical training. Established to train postgraduate-level Army surgical PAs to become integral members of perioperative teams in both deployed and garrison environments. The DScPAS-GS graduate's purpose is to maximize the utilization of Army surgeons and their critical skills by safely assuming non-operative surgical responsibilities and procedures, and serve as surgical (multidisciplinary) first assistants. Also, the DScPA-GS is responsible for helping to improve health care and health care policy in battlefield trauma, trauma/critical care, and

surgical research. Applicants to the program must be available for Special Operations Command DScPA-GS positions, Expeditionary Resuscitation Surgical Team (ERST) forward surgical team missions, and civilian-military partnership opportunities. Graduates will be allocated to 528th Sustainment Brigade, hospitals inside and outside the United States, and Department of Defense level I trauma centers, and serve as faculty at the Army Institute of Surgical Research.

Army Medical Department (AMEDD) Board Internship in Test and Evaluation (T&E)

Program Length: 1 year **ADSO**: 3 years

Program Narrative
The Operational T&E Intern Program provides AMEDD officers with specialized training in the T&E acquisition career field and positions them as acquisition leaders. The training enables them to provide relevant data to acquisition program managers aimed at ensuring sound programmatic decisions and properly equipping operational elements to meet the Army's contingency mission requirements. T&E is described in Army Regulation 73-1, Department of Defense Instruction 5000.66, and the Defense Acquisition Guidebook as a major element of the acquisition process that provides state-of-the art medical and medical-related devices required to accomplish contingency missions. The objective of the internship is to provide the AMEDD with a pool of officers who are fully qualified to fill AMEDD T&E assignments. During the internship, students will receive hands-on practical experience in analysis, research, plan writing, report writing, oral briefings, policy development, and T&E procedures.

Doctor of Medical Science (DMSc)

Program Length: 1 year **ADSO**: 3 years

Program Narrative
This 1-year Doctorate of Medical Science Program is a professional doctorate that directly supports readiness. Graduates of this program will support educational platforms for area of concentration (AOC) 65D and train to fill operational positions that support warfighters' readiness. Examples of these educational platforms are the Interservice Physician Assistant Program (IPAP), Tactical Combat Medical Care Course, and

Brigade Combat Team Trauma Training (BCT3). The DMSc provides the requisite degree necessary for full academic faculty appointment status at affiliated universities, and is further necessary for PAs to assume leadership positions within the 65D educational programs and higher educational jobs (dean, vice provost, commandant).

American Academy of Physician Assistant (AAPA) Fellowship (TWI)

Program Length: 1 year **ADSO**: 3 years

Program Narrative
This training with industry (TWI) experience will provide in-depth training with the AAPA, the only national professional society for PAs in the United States. AAPA experiences include PA professional advocacy, state/federal governmental relations, health care policy analysis, professional education, and constituent organizational outreach. Additionally, the officer will have exposure to organizational governance, interagency coordination and communication, multidisciplinary professional outreach, information and technology affecting health care professionals, and transformations that optimize team-based medical practice.

National Commission on Certification of Physician Assistants (NCCPA) Fellowship (TWI)

Program Length: 1 year **ADSO**: 3 years

Program Narrative
This training with industry (TWI) experience will provide in-depth training with the NCCPA, the only certifying organization for PAs in the United States. This agency will provide exposure to the ever-changing world of PA certification. NCCPA experiences would include certification process/policy, exam writing, data collection, continuing medical education, current issues/problems with certification, and being part of the solution. The knowledge and skills learned in this TWI are directly applicable and invaluable to the military IPAP as well as for the subject matter expert for Army PA certification.

National Registry for Emergency Medicine Technicians Fellowship (TWI)

Program Length: 1 year **ADSO**: 3 years

Program Narrative
This training with industry (TWI) experience will provide the PA with in-depth training with the National Registry of Emergency Medical Technicians. This organization is the only national emergency medical services (EMS) certification organization that provides a valid, uniform process to assess the knowledge and skills required for competent practice by EMS professionals throughout their careers. The PA will be involved with the development of standardized EMS training, certification, and recertification process and policy.

Executive Fellow, Corps Chiefs Office Fellowship (all AOCs, captains only)

Program Length: 1 year **ADSO**: 2 years

Program Narrative
The Office of the Chief, Army Medical Specialist Corps Fellowship Program offers Army Medical Specialist Corps (SP) officers the opportunity to actively participate in the strategic development, planning, and execution of SP-related policies, initiatives, and events. Fellows assist in formulating programs and actions that influence active and reserve component SP officers worldwide and support Army medicine strategic goals and objectives. Graduates of this broadening assignment are prepared to perform as primary staff officers within the Army Medical Command, Office of the Surgeon General, Defense Health Agency (DHA), and medical brigades.

Master in Health Administration (executive track Intermediate Level Education graduates only)

Program Length: 1 year **ADSO**: 3 years

Program Narrative
The 1-year executive MHA program is for senior officers to gain business skills in data acquisition, business metrics, and analysis to understand and solve the most complex enterprise problems arising from the clinical, administrative, or training areas of the AMEDD and

DHA. Students will simultaneously engage in didactics and residency problems that combine the knowledge and application of lessons learned in the MHA program.

Point-of-Care Ultrasound Fellowship (DScPAS graduates only)

Program Length: 1 year **ADSO**: 2 years

Program Narrative

The Point-of-Care Ultrasound Fellowship is a 1-year program designed to enhance the evaluation, assessment, and treatment skills of medical providers who care for service members with injuries that could be detected using bedside ultrasound in clinic and in combat. Graduates of the Ultrasound Fellowship receive the same training as their emergency medicine physician counterparts, including program/course development, instructing students at the novice and advanced levels, research, and administration of ultrasound programs. Graduates become approved subject matter experts and certified trainers for other physicians, PAs, and medics within the force. Graduates will fill positions at the IPAP, Tactical Combat Medical Care Course, DSc program faculty, and major Forces Command installations to bring ultrasound training to the force.

Chapter 5

THE ARMY ORTHOPEDIC PHYSICIAN ASSISTANT

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Orthopedic Physician Assistants are critically important providers within the musculoskeletal care team, both in garrison and downrange, ensuring the readiness of our fighting force and assisting with combat casualty care. Over 80% of combat wounds involve the extremities, and musculoskeletal injuries are by far the most common disabling conditions limiting readiness of our troops at home. Orthopedic Physician Assistants are at the tip of the spear in Army Medicine. Highly trained and highly sought after, they serve alongside surgeons in the clinic and operating room to treat injury and return Service Members to duty. With a broad range of skills ranging from fracture care to surgical first-assist, Army Orthopedic Physician Assistants have an exciting and rewarding career in the Army and in civilian practice.

—Colonel Benjamin Kyle Potter
Orthopedic Surgery Consultant to the Surgeon General

Introduction

The development of the orthopedic physician assistant (PA) profession in Army medicine began in response to Medical Corps personnel shortages in both the US Army Forces Command (FORSCOM) and Medical Command (MEDCOM) in the late 1980s. The Office of the Surgeon General approved the orthopedic PA program in 1989 and extended it to an 18-month doctoral program in 2007.[1] In FORSCOM, orthopedic PAs were specifically utilized to extend orthopedic surgeons' capabilities in combat support hospitals and forward surgical teams, increasing access to orthopedic care on the battlefield. In MEDCOM, orthopedic PAs improved access to orthopedic care in the garrison environment by increasing staffing at orthopedic surgery clinics in medical treatment facilities (MTFs), including community

hospitals. This increased staffing has been imperative for ensuring continued access to care for the deployed force and maintaining medical readiness.[2]

To fill the capability gap caused by personnel shortages, and to produce a cadre of competent PAs with consistent skills, capable of providing advanced care at all levels of Army medicine and covering multiple subspecialties within orthopedic surgery, formal academic education was required. Because orthopedic PAs would need to fill multiple roles in varied environments, on-the-job training would not provide the breadth of knowledge required to operate in the full spectrum of FORSCOM and MEDCOM missions.

Mission

The mission of the Army orthopedic PA is to extend orthopedic surgical care on the battlefield and to enhance the capabilities of Army orthopedic surgeons by serving in MTFs and combat support hospitals. The orthopedic PA provides perioperative orthopedic management, surgical first-assist, and minor procedures for surgical and nonsurgical patients. Orthopedic PAs also conduct performance improvement projects and research approved by an institutional review board (IRB) in order to enhance evidence-based practice and improve care in the military health system. In 2016 orthopedic PAs began contributing to the joint Special Forces mission in the United Arab Emirates, with a dedicated position performing extensive medical planning and treatment for a wide variety of patient complaints at several separate Role 1 treatment facilities. Since 2018, orthopedic PAs have been substituting for the 61M orthopedic surgeon on expeditionary resuscitative surgical teams, sometimes as team leaders.

Duties and Responsibilities

The orthopedic PA profession in FORSCOM and MEDCOM continues to expand and adapt to the Army's requirements. Today, the orthopedic PA plays four vital roles[3]:

1. **Surgeon extenders**. Orthopedic PAs effectively extend the capacity of orthopedic surgeons in all subspecialties and at all levels of military medicine from damage-control orthopedic care

on the battlefield to augmentation of subspecialties at academic MTFs.

2. **Clinical scientists**. Orthopedic PAs advance scientific and medical knowledge by performing as clinical scientists, conducting relevant and valid research that generates evidence-based practices. This ensures that Army medical centers provide consistent and effective health care to service members and their families.

3. **Educators and mentors**. As educators and mentors, orthopedic PAs optimize the education of future clinicians in Army Medical Center of Excellence (MEDCoE) graduate programs. They also act as subject matter experts who direct continued medical education and facilitate comprehensive career-long education for medical professionals at military installations.

4. **Professional service and scholarship**. Orthopedic PAs lead the PA profession at the national level and are recognized experts in PA graduate allied health education. They hold leadership positions and participate in organizational work groups in the American Academy of Physician Assistants, National Commission for the Certification of Physician Assistants (NCCPA), Accreditation Review Commission on Education for the Physician Assistant, and Physician Assistants in Orthopaedic Surgery. They also serve as peer reviewers for numerous national and international journals, including the *Journal of the American Academy of Physician Assistants*, *Journal of Bone and Joint Surgery*, and the *Journal of Orthopaedics for Physician Assistants*.

Education and Training

The US Army orthopedic PA residency and doctoral program was created as a benchmark for postgraduate education, through the pursuit of academic and clinical excellence, of PAs working in orthopedics.[3] The program is an intense 18-month curriculum that includes completion of 36 courses (59 credit hours representing over 700 hours of classroom instruction) and 10 clinical rotations (29 credit hours representing more than 5,000 clinical training hours). Training is completed in the setting of an academic medical center at one of

four graduate medical education (GME) residency programs. The curriculum is modeled after the Accreditation Council for Graduate Medical Education orthopedic surgery residency programs.[3]

Orthopedic PA residents are taught alongside junior orthopedic surgery residents, with a guided educational model, and given comparable responsibilities. This comprehensive model includes both didactic and clinical instruction, on-call responsibilities, management of both inpatient and outpatient orthopedic conditions, and formal education on conducting clinical research. Daily responsibilities include inpatient rounds; outpatient evaluation of urgent, semi-urgent, and routine patients in the cast room, clinic, and emergency department; preoperative evaluation and management; and first-assist in surgical cases of all levels of complexity.

The program is separated into individual rotations by subspecialty and evaluated with formal oral and written requirements. Testing consists of multiple-choice tests administered at periodic intervals as well as oral boards. Orthopedic PA residents complete clinical rotations in general orthopedics and the subspecialties of trauma, sports medicine, hand and wrist, pediatrics, oncology, joint reconstruction, foot and ankle, and spine.

The capstone requirement for the residency is a presentation of an IRB-approved research project to a board panel that includes faculty of the residency program and university. The orthopedic PA residents are required to submit a manuscript to a journal and produce a poster for display. Upon completion, residents are awarded a doctor of science (DSc) degree and an Army additional skill identifier as an orthopedic PA (M1). Graduates incur an active duty service obligation of 3.5 years (3 years for the first 12 months of training, 6 months for the last 6 months of training).

Duty Descriptions

The positions for the specialized PAs (orthopedics, emergency medicine, and general surgery) are outlined in Chapter 4 (Academic Leadership Roles, Professional Education, and Additional Training Opportunities for PAs) to avoid duplicated descriptions for research directors, deputy program directors, program (site) managers, and specialized Interservice Physician Assistant Program instructors. The positions covered in this chapter are orthopedic PA positions. All orthopedic PAs must maintain

National Commission on Certification of Physician Assistants (NCCPA), Basic Life Support (BLS), Pediatric Advanced Life Support (PALS), Advanced Life Support (ALS), and Advanced Trauma Life Support (ATLS) certifications as required by the credentialing and privileging facility.

Orthopedic Physician Assistant (General)

Primarily, orthopedic PAs practice under the supervision of orthopedic surgeons and assist in providing specialized care to patients with orthopedic injuries and conditions. Specifically, orthopedic PAs are responsible for physical examinations, ordering and reviewing diagnostic tests, diagnosis, and developing preliminary goal-oriented treatment plans for musculoskeletal disorders and injuries.

Orthopedic PAs also provide first-assist in surgery and manage patients perioperatively. As part of this management, orthopedic PAs perform orthopedic procedures (Figure 5-1) including administration of local and regional anesthetics, therapeutic and diagnostic joint injection, musculoskeletal ultrasound, fracture fluoroscopy, fracture reduction and management, wound closure/suturing, graft preparation, complex wound debridement, perioperative wound care, skeletal traction, hardware removal, and primary management of nonoperative orthopedic conditions.

Orthopedic Physician Assistant in an Expeditionary Resuscitative Surgical Team or Combat Support Hospital

An orthopedic PA in one of these deployed positions:

- is responsible for the rapid and thorough triage, evaluation, stabilization, and management of urgent medical, surgical, or traumatically injured orthopedic patients;
- performs invasive and noninvasive diagnostic and therapeutic procedures including life-saving procedures within individual credential guidelines and privileges delineated by the hospital;
- orders appropriate available laboratory, radiographic, and other diagnostic tests;
- interprets the total medical and surgical evidence, incorporating information into an accurate diagnosis or appraisal, and initiates proper treatment;



Figure 5-1. Major Timothy Pekari instructs Interservice Physician Assistant Program student officer candidates Lauren Bentley and Sherrie Jansky on ultrasound guided evaluation of the biceps tendon at Evans Army Community Hospital, Fort Carson, Colorado, in April, 2020. Photograph courtesy of Major Pekari.

- develops a patient care plan for each case appropriate to the medical assets and facilities available in the area of operations;
- facilitates patient access to continuing medical care by appropriate referrals to other health care providers and specialists, and determines necessary evacuation to higher roles of care, operating within the policies and regulations of the hospital;
- enhances medical capabilities for forward emergency and resuscitative care and expands capabilities at the tactical level by providing orthopedic stabilization at or near the point of injury; and
- augments emergency medical and orthopedic expertise in the structure of the operating forces, advising the appropriate authority on the management of orthopedic trauma patients within the area of operations.

Chief, Orthopedic Surgery Cast Clinic

The orthopedic PA assigned as chief of an orthopedic surgery cast clinic manages the daily operations for the clinic in support of the orthopedic surgical service, in a 0.75 FTE position. The orthopedic PA serving as a chief of the cast clinic:

- supervises other orthopedic PAs, the cast clinic noncommissioned officer in charge, and Army and civilian orthopedic technicians;
- ensures all faculty members are compliant with FTE and RVU productivity requirements based on duty description and additional duties;
- coordinates logistics and supplies; maintains appropriate stock level of medical and office supplies for orthopedic services;
- maintains accountability and responsibility of equipment in the clinic; and
- precepts and supervises rotational academic program students with orthopedic requirements.

Duty Locations

- Continental United States (CONUS): Fort Bragg, NC; Fort Campbell, KY; Fort Carson, CO; Fort Hood, TX; Fort Polk, LA; and Fort Stewart, GA.
- Outside CONUS: Germany, Korea, and Hawaii.
- Residency training sites: Brooke Army Medical Center, JBSA-Fort Sam Houston, TX (orthopedic PA program director, program manager, program faculty); William Beaumont Army Medical Center, Fort Bliss, TX; Madigan Army Medical Center, Joint Base Lewis-McChord, WA.

Prerequisites

- Extensive experience (including deployments) in battalion and brigade PA positions.
- Completion of long-term health education and training (LTHET) is preferred.
- Rank of major preferred.
- Intermediate Level Education (ILE) graduate preferred (or enrollment in ILE distance learning).

Skills and Attributes

- Must be an excellent role model with the desire to mentor and teach others.
- Strong leadership, administrative, and academic skills.
- Excellent oral and written communication skills.
- Solid work ethic.
- Strong organizational and time management skills.

Lessons Learned

- Orthopedic PAs should maintain their basic clinical skill sets and knowledge in primary care medicine, not only to prepare for recertification examinations, but also for routine patient management in garrison and deployments.
- Orthopedic PAs add value as clinicians and leaders in expeditionary resuscitative surgical teams.
- The vast knowledge and expertise of orthopedic PAs in medical treatment and medical planning contribute to joint Special Forces missions and Role 1 treatment facilities.

Tips for Success

- Have an excellent working relationship with the orthopedic surgeon during residency and beyond.
- Build networks early and get to know specialty staff members in physical therapy, occupational therapy, and internal medicine.
- Develop good working relationships with other members of the health care team, working as a seamless unit to best meet each individual patient's needs.
- Manage and complete documentation thoroughly. Meet with staff who can help you build templates and streamline coding for orthopedic treatment and procedures.
- Share experiences and knowledge by publishing articles.
- Individuals interested in becoming an orthopedic PA should start by shadowing one in clinic for at least a week to experience the full spectrum of assigned tasks.
- Read the annual LTHET military personnel message, which details requirements for shadowing hours and Graduate Record

Examination (GRE) scores needed to apply for the orthopedic PA doctoral program.
- Start learning about the IRB and how do conduct research at the local level by reaching out to clinicians and other researchers.
- Attend a class such as the SP Corps Mary Lipscomb Hamrick Research course before attending LTHET to learn research skills.

Conclusion

In FORSCOM, orthopedic PAs extend surgeons' capabilities in forward environments, increasing access to orthopedic care on the battlefield. In MTFs, orthopedic PAs improve access to specialty care in the garrison environment by increasing staffing in orthopedic clinics and operating rooms. Across the force, orthopedic PAs contribute to the education of general practice providers by precepting students, giving formal board review lectures, and providing patient-centered feedback. Orthopedic PAs mentor future leaders in a variety of dynamic environments, including operational medicine, clinical research, and hospital-based medicine. The orthopedic PA degree program exceeds the civilian standard of on-the-job training and certificate programs, enabling students to participate in damage-control orthopedics and contribute to evidence-based medicine. Military orthopedic PAs also serve in a number of national professional organizations, extending their sphere of influence beyond the uniform. Future orthopedic PAs will serve in a wide variety of leadership positions and further prove the value of specialty-trained PAs to supplement surgeons in far-forward units.

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Chapter 6

THE ARMY EMERGENCY MEDICINE PHYSICIAN ASSISTANT

Monica Casmaer, PA-C, DSc; Sharon Rosser, PA-C, DSc, MPAS; and Ryan Curtis, PA-C, DSc, RDMS

The Army's Emergency Medicine Physician Assistant (EMPA) residency program produces the world's most highly trained Emergency PAs. Fully capable of resuscitating critically ill or injured patients, they have and are decreasing morbidity and mortality both in the Medical Treatment Facilities and on the battlefield. Highly sought after for their advanced training, EMPAs bring modern trauma resuscitation to wounded warriors, saving lives and allowing them to return home to their families.

—Colonel (Retired) Ian Wedmore
Former Emergency Medicine Consultant to
The Army Surgeon General

Emergency Medicine Physician Assistant's Mission

The mission of the US Army emergency medicine physician assistant (EMPA) is threefold: (1) to be a force multiplier by providing emergency medical and trauma resuscitative care on and off the battlefield (Figure 6-1); (2) to perform as a clinical scientist to better serve Military Health System beneficiaries; and (3) to enrich the physician assistant (PA) profession with expertise in emergency medicine. This mission is met through producing EMPA residency program graduates with proficiency in clinical emergency medicine and resuscitative trauma management.

EMPAs provide rapid and thorough evaluation and management of emergent medical, surgical, neurologic, polytrauma, and critical patients (Figure 6-2). They perform emergent bedside procedures to



Figure 6-1. Captain Brian Ahern, an emergency physician assistant assigned to a Defense POW/MIA Accounting Agency (DPAA) recovery team, performs an ultrasound on a local worker during excavation operations in the Houaphan province, Laos, February 16, 2019. As part of the humanitarian mission, DPAA hosts a medical outreach event to treat local villagers. The team deployed in support of DPAA's mission to provide the fullest possible accounting of missing personnel to their families and the nation by searching for the remains of service members lost during the Vietnam War. Photograph by Staff Sergeant Michael O'Neal, US Army.
Reproduced from Defense Visual Information Distribution Service. https://www.dvidshub.net/image/5150551/19-2la

stabilize critical medical and traumatically wounded patients within military medical treatment facilities (MTFs). EMPAs improve access to emergency medical care in MTFs and optimize emergency department (ED) throughput and productivity, which reduces the overall health care cost burden in the current period of physician shortages.[1] EMPAs also increase medical knowledge and performance improvement (PI) by conducting research approved by the institutional review board and other PI projects related to emergency medicine.



Figure 6-2. Captain Ryan Curtis, 36th Area Support Medical Company, and trauma surgeon Lieutenant Colonel Corydon Siffring, work to achieve hemostasis on a coalition partner suffering from a gunshot wound to the face. Both were assigned to the Role 2 forward surgical element at Forward Operating Base Ghazni, Afghanistan. They were deployed in support of Operation Enduring Freedom.
Photograph courtesy of Corydon Siffring, Lieutenant Colonel, Medical Corps, US Army.

Residency Program

Vision

The vision of the EMPA residency program is to create the benchmark for postgraduate EMPA education through the pursuit of academic and clinical excellence. This vision is realized by developing clinical scientists who are prepared to conduct advanced scientific research, as well as to provide quality emergency care for patients with a wide variety of illnesses and traumatic injuries in the ED and on the battlefield. These EMPA clinical scientists will develop as future leaders and mentors by establishing scholarly excellence for the PA profession.

History

In 1981, in response to an Army-wide emergency medicine physician shortage, the Army initiated training in emergency medicine for PAs. PAs were trained to augment physician staff in the perpetually busy EDs. Most assignments were to understaffed MTFs located throughout the continental United States. Selected PAs were enrolled in a training program at Darnall Army Community Hospital, Fort Hood, Texas, which already had an existing emergency medicine physician residency. The program of study was 12 months long and paralleled the second postgraduate year training for emergency physicians. However, suffering a severe PA shortage in line units and poor PA retention, the Army reduced or stopped most postgraduate training for PAs in 1986. A total of 12 EMPAs were trained during those 5 years.

In 1989, the American College of Emergency Physicians (ACEP) published a position paper in the *Annals of Emergency Medicine* on the utilization of PAs in military emergency medicine.[2] While there was some division among physicians as to the practicality of utilizing PAs in emergency medicine, the authors made the important point that training PAs in this field prepared them for the type of trauma anticipated in combat.[3] The authors maintained that EMPAs could be a valuable asset to a military ED, stressing that PAs should be used as physician extenders and not as physician substitutes. ACEP advocated that all EMPAs receive a formal course of training in either a fellowship or residency program for at least 12 months, and that the training be conducted at an approved emergency medicine physician residency program.

In 1991, the Army surgeon general approved a plan for a revised program. The first EMPA training began at Brooke Army Medical Center, Fort Sam Houston, Texas, on July 1, 1991. In 1992, a second program was established at Madigan Army Medical Center, Tacoma, Washington. A third program began in 1995 at Darnall Army Community Hospital (but closed the following year after graduating one class in 1996). All three training sites had active emergency medicine physician residency programs. Upon successful completion and graduation from EMPA training, graduates were awarded the M2 identifier to their area of concentration (65DM2).

In January 2007, ACEP issued a policy statement validating the necessity of additional training for PAs in the ED setting. The policy states that "Physician Assistants working in EDs should have or acquire

specific experience or specialty training in emergency care, should participate in a supervised orientation program, and should receive appropriate training and continuing education in providing emergency care."[4] This is the first time that a non-PA organization acknowledged the necessity for advanced education of PAs.

Traditionally, entry-level training for PAs was either a bachelor's degree or, now more commonly, a master's degree program. PAs desiring doctoral degrees had to pursue the traditional academic route such as the Doctor of Philosophy (PhD), available only in nonclinical subjects. Those desiring postprofessional education emphasizing clinical skills had limited options. Most of the current programs are based on distance learning with very little faculty oversight of the clinical experience. PAs who wanted to specialize in a clinical residency training program could attend a 12-month clinical program that issued a certificate of advanced competency in the specialty upon completion.

In 2006, the US Army partnered with Baylor University to create the world's first Doctor of Science in Physician Assistant Studies specializing in Emergency Medicine (DScPAS-EM) degree. To create the new doctoral degree, the previous 12-month certificate program was extended into an 18-month clinical emergency medicine residency program with a more robust curriculum and additional clinical contact hours. The residency program was developed to provide training in emergency medical care on and off the battlefield. With emphasis on individual research, evidence-based practice, and a superior clinical curriculum, the program is unique. No other existing EMPA residency and fellowship programs can match its strengths in all areas. It has established a standard that other programs are currently attempting to emulate. With this distinction and the prestige earned by its graduates, the DScPAS-EM residency program benefits the Army by serving as a tool to recruit and retain highly qualified military graduates who wish to further their education, specialize in a highly demanding field, and provide emergency medicine capabilities to military units and MTFs (Figure 6-3).

Program Curriculum

The EMPA residency program selects residents from a pool of qualified Army PA applicants based on projected needs of the Army and per guidelines established in the annual long-term health education training



Figure 6-3. Role 3 emergency medical technician section officer in charge, Lieutenant Colonel Jason Naylor, and his team await the arrival of a patient from Baghdad International Airport. They were deployed in support of Operation Inherent Resolve in 2017.
Photograph courtesy of Jason Naylor, Lieutenant Colonel, Medical Specialist Corps, US Army.

message. New EMPA residents begin with a 2-week accelerated research course on how to design a research protocol that can be approved by an institutional review board, conduct research, collect data, analyze the research data, and complete a doctoral-level manuscript. Additionally, EMPA residents learn how to present their research in various platforms including poster presentations, scientific platform presentations, and defense of the doctoral research project.

The EMPA residents join their physician colleagues in an extensive, in-depth, 4-week introduction to critical care and emergency medicine to familiarize the PA with emergency, combat, and polytrauma medicine. During this training, the EMPA resident participates in numerous procedure labs and performs various lifesaving skills to resuscitate the sick and wounded. Next is a 4-week ultrasound training rotation that familiarizes and credentials the EMPA resident in point-of-care

(bedside) ultrasonography. Procedures performed during live tissue and cadaver labs include central venous access, pericardiocentesis, arterial line placement, transvenous cardiac pacing, chest tube thoracostomy, needle thoracostomy, resuscitative thoracotomy, venous cutdown, intraosseous device placement, and lumbar puncture. Additionally, residents perform lateral canthotomy, orotracheal intubation, rapid sequence induction, cricothyroidotomy, tracheostomy, supraglottic airway device placement, and ventilator management.

The program emphasizes patient care through hands-on learning. In total, the EMPA residency consists of 16 didactic sections and 20 clinical rotations comprised of approximately 740 hours of classroom instruction and nearly 4,000 clinical hours. It includes rotations through the medical, surgical, and cardiac intensive care units, the pediatric ED, and eight separate rotations at two level 1 trauma centers with extensive trauma surgery and resuscitation exposure.

Certifications

The EMPA resident must complete the American College of Surgeons Advanced Trauma Life Support (ATLS), Advanced Life Support (ALS), Pediatric Advanced Life Support (PALS), and Basic Life Support (BLS) courses during the residency. Residents may choose to attend Advanced Burn Life Support (ABLS), Neonatal Resuscitation Program (NRP), and the Pediatric Fundamentals of Critical Care Support (PFCCS). After completion of the EMPA residency program, graduates are awarded the DScPAS-EM. Graduates from the DScPAS-EM program may apply for the 1-year ultrasound fellowship.

Ultrasound Fellowship

The ultrasound fellowship is designed to train acute care clinicians to be leaders in bedside ultrasound. It is dedicated to the principle that ultrasound is part of the clinical practice of every emergency physician and PA. The fellowship adheres to the ACEP *Emergency Ultrasound Guidelines* (2013) specifically pertaining to the site qualification requirements and fellowship criteria for graduation.[5] The program focuses on four primary competency areas: sonographer/sonologist training; ultrasound educator; scholarly activity; and administration of ultrasound continuous quality improvement programs.

The EMPA ultrasound fellow is expected to personally perform at least 1,000 ultrasound exams during the fellowship. The fellow must master the applications of diagnostic and procedural emergency ultrasound prior to graduation.[5–7]

Duty Descriptions

The positions for the specialized PAs (orthopedics, emergency medicine, and general surgery) with similar roles and responsibilities are provided in more detail in Chapter 4, Academic Leadership Roles, Professional Education, and Training Opportunities. The following are the duty descriptions specific to EMPAs.

Emergency Medicine Physician Assistant in the Emergency Department or Combat Support Hospital

- Provides direct expert patient care to patients in the ED or combat support hospital under high-stress situations. Provides care and clinical supervision for a wide range of patient presentations, ages, and conditions including emergent, urgent, and non-urgent complaints.
- Responsible for the rapid and thorough triage, evaluation, and management of the pediatric, psychiatric, obstetric, geriatric, surgical, and traumatically injured patients in the ED or combat support hospital. Performs invasive and noninvasive diagnostic and therapeutic procedures including lifesaving procedures within personal credentials and privileges delineated by the hospital.
- Responsible for utilizing considerable ingenuity in identifying symptoms of presenting patients that are often subtle or present with overlapping symptoms due to the presence of more than one condition or ailment, and that require extensive analysis and testing to determine the nature and scope of the problem.
- Orders appropriate laboratory, x-ray, and other diagnostic tests; interprets the total medical and surgical evidence, incorporating information into an accurate diagnosis or appraisal; institutes proper treatment and develops the appropriate patient care plan.
- Facilitates patient access to continuing medical care by appropriate referrals to other health care providers, operating within the policies and regulations of the hospital or MTF. Skillfully interacts with a

variety of patients and consultants in an effort to obtain desired compliance and cooperation. Maintains health and clinical records in accordance with current regulations and standards. Maintains the appropriate level of physical fitness necessary to respond to any emergency medical or trauma situation.

Emergency Medicine Physician Assistant in the Forward Deployed Surgical/Resuscitative Element, Critical Care Transport, US Disaster Response Team, Damage Control Resuscitation Team, and White House

- Responsible for the rapid and thorough triage, evaluation, stabilization, and management of urgent medical, surgical, or traumatically injured patients.
- Performs invasive and noninvasive diagnostic and therapeutic procedures including lifesaving procedures within personal credentials and privileges delineated by the hospital or MTF.
- Responsible for utilizing considerable ingenuity in identifying symptoms of presenting patients that are often subtle or present with overlapping symptoms due to the presence of more than one condition or ailment, and that require extensive analysis and testing to determine the nature and scope of the problem.
- Orders appropriate available laboratory, x-ray, and other diagnostic tests; interprets the total medical and surgical evidence, incorporating information into an accurate diagnosis or appraisal; institutes proper treatment and develops a patient care plan appropriate to the medical assets and facilities available in the area of operations.
- Facilitates patient access to continuing medical care by appropriate referrals to other health care providers and specialists and determines necessary evacuation to higher echelons of care, operating within the policies and regulations of the hospital or MTF.
- Enhances medical capabilities for forward emergency and resuscitative care and expands capabilities at the tactical level by providing specialized advanced trauma management and far-forward damage control resuscitation at or near the point of injury, to prevent deterioration and death in the urgent presurgical patient and reduce the number of deaths from potentially survivable wounds on the battlefield or in other austere conditions of operations
- Augments emergency medical expertise in the structure of the

operating forces, advising the brigade surgeon or appropriate authority on the management of trauma patients within the area of operations.
- Skillfully interacts with a variety of patients and consultants to obtain compliance and cooperation.
- Maintains health and clinical records in accordance with current regulations and standards.
- Maintains the appropriate level of physical fitness necessary to respond to any emergency medical or trauma situation.

Emergency Medicine Physician Assistant Ultrasound Fellow

- Provides education to physician residents, EMPA residents and fellows, medics, nurses, and faculty or medical students. The primary venue for teaching is scanning shifts, when the fellow will help staff hone their skills on the primary applications for emergency and critical care ultrasound, and expand their knowledge of evolving applications.
- Must be able to demonstrate 20 hours per month of hands-on teaching at the end of each 28-day rotation block.
- Runs the weekly ultrasound quality assurance review sessions, during which each bedside and training ultrasound exam is reviewed and critiqued. Exams reviewed include studies done by the fellow, residents, and students during their ultrasound electives. Responsible for educating residents and students in this forum under the supervision of the director.
- Integrally involved in the emergency medicine residency ultrasound curriculum. This involves a combination of pre-scheduled didactic and hands-on teaching sessions, ED scanning shifts, and assisting the fellowship director in leading journal review discussions.
- Presents a minimum of one grand rounds lecture during the course of the year on advanced emergency ultrasound topics.
- Assists and facilitates residents during ultrasound rotations in preparing video review clips and high-yield teaching points for grand rounds "Ultrasound Cases of the Month."
- Conducts research followed by peer-reviewed publication as a significant portion of the nonclinical workload.
- Serves as a primary investigator on one research project approved by an institutional review board and as associate investigator on a

second. Abstract publications as well as one additional publication in the form of images in clinical medicine, case report, case series, expert opinion, letter to the editor, or textbook chapter are also a requirement of the fellowship.
- Attends a national emergency medicine ultrasound section meeting during the fellowship.
- Learns how to set up, direct, and manage an ultrasound continuous quality improvement program. This entails developing a data collection instrument, a database for storing continuous quality improvement data, and a means of developing measures of quality.
- Initiates and conducts at least one interdepartmental quality assurance project to improve the use of ultrasound in the emergency medicine setting.
- Becomes familiar with national recommendations for credentialing and how they are carried out in a hospital-based emergency medicine practice.
- Attends interdepartmental and committee meetings throughout the hospital in relation to ultrasound use in the ED.
- Attends weekly emergency medicine grand rounds and departmental continuing education activities. Registered Diagnostic Medical Sonographer certification is encouraged.

Chair, Emergency Medicine Physician Assistant Program

- Identifies capability gaps the EMPA can fill. Provides recommendations on the use and placement of EMPAs throughout the Army to the emergency medicine consultant to the Army surgeon general, the PA consultant to the Army surgeon general and SP Corps chief, the PA requirements chief at the Directorate of Combat and Doctrine Development, and the Army Medical Department Personnel Proponent Directorate.
- Assists the EMPA program directors by ensuring the EMPA skill sets remain up to date and relevant to possible future capability gaps across the Department of Defense.
- Works closely with the PA graduate medical education committee and dean to ensure that the EMPA residency program is adhering to all standards and producing quality EMPAs. Provides input and recommendations to the PA graduate medical education committee and dean, PA chief, SP Corps chief, and SP Corps education

committee on recommendations for the EMPA program directors. Provides input on applicants to the EMPA residency program.

Duty Locations

- Continental United States: California (Ft Irwin); Colorado (Ft Carson); Georgia (Ft Benning, Ft Gordon, Ft Stewart); Kansas (Ft Riley); Kentucky (Ft Campbell, Ft Knox); Louisiana (Ft Polk); New York (West Point); North Carolina (Ft Bragg); Oklahoma (Ft Sill); South Carolina (Ft Jackson); Texas (Ft Hood); Virginia (Ft Belvoir); and Washington (Ft Lewis).
- Outside continental United States: Alaska, Hawaii, Germany, and Korea.
- Fort Sam Houston: Medical Center of Excellence (Interservice Physician Assistant Program instructor); Brooke Army Medical Center (EMPA program director, EMPA program faculty, and EMPA program manager).

Requirements

- Sincere desire and commitment to attain excellence in providing emergency medical care.
- Must have a Master's Degree in Physician Assistant Studies.
- Must meet Graduate Record Examination requirements for admission to Baylor University.

Desired Skills and Attributes

- Must be an excellent role model with the desire to mentor and teach others.
- Solid leadership, administrative, and academic skills.

Lessons Learned

These are important lessons learned for EMPAs:

- A 65DM2 is a subject matter expert in resuscitation.
- Resuscitation skills require honing and maintenance. This is best accomplished by working no less than 20 hours per week in an ED.

- The 65DM2 needs to be facile in integrating core emergency bedside ultrasound into the patient care flow.

Tips for Success

Along with lessons learned, the following tips for success will enable the future EMPA to succeed beyond expectations:

- If emergency medicine is truly a passion, seek a 65DM2 mentor who is fully engaged in academics and patient care.
- Truly master routine medical complaints to allow the future EMPA to focus on the finer points of emergency medical care.
- Attend the Basic Skills Course to attain a true appreciation of the DScPAS-EM Fellowship.

Conclusion

The EMPA Fellowship is an arduous training program. However, the program generates clinicians capable of handling any emergency at home or abroad. The 65DM2 will experience a career that is both challenging and extremely rewarding.

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Chapter 7

THE ARMY GENERAL SURGERY PHYSICIAN ASSISTANT

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"The most important clotting factor is the surgeon."

—*Moshe Schein, MD*[1]

Mission

The mission of an Army general surgery physician assistant (GSPA) is to extend surgical and critical care far forward on the battlefield. GSPAs are force multipliers, enhancing the capabilities of Army general surgeons by extending advanced care and surgical decision-making. GSPAs serve in conventional or special operation forces to support surgical care and surgical critical care in all roles of care, including forward resuscitative surgical teams, critical care transport/emergency resuscitation teams, and deployable hospitals. In military treatment facilities, GSPAs provide perioperative, postoperative, surgical first assist, critical care, and bedside procedures to surgical patients with the goals of increasing surgical productivity, access to care, and continuity of care within the sphere of surgical practice throughout the Army. Doctorate GSPAs also conduct clinical research and performance improvement projects approved by the institutional review board (IRB) in surgery or critical care with the intent of improving care on and off the battlefield.[2]

History

In the 1960s, surgical assistants were being developed on an apprenticeship basis, although there was no formal training process. During that decade, in response to the shortage of medical providers, the PA training model was developed by Dr Eugene Stead Jr, Dr Richard

Smith, Dr Hu C. Myers, and Dr Henry K. Silver, based on World War II physician medical and nursing models.[3] The military first started training specialty PAs in the 1980s. The first military PA specialty was orthopedics, followed by emergency medicine in the 1990s.

In 1995, the idea first surfaced for developing a surgically trained PA who would serve as an extension for surgeons on forward surgical teams. A surgical PA program was developed that included clinical rotations at the University of Maryland Shock Trauma Center in Baltimore; Brooke Army Medical Center at Fort Sam Houston, Texas; and the University of Texas Health Science in San Antonio.[3] Once trained, these PAs would be able to first assist, perform triage, and provide surgical critical care, thus allowing surgeons to focus on performing operations.

In 2001, a pilot program was conducted to train a surgical Army PA. The selected trainee began a 12-month rotation through surgical services at Fort Hood, Texas. The program was a success, but further development of the program was deferred after the September 11th terrorist attacks (email communication with Major [Retired] Don Adams, January 2014).

According to the first GSPA program directors, Lieutenant Colonel David Freel and Lieutenant Colonel Patrick Sherman, the idea of the GSPA was revived in 2005. Over the next year, a curriculum was developed, and a training site was established at Brooke Army Medical Center, Fort Sam Houston, Texas (email communication with Lieutenant Colonel [Retired] David Freel, December 2013). The first class to attend the 18-month training program began in July 2009. In December 2014, the Doctor of Science in Physician Assistant Studies–General Surgery (DScPAS-GS) was awarded. The program continued to grow, incorporating Air Force PAs, and seeing its first Navy cohort in the 2018–2019 class cycle, making it a truly tri-service program. In October 2019, new operational assignments for GSPAs were added to the 528th Sustainment Brigade to provide direct surgical support to Special Forces missions.

Because of the continued surgeon shortfall, current initiatives to increase trauma surgical capability include the use of the M4 skill identifier. Through collaborative efforts of the Medical Corps and Specialist Corps via the Medical Center of Excellence Personnel Proponency Directorate, the M4 skill identifier is being proposed as a multiple branch means to collectively identify both trauma-trained surgeons and trauma-trained surgical PAs to augment Role 2 through Role 4 surgical employment.[2]

Training

The 18-month DScPAS-GS doctoral program includes general surgery clinical rotations and subspecialty (trauma/critical care, burn surgery, oncological surgery, pediatric surgery, neurosurgery, vascular surgery, plastic surgery, interventional radiology, and intensive care unit procedures) monthly clinical rotations (Figure 7-1). The following procedures are taught during the 18-month program:

- emergency and critical care ultrasound;
- endoscopy (bronchoscopy, colonoscopy, esophagogastroduodenoscopy);
- placement of central lines;
- peripheral inserted central catheter;
- pericardiocentesis;
- thoracostomy tube placement;



Figure 7-1. Captain Josh Randles (left) affixes an autologous split-thickness skin graft with a US Army Institute of Surgical Research staff surgeon (right); October 2019.

- lumbar puncture;
- ventriculostomy;
- surgical airways (crichothyroidotomy and tracheostomy); and
- fluoroscopic guided procedures.

Also taught are basic surgical first assist techniques for trauma, open surgical cases, and laparoscopic and robotic surgical cases. Other critical care and trauma procedures taught are airway management (intubation, crichothyroidotomy, tracheostomy); orthopedic external fixation; continuous renal replacement therapy; burn and wound care; minor procedures; thoracotomy; and ventilator management. The GSPA resident also attends training in the following certifications: Advanced Burn Life Support (ABLS); Fundamentals of Critical Care Support; Emergency War Surgery; and Advanced Trauma Life Support (ATLS).[2]

Current curricular training occurs at Brooke Army Medical Center for 17 didactic courses aligned with 16 clinical rotations and comprehensive IRB-approved doctoral research projects, culminating in a doctoral defense with the affiliated university. These programmatic events are complemented by oral examinations, simulation training/testing, case report publications, surgical presentations in morbidity/mortality and tumor board conferences, and the American Board of Surgery In-Training Examination (ABSITE).[2]

Practice and Certifications

After graduation, GSPAs have the opportunity to practice in a multitude of fields and may obtain additional certifications:

- Specialty practice
  - trauma/critical care
  - acute care surgery/emergency general surgery
  - cardiothoracic surgery
  - interventional radiology
  - neurosurgery
  - vascular surgery
  - bariatric/minimally invasive surgery
  - surgical oncology
  - colorectal surgery

- Certifications
  - Registered Diagnostic Medical Sonographer (RDMS)[4]
  - Certified Wound Care Specialist (CWS)[5]
  - Certificate of Advanced Qualification (Hospitalist)

Duty Descriptions

Chapter 4 described four positions—program director, research director, program manager, and Interservice Physician Assistant Program (IPAP) instructor—with similar roles and responsibilities in managing the DSc programs for clinical orthopedics (Chapter 5), emergency medicine (Chapter 6), and general surgery (this chapter). The following duty descriptions are specific to GSPAs:

Surgical/Critical Care Physician Assistant, Special Operations Forces

These PAs serve as surgical PAs on forward resuscitative surgical teams, providing initial trauma assessments and damage control resuscitation, assisting with damage control surgery and acute care surgery, and providing critical care. They are expected to provide operational context to the team's mission; assist with medical mission planning and training[6,7]; and advise special operations units and commanders on medical threats and permission requirements. Training for these surgical teams consists of working in civilian trauma centers and establishing overseas partnerships. These PAs must be airborne volunteers, willing to deploy at least annually, and agree to a 3-year commitment to the unit. They must be in excellent physical shape, culturally astute with good interpersonal skills, and able to think and operate at both tactical and strategic levels.

Surgical/Critical Care Physician Assistant, Conventional Forces

Positions include the White House surgical PA and PAs assigned to a forward deployed resuscitative surgical element, deployable hospital, critical care transport team, or a disaster response team in the United States. These PAs are responsible for ensuring that all assigned surgical patients receive appropriate triage, preoperative evaluation, resuscitation, and stabilization. They also provide the following care: postoperative care, surgical first assist, inpatient care, intensive care,

minor procedures, ultrasound, endoscopy, and wound care. They assist with placement of external fixators (pelvic and extremity), ensure continuity of care, and perform critical care transportation as required. Additionally, they perform or assist in IRB-approved research and performance improvement projects, and educate and train consulting physicians, PAs, nurses, and medics in surgical disease processes, pathology, and treatments.

General/Trauma Surgery Physician Assistant, Fixed Facility

These GSPAs provide surgical care, under the supervision of a surgeon, for patients admitted to a military medical treatment facility. They conduct the following care: preoperative; postoperative; surgical first assist; inpatient treatment; trauma assessments; intensive care; minor clinic procedures; bedside procedures (ultrasound, central lines); endoscopy (colonoscopy, esophagogastroduodenoscopy); and wound care. These GSPAs also perform on-call duties as first call with surgeon backup, and ensure continuity of care for all patients. Additionally, they participate in morbidity and mortality conferences, cancer care conferences, and wound care conferences. These GSPAs also conduct IRB-approved research and performance improvement projects and train consulting physicians, PAs, nurses, and medics in surgical disease processes, pathology, and treatments.[2] They provide feedback and training to local Role 1 providers and medics on outcomes and possible areas for improvements.[2]

Positions and Duty Locations

- GSPA (availability contingent upon updated Defense Health Agency directives):
  - Fort Belvoir Community Hospital, Fort Belvoir, VA
  - Tripler Army Medical Center, Honolulu, HI
- Special operations surgical PA: 528th Sustainment Brigade, Fort Bragg, NC, with duty at Charlotte, NC
- IPAP general surgery instructor: US Army Medical Center of Excellence, JBSA-Fort Sam Houston, TX
- GSPA program director: Brooke Army Medical Center, JBSA-Fort Sam Houston, TX

- GSPA assistant program director: Brooke Army Medical Center, JBSA-Fort Sam Houston, TX
- GSPA research director: Brooke Army Medical Center, JBSA-Fort Sam Houston, TX

Requirements

- Experience in battalion and brigade PA positions. Deployments as PA are preferred.
- Apply and be accepted to long-term health education and training (LTHET).
- Rank of captain to lieutenant colonel.
- Captains must have completed the Captains Career Course and majors and higher must have completed Intermediate Level Education prior to start of program.[2]

Desired Skills and Attributes

- Must be an excellent role model with the desire to mentor others.
- Solid leadership, administrative, and academic skills.
- Must have an interest in people.
- Must be able to encourage and assist others.
- Good spoken and written communication skills.
- Strong work ethic.
- Strong organizational and time management skills.
- Committed to working in a team environment.

Lessons Learned

- Training via LTHET is primarily an exposure to multiple practice types; the expertise in a discipline begins on becoming a staff GSPA.
- GSPAs should emphasize surgical and procedural skill maintenance as a major component of their required privileges to support surgical care in deployment.
- Open procedures and basic laparoscopic procedures (hernia, appendectomy, cholecystectomy, diagnostic laparoscopy) are the common surgical cases performed outside fixed facilities.
- Surgical care must occur along a continuum beginning with primary care, prehospital Tactical Combat Casualty Care (TCCC) initial

practice; therefore, GSPAs must be routinely familiar with primary care and TCCC practice to bridge care effectively.
- GSPAs must maintain PA-C recertification as general practitioners and must also maintain the associated knowledge and practice base.
- GSPAs are also military medical officers and must meet the milestones for professional military education and consider opportunities for broadening positions that improve the PA career field.

Tips for Success

- Exploiting a PA's career experience to bridge the knowledge gap for the surgeon from the point of injury to the surgical table and intensive care unit (ICU) bed benefits the patient and enhances shared understanding of the surgical team.
- The LTHET application process includes a good Graduate Record Examination (GRE) score, including the essay score—writing ability will have significant bearing on success in LTHET.
- Surgical research is constantly evolving; to participate, a successful GSPA must remain current in surgical and critical care research.
- Surgery is a team practice; the GSPA must carve out a role that adds value and helps the surgeon focus on their role.
- Valuable knowledge and experience can be drawn from all members of the surgical care team—operating room (OR) technicians, OR nurses, anesthesiologists, and post-anesthesia care unit (PACU) and ICU staff.
- The practice of surgery depends on understanding its judicious use in treating disease as well as appropriate nonsurgical management.
- Expertise in the OR is the result of time spent in the OR.
- More surgical care is performed outside the OR than in it.
- Thorough documentation saves lives and supports good surgical decision-making.
- A GSPA cannot rely solely on a radiologist's report; they must personally view the study ordered and know its limits (anatomy is different in 3-dimensional space).
- Elements of additional surgical disciplines (interventional radiology, neurosurgery, burn, plastics, orthopedics, vascular) should be learned in preparation for any austere surgical deployment.

- It is necessary to learn how to use equipment (loupes, headlamp, laparoscopic and other scopes, cautery, suction); GSPAs should know their intended purposes and how to compensate for their shortfalls as needed.

Conclusion

The GSPA is a well-trained and versatile specialty provider. GSPAs have a comprehensive understanding of the anatomy and pathophysiology of not only surgical disease but also traumatic injury—with the ability to manage a patient from the prehospital phase, to the trauma bay, operating room, and intensive care unit. In addition to providing treatment in all roles of care, in both conventional and unconventional forces, the GSPA can serve in force-generating roles as IPAP and LTHET faculty. They also have opportunities to conduct and publish clinical research. Those who have graduated from the training pipeline are adept and experienced health care providers. The GSPA should be a much sought-after career path.

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Chapter 8

ATTENDING INTERMEDIATE LEVEL EDUCATION

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Introduction

Intermediate level education (ILE) broadly describes the US Army's formal education system for field-grade, mid-career Army officers preparing to serve in staff and command roles. ILE is achieved through the Command and General Staff Officer Course (CGSOC), either through resident courses, distance learning, or a combination of these programs. CGSOC programs include officers from other US military services, foreign military services, and civilian interagency leaders who intend to operate in Army, joint, interagency, and multinational environments as commanders and general staff officers.[1] CGSOC is similar to ILE programs in other services, such as Air Command and Staff College education for Air Force officers, and the US Navy College of Naval Command and Staff. Pathways to complete ILE through the US Army include:

- 10-month resident CGSOC at Fort Leavenworth, Kansas.
- 14-week resident courses at satellite locations.
- 18-month distance learning course through independent study, the Total Army School System (TASS) reserve schools option, or a combination of both.

Resident Staff College

Resident CGSOC lasts 44 weeks across three curricular components: (1) the CGSOC Common Core (16 weeks), (2) the Advanced Operations Course (16 weeks), and (3) electives (12 weeks).[2] The Common Core curriculum aims to broaden the perspective of junior majors from the tactical level to an operational level and includes seven blocks, culminating in oral and written exams:

- Foundations
- Strategic Studies
- Operational Studies
- Army Operations
- Managing Army Change
- Rise of the Western Way of War
- Leadership: Forging Success in Uncertain Times[3]

The Advanced Operations Course prepares officers to build and lead operational and tactical formations in unified land operations and covers the following subject areas:

- Today's Operational Environment
- Full Spectrum Operations
- Theory of War and Doctrine
- Conduct of War
- Commandership[3]

The elective curriculum provides students the opportunity to enhance their learning while conducting advanced studies in focus areas, across 192 class hours.[2] Students complete courses in an experiential learning environment that yields adaptive, self-aware, field-grade leaders of character and competence who are capable of shaping the joint operational environment.[1] The instruction is designed to develop students' critical and creative thinking skills, decision-making ability, character, self-awareness, leadership skills, and teamwork approaches to solving complex problems from a systems perspective.[1]

Supervision

Participants are assigned to the CGSOC US Student Detachment (USSD) at Fort Leavenworth, in student status, and placed into one of approximately 64 staff groups, each with 16 students under a group advisor.[2] A staff group consists of officers from multiple branches and various services or governmental agencies, with one or two representatives from multinational partners. Only one Army Medical Department (AMEDD) officer is in each staff group.

Roles and Duties

While assigned to the USSD, each officer participates in a leadership position within the student chain of command. These positions range from small group leader to class president, and all are designed to assist with the daily management of the staff group. Additionally, there are multiple opportunities to serve in various other volunteer positions, some of which result in elective credits toward graduation. Some of these positions include:

- class historian,
- yearbook editor,
- triathlon director,
- adjutant officer,
- international student sponsor, and
- sports and recreation director.[2]

Desired Skills and Attributes

Applicants compete for attendance under the Army special branches ILE selection board, based on the following requirements and desired attributes:

- rank of major or captain promotable;
- Captain Career Course graduate;
- extensive experience as a physician assistant (PA) and AMEDD officer, with working knowledge of the military decision-making process;
- robust oral and written communication skills;

- strong work ethic and ability to work both independently and in a group, and
- desire to think critically about the military's strategic issues.

Training and Coursework

The Fort Leavenworth ILE experience challenges AMEDD students with daily intellectual exercises, rigorous academic assignments, complex problem-solving, impassioned peer-to-peer interactions, and broad exposure to joint, interagency, and multinational perspectives. AMEDD students will be asked not only to represent the AMEDD, but also to operate well outside the normal boundaries of a medical officer within the structure and framework of an Army staff. ILE faculty members intend to produce the field-grade officers soldiers deserve: tactically proficient, professionally competent, intellectually grounded, organizationally skilled, ethically sound, and readily able to exercise disciplined initiative in a brigade, division, corps, or joint headquarters.[2]

The first 7 months of ILE residency are particularly demanding and typically require 8 in-class hours per day and 3 to 5 additional hours of reading and homework. During this time, students participate in the Common Core and Advanced Operations Course curricula, which culminate in a joint exercise with international exchange students who travel to the United States to participate.

After completion of the Common Core and Advanced Operations Course, students proceed to the 8-course elective portion. They choose elective programs or courses of study based on personal interest and professional stewardship, such as:

- Graduate degree program focus, culminating in the Master of Military Art and Science (MMAS) degree or other graduate degrees through Kansas State University, the University of Kansas, or another partnering university.[2]
- Homeland security studies focus, offering students the opportunity to develop expertise in the area of homeland security.[2,4]
- Certificate in Overseas Contingency Operations–Planning, providing students the opportunity to develop expertise critical to the execution of stability operations and reconstruction and stabilization missions.[2,4]

- Foreign language program, providing formal language instruction in a language of the student's choice, or based on projected postgraduation assignments.[2,4]
- International exchange and fellowship programs with the Australian, French, German, or United Kingdom staff colleges in conjunction with the completion of a regional studies certificate.[2,4]
- Defense Support to Civil Authorities (awarding additional skill identifier [ASI] 7A), which trains officers to navigate the challenges of multidisciplinary and interagency roles in global humanitarian assistance/disaster response, emergency operations, and interoperating with National Guard and reserve components.[2,4]
- Joint planner (ASI 3H), which trains students in the Joint Operation Planning and Execution System (JOPES) and supporting information technologies.[2,4]
- Space activities (ASI 3Y), which trains the student on the capabilities, functions, and organizations performing military space missions.[2,4]
- Air operations officer (ASI 5U), which develops the skills for becoming an air operation officer through the joint firepower course.[2,4]
- Historian (ASI 5X), which educates students on the unique skills to serve in positions as Army historians, instructors, and history detachment members.[2,4]
- Strategic studies graduate (ASI 6Z), which prepares officers for future assignments dealing with national security and military strategy.[2,4]
- Red teaming (ASI 7J or 7G), which trains the student on the ability to enhance mission accomplishment by looking at problems from the perspective of the adversary, multinational partners, or alternative strategies.[2,4]

Additional Resident Information

- The resident ILE website is https://usacac.army.mil/organizations/cace/cgsc/cgss#.
- Attendance requires a permanent change of station (PCS) to Fort Leavenworth (see information for inbound students at https://usacac.army.mil/organizations/cace/cgsc/inbound).[4]
- Attendance incurs a 2-year service obligation upon completion. Graduates are normally placed in an operational utilization tour of duty using the skills and knowledge developed during training.[4]

- AMEDD students may be credentialed at Munson Army Health Center at Fort Leavenworth, with participation in half-day clinics (preferably two to four times a month).
- Upon notification of selection to the resident ILE course, applicants have 30 days to accept or decline the assignment.[4]
- Applicants should consider moving their family to Fort Leavenworth; the post is very family-friendly, and many students who do not bring their families regret it. On-post housing for unaccompanied officers is also available. If planning to live on post, call the housing office at Fort Leavenworth as early as possible.
- Complete the required online preparatory courses, which include online tests, writing samples, and significant required doctrinal readings.
- Prior to the start of the Common Core, AMEDD officers additionally complete a 2-week on-site prep course review of tactics, symbology, operations planning, and introduction to Army warfighting challenges.[2]
- Consider whether to pursue an MMAS or master's degree from a civilian university. This work is in addition to ILE coursework.[2]

Common Core Satellite Campuses

The CGSOC satellite campuses are located at Fort Belvoir and Fort Lee, Virginia; Fort Gordon, Georgia; and Redstone Arsenal, Alabama (Figure 8-1).[5] Officers from operations support, information operations, and institutional support career fields join AMEDD officers who attend with board-selected reserve component, National Guard, and special branch officers such as judge advocate generals and chaplains. In total, 12 satellite cohorts per year receive the identical 3.5-month CGSOC Common Core curriculum. AMEDD typically receives 108 satellite campus seats annually.[5]

Satellite Course Administration

Selected students attend in either temporary duty (TDY) or TDY en-route status and stay in centrally funded lodging. All TDY students are directed to use dining facilities, and are entitled to daily meals and incidental expenses.[6] TDY student personnel actions, including leave and finance, are managed by their home unit.[5,6] Limited TDY en-route



Figure 8-1. Major Garrett Larson, APA-C, and Major Lydia Zellers, PA-C, completed Intermediate Level Education through the satellite resident program at Fort Belvoir, Virginia, in March 2020.
Photograph courtesy of Major Larson.

student actions can be forwarded through the satellite campus to Fort Leavenworth for processing. Non-emergency leave during the course is not approved, except during holidays or weekends. Throughout satellite course attendance, students should not perform work activities related to their home or gaining unit. Personal or professional TDY during ILE (eg, conference or change of command ceremony attendance) is not approved unless general/flag officer requests are sent to the Combined Arms Center commander. Students attending in TDY status from duty stations outside the continental United States will not have tours curtailed or extended.[6]

Students are not eligible to attend CGSOC if currently flagged for failure to pass a record physical fitness test, or are noncompliant with Army body fat standards.[2] Temporary profiles are not authorized for incoming students unless due to pregnancy.

Satellite Course Training and Coursework

Four groups of 16 students, from multiple branches and various services, comprise each satellite course. There are typically two or three AMEDD officers in each group. A faculty group adviser leads each group, and the senior ranking student is the student group leader. The following additional duties are available:

- personnel officer
- supply officer
- technology officer
- safety officer
- after-action review officer
- homework officer
- social coordinator
- physical training coordinator
- photography coordinator

The typical satellite course training day is 0800 to 1500 hours, with plenty of free time provided for reading and reflection.[2] Organized small group physical fitness training is mandatory. Self-development undertakings such as journal article publication, scholarly projects, and physical fitness events are highly encouraged and rewarded.[2] The Common Core curriculum at satellite campuses, which differs from the structure at Fort Leavenworth, includes the following nine blocks of facilitated experiential learning instruction[2]:

1. CGSOC Foundations
2. Political and Strategic Environment
3. Joint Operations and Unified Action
4. US Army Doctrine
5. Joint Planning
6. Force Management
7. History
8. Leadership
9. Exams: a computer-based final exam and a rigorous oral board exam

Common Core Distance Learning

The Common Core distance learning (CC-DL) course is completed through independent study. Students are given access to the three phases and the same nine Common Core blocks. Distance learners use non-facilitated instruction to work independently on the Blackboard Learning Management System. Each phase represents a separate "course" in the Army Training Requirements and Resources System (ATRRS), to be completed sequentially. Students are assigned faculty advisors who monitor and support their progress through the course. Army Regulation 350-1 authorizes students 18 months to complete the course, although completion time varies by student, and depends largely on time invested by students.[7]

Total Army School System Common Core Option

Students may also enroll in the US Army Reserve TASS course option, called Command and General Staff Officer Course–Common Core (CGSOC-CC).[5] This option provides US Army Reserve students with a resident-like CGSOC experience. The TASS option is also a three-phase course. The DL and TASS phases of instruction are nearly identical, allowing students to move between either online or TASS instruction. Students enroll in the TASS version of the Common Core course in the same manner they would CC-DL, by applying for the TASS option through ATRRS.[5] TASS organizations include CGSOC-certified instructors to teach the course. For the most up-to-date information, refer to the ATRRS course catalog, www.atrrs.army.mil/atrrscc/, course number 701-1-250-ILE-CC.

Phases 1 and 3 are conducted in two ways:

1. Two-week resident courses at Fort Dix, New Jersey; Camp Parks, California; Fort McCoy, Wisconsin; Hawaii; and Germany.
2. Distance learning.

Phase 2 is conducted in two ways:

1. "2 × 8": 2 days a month for 8 months, October through May, at approximately 45 locations are across the United States, including Puerto Rico.

2. TASS accelerated "4 × 4": 4 days a month for 4 months, at seven locations across the United States, beginning the second quarter of the fiscal year.[5]

Awards

Resident

- George C. Marshall Award (distinguished graduate)
- Arter-Doniphan Award (highest grade point average)
- CGSOC Iron Major Award (physical fitness course)
- Grierson Award for Excellence in Strategic Studies (top strategist)
- MacArthur Military Leadership Writing Award
- Arter-Darby Military History Writing Award (tactical)
- Simons Center Interagency Writing Award
- Outstanding MMAS Thesis
- Excellence in Joint Command, Control, Communications, Computer and Intelligence (JC4I) Writing
- Homeland Security Studies Award
- Father Donald J. Smythe Award (military history)
- Master Tactician
- Master Logistician
- Harris Leadership Award (instructor nomination)
- Excellence in Joint Service Warfare Award

Satellite course

- General John J. Pershing Award (top graduate in each CGSOC satellite course)[2,8]

The Western Hemisphere Institute for Security Cooperation

The Western Hemisphere Institute for Security Cooperation (WHINSEC) is a tenant unit on Fort Benning, Georgia, located in the community of Columbus, Georgia.[9] WHINSEC was established in 2001 and codified in Title 10 USC, §343, as a Department of Defense training and education institution.[9,10] WHINSEC advances democratic principles and promotes interoperability, human rights, and US customs and traditions. These goals are achieved by providing security and defense training to partner nations through partnerships with academic institutions, and by fostering relationships with senior officials from

the Americas and the Caribbean.[10] Of the several courses held at WHINSEC, the School of Professional Military Education delivers a 10-month in-residence CGSOC. Similar to the in-residence CGSOC offered at Fort Leavenworth, CGSOC at WHINSEC is conducted once every academic year.[2,9,10] Students completing CGSOC at WHINSEC achieve the professional military education ILE requirements for intermediate-level officers.[2]

Facilities and Class Structure

Generally, the 64 students attending CGSOC at WHINSEC are a combination of US and international officers in the rank of major (O-4) or lieutenant colonel (O-5), as well as interagency and intergovernmental civilian equivalents. Students are divided into four groups of 15 or 16 officers led by a faculty group advisor. Each group has approximately an even distribution of US and international students, with only one AMEDD officer in each group. The CGSOC at WHINSEC provides state-of-the-art classrooms in Bradley Hall that are nearly identical to those in Fort Leavenworth. Students have access to support facilities and reference facilities at the Maneuver Center of Excellence.[9,10] For most US students, this is their initial exposure to a joint, interagency, intergovernmental, and multinational environment.

Training and Education

CGSOC students receive the same training and education as those attending CGSOC at Fort Leavenworth. However, CGSOC at WHINSEC does have some differences; most notably, the course is taught entirely in Spanish, and students are fully immersed in the Spanish language (although English-language study materials are provided).[9] Therefore, US students selected to attend CGSOC at WHINSEC are required to demonstrate Spanish language proficiency with a rating of at least "2" in both listening and reading, annotated in Section V, Foreign Language, on the officer record brief. Eligible US military students earning a Spanish language proficiency rating of "1" or higher in both listening and reading may receive up to $400 in foreign language proficiency pay throughout their academic year.[11,12] A DA Form 4187, Personnel Action, is generally required to schedule the Defense Language Proficiency Test 5 at a nearby military installation education or testing office.[11,12] CGSOC at WHINSEC also includes additional

classes on human rights, the rule of law, due process, civilian control of the military, and the role of the military in a democratic society.[9]

Faculty and Staff

The faculty and staff that make up the instructors for CGSOC at WHINSEC include military personnel from the different US services, military personnel from the Americas and Caribbean, and a foreign service officer from the Department of State. Guest lecturers include representatives and senior officials from Immigration and Customs Enforcement, the Department of Homeland Security, Department of Justice, Drug Enforcement Administration, United Nations, and various US universities.[9]

Additional Opportunities

Students may pursue the following additional educational opportunities while attending CGSOC at WHINSEC:

- **MMAS**. Enrolled CGSOC students may apply for admission into the MMAS program, which requires a choice of electives and an independent research project approved at the department director level. Students are also eligible to compete for CGSOC resident student awards upon submission of their MMAS thesis.[9] The MMAS may only be pursued while enrolled in the resident CGSOC.[9] Additionally, students attending CGSOC at WHINSEC have a unique opportunity to apply up to 18 hours of their CGSOC coursework to simultaneously earn a Master of International Relations in partnership with Troy University.[13]
- **School of Advanced Military Studies.** Graduates of CGSOC are eligible to apply to the School of Advanced Military Studies Program and earn a Master of Art in Military Operations.[2,9]

Attending CGSOC at WHINSEC allows for building camaraderie, establishing relationships, and further fostering the relationship between the United States and partner-nations of the Americas and Caribbean.[9] Nearly twice a month, and sometimes more often, events called "bocadillos" are held. Translated as "luncheons," bocadillos are an opportunity for partner-nation students to introduce regional cultures and customs through sharing popular food and drinks from their

country. WHINSEC offers an excellent opportunity for PAs to operate outside of their comfort zone, through exposure to a joint, interagency, intergovernmental, multinational environment. WHINSEC also offers the Army ASI 3H, Joint Planner, which trains students in the JOPES and its supporting information technologies.[9]

Lessons Learned and Tips for Success

- Prior to beginning formal ILE coursework, consider themes or challenges from the AMEDD or broader military context to serve as a focal point for study and research.
- Review doctrinal publications, ranging from tactics and leadership to the Army operating concept.
- Maintain a portfolio of written work and resources throughout ILE to aid future professional development.
- Review a personal learning skills inventory to identify the manner in which learning best occurs prior to starting coursework.
- ILE courses include well-established lecture series, allowing students to learn directly from and interact with general officers, leaders, and policy makers in the Department of Defense and legislative and executive branches of government.
- Expect to study hard, develop new relationships, and interoperate with peers from diverse branches, services, functional areas, and nations.

Conclusion

ILE provides a way for AMEDD officers and PAs to expand their roles in strategic- and operational-level planning and leadership contexts. ILE represents a capstone educational experience for developing skills and addressing shared challenges in a diverse peer group, whether in person or online. While ILE centers on the personal and professional development of staff officers, this unique opportunity crucially supports and underwrites the role of PAs throughout the joint and multinational operating environment, today and in the future.

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Chapter 9

LICENSURE, CREDENTIALING, AND GRANTING OF CLINICAL PRIVILEGES

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Introduction

US Army physician assistants (PAs) are required to meet established standards of education, professional licensure, certification, and clinical competency. To maintain the highest quality of military health care, a process is in place to ensure every provider meets these standards. Credentialing and privileging can be a seemingly arduous and lengthy process; however, a basic understanding of procedures and requirements and knowing what to expect can streamline the process. Additionally, Army PAs need to know specific information depending on their component—active duty, Army National Guard (ARNG), or US Army Reserve (USAR). After defining terms, this chapter is structured to describe the overall clinical privileging process for all Army PAs, followed by specific information for the ARNG and USAR (Figure 9-1).

Definitions

Army Medical Department (AMEDD) Professional Management Command (APMC). The APMC was stood up in 2005 with the formation of the Army Reserve Medical Command (AR-MEDCOM). APMC supports USAR commanders by providing personnel, training, finance, and assignment management for medical personnel when there are critical wartime shortages. APMC also provides centralized management of medical professionals to improve readiness, including credentialing and privileging of USAR providers. APMC is a direct



Figure 9-1. Then-Captain Erika Walker, a US Army Reserve physician assistant, conducts a periodic health assessment for Specialist Shuya Yang, an Army Reserve soldier assigned to 7226th Medical Support Unit, based out of Fort Jackson, South Carolina, in December 2017. Operation Reserve Care was an initiative run by Army Reserve Medical Command's 7458th Medical Backfill Battalion performed at Womack Army Medical Center, at Fort Bragg, North Carolina. Photo by Lieutenant Colonel Angela Wallace.
Reproduced from: https://www.dvidshub.net/image/4045101/initial-medical-screening-operation-reserve-care

reporting unit to AR-MEDCOM and derives authority from the US Army Reserve Command (USARC), with guidance from the USARC Surgeon's Office and US Army MEDCOM Quality Assurance Office, in accordance with (IAW) Defense Health Agency Procedures Manual (DHA PM) 6025.13 and Army Regulations (ARs) 40-68 and 40-66.

Health care credentialing. Refers to the process of verifying education, training, and proven skills of health care providers. Steps taken during the credentialing process include verifying licenses, completion of medical education, and completion of training such as fellowships and other certifications.

Privileging. Refers to the granting of permission to provide patient care in an institution within the framework of defined clinical practice.

Interfacility credentials transfer brief (ICTB). The ICTB is a summary of the contents kept in the practitioner credentialed file (PCF), used for all privileged providers when applying for privileges at a temporary duty (TDY) or temporary change of station (TCS) location.

Joint Centralized Credentials Quality Assurance System (JCCQAS). The JCCQAS (https://ccqas.csd.disa.mil/Account/Splash?ReturnUrl=%2f) is a military and civilian medical workforce management and privileging system designed to maintain historical and current medical provider qualifications, certifications, and privileges. All Department of Defense (DOD) applicants possessing a common access card (CAC) must use the JCCQAS to apply for clinical privileges.

Primary source verification (PSV). Refers to verification of a provider's credentials by going to the "primary source"—the entity that provided the education, license, or other credential to ensure the accuracy of the information given by the health care provider.

Practitioner's credentials file (PCF). The PCF is a comprehensive, permanent file containing documentation relevant to an individual's education, experience, licensure/certification, training, and professional history.

Physician Assistant Credentialing Requirements

Education. Army PAs must meet certain educational criteria for commissioning as a 65D (the Army PA area of concentration). According to Army Regulation (AR) 135-101,[1] all PAs must be graduates of a PA training program accredited by the Accreditation Review Commission on Education for the Physician Assistant.

Certification. All PAs (active duty, ARNG, USAR, and civilian) are required to possess current certification by the National Commission on Certification of Physician Assistants (NCCPA) before regular clinical privileges are granted or renewed. PAs who received their training from the Interservice Physician Assistant Program (IPAP) must take the Physician Assistant National Certifying Examination (PANCE) at the first available testing period following Phase 2 of IPAP training, and must receive a passing score within 12 months.[2]

Recertification. The PA National Recertification Examination is required every 10 years.[3] PAs who are unsuccessful in passing this

examination after two attempts will have their privileges revoked and are prohibited from practicing in their area of concentration. PAs with an existing active duty service obligation (ADSO) for training will be processed for involuntary branch transfer, IAW AR 614-100.[4] Individuals with no ADSO may be eliminated from service, IAW AR 600-8-24.[5]

Licensure. 10 US Code § 1098 requires individual practicing health care professionals in the military health system to be licensed. For PAs, the DOD accepts the successful passage of the PANCE as the appropriate authorizing document. State PA licensure requirements are currently waived for active duty PAs due to variations among state regulations (although state licensure is required for off-duty employment).[6–8] The American Academy of Physician Assistants (AAPA) provides open source tools and resources for state licensure at https://www.aapa.org/advocacy-central/state-advocacy/state-licensing/. This site lists all 50 state license requirements and their licensing boards; statutory and regulatory requirements for initial licensure and license renewal; and state laws and regulations. The AAPA also provides licensing tips for members.

National Practitioner Data Bank. A web-based repository of reports regarding medical malpractice payments and adverse actions related to providers.[9]

Clinical Privileging Process

The following is a general overview of the credentialing and privileging process, which may vary slightly from one facility to another.

Initial Application for Clinical Privileges

The new provider (recent IPAP graduate or direct commissioned PA) must establish contact with the credentials office at the gaining military medical treatment facility (MTF) to request privileges and initiate a JCCQAS application. Once contact is established, the gaining credentials office will send a welcome letter listing the required documentation needed to begin the privileging process (outlined below). The MTF credentials staff will use these documents to create a PCF for the new provider in JCCQAS.[2] The provider will then receive two emails

from the JCCQAS system. The first will be a notification that there are tasks to complete in JCCQAS, and the second email will contain a JCCQAS username and password. The following are documents required for initial application for clinical privileges:

- consent form,
- copy of government-issued photo identification,
- official military orders,
- diploma from accredited institution,
- NCCPA certificate,
- national provider identification (apply online at https://nppes.cms.hhs.gov),
- updated curriculum vitae (signed and dated),
- current Basic Life Support (BLS) certification,
- performance assessment completed and signed by the IPAP Phase 2 clinical coordinator or civilian equivalent for direct accession, and
- two peer review questionnaires (current within the last 24 months).

Once these documents are in hand, the credentials staff completes the following: (1) the PSV to ensure accuracy of the education, training, and licensure of the health care providers; and (2) a query to the National Practitioner Database (NPDB), a web-based repository of reports on medical malpractice payments and adverse actions related to health care providers[8] ; to ensure the applicant has no adverse actions against them. The application is then reviewed by the appropriate department chief. If everything is in order, the department chief will forward application to the credentials committee, which is presided over by the deputy commander of clinical services (DCCS). The committee reviews the application. If approval is recommended, it is forwarded to the MTF commander for final approval.

Periodic Reappraisal and Renewal

Clinical privileges are in effect for a period not to exceed 24 months from the date granted. It is the responsibility of each provider to request the renewal of their clinical privileges every 2 years. Requirements for renewal (accomplished in JCCQAS) are the following:

- JCCQAS application for renewal of clinical privileges,

- performance assessment report completed by supervising physician,
- current BLS certification,
- current NCCPA certification, and
- documentation of continuing medical education (100 credits must be earned every 2 years).[3]

The completed application for renewal of credentials goes through the same approval process as an initial application.

Renewal of Privileges Following Permanent Change of Station or Transfer to Another Medical Treatment Facility

Upon notification of an impending PCS or transfer to a new facility, the provider must notify the losing MTF credentials office, which will then initiate transfer of electronic and hard copies of the application and performance assessment report. The transfer of privileges goes through the same approval process as an initial application or renewal of credentials.

Credentialing and Privileges for Temporary Change of Station or Temporary Duty

Military providers who perform temporary duty (TCS or TDY) require an ICTB to render patient care at another location. Requirements (accomplished in JCCQAS) include the following:

- Notify local credentials staff of upcoming TCS/TDY.
- The credentials staff at the parent (sending) MTF initiates the ICTB.
- An email notification is automatically sent to the provider alerting them that there are tasks to complete in JCCQAS.
- The provider logs into JCCQAS and completes a new application for clinical privileges for the gaining MTF.

From this point, the PSV and review processes are similar to those for the original application, with a few important exceptions:

- All provider licenses, certifications, and registrations, as well as those credentials that need to be verified but were not previously verified, must undergo the PSV process. Professional education and other static credentials that generally are not updated over time do

not have to undergo PSV if they have already gone through PSV verification in JCCQAS.
- A new NPDB query is also required.

The privileging authority is the gaining MTF commander. Once the application is approved, the system will import the new privileges into the "Privileges" section of the provider's ICTB record. The system will also automatically calculate new privilege expiration and staff appointment expiration dates for the provider, based upon the end date for the ICTB duty.

Modification of Privileges at Request of the Provider

Modification of privileges requested by the provider can be accomplished at any time, including during a periodic renewal. Requirements (performed in JCCQAS) include:

- a new JCCQAS application with requested modifications, and
- documentation of training or certification and appropriate experience.

From this point, the PSV and review processes are similar to those of the original application upon which the modification is based, with a few exceptions. For a modification of approved privileges, only the provider's licenses, certifications, or registrations and those credentials that require verification but were not previously verified need to undergo the PSV process. A new NPDB query must also be performed. Once the modification application has been reviewed and approved by the privileging authority, the credentials manager will issue the appropriate notifications and complete the application process.

Physician Assistant Scope of Practice and Basic Core Privileges

PAs are awarded privileges commensurate with their education, experience, competence, and the operational needs of the unit they are assigned to. The scope of privileges for a PA includes the evaluation, diagnosis, and treatment of patients of all ages with any symptom, illness, injury, or condition. PAs provide medical services within the scope of practice of the collaborating physicians,

Table 9-1. Basic core privileges for US Army physician assistants.

Diagnosis and management

- Prescribe all medications, controlled substances (including Schedule II through V), and therapy regimens including orthotics and prosthetics required within the scope of practice.
- Recommend temporary limited duty profiles in accordance with service policy.
- Perform occupational and medical surveillance program physical exam.
- Perform examinations in accordance with the Occupational Safety and Health Administration (OSHA) and service policy.
- Provide evaluations of nuclear and chemical surety activities in accordance with applicable law and regulation.
- Place patients on quarters in accordance with service policy.
- Perform electrocardiogram preliminary interpretation.
- Prescribe all medications, controlled substances (including Schedule II through V), and therapy regimens including orthotics and prosthetics required within the scope of practice.

Procedures

- Laceration repair, minor (one layer).
- Excision of superficial cysts and skin lesions.
- Irrigation of the eye, ear, and wounds.
- Indirect laryngoscopy.
- Fluorescein staining.
- Splinting and stabilizing of spine or extremity injuries.
- Casting of extremities.
- Tonometry and tonography.
- Color vision testing.
- Laceration repair requiring more than one layer of closure.
- Aspiration and injection of joints and musculo-tendonous units.
- Complete or partial nail removal with or without destruction of nail matrix.
- Incision and drainage of cysts and minor abscesses.
- Cryosurgical removal of skin lesions.
- Arthrocentesis.
- Reduction of simple closed fractures and dislocations.
- Thrombosed hemorrhoid incision and drainage.
- Needle thoracostomy.
- Emergency cricothyroidotomy.
- Wound debridement.

Anesthesia

- Topical and local infiltration anesthesia.
- Peripheral nerve block anesthesia.

Skin biopsies

- Punch biopsy.
- Shave biopsy.

including routine primary and preventive care of children and adults. PAs may refer patients to specialty clinics, and assess, stabilize, and determine disposition of patients with emergent conditions. However, privileges to treat certain age groups may vary depending on facility and mission requirements. Deviation from core privileges requires documentation of training and experience and approval by the privileging authority. The basic core privileges of the US Army PA are listed in Table 9-1.

PAs with advanced education, training, and experience, and the appropriate privileges, may serve in specialty practice settings such as aviation medicine, cardiovascular perfusion, emergency medicine,

Table 9-2. Advanced privileges for US Army physician assistants (additional training required).

Advanced privileges

- Intrauterine device (IUD) insertion.
- IUD removal.
- Diaphragm fitting.
- Flexible sigmoidoscopy with and without biopsy.
- Subcutaneous contraceptive rod insertion and removal.
- Paracentesis.
- Thoracentesis.
- Tube thoracostomy.
- Lumbar puncture.
- Management of fingertip amputation.
- Direct laryngoscopy.
- Placement of posterior nasal packs or balloons.
- Vasectomy.
- Ultrasonography exam and interpretation for trauma.
- Moderate sedation.
- Regional nerve block anesthesia.

Additional advanced privileges (may depend on specialty)

- Prescribe all medications, controlled substances (including Schedule II through V) and therapy regimens including orthotics and prosthetics required within the scope of practice.
- Recommend temporary limited duty profiles in accordance with service policy.
- Perform occupational and medical surveillance program physical exam.
- Perform examinations in accordance with the Occupational Safety and Health Administration (OSHA) and service policy.
- Provide evaluations of nuclear and chemical surety activities.

occupational health, and orthopedics. Additions and deletions of PA specialties are approved by the Army surgeon general. Advanced privileges that require additional training are listed in Table 9-2.

Army National Guard and Army Reserve Physician Assistants

Most of the information in this chapter applies to all Army PAs; however, a few important differences exist in the credentialing and privileging processes for the ARNG and USAR PAs. These different processes are described below.

Army National Guard Physician Assistants

The Credentials Certification and Privileging Preparation (C2P2) Board credentials ARNG PAs and state surgeons award state privileges. The C2P2 Board holds the authority to approve state-level credentials but does not have the authority to award privileges. The C2P2 Board operates under authority from the ARNG Office of the Chief Surgeon, with guidance from the ARNG Medical Advisory Group and the MEDCOM Quality Assurance Office, IAW DHA PM 6025.13,[6] AR 40-68,[7] and AR 40-66[10] (everything in this chapter applies to the ARNG based on these regulations unless otherwise indicated). AR 40-68 is used for PAs in Title 32 status, and the DHA PM for PAs in Title 10 status. State licensure is required for all ARNG PAs, including Title 32 Active Guard Reserve (AGR) PAs; however, Title 10 AGR PAs can waive the state licensure requirement per DHA PM 6025.13.[6] Title 10 AGR PAs function in the same capacity as the active Army PA, so all regulatory guidance for active Army PAs applies to the Title 10 AGR.

ARNG PAs must contact their state credential coordinator to request privileges. The coordinator then initiates the credentialing process and coordinates with an ARNG credentialing contracted vendor and Office of the Chief Surgeon to prepare the PA's file for the C2P2 Board. The board reviews the file and recommends and approves the PA's credentialing (and additional skill identifier, if applicable). The approved credentials are then sent to the appropriate state surgeon. The state surgeon, an ARNG officer, is the delegated authority to award state privileges for delivering health care to eligible beneficiaries. ARNG

PAs who are mobilized for annual training and for missions outside of the United States require verification of credentials and privileges through the mobilizing MTF.

Army Reserve Physician Assistants

Like the ARNG, USAR PA credentialing and privileging are distinct processes. Credentialing and privileging for the USAR is a two-step process beginning with the APMC and completed by an active component MTF IAW DHA PM 6025.13 and AR 40-68. Providers often think the process is complete after ICTB submission via APMC, but the process is not complete until a designated MTF grants privileges and the provider accepts the approved privileges in JCCQAS. Credentials are managed and maintained by APMC. Privileges are granted by a designated active duty facility. Everything discussed in this chapter applies to the USAR based on these regulations.

APMC verifies credentials every 2 years, and all providers are required to maintain currency at all times. Current, verified credentials are mandatory for a PA to perform readiness evaluations outside an MTF during weekend battle assembly or annual training. USAR military providers who work in an MTF during battle assembly or annual training and are mobilized to a US location, or are deployed outside of the United States, require verification of credentials by APMC, and the generation of an ICTB to the privileging MTF in order to start the privileging process.

Privileges are required to perform any type of clinical duty in an MTF during weekend battle assembly or annual training, or in conjunction with a mobilization or deployment. As stated above, privileging is location dependent and granted by the MTF; APMC does not privilege providers. The privileging facility for USAR and ARNG PAs is determined by deployment location. For example, providers mobilizing out of Fort Bliss, Texas, or Fort Hood, Texas, are privileged through those respective MTFs; Landstuhl Regional Medical Center in Germany is responsible for Europe, Qatar, Jordan, and Kuwait; and MEDDAC (Medical Activity) Bavaria in Germany is responsible for all of Africa.

The process is as follows:

- Upon receipt of the request, APMC will re-verify credentials and request any missing documentation from the soldier.

- Once credentialing is complete, APMC generates the ICTB and sends it to the appropriate MTF.
- The provider logs into JCCQAS and completes a new application for clinical privileges for the gaining MTF.
- Once submitted, the request is reviewed by the gaining MTF privileging committee for approval.
- Once the gaining MTF approves the request, privileges need to be accepted and signed by the provider.
- Access to a CAC-enabled computer and military email is essential for completing the privileging phase. Providers will not deploy from continental US replacement centers without approved privileges.

Additional Information

See the US Army Medical Department Office of Quality Management website (https://www.qmo.amedd.army.mil/credentialing/cp.htm) for the latest information and updates about credentials and privileges.[11] The most current Army PA (65D) credentialing forms are also on the website (https://www.qmo.amedd.army.mil/credentialing/FY19/Physician_Assistant_AOC_65D.pdf).[11]

Conclusion

Licensure, credentialing, and privileging affect readiness. A PA who is not able to see and treat patients hinders the Army's ability to be a medically ready force. PAs must take personal responsibility for these requirements. Additionally, licensure and credentialing are important if the PA will be working in the civilian sector. PAs should always remain aware of their privileges and practice at the highest level of their licenses and credentials, depending on their current training, education, and experience.

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Chapter 10

MAINTAINING CERTIFICATION AND THE CONTINUING MEDICAL EDUCATION CATEGORIES

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Introduction

Every Army physician assistant (PA) must maintain both military PA requirements and civilian-equivalent requirements for certification to practice. This certification is the reason for the "C" on PA credentials (PA-C). In the military, certification is vitally important to obtaining military treatment facility credentials, receive bonuses, and ensure educational proficiency as PAs.

Maintaining Certification

Maintaining the "C" (certification) in "PA-C" is required in accordance with Army Regulation 40-68, *Clinical Quality Management,*[1] and Health Affairs Policy 04-002, *Waivers of Licensure Requirement for Qualified Military Physician Assistants*.[2] According to the National Committee on Certification of Physician Assistants (NCCPA), maintenance of the 10-year certification includes five 2-year cycles. The PA must log 100 continuing medical education (CME) credits online during each cycle. The CME logging window begins May 1 in the PA's certification issuance year and continues through December 31 of the certification expiration year.[3]

At the end of the 10-year cycle, PAs are required to take the Physician Assistant National Recertifying Exam (PANRE). They must also submit a certification fee by December 31 of their certification expiration year.[3]

Continuing Medical Education

CME "consists of clinical and professional education activities that maintain, develop or increase the knowledge, skills, and professional performance and relationships that a PA uses to provide services for patients, the public and the profession."[4] After PAs pass the Physician Assistant National Certifying Exam (PANCE), they maintain certification by completing the required number of credits from two categories of CME options.

Category 1 Continuing Medical Education

There are four types of category 1 CME: (1) regular, (2) certification programs, (3) process improvement [PI-CME], and (4) self-assessment.[5] Fifty credits in each 2-year cycle are required to be from category 1 CME. Category 1 CME includes certification and recertification courses preapproved and classified by the American Academy of Physician Assistants (AAPA), such as seminars, journal post-tests, conferences, and online resources. The following sponsors offer Category 1 CME[5]:

- AAPA
- American Medical Association, with providers accredited by the Accreditation Council for Continuing Medical Education
- American Academy of Family Physicians
- American Osteopathic Association
- Royal College of Physicians and Surgeons of Canada
- College of Family Physicians of Canada
- Physician Assistant Certification Council of Canada

Regular Continuing Medical Education. Programs or certificate-producing courses preapproved by one of the previously mentioned sponsors comprise regular CME. An example is the AAPA annual conference.

Certificate Program Continuing Medical Education. Certificate programs are preapproved by the AAPA for category 1 CME regardless of the program or location. Examples are Basic Life Support and Advanced Trauma Life Support courses.[6]

Performance Improvement Continuing Medical Education. PI-CME activities compare the PA's clinical practice to clinical practice guidelines and other established metrics. PAs apply what they have learned in these activities to improve their practice. PI-CME is conducted alone or in partnership with a physician or others in the practice. Each clinician working on these CME projects can receive credit for PI-CME. Each PI-CME activity follows a three-stage model[7]:

Stage I—performance measurement. Compare your practice to an established evidence-based metric or standard.

Stage II—intervention and improvement plan. Develop and implement a plan to improve your practice based on the standards.

Stage III—remeasurement. Evaluate the impact of the improvement plan on your practice. For example, a PA chooses a PI-CME activity focused on asthma. For stage I, the PA records key data such as disease duration, exacerbations, levels of control, current medication, and other information for current asthma patients. The PA then measures their current practice against the current standard of medical care. In this case, the PA compares patient data to the National Asthma Education and Prevention Program's *Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma,*[8] using a tool that quantifies asthma severity and treatment response.[9] In stage II, the PA corrects the existing clinical practice, based on the current standard of care. Stage III allows the PA to evaluate the improvements based on the adjustments. This final step completes the PI-CME activity, and the PA receives category l CME credit for the module.

Self-Assessment Continuing Medical Education. Self-assessment activities provide a systematic way to review each PA's performance, knowledge base, and skill set. In these CME activities, students typically choose a topic, take a pretest, review current evidence-based material, and take a written or multiple-choice test to assess learning.[5]

In this example, a PA chooses exercise-induced asthma (EIA) as a self-assessment CME subject. The module begins with a quiz on the PA's current understanding of the disease process and treatment. Second, the PA receives evidence-based medical information about EIA.

After reading the information, the PA must pass a multiple-choice test. This final step completes the self-assessment CME activity and the PA receives a category 1 CME credit for the module.

As with all category 1 CME, PI-CME and self-assessment CME activities must be preapproved by AAPA to meet requirements. Since August 2016, NCCPA awards 50% additional credit for SA-CME and PI-CME.[10] Therefore, an SI-CME course worth 10 credits is converted to 15 credits. Additionally, the first 20 PI-CME credits logged during each cycle are doubled.[10]

Category 2 Continuing Medical Education

Category 2 CME consists of any medical-related activity that enhances the role of the PA.[5] This type of CME includes activities such as journal reading, studying for the PANRE, medical writing, and attending medical lectures.[4] Quantification for credit is based on an honor system of how many hours the PA spends. For example, if the PA spent an hour studying for the PANRE, they would log 1 credit hour for category 2 CME.

Logging Credit

In addition to earning CME credit, it is important to log credits earned through the NCCPA website.[3] For national certification maintenance, the PA must provide the following information[3,11]:

- program title,
- provider (the organization that administered the program),
- number of CME credits earned, and
- sponsor (the organization that designated CME credit to the program).

Certification

New Certification Holders

When PA students graduate, their first CME cycle may vary depending on the time of year they graduate and when they successfully pass the PANCE.[12] For example, a PA student may graduate on January 24, 2020; take the PANCE 8 days later; and receive the PANCE score February l5, 2 weeks after the examination. This PA's CME earning cycle will begin on February 15, 2020, and last through December 31, 2022.

Ten-Year Certification Cycle

Before 2014, the PA certification cycle was 6 years. Now, PAs who pass the PANCE or PANRE enter a l0-year certification period. This cycle consists of five 2-year certification maintenance cycles. Table 10-1 shows an example of the l0-year certification cycle.

Lost Certification

If a PA fails to log the appropriate 100 hours of CME and pay the maintenance fee by the due date at the end of the 2-year maintenance period, they must take PANCE or PANRE to regain certification.[13]

Administrative Certification Extension

If a PA does not earn or log all requirements by 2359 hours (Pacific Time) on December 31 of their certification expiration year, they are granted a 1-month administrative certificate extension to complete requirements.[3] If requirements are not met by January 31, current NCCPA policies

Table 10-1. Example of the 10-year certification cycle.

CME Cycle Window	SA-CME (Cat 1)	PI-CME (Cat 1)	Regular Cat 1 CME	Cat 2 CME	Total CME
1 May 2020–31 Dec 2022	20	0	30	50	100
1 May 2022–31 Dec 2024	0	20	50	30	100
1 May 2024–31 Dec 2026	5	15	80	0	100
1 May 2026–31 Dec 2028	15	5	30	50	100
Total Goal: 40 of each SA/PI in first 4 cycles	*40*	*40*			
1 May 2028–31 Dec 2030	0	0	100	0	100

Cat: category; CME: continuing medical education; PI-CME: performance improvement CME; SA-CME: self-assessment CME

determine options and procedures for regaining certification. Appeals for an additional extension are allowed only for extraordinary extenuating circumstance with appropriate documentation.[3]

Lost Certification Due to Disciplinary Proceedings

Under current NCCPA policies, PAs who have lost certification may regain it by completing CME requirements and passing the PANRE. However, PAs who have lost eligibility for certification based on NCCPA disciplinary proceedings must first apply to reestablish eligibility.[3]

Audits

PAs must keep their category 1 CME documentation for the current and previous CME cycles. For example, if a PA is currently on a 2020–2022 cycle, they should keep that documentation and the 2018–2020 CME cycle documentation.

For quality control purposes, the NCCPA randomly conducts audits of category 1 CME after the completion of the previous year's cycle. PAs selected to participate in the audits have 6 weeks from receipt of the written notification to provide NCCPA with completion certificates for all category 1 CME performed during the audit timeframe. If an audited PA cannot provide this documentation, they retain certification but will be re-audited the following certification period and must pay a re-audit fee of $100. The PA must also complete any additional unsubstantiated category 1 CME from the previous audit timeframe. These PAs may face additional random audits over the next three certification maintenance cycles. Failure to comply adequately within 6 weeks of notification in these additional audits results in immediate loss of certification. NCCPA does not audit category 2 CME.[14]

Summary

Understanding the PA certification process, including CME requirements, is vital to avoid losing certification. Obtaining and logging CME is a regulatory requirement for maintaining certification. It is the PA's responsibility to maintain certification as a matter of principle and accountability.

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Chapter 11

CAREER MANAGEMENT

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Introduction

Career management for an Army physician assistant (PA) is multifaceted and requires thoughtful consideration. The first question to answer is, "What do I want to accomplish while I'm wearing the uniform?" The answer will differ from one individual to the next. Personal and professional aspirations are intertwined, and together form the foundation of the path that ultimately shapes a military journey.

A PA's career options will vary depending on timing, the flexibility of the individual's plan, and current and emerging Army requirements. Army PAs should develop a plan focused on factors that are important for their professional experience while balancing their personal and family objectives. This chapter will assist the PA in understanding the key factors to consider in developing a prospective plan to carry them through their military career. It will show how the PA can be proactive in preparing and managing their career in the military and beyond. Included is information on regulations, planning tools, resource documents, lessons learned, and tips for success. The chapter will cover career planning, the domains of leader development, mentorship, the officer record brief (ORB), and computer systems used in these processes. At the end of the chapter are several links and references with additional helpful information on PA career management.

Charting the Path

Army PAs will choose from a variety of challenging and rewarding paths or tracks as they begin their military career. Usually, PAs start

their career in an operational assignment with a company, battalion, or brigade. Thereafter, positions are available in different tracks—clinical; research; broadening assignments, such as recruiter, inspector general, or aide-de-camp; education, such as long-term health education training (LTHET) or teaching in the Interservice Physician Assistant Program (IPAP); and leadership or other nonclinical roles such as a commander or executive staff member. Each Army PA career is unique, and it is important for all PAs to be aware they have the ability and responsibility to manage their own career.

For a junior PA who just finished PA school or a direct-accession PA who still has much to learn about the Army, a 5-year career timeline may seem unfathomable or even untenable given their limited knowledge. However, it is important to start planning early and establish long-term, mid-term, and short-term goals and objectives. An excellent starting point is to "begin with the end in mind," and find a mentor to assist in charting a career path toward that goal. For example, if a PA desires to be assigned to the 82d Airborne Division, an airborne physical must be obtained, and the PA must be willing and able to participate in airborne operations.

A career map is a living document that is developed, maintained, and validated as a PA moves through the ranks. Within this career timeline, the Army PA can incrementally plot a 5-year plan as a starting point that optimally projects several courses of action for the next two jobs, including educational pursuits, while reflecting on personal interests (Figure 11-1). The plan should be revisited as frequently as necessary to manage expectations and reflect changes in goals, priorities, and opportunities. Plans must also consider the needs of the Army; availability of positions will vary from time to time, and desired duty locations may not have a position that matches the PA's rank or skill set. For example, the PA position in the 3rd Infantry Division (the Old Guard), at Fort Myer, Virginia, is a two-deep position designed for a captain that opens about every 3 years.

In revisiting the plan, the Army PA should consult with mentors, Human Resources Command (HRC) career managers, and family members, taking into consideration personal and professional goals and realistic objectives. Various personal issues such as family dynamics (a new child, children in high school, new marriage, divorce, aging parents, unexpected illness or disease) can affect the PA's flexibility for certain assignments. The PA may start their career on a certain track (typically

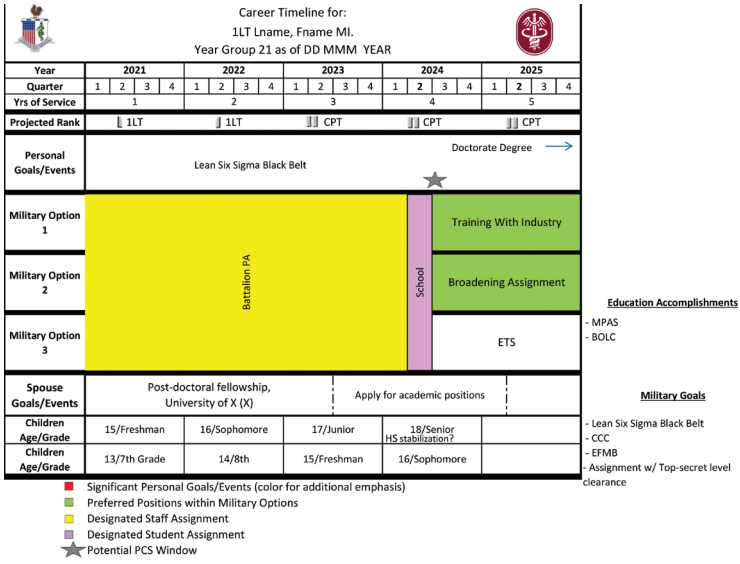


Figure 11-1. Example of a 5-year plan.

operational) and decide to pursue clinical positions, further education or research, perhaps even command, recruiting, and leadership.

Staying in the Army until retirement may be a viable option, and it is important to understand the factors that will affect retirement benefits and options. Some of these factors are retiring as an officer versus a noncommissioned officer for those who are prior enlisted, and accumulating 30 years of active federal commissioned service time versus reaching the mandatory retirement age of 62. The key to success in execution of a proposed career timeline is establishing achievable objectives and milestones along a path toward an individual's personal definition of success. Additionally, PAs must be flexible and recognize opportunities along the way.

Additionally, PAs must recognize and be familiar with the regulations that govern the process of career management. Army competitive category (ACC) officers in the Army derive their guidance from Army Regulation 600-3, *The Army Personnel Development System*.[1] The Army provides guidance to the Army Medical Department (AMEDD) and the

Army Medical Specialist Corps (SP) in Department of the Army (DA) Pamphlet (PAM) 600-4, *Army Medical Department Officer Professional Development and Career Management,* specifically chapters 3 and 4.[2] This pamphlet provides information about expectations for career progression, promotions, positions, and educational opportunities, as well as a lifecycle map. The lifecycle map lays out military educational requirements, training opportunities, and recommendations for positions to be held for each rank, and serves as a starting point to develop a 5- to 10-year plan.

Three Domains of Leader Development

The career plan must take into account the three domains of leader development: institutional training, operational assignments, and self-development.[2] Professional military education is structured to correspond with ranks and promotions, as discussed below. A variety of assignments and positions are necessary to become a well-rounded leader and officer. Self-development includes individual study, research activities, professional reading and writing, completion of certifications and degrees, and continual self-assessment. The Army has developed the Army Career Tracker as a tool to aid officers with professional development, planning, and structured mentorship.[3]

Institutional Training

Professional Military Education. It is important for all officers to attend the appropriate military schools to attain the level of military education and development commensurate to their rank and remain competitive with their peers for promotion. Professional military education focuses on core competencies and leader development to produce competent and technically and tactically proficient officers. It begins with initial military training at the Basic Officer Leader Course (BOLC).

Once an officer is a first lieutenant (promotable), they may request enrollment in the Captains Career Course (CCC) by submitting a DA Form 3838 to their commander (a lieutenant colonel/O-5 or above) for approval by the HRC career manager, or enroll directly in coordination with a permanent change of station (PCS) reassignment with temporary duty en route. Four 9-week CCC resident courses are offered annually. Additionally, a 20-week pilot CCC for AMEDD officers began in

January 2020 (refer to Chapter 56, CCC). The CCC carries a 1-year active duty service obligation (ADSO). The course should be completed prior to the major promotion board and is a prerequisite to taking a command assignment or starting LTHET. Intermediate Level Education (ILE) is the Army's training for field-grade officers. (Chapter 8, Attending ILE, provides in-depth information. Other education that enhances professional development is covered in Chapter 4, Academic Leadership Roles, Education, and Additional Training for PAs.)

Civilian Education. All PAs are required to have civilian education to at least a bachelor's degree level,[4] although the profession is currently based primarily on master's degree-level education. The IPAP awards a bachelor's degree after completing phase 1 and a master's upon graduation. Army PAs can also come from other accredited civilian PA programs. Beyond the entry-level degree requirement, several opportunities for further education are available, such as the LTHET program, in which PAs can earn additional master's or doctorate-level degrees. One of these opportunities is the Doctor of Science degree in emergency medicine, orthopedics, or general surgery (see chapters 5 through 7 for information on these specialties). The Army PA may also attend a civilian school of their choice through the LTHET, and every year there may be different education opportunities. The Army PA incurs ADSO for LTHET; however, they can elect to complete a graduate degree via distance learning, such as a DSc, DMSc, or PhD without incurring an ADSO.

Operational Assignments

PAs can achieve diversity through a balance of operational, clinical, research, educational, SP, and AMEDD developmental and immaterial (can be held regardless of an individual's area of concentration) positions (refer to Section 3 of this handbook for various roles of PAs). SP immaterial positions (designated 65X) include recruiter, recruiting battalion executive officer, corps-specific branch proponency officer, HRC branch chief, SP branch executive officer and fellow, and AMEDD Personnel Proponent Directorate staff officer. AMEDD immaterial positions (designated 05A) include warrior transition unit deputy commanding officer, aide-de-camp, executive assistant, and several strategic staff officer positions at both the Defense Health Agency and the Army Medical Command. At the rank of major (promotable) and lieutenant colonel, opportunities exist to compete for command

select list (CSL) command (for further information about CSL, use the search engine on the HRC website[5] and enter "command management branch").

Key components of a career timeline are the positions, and the experience provided by each one, that are fundamental to becoming a well-rounded officer. At this time, the AMEDD has no positions coded as key and developmental, but there are many duty assignments that serve a similar purpose in PA career development. Examples of potential key developmental jobs are senior brigade combat team PA, division PA, corps PA, Forces Command PA, IPAP phase II coordinator, IPAP program director, IPAP program manager, IPAP instructor and other medical training instructors, and Department of Combat Doctrine and Development staff officer.

Self-Development

Self-development begins with discipline and organization. One tactic is to implement a battle rhythm that orchestrates reading, writing, research, studying, and skill set improvement. For example, one could read a medical journal article once a month, read the news daily, monitor S1Net (https://www.milsuite.mil/s1net)[6] for Army human resources (HR) updates, attend online courses, or obtain new credentials to meet an identified need that will benefit a patient population. The important thing is to have a plan for self-development and tailor it to meet professional needs—as a soldier, leader, clinician, and individual.

Meeting with Mentors

It is important for Army PAs to seek mentorship early and often. The mentor-mentee relationship is bilateral; each person benefits from the other during the course of the mentorship. Mentors should review the mentees' ORB, curriculum vitae (CV), and officer evaluation reports (OERs) before providing guidance, and the mentees should assemble these documents to prepare for meetings.

Officer Record Briefs

The ORB is a military resume, a snapshot of a career, credentials, and accomplishments. Commanders may use the ORB to determine which position inbound officers are best suited for and what they need for

career progression. In addition to the courses listed above, any Army-sponsored school or program recognized by the Army Training and Requirements Resources System (ATRRS) that lasts more than 40 hours can be recorded in the ORB's military education section.

The ORB must be updated on a regular basis, preferably annually, perhaps as a birth month audit. Additionally, updates are recommended when being considered for a new position, moving to a new unit, receiving a new award or rank, going before any board, or returning from a deployment. Job titles on the ORB should describe what duty or position was held, such as deputy, chief, director, assistant chief, or officer in charge.

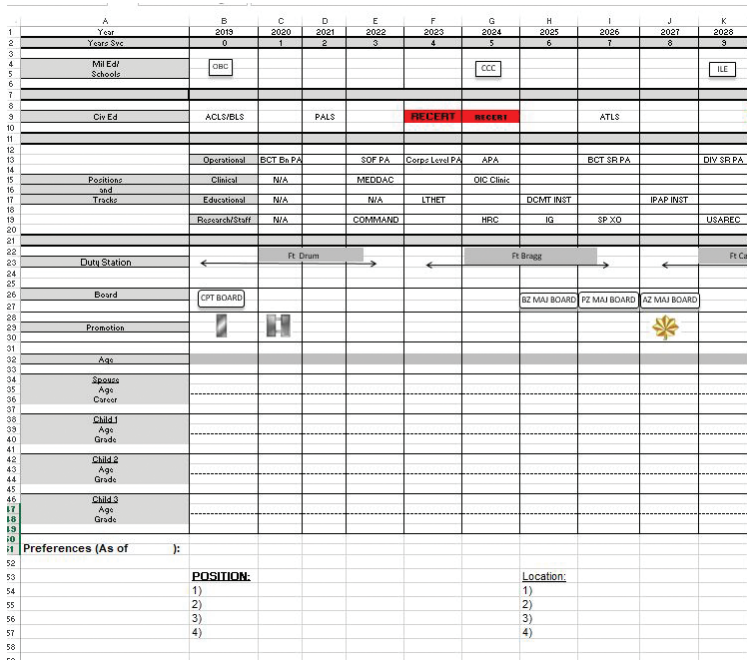
It is important that the designations "known losses" or "surplus soldier" do not appear in the ORB's assignment information when it is sent before any board, whether for a promotion, education, or other selection processes. These phrases demonstrate lack of attention to detail and could be negative factors in the boards' decisions. The Army photo, once an important element of promotion selection boards, was suspended from use effective August 1, 2020.[7]

Curriculum Vitae

Along with the ORB, a professional CV that provides a snapshot of accomplishments is a good document to maintain and is required by most military medical treatment facilities as part of a credentialing packet. Often, HRC will announce opportunities that require nominees to submit a packet including the ORB, a CV, and the last five OERs. The CV should highlight current and past experiences; civilian and military education; certification and affiliations; projects, publications, and presentations; features and recognitions; awards and decorations; special skills; and references. (Note that the CV is different from the Assignment Interactive Module 2.0 [AIM.2] resume that will be discussed later in this chapter.)

Officer Evaluation Reports

OERs, used to assess an officer's performance during a rating period, are an additional communication tool for promotion boards and mentors. An OER provides a concise representation of the officer's performance as evaluated by their rater and senior rater. Several products available on the HRC and MilSuite websites provide tips for officers and their



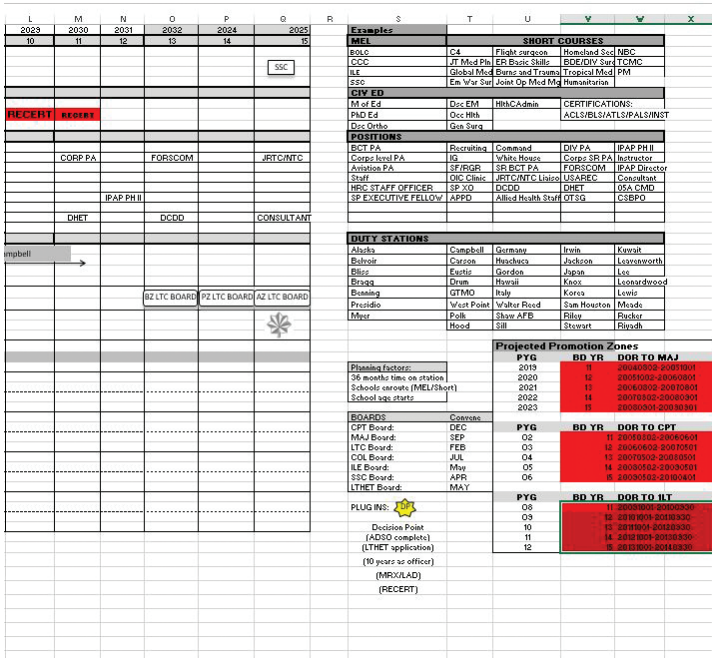
	A	B	C	D	E	F	G	H	I	J	K
1	Year	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
2	Years Svc	0	1	2	3	4	5	6	7	8	9
3											
4	Mil Ed/ Schools	OBC					CCC				ILE
5											
6											
7											
8											
9	Civ Ed	ACLS/BLS		PALS		RECERT	recert		ATLS		
10											
11											
12											
13		Operational	BCT Bn PA		SOF PA	Corps Level PA	APA		BCT SR PA		DIV SR PA
14											
15	Positions	Clinical	N/A		MEDDAC		OIC Clinic				
16	and										
17	Tracks	Educational	N/A		N/A	LTHET		DCMT INST		IPAP INST	
18											
19		Research/Staff	N/A		COMMAND		HRC	IG	SP XO		USAREC
20											
21											
22			Ft Drum				Ft Bragg				Ft Co
23	Duty Station	←		→		←		→		←	
24											
25											
26	Board	CPT BOARD						BZ MAJ BOARD	PZ MAJ BOARD	AZ MAJ BOARD	
27											
28											
29	Promotion										
30											
31											
32	Age										
33											
34	Spouse										
35	Age										
36	Career										
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41											
42	Child 2										
43	Age										
44	Grade										
45											
46	Child 3										
47	Age										
48	Grade										
49											
50											
51	Preferences (As of):										
52											
53		POSITION:						Location:			
54		1)						1)			
55		2)						2)			
56		3)						3)			
57		4)						4)			
58											

Figure 11-2. Example of a career timeline map.

raters on maximizing the OER as an opportunity to reflect the officer's performance and potential. For more information on ORBs, see DA PAM 600-8-104, Chapter 5.[8]

Creating a Career Plan

Once the foundations of a career plan and mentorship have been established, the Army PA can put pen to paper and draft a timeline. There are several examples of career plans, such as Figure 11-2, that can be modified based on individual preference. The timeline should include date, age, years of service, military education, civilian education, deployments, assignments, duty station locations, promotions, spouse's career milestones, and children's milestones. Leave space under the timeline to note future assignment preferences based on location and



position. These preferences should be considered during timeline reviews and meetings with mentors.

Promotions and Boards

The Army PA must track possible promotions and prepare for them. The HRC website is a great tool to help plan the career timeline in coordination with when promotions may occur, depending on the Army PA's year group. For example, a PA in year group 2012 can expect their primary zone for promotion to major in the year 2020, and if selected, promotion in 2021. Officers may view their projected timeline based on their cohort year group in the AIM.2 website under branch pages. A recommendation is to plot the "below the zone" board, the primary or "in the zone" board and if desired, "above the zone" board. Other

boards to follow are LTHET boards (if applying, one must start planning 2 years prior to the board to meet qualifications and appropriately prepare and also plan to be PCS-eligible during the application process), ILE and senior service education selection boards, and CSL command boards. One board no PA will likely forget is the recertification board for national certification. Plotting the first and second year of eligibility to take the test will promote preparedness for this key event. Once all the boards are plotted, it may be a good time to input assignments and positions; this is best accomplished after a discussion with mentors, career managers, and family members.

Assignment and Position Opportunities

The first time a PA has the opportunity to use the "marketplace" to find positions and compete with others in the same permanent change of station cycle, they should pay attention to available options of interest and their locations. One method is to first determine the desired position, and be open to several locations where the position can be held. Knowing that most assignments are at a duty location for approximately 3 years (with some exceptions), a plan to diversify or garner additional experiences at that location should be considered. If a desired position at a senior rank requires certain skills and education, the junior PA should pursue the requirements to be competitive when they achieve that rank. Additionally, they should reach out to officers who have held or currently hold the role to seek additional guidance on how to prepare. Deployment plotting is key as well; certain tasks must be done before or after deployments, such as sitting for certification boards, attending in-person training or certification, and updating board files with documentation that is not available during deployment.

Family Members

Family members are an important part of any Army PA's career planning; for example, individuals may need to care for their parents, or have spouses with their own careers. Children's milestones must also be considered; for example, high school "stabilization" allows parents to remain in one area so a child can stay in one high school.

Assignment Interactive Module Career Management Platform

AIM.2 is a web-based information system designed to enhance the effectiveness and efficiency of the officer management process, and facilitate communication among soldiers, units, commanders, and the HRC Officer Personnel Management Directorate.[9] AIM.2 was developed to improve officer management by integrating multiple aspects of career management that were previously processed through separate mechanisms. The system links many aspects of officer records to ensure they are factored into career management efficiently. AIM.2 uses data in a regulated market system to match officer talent with unit requirements, providing an opportunity for each to learn about each other, and influence both of their preferences.

AIM.2 does more than assist with reassignment actions; it also serves as a communication portal to advertise opportunities, branch information, volunteer assignments, and strategic billets. It allows communication between officers and their career managers, links officers to other electronic records, allows viewing of Army photographs, and processes special actions such as high school stabilizations, Exceptional Family Member Program stabilization, compassionate reassignment requests, and Security Force Assistance Brigade (SFAB) volunteering (see Chapter 13, SFAB, for more details).

An essential element of successful participation in AIM.2 is to prepare and maintain a resume in the system. Officers can build and review their resume on their AIM branch webpage at https://aim.hrc.army.mil/ (select "My Resume").[9] Unit leaders are able to view your resume as a participant in a PCS movement cycle. The resume has two main pages, the ORB (previously discussed), and the officer self-professed talents section. In the self-professed talents section, an officer can advertise more information about themselves beyond what is in their ORB, sharing more information about their knowledge, skills, and attributes, to show they are the best fit for desired assignments. The section has eight parts: summary, education, civilian, assignments, cultural, travel, language, and references. PAs should use this section to add greater depth in these areas, such as education not entered in the ORB, specifics on language skills they possess, and more detail on travel experiences. An officer's communication via the resume can help leaders decide who their preference will be in the market process.

There is no current mandatory way for officers to complete their resume, though they should be written as thoroughly as possible. Officers may be interested in consideration for assignment opportunities at any time, and having an AIM resume ready enhances their opportunities for selection. Like the ORB, the resume should be regularly updated for accuracy. The AIM.2 system is meant to bridge active duty officer talent management during the transition to the Integrated Personnel and Pay System–Army (IPPS–A).

Integrated Personnel and Pay System–Army

The IPPS-A is a web-based HR system that provides integrated personnel and pay capabilities and a comprehensive HR record for all soldiers in each component. Once IPPS-A is fully deployed, the system will enable HR transactions to automatically trigger soldier pay. IPPS-A's ability to combine personnel and pay functions (eg, a promotion or call to active duty) will address current inefficiencies caused by complex interfaces among more than 40 "stove-piped" HR systems. As a result, IPPS-A will leave fewer opportunities for error and will become the authoritative and comprehensive source of Army personnel and pay information.[10] In addition, soldiers will have common access card (CAC) access to their own personal information 24 hours a day via the self-service web portal.

This system will be used by all soldiers across all components of service, active duty, Army National Guard, and Army Reserve, as well as by the HR professionals who support them. It will be launched incrementally in phases. Training is planned for all users based on their roles and phase of integration. A mobile application is available for current service members with access to IPPS-A, and will be available as the system is activated for their components during fielding to the rest of the Army.[10] The program is currently active in the Army National Guard, and at the time of this writing was successful in Pennsylvania and in the process of implementation across the remainder of the National Guard through 2020. The next release is projected to begin integration of active duty and the Army Reserve. For more information on IPPS-A, see https://ipps-a.army.mil/.[10]

Lessons Learned

- PAs should attend and participate in 65D (PA) and SP Corps forums, which are open discussions led by experts and leaders over audio or video media. Often the latest and most relevant information is communicated in these forums.
- PAs should seek advice and mentorship from health service and ACC mentors.
- PAs must develop a strategy to achieve military career goals before leaving the Army. However, they must also remain flexible enough to adjust because their goals may change over time.

Tips for Success

- Review the career timeline at least quarterly with family members, mentors, and leaders.
- Meet with the chain of command in the beginning of each evaluation period, at least quarterly, and again at least a month prior to an OER deadline.
- Let the chain of command know that the Army PA field-grade promotions are not "fully qualified" boards, they are "best qualified" boards (not everyone who is qualified will get promoted).
- Attend at least one military course a year.
- Attend a centrally funded course en route to every PCS.
- Review the ORB and always make an effort to improve at least one aspect of the OER, whether that be military education, civilian education, weight, or a new language.
- Be well read and well rounded; read at least one professional and one personal book a month, and routinely try new skills.
- Be aware of assignment considerations terms for career planning (see the attachment to this chapter provided by Colonel John Detro and Major Drew Kennedy at HRC).

Conclusion

Career management is an individual responsibility. It requires careful thought and the ability to maximize the use of existing tools and resources, while remaining flexible and available when rare

opportunities arise. To make the most informed planning decisions, Army PAs must reach out to mentors and leaders for career guidance. They also have a responsibility to lead and mentor others, guiding junior officers and peers to be as successful as possible while maintaining the role of the AMEDD in ensuring the US Army remains the premier and most talented fighting force in the world.

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Attachment: Assignment Considerations Terms

High School Stabilization (HSS). Intended to provide stability to officers with family members in their senior year of high school and avoid disruption of the school schedule. HSS packets are submitted through AIM.2, after March 1 of the student's sophomore year and before September 30 of the junior year. Assignments officers can provide instructions and sample packets on request.

Married Army Couples Program (MACP). To the maximum extent possible and consistent with valid Army vacancies, married officers enrolled in MACP are assigned to a location where they can establish a joint domicile within a 50-mile radius or 1-hour driving time of their spouse's assignment. Army requirements and readiness goals are paramount, and married Army couples must be prepared to meet military obligations regardless of assignment. Initial enrollment is conducted through the officer's S1. Enlisted IPAP students must re-submit MACP applications upon commissioning and should inform their assignments officer of their MACP status when requesting initial assignments.

Compassionate Reassignment. Officers with serious family problems that can only be alleviated by an assignment to a particular geographical area may request reassignment, deletion, or deferment. The request must involve the health and welfare of a family member. Compassionate reassignments are generally for 12 months only.

Consecutive Overseas Tours (COTs) and In-Place Consecutive Overseas Tours (IPCOTs). A COT requires the officer to PCS between OCONUS duty stations and complete both prescribed tours. An IPCOT requires the officer to complete the first prescribed tour and remain at the current duty station for a second full prescribed tour. Officers must serve the prescribed tour lengths for both tours. Officers applying for COT/IPCOT are eligible for leave with paid travel and transportation expenses to the home of record for the officer and command-sponsored dependents.

Exceptional Family Member Program (EFMP). Officers enrolled in the EFMP receive consideration of their exceptional family member's special needs during the assignment selection process. Enrollment in the EFMP is mandatory for officers with family members with special medical and/or educational needs. Assignment officers will submit requests to ensure the gaining installation can appropriately manage the family member. Officers must pay close attention to their EFMP expiration date; they will not be placed on accompanied orders if EFMP is not approved. Officers cannot waive EFMP for an accompanied tour but may elect to serve an unaccompanied (12-month) tour at a location outside the United States.

Chapter 12

ROLE OF THE BATTALION AND SQUADRON PHYSICIAN ASSISTANT

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Introduction

Being a battalion (BN) or squadron (SQN) physician assistant (PA) is arguably the most significant assignment PAs hold in the Army. These are the first and most forward levels of care during deployments. Working at this level, the PA must be prepared to provide a wide variety of medical services to soldiers under potentially adverse conditions. The PA's primary function is to maintain the health, readiness, and welfare of the service members in their unit. This includes more than just providing direct health care to individual soldiers; PAs must also ensure the soldiers of their unit are medically ready for worldwide deployment to austere environments. Non-deployable service members must receive dispositions promptly through the appropriate systems. Fighting and winning the nation's wars is why the US Army exists, and unit PAs must direct their efforts toward that end. The PA must prepare to provide care in austere and constrained environments with limited logistical resources. Additionally, in the conditions of current operations, the unit PA must prepare to provide medical care to host country nationals and other coalition force service members.

Requirements

To serve in this position, a PA must:

- graduate from an accredited PA program, pass the Physician Assistant National Certifying Examination, and maintain certification with the Physician Assistant National Recertifying Exam through the National Commission on Certification of Physician Assistants;
- hold the rank of first lieutenant or captain;
- graduate from the Basic Officer Leader Course;
- pass the Army fitness test and comply with height/weight standards of Army Regulation (AR) 600-9*, The Army Body Composition Program*[1];
- meet the readiness requirements listed in the 65D (PA) individual critical task list[2];
- be credentialed at the local military medical treatment facility (MTF); and
- be knowledgeable about AR 40-501, *Standards of Medical Fitness*[3]; AR 40-502, *Medical Readiness*[4]; and Department of the Army (DA) Pamphlet (PAM) 40-502, *Medical Readiness Procedures*.[5]

Desired Skills and Attributes

BN/SQN PAs should:

- be able to operate in clinical, deployed, and field settings;
- be able to communicate effectively with command teams at the company/battery/troop (C/B/T) and BN/SQN levels, fellow health care providers and specialists, NCOs, soldiers, and patients;
- have deployment experience or the ability to deploy in support of worldwide operations in accordance with AR 40-501[3];
- be able to operate independently even when not collocated with direct physician supervision (unit PAs are often separated from their supervising physician, making communication and direct oversight a challenge during deployments or field training exercises);
- be a lifelong learner and have an interest in keeping up to date on the latest research and best practices in clinical and prehospital medicine;
- have solid written and oral communication skills;
- have or develop a high level of knowledge and expertise in Tactical Combat Casualty Care (TCCC)[6];

- have the knowledge and ability to train and supervise combat medics (military occupational specialty [MOS] 68W), combat lifesavers, and other allied and ancillary health specialists in Tactical Combat Casualty Care (TCCC)[6,7]; and
- complete unit-specific schools such as airborne and air assault.

Job Duties and Responsibilities

The primary role of the Army PA at the BN/SQN level is to provide world-class health care to soldiers. The unit PA is responsible for organization and supervision of medical care at the Role 1 MTF, at the unit aid station, during field training, and in deployed environments, including prehospital resuscitation, stabilization, and evacuation. In the garrison environment, the PA operates as the primary care manager for the soldiers assigned to their unit. Daily responsibilities include:

- acute care during sick call operations;
- managing routine and chronic conditions in a clinical setting;
- ordering and interpreting laboratory and imaging studies;
- providing treatment and medication to patients;
- coordinating specialty care needs;
- consulting with the supervising physician; and
- communicating matters of medical health and readiness with the BN/SQN executive officer or commander.[8]

As the principal advisor to the commander and their staff, the PA is responsible for:

- maintaining unit medical readiness for deployment by overseeing preventive health measures such as:
  - routine and special-purpose immunizations,
  - periodic health assessments,
  - audiometry,
  - dental exams,
  - up-to-date laboratory test screening, and
  - management of chronic conditions[3];
- when appropriate (as soldiers reach the medical retention decision point), initiating permanent profiles in coordination with the physician approving authority, and referring soldiers to MOS

administrative retention review (MAR2) or enrolling them in the Integrated Disability Evaluation System (IDES);
- planning, supervising, and overseeing the medical training and employment of 68W combat medics within the medical platoon or section (Figure 12-1); and
- overall supervision of the unit's combat lifesaver (CLS) program.[9]

Professionalism

The BN/SQN PA is responsible for cultivating a sense of professionalism and unit confidence in the BN/SQN medical team, whether in garrison or deployed. The team's functionality and appearance, competence, and innate ability to accommodate any requirement are set by the PA. The PA should serve as a mentor to increase the technical and professional capabilities of all team members. The PA guides soldiers interested in becoming a PA and provides opportunities for shadowing (following the PA in performing their daily activities). BN/SQN PAs are also mentees, seeking guidance from the brigade (BDE) or unit surgeon and senior BDE combat team PA.

Collaboration is essential throughout the BDE to ensure its units are successful in their individual missions. This includes collaboration and camaraderie within the PA community for clinical success and professional development. PAs should participate in clinical and officer professional development opportunities within both the unit and the MTF. The local MTF usually has grand rounds or continuing medical education sessions already established for credentialed providers. These events provide networking opportunities and are vital to building relationships within the unit and MTF. The unit PA must demonstrate their leadership role by being visible to unit and MTF leaders. A presence at command and staff meetings, face-to-face counseling, and unit or MTF social events is essential to building relationships with the chain of command, staff peers, other providers, and specialists (such as physical therapy, behavioral health, and dental). It is also crucial the PA get to know non-medical personnel such as the chaplain, sexual assault response coordinator, and victim advocates.



Figure 12-1. Captain Tetevi Torsoo (back end of table), 2nd Battalion, 87th Infantry Regiment, 2nd Brigade, 10th Mountain Division (Light), teaches suturing techniques to medics in Camp Dwyer, Afghanistan, April 13, 2019. Photograph courtesy of Staff Sergeant Andres Rodriguez.

Systems Access Requirements

Numerous software applications have been adopted by the Army and military MTFs for reviewing, documenting, and updating patient care and soldier readiness information. Ensuring proper systems access and being well versed in their use is an important aspect of the PA's duties. A security clearance and current Health Insurance Portability and Accountability Act (HIPAA) training certificate are required to gain access to the secure systems used by the PA. These systems are used to manage and organize vast amounts of information; as with any software application, they are subject to frequent updates and changes that the PA must keep up with. The systems listed below are intended as an outline and are not all that may be required by a PA.

- **Electronic health records** (EHRs), including the Military Health System's Genesis program and its predecessor, the Armed Forces Health Longitudinal Technology Application (AHLTA), which is being phased out, are integral to the daily routine of military PAs.[10] EHRs are used by medical professionals to order medications, request laboratory tests, and document progress notes for the 9.4 million Department of Defense beneficiaries.[10] The EHR system provides for continuity of care and sharing of information across the global military health care network and the Department of Veterans Affairs.[10] The BN/SQN PA must understand appropriate documentation and coding procedures utilizing the current EHR system employed by their MTF and clinic.
- The **Medical Operational Data System** (MODS) is an integrated system of applications used by the Army Medical Department to track medical readiness, education, manpower, and logistics.[11] Data may be exchanged among MODS applications and with Army personnel systems to expand visibility of unit readiness status.[11] The four systems below are applications within MODS, but each requires separate permission for access.
  - The **Medical Protection System** (MEDPROS) is a website that displays a comprehensive review of the medical readiness data for all medical and dental readiness requirements in accordance with AR-600-8-101, *Personnel Processing*.[12] MEDPROS (https://medpros.mods.army.mil/MEDPROSNew/) allows viewing and analysis of readiness information for individuals,

units, and custom task forces. Unit medical personnel usually use MEDPROS, while commanders use the Medical Readiness Portal's Commander Portal.

- The **Medical Readiness Portal** provides a more up-to-date version of MEDPROS with varying functionality dependent on a user's access. Within the Medical Readiness Portal, users can request access to the Healthcare Portal, Commander Portal, Senior Commander Portal, and Admin Portal.[13]
  - The **Healthcare Portal** serves as a single location for integration of medical readiness.[5,14] It provides an updated electronic profile (e-Profile) system to manage soldiers' temporary and permanent medical conditions with specific duty limitations.[15] Medical readiness information such as the Individual Medical Readiness report, PULHES data (discussed below), and immunizations are also viewable here.
  - The **Commander Portal** is a website that assists unit commanders by providing a single interface to view the medical readiness of their organization. It eliminates the need for commanders to log into multiple systems. Through this portal, commanders can view readiness deficiencies and deployment-limiting (DL) profiles, and make deployability determinations that automatically feed into the unit status report. Unit providers can access the Commander Portal and Senior Commander Portal by requesting the "BN Staff" role via MODS. Although PAs may not frequently use the Commander Portal, it is important for their situational awareness and to understand what commanders can view.[16,17]
  - The **Admin Portal** provides "reports that will pull data from all of the readiness systems."[5] Access to this portal is generally limited to users at echelons above BDE. PAs should request access to allow for ease of profile tracking.[18]
- **MEDPROS Web Data Entry** (MWDE) is the module in which the PA can update individual soldiers' medical readiness data for MEDPROS.[19]
- The **Medical Health Assessment** (MHA) is a module used to update periodic health assessments as well as predeployment and postdeployment health assessments. The completion of these requirements is automatically uploaded into MEDPROS.[20]

- The **Transportation Command Regulating and Command & Control Evacuation System** (TRAC^{2}ES) is a significant part of a deployed medical professional's toolkit, used to coordinate and monitor patient movement between MTFs during peacetime, contingency, and wartime operations.[21]

Administrative Duties

The PA must be proficient in various administrative functions. Unit leadership will often seek information from the PA about the availability, limitations, expectations, and courses of recovery for soldiers within the unit. Proficiency in the functions listed below promote a clear understanding between medical and command teams, as well as cultivating a sense of trust within the organization.

Profiles

Physical profiling of a soldier is a medical recommendation intended to inform unit commanders of any limiting condition, provide clear guidance on the functions an individual can and cannot perform, and outline recovery expectations. PAs utilize the Physical Profile, DA Form 3349, on the Healthcare Portal to specify duty and functional limitations. When a medical condition causes a soldier to be non-deployable, the Medical Readiness Portal assigns them one of seven deployment-limiting (DL) codes in MEDPROS. It is vital to educate commanders that they must use the Commander Portal to review each physically limiting profile no more than 14 days after creation (30 days for reservists).[5] During their review, commanders can improve their units deployability by designating soldiers with DL codes 1 and 2 as deployable. Clear and concise communication on a soldier's physical limitations is imperative to allow for a correct deployability determination. Section 5 of DA Form 3349, Medical Instructions to Unit Commander, affords providers an avenue for such communication. It is helpful to organize profiles into the categories below to formulate accurate unit medical readiness data. The Unit Medical Readiness (UMR) report within MEDPROS provides PAs an easy way to view and sort soldiers with temporary and permanent profiles.[22]

- **Temporary and non-deployable**: the soldier has a temporary limitation and is NOT capable of deploying. This classification is

defined by those on profiles greater than 30 days (DL 1), those who are dental readiness class 3 (DL 2), and pregnant soldiers (DL 3). PAs must communicate clearly and knowledgeably with the chain of command about the status of these soldiers. Information commanders need to know includes the total number of days on profile, the soldier's duty limitations, the required steps to recovery, and the amount of time needed to return the soldier to duty (or qualify for entry into IDES).

- **Permanent and non-deployable**: the soldier has a permanent condition and is undergoing a MAR2 (DL 4), medical evaluation board (MEB) or physical evaluation board (PEB) (DL 5), or non-duty PEB (DL 6) for not meeting the standards in AR 40-501, chapter 3. This category also includes soldiers awaiting denotation of physical category codes F, V, X, or Y (DL 7) on DA Form 3349.[3] Once listed, soldiers with code F or V remain non-deployable, while those with X or Y are deployable. Code meanings are as follows:
  - F. No assignment or deployment to areas outside the continental United States (where definitive medical care for the soldier's medical condition is not available).
  - V. Identifies a soldier with restrictions on deployment to certain areas.
  - X. Continuation on active duty or active reserve. Denotes soldiers with a disease, injury, or medical defect that is below medical retention standards, but they are granted a waiver to continue on active status.
  - Y. Fit for duty. Soldiers determined to be fit for duty after a review of a physical disability.[4]
  - Once DL codes 3 through 7 are written on DA Form 3349, commanders are unable to override them and the soldier will remain on permanent profile until their board is complete.[4] Table 12-1 provides an example of non-deployable soldier tracking.
- **Temporary and deployable**: the soldier has a temporary limitation but is available to deploy to an austere environment. For example, a soldier with routine knee pain with a "run at own pace and distance" profile with no limitations in section 4 (Functional Activities) of the DA Form 3349. This group includes those with DL code 1 or 2 who the commander designates as deployable in the Commander Portal.
- **Permanent and deployable**: the soldier has a permanent condition without a non-deployable code (F or V) on their DA Form 3349

Table 12-1. Tracking non-deployable soldiers.

Name	Rank/MOS	Days on Profile	Illness/Injury	Way Ahead
Doe, John	SPC/11B	60	Leg fracture/ surgery 9/03/20	Anticipate RTD 11/10/20
Doe, Jane	PFC/42A	98	Pregnancy, EDD: 2/15/2021	Anticipate RTD 5/15/21

EDD: estimated delivery date; MOS: military occupational specialty; PFC: private first class; RTD: return to duty; SPC: specialist

and can perform duties of their MOS. Examples include a soldier with a permanent shaving profile (facial hair allowed due to pseudofolliculitis barbae), or a 92Y (supply specialist) who meets all physical requirements of their MOS, but has a permanent L2 (lower extremity, minimal limitation) profile and performs an alternative Army fitness test event.

The Army has standardized its profile templates to facilitate physical training, recovery, and performance optimization. To assist the master fitness trainer of a unit, PAs should use the reconditioning physical readiness training (PRT) profiling program in Field Manual (FM) 7-22, *Army Physical Readiness Training*,[23] and the associated Medical Readiness Portal PRT standard templates. Commanders are familiar with references such as FM 7-22, and the PA must be able to provide profiling recommendations to commanders based on these references. To appropriately manage profiles, the PA must also understand what the Army expects of soldiers based on their MOS. The Smartbook version of DA PAM 611-21, *Military Occupational Classification and Structure*, lists physical expectations by MOS.[24] AR 40-501, chapters 3 and 7, contain information on the numerical identification of permanent profiles (1, 2, 3, 4) and the anatomical determination of performance abilities according to the acronym "PULHES": P (physical), U (upper), L (lower), H (hearing), E (eyes), S (psychiatric).[3]

Of note, BN/SQN PAs are unable to extend profiles beyond 180 days without a physician's review, except in cases of profiling pregnant soldiers. They are also limited to writing profiles for 90 days in duration at one time. Once an initial profile is written, it may be extended thereafter. For all profiles, the unit PA must specify when a soldier is eligible for a record physical fitness test. This date may be twice

the length of the profile but cannot exceed 90 days. Additionally, all permanent profiles require co-signature from a physician.

Integrated Disability Evaluation System

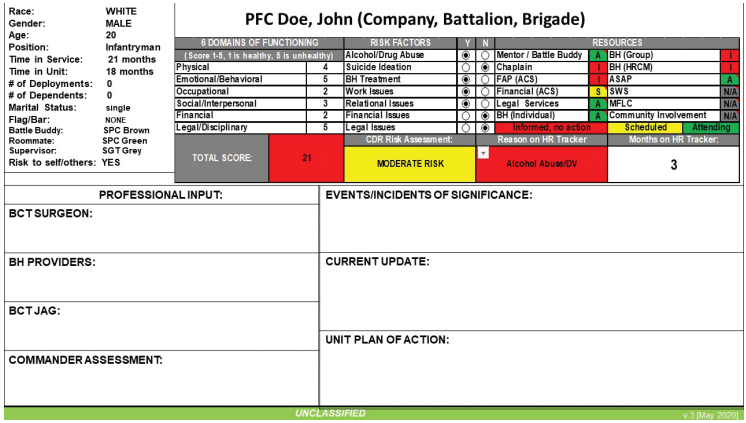
The IDES is commonly referred to as an MEB by command teams, but it is actually a multistage process that includes the MEB—an evaluation to determine if a medical condition renders a soldier non-retainable in the military—as well as the PEB, which determines the degree of compensation, if warranted. The BDE senior PA, clinical nurse case manager, MEB Physician, and the installation Disability Evaluations Chief are typically IDES subject matter experts and can provide guidance. PAs must be familiar with their local IDES process as it varies among installations (see Chapter 30 in this handbook for a detailed overview of the IDES).

Military Occupational Specialty Administrative Retention Review

The MAR2's purpose is to retain quality service members who can no longer meet the physical requirements of their MOS in accordance with DA PAM 611-21.[24,25] Ideally, the process is completed in less than 6 weeks, and the soldier is assigned a new MOS within the limits of the permanent profile. The MAR2 is a tool to keep good soldiers in service and should not be used to move substandard performers to another MOS or unit. The BDE or division career counselor is responsible for maintaining the MAR2 program. The PA is responsible for working with command teams to identify potential candidates and, with the unit career counselor, ensure their profiles meet MAR2 criteria. Once a MAR2 is submitted, soldiers must speak to their career counselor to determine which MOS they qualify for. The career counselor will then submit the required MAR2 documents to Human Resource Command for review.[24] To ensure timely completion of the MAR2 it is good practice for the PA to notify the retention NCO when a MAR2 profile is written and signed.

High-Risk Tracking

The PA is often required to track soldiers in the unit considered "high risk" (Figure 12-2). Soldiers are regarded as high risk due to various concerns, including legal, marital, occupational, behavioral



Race:	WHITE
Gender:	MALE
Age:	20
Position:	Infantryman
Time in Service:	21 months
Time in Unit:	18 months
# of Deployments:	0
# of Dependents:	0
Marital Status:	single
Flag/Bar:	NONE
Battle Buddy:	SPC Brown
Roommate:	SPC Green
Supervisor:	SGT Grey
Risk to self/others:	YES

PFC Doe, John (Company, Battalion, Brigade)

6 DOMAINS OF FUNCTIONING (Score 1-5, 1 is healthy, 5 is unhealthy)		RISK FACTORS	Y	N
Physical	4	Alcohol/Drug Abuse	◉	○
Emotional/Behavioral	5	Suicide Ideation	○	◉
Occupational	2	BH Treatment	◉	○
Social/Interpersonal	3	Work Issues	◉	○
Financial	2	Relational Issues	◉	○
Legal/Disciplinary	5	Financial Issues	○	◉
		Legal Issues	○	◉

RESOURCES			
Mentor / Battle Buddy	A	BH (Group)	I
Chaplain	I	BH (HRCM)	I
FAP (ACS)	I	ASAP	A
Financial (ACS)	S	SWS	N/A
Legal Services	A	MFLC	N/A
BH (individual)	A	Community Involvement	N/A
Informed, no action		Scheduled	Attending

TOTAL SCORE:	21	CDR Risk Assessment:	Reason on HR Tracker	Months on HR Tracker:
		MODERATE RISK	Alcohol Abuse/DV	3

PROFESSIONAL INPUT:	EVENTS/INCIDENTS OF SIGNIFICANCE:
BCT SURGEON:	
BH PROVIDERS:	CURRENT UPDATE:
BCT JAG:	
	UNIT PLAN OF ACTION:
COMMANDER ASSESSMENT:	

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Figure 12-2. Example of a tracking card for high-risk soldiers.

health, polypharmacy, and physical issues.[26] The US Army Soldier Leader Risk Reduction Tool assists commanders in identifying these soldiers and is a useful reference for what behaviors or circumstances constitute "high risk."[26] The PA should be aware of soldiers involved with polypharmacy medications, controlled substances, and substance abuse, as well as the impact that soldiers' physical illness or injury can have on their ability to function. The PA must routinely assess their soldiers for these high-risk behaviors. For example, there is often a correlation between recent legal troubles and increased use of sick call. Establishing a two-way dialogue with the command teams and the BDE behavioral health officer is the fastest way to identify and maintain visibility of these soldiers. It does not matter who identifies the soldier (command, behavioral health officer, or PA); what matters is that all three are in agreement regarding the soldier's status, monitoring, treatment, and projected disposition. Appropriate awareness may allow the PA to identify and address underlying issues on behalf of the soldier. These stressors should be identified and discussed between the PA, behavioral health officer, and leadership. The sole provider medication program is available to PAs wishing to restrict medication access to high-risk soldiers. This program prevents soldiers from receiving specific medications from providers other than those the PA designates. It is useful for soldiers on controlled medications

or those with a high likelihood or past history of abuse. PAs should speak to their MTF's clinical pharmacist for the program specifics and enrollment paperwork.

Enlisted Separation for Certain Physical or Mental Conditions

AR 635-200, *Active Duty Enlisted Administrative Separations,*[27] describes ways in which enlisted soldiers can be separated (discharged) from the Army. PAs must clearly understand AR 635-200's paragraph 5-17, which states that a commander may separate a soldier "on the basis of other physical or mental conditions not amounting to disability . . . that potentially interfere with assignment to or performance of duty."[27] The type of separation described in this paragraph is almost exclusively utilized for behavioral health conditions, and it contains numerous guidelines and exclusionary terms. In particular, the section is a tool to determine if soldiers may not be fit for military service due to the inability to cope with stressors. However, this form of separation should not be used instead of an MEB for known medical conditions that make a soldier unfit for service, per AR 40-501, chapter 3.[3] The BDE behavioral health officer should be consulted for any consideration of a paragraph 5-17 separation.

Operating an Aid Station

Established for 24-hour operations, the aid station often serves as the point of entry into the medical system during field training exercises and deployments. It typically exists as a multifunctional center that can serve as a medical command post, treatment facility, classroom, counseling area, living quarters, or mass casualty (MASCAL) anchor, based on various mission requirements. It can provide "tailgate" medicine (giving care based on what is readily available in a vehicle) until care can be provided at a more established site, such as a tent or other facility in the area of operation. The unit PA is responsible for establishing the aid station based on mission requirements.

The aid station has capabilities to perform sick call, advanced trauma management, basic laboratory procedures, patient administration, and medication supply management, and it must be able to move or relocate at a moment's notice. The aid station is assigned evacuation resources such as field litter ambulances and nonstandard vehicles such as utility vehicles, but the availability of the nonstandard vehicles is based on

local resources, space, and local standard operating procedures (SOPs) and MASCAL procedures. When establishing the aid station, the BN/SQN PA must also designate an easily accessible landing zone to facilitate rapid aeromedical evacuation.[28]

In a deployed environment, requests for medical care are often made by individuals who are not authorized to receive it from military assets. The task force commander decides on the medical rules of engagement, which determine when and to whom military health care providers are allowed to provide medical care (eg, to save life, limb, or eyesight, or stabilize and evacuate patients to a local national medical facility). The needs of the mission, available resources, and capability of the host nation's medical system will significantly affect these decisions. Planning for these situations is imperative. Before the start of the operation, all medical personnel must understand the commander's expectations.

The aid station provides the organizational structure that comprises the medical support system for the unit and its area of responsibility. A thorough understanding of aid station operations is found in Army Techniques Publication (ATP) 4-02.3, *Army Health Systems Support to Maneuver Forces*.[29] Situational training exercises are an opportunity for the medical team to set up its aid station, establish protocols and procedures, and integrate the aid station with unit operations.

Mass Casualty Operations

A MASCAL event is defined as a situation in which "the number of casualties exceeds the available medical capability to rapidly treat and evacuate them."[30] Various options exist for managing a MASCAL event. A holistic or flexible approach can allow for individuals to move among multiple roles as the operation develops and needs are identified; however, a predetermined plan consisting of specific assignments for each individual team member can provide clear understanding within the entire unit. The critical success factor in handling a MASCAL situation is the preparation and tone set by the BN/SQN PA. This section will focus on the BDE medical team in a deployed MASCAL setting. Appendix A of ATP 4-02.3 is an excellent resource and strongly recommended for review before developing a MASCAL plan.[29] Chapter 4 of ATP 4-25.13, *Casualty Evacuation*,[30] also provides valuable information when developing a MASCAL evacuation plan.

Planning

It is critical for the PA to have input in the development and implementation of a MASCAL plan at the earliest opportunity in both the deployed and field settings. The PA must coordinate with the medical operations officer to determine and implement a feasible MASCAL plan. MASCAL plans should be as simple as possible; personnel should not need to make complicated decisions during a MASCAL situation. Personnel responding to a MASCAL situation may be new to the organization, unfamiliar with traumatic events, or simply overwhelmed by the current conditions. A simple plan will be remembered under stress and is often the most successful plan.

Plans should be based on the unit's capabilities; for example, a combat arms (infantry, armor, or field artillery) NCO can serve as a traffic control officer or organize litter teams. The plan must account for ongoing combat operations and limited personnel and resources. Litter bearers who are not medical personnel must be identified so that medical assets are reserved for providing medical care. In MASCAL situations, medical care may be competing with other priorities; for example, a firefight may be ongoing or evacuation assets may be unavailable due to operational requirements or weather constraints. The PA must utilize NCO leadership (medical and non-medical) in both planning and execution. These leaders are the backbone of any operation and will give it structure throughout the process.

The plan must include knowing "the way out": how the unit will get the casualties to where they need to go. The PA is responsible for planning care for all patients in the unit's geographic area of responsibility, which entails the preparation of mobile trauma sets, designation of alternative treatment locations, evaluation of remote locations for storing medical supplies, and plans for moving casualties to and from remote locations. Questions to ask include the following: What is the next level of care? What assets are available at that facility? What modes of transportation are available to move patients? What capabilities does the aid station have to provide care en-route? This line of decision-making prior to an incident will instill confidence that the plan has a legitimate solution in place. In a deployed setting, the medical regulating officer (MRO) can help answer these questions.[31] MROs work in every Role 3 hospital and medical mission command headquarters.[32] They are responsible for regulating and supporting patient movement

and in-transit visibility requirements under the guidance of the division surgeon or subordinate MTF.[29]

Once a MASCAL plan has been formalized and approved, it must be rehearsed until done correctly and repeated periodically to maintain readiness; the PA should strive to create "muscle memory" within the organization. Moreover, rehearsals do not have to be a formal exercise. The PA should quiz personnel on MASCAL procedures at various opportunities (eg, waiting in line at a dining facility or following a routine sick call encounter). It is likely the unit already has a MASCAL plan which is formalized in their Tactical SOP. Upon arriving to a new unit PAs should speak to their BN's operations officer and obtain a copy for review. The PA can then discuss MASCAL procedures with medical personnel and the BN's leadership to determine where a need for improvement or revision exists.

Triage and Evacuation

Triage is the assignment of degrees of urgency to illnesses or wounds in order to decide the priority of treatment for a large number of casualties. It is based on medical supplies and assets available, regardless of the number of patients or casualties.[29] The best way to triage is to use the "DIME" acronym (delayed, immediate, minimal, and expectant) to categorize the severity of casualties' injuries. Triage categories prioritize the casualties for treatment, and evacuation categories (urgent, priority, and routine) prioritize them for evacuation. Patients must be periodically reevaluated to check whether their status has changed. Changes in the patient's condition should immediately prompt a change in the assigned triage or evacuation category. A nine-line medevac (medical evacuation) request is used when calling for evacuation of patients from designated units by ground or air. Information on the request includes the patient's evacuation category, if the patient is litter or ambulatory, and any special equipment (eg, ventilator or hoist) needed.[31]

Accountability

During the MASCAL event, there must be accountability of assigned weapons and equipment as well as controlled medications. A unit's S-4 officer (logistician) typically manages supply and property accountability. Controlled medications must be accounted for inside and outside the aid station. There are several options for accounting

for medications outside the aid station, and procedures should be matched with mission requirements. One option is to store a portion of the aid station narcotics in "ready-bags," such as a plastic sandwich bag with two autoinjectors of morphine and one vial of intravenous diazepam; an RSI (rapid sequence intubation) ready-bag; or the small Pelican 1030 (Pelican Products Inc) medication cases (national stock number: 8145-01-573-2533) included in medical sets (these are a more expensive option). The PA should be familiar with and adhere to the process for signing out and storing narcotics in accordance with AR 190-51, *Security of Unclassified Army Resources (Sensitive and Nonsensitive)*, chapter 4.[33]

Patient Tracking

Patient tracking and documentation are often the most overlooked aspects of casualty operations. Commanders are entitled to know the location and status of their soldiers, and the PA is responsible for having a plan in place for recording medical encounters. Medics must

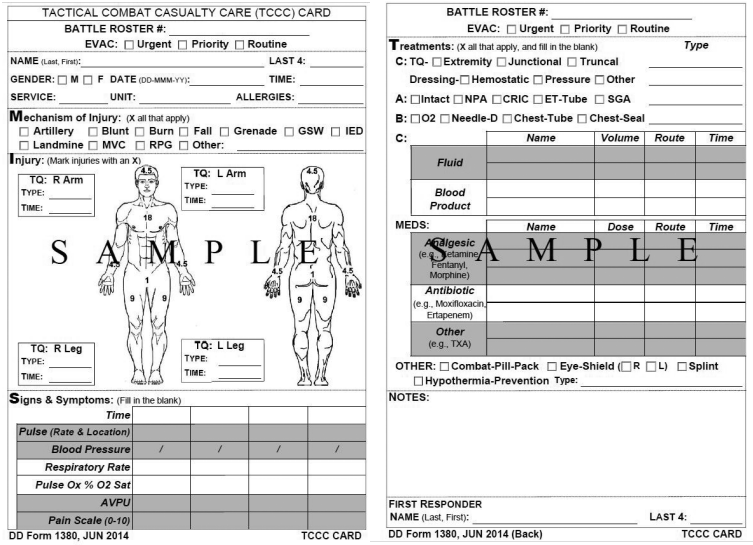


Figure 12-3. DD Form 1380 (Tactical Combat Casualty Care Card) example.

recognize the importance of maintaining accountability for those treated, including their name, injury, and location if evacuated. Necessary medical information is rapidly captured on DD Form 1380, the TCCC card (Figure 12-3). A simple white board in the aid station should also be used to provide redundancy and prevent information loss. When time allows, conversion of analog documentation into EHRs must occur. The Medical Communications for Combat Casualty Care (MC4) computer is used to accomplish this task.

It is imperative that every casualty is accurately accounted for throughout the process. Patient tracking starts with the S-1 (officer in charge of personnel accountability), who uses the TCCC cards attached to the patients as they are evacuated to ensure pertinent information is captured. The BN/SQN PA should contact the unit liaison (either intra- or inter-theater, depending on unit preference) for the commander to gather timely patient tracking status. PAs should provide patient location and disposition to commanders every 24 hours. The Joint Operation Planning and Execution System (JOPES)[34] and TRAC^{2}ES[21] can also be used for real-time casualty tracking. The mortuary affairs NCO, typically assigned to the staff of the BDE support BN, assists in the disposition of deceased soldiers.[35]

Sick Call Operations

Sick call is an assembly of sick and injured soldiers held each day at a designated time and place, usually at the Soldier-Centered Medical Home (SCMH) or unit aid station, for the purpose of providing routine medical examination and treatment. After examination by the senior medical officer (usually the unit PA or surgeon), soldiers who are medically unfit are either referred to the hospital or provided quarters (returned to unit or home for medically directed self-treatment) for up to 72 hours. All others are returned to either full duty or duty with specific limitations. Some clinics are moving away from sick call and going to an "appointment only" system.

The establishment of specific sick call procedures is at the PA's discretion; however, hours and procedures should be coordinated with the unit command sergeant major. For example, if the PA determines that specific sick call hours must be set to account for limited medical personnel, create appropriate sleep/work cycles, or simply consolidate resources, input should be sought from the command team. The PA

should recognize that sick call is designed to enhance the unit's mission readiness, not hinder it.

It is the responsibility of the BN/SQN PA to provide care to unit personnel whether in the aid station or the garrison environment. While in the field, the PA or their medics should conduct sick call rounds (ie, taking an aid bag full of sick call supplies and checking on soldiers) for individuals who have competing requirements and cannot leave their posts. Examples include tactical operations center personnel, who may be working 12- or 14-hour shifts, and command teams, who may be unable to dedicate time to sick call.

Triage During Sick Call

Triage during sick call is managed according to the algorithm-directed troop medical care (ADTMC) system described in Medical Command (MEDCOM) Pamphlet 40-7-21.[36] This system is designed to allow providers to quickly evaluate the urgency of a soldier's acute conditions and, if possible, effectively treat the soldier for return to duty. ADTMC provides a medical complaint-based algorithm for the medical screener, usually a senior medic, to follow to determine the level of care each soldier requires.[36] Once the soldier is triaged using ADTMC, based on the complexity of the medical problems, the screener can either (*a*) treat the acute condition, (*b*) educate the patient on medications and treatment options they may use at home, (*c*) refer the patient to a physician or PA for immediate evaluation, or (*d*) set up an appointment with the physician or PA, who may then refer the patient for specialty care if needed.

"Sick Call Slip"

DD Form 689, known as a "sick call slip," is a communication tool between unit leadership and the medical team for accountability and visibility of duty status.[37] Before reporting to sick call, soldiers should have a sick call slip signed by their unit leadership (usually a platoon sergeant or above). The sick call slip can be found at the unit orderly room or wherever the local SOP dictates. After the soldier is examined by the medical officer, the soldier's disposition is indicated on the sick call slip, which is returned to the unit commander or other leader. The sick call slip should provide duty status recommendations, such as return to duty or quarters (with both duration and expiration date), and time

released from sick call (physical limitations should be entered on DA Form 3349, not DD Form 689). The DD Form 689 may also be used by the commander to request medical evaluations, such as fitness for duty evaluations, by the unit medical provider.[23,37]

Training Medics During Sick Call

The PA is responsible for developing and implementing programs that encourage and teach medics to conduct patient assessments, perform physical exams, and develop proper treatment plans. Sick call is an ideal opportunity to conduct training and teach medics to evaluate patients, especially to prepare for situations when the medic is the only provider available (eg, during a MASCAL at a location distant from the aid station, in which the line medic is the only medical personnel in the immediate area). Medics respond best to hands-on training with actual patients. A focus on identifying "red flags" (conditions that require immediate attention by, or evacuation to, a medical provider) is a good starting point for training new medics. A medic assigned only to take vitals (blood pressure, temperature, pulse, and pain level) and write the subjective portion of a report (what the patient tells the medic) at sick call will not learn to function when separated from medical providers. In addition, cultivating the responsibilities of a medic in the presence of unit soldiers will instill a sense of confidence throughout the unit in their medical personnel.

Clinical Operations

BN/SQN PAs will be in a clinical setting during much of their time at the BDE Combat Team level. The PA is the primary leader in establishing the efficient performance of clinical duties. The medics and SCMH staff will seek guidance from the PA on how to manage schedules, perform procedures, handle medication refills, and conduct unit physicals (ie, the processes for completing each part of the various types of examinations for schools, retirements, chapter separations, periodic health assessments, etc).

In the past, nearly all aspects of primary patient care were completely under the PA's control because most units operated nearly all medical operations out of an aid station. However, over the last few years, the Army has transitioned to the SCMH model and has required PAs to see

patients in troop medical clinics operated by MEDCOM.[38] Therefore, PAs must know which aspects of health care delivery are determined by MEDCOM and which they can influence at the BN/SQN level to ensure the needs of the unit are met. Establishing a good working relationship with MEDCOM soldiers, civilians, and contractors helps in coordinating unity of effort.

To start practicing medicine at a given duty station, the PA must receive appropriate credentials from the local MTF. This process can be lengthy and unique for each MTF, so it should be initiated as soon as the next duty station is known. The BDE PA, BDE surgeon, or MTF staff can provide information about the credentialing process and how to expedite the process. The PA should be very familiar with the expectations and limitations of their role as a provider. Further guidance and expectations for PA performance are available in AR 40-501[3] and AR 40-68, *Clinical Quality Management*.[8]

Although clinical operations are largely affected by the policies set forth by MEDCOM, PAs must remember they answer to the BN/SQN commander and their primary mission is to meet the operational needs of the unit. The PA must also be proactive in communicating clinic schedules and policies to the units within the BN or SQN. For example, units must know sick call times and procedures, the process and schedule for completing periodic health assessments, physical examinations, and audiology and vision screenings. The medical operations officer or platoon sergeant can assist with this. A one-page "smart card" outlining the times, locations, and procedures for these tasks is also an efficient way to ensure all units have the information. The smart card serves as a quick reference and is easily posted in unit areas as a reminder for soldiers. Helpful information includes topics such as separation physical procedures, annual periodic health assessment requirements, or the necessity to complete Department of Veterans Affairs separation history and physical examination forms on the Medical Readiness Portal prior to disability appointments.[39]

Logistical Operations and Property Accountability

Property and Accountability

As the primary provider for the unit, responsible for the health care of its soldiers, the PA should quickly assess the Class VIII (medical) supply level of readiness upon arrival at a new duty station. The PA must know

which medical assets the section has and which it lacks. If the unit has a Medical Service Corps officer, he or she should be the primary hand receipt holder for the section and sub-hand receipt various items to the primary user. However, many units have no assigned Medical Service Corps officer, and in these units the medical platoon sergeant may also manage the hand receipt and supply. Here are some things to consider upon arrival at a duty station:

- When was the last 100% inventory completed?
- Have sub-hand receipt holders been assigned to primary users of all equipment?
- What are the deficiencies of durable, non-durable, and expendable items? Has action been taken to fill the shortages? Shortages should be reflected on a shortage annex (DA Form 2062) and funding verified to requisition replacement supplies.
- When was the last time medical equipment sets (MESs) were inventoried? MESs should be inventoried after every field training exercise or every 6 months, whichever comes first.[40,41] No more than 3% of excess durable and nonexpendable Class VIII items should be maintained.[41] See "Sets, Kits, and Outfits and Medical Equipment Sets" below for more information on how to determine what should be in an MES.
- Has an inventory been completed since the last field training exercise? Inventories should be part of recovery operations and should be documented.[41]
- If not done already, a binder should be made that accounts for all hand receipt items and the national stock number (NSN), authorized quantity, quantity on hand, and an accompanying picture for each item. This will greatly facilitate change of command, cyclic, or expendable Class VIII inventories.

PAs should also ensure a method is in place to track expiration dates of medical supplies with limited shelf lives, typically referred to as "Ps & Ds" (potency and dated items). Medical equipment is unique in that items expire relatively quickly and must be reordered on a regular basis. Two key mechanisms to manage medical supplies are the Medical Materiel Mobilization Planning Tool (M3PT) and the Defense Medical Logistics Standard Support (DMLSS) Customer Assistance Module (DCAM).

M3PT is the approved system for management of MES inventory.[41] Although it requires an investment in time up front to enter all the section's Class VIII items into M3PT, the system can be used to keep track of when items expire; send a notification 30 days before expiration (to allow reordering before items expire); quantify percent fill in accordance with AR 220-1, *Army Unit Status Reporting and Force Registration–Consolidated Policies*; and generate a list of shortages that need to be reordered.[42] If used correctly, M3PT can support the medical platoon's equipment readiness and rapid deployability. Another benefit is M3PT's ability to quantify (in both amount and cost) a unit's Class VIII shortages. For example, a commander may choose to assume risk by underfunding Class VIII replenishment to fund other requirements. The PA should be prepared to provide the commander visibility of the costs (in dollars, capability, and readiness) of this decision. Using reports from M3PT, this data can be rapidly queried to provide such information to the command.

DCAM is a medical logistics ordering tool that enables operational units to order Class VIII and replenish levels when required. It automates the medical materiel supply requisition process at lower levels of care and allows non-logisticians to electronically view and order from their supplier's catalog.[43] DCAM can interface with other Department of Defense medical logistics systems, including the Joint Medical Asset Repository (JMAR), the Theater Army Medical Management Information System (TAMMIS), and the Theater Enterprise-Wide Logistics System (TEWLS). Each section should have two soldiers with access to and training on DCAM.[43]

Sets, Kits, and Outfits and Medical Equipment Sets

One of the most important concepts the PA needs to know is how the Army assigns and accounts for medical equipment in their unit. First, the PA should work with the medical platoon leadership (the platoon leader and platoon sergeant) to identify the numbers and types of equipment authorized on the medical section's modified table of organization and equipment (MTOE). Next, it is important to establish the correct version of components or contents for that equipment.

All equipment is issued from the commander's property book to a sub-hand receipt holder. Most equipment sets are known as sets, kits, and outfits (SKOs); MESs are medical-specific SKOs. The medical

section is authorized and issued multiple MESs based on its required medical capability. The MES's line item number (LIN) identifies a specific medical capability that the unit must be able to accomplish (eg, sick call, tactical combat medical care, ground ambulance).

The number and type of authorized MESs for each unit can be found on the unit's MTOE. The Force Management System website, or FMSWeb (https://fmsweb.army.mil)[44] is the repository for every Army unit's MTOE (Attachment 1). After requesting access from the homepage, the PA can search the website by the unit identification code (UIC, a six-digit alphanumeric code assigned to each Army unit) or unit type (infantry, armor, etc). It is important to note that the MTOE only shows what the unit is authorized. The medical section's actual equipment on hand is on the section's sub-hand receipt from the unit commander. Variation from authorizations may exist.

While every item of equipment on the MTOE (rifle, truck, computer, etc) has an LIN, the specific item assigned to the unit to meet that LIN's required capability is represented by a unique NSN (eg, LIN C06935 is a requirement for an individual weapon, and a Carbine 5.56 mm M4A1 has a different NSN than a Rifle, 5.56 mm M16A4). The specific NSN assigned to each MES LIN represents a "version" of that MES. For example, the addition of new equipment or medication (eg, junctional tourniquets and ketamine) results in a new version of the contents list, and thus a new NSN. This new content list and NSN is associated with a unit assemblage code (UAC).

To determine which version of the MES is issued to the medical section, identify the associated NSN on the medical section's sub-hand receipt and cross reference that NSN to the US Army Medical Materiel Agency (USAMMA) Medical Materiel Information Portal (MMIP) assemblage lists (https://a01.usamma.amedd.army.mil/mmip/).[45] The MESs can be searched under the "Unit Assemblage Search" tab. The USAMMA assemblage list for each UAC also provides a hyperlinked listing of additional information for every item on the list, which includes the subcomponents of each item (eg, the durable and expendable items needed for a blood warmer or a ventilator). It is important to note that if the PA does not correctly identify which UAC (by NSN) the unit is issued, then it is impossible to know exactly what supplies (by item, quantity, and sub-component) are supposed to be maintained within the MESs.

Packing Lists

Packing lists are essential to ensuring appropriate readiness within the section. They can and should be applied to aid bags, ambulances, aid stations, individual chests within the MES, and load plans. The PA should be very involved in managing packing lists to ensure medics and the entire section are properly prepared to treat casualties and that aid stations are set up in an efficient and organized manner. The PA should explicitly state how each item should be packed. A soldier or NCO should then develop a standardized packing list and load plan (Attachment 2) with pictures to incorporate into the section SOP.

Although opinions differ about how and what medics should carry in their aid bag, a minimum packing list should be established (Attachment 3) to provide a certain level of accountability for readiness, while allowing some personal preferences. Whatever the approach, a clear standard should be established and incorporated into the section SOP, and medics' aid bags should be inspected regularly by leadership.

Narcotics Management

Narcotics are a useful and potentially necessary part of patient care in and out of the aid station. However, they can also become a liability to the unit when not managed appropriately. Narcotics are sensitive items and should be treated as such. Each unit or MTF will have its own SOP for safeguarding, storing, managing, drawing from storage, and disposing of narcotics. PAs must become familiar with how to access these medications and the process of turning them back in. In deployment situations, while operating under predefined protocols, junior personnel (eg, line medics) can administer these medications in the absence of direct supervision. It is the PA's responsibility to ensure that the acquisition, storage, inventory, and use of narcotics are in accordance with current regulations, TCCC guidelines, SOPs, and organizational requirements.[33] It is also the unit PA's responsibility to know which narcotics are used forward of the aid station. Furthermore, the BN/SQN PA, in coordination with the supervising physician, must approve the medications their combat medics are authorized to carry and ensure the medics are trained in their proper use. The unit PA, and any medic carrying opioids, should

also carry and know how to use naloxone hydrochloride to counter the effects of an opioid overdose.

In a deployed setting, units may be required to adhere to theater-specific policies in addition to Army regulations. It is critical for the PA to verify current standards with higher levels of command. PAs should become familiar with narcotic SOPs as early as possible to ensure they can quickly support the unit's operational needs. Training should also be started early, before deployment (eg, during field training exercises and Combat Training Center rotations) on how the medical platoon and treatment teams will manage narcotics (Figure 12-4). The BDE surgeon cell, BDE medical supply officer, and Role 3 (eg, combat support hospital) pharmacy are excellent sources of information concerning these policies and procedures in a deployed environment. For further guidance refer to the unit SOP and ARs 40-3, *Medical, Dental, and Veterinary Care*[46]; 40-61, *Medical Logistics Policies* (chapter 3)[40]; 190-51, *Security of Unclassified Army Property* (chapter 4)[33]; and AR 735-5, *Property Accountability Policies*, chapter 2-8.[47] The following list describes a few key components of appropriate narcotic management.



Figure 12-4. Medical platoon, 1st Battalion, 501st Infantry Regiment, 4th Brigade, 25th Infantry Division (Airborne), conducts narcotics refresher training while deployed to Jalalabad, Afghanistan, February 10, 2018.
Photograph courtesy of Major Devon Greer.

- To request controlled medications, a physician or PA must sign a DA Form 1687 (Delegation of Authority/Signature Card).
- A disinterested officer (E-7 or higher) must be appointed by the commander to perform monthly inventories.
- Narcotics must be tracked on a DA Form 3949 (Controlled Substances Record). Any change in the quantity on hand (medication given,destroyed, turned in, or lost) must be documented immediately. Lost medication should trigger an immediate investigation.
- The PA must perform weekly inventories at the hand receipt holder level and document supplies accordingly on DA Form 3949.
- The PA must ensure proper securing of narcotics per unit SOP. AR 190-51 requires a double lock and key.[33] One way to prevent problems is to let the PA have one key and the noncommissioned officer in charge (NCOIC) have the other, so no one can access narcotics by themselves.
- Narcotics issued to a medic must be on the medic's person at all times and under their constant supervision when not locked in an approved narcotics storage container.[33,41,46]
- The PA or NCOIC should provide written counseling to all personnel who will be handling narcotics to clearly communicate their expectations and the consequences of failing to meet those expectations.

Deployment

Prior to deploying, the unit PA should inquire about the Class VIII resupply process to find out how long supplies take to be delivered, what type of storage is available, what the turn-in process is for equipment and narcotics, and how regulated medical waste is disposed of. They must also know what theater-provided equipment is available (there will likely be some if the theater is well-established and other units deploy there on a rotating basis). If the deployment is to an austere environment (eg, the first units into Afghanistan or Iraq), then what the unit brings is what it will have until the supply system is established.

In addition to day-to-day management of supplies, BN/SQN PAs must be aware of the operational tempo and timelines within their unit and other supported elements. They must know when the unit will be executing missions and what type of medical support each might require. Unit PAs must resource the medics and soldiers with appropriate Class VIII supplies and knowledge of medical assets on hand. For example,

units or medics may request a medical "speedball"—a standardized package of Class VIII supplies that is prepackaged, staged, and rapidly dispersible to units in the field when needed. These supplies can be packed per unit SOP (based on the anticipated mission needs) and strategically placed (eg, with a quick reaction force or air medevac team) to facilitate rapid resupply to units in the field.

Combat Medic Training

Combat medic specialists (68W) have several requirements they must meet to maintain their MOS qualification.[48] Most non-medical units are unfamiliar with the requirements and amount of time necessary to complete this training; therefore, the PA must ensure that command teams are aware of these requirements and allow appropriate time in the training schedule to accomplish them.[49]

Tracking all the required medical training can be a laborious process. Proof of all the training conducted must be maintained in a competency assessment file (CAF) and should be given to the medic upon leaving the unit. "Documents that reflect the individual's employment history, education, and assessment of competence will be maintained in the CAF for a minimum of 3 years and may be purged according to local policy."[8] The CAF is best maintained in a brown, six-sided folder (its assembly is outlined in Appendix C of AR 40-68[8]). Below are medic requirements for MOS recertification and validation:

- biennial Emergency Medical Technician (EMT) recertification by the National Registry of Emergency Medical Technicians in accordance with AR 40-68[8,49];
- Basic Life Support certification at the health care provider level;
- 24 hours of continuing education equivalency refresher training;
- 48 hours of additional continuing education;
- verification of skills validation (Table VIII training), an annually required hands-on skills test (refer to Figure 1.1 of TC 8-800, *Medical Education and Demonstration of Individual Competence*[49]); and
- role-based TCCC training every 3 years and within 12 months before deployment.[6,7]

Refer to TC 8-800 for more detailed information on MOS requirements for combat medics (Figure 12-5).[49]



Figure 12-5. Captain Bryan Jow, Regimental Engineer Squadron, 2nd Cavalry Regiment, trains medics on orthopedic physical exams using a simulated patient (First Lieutenant Connor Fink), October 4, 2019.
Photograph courtesy of Staff Sergeant William Maldonado.

When training medics, it is important to remember that requirements for 68W certification may differ from requirements for preparation to provide medical care in combat according to TCCC guidelines.[6] TCCC guidelines have been proven to reduce both morbidity and mortality in combat and are the most effective way to reduce the 25% of battlefield deaths that are potentially preventable.[50] The Committee on TCCC, made up of leading experts in the field of combat and tactical medicine, constantly updates TCCC guidelines as new information and equipment become available.[6] In the past, some medical providers have determined that a skill or medication recommended by the committee was too complex or dangerous for medics to use[50]; however, soldiers on the battlefield deserve the best evidence-based care that the TCCC guidelines provide. If the TCCC guidelines recommend anything medics are not regularly trained in, the PA must develop a training program to fill that knowledge or skill gap. PAs are the subject matter experts in the application of TCCC for their unit, and it is up to them to ensure the following[50]:

- TCCC is the standard of care for prehospital medical care in their unit.
- Commanders and unit leaders are aware of the TCCC guidelines so they can be integrated into training exercises at all levels. Initial casualty response (from point of injury to the casualty collection point) is both a tactical and medical problem. Therefore, it is a maneuver unit, not a medical, responsibility, and must be trained until its practice is automatic.
- Unit medics are trained and resourced to provide care in accordance with the most current TCCC guidelines.

Modified Table of Organization and Equipment Assigned Personnel

With the transition to the Defense Health Agency, the Army eliminated the Professional Filler System (PROFIS). PROFIS providers held assignments in an MTF and deployed in support of Forces Command (FORSCOM) units, filling critical deployment shortages when needed.[51] To replace PROFIS and increase readiness, the MTOE Assigned Personnel (MAP) system was created. With MAP, providers are assigned to FORSCOM units and perform their clinical duty in MTFs. This reorganization makes MAP providers accountable to the unit they are assigned to, instead of the MTF they work in. With MAP, the unit can train and deploy with their organic providers, thus decreasing the likelihood of provider changeover and anonymity.

The unit PA should understand this system because MAP providers are an integral part of the unit's medical team. A MAP provider is likely to be the PA's supervising physician, but they are not always collocated at the same duty station or MTF. Requests for MAP providers stationed elsewhere to attend training must be submitted at least 90 days before the training begins.[51] Because the training (ie, medical specialty) and military experience of MAP personnel will vary, the PA should be prepared to assist with their orientation and integration into the unit. The PA should contact a new MAP provider as early as possible after they are identified and ensure they have needed information (packing lists, points of contact, timelines, etc) to make a smooth transition into the unit.

Combat Lifesaver Training

The unit PA is also ultimately responsible for the success of the unit's CLS program.[9] NCOs in the medical section will likely have experience conducting CLS training, but the unit PA is charged with ensuring the training is relevant, realistic, and applicable to the combat environment. The PA should have an active role in the training while still providing ample opportunity for medics to take charge. CLS competency is an ongoing process, not just a certificate, and the PA should create opportunities for soldiers to revisit CLS principles and procedures during training.

Initial Certification

The 40-hour CLS certification course includes both didactic and practical training, in addition to a 40-question test and a hands-on test. After successful completion of the course, soldiers are considered CLS qualified for 1 year. Unit independence in conducting this training will facilitate flexibility in adjusting to the unit's training calendar.[52]

Recertification

Recertification of combat lifesavers via an 8-hour class must occur annually. Hands-on skills and a written test are required for recertification. Validation and recording of recertification is maintained at the unit level. It is important to monitor the recertification and training needs of the unit combat lifesavers; it is much easier to recertify combat lifesavers in smaller numbers over time than it is to wait until the unit requires a large number to be trained just before deployment, a Combat Training Center rotation, or a command inspection. Training in smaller numbers also makes it easier for the unit medical team to fit this requirement into the unit's training schedule.[52]

"Battle Rhythm"

The following section lists some of the regular day-to-day aspects of being a BN/SQN PA.

Daily

- Sick call: see "Sick Call Operations" earlier in this chapter.
- Clinic: PAs must work a minimum of a 0.5 full-time equivalent day (dependent on MTF and unit leadership guidance).
- Administrative duties: as required, including completing paperwork for physical exams and medical clearances for training.

Weekly

- Command and staff: PAs should be prepared to answer command questions about the unit's medical readiness and training requirements.
- Non-deployable profile reviews: meetings with command teams to review and discuss soldiers in non-deployable status and outline the way forward for these soldiers. These meetings provide an opportunity to educate leaders on medical trends that are adversely affecting their units and answer questions about medical concerns. BN/SQN, BDE, and senior mission commanders must review profiles that exceed 120, 180, and 240 days, respectively.[17]
- Medical platoon huddle: this meeting ensures that unit PAs who work primarily in SCMHs stay in touch with the needs of the platoon and their BN/SQN.
- Medic training meetings: unit PAs must be sure to spend adequate time with their medics. Treatment administered by medics to unit personnel is ultimately the responsibility of the PA. Clinic and leader responsibilities must not prevent PAs from keeping medics trained on both clinical and emergency medical care skills.
- Other regular meetings.

Reserve Component and National Guard

Unit Medical Readiness and Soldier Tracking

In most states, reserve and National Guard unit medical readiness (immunizations, periodic health assessments, etc) is maintained at the state level during annual soldier readiness processing events, in which the entire unit designates one drill period for getting all soldiers ready to deploy. Unit PAs should still know the medical readiness status of

their unit, identify deficiencies and trends, and be able to brief the commander on how the unit can get and stay healthy. This may require coordination and communication with state medical assets.

PAs in the reserve component (RC) face different challenges in tracking non-deployable soldiers in their unit and providing a way forward to command teams. Because many RC units do not have an organic PA, and most RC soldiers are not treated within the military system, staying up to date on their injuries and treatment progress can be difficult. In addition, the PA must rely on each soldier to provide their most recent medical records from non-military medical providers. As stated in AR 40-501:

- It is the responsibility of RC soldiers to maintain their medical and dental fitness. This includes correcting remedial defects, avoiding harmful habits, and controlling weight. RC soldiers are responsible for seeking medical advice and treatment quickly when they believe their physical well-being is in question. RC soldiers must report any change in their health status that impacts their readiness status to their unit commander.
- All RC soldiers are responsible for providing the unit commander all medical documentation, including civilian health records, and for completing the annual physical health assessment. Civilian health records documenting a change which may impact their readiness status will be placed in the soldier's military health record.[3]

RC soldiers get their health care from civilian medical providers, who cannot write profiles. It is possible that the only military medical providers writing soldier profiles are consolidated at the state level and have no interface with command teams. To overcome this communication gap, command teams must pay close attention to their Commander Portal account to keep track of soldiers' medical conditions. The provider writing the profile also has the responsibility to clearly state the recommended next step in the patient's care, which will allow the commander to conduct proper follow-up.

However, given the time constraints on RC units, this close tracking often does not occur. Additionally, RC soldiers may have ongoing, untreated medical conditions because they might not participate in the daily physical training or activities performed by active duty soldiers. Untreated conditions may only become an issue when it is

time to perform the Army fitness test, attend a field training exercise, or deploy. There may be soldiers who are not ready to deploy, yet lack a profile. As a result, command teams may have a false sense of security regarding the readiness of their unit. Thus it is important that RC providers be familiar with AR 40-501 and the requirements for being medically fit.[3]

As soon as a medical condition is identified, a profile must be written. It can be helpful to outline a treatment plan on the profile as permitted by HIPAA. Command teams must track these soldiers closely because there is often no follow-up with a military medical provider once the soldier's profile expires. Soldiers and leaders must remember that RC soldiers have the same maximum 12 months to rectify an ailment as do active duty soldiers. Beyond the 12 months, or as soon as the medical retention decision point has been met, a permanent profile should be completed if the soldier can perform basic soldier functions and the duties of their MOS per DA PAM 611-21.[3,24] If not, the RC soldier should be referred to a MAR2 or IDES as appropriate.

Line of Duty

The line of duty (LD, or LOD, as it is often referred to) determination is a tool commanders can use to determine if an injury, illness, disease, or death occurred while a service member was in an authorized duty status. This determination is used to decide if the Department of Defense is responsible for covering the resulting costs and associated entitlements. AR 600-8-4, *Line of Duty Policy, Procedures, and Investigations*, chapter 2, states, "The Army LOD Program is a commander's program which essentially protects the interest of both the Soldier and the U.S. Government where service is interrupted by injury, disease or death."[53(p6)] The frequency of required LD determinations is higher in the RC because its soldiers are not on duty continuously.[54] LD determinations can have significant financial and professional impacts on soldiers and their families. Although initiating an LD determination is a command responsibility, both active duty and RC PAs should be familiar with the process, and advise command when its use is appropriate. It is especially important when an RC soldier is medically evacuated from theater because a determination that an injury or other condition was incurred in the line of duty is required for admission into a warrior transition unit or BN/SQN.[54]

Deciding whether an injury, illness, or death occurred on duty may or may not require an investigation. If warranted, investigations "are conducted essentially to arrive at a determination of whether misconduct or negligence was involved in the disease, injury, or death and, if so, to what degree. Depending on the circumstances of the case, an LOD investigation may or may not be required to make this determination."[53(p6)] AR 600-8-4, section 2-2 lists the conditions when an LD investigation must be performed. Investigations are imitated on DA Form 2173 and can be performed informally or formally by the chain of command.[53]

LD determinations for the National Guard must be input into the Electronic Medical Management Processing System (eMMPS). Without a completed LD investigation in eMMPS, the service member will not be authorized for any benefits associated with the incident. PAs should check their unit SOP to determine who is responsible for entering this information into eMMPS.

Incapacitation of Reserve Component Soldiers

When an RC soldier sustains an injury or aggravates a preexisting injury, illness, or disease while on active duty, or on inactive duty training orders, that either restricts performance of military duties or causes a loss of income from a civilian job, the soldier can submit an incapacitation pay claim to help supplement lost financial income.[55,56] AR 135-381, *Incapacitation of Reserve Component Soldiers*,[55] and DA PAM 135-381, *Incapacitation of Reserve Component Soldiers Processing Procedures*,[56] provide further details regarding incapacitation of RC soldiers.

Being a Good Steward of the Army Profession

The term "stewardship" expresses the Army's responsibility to strengthen the soldier's profession. "It includes caring for the people and resources entrusted to [us] by the American people, ensuring Army forces are ready, now and in the future, to accomplish the Army's missions."[57] Officers and leaders have a duty to teach, coach, and mentor their subordinates to groom the next generation of Army leaders. Good stewardship is about investing in people and the organization before oneself. PAs should always strive to leave their BN, SQN, medical platoon, or unit better than they found it. Ways to do this include:

- improving SOPs and continuity books to establish best practices for future PAs and MAP providers[58];
- teaching medics and encouraging those who have the desire and aptitude to become PAs;
- mentoring soldiers and NCOs to assist them in performing their assigned duties or preparing for positions of increased responsibility;
- focusing on long-term sustainability over short-term success by establishing systems to accomplish routine tasks that are sustainable in the future; and
- ensuring the medical platoon honors traditions such as military customs and courtesies, the "hail and farewell," and recognition of good performance (awards, certificates of achievement, coins, etc) (Figure 12-6).



Figure 12-6. Medical platoon, 2nd Battalion, 377 Parachute Field Artillery Regiment, 4th Brigade, 25th Infantry Division (Airborne), poses for a group photo after completing a month-long rotation at the Joint Forces Training Center, Camp Shelby, Mississippi, October 15, 2019.
Photograph courtesy of Captain Isaias Lopez.

Lessons Learned

The most fundamental responsibility of the BN/SQN PA is understanding their role in the unit. The unit PA is the commander's medical advisor, responsible for providing informed decisions regarding the health, welfare, and readiness of the unit. As such, their primary duty is working to meet the commander's readiness goals. To effectively do this, they must work in conjunction with the unit's physical therapist, behavioral health officer, nurse case managers, and the specialty clinics, both on post and in the surrounding area. The role and responsibilities of the PA are detailed in ATP 4-02.3, *Army Health System Support to Maneuver Forces*.[29] A thorough understanding of this publication is integral to the PAs success in the BN/SQN.

When arriving at the unit, the PA must become familiar with the base hospital, its clinics, its referral guidelines, and the civilian trauma centers soldiers are likely to be transferred to. The unit's mission and upcoming training events should be discussed with the BN/SQN executive officer, BDE PA, and BDE surgeon. Each person should be seen as a mentor and resource to evaluate performance. Relationships should be built with the other providers in the clinic. It is likely the PA will need their help while assigned to the BDE. The PA should cultivate a good working relationship with the medical platoon sergeant, clinic staff, and medical operations officer (if allocated in the MTOE). The more the PA is integrated into the team, the better they are able to support the unit (Figure 12-7). The PA should take part in organization days, unit/formation runs, hail and farewells, unit balls, family readiness group meetings, and other events. Be a part of the unit!

The BN/SQN PA must also take time to improve their medical practice through continuing their medical and military education, training the unit's medics, and mentoring the medical operations officer, platoon sergeant, and junior medics. The better trained these individuals are, the more the PA is able to focus on providing excellent medical care to the unit's soldiers. Patients should be educated on medical diagnoses, the clinic's procedures, and SOPs to increase understanding and decrease clinic return rates. If soldiers are transferred to civilian emergency rooms or admitted to off-post hospitals, the PA should take the opportunity to visit them during



Figure 12-7. First Lieutenant Danielle Hicks, a battalion physician assistant with the 2-43 Air Defense Artillery Battalion from Fort Bliss, Texas, treats a patient as combat medic Private First Class Jenna Andrada assists during a deployment in Al Asad Air Base, Iraq, in February 2020.
Photograph courtesy of First Lieutenant Danielle Hicks.

their recovery. Without violating HIPAA, the PA should be available to speak with spouses, relatives, or other family members about a soldier's disposition. It must be understood that evaluating patients in clinic may come second to soldier readiness processing, PHAs, or immunization rodeos specified by the commander to increase deployability. Readiness is the first priority!

Conclusion

The PA is the linchpin in the Army Medical Department's mission to conserve the fighting strength. PAs proactively shape their unit's medical readiness by providing mentorship and direction to medical personnel, conducting expert patient care, advising unit commanders, and planning for an array of real-world operations. The unit PA is intimately involved in the aid station, the most forward location providing an MTF. They also serve as liaison between soldiers and their leaders in matters of

health protection, combat health readiness, and preventive care. The discussions outlined in this chapter are an effort to ensure that future BN/SQN PAs are educated and trained in the management of their duties and responsibilities in this critical role.

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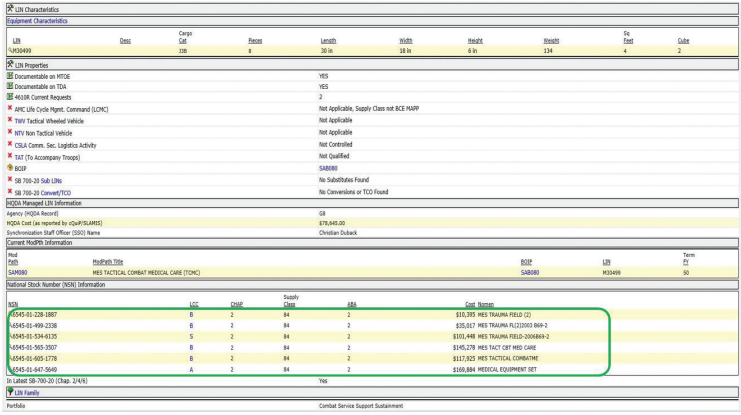
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ATTACHMENT 1: BASIC MEDICAL EQUIPMENT SET INFORMATION

120 - MEDICAL TREATMENT SQUA

PARN O	LIN	ERC	NOMENCLATURE	REQ EQ	AUTH EQ	PARENT UNIT REQ EQ	PARENT UNIT AUTH EQ	RMK 1	RMK 2	CDUIC	MOD PATH	SUBC O
120	A05034	A	AUTOMATIC EXTERNAL DEFIBRILLATOR (AED) :	2	2	2	2				SAM288	
120	A79381	A	ANTENNA GROUP: OE-254(C)/GRC	2	2	2	2				CAM378	
120	C05002	A	COMPUTER SYS DIGITAL: AN/PYQ-10(C)	1	1	1	1				CAM304	
120	C05036	A	COMPUTER SET DIGITAL (IBC-P): AN/UYK-128B(V)3	2	2	2	2				FAM006	
120	C06935	A	CARBINE 5.56 MILLIMETER: M4A1	6	6	6	6				IAM151	
120	C07506	A	CHEMICAL- BIOLOGICAL PROTECTIVE SHELTER (CBPS): M8	1	1	1	1				GAM048	
120	C18345	A	COMPUTER SET: DIGITAL AN/TYQ-106(V)1	2	2	2	2				SAM211	
120	E05008	A	ENCRYPTION-DECRYPTION EQUIP: KGV-72	2	2	2	2				FAM024	
120	G18358	A	GEN SET: DED SKID MTD 3KW 60HZ	1	1	1	1	TEB			OAM926	
120	J00697	A	JOINT CHMCL AGENT: DETECTOR	1	1	1	1				GAM024	
120	M12986	A	MASK CHEMICL BIOLOGICL JOINT SERVICE GENERAL PURPOSE: FIELD M50	8	8	8	8				GAM002	
120	M23673	A	MEDICAL EQUIPMENT SET CHEMICAL AGENT PATIENT PROTECTIVE WRAP:	1	1	1	1				SAM171	
120	M25865	A	MEDICAL EQUIPMENT SET PATIENT DECONTAMINATION & CHEM TREATMENT:	1	1	1	1				SAM172	
120	M30499	A	MEDICAL EQUIPMENT SET TACTICAL COMBAT MEDICAL CARE:	2	2	2	2				SAM080	
120	N05482	A	NIGHT VISION: GOGGLE	8	8	8	8				IAM059	
120	N96248	A	NAVIGATION SET: SATELLITE SIGNALS AN/PSN-13	2	2	2	2				CAM005	
120	P05043	A	PISTOL, MODULAR : XM-17	2	2	2	2				IAM051	
120	P40750	A	POWER SUPPLY: PP-6224/U	1	1	1	1				CAM102	
120	P99881	A	PROC DATA CASS 2.0:	1	1	1	1				NAM006	
120	R20684	A	RADIAC SET: AN/VDR-2	1	1	1	1				GAM013	
120	R31061	A	RADIAC SET: AN/VDR-13	1	1	1	1				GAM021	
120	R44999	A	RADIO SET: AN/VRC-89F(C)	2	2	2	2				CAM006	
120	S60288	A	SIGHT: REFLEX COLLIMATOR	6	6	6	6				IAM064	
120	T56383	A	TRUCK UTILITY EXPANDED CAPACITY ENHANCED 4X4: M1165A1	1	1	1	1				TEH299	
120	T95992	A	LIGHT TACTICAL TRAILER: 3/4 TON	1	1	1	1				TAM056	
120	W69528	A	TOWBAR MOTOR VEHICLE: WHEELED VEHICLE	1	1	1	1				OAM461	

Here is the FMSWeb-generated Modified Table of Organization and Equipment (MTOE) as an example of identifying the Medical Equipment Set Tactical Combat Medical Care (MES TCMC) line item number (LIN) M30499 in the red box. The medical platoon sergeant, company supply sergeant, and battalion S-4 (logistician) are the subject matter experts on property, equipment, and sub-hand receipts and can assist in navigating FMSWeb to find the specific equipment authorized and issued to the medical section. Non-medical supply specialists may not be aware of US Army Medical Materiel Agency (USAMMA) unit assemblage codes (UACs) for the medical equipment sets (MESs).



LIN Characteristics

Equipment Characteristics

LIN	Desc	Cargo Cat	Pieces	Length	Width	Height	Weight	Sq Feet	Cube
M30499		22B	8	30 in	18 in	6 in	134	4	2

LIN Properties

Documentable on MTOE	YES
Documentable on TDA	YES
4610R Current Requests	2
AMC Life Cycle Mgmt. Command (LCMC)	Not Applicable, Supply Class not BCE MAPP
TMV Tactical Wheeled Vehicle	Not Applicable
NTV Non Tactical Vehicle	Not Applicable
CSLA Comm. Sec. Logistics Activity	Not Controlled
TAT (To Accompany Troops)	Not Qualified
BOIP	SA8080
SB 700-20 Sub LINs	No Substitutes Found
SB 700-20 Convert/TCO	No Conversions or TCO Found

HQDA Managed LIN Information

Agency (HQDA Record)	GB
HQDA Cost (as reported by cQuiP/SLAMIS)	$78,645.00
Synchronization Staff Officer (SSO) Name	Christian Dubock

Current ModPrh Information

Mod Path	ModPath Title	BOIP	LIN	Term FY
SAM080	MES TACTICAL COMBAT MEDICAL CARE (TOMC)	SA8080	M30499	50

National Stock Number (NSN) Information

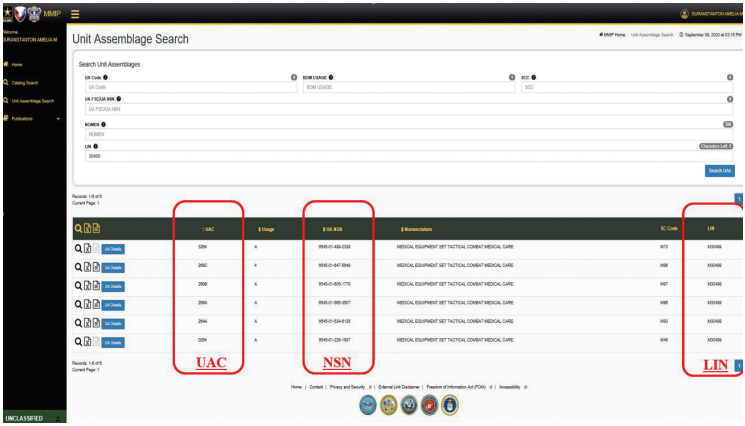
NSN	LCC	CHAP	Supply Class	ARA	Cost Noman
6545-01-228-1807	B	2	84	2	$10,395 MES TRAUMA FIELD (2)
6545-01-499-2238	B	2	84	2	$35,017 MES TRAUMA FLI210003 B69-2
6545-01-534-6135	S	2	84	2	$101,448 MES TRAUMA FIELD-2006869-2
6545-01-565-3507	B	2	84	2	$145,278 MES TACT CBT MED CARE
6545-01-605-1778	B	2	84	2	$117,925 MES TACTICAL COMBATME
6545-01-647-5640	A	2	84	2	$169,884 MEDICAL EQUIPMENT SET

In Latest SB-700-20 (Chap. 2/4/6)	Yes

LIN Family

Portfolio	Combat Service Support Sustainment

On this MTOE, there are different national stock numbers (NSNs) issued to meet line item number (LIN) authorizations. In this example, six different NSNs are issued for the LIN M30499. The MESs have NSNs that correlate to a specific UAC, which can be located on the USAMMA website via the MMIP, as identified in the previous example.



In this example of a USAMMA MMIP search for LIN 30499 (MES Tactical Combat Medical Care [TCMC]), six UACs and the associated NSNs are shown, each representing a different version of the list of equipment contained within the TCMC MES. Additionally, the hyperlinked UAC will provide the assemblage list, and each item on the list is hyperlinked to additional information including the subcomponents of each item on the list, both durable and expendable.

ATTACHMENT 2: EXAMPLE OF BATTALION AID STATION LOAD PLANS

VEHICLE LOAD CARD

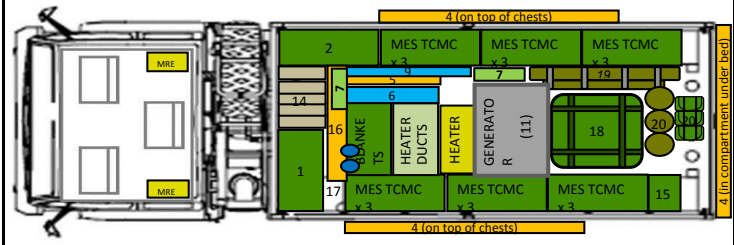
(TB 55-46- 1 & 2) and (FORSCOM Reg 55-1)

UNIT UIC	VEH LIN NO	NOMEN / MODEL NO	SEC / PLT	SHIPMENT UNIT NO	DATE COMPILED
WAJRT0	HQ-10	M1078	MED/TMT		21-May-10

LENGTH OF VEH		WIDTH OF VEH		HEIGHT OF VEH		VEH EMPTY WT
OPERATIONAL	REDUCED	OPERATIONAL	REDUCED	OPERATIONAL	REDUCED	

CARGO AREA			CARGO AREA CUBIC FEET	
LENGTH	WIDTH	HEIGHT	OPERATIONAL	REDUCED

NOT COMPUTED FOR HS TO MS		TEST LOAD VERIFIED BY	DATE
CB/CG IS	INCHED FROM		



CARGO LOC NO	CARGO DESCRIPTION & TYPE PACK	NO OF ITEMS	PC CUBIC FEET	TOTAL CUBIC FEET	TOTAL WT
1	*MES CHEM PATIENT DECONTAMINATION	4.5			
2	*MES CHEM PATIENT TREATMENT	3			
3	*MES TACTICAL COMBAT CASUALTY CARE	25			
4 / 5 / 6	LITTERS REG / RAVEN LITTERS / LITTER STANDS	10 / 2 / 4			
7	SUCTION APPARATUS	1			
8	OXYGEN TANKS	2			
9	SPINE BOARDS	2			
10	HEATER	13			
11	GENERATOR - HQ10G	1			
12	OLD MC4 COMPUTERS (GREEN CASE)	3			
13	NEW MC4 PRINTER (BLACK CASE)	1			
14	HYPOTHERMIA MANAGEMENT KITS (HPMK)				
15	MED DRAWER CHEST	1			
16 / 17	PLASTIC ROLLS (CHEM DECON) / DECON BUCKETS	1			
18 / 19	CAMO NET / POLES	1 / 1 SET			
20	PERSONAL BAGS (1 RUCK / 1 DUFFEL EA)	6			

FORSCOM Form 285-R 1 Mar 93 **EDITION OF 1AUG80 MAY BE USED**

VEHICLE LOAD CARD

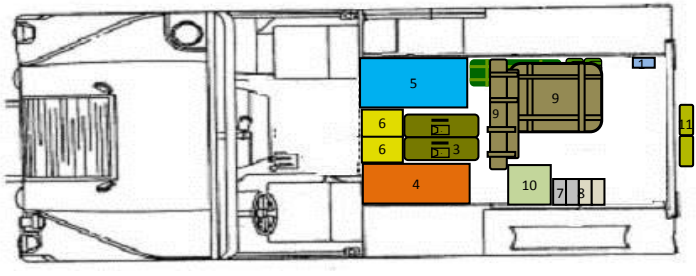
(TB 55-46- 1 & 2) and (FORSCOM Reg 55-1)

UNIT UIC	VEH LIN NO	NOMEN / MODEL NO	SEC / PLT	SHIPMENT UNIT NO	DATE COMPILED
WAJRT0	HQ-85	M998	MED/TMT		20-May-10

LENGTH OF VEH		WIDTH OF VEH		HEIGHT OF VEH		VEH EMPTY WT
OPERATIONAL	REDUCED	OPERATIONAL	REDUCED	OPERATIONAL	REDUCED	

CARGO AREA			CARGO AREA CUBIC FEET	
LENGTH	WIDTH	HEIGHT	OPERATIONAL	REDUCED

NOT COMPUTED FOR HS TO MS			TEST LOAD VERIFIED BY	DATE
CB/CG IS		INCHED FROM		



CARGO LOC NO	CARGO DESCRIPTION & TYPE PACK	NO OF ITEMS	PC CUBIC FEET	TOTAL CUBIC FEET	TOTAL WT
1	LZ MARKING KIT	1			
2	OE-254	1			
3	PERSONAL BAGS (1 RUCK / 1 DUFFEL EA)	4			
4	TRAINING FILES/SOPs/FMs	1			
5	CLASS II SUPPLIES	1			
6	MREs	2			
7	MC4 LAPTOP	2			
8	NIPR LAPTOP	2			
9	CAMO NET W/ POLES	1 EA			
10	MC4 PRINTER	1			
11	FUEL CAN	2			

FORSCOM Form 285-R 1 Mar 93 **EDITION OF 1AUG80 MAY BE USED**

VEHICLE LOAD CARD

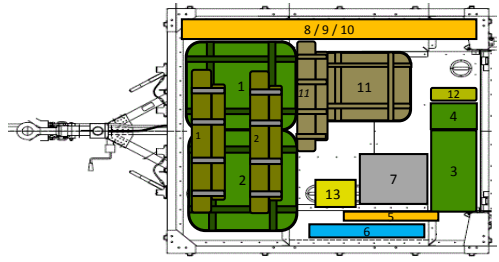
(TB 55-46- 1 & 2) and (FORSCOM Reg 55-1)

UNIT UIC	VEH LIN NO	NOMEN / MODEL NO	SEC / PLT	SHIPMENT UNIT NO	DATE COMPILED
WAJRT0	HQ-11T	M1101	MED / TMT		

LENGTH OF VEH		WIDTH OF VEH		HEIGHT OF VEH		VEH EMPTY WT
OPERATIONAL	REDUCED	OPERATIONAL	REDUCED	OPERATIONAL	REDUCED	

CARGO AREA			CARGO AREA CUBIC FEET	
LENGTH	WIDTH	HEIGHT	OPERATIONAL	REDUCED

NOT COMPUTED FOR HS TO MS			TEST LOAD VERIFIED BY	DATE
CB/CG IS	INCHED FROM			



CARGO LOC NO	CARGO DESCRIPTION & TYPE PACK	NO OF ITEMS	PC CUBIC FEET	TOTAL CUBIC FEET	TOTAL WT
1	TENT, MGPTS, SMALL (BAS) W/ POLES	1 EA			
2	TENT, MGPTS, SMALL (SLEEP/CP) W/ POLES	1 EA			
3	*MES TCMC CHESTS (1A AND 1B)	2			
4	*MED DRAWER CHEST (1D)	1			
5	*RAVEN FOLDING LITTERS	2			
6	*LITTER STANDS	2 PR			
7	PRINTER/COPIER/SCANNER	1			
8	TABLE, FOLDING	2			
9	MAP BOARD	1			
10	DRY ERASE BOARD	1			
11	CAMO NET W/ POLES	1 EA			
12	*OXYGEN TANK	1			
13	CASE OF MRE's	2			
	* Denotes Tailgate Medicine Equipment				

FORSCOM Form 285-R 1 Mar 93 **EDITION OF 1AUG80 MAY BE USED**

ATTACHMENT 3. M9 AID BAG PACKING LIST

OUTSIDE (THREADED THROUGH OR BANDED TO MOLLE WEBBING WITH HEAVY DUTY RUBBER BANDS)

- □ 1PR. - SCISSORS W/ RETRACTABLE LANYARD
- □ 1 EA. - STRAP CUTTER W/ RETRACTABLE LANYARD
- □ 2 EA. - SHARPIE MARKER
- □ 1 EA. - CARABINER
- □ 1 EA.- BACKROLLED GORILLA TAPE ON PVC TUBING

LOWER COMPARTMENT

- □ 1 EA. IV SET CONSISTING OF THE FOLLOWING:
  - □ 1 GALLON ZIP LOCK BAG
  - □ 1 PENROSE DRAIN (WRAPPED AROUND THE ZIP LOCK BAG)
  - □ 1 EA. - 500ML BAG OF HEXTEND
  - □ 3 EA. - 18 GA 1.25″ ANGIOCATHETERS
  - □ 2 EA. - SALINE LOCKS
  - □ 4 EA. - ALCOHOL PREPS
  - □ 2 EA. - TAGEDERM/TRANSPARENT DRESSINGS
  - □ 2 EA. - 18 GA. 1.5″ NEEDLES
  - □ 2 EA. - 10ML PRE-FILLED SYRINGES (NORMAL SALINE FLUSH)
  - □ 4 EA. - 4X4 GAUZE
  - □ 1 PR. - EXAM GLOVES
- □ 1 EA. – FAST IO KIT CONSISTING OF THE FOLLOWING:
  - □ 1 EA. – QUART ZIP LOCK BAG
  - □ 1 EA. - FAST IO DEVICE AND ACCOMPANYING EQUIPMENT
  - □ 1 EA. - SALINE LOCK

- □ 2 EA. - ALCOHOL PREPS
- □ 1 EA. - 10 ML PRE-FILLED SYRINGES (NORMAL SALINE FLUSH)

□ 1 EA. – 500 ML BAG HEXTEND

□ 1 EA. – 100 ML BAG 0.9% NACL (for TXA/ABX)

□ 1 EA. – PRESSURE INFUSER

□ 1 EA. – SHARPS SHUTTLE

MAIN COMPARTMENT

□ 1 EA. - CRIC SET

□ 1 EA. - BVM

□ 1 EA.- NONIN PULSE OXIMETER

□ 1 EA.- BLIZZARD BLANKET

□ 1 EA.- ABDOMINAL DRESSING (W/ SMALL TRASH BAG AND DONUT)

□ 1 EA.- PETZL TIKKA TACTICAL PLUS HEADLAMP

□ 1 EA. - SIGNAL PACK CONSISTING OF THE FOLLOWING:

- □ 1 EA. – SILK SIGNAL PANEL (for example MPIL Mk 1 by BattleSystems,LLC)
- □ 3 EA.- BLUE MINI-CHEMLIGHTS
- □ 1 EA. - SIGNAL MIRROR
- □ 5 EA. - AAA BATTERIES

□ 1-2 EA. - BATTLE PACKS IN 1 GALLON ZIP LOCK BAGS CONSISTING OF THE FOLLOWING:

- □ 1 EA. – TRAUMA DRESSING
- □ 1 EA. – 6″ ACE WRAP
- □ 2 EA. – COMPRESSED GAUZE
- □ 2 EA. – CRAVATS
- □ 2 EA. – - OCCLUSIVE DRESSINGS (at least 1 vented)

- □ 2 EA. – 14 GA. 3.25″ ANGIOCATHETERS (NCD)
- □ 1 EA. – NASAL TRUMPET (NPA)
- □ 2 EA. – TOURNIQUETS
- □ 1 EA. – 3″ SILK TAPE
- □ 1 EA. – SHARPIE MARKER
- □ 1 PR. – EXAM GLOVES
- □ 1 EA. – RED MINI-CHEMLIGHT
- □ 1 EA. – GREEN MINI-CHEMLIGHT
- □ 1 EA. – TCCC CARD (DD FORM 1380)

BOTTOM OF BAG (BENEATH NETTING)

- □ 1 EA. – READY-HEAT BLANKET
- □ 1 EA. – SAM SPLINT
- □ 1 EA. – PRESSURE BOARD
- □ 1 EA. – POLELESS LITTER

Reproduced from: Compton S. Tiered Class VIII course handout, Tactical Combat Casualty Course, Army Medical Department Center and School Health Readiness Center of Excellence, Joint Base San Antonio–Fort Sam Houston, Texas; 2011: 153–162.

Chapter 13

ROLE OF THE SECURITY FORCE ASSISTANCE BRIGADE PHYSICIAN ASSISTANT

Christopher L. Torres, PA-C, MPAS; Stephen A. Karagosian, PA-C, MPAS; and Jacob W. Rouse, PA-C, MPAS

Introduction

The US Army Security Force Assistance Brigades (SFABs) are the US Army's dedicated conventional organizations for conducting security force assistance (SFA) around the world. The SFABs support US security objectives and warfighting combatant commanders, while strengthening US ally security capacity and proficiency.[1]

Security Force Assistance

SFA has played an essential role in US history since revolutionary times. One of the notable examples of SFA occurred in the early 1960s, when the US Army sent approximately 11,000 advisors to assist the pro-western government of Vietnam. More recently, the US Army has been engaged alongside foreign security forces in south central and southwest Asia for the greater part of two decades.

Due to an evolving worldwide threat, the need for a supporting, professionalized advisor force became necessary. The National Security Strategy redirected the brigade combat teams (BCTs) to prepare for conflict in multi-domain operations. SFABs enable the US Army to bolster the lethality of a foreign security force while freeing up BCTs.

Security Force Assistance Brigade

There are currently five active duty SFABs and one National Guard SFAB (Figure 13-1). Each SFAB has six battalions. Four PAs are

assigned to each SFAB, with one allocated to each of the two maneuver battalions, one to the cavalry squadron, and one to the brigade support battalion as the brigade senior PA. Each SFAB is filled to a slightly higher capacity than in a maneuver battalion in a conventional BCT.

Employment

SFABs are employed in teams of 12 soldiers. The brigade headquarters exercises mission command from the home station, with larger echelons deploying and controlling operations in-country, unless the entire brigade deploys into a theater.[2]

The 12-soldier SFAB advisor team is modeled with small team functionality in mind. The SFABs work with conventional partner security forces to improve their capabilities and capacity to provide security.

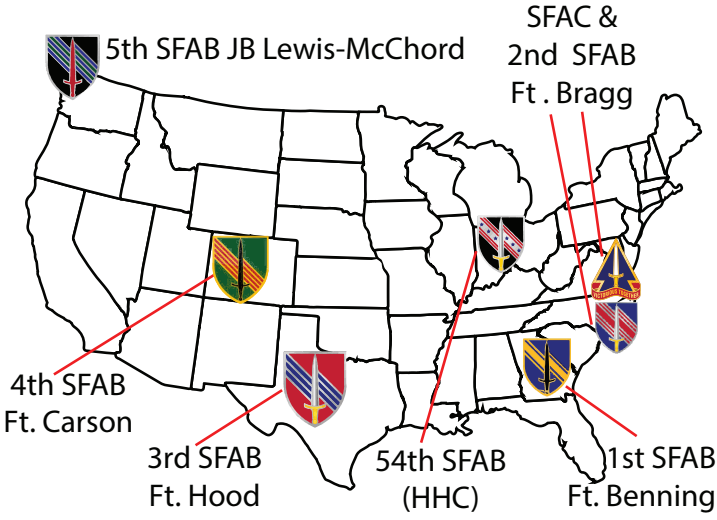


Figure 13-1. The security force assistance brigades are based in several locations around the United States, as depicted by their distinctive unit crests. The Army National Guard's 54th SFAB has battalions in Illinois, Indiana, Ohio, Georgia, and Texas. The Security Force Assistance Command is based at Fort Bragg, North Carolina.

The first SFAB deployed in 2018. It supported Operation Resolute Support in Afghanistan. In early 2019, the second SFAB deployed to continue the "train, advise, and assist" mission in Afghanistan and Iraq. The second SFAB was replaced by the third SFAB in late 2019.

Command and Control

Each SFAB has a command group structure similar to that of a traditional BCT headquarters, with the addition of a deputy commander. Contrary to most conventional BCTs, soldiers within an SFAB are already sergeants (E-5/SGT) or above, giving the ability to advise partner forces two echelons higher.

In addition to SFAB command and control, there is a Security Force Assistance Command (SFAC) at Fort Bragg, North Carolina. This one-star command maintains training and resourcing authority and functionally coordinates the employment of the SFABs (see Figure 13-1).

Duties and Responsibilities

SFAB PAs are unlike most conventional BCT PAs and are expected to conduct numerous duties, some exceeding the traditional PA responsibilities. SFAB PAs must be versatile in a dynamic environment. In a garrison setting, maneuver PAs spend approximately 1 to 2 days in clinic when the brigade is fully staffed with providers. These relatively small clinical requirements are due in part to the roughly 0.25 full-time equivalent requirement, based on patient population size and increased health and physical standards of the SFAB.

While unit readiness is still a top priority, SFAB PAs spend a great deal of time training advisor medics. This training includes refining their basic medical skills, while also focusing on more advanced medical skill sets such as prolonged field care and whole blood transfusion.[3,4] In addition to clinic responsibilities and medical training, the PAs also have a primary staff function as the senior medical advisor to the commander. SFAB PAs will work alongside the rest of the staff sections, attend meetings, and collaborate on product and plan development as prescribed by the battalion commander.

Skills and Attributes

Historically, SFAB PAs attended courses such as Tactical Combat Casualty Care, Prolonged Field Care, Mountain Medicine, Army Trauma Training, 70H (health services plans, operations, intelligence security and training), and numerous others that were applicable to their known deployment areas of operation. While there are no pipeline courses immediately required for SFAB PAs outside of Combat Advisor Training Course (CATC) and Tactical Combat Medical Care (TCMC), battalion PAs should communicate with their commander and brigade surgeon to ensure appropriate training is afforded when feasible.

PAs must also be comfortable supporting partner nation and subordinate medics through face-to-face and telemedicine encounters. While SFAB PAs have relatively little clinical time, they should expect significantly increased staff work. Unlike medical platoons in a BCT, SFAB battalions are not assigned an organic medical operations officer (MEDO) and the PA will fulfill these responsibilities.



Figure 13-2. Captain Christopher Torres (right) and Major Russ Burnham (left) discussing medical evacuation during combat operations in the multinational Train Advise Assist Command-East with an Afghan Army corps surgeon. Meetings like this would occur twice weekly at a minimum, based on current operations within the region.
Photograph courtesy of Captain Christopher Torres.

During deployments, field training, and live-fire exercises, SFAB PAs must maintain the medical integrity of their formation and also support foreign security force medical counterparts on all things medical. This means PAs need to be subject matter experts in medical logistics, operations, patient evacuation, preventive medicine, and field sanitation. All of these can be leveraged to enhance the medical readiness of the foreign security force. SFAB PAs must thoroughly comprehend the military decision-making process (MDMP). They are expected to create and review medical concepts of operation, medical common



Figure 13-3. Captain Christopher Torres (center) being back briefed by an Afghan Army medic (left) following an intravenous infusion train-the-trainer class. The Afghan senior medic will take the skills learned and train fellow medics within his battalion. Instead of teaching medics the basic skills of combat medicine, advisors now focus on enabling and empowering this current generation of Afghan medics to become more self-reliant and independent. Photograph courtesy of Captain Christopher Torres.

operation pictures, and estimates. They must effectively integrate medical intelligence to enable operations. Being able to develop and implement medical support that ties into operations is key to being a successful SFAB PA (Figures 13-2 to 13-4).

Training and Requirements

Requirements for SFAB battalion PAs include mandatory attendance of the Combat Advisor Training Course (CAT-C) and the ability to maintain a security clearance. SFAB PAs must be free of duty-limiting physical



Figure 13-4. Captain Christopher Torres (center) on site at a culminating training event held by a corps-level Afghan Army combat medic program. This training event is held three times per year, ultimately leading to the graduation of the participating Afghan combat medics. Captain Torres and his team worked to align the Afghan tactics, techniques, and procedures with tactical combat casualty care standards.
Photograph courtesy of Captain Christopher Torres.

profiles and able to score a minimum of 240 on the APFT, with at least 70 points in each event, and have a PULHES of at least 111221.[1] There is currently no requirement for the Army Combat Fitness Test.

The SFAB PA is a job for those with experience as a battalion PA who also have a comprehensive understanding of a battalion medical officer. The SFAB PA is one who has mastered the basics and can apply their knowledge and experience to ambiguous and complex problem sets.

SFAB PA candidates must complete a DA 4187, Personnel Action form, and volunteer via the Assignment Interactive Module 2.0 portal. It is best if PAs attended the Captains Career Course prior to selection to an SFAB to facilitate a shared understanding of the MDMP. Additionally, PAs can expect to interview with the SFAB commander and the brigade surgeon or brigade senior PA. The final hiring authority is the SFAB Commander.

Lessons Learned and Tips for Success

The following are lessons learned and tips for success for the SFAB PA:

- The SFAB PA must anticipate training all advisors across their formation in a more deliberate version of the Combat Lifesaver program,[4] and be prepared to create a program if joining one of the newer SFABs.
- The SFAB PA must prioritize battlefield whole blood transfusion certification. They must learn to teach this critical skill. Medics in the first three SFABs are already being certified, and SFAB commanders expect their PAs to have this skill set.
- The SFAB PA must add medical occupational specialty 68W (combat medic) sustainment training to the long-range training calendar. This should be a top priority. Line medics are allocated under their line company, rather than under the headquarters company. This can make sustainment training difficult because the medics are pulled in many directions. If the PA captures this training on the calendar early, it will not be an issue later.
- The SFAB PA must canvass the installation (and other connections) for expired and excess Class VIII medical supplies to support rigorous training in the SFAB. This is especially important if assigned to one of the newer SFABs that have not yet been fitted with their sets, kits, and outfits.

Conclusion

While SFAB utilization is still a very new concept, the deployment of SFAB teams across Afghanistan and Iraq has shown great promise. The NCOs and officers in the SFAB are highly trained, mature self-starters who can operate independently. SFAB PAs work alongside other battalion staff and train medical advisors on the newest combat medical skills. If seeking a new career challenge like this, contact the Human Resources Command through the Assignment Interactive Module 2.0 portal for SFAB consideration.

References

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3. US Department of Defense. *Medical Readiness Training (MRT)*. DOD; 2018. DOD Instruction 1322.24.
4. Deployed Medicine website. Accessed July 2, 2020. https://www.deployedmedicine.com/

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- Remfer K. Army SFAB troops will be dispatched to Colombia next month. *Army Times*. May 28, 2020. Accessed August 8, 2020. https://www.armytimes.com/news/your-army/2020/05/28/army-sfab-troops-will-be-dispatched-to-colombia-next-month/

Chapter 14

ROLE OF THE US SOUTHERN COMMAND AND JOINT INTERAGENCY TASK FORCE–SOUTH PHYSICIAN ASSISTANT

Brian Gomez, APA-C, MPAS

Introduction

The US Southern Command (USSOUTHCOM) is one of six geographic combatant commands (CCMDs). USSOUTHCOM's area of influence includes every nation in the Western Hemisphere south of Mexico, including the Caribbean. South America by landmass constitutes one-sixth of the planet, with over 15.6 million square miles, 31 countries, and 16 dependencies. The region holds more than 45 million indigenous people, over 260 million Spanish speakers, and 200 million Portuguese speakers. While predominantly peaceful, the region faces ongoing sociopolitical and environmental challenges. Because of corruption in many countries, government officials are complicit in illicit activities and public trust in government institutions is eroded. For these reasons, the US government maintains security cooperation activities in the region to promote shared values and prevent instability and foreign adversary influence.

Background

USSOUTHCOM is the nation's military instrument of power in the region and is charged with the mission of countering threat networks and enabling rapid response to natural and manmade disasters common to the region, in order to build and strengthen South American partnerships. Weak governance and corruption are among the most critical challenges that impede strategic objectives. Corruption allows threats to flourish

and provides opportunities for malign regional and external state actors to expand their influence. Corruption also increases vulnerability to environmental shocks, including natural disasters. Transnational criminal organizations and violent extremist organizations threaten citizen safety, regional stability, and the national security of the United States and its allies. The use of bribery, fraud, and violence by illicit networks disrupts legitimate economic opportunity and undermines the rule of law.[1] These illicit networks exploit the interconnected nature of transnational trade and transportation systems to smuggle people, drugs, bulk cash, weapons, and other contraband across borders.

The region is the largest source of illicit drugs and illegal migrants coming into the United States. Many transnational criminal organizations trafficking in drugs are better funded and organized than the security organizations that confront them. Their activities contribute to the challenges of violence, corruption, and poverty, which are also among the primary drivers of illegal migration. In order to curb these negative trends, USSOUTHCOM leverages traditional military capabilities, interagency organizations, and political-military relations in building a framework for success (Figure 14-1).



Figure 14-1. An interceptor team from the USS *Michael Murphy* (DDG 112) provides security from the ship's rigid-hull inflatable boat after a low-profile vessel was sighted by an MH-60R Sea Hawk. US Navy photo by Command Master Chief Jose Ramiro/Released.

Strategy

USSOUTHCOM is responsible for military-to-military relationships and the employment of US forces in its area of responsibility. The strengths and opportunities of the hemisphere are set against a complex array of threats and challenges. Governance and institutional capacity remain uneven across the region. USSOUTHCOM is part of a multinational and whole-of-government team working to advance security, governance, and economic opportunity in the region. While USSOUTHCOM exercises traditional military relationships, the command is intrinsically reliant on the expertise and cooperation from partner institutions to fulfill a whole-of-society approach to security operations.[2] A strong focus is placed on international partnerships, which include foreign partner militaries, academic institutions, and nonfederal entities, with efforts to achieve measurable and sustainable outcomes along three lines of effort: strengthen partnerships, counter threats, and build the team.[1]

Unit Structure

USSOUTHCOM headquarters is located in Doral, Florida. The command has three direct reporting units. The Joint Inter-Agency Task Force–South (JIATF-S), based out of Naval Air Station, Key West, is charged with the interdiction mission of illicit trafficking in the area of operations. Joint Task Force–Guantanamo oversees detainee operations and related intelligence operations at Guantanamo Bay, Cuba. Joint Task Force–Bravo is the forward staged execution arm of USSOUTHCOM. Based in Soto Cano, Honduras, its mission is to organize multilateral exercises, support humanitarian assistance/disaster relief operations in coordination with partner nations, and counter transnational organized crime to promote regional cooperation and security. USSOUTHCOM supports 24 security cooperation offices with 31 country teams out of 24 embassies in the region. Like all CCMDs, the Air Force, Army, Navy, Marines, and Special Operations are represented at USSOUTHCOM and play distinct roles in CCMD operations (Figure 14-2).



Figure 14-2. The hospital ship USNS *Comfort* (T-AH 20) is anchored off the coast of Kingston, Jamaica, as it prepares for a 6-day medical mission. US Navy photo by Mass Communication Specialist 2nd Class Morgan K. Nall/Released.

Roles and Responsibilities

The Army physician assistant (PA) is the chief of clinical operations for USSOUTHCOM, responsible for developing and recommending health care doctrine and policy for the command. In this role, the Army PA also provides clinical quality assurance (QA) and quality management (QM) of all medical operations in the area of responsibility (AOR) on behalf of the USSOUTHCOM command surgeon. QA/QM functions for Department of Defense (DOD) regulatory requirements include AOR medical entry standards, patient movement operations, secretarial designation requests, reciprocal health care agreements, partner nation capacity-building strategies, and clinical input to contingency plans. Additionally, the Army PA at USSOUTHCOM serves as the counter transnational organized crime/counter threat network medical planner and the detainee health care medical policy and compliance officer at Guantanamo.[3] The Army PA also serves as the JIATF-S surgeon, responsible for oversight of the health care of a multinational, multi-service, and multi-agency task force. Lastly,



Figure 14-3. Tactical Combat Casualty Care subject matter expert exchange (training exercise) in Lima, Peru. US Army photo by Specialist Austin Carrillo/ Released.

the Army PA at USSOUTHCOM is expected to serve in an executive medicine function for senior ranking officers, including the four-star combatant commander (Figure 14-3).

Desired Skills and Attributes

Desired skills and attributes of the Army PA at SOUTHCOM include:

- field-grade officer,
- operational experience,
- experience in a senior staff role,
- special operations and interagency experience,
- outstanding written and oral communication skills,
- high-level executive and critical thinking skills,
- top secret clearance,
- fluency in Spanish and Portuguese, and
- familiarity with DOD Instruction 1322.24, *Medical Readiness Training,*[4] and DOD Instruction 6490.03, *Deployment Health*.[2]

Training

Desired training requirements of the Army PA at USSOUTHCOM include:

- Command and General Staff College graduate,
- dive medical officer qualified,
- flight surgeon qualified, and
- Joint Medical Operations Course graduate.

Other training courses available to the Army PA include several resident planning courses, crisis action training, media engagement training, and continuing medical education opportunities. One unique experience available to the PA is a trauma rotation at the Army Ryder Trauma Training Detachment at Jackson Memorial Hospital in downtown Miami.

Lessons Learned

A major lesson learned for the USSOUTHCOM and JIATF-S PA is to create systems. The volume of action items that will cross the PA's desk is not manageable otherwise. Creating products such as operating mail boxes, SharePoint sites, and procedural regulations will make or break the PA. Furthermore, not everything that is requested of the surgeon's cell is necessarily for the surgeon's action. Often, lines of responsibility are grey. Finding the "who" of the problem set is half of the recipe for success. Finally, the PA must not be afraid to have dissenting opinions. At the four-star level it is expected. That said, the PA must always have their facts in order and always have talking points prepared to brief at a moment's notice.

Tips for Success

In addition to lessons learned, here are tips for success in excelling as the USSOUTHCOM and JIATF-S PA:

- The PA must learn joint doctrine, beginning with reading Joint Publications 5-0, *Joint Planning*[5] and 4-02, *Joint Health Services*.[6]

- The interagency and civil affairs staff have a synergistic relationship with the surgeon's office, so the PA should get to know these personnel well.
- The PA has medical expertise that is often sought by high-ranking leaders. The PA must use these opportunities to get face time with their leaders, which builds trust and pays dividends when the PA is seeking support for a project.
- The PA should learn to communicate effectively; public speaking, official correspondence, and policy writing will be an enormous part of the PA's success.

Conclusion

The USSOUTHCOM PA position is an extremely rewarding job. The complexity of the mission and level of responsibility assumed makes this a unique position for Army PAs. It requires inherent maturity, initiative, and an understanding of operational art to develop approaches to complex military problems in sometimes unorthodox ways.

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Chapter 15

ROLE AS A COMMANDER

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Introduction

The diverse operational, clinical, and administrative backgrounds of Army physician assistants (PAs) give them a competitive edge for command. Command opportunities for PAs exist at all levels in nearly every type of medical unit. However, not every PA or officer is well suited for command. Neither is command an automatic path to promotion, although command will distinguish a PA from their peers. PAs must seriously consider the choice of taking command. The hours are long, the decisions are tough, and the risks may be high, but the personal and professional gratification is immeasurable. Army medicine needs great leaders, and PAs who are ready and willing should answer the call.

Why Command?

> *Serving as a commander has been the highlight of my military career. When you become a commander, you are given a great deal of authority and responsibility. You are charged with taking care of America's sons and daughters. Every decision you make or fail to make has an impact.*
>
> —Colonel John F. Detro
> 240th Forward Surgical Team, 2010–2012
> 187th Medical Battalion, 2016–2018

Command is about solving problems every day. No single person has a greater influence or effect on a soldier's life than the commander. Every decision the commander makes can result in great soldiers that will become future leaders. That is a legacy which will span years and generations. PAs have the experience and skills both medically and operationally to make a real difference for Army Medicine as commanders.

—Colonel James G. Pairmore (Figure 15-1)
Public Health Activity Hawaii, 2017–2019
14th Combat Support Hospital and Task Force Medical-Iraq, 2019–2021



Figure 15-1. Colonel James Pairmore, Commander of the 14th Combat Support Hospital, Fort Benning, GA, 2019–2021.

As a medic charged with helping teammates navigate through a convoluted military health care system, I became a PA to have more autonomy in helping soldiers with their care. However, as a 2LT PA, I found that others in health care leadership positions could propagate obstacles to access to care. Despite the bureaucracy, I was able to set up systems to improve soldier care. As a Major, I accepted the opportunity to be a "Charlie MED" commander in an Airborne Brigade Combat Team – only because I was at the right time and right place – no recruiting, just showing value as a PA and potential as a commander. The April Fool's Day change of command was simple, and then I had a seat in the tactical operation center (TOC). PA commanders can improve soldier care, evacuation, and return to duty. They do this by applying resources to streamline the systems and processes of pre- and post-deployment health processing, en route care, primary care, and readiness care from the perspective of a provider and line medic. In those 30 months of command, I experienced some of the most rewarding times of my Army career – developing and mentoring medics, NCOs, and officers to do better every day. Many of a commander's successes come from setting conditions to let others excel – usually by getting out of their way and allowing teammates to innovate and collaborate!

—Colonel David Hamilton (Figure 15-2)
Company C, 173rd Brigade Support Battalion,
Afghanistan, 2008–2010
Public Health Command District Fort Bragg, 2013–2016
9th Hospital Center, 2019–2021

All Army PAs possess the essential tools necessary to command successfully. Many of us were leaders, NCOs and officers alike, before becoming health care providers and leaders in medicine. The IPAP curriculum not only hones our medical knowledge, but that is just the start. Through invaluable operational experience, we refine the soft skills and personal attributes necessary to best care for the sick, ill, or wounded, and while serving on many staffs. The very basis of our profession as Army PAs requires mastery of three necessary clinical core qualities: genuineness, respect, and empathy, the same crucial building blocks for any commander, at any level.



Figure 15-2. Colonel David Hamilton receives the 9th Hospital Center colors from Colonel Robert Howe II, Commander, 1st Medical Brigade, during the change of command of the 9th Hospital Center (formerly the 21st Combat Support Hospital), 1st Medical Brigade, Fort Hood, TX, from Colonel Jeffrey Yarvis, December 12, 2019.
Photograph courtesy of Corporal Yanira Green.

Long ago, in what seems like almost a different lifetime, my battalion commander, LTC Joe Martin (now, VSCA GEN Martin), planted the seed of command. In one of our mentorship sessions, as we decided on my next three broadening assignments, he told me something that I found profoundly inspiring. He said, "Doc, the essence of the Army and our profession is command." He went on to say that it was an absolute must that I pursue and seize any/all opportunities to command soldiers. Fast-forward to today, nearly 9 months into Battalion Command, and I know precisely what LTC Martin was telling me 16 years ago.

It is an awesomely powerful and deeply rewarding experience to command. To recognize and demonstrate to soldiers that they are our most precious commodity. To push and inspire soldiers to be the very best version of themselves. Likewise, I endeavor at all times to give soldiers in my command the very

best of myself. My leadership philosophy is simple: to lead, you must first serve. This is how I view servant leadership – serving among those you lead. My company commanders understand this and that I expect them to do the same, because the best organization is only as good as its leader(s). Commanding is so much more about selflessness than I ever imagined, and it reinforces my belief that as Army PAs, we understand that more than anybody in the AMEDD. We need more PAs to understand this and trust in the robust, diverse, and rare amalgam of skills that they bring to the table. We need more Army PAs to seize the guidon and just lead!

—Lieutenant Colonel Christopher C. Pase
Troop Command, Martin Army Community Hospital, 2019–2021

Commanding soldiers is the very pinnacle of Army leadership and culture. After creating a vision and communicating a vivid picture of the desired end state, you have the privilege of serving, shaping, and mentoring them in the execution of your intent. Done correctly, the commander sets the organization's climate and cultivates the formation's talents towards mission accomplishment and success. Command and leadership precepts transcend either operational (TO&E) or fixed facility (TDA) domains.

Army PAs are well suited to command at all levels because we have medical knowledge and operational experience coupled with an innate perspective and understanding of Army medicine from its most pure and fundamental tactical origins. The tenants of leading, rallying, and developing young soldier medics in the field or around the Battalion Aid Station hold true at all levels and variants of command.

Command is not for the faint of heart nor those unwilling or unable to devote themselves to their teams. You will be expected to lead in and through times of both trial and triumph. In my experience, the greatest reward is to be empowered and purposed to create a space and format to facilitate the patriotic service of our nation's sons and daughters and having the honor to watch each of them grow, mature, and achieve in the process. For me it's the epitome of absolute purpose and fulfillment! It doesn't

come easy, but what truly worthy in life does? As an Army PA if you are up to the task and provided the opportunity – don't hesitate! FROM THE LINE, FOR THE LINE!

—Lieutenant Colonel Avery Carney
601st Medical Company (Area Support), Iraq, 2007–2009
98th Medical Detachment (Combat Operation Stress Control), 2014–2016
US Army Health Clinic Grafenwoehr, 2019–2021



Figure 15-3. On June 13, 2019, Colonel Bill A. Soliz assumed command of the Joint Special Operation Center (JSOC) Joint Medical Augmentation Unit (Special Mission Unit Command Select List) at the JSOC Compound, Fort Bragg, NC.
Photograph courtesy of Joe Belcher, JSOC command photographer.

I thought I had the best job in the Army being a leader of soldiers and a PA as I was able to take care of people and lead change for the better. That was until I became a commander. Commanders are responsible for everything that happens and does not happen within your formation. You have the authority to set policy, the presence to inspire and instill a positive influence, and the ability to change people's lives for the better. All while accomplishing the mission of your command, which for most of us is saving lives in time of war. There is no better reward and self-gratification than to help others become better and save lives. People are your priority and relationships are everything.

—Colonel Bill A. Soliz (Figure 15-3)
California Medical Detachment and Presidio of Monterey
Army Health Clinic, 2015–2017
Joint Medical Augmentation Unit,
Joint Special Operations Command, 2019–2021

Requirements to Compete for Command

PAs may compete for command at any level; however, company and detachment command depends on being at the right place at the right time, and competing when opportunities arise locally or through the Assignment Interactive Module (AIM.2) for O5A Army Medical Department (AMEDD) immaterial positions. These O5A opportunities may include brigade support battalion medical companies and forward surgical teams or medical center and community hospital companies. Command candidates attend and graduate from the appropriate professional military education, such as Captains Career Course, Command and General Staff College, Intermediate Level Education, and Senior Service College, in addition to appropriate pre-command courses (local and major command-driven).

Competition for command is stiff. It takes incredible professional stamina to remain on active duty after 20 years of active federal service, which includes maintaining deployability, health, and fitness. Recent Army chief of staff guidance, reflected in military personnel (MILPER) messages,[1] requires commanders at the battalion, brigade, and above to be fully medically ready and able to participate in and lead unit physical training.[1] Candidates competing for command must attest to the ability

to pass an Army Combat Fitness Test (ACFT) without an alternative event. Commanders must also be deployable worldwide without a waiver (medically and administratively).

Command Selection List Board Process

PAs most frequently enter the command path through competing within the command selection list (CSL) O-5 (lieutenant colonel) and O-6 (colonel) boards for battalion- and brigade-level commands (Table 15-1). CSL command is a formal Army selection process in which eligible personnel must request consideration (opt-in) and prepare their board file (similar to the process for a promotion board).[1] It is important to note that officers can only compete at the O-5 level during the first 3 years of eligibility. Commanders who have completed an O-5 level command are the most competitive for O-6 level commands. The types of CSL command fall into three subcategories: operations (eg, field hospital, multifunctional medical battalion, hospital center); strategic support (community hospitals, clinics, troop commands, public health activities, research facilities); and training and recruiting.

CSL boards are conducted 2 fiscal years before the command positions open. The command selection board opening is announced through a MILPER message and posted on the HRC website, alerting all officers in the zone of consideration (ie, those eligible to compete for the specific board). Within AIM.2, officers opt-in and indicate preference for commands. It is highly encouraged for those not interested to opt-out. Data collected from officers who opt-out informs Army senior

Table 15-1. Command selection list categories.

Code	Subcategories	Competitive grouping
M6AP	AMEDD operations	AN, MC, MS, SP, VC
M6AR	AMEDD strategic support	AN, MC, MS, SP, VC
M6AT	AMEDD recruiting/training	AN, MC, MS, SP, VC

AMEDD: Army Medical Department; AN: Nurse Corps; MC: Medical Corps; MS: Medical Service Corps; SP: Medical Specialist Corps; VC: Veterinary Corps

leaders about the reasons for not competing and informs future boards. Candidates who opt-in should give preference to commands where they feel they will thrive and succeed. An officer does not need to command the most complicated organization to be successful and potentially obtain a next higher level of command, but they must be successful, and it should be enjoyable.

Candidates must attest in writing that they will take the command offered and that they are physically and mentally fit for command. Declining the slated command, once offered, is generally with prejudice (ie, preventing the officer from competing for future commands). When opting in for CSL, officers should be ready to move based on the needs of the Army, in the time frame defined by the MILPER CSL announcement.[1] It is vital to remember that if a PA does not get slated in the command of preference, success depends on pursuing excellence and doing one's best, no matter the circumstance.

To prepare for CSL consideration, officers should review their officer records brief (ORB) for correctness and currency. All pending officer evaluation reports (OERs) should be completed and submitted to HRC by the OER cutoff date in the MILPER message announcing eligibility for the CSL. Officers should obtain a current ACFT and be prepared to report the score and date in the fitness attestation. A current periodic health assessment is also recommended. In short, a competitive board file is current and validated, including an updated ORB, supporting documents from the interactive Personnel Electronic Records Management System (iPERMS), and slate of recent OERs that paint a picture of a motivated, well-balanced leader with the professional stamina to endure the demands of command.

HRC holds the CSL boards at the Department of the Army (DA) secretariat (a panel that puts together all DA boards). Board members vote to develop an order of merit list (OML), with both principal and alternate selections. There are twice the number of alternates as principals. The DA secretariat uses the preferences and OML to place officers within respective subcategories; for example, an officer who is first on the OML will get their subcategory of choice. The results are released in two stages, referred to as a split release. The names are released after being approved by the chief of staff of the Army (CSA), and several months later the slate of specific commands is released, as follows:

1. **By-Name Release**. Following the board and review by HRC's Leader Development Branch (LDB), Health Services Division (HSD), the list is forwarded to the CSA for approval. This approval allows for the release of the principal and alternate list. This early release provides some predictability to officers, who now know they will be taking command in 2 years. If activated, those positioned high on the alternate list of the OML could potentially take command up to 2 years before the principals.
2. **Slate Release.** Following CSA approval of the by-name release, the LDB assembles the AMEDD's six HRC branch chiefs to slate officers within their selected subcategories to specific commands, with guidance from the CSA and the surgeon general (TSG). The team begins with the first officer on the OML and works down the list until the last officer is slated. In addition to the OML, considerations include candidate preferences; the Exceptional Family Member Program and Married Army Couples Program; candidates' knowledge, skills, and attributes; and other factors. Following this process, the slate is briefed at multiple levels before being released. The LDB chief briefs, in the following order: the HSD chief, the director of the Officer Personnel Management Directorate, the HRC commander, Army G1/4/6 staff, TSG, the vice-CSA, and finally the CSA. Once the CSA approves the slate, it becomes official and is released through the HRC webpage. This year's colonel (O-6) CSL board met in August, and the slate will be release around March or April 2021.

Non-CSL Commands

PAs may choose to compete for non-CSL commands or commands not selected by a centralized process. In the past, the majority of these commands were filled locally. However, with the development of the AIM.2 marketplace, all officers who are eligible can compete. These opportunities include company commands (for captains [O-3]), forward surgical teams (majors [O-4]), and combat and operational stress control teams (majors [O-4]). PAs considering competing for command at the company level should first discuss this opportunity with their HRC assignment officer.

Additionally, TSG requested that the most complex commands be removed from the CSL process to allow senior AMEDD officers to

better align talent for these organizations. These senior nominative commands (SNCs) include medical centers, medical brigades, and the largest research facilities. These commands were previously referred to as CSL Level II, requiring an officer to have commanded once at the colonel level to be eligible, but were removed from CSL in 2016. Today, a board composed of AMEDD general officers and one Army competitive category general officer choose these commanders in a single day. Board members establish the OML and then immediately discuss the principals and slate them using the same criteria as with the CSL. The slate is established and a General Officer Steering Committee (GOSC) meeting is established to brief TSG and gain their approval. Once the slate is approved, it is released by HRC. Currently, several Army PAs are completing CSL colonel-level



Figure 15-4. Colonel Robert Heath provides remarks upon receiving the colors as the Fort Drum Medical Activity commander from Brigadier General Michael Place (commanding general, Regional Health Command–Atlantic) during the change of command ceremony on August 9th, 2019, at Fort Drum, NY. Photograph courtesy of Colonel Robert Heath.

commands, making them eligible to compete for SNCs in fiscal year 2022 (Figure 15-4).

Ready for Command

PAs are not typically groomed to serve in command, so preparation can be a challenge. However, PAs possess a wealth of knowledge and experience that makes them ideal candidates for command. These experiences vary, but time as a primary and special staff officer, noncommissioned officer (NCO), and perhaps even first sergeant provides PAs with a sound foundation. Embracing the idea of commanding is a psychological process in which one crosses from a comfortable role (seeing patients every day, serving as a medical advisor, teaching) to a new, unfamiliar situation. To prepare for command, a PA must establish the mindset for command and stop thinking like a staff officer. It will also help for the PA to complete any unfinished personal and professional business, close out administrative issues from their last position, and get their family settled in the new environment.[2]

Command Preparation Assessment and Training

Recent changes in Army chief of staff policy require battalion and brigade commanders to attend the Pre-Command Course (PCC) through the School for Command Preparation at Fort Leavenworth, Kansas, before taking command, or shortly after, in cases of late notification or activation from an alternate list.[1] The following represents the phased approach to completing pre-command requirements: Phase I, Army Branch Immaterial; Phase II, Specific Command Training (recruiting, modified table of organization and equipment [MTOE] operational, initial military training, garrison); Phase III, Branch/Functional (AMEDD PCC); Phase IV, Senior Officers Legal Orientation course (for those eligible).[3]

Seasoned, recently retired brigade commanders are the small group leaders at PCC who provide and lead valuable presentations and discussions. Rare opportunities exist to meet and hear from principal Army senior leaders and the Army staff. Small group work allows commanders to share experiences and develop command products such as introductions, philosophy, training guidance, and terms of reference.

Advice from Brigadier General (Retired) Halstead

This section is adapted (with additions) from a typewritten document labeled "To: Future Commander, From: COL Becky Halstead, as of 04/19/01" (typed communication provided to then-MAJ Amy Jackson from COL Kirk Whitson, July 2014). The document describes command duties and includes useful advice.

Before Arrival

1. Make contact with your new unit and rater. To get acquainted with current issues and become familiar with key personnel prior to arrival, ask to be included in the distribution of pertinent email traffic.
2. Review biographies of key leaders; know who they are.
3. Review key briefs, including the last quarterly training brief, annual training guidance, current quarter training guidance, current review and analysis briefings, and command and staff briefings.
4. Prepare a change of command speech (incoming commanders should be very brief).
5. Draft a leadership philosophy, considering what matters to you and identifying expectations.[4] Consider having a shared command philosophy with your NCO counterpart (both may sign the document). This demonstrates that the command team of commander and senior NCO are in agreement. A commander should have a vision that identifies the organization's culture and provides a picture of its desired end state.[5]
6. Prepare an introductory brief, something that tells people who you are and where you come from. This can often result in finding common ground with people.

Duties: First 30 Days

1. Review and publish appropriate policy letters. Make command policies concise and direct. Research the various regulations that govern each policy subject and ensure that referenced regulations are current. It is also appropriate to look into higher headquarters' policies to ensure that your policies align with unit policy.
2. Request and review higher headquarters' CCIRs (commander's critical information requirements). Events such as death, injury, accident, incapacitation, or misconduct of key leaders; loss of

sensitive items; classified information breaches; sexual assault or harassment; or driving under the influence, arrests, and incidents with military police involvement often demand timely notification and reporting to various levels.

3. Commanders must understand public affairs and media relations. They need to tell the Army story in a timely and truthful manner while observing operational security measures. Public affairs officers can provide additional guidance to ensure appropriate and successful media relations.
4. Establish a "battle rhythm" that applies up and down in the organization. Be conscious that changes you make in the first 30 days may have second- and third-order effects. A battle rhythm will help organize the daily meetings, giving structure to the work week while also identifying "white space" (time that is available). It is critical to establish and stick to a predictable rhythm of meetings and times to manage specific recurring tasks. Incorporate battle rhythm events into your calendar and, if desired, allow your executive officer (XO), command sergeant major (CSM) or first sergeant, and personnel officer (S1) to manage access to your calendar. Having your staff and subordinates adhere to a routine schedule whenever possible will preserve your much-needed time to do things commanders must do: decide, proactively plan, guide, mentor, counsel, set policy, contemplate, write, predict, discipline, enforce, and communicate. Many other, routine tasks may be performed by the staff or XO.
5. A rating scheme is a published document that identifies the rater and senior rater for all officers, as well as the rater, senior rater, and reviewer of all NCOs. Civilians also have rating schemes. Have your administrative assistant establish the rating scheme for all, publish it for visibility, and review it regularly with your key staff to ensure it is accurate and appropriate.
6. Meet with the CSM (or first sergeant depending on type of command), the commander's "right hand," and the subordinate leaders (eg, company commanders and first sergeants in a battalion command, or platoon leaders and platoon sergeants in a company command). Provide them the command philosophy and discuss priorities. Remember to provide officer evaluation report support forms (DA Form 67-10-1A[6]), which define the officer's goals and objectives for the rating period and are later used to validate

contributions. Rated service members should receive the support forms from the two supervisors over them (rater and senior rater).

7. Ensure that all leaders in the organization conduct initial counseling of their subordinates on expectations and standards,[4] and discuss how each leader will support their subordinates in achieving their goals. Counseling, which may also be event-oriented, provides feedback for performance. Spot-check leaders to ensure they are completing all counseling.
8. Conduct both required command climate[7,8] and safety surveys[9] (your equal opportunity representative and safety officer, respectively, will assist you with this), followed by additional surveys in 12 months. Army command policy[7] states that a company-level unit will have a command climate survey conducted within 30 days of a new officer assuming command, followed by another 6 months after that and a third 12 months later. Above the company level, initial command climate surveys will be completed within 60 days. Command climate assessments assist commanders in establishing an effective organization and maintaining a positive, harassment-free environment. In conjunction, equal opportunity officers can conduct sensing sessions at various personnel levels: E-4 (specialist) and below; E-5 (sergeant) to E-6 (staff sergeant); E-7 (sergeant first class) and above; company-grade (second lieutenant, first lieutenant, captain, and warrant officers); and field-grade officers (majors). Sensing sessions can be conducted by the inspector general or equal opportunity officer. If the inspector general conducts a sensing session, any issue or allegation that arises during the meeting must be addressed by the inspector general.[10]
9. For key additional duties, put key individuals on written appointment orders and establish programs (see below).
10. Initiate and conduct key meetings (incorporating them into the battle rhythm) such as a training meeting, command and staff meetings, and legal briefs (in which the organization's legal advisor briefs all current and ongoing non-judicial and judicial punishment actions).

Advice: First 30 Days

1. Request and review all officer record briefs (a one-page summary of the career, assignments, overseas tours, demographics, etc, of an officer). This is a way of getting to know the officers under your

charge and also helps you assign the right officer to the right position, based on their experiences and expertise.
2. Develop and foster relationships. Key people to engage with are one level up and lateral XOs and staff officers, support personnel and support agencies such as the judge advocate general, medical providers and leaders, the chaplain, installation support leaders, Office of the Inspector General staff, and Criminal Investigations Division staff. Ensure you receive the blotter (a report of all crimes, property damage, and other incidents) from the provost marshal's office.
3. Make a point to visit subordinate units, going to their location, and allowing them to set the agenda.
4. Assess the environment and avoid major changes. Look for quick wins. Be open and flexible. Be positive and avoid overreacting when negative things happen. Discover the resources that are available. Use post agencies to assist soldiers.

Duration of Command

1. Always consult the legal advisor in matters involving money, financial liability, investigations of property loss, and Uniform Code of Military Justice (UCMJ) actions. When in doubt, CYA (contact your attorney).
2. Remember the roles of your leadership. The XO or deputy commander runs the staff. The CSM oversees the first sergeants. Good commanders support their staff and empower them to do their jobs, hence affording the commander the time to command. Delegation is a tool that commanders use to empower individuals. A clear and concise intent with left and right parameters (proper resourcing) can be enough for a good staff officer or subordinate commander to develop a concept and execution plan. For more information about mission command, refer to Army Doctrine Publication 6-0, *Mission Command*.[5]
3. People are watching to see how the new commander handles things. It is easy to command when no problems occur, but your subordinates will pay attention to what you do and say when things are difficult or stressful. Their acceptance and trust must be earned.
4. You should personally meet as many people as possible in your command and tell them they are trusted to do what they need to do on a daily basis. Attending training and observing your subordinates

performing their daily duties can give you an appreciation for what the soldiers and civilians are experiencing. A good leader will go to see soldiers where they live and work, which they will appreciate.

5. How one commands is an art; not everyone will do it the same way. The commander must, however, ensure that everyone in the command adheres to the organization's values and principles of legality, morality, and integrity. The intent is to build depth in the organization and develop leaders to make good decisions.
6. Be present and approachable. Have an open-door policy.
7. A good technique for ensuring good order and discipline is to establish policies that incentivize and reward good behavior.
8. Command team relationships are paramount. Nothing should be allowed to drive a wedge between the commander and their senior enlisted advisor; they should disagree behind closed doors and always be in agreement in public. Building a solid relationship with the first sergeant or CSM is essential.
9. Leadership is a privilege. Enjoy every day that this opportunity brings.

Thoughts Shared from Previous Battalion Commanders

What to expect for a new commander can be summed up in seven words: "you don't know what you don't know." How-to books and regulations are out there but until you go through it yourself as a commander, you do not know. In the first 90 days of being a commander, I had a suicide and a sexual assault in my command. Fellow commanders helped me realize what I didn't know and got me through those difficult times. So I recommend:

- *Make friends with fellow Commanders/Senior Enlisted Advisors (SEAs) of the same and higher levels; more than likely whatever you are going through at least one of them has been through and can offer advice.*
- *Make yourself available to your subordinate and peer Commanders/SEAs; the bonds that you form will help you out of tough situations.*
- *Remember when giving an order to a junior Soldier how you*

felt when an order was given to you at that rank; it will give you a perspective on commanding like nothing else.
- *Treat the E-1 and the O-6 the same, if all are treated the same (eg, awards, investigations, UCMJ), then there will never be a reason for your integrity to be called into question.*
- *Lastly, providing they are legal, ethical, and moral, carry YOUR superior commander's orders out to the best of your ability; this will create an environment for a successful command.*

—Colonel Richard A. Villarreal
Troop Command North,
Walter Reed National Military Medical Center, June 2013–July 2015

As a previous company and battalion commander, I want to pass along several thoughts about my experience, things to do and things to avoid. I hope that my notes may impart some concepts to hold to and ideas to consider that will help PAs be successful.

Do:

- *Start by communicating your vision and who you are, and keep delivering your message!*
- *Set goals early, know what you want to accomplish, and purposefully plan.*
- *Create your battle rhythm, guard time for administration, PT, and lunch!*
- *Be authentic. Be "all in" for your organization.*
- *Build trust in your organization through teambuilding and put it on the calendar.*
- *Be mindful of other people's time; keep meetings to an hour if possible for expectation management.*
- *Recognize NCOs as the backbone of the Army and allow them to do what they do best.*
- *Enable others to act through empowerment.*
- *Create space for the organization to create value for their organization and community.*
- *Go to the fringe of your unit footprint and see what life is like out there! Then look back and gain perspective on how things*

appear from that vantage point.
- *Gather with your people! Know your "squad," their passions, their talents, their personal and professional pursuits.*
- *Legal and Inspector General (IG) folks are inner circle-type, bring them into the fold.*
- *As a commander, your higher command wants your input on the packets (awards, legal, actions) that come from your desk. Give your recommendation, don't just pass it along.*

Do not:

- *Allow separation between you and your senior enlisted advisor. Be present together, and agree in the open, disagree behind closed doors.*
- *Command in fear of taking a risk; have courage, this is what you signed up for, lead.*
- *Spend most of your time in your office; get out and see the organization and the people. Take the opportunity for unscheduled one-on-one time as it presents itself.*
- *Delay legal packet processing. You should meet with the lawyer once a week if there are active legal cases and know the status of every one.*

Other thoughts:

- *If you are seeking to make a culture change in your organization, look to those doing positive things and doing it right. Recognize a squad or platoon that all passed their APFT. Recognize the unit for hitting a goal of days without driving under the influence (DUI). (One of my posts used to have the day counter for how many days the division had survived without a DUI . . . and we all knew that when we reached a certain point, it meant we would get a pass!)*
- *If you hear people say, "my commander" versus "the commander," you're doing something right.*
- *If you have young soldiers or trainees, you must have a presence in the barracks: leadership presence. Soldiers need to know that you are going to visit. The adage of "soldiers do what the commander checks" is a real thing. Monitor maintenance in the barracks and workplaces and engage when there*

is a critical need (electricity, water, heat, air conditioning) or when things are taking a tad too long.

These are not the "end all, be all" to a successful command; however, they will surely help you get started, along with all the other guidance from successful commanders in this chapter. Lead well!

—Colonel Amy L. Jackson
Echo Company, 704th Division Support Battalion, 2001–2002
Academy Battalion (Provisional), later designated as
188th Medical Battalion, 2015–2017
Keller Army Community Hospital, 2020–2022

These are the seven principles I apply when in command.

1. *Trust is the bedrock of any successful organization. The commander must allow for individual development by providing clear guidance while allowing subordinates to employ disciplined initiative within the commander's intent. As a commander, you must be willing to write off and taking responsibility for these mistakes. Only by allowing subordinates to make mistakes in training will they be ready for war.*
2. *Mission Command: Your subordinates must understand what is important to you for it to become important to them. Effective leadership requires that you establish a clear command philosophy while providing subordinates with an achievable vision and mission statement. Every member of the team must understand both and must be able to execute in your absence. Your vision and mission must be nested with your higher headquarters.*
3. *Balance: It is your calling to inspire the team to accomplish any mission while also balancing the individual and family needs of your Soldiers and Civilians. The mission must be accomplished, but as a leader you must balance completion of the mission with care of your team.*
4. *Command Climate: You will know when your unit has the right command climate when personnel are fighting to stay within it. The commander must set the right example for oth-*

ers to follow. Sergeant Major of the Army Richard Kidd once stated, "Soldiers learn to be good leaders, from good leaders." Timely recognition and discipline are important. When a Soldier/Civilian makes a mistake requiring discipline, my direction to subordinate commanders is to remain impartial and unemotional. Deal with the situation in a professional manner regardless of the eventual outcome. Even good Soldiers make mistakes.

5. *Key Enablers: It is important to quickly establish a positive repertoire with key enablers to include your legal team, Equal Opportunity Advisor, SHARP Advisor, and the Inspector General to name a few. If your organization includes GS or Contract employees then you should establish an early working relationship with the union representative and contract Contracting Officer's Representative. Your first engagement should not be during a crisis.*
6. *Support Your Boss: As a leader, it is important to be frank and honest with your Commander, but once the discussion is over, it is important to own the decision whether or not it aligns with your recommendations. Never disagree with your boss in front of your subordinates and never tell the team "we are doing this because the boss said so." Once the decision is made you own it.*
7. *Leader Development: The commander is responsible for ensuring the unit has both a formalized and informal leader development program. In many cases, informal mentorship will have the biggest impact. Leader development is an investment in the future of your organization and the Army.*

—Colonel John F. Detro
240th Forward Surgical Team, 2010–2012
187th Medical Battalion, 2016–2018

As a Commander, everyone will look to you for how you will set the tone. Everything you say and do will influence that tone. If you are positive, they will be positive. The command will get their energy from you. How you respond to bad news and crisis will have tremendous impact on the command and the people

you lead. Trust is the foundation of relationships; you cannot lead effectively without it. Your people really just want to know the answer to three things about you: Are you competent, do you care, and can I trust you? Lead Well!

—Colonel Bill A. Soliz
California Medical Detachment and
Presidio of Monterey Army Health Clinic, 2015–2017
Joint Medical Augmentation Unit,
Joint Special Operations Command, 2019–2021

Conclusion

In closing, command is both a great opportunity and a privilege. It is key to remember that a command is a marathon, not a sprint. PAs bring a wealth of knowledge and experience that makes them ideal for command. Commanders should go into command prepared. They should let soldiers know what is important to them and what they expect. A commander's most important responsibility is to take care of their soldiers and their families. No one can command from behind a desk. Commanders should watch their soldiers train and work; they should delegate and empower subordinates to do their jobs; and they should ensure that their soldiers have everything they need to succeed and complete the unit's mission. Command is a vitally important position, both challenging and fulfilling, in which PAs can excel.

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Chapter 16

ROLE OF THE AEROMEDICAL PHYSICIAN ASSISTANT

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"There is a very interesting togetherness between medicine and aviation with which I have been fascinated over the years."

—Major General (Retired) Spurgeon Neel[1]

Introduction

The aeromedical physician assistant (APA) is an essential member of the aviation medicine health care team. While an APA performs their duties under the guidance and supervision of the unit's flight surgeon (FS), together they jointly manage the unit's aviation medicine program (AMP). The AMP is supported by a multispecialty and multidisciplinary team to provide the highest quality of medical support to Army aviation operations. The APA is considered a subject matter expert with an intimate knowledge and understanding of aviation medicine. APAs are relied on by the command and the FS to assist with managing the AMP. They ensure compliance with aeromedical requirements and the various Army regulations (ARs) governing aviators and aircrew members. By doing so, APAs ensure the medical readiness of aircrew members, help prevent aviation accidents, and safeguard the execution of aviation operations.[2,3]

Aviation Medicine Team Structure

The aviation medicine team (AMT) differs in the number of providers and medical specialties according to structure. A combat aviation

brigade will typically contain eight medical personnel in the AMT, whereas general support aviation battalions and other aviation battalions will have five medical personnel in the AMT (Tables 16-1 and 16-2).[4] Providers in each medical discipline (except the combat medic sergeant and specialist) must complete aeromedical specialty training specific to their medical field before providing health care to assigned aircrew members. Aeromedical specialty training can only be completed at the School of Army Aviation Medicine (SAAM) at Fort Rucker, Alabama.[3,5]

Requirements

To serve in this position, a PA must:

- pass the Army Class 2 Flying Duty Medical Exam, with a "Qualified" or "Waiver granted" stamp by the US Army Aeromedical Activity, indicating they are fully qualified;
- be in the grade of captain (O-3) through colonel (O-6);
- be assigned or on orders to a modified table of organization and equipment or table of distribution and allowances as an APA; and
- complete the required utilization tour of at least 18 months following completion of the Army Flight Surgeon Course–Primary (AFSCP) training at the SAAM.

Table 16-1. Aviation medicine team in the combat aviation brigade structure.

AOC/MOS	Grade	Title	Branch	Quantity
61N	O-4	FS	MC	1
65DM3	O-3	APA	SP	1
73BN7	O-3	Aeromedical Psychologist	MS	2
68W30	E-6	Combat Medic Sergeant	NC	1
68X20	E-5	Behavioral Health NCO	NC	1
68W10	E-4	Combat Medic Specialist	EN	1
68W10	E-3	Combat Medic Specialist	EN	1

AOC: area of concentration; APA: aeromedical physician assistant; EN: enlisted; FS: flight surgeon; MC: Medical Corps; MOS: military occupational specialty; NC: noncommissioned; NCO: noncommissioned officer; SP: Army Medical Specialist Corps

Training

At the SAAM, APAs attend the 6-week AFSCP (Figures 16-1 and 16-2) and are awarded the M3 (aviation medicine PA) skill identifier upon graduation from the course. Completion of the AFSCP is required for the APA to be credentialed and privileged by the local military medical treatment facility to provide aviation-related medical services.[6] APAs who have not actively practiced or participated in an AMP for 3 years or more may attend the Operational Aeromedical Problems Course,[6-8] conducted annually at SAAM. Students can register for attendance by contacting the SAAM Operations Division.[7]

The APA's understanding and ability to teach and train medical tasks and skills to unit personnel is key to maintaining operational readiness. The APA must be intimately knowledgeable about the US Army Medical Evacuation (MEDEVAC) Standard Medical Operating Guidelines (SMOG) protocols and other standing orders used by critical care flight paramedics (CCFPs) holding the military occupational specialty and additional skill identifier 68WF2.[9,10] The AFSCP includes content on the SMOG but does not cover its administrative aspects in depth. It is important for APAs to understand that the SMOG protocols and other standing orders must be signed by the unit FS and commander. If a battalion or brigade FS is not available, the medical treatment facility commander assumes the responsibility for the SMOG protocols and other standing orders. APAs must also be skilled and proficient in the

Table 16-2. Aviation medicine team in the general support aviation battalion structure.

AOC/MOS	Grade	Title	Branch	Quantity
61N	O3	FS	MC	1
65DM3	O3	APA	SP	1
68W30	E6	Combat Medic Sergeant	NC	1
68W10	E4	Combat Medic Specialist	EN	1
68W10	E3	Combat Medic Specialist	EN	1

AOC: area of concentration; APA: aeromedical physician assistant; EN: enlisted; FS: flight surgeon; MC: Medical Corps; MOS: military occupational specialty; NC: noncommissioned; SP: Army Medical Specialist Corps



Figure 16-1. First Lieutenant John D. Howell practices hoist operations for an ambulatory patient at the Dust Off Training Complex at the School of Army Aviation Medicine, Fort Rucker, Alabama; January 14, 2020.
Photo courtesy of Major Timothy B. Pekari.



Figure 16-2. Captain Samuel Cheek sits inside a helicopter spatial disorientation simulator, preparing to experience the Coriolis effect, at the School of Aviation Medicine, Fort Rucker, Alabama; January 14, 2020.
Photo courtesy of Major Timothy B. Pekari.

required sustainment and deployment training as directed in Department of Defense Instruction (DODI) 1322.24, *Medical Readiness Training*,[11] and DODI 6040.47, *Joint Trauma System*.[12]

Aviation Medicine Program

Aviation commanders are ultimately responsible for establishing an AMP.[13] However, the FS is the medical director and medical authority

responsible for the AMP's execution. The APA is considered a medical technical advisor to the commander and assists the FS in developing the commander's aeromedical training program, the commander's approved air ambulance clinical operations standing orders, and treatment guidelines based on the CCFP SMOG.[9,14]

The APA routinely assists the FS in completion of both clinical and nonclinical duties. Aviation medicine duties include all functions of health service support and force health protection. The APA should participate in all aspects of the Aviation Safety Program and assist the FS in developing and updating medical tasks and requirements of the pre-accident plan. Absent an FS, potentially due to operational requirements (aviation units split between rear and forward operations), the commander may require the APA to assume primary responsibility for all aviation medicine duties. However, the APA will need to coordinate for a supervisory FS at the next higher echelon or from an adjacent unit.[6]

Additional Duties

Although they may be authorized to conduct flight duties at command discretion, APAs have no regulatory obligation to do so. At this time, there is no established guidance for APAs to earn senior or master flight surgeon wings. This issue is known, and updating the current regulations will require concurrence from the aerospace medicine consultant. Otherwise, if an FS is operationally absent or not assigned, the APA is expected to participate in the commander's Aircrew Training Program (ATP). Therefore, the APA should meet all ATP requirements, successfully complete the annual proficiency and readiness testing, and attain the minimum flight hours to maintain currency for hazardous duty incentive pay for flying.[15,16] Completion of ATP requirements are documented on DA Form 7120, Commander's Task List, and DA Form 7122, Crew Member Training Record, for each aircraft the APA is considered qualified for and will fly regularly.[17] The APA may also assist with monitoring the aviation life support equipment (ALSE) program, including supervising the fitting and use of ALSE and crewmember personal safety equipment. However, it is important to note that the APA is not a substitute for an FS in these activities, per AR 40-68, *Clinical Quality Management.*[6]

Nor can the APA substitute for the FS in aircraft mishap investigations or flight evaluation boards (FEBs), or sign reports

for these investigations or FEBs.[6] An FS must be on the accident investigation board if the accident involves injuries or problems with personal protective equipment, egress from the aircraft, MEDEVAC, or rescue or survival, per AR 385-10, *The Army Safety Program*, and AR 40-21, *The Medical Aspects of Army Aircraft Accident Investigation*.[18,19] The APA may assist in these investigations, but the FS must manage casualties, assist at the mishap site, and obtain any necessary lab specimens for biochemical testing.

Although stated otherwise in AR 40-68, there can be extenuating circumstances when an APA performs an aviation accident investigation[6]: in remote locations where an FS is physically unavailable and contingent on the aviation accident class (Table 16-3).[20] In these cases, the supervising FS must remotely guide the APA through conducting the initial mishap site assessment, evaluation, treatment, and specimen or data collection from crewmembers in the mishap.[18,19,21]

Aviation Medicine Team Timeline

As a crucial member of the AMT, the APA should coordinate with the FS to establish goals during the first 30, 60, and 90 days after arriving at a unit. AMT goals should be easily actionable and focused so they can be accomplished within the defined timeframe. Achieving the established goals ensures the success of the AMT's mission of supporting the aviation community. Several resources are available to assist APAs in accomplishing these goals, including the Joint Technical Data Integration (JTDI) website,[22] for viewing the US Army Forces Command commander's aeromedical-specific Aviation Resource Management Survey (ARMS) guide; the US Army Operational Aviation Medicine group in MilSuite, for examples of aviation medicine and other administrative standard operating procedures[7]; and the US Army Combat Readiness Center for additional specific guidance on safety regulations, procedures, and readiness information.[23,24] Table 16-4 lists suggested 30-, 60-, and 90-day AMT goals.

Lessons Learned and Tips for Success

APAs are key to ensuring the medical readiness of aviation units. With the inception of newly codified medical readiness guidance, it is important that aviators are not just fit for flight duties, but fully medically

Table 16-3. Army aviation accident classifications.

Class	Property damage and/or injury/occupational illness
A	$2M or more and/or Army aircraft, missile, or spacecraft missing, destroyed, or abandoned. Fatality or permanent total disability. NOTE: a destroyed, missing, or abandoned UAS will not constitute a Class A accident unless repair or replacement is >/= $2M.
B	>/= $500K, but < $2M. Permanent partial disability and/or three personnel are hospitalized as inpatients.
C	> $50K but < $500K. Nonfatal injury or occupational illness resulting in days away from work beyond the day/shift when the injury occurred.
D	> $2K but < $50K. Nonfatal injury or illness resulting in restricted work, transferal to another job, medical treatment more than first aid, needle stick injuries and cuts from sharps that are contaminated with another person's blood or other potentially infectious material, medical removal under medical surveillance requirements of an OSHA standard, occupational hearing loss, or a work-related tuberculosis case.
E	< $2K and/or an operational or maintenance mission is interrupted or not completed (intent for flight may or may not exist) due to fair wear and tear or malfunction of a component or part.
F	Unavoidable aircraft turbine engine damage as a result of internal/external FOD.

Data source: Headquarters, Department of the Army. *Army Accident Investigations and Reporting.* HQDA; March 18, 2015. DA Pamphlet 385-40 Accessed July 8, 2020. https://armypubs.army.mil/epubs/DR_pubs/DR_a/pdf/web/p385_40.pdf
FOD: foreign object damage
OSHA: Occupational Safety and Health Administration
UAS: unmanned aircraft system

ready to deploy, fight, and win in the multi-domain operational environment and large-scale operations. Conserving the flying force should not be a distraction from obtaining and sustaining the aviation unit's medical readiness standard.

The APA is not only a practitioner of aviation medicine for their unit, but is also considered a special staff officer. The APA assists with forming a bridge between the AMP and unit commanders. To optimize success, the APA should thoroughly understand the relationships and responsibilities of the FS, the AMT, and unit leadership, as well as the applicable regulations governing the AMP in order to successfully execute full-spectrum aviation operations.

Table 16-4. Aviation medicine team goals timeline.

Time period	Goals
Complete within 30 days	• Complete unit in-processing; become integrated into the unit headquarters, especially the operations (S3) staff, other unit leaders, and medical section personnel. Reinforce AR 40-8, *Temporary Flying Restrictions Due to Exogenous Factors Affecting Aircrew Efficiency*, requirements and understanding of individual responsibilities of all unit assigned aircrew members.[1] • Ensure physical and electronic system access training requirements are current and completed for medical personnel assigned.[2–4] • Gain and maintain access to electronic systems used for monitoring and documenting the medical care of aircrew members.[5,6] • Review medical supply and equipment inventory. Begin requisition process for replacing medical supplies.[7] • Update or establish an automated or manual tracking system for the medical equipment maintenance program; ensure all biomedical equipment is functional and calibrated in accordance with federal regulations, Army directives, manufacturer literature, or other applicable standards.[8,9] • Review previous aeromedical-specific FORSCOM ARMS results; maintain and reinforce best practices or develop and implement a plan to correct deficiencies over the next 60 to 90 days.[10]
Complete within 60 days	• Review, update, and correct deficiencies of the unit's individual flight records folders for applicable medical waivers and approval letters; electronic health records; medical readiness; and DD Form 2992s, Medical Recommendation for Flying or Special Operational Duty.[5,6,11,12] • Update or generate unit administrative, aviation medicine, and personnel recovery standard operating procedures.[10,13–15] • Participate in the unit's Pre-accident Plan Safety Council; schedule AAP surveys; record identified and corrected deficiencies in the unit hazard log.[16] • Continue to correct deficiencies of the aeromedical portion of the FORSCOM commander's ARMS guide. • Obtain a copy of flight duty appointment orders; participate in the commander's ATP.[17–20] • Begin making regular visits to aviation hangars, airfields, and other spaces to assess unit esprit de corps and safety consciousness of aircrew.

AAP: aviation accident prevention
ALSE: aviation life support equipment
ARMS: Aviation Resource Management Survey
ATP: Aircrew Training Program
FORSCOM: Forces Command
ICTL: individual critical task list

Table 16-4 ***continued.***

Complete within 90 days	• Complete correction of deficiencies of the aeromedical portion of the FORSCOM commander's ARMS guide; review the entire ARMS checklist and ensure all additional requirements are accounted for and completed. • Maintain proficiency and currency with the deployment readiness training and the current 60 readiness requirements listed in the ICTL approved on July 19, 2019.[21–23] • Review and schedule, through the unit S3, medical-specific training requirements for assigned medical personnel.[22–23] • Collaborate and coordinate with the FS, the unit's aviation safety and standards officer, and the S3 to schedule quarterly safety stand-down lectures and briefs on potential in-flight stressors for aircrews to promote aviation safety and decrease potential for aircraft mishaps.[16,24] • Conduct frequent and regular aerial flights in all types of aircraft supported units as required.[17,19] • Assist the unit aircrew ALSE shop with Class VIII support and survival education.[25]

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Table 16-4 *continued.*

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Conclusion

The duties of the APA are vital to the operational aspects of their assigned unit's AMP. An APA has a unique role in which clinical and nonclinical duties are interwoven. The main mission of the APA is to support the AMP in order to achieve mission success. This is accomplished by ensuring medical readiness and emphasizing the importance of aviation safety to prevent personnel injuries and fatalities.

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Chapter 17

THE ARMY NATIONAL GUARD PHYSICIAN ASSISTANT

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Introduction

The Army National Guard (ARNG) is one component of the total Army, which consists of the active Army, the ARNG, and the Army Reserve. The ARNG is composed primarily of civilians serving their country, state, and community on a part-time basis. The ARNG is responsible for Role 1 and Role 2 care at the battalion level. The physician assistant (PA) is a critical member of the ARNG medical team, accountable for a multitude of missions. This tactical role represents the cornerstone of the care provided by the PA in the ARNG. As a part-time provider, the ARNG PA aids the local community during times of natural disasters, performs counterdrug and border control missions, participates in overseas state partnerships programs, and deploys to support Department of Defense (DOD) missions.

Unit Structure

The ARNG is an operational force that serves as a primary combat reserve of the Army and provides ready units that support global and domestic requirements. Because of this, the ARNG will replace an active Army unit structure in combat, necessitating a unit structure that mirrors the Army. When an ARNG unit deploys, it must be able to operate in the same capacity as its active duty counterparts.

Basic Duty Types

Traditional Guard

The vast majority of ARNG PAs are part-time members who serve one weekend each month and an additional 2 weeks per year (usually during the summer). These traditional ARNG members may also mobilize to support state or federal missions.

Active Guard Reserve

Although ARNG PAs usually support Army health services on a part-time basis, the Active Guard Reserve (AGR) program provides some full-time opportunities as well. The AGR program increases overall readiness in a National Guard force that primarily trains and operates part time. AGR PAs who serve full time enjoy the same benefits and entitlements as active component PAs. This includes an active duty retirement after 20 years of active federal service.

US Code identifies two categories of AGR positions available for ARNG PAs, Title 10 and Title 32.[1,2] Title 10 AGR PAs work at the federal level in support of the DOD, Department of the Army, National Guard Bureau, and the 54 states, territories, and federal district. Title 10 positions typically necessitate permanent change of station moves to assignment locations within or outside the continental United States (CONUS or OCONUS). The Title 32 AGR PA's duty assignment is linked to a specific state. It is usually a fixed position, but permanent change of station moves within the confines of the state border might be required.[2]

Career Opportunities

ARNG assignments vary from state to state due to differences in force structure and individual state operating requirements. There are multiple posts and opportunities for the PA (area of concentration 65D) serving in the ARNG. Generally, part-time PAs are assigned to ARNG TOE (table of organization and equipment) units that mirror the TOE structure of the active Army (eg, the composition of a brigade combat team). The following PA positions are examples of the assortment of opportunities that are available to both traditional and AGR PAs.

Brigade or Battalion Physician Assistant

There are numerous ARNG 65D TDA (table of distribution and allowances) positions at joint force headquarters in each state and territory. PAs are responsible for overall medical readiness. The PA participates in all soldier readiness processing and performs statewide periodic health assessments as part of the medical readiness mission. A thorough understanding of DOD health care policy and relevant Army regulations is crucial for the joint force headquarters PA because these positions are primarily engaged in administrative medical duties.

Civil Support Team Physician Assistant

Civil support teams (CSTs) are unique to the ARNG. These rapidly deployable teams support civil authorities in response to chemical, biological, radiological, or nuclear threats or hazards. There are 57 operational National Guard teams spread across the states and territories.

The role of the CST PA extends beyond the clinic to subject matter expertise on biological and chemical weapon exposure treatment. The CST PA provides technical and clinical expertise as the principal medical advisor to the CST commander. The CST PA's primary mission is to respond to and assess suspected chemical, biological, radiological, or nuclear events. The CST PA also advises civilian responders regarding appropriate actions and facilitates requests to expedite the arrival of additional state and federal assets to help save lives, prevent human suffering, and mitigate property damage. Additionally, the CST PA manages the occupational health program for the 22 assigned HAZMAT (hazardous materials) technicians and is responsible for providing emergency medical treatment for CST members during incident responses. CST PAs often speak and instruct at disaster management and preparedness conferences statewide.

Aeromedical Physician Assistant

The ARNG is home to 21 air ambulance companies and 27 Charlie medical companies (housed in a general support aviation battalion), and is responsible for approximately 60% of the Army medevac capability, providing numerous part-time APA opportunities. There are multiple ARNG AGR Aeromedical PA positions across the National

Guard. These positions include Title 32 assignments at the following locations:

- 49th Missile Defense Battalion, at Fort Greely, Alaska;
- Eastern ARNG Aviation Training Site (EAATS) at Fort Indiantown Gap, Pennsylvania;
- High-Altitude ARNG Aviation Training Site (HAATS) at Gypsum, Colorado; and
- Western ARNG Aviation Training Site (WAATS) at Marana, Arizona.

An aeromedical physician assistant (APA) works along with the supervising unit flight surgeon to function as an aviation medicine team. They jointly manage their assigned unit's aviation medicine program to help prevent aviation accidents and ensure that all aircrew members are trained and fit for flying duty.

Deputy State Surgeon

Deputy state surgeons (DSSs) plan, coordinate, direct, and implement the medical readiness programs of the state. They serve as the state surgeon's full time representative to the adjutant general, the chief of staff, and other directorate-level staff elements. They function as a liaison between the state, the National Guard Bureau, and federal organizations concerning matters relevant to medical readiness and medical support missions. Direct responsibilities include command health programs, and medical and dental readiness requirements for mobilization and deployment. Additional DSS duties include operations, medical education, sustainment, clinical proficiency training, credentialing of state health care providers, and the fiscal management of the state's medical readiness funding.

Army Medical Department (AMEDD) branch qualification is required for this position. Medical Service Corps (MS), Medical Specialist Corps (SP), and Nurse Corps (NC) officers frequently compete for the DSS position.

Special Operations Physician Assistant

The ARNG special forces (SF) PA has additional training requirements due to the nature of the mission. They typically go through an extensive, demanding training cycle that meets active duty standards. They train

with their units 3 or 4 days per month, plus an additional 2 to 4 weeks per year. The ARNG special forces group (SFG) headquarters are in Alabama (19th SFG) and Utah (20th SFG). However, company elements are located in Texas, California, Washington, Colorado, Florida, South Carolina, Indiana, Ohio, West Virginia, Maryland, Rhode Island, Mississippi, and Massachusetts.

The missions undertaken by National Guard SF encompass a broad spectrum of capabilities, including unconventional warfare, counter-terrorism, foreign internal defense, and special reconnaissance. The Florida element developed a Rapid Impact Assessment Team (RIAT). Their mission is to rapidly mobilize and deploy to a disaster area and, in coordination with local officials, determine and report immediate victim needs (food, water, shelter, medical, and security) following a major or catastrophic disaster. SF soldiers from 3rd Battalion, 20th SFG, make up the RIAT and perform the RIAT missions.

Duty Locations

Each state has its own Guard, as required by the Constitution. No other branch of the military exists by constitutional requirement. In addition to a presence in the 50 states, today's ARNG is based in the District of Columbia and the US territories of Guam, Puerto Rico, and the US Virgin Islands, collectively referred to as the "54." Traditional and Title 32 PA assignments are established throughout the 54 states and territories. The Title 10 PA jobs primarily exist in the national capital region; the regional health commands; US Army Forces Command; and the Medical Center of Excellence, Joint Base San Antonio–Fort Sam Houston, Texas. There are multiple positions in the national capital region, at the Pentagon, the Office of the Surgeon General, and the National Guard Bureau.

PAs considering a transition from active duty to the ARNG and civilian PAs interested in serving with the ARNG should contact the state's Army Medical Department recruiter.

Lessons Learned and Tips for Success

Career development for the ARNG PA is crucial. Professional military education is integral to career progression for the ARNG PA, and completing the appropriate military schools is important to progressing

through the ranks on time.[3] Although Intermediate Level Education is not required, it makes officers more competitive for the Department of the Army lieutenant colonel promotion board.[3,4]

The ARNG PA must be proactive as their own career manager. They must work with their unit S1 (personnel staff officer) to maintain and regularly update their officer record brief. They should also seek educational and career broadening opportunities.

Conclusion

The majority of ARNG PA positions at the brigade level and below emphasize the critical function of PAs in Role 1 and Role 2 missions. ARNG battalion PAs should understand their responsibility in mentoring and training unit combat medics, and recognize their duty as advisors to unit commanders in matters of combat health readiness and preventive care.

Regardless of position, the central task of the ARNG PA is primary medical officer of the state medical command, infantry battalion, or one of the many other combat arms or combat support units. Specialty assignments, with different professional requirements, provide additional opportunities for PAs.

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Chapter 18

PHYSICIAN ASSISTANTS IN TACTICAL MEDICINE TRAINING PROGRAMS

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Introduction

To support the US Army warfighter, physician assistants (PAs) provide primary instruction and oversight to tactical medicine training programs in multiple organizations. Medics, nurses, PAs, and physicians receive training on initial entry to the military or as part of deployment or sustainment training. The branch assignments officer selects PAs for the training programs based on their qualifications and combat experience.

Unit Structure

The Department of Operational Medicine (DoOM) of the Medical Center of Excellence (MEDCoE) at Joint Base San Antonio–Fort Sam Houston (JBSA-FSH), Texas, is the parent organization for the tactical medicine training programs PAs serve in. This organization is newly aligned, and currently has a proposed unit structure. The DoOM encompasses the Department of Combat Medic Training (DCMT), the Brigade Combat Casualty Course (BCT3), the Tactical Combat Medicine Training (TCMC) program, the Defense Medical Readiness Training Institute (DMRTI) Combat Casualty Care Course (C4), and the Combat Paramedic Program (CPP). Each of these training programs has one to five PAs assigned in dual instructor and leadership roles.

Department of Combat Medic Training

The DCMT annually trains up to 6,500 soldiers to become combat medic specialists (military occupational specialty [MOS] 68W). This makes DCMT the second largest military occupational specialty training program in the US Army (after infantry), and the largest medical training program in the world. The training curriculum is 16 weeks, divided into 6 weeks of Emergency Medical Technician-Basic (EMT-B) training and 9 weeks of tactical medicine training, followed by a culminating field training exercise (FTX).

The EMT-B training is taught by 80 Defense Health Agency (DHA) civilian EMT-B and paramedic instructors, in conjunction with the Academic Standards Department of DCMT, utilizing the National Registry of Emergency Medicine Technicians (NREMT), the national certifying and accrediting agency for prehospital care providers through the Army Emergency Medical Services program. The didactic and hands-on instruction is tested by the administration of six written tests, two hands-on culminating tests, and the NREMT national examination. All medics must pass the NREMT examination prior to proceeding to the FTX. Soldiers who cannot pass the NREMT exam on the third attempt are reclassified in needs-of-the-Army MOSs (those with personnel shortages). The tactical medicine segment is subdivided into limited primary care training (used during sick call) and tactical combat casualty care (TCCC) training. The culminating FTX is a rigorous, 72-hour event held in an austere field environment at the Soldier Medic Training Site (SMTS) at JBSA-Camp Bullis.[1]

Organization Structure and Role of the Physician Assistant

The 68W program is led by a team of military and civilian PAs. The program is administered under the Medical Education and Training Campus (METC) through the DHA.[2] Under METC, the program's senior leader is the department chair, who is an O-5 (lieutenant colonel) PA. The department chair is responsible for the program's nearly 300 civilian and military instructors, academic administration, and management. The chair is dual-hatted as the Combat Medical Specialist Training Branch chief through MEDCoE, which provides service-specific strategic guidance for the 68W MOS. The program director is a civilian PA who provides the program's day-to-day administration

and acts as the chief of staff. The director also frequently assists with the capabilities assessment of related equipment and practice innovations. He or she works with training team leaders, critical care and emergency room nurses, instructors, noncommissioned officers (NCOs), and paramedic-certified civilians to ensure students receive optimal training experiences.

Duties and Responsibilities of the Field Craft Physician Assistant

The three field craft PA O-3 (captain) positions, also known as the "Whiskey team officer in charge (OIC)," are responsible for the overall instruction and conduct of field craft training during all scheduled training events for their specific team. Team OICs must be credentialed providers to maintain proficiency and support Brook Army Medical Center and satellite clinics. The OIC's duties include, but not exclusively, periodically reviewing and rewriting lesson plans, reviewing training schedules, serving as subject matter expert on all medical matters and training, counseling up to 35 NCOs and Army civilians, reviewing physical profiles of all initial entry training (IET) soldiers to determine their ability to safely conduct training, and teaching classes of up to 420 IET soldiers.

The OIC actively works with the field craft chief to deconflict resource obstacles and support other field craft and EMT training teams for high-demand instructor events. The OIC must stay current on TCCC guidelines and impending changes to best practices in trauma treatment. He or she develops recommended changes to the curriculum and ensures all instructors are aware of TCCC updates and ways to implement them into the field craft curriculum. The Whiskey team OIC must be prepared to support MEDCoE, DHA, and Army deployments to Central Command, Africa Command, or European Command theaters, as well as local Tank-Automotive and Armaments Command tests for feasibility of replacement or new military technologies.

The successful team OIC will support key MEDCoE instruction by networking with TCMC, the Interservice Physician Assistant Program (IPAP), the Basic Officer Leader's Course (BOLC), and the Captains Career Course (CCC) to augment high-demand instructor training and testing and potentially becoming credentialed as an associate professor to teach IPAP on an as-needed basis. It is also possible to apply for long-term health education and training (LTHET) to obtain a DMSc

in PA studies or clinical education during the assignment because this position also meets the requirements for a utilization tour. Whiskey team OICs may also transition to a company command position if available.

Duties and Responsibilities of the Field Training Exercise Officer in Charge

The 68W FTX branch chief is an O-3 or O-4 65D PA who is responsible for the overall instruction and management of the SMTS. Additionally, they continuously update the FTX to align it with current doctrine and simulate large-scale ground combat.

Desired Skills and Attributes

The desired skills and attributes for a field craft or FTX PA are leadership, trauma experience, medical and tactical competence and experience, and the ability to be a thorough and resourceful planner and team builder.

Brigade Combat Team Trauma Training

The MEDCoE BCT3 is a 5-day course that teaches advanced point-of-injury care to combat medic specialists (68W) and flight medics within their 90-day predeployment window, in accordance with Department of the Army EXORD (execute order) 096-09, *Mandatory Pre-Deployment Trauma Training (PDTT) for Specified Medical Personnel and the Regionally Aligned Forces (RAF)*.[3] Annually, the BCT3 conducts an average of 7 courses at Camp Bullis, and approximately 20 courses at 10 different Forces Command (FORSCOM) installations using a mobile training team (MTT), training units of over 2,000 combat medics in approximately 20 separate iterations.

BCT3 training focuses on saving lives and addressing the four most common causes of preventable death on the battlefield: massive hemorrhage from junctional and extremity wounds, airway compromise, tension pneumothorax, and hypothermia.[1] BCT3 also teaches current tactics, techniques, and procedures (TTPs) derived directly from lessons learned in the operational environment, and provides an introduction to prolonged field care. In addition to conducting training, all members of the team must remain current on emerging point-of-injury trauma

techniques and recommendations from the Committee on Tactical Combat Casualty Care and the Joint Trauma System.[1]

Organization Structure and Role of the Physician Assistant

The BCT3 branch chief is an O-4 PA OIC. A second O-3 PA position serves as the MTT leader (though either PA can perform this role as needed), providing the capability for simultaneous training events. The training team cadre consists of active duty NCOs in the rank of staff sergeant and sergeant first class and two DHA civilians. The PAs and senior NCOs must have at least two combat tours each. The PA is supervised by the chief of the Tactical Medicine Readiness Division, who assists with guidance on training and efficiency ratings of the team NCOs.

Prerequisites

Those seeking a position as a BCT3 PA team leader require:

- the rank of captain with completion of the Army Medical Department (AMEDD) CCC;
- a history of assignment to a battalion, squadron, or team PA position for 4 years or more; and
- two or more combat deployments with trauma experience.

Roles and Responsibilities

- Serves as OIC and program director for the BCT3 course.
- Responsible for course direction, improvement, coordination, and guidance of the mandatory predeployment trauma training for 68W combat medics and flight medics.
- Ensures didactic curriculum and practical exercises are current and relevant for Role 1 and 2 medical care on the battlefield.
- Responsible for leading, mentoring, developing, training, instructing, and supervising the MTT's 20 NCOs and 2 civilians.
- Responsible for equipment and supplies worth over $3 million.

Desired Skills and Attributes

A successful BCT3 OIC will:

- have excellent communication and interpersonal skills;

- be able to conduct operations with minimal oversight or guidance, especially during MTT missions;
- be comfortable interacting with brigade and division staff and command teams;
- builds relationships with other MEDCoE programs such as TCMC, IPAP, and BOLC, and be prepared to assist as needed; and
- be a highly competent medical provider and maintain credentials at Brooke Army Medical Center and outlying clinics.

Pertinent Program Resources

- The milsuite.mil BCT3 organizational webpage provides administrative and course content information.[4]
- The deployedmedicine.com website provides current TCCC guidelines, evidence-based medicine explanations, and classes.[1]
- The prolongedfieldcare.org website provides additional resources to assist deploying personnel.[5]
- The Joint Trauma System provides common practice guidelines and tools for deployed medical personnel.[6]

Tactical Combat Medical Care Course

The TCMC course provides the PA, physician, nurse practitioner, and senior medical NCO with a practical working knowledge of how to manage injured patients in a combat environment from point of injury to Role 1 or Role 2. The course information is based on TCCC, known trauma resuscitation methods, lessons learned from combat, and newly developed technology. Training consists of didactic lecture and hands-on practical training conducted at JBSA-FSH, where combat casualty management is taught in a simulated tactical environment. The course lasts 5 days and has 22 to 24 iterations per year.[7]

Organization Structure and Role of the Physician Assistant

Initially created by active duty PAs, TCMC currently employs two active duty PAs and three civilian PA instructors who plan, coordinate, and instruct the course. The senior active duty PA is also the section OIC.[7]

Prerequisites

Those seeking a PA position at the TCMC course require:

- the rank of captain with completion of the AMEDD CCC for those seeking the position of instructor;
- the rank of major for those seeking the position of OIC;
- a history of assignment to a battalion, squadron, or team PA position for 4 years or more; and
- 2 or more years of experience in combat trauma.

Defense Medical Readiness Training Institute Combat Casualty Care Course

DMRTI's C4 program, a faculty affiliate of the National Association of Emergency Medical Technicians, trains 750 triservice and international medical officers annually in the TCCC curriculum, supporting prolonged field and prehospital care training and education. C4 is an 8-day course consisting of a classroom-based professional program and a prolonged FTX. The course also requires prerequisite distance learning through the Joint Knowledge Online Emergency Preparedness Response Course–Clinician Course.

The professional program is targeted according to the student's medical field: physicians, dentists, and some PAs receive Advanced Trauma Life Support–Operational Emphasis; nurses receive Trauma Nursing Core Course–Operational Emphasis; all others receive Pre-Hospital Trauma Life Support.

The FTX is conducted in a forward operating base environment, in which C4 students must demonstrate medical proficiency in all three phases of TCCC (care under fire, tactical field care, and tactical evacuation care) while conducting mission-oriented exercises based on current combat theater scenarios or potential scenarios in other threat locations. Hands-on chemical, biological, radiologic, and nuclear training is included. The exercise integrates mission-oriented medical care in the following contexts: military operations in urban terrain, village stability operations, and tactical evacuation care on a Sikorsky UH-60 Black Hawk helicopter simulator, a simulated Role 2 facility, a tactical medicine obstacle course, and a mass casualty situation.

Organization Structure and Role of the Physician Assistant

DMRTI is under the DHA, which reports directly to the Assistant Secretary of Defense for Health Affairs. Its director is an Army, Navy, or Air Force physician. An Army PA serves as the C4 branch chief or deputy branch chief, and the staff consists of medics and corpsmen from the Army, Navy, and Air Force. The triservice role allows for joint staffing, training, and equipping to meet the requirements of TCCC training.

Prerequisites

Those seeking a position as the C4 PA require:

- the rank of major;
- completion of Intermediate Level Education training;
- a history of assignment and deployment in a brigade or regiment PA position for 2 years; and
- experience in combat trauma.

Combat Paramedic Branch

The Combat Paramedic Branch falls within the Combat Medic Division of the MEDCoE's DoOM. The branch is responsible for the annual total force generation of the Army's flight medic (68WF2) populations within all service components. This requirement includes initial training for 190 to 210 soldiers, as well as recertifying over 160 flight medics annually. Initial training for flight medics includes the 30-week CPP (Combat Paramedic Program), the 8-week Critical Care Course, and the 6-week AMEDD Aviation Crew Member Course (which falls within a separate MEDCoE department, the Department of Aviation Medicine at Fort Rucker, Alabama). The Combat Paramedic Branch also conducts the 2-week recertification course nine times annually.

Organization Structure and Role of the Physician Assistant

There are several opportunities for active duty PAs in the Combat Paramedic Branch, and more specifically the CPP. The chief of the Combat Paramedic Branch is an O-5 (lieutenant colonel) 65D and

functions as both the OIC/branch chief and the CPP program director. In addition to the program director, the CPP has three O-4 (major) PAs who act as OICs for each block of instruction. Each OIC is responsible for the instruction in either block I, II, or III within the 30-week curriculum.

The CPP is a redesigned pilot course utilizing lessons learned and best practices from the previous Expeditionary Combat Medic program, as well as the legacy paramedic course, which was focused on civilian emergency medical services. The new course integrates paramedic curricula into an Army training program designed to meet the requirements of multi-domain operations and large-scale combat operations. The desired outcome is to produce operationally focused paramedics trained in prehospital medicine, as well as TCCC (to preserve life), prolonged care (to sustain life), force health protection (to protect the force), and focused primary care (to sustain the force). The course is expected to grow to include ground evacuation medics and austere duty medics (eg, security force assistance brigades and FORSCOM civil affairs battalions). Current graduates will proceed to the second and third courses of flight paramedic training.

Roles and Responsibilities

Responsibilities of the branch chief include:

- management, direction, oversight, and control of the flight paramedic program to meet the requirements of current and future operating environments, as well as the National Defense Authorization Act of 2013 (NDAA),[8] which stipulated all flight medics be paramedic certified and critical care trained;
- CPP direction, oversight, improvement, and coordination to meet requirements in TCCC, prolonged care, primary care, and force health protection;
- ensuring evidence-based didactic curricula and practical exercises are current, relevant, and rigorous to prepare medics for the challenges of multi-domain operations and large-scale combat operations;
- leading, mentoring, developing, training, instructing, and supervising a team of three PAs, two critical care nurses, six civilians, and eighteen senior NCOs; and
- accountability and execution of over $5 million in equipment and supplies annually.

Responsibilities of team chiefs include:

- management, direction, oversight, and control of 7 to 10 weeks of assigned instruction, including the continuous use of the TRADOC "analysis, design, develop, implement, evaluate" (ADDIE) model to identify course requirements and ensure evidence-based didactic curricula and practical exercises are current, relevant, and rigorous to prepare medics for the challenges of multi-domain operations and large-scale combat operations; and
- leading, mentoring, developing, training, instructing, and supervising a team five or six personnel, comprised of experienced senior NCOs and civilians.

Prerequisites

Those seeking a position as the Combat Paramedic Branch chief require:

- the rank of major (promotable) or lieutenant colonel with completion of the Army's Intermediate Level Education;
- a history of assignment to a battalion, squadron, or team PA position for 4 years or more; and
- a minimum of 1 year's experience serving as an aeromedical PA (65DM3).

Those seeking a position as a CPP team chief require:

- the rank of major (promotable) or lieutenant colonel (completion of the Army's Intermediate Level Education preferred); and
- a history of assignment to a battalion, squadron, or team PA position for 4 years or more.

For both positions, experience in combat trauma, certification as a paramedic, experience as an AMEDD special operations officer (S1), and being an LTHET graduate are preferred.

Desired Skills and Attributes

Those seeking a position as the Combat Paramedic Branch chief or a CPP team chief must:

- possess superior communication skills and be able to quickly

establish rapport with and commitment from those both within and outside the organization;
- have exceptional technical competency and be able to plan, prepare, and execute training to a high degree of excellence;
- be comfortable leading and empowering advanced practice medical NCOs and civilians to identify problems, develop solutions, and implement plans to achieve resolutions; and
- be agile, adaptable, and willing to alter course to achieve desirable outcomes.

Conclusion

The Army's operational medicine training encompasses a wide swath of programs. Selected PAs who serve as leaders and instructors in these courses affect up to 9,000 medics, physicians, PAs, and nurses annually, across the spectrum of services. The experience and tactical and technical expertise of these PAs provide an excellent foundation of lifesaving skills and tactics to the operational force, and their importance to Army medicine at large cannot be overstated. Army PAs have served in an irreplaceable role in cutting-edge instruction and leadership for 7 decades, and by serving in the roles described here, will continue to lead in these capacities.

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Chapter 19

ROLE OF THE CLINIC OFFICER-IN-CHARGE

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Introduction

This chapter discusses the job duties and responsibilities of a clinic officer-in-charge (OIC). Although each clinic OIC's exact duties and responsibilities will vary depending on the specific type and location of the clinic, there are certain standard functions of all OIC positions. Since most OIC positions are in primary care clinics, a section in this chapter is dedicated to the Army Medical Home (AMH) model, which encompasses some specifics of the Patient-Centered Medical Home (PCMH) and Soldier-Centered Medical Home (SCMH) models. These three models make up the Army's primary care system.[1] Taking a position as a clinic OIC is a challenging yet rewarding experience. For physician assistants (PAs), it provides an opportunity to expand their knowledge of the business of medicine, which is vital in both military and civilian health care systems. At the end of the chapter is a list of helpful resources.

Duties and Responsibilities

Army PAs selected as clinic OICs are responsible for the overall oversight and management of their assigned clinic. This oversight includes budgetary and personnel management, as well as ensuring clinic compliance with all clinic accreditation requirements. Fiscal duties involve overseeing the non-salary budget and ensuring that the clinic achieves productivity and receives maximum financial reimbursement. Personnel management duties include, but are not limited to, hiring actions, awards, counseling, evaluations, professional development, and disciplinary actions for both civilian and military personnel. The local troop command retains

the Uniform Code of Military Justice and administrative authority over active duty staff. The management of civilian staff may be new to many PAs and involves working closely with the Labor/Management Employee Relations (L/MER) office and employee unions.

The OIC also oversees customer and patient services, strategic planning, business practices, and process improvement. The OIC is responsible for safety and compliance with requirements of the Joint Commission (a national organization that accredits more than 20,000 health care organizations and is considered a condition of licensure by the majority of state governments) and the Health Insurance Portability and Accountability Act (HIPAA). OICs must also update clinic standard operating procedures annually and develop appropriate memoranda of understanding between the local military medical treatment facility (MTF) and other units that work with the clinic. Also, the OICs are responsible for providing medical care to their assigned panel of patients.

Requirements

To serve in this position, a PA must:

- have experience as a PA and Army Medical Department officer,
- hold the rank of captain, major, or lieutenant colonel, and
- be a graduate of Intermediate Level Education or Captain's Career Course (recommended),
- be credentialed and privileged in the clinic they work in, and
- have access to and proficiency in the systems used in the clinic, such as Medical Protection System (MEDPROS), Automated Time and Assistance Production System (ATAAPS), Defense Medical Human Resource internet (DMHRSi), and the Armed Forces Health Longitudinal Technology Application (AHLTA)/Genesis, as well as additional systems required for a joint service clinic.

Desired Skills and Attributes

The following attributes are helpful:

- diverse operational experience including deployment experience, preferably in multiple roles of care;
- strong work ethic;

- ability to work well with both military and civilian organizations;
- interest in medical administration processes;
- excellent customer service skills;
- solid written and verbal communication skills;
- excellent rapport with the leadership of both the MTF and the supported unit; and
- the ability to balance the demands of multiple mission requirements while ensuring the staff are taken care of.

Training

Because PAs typically spend most of their company-grade (ranks of the second lieutenant to captain) time with Army units outside of MTFs, previous MTF experience, along with a period working with the outgoing OIC, is essential during the initial transition phase. Additional recommended training is listed below.

- **Basic Healthcare Administration Course**. This was a 1-week course that provided an introduction to the administrative side of health care, offering basic knowledge about data quality and productivity metrics for a better understanding of the medical business model and improved communication with administrators. As of publication, the Defense Health Agency (DHA), now owner of the Military Health System and the AMH model, will identify a course for defining levels of performance. For additional information, individuals should contact their respective regional health centers on the status of this course or its equivalent (Regional Health Command/Atlantic, Regional Health Command/Europe, Regional Health Command/Pacific, or Regional Health Command/Central).
- **Supervisor Development Course**. This course is essential in learning the requirements for managing civilian employees. It must be completed by all newly appointed supervisors within 1 year of appointment to the supervisory position. It is available through the Army Training Requirements and Resources System (ATRRS) online.[2]
- **Patient-Centered Medical Home Training**. This training provides students a good understanding of the PCMH/SCMH model, which is necessary to ensure the clinic meets all National Committee for Quality Assurance (NCQA) requirements.

- **Team Strategies and Tools to Enhance Performance and Patient Safety** (TeamSTEPPS; Health Research & Educational Trust, American Hospital Association). This system is the foundation for communication within the medical home.[3]
- **Lean Six Sigma**. This optional training is a continuous process improvement certification program used throughout the Army. Knowledge in this area will help in developing clinic process improvement plans.[4]
- **Army Medical Department Executive Skills Course**. This optional course is designed to prepare new and projected deputy commanders, command sergeants major, and other Army Medical Department leaders for executive medical positions within MEDCOM.[5] The course is part of the Joint Medical Executive Skills Program and focuses on teaching management and executive leadership skills.[6]

Key Facts

This position is typically a 2- to 3-year tour and is considered a broadening assignment, usually coded as an 05A (Army Medical Department immaterial officer) or 61H (Medical Corps officer in Family Medicine) position with no other additional skill identifier requirements. The exact position of the 65D PA within the organization varies depending on rank, the PA's experience, and openings available; however, it usually falls under the chief of the Department of Family Medicine or whichever department the clinic falls under. This is a leadership position and is primarily nonclinical, but the clinic OIC must maintain National Commission on Certification of Physician Assistant certification and MTF credentials, and perform the required patient workload or FTE requirements (which may vary but usually range between 0.25 and 0.7 FTE).

The rater is frequently the primary care chief, and the senior rater is the deputy commander for clinical services (DCCS), but this can vary from facility to facility. Alternatively, the OIC may be rated by the DCCS and senior-rated by the hospital commander. While the position is frequently a Medical Department activity position, some models operate under a memorandum of understanding (MOU) with the Forces Command (FORSCOM) unit providing the OIC.

Under this model, the rater is typically the unit executive officer, the intermediate rater is the primary care chief, and the senior rater is the unit commander.

The Army Medical Home Model

The SCMH, PCMH, and Community-Based Medical Home (CBMH) have been combined to make up the AMH. The use of the term AMH is designed to spread parity across the health care system and limit any perceived difference between the SCMH, PCMH, and CBMH. The implementation of the AMH is a top priority for DHA; if a clinic is not already an AMH, it is in the transition process of becoming one.[1]

The overall goal of an AMH is to "deliver care using the whole-person concept, coordinating and integrating evidence-based primary, specialty and wellness/preventive care in a comprehensive care plan process to customize care to the unique needs of each patient."[1] Health care is coordinated across the entire spectrum of care, including acute care, chronic care, preventive services, and care received outside of the facility. Doing this efficiently and effectively requires team organization and the understanding that it is a team effort. Each team member plays an integral and essential role in providing patient-centered health care.[3]

The AMH leadership team consists of the clinic OIC, medical director, practice manager/administrator, clinical nurse OIC, and clinic noncommissioned officer-in-charge (NCOIC). The leadership team deals with the day-to-day activities of running the AMH, ensuring that high-quality, evidence-based, friendly, and efficient patient care is provided at all times. The clinic OIC has overall responsibility for the supervision and management of the clinic. If the clinic OIC is a PA, there will also be a medical director, within either the clinic or the department, who is the senior clinical expert.[3]

The AMH is a business. It involves specific metrics that are reported to DHA through the accountable care organization (the MTF)[3] and the regional health command. The OIC serves as the commander's expert on the requirements for setting up an AMH and using the Healthcare Effectiveness Data and Information Set (HEDIS)—health care performance metrics used to determine and improve the overall health of the clinic's beneficiaries.[3,7] It is crucial that the OIC be well educated on the metrics and requirements of the NCQA.[8]

Tips for Success

These are the tips for success for the clinic OIC:

- Data quality and productivity measures are a crucial part of the job and are used to evaluate the success of the clinic. Coding is part of the data quality/productivity metrics used to assess the clinic's ability to be productive and adequately resourced.
- It is vital to have an excellent working knowledge of these data and ensure the clinic complies. The OIC must understand coding, apply it, and be able to articulate to subordinates and peers why it is vital to complete it correctly.
- The OIC should have monthly meetings with the division, corps, or senior command surgeon to optimize the use of division and corps assets (providers and medics) in the clinic. OICs should develop MOUs and installation support plans with the senior mission commander for the installation, which will help ensure that the AMH is primarily staffed with organic FORSCOM medical assets along with additional MEDCOM support. Having these documents in place and a good working relationship between MEDCOM and FORSCOM units is necessary for clinic success.
- Several operational order requirements involve having a specific number of specialties in the clinic. Specialties such as PharmD (Doctor of Pharmacy), registered dietician, physical therapist, behavioral health care provider, nurse case managers, public health nurse, and medical support assistant/administrative support will enhance the efficiency of the clinic.[3]
- The AMH model dictates a 3:1 ratio of support staff per provider, which is extremely important to ensure the proper flow of patients. This team includes licensed practical nurses, screening medics, team registered nurses, and medical support assistants.
- The MTF has a signed collective bargaining agreement with the employee union. It is essential to have a good working relationship with the L/MER specialist (an advisor to management in dealing with bargaining union employees concerning conditions of employment and personnel actions).[8] A good relationship will allow the organization to run smoothly, and buy-in from the union will make temporary changes easier.

- Stakeholder meetings with the active duty units supported by the clinic, including representatives from the unit family readiness group, will improve the working relationship between the clinic and patients and provide valuable feedback for clinic improvement. It is better to be proactive and meet beneficiaries outside of the clinic, where information on policies and procedures can be provided, than to meet them in the clinic after they have had a problem navigating the system or have filed a complaint.
- The OIC should handle patient concerns and complaints directly and quickly. They should develop an understanding of which concerns or complaints need their attention and which can be delegated to the medical director, administrator, or patient representative. Remember, there are three sides to every story (patient, staff, and correct). The effect of an OIC or key clinic leader speaking directly to a concerned patient, in person or via telephone, should not be underestimated.
- The OIC must have an understanding of the jobs and requirements of the administrator, clinic NCOIC, and medical director. OICs should not micromanage the staff, but should do spot checks and hold leadership accountable.
- The clinic will not run successfully if the OIC is behind the computer all day. It is imperative to walk through the clinic and engage staff and patients regularly. The OIC should also attend morning staff or team huddles and conduct routine checks to ensure standards are being met. Random visits should be made to the clinic during all hours of operation (morning sick call, regular duty hours, and evening clinics) to ensure standards are being met throughout the day.

Lessons Learned

These are lessons learned for the clinic OIC:

- Understanding the needs of the hospital and the supported units is critical for the OIC. If there is a robust training schedule for the supported units, the providers may not be available to meet all DHA metrics, and demand may vary based on training cycles.
- If several units fall under the clinic for support, the OIC should discuss and review the training calendars with unit providers. Anticipating absences well in advance will help reduce facility cancellations and allow time to adjust staffing.

- The OIC should attend required training as early into the tour as possible. The needs and rules of clinics are frequently interpreted because "it's the way we do it here." Learning the right way early will reduce these instances and improve the outcome when the Joint Commission visits.
- Leadership should be engaged early when problems arise. Some changes take several months to implement within the facilities, so the sooner leadership buys in, the more successful the OIC will be.
- The OIC should read and understand the installation health services plan and MOUs with any unit that falls within the clinic's footprint.
- The OIC, or a designated representative, should ensure that everyone working in the clinic knows how to input their DMHRSi timecards upon arrival to the clinic. Improper timecard entry may result in the loss of staff and support in the future.
- If the local hospital or clinic has established referral guidelines, the OIC should make sure new providers know how to find them. This will decrease unnecessary referrals and help maintain access for specialty providers.
- Documentation is still one of the most important things an OIC can do, even for civilian employees. Documenting good and poor performance will help everyone.

Conclusion

The clinic OIC position is an excellent opportunity for PAs to gain clinic leadership experience and implement changes that can transform the Military Health System, while learning the business of medicine. It is a challenging and rewarding position that is not afforded to all PAs. The OIC PA will learn the importance of supervising and rating civilian employees, coordinating with other departments in the facility, and balancing the demands of multiple entities within the footprint. Once the tour is complete, the PA will have a much greater knowledge of the role of the Military Health System and its impact on the medical readiness of Army soldiers and the PA profession.

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Helpful Resources

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Chapter 20

ROLE OF THE ARMY PHYSICIAN ASSISTANT IN THE AIRBORNE AND RANGER TRAINING BRIGADE

Jon C. McBride, APA-C, MPAS

Introduction

The Airborne and Ranger Training Brigade (ARTB), headquartered at Fort Benning, Georgia, conducts the majority of high-risk, advanced skills training for the US Army Infantry School. It consists of the 4th, 5th, and 6th Ranger Training Battalions (RTBs), as well as the 1-507th Parachute Infantry Regiment. The ARTB conducts training to create and deliver combat-ready Rangers, paratroopers, jumpmasters, pathfinders, and reconnaissance leaders to the US Army and the Department of Defense in order to increase the leadership ability, tactical skill, and technical competence of the fighting forces of the United States.[1]

Ranger school is the Army's toughest course and the premier small-unit tactics and leadership school (Figure 20-1). The Ranger course is a mentally and physically challenging school that develops functional skills directly supporting units whose mission is to engage the enemy in close combat and direct fire battle. For 62 days, Ranger students train to exhaustion, pushing the limits of their minds and bodies. The course incorporates three phases (Benning, Mountain, and Swamp), each following the "crawl, walk, run" training methodology. After these three phases, Ranger students are proficient in leading squad and platoon dismounted operations around the clock in all climates and terrain. Rangers are trained to a higher level than most soldiers. Rangers are better trained, more capable, more resilient, and better prepared to serve and lead soldiers in their next duty position.[2]

The Reconnaissance and Surveillance Leaders Course (RSLC) is a 33-day program that teaches the fundamentals of dismounted



Figure 20-1. A Ranger student receives the coveted Ranger Tab during graduation at Hurley Hill, Fort Benning, Georgia. Photograph by Patrick Albright, Maneuver Center of Excellence, Fort Benning Public Affairs. Reproduced from: https://fortbenning.smugmug.com/Infantry-School/Airborne-Ranger-Training-Briga/Ranger-School/US-Army-Ranger-School/2019-08-30-Airborne-and-Ranger-Training-Brigade-Graduation/

reconnaissance, surveillance, and target acquisition to soldiers, noncommissioned officers, and officers. The RSLC physically and mentally challenges students, with each block of instruction building on previous blocks. It culminates in a multi-day, graded, field training exercise executed in both urban and woodland environments.[3]

The 1st Battalion, 507th Parachute Infantry Regiment, is responsible for training basic and advanced parachuting techniques, including pathfinder and jumpmaster training. These paratroopers from all services conduct airborne operations anywhere in support of the Department of Defense.[4]

Supervision

There are no authorizations for physicians within the ARTB, so there are no brigade or battalion surgeons. The medical director of the Department

of Warrior Care at Fort Benning supervises PAs assigned to the ARTB. Battalion executive officers serve as raters for each Ranger Training Battalion (RTB) PA, battalion commanders serve as senior raters, and the medical director serves as intermediate rater. The brigade PA has a similar rating scheme, but is rated and senior-rated by the brigade executive officer and brigade commander.

Unit Structure

Each RTB is responsible for executing their respective phase of Ranger school in three geographic locations. The 4th RTB executes Benning Phase at Fort Benning. The 5th RTB executes Mountain Phase at Camp Merrill near Dahlonega, Georgia. The 6th RTB executes Swamp Phase at Camp Rudder, located on Eglin Air Force Base, Florida.



Figure 20-2. The 4th Ranger Training Battalion conducts hoist operations with an air ambulance detachment. Photograph by Patrick Albright, Maneuver Center of Excellence, Fort Benning Public Affairs.
Reproduced from https://fortbenning.smugmug.com/Infantry-School/Airborne-Ranger-Training-Briga/Ranger-School/US-Army-Ranger-School/2019-08-30-Airborne-and-Ranger-Training-Brigade-Graduation/

Each battalion has three line companies consisting of Ranger instructors who are responsible for all training and supervision of students. Each RTB has a Headquarters and Headquarters Company (HHC) element that executes normal staff functions, a medical platoon that provides 24/7 medical support, and an infantry platoon that acts as opposing forces during patrols. In addition to the standard task organization, the 4th RTB has an additional three companies. Echo Company, 4th RTB, executes RSLC. The air ambulance detachment provides medical evacuation coverage for the installation and surrounding areas, including Camp Merrill (Figure 20-2). Raven Flight Company conducts air movement, air assault, and other support to units on and around Fort Benning.

A PA, responsible for all medical functions within the battalion, is assigned to each RTB. The 4th RTB maintains two battalion aid stations that support the Benning Phase of Ranger school. Additionally, the 4th RTB PA and medical platoon cover all airborne operations conducted by the 1-507th Parachute Infantry Regiment. Both the 5th and 6th RTBs maintain a battalion aid station on their respective camps. Additionally, a troop medical clinic is located at both Camp Merrill and Camp Rudder. These serve RTB cadre and their families, as well as supplementing the medical care of Ranger students.

Roles and Responsibilities

PAs assigned to the ARTB are primarily responsible for the health and welfare of students attending Ranger school and RSLC. They conduct sick call and routine, urgent, and emergent care, as well as minor surgical procedures. PAs also provide recommendations to their commanders regarding the retention of ill or injured students. PAs are the only medical officers within the ARTB, so they shape all medical support and training within the unit. PAs also serve as advisors to their commanders on all student and cadre medical issues.

Each PA supervises a medical platoon that provides field medical support and maintains a battalion or forward aid station. Ranger students are subject to extreme physical conditions for 62 days, and generally present with more serious ailments than would be seen in a typical field or clinical setting. Therefore, PAs must have extensive clinical skills and be confident in an independent setting. Due to the austere settings, ARTB medics are also trained to a high level. RTB

PAs must maintain a high-functioning training program, and empower medics through standing orders and medical standing operating procedures.

The ARTB frequently conducts aviation and diving operations. In order to support these operations, PAs should be flight surgeon and hyperbaric and dive medical officer qualified. PAs that do not hold these qualifications must meet all prerequisites and volunteer for these courses as soon as possible.

Qualifications and Training Opportunities

Due to the unique training environment, the following qualifications are required (exceptions may be made for exceptional applicants):

- rank of captain,
- Ranger qualified, and
- airborne qualified.

Additional recommended training that may be provided while stationed at the ARTB:

- Advanced Life Support
- Tactical Combat Medical Care
- Delayed Evacuation Combat Management
- Rough Terrain Evacuation (Figure 20-3)
- Swift Water Rescue
- Wildlife Medicine

Qualified PAs who are interested in joining the ARTB should contact the ARTB senior PA to be considered for the position.

Lessons Learned

The intense conditions imposed on Ranger students create a difficult operating environment for the ARTB PA. PAs must be capable of making rapid decisions that will directly influence a student's ability to complete the course. Ranger students are not generally afforded a physical profile, which severely limits the PA's ability to rehabilitate the sick or injured. Therefore, PAs in the ARTB often



Figure 20-3. The 5th Ranger Training Battalion medical platoon moves a simulated casualty using a rope bridge in the Rough Terrain Evacuation Course. Photograph courtesy of Captain Andrew Nielsen, APA-C.

treat medical conditions more aggressively than is seen in a typical clinical setting for the purpose of returning students to training as rapidly as possible.

Reliable telemedicine is essential for an ARTB PA to be effective. ARTB PAs have limited diagnostic tools available due to the austere environment. Additionally, PAs will operate independently without direct support from other providers. In order to mitigate these limitations, PAs must maintain an extensive network of providers to call upon when assistance is needed.

The ARTB operates at a high operational tempo nearly year round. There is very little time available for training medics. PAs must maximize training opportunities during patient encounters as a means to ensure medics maintain both competence and confidence.

Conclusion

Serving as an ARTB PA is both extremely demanding and highly rewarding. PAs have a direct impact on the successful execution of the ARTB mission in many ways. In addition to providing expert medical care, PAs play a large role in shaping the methods used to train students, and in developing effective risk mitigation measures to protect students. In order to support the high-risk training, PAs will have multiple opportunities for additional training and certifications that are not commonly offered across the rest of the Army.

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Chapter 21

ROLE OF THE ARMY SERVICE COMPONENT COMMAND PHYSICIAN ASSISTANT AT US ARMY AFRICA

P. Jason E.E. Auchincloss, APA-C, MPAS, and Christopher R. Smith, PA-C, MPAS

Introduction

The US Army Africa (USARAF) physician assistant (PA) supports the USARAF command, which aligns under US Africa Command (USAFRICOM), the unified geographic combatant command. USARAF is an Army service component command currently headquartered in Vicenza, Italy. The assignment provides a unique opportunity for the PA to expand operational acumen and serve in a job that often bears both operational and strategic importance.

Unit Structure

USARAF, as an Army service component command, is typically a two-star command comprised of a headquarters and headquarters battalion (HHBn) with three companies (Figure 21-1). The companies are organized into two functional companies. The headquarters support company and the operations company form one large company with a single commanding officer and first sergeant. The intelligence and sustainment company creates the second company with its commander and first sergeant. The USARAF commander falls under the command group within the headquarters support company. The USARAF PA, along with the public affairs officer and chaplain, logically falls into the headquarters support company for administrative purposes, but is ultimately a member of the HHBn special staff.

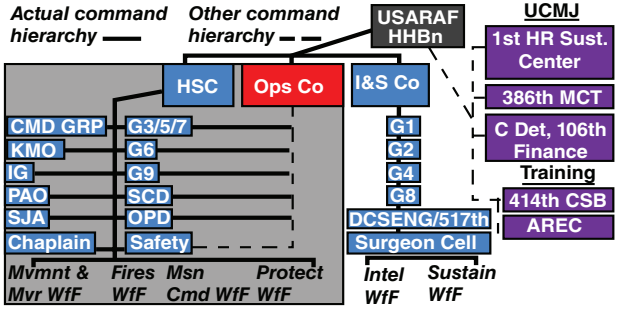


Figure 21-1. US Army Africa Headquarters and Headquarters Battalion organization diagram, presented in June 2018 as part of an inbrief for newly assigned personnel.
Diagram courtesy of Colonel Brett Medlin.
AREC: Army Reserve engagement cell; CSB: contracting support brigade; CMD: command; DCSENG: deputy chief of staff engineer; Det: detachment; GRP: group; HHBn: headquarters and headquarters battalion; HR: human resources; HSC: headquarters support company; I&S Co: intelligence and sustainment company; IG: inspector general; Intel: intelligence; MCT: movement control team; Msn: mission; Mvmnt: movement; OPD: Operational Protection Directorate; Ops Co: operations company; PAO: public affairs officer; SCD: Security Cooperation Division; SJA: staff judge advocate; Sust: sustainment; USARAF: US Army Africa; WfF: warfighting function

The HHBn medical team consists of the senior PA, a staff sergeant (E-6) combat medic (68W30) noncommissioned officer in charge, and one specialist (E-4) combat medic (68W10). The PA answers to the battalion commander, however, must be amenable to acting on medical guidance from the command surgeon (colonel/O-6) and USARAF commanding general (major general/O-8). The USARAF surgeon cell consists of the command surgeon and staff of Medical Service Corps officers, whose primary focus is planning.

Roles and Responsibilities

USARAF has only one PA authorized within the command. The USARAF command surgeon occupies the only other clinical position in the organization. The USARAF PA's primary role is to serve as special

staff and medical advisor who supports the battalion commander, the command surgeon, and the regionally aligned force medical staff on the African continent. The latter is comprised of approximately seven physicians, nine PAs, seven nurses, and numerous combat medics. It is because of their oversight and input that the USARAF PA earns the moniker of "USARAF senior PA," despite no additional PAs or physicians assigned to the HHBn.

The USARAF senior PA advises the command team on all health, occupational, and environmental concerns while in garrison and when deployed. While in garrison, the USARAF senior PA provides routine and emergency medical care to USARAF and garrison personnel. Typically, the PA is also responsible for delivering health care to the two-star commander and executive staff. Additional clinical responsibilities may include daily urgent care visits, chronic care, and physical examinations. While not empaneled with the members of USARAF due to the additional special staff requirements, the PA does periodically operate in a borrowed manpower role at the US Army Health Clinic–Vicenza. The primary patient workload requirements range between 0.25 and 0.4 full-time equivalents.

Ultimately, the USARAF senior PA is responsible for battalion-level medical logistics, medical operations and plans, and the medical readiness of approximately 750 military and civilian employees. The PA is routinely assigned the management of day-to-day operations of the USARAF Travel Medicine Clinic at the Vicenza Health Clinic. The primary purpose of this clinic is to medically screen and medically clear personnel traveling to Africa in support of USARAF. The USARAF command surgeon is the waiver authority; however, the USARAF PA is delegated to assist with waiver adjudication for all US Army personnel with disqualifying medical conditions entering the AFRICOM theater.[1]

At all times, the USARAF senior PA is prepared to establish and staff a forward aid station in Africa for the USARAF contingency command post. In the forward aid station, the PA and USARAF medical team execute clinical medical support for select exercises in Africa hosted by USARAF. When directed, the USARAF senior PA serves as the medical officer in charge and the joint task force surgeon's clinical representative forward in the deployed setting.

As a special staff officer, the USARAF PA must balance the demands of the HHBn commander and staff, with those required by the USARAF commander, the executive team and directors, and the command surgeon

and their directorate. It is during this daily fulfillment of obligations and requirements that USARAF PAs truly hone their skills in the art of diplomacy and the delivery of personalized care. While many will refrain from the term "executive medicine," one cannot overlook the timeless skill of providing "executive access to care."

Supervision and Evaluation

The USARAF PA is supervised by the HHBn commander, who serves as the PA's rater on the officer evaluation report. The PA's senior rater is the chief of staff, with the command surgeon providing medical input as the intermediate rater. However, a more traditional supervisory chain may exist based on rank (eg, the battalion executive officer as the rater, the command surgeon as the intermediate rater, and the battalion commander as the senior rater). Landstuhl Regional Medical Center (LRMC) in Germany processes credentialing and privileging for the USARAF PA.

Skills and Attributes

All candidates for the USARAF PA position must meet medical requirements to enter the Africa area of responsibilities.[2] In addition to medical eligibility, there are numerous desired skills and attributes of a PA in USARAF, including the following:

- current in all skills mandated by the individual critical task lists,
- operational experience,
- rank of senior captain or junior major,
- a graduate of the Captains Career Course, and
- outstanding written and oral communication skills.

The following attributes are also helpful for success as a USARAF PA:

- Mixed operational experience within multiple roles of care is preferred, with a minimum of Role I deployment experience.
- Knowledge and understanding of the joint and combined environments.
- The ability to work well with both military and civilian personnel and organizations, and excellent customer service skills. Having these skills will prove helpful when working in an environment

dominated by senior military and civilian leaders. A collegial working relationship must prevail at all times with the local health center and the surrounding units.
- An understanding and interest in the administrative aspects of managing a large medical equipment set that might be located in up to two or three countries simultaneously.
- The ability to work with multiple high-ranking African military leaders from the ranks of captain to a two-star general.
- Ability to understand, navigate, and execute the medical evacuation process using International SOS and the Theater Patient Movement Requirements Center–Europe.[2]

Training

The position requires no additional training outside of the credentials requirements.[3] However, the following additional training is highly recommended:

- **Brigade Surgeon Course.** This course prepares Medical Corps officers to function as brigade surgeons. It highlights the health and readiness issues that most often occur at the brigade or division task force levels. The course takes place at the Army Medical Center of Excellence.
- **Army Flight Surgeon Course**. This 6-week course teaches aviation and aviation survival, flight physiology, aviation operations, and mishaps and aviation medicine programs. It prepares graduates to implement an aviation medicine program at their home station and to address the medical needs of aviators. This course provides the Army service component command PA the ability to care for the aviators in the formation.
- **Joint Humanitarian Operations Course**. This is a 2-day course that highlights the relationship between the United States Agency for International Development, Office of Foreign Disaster Assistance and its partners.
- **Military Tropical Medicine Course**. This program of instruction offers enhanced training in tropical medicine to Army, Navy, and Air Force medical officers.[4] The course discusses a wide variety of topics to include environmental illnesses, pre- and post-travel medical evaluations, viral, bacterial, and parasitic infections, and

public health issues in the developing world. Any PA operating in the AFRICOM area of responsibility (AOR) must attend this course.
- **Tactical Combat Medical Care Course**. This course provides the clinician (physician, PA, nurse practitioner, and senior medics) with a practical working knowledge of how to deal with injured patients in a combat environment. The course provides training on the evaluation, resuscitation, stabilization, emergency surgical procedures, and the post-resuscitation management of the wounded soldier.

Recommended Certifications

- American Red Cross (ARC) Cardio Pulmonary Resuscitation (CPR) Instructor
- American Heart Association (AHA) Advanced Life Support (ALS)
- American Heart Association Pediatric Advanced Life Support (PALS)
- Advanced Trauma Life Support (ATLS)
- Advanced Burn Life Support (ABLS)

Basic Life Support, Advanced Cardiac Life Support, and Pediatric Advanced Life Support training are available through the Vicenza Health Clinic and Landstuhl Regional Medical Center.

Key Factors

The position is typically a 3-year assignment in Vicenza, Italy. The USARAF senior PA must be medically deployable to the very restrictive AFRICOM AOR.[5] The theater medical entry requirements reflect several factors including (1) the austere nature of the environment; (2) the size of the AOR (Figure 21-2); and (3) the medical infrastructure across the AOR.

Housing is available on base for families. The local housing office, staffed by English-speaking Italians, assists in finding appropriate accommodations for military and civilian personnel off-post. The Department of Defense Education Activity has an American elementary and high school for school-aged children.

Morale, welfare, and recreation (MWR) activities are plentiful in Europe. Outdoor recreation sponsors paid travel events to local Italian sites and other parts of Europe, providing a plethora of tourist



Figure 21-2. The true size of Africa—approximately 3.5 times the size of the continental United States. Medical evacuation and casualty evacuation movements frequently cover distances similar to moving a patient from Maine to Florida. There is NO "golden hour" in the US Africa Command area of responsibility.

experiences. Bike, ski, and kayak rentals are available. The local train network also offers an easy opportunity to travel. Venice Airport is located 45 minutes from Vicenza. Garrison provides a shuttle to and from the airport, with seating based on priority and availability. Preference is typically provided based on the following guidelines in order of precedence: emergency leave, permanent change of station travelers, temporary duty, and leave.

The Vicenza Health Clinic offers primary care for service members and their families. Additional services available include immunizations, hearing, optometry, behavior health, laboratory, radiography, pharmacy, physical therapy, and nurse case management. Services not provided at the clinic are either available on the local economy or at LRMC. Typically, service members and their families are referred to the local economy for imaging or basic health services not available at the clinic. Service members and their families may receive subspecialty services at LRMC. The Vicenza–LRMC shuttle runs twice weekly. The Italian San Bortolo Hospital provides local emergency care, and this hospital includes a staff of patient liaisons who are available 24/7 to assist the local military community with the language barrier. The nurse case managers at the Vicenza Health Clinic closely follow all inpatient care.

Opportunities and Experiences

The USARAF PA will travel to the Africa AOR frequently in support of exercises and real-world events (Figure 21-3). These activities gain notoriety from the international press and have high visibility at the strategic level. The USARAF PA is involved in the medical planning of exercises and forward operations, as a vital member of the staff.

The PA is often responsible for the medical care of senior commanders and leaders on the continent. Previous leaders and clients have included the chief of staff of the Army, the vice chief of staff of the Army, the AFRICOM and USARAF commanders, and many other senior government officials. The majority of this VIP medical coverage occurs annually during the African Land Forces Summit, which brings together chiefs of defense forces and senior military leaders from as many as 43 countries. This major event is vital to ensuring senior defense officials from across the continent can discuss regional and cross-regional challenges within the AFRICOM AOR.

In 2014 the USARAF PA was the primary clinical provider responsible for the health and welfare of the joint task force tasked to stop the spread of Ebola virus in Liberia, West Africa. The PA provided en-route and on-site medical coverage for the president of Liberia and other senior officials. At the same time, they visited the sites of the Ebola treatment units on a US Marine Corps V22 Osprey aircraft.

Later in 2015, the USARAF PA and a medic deployed to provide clinical oversight for the Special Purpose Marine Ground Task



Figure 21-3. US Army Africa physician assistant and medics working alongside a Host Nation medical team to treat a patient injured during riots in West Africa. Photograph courtesy of Major Paul Auchincloss.

Force (SPMGTF) during their infiltration and establishment of a contingency location in Cameroon, West Africa. This deployment lasted approximately 3 months and was pivotal in the establishment of the AFRICOM policy regarding the use of antivenin by conventional forces on the continent.

Lessons Learned and Tips for Success

These are tips for success that will enable the future USARAF PA to succeed in their role:

- Attend command and staff meeting at least every other week. The command team and primary staff will appreciate involvement and input regarding the daily operations and medical readiness of the unit.
- Attend monthly meetings with the senior medical council members at the Vicenza Health Center.
- The USARAF PA will be extremely busy and on call most of the time. Developing an effective work–life balance is crucial to a successful assignment.

- Develop or maintain subject matter expertise regarding tropical diseases, and the threats service members of the command may be exposed to while forward on the continent.
- Step away from the office and circulate. Engage with the clinic staff and members of the command. Conducting weekly "rounds" to determine the health of the command team, staff, and directors is beneficial and appreciated. Everyone works extended hours, and individual health care is not always a priority for leaders.
- Attend morning staff or team huddles at least once a week at the health center. Doing so will solidify a relationship with the clinic staff and provide them an opportunity to discuss concerns regarding predeployment and travel requirements, as well as management of returning travelers who are ill.

Conclusion

US Army Africa offers a multitude of professional and international experiences not available at other duty stations. The position is unique due to the geographical and medical challenges associated with the Africa area of operation. As an assignment, it can provide a vital stepping stone to working in a joint environment.

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Chapter 22

ROLE OF THE THEATER SPECIAL OPERATIONS COMMAND PHYSICIAN ASSISTANT

P. Jason E.E. Auchincloss, APA-C, MPAS; F. Eddie Criss, APA-C, MPAS; Christopher Sacheli, APA-C, MPAS; and Geoffrey Washburn, APA-C, MPAS

Introduction

A Theater Special Operations Command (TSOC) is a one- or two-star subordinate, unified command of US Special Operations Command. TSOCs perform broad, continuous missions uniquely suited to special operations forces (SOF) and the capabilities they bring to the fight. The secretary of defense has assigned operational control of the TSOCs and their attached SOF tactical units to their respective geographic combatant commanders via the Global Force Management Implementation Guidance.[1]

While the geographic combatant command-aligned TSOCs vary widely in their task unit organization, and day-to-day operational activities, all TSOCs incorporate functional medical staffs designed to support and advise the commander on all aspects of health service support. The role of the physician assistant (PA) in the medical staff varies from senior primary care clinician, to deputy surgeon, to medical operations officer, or any combination thereof.

While there may be some slight variations in each TSOC (mainly due to manning, assigned forces, and geographic responsibility), the PA duties will be inherently similar. Filling a TSOC PA position is both rewarding and challenging. The assignment provides a unique joint force opportunity for the tactical PA to expand their operational acumen, and serve in a post that often bears both operational and strategic importance.

Unit Structure

Figure 22-1 shows an example of a TSOC organizational structure, although they vary. Each TSOC has a unique set of component commands, but the command relationship between the TSOC, US Special Operations Command, and the geographic combatant command remains the same (Figure 22-2).[2]

In some cases, the PA is assigned as the command surgeon, without a physician or additional deputy on staff (eg, Special Operations Command North). As the TSOC surgeon, the PA is medical advisor to the commander. The PA is also responsible for the entire medical directorate along with the previously stated responsibilities. The TSOC PA position is rewarding and career enhancing, unique within the PA (65D) career field. The TSOC PA for Special Operations Command Africa serves as the command PA and the deputy surgeon for clinical services and any other patient-related issues. Another medical officer, the operations deputy surgeon, is the lead medical planner.

For example, within Special Operations Command Africa, the command PA provides the "care there" clinical focus—honing in on clinical operations on the continent of Africa. A second PA (a US Army Reserve officer) works in the surgeon cell and focuses on "care here"—specifically in-garrison medicine and preservation of the force and family. This second PA position is not part of the baseline manning document and may not be filled. As a result, the command or TSOC PA must be familiar with all clinical duties, because they may have to assume both roles at any time.

Supervision

TSOC PAs traditionally practice medicine as general medical officers or within their trained specialties. The TSOC surgeon typically supervises these officers.[3–5] Depending on the unit's organizational structure, the TSOC PA may oversee other assigned or attached PAs, special operations medics, and additional medical and human performance enablers (eg, preventive medicine personnel and a preservation of the force and family team). Sometimes, the TSOC PA may be the senior medical staff member, requiring an intermediate

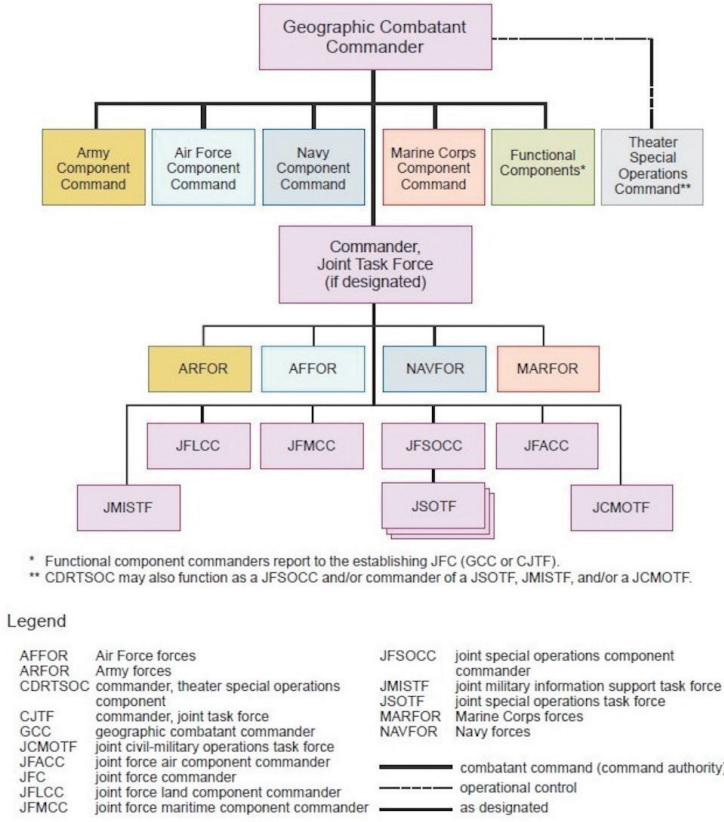
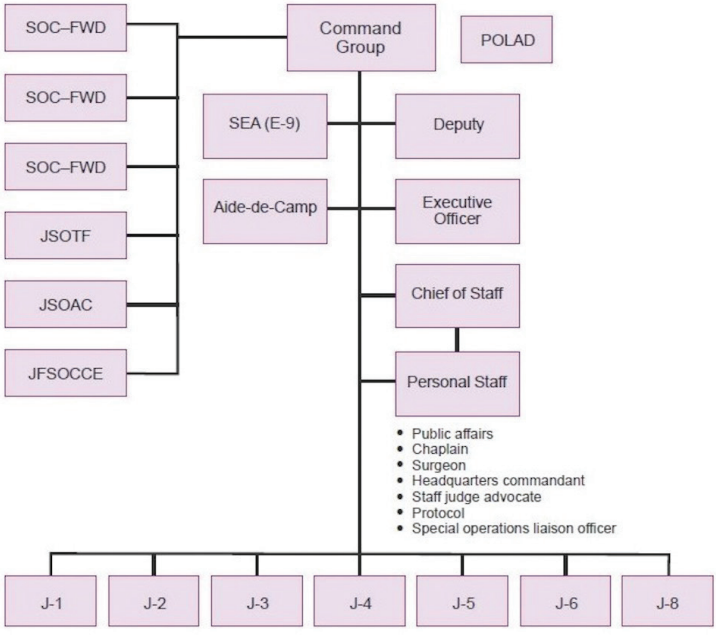


Figure 22-1. A notional organization chart that demonstrates the command structure and relationships of the different directorates in a Theater Special Operations Command. The surgeon falls under the personal staff (or special staff).
Reproduced from: US Department of Defense. *Special Operations.* DOD; 2014. Joint Publication 3-05, Figure III-2.

rater on official evaluations. In most TSOCs, the PA's rater will be the TSOC command surgeon, and the senior rater will be the TSOC chief of staff or TSOC commander.[2]



Legend

J-1	manpower and personnel directorate of a joint staff	JFSOCCE	joint special operations command and control element
J-2	intelligence directorate of a joint staff	JSOAC	joint special operations air component
J-3	operations directorate of a joint staff	JSOTF	joint special operations task force
J-4	logistics directorate of a joint staff	POLAD	political advisor (Department of State)
J-5	plans directorate of a joint staff	SEA	senior enlisted advisor
J-6	communications system directorate of a joint staff	SOC–FWD	special operations command–forward
J-8	force structure, resource, and assessment directorate of a joint staff		

Figure 22-2. A notional organization chart that demonstrates the command relationships within a geographic combatant command. The geographic combatant commander has operational control over the Theater Special Operations Command.
Reproduced from: US Department of Defense. *Special Operations.* DOD; 2014. Joint Publication 3-05, Figure III-3.

Roles and Responsibilities

Primary Care Manager

The PA is responsible for the routine care of TSOC headquarters staff and their families. Duties may include functions such as facilitating completion of everyday medical readiness requirements and conducting routine physical examinations, sick call, and referral management. The PA often creates and maintains a deployable medical package (a modular, lightweight equipment set) for use in providing medical support for short-notice missions in their area of responsibility.

Deputy Command Surgeon

As the executive officer to the TSOC command surgeon, the PA is responsible for deputy director-level engagements and serves as a director in the surgeon's absence.

Human Performance Coordinator

The PA leads and facilitates the human performance team, which is made up of individuals in a variety of subspecialties, such as physical therapists, strength and conditioning coaches, athletic trainers, performance dietitians, and behavioral health specialists.

Medical Planner

The PA is the lead for health service support on operational planning teams, which develop operational and strategic policies and plans. In this role, the PA coordinates with higher and adjacent headquarters' medical staff. The PA also advises and reviews subordinate unit concepts of operation for both risks to mission and risk to force. Focus areas include medical support packages, the type of care available in the local hospitals, the level of care available on the mission, and the medical equipment needed.

Medical Exercise Planner/Scenario Controller

The PA serves as the lead medical exercise planner for joint and multinational special operations exercises. Duties include developing

plans, determining resource requirements, and executing complex medical scenarios. At the end of each exercise, the PA provides relevant feedback to the training audience.

Requirements

The requirements to serve as a TSOC PA are the following:

- National certification and good standing with the National Commission on Certification of Physician Assistants.
- Eligible for credentials at a servicing military medical treatment facility.
- Current in all skills mandated by the individual critical task lists.
- Rank of major (recommended).
- Possess outstanding written and oral communication skills.

Desired Skills and Attributes

Desired skills and attributes of a TSOC PA include the following:

- Top secret-sensitive compartmentalized information security clearance.
- Graduate of Intermediate Level Education.
- Knowledge and experience in the training and scope of practice of special operations medics working throughout the joint force.
- Working understanding of the geographic area of responsibility, including relevant historical and current events, goals, opportunities, threats, military structures, and organizations.
- Working knowledge of US special operations core activities and the nuances of medical support to these operations.
- Understanding of the US Transportation Command and Defense Health Agency medical care, evacuation infrastructure, capabilities, and processes across the geographic area of responsibility.
- Knowledge of the capabilities, limitations, strengths, and weakness of joint force deployable medical treatment capabilities (eg, forward resuscitative surgical team, ground surgical team, emergency resuscitation surgical team, special operations surgical team, and special operations resuscitation team).
- Expertise in tactical combat casualty care.

- Working knowledge of the Joint Trauma System clinical practice guidelines, fundamentals of damage control resuscitation, and prolonged field care.

Training

- Joint Special Operations Medical Orientation Course
- NATO Special Operations Medical Planning and Support Course
- Flight surgeon and dive medical officer certifications
- Other recommendations by geographic area of responsibility
  - Operational Clinical Infectious Disease Course (3-day course)
  - Tropical Medicine Course (Special Operations Command Africa, either a 5-day or 1-month course)
  - Medical Management of Chemical and Biological Casualties Course and Medical Management of Radiologic Casualties Course (Special Operations Command North)

Recommended Certifications

- Cardiopulmonary Resuscitation Instructor
- Advanced Life Support
- Pediatric Advanced Life Support
- Advanced Trauma Life Support

Opportunities and Experiences

- Opportunity to engage, liaise, and learn from the whole US special operations joint force as well as partner and allied nation SOF.
- Broadening opportunity—working directly at the operational level and serving as a vital link between strategic policy and the "doers" at the tactical level.
- Geographic area of operations focus—opportunity to gain specific knowledge and expertise in the foreign policy goals, opportunities, and threats to a particular geographic area.

Lessons Learned

TSOC PA hours are often long, with many weekends spent on call as SOF continue their missions across the globe. TSOC PAs must be

versatile and proficient in their clinical skills. They must be adept at communicating across multiple platforms, and with commanders and operators at all levels. The position will challenge TSOC PAs in the areas of casualty evacuation, medical evacuation, communication, and logistics. The mission seldom slows, so excellent time management skills that enable a reasonable family–work life balance are critical. If a TSOC PA knows something that may be important to the mission, they must speak up; if they do not know something, it is their duty to ask. Lives are often at stake, and as a professional, the PA must always place the soldier and the mission before personal pride.

Tips for Success

These tips for success can set up a rewarding tour:

- PAs should understand the operational environment and help the command team understand the medical risks. They should recommend risk reduction and mitigation activities that do not adversely affect the overall mission.
- Medical counterparts across the regionally aligned forces must be identified and integrated into each mission. If their supporting contributions are not planned and incorporated into the medical objectives they can hinder progress.
- Medical objectives must nest within command priorities. While seemingly obvious, medical lines of effort sometimes do not support directed priorities and threaten the credibility, resourcing, and relevance of the TSOC medical staff.
- PAs should always seek to expand and reinforce their medical knowledge at every opportunity.
- It is important to balance the requirement to provide primary medical care for patients with the operational and staff aspects of the TSOC PA job.

Conclusion

The TSOC PA is a very fast-paced and challenging position, albeit extremely rewarding. The position provides an excellent opportunity to straddle both the clinical and operational worlds of special operations. PAs will likely serve in both a health care delivery and primary trainer

capacity, but also be heavily involved in operationalizing SOF medicine across the joint force. Special operations, under the TSOC proponent, have certain mission relevance as they are constantly engaged in all facets of special operations, across the full spectrum of military operations. The PA position offers a broadening opportunity, and a chance to serve in an operational-level joint headquarters, working alongside some of the finest officers and noncommissioned officers across both the joint SOF, and allied or partner nation SOF.

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Chapter 23

ROLE OF THE BRIGADE SENIOR PHYSICIAN ASSISTANT

Stephanie Bocanegra, PA-C, MPAS

Introduction

The role of the brigade senior physician assistant (BDE PA) is arguably one of the best positions a physician assistant (PA) can be selected for in the Army. Why one of the best? Because in this position, a PA is no longer involved in the daily grind of balancing patient care with unit obligations, like a junior battalion PA (BN PA), and is not encumbered with the scope of responsibilities and complex planning duties of a division PA (DIV PA). A BDE PA works directly with BN PAs and medics and, while still involved with patient care, has the opportunity to provide more direct daily mentorship and shape policy within brigade medical operations. The BDE PA position bridges the middle ground between the BN PA and the DIV PA while working directly with the brigade surgeon (BDE SURG) to ensure that health service support and force health protection are executed appropriately. This chapter will provide a brief overview of both the clinical and the administrative duties and responsibilities of the BDE PA (refer to Chapter 12, Role of the Battalion PA, and to Chapter 25, Role of the Division PA, in this handbook for more in-depth details).

The BDE PA serves as the primary advisor to the BDE SURG on all clinical operations (CLINOPS), functions as the liaison between the local medical treatment facility (MTF) and division, and provides mentorship and career advice to all PAs within the brigade. The BDE PA plays an integral role in planning brigade garrison and deployment medical operations, developing mass casualty exercises, monitoring medical readiness, enforcing and coordinating medic military occupational specialty (MOS) sustainment training and continuing education for assigned providers, and performing oversight of daily CLINOPS in keeping with MTF quality management.[1]

Supervision

Supervision of the BDE PA is performed by the BDE SURG as outlined in Army regulations (ARs) 623-3, 40-3, and 40-68, and in the local MTF credential policies.[1–3] Traditionally, the BDE PA is rated by the BDE SURG and senior-rated by the brigade commander (BDE CDR). However, there can be a few variations, so a new BDE PA must ensure understanding of the rating scheme immediately (this is typically addressed in initial counseling by the supervisor or rater).

The Brigade Surgeon Section

The BDE SURG is responsible for the Army health system (AHS) support for the brigade combat team (BCT). In accordance with *Army Health Systems Support to Maneuver Forces* (Army Techniques Publication 4-02.3[4]), the BDE SURG is considered a:

> brigade-level special staff officer that coordinates AHS support activities with the brigade S-1 [personnel/administration officer] and other headquarters elements that affect AHS support in the brigade. The BDE SURG is responsible for the technical supervision of all medical activities in the command. The BDE SURG is part of the brigade commander's special staff, and as such, provides advice to the BDE CDR on all medical or medically related issues. The BDE SURG keeps the BDE CDR informed on the status of AHS support for the brigade and the health of the command.[4(p16)]

Per Army Techniques Publication 4-02.3,[4] the BDE SURG section does not include a BDE PA (although the BDE PA receives guidance from the section). The BDE SURG's staff consists of a field surgeon, a medical operations officer, and a health care noncommissioned officer who is battle staff-qualified. The section's three medical personnel are typically assigned to the headquarters company and are utilized as a sustainment warfighting component jointly with the S-4 (logistics) of an infantry BCT, armored BCT, or Stryker BCT. The sustainment element determines the type, amount, and the duration of support needed to meet command objectives. A BDE SURG section that is fully integrated in sustainment operations is responsible for planning, coordinating, and synchronizing the health service support mission for commanders and maneuver forces within the BCT's area of operations (Table 23-1).[4]

Table 23-1. Sustainment (S-4) medical staff.

Paragraph title	AOC/MOS	Grade	Title	Branch	Quantity
Sustainment–S/4 Medical	62B00	O-4	Field Surgeon	MC	1
	70H67	O-3	Medical Operations Officer	MS	1
	68W402S	E-7	Health Care NCO	NC	1

2S: battle staff operations
AOC: area of concentration
MC: Medical Corps
MOS: military occupational specialty
MS: Medical Service Corps
NC: noncommissioned
NCO: noncommissioned officer
S-4: logistics staff officer
Reproduced from: Department of the Army. *Army Health System Support to Maneuver Forces.* HQDA; 2014. Army Techniques Publication 4-02.3: Table 2-2.

The BDE PA is typically assigned to the medical company within the brigade support battalion. According to the modified table of organization and equipment (MTOE), the BDE PA is part of an area medical treatment squad, which provides basic primary care services and advanced trauma management to a supported area of operations within the brigade footprint. The treatment squad serves as the main source of medical care for the brigade support medical company's Role 2 treatment facility. The Role 2 consists of a medical treatment squad and other key elements that provide patient holding capabilities and multiple ancillary services, such as dental, laboratory, physical therapy, and radiology (Table 23-2).[4]

Job Duties and Responsibilities

Although the BDE PA does not align directly within the BDE SURG section, they function as the direct supporting element to the BDE SURG on all CLINOPS and PA matters. Typically, the BDE PA has been in the operational setting for several years. Therefore, their role is vital during garrison and deployment operations. The BDE PA's daily duties depend on the unit of assignment and the expectations of the BDE SURG and command team. Time is divided among meetings, staff work, training, and clinic. The BDE PA is often the first point of contact for incoming medical officers, so they will need to be heavily engaged

Table 23-2. The medical treatment squad (area).

Paragraph title	AOC/MOS	Grade	Title	Branch	Quantity
Medical Treatment Squad (Area)	62B00	O-4	Field Surgeon	MC	1
	65D00	O-4	Senior Physician Assistant	SP	1
	68W30	E-6	Health Care Sergeant	NC	1
	68W20	E-5	Health Care Sergeant	NC	2
	68W10	E-4	Health Care Specialist		1
	68W10	E-3	Health Care Specialist		2

AOC: area of concentration
MC: Medical Corps
MOS: military occupational specialty
NC: noncommissioned
SP: Medical Specialist Corps
Reproduced from: Department of the Army. *Army Health System Support to Maneuver Forces.* Washington, DC: HQDA; 2014. Army Techniques Publication 4-02.3: Table 2-14.

with sponsorship, communication, and streamlining credentialing and in-processing for these individuals.

Besides being heavily involved in day-to-day CLINOPS, the BDE PA should be significantly involved in the medical readiness training and associated professional development of all the medical personnel in the brigade. Teaching, coaching, and mentoring the approximately seven other PAs in the brigade, and support to the brigade nurse, physical therapist, dentist, and battalion surgeons are essential to the success of the brigade's overall medical mission. Fostering an environment of support and teamwork, while providing consistent communication and clear guidance on policies and systems that work, will ensure that all are moving forward together as a team. The BDE PA needs to actively encourage subordinate PAs to participate in medical and officer professional development opportunities in both the operational and clinical realms. They are also responsible for educating each BN PA to expand their technical and professional capabilities. These responsibilities include advising them through regular counseling (written and verbal) on how to write and review officer evaluation reports and officer record briefs, the importance

of maintaining a current Army photo, and creating/updating their curriculum vitae. In some cases, the BDE PA may also serve as an intermediate rater for BN PAs.

Requirements

To serve in this position, a PA must:

- graduate from an accredited PA program, pass the Physician Assistant National Certifying Examination, and maintain certification with the Physician Assistant National Recertifying Exam through the National Commission on Certification of Physician Assistants[1];
- hold the appropriate rank;
- have completed the Captains Career Course;
- pass the current physical fitness test and be in compliance with height/weight standards of AR 600-9*, The Army Body Composition Program*[5,6];
- have current Basic Life Support certification at a minimum, and required Department of Defense Instruction (DODI) 1322.24 and service-directed medical readiness training[7];
- be credentialed at the local MTF;
- be a subject matter expert on readiness[7,8];
- know the entry criteria for warrior transition and soldier recovery units, and understand the Integrated Disability Evaluation System (IDES)[9–14]; and
- understand physical requirements of soldiers based on their MOS in accordance with DA Pamphlet 611-21, *Military Occupational Classification and Structure*.[15]

Desired Skills and Attributes

BDE PAs should:

- have an additional skill identifier of M2 (emergency medicine) per MTOE (this is not currently enforced due to personnel shortages);
- be able to operate in clinical, deployed, and field settings;
- be able to communicate effectively with their BDE SURG, command teams at the battalion and brigade levels, fellow health care providers and specialists, noncommissioned officers, soldiers, and patients;

- have deployment experience and be capable of worldwide deployment operations;
- be able to operate independently with little supervision or guidance;
- have solid written and oral communication skills;
- have current Tactical Combat Casualty Care foundational knowledge;
- have the knowledge and ability to train and supervise 68W combat medics and combat lifesavers, as well as other allied and ancillary health specialists;
- have a basic understanding of the individual critical task lists (ICTLs) for each medical area of concentration (AOC) for officers and military occupational specialty (MOS) for enlisted personnel under their purview[16]; and
- obtain access and understand the use of various software applications required for patient care and soldier readiness, including the electronic health record and key modules within the Medical Operational Data System (eg, the Medical Readiness Portal, Medical Protection System [MEDPROS], MEDPROS Web Data Entry, and Medical Health Assessment).

Intermediate Level Education is recommended but not required. BDE PAs are also encouraged to obtain and maintain Advanced Life Support (ALS).[1] Per AR 40-68, Advanced Trauma Life Support (ATLS), Medical Management of Chemical and Biological Casualties, and Tropical/Global Medicine are additional recommended courses.[1] However, ATLS and the Medical Management of Chemical and Biological Casualties are required courses on the 65D (PA) ICTL, along with ALS, Pediatric Advanced Life Support, Tactical Combat Casualty Care, and Medical Effects of Ionizing Radiation.

"Battle Rhythm"

Below are examples of the BDE PA's regular operations (this list is not all inclusive).

Daily

- Sick call (refer to "Sick Call Operations" in the Chapter 12, the BN PA).
- Clinic: BDE PAs are often primarily in charge of the day-to-day CLINOPS for their unit in both the garrison and field setting; this will

encompass the majority of their time. Managing provider schedules and medic coverage, ensuring algorithm-directed troop medical care[17] is incorporated into sick call and for acute walk-in patients, enforcing MTF safety protocols to prevent adverse outcomes, ensuring Health Insurance Portability and Accountability Act (HIPAA) compliance, and addressing patient satisfaction issues are just a few examples of a BDE PA's CLINOPS functions, in addition to overall unit readiness. BDE PAs are considered to fill an executive leadership role, and are therefore required to perform clinical care only to maintain their skills, proficiency, and credentialing (equating to 40 patient-contact hours per year, depending on MTF and unit leadership guidance). However, clinic time is often significantly more for involved BDE PAs, especially with recurrent PA shortages within the military.[1,3,4,7,9,13,14,17]

- Miscellaneous administrative duties and conference calls with various staff within the brigade, clinic, division, and MTF.

Weekly/Biweekly

- Command and staff meetings are typically twice monthly at the brigade level. BDE PAs should be present at both or at least one monthly (if splitting meetings with the BDE SURG), not only for situational awareness, but also to build rapport with unit leadership and staff.
- Regular clinic duties to maintain credentials and privileges of at least 40 hours of patient care and continuity of medical skill sets annually.
- Medical operations meetings outside the brigade to synchronize the AHS with higher headquarters.
- BDE SURG synchronization meetings with the other BN PAs and surgeons.
- Review of current operations orders (OPORDs) and fragmentation orders (FRAGOs) for clinically relevant material (be prepared to provide input and write OPORDs and FRAGOs to direct subordinate units as needed).

Monthly

- Monitoring the IDES management and non-deployable profile review boards at brigade and division levels for profiles that exceed 180 and 240 days, respectively.[10,11,13]

- Membership boards that involve key medical, behavioral, and legal subject matter experts who offer feedback on personnel identified by the command to be at a higher risk to themselves or others.
- Participation in warrior transition unit and soldier recovery unit entry boards.
- Division surgeon synchronization meetings.
- PA meetings, professional development, and team-building events.

Continuous/Ongoing

- Coaching, mentoring, and training new providers and medics.
- Professional development of self and others.
- Oversight of the first responder program and Combat Lifesaver training in accordance with the Tactical Combat Casualty Care guidelines.[7]
- Managing 68W sustainment training in close coordination with the installation medical simulation training centers, tracking certification status and ICTLs, and assisting units with the health care specialist management module of the medical operational data system web-based platform.
- Reviewing and updating standard operating procedures and continuity books.
- Open and effective communication with incoming providers and MTOE-assigned personnel.[18]
- Close coordination with clinic leadership and the local MTF concerning garrison health care issues, including borrowed military manpower personnel, clinic schedules, training, and deployment calendars.
- Ensuring sustainment and predeployment medical training requirements are conducted in accordance with Department of Defense Instruction 1322.24, AR 350-1, and AR 40-68, in close coordination with the MTF, the installation medical simulation training center, and the Medical Center of Excellence at Joint Base San Antonio–Fort Sam Houston, Texas.[1,5,7,16]

Lessons Learned and Tips for Success

For a BDE PA, the most important concept to understand is where they are in the hierarchy of leadership in relation to their battalion counterparts. Many PAs come into this position excited to have

finally worked their way up to being in charge of a group of fellow professionals; however, being a BDE PA simply means they are the most senior and potentially the most experienced PA in their unit. The BDE PA is technically not in the BN PA or BN SURG chain of command; therefore, the BDE PA can provide guidance, input, and feedback on battalion-level daily operations and functions of the PAs and surgeons, but the unit will dictate their battle rhythm. Taskings must go through official operational channels for approval. While the BDE PA may be disheartened to limit themselves to what may seem "just an advisory role," they must understand that their BN PAs and surgeons still value their leadership position, mentorship, and advocacy on their part with their command teams.

The BDE PA position should be seen as an advocate for battalion providers, medics, and ancillary staff while also serving as a protective barrier against internal and external distractions that may hinder readiness and overall health service support operations. The BDE PA must take their role seriously as the most senior PA working with the health care professionals in their brigade; they are all focused on the same goals. If the BDE PA's subordinates know they are available to them, that they provide sound leadership and mentorship, and are a true team player while remaining flexible and resilient, they will together accomplish the mission in the most cohesive manner possible.

Conclusion

Filling a key leadership role that bridges the gap between the BN PA and DIV PA, the BDE PA plays a pivotal role in overall unit readiness, CLINOPS in the garrison and deployed setting, and sustained health service support and force health protection within the brigade area of operation. Daily, BDE PAs provide clear leadership, communication, and mentorship to their unit providers and staff while performing key advisory duties to the BDE SURG and BDE CDR. They also serve as liaison between the unit and the MTF, supporting readiness, health protection, and preventive care. Additionally, BDE PAs coordinate sustainment and continuing education training, clinical quality care, and professional development, ensuring their unit medical personnel are in keeping with the AMEDD motto, "to conserve the fighting strength."

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Chapter 24

ROLE OF THE PHYSICIAN ASSISTANT IN THE US ARMY TRAINING AND DOCTRINE COMMAND AND INITIAL MILITARY TRAINING

Sean M. Donohue, PA-C, MPAS, and Gail A. Evans, PA-C, MPAS

Introduction

The US Army Training and Doctrine Command (TRADOC), headquartered at Joint Base Langley-Eustis, Virginia, is the proponent for all Army training and doctrine. TRADOC works across the domains of doctrine, organization, training, materiel, leadership, personnel, facilities, and policy (DOTMLPF-P) to provide the structure and framework the Army operates within every day. TRADOC oversees 32 Army schools, organized under eight Centers of Excellence (CoE), each focused on a separate area of expertise within the Army (such as medical, maneuver, maneuver support, and signal). In total, these centers train over 500,000 soldiers, sailors, airman, marines, and international students worldwide each year.[1]

The US Army Center for Initial Military Training (CIMT), also located at Joint Base Langley-Eustis, was created by an act of Congress on September 24, 2009. CIMT is the core function lead under TRADOC for all initial military training (IMT). CIMT trains over 120,000 people annually, and the CIMT surgeon, an Army physician assistant (PA), is responsible for the health care oversight and policy affecting those trainees.

Training and Doctrine Command Unit Structure

TRADOC is commanded by a four-star general officer and has two core functional deputy commanding generals (DCGs): the DCG for

Combined Arms (Fort Leavenworth, KS), a lieutenant general (three-star) who oversees all CoEs, and the DCG for Initial Military Training (IMT), a major general (two-star) who oversees all IMT operations and the Army Training Center (Fort Jackson, SC). TRADOC also has oversight of the Army Recruiting Command, Army Cadet Command,

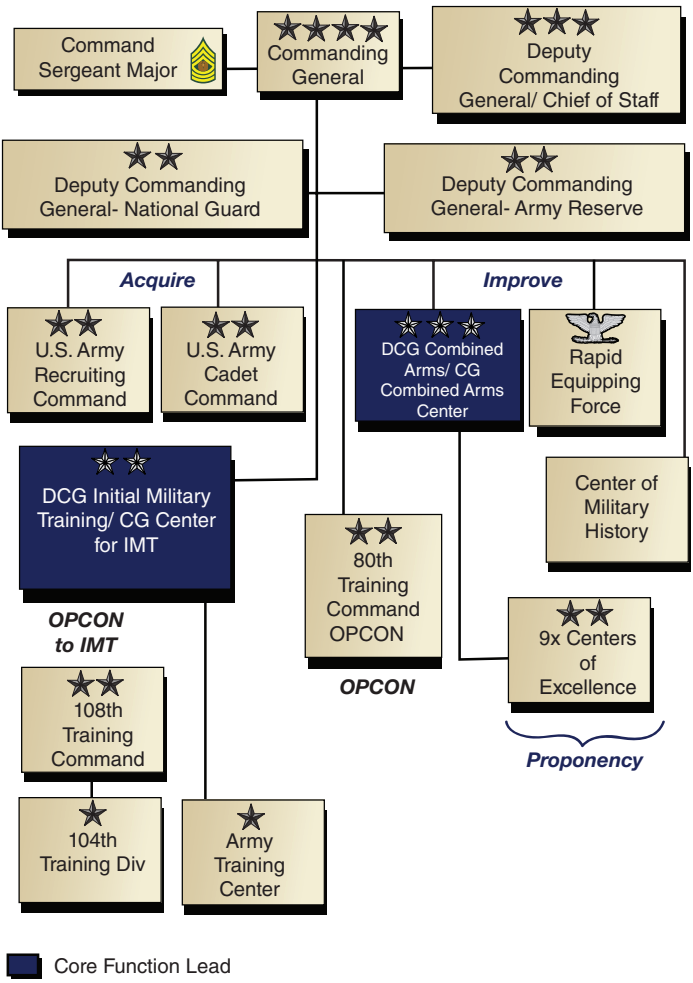


Figure 24-1. Training and Doctrine Command organizational chart (simplified).

Army Rapid Equipping Force, and Army Center of Military History. There are also DCGs (major generals) for the National Guard and Army Reserve components (Figure 24-1).

US Army Center for Initial Military Training Structure

CIMT oversees basic combat training (BCT), advanced individual training (AIT), one-station unit training (OSUT, where BCT and AIT are combined), the Basic Officer Leadership Course, and the Warrant Officer Basic Course. CIMT's Leader Training Brigade, located at Fort Jackson, educates, develops, and equips leaders with current, rigorous, and relevant curriculum in leadership, fitness, and resiliency. The brigade oversees three schools: the IMT Leadership School, Physical Fitness School, and Army Master Resiliency School. CIMT also oversees the Drill Sergeant Academy. These schools use a process that aligns the development of competencies (knowledge, skills, abilities, attributes) and behaviors so that civilian volunteers become soldiers who are physically ready, grounded in Army values, and competent in their skills. IMT includes developing baseline proficiency in warrior tasks, battle drills, and critical skills associated with the student's military occupational specialty or area of concentration. After completing IMT, graduates are prepared to contribute as leaders or members of a team upon arrival at their first unit of assignment.

CIMT is also the Army developer and proponent for the Army Expert Soldier Badge,[2] the *Soldier's Blue Book* (a guide to IMT),[3] the Army Combat Fitness Test (ACFT),[4] and the Holistic Health and Fitness (H2F) program.

Key Factors

The CIMT surgeon, an O-4 (major) PA (area of concentration [AOC] 65D), serves as the senior medical officer for the CIMT commanding general. Practically, the CIMT surgeon's role is to advise the commander on topics germane to the IMT training environment. These topics range from accessions and reception medical policy, the health care and wellness of recruits and soldiers in training at IMT courses, to evaluation and mitigation of attrition related to medical causes. Due to the proximity of CIMT to TRADOC, as well as the density of trainees in IMT, the CIMT surgeon also functions informally as the senior TRADOC PA. In the role of senior PA, the CIMT surgeon liaises with and advises the TRADOC

command surgeon (an O-6 [colonel], AOC 60A, Operational Medicine Specialist) and serves as a coordinating or informal staff officer to the TRADOC surgeon. Because nearly all TRADOC surgeon initiatives and operations specifically affect the IMT population, the TRADOC surgeon staff and CIMT surgeon staff are inextricably linked.

TRADOC Surgeon Cell

TRADOC headquarters has a modest surgeon cell under the G1/4 (personnel and logistics staff section) at the headquarters element, principally consisting of the command surgeon and a deputy surgeon/environmental science officer (an O-5 [lieutenant colonel], AOC 72D), as well as three civilian positions: a medical operations officer, clinical operations officer, and executive assistant. The surgeon staff also includes a sergeant major (E-9), civilian command psychologist, and the civilian command ready and resilient integrator (CR2I).

CIMT Surgeon

The CIMT surgeon falls within the CIMT Research and Analysis Directorate. The directorate, under civilian leadership, also includes a senior medic (sergeant first class, military occupational specialty [MOS] 68W40, health care noncommissioned officer), command physical therapist (O-5, AOC 65B), command dietician (O-5, AOC 65C), and an occupational therapist (O-5, AOC 65A). Each position is intended for a traditional 3-year assignment and all positions serve as H2F action officers. The directorate also includes a variety of civilian analysts, doctrine writers, research physiologists, and the CR2I lead for Fort Eustis. The Research and Analysis Directorate areas of responsibility include:

- development and implementation of Army-level surveys, H2F doctrine, and pilots and tests for implementation of the ACFT;
- review of all proposed human subjects research involving trainees or cadre within IMT;
- tracking of attrition within IMT (including BCT, OSUT, and AIT); and
- developing policy, including Field Manual 7-22, *Army Physical Readiness Training*[5] (the name will soon become "Holistic Health and Fitness").

Additionally, the CIMT surgeon, dietician, and medical noncommissioned officer support the CIMT's Staff Assistance Visit (SAV) program to IMT sites (Figure 24-2) to evaluate compliance with applicable TRADOC regulations (TRs) and identify areas for support and improvement in the development of all initial training programs of instruction. The CIMT surgeon reviews and updates pertinent medical policy as it pertains to IMT, including the following TRs:

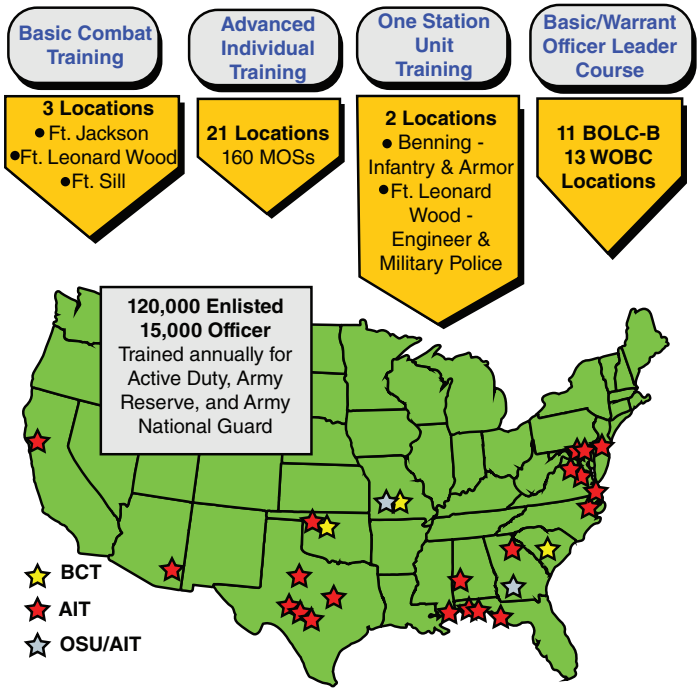
- TR 350-6, *Enlisted Initial Entry Training Policies and Administration*[6];
- TR 350-16, *Drill Sergeant Program*[7];
- TR 350-36, *Basic Officer Leader Training Policies and Administration*[8]; and
- TR 350-29, *Heat and Cold Casualties*.[9]

Other policy reviewed includes various Army regulations (ARs) as they pertain to CIMT:

- AR 40-501, *Standards of Medical Fitness*[10]; and
- AR 612-201, *Initial Entry/Prior Service Trainee Support*.[11]

Duties and Responsibilities

The daily duties of the CIMT surgeon are similar to those of other division or corps surgeon assets. Typical operations include enterprise-level observation of medical readiness, management of current and future operations, review and revision of policy guidance, generation of orders, contract preparation and execution, evaluation of studies and outcomes, evaluation of training programs for effectiveness and modification, and analysis of attrition. What truly makes the role of the CIMT surgeon unique, however, is the vast reach the position has across the DOTMLPF-P domain. In a typical day, the CIMT surgeon might address issues with the Military Entrance and Processing Command; review the program of instruction for Combat Lifesaver courses; evaluate the impact of community health threats on trainees and the greater population; participate in the planning, preparing, and budgeting and execution process; contribute to public affairs messaging; respond to congressional inquiries: present to various Army schools; meet with industry; and address problems with contracts. Because the CIMT surgeon's scope is so wide, it brings the incumbent into routine contact



Daily Load				
BCT	OSUT	AIT	BOLC	Total
17,372	7,124	12,163	2,776	39,435

Annual Mission - FY 20	
Basic Combat Training	84,959
Advanced Individual Training	107,670
One-Station Unit Training	32,153
Basic Officer/Warrant Officer	15,002

Figure 24-2. Center for Initial Military Training map.
AIT: advanced individual training
BCT: basic combat training
BOLC-B: Basic Officer Leader Course
MOS: military occupational specialty
OSUT: one station unit training
WOBC: Warrant Officer Basic Course

with military medical treatment facility (MTF) commanders, CoE leadership, Office of the Surgeon General staff, and other Army senior leaders. Due to the sensitivities of representing IMT and TRADOC, whenever the CIMT surgeon travels on temporary duty, it is appropriate to notify the local MTF and senior commander staff.

The CIMT surgeon participates in human research study proposal review and approval, oversight of all medical trends and analysis, consultation and advice on accessions health policy and line-of-duty regulations, review of training deaths and significant injuries, and other topics of concern to the IMT commander. Recommendations for changes to regulations governing IMT outside of TRADOC are submitted directly to the proponent for the regulation (in many cases, Army Medical Command [MEDCOM]). It is CIMT's responsibility to identify and address any policy, extending across all Army components, that affects the initial military population, including international students.

The CIMT surgeon also performs other missions as assigned. As an H2F action officer, the CIMT surgeon serves as an integral member of the development of the Army concept on H2F, policy and doctrine development, and fielding to the Total Army. For the ACFT, the CIMT surgeon supports doctrine and policy development, fielding, and related research.

While the CIMT surgeon position is administrative rather than clinical in nature, it is imperative that the incumbent maintain clinical practice and relevant medical technology infrastructure access. Fort Eustis is home to McDonald Army Health Clinic (MCAHC), which operates one MTF, two troop clinics (one permanent party, one for trainees), and a community medical home for dependents in Williamsburg. The CIMT surgeon should maintain privileges with MCAHC and provide the MTF with semi-routine clinician support. Maintaining privileges supports the CIMT surgeon's clinical competency, and allows the surgeon to better understand the challenges of caring for trainees, observe firsthand the medical condition of trainees, observe the implications of TRADOC policy on trainee care decisions, and provide periodic health assessment and soldier readiness processing support for the small number of operational forces on the installation when needed. While observing medical and TRADOC leadership issues related to health care on an SAV is relevant, the impact of experiencing those same issues as a clinician brings better clarity for enterprise solutions.

As the TRADOC senior PA, the officer in this position provides routine operational and programmatic updates to the Army PA branch chief, the PA consultant to the surgeon general, and other senior medical staff across the Army, Navy, Air Force, MEDCOM, Joint Staff, and Department of Homeland Security elements. The CIMT surgeon also briefs the Medical Specialists (SP) Corps chief on a quarterly basis regarding TRADOC operations affecting the SP Corps writ large. The CIMT surgeon is also encouraged to conduct regular interactions and briefings internal and external to the SP Corps and the PA community. He or she routinely works with the CIMT public affairs officer to present ACFT and H2F topics to the media and groups with an interest in military training.

Because the CIMT commander also functions as the senior mission commander/senior commander of the Army element at Joint Base Langley-Eustis, the CIMT surgeon also functions as an interlocutor and liaison between the Installation Management Command commander, the MTF commander, and the commanding general. Similarly, in case of an emergency such as a pandemic or another situation requiring a unified incident command, the CIMT surgeon works to facilitate coordination of IMT organic and installation assets and resources in support of the senior mission commander.

Training and Desired Characteristics

The CIMT surgeon must have completed Command and General Staff College, and prior service on a corps or Army service component command staff is desirable. Some background in research or public health is beneficial, as is former service on the Army staff. There is no requirement for a background in doctrine development, capabilities development and integration, or contracting; however, a familiarity with these subjects is highly beneficial.

Individuals must be extremely diligent in time and workflow management. Executive-level operations require that numerous high-level missions be conducted concurrently and executed to the highest possible standard. Individuals must think critically and apply measured responses to high-intensity drivers for change. The CIMT surgeon must consider the impact that each decision could have across TRADOC and the IMT enterprise, and be prepared to present senior and command leadership with appropriate, relevant, and thoughtful guidance.

The direct leadership role of the CIMT surgeon is small, supervising one noncommissioned officer and one Army civilian. However, the indirect leadership role spans the entire Army, involving constant interaction with leaders inside and outside the Department of Defense. The CIMT surgeon must be succinct in presenting complex ideas, considerate of Defense and Army policy and guidance, and cognizant that their comments may be perceived as official policy guidance.

TRADOC Organic Medical Structure Initiative

As of the first quarter of fiscal year 2020, TRADOC has been approved to proceed with changes to the current organic medical structure. Historically, a very low number of medical officers and medical enlisted personnel have served in TRADOC to provide health care to trainees in IMT. The TRADOC Organic Medical Structure (TOMS) initiative will bring a brigade (BDE)/battalion (BN) surgeon cell capability, traditionally seen in Forces Command, to TRADOC. TRADOC BDE-level BCT and OSUT units will be resourced with one surgeon (O-4, AOC 65D or 62B, field surgeon), a behavioral health officer (O-3 [captain], AOC 66R, behavioral health nurse practitioner), a medic (68W40), and a behavioral health noncommissioned officer (staff sergeant, MOS 68X20, behavioral health noncommissioned officer). As of this writing, BN echelons will receive one surgeon (O-3, AOC 65D or 66P, nurse practitioner, or possibly a contract clinician) and two medics (MOA 68W, health care specialist).

The intent of the TOMS structure is to provide TRADOC units with the organic support they need to generate and sustain readiness. Eventually, AIT units and Army reception battalions will also receive a complement of medical personnel. The TOMS staff will also serve as part of the governance structure for H2F (described below). Conceptually, the BDE/BN providers will function much as they do in the Forces Command realm, as personal staff to the commander advising on medical issues and readiness. It will be imperative for these staff to be well versed in their core skill sets as providers, and to be willing to use great initiative to drive needed changes and support their units. The senior BDE positions will become CoE surgeons and have an informal linkage to the TRADOC surgeon via the TRADOC DCG for Combined Arms.

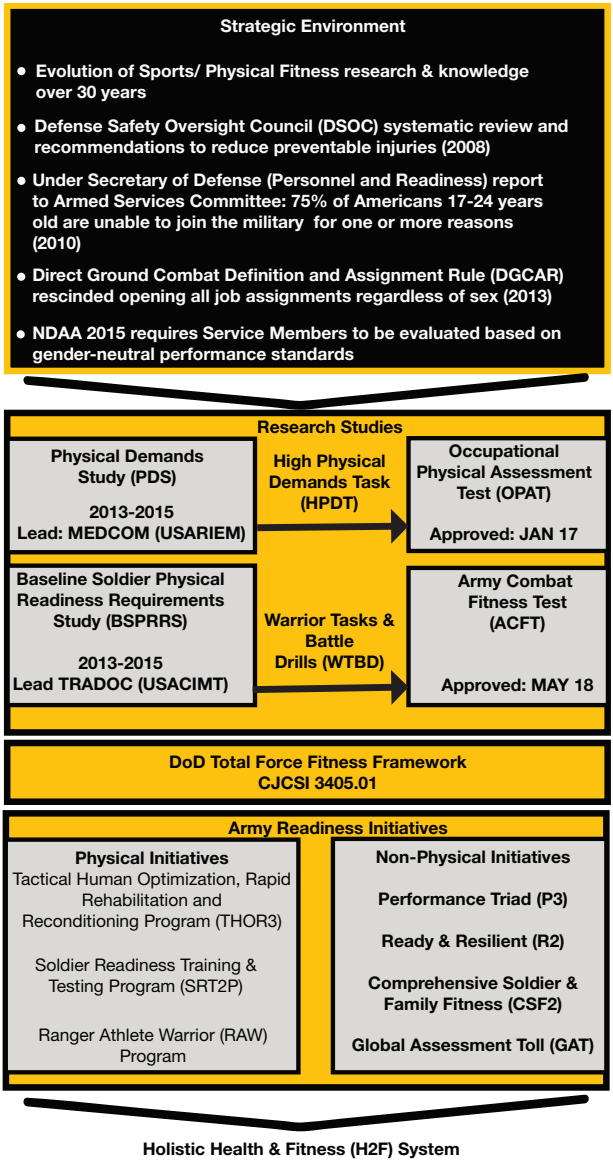


Figure 24-3. Holistic Health and Fitness (H2F) strategic environment. NDAA: National Defense Authorization Act

Holistic Health and Fitness

H2F is a comprehensive, integrated, and immersive health and fitness system that generates lethal soldiers who are physically, mentally, and spiritually ready to engage with and overmatch the enemy in multi-domain operations[12] (Figure 24-3). The system is composed of five elements—governance, programming, equipment, personnel, and leadership education—and spans five domains—physical, spiritual, mental, nutritional, and sleep. These elements, often absent or out of sync in legacy fitness programs, are essential to future Army readiness. As a system, the elements are aimed to comprehensively support all domains of soldier readiness.

The Army's continued investment in the human dimension will ensure soldiers are ready to deploy, fight, and win the nation's wars. From 2025 to 2030, physical and nonphysical performance training will continue to evolve as TRADOC, through IMT, develops plans for the integration of performance personnel into support brigades, Special Operations units, and training brigades. H2F personnel will expand to include cognitive enhancement and athletic trainer capabilities. In coordination with the Army Corps of Engineers and the Office of the Assistant Chief of Staff for Installation Management, TRADOC, through CIMT, will continue to develop the Soldier Performance Readiness Center training facility concept to provide a centralized location for unit-level physical and nonphysical performance training. Finally, TRADOC, through CIMT, will continue to align Army regulations and policies with the H2F doctrine, and begin systematic program assessment across units.

Army PAs must be prepared to support the H2F initiative as medical providers and medical readiness experts for their respective commanders. Army PAs must be integrated with the H2F leadership and staff to ensure continuity of care and conditioning for the entire command. While there are no formal leadership relationships between the BDE surgeon and the H2F staff, a preponderance of H2F staff are within the SP Corps, and include occupational therapists, physical therapists, and dieticians.

Lessons Learned and Tips for Success

Individuals considering service as the TRADOC CIMT PA should be prepared for a high-paced and rewarding position with a substantial impact on the generating force. Individuals must be willing to reach

across the Army to accomplish a wide variety of missions and champion the health of the trainee. Understanding basic research and statistical analysis principles is helpful due to the wide variety of research and analysis conducted in the trainee realm. The CIMT PA should understand the generalizability of findings and be able to convey complex analysis in general terms. The position includes moderate amounts of travel.

Conclusion

Service as the TRADOC CIMT command surgeon is a rewarding position that provides the incumbent with the unique opportunity to affect the Army generating force. The scope of the position continues to grow as CIMT and TRADOC implement new Army-wide initiatives. The position allows the incumbent to leave a lasting and profoundly positive mark on the Army for years to come.

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Chapter 25

ROLE OF THE DIVISION PHYSICIAN ASSISTANT

Stephanie Bocanegra, PA-C, MPAS; David W. Broussard, PA-C, MPAS; Peter Carroll, PA-C, MPAS; Walter Engle, PA-C, MPAS; and Bradley Tibbetts, PA-C, MPAS

Introduction

The mission of the division physician assistant (DIV PA) is to serve as advisor to the division surgeon (DIV SURG) on clinical operations (CLINOPS), liaise with the local military medical treatment facility (MTF), and provide mentorship and career advice to all PAs within the division. With 10 active component divisions within the US Army, being selected to serve in one of these highly sought-after positions is not something to be taken lightly. The DIV PA serves as a medical subject matter expert under the sustainment warfighting function and is pivotal in helping create policy and synchronize health service support. Additionally, the DIV PA provides guidance, leadership, and mentorship to all medical personnel within the formation. DIV PAs have similar duties and functions as battalion or brigade PAs, but with differences in the level of complexity, scope of planning, and professional obligations affecting the Army health system. This chapter will provide information on both the clinical and administrative duties and responsibilities of the DIV PA.

Division Command Structure

The commanding general (CG) has clearly defined responsibilities and authorities for key leaders of the command group. Four principal assistants help the CG carry out their duties. They are the deputy commanding general for maneuver (DCG [M]), the deputy commanding general for support (DCG [S]), the chief of staff (CoS), and the division

command sergeant major (DCSM). Each is delegated the authority to supervise execution of decisions and guidance policies, and to clarify these for subordinates as required.[1] The command group's medical responsibilities are as follows:

- The **DCG (M)** oversees brigade combat teams. Along with the DCSM, the DCG (M) also oversees expert field medical badge testing.
- The **DCG (S)** has responsibility for the combat aviation brigade, fires brigade, division headquarters, and headquarters battalion. Other areas of responsibility include force health protection, profile review boards, fatality review boards, and wounded warrior programs. The DCG (S) also oversees the division deployment and redeployment efforts, and the sexual harassment/assault response and prevention and suicide prevention programs.
- The **CoS** coordinates staff actions with the corps staff and brigade combat teams in support of policy and guidance from the CG and deputy CGs. The CoS supervises the general and special staffs, and every activity that occurs within the division is of special interest to the CoS. The DIV SURG staff works with other staff officers and reports through the CoS to the DCG (S) to ensure they are apprised of all matters related to medical support.
- The **DCSM** is the principal advisor to the CG on all matters pertaining to noncommissioned officers (NCOs), enlisted soldiers, and soldiers' family members. This includes being apprised of the health and welfare of the command. The DCSM oversees expert field medical badge testing in support of the DCG (M), all warrior tasks and drills, and individual training of soldiers, including medical training.

The Division Surgeon Section

The DIV SURG section (Table 25-1) is headed by the DIV SURG, who is a special staff officer to the CG and the senior medical advisor for the division. In accordance with Army Training Publication 4-02.3, the DIV SURG "…coordinates AHS [Army Health System] support under the sustainment warfighting function with the division assistant chief of staff, logistics, the division chief of staff, and other headquarters elements that affect AHS support in the division."[1(p20)] The DIV SURG

Table 25-1. Division Surgeon Section personnel.

Paragraph title	AOC/MOS	Grade	Title	Branch	Quantity
Division Surgeon Section	60A00	O5	Surgeon	MC	1
	70H67	O5	Medical Operations Officer	MS	1
	60W00	O4	Psychiatrist	MC	1
	65D00	O4	Physician Assistant	SP	1
	67J00	O4	Aeromedical Evacuation Officer	MS	1 1
	70E67	O4	Patient Administration Officer	MS	1
	70H67	O4	Medical Plans Officer	MS	1
	70K67	O4	Health Service Materiel Officer	MS	1
	72D67	O4	Environmental Science Officer	MS	1
	68Z50	E9	Chief Medical Noncommissioned Officer	NC	1
	68W50	E8	Operations Noncommissioned Officer	NC	1
	68W40	E7	Operations Sergeant	NC	1
	68J30	E6	Medical Logistics Sergeant	NC	1
	68W30	E6	Medical Noncommissioned Officer	NC	1

LEGEND:

AOC	area of concentration	MS	Medical Service Corps
MC	Medical Corps	NC	noncommissioned
MOS	military occupational specialty	SP	Army Medical Specialist Corps

Reproduced from: Headquarters, Department of the Army. *Army Health System Support to Maneuver Forces.* HQDA; 2014. Army Training Publication 4-02.3:20.

section is staffed differently in the Army's various divisions (airborne, cavalry, armor, air assault). The example in Table 25-1 is comprised of 14 soldiers, including 9 officers and 5 NCOs. When deployed, the DIV SURG section can also be augmented by additional personnel such as a preventive medicine officer, public health nurse, and pharmacist.

Besides the DIV SURG and the DIV PA, two additional key roles within this section are the chief medical NCO and the Deputy DIV SURG. The chief medical NCO, who works closely with the DIV SURG and is the senior enlisted leader for the section, typically holds the rank of sergeant major. The chief medical NCO is responsible for the same functions as the DCSM related to medical tasks and the assignments of NCOs and enlisted personnel, while working closely with Human Resources Command (HRC), division manpower and personnel (G1), and the DCSM. The deputy DIV SURG is typically the senior medical operations officer within the section. The deputy DIV SURG coordinates and supervises the work of the DIV SURG staff, tracks all internal and external tasks and projects that involve the section, and attends the CG's staff meetings, funneling information and guidance from the meetings to the separate sections within the DIV SURG office. In some cases, the DIV PA serves as the deputy DIV SURG and chief of CLINOPS (discussed in more detail below).

Supervision

Supervision of the DIV PA is performed by the DIV SURG as outlined in Army regulations (ARs) 623-3,[2] 40-3,[3] and 40-68,[4] and in the local MTF credential policies. The DIV PA is typically rated by the DIV SURG and senior-rated by the division CoS.

Requirements

Those seeking a position as a DIV PA must:

- be a certified PA with ability to maintain credentialed provider status and Basic Life Support certification at the installation MTF;
- have the rank of a senior major (Intermediate Level Education graduate preferred);
- be capable of deploying outside the continental United States;

- have a history of diverse assignments, including as battalion or squadron PA, brigade or regiment PA, or another table-of-organization-and-equipment unit staff position;
- have writing skills using the Army writing style;
- have knowledge of computer automation systems, including the Medical Readiness Portal and all modules within the Medical Operational Data System (MODS); and
- be familiar with orders production.

Duties and Responsibilities

The DIV PA functions as the advisor to the DIV SURG on all PA matters and CLINOPS. In the division, the DIV PA may also serve as the chief of CLINOPS and/or as the deputy DIV SURG, depending on mission and section manning. Primary functions of the position are divided into three main categories: CLINOPS, MTF liaison, and professional development of PAs.

Clinical Operations

The DIV PA is responsible for keeping the DIV SURG informed of all clinical aspects of the division. This responsibility covers both garrison and field operations, so clinical aspects of the garrison standard operating procedures and the medical annex to all operations orders (OPORDs) are his or her responsibility, when delegated. The DIV PA coordinates and provides guidance to the brigade surgeons and PAs on:

- predeployment readiness, the sustained readiness model, and redeployment preparation, in accordance with regulatory guidance and close coordination with the installation soldier readiness processing site or deployment readiness centers[5,6];
- battalion or brigade aid station operations and operations within the Soldier-Centered Medical Home clinics;
- the first responder program and combat lifesaver course in accordance with Tactical Combat Casualty Care guidelines and the Joint Trauma System[7];
- medical training and sustainment for medics (68W military occupational specialty)[8];
- clinical aspects of medical evacuation for air and ground in

coordination with the MTF, installation emergency medical services, and installation training area range control for daily operations and mass casualty management;
- profiles and the profile review board, including controlled substance profiling and reporting;
- management of the Integrated Disability Evaluation System;
- coordinate for clinical quality management[4]; and
- continuing medical education and individual critical task list (ICTL) training for credentialed providers in the division.[8]

Military Medical Treatment Facility Liaison

Close coordination between the units and the local MTF are crucial to medical support for soldiers. All garrison health care is the responsibility of the MTF commander. The way in which a DIV PA augments the MTF's mission directly impacts the support provided by the MTF for the division. The DIV PA can help foster this relationship by participating in the risk management program, or by contributing to root cause analyses after serious adverse events. Coordinating calendars for borrowed military medical personnel clinic schedules, training, or deployment with the MTF and Soldier-Centered Medical Home will support continuity of care.

Physician Assistant Professional Development

Teaching, coaching, and mentoring the division's approximately 40 PAs is essential to the success of the division's medical mission and the professional development of Army PAs. Fostering an environment of support and teamwork and providing guidance on policies and systems that work will ensure that no one fails the commander.

- The DIV PA should begin by educating the brigade PAs on the essential items in a professional officer's career: the officer evaluation report (OER), officer record brief (ORB), Army photo, and curriculum vitae. ORBs (including photos) should be reviewed during each routine counseling session and updated as necessary. ORBs are used not only by promotion boards, but also by the 65D (PA) consultant and the HRC branch representative to facilitate selections for special assignments. Recommendations for each PA's personal growth,



Figure 25-1. Major Stephanie M. Bocanegra (left), the 1st Cavalry Division physician assistant, dedicates time during a command post exercise to promote Captain Joelle I. Black (right) to major at the 1st Cavalry Division Horse Cavalry Detachment in December 2019. Photo courtesy of Major Stephanie Bocanegra.

military and civilian education, and assignments are also discussed during counseling sessions. Consideration should be given to attending appropriate military education and leadership schools, such as the flight surgeon, air assault, airborne, or expert field medical badge courses, and attaining skill sets and additional skill identifiers (ASIs) while accomplishing ICTL-required training.[8] Each brigade PA and the DIV PA can review all OERs and ORBs to assist brigade surgeons in their rating responsibilities and PA career progression.

- The DIV PA should seek counseling and mentorship for themself by pursuing a monthly telephone or in-person conference with the corps PA (III, XVIII, or I Corps) and the US Army-Europe PA to collaborate and share lessons learned by all DIV PAs.
- The DIV PA manages division personnel in special positions requiring ASIs or specific experience, such as serving in a combat aviation battalion or being aeromedically qualified (Figure 25-1).

Garrison Duties

The DIV PA has additional duties that can be categorized as garrison and deployment duties. Garrison duties are those that the DIV PA performs when they are not deployed. The DIV PA's garrison duties depend on the unit of assignment and the expectations of the DIV SURG. The deputy DIV SURG coordinates day-to-day operations of all DIV SURG staff personnel and their products. The DIV PA's time, unless otherwise directed, is divided among meetings, staff work, training, and clinic. A variety of meetings are attended on a weekly, monthly, or quarterly basis, such as the following (dependent on unit command, higher headquarters, and installation MTF timelines):

- clinic provider meeting (weekly),
- DIV SURG synchronization meeting (monthly),
- soldier recovery unit approval meeting (monthly),
- Suicide Engagement Response Team meeting (monthly),
- PA meeting (monthly),
- division and corps profile review board (monthly and quarterly respectively),
- medical evaluation board preparation meeting (quarterly),
- MTF risk management meeting (as needed), and
- MTF root cause analysis meeting (as needed).

The DIV PA should review all OPORDs and fragmentation orders for clinically relevant material. On occasion an order that is solely clinical in nature must be written by the CLINOPS section, with the DIV PA taking the lead. Reporting is limited to clinical information such as the disease and nonbattle injury report, narcotics inventory reports during field operations, and immunization reports. Time during the month must also be scheduled for providing health care. Because the DIV PA is a staff officer, command



Figure 25-2. Major Christopher B. Cordova, the 4th Infantry Division physician assistant, conducts a medical advising engagement with the Afghan National Army, 203rd Corps, Medical School commandant, at Forward Operating Base Thunder in Gardez, Afghanistan, in February 2019. Photo credit Sergeant First Class Shana Hutchins.

group clinical support is not a primary responsibility, but it is essential for fostering the DIV PA's education and relations with colleagues.

The DIV SURG and DIV PA are responsible for the medical training conducted for division personnel. The DIV PA's ability to coordinate with the MTF, the installation medical simulation training center, and the Medical Center of Excellence at Joint Base San Antonio is vital to ensure that sustainment and predeployment preparedness medical training are conducted in accordance with Army Regulation (AR) 40-68,[4] Department of Defense Instruction 1322.24,[5] AR 350-1,[9] and Medical Command Pamphlet 40-7-21.[10]

Deployment Duties

During deployment operations, the DIV PA employs the training and preparation completed during garrison operations. Deployment is basically the capstone event, where the DIV PA's function will be tested. It is imperative to be up-to-date on medical regulatory guidance

and tactics, techniques, and procedures (TTPs); to remain resilient and confident; and to be available to leadership as well as subordinate unit leadership as a subject matter expert. During deployment, the DIV PA normally supports the CLINOPS section of the DIV SURG staff, which has three additional personnel assigned:

- A preventive medicine officer (60C) physician, or environmental science officer (72D) non-physician, assigned to perform disease and nonbattle injury surveillance, advise the DIV SURG on matters relating to disease prevention, and inspect food and water sites and contracting personnel.
- A public health nurse (66B), who assists the preventive medicine officer with surveillance, immunization tracking, rabies treatment monitoring, positive results on blood donation screening, and other assignments.
- A pharmacist (67E), who assists with narcotics inventory reports, adverse drug reactions, cold chain monitoring, and special drug requests (Figure 25-2).

Battlefield Circulation

One of the most important deployment functions of the DIV PA, as the chief of CLINOPS, is battlefield circulation. Battlefield circulation requires the DIV PA to move across the division footprint into brigade battlespaces to assess the different roles of care. This is not only a morale function, but will also address shortfalls, test new TTPs, and capture lessons learned from the overall experience. A regular rotation of visits to battalion aid stations throughout the operational environment can provide a wealth of experience and guidance to new providers and medics needing assistance. During battlefield circulation, information is gained that no amount of reporting can achieve.

As part of their battlefield duties, the DIV PA assists in preparations for Purple Heart presentations. The CG, DCSM, and a State Department senior civilian representative present Purple Heart medals at Role 3 MTFs to soldiers within their command. The DIV PA reviews the medical records for pertinent information to answer command group inquiries on the patient's condition prior to the presentation. The DIV SURG is responsible for briefing the CG, and may also be involved in briefing State Department officials prior to the presentation.

Personnel Recovery Coordination Cell Medical Advisor

The DIV PA is also the personnel recovery coordination cell (PRCC) medical advisor. The division is responsible if a soldier, sailor, airman, or marine becomes isolated due to capture, aviation mishap, or dislocation. During phase 1 reintegration of a formerly isolated returnee, the primary focus is the medical and psychological care of the returnee and the tactical debriefing.[11] The PRCC varies according to unit size and need, but contains at a minimum a chief; assistant chief; medical advisor; survival, evasion, resistance, and escape psychiatrist; and debriefer. As the medical advisor, the DIV PA advises the PRCC chief on the medical condition of the recovered personnel and the options for a timely debrief should the availability exist. Personnel recovery training is provided prior to deployment by the Joint Personnel Recovery Agency.[11,12]

Lessons Learned and Tips for Success

Good expectation management is essential when entering this position. Intending to take the position and change the PA world overnight will result in a great deal of frustration. In a time when PA shortages are significant, DIV PAs will fill different roles within subordinate units in order to assist with their mission. It is important to remain flexible, empower junior PAs to figure things out on their own, and try to "be the change you want to see."

Conclusion

The DIV PA plays an integral role in the overall Army health system, affecting division readiness and CLINOPS in both garrison and deployed settings. The DIV PA is a leader and subject matter expert who works hand-in-hand with the DIV SURG in key advisory and operational roles while synchronizing health service support across division activities. DIV PAs serve as a bridge between the unit and the MTF, promoting readiness, health protection, and preventive care while also coordinating sustainment warfighter functions, continuing education training, clinical quality care, and professional development. To serve as a US Army DIV PA is an incredible honor and a credit to those selected.

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Chapter 26

ROLE OF THE PHYSICIAN ASSISTANT AS THE CONGRESSIONAL LEGISLATIVE LIAISON

Sean M. Donohue, PA-C, MPAS, and Maureen Giorio, PA-C, MPAS, MHA

"The Congress shall have the power to . . . raise and support Armies, but no Appropriation of Money to that use shall be for a longer term than two years."

—Article I, Section 8, Clause 12 of the US Constitution

Introduction

The mission of the Office of the Chief, Legislative Liaison (OCLL), is to provide effective liaison between the US Army and Congress to gain congressional trust and support. This is a strategic mission that involves the participation of legislative subject matter experts from across the Army. The chief of legislative liaison (CLL) is directly responsible to the secretary of the Army (SECARMY) regarding legislative affairs, including formulating, coordinating, supervising, and executing the Army's congressional policy and strategy. The CLL ensures the overall integration of the Army's efforts with Congress, develops comprehensive congressional engagement strategies for Army senior leaders (ASLs), and disseminates critical information on all significant congressional activities.[1]

Army congressional fellows, other Army officers, senior noncommissioned officers (typically sergeants major), and Army civilians comprise the staff of OCLL. These individuals represent various interests and portfolios to members of Congress (MoCs) and their personal and professional staff. Numerous Army civilians,

including two in Senior Executive Service positions, manage daily operations, strategic planning, and routine correspondence to MoCs and congressional staff who serve on committees of authorization (primarily the House Armed Services Committee, and Senate Armed Services Committee, and associated subcommittees). The assistant secretary of the Army for financial management, budget liaison (SAFM-BUL), accomplishes much of the same functions as the OCLL; however, the SAFM-BUL deals specifically with MoCs responsible for congressional appropriations (eg, the House Committee on Appropriations–Defense).

Army Medicine Within the Legislative Community

Army medicine maintains two positions within the legislative liaison community. The first position is an 05A (area-of-concentration-immaterial Medical Portfolio Lead) within the OCLL Programs division, which has been occupied by officers from the varying medical branches of the Army Medical Department (Army Nurse Corps, Medical Specialist Corps, Medical Corps, Medical Service Corps). This position is assigned to the Army Medical Command (MEDCOM) with duty in the Pentagon under the personnel services directorate. The position covers all topics germane to Army health care and is focused on defense authorizers with oversight interests in the Army health system, as well as committees within their jurisdiction, including the House and Senate armed services committees. Typically, the officer is a senior major and a Command and General Staff College graduate who is selected by the Office of the Surgeon General (OTSG) in consultation with MEDCOM.

The second position, coded for a 70C (Medical Comptroller), is assigned to OTSG with duty at SAFM-BUL, also located at the Pentagon. The SAFM-BUL position focuses exclusively on congressional appropriation committees. The OCLL and SAFM-BUL medical portfolio liaisons work closely with the MEDCOM congressional affairs contact officer (CACO) and senior OTSG/MEDCOM leaders to craft Army medicine messages, develop a congressional engagement strategy to socialize and explain Army medical policies to relevant MoCs and committees, escort Army medical leaders to meetings and hearings on Capitol Hill, and escort MoCs and their staff to Army health care entities worldwide.

A third position was established within the OCLL House Liaison Division (HLD) by Lieutenant General Patricia Horoho, the 43rd Army surgeon general, to increase the Army medicine presence on Capitol Hill and perform critical functions as a forward medical liaison. As liaison to the House, this person serves the preponderance of the congressional community. Responsibilities of this position are primarily those of a legislative liaison and include planning, supporting, and executing Army events on Capitol Hill; rapidly responding to questions about medical policy and operations; supporting ASL meetings and engagements with MoCs and their staff; and supporting congressional travel when requested. As a MEDCOM asset, the position provides an unparalleled opportunity to support Army medical leadership engagements on Capitol Hill.

Unit Structure

The OCLL falls under the Secretariat of the Army (Figure 26-1) and is led by a major general who reports directly to the under secretary of the Army and the SECARMY (both of whom are nominated by the president and confirmed by the Senate). Within OCLL are seven subdirectorates (Figure 26-2), each led by a colonel (or GS-15 civilian): the House, Senate, Operations, Inquiry, Programs, Investigations and Legislation, and Management and Support divisions.[2] The Senate division functions much like the House division, but with a smaller staff. The Operations division manages OCLL plans, training, and strategy. The Inquiry division tracks, researches, and replies to inquiries originating from MoCs and their staff. The Programs division contains subdivisions that manage various portfolios, including medical, munitions, tracked vehicles, rotary-wing aircraft, cyber, missile defense, personnel, and many other subjects. Investigations and Legislation manages all operations involving legal review and prepares political appointees and general officers for confirmation hearings. The Management and Support office conducts the daily management of OCLL and supports congressional travel operations. The medical legislative liaison is typically rated by the division deputy chief (a GS-14 civilian) and senior-rated by the division chief, usually a colonel or equivalent (O-6 or GS-15).[2] A liaison who is a practicing medical provider may choose to have an intermediate rating by their supervising physician if applicable under the provisions of Army Regulation (AR) 623-3, *Evaluation Reporting System*.[3]

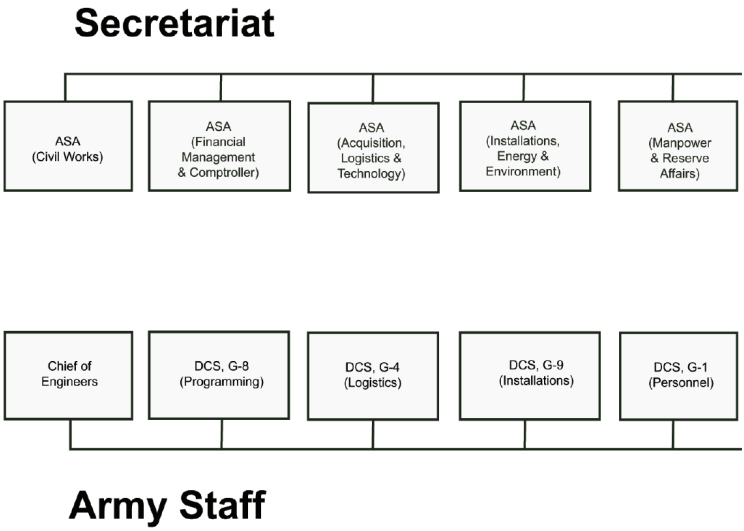
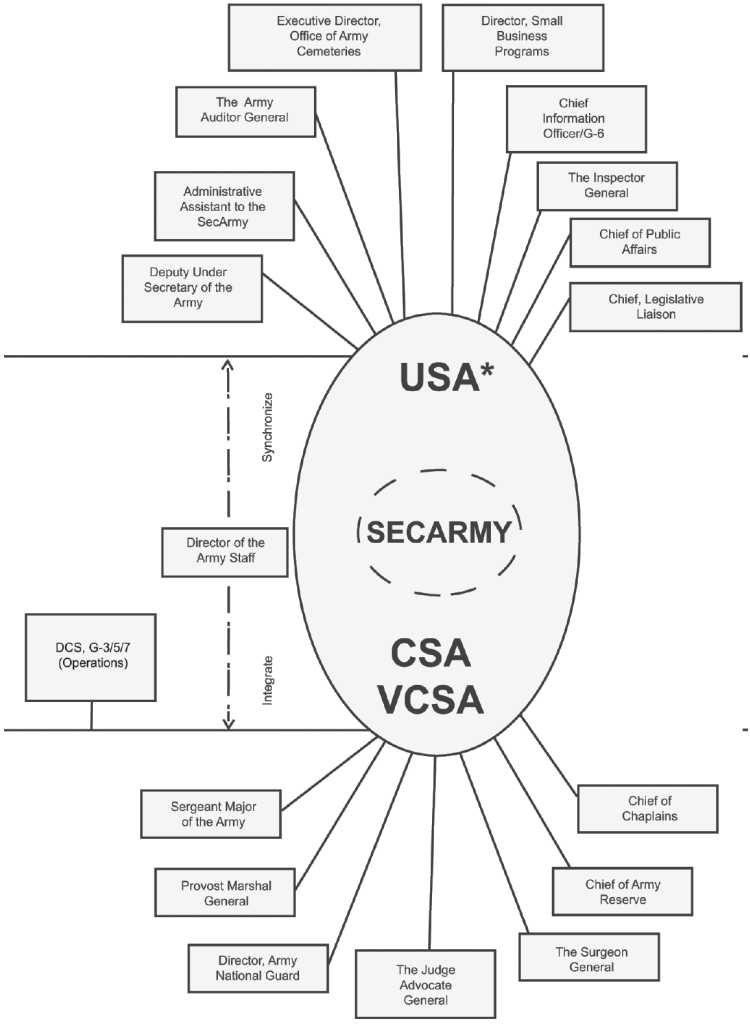


Figure 26-1. Structure of the Headquarters, Department of the Army.
ASA: Assistant Secretary of the Army
CSA: Chief of Staff of the Army
DCS: Deputy Chief of Staff
SECARMY: Secretary of the Army
USA: Under Secretary of the Army
VCSA: Vice Chief of Staff of the Army


Executive Director, Office of Army Cemeteries
Director, Small Business Programs
The Army Auditor General
Chief Information Officer/G-6
Administrative Assistant to the SecArmy
The Inspector General
Deputy Under Secretary of the Army
Chief of Public Affairs
Chief, Legislative Liaison
USA*
Synchronize
SECARMY
Director of the Army Staff
DCS, G-3/5/7 (Operations)
Integrate
CSA
VCSA
Sergeant Major of the Army
Chief of Chaplains
Provost Marshal General
Chief of Army Reserve
Director, Army National Guard
The Judge Advocate General
The Surgeon General

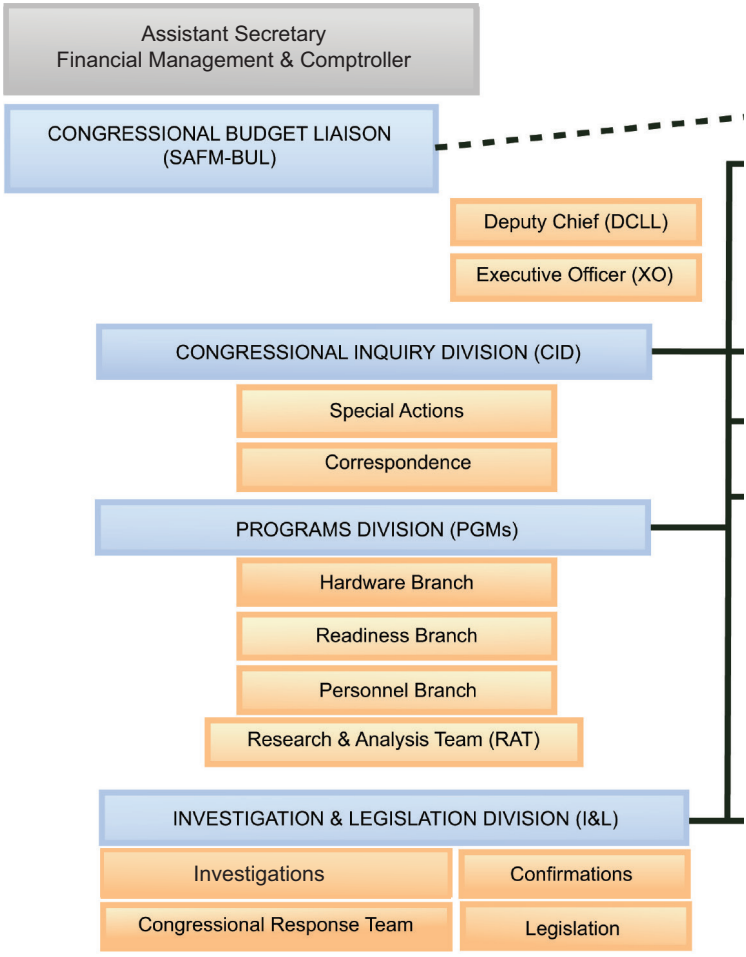
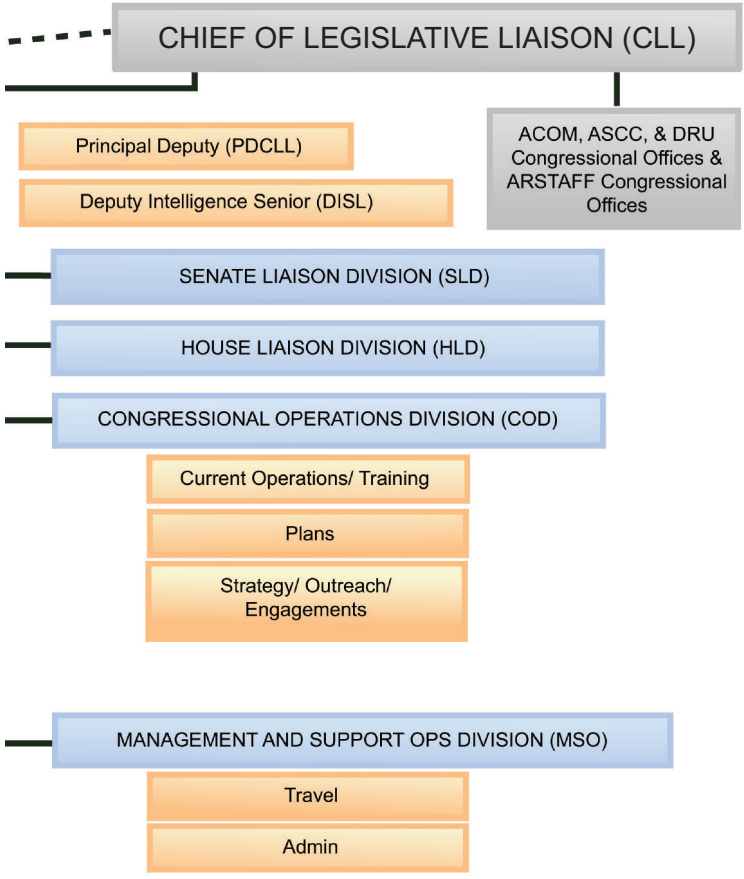


Figure 26-2. Office of the Chief, Legislative Liaison, organization chart.
ACOM: Army command
ARSTAFF: Army staff
ASCC: Army service component command
DRU: direct reporting unit
SAFM-BUL: Secretary of the Army, Financial Management–Budget Liaison


CHIEF OF LEGISLATIVE LIAISON (CLL)
Principal Deputy (PDCLL)
Deputy Intelligence Senior (DISL)
ACOM, ASCC, & DRU Congressional Offices & ARSTAFF Congressional Offices
SENATE LIAISON DIVISION (SLD)
HOUSE LIAISON DIVISION (HLD)
CONGRESSIONAL OPERATIONS DIVISION (COD)
Current Operations/ Training
Plans
Strategy/ Outreach/ Engagements
MANAGEMENT AND SUPPORT OPS DIVISION (MSO)
Travel
Admin

Legislative Liaison as a Clinician

The legislative liaison position is not wholly consistent with the execution of routine clinical duties due to the OCLL's high operational tempo. With planning, however, the position is amenable to maintaining at least the minimum clinical requirements called for in policy: title 37 USC § 335, Pay and Allowances of the Uniformed Services[4]; Department of Defense Instruction (DoDI) 6000.13, *Accession and Retention Policies, Programs, and Incentives for Military Health Professions Officers*[5]; and AR 40-68, *Clinical Quality Management*.[6]

Options for credentialing in the national capital region (NCR) are numerous, including Walter Reed National Military Medical Center, the Fort Meade Army Medical Activity, and Fort Belvoir Community Hospital. DiLorenzo Troop Medical Clinic (DTMC), under the oversight of Fort Belvoir, is located in the Pentagon (8th corridor) and may provide the most appropriate option for guest providers due to its proximity to Capitol Hill and the OCLL-HLD offices. Individuals can easily utilize the Washington DC Metro, Pentagon shuttles, or a personal vehicle (parking is available at the Pentagon). The Fort McNair Army Health Clinic, under the oversight of Fort Meade, and Radar Health Clinic, at Joint Base Myer-Henderson Hall, also offer guest provider options, with dedicated parking and quick access to the Waterfront Metro Station. The DTMC serves a preponderance of the 26,000 people working in the Pentagon and consistently needs support in the acute, primary, or executive care clinics. Credentials and privileges at DTMC are obtained through the credentialing coordinator at Fort Belvoir. It is also possible to work at other regional clinics within the NCR, including Fort Myers, Joint Base Anacostia–Bolling, and Andrews Air Force Base.

Numerous MoCs and their staff are members of the Army National Guard or Reserve and routinely contact OCLL for various support functions. When OCLL-HLD is occupied by a credentialed and privileged provider, the position is capable of supporting basic Army medical readiness requirements, such as periodic health assessments and vision screenings, for these individuals; additional support can be provided as appropriate. Providers assigned to OCLL do not function as the primary care provider or medical operations officer for MoCs or the OCLL and should maintain caution and boundaries as appropriate. Health care

for MoCs and congressional staff with congressional health insurance is provided by the Office of the Attending Physician or through the individuals' insurance provider.

Daily Operations

Liaisons who work exclusively on Capitol Hill usually wear formal business attire (business suits that are dark in color, white or blue shirt with a conservative tie, or similar attire for men, and commensurate business attire for women). When Congress is not in session, more relaxed business casual attire is appropriate (eg, open-collar shirts or Army-related polo-style shirts). There is no uniform allowance for officers assigned to OCLL. When working at the Pentagon, liaisons may wear the Army Combat Uniform (ACU) within the building, but must wear formal business attire (or Army Service Uniform with cap or Army Green Uniform with cap) when conducting business on Capitol Hill. At no time should soldiers wear the ACU on Capitol Hill. When escorting ASLs, liaisons commonly wear business attire. When traveling in support of congressional delegations or congressional staff delegations, liaisons should anticipate wearing both business attire and business casual attire throughout; liaisons will not wear military uniforms or carry weapons (Figure 26-3).

Beyond daily interaction with military legislative staff, liaisons provide a critical role in supporting and shaping congressional oversight travel. MoCs and their staff routinely execute oversight visits to military treatment facilities (MTFs) and other medical facilities to ensure that the Department of Defense (DOD) and Army Medical Department (AMEDD) are responsible stewards of appropriated funds and in compliance with legislative changes and policy implementation. Congressional travel may be investigative in nature (causing elevated concern), or purely informational (Figure 26-4). In conjunction with various CACOs, liaisons help develop delegation itineraries that include presentations, demonstrations, tours, and activities of interest to the MoC or their staff. Coordinating for travel includes planning for all aspects, including but not limited to arranging air and ground transportation; coordinating with government, nongovernment, and possibly foreign agencies to conduct requested meetings; managing all baggage and support supplies for travel, planning events, and meals; and managing and disbursing per diems. The OCLL Management Support Operations office supports liaisons in these efforts.



Figure 26-3. Major Sean Donohue and Representative Greg Harper of Mississippi's 3rd Congressional District, in Provence, France, on a congressional delegation addressing national museums, digitizing national archive content, and cybersecurity for national museum operations; May 2019.



Figure 26-4. Congressional staffers observe a demonstration at the Tactical Combat Medicine Course, Joint Base San Antonio, Texas, September 2018.

Liaisons may also be tasked with coordinating and executing Army briefings in the US Capitol complex. This includes advertising the events, contracting for catering, and providing a room and audio-visual support. Liaisons may also plan for and execute large-scale events such as the Army Birthday Congressional Cake Cutting ceremony (Figure 26-5), the Joint Service Congressional Social, and other Army and Defense Secretariat-level congressional receptions. Liaisons may also be called on to support other defense and NCR missions such as state funerals, the State of the Union address, and the presidential inauguration.

Medical Recruiting Liaison

The legislative liaison positions also serve as a liaison between Army medical recruiting and Congress. Historically, the OCLL-HLD liaison has assisted in the recruitment of MoCs into the Army Reserve Medical



Figure 26-5. Lieutenant Colonel Maureen (Mo) Giorio stands in the US Capitol Congressional Atrium during the Army Birthday Congressional Reception, June 2016. The Congressional Cake Cutting ceremony recognizes the connection the Army has with Congress and the establishment of the Continental Army by congressional resolution in 1776.

Corps, assisted staff with enlisting in the Army, recruited civilians visiting the office, and helped congressional offices assist constituents who join the AMEDD through their local medical recruiting office.

Army Congressional Fellowship Program

Those wishing to complete the Army Congressional Fellowship Program should reference AR 1-202, *Army Congressional Fellowship Program.*[7] The fellowship program provides outstanding commissioned officers, noncommissioned officers, and Army civilians with firsthand experience and understanding of the strategic relationships between the Army and Congress, and allows fellows to learn about the Army as an institution through contact with Army personnel working in their office. Officers wishing to apply for the fellowship should be in the grade of captain or major (O-3 or O-4), with at least 6 years of active federal commissioned service, and have graduated from the Captains Career Course. Upon selection by the annual liaison selection board, students will conduct a permanent change of station move to the NCR, with an assignment to the Army Student Detachment at Fort Jackson, South Carolina. Fellows will complete a Masters in Legislative Affairs at George Washington University and work as a legislative fellow within the office of a MoC (typically a member of the House Armed Services Committee). Upon completing the fellowship, the officer will execute a 2-year utilization tour and concurrent active duty service obligation with OCLL or SAFM-BUL. (Selection for the fellowship as an Army medical officer does not mean that the officer will serve their utilization as the medical liaison.)

Medical Command Congressional Affairs Contact Officer

The MEDCOM CACO is a colonel (O-6) position serving as a personal staff officer to the surgeon general. The CACO's staff includes two major (O-4) positions, one senior enlisted, and two civilians (Figure 26-6). The MEDCOM CACO is the proponent for all Army medicine-related issues involving Congress, supporting AMEDD and OTSG efforts such as congressional testimony, and supporting the OCLL Programs medical lead. The MEDCOM CACO also interviews and recommends officers for proponency positions within OCLL when appropriate. It is also worth

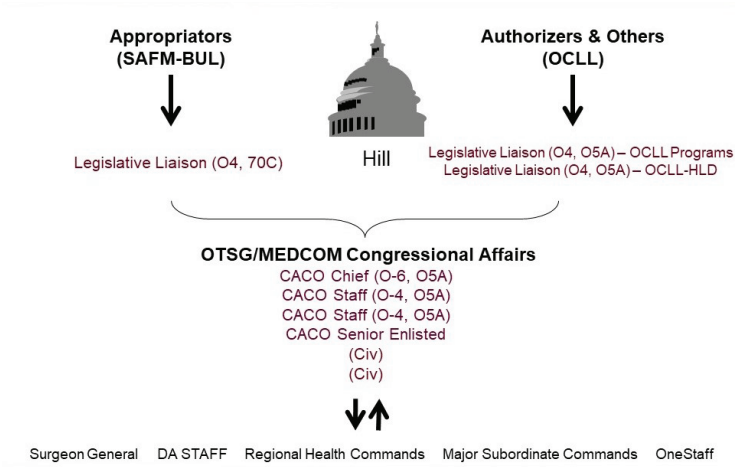


Figure 26-6. Legislative relationships and structure.
CACO: Congressional Affairs Contact Office
CIV: civilian
HLD: House Liaison Division
OCLL: Office of the Chief, Legislative Liaison
SAFM-BUL: Secretary of the Army, Financial Management–Budget Liaison

noting that most Army garrisons and division elements and above have a formal or informal CACO responsible for congressional interactions, often combined with the political advisor position. Historically, the O-4 staff positions have been filled by a Medical Service Corps officer, one of whom concentrates on appropriations (budgeting) and the other on authorizations (programmatic). In 2016, a 65D (Army Physician Assistant [PA]) served in the appropriation position (therefore, precedence exists for future consideration of PAs). A clinician working as a CACO must be prepared for an increased operational tempo; however, guest privileges can be obtained for biweekly or monthly clinic time for skills maintenance (see Legislative Liaison as a Clinician, above).

While the CACO position is largely a deviation from clinical practices, it rewards the clinician with a greater understanding of medical policy and the delicate balance of the finite medical resources required to achieve readiness across the Army, MTFs, and other military services. A clinician as CACO also has a unique opportunity to see and learn from best practices across clinical service lines, MTFs, Centers of Excellence,

and operational units—and how to avoid common clinical leadership issues and pitfalls. Moreover, there is ample mentorship opportunity and face-time with ASLs. Skills gained in the CACO position set up the PA clinician for future broadening and leadership opportunities.

The CACO's staff communicate daily with the legislative liaison to support and enhance the overall congressional engagement strategy. As liaisons plan and organize staff and congressional delegations, the CACO's staff works in parallel to prepare medical leaders and MTF commanders for visits. Delegation preparation includes a thorough analysis of current political optics, MoC interests, past congressional visits, and any relevant activities to highlight. Delegations are *strategic opportunities* for ASLs to communicate success, needs, and challenges to legislators. Military services are unable to lobby; therefore, the liaison, CACO, and ASLs must synergize efforts to ensure that timely information is delivered via the right platform to successfully influence future legislation or policy implementation.

CACO staff also prepare official responses to congressional inquiries, compose oral and written testimony for the surgeon general, and prepare witnesses (ASLs) for congressional hearings. Testimony writing and preparation is a sensitive and time-consuming process that can be stressful when a hearing is called on short notice or in response to a negative issue.

The CACO, OTSG staff, legislative liaison, and senior leaders work closely to ensure delivery of consistent themes, messages, and talking points, and to articulate best practices and relevant concerns across MTFs and other medical equities. Of recent interest, the military health system reform first prescribed in the 2017 National Defense Authorization Act (NDAA) has dominated ASL attention and the AMEDD's congressional interactions. Changes set in motion by this groundbreaking legislation have caused both concerns and opportunities for care delivery. The CACO and legislative liaisons serve as the AMEDD's front line to form and maintain beneficial relationships and facilitate key leader meetings to communicate concerns, affected entities, and projected outcomes associated with the NDAA and related policy implementation.

Desired Skills and Attributes

Those considering service with OCLL, as CACO, or as a congressional fellow should have solid and advanced organizational, writing, and briefing skills; maintain good fiscal habits; and be comfortable with

public speaking. A history in government policy or politics is not required but can be helpful. Because liaisons are routinely trusted with sensitive national military strategic messaging priorities, sensitive social military topics, and large sums of money, a solid ethical and moral footing is paramount to success. To be successful, individuals serving in the OCLL must be sound time managers, as well as proving themselves accountable, efficient, and dutiful.

Lessons Learned

Army PAs thinking of serving within the congressional community should consider several issues before undertaking such a position, primarily the impact on family. Living in the NCR can be fun and exciting, with the proximity to museums, sports, and outdoor activities, but the area is also notorious for traffic problems. Housing becomes more affordable the further it is from the Pentagon or the Capitol, but even a mile outside the beltway can significantly increase commute times. However, joint-basing has improved options for those who desire to live closer to the city and are willing to make some trade-offs. Joint Base Anacostia-Bolling is on the southeast side of Washington and within an easy commute of the Capitol or the Pentagon by car or commuter bus. Because liaisons must often work hours outside the typical 0800 to 1700 workday, and there is consistent travel (typically flying from Dulles or Reagan National airports, and occasionally from Andrews Air Force Base), choosing where to live is important.

Inconsistent schedules also make it difficult to maintain personal fitness. Legislative liaisons working at the Capitol can join the congressional staff gym for a nominal fee; those working at the Pentagon or MEDCOM headquarters also have gyms within their respective footprints.

Liaisons working in the congressional realm must be responsive and tactful. Any engagement, from email to casual conversation, may include topics of national interest and defense policy. Liaisons must understand that their every word may be circulated well outside their immediate realm of influence and be seen and heard by numerous general officers and elected officials. It is crucial to understand that a liaison's role is to stick to talking points while remaining approachable and forthright in conversation. Although it is best to maintain conduct as though every conversation is "on the record," there are still many

opportunities to forge personal relationships with congressional staff and MoCs. Liaisons must not forget they are specially selected representatives of the Army and DOD.

Tips for Success

Legislative liaisons must be highly organized and detail-oriented; have solid grammar and editing skills; and be proficient in Microsoft Office software. To guide the approach of ASLs to MoCs and their staff, it is imperative that liaisons and CACOs track the MoCs' personal preferences, committee assignments, and constituent interests. Liaisons must maintain close working contacts across congressional offices to understand the mood and opinions on Capitol Hill. These relationships are forged with hard work and consistent contact; they subsequently help inform ASLs about congressional opinions of Army efforts and programs. Coordinating correspondence and requests for information



Figure 26-7. Major Sean Donohue (second from the left) with members of the Army House Liaison Division staff and the 54th Speaker of the House, Paul Ryan, during the 115th Congress.

are essential to daily liaison operations, who must ensure that each question is answered to the satisfaction of the office requesting the information (Figure 26-7).

Conclusion

Service as a legislative liaison or a CACO is a highly competitive and rewarding broadening opportunity that brings selected individuals into daily contact with senior DOD and elected government leadership. These assignments will provide participants a high-level, behind-the-scenes understanding of the legislative branch of government and Army operations.

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Chapter 27

ROLE OF THE PHYSICIAN ASSISTANT IN A JOINT ENVIRONMENT

Cleve Sylvester, PA-C, DSc, MPAS, and Colin Frament, APA-C, MPAS

> The Joint Chiefs of Staff, in view of their global responsibilities and their perspective with respect to the worldwide strategic situation, are in a better position than any single theater commander to assess the risk of general war. Moreover, the Joint Chiefs of Staff are best able to judge our own military resources with which to meet that risk.
>
> *—Chairman of the Joint Chiefs of Staff Gen. Omar N. Bradley to the Senate Foreign Relations Committee, 1951*[1]

The Army physician assistant (PA) serving at the Office of the Joint Staff Surgeon (OJSS), Joint Staff, Pentagon, must have a firm set of clinical and operational skills with significant planning acumen. It is important to begin the tour of duty with basic knowledge of joint operations and understand that the joint environment transcends all services, specialties, and combatant commands (CCMDs).The PA must have or be prepared to develop a strategic mindset, with the ability to conduct analyses, develop processes, generate solutions, articulate risks to senior leaders at the three-star and four-star levels, and occasionally convey the Department of Defense (DOD) position on applicable subject areas to congressional leaders and other government agencies. The Army PA is the most well-rounded medical officer in the DOD, and as a Joint Staff officer, must always be prepared to offer subject matter expertise on demand. This expertise may range from individual medical readiness to operational medicine or even hospital operations. The PA experience is instrumental in providing crucial insight that may shape care for the warfighter across the joint force.

Strategic Environment

The PA must be prepared to interface and coordinate with both military and civilian senior leaders, including general/flag officers, congressmen, department secretaries, and foreign representatives. Senior leaders expect good staff officers to have well-developed communication and technology skills, including conducting basic research, using productivity software, and performing general analyses. Additionally, the staff officer must acquire working knowledge of other capabilities such as the Joint Staff tasking management system, the Joint Staff action process (JSAP), and other joint systems and tools such as the Joint Operations Planning and Execution System (JOPES); the Joint Capabilities Integration and Development Systems (JCIDS); the Joint Training Information Management System (JTIMS); and the integrated priority list process.

All Joint Staff officers, including the PA, must have a firm understanding of national strategies as well as the roles, duties, and responsibilities of the chairman of the Joint Chiefs of Staff (CJCS) and the Joint Staff; the PA must also focus on the roles and responsibilities of the Joint Staff surgeon. This perspective is extremely important when framing responses and corresponding across the joint force. Arriving on the Joint Staff with some basic knowledge may significantly ease transition and potentially decrease the learning curve—slightly. For starters, awareness of national strategy, joint doctrine, and the function and priorities of the OJSS may be very helpful. The following major national strategy documents drive all military operations and are required knowledge for all Joint Staff officers.

- **The National Security Strategy (NSS)** informs the National Defense Strategy (NDS), which, in turn, informs the National Military Strategy (NMS). The NSS is written by the White House (executive branch) and presented to the American public and Congress during the president's State of the Union address. The document is grounded in the Goldwater Nichols Act of 1986 and outlines the president's assessment of the capabilities necessary to mitigate threats to the nation. The administration presents both a classified and unclassified version of the report.[2]
- **The National Defense Strategy (NDS),** written by the secretary of defense, is informed by the NSS. The NDS outlines the threats to the

complex global security environment and the risks and challenges posed by great power competition. The 2018 NDS states, "The central challenge to US prosperity and security is the reemergence of long-term, strategic competition by what the National Security Strategy classifies as revisionist powers."[3] As such, the three lines of effort outlined in the strategy are (1) rebuilding military readiness through a more lethal joint force; (2) strengthening alliances and partners; and (3) reforming the DOD's business practices for higher performance and affordability.

- **The National Military Strategy** (NMS), written by the Joint Chiefs of Staff and signed by the CJCS, is informed by the NDS. It is issued to the secretary of defense and outlines the strategic aims of the armed services. The 2018 NMS provides an integrated approach composed of three national military objectives: (1) to deter, deny, and defeat state adversaries; (2) to disrupt, degrade, and defeat violent extremist organizations; and (3) to strengthen the global network of US allies and partners.[4] The NMS also includes the overlapping concept of the "continuum of strategic direction": "Force employment (how the Joint Force will meet the challenges of the current strategic environment); Force development (adaptation of the existing Joint Force to do what it does better; and Force design (innovation to enable the Joint Force to do what it does differently in a fundamentally disruptive way)."[5]

The Joint Staff

The PA may have the opportunity to directly engage the CJCS and executive staff (vice chairman, director of the Joint Staff, vice director of the Joint Staff), as well as other military and civilian leaders. Therefore, it is important to understand the Joint Staff and its functions (Figure 27-1). The Joint Chiefs of Staff consist of the CJCS, the vice chairman of the Joint Chiefs of Staff, the chief of staff of the Army, the chief of naval operations, the chief of staff of the Air Force, the commandant of the Marine Corps, and the chief of the National Guard Bureau.[6] The CJCS is the senior ranking member of the Joint Chiefs of Staff. *The Joint Staff supports the* CJCS *in meeting the congressional* intent to provide "(1) for the unified strategic direction of the combatant forces; (2) for their operation

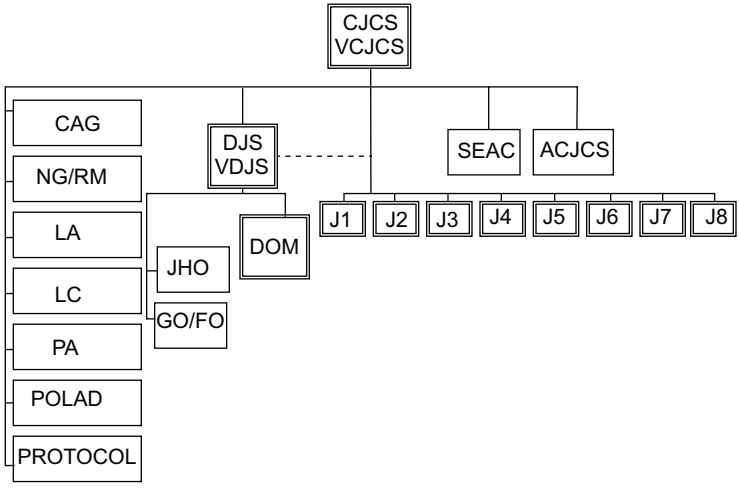


Figure 27-1. The Joint Staff organizational structure.
ACJCS: Assistant to the Chairman, Joint Chiefs of Staff; CAG: Chairman's Advisory Group; CJCS: Chairman, Joint Chiefs of Staff; DJS: Director, Joint Staff; DOM: Directorates of Management; GO/FO: General Office/Flag Officer; JHO: Joint History Office; LA: Legislative Affairs; LC: Legal Counsel; NG/RM: National Guard and Reserve Matters; PA: Public Affairs; POLAD: Policy Advisor; SEAC: Senior Enlisted Advisor to the Chairman; VCJCS: Vice Chairman, Joint Chiefs of Staff; VDJS: Vice Director, Joint Staff

under unified command; and (3) for their integration into an efficient team of land, naval, and air forces."[7] Responsibilities as members of the Joint Chiefs of Staff take precedence over duties as the chiefs of military services.[6] The CJCS is the global integrator and exercises Title 10 responsibilities that include comprehensive joint readiness, strategic direction and planning, global military integration, joint capability, and joint force development.[8] In the role of global force integrator, the CJCS has the responsibility of advising the secretary of defense on the risks to the mission and risks to the force involved in the transfer and allocation of forces across geographic commands. Staff sections, called joint directorates, that support the CJCS in their duties are as follows[9]:

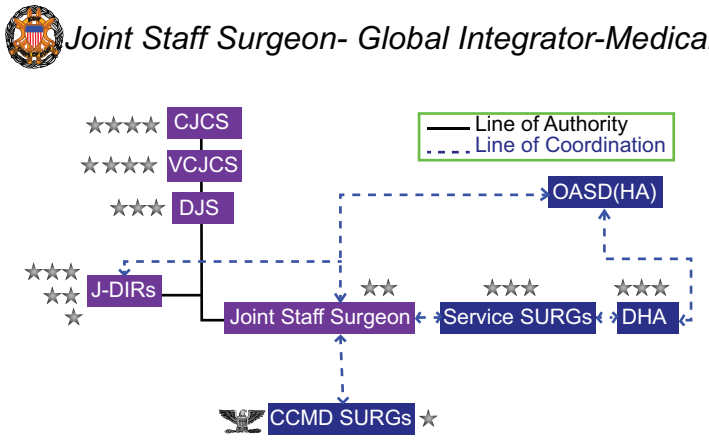


Figure 27-2. Joint Staff global medical integration. The Joint Staff surgeon maintains robust lines of coordination across the Department of Defense. CCMD SURG: Combatant Command Surgeon; DHA-Defense Health Agency; J-Dir: Joint Directorate; OASD(HA): Office of the Assistant Secretary of Defense for Health Affairs

DOM: Directorates of Management
J1: Manpower and Personnel
J2: Intelligence
J3: Operations
J4: Logistics
J5: Strategy, Plans, and Policy
J6: Command, Control, Communications, and Computers/Cyber
J7: Joint Force Development
J8: Force Structure, Resources, and Assessment

The OJSS, originally under J4, is now under DOM (see Figure 27-1).

Office of the Joint Staff Surgeon

The Joint Staff surgeon is the global medical integrator for the Joint Staff and synchronizes health services to enable globally integrated

operations across the joint force (Figure 27-2). In this capacity, the Joint Staff surgeon provides medical advice to the CJCS; oversees medical requirements and capabilities; manages education, evaluations, and assessments; synchronizes CCMD and service efforts; and maintains a full sphere of influence through strong coordination relationships with other government agencies, the CCMDS, and the services. The OJSS is responsible for several strategic documents that shape medical operations across the DOD, two of which are Joint Publication (JP) 4-02, *Joint Health Services*,[10] and the *Joint Concept for Health Services (JCHS)*.[11]

- JP 4-02 is the doctrine for health services support across the joint force, and provides guidance for the exercise of authority by the CCMDs and other joint force commanders regarding force health protection, health service support operations, and health service support planning.[10] The PA must fully understand the scope and purpose of JP 4-02 and may be a key player in its interpretation and ultimately its revision.
- The JCHS, released by the CJCS in 2015, presents a comprehensive set of medical capabilities that enable joint, integrated, and optimized health services across the continuum of care. The JCHS is informed by several strategic documents,[11] including the *MHS Strategic Plan: A Roadmap for Medical Transformation*, 2008; *The Joint Operating Environment*, 2010; *Health Readiness Concept of Operations*, 2010; the Navy Medicine Strategy Map FY15,[12] and the *2018 Army Medicine Campaign Plan*.[13]

Unit Structure

Currently there are eight permanent positions on the OJSS manning document. The other 13 personnel on staff are a mix of contractors, liaison officers, and detailed personnel from the services. The OJSS is a two-star billet, with a civilian deputy (GS-15) and a uniformed deputy (O-7 [general or flag officer] or O-6 [colonel or captain]). The rest of the staff include specialists in plans, operations/logistics, clinical operations, force health protection, and strategic management. This composition may change based on availability of personnel.

Knowledge, Skills, and Attributes

The PA's experience and prior assignments on the Joint Staff will impact their effectiveness and efficiency. Previous assignments at the Army Medical Command and or a CCMD will assist them in understanding the roles and responsibilities of the Joint Staff surgeon. The PA's expertise and clinical experience become important during meetings, working groups, and capability-based assessments. The PA is a clinical subject matter expert on readiness and care of the warfighter. The operational experience a PA has from supporting "the line" can be instrumental in providing perspective during discussions that will impact the future of the joint medical force and how care is provided to service members. Concise written and verbal communication skills are important to being a successful staff officer, and the PA's ability to write and brief effectively will continue to be developed during a Joint Staff assignment.

Duties and Responsibilities

The primary duties and responsibilities of the PA are to assist the Joint Staff surgeon in providing the CJCS with the best medical advice on time, every time. A PA assigned to the OJSS should be the rank of lieutenant colonel or major (promotable) and have completed the requisite professional military education. Prior assignment as a Joint Staff intern, an Army staff officer, or CCMD staff officer may enhance understanding of the strategic environment and better facilitate strategic planning and resourcing at the OJSS.

Daily Routine

The OJSS has a very dynamic "battle rhythm." The typical day begins with the morning meeting, nicknamed the "Jolt," in which the staff provides an internal update and attempts to synchronize and crosswalk priorities, actions, tasks, and deliverables. Generally, the Monday Jolt includes an update to the Joint Staff surgeon, and the Tuesday Jolt includes a session on professional development. The rest of the day is spent performing staff work, coordinating, planning, performing action officer (AO) taskings, and attending meetings. A significant portion of the day is spent coordinating and generating correspondence. This

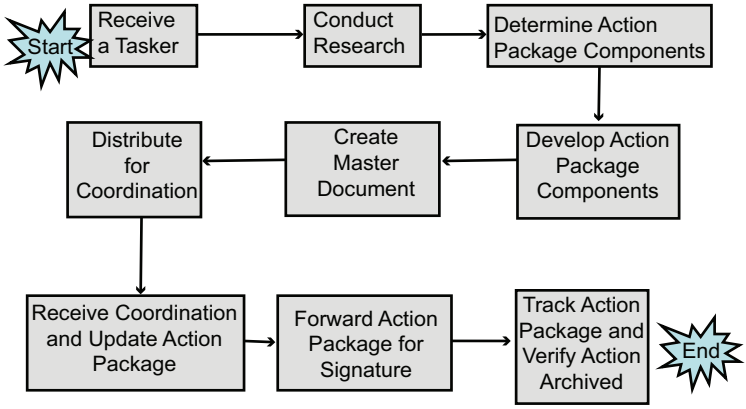


Figure 27-3. Joint Staff action package process flowchart.

includes a lot of research, reading, and writing action and information memoranda, information papers, position (decision) papers, and talking points. Other correspondence includes fact sheets, memoranda for the record, background papers, and coordination papers (summary sheets, letters, messages, and estimates).[14]

The PA will become integrated into the team that steers the joint force into the future while simultaneously receiving a high level of professional military education as outlined in *Developing Today's Joint Officers for Tomorrow's Ways of War: The Joint Chiefs of Staff Vision and Guidance for Professional Military Education & Talent Management*.[15] The PA generates products that will influence decisions at the level of the secretary of defense and, on occasion, assist Congress and the White House in shaping national policies. The OJSS is the Joint Staff's repository for all things medical, and the PA supports the Joint Staff surgeon in providing the best available military medical advice to the CJCS. The PA must be mentally agile and flexible, and must be prepared to respond to inquiries at the speed of strategic relevance. A tardy but accurate answer (in some cases, minutes late) may no longer be needed because the discussion has already progressed or the decision has already been made. Requests for information may come to the OJSS via phone calls, email, office visits, or formally through the JSAP.

Joint Staff Action Process

The JSAP system (Figure 27-3) is the tasking process of the Joint Staff used to formally request information, direct action, coordinate responses, or disseminate information across the DOD. A prime responsibility of Joint Staff officers is to work action packages using the JSAP system. The DOM funnels all tasks that require medical responses to the OJSS, and the JSAP manager within the office assigns each task an AO. Working a task as an AO is perhaps one of the most important, time-consuming actions at the OJSS, with potential high visibility and high impact. The JSAP task instructions may direct the AO to consolidate information and responses from other organizations, prepare packets for senior leader approval/signature, or disseminate information across the joint force. Additionally, AOs may develop executive summaries, letters, memoranda, and other documents, or coordinate actions among directorates, services, CCMDs, and other government agencies. The AO working a JSAP must ensure that the response meets the intent of the tasker and that the packet is completed by its suspense date. Late JSAPs are reported to the level of the director of the Joint Chiefs of Staff.[16]

Other aspects of the PA's portfolio are integrated into the daily routine and mainly include areas within clinical operations that require medical or clinical expertise. The PA may also perform duties related to JCIDS, global health engagement, research and development, or science and technology.

Joint Capabilities Integration and Development System

The PA must understand the intricacies of the JCIDS and be able to articulate and explain the process to those seeking clarification and guidance from the OJSS. The CCMDs and services use the JCIDS process to identify, develop, and validate requirements; identify and match capabilities to those requirements; identify capability gaps; and develop sourcing solutions. The Joint Requirements Oversight Council owns the JCIDS process and is chartered to conduct JCIDS activities and validate capability requirements, unless independent validation authority is identified.[17] The purpose of the JCIDS process is to support and enable the council in executing the CJCS's responsibilities in identifying, assessing, validating, and prioritizing joint military capability requirements.[18]

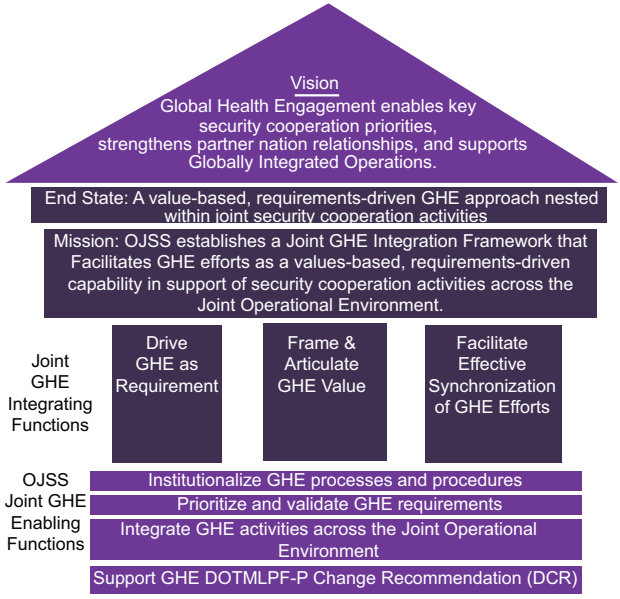


Figure 27-4. Joint Global Health Engagement Integration Framework facilitates global health efforts as a values-based, requirements-driven capability in support of security cooperation activities across the joint operational environment.

Non-materiel solutions proposed from capabilities-based assessments result in doctrine, organization, training, materiel, leadership, personnel, facilities, and policy (DOTMLPF-P) change recommendations (DCRs). The DCR is part of the JCIDS process and provides a format for considering solutions for each DOTMLPF-P domain.[19] The OJSS chairs the Health Services Working Group, which serves as a gateway and validation authority for capabilities-based assessment outputs as well as tasks assigned within a DCR. Current DCRs with enduring requirements include:

- The **Defense Trauma Enterprise** DCR identifies gaps in DOD's ability to deliver and manage trauma care from the point of injury to Role 4.
- The **Forward Resuscitative Care** DCR identifies gaps in DOD's ability to provide and manage resuscitative care during operations in austere and remote environments.

- The **Medical Readiness Skills Sustainment During Deployed Operations** DCR identifies capability requirements for preserving the highly perishable mission-essential medical skills of deployed medical personnel involved in patient treatment in support of the joint force.
- The **Global Health Engagements** DCR identifies global health engagement shortfalls across the joint force that limit practical and useful support to the combatant commander's theater objectives.

Global Health Engagement

The PA must have a working knowledge of global health engagement and understand how it is informed by strategic documents and executed at the CCMD level (Figure 27-4). Global health engagement is nested within security cooperation and is an interdepartmental collaborative of DOD global health engagement, the Joint Staff, the Uniformed Services University Center for Global Health Engagement,[20] services, and CCMDs, as well as other governmental agencies such as the Defense Threat Reduction Agency, Centers for Disease Control and Prevention, and US Agency for International Development.

Current Operations

Activities within current operations range from the Defense support for civil authorities during disaster response (southern border operations, hurricane and other natural disaster support, infectious diseases, epidemic and pandemic support) to CCMD activities. The PA may be the subject matter expert with the requisite experience and knowledge to appropriately respond to requests for assistance from other government agencies or to validate requests for forces from the CCMD.

Lessons Learned

The following are lessons learned from service at the OJSS:

- A few courses that are not required but will be helpful are How the Army Runs, Joint Medical Officer's Course (JMOC) Basic and JMOC-Advanced, and the Joint Senior Medical Leaders Course.

- Balance is important. Being an AO for the Joint Staff surgeon requires self-discipline and balance between work and home. The office's high operational tempo can be daunting; being mindful of life outside the Pentagon walls is very important.
- An assignment on the Joint Staff is an opportunity to understand the role of the OJSS and its influence on how health care is provided to the joint warfighter. The challenge is to adjust focus from an Army-centric view to a joint view. Army PAs assigned to the Joint Staff must understand they are AOs whose mission is to develop joint solutions that nest with the Joint Staff surgeon's priorities.
- Movement, action, and decision-making at the strategic level can be slow and deliberate. Exercising tactical patience is rewarding. Conversely, impatience and ignorance can lead to frustration, especially during the first 6 months.
- Learning to navigate the Pentagon is essential. Many meetings require physical attendance, so understanding the Pentagon's layout makes coordination and daily tasks less daunting. The Pentagon is composed of five floors, five interconnected rings with ten interlinked corridors, several internal hallways, and an open courtyard in the center of the building. It is easiest to identify a corridor or office by going through the center courtyard. Walking along the rings is generally ill-advised if time is of the essence; the outmost ring (E-ring) is almost 1 mile long.

Tips for Success

Along with lessons learned, the following tips will help future Joint Staff PAs succeed:

- The Joint Staff PA should allow at least 90 days for orientation and onboarding. A good sponsor will ensure a smooth transition and in-processing. This time affords the Joint Staff PA an opportunity to put things into context.
- Joint Staff PAs must be prepared to live outside their comfort zone. Being called on to respond to unfamiliar things is a way of life at the Pentagon. The PA should project confidence, ask for help, ask if they do not know something, and never refuse help when offered.

- "There is no casual conversation; every discussion is an evaluation." The Joint Staff PA should know that media is present throughout the building, and always assume someone is watching or listening.
- The Joint Staff PA must put conversations into context. Conversations taken out of context, discussions that are unintentionally expanded beyond intended audiences, or emails circulated inadvertently and inappropriately can have devastating consequences. Office discussions, often intended to frame and support internal tasks and actions, can pose unintended consequences when discussed with persons outside the group.
- "Words have meaning." The Joint Staff PA's discussions with senior leaders and fellow Joint Staff officers must be as accurate, brief, and concise as necessary.
- The Joint Staff PA must not forward general officer/flag officer emails.
- The Joint Staff PA must listen and learn. No matter how much a PA thinks they know, there is much more that they do not.
- The Joint Staff is about joint solutions. Service-specific solutions that do not support CCMD interests or conflict with the CJCS's priorities are of less interest to the Joint Staff. A PA who cannot move beyond Army-specific issues will certainly struggle.

Conclusion

An assignment to the OJSS is an excellent opportunity for field-grade officers to further develop their strategic acumen. Service on the Joint Staff affords the opportunity to interact with service medical leadership, Defense Health Agency staff, CCMD surgeons, and senior leaders from other government agencies. These engagements will not only build career-long relationships but also set the stage for future operational and strategic assignments for PAs as future Army leaders.

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Chapter 28

ROLE OF THE CHIEF OF THE READY AND RESILIENT INTEGRATION BRANCH AT HEADQUARTERS, INSTALLATION MANAGEMENT COMMAND

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Introduction

The physician assistant (PA) assigned as the chief of the Ready and Resilient (R2) Integration (R2I) branch and deputy surgeon at Headquarters, Installation Management Command (HQ IMCOM), provides recommendations to IMCOM staff, the deputy commanding general, and the commanding general, as subject matter expert for all aspects of the Army's strategy for maintaining a ready and resilient force, including sexual harassment/assault response and prevention (SHARP), risk reduction, and suicide prevention programs. To provide a comprehensive awareness of the chief, R2I, role, this chapter will also provide information on the IMCOM and R2/Alcohol Substance Abuse Program (ASAP) Division.

Supervision

The chief of the R2I branch is a branch immaterial (O1A) position aligned under the HQ IMCOM G1 (Personnel) R2/ASAP Division. It is rated by the R2/ASAP division chief and is senior-rated by the HQ IMCOM G1 deputy director.

Roles and Duties

The position requires assisting in the execution of health care policies pertaining to soldiers, families, and civilians at 64 garrisons worldwide. Primary duties include coordinating and contributing health care expertise across the Installation Management Command leadership worldwide to execute a comprehensive plan to communicate and address immediate and enduring R2 programs for soldiers, families, and communities. The position unifies efforts across all services, as well as external civilian agencies, to coordinate multidisciplinary teams to implement Army readiness programs and initiatives. If the incumbent is a clinician, they can also fill the role of the IMCOM deputy surgeon, who advises and acts as a medical liaison between Army service component command surgeons, the US Army Medical Command, Training and Doctrine Command, Office of the Surgeon General, Defense Health Agency, and support staff.

Desired Knowledge, Skills, and Attributes

Knowledge

- Knowledge of Army culture and organizations, systems, policies, and processes.
- Understanding of military medicine and the business of health care.
- Experience with writing and updating policies.
- Good understanding of joint, Army, IMCOM, and Army Medical Command cultures.
- Competence in using Microsoft Office, MilSuite, and SharePoint applications.

Skills

- Strategic thinking.
- Exceptional written and oral communication skills.
- Unwavering military bearing and tact with senior leadership.
- Strong interpersonal skills; consensus-building across a variety of stakeholders and agencies; persuasion/negotiation skills and tactics; team-building.
- Attention to detail and exceptional organizational skills are an absolute must.

- Proficiency in editing military and civilian correspondence and other documents.
- Strong leadership skills; the ability to coach, teach, and mentor civilian employees.

Attributes

- Critical thinking and problem-solving skills.
- Self-starter; able to see a need and begin action in response.
- Systems thinker; able to connect dots and see the big picture.
- Ability to effectively handle pressure, remaining calm and rational.
- Ability to effectively multi-task.
- Willingness to do any task required for mission success.
- Assertive; able to tactfully enforce requirements with senior staff.
- Good at planning; able to anticipate needs and develop options.

Training

Systems training required for managing civilian employees includes the Automated Time and Attendance Production System (ATAAPS) and



Figure 28-1. Lieutenant Colonel Amelia Duran-Stanton engages with a program manager during a scenario-based discussion at the Army Substance Abuse Program Manager Course.
Photo courtesy of Ms. Leslie Sweeney.

Defense Performance Management and Appraisal Program (DPMAP). There is also the opportunity to attend the training conducted by the staff, such as the Suicide Prevention Program Manager, Risk Reduction Program Manager, and Army Substance Abuse Program Manager Courses (Figure 28-1). Table 28-1 lists courses offered by the R2/ASAP Division. When the incumbent is a clinician and fills the role of a deputy surgeon, there are training recommendations that will be outlined in the IMCOM surgeon chapter (Chapter 47).

Key Factors

This position is typically a 2-year tour and is coded for 01A (branch immaterial) lieutenant colonel (O-5) with no additional skill identifier requirement. The position is primarily nonclinical but utilizes clinical regulatory knowledge learned throughout a clinician's career, which enhances the ability to make sound and timely decisions in managing the programs and civilian staff. PAs in the position must maintain their credentials and perform at least 40 hours annually of the clinical duties they are privileged and credentialed for at the local medical treatment facility.

Installation Management Command

A three-star-level command currently located at Joint Base San Antonio–Fort Sam Houston, Texas, IMCOM integrates and delivers base support for all assigned installations to enable readiness for a globally responsive Army. IMCOM is committed to providing base operations support in accordance with established standards to accomplish the mission. It is also invested in providing appropriate programs and services at the right time and place for soldiers and their families. IMCOM's tagline is "We are the Army's Home" (Figure 28-2).

Ready and Resilient/Army Substance Abuse Program Division

The HQ IMCOM G1 R2/ASAP Division is comprised of two branches: the Prevention Services Branch and the R2I Branch (Figure 28-3). Each branch has a chief and is aligned with specific programs, discussed in detail below. The division's **vision** is to establish integrated community

Table 28-1. Courses offered by the Ready and Resilient/Alcohol and Substance Abuse Program Division.

Course	Target Audience
Drug Testing Coordinator Recertification Course	Drug testing coordinators
Suicide Prevention Program Managers Course	Suicide prevention program managers
Community Ready and Resilient Integrator Course	Community R2 integrators who are IMCOM employees
Drug Testing Coordinator Full Course	Drug testing coordinators
Prevention Coordinators Course	Prevention branch chiefs and prevention coordinators
Army Substance Abuse Program Manager Course	Army substance abuse managers
Commander's Risk Reduction Dashboard/Risk Reduction Coordinators Course	Risk reduction prevention coordinators
Prime for Life	Prevention coordinators
Employee Assistance Program Coordinator Course	Employee Assistance Program coordinators

IMCOM: Installation Management Command; R2: Ready and Resilient

resources that enhance readiness and resiliency. Its **mission** is to strengthen readiness and support the resilience of the Army's most valuable resource: people. The R2/ASAP Division operates along three lines of effort: to deter, to prevent, and to assist.

- To **deter** risky behaviors involves setting conditions to help individuals to make the right choice. The goal of deterrence is to discourage high-risk behaviors by clearly identifying consequences of negative choices (eg, drug use, drinking and driving, sexual harassment, and assault).
- To **prevent** risky behaviors includes efforts that increase knowledge, skills, or experience as the desired outcome. Educational/motivational programs focus on the adverse effects and consequences of alcohol and other drug abuse. These efforts create and foster conditions that promote mission readiness by preventing high-risk behaviors.



Figure 28-2. Staff of Headquarters, Installation Management Command (IMCOM), left to right: Derek Ferrell (Suicide Prevention/Risk Reduction program manager), Leslie Sweeney (Ready and Resilient integrator), Captain Cynthia Stephenson (aide-de-camp to the IMCOM commanding general), J. Randall Robinson (executive deputy to the IMCOM commanding general), Lieutenant Colonel Amelia Duran-Stanton, Rhonda DeVries (assistant to the IMCOM chief of staff).
Photo courtesy of Installation Management Command Public Affairs Office.

- To **assist** means intervening early to lessen the impact of risky behaviors and to help individuals return to full functioning and full duty.

Prevention Services Branch

This branch provides the following services: drug testing, budget assistance, prevention and education, and employee assistance.

Drug Testing

Drug abuse is inconsistent with Army values and readiness. Drug testing is governed by Army Regulation (AR) 600-85, The Army Substance Abuse Program.[1] Program staff perform the following services:

- Provide professionals at garrisons the tools necessary to deter soldiers from abusing drugs (including illegal drugs, other illicit substances, and prescribed medication).

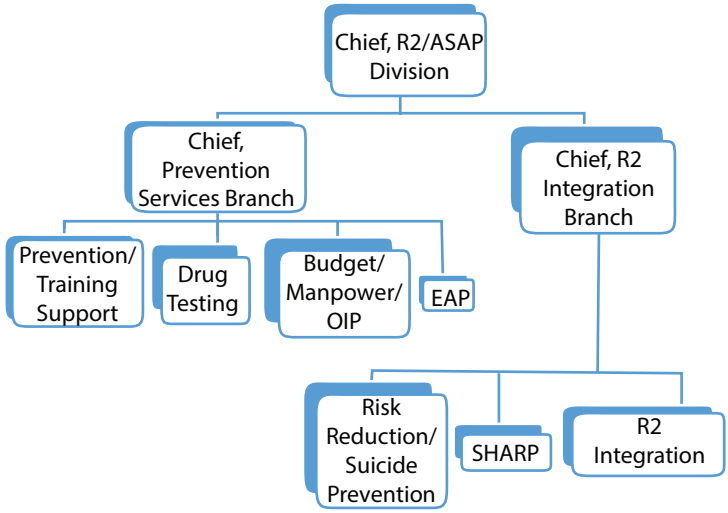


Figure 28-3. Ready and Resilient/Alcohol and Substance Abuse Program (R2/ASAP) Division organizational chart.
EAP: Employee Assistance Program; OIP: Organizational Inspection Program; SHARP: Sexual Harassment/Assault Response and Prevention Program

- Provide information for garrison ASAP staff to facilitate early detection of drug abuse.
- Enable commanders to assess the security, military fitness, and good order and discipline of their units, and to use information obtained to take appropriate disciplinary or other administrative actions.
- Collect data on the prevalence of drug abuse within the Army.
- Track aggregate garrison drug testing collection numbers across IMCOM to ensure compliance with AR 600-85.[1]
- Promote the Army Drug-Free Federal Workplace Drug Testing Program as directed by the Executive Order 12564, dated September 15, 1986, and establish the goal of a drug-free federal workplace.[2]
- Provide certification courses to garrison ASAP staff (namely, drug testing coordinators and drug testing technicians) or any other staff members who carry out drug testing functions to maintain forensically sound drug testing collection points at each garrison.

- Advocate for a workplace that is free from illegal use, possession, or distribution of controlled substances by its civilian workforce and that is safe, healthful, productive, and secure.

Budget Assistance

- Assist garrisons with budget requirements and spend plans.
- Partner with IMCOM G8 (budgeting) in carrying out workforce studies for ASAP coaches and mentors, and assist garrison drug testing coordinators in service delivery.

Prevention Services

- Promote ASAP services using marketing, networking, and consulting strategies.
- Ensure garrisons comply with regulatory requirements and support the Army's priorities.
- Analyze prevention data for trends in service delivery as well as completed alcohol and drug abuse prevention training.
- Provide training and other services to assist organizations in ensuring all military and civilian personnel are provided prevention education training.
- Provide an array of professional development opportunities for ASAP professionals.
- Design and develop community-targeted, group-oriented alcohol and other drug interventions in coordination with the ASAP staff and other installation prevention professionals.

Employee Assistance

- Coach, mentor, and assist the garrison Employee Assistance Program (EAP) coordinators in service delivery.
- Provide working groups to create EAP client satisfaction surveys and other data-gathering resources.
- Provide screening, assessment, short-term counseling (one to four sessions), and referral for problems that may affect work performance.
- Provide guidance, advice, mediation, and prevention education on topics that promote the well-being of civilian employees.
- Services are not limited to worksite-related problems.
- Provide supervisory consultation to supervisors.

- Eligibility for EAP services: Army civilians, civilian and military family members, military retirees, and family members of military retirees.

The Ready and Resilient Integration Branch

The R2I Branch is comprised of four programs: Risk Reduction, Suicide Prevention, Ready and Resilient Integration, and SHARP.

Risk Reduction Program

The Risk Reduction Program uses a database to collect and report on risk factors, using an interface called the Commander's Risk Reduction Toolkit.

- Designed to remove the burden of multiple meetings for commanders and leaders.
- Initially collected data on 20 Army-defined risk factors.
- Currently reports on 14 of those factors to installation commanders and leaders.
- Has flexibility and capability to obtain and report on risk factors not identified by the Army but deemed necessary to installation leadership.
- Collects data on active duty Army personnel only.
- Able to report on geographically dispersed units.

Suicide Prevention

The Army's efforts to prevent suicide are executed in three phases; (1) prevention; (2) intervention (education with "ACE" [Ask, Care, and Escort] and "ACE-SI" [Ask, Care, and Escort—Suicide Intervention] courses); and (3) "post-vention" (follow-up support services and care). The installation's suicide prevention program manager (SPPM) is the subject matter expert for the senior commander and installation leaders on all suicide prevention matters.

- The SPPM is aligned under and works for the ASAP manager in most cases.
- The SPPM provides data and trend analysis and advises and assists the community R2 integrator on all suicide prevention matters pertaining to the Community Ready and Resilient Council (CR2C).

- The SPPM is responsible for tracking all ACE-SI and Applied Suicide Intervention Skills Training trainers.[3]
- The SPPM is required to submit a monthly report to HQ IMCOM.

The Ready and Resilient Integrator

The HQ IMCOM R2 integrators synchronize and provide support for garrison-level community R2 integrators. The information below provides background information on the R2 Council and integrators at the garrison level.

- **Community R2 Councils** integrate and synchronize the Army's multiple efforts and programs designed to improve readiness and resilience.[4] The process integrates garrison, medical, and mission efforts in support of the synchronization of health promotion, risk reduction, and suicide prevention programs. At the installation level, the council is chaired by the senior commander. It includes the garrison commander, medical treatment facility commander, brigade commanders, tenant unit representation, and appropriate subject matter experts across the installation. AR 600-63[5] specifies the objectives of the health promotion program to enhance the quality of life, resiliency, and wellness for all soldiers, family members, civilians, and retirees and to optimize and coordinate organizational efficiencies related to health promotion.[4,5]

- **Community R2 integrators** are responsible for coordinating, planning, organizing, and implementing comprehensive health promotion and well-being processes based on initiatives to enhance readiness and resilience for the total Army.[4] The Suicide Prevention Task Force, the Installation Prevention Team, and five other workgroups support the resiliency pillars that support the senior commander's priorities. Community R2 integrators are also responsible for the Community Resource Guide, an app-based resource that provides information for all the local communities.

Sexual Harassment/Assault Response and Prevention Program

The IMCOM HQ SHARP program manager standardizes processes with multiple organizational alignments at the garrison level, coordinating

with over 50 other program managers to support the senior mission commander (there is no cookie-cutter approach). They provide guidance on policy, track client caseloads, manage training, and collate required annual reports.

Some sexual assault response coordinators/victim advocates (SARCs/VAs) fall under different chains of command depending on the installation. Based on experience, the IMCOM SHARP Manager recommends including the garrison commander or deputy/command sergeant major in the rating scheme. The garrison SHARP office manages about 80% installation cases and about 20% garrison cases.

- Per Army Directive 2018-23, only face-to-face SHARP refresher training is mandatory (the online version is not required, but still available to use).[6]
- SHARP personnel must be certified or recertified every 2 years, and have background checks every 3 years.
- The Army G1 SHARP Program Improvement Forum is a national forum where senior SHARP personnel discuss policies and procedures for the program. Breakout workshops are conducted to brainstorm issues and challenges.
- SHARP staff participate in a National Organization for Victim Assistance (NOVA) annual training event. NOVA is a DOD-endorsed credentialing program.[7]

Lessons Learned

These lessons learned may help PAs assigned to IMCOM as well as in other assignments. The PA should:

- gain an understanding of the IMCOM leadership vision and mission, and how the organization fits into the bigger scheme of the Army as a large organization;
- maintain a network of liaisons established from previous organizations, and gain new ones;
- manage competing priorities and seek guidance when necessary;
- attend, and get credit for, all the courses conducted by the R2/ASAP team as early as possible (these courses may lead to future opportunities);

- manage their calendar wisely and ensure internal team members have access to it;
- know the functions of the IMCOM directorates in garrisons worldwide;
- learn how to write civilian evaluations before coming to IMCOM, and hone skills while at IMCOM;
- manage regulatory guidance updates and be familiar with both previous and current policies;
- create a continuity mechanism to share experience and lessons learned with the next team; and
- empower subordinates in creating standard operating procedures.

Tips for Success

Along with lessons learned, these tips for success will enable PAs to maximize the opportunity afforded to them at IMCOM. The PA should:

- maintain ties with the medical community (it is a value-added network of professionals that IMCOM will benefit from);
- maintain a routine battle rhythm but be prepared for ad hoc meetings and events;
- collaborate locally with civilian entities in all R2-related programs;
- maintain clinical credentials and privileges;
- manage leave wisely and ensure the team does the same;
- stay humble and learn from everyone they contact (the IMCOM team is a highly functional group of professionals, and each individual will add value to the PA's experience at IMCOM and beyond);
- seek opportunities to improve personal health and fitness, and fit them into their schedule routinely;
- continue to be involved in the Army Medical Specialist (SP) Corps and the Medical Center of Excellence by taking every opportunity as schedule permits to meet with SP Corps leaders who are stationed or on temporary duty at Joint Base San Antonio (JBSA);
- remain flexible and keep the team informed of any schedule or event changes as needed; and
- take full advantage of local courses at JBSA as schedule permits.

Conclusion

An assignment with IMCOM is a unique and broadening experience that will provide PAs an opportunity to build on their previous skills and also to develop new ones. A unique leadership experience that requires management of multiple, high-visibility programs and portfolios, this position will enable PAs to develop and display their strengths in clinical, administrative, management, and leadership abilities.

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Chapter 29

WHAT ARMY PHYSICIAN ASSISTANTS NEED TO KNOW ABOUT ELIMINATING POTENTIALLY SURVIVABLE DEATHS ON THE BATTLEFIELD

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Introduction

The diversity of the physician assistant (PA) profession in the armed forces offers opportunities for PAs to lead the way in eliminating preventable deaths on the battlefield. Army PAs are subject matter experts in the application of Tactical Combat Casualty Care (TCCC) for their assigned units, which places them in a position to impact combat medic training and the development of TCCC guidelines. During the Iraq and Afghanistan conflicts, combat casualty care evolved to dramatically improve delivery of life-saving measures to service members at the point of injury and beyond. Data collection from battlefield casualties has led to paradigm shifts in many types of battlefield care, with the ultimate goal of eliminating preventable deaths on the battlefield. The evolution and implementation of TCCC principles continues to change the definition of preventable deaths.

In a 2011 article, "Eliminating Preventable Death on the Battlefield,"[1] Kotwal et al reported the 75th Ranger Regiment's casualty survival rate from October 2001 to March 2010, which was higher than the rate for the Department of Defense as a whole. The article described

the concepts the unit implemented to achieve their superior casualty survival rate: tactical leader prioritization of TCCC medical training for all unit members, tactical leader ownership of the casualty response system, and using feedback from the trauma registry to drive medical treatment protocols in the prehospital setting. This model should be thoroughly understood by all PAs, communicated to the unit leadership for implementation, and embraced by all deploying units.

Emerging capabilities in damage control resuscitation (DCR) and advanced resuscitative care (ARC), coupled with forward delivery of these interventions, are changing the definition of a potentially survivable death on the battlefield. The ability to deliver DCR and ARC interventions demonstrates great potential to improve battlefield survivability. This chapter will describe how the Army PA can continue to lead Army medicine by taking a key role in the development and execution of the use of fresh whole blood (FWB), resuscitative endovascular balloon occlusion of the aorta (REBOA), ARC, and prolonged field care (PFC).

Background of Tactical Combat Casualty Care and the Committee on Tactical Combat Casualty Care

In the final years of the 20th century, battlefield medicine was driven by advanced trauma life support (ATLS) principles.[2] While ATLS remains the standard of emergency department trauma care, it was not designed to address the most common causes of potentially preventable death on the battlefield.[3] The TCCC guidelines resulted from a 2-year study by the US Special Operations Command,[2] and the groundwork for their early adoption took place in the special operations community. Although TCCC is still evolving, the current guidelines embody the core principles of battlefield medicine as it is practiced today. In 2001, the Committee on Tactical Combat Casualty Care (CoTCCC) was formed.[4] As of 2019, the CoTCCC falls under the Joint Trauma System (JTS), has 42 members, meets biannually, and provides several updates per year. The JTS TCCC Guidelines for Medical Personnel Clinical Practice Guideline (CPG), listed in the Resources section of this chapter, provides the current TCCC recommendations.

Tactical Combat Casualty Care Phases

According to Butler et al, the goals of TCCC are to treat the casualty, prevent additional casualties, and complete the mission.[4] To accomplish these goals, there are several factors specific to TCCC and the distinct phases that must be considered, which include[4]:

1. The care team and the patient may be receiving accurate fire while care is being rendered. This requires that treatment be performed selectively at appropriate times and in a focused, deliberate, and timely manner.
2. Interventions should be focused on the leading causes of preventable death in combat: limb hemorrhage, airway obstruction, tension pneumothorax, junctional hemorrhage, and noncompressible torso hemorrhage (NCTH).
3. Evacuation times may be much longer than what is commonplace in civilian hospital systems.
4. Multiple casualties may be sustained in a single incident.
5. TCCC practitioners must often plan for and care for injuries in austere environments under adverse weather conditions.

Basic knowledge of TCCC begins with understanding the TCCC phases, defined as follows:

- **Care under fire.** Care that occurs at or close to the point of injury while the injured person and the care provider are under effective hostile fire. Equipment is generally limited to what can be carried by the medical provider. Care is limited to limb tourniquet application.[3]
- **Tactical field care.** Similar to care under fire, but there is no effective hostile fire. Medical equipment is limited to that which was brought on the mission.[3]
- **Tactical evacuation care.** Describes the care provided in both casualty evacuation (CASEVAC) and medical evacuation (MEDEVAC) scenarios. It begins with staging a casualty for evacuation and ends with delivering the casualty to the next level of care, with continual reassessment of previous interventions. Medical capability is augmented by both pre-staged equipment and personnel or dedicated medical evacuation assets and personnel.[3]

In order to understand the "why" behind the TCCC guidelines, it is important to know the data that drives the guidelines. The driving data point is the leading cause of preventable death on the battlefield.

Leading Causes of Preventable Death on the Battlefield

The leading causes of death on the battlefield as identified by Butler et al at the inception of TCCC were extremity hemorrhage, airway compromise, and tension pneumothorax.[2] More recent studies comparing data from before and after the widespread institution of TCCC training and interventions highlight a steep reduction in preventable deaths on the battlefield.[5,6] With the widespread issuance of ceramic hard plate body armor and Kevlar (DuPont) helmets and vests, injury patterns in Operation Iraqi Freedom and Operation Enduring Freedom shifted to include more extremity injuries and fewer head and torso injuries.[7] Widespread issuance of and training on tourniquets, nasopharyngeal airway adjuncts, and chest seals have served to equip battlefield first responders with the tools to address aspects of all three leading causes of preventable battlefield death.[8] Additionally, empowering 68W combat medics with the ability and training to conduct more advanced interventions, such as supraglottic airways, needle chest decompression, and in some cases cricothyrotomy, has affected causes of death far forward from even the battalion aid station.[9–11]

A further innovation has been treatment of both junctional hemorrhage and NCTH. The military has introduced junctional tourniquets and hemostatic impregnated gauze in an attempt to improve battlefield survivability of junctional hemorrhage. Unfortunately, treatment for NCTH remains difficult at Role 1. While an extended focused assessment with sonography for trauma (e-FAST) exam can assist in the decision to transport a casualty to definitive management, and tranexamic acid (TXA) and FWB can address coagulopathy and hemostasis, the mainstay of treatment for NCTH is rapid transport to surgical management.[12]

Fresh Whole Blood

The next innovation in advancing medical capabilities beyond the TCCC phases at the point of injury and Role 1 was administration of FWB (Figure 29-1). FWB entails blood recently acquired from local



Figure 29-1. Major Christopher Cordova, PA-C, conducts trauma training scenarios, incorporating TCCC principles and fresh whole blood transfusion capability, to PA students (Captain Alixandra Mackey, Lieutenant Mitchell Andreas, and Lieutenant Benjamin Williams) at the Fort Carson Medical Simulation Training Center in January 2018.
Photographs courtesy of Captain Tiffany Pittman.

volunteer donors, generally through the use of walking blood banks, in which volunteers are called en masse to donate blood for patients in hemorrhagic shock. Although cold stored whole blood is preferred over FWB because it has been prescreened and transfusions can be started immediately, it may not be available in all forward deployed locations. Army PAs are commonly deployed to remote locations without the logistical support to store whole blood or blood component products, so FWB collection from donors is likely the only blood product available in most scenarios. The blood collected through this method does not go through regulated testing; therefore, the resulting product is not approved by the Food and Drug Administration (FDA). In order to implement a successful FWB program, planning should occur well before the execution of this capability.

Use of FWB is an important capability available to frontline medical providers with the potential to prolong survivability of critically injured

patients.[13] However, FWB must be employed in conjunction with other DCR principles.[14] The implementation of FWB transfusion protocols must be guided by the recommendations of Strandenes, Fisher, and JTS CPGs.[15–19] Army PAs deployed or preparing to deploy should thoroughly review these protocols. The protocols must be adapted to individual trauma teams of forward deployed units, and the tailored protocols must be repeatedly trained and implemented by the provider-led trauma team, well before the unit is deployed to a combat environment.

Implementation

FWB transfusion is currently widely implemented at most Role 1 facilities and executed at the point of injury and during air medical evacuation in combat theaters. The JTS Whole Blood Transfusion and Damage Control Resuscitation CPG, listed in the Resources section of this chapter, provides the most recent recommendations for implementation. Planning is paramount! The implementation and execution of a successful FWB protocol must be integrated well before the combat training center rotation and combat deployment. Through proper coordination, the Armed Services Blood Program (ASBP) can screen soldiers for transfusion-transmitted diseases (TTDs) and anti-A/anti-B titer less than 1:256 (low-titer group O whole blood [LTOWB]). The ASPB documents screening results in the Theater Medical Data Store (TMDS) blood module. This critical predeployment action enables faster administration of FWB at the time of need because it eliminates point-of-care (POC) blood typing for the donor and recipient.

Equipment

Upon completion of screening, the next focus is acquisition of equipment required to execute the transfusion. Blood transfusion kits or sets are available for purchase through a variety of medical companies. These products contain the items required for performing an FWB transfusion, such as blood type test kits (if blood was not prescreened), like the EldonCard (Eldon Biologicals) to test recipients and donors; blood collection bags; intravenous (IV) tubing with a filtered chamber; and typical items used to obtain IV access. PAs must also ensure possession of Standard Form 518, Blood or Blood Component Transfusion Medical Record, to properly document the medical intervention.

Blood collection bags differ from other standard IV fluid bags in their additives and anticoagulants that allow for preservation of donated blood. Each bag contains either citrate phosphate dextrose (CPD) or citrate phosphate dextrose adenine-1 (CPDA-1), which prevent blood clot formation by binding calcium in the donor's blood and thus inhibiting the coagulation pathway. CPD allows for 21 days of refrigerated storage in case an FWB donation is not utilized immediately, while CPDA-1 allows for up to 35 days of refrigerated storage.

The use of proper IV tubing, containing a micron filter, is essential to further mitigate the risk of blood clots. These administration sets filter blood and any clots that may be formed and, combined with the use of blood collection bags containing CPD or CPDA-1, significantly reduce the likelihood of clot formation and transfusion into the recipient.

Storage of blood should be avoided but is possible at room temperature up to 6 hours, after which it must be refrigerated. However, it is still considered FWB up to 48 hours after donation.[17] Blood storage devices can extend capabilities in combat missions. Portable storage devices like the Golden Minute Container and Golden Hour Medic Thermal Blood Transfer Container (both manufactured by Pelican BioThermal) are available. Storage options requiring a constant power supply may be obtained for a fixed military medical treatment facility (MTF).

Importance of Training

All medical capabilities should be rehearsed repeatedly, utilizing the most realistic scenarios possible, in order to execute the capability during a high-stress trauma situation. Executing an FWB transfusion should not be taken lightly. This capability should be rehearsed thoroughly with critical focus on the administrative details in order to avoid incorrect administration of type-specific blood.

As the primary trainers of medical skills to unit medics, Army PAs should be deeply involved in the implementation and execution of an FWB training program. Mastery of military and medical skills requires effective initial training, and continued training is required to maintain proficiency. While most procedures involved with FWB transfusion, such as initiating an IV, are baseline skills for combat medics and medical providers, regular training must be conducted to maintain confidence in equipment and personnel. To ensure optimal

blood matching and avoid unnecessary hemolytic reactions for training purposes, autologous transfusions (self-to-self) are used for FWB transfusion training. This process involves drawing blood from one location of the body (such as the left antecubital fossa) and "donating" it into another location (such as the right antecubital fossa).

Training Risks and Mitigation

All training, including FWB transfusion, involves risks that should be mitigated to the fullest extent. Despite the use of autologous transfusions, risks remain. As the medical subject matter expert in their unit, the Army PA should understand and acknowledge all risks while making every effort to effectively mitigate them. The Army PA should conduct a formal risk assessment with approval of the accepted risk by the unit commander.

The most common side effect with blood donation is the onset of a vasovagal reaction (VVR).[20] In a recent military study by Donham et al, VVR occurred in less than 0.5% of participants.[20] As with most regular donor protocols, VVR can be mitigated by ensuring participants eat and drink regularly prior to donation and lie flat on a stable surface during the donation event. If a reaction occurs, the donor's legs should be lifted above the level of their heart to optimize venous return.

A study of over 3,400 US military autologous transfusions found that besides VVR, ocular blood exposure and a minor allergic reaction (urticaria) occurred only twice and once, respectively.[20] There were no reports of anaphylaxis or major hemolytic transfusion reactions.[20]

Clinical Indication for Fresh Whole Blood Transfusion

Once population screening and equipment acquisition is complete, the Army PA is fully prepared to execute the FWB transfusion when encountering a casualty meeting the clinical indication. The clinical signs of hemorrhagic shock (decreased mentation, pulse > 120 beats per minute, absent or weak radial pulse, systolic blood pressure < 90 mm Hg), along with a mechanism of injury suggesting significant blood loss (eg, limb amputation, penetrating chest or abdominal injury) are the indications for initiation of the DCR protocol[17]: hemostasis through tourniquet use in junctional and peripheral penetrating wounds, administration of TXA within 3 hours of injury, and early blood product resuscitation.[14]

Fresh Whole Blood Tips for Success

The following are tips for success for the Army PA regarding fresh whole blood.

1. The PA must review and understand the FWB CPG produced by the JTS.[19]
2. The PA must conduct unit screening for LTOWB and TTDs 3 to 6 months prior to deployment through the ASPB or local MTF. The roster should be verified through the TMDS blood module.
3. The PA must procure necessary equipment from installation supply channels or through vendor purchase 3 to 6 months prior to deployment to perform FWB and store FWB or cold stored whole blood in austere environments as the mission conditions dictate (eg, FWB kits, Golden Minute Container or Golden Hour Medic Thermal Blood Transfer Container).
4. The PA must rehearse protocols routinely with dedicated medical staff in collective unit training exercises and in the deployed MTF. Training should include:
   a. identification of FWB transfusion indications in notion casualties;
   b. notification of prescreened population and reporting to an MTF;
   c. screening of donor and recipient with EldonCards (if needed; this may be omitted if prescreened for LTOWB and documented in TMDS);
   d. autologous (self-to-self) FWB transfusions; and
   e. proper documentation on Standard Form 518.
5. The PA must execute FWB transfusion as part of the DCR protocol when clinically indicated in an actual casualty.

Resuscitative Endovascular Balloon Occlusion of the Aorta

Almost 90% of all deaths in combat occur in the prehospital setting.[5] Of these deaths, the leading cause of potentially survivable death in combat is NCTH.[5] Army PAs may help reduce these deaths through the use of REBOA, first described by Lieutenant Colonel Carl W. Hughes during the Korean War. Hughes placed a balloon tipped catheter

into two combat casualties,[21] and although he was unsuccessful in saving their lives, he surmised that early implementation would have better outcomes.[21] In recent years, the REBOA procedure has gained popularity as a means to gain distal hemorrhage control while increasing blood pressure and central aortic pressure until hemorrhage control can be achieved. REBOA consists of inserting a flexible catheter with a balloon tip through the common femoral artery into the aorta. Other than cessation of blood flow distal to the balloon, early use is believed to preserve cerebral perfusion and coronary filling in patients with life-threatening hypotension and hypovolemia secondary to hemorrhage.[22] The use of REBOA is not a definitive treatment, but rather a temporizing measure that may allow more time for a critically wounded casualty to receive surgical care.

Considerations for Use

REBOA insertion requires appropriate training to ensure successful implementation and use in the prehospital setting, and there is still considerable concern about the benefit and safety of prehospital REBOA placement. A statement released by the American College of Surgeons Committee on Trauma, the American College of Emergency Physicians, the National Association of Emergency Medical Services Physicians, and the National Association of Emergency Medical Technicians considered the use of REBOA in the prehospital setting inappropriate, but did not make recommendations regarding the military use of REBOA.[23] Military providers must consider who is best prepared and at what level of care this procedure should be implemented. As of 2019, Role 2 is the first level of care in which REBOA is being performed, with or without a forward surgical team (FST). Role 2 has patient resuscitation capability, accessibility to various blood products (stored or via a walking blood bank), and the ability to surgically stabilize patients when collocated with an FST element. However, with the availability of training designed for the non-surgeons and providers without critical care training, improved tools including POC ultrasound and the ER-REBOA (Prytime Medical), and changing protocols, it is feasible to use REBOA at a Role 1 facility and even at the point of injury. REBOA use and implementation are currently addressed in greater detail by the JTS Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) for Hemorrhagic Shock CPG.[24]

Anatomy

The REBOA balloon is inflated at specific areas of the aorta to achieve desired hemorrhage control based on injury location. The aorta is divided into three zones[25]:

Zone I begins at the commencement of the left subclavian artery and extends to the celiac trunk.
Zone II begins at the celiac trunk and extends to the lowest renal artery.
Zone III begins at the lowest renal artery and ends at the bifurcation.

To impede bleeding resulting from abdominal injuries, REBOA should be placed into zone I; when trying to prevent bleeding resulting from pelvic trauma, the balloon should be inserted into zone III (however, insertion into zone III is not recommended in the prehospital setting). Zone II is the paravisceral aorta and generally accepted as a no-go zone.

Indications

REBOA offers a less invasive alternative than emergent resuscitative thoracotomy (ERT) for controlling NCTH in patients at risk for imminent cardiovascular collapse.[26] Patients with abdominal, pelvic, or junctional lower extremity bleeding are likely to benefit if hemorrhagic shock is recognized early. Precise indications for REBOA are not well studied; however, the REBOA CPG from the JTS recommends use for patients with[24]:

- blunt trauma with no major chest bleeding (negative chest radiograph, ultrasound, or bilateral chest tubes);
- a positive abdominal e-FAST exam;
- penetrating trauma to the abdomen or pelvis;
- pelvic fracture; or
- massive proximal lower extremity hemorrhage with signs of impending cardiovascular compromise (Figure 29-2).

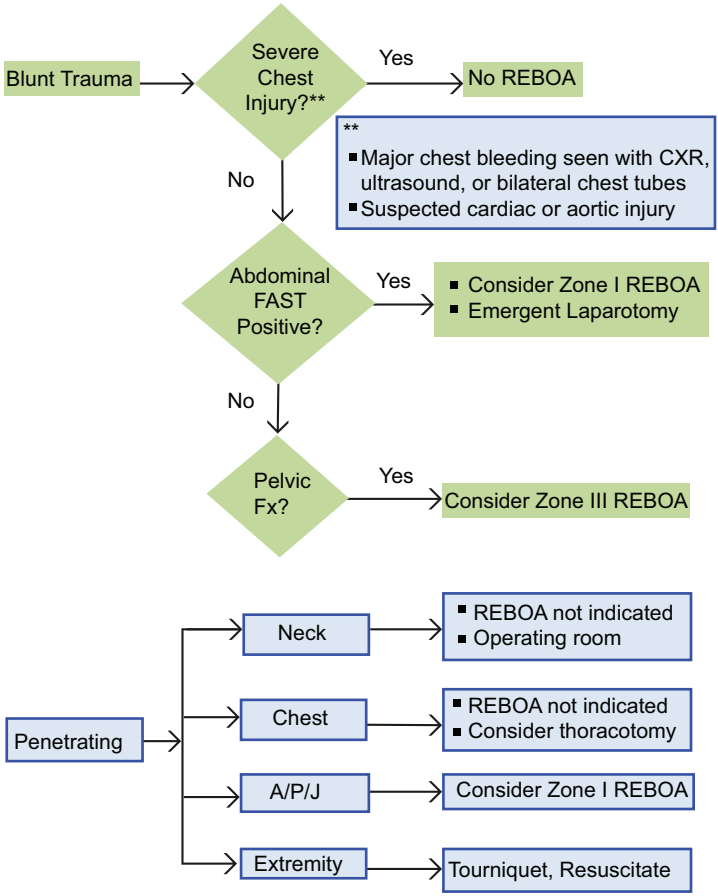


Figure 29-2. REBOA algorithm proposed by the Joint Trauma System.
A/P/J: abdominal/pelvic/junctional
CXR: chest x-ray
Fx: fracture

A more simplified approach is provided by the Committee on TCCC's ARC guidelines, which recommend use on patients with[27]:

- an injury pattern that suggests abdominopelvic non-compressible hemorrhage;

- systolic blood pressure < 90 mmHg; and
- an unsatisfactory response to the first unit of whole blood.

REBOA should not be used without proper resuscitation. The use of REBOA is still a controversial procedure and without a clear benefit for prehospital use.[28] However, combat death is a compelling motivator to implement programs and procedures that may have an unclear benefit, and REBOA may provide the temporary measure that allows adequate time to deliver severely wounded patients to a surgical capability.

Contraindications

Avoid REBOA in patients with thoracic trauma or hemorrhage.[26] These injuries should be ruled out using chest x-ray, thoracic ultrasound, or bilateral simple or tube thoracostomy. Careful planning should be done before the use of REBOA to ensure the availability of surgical resources for more definitive management.

There may be short-term and long-term sequelae to areas of the body not receiving blood flow during REBOA balloon inflation. Complications from REBOA include mesenteric ischemia and ischemia of the lower extremities; also, deployment of REBOA in thoracic aortic injury could increase hemorrhage and make the injury worse.[29] However, when compared to the more invasive emergent resuscitative thoracotomy (ERT) with aortic cross-clamping, the REBOA may be a safer and more feasible option for the Role 1 provider. ERT has its own set of complications and sequelae in addition to those outlined for REBOA; however, a detailed description of ERT is beyond the scope of a PA's practice.

Equipment and Placement

The majority of the equipment required to perform REBOA safely in the prehospital environment is available through the military logistical system. Obtaining an ultrasound may be more difficult, and PAs should purchase a handheld ultrasound device, either with unit funds or on their own. Handheld ultrasound devices are beneficial not only for use in the ARC setting, but also as a tool in the clinic.

The ER-REBOA device consists of a curled distal tip (P-tip [Prytime Medical]) and a compliant occlusion balloon. The catheter contains

two lumens that run the length of the catheter and connect to extension lines with stopcocks. The balloon lumen is used to inflate and deflate the balloon. The arterial line lumen is used to monitor blood pressure. A peel-away sheath is pre-loaded on the catheter shaft to ease insertion of the catheter's P-tip into an introducer sheath hemostasis valve. The JTS Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) for Hemorrhagic Shock CPG, listed in the Resources section of this chapter, outlines a six-step process for successful REBOA employment.[24] It also lists standard equipment needed for REBOA placement.

Initial Training

The Basic Endovascular Skills for Trauma (BEST) course at the University of Maryland's R. Adams Cowley Shock Trauma Center was the first to offer training in the use of REBOA. This training was initially for surgeons and critical care fellowship-trained emergency medicine physicians. In 2015, a physician, a PA, and a Special Operations Combat Medic (SOCM) not trained in critical care attended the BEST course as a pilot project to evaluate the possibility of performing the procedure in the prehospital setting.[30] When the ER-REBOA catheter became FDA approved, the ability to train PAs and enlisted medical personnel became more feasible. This device decreased the number of steps required to access the common femoral artery and place a REBOA catheter. Currently, the Army and the American College of Surgeons both have REBOA training programs. Additionally, the Resuscitation Adjuncts: Prehospital Transfusion & REBOA (RAPToR) course (https://www.raptocourse.com/) is specifically designed for prehospital implementation of REBOA. The 2-day course provides REBOA and FWB training in the context of ARC. The RAPToR course is sponsored by Combat Medical and Prytime Medical, and is recognized by the CoTCCC as a training option.

Sustainment Training

The military tends to offer initial training that meets standards, but often fails to offer suitable sustainment training in a quality manner. Many medical officers assigned to maneuver units have difficulties maintaining currency in various skills because of many factors, including finding

time for appropriate health care coverage for their units and time to attend courses. While it is not critical for Army PAs to maintain the skill required to perform REBOA during a training cycle, it is important to attend a training course at least 60 days prior to deployment. There are several options that could allow the Army PA to successfully employ the skills required for REBOA. The most useful is training with the perfused cadaver model.[31] (Cadavers can be used for training multiple skills beyond REBOA. The use of cadavers also eliminates hospital intrusion.)

Live tissue training (LTT) is another option for sustainment training. However, any LTT requires approval from an Institutional Animal Care and Use Committee (some units have an animal use committee within their major command; others may have to check with their local MTF). The swine is the patient model of choice for REBOA sustainment training. Recently, Borger van der Burg et al described a method that allows for multiple attempts at gaining access using a swine model and placing a silicone tube next to the common femoral artery.[32]

Other sustainment options include working with the local MTF to perform arterial access, which can be as simple as ultrasound-guided radial artery access. Other options include establishing memoranda of agreement with civilian hospitals that currently use REBOA or conducting sustainment training with the Simulation Trainer for Arterial Access and REBOA (STAAR) (Prytime Medical).

Advanced Resuscitative Care/Advanced Resuscitative Care Teams

FWB transfusion and REBOA comprise the evolving concept of ARC. ARC is a momentous update to TCCC that may provide further opportunity for PAs to play a key role in reducing battlefield fatalities from exsanguination. Although TCCC has saved numerous lives since its inception in 1996, it arguably did not address the most lethal of battlefield injuries—NCTH. In an evaluation of over 4,596 battlefield fatalities from 2001 to 2011, Eastridge et al found that 87.3% of casualties die before reaching a surgeon.[5] Of these fatalities, 67% were due to NCTH (Figure 29-3).[5] This landmark study reinforced the need for a modality to address the potentially preventable deaths caused by NCTH in the prehospital setting. ARC is a concept within TCCC that specifically addresses the need to control NCTH in prehospital

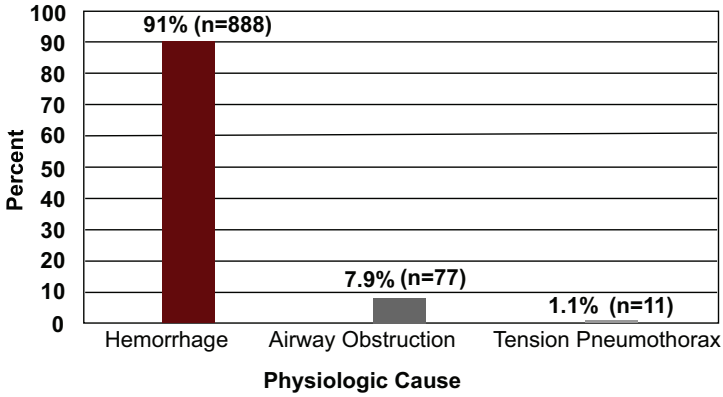


Figure 29-3. Data demonstrating non-compressible torso hemorrhage as the leading cause of death on the battlefield.
Reproduced with permission from: Eastridge BJ, Mabry RL, Seguin P, et al. Death on the battlefield (2001–2011): Implications for the future of combat casualty care. *J Trauma*. 2012;73(6 Suppl 5):S431–S437. https://journals.lww.com/jtrauma/pages/default.aspx

and Role 1 settings. ARC interventions include early and aggressive DCR with whole blood transfusions and use of the REBOA (see Figure 29-3).

Advanced Resuscitative Care Team

ARC is not meant to be performed by lone combat medical personnel, regardless of their skill level. Rather, ARC is specifically designed to be executed by an identified, well-trained, and properly equipped team. Ideally, the ARC team is composed of three or four members. The team who performs REBOA should have obtained initial training at a recognized REBOA training course and maintained their skill through an accepted means (cadaver, LTT, or STAAR).[27]

However, the official composition of teams performing ARC is yet to be determined. In the meantime, the team leader should delegate the multiple required tasks. The ARC team executes nine specific tasks: (1) ensure an adequate airway, (2) electronically monitor vital signs,

(3) establish IV or intraosseous access, (4) prepare and infuse blood products, (5) insert e-FAST and bilateral chest tubes, (6) establish common femoral artery access, (7) prepare the REBOA site, (8) perform the REBOA procedure, and (9) record the events that occur during resuscitation.[27]

As the primary medical trainer and the medical officer with the most continuity for the unit, the Army PA should lead the ARC team. PAs should seek out the appropriate training and be ready to execute this advanced resuscitative measure at the Role 1 or at the point of injury.

Training the Advanced Resuscitative Care Team

Because the ARC team is required to perform multiple tasks in a rapid and proficient manner, it is critical that the team is competent in the above listed skill sets, with particular emphasis on performing the REBOA procedure. Ideally, the ARC team would establish a baseline competency at a training course, then continue to sustain skill sets through ongoing experience with trauma patients, simulation training, or perfused cadaver-based training. At this time, there are multiple venues that can provide training in ARC: the Air Force Center for the Sustainment of Trauma and Readiness Skills (C-STARS) program, the Army Trauma Training Course, and military and civilian trauma training centers (with local training agreements).[27] As discussed above, the Army and the American College of Surgeons both have REBOA training programs. ARC was recently approved by the CoTCCC as a new component of TCCC. "TCCC Skill Sets by Responder Level,"[33] published in April 2019 by JTS and CoTCCC, includes the specific skill set that should be performed by TCCC ARC teams.[33] Although resources for ARC training are available, the CoTCCC is developing a specific ARC curriculum going forward.[34]

Unfortunately, not all casualty situations will be resolved with TCCC, DCR, and ARC due to constraints in medical evacuation or mission requirements. Therefore, Army PAs should be aware of and able to execute the principles of PFC.

Prolonged Field Care

In 2008, then Secretary of Defense Robert Gates issued a mandate that all military medical evacuation to a surgeon must occur in less than

60 minutes.[35] Although this has led to the lowest mortality rate of any conflict, providers cannot rely on 1-hour evacuations in current and future operations, and providers must plan for care over hours and even days. It should be noted, however, that findings by both Kotwal and Howard found it was not just rapid evacuation that decreased mortality, but also the ability to provide faster advanced care to the casualty.[35,36]

PFC is defined as "field medical care, applied beyond 'doctrinal planning time-lines' by a SOCM (Special Operations Combat Medic) or higher, in order to decrease patient mortality and morbidity. It utilizes limited resources and is sustained until the patient arrives at an appropriate level of care."[37] PFC was developed and became a focus of interest over the last decade in special operations and conventional forces due to the changes in deployed operations into more austere prehospital environments (Figure 29-4). PFC is an ongoing process that starts once the patient has been stabilized after initial presentation, whether in a trauma or a medical setting. It encompasses the best practices of TCCC, DCR, and continuous, assertive nursing care, and is broken down into 10 core principles. These principles have corresponding CPGs to explain and universalize medical practice (provided at www.prolongedfieldcare.org, with links to numerous articles and position papers covering the development, training, and implementation of PFC[38,39]). The JTS PFC CPGs, listed in the Resources section of this chapter, provide current recommendations on analgesia sedation management, burn management, crush syndrome, DCR, documentation, nursing care, ocular injuries, traumatic brain injury, and wound management.

Ten Core Principles of Prolonged Field Care

1. Trending vitals and documentation.
2. Resuscitation using blood products.
3. Ventilation and oxygenation.
4. Airway control.
5. Pain control.
6. Continued monitoring for potential complications.
7. Aggressive nursing care.
8. Surgical procedures (ARC).
9. Telemedicine.
10. Documentation and evacuation.[38]



Figure 29-4. Captain Megan Smith, PA-C, with medics and soldiers at Mosul Dam, Iraq, May 2019. The unit conducted base defense drills incorporating a mass casualty exercise including evacuation of casualties from the perimeter to the Role 1. The focus was working as a team on a trauma bed with minimal medics and a single PA. The closest aeromedical evacuation asset was 1.5 hours away. The training was focused on prolonged field care and advancing 68W skills to increase medical capabilities.
Photograph courtesy of Staff Sergeant Ronald Monsen.

Training

PFC encompasses a wide spectrum of medical skills, and units may be challenged to prepare and train for situations requiring PFC skills. Situations requiring PFC can happen during stateside training events, in combat, in humanitarian deployments, and even on vacation, so it

is necessary to be as prepared as possible. Limited time and resources may be obstacles, but there is no substitute for hands-on training in all components of PFC. The first things to consider are what objectives need to be accomplished to acquire a good working knowledge of PFC components. The training should be well thought out and structured to ensure all members of the team are proficient in the smallest of tasks prior to a culminating event. A short-term train-up will not sufficiently prepare a medical team to be prepared for managing a real-world PFC scenario.

Role of the Physician Assistant in Prolonged Field Care

Army PAs have a high probability of being assigned to an austere environment with limited medical resources, where they are the senior medical provider with a small team of medics. Part of a battalion PA's job is to train the medics assigned to them. Training medics to work as team is as important as training them to be competent in all medical tasks in the scope of practice. The medic team is the PA's best asset in PFC situations. PAs must therefore understand how to optimally care for a casualty if placed in a PFC scenario, and they must also understand the limitations of PFC. PAs should maintain their skills by attending medical courses that advance their capabilities; however, employing life-saving techniques on patients will always surpass simulations. The PA should be proactive in this approach by utilizing local civilian trauma centers, most of which have medical training agreements in place with MTFs that are established by MTF commanders.

Conclusion

Eliminating potentially preventable deaths on the battlefield will always be a dynamic process. As forward medical capabilities improve, the leading cause of death on the battlefield will change. However, the role of the Army PA will remain constant—implementing current medical capabilities to treat combat casualties on the front lines of the battlefield. With the implementation of FWB transfusion, REBOA, ARC, and PFC on the battlefield, the Army PA must remain educated and knowledgeable about the JTS CPGs for each of these disciplines. It is the responsibility of the Army PA to train the medical team through rehearsals that implement novel capabilities on the battlefield—well

before the combat deployment. Employment of these principles will continue to reduce potentially preventable deaths on the battlefield.

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Additional Sources

- The CoTCCC's official website is https://www.deployedmedicine.com, and the mobile phone app is Deployed Medicine. These TCCC resources offer updates, background and supporting evidence, videos, JTS podcast information, and more.
- JTS CPGs: for TCCC, DCR, FWB, and REBOA are found at the links below.
  - TCCC Guidelines for Medical Personnel: https:/jts.amedd.army.mil/assets/docs/cpgs/Prehospital_En_Route_CPGs/Tactical_Combat_Casualty_Care_Guidelines_01_Aug_2019.pdf
  - Damage Control Resuscitation (CPG ID: 18): https://jts.amedd.army.mil/assets/docs/cpgs/JTS_Clinical_Practice_Guidelines_(CPGs)/Damage_Control_Resuscitation_12_Jul_2019_ID18.pdf
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- JTS CPGs for the numerous PFC subcategories are found under the "Prehospital/En Route CPGs" header at https://jts.amedd.army.mil/index.cfm/PI_CPGs/cpgs
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Chapter 30

ROLE OF THE PHYSICIAN ASSISTANT IN THE DISABILITY EVALUATION SYSTEM

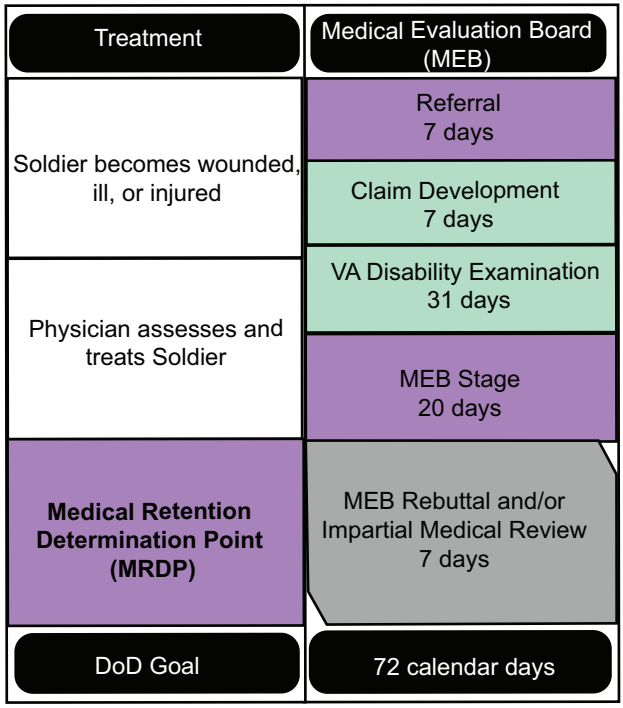
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Introduction

The Disability Evaluation System is a US Department of Defense (DOD) process for determining if a wounded, injured, or ill soldier will be able to return to duty or if they will be medically separated or medically retire due to their disability. The Integrated Disability Evaluation System (IDES) is a combined process used by the DOD and the Department of Veterans Affairs (VA). The two departments work concurrently to determine the soldier's capability to continue to perform their duties and serve in the Army.

Prior to the implementation of IDES in the early 2010s, the DOD and VA disability and rating processes were completed separately. The Legacy Disability Evaluation System (LDES) process resulted in a long wait for and between evaluations, a benefits gap between soldiers' separation from the Army and when they started receiving VA benefits and disability compensation payments, and differences in the disability ratings between the Army Physical Evaluation Board (PEB) and the VA.

IDES was intended to resolve these issues by providing a simple, unified system[1,2] that resulted in consistent evaluations and ratings, and, most importantly, ensured that disabled soldiers leaving the Army were immediately linked into the VA and began receiving benefits. Although IDES streamlined the system overall, it also increased the time soldiers remained on active duty while undergoing medical evaluation and being



assigned disability ratings. Designed at the height of the surge of forces in Iraq and Afghanistan, the IDES process has retained its value during the more recent times of sequestration and military drawdown, helping the DOD preserve a fit and vital force and maintain military readiness.[3]

However, the LDES system allows for a DOD-led process that can be more time efficient based on the need of the soldier, the Army, or both.[3] The soldier or their commander can request that the LDES process be used instead of the IDES. The local military medical treatment facility (MTF) commander can approve the soldier's enrollment in the LDES or elect to send the soldier through IDES.

The IDES Process

The IDES process is outlined in Figure 30-1.[2] Once a soldier has reached the medical retention determination point (MRDP) and is referred to

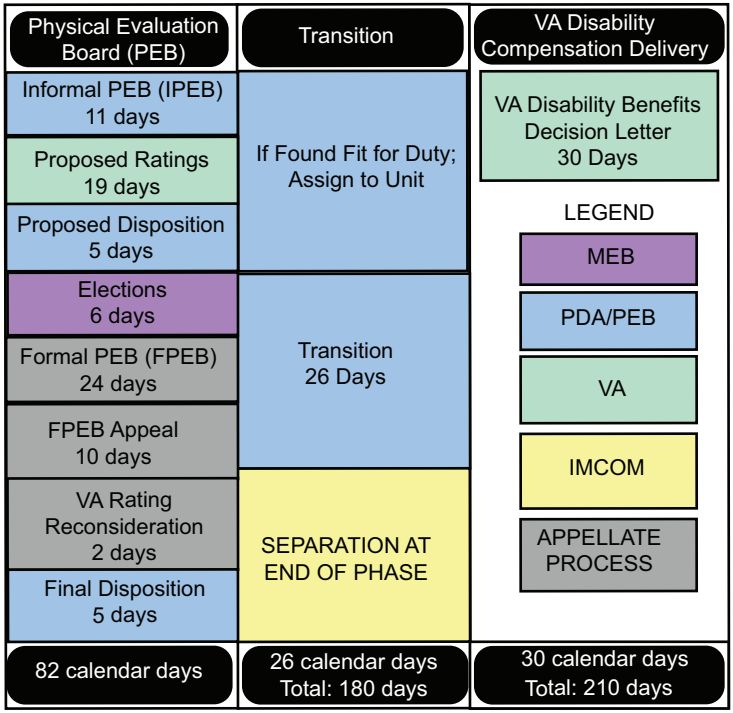


Figure 30-1 ***(left and above).*** Department of Defense/Veterans Administration Integrated Disability Evaluation System (IDES) timeliness goals.
IMCOM: Installation Management Command; PDA: Physical Disability Agency; VA: Department of Veterans Affairs
Data source: Wilkie RL. *Directive-Type Memorandum (DTM)-18-004–"Revised Timeliness Goals for the Integrated Disability Evaluation System (IDES).*" Under Secretary of Defense; July 30, 2010, Incorporating Change 2, September 19, 2019.

IDES, the process is expected to take 180 days. There are five key phases to this system, outlined below.

Treatment Phase

Once a soldier becomes injured or ill and seeks medical care, they enter the treatment phase. This will be the most common phase that physician

assistants (PAs) will participate in while serving in their role as the primary care provider for the soldier. Treatment may be prescribed by the PA, or the soldier may be referred to a specialty provider. If, during the course of the treatment phase, the PA or specialty care provider determines that a soldier has at least one condition that fails to meet the medical retention standards as defined in Chapter 3 of Army Regulation (AR) 40-501, *Standards of Medical Fitness*,[4] and the soldier has reached optimal medical benefit, then the soldier has reached the MRDP and should be referred to the IDES system.

The MRDP determination and referral to a Medical Evaluation Board (MEB) and PEB must be made within 1 year of the diagnosis with the medical condition that does not appear to meet medical retention standards, but the referral may be earlier if the medical provider determines the soldier will not be capable of returning to duty within 1 year. A profile containing a "3" or more means that the individual has at least one medical condition or physical defect that requires significant limitations. The completion of the permanent 3 or 4 on the Department of the Army (DA) Form 3349, Physical Profile, with the required approval signature of the designated physician assigned by the MTF commander initiates the process transitioning to the MEB. The PA's role in this phase is further discussed below.

Medical Evaluation Board Phase

Upon referral to the IDES system, the soldier enters the MEB phase of the IDES system. This phase takes place at the local installation (or the nearest Army installation). Upon referral to the MEB, the soldier is assigned a physical evaluation board liaison officer (PEBLO), who will serve as the link to the IDES system for the soldier and the soldier's commander. The PEBLO counsels the soldier on the IDES process, assembles the soldier's case file, and gathers all necessary documents, including medical records and a nonmedical assessment from the soldier's commanding officer. The PEBLO will ensure a complete, accurate, and fully documented case file, which is the foundation for a fair and equitable disability evaluation. The PEBLO's goal is to ensure each member's case is properly documented, fairly presented, and fully considered by all elements of the disability system, with appropriate compensation.

Once the soldier's case is assembled, including a list of all potential medical conditions that require evaluation for potential disability, the soldier's medical evaluation is scheduled. Conducted by the VA, the medical examination includes both general and specialty evaluations. This evaluation is the exam of record for IDES: if there are discrepancies between the VA and any prior DOD health care provider's diagnoses or limitations, the VA exam is used for determination of disability ratings. The exam is generally completed at the nearest VA facility. Several military installations have VA clinics located on site; however, this practice varies from site to site.

Upon completion of the VA's comprehensive medical exam, the findings and evaluation are returned to the local IDES team, where the exam is reviewed by the MEB physician. The physician reviews all of the diagnoses, limitations, and conditions and applies Chapter 3 of AR 40-501[4] to determine whether the soldier meets medical retention standards. If the soldier does meet medical retention standards, the MEB is terminated at this time and the soldier is returned to duty. If the MEB physician determines that the soldier does not meet the medical retention standards, the physician must determine whether the condition existed prior to military service, if it was aggravated by the service, and whether the soldier complied with treatment recommendations and protocols. These three areas can all have an impact on the disability rating awarded for a condition. The MEB physician summarizes these findings in the narrative summary (NARSUM).

Prior to the next phase, the soldier has the opportunity to review the NARSUM and may appeal to the MEB physician or request an impartial medical review of the findings and recommendations at the local MTF. As part of the system, the soldier has access to legal counsel trained and familiar with the IDES process, who can provide recommendations on responses. Upon either the soldier's approval or disposition of the appeal, the NARSUM is forwarded to the PEB. This action completes the MEB phase of IDES. The total time for this process should not exceed 72 days. The timeline may be affected by any delays in the VA comprehensive exam, scheduled by the PEBLO, as well as the time required to address appeals of the NARSUM. It is important to note that during this phase, soldiers must be readily available for their medical evaluations and review of their NARSUM. Therefore, non-emergent leave should be discouraged.[5]

Physical Evaluation Board Phase

The PEB phase begins when the PEBLO forwards the MEB case file, including the NARSUM, to the PEB. All PEBs take place at Joint Base San Antonio. The PEB reviews the soldier's NARSUM, medical records, VA evaluation, and commander's statement about the soldier's performance, and determines whether the soldier meets fitness-for-duty standards. One of the most influential documents in this review process is the commander's statement, which provides important information about how the medical condition and any duty limitations impact the soldier's ability to perform individual tasks, and the unit's ability to complete its mission. If the soldier elects to appeal the findings of this initial review, they may request a formal hearing to present the appeal to the PEB in person.

If the PEB determines that all of the soldier's conditions render them fit for continued duty, the IDES process is complete and the soldier is returned to duty. However, if any of the medical conditions are determined to render the soldier unable to meet fitness-for-duty standards, the PEBLO forwards the soldier's case to the VA, where it is sent to the VA Disability Evaluation System rating activity site (D-RAS). D-RAS staff apply the VA Schedule for Rating Disability to assign a disability rating for each condition. Ratings are impacted by certain circumstances: when the condition began (ie, if it existed prior to service); if it was the direct result of combat service; and if it was aggravated during military service. Once D-RAS staff assign the ratings, the case is sent back to the PEB, which makes final determination on whether the soldier will be medically retired or separated as a result of their conditions.

When this process is complete, the PEB forwards the results to the soldier's PEBLO. The soldier will review the results and has the opportunity to appeal the final results. As before, the soldier is afforded opportunity for legal counsel. This stage ends when the soldier signs off on DA Form 199, Informal PEB Proceedings, which documents the findings and ratings.[1] In total, the PEB phase must be completed within 82 days; however, the time period varies significantly based on the number and type of conditions, the ongoing workload of the PEB and D-RAS, and the number of appeals submitted.

Transition Phase

After concurring with the PEB findings and D-RAS ratings, the soldier enters the transition phase. During this process, the soldier undergoes either military retirement or separation. The local installation will generate the appropriate orders, and the soldier begins the process of clearing the installation and preparing for departure from the military, including returning all required equipment, closing out evaluations, clearing housing, and shipping household goods. While the goal for this phase is 26 days, this period often does not account for any accumulated leave soldiers may take prior to their separation or retirement (leave frequently extends this timeline beyond 26 days). This phase is completed when the soldier is officially out of the military.

Reintegration Phase

Upon departure from the military, the goal of the IDES system is to ensure that the soldier becomes a VA beneficiary within 1 month. This includes receiving VA compensation payment for all service-connected medical conditions and being integrated into the VA health care system for ongoing medical care. The PEBLO and VA's medical service coordinators are integral to the success of this phase; they ensure appointments are established with the local VA wherever the soldier chooses to locate after departing the military.

Physician Assistants in the IDES

While PAs are not directly involved in the MEB process, they should be generally aware of the process and able to brief their commander on the timeframe and status of their enrolled soldiers. The soldier's assigned PEBLO will be able to provide detailed answers both to the soldier's primary care provider and directly to the chain of command. Because most PAs serve as primary care providers to soldiers, there are two key aspects in which the PA has a significant role:

1. The most important role of the PA is the initial identification and treatment of potential duty-limiting conditions and determination of the MRDP. Key parts of this process are ensuring access to care, preventing delays in care, active monitoring of soldiers

with duty limitations, and ensuring high-quality medical documentation.

2. The second key aspect is the PA's responsibility to the chain of command. Although privacy laws restrict certain aspects of what a health care provider shares with their commander, the health and welfare of a unit is one of the commander's overall responsibilities. Therefore, it is imperative for a medical officer to track medical readiness and brief the commander on the unit's deployment status.[6] Soldiers nearing MRDP will most likely be placed into the MEB process, which can affect a deploying unit. The electronic profile system provides a key mechanism for tracking medical profiles.[6] PAs should be prepared for varying levels of review to discuss duty limitations and MRDPs.

Chapter 3-3 of AR 40-502, *Medical Readiness,* defines the MRDP as "medical condition has stabilized or cannot be stabilized in a reasonable period of time for up to 12 months and impacts successful performance of duty; the ability to perform basic soldiering skills required by all military personnel and MOS [military occupational specialty] specific duties."[6] The regulation goes on to state that a referral to MEB will be made within 1 year of a soldier being diagnosed with a medical condition. However, it is more important to ensure that the soldier's medical condition has stabilized and all reasonable treatment options have been exhausted.

When working toward an MRDP with a soldier, it is important to document how any injury occurred as well as where it occurred, when applicable. Conditions noted as combat related or aggravated in a combat zone can have significant effects on a soldier's ratings and compensation. Conversely, it is also important to document any noncompliance with therapy, which may not only affect ratings, but also guide further treatment.

PAs can refer soldiers to IDES once the MRDP has been reached without the recommendation of a specialist. However, it is extremely beneficial if at least one specialist has also recommended initiation of IDES to ensure all medical care possibilities have been explored. Once it is determined that a soldier has reached the MRDP, and ideally a specialist has concurred, the soldier should be called in for a face-to-

face encounter with the primary care provider to discuss the process. Soldiers should be aware that they are still under the authority of the Uniform Code of Military Justice (UCMJ)[7] and all applicable Army regulations during this phase. A permanent profile is initiated by the referring primary care manager and becomes official after the second approval signature. If the electronic profile has not been signed within 30 days, it will automatically be canceled. The MEB physician must complete a Defense Department (DD) Form 2807-1 documenting the soldier's medical history. Every prior medical complaint must be addressed to ensure that a particular complaint either meets, or does not meet, the standards of AR 40-501, Chapter 3.[4] The DD Form 2807-1 screening should be as complete as possible at the beginning to expedite the remainder of the MEB process and to reduce the number of appeals for unaddressed complaints.

Medical Care During IDES

The soldier's primary care manager remains responsible for the care of all the soldier's acute illnesses and injuries during the MEB process. Because the IDES process can take up to 210 days, it is important to maintain frequent, ongoing medical visits and coordination of care for the management of all the soldier's medical needs. Of note, once the soldier enters the PEB phase, they may undergo elective surgeries, in accordance with local policies and procedures as well as with Medical Command policy memo 13-044, *Medically Optional Surgeries for Service Members Undergoing Disability Evaluation through the Integrated Disability Evaluation System*,[8] that may impact the soldier's quality of life. The policy memo's proponent is the Medical Command's Clinical Policy Services, Health Care Delivery (G3/5/7). The approving authority for optional surgery is never a unit commander but is delegated down by the MTF commander or deputy commander of clinical services as the senior medical provider of the MTF. It is important for PAs to know these policies and procedures to prevent any unnecessary delays in the process or the soldier's medical care.

Legacy Disability Evaluation System

The LDES process is similar to the IDES, except it does not involve the VA.[3] In contrast to the IDES, the LDES should not take more

than 105 days. The DOD completes the medical examinations for the qualifying conditions, processes the MEB and PEB determinations, and produces the disability ratings for the conditions that caused the service member's inability to continue service. This process has the same appeal options as the IDES. If the service member is separated or medically retired through LDES, they may apply for VA disability benefits prior to separation through VA's pre-discharge program, or they may apply after leaving the military.

Chapter Separations

As unit medical advisors, PAs must be familiar with the guidelines associated with legal actions, non-medical military separations, and IDES/LDES. In general, court martials (Article 32 of the UCMJ)[7] supersede IDES/LDES cases, while IDES/LDES supersedes administrative separation actions (involuntary separation from the service due to failure to rehabilitate or failure to meet Army standards, such as Army Substance Abuse Program participation or physical fitness and height/weight standards).[3] In most cases, if a soldier enrolled in IDES/LDES is brought up on charges and referred for a court martial, they are disenrolled from IDES/LDES, and their case is reviewed again after the conclusion of the court martial. The soldier's primary care provider will continue to provide medical care during this process.

An exception to this rule is if the soldier is recommended by their chain of command for separation in which the discharge is characterized as "other than honorable." The most common reason for this type of separation is a pattern of misconduct. In these cases, both the involuntary separation process and IDES/LDES will proceed concurrently. When the chapter separation packet (see AR 635-200, *Active Duty Enlisted Administrative Separation*[7]) is completed and the current phase of the IDES/LDES process finalized, the case will be referred to the installation's senior mission commander (the commanding general). As a unit advisor, the PA may be asked if they believe the soldier's misconduct was associated or related to their medical condition.

Conclusion

Once a soldier has reached MRDP, they are referred to IDES/LDES. PAs are generally only involved in the referral process. It is important

for PAs to understand their role and how their decisions impact initiation of a MEB and ultimately the benefits a soldier may receive. Because the IDES/LDES process can take up to 210 days, a soldier can be on profile almost 2 years before the process is complete. Although it is challenging for commanders to understand the lengthy process, it is imperative that PAs explain the medical course of action, the length of time expected for the process, and the progression through each phase of IDES/LDES. This will help the commander know what to expect once a soldier is referred to IDES/LDES, and understand that due process and diligence is paramount in providing the care that soldiers deserve.

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US Department of the Army. *Patient Administration*. HQDA; July 8, 2014. Army Regulation 40-400.

Chapter 31

WHAT PHYSICIAN ASSISTANTS NEED TO KNOW ABOUT OPERATIONAL VIRTUAL HEALTH

Robert Cornfeld, MD, and P. Jason E.E. Auchincloss, APA-C, MPAS

Introduction

Since the invention of the telegraph, military medicine has utilized virtual health (VH) technologies to deliver health care to the point of need.[1] Digital health care delivery is a tool to assist decision-making at the point of need and address the challenges of time and distance, limited medical resources, and the requirements of immediacy in health care delivery. The multi-domain battlefield and the anti-access, area-denial future combat models demand an innovative health care delivery toolkit, including prolonged field care and VH.

Existing VH technologies offer a spectrum of modalities to provide a range of options for providers. The variety of options enables providers to utilize available bandwidth and connectivity tools depending on the military situation and their local resources. This chapter reviews existing asynchronous and synchronous technologies; highlights their innovative use by providers, both as the tools were designed and outside of their original design intent; and concludes with a view toward the future of VH.

Asynchronous Tele-Consultation

Asynchronous tele-consultation uses store-and-forward technologies to enable communication when there is no immediate timing requirement. The Pacific Asynchronous TeleHealth System (PATH) and Health Experts OnLine Portal (HELP) platforms are web-based, asynchronous,

provider-to-provider tele-consultation platforms available to US government medical providers and ancillary providers to provide care for their beneficiary population. Although PATH and HELP utilize the same background technology, they cover different geographic regions: PATH is best suited to providing feedback for patients located on the West Coast and Pacific region, while HELP covers the East Coast, Europe, and Africa. Entering the patient into the appropriate site based on location can improve response times because the information does not have to be passed to the "sister" site.

Patients must have a valid Department of Defense identification number to be entered into the system. The system also accommodates military working dogs, with veterinary staff available for consultation. After the originating (patient) site provider enters pertinent patient and consultation information, consultations are answered in 8 to 72 hours by specialists at a distant Role 4 medical center. Originating site providers receive an email response when the specialist reply is available. Both systems support more than 50 specialties, are available in garrison and operational environments, and notably do not require a Common Access Card (CAC) for use (Figure 31-1). Multiple studies have validated both the requirement and benefit of asynchronous consultation on land and sea.[2,3]

There are recognized limitations to these systems, which are being addressed as the two programs are unified under a future "Global Telecommunications Portal." In the operational space, the inability to upload end-user documents from a smart phone or a tablet compromises full capabilities; a computer is needed for this function. In the austere environment, providers are unable to ask specialists about dermatologic conditions or send electrocardiograms or ultrasound images through a smart phone. However, this limitation and others should not preclude end users from adding this valuable capability to their toolkit.

In addition to provider-to-provider tele-consultation across the US European Command (EUCOM), Africa Command (AFRICOM), and Central Command (CENTCOM), the HELP platform is used by Landstuhl Regional Medical Center (LRMC) in Germany to fill clinical gaps in the Transportation Command (TRANSCOM) Regulating and Command & Control Evacuation System (TRAC2ES) program. Providers at the patient originating and distant sites typically do not have access to TRAC2ES due to knowledge, equipment, and connectivity gaps. Additionally, due to the rotational nature of their mission, deployed

Adult Medicine Specialties

Allergy/Immunology (Adult & Pediatric)
Audiology
Cardiology/ Interventional Cardiology
Clinical Pharmacy
Critical Care/ Intensivist
Concussion Clinic
Dermatology
Endocrinology
Endocrinology/ Infertility
Flight Surgeon
Gastroenterology
Gynecology
Gynecologic Oncology
Hematology Oncology
Internal Medicine
Infectious Disease
Nephrology
Nutrition (Adult & Peds)
Pain Integrative Specialty
Pathology
PM&R Specialist
Pulmonology
Rheumatology
Sleep Medicine
Sports Medicine
Vaccine Healthcare

Surgical Specialties

Breast Surgeon
Cardiothoracic Surgeon
Colorectal Surgeon
Endo-Urologist
Foot and Ankle Surgeon
Hand and Upper Extremity Surgeon
Head and Neck Surgeon
Facial Plastic and Reconstructive Surgeon
Metabolic and Advanced Laparoscopy/Bariatric Surgeon
Neuro-otologist
Neurosurgeon
Ophthalmology (Adult & Pediatric)
Refractive Surgery
Oral & Maxillofacial Surgeon
Orthopedics (Adult & Pediatric)
Orthopedics/Spine
Plastic Surgeon
Sleep Surgery
Sports Medicine Orthopedics
Surgical Oncology
Trauma & Critical Care Surgeon
Urologist (Adult & Pediatric)
Urology Oncologist
Vascular Surgeon

Pediatric Specialties

Adolescent Medicine
Cardiology
Developmental Pediatrics
Endocrinology
Gastroenterology
Genetics
Hematology Oncology
Infectious Disease
Intensive Care Medicine
Neonatologist
Nephrology
Neurology
Pulmonology
Rheumatology
Speech Language Pathology
Physical & Occupational Therapy

Radiology Specialties

Pediatric Radiology
Interventional Radiology
Nuclear Medicine
Radiation Oncology
Musculoskeletal/ Radiologist

Behavioral Health Specialties

Child & Adolescent Psychiatry
Inpatient Psychiatry
Neuropsychology
Psychology
Chemical Addictions
Pediatric Psychologist

Figure 31-1. Asynchronous specialties available for consultation. The Pacific Asynchronous TeleHealth System (PATH) and Health Experts OnLine Portal (HELP) platforms offer tremendous depth of remote specialty consultation. PM&R: physical medicine and rehabilitation

providers are often unfamiliar with the medical center specialists taking care of their service members and do not have a mechanism for routine clinical updates. Finally, TRAC2ES is CAC-enabled, making mobile device use impossible.

These TRAC2ES challenges led to HELP's emergence as a medical communication platform across Eastern Europe. Originating site providers utilize the shared HELP platform to communicate directly with the LRMC's specialists taking care of their service members. Additionally, deployed service member discharge information from LRMC is entered into HELP for the originating site provider to review in order to improve continuity of care.

Synchronous Tele-Consultation

The Advanced Virtual Support for Operational Forces (ADVISOR) program provides contingency support via telephone at any time across eleven specialties (Figure 31-2). Specialty care providers are available for immediate operational support through a single, United States-based toll free phone number (+1 833-238-7756).

As do the HELP/PATH systems, ADVISOR offers a training module for originating site providers to familiarize themselves with receiving telephone-based consultation. Training and use of an ADVISOR call script is highly recommended.[4] The script provides an easy-to-follow format for providers to rapidly present information to the consultant. Consultants, in turn, are trained in the use of the script to ensure easy and error-free capture of the call details.

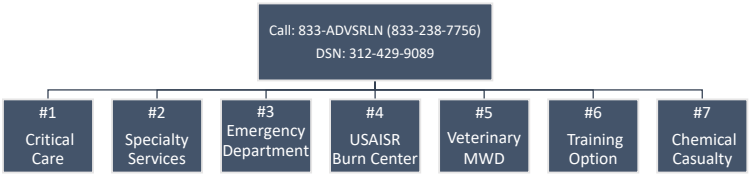


Figure 31-2. The Advanced Virtual Support for Operational Forces (ADVISOR) program line is constantly adding on-demand specialties for support of the warfighter at the point of need.
MWD: military working dog; USAISR: US Army Institute of Surgical Research

As with all communications tools, users should perform routine and deliberate verification that systems are functional. All downrange personnel should routinely confirm communications with their Theater Patient Movement Requests Center and ADVISOR to ensure clear communication prior to emergencies. This training also provides an opportunity for less seasoned providers to rehearse call scripts and ensure ease of access.[4] Testing on multiple communications platforms including Defense Switched Network (DSN), commercial dial, and satellite phone will ensure robust contingency plans.

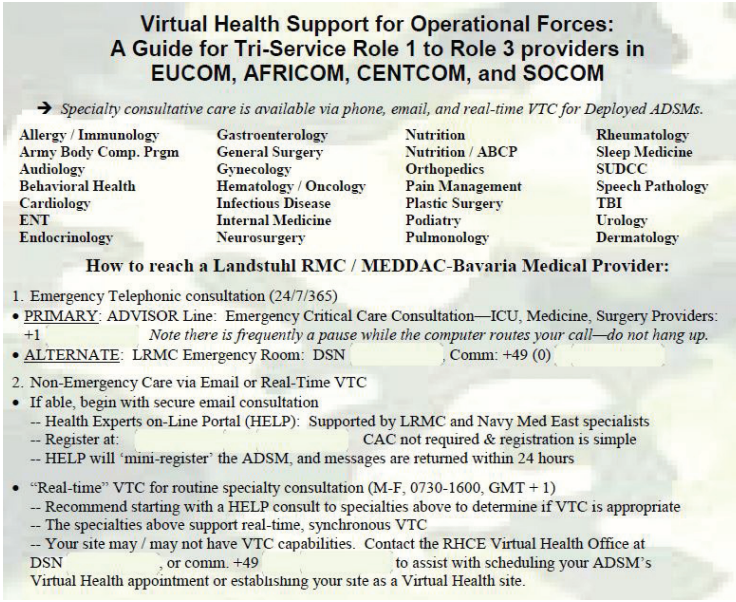
Case Study 31-1. An active duty service member in rural Africa received an injury to his distal phalanx from use of a band saw. Medical providers utilized ADVISOR to initiate consultation with the on-call orthopedic surgeon. ADVISOR consultation progressed to use of a secure, civilian private messaging service to send images that were used to guide treatment, demonstrating that multiple modes of VH delivery are often needed.

Synchronous Video for Direct Patient Care

Military providers have leveraged existing video conferencing systems, such as Global Video Services and Cisco Jabber, for direct-to-patient care. Like traditional in-person health care, video conferencing requires patients to be scheduled when providers are available; both allow for patient privacy; and providers must be comfortable with delivering health care in both manners. Synchronous video delivery has the additional requirements of connectivity, patient presenter training, and familiarity with the technology.

The Virtual Medical Center–Europe (VMC-E) has pioneered a system called Virtual Healthcare for the Warfighter (VIEW) to address challenges of specialty health care delivery across Eastern Europe. The program enables direct-to-patient care across more than 40 specialties, building on a successful garrison-based program.[5] Technical requirements include access to the internet and a web-cam at the originating site (Figure 31-3). In contrast to commercial video platforms including Facebook and FaceTime, no software is required for download, and originating site users simply access an LRMC-hosted webpage for care delivery.

Specialty consults begin with a HELP message that initiates the care spectrum at LRMC, enables determination of whether direct-to-patient care is required, and enrolls the patient into LRMC's medical systems



Virtual Health Support for Operational Forces: A Guide for Tri-Service Role 1 to Role 3 providers in EUCOM, AFRICOM, CENTCOM, and SOCOM

➔ *Specialty consultative care is available via phone, email, and real-time VTC for Deployed ADSMs.*

Allergy / Immunology	Gastroenterology	Nutrition	Rheumatology
Army Body Comp. Prgm	General Surgery	Nutrition / ABCP	Sleep Medicine
Audiology	Gynecology	Orthopedics	SUDCC
Behavioral Health	Hematology / Oncology	Pain Management	Speech Pathology
Cardiology	Infectious Disease	Plastic Surgery	TBI
ENT	Internal Medicine	Podiatry	Urology
Endocrinology	Neurosurgery	Pulmonology	Dermatology

How to reach a Landstuhl RMC / MEDDAC-Bavaria Medical Provider:

1. Emergency Telephonic consultation (24/7/365)
- PRIMARY: ADVISOR Line: Emergency Critical Care Consultation—ICU, Medicine, Surgery Providers: +1 *Note there is frequently a pause while the computer routes your call—do not hang up.*
- ALTERNATE: LRMC Emergency Room: DSN , Comm: +49 (0)

2. Non-Emergency Care via Email or Real-Time VTC
- If able, begin with secure email consultation
  -- Health Experts on-Line Portal (HELP): Supported by LRMC and Navy Med East specialists
  -- Register at: CAC not required & registration is simple
  -- HELP will 'mini-register' the ADSM, and messages are returned within 24 hours
- "Real-time" VTC for routine specialty consultation (M-F, 0730-1600, GMT + 1)
  -- Recommend starting with a HELP consult to specialties above to determine if VTC is appropriate
  -- The specialties above support real-time, synchronous VTC
  -- Your site may / may not have VTC capabilities. Contact the RHCE Virtual Health Office at DSN , or comm. +49 to assist with scheduling your ADSM's Virtual Health appointment or establishing your site as a Virtual Health site.

Figure 31-3. Virtual health information provided to operational force providers.

to allow for patient documentation. Patient presenters ranging from specifically trained medics (military occupational specialty 68W) to unit PAs perform examinations at the direction of the distant site provider. The distant site provider documents visits in the Armed Forces Health Longitudinal Application (AHLTA), the current electronic health record, or the future Military Health System Genesis program, when available. More than 70 operational sites across EUCOM, AFRICOM, and CENTCOM are actively performing synchronous VH, receiving consultation both from LRMC and within their own units.

The VMC-E also pioneered the use of "Telehealth in a Bag" (THIAB). THIAB is a set of off-the-shelf universal serial bus (USB) devices that attach to a computer, require no native software, and leverage capabilities of Windows and Macintosh OS systems. The system enhances the capabilities of the originating site to provide greater information to distant site providers. Currently, the THIAB set includes a stethoscope and a high-definition camera for viewing the

patient, including attachments for otoscopic and oronasopharyngeal examinations. The system interfaces with remote specialists and consultants using Web real-time communication.[6] PAs should contact VMC-E for guidance on obtaining a THIAB.

Case Study 31-2. The imaging capabilities of a THIAB were utilized by a unit PA to prevent medical evacuation (medevac) to LRMC. A soldier injured with a fire extinguisher during a training accident was directed to a local host nation facility for treatment, in alignment with the unit's medical concept of support. The wound was stapled closed, and over the following days developed purulence and surrounding erythema. Rather than medevac the soldier to LRMC for follow-on care, with the loss of both the soldier and an escort for an extended period, the medic (68W) utilized a THIAB and the VIEW system to demonstrate the infected wound to the unit's organic PA. The PA directed movement of the soldier to the nearby aid station in Romania, opened and packed the wound, and returned the soldier to duty, utilizing the THIAB/VIEW system for follow-on care. The use of VH maintained a vital warfighter at her place of duty for 14 days rather than having her recover at LRMC.

Synchronicity in Multiple Modalities

A recent study demonstrated the impact of the spectrum of VH modalities during a Stryker Regiment's deployment to rural Poland.[7] The availability of VH modalities for care delivery enabled individual service members to receive centralized waivers to deploy, and reduced mission days lost for health care during the unit's deployment by 213 days. Unit providers leveraged organic behavioral health assets that remained in the home station, relied on LRMC for specialty care delivery, and utilized both the HELP and VIEW platforms.

Conclusion

The VH tools described here are designed for ease of use by the end user. As in any health care procedure, frequency of use and familiarity with the modality will determine ultimate success at the time of need. Providers are encouraged to train themselves—and their care teams, including medics—on the available VH modalities prior to deployment. For example, use of the HELP/PATH platforms in garrison for tele-consultation rather than referring a service member for off-post care will develop the fluency required for use in the deployed environment.

Training for medics can incorporate use of the ADVISOR line for real-time trauma support during a prolonged field care exercise.

A spectrum of VH modalities will be a critical requirement on the future battlefield, where communication is more likely to be analogous to that on a submarine—limited, infrequent, and both synchronous and asynchronous as permitted. The benefits of virtual tele-consultation, tele-mentorship, improved medical regulating (patient movement), and direct-to-patient VH care are clear.

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Chapter 32

ROLE OF THE PHYSICIAN ASSISTANT IN RESEARCH

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Introduction

Army physician assistants (PAs) conduct research in both academic and clinical settings. PAs hold official research positions at the US Army Research Institute of Environmental Medicine, and they also drive investigations at other institutions, hospitals, and clinics. Regardless of setting, Army PAs should attempt to align research interests with the lines of effort designated by the Army Medical Specialist Corps (AMSC) with the intent of better serving Army soldiers. Current lines of research include:

- illness and injury prevention,
- disease and nonbattle injury management and rehabilitation,
- combat trauma management and rehabilitation, and
- health and performance optimization and reintegration.

A complete list of lines of research and their subcomponents can be obtained from the AMSC Research Committee. This committee provides support, advice, and guidance on research directly to the AMSC chief, who typically appoints the committee's head (Figure 32-1).

The onset of any research project should entail a search for similar, previously published literature. Generally, research requires a degree of originality and innovation that adds something to the current



Figure 32-1. Colonel Renee Cole (left) presents the 2019 Mary Lipscomb Hamrick Research Course Lifetime Research Award to Major Seth Holland at JBSA-Fort Sam Houston, TX. Colonel Cole is currently the AMSC Research Committee lead. Major Holland is a graduate of the US Army/Baylor Doctor of Science in Physician Assistant Studies in General Surgery.
Photograph courtesy of Major Robin Cushing.

body of literature. Prior to starting any research, PAs should search online publication depositories (such as PubMed, the Army Medical Department Virtual Library, and the specific academic institution the PA is enrolled in) to ensure their idea meets this criteria.

Evaluating and Conducting Research

Evaluating and conducting research is vital to the growth and development of medical knowledge and practice, for both individual PAs and the medical community as a whole. While isolated laboratory tests provide foundational knowledge in medicine, clinical studies evaluate diagnostic and treatment hypotheses in human subjects for a more direct application to practice. When evaluating existing research and planning future research, PAs must understand the different types of studies and the hierarchy of their evidence. The levels of evidence for clinical studies and examples are provided by Elsevier at: https://www.elsevier.com/__data/promis_misc/Levels_of_Evidence.pdf.[1]

The "PICO" Approach

In developing and evaluating clinical studies and research, PA researchers should understand the goals and applications of each. Integral to this approach is the use of the "PICO" model:

P: patient or population
I: intervention (or exposure)
C: comparison (or control)
O: outcome

An example of utilizing the PICO model is a study of adult patients 18 to 65 years old complaining of a migraine headache (P), receiving 1 g of intravenous acetaminophen (I), compared to those receiving 975 mg of oral Tylenol (C), for a decrease in reported pain based on a visual rating scale (O).

A refined PICO model can be translated into a specific research question, which should include each of these four aspects. Having established these elements, PAs can start to develop and refine a research hypothesis and begin to organize a clinical study. It is important to note that, with the exception of individual case studies, case series,

and expert opinions, all clinical studies require a formal submission to the institutional review board (IRB) for review and approval prior to conducting research.

Types of Studies

The different types of analytic and descriptive studies vary in strength based on the scientific rigor of their respective designs, as outlined in Exhibit 32-1. They are briefly described below.

Metaanalyses

- Metaanalyses systematically group multiple clinical trials, generally with similar characteristics, to test for a shared hypothesis with a larger sample population.
- A popular meta-analysis resource is the Cochrane Reviews database, which contains over 7,500 systematic reviews of literature.
- Strengths: establish a larger sample population for enhanced testing power; draw more diverse populations for enhanced comparison and broader application.
- Weaknesses: strength of evidence depends on strength of sampled

Exhibit 32-1. Study types, from strongest to weakest, based on the scientific rigor of their respective designs.

1. Analytic studies
    a. metaanalysis
    b. experimental: randomized clinical controlled trial
    c. observational
        i. cohort study
        ii. case-control study
        iii. cross-sectional study
2. Descriptive studies
    a. aggregate: ecologic study
    b. individual
        i. cross-sectional study
        ii. case series
        iii. case report
3. Other: expert opinions

trials; time consuming; heterogeneity of sampled studies may confound results; possible selection bias in choice of studies included.

Randomized Clinical Controlled Trials

- In clinical trials, the exposure is determined by the investigator.
- "Randomized" means that differential confounding factors are removed by randomly assigning the exposure.
- Strengths: provide strongest evidence for causality because of clear temporality, cause and effect, and control for unknown confounding factors.
- Weaknesses: expensive; time consuming; possibility of selection bias; potential lack of generalizability to the population of interest.

Cohort Studies

- Cohort studies are prospective studies in which individuals with an exposure are identified and compared to individuals without the exposure with respect to future outcomes of interest. They are longitudinal studies (conducted over time) in which outcome incidence is compared between exposed and unexposed groups.
- Yields: cumulative incidence relative risk ratios and incidence density relative risk ratios.
- Strengths: clearly defined temporality because the exposure occurred before the outcome.
- Weaknesses: time consuming; costly; loss to follow-up is common.

Case-Control Studies

- Case-control studies are retrospective studies in which individuals with a condition (cases) are identified and compared to individuals without the condition (controls) with respect to prior exposures.
- Yields: odds ratios and prevalence ratios.
- Strengths: efficient use of time; less costly; can study rare diseases; statistically efficient.
- Weaknesses: temporal ambiguity; recall bias; selection bias.

Cross-Sectional Studies

- Cross-sectional studies can be seen as "snapshots" in which individuals are selected without regard to outcome or exposure status. Data is collected at one point in time at the individual level. Often these are the first analytic studies to be conducted, because if a causal relationship is not identified, no further studies are needed.
- Yields: odds ratios and prevalence ratios.
- Strengths: relatively inexpensive and efficient.
- Weakness: temporality (because data on exposure and outcome is captured at one point in time, the exposure could have occurred after the outcome of interest).

Ecologic Studies

- In ecologic studies, the units of measurement are captured at the population level (as opposed to the individual level). These studies use group data to describe correlations between conditions and exposures in various populations.
- Yields: correlation ratios.
- Strengths: quick; efficient; yields multinational and multiorganizational comparisons.
- Weaknesses: no direct linkage between exposures and outcomes at the individual level; risk of ecologic fallacy (the correlation identified at the population level does not necessarily represent a relationship at the individual level).

Case Series

- Case series consist of multiple patients who have a similar pattern of presentation, evaluation, or diagnoses, providing a theme for reader learning. These studies are essential for the early identification of problematic exposures, but are not analytic in nature like the studies listed above.
- Yields: illness characteristic and treatment themes.
- Strengths: provide insight into patient populations too small, diverse, or dispersed (in time or place) to effectively conduct proper trials.
- Weaknesses: largely retrospective in nature; small populations; no explicit comparison group.

Case Reports

- Case reports (Figure 32-2) consist of a single patient who has a unique presentation, evaluation, or diagnoses, providing notable insight into an illness. They are essential for reference of rare cases, but are not analytic in nature and cannot establish definitive trends for diagnosis and treatment.
- Yields: illness characteristics and anecdotal treatments.
- Strengths: provide insight into patient populations that are too small, diverse, or dispersed (in time or place) to effectively conduct proper trials.
- Weaknesses: retrospective in nature; isolated cases; no explicit comparison group.

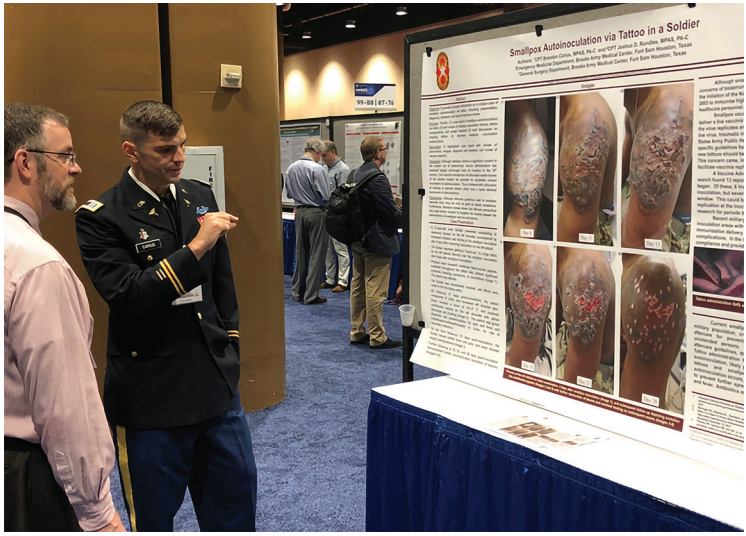


Figure 32-2. Then-Captain Brandon Carius presents a poster on a case report during the Military Health System Research Symposium in Kissimmee, Florida, in August 2018. Major Carius is a graduate of the US Army/Baylor Doctor of Science in Physician Assistant Studies in Emergency Medicine program. Photograph courtesy of Major Brandon Carius.

Expert Opinions

- Expert opinions are statements on the diagnoses or treatment of illness by a prominent member or several members of a specific or overlapping medical specialties, who may or may not refer to published studies for support of their position.
- Yield: an opinion.
- Strengths: provide guidance and insight into the diagnosis and treatment of conditions in the absence of published literature.
- Weaknesses: largely uncited/otherwise unsupported positions.

Collaboration

Current scientific research is expected to include complexity and in-depth analysis. It follows that a substantial range of resources must be marshaled to conduct a research project, particularly in terms of individual talents. Collaboration has therefore been seen as integral to modern research, ensuring that each project is a productive endeavor, with input from multiple perspectives.[1] Research collaboration represents more than the simple involvement of many people, however. Collaboration is a complex process that is not easily defined or assessed,[2] although the presence of differing talents and perspectives is a key component. Collaborations can be established among individuals, departments, or institutions. As providers accustomed to practicing in and leading collaborative medical teams, PAs are well suited to lead this process. In this era of evidence-based medicine, their foundation in clinical science ensures the critical perspective needed for productive medical research.

The recognized benefits of collaboration in research[3] each apply to PAs. Collaboration promotes the effective use of individual talents, while providing PAs an opportunity to employ clinical experience in addition to research-related training (Figure 32-3). Research allows the transference of knowledge. PAs may therefore find that collaboration provides a new mechanism to impart wisdom, both to partner researchers and to readers of publications. Their involvement in collaborative research allows critical experiences and lessons learned to be incorporated into evidence-based practice standards. Collaboration is also a source of intellectual stimulation and companionship as well



Figure 32-3. Major Meghan Joyce (left) and Lieutenant Colonel Amelia Duran-Stanton (right) validate goniometer elbow measurements on Captain David Korb (center), a physician assistant student during his orthopedics rotation at the Brooke Army Medical Center in March 2020. Lieutenant Colonel Duran-Stanton and Major Joyce are graduates of the US Army/Baylor Doctor of Science in Physician Assistant Studies in Clinical Orthopedics program. Lieutenant Colonel Duran-Stanton also earned a Doctor of Philosophy in Postsecondary and Adult Education through Capella University.
Photograph courtesy of Lieutenant Colonel Amelia Duran-Stanton.

as professional networking. PAs may find these benefits refreshing after prior clinical experience involving relatively limited interaction with other professionals.

Balancing Research with Clinical Duties

Research is detail-oriented and requires a significant time investment. While interactions with subjects may occur in the course of normal clinic duty, work for research is often completed outside of these times. It is important to establish a schedule and remain disciplined throughout the research process, which will allow for effective management of multiple requirements. In the beginning of the research process, it is

important to identify the primary and associate investigators (PI and AI, respectively). Assigned roles and responsibilities should be determined at project initiation so all investigators can appropriately balance their clinical responsibilities with the research requirements.

The PI should devise a project timeline and routinely schedule team meetings, whether virtual or face-to-face, to establish accountability. A realistic schedule must be developed to minimize conflict with clinical duties. Backward planning from an agreed-upon end goal is key. Incremental goals and metrics should be established and divided among the research team. Setbacks are inevitable, making it imperative for team members to remain flexible. Time management is a cornerstone to successful research, particularly for those who have clinical duties, required professional development, or travel.

Programs Requiring Research

Currently, the Doctor of Science (DSc) in emergency medicine, general surgery, and orthopedics residency programs, as well as the Doctor of Medical Science (DMSc) degree, require Army PAs to complete a research project. The research may include primary data collection and analysis, secondary data analysis, or metaanalysis. Army PA residents should choose a topic that interests them and solicit feedback from staff along the way. Army PA residents are also required to choose a staff advisor for their topic and routinely meet with the advisor to discuss progress. It is also important to get explicit guidance from the program director on all research requirements. Residencies are generally 18-month programs, and residents must dedicate adequate time to completing their research while managing clinical and didactic responsibilities. All DSc residents are required to defend their research project at the end of the program to university and residency faculty.

When an Army PA is selected for funding to pursue a PhD at a civilian school of choice, they must meet the research requirements of the selected program. Earning a PhD requires completing a dissertation project, which usually includes primary data collection and analysis. Most military schools also require research skills, so it is important to hone research skills as early as possible. During the Interservice Physician Assistant Program, for example, students are required to conduct a literature review for their master's paper.

Captains Career Course students must research and write an analysis of command principles applied to a historical battle. The Command and General Staff College requires students to submit defense papers that include research. The Senior Service College requires students to complete, at minimum, a strategy paper and a research project. The earlier a PA learns how to conduct research, finds out how to format papers depending on the academic or publication requirements, and understands the basics of technological research tools and resources, the better the quality of their work will be as they progress throughout their career.

Institutional Review Board Process

Most types of research involve review and oversight by a third party in order to ensure safe conduct and protections for participants. Military and civilian institutions utilize an IRB as an impartial third party to assess the safety of proposed research prior to its initiation. Before starting an IRB submission, potential investigators should familiarize themselves with the latest requirements, although several have remained consistent. These include an updated curriculum vitae (CV) and completion of Collaborative Institutional Training Initiative (CITI) instruction. CITI course certification, which is good for 3 years, provides potential investigators with a thorough background on the Human Research Protections Office, its purpose, and the paramount need for human protection and safety in conducting scientific research. In the military, IRB organization is generally aligned with the regional health command structure. Using templates, prospective research is submitted to the IRB, where it is first administratively reviewed for proper packet completion, and then categorized for one of three stratified levels of review:

Exempt

- Studies that are deemed to have less than minimal risk to participants, and fit into one of several categories, such as being conducted in an educational setting.
- Examples include anonymous surveys, laboratory studies not involving human samples, or comparing two different educational curricula.

Expedited

- Studies that involve only minimal risk to participants, defined as not being "greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests"[4]; that do not involve vulnerable populations (such as prisoners or military trainees); and that fit into one of several categories, such as data obtained through noninvasive means routinely employed in clinical practice (such as radiographic imaging), or blood samples collected by venipuncture from healthy volunteers.
- Examples include examination of human specimens (such as a blood sample study) or a records review of identifiable patient information.

Full Board Review

- Studies deemed to involve more than minimal risk to participants, or that involve certain categories such as vulnerable populations (eg, persons under age 18, prisoners, military trainees); procedures that might cause physical harm; or collection of information that could seriously harm the participant legally, socially, or financially if other people could identify them.
- Examples include physical exertion testing after blood donation; comparing ketamine to acetaminophen for intravenous pain relief; testing a new type of endotracheal tube for emergent intubation.

Potential investigators must maintain perspective and patience when approaching their local IRB for review and approval of a study. While exempt studies can be returned with approval within weeks, those involving full review, or even expedited review, can take many months or even over a year for approval. IRB panels generally meet on a monthly basis to conduct reviews, and often require multiple revisions and additional input (generally referred to as "stipulations") prior to approval.

Upon approval, investigators should ensure that they understand future requirements from the IRB, including potential ongoing reviews on a scheduled basis (such as annually). Deviations from the approved protocol necessitates notification to IRB office personnel and potentially halting study execution until further review. This is generally outlined in the IRB approval packet.

Upon completion of data collection, IRB procedures must be followed to successfully "close" a study. After a study is closed, investigators must either maintain or destroy paper copies of data as specified in their protocol. Investigators should work with a statistician, either local or easily accessible through electronic communication, to verify their data for statistical analysis. Upon completion of data analysis, investigators create a draft manuscript, presentation, or both, which must be submitted to the IRB public affairs office prior to submission to any conference or journal.

Writing and Publishing

Research is conducted for the primary purpose of increasing medical knowledge, but its effect is limited if not effectively disseminated. Publishing research is the best method to reach the greater medical community. Journal themes range from general practice (eg, the *Journal of the American Academy of Physician Assistants*) to various medical specialties. It is important that PAs have target journals in mind from the outset to ensure compliance with the publisher's requirements (see a partial list of journals under Tools and Resources at the end of this chapter). Formatting guidelines are found on most journals' websites. Strictly following these guidelines, in addition to striving for effective writing (keeping the article as short and succinct as possible), will ensure the best chance of a smooth submission process and, ultimately, article acceptance. Additionally, when conducting a literature review, Army PAs should consult local and online resources available through the military prior to purchasing any references. These are most easily accessed by consulting the local hospital or regional medical center librarian.

The AMSC has recently added publications, presentations, and civilian organization involvement as part of the requirements to earn the 9A proficiency designation (discussed in the attachment to Chapter 1 of this handbook). Additionally, PAs should attend the AMSC's annual Mary Lipscomb Hamrick (MLH) Research Course, taught by subject matter experts, even when they are not in academic programs (Figure 32-4). The earlier PAs attend this course, the earlier they can learn the basics of research and begin networking and collaborating with fellow researchers, while earning continuing medical education and military school credit. (Additional details about the MLH course are available



Figure 32-4. Army Medical Specialist Corps faculty and attendees during the 2019 Mary Lipscomb Hamrick Research Course.
Photograph courtesy of Major Robin Cushing.

on the AMSC's MilSuite page at https://www.milsuite.mil/book/groups/army-medical-specialist-corps. See other chapters in this handbook for additional course listings, as well as information on PAs who have earned MLH research awards.)

Mentoring in Research

There are many opportunities for mentorship within the research community, both supervisor-subordinate and peer-to-peer.

Academic Settings

Army PAs pursuing an advanced graduate degree benefit from mentorship, not only by their academic advisors, but also by fellow Army PAs who have previously earned an advanced degree. Particularly when studying in a civilian school, guidance on how to maneuver through the program in a timely fashion as an active duty PA is imperative. Earning a PhD requires planning and execution of very specific steps, including didactic studies, comprehensive exams, research proposals, and dissertation defense. Similar key events may be present in master's-level programs as well. Failing to complete or meet the standards at every step can result in significant delays or failure to complete the program. Army PA mentors can help provide the guidance necessary to stay on track throughout these programs.

Research Institutes

Army PAs may serve in a research institute, including the US Army Research Institute of Environmental Medicine, where the focus of their duties is to plan, execute, and analyze research (Figure 32-5). These positions may or may not require an advanced or specific degree. Peer-to-peer mentorship while working in these settings can be very useful: learning the steps to getting a research protocol approved by an IRB,



Figure 32-5a. Major Bradley Warr, research physician assistant and chief of the Military Performance Branch of the US Army Research Institute of Environmental Medicine in Natick, Massachusetts, prepares a soldier for measurement of oxygen consumption while carrying 25-mm ammunition cans at Fort Hood, Texas, as part of the Training and Doctrine Command Physical Demands Study in December 2013. Major Warr earned his Doctor of Philosophy in Physical Activity, Nutrition and Wellness from Arizona State University. Photograph courtesy of Major Bradley Warr.



Figure 32-5b. Major Robin Cushing and Sergeant First Class Eileen Tavarez discuss drug research protocols with human volunteers. This double-blind experimental study evaluated the effects of cocoa flavonoids on blood circulation in February 2020. Major Robin Cushing earned her Doctor of Philosophy in Public Health from the University of Hawaii.
Photograph courtesy of Major Robin Cushing.

evaluating the scientific rigor of a proposal, efficiently using available resources, and reviewing manuscripts are all topics that can be discussed among peers. Finding a mentor with significant experience in these processes is appropriate and will contribute to successful research.

Lessons Learned

The following lessons learned will help PAs in navigating the world of research as well as in pursuing other endeavors. PAs should:

- begin with the end in mind—determine when a product or project is due and backwards plan from that goal;
- collaborate early and often—it is important for a researcher to identify their resources and network;
- discuss projects frequently with mentors, especially those who can assist in moving them forward; and
- involve statisticians early in the project, not just when needed.

Tips for Success

Along with lessons learned, the following tips for success will help PAs maximize their opportunities in research. PAs should:

- maintain an updated CV for all authors and collaborators;
- review the IRB requirements and follow them (when in doubt, ask for clarification);
- meet with a senior researcher or researchers in the beginning of the research endeavor, which will save a lot of time and missed steps, especially for junior researchers;
- utilize all the research platforms available in streamlining the project (see Tools and Resources at the end of this chapter);
- attend a research course at the earliest possible time and before it is required, particularly if planning to attend a long-term health education and training program;
- manage time wisely and know all the deadlines required to complete a project; and
- take the time to identify past and current literature that supports the project. A strong literature review is the foundation of the research project.

Conclusion

The ability to conduct research is important for all PAs. Conducting research helps PAs improve their clinical practice while contributing to the body of existing medical literature. All PAs, regardless of educational background, can learn new skills and use them in their current environment. PAs do not need doctorate-level education to conduct research; they require only willingness, fortitude, and interest; time-management skills; and eagerness to learn, especially from senior researchers.

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Tools and Resources

Reference Management Tools

- EndNote: https://endnote.com/
- Mendeley: http://www.mendeley.com (also a collaboration tool)
- Microsoft Word: https://support.office.com/en-us/article/create-a-bibliography-citations-and-references-17686589-4824-4940-9c69-342c289fa2a5

- Paperpile: http://www.paperpile.com
- RefWorks: https://www.refworks.com
- Zotero: http://www.zotero.org (also a collaboration tool)

File Sharing

- DoD SAFE: https://safe.apps.mil/
- Box: http://www.box.com
- Google Drive: https://www.google.com/drive
- Dropbox: https://www.dropbox.com

Statistical Tools

- Power and Sample Size Calculator: http://powerandsamplesize.com/
- Statistical Package for the Social Sciences: https://www.ibm.com/analytics/spss-statistics-software
- MiniTab https://www.minitab.com
- Survey Monkey
- Poll Everywhere

Online Publication Depositories

- PubMed: https://www.ncbi.nlm.nih.gov/pubmed
- AMEDD Virtual Library: https://medlinet.amedd.army.mil/
- Research Gate: https://www.researchgate.net/
- Army Public Health Center: https://phc.amedd.army.mil/topics/discond/ptsaip/Pages/References.aspx
- ProQuest: https://www.proquest.com

Collaboration Tools

- Skype
- Zoom
- Facebook Messenger
- Google
- MilSuite
- Trello
- Blackboard Collaborate
- Adobe Connect

Journals

- *American Journal of Emergency Medicine*
- *Cureus*
- *Journal of the American Academy of Physician Assistants*
- *The Medical Journal* (US Army Medical Center of Excellence)
- *Journal of Orthopaedics for Physician Assistants*
- *Journal of Special Operations Medicine*
- *Journal of Trauma and Acute Care Surgery*
- *Military Medicine*
- *Prehospital Emergency Care*
- *Transfusion*
- *Visual Journal of Emergency Medicine*

Research Resources

- Army Human Resource Protection Office
- Army Medical Research Development Command: https://mrdc.amedd.army.mil/index.cfm/collaborate/research_protections/irbo
- Brooke Army Medical Center Department of Clinical Investigation: https://www.bamc.health.mil/staff/research/dci/
- Collaborative Institutional Training Initiative: https://www.citiprogram.org

Chapter 33

ROLE OF THE PHYSICIAN ASSISTANT IN GLOBAL HEALTH ENGAGEMENT

Christopher G. Metcalf, PA-C, MPAS, and Erin Stibral, APA-C, MPAS

Introduction

Global health engagement (GHE) comprises a very rewarding, and often challenging, mission set. GHE activities are diverse and support numerous strategic goals that support the Department of Defense (DOD) and advance US security objectives. US military medical personnel may participate in GHE activities at many levels. Most often Army physician assistants (PAs) will be involved in GHE at the tactical level; however, they may also have opportunities to participate at the operational level, while serving at an Army service component command (ASCC), or on a strategic level within the combatant commands (COCOMs). PAs involved in GHE work within the US government and military systems and also work closely with other entities, including nongovernmental organizations and partner nation (PN) military systems. Individuals working in GHE at the tactical or operational level will be part of a command surgeon's staff.

Background

Department of Defense Instruction (DODI) 2000.30 provides a framework for DOD GHE activities and delineates how GHE activities support US National Security Policy and defense security cooperation strategy.[1] Because of the linkage of GHE and national security it is imperative that all individuals planning and conducting GHE activities have a basic understanding of military GHE principles and underlying

purposes, country-specific security cooperation (SC) objectives, and the overarching National Security Strategy.

Security Cooperation

SC is a means by which the combatant commander can achieve their objectives as laid out in the theater campaign plan. SC activities are engagements that build defense relationships while also promoting US security interests and can span all phases of military operations. The broad US objectives from which campaign plans are derived are outlined in the National Security Strategy.

GHE activities are a subset of SC and should directly support the ASCC or CCMD security cooperation plan, US embassy integrated country plan, and National Security Strategy objectives. Detailed information on security cooperation can be found in DA Pamphlet 11-31, *The Army Security Cooperation Handbook*.[2]

Global Health Engagement

DOD GHE activities are used to enhance stability and support medical capacity development within PNs. GHEs are an important tool for maintaining influence and building trust with US allies and PNs. A key consideration for any DOD GHE activity is that it must benefit the US military in addition to supporting the PN. This benefit can include improving military-to-military relationships, increasing interoperability, enhancing security, and providing readiness opportunities for US personnel.[1]

The directive that DOD GHE must provide a benefit to the DOD as well as the PN is a key discriminator between how nongovernmental organizations (NGOs) and governmental organizations, including the military, approach these types of engagements. NGOs abide by four humanitarian principles. One of these principles, the humanitarian imperative directs engagements based solely on providing humanitarian assistance wherever it is needed. Medical providers, including military providers, often view these activities from a humanitarian perspective, but the main purpose behind military GHE activities is supporting defense and security objectives.[3] NGOs, on the other hand, participate in GHE events solely for the humanitarian goal of improving global health and health systems.

GHE in the broadest sense is any health engagement between military members of different nations. Planned GHE events may be distinct engagements that are coordinated with a country, or they may be events embedded within an exercise. GHE events include but are not limited to subject matter expert exchanges (SMEEs), disaster relief exercise and exchange (DREE), medical conferences, and medical seminars (MEDSEMS). GHE can also be medical personnel from both nations working side by side to provide direct care as part of a subject matter expert exchange. GHE includes not only human health care, but also veterinary medicine, preventive medicine, and medical operations planning. Figure 33-1 is an example 5-year health engagement plan. Examples of individual GHE events are shown by year and line of effort (LOE). This well-developed plan demonstrates how distinct GHE events can be coordinated across organizations and LOEs to support both PN and US objectives.

Implementation Considerations

Concerns have been raised from both within and outside the DOD regarding the way DOD GHE activities are conducted. Common concerns include the risks of providing short-term solutions to chronic problems and undermining PN health care systems. DOD GHE activities also have the potential to undermine nonmilitary GHE activities.[4] For this reason, GHE activities should never be stand-alone medical events. GHE activities should tie into a health security cooperation strategy designated by the ASCC or CCMD surgeon's office. They should attempt to support the needs of both the US military and the PN by developing a long-term, sustainable medical capability or capacity. To ensure the GHE activities are having the desired effect, a system for assessment, monitoring, and evaluation must be part of the SC plan.[5]

Roles and Duties

Tactical Level

At the tactical level (corps and below), PAs assigned as staff officers usually participate in GHE as planning team members or by conducting GHE activities as part of an exercise. For successful GHE planning and exercising, it is important to understand the higher headquarters

Strategic Enablers, Tools, and Resources
Pacific Pathways, Disaster Response Exercise Exchange (DREE), PACIFIC ANGEL, Joint Chief of Staff Exercises, Global Health Security Agenda Phase 1 Country (CDC Liaison), National Guard SPP, Uniformed Services University Center for Global Health Engagement (USU CGHE), APMHE, AFRIMS, USAID, APCSS, CFE-DM, NEPMU

	2018	2019	2020
Line of Effort	**Engagement**	**Engagement**	**Engagement**
Health System Support (Shape)		PKO L2H Trauma SMEE (ASCC) AVN Patient Movement SMEE; PACIFIC ANGEL (AF, ASCC)	Med Spt to PKO Clinical/ Functional SMEE (ASCC) Site visit to TCCC training center (ASCC)
Health Service Support (Posture)	BioPrep/ Emergency response SMEE Phase 2 (RHC/ CDC/AFRIMS); GPOI FHP Multi-Lat with a 3rd nation	BioPrep/Emergency response TTX Phase 3 (RHC/CDC/ AFRIMS/AF)	Clinical Laboratory Infectious Borne Diseases SMEE (MEDCEN/ AFRIMS)
Force Health Protection (Ready)	Used GPOI funding and integrated into the BioPrep/Clinical Lab SMEE	PH/PM Capacity Building (Navy/AF/ PHC/AFRIMS) DREE	Preventive Med Deployment OEHSA Phase I SMEE (Navy/AF/ PHC/AFRIM)
Strategic Leadership (Communicate)	• Land Forces Talks (annual) • Bilateral Defense Dialogues • Senior Leader Engagement (ASCC 2017/2019/2021) • APMHE		
Priorities	PARTNER NATION-HMA, HADR, PKO COCOM-HA/DR, PKO, Defense Professionalization ASCC-HA/DR, PKO, Counter Improvised Explosive Devices (CIED), Mil-Mil Relationships		

Figure 33-1. Example of a 5-year health engagement plan. Examples of individual global health engagement events are shown by year and line of effort. AF: Air Force; AFRIMS: Armed Forces Research Institute of Medical Sciences; APMHE: Asia Pacific Military Health Exchange; APCSS: Asia Pacific Center for Security Studies; ASCC: Army service component command; AVN: aviation;

2021	2022	2023
Engagement	**Engagement**	**End State**
Med Spt to PKO Med Ops TTX (ASCC)	Med Spt to PKO Med Ops TTX (ASCC)	Improved operational military medical training from individual to collective skills, with a trauma focus (Supports HA/DR, PKO) Increased capability to detect and respond to emerging infections/ pandemics (Supports HA/DR, GHSA) Improved ability to evaluate environmental threat during HADR/ PKO events (supports HA/DR, PKO)
Clinical Laboratory Disposal of Haz Waste SMEE (MEDCEN)	Five-Year Evaluation Biopreparedness and PKO SMEEs (ASCC/HHS/ CDC)	
PH/PM ISO deployment operations SMEE (ASCC)	PH/PM ISO deployment operations SMEE (ASCC)	

CDC: Centers for Disease Control and Prevention; CFE-DM: Center for Excellence in Disaster Management and Humanitarian Assistance; COCOM: combatant command; FHP: Force Health Protection; GHSA: global health security agenda; GPOI: global peace operations initiative; HA/DR: humanitarian assistance/disaster response; HHS: Department of Health and Human Services; HMA: Humanitarian Mine Action Program; L2H: level 2 hospital; MEDCEN: Medical Center; NEPMU: Navy Environmental Preventive Medicine Unit; OEHSA: Occupational and Environmental Health Site Assessment; PKO: peace-keeping operations; RHC: Regional Health Command; SMEE: subject matter expert exchange; SPP: State Partnership Program; TCCC: Tactical Combat Casualty Care; TTX: table-top exercise; USAID: US Agency for International Development

country plan and underlying purpose of the activity (Figures 33-2 and 33-3). If at all possible, PN medical personnel should be included in the event. To plan or execute a successful engagement, the following items must be considered:

- country health context (determinants or variables that effect the health of the local population including social, political, cultural, and economic issues);
- the CCMD or ASCC health security cooperation plan;



Figure 33-2. Specialist Kassandra King (left front), a combat medic with US Army Africa, performs an intravenous procedure. Major Paul "Jason" Auchincloss (left rear), a senior physician assistant with US Army Africa, discusses Army treatment techniques with South African soldiers during a training session for the Shared Accord exercise at the South African Army Combat Training Center in Lohatla, July 26, 2017. Photograph by Sean Kimmons.
Reproduced from Kimmons S. South African exercise becomes homecoming for USA Army physician assistant. US Army Africa website. Published August 16, 2017. Accessed May 27, 2020. https://www.usaraf.army.mil/media-room/article/28355/south-african-exercise-becomes-homecoming-for-us-army-physician-assistant



Figure 33-3. Then-Captain Erin Stibral examines a local Afghan child during a Medical Civilian Assistance Program (MEDCAP) visit in 2009, Kandahar Province, Afghanistan.

- overall security cooperation country plan and LOEs;
- coordination with the US embassy country team for approval, PN contacts, and other planning considerations; and
- general knowledge of PN military and military medical systems.

These considerations are complex and may involve intricate coordination among US and PN stakeholders, as well as approval from appropriate DOD and embassy authorities. GHE are multifaceted operations with established systematic procedures that must be followed by all planners and participants.

Operational Level

PAs working in GHE at the operational level may be assigned to the ASCC or regional health command. They usually have GHE as a

primary duty and work closely with SC teams. If the primary duty of an individual is GHE, they are part of the SC workforce and are required to have some level of SC training. These PAs often participate in bilateral (Army-to-Army) talks and provide input to the overall SC plan and country plans. A PA serving as the GHE officer develops a GHE strategy and specific health engagement plans for any country where GHE is being conducted. This plan should be developed with medical input from bilateral talks, COCOM, and ASCC SC guidance (see Figure 33-1).

Another important consideration is that GHE has no dedicated funding stream. GHE events compete against other requirements for SC and COCOM funding, so it is very important to understand funding authorities to ensure they meet the legal requirements.

Some of the key tasks for an operational-level job are listed below.

- Develop ASCC GHE strategy.
- Develop 5-year country plans to ensure activities support specific health LOEs that aim to develop sustainable capacity.
- Coordinate with US embassy country teams for engagement planning.
- Ensure subordinate units conducting GHE activities understand the overall GHE strategy and country-specific health engagement plans.
- Provide oversight to subordinate units and track GHE activities to ensure they support the GHE plan.
- Submit engagement proposals for funding in accordance with appropriate authorities.
- Review and validate all GHE efforts submitted for funding within the ASCC.
- Coordinate with CCMD and sister services to ensure GHE strategies are mutually supportive and to prevent duplication.

Strategic Level

Currently, PAs are less likely to find themselves in key strategic billets executing GHE activities at CCMD or higher levels. However, many GHE activities at both the tactical and operational level can have lasting strategic implications.

PAs working in GHE at CCMD or higher levels should have a thorough understanding of the National Security Strategy and other US government strategic documents that support and direct DOD GHE

activities. They must work closely with their respective SC sections and have a well-developed CCMD GHE strategy (see Figure 33-1) that synchronizes the activities of the services. A few of the key tasks for this position are listed below.

- Participate in bilateral military-to-military talks.
- Develop CCMD-level GHE strategy and country plans.
- Provide guidance in areas of expertise.
- Deconflict GHE activities among the services.
- Look for opportunities to conduct synergistic activities with other units and services.
- Coordinate with US Agency for International Development (USAID) and nongovernmental organizations working in the operational area to share resources and deconflict engagements.
- Review and validate all GHEs submitted for funding within the COCOM.

Desired Skills and Attributes

The following attributes are helpful for someone desiring to work in the GHE arena:

- ability to travel frequently;
- enjoy travel to foreign countries;
- ability to work independently;
- strong work ethic;
- knowledge of US military capabilities and military medical planning;
- ability to work well with both military and civilian organizations;
- cultural sensitivity;
- excellent written and verbal communication skills;
- civilian global health or public health training;
- interest in international relations; and
- diverse operational experience including deployment experience, preferably in multiple roles of care.

Training

The Air Force and Navy both have developed a pathway to train their medical personnel on global health competencies. These programs are specifically designed to train individuals to work within the GHE

arena. The Air Force International Health Specialist program was established in 2000 to develop health professionals to provide global health expertise to the major commands, component commands, and CCMD.[6] The Navy established the Office of Global Health Engagement in 2012. In 2017 a Global Health Specialist Program was established to facilitate the growth of global health knowledge and skills within Navy medicine to support SC through GHE.[7] Both of these programs confer a skill identifier to individuals who complete the training. Currently, the Army does not have a formalized GHE training program for medical personnel. However, it is essential that those working at the operational and strategic levels have both GHE and SC training. These training opportunities are important to effectively support a professional SC workforce and ensure GHE activities are embedded with the overall SC plan.

Despite the lack of a formal training program for Army GHE, courses are available. The two primary organizations that offer training are the Uniformed Services University (USU) Center for Global Health Engagement (CGHE), and the Defense Security Cooperation Agency Defense Security Cooperation University (DSCU). To professionalize the entire SC workforce, including GHE, these two organizations are updating training and materials designed to support the workforce. DSCU opened its doors in September 2019 with the goal of ensuring that everyone working in an SC position has a basic understanding of how SC links to the National Security Strategy and is certified at the basic level by 2020. For this purpose, an SC position is defined as one in which 50% or greater of assigned duties are SC related.[8] The courses include both online and resident training options. USU CGHE holds several courses that are tailored toward understanding GHE. Additionally, they are in the process of developing a GHE handbook that will help individuals working in GHE positions.

PAs participating in GHE events at the tactical level should have a general understanding of GHE and how it is nested within the larger SC plan. They should communicate with their ASCC and ensure all events support the ASCC GHE strategy. They would benefit from attending the USU CGHE Fundamentals of Global Health Engagement course, and having access to USU CGHE resources, but do not require the formalized SC courses offered by DSCU.

Fundamentals of Global Health Engagement Course

This 3-day course administered by the USU CGHE is intended to provide a basic understanding of strategic, operational, and civil–military considerations during GHE activities. The course provides an understanding of the processes involved from planning to assessment, monitoring, and evaluation. This course is recommended for anyone participating in GHE activities, especially those involved in planning. The course is taught by a mobile training team to classes of approximately 30 students.[9]

Global Health Strategies for Security Course

GHSS is a 1-week graduate-level certificate course offered through USU's CGHE. This course focuses on the strategy behind military GHE and the interactions between the military and other organizations within this space. This course is designed for DOD line and medical personnel who are involved in the planning assessment, implementation, and evaluation of DOD GHE activities. The USU CGHE Fundamentals of Global Health Engagement course is a prerequisite for this course.[9]

Introduction to Security Cooperation

This DSCU course is a 12-hour distance learning course for personnel who perform SC duties. The overview covers the full range of SC activities including policy, planning, execution, and evaluation. The course website is https://www.discs.dscu.mil/_pages/courses/course.aspx?id=SC-101.[10]

Intermediate Security Cooperation Planning, Oversight, and Execution

This DSCU course includes 16 hours of distance learning and 4 days of in-residence training. It is designed to provide students with the skills to plan, oversee, and execute SC at a COCOM level. The course includes discussion on authorities, funding, and interagency coordination. Introduction to Security Cooperation is a prerequisite for this course. The course website is https://www.discs.dscu.mil/_pages/courses/course.aspx?id=POE-201.[10]

Development in Vulnerable Environment Course

This USAID Office of Civilian-Military Cooperation course provides an overview of USAID structure, mission, and policies. The intent of the course is to enhance collaboration and planning between DOD and USAID.[11]

Department of Defense Regional Security Cooperation Centers

There are five DOD regional centers that host region-specific SC courses that are extremely beneficial for familiarizing PAs to the region and region-specific challenges. These centers offer orientation and more in-depth SC courses[12]:

- George C. Marshall European Center for Security Studies, Garmisch, Germany
- Daniel I. Inouye Asia-Pacific Center for Security Studies, Honolulu, HI
- William J. Perry Center for Hemispheric Defense Studies, Washington, DC
- Africa Center for Strategic Studies, Washington, DC
- Near East-South Asia Center for Strategic Studies, Washington, DC

Evaluation

PAs serving in staff positions at the tactical or operational level are most often rated by either the deputy surgeon or command surgeon. The senior rater will either be one of the general officers in the command or the surgeon, depending on the rater. Either of these rating schemes will allow the PA to have a physician within their rating chain.

Lessons Learned and Tips for Success

Working in GHE is both rewarding and challenging. At the tactical level, a PA will get experience working alongside PN forces, building relationships that can be drawn upon during times of crisis or during GHEs. PAs will experiences challenges in planning within the framework of another nation's timeline, and might have both language and cultural barriers to overcome.

At the operational and strategic level, PAs will have the opportunity to meet with senior military leaders, and work with PN counterparts to develop a joint GHE plan that provides long-lasting benefits for both the PN and the US military. A strong understanding of the region involved is extremely important, and the following tips will also increase success:

- Develop a close relationship with SC counterparts. They can provide invaluable country information. At the operational or strategic level, PAs will likely spend just as much, if not more time, working with them as with other surgeon section staff.
- The PA will be seen as the subject matter expert in GHE and should seek out training opportunities to develop their knowledge base.
- Every opportunity to learn about the GHE region or country should be exploited.
- Tie in with the embassy team early and frequently during planning.
- Ensure the GHE engagement is part of the overall SC plan and supports the theater campaign plan.

One of the challenges of being a PA serving as a staff officer is ensuring enough clinical hours to meet credentialing and privileging requirements. PAs in these types of positions must seek out clinic opportunities to work in a clinic that meets their unique requirements.

Conclusion

The role of GHE will continue to evolve and grow in importance for SC plans. Medical activities can be considered a "soft" initial entry operation to establish military-to-military relationships. These relationships can evolve to encompass virtually all warfighting functions to further the SC and theater campaign plans.

In order for GHE to be an effective tool, activities must nest within the overall SC plan. It is imperative that the workforce has sufficient training and resources to effectively plan and manage GHE activities. PAs currently participate in GHE at the tactical level whether they realize it or not. As GHE becomes a more formalized part of SC, PAs with proper preparation and training are capable of executing a larger role as GHE planners at both the operational and strategic levels.

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Chapter 34

ROLE OF THE CIVILIAN PHYSICIAN ASSISTANT IN A MILITARY MEDICAL TREATMENT FACILITY

Christine C. Cabal, PA-C, MPAS

Introduction

The primary role of a civilian physician assistant (PA) in a military medical treatment facility (MTF) is to serve as a health care provider in the capacity they are credentialed in. Civilian PAs also provide continuity of operations and expertise when there are provider shortages and problems with patient access. Uniformed PAs often leave for deployments and field training exercises, resulting in understaffing in both tactical and clinical settings. Uniformed PAs also have a high turnover rate due to permanent change of station cycles, the expiration of term of service, or retirement. By filling valid authorizations and serving as augmentation, civilian PAs optimize the health and readiness of service members, the retired community, and their families, ultimately adding to the overall strength of the US Army. Civilian PA positions are filled by prior service military personnel as well as civilian trained personnel.

Mission

The Army civilian PA supports service members, retirees, and families during times of peace, conflict, and war. The Army Civilian Corps Creed is very similar to the Soldier's Creed. Army civilians share the same values and overall mission as the Army enlisted and officer personnel (Figure 34-1).

Army Civilian Corps Creed

I am an Army Civilian – a member of the Army Team.
I am dedicated to our Army, our Soldiers and Civilians.
I will always support the mission.
I provide leadership, stability, and continuity during war and peace.
I support and defend the Constitution of the United States and consider it an honor to serve our Nation and our Army.
I live the Army values of Loyalty, Duty, Respect, Selfless Service, Honor,
Integrity, and Personal Courage.
I am an Army Civilian.[1]



Figure 34-1. The Army Civilian Corps crest.

Supervision

The civilian PA is supervised by a physician, who ensures the practice remains within recognized medical standards. The PA is usually self-directed and has the autonomy to apply evidence-based clinical practice guidelines and engage patients actively in their health care. The extent and nature of supervision varies with the setting and patient problems.[2]

Duties and Responsibilities

Civilian PAs are responsible for the examination, diagnosis, and treatment of pediatric, adult, and geriatric populations within personal credentials and privileges delineated by the MTF. The civilian PA works collaboratively with a physician in patient evaluation, management, and creating an integrated plan of care that the patient understands and can comply with.[2]

Civilian PAs must be competent leaders to effectively manage others. They must possess fundamental capabilities such as understanding Army culture, developing a team, building trust, and supporting the commander. As an Army civilian PA, it is essential to have an understanding of Army culture, including terminology, customs, values, and ranks. Understanding customers is the key to delivering high-quality health service support. Civilian PAs need to know the MTF's organizational processes and procedures to manage expectations. Investing time and energy in learning the system produces better outcomes. MTFs follow high-reliability organization (HRO) principles that help develop and sustain the organizational objectives. The five principles of HRO are:

1. Sensitivity to operations.
2. Reluctance to simplify.
3. Preoccupation with avoiding failure.
4. Deference to expertise.
5. Commitment to resiliency.[3]

Civilian PAs have the opportunity to teach, coach, and mentor the next generation of PAs and medics. They can inspire, encourage, and develop a team of soldiers, health care professionals, leaders, and administrators (Figure 34-2). Trust is necessary to create a strong bond among Army professionals. A civilian PA must embrace team practice

by not only focusing on their empanelment, but also striving to help other staff members. Expect to be another provider's surrogate due to high turnover. Expect to see Army, Air Force, Navy, and Marine patients, including reserve component and National Guard members. Civilian PAs must support the priorities, initiatives, and requirements of the MTF commander.



Figure 34-2. Mr. Andrew Flores precepts an Interservice Physician Assistant Program Phase 2 student, Officer Candidate Joshua Lane, at Evans Army Community Hospital Emergency Room in Fort Carson, Colorado.
Reproduced from: Troth JL. Evans trains future physician assistants. US Army website. Published January 19, 2016. Accessed May 15, 2020. https://www.army.mil/article/161103/evans_trains_future_physician_assistants

Desired Skills and Attributes

The following skills and attributes are beneficial:

- Reviewing, documenting, and updating patient care through the electronic health record systems such as the Armed Forces Health Longitudinal Technology Application (AHLTA), Military Health System GENESIS, Composite Health Care System, and Essentris.
- Appropriately completing DD Form 689, Individual Sick Slip, or DA Form 3349, e-Profile (if applicable), to communicate to the chain of command patients' physical limitations to prevent further harm.
- Navigating through web-based applications for management of individual medical readiness such as the Army Medical Protection System (MEDPROS), the Air Force Aeromedical Services Information Management System (ASIMS), and the Navy Medical Event Reporting (MER) system.
- Being an ideal team player by having a strong work ethic and by motivating other staff members to do the same.
- Initiative and innovative thinking to improve policies, processes, and practices.
- Demonstrating flexibility by maintaining productivity, quality of work, and morale while adapting to changing conditions or unexpected obstacles.
- Providing excellent customer service through active listening, spoken and email communication, and telephone etiquette.
- Communicating effectively, both orally and in writing, and providing consultation, teaching, and coordination with patients and their family members regarding medical care. Establishing ongoing information exchange with leaders and subordinates promotes individual and organizational transparency in all actions and decision making.

Education and Training

A civilian PA must graduate from an accredited PA program, become certified by passing the Physician Assistant National Certifying Examination (PANCE), and maintain certification through the National Commission on Certification of Physician Assistants (NCCPA) by (*a*) taking a recertification exam every 10 years, (*b*) earning 100 continuing medical education (CME) credits every 2 years, and (*c*) paying a

certification maintenance fee every 2 years. Civilian PAs utilize the three training domains of the Army leader development model: operational, institutional, and self-development. [4]

Operational Training

Civilians gain experience from operational assignments at current positions, different organizational levels, specialty areas, and various geographical sites. The operational training environment will challenge Army civilians to excel in positions of higher responsibility. The Defense Health Agency (DHA) incorporates standardized medical trauma training to support current initiatives, such as tactical combat casualty care (TCCC) and prolonged field care. In the operational setting, TCCC prioritizes triage, treatment, and management of the most common preventable deaths resulting from combat.[5,6]

Institutional Training

- Army civilians complete Civilian Education System (CES) courses by registering through the Civilian Human Resources Training Application (CHRTAS), a portal of the Army Training Requirements and Resources System (ATRRS). CES includes five levels of courses to provide leadership education for Army civilians throughout their careers, depending on their general schedule (GS) grades [7]:
- Foundation Course (level 1) for GS 1–15.
- Basic Course (level 2) for GS 1–9.
- Intermediate Course (level 3) for GS 10–12.
- Advanced Course (level 4) for GS 13–15.
- Continuing Education for Senior Leaders (level 5) for GS 14 and 15.

Self-Development Training

Civilian PAs must maintain knowledge of changing treatment protocols and procedures; self-development is their own responsibility. There are many ways to strengthen competencies to maintain or improve performance. These include but are not limited to the following:

- professional reading or self-study;
- attending conferences or seminars (web-based training, classroom training, or international events);
- independent research;
- community leadership positions that support development goals;
- individual study or practice;
- volunteer opportunities (search and rescue, medical volunteer abroad);
- off-duty academic schooling to acquire an advanced degree;
- earning certifications (fellowship in wilderness medicine, diploma in mountain medicine, tactical emergency casualty care);
- mentoring or being mentored; and
- professional mobility—civilian PAs can often change specialties and receive on-the-job training.[2]

Performance Management

Army civilians create an individual development plan (IDP) to outline development objectives, training opportunities, and career goals. Army civilians can refer to the Army Career Tracker for specific professional developmental models with key assignment lists.[8] The IDP is an instrument to help project a professional path and establish a timetable to achieve short-term and long-term career goals. The IDP should be completed annually in conjunction with the annual performance plan. Just as uniformed PAs have the officer evaluation report (OER) to monitor career progression, civilian PAs use the Department of Defense Performance Management and Appraisal Program (DPMAP) to discuss performance expectations with supervisors. Performance management helps civilians grow into competent leaders who can potentially advance to higher levels of personal fulfillment and professional achievement.[9-11]

Sample IDP

Short-Term Goal (1-Year Plan)

- CES Foundation Course no later than 90 days after in-processing.
- Attend Emergency Medicine Boot Camp.
- Listen to monthly EM:Rap videos.

- Read 1 professional book per month.
- Self-study.
- Conduct team briefings/group presentations.

Long-Term Goal (5-Year Plan)

- CES Intermediate Course (distance learning and resident instruction).
- Take college or university classes.
- Participate in professional organizations (NCCPA, Wilderness Medical Society).
- Perform volunteer work (search and rescue, Army Ten Miler).
- Networking.

Sample DPMAP Performance Element and Standards for a Civilian PA

- **Objective 1:** Meet Medical Command (MEDCOM) efficiency standards for a PA in a community hospital setting.
- **Standard:** Achieve a combined 75% of established MEDCOM standards for Joint Outpatient Experience Survey (JOES), relative value unit (RVU), and Practice Management Revenue Model (PMRM) values.
- **Objective 2:** Maintain current licensure, CME benchmarks, and required certifications.
- **Standard:** Maintain current and active NCCPA licensure.
- **Standard:** Earn the required 100 hours per 2 years of CME to maintain current NCCPA licensure.
- **Standard:** Maintain current certification in Basic Life Support (BLS), Advanced Life Support (ALS), and Pediatric Advanced Life Support (PALS) disciplines.
- **Objective 3:** Train students across multiple disciplines in emergency medicine.
- **Standard:** Work with PA students, nurse practitioner students, medical students, and student medics to ensure at least 80% pass rate for emergency department rotations in their respective fields.
- **Objective 4:** Complete charting and mandatory training in a timely manner.
- **Standard:** Work with emergency department coders to ensure 75% of patient encounter charts are completed during initial patient encounter.

- **Standard:** Maintain 75% currency of mandatory Swank Health Training, both online and face to face.
- **Objective 5:** Complete assigned additional duties.
- **Standard:** Complete assigned additional duties as designated to meet 75% of suspense dates established by the department chief or appropriate committee chair.[10]

Continuing to Serve

Civilian PAs with a military background have the advantage of familiarity with policies and procedures that enable them to excel in the MTF environment. They have unique skill sets in operational medicine and staff briefings that allow them to relate to most of the patient population and have confidence in delivering high-quality health care regardless of the circumstances. Expertise gained through military training and remote conditions allows these PAs to practice medicine by using effective communication, leading by example, and being highly adaptable in constantly changing situations.

Many prior armed forces personnel hang up their uniform before military retirement but continue to serve the country by becoming civilian employees in the federal government. Those who performed honorable active military service have additional benefits under the Federal Employees Retirement System (FERS). To allow creditable military service to be used toward retirement eligibility, for example, GS employees can make military service deposit (MSD) payments to their civilian retirement fund prior to separation from federal employment. The MSD amount is a sum equal to 3% of military basic pay during the period of military service, plus interest (which starts accruing after 2 years of federal employment). The deposit may be paid to the Defense Finance and Accounting Service in a lump sum or through payroll deduction. Those who are eligible can also apply their active duty service time toward both Guard and Reserve retirement and FERS retirement.[12]

Lessons Learned

The following are lessons learned for civilian PAs:

- A team is only as strong as its weakest link. Identify deficiencies in the organization and focus on improving these shortfalls to enhance staff

motivation and work ethic. Common operational problems include interpersonal conflict, stress, lack of motivation, poor teamwork, lack of trust, lack of accountability, and poor communication.

- Medics and nurses should be extensions of the civilian PA's capabilities. The more competent the health care staff, the more efficient the PA will become as a member of a cohesive team. Leaders have the ability to influence people, and that's one of the keys to success (Figure 34-3).



Figure 34-3. Mr. Arne E. Oas teaches bedside ultrasound techniques on a simulated patient (Sergeant Jason Williams) as a physician assistant student, Officer Candidate Daniel W. Matthes, learns how to conduct a focused assessment with sonography in trauma (FAST) exam.
Photograph courtesy of Christine C. Cabal.

- Learn to humanize medicine. See patients as people and not as objects. The PA must treat patients as if they are their own family. Recognize that no one likes to go to the hospital. Patients are there to get help from the PA and their staff. Some may require more education than others; therefore, part of the job is having patience with patients. The PA will never know if that "chronic knee pain" is a superficial reason for a rape victim to seek help. The PA will never know when that "STD check" is actually testicular cancer in a 21-year-old soldier. The PA is going to come into contact with people who are at their absolute breaking point in their MTF. If patients are angry and have an attitude, the PA should not take it personally (this may be the saddest, most stressful, loneliest time for that patient). The PA has the privilege of being able to take care of the nation's finest soldiers, families, and civilians. The PA must take care of them like they were their own.

Tips for Success

Along with lessons learned, these tips for success will help future civilian PAs succeed beyond expectations:

- Focus on outcomes. Develop a strategy for the team and the overall health care system to meet desired results with measurable targets and standards. When there is a goal in mind, it is easy to know which priorities and initiatives to support. Consistently holding others accountable to a high standard (as opposed to waiting for the annual evaluation) raises the performance level of each team member. Ultimately, organizations and team members without growth and purpose do not flourish and have low job satisfaction.
- Do not strive to make everyone happy. Some patients or customers will disapprove of their plan of care (eg, they cannot get the magnetic resonance imaging they want or the pain medication they prefer). All the PA has to do is ask themselves, "Did I meet the standard of care?" If the answer is "YES," do not lose sleep over the negative interactive customer evaluation comments and move on. If the answer is "NO," then conduct a self after-action review and determine how the PA can make the situation better next time, learn from it, and then move on.
- The PA is in charge of their career and life goals. Maintain discipline to consistently work for professional and personal growth. Attend

seminars, read journals, and use podcasts. Most importantly, the PA must take care of themselves (not just their physical fitness, but also their emotional, spiritual, social, and family fitness).

Conclusion

The civilian PA contributes tremendously to the MTF by providing high-quality care to service members, the retired community, and their families. They serve as teachers and mentors to medics, as an augmentation to uniformed providers on tactical missions, and as leaders who inspire devotion and hard work. Civilian PAs enhance the overall readiness of the armed forces through effective leadership, skilled management of expectations, continuous learning, and embracement of team practice.

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Chapter 35

THE INDEPENDENT MEDICAL OPINION PROCESS AND THE PHYSICIAN ASSISTANT'S ROLE

Leah Bucholz, PA-C, MPAS, and Maura Lappin, DO

Introduction

The Department of Veterans Affairs (VA) disability process is a benefits program available for veterans who have become sick or injured while serving, or who may have had an injury or illness worsened by their service on active duty while serving their country. The process can be complex and even overwhelming for any soon-to-be-exiting service member as well as for the current veteran population. The military clinician has a dual role as a veteran entitled to benefits and as a potential health care practitioner involved in the process. A new and inexperienced physician assistant (PA) is generally focused on current mission requirements and may not comprehend the importance of their position for patients they evaluate and treat. On the other hand, a seasoned PA nearing retirement likely understands the importance of documentation and the impending likelihood that a patient may enter the VA disability process. It is the goal of this chapter to help the junior PA as well as the seasoned PA understand the independent medical opinion process, as well as how the PA can impact the lives of disabled service members in their transition to veteran status.

Preparation for Service Members

Active Duty

Active duty PAs can best prepare veterans by encouraging them to seek medical care for all ailments and by ensuring these complaints are thoroughly documented in their service treatment record. The

Department of Defense (DD) Form 2807, Report of Medical History, and the DD 2808, Report of Medical Examination, are especially crucial during the separation process. These medical appointments and reports may be the only opportunity service members have to discuss some of the conditions they have suffered over their years of military service. Many transitioning service members, especially those with over 20 years of active duty service, may require several visits to comprehensively document their medical histories.

Army National Guard and Army Reserve

Army National Guard and Army Reserve service members may experience more difficulty obtaining evidence of disability than active duty service members. For National Guard and Reserve service members during periods of inactive duty service, documentation of an injury incurred in the line of duty (LOD) is generally helpful when applicable. This can be a formal or informal process and should start with the completion of a Department of the Army (DA) Form 2173, Statement of Medical Examination and Duty Status, which describes the incident and injury and is signed by the unit commander and the attending physician or patient administrator. Of note, LOD investigations can be performed for active duty, National Guard, and Reserve components. Information on this type of investigation can be found in Army Regulation 600-8-4*, Line of Duty Policy, Procedures, and Investigations.*[1]

Independent Medical Opinion Letters

Independent medical opinion letters, often referred to as "nexus letters," illustrate a link or nexus between an in-service injury and the veteran's current disability. They may demonstrate that a condition occurring during service is still affecting the veteran or link a service-connected condition to another condition that developed more recently. These letters can be helpful, especially after a veteran has exited service, if there is a lack of clear contemporaneous medical documentation in the active duty record.

What to Include

The best nexus letters are brief, yet comprehensive enough to include all pertinent material and medical evidence that may apply.

There are several main components to writing a quality nexus letter. First, the author of the expert opinion should substantiate their credentials, which will help the reader understand that the content is the author's best clinical judgment, made with the guidance and knowledge from all their accumulated training and experience, and not merely a random statement. It is also vital to inform the reader that appropriate documentation and evidence has been reviewed in order to reach the letter's conclusion. Including specific references to the facts in the reviewed medical records will affirm that the author has evaluated available medical and service records provided by the veteran.

A persuasive nexus letter will also provide ample evidence to back up the opinion. Merely stating that in the author's opinion, condition A is connected to condition B, garners some weight if the appropriate credentials and qualifications have been included, but it is often not enough. Including an explanation of why or how the conclusion has been reached based on facts in the patient's medical records and references to the medical literature will strengthen the letter and opinion immensely. To be valuable to the VA, the nexus letter must be based on the medical records and the applicable literature.

Quantifying the Opinion

A critical part of a nexus letter is quantifying the opinion on the link between the two conditions. The author has told the reader who they are (why the author is qualified to present an opinion) and what evidence has been considered (the veteran's medical and service records as well as evidence from medical literature); the reader should then attempt to quantify how likely the connection is between conditions. This may be achieved by several different statements that convey different levels of certainty, as follows:

- "is due to" conveys the author believes with 100% certainty the conditions are linked (as with all things in medicine, there are few certainties, and this is not a frequently used statement);
- "more likely than not" communicates there is a greater than 50% chance the conditions are linked;
- "at least as likely as not" expresses the author believes the conditions are linked with equal to or greater than 50% certainty based on the author's expertise and literature;

- "not at least as likely as not" conveys a less than 50% certainty of linkage; and
- "is not due to" states that in the author's opinion, there is a 0% chance the conditions are linked (this not a commonly used statement since full certainty is rare in medicine, and this statement would negate any previous information in the letter about the connection; the lack of a causal link would also be a reason not to provide a letter).

Conclusion

In closing, it is essential to remember there is no greater honor than caring for service members on and off the battlefield. Continuing to care for them after separation is a choice PAs can make—to further care for veterans in the VA disability process. It is an extremely complex process, often difficult to navigate, even for experienced PAs with a wealth of medical knowledge. The process can be even more difficult to navigate and overwhelming for separating service members and veterans. The medical documentation in each service member's record is vital to the claims they may ultimately file. All injuries and illnesses may become the basis for a future disability claim. For these reasons among many others, it is important that PAs operating in the military health system or providing care to service members and veterans make a concerted effort to not only provide outstanding care, but also to ensure quality documentation is established within the record.

Acknowledgements

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Chapter 36

THE FOUR PILLARS OF THE PHYSICIAN ASSISTANT PROFESSION

R. Scott Harrison, PA-C, MPAS

Introduction

The physician assistant (PA) profession is regulated and supported by four independent organizations: the American Academy of Physician Assistants (AAPA), the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), the National Commission on Certification of Physician Assistants (NCCPA), and the Physician Assistant Education Association (PAEA). The goal of this chapter is to educate prospective PAs, PA students, and current PAs about these organizations and to show how they affect the profession and PAs as individuals. These four organizations are independent, not-for-profit corporations, each fulfilling a key role in representing and advocating for the profession, accrediting the educating institutions, certifying individual PAs, and representing PA programs (Figure 36-1).

The AAPA is a professional association that focuses on federal- and state-level advocacy and provides ongoing professional development for PAs.[1] The ARC-PA is the accrediting organization for the educational programs that produce PAs.[2,3] The NCCPA is the testing and certifying organization that certifies and recertifies individual PAs and determines the standards for maintenance of certification.[4] Lastly, the PAEA supports PA educational programs by collecting, publishing, and disseminating information to its member programs and creating development tools for program faculty and staff.[5] In concert, all four independent organizations work to support the PA profession in a continuous endeavor to provide the structure to ensure PAs provide quality healthcare.

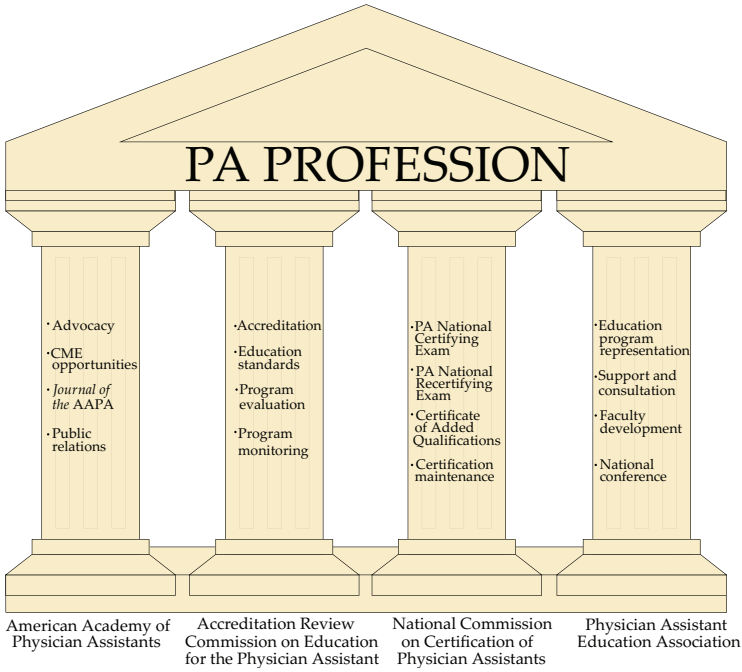


Figure 36-1. The "Four Pillars" of the physician assistant profession.

American Academy of Physician Assistants

The AAPA is the national professional society for PAs, representing all PAs across the United States. As an organization, "AAPA advocates and educates" the public "on behalf of the profession."[6] The AAPA also "works to ensure professional development, personal excellence, and recognition of PAs."[6] The AAPA enhances PAs' ability to "improve the quality, accessibility, and cost-effectiveness of patient-centered health care."[7(p3)] As leaders in the profession, the AAPA "empowers members to advance their careers and enhance patient health."[8(p7)]

History

The American Association of Physician Assistants, AAPA's previous name, had its inaugural meeting in North Carolina in 1968, sponsored

by the initial Duke University PA graduates.[1] These graduates were returning Vietnam veterans with real-world knowledge and skills resulting from combat medical experience. Beginning in 1973, the organization moved several times, from Washington, DC, to Arlington, Virginia, in the late 1970s, followed by another relocation, to Old Town Alexandria, Virginia, in the late 1980s. In 2001 AAPA relocated to the Carlyle area of Alexandria.[1]

Key Contributions

- PA advocacy at the state and national levels.
- Provision of continuing medical educational opportunities.
- Information repository for the profession via the *Journal of the American Academy of Physician Assistants*, practice resources, professional news, and research.
- Constituent organization support.
- Public relations.[9]

Accreditation Review Commission on Education for the Physician Assistant

The ARC-PA provides accreditation of PA programs "by defining the standards for PA education and evaluating PA educational programs."[2] Throughout the year, ARC-PA works across the United States evaluating PA programs through site visits and program portals to ensure compliance with its standards.[2] By accomplishing this mission, the ARC-PA "protects the interests of the public, current and prospective PA students, and the PA profession."[2]

History

In May 1971, the American Medical Association (AMA) developed "the Essentials of an Accredited Educational Program for the Assistant to the Primary Care Physician," later referred to as "the Essentials."[10] Seven medical academies comprised the Subcommittee of the Council on Medical Education's Advisory Committee on Education for Allied Health Professions and Service.[10] The subcommittee accepted the Essentials, allowing for educational programs that meet the accreditation requirements to become approved PA educational programs.[10]

In 1972, the Joint Review Committee for Educational Programs for the Assistant to Primary Care Physician (JRC-PA) had a year of three firsts.[10] JRC-PA held its first meeting; elected its first chair, Dr Malcolm L Peterson; and made its first accreditation recommendations to the AMA.[7] In 1988, JRC-PA took on a new name, "Accreditation Review Committee on Education for the Physician Assistant (ARC-PA)."[10]

In 1991, AAPA assumed responsibility as the sponsoring organization for ARC-PA.[10] Ten years later, on January 1, 2001, ARC-PA became a "freestanding accrediting agency for the PA profession."[10] On October 1, 2004, the ARC-PA moved its current operations to Duluth, Georgia.[10]

After a maximum of 7 years, accreditation for PA programs must be renewed.[11] ARC-PA monitors programs through annual reports to ARC-PA and site accreditation visits based upon the length of the program's accreditation status.[11] ARC-PA accreditation regulates the profession via a published manual and its commissioners (who serve as program reviewers and inspectors).[9] ARC-PA accreditation focuses on three main areas of academia: administration, curriculum and instruction, and evaluation.[12]

Key Contributions

- Establish educational standards utilizing broad-based input.
- Define and administer the process for comprehensive review of applicant programs.
- Define and administer the process for accreditation decision-making.
- Determine whether PA educational programs are in compliance with the established standards.
- Work collaboratively with collaborating organizations.
- Define and administer a process for appeal of accreditation decisions.[3]

National Commission on Certification of Physician Assistants

The mission of the NCCPA is "to provide certificate programs that reflect standards for clinical knowledge, clinical reasoning, and other skills and professional behaviors required upon entry into practice and throughout the careers of physician assistants."[4] As the only national

certification body for the PA profession, the NCCPA is devoted to serving the public and PAs to support the structure of affordable, high-quality healthcare.[4,13]

History

In 1974, the National Board of Medical Examiners and the AMA assembled to consider "establishing an independent certifying authority for the PA profession."[4] "Fourteen national organizations [representing] major medical specialty societies, state licensing authorities, education associations, government agencies, and the existing PA organizations" participated in establishing the NCCPA.[4]

Governance of the NCCPA is by a board of directors that currently includes ten PAs, seven physicians, and two members of the public.[14] The board will be reduced in size through tenure attrition in 2016 to nine PAs, five physicians, and two members of the public.[14] "All US states, the District of Columbia, and the US territories have decided to rely on NCCPA certification criteria for initial licensure or regulation of PAs."[4] Since NCCPA's inception, more than 102,000 PAs have been certified.[4]

Key Contributions

- Physician Assistant National Certifying Exam (PANCE).
- Physician Assistant National Recertifying Exam (PANRE).
- Certificate of Added Qualifications (CAQ).
- Certification maintenance, requiring continuing medical education (CME).[13]

Physician Assistant Education Association

As AAPA represents the profession, the PAEA provides similar representation to PA educational programs, focusing on the education process of the profession.[5] As the "only national organization in the United States representing PA educational programs,"[5] PAEA assists in organizing resources for "individuals and organizations from various professional sectors interested in the educational aspects of the PA profession."[5] The PAEA's primary responsibility is to gather the information that supports faculty within the programs, and to publish data ensuring faculty have the information they need to provide the

best possible education to PA students.[5] As the healthcare industry continues to change, PAEA works to ensure that PA programs can meet emerging needs.[5]

History

In 1972, PA program administrators realized there were important issues concerning "accreditation, certification, continuing educational requirements and role delineation"[15] from the educational perspective that required a focused effort to address. The Association of Physician Assistant Programs, now PAEA, took up this effort with the "overall goal of improving the quality and accessibility of healthcare through the selection, education, and deployment of PAs."[15]

Prior to 2004, the association was housed with AAPA and under its management.[15] Beginning in 2004, it decided to become an entirely independent organization separate from AAPA. In October 2005, the association voted to change its name to PAEA.[15] In May 2006, it moved to an independent location in Alexandria, Virginia,[15] and in 2015, PAEA relocated to the Association of American Medical Colleges building in Washington, DC.[15] PAEA's membership continues to grow, now including "over 196 accredited US PA programs."[15,16]

Key Contributions

Program support resources include:

- end-of-rotation exams and
- the Physician Assistant Clinical Knowledge Rating and Assessment Tool (PACKRAT).

Faculty development resources include:

- the *Journal of Physician Assistant Education*;
- PAEA Professional Service, a consultation service for program development and accreditation;
- the PAEA National Educational Conference;
- *A Comprehensive Review for the Certification and Recertification Examinations for Physician Assistants*;[17]
- the Central Application Service for Physician Assistants (CASPA), a web-based application system that allows students to apply

to multiple participating PA educational programs with a single application; and
- advocacy for PA education.[18]

The Four Pillars Within the Military Physician Assistant Career Lifecycle

An examination of these four key organizations provides a lens through which military PAs can track their career from initiation into the profession as a student through decades of practice and ultimate retirement. The ARC-PA maintains the educational requirements for the profession. All PA programs, including the Interservice Physician Assistant Program (IPAP), are regulated by the ARC-PA. ARC-PA commissioners monitor the IPAP yearly through regular reporting via an electronic portal, and ARC-PA site visitors conduct a physical site inspection of the IPAP at most every 10 years.[2,11] During these inspections, site visitors evaluate the IPAP's administration, curriculum, instruction, and evaluation processes, and conduct faculty and student interviews. ARC-PA accreditation is a requirement that the IPAP must maintain for students to become eligible for initial certification via successful completion of the PANCE.[19]

The PAEA's role in the PA profession is integral to the development of educational processes. The PAEA assists PA programs with the educational training of program directors, academic coordinators, and clinical coordinators, as well as the professional development of all faculty. The PAEA produces the PACKRAT to evaluate students at the end of their didactic phase and develops end-of-rotation exams for the purpose of evaluating clinical rotation knowledge.[18]

The ARC-PA and PAEA have a critical impact on the development and sustainment of PA programs. Faculty members become intimate with the ARC-PA standards as they guide students through their academic pursuits, and the PAEA contributions assist the faculty as they look for better ways to educate their students. As students near graduation, NCCPA and AAPA begin to play a bigger role in their future careers as PAs.

PA programs register students with the NCCPA, allowing them access to create accounts and schedule testing for the PANCE. The PANCE is the national certification examination that all PAs must pass upon completion of their formal educational training to practice

in the military healthcare system.[20] After passing the PANCE, students become certified and are authorized to use the title "PA-C" (Physician Assistant-Certified).[18] This certification enables them to access the NCCPA portal (known as a PA's "dashboard") to log their CME credits. One hundred CME credits must be completed every 2 years and be recorded and maintained within the NCCPA's portal. PAs also use the portal to keep records of their certification and schedule PANRE certification maintenance exams.

The AAPA assists PAs in the CME process by approving, centralizing, and developing CME activities. The AAPA defines and approves category 1 CME, including activities designated as self-assessment (SA) and performance (PI) CMEs.[9] The AAPA also works as the profession's advocate by developing leadership, promoting research, and lobbying at the national and state levels.[9] For military PAs, AAPA's non-CME contributions usually become more evident with the transition to civilian life and search for civilian employment.

The ARC-PA, PAEA, and NCCPA all have roles to play as former active duty PAs transition into myriad roles as civilian professionals. AAPA resources are invaluable during searches for employment and research into contract negotiations and state rules and regulations. PAs who wish to seek an educational component to their practice will find PAEA a doorway to transition into scholarly endeavors. Furthermore, all PAs will have a career-long relationship with NCCPA because continued certification maintenance is a requirement for employment with the federal government and half of the states.[4] Regardless of career choices, the four pillars of the PA profession continue to support PAs throughout their professional careers.

Conclusion

The PA profession began as a revolutionary idea and has become a staple of the medical field. The year 2020 marks 55 years of the modern PA profession, which started with one program at Duke University in 1965 and progressed to its current status of "196 ARC-PA–accredited PA programs."[6,16] Advancing from certificate programs to the present Master's Degree in Physician Assistant Studies (MPAS) as the entry-level and terminal degree, the PA profession continues to evolve. Formerly overseen by physician boards, the PA profession is now self-regulated and supported by the four independent pillars.

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Chapter 37

SENIOR SERVICE EDUCATION

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> "Not to promote war but to preserve peace by intelligent and adequate preparation to repel aggression."
>
> *—Elihu Root, US Secretary of War, 1903*[1]

Introduction

This chapter discusses the selection process for senior service education and the options available for completing the training. Senior service education represents the Department of Defense's highest level of an officer's professional military education or military education level.[2] This education prepares senior military officers to be strategically minded joint leaders ready for assignments at the joint, interagency, intergovernmental, and multinational levels.[2] Options for this education level include attending a senior service college (SSC), either as a resident student or in a distance learning capacity, or attending a fellowship program. Students must be focused, motivated, and disciplined to thrive within the various senior service education programs and obtain maximum benefit no matter the route (Figure 37-1).

Selection

The Army conducts selection for senior service education through a competitive centralized board process, similar to a promotion selection board, at the Human Resources Command (HRC). The Army annually conducts one selection board for branches that fall within the

operations, operations support, force sustainment, and information dominance components; separate boards for each of the specialized branches (the Army Medical Department [AMEDD], Judge Advocate General, and Chaplain Corps); and a board for Army Reserve forces.[3] Lieutenant colonels and above who have completed their intermediate-level education are eligible to compete for SSC selection.[2] The initial selection opportunity occurs 1 to 2 years after promotion to the rank of lieutenant colonel. To be considered for SSC selection, eligible officers must opt-in and review their record to verify its accuracy through the My Board File on HRC's My Record Portal website.[4]

The AMEDD receives a limited number of resident SSC authorizations each year, approximately 24 this writing time. The centralized school board reviews the eligible AMEDD officers' board files and selects the best-qualified officers within each branch. Officers chosen for senior service education as a "principal" then rank their preference of the available resident SSC and fellowship options before the slating process. The locations currently available to AMEDD officers for resident senior service education are listed below.[5]

Senior Service Colleges

- Army War College (AWC), Carlisle Barracks, PA
- Dwight D. Eisenhower School for National Security & Resource Strategy, Fort McNair, Washington, DC
- Naval War College, Newport, RI
- National War College, Fort McNair, Washington, DC
- Air War College, Maxwell Air Force Base, AL

Fellowships

- Secretary of Defense Executive Fellowship with placement at a leading corporation (location varies)
- Department of Health and Human Services, Office of Policy and Planning, Washington, DC
- Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, Washington, DC
- Department of Veterans Affairs, Washington, DC
- George Washington University School of Public Health and Health Services, Washington, DC

- The University of Georgia, Infectious Diseases and Population Health, Athens, GA
- George Washington University School of Public Health, Washington, DC
- Harvard University, John F. Kennedy School of Government, Cambridge, MA

Resident Education Program

The Army War College offers students a traditional classroom setting through seminars taught by military and civilian professors and instructors. Each seminar group comprises a diversity of students from across the Army branches, individuals from the joint services and interagency departments, and international military officers.

The AWC provides instruction through five core courses: (1) strategic leadership, (2) theory of war and strategy, (3) national security policy and strategy, (4) theater strategy and campaigning, and (5) defense management. In addition to the five core subjects, resident students participate in:

- a regional studies program;
- a strategic research project;
- national security staff rides to Gettysburg, New York City, and Washington, DC; and
- elective courses based on the student's interest.

Through this curriculum and completing the strategic research project, students earn a master's degree in strategic studies and receive Joint Professional Military Education (JPME) level 2 credit.[2,6]

US Army War College Fellowship Program

Through placement in leading universities, government institutions, and renowned corporations, the AWC fellowship program provides an educational experience that cannot be obtained through traditional resident SSC education.[7] As fellows, officers are afforded unique personal and professional educational opportunities to study and critically evaluate broad national security policy, strategy, interagency affairs, civil-military relations, and operational issues .[2] Fellows also

act as Army ambassadors, engaging their host organization through formal and informal engagements. The fellows' experience in the program helps prepare them for positions in highly complex and ambiguous environments.[6] Resident fellows complete a strategic research project; however, the fellows' program does not provide an opportunity to earn a master's degree, and fellows do not receive JPME credit (Figure 37-1).



Figure 37-1. Lieutenant Colonel Kane Morgan (left) and Colonel Amy Jackson (right) stand in front of the Army War College Lantern during their Army War College Fellowship 2019–2020 academic year orientation. Colonel Jackson completed the fellowship with George Washington University School of Public Health and Health Services, and Lieutenant Colonel Morgan completed the fellowship through the Secretary of Defense Executive Fellows program.

Lessons Learned and Tips for Success for the Fellowship Program

Officers selected for the AWC fellowship will benefit from participation in academia, industry, and policy, with a considerable amount of autonomy. Each fellow will have a tailored and individualized experience based on their host institution and location. The first recommendation is to maximize the opportunity to network and meet AWC staff during orientation. There will be ample opportunity to attend local conferences and other events. Numerous fellows will operate out of the National Capital Region (NCR); therefore, making a fellowship network to collaborate and share items of interest can be helpful. The fellowship director will send out email highlights identifying think-tank events and various other opportunities in the NCR. Visits to the White House, Pentagon, Brookings Institute, Department of Veterans Affairs, Defense Health Agency, Defense Health Headquarters, and many other NCR based places are opportunities for exploration. It is also a good idea to join the Association of the US Army (AUSA), which holds an annual conference and offers a breakfast series, forums, and a lecture series. AUSA members will receive notification of such events.

Next, given the autonomy a fellow will have, it is essential to begin developing goals and objectives, and create a battle rhythm to stay on track with reading, research, and writing. The fellow will have the opportunity to read rather than skim material, and it will be useful to develop a reading list with a mixture of subject matter. A fellow will do well to dedicate time to writing and reading daily, particularly for the two assigned scholarly writing projects, the first with a length of 1,500 words, and the second about 5,000 words (Figure 37-2). To prepare for the writing projects, a fellow should invest in the citation source manual identified by the AWC and consider purchasing a year's subscription to a manuscript editing software program. Grammarly, a software program that can be downloaded for individual use, provides online grammar, spelling, sentence structure, and plagiarism checks.[8] This tool will help the fellow with the finer points of writing. There are also reference and file-sharing tools available that can assist in managing references and allow collaboration. Refer to Chapter 32, The Role of the Physician Assistant in Research, for examples of reference management and file-sharing tools. The benefits vary depending on the selected product, and the decision on which tool to use is a personal preference.



Figure 37-2. Colonel Amy Jackson (center) meets with several subject matter experts from the Force Development Directorate at the Combined Arms Support Command and Sustainment Center of Excellence at Fort Lee, Virginia, in April 2020. Colonel Jackson conducted meetings and networked with multiple agencies as part of her fellowship project in investigating the strategic sustainment of water in multi-domain operations.

Initiating the writing process can be very daunting, and fellows may not know where to start. A successful researcher will identify subject matter experts within a selected topic field to conduct initial data gathering and confirm the subject's value. An outline should then be created, followed by a literature review, which involves gathering all of the documents, articles, regulations, books, and any online sources regarding the topic. The researcher should place these sources into an internal library or collection where they can be easily managed. The researcher should then note key findings by highlighting or copying and pasting pertinent data into a literature review spreadsheet to track the relevant points. This tactic will help in putting the paper together and citing sources with page numbers. A final piece of advice is to have an academic "lifeline," someone who is well versed in research and writing and will spend the time to shepherd the fellow along in the process.

Distance Education Program

AMEDD officers selected by the SSC board as an "alternate" and not activated for resident attendance may have the opportunity to achieve

their senior service education through the AWC's distance education program. The AWC's resident and distance education programs offer equivalent curriculums. Distance education students will also earn a master's degree in strategic studies and may be eligible to receive JPME level 1 or level 2 credit.[6] Officers offered the distance education program must accept or decline before the next SSC selection board. If the officer is accepted in the distance learning program, they are not eligible for future SSC boards. Officers who are not accepted into the distance learning may re-compete in future SSC school boards, but there is no guarantee of their selection as a principal or an alternate (Figure 37-3).



Figure 37-3. Colonel Jeffrey Oliver, Lieutenant Colonel Roberto Marin, Lieutenant Colonel James Pairmore, and Lieutenant Colonel Dawn Orta during their Army War College graduation ceremony at Carlisle Barracks, Pennsylvania, in July 2018. The graduates attended the distance learning program.

Lessons Learned and Tips for Success for the Distant Education Program

Applying for distance education is a decision best made after self-reflection and guidance from mentors, family, friends, and prior SSC graduates. Completing senior service education, whether through the resident course, fellowship program, or distance education program, is not a guarantee of promotion, command, or strategic positions, but it helps. The time spent in distance education needs to be allocated against current military and family requirements and responsibilities; therefore, the individual is committing to balancing work, family, and course work. If selected, students should devote themselves to completing the course, beginning with the orientation weekend designed to set expectations and provide guidance on achieving work-life balance and succeeding in the first year.

It is crucial to keep up with the readings during the course and build a focused battle rhythm. Based on the time requirements, the student must know their capabilities and limitations. On average, students should prepare to dedicate 12 to 15 hours a week to the AWC program. They should set a schedule for study and writing and be creative with time management. For example, while reading or listening to study material, a student can run, walk, or use a stationary bike. Take periodic breaks as needed, but completion of assignments before the due date is a must. Classes usually continue through holidays, but extra time is built in to allow for flexibility. An advantage of the distance education program is applying what is being learned immediately and developing the core skills needed for critical, creative, and strategic thinking.

Post-Senior Service Education

Officers incur a 2-year active duty service obligation upon completion of the program.[9] The Office of the Surgeon General's talent management office individually manages graduates of resident SSC or fellowships, and these officers can compete for nominative positions through the marketplace process. This oversight ensures that strategic leaders are assigned to appropriate jobs that best utilize their experience, knowledge, and skillsets. Examples of these assignments include senior leadership positions within the Office of the Surgeon General or the

Defense Health Agency, executive leadership positions within medical commands and medical treatment facilities, placement with Army or joint commands, or interagency or multinational organizations.

Conclusion

Senior service education provides officers the opportunity to prepare for the demands of leading in an increasingly complex strategic environment and ever-changing Army. In addition to the academics and research knowledge gained, the associations and contacts made in the senior service education environment are advantageous. The combination of education and relationship building helps prepare individuals for the joint and interagency environment in which post-senior service education officers will serve.

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Chapter 38

THE INTERSERVICE PHYSICIAN ASSISTANT PROGRAM

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Introduction

The United States has recognized the physician assistant (PA) profession since 1967, when an insufficient number of medical doctors in the military and civilian health care systems led to the development of the first PAs.[1] Dr. Eugene Stead, chair of the Department of Medicine at the Duke University Medical Center in Durham, developed the first PA academic program in 1965. Less than 2 years later, the first PA students graduated from the program on October 6, 1967. In 1971, the US Air Force developed the first military PA program, modeled after the program developed by Dr. Stead. The US Army and Navy developed their own programs later that same year.[1]

In the early 1990s, the chairman of the Joint Chiefs of Staff directed an internal review to determine ways to reduce waste, including combining analogous programs throughout the services (US Navy Vice Admiral Timothy W. Wright, written communication, August 22, 1995). In 1992, the Interservice Training Review Organization (ITRO) examined analogous programs across the services to determine those capable of consolidation. To evaluate the possibility of consolidating the PA programs of three services (Army, Navy, and Air Force), ITRO created three teams of two representatives from each service (US Navy Captain [Retired] C. Brakhage, PA-C, former Interservice Physician Assistant Program [IPAP] program director, written communication, July-August 2014, San Antonio, TX). On "30 May 1995, the ITRO Executive Board . . . approved the consolidation" of the military PA

programs (Timothy W. Wright, written communication, August 22, 1995). The intent was to consolidate approximately 180 candidates matriculating among three classes per year: "approximately 90 Army, 30 Navy, and 60 Air Force Students will train at the [Army Medical Department] AMEDD Center and School" (Timothy W. Wright, written communication, August 22, 1995). With this consolidation, the AMEDD Center and School at Fort Sam Houston in San Antonio, the site of the former Army PA program, became the new home of the IPAP. On April 29, 1996, 59 students began the first class (C. Brakhage, written communication, July-August 2014, San Antonio, TX).

Today, instruction at the IPAP occurs in two phases. Phase 1, the didactic phase, occurs at the Army Medical Center of Excellence (MEDCoE) at Joint Base San Antonio–Fort Sam Houston (JBSA-FSH). Phase 2, the hospital-based training phase, occurs at 23 military medical treatment facilities (MTFs) in the Department of Defense (DOD) footprint: 16 Army, 1 Navy, and 6 Air Force. After completing the 16-month Phase 1 portion of the curriculum, students conduct a permanent change of station (PCS) to one of the Phase 2 sites. The Phase 2 MTFs have the general and specialty medical services required to train the future military PA. Since 1995, the University of Nebraska Medical Center (UNMC) has been the affiliated university, which is the degree-granting institution for the IPAP. The Accreditation Review Commission on Education of the Physician Assistant (ARC-PA) certifies all US PA programs, and the IPAP has maintained ARC-PA accreditation since 1996. This accreditation allows a PA program graduate to sit for the National Commission on Certification of Physician Assistants (NCCPA) Physician Assistant National Certifying Exam (PANCE). The IPAP organizational chart is shown in Figure 38-1.

Interservice Physician Assistant Program Army Leadership Positions

The IPAP mission is to educate PAs for the uniformed services through a shared division of leadership and faculty responsibilities among the Army, Air Force, Coast Guard, and Navy. The three core leadership positions in the IPAP are the program director (PD), medical director (MD), and clinical coordinator (CC). The Army, Air Force, and Navy

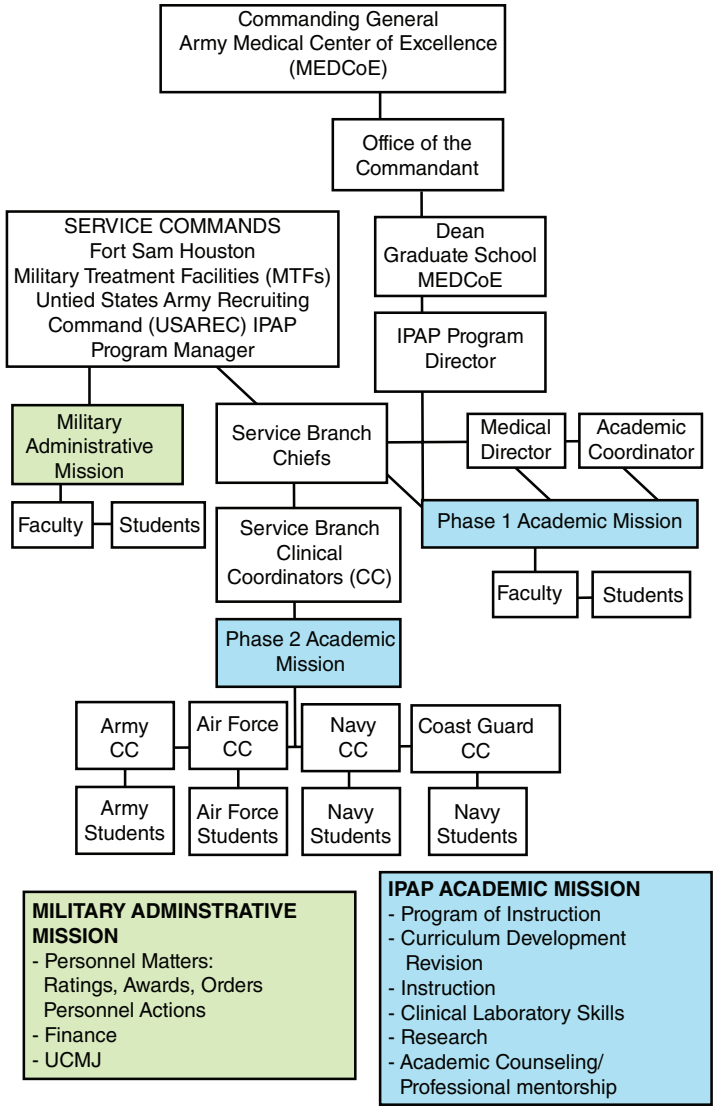


Figure 38-1. Interservice Physician Assistant Program organizational chart showing administrative and academic missions.
MTF: medical treatment facility; UCMJ: Uniform Code of Military Justice

rotate these core leadership positions according to an agreement in which no single service can occupy more than one of the positions at any time. The services switch the leadership positions every 3 to 4 years, or as necessary. For example, from 2017 to 2020, the Army held the PD, the Air Force the MD, and the Navy the CC position. The planned rotation for 2021 has the Air Force holding the PD, the Navy the MD, and the Army the CC. Though this rotation has been in place since 1996, a 2010 addendum to the ITRO memorandum of agreement between the services allows the Coast Guard to petition for the PD position. Regardless of service, individuals serving as the PD and MD must meet the minimum positional requirements in accordance with the Accreditation Standards for Physician Assistant Education as outlined by ARC-PA.[2]

For the Army, senior PAs and physicians serve in a number of key IPAP leadership positions (see Figure 38-1). Generally, these are senior commissioned officers in ranks ranging from major to colonel, with each position having a rank requirement. For instance, the positions of PD and branch chief require a 65D (PA area of concentration) colonel or a highly qualified lieutenant colonel, the Phase 2 CC requires a 65D major or lieutenant colonel, and the Army Phase 2 site CC can range from captain to lieutenant colonel. When occupying the position, the MD must be a physician in the rank of lieutenant colonel. The IPAP PD, MD, branch chief, and Phase 2 CC are located at MEDCoE. The IPAP program manager is located at the US Recruiting Command (USAREC) at Fort Knox, Kentucky. The Phase 2 site CCs are located at various MTFs (Table 38-1).

Program Director

The PD must be a PA with at least 3 years of full-time higher education teaching experience,[2] a current NCCPA certification, and the rank of colonel or lieutenant colonel. The PD is responsible for the overall management of the IPAP, and serves as the program's representative to the ITRO, the Health Care Interservice Training Advisory Board (HC-ITAB), and the dean of the MEDCoE Graduate School. The PD is also the representative to civilian agencies such as the ARC-PA, the NCCPA, the Physician Assistant Education Association (PAEA), and other PA professional organizations.[3]

Duties and Responsibilities

- Responsible for overall management of the IPAP.
- Plans and manages the budget through channels within the MEDCoE Graduate School.
- Reviews and submits ARC-PA applications and reports necessary to coordinate actions required to maintain accreditation.
- Uses the Army Training Requirements and Resources System (ATRRS) to track student allocations within each cohort.
- Meets all suspenses for the Graduate School, MEDCoE, and Training and Doctrine Command (TRADOC).
- Recommends acceptance or rejection of out-of-branch taskings in accordance with ITRO policy.
- Reviews and acts upon student end-of-course surveys from both Phase 1 and Phase 2 in conjunction with the MD and the academic coordinator.
- Hosts all opening and closing ceremonies for all IPAP classes.
- Coordinates input from all services on the program of instruction (POI) in accordance with the ITRO memorandum of agreement, TRADOC requirements, and ARC-PA accreditation standards.
- In coordination with executive committee and IPAP faculty, validates currency and pertinence of the POI, the individual student assessment plan (ISAP), textbooks, additional instructional materials, tests, curriculum, instructor performance, and ongoing program self-study. Keeps HC-ITAB apprised of any issues affecting resources.
- Recommends students for appropriate student actions in accordance with the ISAP, as well as advising the Graduate School dean on appeals cases.
- Supervises all IPAP faculty and staff, including all primary, intermediate, or supervisory evaluations.
- Reviews duty-related travel and leave requests for IPAP faculty and staff to ensure adequate staffing for uninterrupted instruction.
- Tracks current regulations and policy letters applicable to IPAP as a tenant of the MEDCoE, particularly the POI, ISAP, and MEDCoE Regulation 351-12, *Enrollment, Relief, New Start/Recycle, Administrative Disposition, and Counseling of Student Personnel.*[4]
- Performs duties of Phase 1 instructor as required.
- Chairs the IPAP executive committee.[3]

TABLE 38-1

POSITIONS, LOCATIONS, AND ROLES OF ARMY POSITIONS IN THE INTERSERVICE PHYSICIAN ASSISTANT PROGRAM

Phase	Position	Location	Role
Student selection	USAREC IPAP Program Manager	Fort Knox, KY	Manages IPAP applications and board selections
	Affiliate university admissions office	Depends on contract, currently UNMC, Omaha, NE	Approves students for academic enrollment into the IPAP
	IPAP Leadership	MEDCoE, JBSA, TX and various MTFs	Selected board members travel to USAREC to conduct IPAP Selection Board
Phase 1, Didactics (16 months)	IPAP Program Director*	MEDCoE, JBSA, TX	Manages all Phase 1 and Phase 2 IPAP students
	Army, Branch Chief, IPAP*	MEDCoE, JBSA, TX	Manages all Phase 1 and Phase 2 Army students; service liaison to Program Director regarding entry criteria, academic actions, and Army faculty assignments
	Graduate Faculty	MEDCoE, JBSA, TX	Academic and clinical skills instruction; academic mentor/counselor

			to Phase 1 students; curriculum development
Phase 2, Clinical (13 months)	IPAP Program Director*	MEDCoE, JBSA, TX	Manages all Phase 2 (and Phase 1) IPAP students
	Army, Branch Chief, IPAP*	MEDCoE, JBSA, TX	Manages all Phase 2 (and Phase 1) Army students; service liaison to Program Director regarding entry criteria, academic actions, and Army faculty assignments
	Army IPAP Phase 2 Clinical Coordinator	MEDCoE, JBSA, TX	Serves as liaison to IPAP leadership and faculty for administrative issues from Phase 2; conduit between Phase 1 and Phase 2 Transition
	Army Phase 2 Site Clinical Coordinator	Designated MTFs	Administrative coordination and clinical preceptor for Army Phase 2 students
Graduation	USAREC IPAP Program Manager Phase 2 Site Clinical Coordinators	Fort Knox, KY, & MEDCoE, JBSA, TX, and various MTFs	Manage the administrative requirements for graduation and/or commissioning
	Affiliated university	UNMC, Lincoln, NE	Awards bachelors and MPAS degree; provides to Phase 1 administration for distribution to the Phase 2 Site Clinical Coordinators

*These positions are the same for Phase 1 and Phase 2.
IPAP: Interservice Physician Assistant Program
MEDCoE: Army Medical Center of Excellence
MPAS: Master of Physician Assistant Studies
MTF: medical treatment facility
UNMC: University of Nebraska Medical Center
USAREC: US Army Recruiting Command

Skills and Attributes

- Rank of colonel, or highly qualified lieutenant colonel (eg, prior graduate school teaching experience preferably in IPAP).
- Mandatory 3 years of Phase 1 IPAP instructor experience (ie, higher education teaching experience in accordance with ARC-PA accreditation requirements).
- Extensive experience as a PA and AMEDD officer.
- Master's degree required, doctoral degree preferred.

Training

The MEDCoE Instructor Training Course is required. The PD must be knowledgeable about ITRO policies, ARC-PA standards, PAEA guidelines, IPAP policies, standard operating procedures, handbooks, the ISAP, and MEDCoE Regulation 351-12.[3,4]

Key Factors

The PD position is not an enduring TDA position since it rotates among the different services. This position is typically a 4-year tour and coded for a 65D colonel (O-6) with a 5K (instructor) additional skill identifier requirement. The position is primarily administrative with some academic duties; however, the PD must maintain national certification and clinical privileges.

Army Branch Chief

The IPAP branch chief is a 65D (PA) officer responsible for the day-to-day administration of the program. The branch chief coordinates with the PD, MD, and academic coordinator; USAREC; US Army Human Resources Command (HRC); the dean of the MEDCoE Graduate School; National Guard Bureau and Army Reserve liaisons; and the 187th Medical Battalion (the unit all IPAP staff and students are assigned to) leadership to work on issues concerning Army faculty, staff, and students.[4,5]

Duties and Responsibilities

The branch chief is the senior Army PA instructor. He or she is responsible for the Army administration (excluding academics) of

the IPAP. The branch chief supervises and rates Army PA instructors, physicians (based on positional authority), education technicians, and noncommissioned officers. The branch chief advises Phase 2 MTF staff on Army-specific student issues, accreditation inspections, site clinical coordinator selection, and administrative issues.

Additionally, the branch chief is staff officer for Army PA training issues that are extraneous to the IPAP but affect staffing and education decisions for PAs. The branch chief advises the chief PA of the Army Medical Specialist Corps on PA training, utilization, and career management, as well as deployment of Army IPAP instructors. The branch chief is the alternate IPAP Army recruitment point of contact for Army applicants, including active duty, Reserve, and National Guard troops. The branch chief interfaces with USAREC, HRC, the Office of the Surgeon General (OTSG) PA consultant, MEDCoE National Guard and Army Reserve liaisons, and Phase 2 site leadership.[2,5,6]

Skills and Attributes

- Extensive experience as a PA and AMEDD officer.
- Rank of colonel, or highly qualified lieutenant colonel.
- IPAP instructor experience preferred.
- Good speaking, writing, and communication skills.

Training

The MEDCoE Instructor Training Course is required. The branch chief must be familiar with USAREC and National Guard IPAP application processes, HRC assignment and promotion processes, and MEDCoE Regulation 351-12.[2,4–6]

Key Factors

This position is typically a 3-year tour and coded for a 65D colonel (O-6) with a 5K (instructor) additional skill identifier requirement. This position is primarily administrative with some academic duties; however, the branch chief must maintain their national certification and clinical privileges (Figure 38-2).

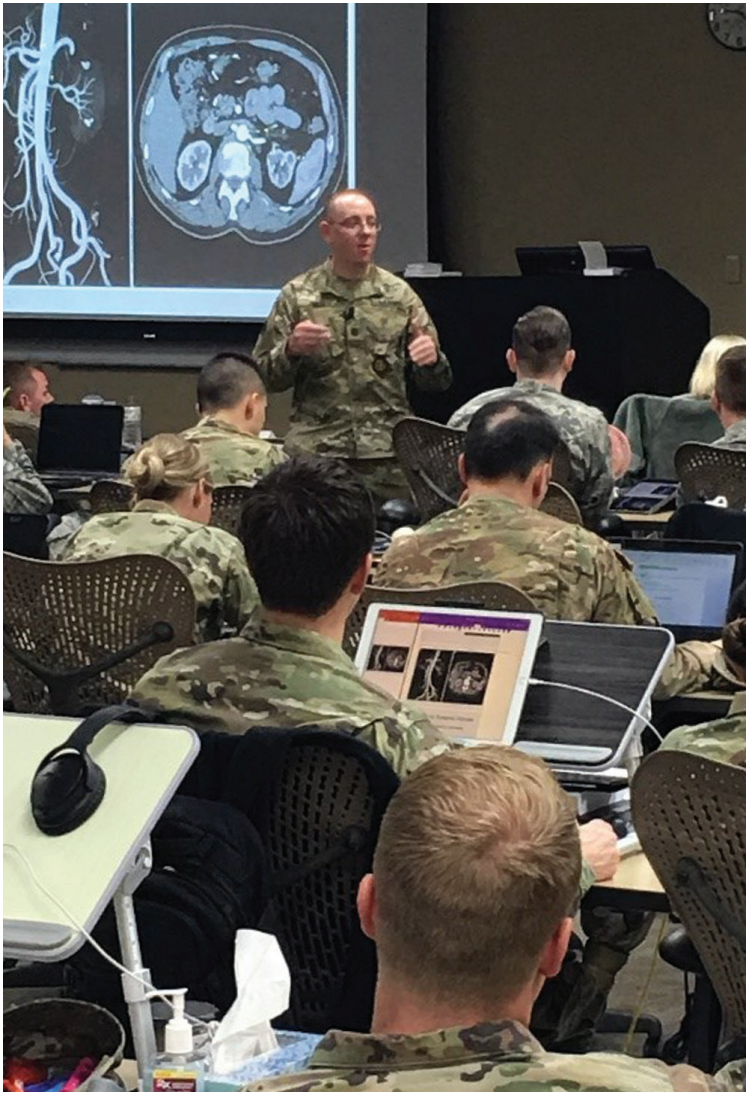


Figure 38-2. The senior Army PA instructor is the Army branch chief and Army senior service representative. Pictured is Lieutenant Colonel James Jones during a genitourinary class session on February 26, 2019. Photograph courtesy of Colonel Brian E. Burk.

IPAP Clinical Coordinator and Army Phase 2

Clinical Coordinator

Because one of the key leadership positions in the IPAP is the CC, the Army Phase 2 CC may serve in both positions (IPAP CC and Army Phase 2 CC) when the Air Force holds the PD position and the Navy holds the MD position. During this 3- to 4-year duration, the IPAP CC has responsibility for all Phase 2 sites. When another service holds the IPAP CC, the Army Phase 2 CC, located at MEDCoE, oversees the all Army Phase 2 clinical training sites and the Army Phase 2 Site CCs.

Job Duties and Responsibilities

IPAP Clinical Coordinator. The IPAP CC oversees the hospital-based training (HBT) at all Phase 2 sites and serves as the lead CC for all services. The primary responsibility is to ensure HBT remains in compliance with applicable TRADOC and ARC-PA procedures and standards.[2,7] As a key member of the IPAP executive committee, the IPAP CC advises the PD, MD, and all senior service representatives of any issues involving Phase 2 training. He or she coordinates an IPAP site CCs' conference every other year at JBSA-FSH to facilitate distribution of IPAP policies and procedures and conduct training. The IPAP CC also conducts quarterly video teleconferences with the Army Phase 2 site CCs. Additional responsibilities encompass all the duties of the Army Phase 2 CC.

The Army Phase 2 Clinical Coordinator (IPAP). The Army Phase 2 CC oversees HBT at all Army Phase 2 sites. He or she ensures all Army site CCs coordinate HBT experiences in accordance with IPAP policies and established ARC-PA procedures and standards.[2,7] These include overseeing the selection and training of Army site CCs, mentoring the site CCs on administrative management of students, and assisting with Phase 2 examination reviews.[3] The Army Phase 2 CC manages the Phase 2 assignment process for the Army, National Guard, and Army Reserve students in coordination with the Army branch chief. Additionally, he or she is responsible for reviewing and coordinating updates of the memoranda of understanding between MEDCoE and the Army MTFs, as well as conducting annual site accreditation inspections of each Army HBT site.

Desired Skills and Attributes

The IPAP CC and Army Phase 2 CC must:

- have at least 2 years' experience as a Phase 2 Site CC;
- have at least 1 year experience as an IPAP instructor;
- have extensive experience (preferably with deployments) in battalion and brigade PA positions;
- be an excellent role model with the desire to mentor others;
- have solid leadership, administrative, and academic skills;
- be experienced in evaluation and rating; and
- have good speaking, writing, and communication skills.

In addition, it is preferable that candidates for these positions have completed Intermediate Level Education (ILE).

Training

IPAP uses the affiliated university's educational platforms. Currently, these primarily consist of two online educational platforms called CANVAS[8] and MyEvaluations.[9] CANVAS contains policies and procedures that Phase 2 CCs must learn upon entering the positions. MyEvaluations is used for grading and certification for students' rotations, hours, and patient/procedure logs, along with qualitative and quantitative assessments of rotational efficacy by the preceptors.[9] These systems are best learned through hands-on experience and over-the-shoulder coaching.

Key Facts

IPAP Clinical Coordinator. Because it does not exist specifically on the TDA, this position encompasses the roles and responsibilities of the Army Phase 2 CC. In accordance with a 2010 ITRO memorandum of agreement amendment, the IPAP CC must be a 65D lieutenant colonel (O-5) with the 5K skill identifier.

Army Phase 2 Clinical Coordinator. The Phase 2 CC position is typically a 3- to 4-year tour, coded for a 65D major (O-4) or lieutenant colonel (O-5) with the 5K identifier. Currently, the IPAP Army Phase 2 sites are

- Blanchfield Army Community Hospital, Fort Campbell, KY
- Carl R. Darnall Army Medical Center, Fort Hood, TX
- Evans Army Community Hospital, Fort Carson, CO
- Fort Belvoir Community Hospital, Fort Belvoir, VA
- General Leonard Wood Army Community Hospital, Fort Leonard Wood, MO
- Ireland Army Health Clinic, Fort Knox, KY
- Irwin Army Community Hospital, Fort Riley, KS
- Keller Army Community Hospital, West Point, NY
- Landstuhl Regional Medical Center, Germany
- Madigan Army Medical Center, Joint Base Lewis-McChord, WA
- Martin Army Community Hospital, Fort Benning, GA
- Brooke Army Medical Center, Joint Base San Antonio-Fort Sam Houston, TX
- Tripler Army Medical Center, Honolulu, HI
- William Beaumont Army Medical Center, Fort Bliss, TX
- Winn Army Community Hospital, Fort Stewart, GA
- Womack Army Medical Center, Fort Bragg, NC

Sites may open and close depending on the capacity for students and availability of required rotations at the hosting MTFs. In coordination with the IPAP CC, an IPAP faculty member conducts a site accreditation inspection every other year at each HBT location (see Table 38-1).

Phase 2 Site Clinical Coordinator

Although some of the duties and responsibilities of Army Phase 2 CC and the Phase 2 site CC overlap, there are certain distinct functions. Overall, duties of positions are synchronized to ensure students receive proper training and management at the various MTFs serving as Phase 2 sites. The IPAP Army Phase 2 CC, located at MEDCoE, oversees all Army Phase 2 clinical training sites and the site CCs. The IPAP Phase 2 site CC is responsible for supervising and mentoring new IPAP Phase 1 graduates through their 13 months of clinical rotations.

Duties and Responsibilities

The main responsibilities of the IPAP Phase 2 site CC are to prepare new PAs to perform duties as primary care providers. Students must

be prepared to operate in settings such as a remote aid station during deployments, a garrison clinical environment, and in the field during training exercises; to interface with their battalion staffs to optimize battalion medical readiness and 68W (combat medic) training; and to serve as a mentor to help guide new PAs through their careers. IPAP graduates three classes per year, and each Phase 2 site CC receives up to six students from each class, depending on the MTF's capacity. This typically results in two to eighteen students at a Phase 2 site at any one time, arranged in freshman, junior, and senior classes. Students may be assigned class leadership positions to aid in student accountability and management.

The site CC position is generally a 0.5 full time equivalent (FTE), with the other 0.5 FTE of the person's time performed in a primary care or specialty clinic position. Specific responsibilities vary based on the Phase 2 site. Some sites (usually those with Graduate Medical Education [GME] programs) have an assistant to the CC who builds and maintains academic rotation schedules, manages grades, proctors tests, and performs various other administrative tasks. Many smaller sites require the CC to do those tasks.

Serving as the IPAP Phase 2 site CC provides experienced PAs, those with a variety of battalion, brigade, clinical, and staff PA assignments, the opportunity to shape the next generation of Army PAs. This rewarding assignment allows the transfer of clinical, professional, and soldiering skills to new PAs, and sets up a lifetime network of mentoring relationships to guide PAs through successful careers. One mentoring technique used by clinical coordinators is to team up a PA student with a staff PA on the installation. This enables the student to attend battalion staff meetings, observe sick call at the aid station, interface with battalion medics, and potentially participate in a field problem or soldier readiness processing from a PA's viewpoint. CCs perform many administrative tasks, including creating training schedules, managing students' presentation requirements, and meeting with clinical preceptors. Additionally, the CC organizes the weekly academic half-day to ensure students are prepared to pass the PANCE. Monthly student counseling sessions and feedback from preceptors must be conducted and documented to meet IPAP standards. Test scores must also be recorded. If a student is struggling academically, academic probation and a remediation plan must be developed and approved by the MD (usually the physician GME director, the deputy commander

for clinical services, or the chief of primary care) and monitored for adherence and progress until the student proves competence.

Some flexibility in the IPAP ISAP allows academic or administrative delays to allow students to repeat a limited number of rotations, or provide time to manage personal crises. However, the IPAP PD must approve such actions.[4] Professional relationships with preceptors, department chiefs, and the local IPAP MD are critical for the student success. In facilities with large GME programs, IPAP student rotations require careful scheduling to provide the maximum student contact with the preceptor. DOD students must have priority over other PA students in clinical rotations. With student motivation and effective CC involvement, almost every student who reaches Phase 2 graduates and becomes a successful Army PA.

Desired Skills and Attributes

All Army Phase 2 site CCs must:

- have extensive experience (preferably with deployments) in battalion and brigade PA positions;
- be an excellent role model with the desire to mentor others;
- have solid leadership, administrative, and academic skills; and
- be experienced in evaluation and rating.

In addition, it is preferable that candidates for these positions have completed ILE.

Training

The most important training to help Phase 2 site CCs be successful is gained on the job experience and developing a vision for education. A 2-month overlap with the outgoing CC is imperative for effective preparation. Phase 2 site CCs use the online educational platforms CANVAS and MyEvaluations, as described above.[8,9] When starting in the position, CCs must review policies and procedures on CANVAS, and CCs use MyEvaluations for grading, certification of student rotations, patient/procedure logs, and the qualitative/quantitative assessment of students by the preceptors.[9] In addition, expertise in the current electronic medical record systems and standard office

programs (particularly Microsoft Excel and Outlook) are critical for the Phase 2 CC.

Key Facts

The Phase 2 site CC position is typically a 2- to 3-year tour and is coded for a 65D major (O-4), although a 65D captain promotable (O-3) or lieutenant colonel (O-5) can also be selected, with no additional skill identifier requirement. Sites may open and close depending on the capacity for students and availability of required rotations at the hosting MTFs. The site CC is usually rated by the clinic officer in charge, and senior-rated by the MTF's deputy commander for clinical services or chief of the site CC's department. An IPAP site accreditation inspection is conducted at most sites every other year. The site CC must maintain excellent rapport with clinic and service chiefs, MTF leadership, and the medical company to maintain a solid rotation curriculum and protect students' interests.

Time management is a key skill because student management can easily encroach on the CC's clinic productivity, and vice versa. The CC serves as a mentor, supervisor, clinician, program chief, educator, preceptor, scheduler, assignments manager, and resource manager for the site. Often the Phase 2 CC may be one of senior PAs (or the senior PA) on the installation, which extends these mentoring responsibilities to all of the PAs on the installation.

IPAP Phase 1 Associate Professor

Duties and Responsibilities

The main responsibilities of an IPAP associate professor is the coordination and instruction of an assigned course during the 16-month didactic phase of the IPAP. This includes ensuring course content remains aligned with the current NCCPA blueprint, reviewing course curriculum each semester, and recommending any necessary changes to curriculum committee. Additional duties involve academic counseling of IPAP students, grading master's papers of assigned counselees, and supporting other IPAP educational activities such as physical exam practice and testing, exam proctoring, and other identified educational activities. Associate professors also serve as

members of committees assigned by the PD as part of program support and development.

Desired Skills and Attributes

All Army associate professors must:

- hold an appropriate Doctorate of Clinical Science or equivalent degree if assigned as the orthopedic, general surgery, or emergency medicine professor;
- have current NCCPA certification and maintain clinical privileges at a local MTF;
- have extensive experience (preferably with deployments) in battalion and brigade PA positions;
- be an excellent role model with the desire to mentor others; and
- have solid leadership, administrative, and academic skills.

Also, it is preferable that candidates have completed ILE.

Training

All new faculty must attend and complete the MEDCoE Instructor Training Course or already have the 5K additional skill identifier.

Key Facts

IPAP associate professor positions are typically a 3- to 4-year tour and are coded for a 65D major (O-4) or lieutenant colonel (O-5), although a 65D captain promotable (O-3) can also be selected. Some positional authorizations require additional skill identifiers, such as M1 (orthopedic) and M2 (emergency medicine), and general surgery recognitions gained through a DSc program (Figure 38-3).

Program Manager

The IPAP program manager receives, processes, and boards applications for the IPAP at USAREC headquarters. This position is rated by the director of USAREC's Health Service Directorate and is senior-rated by the USAREC chief of staff.



Figure 38-3. The multiservice faculty and staff of the Interservice Physician Assistant Program at the Army Medical Center of Excellence, December 12, 2019. Front row, left to right: Maria Charles, Lieutenant Commander Lance Beahm, Lieutenant Jeremy Fisher, Major Jamie Robey, Colonel Brian Burk, Lieutenant Colonel James Jones, Lieutenant Colonel Jacqueline Bvlgari, Major Karen Salyars, Sergeant Ashton Cole-Johnson. Second row, left to right: Dr. James Jelen, Major Zachary Leftwich, Major Jason Unsworth, Lieutenant Colonel Vu Nguyen, Denise Fricchione, Stacyann Walters, Colonel Edward Michaud, Major Lauris Trimble, Major Chad Roasa. Third row, left to right: Dr. James Murray, Captain Kevin Graham, Captain Terrance Nevels, Lieutenant Commander Joe Hamm, Richard Weber, Lieutenant Commander Jeff Bateman, Major James Winstead, and Lieutnant Colonel Bruce Callahan. Photograph courtesy of Lieutenant Colonel James Jones.

Desired Skills and Attributes

- Extensive experience as a PA and Army officer.
- Rank of major or lieutenant colonel.
- ILE graduate preferred.
- Brigade senior PA or brigade surgeon experience preferred.
- Excellent communication skills.
- Must be an excellent role model with a desire to mentor others.
- Knowledge of Microsoft Word, Access, and Excel software is helpful.

Training

Training required for the IPAP program manager includes access and familiarity with several USAREC systems:

- Total Army Personnel Management Information System, used to create new regular Army accessions;
- Medical Operating Data System, which holds Active Component Health Professional Loan Repayment Program documentation;
- IPAP accession database, used in processing and managing IPAP applicants and selectees;
- Direct Commissioning and Accessing System, which allows recruiters to build new accession packets remotely for boarding direct accession AMEDD officers and future officers for AMEDD commissioning programs; and
- The Health Care Recruiter Course and specialized training in procurement and processing procedures unique to AMEDD recruiting efforts.

Duties and Responsibilities

The duties of the IPAP program manager are many and varied. They include managing the active duty and Reserve PA recruiting and accession programs; processing all documents for boarding, selection, and appointment of IPAP students; overseeing policy revision (Army Regulation [AR] 601-20, *The Interservice Physician Assistant Training Program*[10]); and coordinating application and appointment procedures. Additionally, the IPAP program manager develops recruiting strategies to ensure that high-quality soldiers participate in IPAP, and oversees the marketing of civilian-trained PA recruitment. The IPAP program manager provides input to the chief of the Army Medical Specialist Corps and the Army PA consultant on strategic issues affecting IPAP and direct accession recruiting. Additionally, the IPAP program manager is responsible for in-processing new IPAP students, processing commissioning documents for graduation, and coordinating staffing actions among command headquarters, recruiting staff, and external agencies, including OTSG, MEDCoE, and HRC.

This position is typically a 3-year tour and coded for a 65D major (O-4) with no additional skill identifier requirement. The IPAP program

manager performs face-to-face counseling and field interviews for prospective IPAP applicants. Fiscal constraints may restrict travel to make contact with IPAP applicants; however, whenever feasible these visits are key to interacting with applicants in the field. This position is primarily non-clinical; however, the program manager must perform limited clinical duties to maintain their credentials. Duties are further described below.

- **Advertising.** The IPAP program manager evaluates admission criteria annually based on guidance from the OTSG PA consultant, the Army Medical Specialist Corps chief, MEDCoE, National Guard Bureau, and HRC, and advertises the updated annual application criteria through an annual military personnel (MILPER) message, articles, the IPAP USAREC webpage (http://usarec.army.mil/army/PA), broadcasts, and flyers.
- **Recruiting.** The IPAP program manager coordinates installation and video teleconference briefings with soldiers interested in IPAP, the AMEDD Enlisted Commissioning Program, and other AMEDD commissioning programs. The program manager further ensures that major Army installations inside the continental United States are briefed every 24 months, and installations outside the continental United States are briefed every 36 to 48 months. The IPAP program manager maintains communication via email, Facebook, and telephone, and requisitions and mails recruiting materials for presentation purposes as needed.
- **Direct accessions.** "Direct accession" is a term used when a trained professional enters military service. The IPAP program manager performs curriculum vitae reviews on all regular Army and Reserve PA applicants through the Direct Commissioning and Accessioning System, and conducts phone interviews and addresses applicant questions as needed. When requested, the program manager will conduct briefings or presentations at civilian PA training programs and conferences. The program manager also performs curriculum vitae reviews on all civilian PAs who wish to serve in the regular Army or Army Reserve. Additionally, the IPAP program manager provides input for the fiscal year mission with guidance from the OTSG PA consultant, Specialist Corps chief, and HRC through articles, the USAREC webpage, flyers, and the annual American Academy of Physician Assistants conference.

- **Applicant processing.** The IPAP program manager reviews all IPAP applicant packets to ensure that packets are complete and that candidates meet the eligibility requirements for commissioning in accordance with ARs 40-501, 135-100, 135-101, 600-9, 601-100, and 670-1.[11–16] The program manager evaluates each commissioning physical exam and processes all medical waivers through the USAREC surgeon. They ensure that the PA consultant has reviewed all "P2" profiles (an activity-limiting condition under the Army Physical Disability Evaluation System) and that all approved exceptions are boarded. The program manager ensures that all moral, age-in-grade, and time-in-service waivers are processed through the Army Medical Specialist Corps prior to boarding. When an applicant is deemed academically ineligible by the affiliated university (currently the UNMC), the program manager performs an academic review to ensure that all eligible packets are processed. If the UNMC academic review of an applicant identifies a discrepancy, the IPAP program manager performs a final review to ensure the affiliate university was not in error.
- **Boarding.** The program manager briefs the IPAP selection board members on the IPAP application requirements and provides additional requested information to the board president during the boarding process. Applicants are not enrolled in IPAP until the boarding process is complete.
- **Post-board.** The program manager releases the board results via a MILPER message. "Selectee" is the term used for board-selected IPAP candidates (pre-matriculation). The IPAP program manager contacts all HRC branch managers to discuss the start date for each selectee (January, April, or August) based on the branch's needs, and provides a welcome letter and initial instructions to each selectee.

  Additionally, the program manager "scrolls" all selectees and requests assignment instructions through HRC. (All soldiers recommended for commissioning are placed on a list ["scroll"] submitted to Congress for approval, then signed by the secretary of the Army, after which appointment orders are generated, and enlistees tender their oath.) The program manager ensures that all background investigations have been completed, reenlistment contracts have been signed, and students remain eligible (academically, morally, and medically) throughout the length of the program.

- **Classes.** The program manager ensures that all remaining academic coursework has been completed and all documents have been received prior to orders being published, and further ensures that each candidate signs a statement of understanding outlining their service within 60 days of reporting to school.
- **Graduation.** The IPAP program manager ensures that all program graduates have an approved scroll, have up-to-date security clearances, and complete qualifying physicals prior to graduation. The program manager ensures that all new waivers are processed within 12 months of graduation, and forwards all graduation documents and contracts to HRC.

Conclusion

Assignment to the IPAP constitutes significant recognition of an individual's leadership, dedication, and desire to mentor the next generation of PAs in the military. Because both civilian and military agencies govern education for PAs, any position related to the IPAP depends on an individual's awareness and understanding of these mandated educational requirements. For the PD, the most crucial association for the IPAP is the accreditation received from the ARC-PA, since without this accreditation, IPAP graduates cannot sit for the PANCE. Furthermore, the PD, Army branch chief, and CC must ensure adherence to TRADOC requirements and those of the different services as outlined by the ITRO agreements. From didactics to supervised clinical practice experiences, all IPAP members must ensure students receive only the highest quality of training in accordance with the ARC-PA, ITRO, and TRADOC standards. Success depends on the efforts of the IPAP PM to recruit the best applicants, the IPAP associate professors to provide the highest quality of didactic instruction, and the CCs to ensure exceptional supervised clinical practice experiences. The ability of the IPAP to function as the world's largest PA program depends on effective leadership at all levels, and a thorough understanding of the requirements for PA education. An important consideration is that IPAP graduates will spend only a short time as military PAs, since nearly all will become civilian PAs after completing their military service. For most, the bulk of their years as a PA will occur in the civilian sector. Therefore, all IPAP members must ensure all graduates receive preparation to succeed in the PA profession across the scope of the nation's health care landscape.

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Chapter 39

TRAINING WITH INDUSTRY PROGRAM OPPORTUNITIES FOR PHYSICIAN ASSISTANTS

Courtney Legendre, PA-C, MPAS

Introduction

Physician assistants (PAs) have the opportunity to broaden their skills and knowledge by competing for participation in a Training With Industry (TWI) program. Depending on which program they apply for, the experience can broaden their knowledge of legislative and national affairs. This chapter discusses the requirements and options to compete for TWI. The three primary agencies partnering with the Army in running these programs for PAs are the American Academy of Physician Assistants (AAPA), the National Commission on Certification of Physician Assistants (NCCPA), and the National Registry of Emergency Medical Technicians (NREMT). These partnerships provide an opportunity for PAs to exchange knowledge and ideas with their civilian counterparts, and to bring what they learn back to the Army. This exchange ensures the Army stays relevant with respect to PA training, regulations, and certifications, and the profession remains in line with the civilian workforce.

Duties and Responsibilities

Army PAs selected for the TWI program will have duties consistent with the goals of the organization they are working for. Duties may include lengthy research projects, data entry, reviewing protocols, and advising internal committees. Other projects may include state law reviews, preparing for the AAPA annual conference, curriculum development for emergency medical technicians, continuing medical education

(CME) development, and contributing to NCCPA test development. Additionally, to facilitate integration of Army medicine goals with project development, PAs should develop working relationships with Army leaders.

Requirements

Requirements to compete for TWI, released in annual military personnel (MILPER) messages, may vary from year to year but often include the following elements.[1] Applicants must:

- be a graduate of the Captains Career Course, if a first lieutenant (promotable) or higher[1];
- be a graduate of Intermediate Level Education, if a major (promotable) or higher;
- have 4 to 13 years of active federal commissioned service (waiver eligible);
- have sufficient remaining service upon completion of training to fulfill the incurred active duty service obligation (ADSO);
- not be in a non-select promotable status (waiver ineligible);
- have 3 years of clinical experience by course date (waiver eligible); and
- have passed the Army Combat Fitness Test and complied with height/weight standards within 6 months of application.

Additionally, overseas applicants must have complete their prescribed overseas tour, include any previously approved extensions, before starting the program.

Desired Skills and Attributes

Applicants should be hard working, productive, and insightful, and have the following skills and abilities:

- strong communication skills;
- ability to work well with both military and civilian organizations;
- excellent customer service skills; and
- superb written and verbal communication skills.

Organizations Available for Training Programs

American Academy of Physician Assistants

The AAPA is the national professional society for PAs. Representing more than 140,000 PAs, it advocates and educates on behalf of the profession to improve quality, accessibility, and cost-effectiveness of patient-centered health care.[2] Some of the key sections to explore within the AAPA are:

- **The PA Foundation**. A nonprofit, philanthropic section of the AAPA that provides resources for PAs and PA students to improve their communities.
- **Advocacy and Government Affairs**. Efforts by the organization to promote the profession at the state and national level, including within the Department of Defense.
- **Education**. Development and certification of CME within the profession, including the annual AAPA conference and multiple other opportunities. The education department frequently conducts research within the profession as well; recurring projects include the annual salary survey and surveys to identify the need for CME.
- **The Center for Healthcare and Leadership Management**. Provides strategic and operational guidance on how to best utilize PAs within an organization.

National Commission on Certification of Physician Assistants

The NCCPA is the only certifying organization for PAs in the United States. It ensures that PAs meet established standards of knowledge and clinical skills upon entry into practice and throughout their careers.[3] While the NCCPA is most known for developing of the Physician Assistant National Certification Exam (PANCE), it has other components that contribute to the profession as well. Like the AAPA, the NCCPA works with lawmakers on legislation that drives the profession and some state laws. Some other key sections in the NCCPA are:

- **The NCCPA Health Foundation**. A nonprofit organization designed to promote the PA profession; improve patient care; and collaborate with partners to advance the role of certified PAs and improve health.[4]

- **The PA History Society**. Shares the history and development of the PA profession and how PAs continue to make a difference in society.[5]

National Registry of Emergency Medical Technicians

The NREMT provides a valid, uniform process to assess the knowledge and skills required for competent practice by emergency medical services professionals throughout their careers. The organization also maintains a registry of certification status.[6,7] Because all combat medics (68W) are required to maintain their certification with NREMT, in accordance with Army Regulation 40-68,[7] an ongoing collaboration can improve opportunities and training for Army combat medics and civilian paramedics, potentially impacting all of the medical care in the Army. Training with the NREMT provides PAs with the opportunity not only to learn about training and testing associated with certification maintenance, but also to see how the newest changes are pushed to the profession and how instruction and training will need to adapt to meet standards in training and care.

Key Facts

The TWI program provides a unique opportunity for competitively selected officers and noncommissioned officers to learn managerial techniques and skills specific to their profession. This training is otherwise not available through the military or civilian school systems. Following the participants' tenure in the TWI program, they are placed in a validated utilization assignment for 2 years. Participants also incur an ADSO of 3:1 ratio computed in days, which is currently 3 years.[8] Ideally, PAs who complete the training will fill the ADSO in utilization tours and share what they have learned with the profession. Potential utilization tours include serving in the Interservice Physician Assistant Program and instructing medics at the Department of Combat Medic Training at the Army Medical Center of Excellence at Joint Base San Antonio-Fort Sam Houston, Texas.

Tips for Success

- Several TWI opportunities for PAs directly deal with governance and legislative processes. The trainee should ensure they know

the current Army goals in these areas, and they must be able to distinguish between their own views and the Army's vision.
- Engage key leaders early and often to maintain collaborative efforts.
- Engage career managers before applying to ensure engagement timelines will line up with career timelines.
- Know the roles of medics, the training and credentials they are required to maintain, and efficiencies and deficiencies of medic training at various installations—some have robust training while others struggle to maintain credentials for medics. Newly trained PAs may have an opportunity to narrow the education divide.
- Know the resources available at training sites that include DHA (Defense Health Agency) military medical treatment facilities.
- Be familiar with state and national laws, as well as regulations that cover PAs. There may be opportunity to improve both through improved regulations, laws, and collaborative projects.

Conclusion

The Army TWI program provides opportunities for PAs to collaborate with civilian counterparts in multiple facets of the profession. By participating in these programs, PAs within the Army gain insight into advocacy, training, credentialing, certification, and many other professional considerations. TWI programs allow Army PAs to maintain first-hand knowledge of major transitions within the profession and enable Army doctrine and recommendations to stay up to date and relevant.

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Chapter 40

ROLE OF THE CHIEF AND DEPUTY CHIEF, ARMY MEDICAL SPECIALIST CORPS

Jeffrey E. Oliver, APA-C, MPAS, MSS

Introduction

The chief of the Army Medical Specialist (SP) Corps, informally known as the corps chief (CC), is authorized for the Army Medical Center of Excellence (MEDCoE), per the SP Corps table of distribution and allowances. In addition to heading the SP Corps, the CC is assigned as an Army senior leader at-large. Per Title 10 USC § 7070, upon recommendation by the Army surgeon general (TSG), the secretary of the Army appoints the CC from officers of the regular Army in the SP Corps.[1] The SP Corps consists of over 1,300 active component officers and over 1,400 reserve component officers (Army Reserve and Army National Guard), in four distinct areas of concentrations (AOCs): (1) 65A, Occupational Therapist; (2) 65B, Physical Therapist; (3) 65C, Registered Dietitian; and (4) 65D, Physician Assistant.[2]

The CC serves at the discretion of the Army secretary for no more than 4 years, and may not be reappointed. TSG has delegated the branch proponency of the SP Corps to the CC in accordance with Army regulations, which assign specific duties to the CC.[3,4] The CC serves as the principal advisor to TSG on all matters concerning the SP Corps. At the strategic level, the CC holds branch-proponent responsibilities to make recommendations affecting the corps' doctrine, organization, training, materiel, leader development and education, resourcing, personnel, and policy (Figure 40-1).

The deputy chief of the SP Corps, informally known as the deputy corps chief (DCC), is also assigned to the SP Corps office and serves as its senior executive for strategy and future operations. The DCC acts as the CC's principal at the Office of the Surgeon General (OTSG) and on



Figure 40-1. Lieutenant General Nadja Y. West, the 44th Army surgeon general, issues Colonel John E. Balser the oath of office as the 19th chief, Army Medical Specialist Corps, March 30, 2017.

essential Army working groups, in support of SP Corps strategic efforts. The DCC integrates and coordinates SP Corps initiatives, ensuring they are nested within the framework of Army medicine and Army campaign plans. The DCC coordinates with other Army Medical Department

(AMEDD) and Army agencies to accomplish SP Corps strategic goals. The DCC facilitates a team-centric environment through collaboration and promoting leader development. They represent the corps-specific branch proponent officer (CSBPO) or the CC in their absence. The DCC can also be from any of the SP Corps AOCs and serves in a 65X (SP Corps immaterial) capacity (Figure 40-2).

Supervision

The CC serves in an advisory role to TSG while being assigned in the Army at-large. The CC's rater and senior rater supervision is maintained within their operational unit, medical facility, or military organization in accordance with Army regulations.[5] While assigned at the OTSG, the DCC has an indirect reporting role to the deputy surgeon general as an advisor on the SP Corps. The DCC is a multi-level, indirectly supervised position. The DCC is rated by the CC, and senior rated by the deputy surgeon general.



Figure 40-2. Colonel John E. Balser and Colonel Jeffrey E. Oliver with the 2019 Army Medical Department Iron Majors in the Indian Treaty Room, Eisenhower Executive Office Building, adjacent to the White House, Washington, DC, August 6, 2019.

Unit Structure

The CC and DCC are strategic positions within the MEDCoE. They support the Title 10 responsibilities of the SP Corps, as they pertain to the Title 10 USC § 7036 (effective February 1, 2019) authorities of TSG, which are responsibilities specific to manning, training, and equipping the Army with medical capabilities.[1]

Duties and Responsibilities

The CC makes recommendations and provides guidance on regulations, policy, standards, practices, procedures, missions, and programs related to the SP Corps. The CC:

- assists with developing staffing guidelines and distribution of manpower authorizations for the SP Corps to support the Army strategy and mission;
- advises and makes recommendations on resource requirements for delivering health care, holistic health and fitness, and other relevant programs involving the SP Corps, including funding, personnel, materiel, facilities, and training;
- recommends appointment of the DCC and CSBPO to TSG;
- acts as a reviewer and advisor to TSG on all legislative, regulatory, and other proposals affecting the professions within, and services performed by, the SP Corps;
- serves as the SP Corps' primary liaison with the offices of the chiefs of the Army Reserve and National Guard Bureau, the Army Recruiting Command, Joint Staff, intra-service and inter-service agencies, international and government bodies, civilian health care organizations, professional societies, and educational institutions on matters affecting the SP Corps; and
- serves as TSG's lead for the SP Corps long-term health education training program.

The CC has the authority to delegate a number of responsibilities to the DCC or CSBPO for day-to-day operations.

At the corps level, the CC is responsible for establishing a cooperative organizational climate that integrates the SP professions into the AMEDD's most resilient, responsive, ready, and relevant team.

The CC has the critical role as a subject matter expert on the SP Corps. Medical readiness is maintained through providing health promotion, human performance optimization, treatment and rehabilitation, injury control, and education to the total force, their families, and soldiers on and off the battlefield. The CC is key in providing guidance for the management, training, and utilization of the enlisted counterparts in military occupational specialties (MOS): 68L, Occupational Therapy; 68F, Physical Therapy; 68M, Nutrition Care; and 68W, Health Care/ Combat Medic, and associated skill identifiers.

The DCC assists in building relationships with all organizations throughout the AMEDD; Department of Defense (DoD); Headquarters, Department of the Army (HQDA); the Defense Health Agency (DHA); and other internal and external stakeholders. The DCC maintains active lines of communication with OTSG, the MEDCoE, and SP Corps officers in Forces Command, Training and Doctrine Command, Army Futures Command, Army Materiel Command, and Special Operations Command, relating to SP Corps current capabilities and emerging requirements. Like the CC, the DCC coordinates with the offices of the chiefs of the Army Reserve and National Guard Bureau, the Army Recruiting Command, and other components on joint proponency issues (eg, doctrine and training) or other intra-service and inter-service matters affecting the SP Corps.

The DCC also:

- supports the CC as the principal advisor to TSG on all matters concerning the SP Corps;
- advises on branch-proponent responsibilities and makes recommendations related to SP Corps-specific or applicable doctrine, organization, training, materiel, leader development, resourcing, and personnel;
- recommends and guides policy, standards, practices, procedures, missions, and programs involving the SP Corps;
- provides counsel to the CC on all aspects of lifecycle management for the corps, including personnel recruitment, classification, utilization, promotion, education, training, assignments, retention, separation, and retirement of the military, and as needed for civilian personnel;
- assists in developing staffing guidelines and distribution of workforce authorizations, including corps strategic billets, as well as key and developmental positions, to support assigned missions;

- assists with recommendations on resource requirements for delivering health care and wellness programs involving SP Corps funding, personnel, materiel, facilities, and training;
- provides recommendations to the CC on all legislative, regulatory, and other proposals affecting the SP Corps and its services;
- participates in the corps consultants selection process, the strategy advisory board, and the corps educational committee, and provides recommendations to the CC for decisions; and
- provides key recommendations for the management, training, and utilization of enlisted personnel in corresponding MOS career fields, and any additional associated skill identifiers.

Desired Skills and Attributes

The CC and DCC must be warrior leaders, skilled in tactics, techniques, and procedures, focused on understanding and supporting the dynamic warfighter. They must maintain the highest standards of personal and professional integrity, possess strong Army values, leader attributes, and skills, and fully understand key leadership actions that ensure success. They must be flexible, adaptable, and prepared to face unique tactical, operational, or strategic challenges related to emerging strategic developments and warfighting doctrine. The CC and DCC should have the ability to apply non-textbook solutions in unconventional circumstances, and must be able to apply critical thinking while making decisions.

The CC and DCC possess a working understanding of the unique skills, knowledge, and attributes in each AOC that make up the SP Corps. They must possess expert clinical skills as well as knowledge of personnel and resource management in the Corps' four AOCs. Some other desired skills and attributes include:

- rank of colonel or lieutenant colonel (promotable);
- Senior Service College (SSC) graduate;
- advanced civilian degree (a Master of Strategic Studies received from SSC qualifies);
- extensive experience of the SP Corps, previous SP leadership experience, or prior field grade command experience;
- understanding of military medicine and the business of health care through a military medical treatment facility, regional health

command, OTSG, AMEDD, or Military Health System/DHA experience;
- knowledge of AMEDD culture and organizations, including joint health services support, the military health system, and the DHA;
- familiarity with USC Title 10 § 7070 (as amended August 13, 2018)[1];
- knowledge of human resources systems, policies, and processes and talent management principles;
- mental agility and flexibility as a strategic and critical thinker, planner, and decision-maker;
- ability to build and maintain critical relationships, strong interpersonal skills, consensus building across a variety of stakeholders and agencies, negotiation skills, and team building skills;
- analytical skills to review, analyze, and resolve high-level problems across a broad organizational spectrum;
- strategic planning skills to produce results through the implementation and evaluation of programs and policies;
- excellent organizational skills, and ability to effectively communicate through oral and written communication;
- demonstrated professional astuteness and confidence, emotional intelligence, and situational awareness;
- ability to represent the organization across a broad spectrum of strategic, operational, legislative, and executive levels of the public and private sectors;
- ability to embrace change and new information while thriving within a complex and ambiguous environment; and
- systems thinker (understanding interactions and interdependencies of a "system's parts" to realize the second- and third-order effects of a change).

Training

The training required for these positions includes, but is not limited to, the Medical Operating Data System (MODS), which includes AMEDD human resources web reporting for AMEDD Distribution Plan projections. Additionally, working knowledge of the Active Duty Officer Assignment Interactive Module Version 2 (AIM.2) unit preference management tool is required for managing the strategic positions in the marketplace, which includes the SP Corps' 65X authorizations. Other systems and courses the CC and DCC should have access to

or familiarity with include the Force Management Support Agency (FMSWeb) system for Army unit requirements and authorizations for personnel and equipment documentation[6]; the Global Electronic Approval Routing System (GEARS) for initiating, managing, and completing unit-level tasks and actions; and the Army Task Management Tool (TMT), used for initiating, managing, and completing Army-level tasks and actions. TMT training is available by attending the Action Officer Integration Course offered by HQDA. The CC and DCC must also have access to several OTSG and MEDCOM SharePoint services that contain current regulatory and policy guidance affecting the SP Corps.

Key Factors

The CC and DCC positions are validated OTSG strategic positions, typically a 4-year and 2-year tour, respectively, and are available for any of the 65-series AOCs that make up the SP Corps. The positions are in the grade of O-6 (colonel) with no additional skill identifier requirement. Both positions are primarily nonclinical; however, 65D officers, when serving in this 65X position, must maintain their credentials and privileges through local military medical treatment facility policies and procedures. Members of all other 65-series AOCs are encouraged to maintain clinical currency when serving in these positions.

Lessons Learned and Tips for Success

For senior leaders in a 3-star general officer command and Department of Defense combat support activity, a weekly schedule consists of a number of meetings and internal SP Corps office battle rhythm events. Meetings can range from operational planning team efforts or strategic decision briefs on health care and organizational reforms, to command update briefs from TSG's staff and key senior leaders. Internal SP Corps office events include weekly updates to the CC from internal and external stakeholders and subject matter experts on issues affecting the SP Corps across the Army and joint force. Additionally, planning and executing the biannual SP Corps Strategic Advisory Board (SAB) is a primary focus of the DCC. The SAB provides the CC a week-long strategic workgroup to focus on medium and long-range priorities and goals of the corps in support of Army medicine and Army campaign

plans and strategies. For the DCC, there are a few opportunities for temporary duty travel throughout the year to participate in CC-sponsored events, or to represent the CC in their absence. The DCC is expected to participate in mentorship opportunities with SP Corps officers during the Basic Officer Leadership Course and Captains Career Course, as well as events in the national capital region including the Junior Leaders Course and the AMEDD Iron Majors Week. The DCC also serves as the senior leader mentor for SP Corps officers attending senior service education.

Conclusion

Future senior leaders interested in serving as the CC or DCC are encouraged, throughout their lifecycle model, to seek opportunities that diversify their resume. These career opportunities include, but are not limited to, opting in for command and professional military education; competing for the executive fellow of executive officer positions; applying to become a consultant to TSG; and applying for positions supporting the White House, HQDA, OTSG, DHA, or DoD.

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Chapter 41

ROLE OF THE PHYSICIAN ASSISTANT CONSULTANT AND ARMY MEDICAL SPECIALIST CORPS OFFICE

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Introduction

The Army Medical Specialist (SP) Corps office functions as the central coordinating body for all strategic initiatives and daily actions, requirements, and communications critical to the success of the SP Corps, one of the six corps that comprise the Army Medical Department (AMEDD). The SP Corps (active, reserve, and National Guard) consists of over 3,000 officers in four distinct professional specialties who serve throughout the world: occupational therapists, physical therapists, dietitians, and physician assistants (PAs).[1–3] On a daily basis, the SP office works closely with the corps chief, deputy corps chief, corps-specific branch proponency officer (CSBPO), four consultants to the surgeon general, and five reserve component individual mobilization augmentees. Frequently, the office coordinates with the US Army Medical Command (MEDCOM), Office of the Surgeon General (OTSG), Forces Command (FORSCOM), Human Resources Command (HRC), Defense Health Agency, and the AMEDD Personnel Proponent Directorate, Professional Education and Training Department, and Training and Doctrine Command (TRADOC) Capabilities Integration Manager.

Historically, within the SP Corps one individual executed the duties of assistant corps chief and consultant. At the SP Corps fall

2014 Strategy Advisory Board meeting, senior SP corps leadership decided to separate the two positions to allow for additional personnel to fill key and developmental leadership positions. By installing a PA branch/assistant corps chief (under US Code Title 10, Section 3070, authority[1,3]), and establishing a PA consultant to the Army surgeon general, this change aligned the SP Corps with the rest of the AMEDD. The resulting leadership structure allowed the chief of the PA section to focus on the profession's strategic aspects and its impacts on Army medicine, while the PA consultant concentrated on the PA community.

In 2018, however, the structure reverted to a sole PA consultant to cover the duties of both positions,[1,3] and the section of US Code was renumbered Title 10, Section 7070.[3] This change decreased the time the consultant has available to perform the vital functions of both consultant and chief of the PA section, as well as the duties of their assigned position, usually as a commander, deputy commander, or other senior AMEDD leader. For the purpose of this edition of the PA Handbook, the duties of the chief of the PA section and those of the PA consultant have been combined.

The Physician Assistant Consultant to the Surgeon General

The PA consultant is designated by the surgeon general under OTSG/MEDCOM Policy Memo 12-051,[4] *Appointment Process for Consultants to The Surgeon General*, and DA Pam 600-4.[5] The consultant serves at the pleasure of the surgeon general as the primary advisor on the PA profession, including issues related to deployment medicine, emergency medicine, orthopedics, general surgery, aerospace medicine, occupational health, and any future specializations developed to improve Army medicine and for the PA community. The duties include reaching out to PAs throughout the Army on these issues. The consultant coordinates with fellow consultants and senior leaders; works with HRC to manage talent; and serves as the subject matter expert on predeployment training, operational medicine, clinical operations, and command opportunities. The consultant is dual-hatted as the principal adviser to the SP corps chief on all matters concerning PAs. Thus, the consultant has two routes of communication to the surgeon general—directly as the consultant, and through the SP corps chief. The consultant

works with the corps chief to determine resource requirements for the delivery of health care and wellness programs involving PAs, including funding, materiel, equipment, and facilities. To assist the corps chief in planning, directing, and supervising health services for the Army, the PA consultant initiates and reviews recommendations on doctrinal, legislative, and regulatory proposals affecting the PAs.

The consultant works with HRC on the Human Capital Distribution Plan, the process employed to estimate the projected strength of each AMEDD area of concentration (AOC) at the end of the fiscal year. Because shortages may occur within specific subspecialties, the consultant, in coordination with HRC, prioritizes staffing of PA authorizations to optimize distribution based on readiness factors, training requirements, beneficiary population, demand for care, unit productivity, and economic factors. Additionally, the PA consultant coordinates with the AMEDD Personnel Proponency Directorate to develop future authorizations. When operating, generating, or institutional organizations identify an emerging requirement or developmental opportunity and request a directed military overstrength (DMO) position, the PA consultant is makes the recommendation, and decision authority resides with Headquarters, Department of the Army, Deputy Chief of Staff, G-3/5/7.

The Army and Army medicine must continually adapt to external changes. To help meet changing Army medicine demands, the PA consultant works with the corps chief and the TRADOC Capability Integration Manager on future combat medicine doctrine, and with the Professional Education and Training Department on entry-level and postgraduate PA education.[6] To meet the demands of a ready, deployable medical force, the PA consultant coordinates with the FORSCOM Surgeon's Office and the MEDCOM allied health officer to fill deployment requests for PAs.

The consultant assists with the lifecycle management of Army PAs, including liaising with USAREC on recruitment and accessions of civilian-trained PAs who wish to enter the Army; consults with the Interservice Physician Assistant Program (IPAP) manager; and serves as the IPAP waiver approval authority for the PA section. As part of the SP Corps talent management process, the PA consultant works with the HRC SP Branch chief and the CSBPO to nominate PAs to serve on long-term civilian training boards, promotion boards, resident integrated learning environments, senior service college boards, and active

duty accession boards. The consultant helps identify fully qualified officers for future key, developmental, and broadening assignments in the HRC marketplace and nominative processes. In support of training and professional development, the consultant also coordinates MEDCoE professional postgraduate short courses and long-term health education and training programs, and reviews, approves, and makes recommendations for validated requirements for PA graduate education. To synchronize PA interests across the Total Force (active Army, Army Reserve, National Guard, and retired rolls), the consultant interacts with the PA reserve chief and National Guard chief on matters affecting the SP Corps and training and doctrine issues.

As the primary communicator to PAs in the Army, the PA consultant is the lead agent for the quarterly 65D Worldwide Forum, which delivers information about the PA profession, the SP Corps, and Army medicine. This online venue helps disseminate the vision, mission, and priorities of the surgeon general and the SP Corps chief; the best business practices of PAs across deployed and garrison environments; and results generated by the PA strategic committees. The PA consultant promotes participation in professional conferences, training symposiums, and professional affiliations to advance the PA profession.

As one of four consultants within the SP Corps, the PA consultant is an integral part of the SP Corps Strategy Advisory Board, responsible for projecting and strategic planning for future utilization of the all SP Corps officers, including PAs. The PA consultant serves as liaison with government, civilian, and international health care organizations, professional societies, educational institutions, and legislative bodies on matters relevant to the Army PA profession.

As the senior subject matter expert, the PA consultant assists with credentialing and privileging issues and other concerns of PAs within Army medicine. The PA consultant also serves as the central point of contact for the Army Medical Department Quality and Safety Center's Risk Management Division for PAs identified in serious risk management cases. These PAs may be referred to a peer review panel that may result in a recommendation to the surgeon general to report the PA to the national practitioner database. Peer review panel members (usually three PAs with similar training and experience to the PA under review) are appointed by the PA consultant to serve on the panel. PAs under review may employ legal counsel, and are afforded due process and the opportunity to appeal panel and board decisions.

The PA consultant is the primary liaison between the SP Corps and the enlisted combat medic community to ensure that initial and sustainment training meets the needs of the Army. In this position, the PA consultant works to ensure that PAs are involved in leadership, instruction, education, and training, and recertification requirements of combat medics.

When dealing with military personnel, the PA consultant assists other senior PA leaders with mentorship of all PAs (military and civilian) in tactical, garrison, and hospital environments. This mentorship may consist of local town halls, journal clubs, and virtual desk-side sessions, ensuring accountability and appropriate officer professional development. To recognize outstanding performance, the PA consultant participates in the SP Corps awards program and the surgeon general's PA of the Year award process. The PA consultant and their deputies track award submissions, such as the Order of Military Medical Merit[7] and the AMEDD "A" proficiency designator.[8] The consultant contributes to the SP Corps annual historical report to document PA achievements.

Physician Assistant Consultant's Cabinet and Committee Structure

To manage the heavy workload of promoting the Army PA profession and managing the daily work as a steward of the Army PA profession, the PA consultant has a cabinet consisting of a distributed network of senior PAs who serve as deputy consultants and strategic committee members. The cabinet advocates for more than 2,550 PAs of all components who serve the Army and military health system. The cabinet has a committee structure to streamline information flow and spread tasks to subject matter experts throughout the Army PA force, consisting of the following:

- **Senior Executive Committee**. Composed of selected colonels and their deputies, acts as the board of directors, receives and reviews the work of other committees and coordinates strategic action. The consultant is chair.
- **Committee on Recruitment and Retention**. Includes leads from Human Resources Command, Recruiting Command, Forces Command, the Medical Center of Excellence (MEDCoE), and corps and division leadership. Focus is on junior officer outreach and

mentorship, PA recognition (awards), career and talent management, bonuses, and other recruitment and retention tools.

- **Committee on Professional Policy and Modernization**. Concentrates on regulatory policy and guidance, synergizing medical organization initiatives for modified table of organization and Equipment (MTOE) changes, personnel and equipment, Defense Health Agency transformation, and privileges and credentials.
- **Committee on Combat Medicine and Medical Readiness/ Sustainment**. Applies to individual critical task lists, the postprofessional short course program, 5-year long-term health education and training plans, continuing medical education, and force generation management.

This structure provides a systematic avenue to refer routine issues to the consultant level, provides a broad-based approach to problem-solving, and elicits multigenerational input to shaping the Army PA strategic plan.

Corps Office Personnel and Staffing

The SP Corps Office has two separate and geographically distinct locations: the primary office, or current operations cell, is located at the MEDCoE, Joint Base San Antonio-Fort Sam Houston, Texas. The secondary (forward) office, or strategic operations cell, is located at the Defense Health Headquarters, in Falls Church, Virginia. Together these two operational cells form the "brain trust" of the SP Corps Office and collaborate routinely to synchronize efforts in support of the SP Corps chief. The SP Corps Office staff consists entirely of AOC-immaterial, nominative positions (coded as 65X, available by open competition to all SP officers). HRC works through the SP Corps Office to announce openings for the positions, and candidates are interviewed by the entire Corps Office staff. The SP Corps chief is the approving authority for the positions.

Positions in the Corps Office are broadening assignments that are crucial to further professional development and talent management of the corps' future leadership. Prerequisites common to all positions include superior interpersonal skills, excellent writing and speaking skills, a robust knowledge of data systems, and good typing and computer skills. Additionally, the appropriate level of staff or command experience, and the commensurate military education level for the

officer's rank, are strongly considered. Officers previously selected as an Iron Major or recipients of the Award of Excellence are ideal candidates. SP Corps Office positions are detailed below.

Corps Chief

The SP Corps chief is a colonel appointed by the secretary of the Army who serves as chief executive officer of the corps. Duty locations vary. As a US Code Title 10 responsibility, the SP Corps chief advises the Army surgeon general on all activities pertaining to Army dietitians, physical therapists, occupational therapists, and PAs. They are specifically responsible for the professional development, talent management, and career lifecycle needs of SP Corps officers in both the active and reserve components, while routinely interfacing with the surgeon general and the deputy surgeon general on all issues impacting the SP Corps. The corps chief develops the SP mission, vision, and strategy that not only orient the direction of the SP Corps but also optimize the health, readiness, and resilience of soldiers and their families. They serve as chairperson of both the Corps Executive Committee and the Strategic Advisory Board, acts as subject matter expert on force management and structure of the SP Corps, and provides leadership and guidance to the four AOC chiefs or assistant corps chiefs and four consultants to the surgeon general. The corps chief champions opportunities for all SP officers and their respective skills that add value to Army medicine.

Deputy Corps Chief

The deputy corps chief, a colonel assigned to OTSG, serves as the corps chief's director of strategic initiatives and senior executive for strategy and future operations. They facilitate a team-centric environment through collaboration with various working groups, integrating strategic initiatives of the SP Corps with Army medicine's corporate strategy within the framework of the balanced scorecard. The balanced scorecard depicts how SP Corps contributions are nested within the overall strategic mission of the AMEDD, MEDCOM, and the Army surgeon general. The deputy serves as the corps chief's principal at OTSG, personally representing the corps chief at the OTSG and at key Army medicine meetings in support of SP Corps-specific policies. They facilitate, develop, and lead high-performing

teams within the corps and fosters key senior leader relationships across multiple executive levels of the AMEDD and Army medicine as a whole.

Corps-Specific Branch Proponency Officer

A colonel based at MEDCoE, the CSBPO serves as the principal executive staff officer to the SP Corps chief for current operations, including policies, procedures, and matters pertaining to all active and reserve SP Corps officers. The CSBPO is responsible for all SP Corps training and education (four entry-level graduate programs, long-term health education and training opportunities, and multiple postprofessional short-course programs). They develop, integrate, and coordinate initiatives involving SP officers' lifecycle and development, including promotion, accession, retention, and separation. The CSBPO routinely collaborates with representatives from HRC and the USAREC to develop strategies to maximize SP Corps recruiting and retention goals, and frequently collaborates closely with fellow senior AMEDD CSBPOs on issues affecting individual and collective AMEDD corps.

Executive Officer

A major assigned to MEDCoE, the executive officer (XO) to the corps chief serves as the primary action officer of the corps chief's strategic vision while synchronizing all executive functions of the SP Corps Office. The XO is a key enabler ensuring unity of action for the corps. They assist strategic leaders with aligning resources to support strategic plans, vital initiatives, and daily activities. As the conduit of information flow to the field, the XO uses various communication platforms to routinely deliver critical messages to all SP officers in both active and reserve components. They provide critical oversight on key SP Corps projects, awards, advisory boards, newsletters, national conferences, worldwide video or teleconferences, websites, and the entire SP Corps operating and travel budgets. This unique and broadening opportunity for field grade officers prepares them for future professional staff positions.

Executive Fellow

A captain based at MEDCoE, the executive fellow to the corps chief serves on a 1-year internship in direct support of the XO and all

activities crucial to the success of the SP Corps. The fellow conducts planning, coordinating, and executing of SP activities within the MEDCoE, MEDCOM, Fort Sam Houston, and other commands throughout the Army. They are directly responsible for facilitating the SP Corps Branch Day for both the Basic Officer Leader Course and the Captains Career Course; preparing official correspondence and presentations for the corps chief; managing the SP Corps education and research committees; conducting the SP Corps Special Recognition/ Retirement Program; and editing the *Corps Connection* newsletter. This unique and broadening opportunity for company grade officers prepares them for future leadership demands and helps them develop executive level skills.

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Chapter 42

ROLE OF THE CORPS SENIOR PHYSICIAN ASSISTANT

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Introduction

The corps is the deployable element of the US Army Forces Command. It is responsible for synchronizing forces for the execution of wartime missions and peacetime contingency operations. Commanded by a lieutenant general (the corps commanding general [CG]), and supported by an extensive staff, the corps provides mission command and logistical support for (usually) four divisions. In addition to its wartime mission, the corps headquarters also provides the framework for joint-level multinational operations such as peacekeeping operations, disaster relief, and humanitarian missions.

There are currently four corps in the active duty component of the Army: I Corps, III Corps, V Corps, and XVIII Airborne Corps; all are headquartered within the continental United States. The Corps Surgeon Office, led by the corps surgeon (Medical Corps), is the special staff component of the corps headquarters. The corps surgeon is a colonel, responsible to the corps CG for health care policy, medical readiness, and special medical programs in support of the CG's initiatives. The corps surgeon is supported by medical operations (MEDOPS) and clinical operations (CLINOPS) sections.

Doctrinally and by the modified table of organization and equipment, the corps senior MEDOPS officer is a colonel, and the CLINOPS senior officer is a lieutenant colonel. The corps senior physician assistant (PA) is the CLINOPS officer in the III Corps; in the XVIII Airborne and I Corps, the corps PA is formally referred to as the deputy surgeon for

CLINOPS. The CLINOPS deputy is the principal advisor to the corps surgeon for health policy and medical readiness of soldiers assigned to the corps' direct reporting units. The terms "deputy surgeon for CLINOPS," "CLINOPS deputy," and "corps senior PA" are used interchangeably, although the position is most commonly known, and referred to, as simply the "corps PA."

Although the corps PA is involved in the entirety of daily operations in the Corps Surgeon Office, major facets of their responsibilities are health care policy, medical readiness, and oversight of the installation Medical Simulation Training Center (MSTC). MSTCs have the capability to provide training and testing for annual medic training requirements, and can also be used in training other medical units and first responders for courses such as Tactical Combat Casualty Care, Basic Lifesaver, and Advanced Life Saver. Health care policy, medical readiness, and medical training encompass all activities that prepare soldiers for wartime missions and peacetime operations. Additionally, it is CLINOPS's responsibility to advise the corps surgeon and the CG to facilitate a safe, healthy, and productive environment for soldiers and their families in garrison.

Health Care Policy

Military health care policy deals with issues across the spectrum of health care, from preventive medicine and primary care through rehabilitative care. Initiatives include immunizations, access to care, and access to subspecialty care when such care is not available on the military installation, as well as force readiness for military deployment. The corps senior PA reviews health care policies that affect the wellbeing of soldiers and their families.

Immunizations

Preventive medicine efforts are managed by the corps force health protection (FHP) officer, who is either the corps PA, a Medical Corps preventive medicine officer (60C), or a Medical Service Corps environmental science officer (72D). Duties of the FHP officer include reviewing immunization policies for soldiers, military family members, and students who attend Department of Defense education activity schools. The corps PA, through liaison with the combatant command surgeon offices (Central Command, Pacific Command, etc),

is responsible for producing directives for FHP requirements unique to the missions, such as deployment-related immunizations, to prevent an outbreak in the community or deployed environment that could impact readiness.

The corps senior PA is the corps surgeon's liaison to the Defense Health Agency–Immunizations Healthcare Branch (DHA-IHB). Usually, a DHA-IHB representative (usually a physician trained in allergies and immunology) is located on larger military installations. On installations not supported by an allergy/immunology clinic, the installation preventive medicine clinic usually interacts with DHA-IHB. The corps PA interacts closely with the allergy/immunology clinic or DHA-IHB, the corps preventive medicine or FHP officer, and installation military medical treatment facility (MTF) preventive medicine staff. The district and regional public health command is another valuable resource for community and individual preventive medicine guidance and assistance.

Access to Care

The corps senior PA is responsible to the corps surgeon and CG for health care resource allocation for military units and military families. They interact with the local military MTF to coordinate adequate facility and staffing resources, as well as access to care for soldiers at Soldier-Centered Medical Homes (SCMHs) and dental activities. Furthermore, CLINOPS advocates for military family members at their Patient-Centered Medical Homes (PCMHs). Typically, SCMHs are located on the military installation, whereas PCMHs may be located either on the installation or off post, within the local community. A centralized installation medical care plan may be agreed upon in a memorandum of understanding between the corps CG and the MTF commander or regional health command with the goals of improving access to care for soldiers and family members, maintaining and improving provider professional and technical skills, improving the overall medical readiness of the supported troop population, and ensuring medical support for the current Army force generation cycle.

Subspecialty Care

When MTFs, SCMHs, or PCMHs lack adequate subspecialty care, the MTF commander is responsible for coordinating adequate

subspecialty care within the local community. The corps senior PA serves as patient advocate, ensuring that sufficient subspecialty care appointments are available and provided in a timely manner, per current Department of Defense access-to-care standards. For installations within the corps footprint, the division or brigade medical teams provide this service.

Quality Management

As the deputy for CLINOPS, the corps PA may participate in various MTF committee meetings, such as the risk management committee, credentials committee, and medical staff executive committee. Ideally the corps will have a voting seat on these committees to provide input from the operational medical force and track credentials for operational providers.

Medical Readiness

The most important responsibility of the CLINOPS staff is the medical readiness of the corps fighting force. Readiness involves preparing soldiers to deploy in support of a projected military operation or in response to a no-notice military deployment. Additionally, coordinating training for first responders, mid-level providers, physicians, and medical units to perform their assigned roles during combat, peacekeeping, or humanitarian operations falls under CLINOPS's purview.

For preplanned military deployments, time is allotted before a unit departs its home station to complete requisite training, screening, and immunizations. Perhaps not so obvious is the requirement to maintain a healthy, postured force in the event of a no-notice deployment. On installations that maintain a Soldier Readiness Center, the corps senior PA interacts with the center to ensure soldiers and units are prepared for deployment.[1,2]

During soldier readiness processing (SRP), soldiers' medical, legal, and financial documents are updated. Changes, additions, or updates to financial or legal documents are typically accomplished as necessary, on-site. Soldiers' medical records are reviewed for completeness and currency. Records are screened for vaccination history; hearing and vision screening; exacerbation of preexisting medical, psychiatric, or psychological conditions; medication changes; limitations to military duties; and other behavioral indicators.

Medical issues identified during SRP occasionally require follow-up appointments or intervention, but there is little time for such follow-up appointments during preparations for a no-notice deployment. The SRP must be comprehensive, efficient, and conducted with regularity for the Army's rapid-deployment forces. The corps senior PA is the principal advocate for the CG in ensuring that the medical portion of SRP is executed in an effective manner. Additionally, the corps senior PA assists and supports battalion, brigade, and division surgeons on behalf of concerned brigade commanders in submitting medical waivers for soldiers who fail to meet medical requirements. Medical waivers are discussed (usually by teleconference) with the combatant command surgeon for consideration on a case-by-case basis.[3]

Mentorship

The corps PA is often the most senior PA on the installation, and the majority of PAs on the installation work within subordinate units; this situation positions the corps PA to be a senior mentor for junior PAs. In this role, the corps PA provides on-going mentorship to junior PAs and works with Human Resources Command to manage talent across the installation.

Required Training and Education

- Graduate of Intermediate Level Education (ILE).
- Experience with operational medicine at the battalion, brigade, and division levels.
- Rank of lieutenant colonel or major (promotable).
- Army Training Requirements and Resources System (ATRRS) courses suggested include:
  - Brigade Surgeon Course
  - Division Surgeon Course
  - Army Medical Department Executive Skills Course
  - Joint Medical Executive Skills Institute Healthcare Management Course
  - Emergency War Surgery

Desired Skills and Attributes

Corps PAs must be deployable (medical readiness classification 1, 2, or 3) and maintain all military requirements; optimally, corps PAs should also possess the following skills and attributes:

- Interpersonal skills, including coaching, mentoring, and teaching for battalion, brigade, and division PAs who may serve on profile review boards[4] and participate in staff assistance visits (usually to separate brigades).
- Ability to function in collaborative, interdisciplinary, interagency teams, such as installation influenza campaign reviews, warrior transition boards, and separation implementation teams for active duty, reserve, and National Guard units.
- Professional knowledge and emotional maturity. The PA must be able to communicate laterally and vertically with the Human Resources Command, Medical Command, and other elements regarding PA installation strength management and other readiness issues.
- Leadership ability in supporting operational medicine concerns including various health service support working groups.

Lessons Learned and Tips for Success

The role of the corps PA as a liaison between the operational force and the MTF is crucial. This role will likely be even more important as MTFs transition to the DHA. Corps PAs should develop a good working relationship with local MTF leadership. While the MSTC does not belong to the corps, having a close relationship between the corps surgeon's office and the MSTC is instrumental in a successful medical training[1] for the installation. The corps can assist with medical oversight, logistical support, and military leadership.

Conclusion

Most corps senior PAs represent the education and experience of a prior enlisted soldier and a noncommissioned officer. Additionally, the corps PA has ideally navigated the officer ranks and positions of battalion, brigade, and division PA, and has attended the requisite training. With this experience, the corps senior PA is well positioned

to provide experience-based advice, counsel, and guidance to the corps surgeon and staff. Although principally engaged in the administrative medical duties and responsibilities of the corps, the corps senior PA is also well positioned to mentor junior PAs working at battalion, brigade, and division levels in both their administrative duties and clinical responsibilities.

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Chapter 43

ROLE OF THE PHYSICIAN ASSISTANT AS THE ARMY MEDICAL SPECIALIST CORPS PERSONNEL PROPONENCY OFFICER

Owen T. Hill, PA-C, MPAS, PhD, and Heather Sultemeier, MS

Introduction

The physician assistant (PA) filling the position as the Army Medical Specialist (SP) Corps personnel proponency officer (PPO), located at the Army Medical Department (AMEDD) Personnel Proponent Directorate (APPD), Medical Center of Excellence (MEDCoE), Joint Base San Antonio–Fort Sam Houston, Texas, holds a critical role for the SP Corps and the AMEDD. PAs are uniquely suited for the SP position given their vast experience in both table of organization and equipment (TO&E) and table of distribution and allowances (TDA) units at senior levels, in which they are required to work closely with and understand the responsibilities and requirements of all other SP professions. Also, PAs are adept in conducting analysis and research to inform AMEDD personnel initiatives. The briefs and papers the SP PPO prepares are heavily weighted as critical at AMEDD and Army senior leader decision points. The SP PPO's analysis undoubtedly shapes and influences the future of the AMEDD.

Unit Structure

The APPD is a directorate organic to the MEDCoE. At APPD, each AMEDD corps is represented by a PPO, filled at the lieutenant colonel or colonel rank. The SP PPO is rated by the APPD's director and senior-rated by the MEDCoE's deputy commanding general. APPD also assists in conducting analysis for other MEDCoE directorate initiatives, and

the SP PPO answers questions requiring analysis for units outside of its organic structure, such as the Office of the Surgeon General (OTSG), the US Army Recruiting Command (USAREC), and Army Human Resource Command (HRC).

Skills and Attributes

The SP PPO requires a self-starting, critical thinking officer who can build on existing relationships and negotiate and collaborate effectively with AMEDD leaders, while ensuring that personnel lifecycle management functions are integrated in all decisions and changes to doctrine, organization, training, materiel, leadership/education, personnel, facilities, and policy (DOTMLPF-P). The position requires prior leadership or senior staff experience and the following attributes:

- knowledge of AMEDD and military medicine administrative functions across the TDA and TO&E;
- competence in the Microsoft Office Suite, especially Excel and PowerPoint;
- ability to prioritize;
- effective decision-making skills;
- ability to identify and mitigate adverse second- and third-order effects;
- knowledge of personnel database systems such as the Force Management System Web (FMSWEB), Medical Operational Data Systems (MODS), and Total Officer Personnel Management Information System (TOPMIS);
- general knowledge of statistical analysis;
- effective verbal and written communication skills, including the ability to produce cogent and persuasive written materials for diverse audiences; and
- ability to resolve and manage conflict.

Additionally, the SP PPO must have completed the following training:

- Organizational Research and Systems Analyst (ORSA) Military Applications Course,
- Force Management Orientation Course, and
- the “How The Army Runs” course.

Duties and Responsibilities

When APPD, other MEDCoE directorates, or outside units recommend changes to DOTMLPF-P, the SP PPO analyzes the recommendations from a personnel developer lens to ensure that personnel lifecycle management functions will survive the recommended change. During any recommended SP Corps change analysis, the SP PPO must understand and support eight personnel lifecycle management functions (Figure 43-1) as described in AR 600-3, *The Army Personnel Development System*.[1] Prior to making any recommendation, the SP PPO must carefully consider other subjects, including applicable laws and regulations (US Code Title 10 and 32)[2]; force structure authorizations (as determined by Total Army Analysis and the planning, programming,

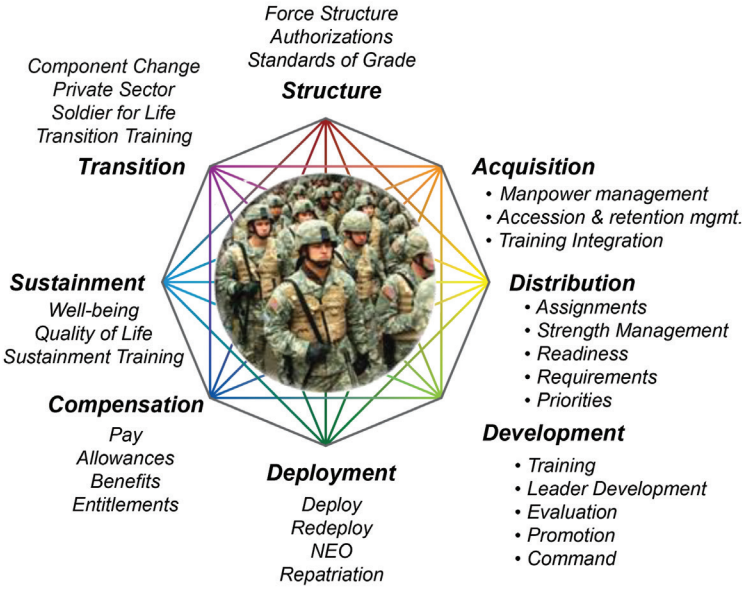


Figure 43-1. The personnel development system lifecycle management functions described in AR 600-3, *The Army Personnel Development System.* Graphic developed by the Army Force Management School, Ft Belvoir, VA.

budgeting and execution process); accession requirements (per AR 601-100, *Appointment of Commissioned and Warrant Officers in the Regular Army*)[3]; training requirements (as determined by the Army Program for Individual Training with input from the Structure and Manning Decision Review; AR 350-1, *Army Training and Leader Development*[4]; and AR 351-3, *Professional Education and Training Programs of the Army Medical Department*)[5]; promotion and or manning requirements such as annual Army manning guidance and the surgeon general's annual manning guidance; specific SP Corps guidance; and other initiatives or input from higher headquarters.

The SP PPO also has many "battle rhythm" requirements. The SP PPO works with in-house ORSAs to develop monthly SP Corps histograms, which are important and informative charts that give a snapshot of the current state of each SP Corps areas of concentration (AOC), including promotion year groups and personnel strength. These factors are compared to Title 10 personnel requirements and displayed graphically to visually inform personnel shortages or overages at certain ranks. Another SP PPO responsibility is preparing promotion board requirement recommendations for all SP Corps promotion boards, which may include histograms and Title 10 promotion limits. The SP PPO briefs these recommendations to the SP Corps chief for a final decision to be included in promotion board memoranda of instruction.

Additionally, the SP PPO gathers and evaluates personnel and manpower data, identifies issues, develops initiatives, and recommends force structure changes utilizing force-modeling techniques. The SP PPO analyzes and predicts accession needs, training requirements, potential future promotion rates, and the impact of proposing staffing changes or initiatives. The SP PPO coordinates with Army Reserve and Army National Guard PPOs to ensure PPO consistency across the total AMEDD. The SP PPO maintains coordinating staff relationships with OTSG, Medical Command (MEDCOM), USAREC, HRC, and Department of the Army deputy chief of staff for personnel (DA G-1) proponents responsible for force structure and personnel policy changes.

Lessons Learned

A key lesson learned is to rapidly develop a keen understanding of the other AMEDD corps and their respective AOCs, as well as the other SP Corps AOCs (65A, 65B, 65C, and 65X [SP immaterial]). In

addition, the SP PPO should work closely with the SP corps-specific proponent officer and the SP corps representative assigned as the capability developers.

Tips for Success

Some key tips for success in excelling as the SP PPO are attending the Capability Developers Course and the "How the Army Runs" course before or upon assuming the SP PPO role. In addition, the SP PPO must develop a thorough understanding of Microsoft Office applications, including PowerPoint, Excel, and Access. The SP PPO must be confident with public speaking and consulting senior AMEDD leaders as required. Other important tips include adhering strictly to all battle rhythm analysis to meet the given suspense; working closely with the available ORSAs; remaining confident in the analysis but always checking and re-checking the work; and being an "honest broker" with the information (not "spinning" the analysis to meet an agenda).

Conclusion

The SP PPO is a fantastic career opportunity for the PA and provides a behind-the-scenes view of many aspects of the SP Corps and the 30-year career lifecycle. The SP PPO has an opportunity to work with the corps chief, deputy corps chief, and the different AOC consultants to influence the multitude of emerging AMEDD and Army-wide initiatives. The PA PPO holds the critical position of conducting analysis to provide senior leaders the information needed to inform decisions.

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Chapter 44

THE ARMY ACQUISITION CORPS: BASIC KNOWLEDGE FOR THE ARMY PHYSICIAN ASSISTANT

Amelia M. Duran-Stanton, PA-C, PhD, DSc, MPAS, AAC Member

Introduction

The clinical knowledge and expertise of Army physician assistants (PAs) add tremendous value to their service in the Army Acquisition Corps (AAC). Army PAs have the opportunity to earn credentials and become a member of the AAC. As an AAC member, an Army PA can also compete for AAC Centralized Selection List (CSL) positions. Current AAC opportunities for Army PAs are with the Army Medical Department Board (AMEDDB) at Joint Base San Antonio-Fort Sam Houston, Texas, and the US Army Research Institute of Environmental Medicine (USARIEM) in Natick, Massachusetts. This chapter will review basic information about the AAC, training for service in the corps, and systems used to manage the requirements.

The Acquisition Corps

In 2005, Department of Defense (DOD) Directive 5000.52 consolidated the separate DOD component acquisition corps into a single Defense Acquisition Corps (DAC).[1,2] However, each service still maintains its own separate corps for acquisition career management. The Army's corps consists of acquisition officers specialized in development, fielding, and support. In 2015, a memorandum of understanding (MOU)[2] was signed by the Army director of acquisition career management, the surgeon general, and the Army human resources commanding general about Army acquisition workforce management of medical officers in unique education and training specialties. The MOU addressed the unique Army medicine training and education requirements for highly

technical medical personnel with the additional skill identifier of 8X (acquisition management), to create a common understanding of their identification, certification, utilization, and management.[3]

The Defense Acquisition Workforce Education, Training, Experience, and Career Development Program, commonly called the "AWF program," establishes policies and procedures for the workforce.[4] The AWF program desk guide provides workforce procedures established by DOD Instruction 5000.66, *Defense Acquisition Workforce Education, Training, Experience, and Career Development Program*.[3] The US Army Acquisition Support Center provides oversight of the AWC. The US Army Director of Acquisition Career Management (DACM) Office provides more detailed information on the membership requirements for AAC membership (https://asc.army.mil/web/wp-content/uploads/2019/06/AAC-and-CAP-Tentative-Selectee-Waiver-Process.pdf).[4] Submissions are reviewed and approved by the Workforce Development and Engagement office.[4]



Figure 44-1. Colonel Roberto Marin, PA-C (center), the Medical Systems Branch chief, Army Medical Department Board, testing the capabilities of the Diesel canine simulator during the Health Readiness Center of Excellence Strategic Medical Simulation Synchronization Summit, Joint Base San Antonio, Texas, in May 2019.

The Army Medical Department Board

The AMEDDB is the test and evaluation activity of the Army Medical Department (Figure 44-1). It is responsible for testing all medical materiel, medical-related materiel, and medical information technology systems. AMEDDB's leadership and test officers are members of the AAC and are certified experts in their field (see Chapter 45 for the role of the Army PA as a member of the AMEDDBD). [5]

US Army Research Institute of Environmental Medicine

USARIEM officers, including the Army PA assigned at USARIEM, are required to meet acquisition skill identifiers in science and technology at a minimum. Training classes to earn these certifications are mostly online through the Defense Acquisition University (DAU; see below).

Managing Requirements

Requirements for an Army PA to be an AAC officer are based on experience, education, and duty. The DACM Office uses the Career Acquisition Management Portal (CAMP) for interactions between officers and supervisors (Figure 44-2). An AAC officer must identify a supervisor in CAMP, and the supervisor uses the system to approve individual development plans (IDPs), course attendance, and skill identifier requirements. AAC officers must have IDPs, which are used to plan, coordinate, and manage continuing education and training, covering a 5-year period. IDPs are used as a communication tool between personnel and their supervisors.

A CAMP application called the Career Acquisition Personnel and Position Management Information System (CAPPMIS) is used to manage career requirements of AAC personnel. Army PAs may also be assigned as a supervisor of employees with acquisition requirements. There are separate requirements for serving as supervisor of these personnel; instructions are available in CAMP.

Acquisition officers complete and maintain online training requirements through the DAU (Figure 44-3). The DAU website also provides resources, guidebooks, and catalogs on acquisition career field requirements.



Figure 44-2. The Career Acquisition Management portal.

Tips for Success

These tips will enable future AAC officers to succeed:

- AAC officers must ensure officer record brief (ORB) and officer evaluation reports (OERs) include duties related to acquisition.
- They must document and plan for all required courses in advance.
- They must communicate with mentors and career managers on AAC membership with potential to compete for command CSL positions, if desired.
- They should discuss the requirements to meet and maintain AAC membership with their chain of command.
- They need to update and review their IDP with their chain of command.

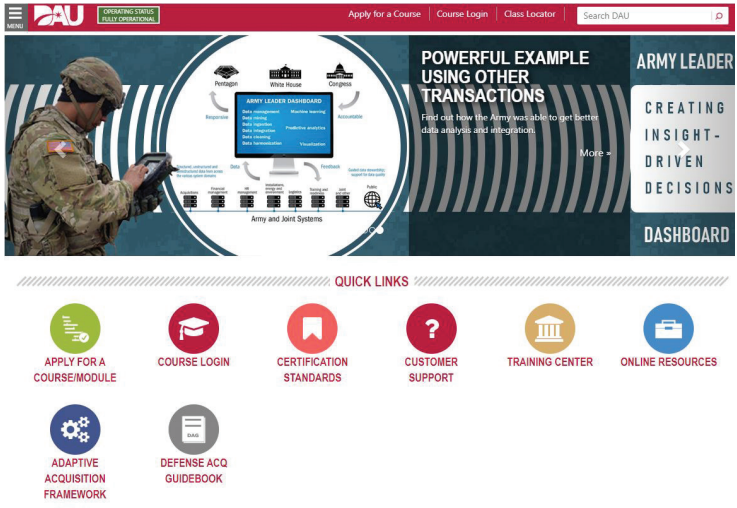


Figure 44-3. The Defense Acquisition University website.

Conclusion

Army PAs with their clinical and leadership acumen can gain opportunities to learn new skill sets based on the requirements for AAC membership. PAs in these positions should become familiar with the AAC's web portals and other tools for training and sustaining their membership as required. PAs can also maintain their training even when not in an acquisition position.

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Chapter 45

ROLE OF THE PHYSICIAN ASSISTANT ON THE US ARMY MEDICAL DEPARTMENT BOARD

Roberto E. Marin, PA-C, DHSc, DMSc, MPAS, MPH

Introduction

The US Army Medical Department Board (AMEDDBD) has a unique mission to support the surgeon general's Title 10 US Code authority to perform the duties of an independent operational tester, through the commanding general of the Army Medical Center of Excellence (MEDCoE), the Training and Doctrine Command, and the Department of Defense acquisition process. The AMEDDBD is the only Army directorate to perform the duties of an operational tester and evaluator for medical materiel systems, including medical command, control, communications, and computers/information technology (C4/IT) systems for the Medical Department.[1] The AMEDDBD provides nonbiased, independent operational testing and evaluation (OT&E) of medical and medical-related materiel and information technology products in support of readiness. It assesses emerging concepts, doctrine, and advanced technology applied to the delivery of health care—both on the battlefield and in fixed US facilities (Figure 45-1).

The AMEDDBD operational testers' main customer is the US Army Medical Materiel Development Activity (USAMMDA), a subordinate command of the Medical Research and Development Command (MRDC). USAMMDA has responsibility for medical research, development, and acquisition and coordinates testing of all nondevelopmental medical systems, items, and medical assemblages through program managers who work with the AMEDDBD. After AMEDDBD has completed the testing and evaluation, USAMMDA decides whether or not to field combat medical systems and products for the US armed forces. USAMMDA, the materiel developer, along with



Figure 45-1. The US Army Medical Department Board (AMEDDBD) logo. The AMEDDBD was established in 1963 and adopted this logo in 1982.

the AMEDDBD, the independent tester, work in collaboration with the MEDCoE Capability Development Integration Directorate, the combat developer. These three organizations interface to close capability gaps.

The AMEDDBD is chaired by a president and has two branches: Materiel Systems OT&E and Information Management/Information Technology OT&E. Only two physician assistants (PAs) have been consecutively assigned to the AMEDDBD as chiefs of the Materiel Systems OT&E Branch. Out of 15,168 AMEDD officers, only one PA officer holds this OT&E position. The position is now an O5A (all AMEDD, branch-immaterial officer) long-term health education and training (LTHET) internship.[2]

Background

Testing and evaluation is noted in Army Regulation 73-1,[1] Department of Defense Instruction 5000.66,[3] and the Defense Acquisition

Guidebook[4] as a major element of the acquisition process that provides state-of-the-art medical and medical-related devices required to accomplish contingency missions. Formed in 1963 as part of MRDC, the AMEDDBD was originally called the Medical Field Service School (Laboratory Sciences Division).[5] On October 1, 1964, the US Army Medical Service Test and Evaluation Activity was activated under the jurisdiction of the surgeon general and assigned to the Brooke Army Medical Center. Four years later, the name was changed to the US Army Medical Department Test and Evaluation Activity, through General Order No. 52, October 15, 1968.[5] Subsequent organizational realignments and name changes occurred, including Medical Equipment Test and Evaluation Division (1971–1973); Directorate of Medical Equipment Test and Evaluation (1978–1982); and finally US Army Medical Department Board (1982–present).

Army Medical Department Board Functions

The AMEDDBD is fully engaged in contributing to the Army's multi-domain operations and its capabilities requirements. It conducts independent, realistic, and objective OT&E and assessment of enhanced medical equipment, performed by a cadre of seasoned military and civilian experts. Numerous key instructions, directives, pamphlets, and regulations govern AMEDDBD OT&E in the acquisition process (Figure 45-2).[1,6–16] The AMEDDBD executes the following functions:

- performing medical OT&E;
- providing consultants, subject matter experts, and test players (medical personnel end users) to carry out the test planning, execution, and reporting;
- providing representation to OT&E forums as required;
- participating in the Test Schedule and Review Committee, a semi-annual process for addressing test requirements; and
- performing system evaluation for assigned systems in accordance with US Army Test and Evaluation Command policies and procedures.[1]

All customer-requested OT&E requirements that pertain to specific system acquisition, regardless of acquisition category (ACAT), must be incorporated into the AMEDDBD test plan. Most AMEDDBD OT&E

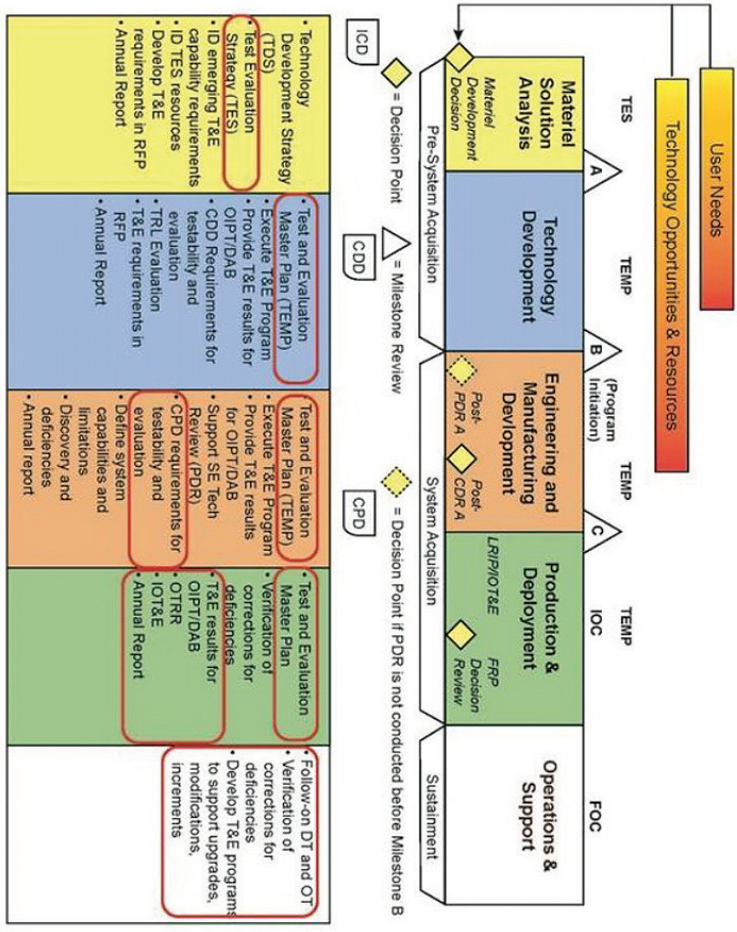
Figure 45-2 (*right*). As an independent test agency, the Army Medical Department Board can assist materiel developers at different milestones through operational testing and evaluation in the acquisition process.
CDD: capabilities development document; CDR: critical design review; CPD: capabilities production document; DAB: Defense Acquisition Board; DT: developmental test; FOC: full operational capability; FRP: full-rate production; ICD: initial capabilities document; IOC: initial operational capability; IOT&E: initial operational test and evaluation; LRIP: low-rate initial production; OIPT: overarching integrated product team; OT: operational test; OTRR: operational test readiness review; PDR: preliminary design review; RFP: request for proposal; SE: systems engineering; TEMP: test and evaluation master plan; TES: test evaluation strategy; TRL: technology readiness level

is for ACAT III, commercial off-the-shelf medical equipment. OT&E is warranted for this equipment to ensure operational suitability and effectiveness. After performing OT&E, AMEDDBD must submit a publishable operational test report and supporting data to the Defense Technical Information Center (DTIC).

Duties and Responsibilities

As chief of the Materiel Systems OT&E Branch, the AMEDDBD PA is Army medicine's only materiel test and evaluation branch chief and the senior proponent tester of medical materiel solutions and equipment developed in support of readiness. The AMEDDBD PA is a strategic PA leader who contributes to OT&E as a medical subject matter expert. The PA must be skilled in Tactical Combat Casualty Care and experienced in operational efforts. They must maintain deployability and credentials in support of contingency and support operations. The AMEDDBD PA has the following duties:

- directs, plans, coordinates, and oversees all materiel OT&E activities within Army medicine;
- provides technical guidance to 25 soldiers, Army civilians, and contractors;
- serves as test planner, analyst, and evaluator for medical materiel solutions and equipment developed through the acquisition process;
- reviews and edits documentation, plans, and reports of nonbiased OT&E; and



- serves as a PA specialty consultant (in orthopedics, emergency medicine, or occupational health) or a family medicine PA, as well as a subject matter expert for Army and Defense Health Agency initiatives.

Requirements

Requirements for serving as the chief of the Materiel Systems OT&E Branch are as follows:

- Role 1 to Role 3 deployment experience;
- rank of major (promotable) or lieutenant colonel;
- graduate of the Command and General Staff College; and
- maintenance of PA credentials, privileges, fitness, and deployability.

Knowledge, Skills, and Attributes

Future chiefs should maintain all military requirements and have the following skills and attributes:

- promotion potential for future service in broadening and operational assignments;
- professional knowledge and emotional maturity;
- critical thinking skills;
- skill with people, including coaching and teaching;
- ability to both function on a collaborative team and work independently;
- leadership ability in promoting the PA specialty;
- motivation to work with Forces Command and Training and Doctrine Command stakeholders; and
- effective communication skills, both laterally and vertically.

Significant Contributions

The Materiel Systems OT&E Branch chief and team have made numerous contributions in support of readiness by providing enhanced medical and medical-related materiel to both fixed facilities and the battlefield. Because AMEDDBD's OT&E encompasses testing from the point of injury to Role 3, realistic conditions, including stress and heightened operational tempo, are required during the process. Items are assessed against valid and current requirements.

Customers and partners for materiel systems testing include MRDC; USAMMDA; US Army Medical Materiel Agency (USAMMA); Joint Program Executive Office (JPEO) for Simulation, Training

and Instrumentation; JPEO for Chemical, Biological, Radiological, and Nuclear Defense; US Army Operational Test Command; US Navy Operational Test and Evaluation Force; US Air Force Medical Evaluation Support Activity; and US Marine Corps Operational Test and Evaluation Activity. In the last 3 years, these collaborations have resulted in numerous project event design and operational test reports submitted to DTIC, as listed in Table 45-1. Figures 45-3 through 45-8 show scenes from these tests.

Lessons Learned

The following are lessons learned to help the PA be successful as chief of the Materiel Systems OT&E Branch. The PA should:

- be prepared to brief at the brigade O-6 (colonel) level;
- be up to date with all key documents from the staff and article delivery dates;



Figure 45-3. A Fort Bragg paratrooper medic (a test event player) from the 82nd Airborne Division uses a Traumatic Brain Injury at Point of Injury (TBI-POI) device to scan a fellow paratrooper during a 2018 test event, while a test officer (not shown) annotates observations.

Table 45-1. Army Medical Department Board collaboration projects, 2018–2020

- Automatic Chest Compression Device
- Bed Net System
- Defibrillator Pacemaker Physiological Monitor
- Nerve Agent Antidote Auto Injector
- Noise-Immune Stethoscope
- Pathogen Reduction Device
- Pneumatic Tourniquet
- Portable Digital Radiography System
- Sublingual Sufentanil Tablet
- Modified Rescue and Innovative Rescue Litters Phase I & II
- Portable Ophthalmic Microscope
- Modified 7309 and Quad-Fold Litters with Litter Straps
- Deployable Oxygen Generating System–Small
- Laboratory Assay for Traumatic Brain Injury and iSTAT (2 biomarkers)
- Tent, Extendable, Modular, Personnel (TEMPER) Air-Supported Shelter (TAS)
- Traumatic Brain Injury at Point of Injury Device
- Medical Simulation Manikin
- Freeze Dried Plasma
- Atropine Auto-Injector
- Chemical Biological Defense Auto Injector Device
- Delivery of Nucleic Acid Vaccines
- Field Hospital Suction Apparatus
- Intrathoracic Pressure Regulation Therapy
- iDirectDoc Ruggedized-Mobile Telekit
- Medical Hand-free Unified Broadcast (MEDHUB) Device
- Rigid Immobilization System for Extremities (RISE)
- Individual First Aid Kit (IFAK) Generations I & II
- Whole Blood Pathogen Reduction Device
- Armored Multi-Purpose Vehicle
- Extracorporeal Life Support
- Point-of-Care Hand-Held COVID-19 Test Device
- Veterinary Ultrasound
- Human Ultrasound Field Portable

Data sources: (1) Prater S. Experimental flooring–Spartan medics test field hospital material. *Fort Carson Mountaineer* website. Published September 2, 2019. Accessed October 8, 2020. https://www.fortcarsonmountaineer.com/2019/09/experimental-flooring-spartan-medics-test-field-hospital-material (2) Crown E. Army operationally tests brain injury evaluation devices. US Army Medical Materiel Command website. Published September 10, 2019. Accessed October 8, 2020. https://www.usammda.army.mil/index.cfm/public_affairs/articles/2018/army_operationally_tests_brain_injury_evaluation_devices (3) Upgraded medical manikins enhance realistic, rugged training. Defense Visual Information Distribution Service website. September 10, 2019. Accessed October 8, 2020. https://www.dvidshub.net/image/5753167/upgraded-medical-mannequins-enhance-realistic-rugged-training (4) Micheliche B. Freeze dried plasma gets air dropped. Defense Visual Information Distribution Service website. Published September 23, 2019. Accessed October 8, 2020. https://www.dvidshub.net/news/343202/freeze-dried-plasma-gets-air-dropped (5) Rodriguez JE. U.S. Army Medical Department Board tests extracorporeal life support. US Army website. Published March 4, 2020. Accessed October 8, 2020. https://www.army.mil/article/233404/u_s_army_medical_department_board_tests_extracorporeal_life_support



Figure 45-4. During an August 2019 test event, several soldiers (test players) from Fort Carson's 10th Field Hospital were trained, participated in testing, and provided valuable feedback on the Tent, Extendable, Modular, Personnel (TEMPER) Air-Supported Shelter (TAS) Protective Insulated Flooring at Training Site 13. Photograph by AMEDDBD test team. For more information, see Prater S. Spartan medics test field hospital material. *Fort Carson Mountaineer.* Published August 30, 2019. https://www.fortcarsonmountaineer.com/wp-content/uploads/2019/08/Mountaineer_2019-08-30.pdf

- remember that safety is paramount during testing at the operational sites;
- ensure staff maintain continuing learning points, maintaining the T&E certification requirement, and update individual development plans for both the Army Career Tracker and T&E certification;[3]
- maintain positive customer relationships with internal and external stakeholders; and
- keep the AMEDDBD president up to date with upcoming projects, and any challenges or concerns.

Internship Key Facts

The new 12-month LTHET training and evaluation internship provides AMEDD officers with specialized testing and evaluation training and



Figure 45-5. Major Scott A. Kavan, a 65D physician assistant (provider test player) from the 82nd Airborne Division, 3rd Brigade Combat Team, screens a soldier for moderate-to-severe traumatic brain injury during a 2018 operational test event by the AMEDDBD. Photograph by AMEDDBD test team. For more information, see Crown E. Army operationally tests brain injury evaluation devices. US Army Medical Materiel Development Activity website. Published August 14, 2018. https://www.usammda.army.mil/index.cfm/public_affairs/articles/2018/army_operationally_tests_brain_injury_evaluation_devices

positions them as acquisition leaders, helping them to qualify for future command selection list (CSL) positions in the acquisition competitive category. It also enables them to provide relevant data to acquisition program managers aimed at ensuring sound programmatic decisions so that operational elements are properly equipped to meet the Army's contingency mission requirements.



Figure 45-6. Major Robert M. Levesque, a 65D physician assistant (provider test player) with the 3rd Brigade Support Battalion, 1st Armored Brigade Combat Team, 3rd Infantry Division, evaluates pupillary reaction on a simulated casualty for brain activity during a Medical Simulation Mannequin customer test for the recently upgraded mannequins, September 10, 2019, at Fort Stewart, Georgia. Medical Simulation Mannequins replicate the entirety of an adult human and reacts to injury and medical intervention as a live human would. US Army photo by Sergeant Arjenis Nunez/Released.
Reproduced from: https://www.dvidshub.net/image/5753167/upgraded-medical-mannequins-enhance-realistic-rugged-training

Completing the LTHET internship results in an 8X additional skill identifier (for highly technical medical personnel in acquisition management), establishing identification, certification, and utilization, thereby enabling the PA to be assigned to acquisition positions. The intern incurs in a utilization tour requirement and an active duty service obligation of 24 months. During the internship, students will receive hands-on practical experience in analysis, research, plan-writing, report-writing, oral briefings, policy development, and OT&E procedures.

The objective of the internship is to provide the AMEDD with a pool of officers that are fully qualified to fill AMEDD testing and evaluation assignments. There are only four AMEDD positions that require acquisition-certified officers; the chief of the Materiel Systems OT&E Branch is one of two requiring Defense Acquisition University



Figure 45-7. Specialist Yasmine Schmidt, of the 432nd Blood Support Detachment, 28th Combat Support Hospital, 44th Medical Brigade, reconstitutes the article under test, freeze-dried plasma (FDP), during the AMEDDBD's inject-into-the-units field training exercise, as an AMEDDBD test officer records observational data (September 19, 2019, Fort Bragg, NC). Photograph by Sergeant Brian Micheliche, 22nd Mobile Public Affairs Detachment.



Figure 45-8. During an international (Italian) operational test event for the Extracorporeal Life Support (ECLS) system, held February 18–20, 2020, at the Deployable Medical Systems Equipment for Training site, kidney and pulmonology provider teams are trained, test the system, and provide valuable end-user feedback on the system's functionality and usability. The system is being used in China, Italy, and other countries as an adjunct for COVID-19 patients. Photograph by AMEDDBD. For more information, see Rodriguez JE. US Army Medical Department Board tests extracorporeal life support. Joint Base San Antonio website. Published March 5, 2020. https://www.jbsa.mil/News/News/Article/2102241/us-army-medical-department-board-tests-extracorporeal-life-support/

(DAU) level III training and evaluation certification. The pool requires at least 12 officers to allow for other professional, operational, and developmental assignments.

Internship Requirements

Currently the internship is open to Medical Service Corps and Specialist Corps officers. There are no minimum Graduate Record Examination, Graduate Management Admission Test, or grade point average requirements. Interns are selected by the surgeon general 8X consultant and the AMEDDBD president. To qualify for the LTHET internship program, officers must:

- be a member of the active duty US armed forces serving in the rank of major (promotable) or lieutenant colonel, and be selected by the LTHET board[2];
- have a baccalaureate degree or higher from an accredited educational institution; and
- have completed 24 semester hours (or equivalent) from an accredited institution of higher education in the science, technology, engineering, or mathematics.

During the internship, the officer must attain DAU level I and II certification and complete the didactic course work with eventual level III certification and subsequent future Army Acquisition Corps (AAC) membership.[3,17]

Tips for Success

Along with lessons learned, the following tips for success will help AMEDBD PAs to succeed beyond expectations:

- When briefing the test team leads and test players (tasked to engage as end users), the PA should enforce safety, rules of engagement, and the importance of honest feedback (via surveys, after-action reviews, recommendations, etc) on the item being tested.
- The PA should always review, make recommendations, and discuss (if needed) the test plans and reports that are staffed up to the AMEDDBD president for DTIC submission.
- The PA should update their Officer Record Brief with DAU testing and evaluation certification level and AAC membership in the career acquisition management portal.

Conclusion

The AMEDDBD carries on the mission to provide independent OT&E of medical and medical-related materiel and information technology products in support of readiness for the warfighter. The AMEDDBD PA is a team member who assesses emerging concepts, doctrine, and advanced technology applications applied to the delivery of health care—both on the battlefield and in fixed facilities. The PA contributes

as a member of a diverse team in operationally testing equipment before it is fielded to ensure operational functionality and usability by the end user, in support of the primary customer, the warfighter, whether in the United States or deployed outside the country. The potential for such contributions, and the opportunity to compete for the coveted upcoming CSL acquisition competitive category, offer challenges to the LTHET selected intern PA who will begin in academic year 2021.

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Chapter 46

ROLE OF THE FORCES COMMAND PHYSICIAN ASSISTANT

Thomas A. Bryant, APA-C, MPAS

Introduction

Forces Command (FORSCOM) is the largest Army command, providing expeditionary, campaign-capable land forces to combatant commanders. Senior physician assistants (PAs) assigned to FORSCOM will contribute to shaping clinical operations and health care policies affecting training and health care of the military.

Background

Led by a four-star commander and headquartered at Fort Bragg, North Carolina (Figure 46-1), FORSCOM consists of more than 750,000 active Army, Army Reserve, and Army National Guard soldiers. For the Army of 2020, FORSCOM provides enhanced land power depth and versatility through fully integrated active and reserve component forces operating in a joint, interagency, intergovernmental, and multinational environment. FORSCOM organizations are expeditionary, campaign-focused, and tailored to operate effectively across the range of military operations in defense of the nation at home and abroad.[1]

FORSCOM trains, prepares, builds, and sustains readiness to meet combatant command requirements. The vision of FORSCOM is to have combat ready and globally responsive total Army forces that are well led, disciplined, trained, and expeditionary—ready now to deploy and win in a complex world.[1]

The FORSCOM headquarters has multiple G-staff (nomenclature for organizations commanded by generals) departments and directorates. The surgeon's directorate is led by the FORSCOM surgeon, a brigadier



Figure 46-1. The Forces Command Headquarters at Fort Bragg, North Carolina.

general, who may come from a variety of medical backgrounds (Figure 46-2). Figure 46-3 shows the structure of the surgeon's directorate. It consists of three divisions—clinical operations, medical operations, and operational medicine. The current chief of clinical operations is a colonel (O-6 grade) Army nurse and the deputy of clinical operations is also a colonel (O-6 grade) PA although slated as a lieutenant colonel (O-5 grade).

Due to the growing force structure of colonel PAs, Human Resources Command intends to keep a colonel PA assigned to the FORSCOM surgeon's directorate indefinitely. This PA's official title may vary depending on the need of the FORSCOM surgeon.

Roles and Responsibilities

Clinical Operations

The FORSCOM PA is intimately involved in all aspects of clinical operations affecting military medical policy and frequently interacts with members of the Office of the Surgeon General, members of the Pentagon, senior leaders at FORSCOM headquarters, senior medical



Figure 46-2. The Forces Command surgeon directorate under the leadership of Brigadier General Wendy Harter (summer 2018).

leaders in subordinately units, and other entities contributing to the military medical mission. Although maintaining clinical practice is expected and authorized on a part-time basis, providing necessary staff support to the FORSCOM surgeon is the PA's assigned primary mission.

FORSCOM PA duties and responsibilities may vary based upon rank and experience and the FORSCOM mission requirements of the surgeon's directorate during the PA's tenure. One example of an officer evaluation report support form follows:

> Senior Physician Assistant (PA) to the FORSCOM command surgeon on issues pertaining to force health promotion and readiness for over 770,000 active and reserve component soldiers. Serve as the deputy to the chief of clinical operations, addressing issues that affect the operational unit health care team and their ability to maintain readiness of the force. Provide mentorship to subordinate PAs and work closely with the PA

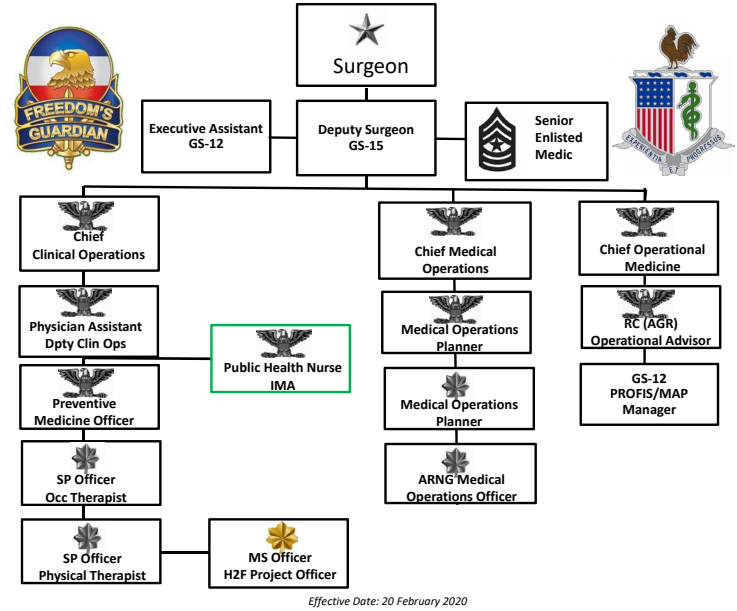


Figure 46-3. Current Forces Command surgeon directorate structure.
AGR: Active Guard Reserve; ARNG: Army National Guard; GS: general schedule; H2F: holistic health and fitness; IMA: individual mobilization augmentee; MAP: modified table of organization and equipment assigned personnel; MS: Medical Service Corps; PROFIS: professional filler system; RC: reserve component; SP: Medical Specialist Corps

consultant and the chief of the Army Medical Specialist Corps to improve policies and procedures that affect the readiness, personnel, training, logistics, and other issues that impact operational medicine in support of the FORSCOM mission.

This example can be used in conjunction with the preceding FORSCOM PA's support form to tailor a narrative that best fits the current duty circumstances.

Health Care Policy

Health care policy in the military deals with all issues across the spectrum of health care, from preventive medicine and primary care

through rehabilitative care. Current initiatives include transitioning health care delivery to the Defense Health Agency (DHA), organizing the modified table of organization and equipment (MTOE) assigned medical personnel, modernizing the total force, and having a medically ready force and ready medical force.[2,3]

The FORSCOM PA, in collaboration with other senior medical leaders at the Office of the Surgeon General and other senior military levels, influences needed changes in health care policies that impact all current initiatives. This ultimately affects soldiers on the battlefield and the care they and their families receive throughout the military health system (MHS).

Required Experience

To become a FORSCOM PA, the candidate must have:

- operational experience as a PA,
- staff experience at the brigade level or above,
- military supervisory experience with officers,
- clinical experience with the use of the Armed Forces Health Longitudinal Technology Application (AHLTA) and/or MHS Genesis, and
- familiarity with the Medical Operational Data System (MODS)/ Medical Protection System (MEDPROS) and Microsoft applications.

Desired Experience

The FORSCOM PA should:

- be familiar with the duties, training, and responsibilities of the combat medic;
- be a division- or corps-level PA;
- have had Special Operations assignments;
- have had combat deployment as a combat medic or PA;
- have been PA in a military medical treatment facility;
- have experience working with the Army National Guard and Army Reserve; and
- have experience working in the MHS or DHA.

Required Training and Certifications

The FORSCOM PA should be:

- currently certified by the National Commission on the Certification of Physician Assistants (NCCPA),
- eligible for privileging at the local military medical treatment facility (MTF), and
- an Intermediate Level Education graduate.

Desired Training

- Aeromedical PA graduate.
- Ranger school.
- Airborne school.
- Air assault school.
- Expert Field Medical Badge recipient.
- Senior Service College.

Required Skills and Attributes

FORSCOM PAs must meet all retention standards in accordance with Army Regulation 40-501, *Standards of Medical Fitness*. They must also possess the following:

- strong initiative,
- excellent communications skills in both written and spoken formats,
- comfort with public speaking and communicating with general officer (≥ O-7) staff,
- ability to work outside normal areas of expertise,
- ability to develop solutions to complex problems,
- willingness to present diverse and minority perspectives to senior officers and civilians,
- ability to rapidly expand knowledge in new areas,
- excellent organizational skills,
- ability to provide intent and delegate key tasks and functions to subordinates,
- ability to function independently with limited direct supervision, and

- knowledge of the Army Medical Department culture and organizations.

In addition to the above skills and attributes, the FORSCOM PA must have an understanding of military medicine and the business of health care from military MTFs and regional health commands to higher-level organizations such as the Office of the Surgeon General, Army Medical Command (MEDCOM), and DHA.

Lessons Learned

The FORSCOM PA position comes with many challenges. The following lessons learned may help prospective candidates integrate well within the organization:

- The FORSCOM PA is a valuable contributor to policies affecting medical training and health care of the military.
- Great relationships with colleagues and at the Office of the Surgeon General, MEDCOM, and DHA will make daily tasks easier.
- Most of the other G-staff do not understand how military medicine works.
- The FORSCOM surgeon may not be clinical.
- The deputy surgeon is not a clinician and is very dependent on the clinicians in the directorate.
- FORSCOM and US Army Reserve Command (USARC) do not have an organic PA for primary care on their manning document; Womack Army Medical Center (WAMC) provides that asset.

Tips for Success

Along with lessons learned, the following tips for success will enable the future FORSCOM PA to succeed beyond expectations and make the assignment easier to navigate:

- The PA should review the Senior Executive Service (SES) system in order to understand the civilian leadership structure of the command.
- The PA should also review all subordinate commands and direct reporting units in order to understand those supported by FORSCOM.
- The PA should stay abreast of all aspects of military medicine as

much as possible. Often, the PA will be asked to give updates on issues outside the realm of clinical medicine.
- The PA should build strong relationships throughout the command.
- The PA should ask the direct reporting units what challenges they have and how the FORSCOM surgeon's directorate can support them.
- The PA should never speak from a position of authority on the phone or email. They should always collaborate on issues and have external messages (outside the directorate) vetted through the deputy or the surgeon.
- The PA should advocate for valuable clinic hours and continuing medical education opportunities. Friday seems to be the slowest and most accommodating day for professional development.

Conclusion

Serving as the FORSCOM PA is a rewarding broadening experience and a great opportunity to grow personally and professionally within the Army health care enterprise. The FORSCOM surgeon's directorate is highly reliant on the experience the PA brings, as the person in the center of health care and readiness of the operational force. For those desiring to build and expand their career opportunities, influence initiatives that impact soldiers and families, and improve their chances of upward mobility, serving with the FORSCOM staff is sure to be a career-enhancing and life-changing experience.

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Chapter 47

ROLE OF THE COMMAND SURGEON AT THE INSTALLATION MANAGEMENT COMMAND

Pauline V. Gross, PA-C, MPH; William Paul Barras, CRNA, MSN, MS; and Amelia M. Duran-Stanton, PA-C, PhD, DSc, MPAS

Introduction

A physician assistant (PA) can be assigned as command surgeon at the three-star level Installation Management Command (IMCOM) as a key strategic billet. The position of command staff medical advisor/surgeon for IMCOM was officially established in 2013 in support of the Command Emphasis on Comprehensive Soldier and Family Fitness program[1]; medical care programs were further aligned under the assistant chief of staff for installation management with Army Materiel Command, IMCOM, Office of the Surgeon General (OTSG), and Army Medical Command (MEDCOM).

Supervision

The IMCOM surgeon position is currently rated by the IMCOM chief of staff and senior-rated by the IMCOM commanding general.

Unit Structure

IMCOM integrates and delivers base support to enable global readiness for the Army (Figure 47-1). Committed to providing operations support in accordance with established standards to accomplish the mission, IMCOM is also invested in providing appropriate programs and services at the right time and place for soldiers and their families. IMCOM's



Figure 47-1. The Installation Management Command crest.

tagline is "We are the Army's Home."[2] All the IMCOM garrisons are listed under its website: https://home.army.mil/imcom/index.php/garrisons.[3]

Roles and Duties

The IMCOM surgeon serves as the command's advisor for all health care, medical readiness, and medical matters relating to installations. They promote the integration of force health protection principles and provide command advice and recommendations for all aspects of health care. The IMCOM surgeon works closely with IMCOM coordinating staff and directorates to ensure garrison commanders are informed and provided the requisite support to accomplish both health care delivery and medical readiness missions, as well as responding to any

contingency medical issues that may arise. This is particularly important in the area of health care delivery as this responsibility transitions from MEDCOM to the Defense Health Agency (DHA). As the transition evolves, it is imperative to ensure garrison-level issues are addressed, especially in the areas of mutual support agreements and reimbursable services. The IMCOM surgeon also acts in a direct support role to the installation regional directors.

The IMCOM surgeon's specific responsibilities are as follows:

- Internal support to all IMCOM directorates, especially human resources; operations, plans, and training; logistics and facilities management; the provost marshal office; and safety, with the following critical missions:
  - Suicide prevention, sexual assault prevention, maintenance of the Medical Readiness Assessment Tool, soldier readiness processing, health education, and holding an annual health fair.
  - Support for health promotion efforts across installations, including Army child, youth, and school services; Healthy Army Communities; ready and resilient strategy; and the Performance Triad for soldiers, families, and the civilian workforce. Serve as liaison for OTSG and MEDCOM to ensure up-to-date medical information is available in support of these programs.
  - As the IMCOM medical authority, ensure all Department of Army, OTSG, and MEDCOM draft publications are vetted and supportable by the installation and directorate leadership. The IMCOM surgeon ensures that installation leadership is provided timely medical publications and guidance as required, such as those on occupational and environmental health and safety.
  - Coordination and synchronization of medical oversight of Kwajalein Atoll (the only location where IMCOM has direct medical oversight).
  - Emergency management planning, preparedness, and response; prehospital ambulance service; automated external defibrillator programs and maintenance; Army Protection Program assessment of command compliance with risk management[4]; and food vulnerability detection.
  - Support for garrison commanders to ensure training areas are provided requisite medical support as determined by senior commander requirements.

- Act as the liaison for all medical assets outside IMCOM, including OTSG, MEDCOM headquarters, the Medical Center of Excellence, Public Health Center, and other command surgeons to ensure timely medical information is provided, as well as information on medical treatment options available. Liaison duties include the following:
  - Attend all weekly military health service synchronization meetings.
  - Provide a situation report to the IMCOM leadership on the status of the MTF-to-DHA transition, especially highlighting issues that affect the directorates and garrisons.
  - Be aware of all medical assets that are transitioning to other organizations; for example, the Public Health Center is currently scheduled to transition to DHA by 2022. These transitions will affect public health support to local garrisons, and the IMCOM surgeon must ensure stakeholders know what joint assets are available, in addition to Army assets.

Desired Knowledge, Skills and Attributes

Knowledge

- Knowledge of industrial hygiene and public health.
- Knowledge of Army culture and organizations, systems, policies, and processes.
- Understanding of military medicine and the business of health care.
- Experience with writing and updating policies.
- Good understanding of joint, Army, IMCOM, and MEDCOM cultures.
- Competent using Microsoft Office, MilSuite, and SharePoint applications.

Skills

- Strategic thinking.
- Exceptional written and oral communication skills.
- Unwavering military bearing and tact with senior leadership.
- Strong interpersonal skills; consensus-building across a variety of stakeholders and agencies; persuasion and negotiation skills and tactics; team-building.

- Attention to detail and exceptional organizational skills are an absolute must.
- Proficiency with editing a variety of military and civilian correspondence and other documents.
- Strong leadership skills; ability to coach, teach, and mentor civilian employees.

Attributes

- Critical thinking and problem solving skills.
- Self-starter; able to see a need and take action.
- Systems thinker; able to connect the dots and see the big picture.
- Ability to effectively handle pressure, remaining calm and rational.
- Ability to effectively multi-task.
- Willingness to do any task required for mission success.
- Assertive; able to tactfully enforce requirements with senior individuals.
- Good planning skills; able to anticipate requirements and develop options to assist the command and other leaders.

Training

Training in public health and industrial hygiene are highly recommended, as is training in prehospital care and executive medical skills. Federal Emergency Management Agency disaster management courses and the Public Health Emergency Management Course offered by the Defense Medical Readiness Training Institute are encouraged.[5] Additionally, training on systems to manage civilian employees, such as the Automated Time Attendance and Production System and Defense Performance Management and Appraisal Program, is necessary. There is also opportunity to audit the training conducted by the R2/ASAP (Ready and Resilient/Alcohol and Substance Abuse Program) Division staff (the R2/ASAP Division is further discussed in chapter 28 of this handbook).

Key Factors

This position is typically a 2-year tour and is coded for an O5A (branch-immaterial) colonel (O-6) with no additional skill identifier

requirement. IMCOM is currently located at Joint Base San Antonio-Fort Sam Houston, Texas. This position is primarily nonclinical; however, PAs must maintain their credentials. The IMCOM surgeon coordinates care for the command staff, but does not provide direct clinical care. The deputy surgeon is not on the table of distribution and allowances (TDA), but if the chief of the Ready and Resilience Integration Branch of the R2/ASAP Division is a clinician, they can fill the role as the deputy surgeon as a secondary position (Figure 47-2). The R2 Branch and the R2/ASAP Division are described in detail in chapter 28 of this handbook.



Figure 47-2. Staff at Installation Management Command (IMCOM) headquarters. Left to right: Lieutenant Colonel Amelia Duran-Stanton, Ready and Resilient (R2) Integration Branch chief and deputy surgeon; Pamela Budda, R2/Army Substance Abuse Prevention division chief; Colonel (Retired) Pauline Gross, IMCOM surgeon 2015–2018; Colonel William "Paul" Barras, IMCOM surgeon, 2018–2021.

Lessons Learned

Based on lessons learned, the IMCOM surgeon should do the following:

- Leverage and utilize the OTSG, Army Medical Department (AMEDD) and MEDCOM contacts as the liaison between OTSG, AMEDD, MEDCOM and IMCOM. Having a continued relationship with OTSG, AMEDD and MEDCOM while at IMCOM definitely helps with getting answers quickly, especially in the public health arena.
- Be cognizant that the medical information provided to the command and the garrisons is not "from the IMCOM surgeon" but from the subject matter experts such at MEDCOM, Public Health Command, and other established proponents for medical guidelines and regulatory guidance.
- Provide assistance to the IMCOM G-9 (oversees family, morale, welfare, and recreation efforts) to establish measurable metrics for evaluations of armed forces recreation centers.
- Reach out to experts and get their guidance.
- Build a strong network from all the major commands: Army commands, Army service component commands, and direct reporting units.
- Assimilate the information and guidance from experts to provide what the command and the garrisons need.
- Ensure that IMCOM (including the supported directorates and garrisons) is situationally aware of issues that affect all beneficiaries in all things medical. In particular, keep in mind that the garrison command leadership must attend and lead local town halls, so they must be able to respond to concerns raised by participants, including retirees and spouses. Garrison leaders need to address all questions appropriately.

Tips for Success

To be successful, the IMCOM surgeon should do the following:

- Have a basic understanding of public health and industrial hygiene.
- Get to know the IMCOM headquarters staff and all the directorates.
- When receiving an email from someone, take the time to meet them in person; this will give tremendous payoffs.

- Be visible and talk to leaders and staff.
- Build excellent working relationships with all supporting staff, such as the staff judge advocate, chaplain, public affairs officer, and the inspector general.

Conclusion

The IMCOM surgeon position is one of the most unique surgeon positions in the Army. The IMCOM surgeon must know strategic-level priorities of the Department of Defense, Department of the Army, and Army Materiel Command. However, the IMCOM surgeon must remember that their own position is not the direct point of contact for these priorities; rather, their responsibility is to transmit information and serve as liaison for the command and garrisons on medical issues. The IMCOM surgeon must be versed in medical health reform by continuing to attend medical forums, and serve as the conduit for the medical community in supporting commanders, IMCOM directorates, and garrisons.

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Chapter 48

PHYSICIAN ASSISTANTS IN THE US ARMY RESERVE

T. Lee Clark Jr, PA-C, MPAS

Introduction

The US Army Reserve (USAR) provides trained, equipped, and ready soldiers, leaders, and units to meet America's military requirements at home and abroad. The USAR command structure creates a versatile mix of technical and tactical capabilities in service to the total force. USAR is comprised of operational, functional, training, and support commands. The USAR physician assistant (PA), integrated through multiple command levels, is instrumental in contributing to sustained readiness of over 200,000 soldiers and more than 2,000 units in twenty different time zones.[1]

Opportunities

The majority of USAR PAs serve in one of the three USAR medical commands: (1) Army Reserve Medical Command (ARMEDCOM), (2) 3rd Medical Command Deployment Support (MCDS), or (3) 807th MCDS. Positions in these commands are found in medical backfill battalions, medical support units, medical training brigades, and field hospitals. PAs in these positions provide essential readiness services and have clinical responsibilities while deployed.

ARMEDCOM (https://www.usar.army.mil/ARMEDCOM/) is uniquely capable of providing medical, dental, and veterinary services as well as assisting civil authorities during an emergency or disaster. The major subordinate headquarters focus on training, professional management, credentialing, and mission command of medical units.[2]

The 3rd MCDS (https://www.usar.army.mil/3rdMCDS/) is a senior deployable medical command and control headquarters, providing support to US Army Africa and US Army Central area of operations. The 3rd MCDS provides support and technical supervision for more than 6,000 soldiers located in 21 states to prepare and provide trained and ready soldiers and units to Army Reserve Headquarters-Fort Bragg for mobilization.[3]

The 807th MCDS (https://www.usar.army.mil/807thMCDS/) is the largest medical command in the USAR, consisting of 99 units located in 26 different states and nearly 10,000 soldiers. It is responsible for managing all of the USAR's deployable field medical units from Ohio to California, providing general medical, surgical, dental, ambulance, behavioral health, preventive medicine, and veterinary support to unit and civilian populations.[4]

The USAR PAs serve in command positions across all echelons of the USAR from company command to field hospital commands. They also serve in various staff positions ranging from operations officers to command surgeons.

The USAR aeromedical PA (APA) serves in the Army Reserve Aviation Command as an integral part of the medical team in USAR aviation brigades. APAs, along with their flight surgeons, manage aviation units' medical programs and ensure all aircrew meet readiness requirements for deployment and are fit for flying duty.

USAR PAs are essential members of USAR MDRE (medical dental readiness event) teams. These teams of physicians, PAs, dentists, and support personnel complete readiness requirements during battle assembly weekends. These events ensure a steady state of readiness and allow commanders flexible opportunities for training.

Deployment and Operational Support Opportunities

USAR PA deployments are managed by the Army Reserve Command 90/180-day Boots on Ground (BOG) team and are governed by the Assistant Secretary of the Army's Manpower and Reserve Affairs (ASA M&RA) 180-day BOG policy. The 180-day BOG policy limits the length of deployment and mobilizations to a total of 180 days "boots on ground", followed by a three year dwell period.[5] This policy was established to demonstrate a commitment by the Army Reserve to the preservation of civilian professional commitments and

encourage retention of a critical wartime specialty. The policy also allows centralized management of deployments and provides diverse opportunities that capitalize on the vast array of specialty skills PAs possess. USAR PAs may mobilize to soldier readiness processing sites in the continental United States and deploy with area support medical companies, aviation battalions, field hospitals, and civil affairs battalions. USAR PAs also deploy in various senior staff positions as a deputy commander for clinical services (DCCS), command surgeons, deputy surgeons, and chiefs of clinical operations and plans.

A unique position available to USAR PAs is serving on ADOS (active duty for operational support) status as the 90/180-day BOG manager. This Army Reserve Headquarter-Ft. Bragg position is a tremendous broadening assignment and is responsible for medical professional mobilization and deployment of all USAR physicians, dentists, veterinarians, nurse anesthetists, PAs, and nurse practitioners. As manager of this program, the USAR PA can provide critical analysis and advice to Army senior leaders on vital wartime medical areas of concentration shortages, and provide medical readiness expertise at the corps level. Expertise must include understanding and qualification in directed medical training and understanding of the Joint Trauma System.

Other ADOS opportunities involve staff positions at US Army Africa, Special Operations Command Africa, US Army Europe, and US Army Pacific. ADOS positions are advertised on the Mobilization Common Operating Picture, Tour of Duty (TOD) website (https://mobcop.aoc.army.pentagon.mil) and applicants are selected based on experience and qualifications. ADOS tours cannot exceed 1,095 days.[6] USAR soldiers can apply and accept additional ADOS tours after being off orders for 1 year.

Senior PAs have the opportunity to serve as the USAR PA consultant to the Army Medical Specialist Corps chief. PAs can also serve in a 65X position (allied operations specialist [Specialist Corps immaterial]) as the USAR deputy corps chief.

Tips For Success

Selection of broadening assignments and command opportunities will challenge USAR PAs and enable service at progressively higher levels. While PAs may be educationally qualified for promotion based on professional degrees, military professional education is a critical

component for promotion to the senior ranks.[7] USAR PAs must also take advantage of military training and educational opportunities. Completing the Captains Career Course at the earliest opportunity is highly encouraged. In order to be competitive for promotion to lieutenant colonel and colonel ranks, USAR PAs should complete Command and General Staff College and US Army War College when eligible. As professionals, USAR PAs are expected to be proficient in medical skills, but expanding military knowledge broadens leadership and strategic thinking capabilities.

Career Field Evolution

As the Army moves into a new decade, expansion of PA training and educational opportunities for operational assignments is anticipated. These also include access to residency programs in long term health education and training programs and new operational assignments in the surgical specialties. Efforts are underway to incorporate surgically trained PAs into forward surgical resuscitative teams. Emergency medicine PAs are already a part of the new field hospital structure.

Leveraging specialty skills obtained in civilian practice in mobilizations and deployments can provide additional operational depth to missions. At this time there are no Active Guard Reserve positions for PAs; however, inclusion of PAs in this program would bring a critical clinical skill to meet readiness demands in the USAR.

Conclusion

PAs serving in the USAR bring unique skills across the spectrum of civilian medicine from primary care to surgical subspecialties. Serving as a PA in the USAR can be a tremendously rewarding experience that broadens capabilities outside of a traditional civilian clinical structure or hospital system.

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Chapter 49

ROLE OF THE OFFICE PROGRAM MANAGER–SAUDI ARABIAN NATIONAL GUARD MEDICAL EDUCATION AND BRIGADE TRAINING ADVISOR FOR HEALTH AFFAIRS

Michael A. Davidson, PA-C, MPAS, and Edwin X. Gutierrez, PA-C, MPAS

Introduction

The Office of the Program Manager, Saudi Arabian National Guard (OPM-SANG) was created in 1973 by a memorandum of understanding between the United States and the Saudi Arabian government in response to a request from then King Faisal Bin Abdul Aziz to modernize the Ministry of the National Guard (MNG).[1] Office personnel carry out their mission through direct advising, contracted training support, and foreign military sales (FMS) case management, producing a capable and professional medical force capable of sustaining health on the battlefield.[2] The physician assistant (PA) assigned to OPM-SANG is the principal military medical and training advisor for the strategic military modernization program between the United States and Saudi Arabia. The PA coordinates with soldiers and civilians from the MNG and National Guard Health Affairs on programs of instructions, faculty development, instructor training, medical unit sustainment training, and the management of the various departments within the Allied Health Sciences Military School (AHSMS) system and the MNG brigades.

Unit Structure

An FMS organization, OPM-SANG is subordinate to the US Army Security Assistance Command at Fort Bragg, North Carolina, and its next higher headquarters is the Army Materiel Command. The program manager is currently a colonel. The Health Affairs section consists of an assistant program manager (APM), also a colonel; a deputy (lieutenant colonel); officers; and noncommissioned officers serving in various advisory roles within the MNG. Currently, OPM-SANG has over 100 active duty advisors (all sergeants first class or majors and above) and approximately 150 civilian employees.

Roles and Duties

The PA assigned to OPM-SANG integrates health service and medical training modernization in field and fixed medical units within the MNG by ensuring the addition of individual and collective medical training to training schedules, and by developing and providing medical leadership. In addition, the PA oversees military medical training programs for the AHSMS, which produces professional development courses to ensure that high-quality, current, and relevant military medical protocols and procedures are incorporated into programs of instruction. Specifically, the advisor directly oversees all aspects of the Allied Health Sciences Education Branch, which establishes curriculum, faculty, and medical doctrine development for all programs of instruction within the AHSMS. The advisor also provides direct supervision of the AHSMS Combat Medical Training Center. Furthermore, the PA collaborates with the APM and deputy of health affairs on command health issues, including planning, monitoring, and implementing medical preparedness plans. The PA provides direct primary care and monitors the medical readiness of all personnel assigned to OPM-SANG, while maintaining professional, physical, and technical readiness. In the absence of the APM, the PA serves as the command surgeon for OPM.

Desired Skills and Attributes

- Extensive experience as a PA.
- Combat deployment experience.
- Tactical Combat Casualty Care instructor.

- Minimum rank of major.
- Credentialed medical provider.
- Intermediate Level Education and Command and General Staff College graduate.
- Medical simulation training center experience.
- Expert writing and communication skills.

Training

The training required prior to arrival at OPM-SANG is the Security Assistant Team Training Orientation Course (SATTOC) offered at Fort Bragg. The PA must have access to the Medical Operating Data System (MODS) to update electronic profiles and address other medical readiness concerns within OPM-SANG. Additionally, taking a contracting course is helpful to ensure understanding of new purchase requests related to an FMS. Other required or recommended courses are as follows:

- **Must be completed before SATTOC:** Defense Institute of Security Cooperation Studies Security Cooperation Management Familiarization Course (101) online (https://www.discs.dscu.mil/)
- **Must be completed during or prior to SATTOC:** Defense Institute of Security Cooperation Studies Security Cooperation Online Orientation Course (201)
- **Highly recommended for a better understanding of acquisitions and the FMS system:** the following Defense Acquisitions University (https://www.dau.edu) classes:
  - CLM 003, Overview of Acquisition Ethics
  - CLC 106, Contracting Officer's Representative With a Mission Focus
  - COR 222, Contracting Officer's Representative Course Book 1
  - CLC 222, Contracting Officer's Representative Course

Key Factors

This position is typically a 1-year tour with and optional 1-year extension. It is coded for a male PA in the rank of major (O-4), with no additional skill identifier. This position is primarily nonclinical; however, there is a clinic on the installation that allows the PA to see OPM personnel and

provide health care. All medical providers' credentials are maintained at Landstuhl Regional Medical Center in Germany. The PA can maintain continued medical education proficiency by taking courses through the Postgraduate Training Center located at the King Abdulaziz Medical City, which offers courses such as Basic Life Support, Advanced Life Saver, Pediatric Advanced Life Support, and Advanced Trauma Life Support. Funds are also available for travel to additional locations to maintain licensure through the National Commission on Certification of Physician Assistants during the assignment.

Lessons Learned

The following are lessons learned for the PA assigned in the OPM-SANG position:

- Understanding the MNG command structure will require patience. Establishing relationships will be instrumental.
- MNG doctrine is very similar to US doctrine. The PA must continually emphasize the need to use established doctrine in current operations.
- The PA must seek to understand MNG operational needs and provide appropriate coaching and mentoring.
- The MNG does not have all the appropriate medical positions, areas of concentration, or military occupational specialties required.
- The MNG does not have a mature medical logistical system for field medicine.
- The MNG values Role 4 over Roles 1, 2, and 3; the PA should emphasize the importance of all roles in coordination with leaders and civilians from the MNG and National Guard Health Affairs.
- The head of their fixed facility (non-military) makes decisions for acquiring any field medical equipment/supplies.
- The MNG does not have the leadership or a department equivalent to the Office of the Surgeon General.
- The MNG relies heavily on committees to gain consensus on information, which may delay decisions.
- The MNG does have acting commanders and may delay decisions until the commander is present; this requires the advisor to remain flexible.

- MNG leadership may need coaching and mentoring on improving communication to ensure information is shared across the entire formation.

Tips for Success

The following tips for success will help the PA assigned in the OPM-SANG position:

- The PA must maintain a positive relationship with MNG counterparts.
- The MNG is NOT the US Army; the PA's job is to advise and assist, not to be the middle person.
- The PA must leave a road map so their replacement can continue to follow up on the work they have started; US personnel should speak with "one voice."
- The PA must never commit to something they cannot get done.
- The PA must discuss issues with the MNG leadership and agree on goals that are achievable; they should avoid promising resources.
- The PA must learn as much as they can about the FMS process before arriving.

Conclusion

The OPM-SANG was started to help modernize the MNG through providing direct advice and FMS case management. Since the early years, it has transitioned away from advising fixed facilities and toward advising military field medicine. The OPM-SANG PA has a very challenging position that will rely on their military and field medical experience to assist with programs of instruction, faculty development, instructor training, medical unit sustainment training, and management of various departments within the AHSMS system and MNG brigades. Although challenging, this is also a broadening assignment, providing the PA opportunities to engage with host nation leaders and assist them in making decisions that will affect their entire military.

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Chapter 50

ROLE OF THE PHYSICIAN ASSISTANT AS HUMAN RESOURCES COMMAND CAREER MANAGER

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Introduction

The physician assistant (PA) assigned to the Human Resources Command (HRC), located in Fort Knox, Kentucky, is responsible for supporting Army PA personnel readiness requirements worldwide, including career management, professional development, and coaching for all active duty Army PAs (area of concentration 65D). The career manager coordinates with the assistant to the chief of the Medical Specialist (SP) Corps (the PA consultant), the Corps Specific Branch Proponent Office, the US Army Recruiting Command (USAREC), the Interservice Physician Assistant Program (IPAP) manager, the IPAP program director, the reserve component SP Corps career manager, and Forces Command and Medical Command leadership in the assignment and career management process.

Unit Structure

HRC is the functional proponent for military personnel management (except for the judge advocate general and the Chaplain Corps), and a direct reporting unit to the Office of the Deputy Chief of Staff for Personnel (G-1). The organization is composed of the following departments[1]:

- Enlisted Personnel Management Directorate: manages active and reserve soldiers with career guidance and support.
- Officer Personnel Management Directorate (OPMD): provides active and reserve officers with career guidance and support. OPMD's Health Services Division manages the careers of Army Medical Department (AMEDD) officers in all corps.
- Adjutant General Directorate: manages soldier records, promotion boards, evaluation processing, personnel actions and entitlement programs, regulation updates, and veterans' support.
- Personnel Information Systems Directorate: provides information technology support to command functions and staff elements such as operations, resource management, the chief information officer, the surgeon, the inspector general, and the judge advocate.
- Reserve Personnel Management Directorate: established in October 2019 to increase efficiency, transparency, and accessibility of Army Reserve personnel actions. The directorate consists of four primary divisions: personnel management departments for both enlisted soldiers and officers, Army Reserve health services management, and operational readiness support.[2]

HRC also supports the director of the Army National Guard and the chief of the Army Reserve in the management of the Selected Reserve (units under the Army Reserve Command). The HRC commander is in charge of the Individual Ready Reserve, the Standby Reserve, and the Retired Reserve. The HRC Health Services Division, within OPMD, manages the careers of AMEDD officers in the Medical Corps, Dental Corps, Veterinary Corps, Nurse Corps, Medical Service Corps, and the PAs' branch, the SP Corps.

Supervision

This position is either rated by the SP Corps branch operations officer and senior-rated by the SP Corps branch chief, or rated by the SP Corps branch chief and senior-rated by the HRC chief of the Health Services Division. The Health Services Division chief may be an officer of any AMEDD branch.

Roles and Duties

The HRC career manager assists officers with shaping their career progress and professional development. Officers are assigned based on their knowledge, skills, and behaviors according to priorities identified by the Army chief of staff and guided by the Active Component Manning Guidance[3] and by specific guidance for the AMEDD from the Army surgeon general. Placement of officers in support of different lines of effort depends on their knowledge, skills, and behavior via the Army Talent Alignment Process (https://talent.army.mil/atap/).

Career management involves communication, assistance in professional military education, promotion boards, evaluations, and career plan development. These efforts are guided by anticipating requirements based on projected priorities for the Army, identifying broadening opportunities, feedback from the SP Corps 65D consultant, and the Health Services Division's Readiness and Strength branch.[4] The career manager may assist officers in updating officer record briefs and the Army military human resource record for board preparation and for submitting requests for training, including professional military education, long-term health education and training (LTHET), and Army Training and Requirements Resource System (ATRRS) courses. Additionally, there are broadening opportunities (those that round out an officer's experience by exposure), such as 65X (corps area of concentration) and 05A (AMEDD area of concentration) immaterial positions. A message is released annually on HRC's website[5] listing the broadening opportunities offered for the next fiscal year. A complete listing of broadening opportunities can also be found on HRC's website.[6]

PAs may also participate in training with industry, a work experience program within particular institutions, typically within organizations that align with the AMEDD mission. Through the LTHET program, 65Ds may attend training with the American Academy of Physician Assistants, the National Commission on Certification of Physician Assistants, or the National Registry of Emergency Medical Technicians. Other opportunities include training with the RAND Corporation,[7] a 3-month fellowship with Defense Advanced Research Project Agency, and strategic fellowships.[8] For more information about eligibility and requirements for strategic fellowships and civilian institution education, refer to Army Regulations 621-7[9] and621-1.[10]

It is key for the career manager to identify and capitalize on individual and collective talent. The officer must predict requirements by monitoring authorization documents and projected losses and gains. AMEDD holds a biannual planning conference to validate manning proposals based on unit requirements and officers in the personnel inventory, called the AMEDD Distribution Plan (ADP). The ADP informs the requirements phase of HRC's formalized distribution processes, which also occur twice per year (the ADP focuses on requirements while the Army Talent Alignment Process focuses on staffing the requirement with the right officer).

Administrative duties include assisting officers with administrative processes, in accordance with AMEDD and Army personnel guidance and policy, such as retirements, separations, stabilization requests, compassionate reassignments, joint domicile issues, the Married Army Couples Program, deletions or deferments of existing assignment instructions, and foreign service tour extensions and curtailments. In coordination with the USAREC IPAP program manager, the career manager guides assignments for IPAP graduates. PAs educated at nonmilitary schools are assigned in coordination with the USAREC program manager for SP Corps.

Desired Skills and Attributes

- Extensive experience as a PA and AMEDD officer.
- Rank of major.
- Intermediate Level Education graduate preferred.
- Must be an excellent role model with the desire to mentor others.
- Must have an interest in people and be able to encourage and assist others.
- Good oratory, communication, and resiliency skills.
- Strong work ethic.
- Solid writing techniques.
- Be prepared to take on additional duties such as Sexual Harassment/Assault Response and Prevention victim advocate or casualty notification/casualty affairs officer.

Training

Training required for the HRC career manager includes familiarity with several human resources data systems:

- OPMD Toolkit: An application with a suite of functions to support personnel management, including the Assignment Interactive Module 2.0 (AIM2) and the Total Army Personnel Management Information System (TOPMIS). The toolkit also provides access to personnel status, records, inventory, authorizations, requests for orders, and special actions review, such as retirements, separations, high school senior stabilization (preventing reassignment for a month after a child's graduation), the Exceptional Family Member and Married Army Couples programs, compassionate reassignments, continuing overseas tours, and foreign service tour extensions and curtailment.
- TOPMIS: part of the OPMD Toolkit, used to maintain and update officer records and manage requests for orders;
- iPERMS: Used to maintain Army military human resource records.
- Medical Operating Data System (MODS): Used to review distributable personnel inventory projections and advise the 65D consultant on inventory allocation in support of the ADP.
- Force Management Support Agency (FMSweb): Used to document Army unit requirements and authorizations for personnel and equipment.
- Army Selection Board System (ASBS): Used to collect and build officer board files for board processes.
- Soldier Management System (SMS): A web-based collection of data, applications, and tools to assist career managers and other human resource personnel in supporting active duty, reserve, and National Guard soldiers, veterans, retirees, family members, and other stakeholders.

Key Factors

This position is typically a 3-year tour and is coded for a 65D O-4 (major) with no additional skills identifier requirement. Group briefings, face-to-face counseling, and interviews are the best way to interact with PAs in the field; however, fiscal constraints may restrict travel

to make these contacts. Correspondence via AIM2 is the preferred method for communication and distribution of information. This position is primarily nonclinical, but professional PA credentials must be maintained. Credentialing requirements can be supported by the local medical treatment facility, Ireland Army Health Clinic.

Lessons Learned

This assignment is unique in the field of opportunities for Army PAs. An officer in this role has an opportunity to improve the SP Corps and provide Army-wide informed guidance, counseling, and mentorship. Understanding how the Army runs, and all the factors involved in the assignment of an officer, is an invaluable asset, and this experience affords strategic knowledge and experience essential to shaping the future of the SP Corps. The assignment is demanding, and organization and time management skills are critical. Prior adjutant general branch or personnel experience, such as area of concentration 70F (health services human resources), is beneficial. PAs in this position must be familiar with and able to interpret regulatory guidance for topics such as the Married Army Couples and Exceptional Family Membership programs, and permanent change of station policy.

Tips for Success

Intermediate Level Education helps prepare officers for this assignment, in particular its Force Management course module. The career manager must balance multiple responsibilities, and must not limit themselves to career management only; family, personal fitness, medical, and clinical readiness are also matters paramount to the position. The career manager must get to know all subject matter experts in the organization, and be able to recruit them for guidance and support. They must seek additional training, such as Lean Six Sigma and ATRRS personnel courses. Excellent communication skills are required when making hard assignment decisions. Learning the systems quickly and applying decisions consistently and equitably is essential to success.

Conclusion

The HRC PA career manager position exists to balance the needs of the Army with the needs and desires of the PA population; helping others manage their career to get the most professional and personal benefit from Army opportunities is a rewarding experience. Army PAs deserve a highly motivated and dedicated career manager looking out for their best interests while they achieve Army objectives. To that end, this is a job for an astute PA who listens to others, is a forward thinker, and is prepared to make a difference for nearly 1,000 PAs at any given time.

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AR 15-185	31 Mar 2006	*Army Board for Correction of Military Records*
AR 135-175	30 Mar 2020	*Separation of Officers*
AR 600-8	9 Jul 2019	*Military Human Resources Management*
AR 600-8-22	5 Mar 2019	*Military Awards*
AR 600-8-24	8 Feb 2020	*Officer Transfers and Discharges*
AR 600-8-29	25 Feb 2005	*Officer Promotions*
AR 600-8-104	7 Apr 2014	*Army Military Human Resources Records Management*
AR 600-8-105	22 Mar 2019	*Military Orders*
AR 614-30	22 Dec 2016	*Overseas Service*
AR 623-3	14 Jun 2019	*Evaluation Reporting System*
DA Pam 623-3	27 Sep 2019	*Evaluation Reporting System*

Chapter 51

ROLE OF THE PHYSICIAN ASSISTANT IN ARMY MEDICAL RECRUITING

Robert K. Greener, PA-C, MPAS; Kelly A. Guerra, APA-C, MPAS; Michael Plotkowski, PA-C, MPAS; and Amy L. Jackson, PA-C, MPAS

Introduction

A US Army Physician Assistant (PA) may be assigned as an Army Medical Department (AMEDD) health care recruiter. An AMEDD recruiting officer is responsible for leading a team of noncommissioned officers (NCOs) in recruiting the best medical professionals for the Army to sustain and maintain a healthy fighting force. As a leader first and recruiter second, the PA recruiter implements plans and actions to make the team a successful contributor to the overall mission set by the US Army Recruiting Command (USAREC). The PA AMEDD recruiter serves as a medical subject matter expert for the medical recruiting brigade, and as a mentor for new AMEDD officers.

Duties and Responsibilities

The job duties and responsibilities of the PA in AMEDD recruiting are based on the USAREC mission and the officer's role as leader or officer in charge (OIC) of a small team of NCO recruiters. In AMEDD recruiting, Medical Specialist Corps officers are placed in a leadership position at the medical recruiting station (MRS).

USAREC has one medical recruiting brigade (MRB), comprised of five medical recruiting battalions (MRBns), each of which contains three to five companies of four to seven MRSs,[1] as depicted in Figure 51-1**.** To ensure complete nationwide coverage, every battalion, company, and MRS is located in a strategic regional location. Depending on the

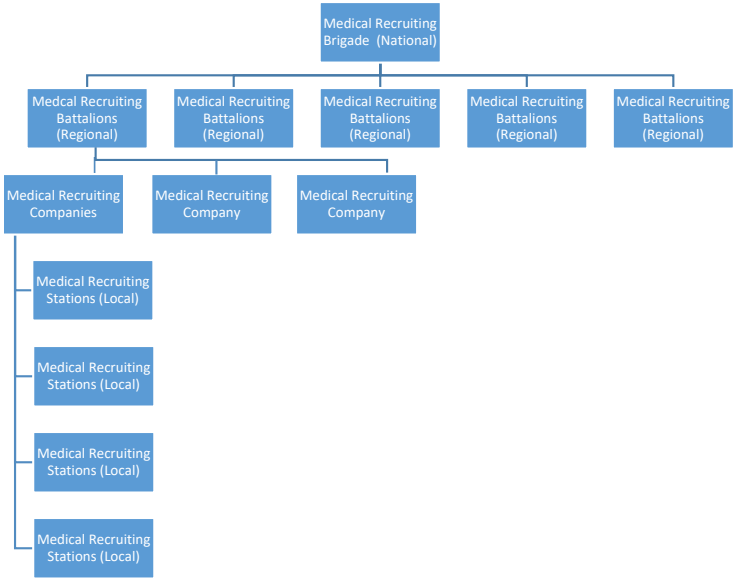


Figure 51-1. The medical recruiting organizational chart. The number of companies and medical recruiting stations may vary.

size and population density of the office's territory, each MRS has a station OIC, a station commander (the senior NCO), and one to seven NCO recruiters.

Before each fiscal year begins, USAREC assigns an annual medical recruiting mission assignment (USAREC Form 711) to the MRB, which details the specific positions needed to ensure optimal health care of the US Army.[2] These positions include areas of concentration from the Medical Corps, Nurse Corps, Dental Corps, Veterinary Corps, Medical Service Corps, and Specialist Corps. The MRB disseminates recruiting assignments to the MRBns, who apportion them to the companies, using historical and geographical data to facilitate mission achievement. Each company then meets with their MRSs and gives them specific mission assignments. Each MRS mission specifies the number of health care professional recruits needed for the year by area of concentration

and component (regular Army and Army Reserve). These recruiting missions will include student programs such as the Health Professions Scholarship Program.

PAs in recruiting serve as one of the five Specialist Corps representatives in USAREC and are the only Specialist Corps representative for each regional MRBn. Being one of the few Army health care recruiters with professional clinic experience, PAs are indispensable for attracting top health care professionals at a high level (Figure 51-2). PA skills and experiences used at the national recruiting level help develop and implement effective recruitment strategies.

According to the Total Army Involvement in Recruiting (TAIR) Program, the entire US Army supports recruiting efforts.[2] Funding is available for recruiting activities involving subject matter experts from throughout the Army health care team. Subject matter experts convey a rich appreciation for the accomplishments of the Army health care team to civilians.



Figure 51-2. Then-Captain Kelly A. Guerra, MPAS, PA-C, Valencia AMEDD Recruiting Center OIC, Valencia, CA, meets a physician assistant student at Western University's Physician Assistant Career Expo and discusses opportunities for student loan repayment and bonuses in the Army.

Once a potential recruiting lead demonstrates interest, it is the responsibility of the MRS to provide information about the benefits and opportunities of Army health care to engender their commitment and turn them from a prospect into an applicant. The MRS team works with the applicant to accomplish all required tasks so their packet is ready for the next selection board. If selected, the MRS will complete the commissioning ceremony, turning that health care professional into an AMEDD officer. The OIC plays a vital role of mentoring the new AMEDD officer until they successfully integrate into their first active duty or Army Reserve unit.[3]

USAREC needs the expertise of all AMEDD officers for local, state, and national events to inspire health care professionals to join the Army health care team. AMEDD officers with an interest in supporting this vital mission should contact their branch manager and volunteer to assist in health care recruiting events. Supporting the USAREC mission involves networking with military and civilian leadership throughout the nation and speaking to civilian health care professionals and students who demonstrate curiosity about Army medicine. It may include attending professional events as an AMEDD subject matter expert or talking with prospects in person, on the phone, or electronically. Performing commissioning events at major regional events honors new AMEDD officers and may motivate other potential Army health care prospects**.**

To fulfill the recruiting mission, the station OIC must perform the following duties:

- Mission planning—plan and conduct research and events to attract interested students or future Army health care professionals.
- Market management and analysis—use the tools provided by the respective battalion operations section, conduct research, and optimize market and demographics penetration. To find the most qualified students and health professionals, recruiters must determine where they live, work, and attend college.
- Quarterly and annual "battle rhythm" development—devise plans to ensure active pursuit of required new positions and maintenance of currently filled positions.
- Centers of influence development—engage with the civilian community to build relationships with universities, hospitals, clinics, and other potential resources.



Figure 51-3. Captain Robert Greener, Louisville, Kentucky, health care recruiting officer in charge, creating a "Stop the Bleed" train the trainer video for Army Medical Department recruiters.

- Future soldier management—assist and mentor those selected for service to ensure their success at their first unit.
- Event management—research, plan, coordinate, and conduct exhibit booths and speaking events at conferences, schools, and other professional gatherings (Figure 51-3).
- Prospect management—establish and maintain effective avenues to target potential Army medical officers.

The average day of an AMEDD OIC varies depending on the evolving needs of the MRC, which drives the plans (Figure 51-4).

0700–0900	Physical training, hygiene, travel to recruiting center
0900–0930	Center planning meeting
0930–1000	Follow up on email leads
1000–1200	Email potential prospects
1200–1300	Lunch
1300–1400	Process current applicants
1400–1500	Plan for upcoming events
1500–1700	In-person recruiting event

Figure 51-4. One example of a recruiter's typical day at the recruiting station. The schedule and activities vary depending on temporary duty travel, events outside of business hours, and recruit needs.

Skills and Attributes

Subject matter expertise as a PA is not solely sufficient for recruiting success. Recruiters must also have the following crucial skills and attributes:

- high role model aptitude and a desire to mentor others,
- broad knowledge of the Army,
- basic understanding of medical area of concentration job descriptions,
- solid leadership and administrative skills,
- capability to thrive in an autonomous work environment,
- ability to meet hard deadlines and always be punctual,
- experience in evaluation and rating,
- interest in people and be able to encourage and assist others, and
- excellent speaking and communication skills.

Benefits of the Position

This position provides the following benefits:

- opportunity to live in non-traditional Army locations,
- flexible work schedule (can make family commitments and make up work without jeopardizing the mission),
- flexibility to accomplish the mission (use your skill set to determine the needs of the target audience and identify opportunities to recruit them),

- camaraderie (a small team setting allows for strong working relationships),
- travel opportunities (to attend events, conferences, and training)
- networking with civilian health care professionals (use many civilian medical recruiting practices and responsibilities in civilian hospitals and universities),
- opportunity to affect change throughout Army health care (your ideas can lead to greater success of the Army health care mission),
- opportunity to obtain and conduct continuing medical education.

Training

Medical recruiters attend the health care recruiting course after arriving at their health care recruiting center. This 3-week course at Fort Knox, Kentucky, teaches the fundamentals of medical recruiting. The "5N" additional skill identifier is awarded upon course completion. This course is followed by a 1-week health care OIC course that teaches the skills needed to perform as a health care recruiting OIC.

Metrics of Success

Evaluation of medical recruiters uses several criteria. Each medical recruiting center is assigned an annual recruiting mission, broken down by the number of personnel in each AMEDD specialty. A medical recruiting center that meets or exceeds the assigned mission demonstrates success. The ability of the team to reach and motivate high quality health care professionals to join Army medicine strengthens evaluations. Leading the center's efforts to build relationships with referral sources, using various methods to contact prospects, creating and attending inspiring events, and ensuring a smooth transition for AMEDD applicants are all measures of success that culminate in meeting or exceeding the mission.[3]

As both an OIC and a health care professional, PAs can contribute to the team's success by harnessing personal and teammate leadership skills, learning and adapting to the recruiting center processes and culture, and maintaining clinical skills to train other health care recruiters. Ultimately, great leadership and strong teamwork leads to a legacy of success.

Lessons Learned

The following are lessons learned to help foster AMEDD recruiter success:

- Network early. Reaching out to various AMEDD leaders (active duty and reserves), both locally and nationally increases your available resources. AMEDD recruiters use this expertise both in person and electronically to assist in mission accomplishment. Two years is a short time to develop these relationships, so start as soon as possible.
- Collaborate with the AMEDD recruiters in the company, battalion, and brigade for best practices and available resources. This diverse team will develop the best approach to bring healthcare professionals into the AMEDD team.
- Use a personal Army story to humanize military service. Technically and tactically proficient recruiters who can effectively personalize their AMEDD experiences present a compelling combination for AMEDD healthcare team prospects.

Tips for Success

Along with lessons learned, the following tips for success will enable future AMEDD recruiters to succeed beyond expectations:

- Encourage innovation in the team. Health care professionals are heavily recruited by electronic means by non-clinicians. However, the ability to reach them as a fellow clinician, preferably in person, is powerful.
- Rely on the enlisted recruiters' experience and share with them firsthand knowledge of life as an AMEDD officer.
- Use subject matter experts to provide training to targeted healthcare professionals. They will inspire civilians to join the Army healthcare team.
- Listen to the skills and interests of prospects and show them how they can contribute to the AMEDD team.
- Have fun! Fun inspires AMEDD prospects and leads to successful recruiting operations when coupled with sound recruiting strategies.

Conclusion

The PA in AMEDD recruiting serves a vital role in attracting students and health care professionals into the Army health care team. Success requires learning how to operate in a new environment, which provides unique opportunities for growth, professional recognition, and personal satisfaction. As a leader and healthcare professional, the Army PA brings the ideal skill set to the Army recruiting effort. This skill set is greatly needed throughout the nation. The pathway to success in this position is varied, and the recruiting mission sets up the PA recruiter to help shape the Army healthcare team of the future.

Every commissioning ceremony will be a rewarding event for the Army health care recruiting officer. Newly commissioned officers will reflect on the inspiration of recruiters that led them to join the Army team. These officers will know that they joined in the ultimate mission of "conserving the fighting force." Any Army PA with the ability to clearly communicate the mission of the AMEDD and think creatively should consider becoming a health care recruiter.

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Chapter 52

ROLE OF THE SPECIAL OPERATIONS FORCES PHYSICIAN ASSISTANT

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Introduction

The US Army special operations forces (ARSOF) enterprise includes a variety of units and missions that require physician assistants (PAs) with varying prerequisites and skill sets. Special operations forces (SOF) performs nine doctrinal missions: unconventional warfare, foreign internal defense, special reconnaissance, direct action, combating terrorism, counter-proliferation, counter-insurgency, security assistance, and information operations.[1]

ARSOF operates in all phases of military operations from peacetime engagement around the globe to declared theaters of conflict. ARSOF is usually present in areas of operations before conventional forces arrive and after conventional forces have left. The term "special forces" (SF) applies to the special forces groups (SFGs), commonly known as Green Berets, while "SOF" applies to other units that conduct portions of the doctrinal missions.

General Prerequisites and Selection Criteria

Prerequisites common to all SOF PA positions include 1 to 2 years of Army PA experience, willingness to attend both the Basic Airborne Course and Army Flight Surgeon Primary Course, and ability to obtain a security clearance. Regardless of prior experience, a previous PA

assignment is required to hone clinical skills and mature as an officer before joining SOF.

Most SOF PA assignments require some type of interview and selection process, which varies depending on the unit, ranging from interviews to multiple-day assessments. Like all SOF personnel, candidates should be mature professionals.

The US Army Special Operations Command (USASOC) Surgeon's Office oversees staffing and resourcing of its subordinate commands; however, each senior or regimental PA hires individuals in accordance with mission needs. PAs interested in special operations assignments should contact the USASOC PA for more information at (910) 432-3913.

US Army Special Operations Command

USASOC (Figure 52-1) is a three-star command at Fort Bragg, North Carolina, that generates and sustains Army SOF to conduct worldwide missions across the range of military operations in support of geographic combatant commanders, US ambassadors, and other agencies as directed.[2] The senior command PA serves as the direct liaison to the Human Resources Command 65D (the PA area of concentration) manager for all of ARSOF. They review, select, and coordinate assignments. The following are USASOC's subordinate commands.



Figure 52-1. US Army Special Operations Command insignia.



Figure 52-2. 1st Special Forces Command insignia.

US Army 1st Special Forces Command (Airborne)

The US Army 1st Special Forces Command (Airborne) (Figure 52-2) is a two-star command that oversees the seven SFGs, the 95th Civil Affairs Brigade, the 4th and 8th Psychological Operations Group (POG), and the 528th Sustainment Brigade, Special Operations (Airborne [A]). The mission of the command is to organize, equip, train, and validate forces to conduct full spectrum special operations in support of the unified combatant command, US Special Operations Command (USSOCOM); geographic combatant commanders; US ambassadors; and other governmental agencies. The command's regimental PA is the lead for hires of the 43 PA positions within the division-sized command.

Special Forces Groups

There are five active component SFGs, and two US Army National Guard groups (Figure 52-3). Each active SFG is regionally oriented to support one of the war-fighting geographic combatant commanders. The cornerstone of the SFG's capability is the Operational Detachment-Alpha (ODA), a highly trained team of 12 SF Green Berets. Cross-trained in weapons, communications, intelligence, medicine, and engineering, the ODA member also possesses specialized language and cultural training. The ODA is capable of conducting the full spectrum of special operations, from building indigenous security forces to identifying and targeting threats to US national interests. Each group contains five battalion PA positions and one group PA, located at the following duty stations:

- 1st SFG (A), based at Joint Base Lewis-McCord, WA, and Okinawa, Japan
- 3rd SFG (A), based at Fort Bragg, NC
- 5th SFG (A), based at Fort Campbell, KY
- 7th SFG (A), based at Eglin Air Force Base, FL
- 10th SFG (A), based at Fort Carson, CO, and Stuttgart, Germany
- 19th and 20th SFG (A), National Guard

Prerequisites for 65D assignments within an SFG are completion of at least one assignment as a battalion or brigade PA, proficiency in operational and clinical medicine, and a strong desire to teach ARSOF medics within an SFG battalion. Completion of the Army Flight Surgeon

course is required, either prior to the assignment, or soon after the PA arrives at the battalion. The opportunity to complete the Special Forces Diving Medical Technician Course, to qualify for the hyperbaric medical officer (HMO) designation,[3] will be offered as the mission allows. PAs may also qualify for the diving medical officer (DMO) designation after passing the US Navy Diving Medical Officer Course.[4]

The SFG PA's role in SF is primarily as mentor and trainer for the SF medic (military occupational specialty 18D), and operational advisor to the battalion surgeon and command staff. PAs are also responsible for unit medical care and readiness for multiple rapid and short-notice deployments and exercises.

95th Civil Affairs Brigade (Airborne)

95th Civil Affairs Brigade (Figure 52-4) soldiers enable military commanders and US ambassadors to improve relationships with



Figure 52-3. Special Forces Group insignia.



Figure 52-4. 95th Civil Affairs Brigade (Airborne) insignia.

various stakeholders in a local area to meet the objectives of the US government. CA teams work with US Department of State country teams; government and nongovernmental organizations at all levels; and local populations in peaceful, contingency, and hostile environments. CA units can rapidly deploy to remote areas with small villages, as well as to larger population centers around the world. They help host nations assess the needs of an area, bring together local and non-local resources to ensure long-term stability, and ultimately degrade and defeat violent extremist organizations and their ideologies. They may be involved in disaster prevention, management, and recovery, and with human and civil infrastructure assistance programs.

The PA assigned to the 95th Civil Affairs Brigade is responsible for the medical care, readiness, and training for assigned soldiers and special operations medics, who are often deployed in austere conditions. During deployments and exercises, the PA's role expands to include forward casualty care and medical operations.

Requirements to serve in this position are 2 years' experience as a battalion PA and willingness to attend the Basic Airborne Course; survival, escape, resistance, and evasion (SERE) training; and the Army Flight Surgeon Primary Course. Interest and experience in preventive medicine and foreign languages are preferable. The 95th Civil Affairs Brigade and its five subordinate battalions (91st, 92nd, 96th, 97th, and 98th) are located at Fort Bragg. Each battalion is regionally aligned with a geographic command.

4th and 8th Psychological Operations Groups (Airborne)

The 4th and 8th Psychological Operations Groups (POGs) (Figure 52-5) provide military information support forces to combatant commanders, US ambassadors, and other agencies to synchronize plans and execute, inform, and influence activities across the range of military operations.[5] Each POG is comprised of three regionally aligned battalions. Each POG has a PA assigned as the sole provider and medical staff officer. The PA's role involves medical care, readiness, and training for assigned soldiers and special operations medics, who are often deployed in austere conditions. The PA ensures that medical capabilities for the unit in the deployment setting are adequate for the specific area of operation. During deployments and exercises, the PA's role expands to include forward casualty care and medical operations.

Requirements for the PA position are 3 years' experience as an Army PA and willingness to attend the Basic Airborne Course, SERE training, and the Army Flight Surgeon Primary Course. Candidate PAs should be well rounded, with skills and experience in planning and executing medical operations. Interest and experience in foreign languages are preferable.

528th Sustainment Brigade (Special Operations) (Airborne)

The 528th Sustainment Brigade (Figure 52-6) provides operational command and control of logistics, medical, and signal operations in any environment, anywhere in the world. The brigade is capable of conducting full spectrum operations, but is chartered to provide mission command and sustainment management capability in support of early-entry and rapid-response ARSOF and joint SOF operations.[6]

The brigade provides ARSOF's only Role 2 medical capability. Forward resuscitative surgical teams can augment the Role 1 capability



Figure 52-5. 4th and 8th Military Information Support Group insignia.



Figure 52-6. 528th Sustainment Brigade insignia.

of other ARSOF units and integrate with conventional surgical assets. The 528th has five PA positions. The brigade PA's role involves medical care, readiness, and training for assigned soldiers and special operations medics, who are often deployed in austere conditions. During deployments and exercises, the PA's role expands to include forward casualty care and medical operations.

Requirements to serve as the 528th PA are 3 years' experience as an Army PA and willingness to attend the Basic Airborne Course, SERE training, and the Army Flight Surgeon Primary Course. The other four PA positions serve within the forward resuscitative surgical teams. While in garrison, surgical PAs assigned to the surgical teams live in Charlotte, North Carolina, and work at the Atrium Health medical facilities along with their teammates. PAs assigned to these positions must be graduates of the Army (in association with a degree-granting institution) general surgery PA doctoral program (See Chapter 6 for the Army General Surgery Physician Assistant for details).

US Army John F. Kennedy Special Warfare Center and School

The John F. Kennedy Special Warfare Center and School is the Army's Special Operations Center of Excellence (Figure 52-7). Its mission is to train, educate, develop, and manage world class CA, psychological operations, and SF soldiers and leaders to provide the ARSOF regiments with professionally trained, highly educated, innovative, and adaptable operators.[7]

The Center's subordinate units include the Special Warfare Medical Group (A), which educates and trains the full spectrum of USSOCOM combat medics through instruction based on educational goals and curriculum development synchronized with the requirements of the force. There are two PA assignments within the Special Warfare Medical Group:

1. The headquarters company commander position is the only special operations 65D command opportunity. Requirements are being a senior captain or major with an ARSOF background.
2. Special Forces Medical Sergeant Course director. Responsibilities are to supervise and improve the education and training for future 18D SF medics and special operations independent duty corpsmen based on input from the force. Prior 18D experience is preferred.

Army Special Operations Aviation Command

The mission of the Army Special Operations Aviation Command (ARSOAC) provides aviation oversight as well as service and component interface to ensure system integration, fleet modernization, material readiness, training, and doctrine development. ARSOAC is located at Fort Bragg. The major (O-4) 65D assigned to ARSOAC provides primary medical care and is a special staff liaison to general officer level staff. They are responsible for strategic planning and policy development for Army special operations aviation.

The ARSOAC Special Operations Aviation Training Battalion (SOATB) is the subordinate unit charged with training and producing operationally ready aviation crew members. The 65D assigned to the battalion provides oversight and instruction to special operations flight medics in clinical and operational medicine. They also oversee medical training for all soldiers assigned to the 160th Special Operations Aviation Regiment (Airborne). They manage a diverse flight medicine program that includes senior pilots, staff, and trainees.



Figure 52-7. John F. Kennedy Special Warfare Center and School insignia.



Figure 52-8. 160th Special Operations Aviation Regiment insignia.

160th Special Operations Aviation Regiment

The mission of the 160th Special Operations Aviation Regiment (SOAR) is to organize, equip, train, resource, and employ Army special operations aviation forces worldwide in support of contingency missions and combatant commanders (Figure 52-8). Known as Night Stalkers, these soldiers are recognized for their proficiency in nighttime operations. They are highly trained to accomplish the toughest missions in all environments, anywhere in the world, day or night, with unparalleled precision.[8]

The SOAR's regimental PA is the lead for 65D hires within the regiment. Requirements for 65Ds to serve as a SOAR PA are 2 years' experience as a PA and willingness to attend the Basic Airborne Course, SERE training, water survival training, Army Flight Surgeon Primary Course, and Special Operations Aviation Medical Indoctrination Course. Prior experience in airborne and infantry battalions is encouraged. Prior flight surgeon experience is also preferred, but the regiment is willing to train the right person for the job. Candidates are assessed and interviewed (like all SOAR volunteers). Once accepted, they attend a month of common core combat skills development, also known as Green Platoon. The training pipeline for medical officers in the 160th lasts 8 to 12 months before they are available for overseas contingency operations. The PA's role includes primary and aviation-specific medical care, readiness, and training for assigned soldiers and special operations flight medics. These soldiers perform flight duties under challenging conditions while deployed in austere settings. During deployments and exercises, the PA's role expands to include medical threat intelligence, contingency response planning, and in-flight casualty care and planning. The 160th SOAR PA positions are captain (O-3) billets with the exception of the major (O-4) billet for the deputy regiment surgeon. The positions are as follows (one PA is assigned to each):

- 160th Regimental Headquarters (Ft Campbell, KY)
  - deputy regiment surgeon (O-4)
  - regiment PA
- 1st Battalion (Ft Campbell, KY)
- 2nd Battalion (Ft Campbell, KY)
- 3rd Battalion (Hunter Army Airfield, Savannah, GA)

- 4th Battalion (Joint Base Lewis-McChord, WA)
- Special Operations Aviation Training Battalion (Ft Campbell, KY)

75th Ranger Regiment

The 75th Ranger Regiment (Figure 52-9) is an agile and flexible force capable of executing myriad complex joint special operations missions in support of US policy and objectives. It is the Army's premier raid force. Each of the four geographically dispersed Ranger battalions is continuously combat ready, mentally and physically tough, and prepared to fight against terrorism. Their capabilities include air assault and direct action raids to seize key terrain such as airfields, destroy strategic facilities, and capture or kill enemies. Rangers are capable of conducting squad- through regiment-sized operations using various infiltration techniques, including airborne, air assault, and ground platforms. The regiment is an all-volunteer force with an intensive screening and selection process, followed by combat-focused training. Rangers have sufficient resources to maintain exceptional proficiency, experience, and readiness.[9]

Requirements for the 75th Ranger regimental PA are 2 to 3 years' experience as a PA, preferably with combat deployments. If not

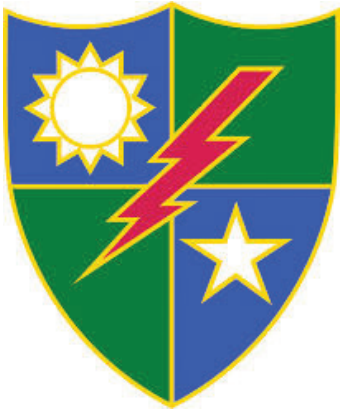


Figure 52-9. 75th Ranger Regiment insignia.



Figure 52-10. Ranger Training Brigade insignia.

already qualified, candidates must attend and successfully complete the Army Airborne and Ranger courses prior to assignment. Prior Ranger, airborne, or light infantry experience is a plus, although the regiment is willing to train promising candidates. The 3-week Ranger assessment and selection program (RASP 2) includes a 12-mile rucksack (45 lbs.) march (must be completed within 3 hours); a 5-mile run (completed within 40 minutes); the Army Physical Fitness Test (score must be at least 270 using criteria for the youngest age range); a complete psychological evaluation; and a formal board interview. As of publication, the requirements have not yet transitioned to the upcoming Army Combat Fitness Test.

The 75th Ranger regimental PA is the coordinator for 65D hires within the regiment. The PA's role is medical care, readiness, and training for assigned soldiers and medics, who are often deployed in austere conditions. During deployments and exercises, the PA's role expands to include forward casualty care and medical operations. One 65D is assigned to each of the regiment's units:

- 75th Regimental Headquarters (Ft Benning, GA)
- Regimental Special Troops Battalion (Ft Benning, GA)
- 1st Battalion (Hunter Army Airfield, Savannah, GA)
- 2nd Battalion (Joint Base Lewis-McChord, WA)
- 3rd Battalion (Ft Benning, GA)

Other Special Operations Physician Assistant Positions

The organizations described below are not subordinate to USASOC, but the USASOC PA serves as their point of contact.

Airborne and Ranger Training Brigade

The Airborne and Ranger Training Brigade (ARTB) (Figure 52-10) is responsible for training and delivering combat-ready Rangers, paratroopers, jumpmasters, pathfinders, and reconnaissance leaders to the US Army and the Department of Defense (DOD). It is part of the US Army Training and Doctrine Command (TRADOC) under the guidance of the Maneuver Center of Excellence's Infantry School at Fort Benning, Georgia. The brigade includes four battalions, the

4th, 5th, and 6th Ranger Training Battalions (RTBns) as well as the 1st Battalion, 507th Parachute Infantry Regiment (1-507th PIR). Additionally, the 4th RTBn includes the Ranger Flight Company, comprised of an assault aviation detachment and an air ambulance detachment. It conducts some of the US military's most high-risk training on a daily basis. Of note, the ARTB is a TRADOC organization, but it maintains a working relationship with the 75th Ranger Regiment, a USASOC organization.

The ARTB is separated into two divisions. The Ranger branch administers programs of instruction (POIs) for the US Army Ranger School and the Reconnaissance and Surveillance Leader's Course (RSLC). The 1-507th PIR conducts POIs for the US Army Basic Airborne Course, Jumpmaster Course, and Pathfinder Course. The ARTB also conducts the annual Best Ranger Competition and has a freefall parachute demonstration team.

There are four 65D positions within the brigade. The senior brigade PA serves as the senior medical officer in the brigade. The other three PAs are assigned to the three individual RTBns. An applicant does not have to be Ranger of Airborne qualified, but must be willing and able to attend the rigorous training. All PAs operate under the supervision of a physician assigned to Benning Martin Army Community Hospital. The 1-507th PIR does not currently have a battalion PA or any organic medical assets.

PAs assigned to the brigade and battalions must have extensive clinical experience. They are often the sole medical provider at isolated locations. Each RTBn PA supervises a medical platoon of combat medics responsible for field medical coverage and student sick call. Benning Martin Army Community Hospital operates two satellite troop medical clinics in support of Ranger training in Dahlonega, Georgia, and Eglin Air Force Base, Florida. Together, the RTBn medics and troop medical clinic staff attend to student injuries and illnesses that occur during this high-risk training. The PAs at the 4th and 6th RTBns must be qualified as a dive medical officer or hyperbaric medical officer to support rescue divers. Flight surgeon qualification is also required to manage assigned or attached aviation assets.

Defense Prisoner of War/Missing in Action Accounting Agency

The Defense Prisoner of War/Missing in Action Accounting Agency (DPAA) (Figure 52-11) conducts global joint field activity search,

recovery, and laboratory operations to identify unaccounted-for American service members from past conflicts in support of the DOD's personnel accounting efforts. The agency is located on the island of Oahu in Hawaii and continues the search for the more than 83,000 American service members still missing from past conflicts. The PA assigned to DPAA develops joint health service support and force health protection plans for over 60 joint field activity missions annually in the US Pacific Command and US European Command areas of operation.

Additionally, the PA supervises and trains ten Army medics comprised of SF medical sergeants and special operations combat medics, eight Navy independent duty corpsmen, and five Air Force independent duty medical technicians who deploy in austere conditions throughout the world. The assigned PA should have an SOF background, preferably as a former 18D, with strong interest in tropical medicine.

US Special Operations Command

Located in Tampa, Florida, USSOCOM is the four-star combatant command headquarters for SOF from all services (Figure 52-12).



Figure 52-11. Defense Prisoner of War/Missing in Action Accounting Agency insignia.



Figure 52-12. Special Operations Command insignia.

The assigned PA must be a lieutenant colonel with an extensive SOF background, able to work within a joint staff and interagency environment.

Theater Special Operations Commands

Theater special operations commands (SOCs) are located at the geographic combatant commands to integrate and support USSOCOM forces. The assigned PA must be a senior captain or midgrade major with a strong SOF background, able to work within a joint staff environment. SOCs and their locations are as follows:

- SOC Europe (Stuttgart, Germany)
- SOC Africa (Stuttgart, Germany)
- SOC Central (Tampa, FL)
- SOC North (Peterson Air Force Base, CO)
- SOC Pacific (Camp Smith, HI)
- SOC South (Homestead Air Force Base, FL)

Joint Special Operations Command

The Joint Special Operations Command (JSOC) (Figure 52-13) is a subordinate unified command (established to assume a specific role or mission of a parent command) of USSOCOM. The Joint Medical Augmentation Unit (JMAU) provides highly mobile, far-forward,



Figure 52-13. Joint Special Operations Command insignia.

expeditionary damage-control surgery, resuscitation, and emergency critical care transport in support of JSOC mission requirements in order to achieve US national objectives. Additionally, the JMAU provides or coordinates integrated theater-level medical support such as medical planning, theater and strategic medical evacuation, medical logistics, blood support, and veterinary operations. The JMAU medical squadron commander or senior PA is the lead for 65D hires. Requirements are 2 years' experience as a PA, preferably with a combat deployment, strong SOF background, and demonstrated ability as a small-unit leader. Candidates are nominated, assessed, and interviewed.

NATO Special Operations Headquarters

Located in Belgium, North Atlantic Treaty Organization (NATO) Special Operations Headquarters is the single point of direction and coordination for all NATO special operations-related activities. Its mission is to optimize SOF employment, including an operational command capability. The headquarters is the proponent for NATO SOF policy, standards, doctrine, training, education, and assessments. It maintains and develops a robust operational command, control, communication, computers, and intelligence (C4I) capability equipped with organic SOF enablers to ensure interoperability and enhance employment of NATO SOF.[10]

A SOF enabler is a specialist attached to the assault force (SF ODA, SEAL team, or Ranger platoon) to perform roles that are not organic to the SOF assault team, such as military intelligence, advanced medical, explosive ordinance disposal, cultural support, and linguist. The assigned PA must be a senior captain or major and have a strong SOF background. This job is not a permanent US Army billet and may rotate between services.

Integrating the Force

Historically, after graduation from PA school, men could be assigned to specialized units, whereas women served in support battalions. Many of these types of support units included brigade support battalions, sustainment brigades, and aviation units. However, many missions required women and they were often requested to support the maneuver units.



Figure 52-14. Female special operations forces physician assistants at the Flight Surgeon course graduation, April 2018, Ft Rucker, AL. From left to right: Captain Kayla Holtz, 3rd Special Forces Group, Ft Bragg, NC; Captain Leah Bucholz, 5th Special Forces Group, Ft Campbell, KY; and Captain Kati Monti, 1st Special Forces Group, Ft Lewis, WA.
Photograph courtesy of Elizabeth Hays.

Opening Military Occupations to Women

In December 2015, Secretary of Defense Ash Carter announced that all military training, occupations, and units would be open to women, including those found within the special operations.[11] Since this change in policy allowed female Army PAs to be assigned to combat units, women officially provided medical care on the front lines starting in 2016 (Figure 52-14). Captain Leah Bucholz was the first female PA assigned to an SFG (5th SFG), followed by Major Kati Monti to the 1st FSG, Captain Kayla Holtz to the 3rd FSG, and Captain Jamie Mueller to the 10th FSG. In 2018, Major Monti filled the first SFG senior PA position. Today, the role of female Army PAs is that same as their male counterparts: maintaining the health

and welfare of the soldiers organic to the individual units, while simultaneously meeting mission requirements of the organization in both clinical and tactical settings.

Since all positions were opened to women, the first female PAs placed in traditionally male-dominated units were effectively able to assist those commands by advising on new female-related policies and women's health issues. Pregnancy, contraception, breastfeeding, menstrual cycles, field conditions, and even elective abortion have been hot topics that continue to challenge readiness and unit fitness. Since the initial inception of the directive from Secretary Carter, having a female provider in these units provided an asset to the commander to address these types of concerns during the integration of female soldiers into their ranks.

Women's Roles in Shaping Operations

In the past, female medical providers, including combat medics, were often requested by infantry and SOF units to accompany them on missions to assist with shaping operations and to gain access to specific areas by providing medical care to the local female populations. Assigning female providers to these units allows more flexible mission support when required. Often, having a female health care asset eases tensions across cultures in the medical care of local nationals.

Lessons Learned

These are lessons learned for SOF PAs:

- PAs should do everything possible to obtain solid clinical skills and expertise while in a conventional assignment prior to assessing for a SOF PA assignment.
- Strong physical fitness is always a distinguishing factor, both for application purposes and while assigned as a SOF PA.

Tips for Success

These are tips for success for SOF PAs:

- PAs must be able to operate autonomously. During overseas and training operations, PAs will potentially operate far from organic

military medical support and must utilize any combination of civilian, contractor, or partner nation medical assets to care for their patients.

- PAs must understand that they are a part of SOF support, not "operators." Whether a PA has prior SOF experience or not, the primary role is to provide superior care and training as a clinical and tactical battlefield medicine expert.
- PAs should constantly focus on innovation. SOF units are known for constantly developing newer techniques and technologies, continuously evolving to stay ahead of US adversaries. SOF medical officers must be no different.

Conclusion

The men and women of ARSOF are the tip of the spear in the current fight against enemies of the United States throughout the world. The medical support PAs provide is extremely important to the success of the mission now and in the near-peer battlefields of the future. The SOF community focuses on recruiting the best possible talent from the pool of exceptional PAs in the Army ranks. As the Army makes an effort to become more inclusive on who serves in these slots, all interested 65D officers are encouraged to apply.

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Chapter 53

ROLE OF THE GUANTANAMO BAY PHYSICIAN ASSISTANT

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Introduction

Welcome to "The Pearl of the Antilles"

Guantanamo Bay Naval Base, Cuba, often referred to as "GTMO," contains a joint task force (JTF) comprised of Army, Navy, Air Force, and Coast Guard personnel (Figure 53-1). The joint troop aid station, Kittery Beach Aid Station (KBAS), provides medical and dental care to all the military members of the JTF. A joint medical group (JMG), as the medical command structure for the JTF, supervises the providers and corpsmen who care for the patients at the camps, as well as oversee KBAS. The joint detention group (JDG) oversees all activities for the



Figure 53-1. Joint Task Force–Guantanamo Bay logo.
Photograph courtesy of Joint Task Force–Guantanamo Bay.



Figure 53-2. United States Naval Hospital Guantanamo Bay (USNH-G).

residents in each camp, including life support functions (food, clothing, housing, etc). Each camp has its own medical clinic that provides medical care to the individuals who reside there, including specialty care. Residents of the camps receive all care within the camp facilities. US Naval Hospital Guantanamo Bay (USNH-GB) provides care for all personnel assigned to Naval Station Guantanamo Bay, government employees, family members, and contractors (Figure 53-2).

Supervision

Physician assistants (PAs) are traditionally general medical officers and are supervised, as outlined in Army regulations 623-3,[1] 40-3,[2] and 40-68,[3] by battalion (BN) physicians in the 525th Military Police (MP) BN and, as available, a rotational MP BN (a separate headquarters element usually assigned to the JDG; typically a reserve or National Guard unit with responsibilities such as facility security). Credentialing and privileging for all providers of the KBAS and the camps are processed by the JMG.[4]

Unit Structure

The 525th MP Detention BN and the rotational BN are each assigned a PA and a physician. Both Army BNs and the JMG provide medics and corpsmen to work in the aid station; however, not all of the rotational units that make up the JTF bring medics, so the number available fluctuates. KBAS also has an independent duty corpsman who is supervised by the 525th MP BN surgeon. The JMG provides a dentist and two dental technicians, as well as a physical therapist (who splits time between the clinic and the camps), a physical therapy technician, and a nonspecialized corpsman to augment physical therapy for KBAS. The 525th MP Detention BN and the rotational BN provide a preventive medicine officer and technicians to the JMG. The clinic officer in charge (OIC) reports operationally to the 525th MP Detention BN commander and clinically to the JMG.

Roles and Responsibilities

Traditionally, the PA with the 525th MP Detention BN has been the OIC of KBAS, based on either rank or experience.[5] The USNH-GB commander (serving jointly as the JMG commander) decides which provider will take the position. The OIC is responsible for medical readiness, including patient care, quality management of clinic personnel, tracking information about service members attending medical temporary duty, monthly clinic reports to the JMG commander, rating the noncommissioned OIC, completing line of duty medical recommendations, and attending a variety of meetings held by the JMG, JDG, and both BNs. KBAS is tasked to complete all influenza vaccinations and tuberculosis screening for all JTF members prior to their departure from the island, in addition to routine and urgent health care for their patient population.

Desired Skills and Attributes

Desired skills and attributes of a PA at Naval Station Guantanamo include:

- operational experience,
- rank of senior captain or junior major,

- secret clearance,
- experience as medic trainer,
- graduate of the Captains Career Course, and
- outstanding written and oral communication skills.

Training

Other than traditional credentialing requirements, no training is required for the position. Training in Basic Life Support, Advanced Life Support, and Pediatric Life Support is available at USNH-GB.

Key Factors

Transportation

The position in 525th MP Detention BN is typically 1 year long, with 25 days of leave authorized during that year. Outside of leave, departure from the island is not readily available. Rotator flights occur every other Tuesday, originating at Naval Station Norfolk, Virginia, with a stop at Naval Station Jacksonville, Florida, for passenger pickup, then on to Guantanamo Bay, and returning by same route. Every Friday, a rotation flight from Naval Station Jacksonville to Guantanamo Bay and back occurs. Medical evacuation for urgent patients can be done via the existing rotator schedule; however, emergent medical evacuation is conducted using Tricare evacuation processes.

Rotation Battalion

The provider position in the rotational BN started in February 2014 as a permanent rotation. The slot for the general medical officer is a 3-month billet, and the slot for the PA is a 9-month billet on temporary change of station or temporary duty orders. These positions are filled by the National Guard and reserves. When lack of funding has prevented authorization of the rotational BN, the only medical providers available have been part of the 525th MP Detention BN, which limits access to care and requires the OIC take a larger role in providing medical care, as well as shifting administrative responsibilities to noncommissioned officers and other staff.

Patient Population

All service members aligned with the JTF receive care at KBAS, which is open Monday through Friday and provides service to military personnel only. Service members are Army active duty, National Guard, and reserve; Navy active duty and reserve; Air Force reserve, and Coast Guard reserve. The Guantanamo service member population tends to be older than the average active duty personnel seen in US military clinics. Because many are reserve component, they may or may not have access to routine insurance and health care, and their medical records may not be readily available for review. The majority of patients are seen for musculoskeletal injuries sustained during morale, welfare, and recreation (MWR) sports.

Medical Assets

Medical assets on the island outside of the aid station consist of USNH-GB, which provides limited emergency room, obstetrics and gynecology, optometry, pediatric, family medicine, and general surgery services. Limited ultrasound in the context of obstetrics/gynecology and general surgery may be available depending on the assigned provider. There are also occupational health and physical therapy services at the hospital complex. The hospital has a psychiatrist, but the JTF population primarily receives behavioral health care from the Joint Stress Mitigation and Restoration Team. Other specialties such as cardiology, dermatology, neurology, podiatry, otolaryngology, pulmonology, orthopedics, and urology rotate onto the island for patient care on an as-needed basis. Imaging services, such as computed tomography, limited ultrasound, and radiography, are available at USNH-GB. Providers at the aid station who want to review the actual images for ordered exams cannot be accommodated (at this time) due to insurmountable firewall issues. Magnetic resonance imaging and broader use of ultrasound are not available as of publication; personnel are routinely sent for medical temporary duty to Jacksonville Naval Station.

Medical Supplies

The biggest hurdle for providers at Guantanamo is working within the constraints of supplies arriving by barge, and frequently running

out of commonly used medications such as acetaminophen and diphenhydramine. This assignment is similar to providing medicine provided in rural America, where access to specialty care requires extensive travel, and medications and procedures may not be readily available. Providers often need to consult with the command about patient care to determine if medical temporary duty off the island should be authorized and funded by the unit, if evaluation and treatment by a specialist is needed and unavailable on the island.

Housing

Housing on-island is unique. Unaccompanied or single officers are housed in furnished duplexes and assigned roommates of the same gender. These houses have two to four bedrooms per unit. Company-grade officers tend not to be housed with field-grade officers. Cell phone service is available. Internet access can also be purchased and is sold based on speed and number of devices.

Morale, Welfare, and Recreation Activities

MWR activities are plentiful on Guantanamo, with "fun runs," bike rides, and triathlons scheduled throughout the year. Arts and crafts activities such as ceramics and wood-working are offered, and recent movies are shown nightly in three different outdoor theaters free of charge. Swimming lessons are available for beginners and are free (up to 10 lessons) for military members. Kayaking, paddle boarding, scuba diving, spear fishing, intramural sports, sailing, fishing, automotive skills, and boating are also available.

All boating activities require an MWR captain's license. Training and testing for the license is available, and licenses are printed for a small fee. Scuba diving requires certification; if incoming personnel are already certified, they require only an orientation dive. There is a hyperbaric chamber on the island for dive emergencies.

Medical Training

With the exception of the medics assigned to 525th MP Detention BN, the rotational units, National Guard, and reserve units provide aid station staff. Many of these medics do not work in the medical field during

their civilian jobs and perform medical care only while deployed. It is therefore necessary to have a strong training program and validation system (including Department of Defense instructions 1322.24[6] and 6040.47[7]) in place to ensure medical information passed to the providers is correct and relevant. Because of their lack of experience, many of these soldiers are eager to engage in quality medical training.

Volunteer Opportunities

Many service members deployed to Guantanamo participate in volunteer activities, including "Safe Ride GTMO," "liberty" activities (Navy MWR equivalent), and beach clean-up, just to name a few. Many of the participants volunteer extensive time, contributing significantly to the health and welfare of service members, contractors, and families and are eligible for the Military Outstanding Volunteer Service Medal.

Lessons Learned

Due to the number of orthopedic injuries related to MWR sporting activities, a strong understanding of orthopedics is imperative. A PA with experience doing joint, bursa, and trigger joint injections is essential to providing care at this remote site. Having a physical therapist available is a valuable resource, but these providers are available only part time because they also provide treatment at the camps.

Tips for Success

Due to limited storage, it is recommended all assigned personnel bring essentials only. Limited organizational clothing and individual equipment is required at this site. There is also a limited availability of uniform items through the Naval Exchange, so picking up additional boots, uniforms, and essential military clothing is best done prior to arrival. In addition to military clothing, a supply of fitness clothing, as well as shorts and other lightweight clothing, is recommended. The 525th MP Detention BN providers are each assigned a vehicle for transportation during their time here. Soldiers cannot ship their vehicles to this location but can purchase a vehicle at Guantanamo; however, these vehicles often have mechanical problems and cannot be shipped off the island.

Conclusion

Guantanamo Bay Naval Base provides a unique opportunity for a PA to practice rural style medicine on a diverse, older population of patients. In this assignment, PAs will able to enhance history-taking and physical examination skills while decreasing reliance on advanced imaging. Outside of medicine, there are numerous opportunities for personal education and development, as well as a plethora of activities for relaxation.

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Chapter 54

ROLE OF THE 3D US INFANTRY REGIMENT PHYSICIAN ASSISTANT

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Introduction

Physician assistants (PAs) assigned to the 3d US Infantry Regiment (The Old Guard) are presented with the opportunity to perform medical and ceremonial duties in a unique organization located in the national capital region (NCR). Old Guard PAs are responsible for urgent, emergent, and primary care provided to the soldiers of the US Army's oldest active duty infantry regiment (Figure 54-1).

Unit Background and Structure

The Old Guard traces its lineage to 1784.[1] Currently located at Joint Base Myer–Henderson Hall (formerly Fort Myer) in Arlington, Virginia, the unit has a unique mission and responsibility. In addition to functioning as an infantry regiment, Old Guard soldiers have the privilege of rendering final honors in Arlington National Cemetery and serving as the official Army honor guard and escort to the president of the United States.

The regiment is divided into two distinct battalions, each with its own mission and specialty sections, including the Caisson Platoon, Presidential Salute Battery, Continental Color Guard, US Army Field Band, Fife and Drum Corps, and Tomb of the Unknown Soldier. Officers, noncommissioned officers, and junior enlisted soldiers are specially selected to serve in the unit, and leaders are required to have experience at multiple Army units. Each rifle company commander has commanded at least one company before taking a command in

the Old Guard, and is evaluated not only on military proficiency, but also on ceremonial excellence. All soldiers, regardless of rank or duty, must successfully complete the regiment's rigorous ceremonial training program (Figure 54-2). Old Guard soldiers and officers may earn the right to wear the unit-distinctive trimming, known as the "buff strap," on the left shoulder of the dress blue uniform. The black and tan buff strap is a replica of the knapsack strap used by the unit's 19th century predecessors to display its distinctive colors and distinguish its members from other Army units.[2] The buff strap continues to signify an Old Guard soldier's pride in personal appearance and precision performance, which has marked the unit for 200 years (Figure 54-3).



Figure 54-1. 3rd US Infantry Regiment (The Old Guard) crest.



Figure 54-2. 3rd US Infantry Regiment (The Old Guard) formation, December 6, 2019. The Old Guard soldiers take pride in personal appearance and precision performance, which has marked the unit for 200 years.

Mission and Task Organization

The Old Guard's medical platoon provides urgent, emergent, and primary medical care to soldiers of the regiment. The platoon is comprised of a regimental surgeon, two PAs, and 40 noncommissioned officers and soldiers. Each PA is assigned to one of the infantry battalions and supports its unique mission. The PAs are rated by their respective battalion executive officer and senior-rated by their battalion commander; the regimental surgeon serves as intermediate rater. The medical section maintains a regimental aid station located within the regiment's footprint, allowing for rapid treatment while maintaining medical readiness. Physical therapy and a holistic care team schedule appointments and assist with sick call at the regimental aid station to increase access to care for unit soldiers. The Andrew Rader US Army Health Clinic on Joint Base Myer–Henderson Hall provides ancillary services, including laboratory, radiography, and pharmacy support.

As an infantry regiment, the Old Guard is required to maintain mission readiness and worldwide deployability. The unit is ready to defend the NCR in times of increased national security and civil disturbances.[1] The Old Guard has deployed several times in support of global contingency operations and supports public events in the NCR year-round. From the Army Ten-Miler to Independence Day celebrations, soldiers of the Old Guard are at the core of countless public events providing logistical support and security.

Roles and Responsibilities

Old Guard PAs are responsible for leading, mentoring, and training the regimental aid station staff and medical platoon, providing these personnel with career development and professional guidance (Figure 54-4). Additionally, they have an essential role in guiding and shaping the medical support and readiness training provided to the regiment. Unit PAs also serve as medical advisors to the regimental and battalion commanders on all medical issues, and function as liaisons



Figure 54-3. Soldiers of the 3d US Infantry Regiment (The Old Guard) graduate from the Regimental Orientation Program (ROP), July 21, 2014, at Summerall Field on Joint Base Myer-Henderson Hall, VA. ROP is designed to train new soldiers in rifle movements, ceremonial marching, and uniform styles unique to The Old Guard.
US Army photo by SPC Cody Wes Torkelson.



Figure 54-4. Captain Vince vanderMaarel dons his 3rd US Infantry Regiment (The Old Guard) service uniform, September 19, 2018. The Old Guard physician assistants are responsible for urgent, emergent, and primary care to the soldiers of the US Army's oldest active duty infantry regiment.

between the regiment and higher levels of the medical system. They provide care for high-visibility units and soldiers such as those who maintain 24-hour vigil at the Tomb of the Unknown Soldier, the US Army Drill Team, and the Caisson Platoon. They plan, coordinate, and execute medical support for the regiment's high-visibility events through a team approach that encourages communication across organizations.

Medical credentialing and privileging is provided by Kimbrough Army Community Hospital at Fort Meade; Fort Belvoir Community Hospital and Walter Reed National Military Medical Center are the two higher levels of care within the regional military medical system. Old Guard PAs interact with providers from these and civilian medical facilities in the area to coordinate emergency and follow-up care for their patients.

In addition to providing robust medical care, Old Guard PAs train future generations of PAs through the regimental aid station's candidate evaluation program associated with the Interservice Physician Assistant Program Phase 2 site at the Fort Belvoir Community Hospital.

Skills and Attributes

- Prior operational experience as a battalion PA.
- Rank of captain.
- Graduate of Captains Career Course.
- Must be an excellent role model with the desire to mentor others.
- No prior Uniformed Code of Military Justice violations.
- Applicants should apply through the Human Resources Command assignment officer.

Lessons Learned

Providing medical care to a high-visibility team with a no-fail mission is equal parts rewarding and challenging. Old Guard PAs function in a broad operational paradigm, so adaptive problem-solving is a daily requirement. Whether coordinating medical coverage for a state funeral, briefing senior leaders on emerging epidemics, developing investigative studies to address mission-specific threats, or adjusting to unique mission requirements, Old Guard PAs are at the forefront of Army medicine, often in novel and creative ways.

Conclusion

Providing medical support in the NCR offers unique challenges and opportunities. Medical providers assigned to the Old Guard have an essential role in maintaining readiness while coordinating and conducting care in that complex environment.

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Chapter 55

ROLE OF THE BASIC OFFICER LEADERS COURSE PHYSICIAN ASSISTANT INSTRUCTOR/WRITER

Lakeshia T. Logan, PA-C, MPAS

Introduction

The physician assistant (PA) instructor/writer (I/W) at the Medical Center of Excellence (MEDCoE) Basic Officer Leader Course (BOLC) is responsible for planning, resourcing, developing, documenting, and implementing common core curriculum based on established standards of the US Army Training and Doctrine Command (TRADOC). The BOLC instruction teaches students the basic knowledge required for a new Army medical officer, providing initial military training for over 1,500 Army medical officers annually. The BOLC PA I/W plays a key role in educating and mentoring new medical officers of various company and field grades so they become familiarized with discipline, teamwork, basic soldier skills, tactical and operational medical doctrine, and the principles necessary for becoming a resilient, agile leader.[1]

Course Description

The MEDCoE BOLC is a two-phase program. Phase 1 consists 7 weeks of common core training, and phase 2 area of concentration (AOC) track phase. The length of the track phase is specific to each AOC, and ranging from 1 to 5 weeks. BOLC is designed to provide orientation, training, and initial leader development for newly commissioned officers (Figure 55-1). Students are taught the technical and tactical application of leadership through a performance-based



Figure 55-1. Basic Officer Leaders Course students during a Role 1 mass casualty exercise, preparing patients for casevac (casualty evacuation), at Joint Base San Antonio–Camp Bullis, Texas, February 27, 2018.

curriculum in the areas of health service support, Army warrior tasks, collective training, force structures, and the military decision-making process. Phase 1 (common core) training culminates with a MEDCoE-specific field training exercise. Instructor-to-student ratios ideally range from 4:30 to 4:40. AMEDD BOLC students are evaluated on their written and oral communication skills throughout BOLC.

All Army medical officers are required to complete BOLC at Joint Base San Antonio (JBSA), Texas. Active duty AMEDD officers and Reserve 70-series Medical Service Corps officers attend the 7-week core curriculum on temporary duty status during one of five classes per year. The summer BOLC class is a condensed 6-week class designed for Army Health Professions Scholarship Program officers, who are typically medical students and veterinarians between their 3rd and 4th year of schooling. Reserve component officers, with the exception of 70-series AOCs, attend a 3-week BOLC course, which has six sessions per year and runs concurrently with the active duty BOLC classes.[2]

Instructor/Writer Roles and Responsibilities

BOLC PA I/Ws are responsible for the development, documentation, and implementation of initial entry military training for all AMEDD officers annually. The I/W operates under the Army Learning Concept for Training and Education 2020-2040, a "leadership-directed concept" that outlines the requirements needed to build the future of Army learning across the spectrum of training, published by TRADOC.[2] I/Ws mentor the AMEDD officers assigned to their platoon on common core didactic training. In addition to didactic training, the I/W, as the senior representative for all Specialist Corps officers and specifically PAs in the MEDCoE BOLC, is expected to provide specific guidance and career advice for PAs in the course. The BOLC PA I/W is also responsible for providing mentorship opportunities for PA branch and program managers, as well as coordinating social events for the PAs (Figure 55-2). I/Ws are responsible for creating a positive learning environment in which students work as a team to improve themselves and each other. In addition, the I/W may complete strategic projects for the PA branch, TRADOC, MEDCoE, or the Office of the Surgeon General.

Area of Concentration Track Phase

The PA I/W also develops curriculum and instructs the AOC track phase for PAs (AOC 65D) (Figure 55-3). The I/W arranges the program of instruction by teaching classes and arranging for guest speakers to present information on Army PA roles and responsibilities, operational functions, and medical readiness systems and processes. The final week of training includes a session with the Tactical Combat Medical Care course, which provides training in practical medicine on the battlefield and in urban warfare.

Desired Skills and Attributes

- Candidates must be a BOLC graduate.
- Rank of captain or major and Captains Career Course graduate are preferred.
- Must have operational, tactical, and strategic planning experience as a PA with knowledge and experience working with hospital leadership. Leadership positions as a battalion or brigade PA or in company or



Figure 55-2. Basic Officer Leaders Course student leaders discussing the plan of action for the activities scheduled for the day. The student command sergeant major, Army physician assistant First Lieutenant Antonio Narvaes (right), was responsible for the daily dissemination of information while mentoring and developing his subordinate leaders during the field training exercise at Joint Base San Antonio–Camp Bullis, Texas, February 14, 2018.

clinic command are preferred.

- Must have strong knowledge and application of leader attributes and competencies per Army Doctrine Publication 6-22, *Army Leadership*.[3]
- Must be an excellent role model with a strong desire to mentor others.
- Must have expert knowledge of AMEDD business practices and processes.
- Must be able to serve as a BOLC PA I/W for at least 2 years (3 years preferred).
- Must possess strong spoken and written communication skills, have a people-oriented personality, and exhibit superior field technical and tactical knowledge.



Figure 55-3. Major Lakeshia T. Logan (left) and Major Bonnie Wickham (right) at Joint Base San Antonio–Camp Bullis, Texas, August 14, 2018. Major Wickham is an aeromedical physician assistant who travels with the medevac team to teach the students how to load and unload patients.

Training

Army Medical Department (AMEDD) officers who receive direct commission into the Army are required to attend the Direct Commission Course (DCC) at Fort Sill, Oklahoma, prior to attending BOLC at JBSA. The DCC portion of training can be waived if the officer has completed any of the following courses: Reserve Officers' Training Corps, Officer Candidate School, Army Sergeants Major Academy, National Guard Bureau Officer Candidate School, or Warrant Officer Candidate School.[4] The 4-week DCC trains officers in fundamental skills, foundations of leadership, physical readiness, and tactical and technical proficiency. BOLC PA I/Ws must complete faculty development training (parts 1 and 2) after arriving, which results in a 5K additional skill identifier.

Lessons Learned

The following are lessons learned in being a MEDCoE BOLC PA I/W:

- The initial 6 months in the position should be a time set aside to gain an understanding of the overall mission of BOLC and how to balance practicing medicine and being an active I/W.
- The I/W position is a unique opportunity to influence new AMEDD officers, whether they are direct accessions or prior service.
- The I/W must be prepared to learn Army doctrine outside of the practice of medicine, and possibly outside their comfort zone.
- The I/W should establish guidelines to create healthy boundaries when performing multiple responsibilities.

Tips for Success

Along with lessons learned, the following tips for success will enable future I/Ws to succeed beyond expectations:

- The I/W should not hesitate to do more than other instructors. PAs can easily hold two positions as the 65D track phase coordinator and field training exercise PA.

- If a platoon advisor position is offered, it should be accepted; it will make the I/W a standout among their peers and prepare them for future Army professional military education schools.

Conclusion

The PA I/W works in a nonclinical capacity as the PA representative in the MEDCoE BOLC. This position allows the PA an opportunity to make a lasting impression on initial entry medical officers. The PA I/W can offer relevant guidance on the roles and responsibilities of all AMEDD officers and how they interact with other AOCs in the Army. The PA I/W provides both clinical and operational viewpoints during the course and acts as the subject matter expert on clinical operations for all other instructors.

Acknowledgement

Thank you to Captain Larry A. Williams, PA-C, MPAS, for his contribution in editing this chapter.

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Chapter 56

ROLE OF THE CAPTAINS CAREER COURSE PHYSICIAN ASSISTANT SMALL GROUP LEADER

Christopher Rogers, APA-C, MPAS, and Manuel Menendez, APA-C, MPAS

Introduction

The physician assistant (PA) filling the role as the small group leader (SGL) at the Medical Center of Excellence (MEDCoE) Captains Career Course (CCC) is responsible for planning, developing, and presenting graduate-level professional military education (PME) to active duty, reserve, and international students. This education builds on a PA's leadership attributes. The curriculum provides CCC students with the skills and knowledge to lead company-size units and serve on battalion and brigade staffs operating in joint environments throughout the full range of military operations.[1] Students also gain advanced training in combat health service support operations, as well as Army Medical Department (AMEDD) specific skills and knowledge required to succeed at clinic and hospital assignments. The MEDCoE CCC PA SGL plays a key role in educating and mentoring AMEDD company- and field-grade officers to succeed in battalion to brigade level assignments.[1]

Captains Career Course Background

The mission of the MEDCoE CCC is to train AMEDD officers to lead company or equivalent-sized organizations and to serve successfully in US Army staff positions. Graduates will possess the tactical and technical knowledge necessary to execute Army health systems in support of unified land operations.

Active component officers attend the 9-week course on a temporary duty status during one of four sessions per year. Reserve component

officers attend the 2-week session that meets annually during the summer. Active component officers are encouraged to attend as soon as practical, once promotable to captain (O-3), or between their 4th and 7th year of federal commissioned service.[2] Officers incur a 1-year service obligation for course attendance.[1] All officers should plan their long-term individual, organizational, and institutional education goals by utilizing the Army Career Tracker at https://actnow.army.mil.[3]

The MEDCoE, at Joint Base San Antonio (JBSA), Texas, hosts the course. Both AMEDD officers and international military students attend the 9-week resident course. The SGL-to-student ratio ideally ranges from 1:12 to 1:16.[4] SGLs are responsible for facilitating learning through counseling, coaching, and team building (Figure 56-1). Students hone their critical thinking skills and challenge each other to succeed, through shared knowledge and lessons learned. Measures of effectiveness include graded written and oral communication skills evaluations, demonstrated knowledge of the military planning process, demonstrated knowledge of medical business processes, and improved leadership skills as demonstrated by peer evaluations.[5]



Figure 56-1. The small group leader (right) provides instruction to students during the leader reaction course in January 2020 at Joint Base San Antonio-Camp Bullis, TX.

Small Group Leader Roles and Responsibilities

The SGL operates under the Army Learning Concept, published by the Army Training and Doctrine Command (TRADOC).[3] Each SGL is responsible for creating a positive learning environment in which students work as a team to improve themselves and each other (Figures 56-2 and 56-3). The SGLs must possess strong spoken and written communication skills, a people-oriented personality, knowledge of AMEDD business processes, and superior field technical and tactical knowledge.

All SGLs mentor AMEDD CCC officers assigned to their class regarding course performance, professional development, and their individual careers. The PA SGL, as the senior representative for PAs in the MEDCoE CCC, provides specific guidance and career advice for all PAs in the course. The PA SGL is also responsible for providing mentorship opportunities for PA branch and program managers, as well as coordinating social events for the PAs.



Figure 56-2. The Captains Career Course students discuss their medical concept of support plan with small group leaders (middle) during the military decision making process exercise in January 2020 at Joint Base San Antonio-Fort Sam Houston, TX.

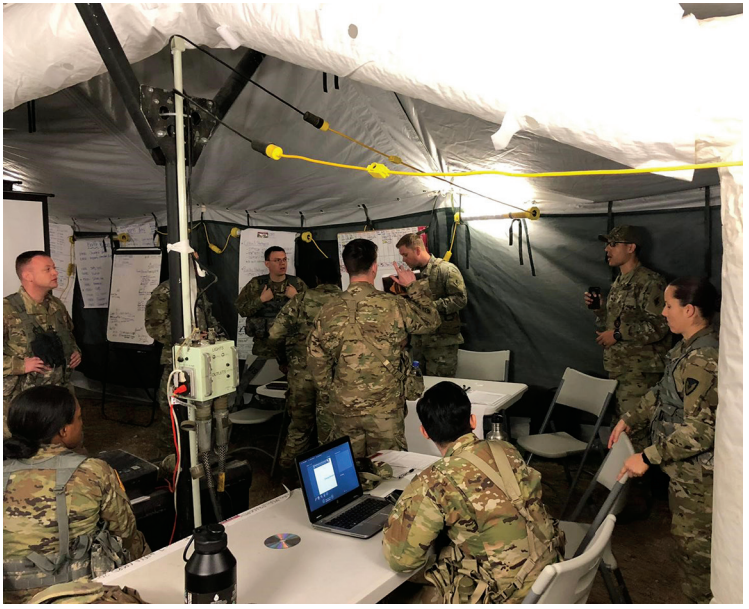


Figure 56-3. The small group leader (right) observes students during their defense support to civil authorities staff exercise in January 2020 at Joint Base San Antonio-Camp Bullis, TX.

Teaching, guiding, and mentoring are not the only activities PAs conduct while assigned to the MEDCoE. There are also assigned additional duties and opportunities to complete strategic projects for the PA branch, TRADOC, AMEDD, or Office of the Surgeon General.

Area of Concentration Day

The PA SGL coordinates "AOC (area of concentration) Day," also referred to as "PA Day," for the PAs in the course. AOC Day occurs during the beginning of the course. The PA SGL arranges for guest speakers to present information to the students on issues pertinent to promotion, career progression, or professional education. Topics include long-term health education and training opportunities, job progression, future promotions, and job opportunities (delivered by a representative from Human Resources Command).

Desired Skills and Attributes

PA SGLs have a variety of backgrounds and experiences. Success is maximized when selectees have combinations of the following traits, experience, and training:

- Candidates must be CCC graduates in the rank of lieutenant colonel or major. Intermediate Level Education graduates are preferred.
- Hospital leadership; operational, tactical, and strategic planning experience as a PA; and senior leadership positions (division or corps PA, company command, clinic command) are preferred.
- Candidates must have strong knowledge and application of leader attributes and competencies.[6]
- Candidates must be excellent role models and have a strong desire to mentor others.
- Knowledge of MEDCoE business practices and processes is preferred.
- Strong written and spoken communication skills and excellent teaching skills are required.
- Experience working on strategic-level projects is preferred.
- PAs chosen as SGLs in CCC should be able to serve for no less than 2 years (3 years is preferred).

Small Group Leader Training

SGLs must complete the 2-week faculty development training (parts 1 and 2) after arriving, which results in a "5K" additional skill identifier. SGLs will have an opportunity to complete this training prior to the start of their primary instructor duties at MEDCoE. Further educational opportunities specific to SGLs are available and include the Curriculum Development Course.

Lessons Learned

Flexibility and adaptability are keys to success for MEDCoE PA SGLs. As the Army continues to evolve in the demanding realm of multi-domain operations, so too will the MEDCoE and Army medicine.

It is highly recommended that SGL PAs maintain lines of communication with previously established Forces Command entities

in order to stay relevant with today's complex operational environment. PAs can leverage contacts within the US Army Combined Arms Center, combat training centers, and Center for Army Lessons Learned for the most up-to-date operational trends and relevant data.

Additionally, SGL PAs should stay abreast of the evolving doctrinal changes to better understand and apply the lessons learned from past successes and failures. The most updated doctrinal references are available at the Army Publishing Directorate, https://www.armypubs.army.mil. Knowledge of current doctrine coupled with education on lessons learned from the National Training Center, Joint Readiness Training Center, and Center for Army Lessons Learned will allow SGLs to influence the leaders of tomorrow.

While stationed at Joint Base San Antonio, PAs may complete professional credentialing at Brooke Army Medical Center. This ensures seamless transfer of provider credentials and allows for completion of the required annual 40 clinic hours. Patient treatment is not part of the instructor primary duties; however, it is essential to stay medically relevant.

Conclusion

The CCC PA SGL works in a nonclinical capacity as the PA representative in the MEDCoE CCC. The PA SGL provides a clinical perspective during the course and acts as a resource for clinical operations to all other instructors. This position is vital in developing and influencing future leaders who can relate and apply doctrinal concepts to medical operations.

As part of the institutional learning domain, the CCC establishes a foundation for leaders to think both critically and creatively to address the myriad challenges of tomorrow's Army. Both course graduates and SGLs gain a greater appreciation of how the Army operates at the operational and tactical levels, and how the MEDCoE supports decisive operations through sustainment and protection.

PAs who are looking for a broadening assignment that challenge their communication skills, understanding of Army doctrine, and small group leadership should consider competing for this rewarding position.

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Chapter 57

ROLE OF THE COMBAT TRAINING CENTER COMMAND SURGEON

Michael A. Davidson, PA-C, MPAS; Jim Beecher, PA-C, MPAS; Sean M. Donohue, PA-C, MPAS; Larry France, PA-C, MPAS; and Brad Tibbetts, PA-C, MPAS

Introduction

There are two combat training centers (CTCs): the National Training Center (NTC), located at Fort Irwin, California, and the Joint Readiness Training Center (JRTC), located at Fort Polk, Louisiana. The CTCs are the Army's premier training platforms for achieving lethality, executing large-scale combat operations, building allied partner capacity, and developing multidomain capabilities. The experience and engagement of a senior leader physician assistant (PA) ensures the medical capabilities and priorities are implemented and sustained by the medical personnel assigned to the rotational training units. As a result, the medical lines of efforts that include medical readiness and training are validated, enhanced, and sustained at the CTCs, currently and in the future.

Position Descriptions

The NTC surgeon position on the installation is the liaison for medical readiness. The NTC surgeon is a table of distribution and allowances (TDA) position within the Weed Army Community Hospital medical activity (MEDDAC) command section, coded for a 67A (Medical Service Corps officer). This position not filled by the Medical Corps branch, which typically fills surgeon positions. Historically, the NTC surgeon was an accepted list position (ALP) occupied by a PA assigned to NTC headquarters (HQ) with duties at Weed Army Community

Hospital MEDDAC; the position existed on the TDA, and the MEDDAC deputy commander for clinical services (DCCS) performed the function as an additional duty. However, input from the NTC commander, the US Army Forces Command (FORSCOM) surgeon, and Western Regional Medical Command prompted a requirement for a continued fill for this position, with an end-state goal of TDA authorization for a PA for HQ NTC. Due to various issues, the position has not yet been codified on the TDA for a PA, but continues to be filled by a PA from the Medical Specialist Corps (Figure 57-1). Colonel Larry France was the first officially recognized NTC surgeon, serving in this position from March 2011 through 2014. Subsequent NTC surgeons include Lieutenant Colonel Pamela Roof, Major Sean Donohue, and Major William Edmonds.

The JRTC surgeon serves as JRTC and Fort Polk command surgeon as well as installation subject matter expert (SME) for medical readiness. The JRTC and Fort Polk surgeon was formerly an ALP filled by a 65DM3 (flight medicine physician assistant) major assigned to HQ JRTC and Fort Polk. The Office of the Surgeon General denied a subsequent ALP request in 2017. Currently, per the TDA, the JRTC surgeon is a 65D (PA) lieutenant colonel (O-5) assigned to the

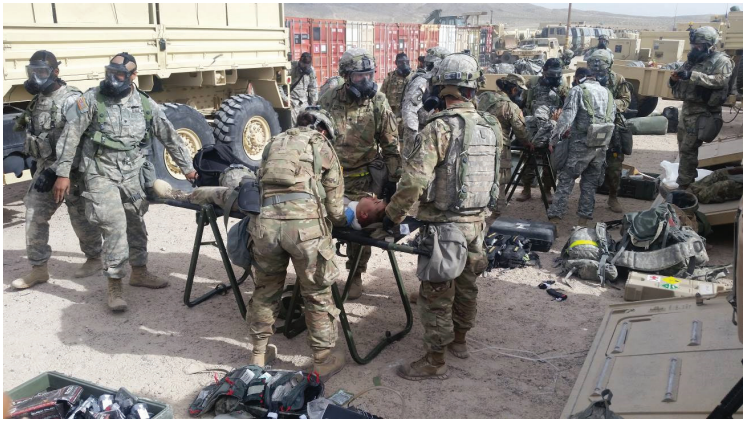


Figure 57-1. 1st Cavalry soldiers conduct Role 1 operations at the National Training Center under chemical conditions in 2015.

MEDDAC at Baynes Jones Army Community Hospital, with duties at HQ JRTC and Fort Polk. Previously, this position was filled by the MEDDAC commander as the JRTC surgeon. Input from the JRTC and Fort Polk commanding general, the JRTC chief of staff, the FORSCOM surgeon, and MEDDAC Fort Polk commander resulted in a recognized requirement for a continuous fill of this position, with an end-state goal of a TDA authorization on the unit identification code for HQ JRTC.

Supervision

The NTC surgeon is rated by the Fort Irwin MEDDAC DCCS (a lieutenant colonel [O-5]) and senior-rated by the MEDDAC commander (a colonel [O-6]); this rating scheme complies with Army regulations (ARs) 623-3, *Evaluation Reporting System*,[1] and AR 40-68, *Clinical Quality Management*.[2] The NTC surgeon has routine interface with the MEDDAC DCCS and Patient Administration Division chief, and leads monthly face-to-face medical team meetings with the chiefs of orthopedics, behavioral health, pharmacy, the Patient Administration Division, and the Integrated Disability Evaluation System; the DCCS; and each tenant brigade-level command team. The JRTC and Fort Polk command surgeon rating scheme is determined by the JRTC and Fort Polk commanding general and the MEDDAC commander. In the past, the position was rated by the JRTC chief of staff (an O-6), intermediate-rated by the MEDDAC DCCS (an O-6 physician, if the MEDDAC commander was not a physician), and senior-rated by the MEDDAC commander (an O-6). The JRTC and Fort Polk command surgeon is currently senior-rated by the JRTC and Fort Polk commanding general (a brigadier general [O-7]). Both of these rating schemes comply with ARs 623-3 and 40-68.[1,2]

Unit Structure

The NTC annually trains 10 to 12 brigade combat teams (BCTs), or their equivalents, in support of joint operational area deployments. Approximately 5,000 active duty soldiers are assigned to the training center, yet daily mission support requirements encompass roughly 20,000 people, including family members and civilians. Current FORSCOM tenant units assigned to the NTC and Fort Irwin with colonel (O-6) command billets include the 11th Armored Cavalry

Regiment (active duty soldiers who serve as enemy forces against rotational soldiers), the 916th Sustainment Brigade (which replicates theater-opening and theater-closing capability), and the operations group (which covers the command and control and observer controller/trainer [OC/T] mission in support of BCT rotations). The MEDDAC, a dental activity, a veterinary detachment, and the US Army Garrison (USAG) Irwin comprise the non-FORSCOM assigned tenant units with colonel (O-6) command billets. The NTC surgeon's office is located within the extended MEDDAC footprint. The NTC surgeon's office staff includes a deputy NTC surgeon; a Medical Protection System (MEDPROS) coordinator; a noncommissioned officer in charge (NCOIC/sergeant first class [E-7]) who serves as senior medical OC/T; and a sergeant (E-5) who serves as an additional medical OC/T and occasional driver (Figure 57-2).

JRTC annually trains 11or 12 BCTs in support of the Global Reaction Force mission (worldwide deployments) and joint operational area deployments. Over 8,000 active duty soldiers are assigned to the training center. Daily mission support requirements encompass roughly 40,000 when family members and civilian workforce numbers are included. Current FORSCOM tenant units assigned to JRTC and Fort Polk with colonel (O-6) command billets include the 3rd Brigade, 10th Mountain



Figure 57-2. A unit conducts defensive operations while in chemical-defense posture at the National Training Center in 2015.

Division, 32nd Hospital Center, and JRTC operations group). As at Fort Irwin, the MEDDAC, a dental activity, and USAG Polk comprise the non-FORSCOM assigned tenant units with lieutenant colonel (O-5) and colonel (O-6) command billets. Non-colonel command billets assigned to JRTC and Fort Polk include the 1-509th Parachute Infantry Regiment (the opposing forces in support of BCT rotations), 1st Battalion/5th Aviation Battalion, 519th Military Police Battalion, and 46th Engineer Battalion. The JRTC command surgeon's office is located in the JRTC and Fort Polk HQ building. The surgeon's staff includes a staff sergeant NCOIC who oversees the administration and logistics for the JRTC Aid Station–Rear during unit rotations. The NCOIC's office is located in the MEDDAC Plans, Training, Mobilization, and Security section of Bayne-Jones Army Community Hospital.

Roles and Duties

The CTC command surgeon position replicates a division surgeon; however, there are differences between the NTC and JRTC positions. The NTC surgeon is responsible for the integration of FORSCOM, Training and Doctrine Command, Army Materiel Command, and Medical Center of Excellence (MEDCoE) doctrinal medical training into the 10 to 12 BCT yearly rotations at the NTC. NTC training operations are governed by FORSCOM Regulation 350-50-1, *Training at the National Training Center*,[3] and AR 350-50, *Combat Training Center Program*.[4] The NTC surgeon also serves as:

- higher-headquarters surgeon for training brigades;
- director of the Fort Irwin Medical Management Center;
- MEDDAC SME on medical readiness in support of the six installation commands, totaling over 5,000 active duty soldiers; and
- installation SME and point of contact for all aspects of unit medical readiness tracking.

The NTC surgeon also:

- assists the MEDDAC's patient administration division on all aspects of the Integrated Disability Evaluation System;
- provides oversight to the installation troop medical clinic's daily operations as they pertain to Soldier-Centered Medical Home issues and challenges;

- provides Role 1 and Role 2 SME oversight to MEDDAC contract providers working in the rotational unit base area aid station; and
- oversees the individual medical readiness status of the assigned senior command teams, and is their conduit for health care readiness operations access.

The NTC surgeon is expected to be available by handheld radio and phone at any time during the 14 days that rotational training units occupy the training area (Figure 57-3).

The JRTC command surgeon's primary duty is to provide oversight of medical welfare and readiness for the 8,000 soldiers assigned to the installation. Like the NTC surgeon, the JRTC command surgeon integrates FORSCOM policies as well as Training and Doctrine Command and MEDCoE doctrine into training for the 11 or 12 BCT rotations per year. The JRTC command surgeon is also responsible for:

- advising the commanding general and staff on health-related issues and concerns that affect medical readiness and operations on Fort Polk;
- supporting medical operations for combat and contingency operations outside the continental United States for units assigned to Fort Polk;



Figure 57-3. The Fort Carson 2nd Infantry Division conducts tailgate medical operations at the National Training Center in 2015.

- supporting planning and evaluation of Defense support of civil authorities missions throughout the Northern Command area of responsibility;
- coordinating with the installation director of health services to minimize or eliminate care and evacuation capability gaps in both air and ground medical evacuation when appointed by the commanding general as director of operational health services;
- ensuring that the medical evacuation continuum of care outside of installation cantonment areas links appropriately with installation prehospital emergency medical providers;
- identifying risks and recommending ways to mitigate them;
- serving as SME for the Installation Health Support Plan in direct collaboration with the hospital commander;
- co-chairing the installation suicide prevention working group and participating in other groups as liaison for the installation health promotion council, liaison to the FORSCOM surgeon, senior FORSCOM provider on the installation senior medical council, and senior FORSCOM provider on the credentials committee;
- serving as senior mentor to the junior medical officers assigned to FORSCOM units at Fort Polk;
- advising the command on medical support requirements and overseeing the echelons above brigade real-world health service support for the 11 or 12 BCT rotations per year;
- serving as a member of the installation Crisis Action Team, which activates in response to disasters such as severe weather, mass casualty events, or terrorist incidents, to coordinate installation response and advise the senior mission commander;
- serving as senior medical trainer and advisor for all medical training conducted at the medical simulation training center;
- ensuring planning and coordination for the Expert Field Medical Badge event, which is conducted at least annually each year at JRTC;
- serving as OC/T for medical providers during unit rotations and interfacing with the FORSCOM surgeon's office and Army Medical Command to ensure inbound BCTs have adequate medical support for the rotation and future deployment;
- serving as SME on medical readiness in support of over 8,000 active duty soldiers and senior leaders; and
- providing executive medicine (medical care to high ranking military members and their families) and overseeing the individual medical readiness of the JRTC and Fort Polk command team.

Desired Skills and Attributes

The NTC and JRTC command surgeon must be credentialed and privileged as a provider at the installation medical treatment facilities. Aviation medicine qualification is recommended for JRTC, but not required. The CTC surgeons also should:

- be a lieutenant colonel (O-5) or a senior major (O-4) with verbal and military skill sets affording daily interface with senior installation commanders on strategic issues;
- have extensive tactical and operational experience as a PA and Army Medical Department (AMEDD) officer;
- have had a combat deployment at the BCT or division level within 3 years of assignment;
- be an Intermediate Level Education graduate;
- have previous experience as a rotational or operational forces provider at the CTC of assignment;
- have solid writing skills and working knowledge of the military decision-making process;
- have a solid understanding of AR 40-501, *Standards of Medical Fitness*[5]; AR 600-8-4, *Line of Duty Policies, Procedures, and Investigations*[6]; AR 635-40, *Disability Disability Evaluation for Retention, Retirement, or Separation*[7]; AR 635-200, *Active Enlisted Administrative Separations*[8]; AR 40-400, *Patient Administration*[9]; AR 40-68, *Clinical Quality Management*[2]; AR 40-502, *Medical Readiness*[10]; and current Army Central Command medical policies;
- have keen insight and ability to mentor junior providers on issues regarding temporary and permanent profiling of active duty soldiers;
- have a Humvee military driver's license, preferably with night vision goggles endorsement; and
- have Federal Emergency Management Agency training and knowledge of the National Incident Management System (Figure 57-4).

Training

To provide medical readiness oversight, aviation medicine services, and senior leader medical care, the CTC command surgeons at all locations need to be trained and have access to the Medical Protection System



Figure 57-4. A litter team evacuates a simulated casualty patient using a UH-60 Black Hawk from the 1st Battalion, 5th Aviation Regiment, a medevac unit known as the "Cajun Dustoff," at the Joint Readiness Training Center, February 2020.
Photograph courtesy of Chuck Cannon, Joint Readiness Training Center/Fort Polk Public Affairs Office.

(MEDPROS), especially its Medical Readiness Portal; the Aeromedical Electronic Resource Office (if aviation medicine qualified); and all the systems that use the electronic medical record (EMR), such as the Armed Forces Health Longitudinal Technology Application (AHLTA), the Composite Health Care System (CHCS), and MHS-Genesis. The JRTC command surgeon also needs to complete the OC/T 2-day academy to serve as the OC/T for medical providers during unit rotations.

Additional Factors

Fort Irwin is located in the Mojave Desert of southern California along Interstate-15, halfway between Los Angeles to the southwest and Las Vegas to the northeast. The closest town (Barstow, CA) is 38 miles from the installation. Shopping, dining, and outdoor sports and recreation require further drive time. The installation has good housing options and is known to have a close-knit community feel. Because the battle rhythm is codified 18 to 24 months in advance, it is easy to plan vacations and other events; however, the NTC surgeon occasionally works over major holidays like Thanksgiving or Independence Day. Because of the highly predictable training schedule, the NTC surgeon should anticipate working on post 2 weekends per month while also having one 3-day and one 4-day training holiday per month. An elementary

and junior high school are both on post, while high school students commute by bus to Silver Valley High School in Yermo, a 45-minute drive from post. Because of its remoteness and the potential for skills degradation, this position is typically a 2-year tour of duty, but can last 3 years (Figure 57-5).

Fort Polk is located in central Louisiana in a medically underserved area. The nearest town, Leesville, is very small and 7 miles away. The nearest city is Alexandria (54 miles away), which has the closest large hospitals and level II trauma center. Access to some specialty care is limited and may require travel. Due to the remote location, anyone with dependents enrolled in the Exceptional Family Member Program should ensure their information is updated as soon as they receive their request for orders. The training cycle and battle rhythm at JRTC are similar to those at NTC; the major differences are that there may be less direct involvement in JRTC rotations, and working over weekends and major holidays is possible, but not a consistent occurrence. This is due to the presence of deployable FORSCOM tenant units stationed at Fort Polk (which is not the case at Fort Irwin). For this reason, the primary duties of the JRTC and Fort Polk surgeon more closely mirror those of a division surgeon, although replicating a division surgeon during CTC rotations is not an official responsibility (Figure 57-6).



Figure 57-5. Major Sean Donohue points out terrain features to Lieutenant General Nadja West, the 44th surgeon general, in 2015.
Photograph courtesy of the US Army Medical Activity Fort Irwin Public Affairs Office.



Figure 57-6. Brigadier General Patrick D. Frank (the Joint Readiness Training Center and Fort Polk, LA, commanding general) briefs the Expert Field Medical Badge (EFMB) cadre before EFMB candidates start night land navigation, February 2020.
Photograph courtesy of Chuck Cannon, Joint Readiness Training Center/Fort Polk Public Affairs Office.

Conclusion

The CTC and the JRTC Command Surgeon positions continue to be very important positions within the Army's premier training platforms for achieving lethality, executing large-scale combat operations, building allied partner capacity, and developing multidomain capabilities. The ability of an experienced and engaged senior leader PA ensures the medical training standards are enhanced and relevant. Lastly, the importance of providing the necessary coaching and mentorship to each of the medical Brigade Combat team members will continue to be essential to facilitate in collaboration and learning.

Aknowledgments

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Chapter 58

ROLE OF THE SURVIVAL, EVASION, RESISTANCE, AND ESCAPE SCHOOL PHYSICIAN ASSISTANT

Jason Bruno, PA-C, MPAS, and Denise Souza, PA-C, MPAS

Introduction

The Survival, Evasion, Resistance, and Escape level C (SERE-C) school is a 3-week course held at Fort Rucker, Alabama, and Fort Bragg, North Carolina. The SERE school physician assistant (PA) serves at Fort Rucker; there is no designated PA position at the Fort Bragg SERE school. The SERE-C school is a full-spectrum course that encompasses in-depth teachings about survival methods, evasion tactics, means of resistance, and methods of escape that align with the values of the Code of Conduct for Members of the United States Armed Forces.[1] The Code of Conduct was established by President Dwight D. Eisenhower in 1955 through Executive Order 10631.[2] It is used as a guide for all service members if they may find themselves as isolated personnel in situations that result in confinement or detention against their will by adversaries.

The Six Articles of the Code of Conduct

Article 1—I am an American, fighting in the forces that guard my country and our way of life. I am prepared to give my life in their defense.

Article 2—I will never surrender of my own free will. If in command, I will never surrender the members of my command while they still have the means to resist.

Article 3—If I am captured I will continue to resist by all means available. I will make every effort to escape and to aid others to escape. I will accept neither parole nor special favors from the enemy.

Article 4—If I become a prisoner of war, I will keep faith with my fellow prisoners. I will give no information or take part in any action which might be harmful to my comrades. If I am senior, I will take command. If not, I will obey the lawful orders of those appointed over me and will back them up in every way.

Article 5—When questioned, should I become a prisoner of war, I am required to give name, rank, service number, and date of birth. I will evade answering further questions to the utmost of my ability. I will make no oral or written statements disloyal to my country and its allies.

Article 6—I will never forget that I am an American fighting for freedom, responsible for my actions, and dedicated to the principles which made my country free. I will trust in my God and in the United States of America.[3(p3-5)]

History

The first Army SERE course was developed and led by Colonel James "Nick" Rowe in 1986.[4] Colonel Rowe was a Special Forces detachment commander taken as a prisoner of war (POW) by the Viet Cong while conducting operations in Vietnam in 1963.[4] He was held in captivity for 5 years and endured extreme hardship in the form of physical abuse, starvation, and mental anguish. While in captivity, Colonel Rowe kept a diary, which helped keep his mind sharp and became a tool to stay engaged and never give up hope. In 1968, while being moved to a different location by his captors, the group was attacked by American helicopters, and Colonel Rowe fled his captors and escaped. When Colonel Rowe created the SERE school at Fort Bragg 18 years later, he used his experience as a POW to develop tools and education for future Special Forces operators in similar situations.[5]

Currently, the Department of Defense has three levels of required SERE training for military personnel.[1] SERE-A is the basic requirement for all military personnel. SERE-B is required for personnel whose position places them at a moderate risk of capture and exploitation. SERE-C is for personnel whose job places them at an increased risk for capture or exploitation in both wartime and peacetime, such as Special Operations forces and aviation personnel.[1] In 2007, the Army created a second SERE-C school at Fort Rucker and made it a mandatory part of flight school for future aviators.[6]

Unit Structure

Fort Rucker is predominantly a US Army Training and Doctrine Command (TRADOC) installation, which is headed by a two-star command at the US Army Aviation Center of Excellence (USAACE). Within USAACE, the SERE detachment falls under the 1st Aviation Brigade, 1-145th Aviation Regiment. The commander of the SERE detachment at Fort Rucker is a major (O-4). The SERE detachment employs a variety of active duty personnel, civilian contractors, and government service employees. For rating purposes, the SERE commander serves as the rater of the SERE school physician assistant (PA), their senior rater is the 1-145th Aviation Regiment commander, and the intermediate rater is the supervising physician at Lyster Army Health Clinic (LAHC). The SERE PA obtains credentialing and privileges and maintains their clinical hours at LAHC. As a qualified aeromedical PA, they work in the LAHC aviation medicine clinic, employing the skills and knowledge obtained in the Flight Surgeon Course.

Roles and Responsibilities

The SERE PA serves as the officer-in-charge of the SERE medical section and is responsible for providing acute, urgent, and emergent medical care for over 2,200 joint service members and civilian contractors annually. The PA provides medical training, leadership, and mentorship for a medic team with up to 10 personnel. The PA acts as an advisor to the SERE commander and course chief on all matters involving health, occupational, and environmental risks to students and cadre. Their role in risk mitigation helps minimize lost training time due to medical injury and illness. Daily duties and responsibilities are as follows:

- Conduct daily sick call operations while students are in the academic portion of training. During field training, the PA and unit medics conduct health and welfare checks at various stages. Direct patient care is documented on a Standard Form 600, which is reviewed and signed by the PA, then sent to LAHC patient administration for upload into the service member's electronic medical record.

- Provide oversight and medical care during training labs and high-risk operations. This allows for monitoring the health status of students directly and indirectly; it also allows for oversight to ensure safety protocols are followed by all cadre.
- Reinforce survival medicine skills to students throughout training. Provide emphasis on skills taught and allow the students to take an active role in their medical needs where appropriate.
- Conduct first responder and basic life support training for all cadre and contractors assigned. This allows for immediate response to any potential emergent situations.
- Review medical packets for all course attendees prior to their arrival and ensure compliance with Army Regulation 40-501, *Standards of Medical Fitness*.[7] The regulation contains SERE-specific requirements for course attendance.[8]
- Advise the battalion and brigade command teams on medical readiness for all personnel assigned to the 1st Aviation Brigade. The command teams will seek the opinion of the PA, as the only medical provider organic to the unit, on personnel and expected return-to-duty timelines, not only for SERE students, but for flight school students as well.
- Attend course revision and planning meetings in an effort to improve programs of instruction and mitigate risk. This helps the PA fully understand the desired outcome for each modification to training and provide pertinent medical input to reach that outcome without detriment to the student.
- Conduct medic (68W military occupational specialty) training in the areas of sick call, medications, urgent care, and emergent scenarios. Issues commonly encountered may be gastrointestinal (nausea, vomiting, diarrhea, dehydration); dermatologic (rash, insect bites, poison ivy, tick bites); and orthopedic (sprains, strains, fractures) in nature.

Position Requirements

To hold this position, the PA must pass and maintain a Class 2 flight physical exam and must:

- be a graduate of an accredited PA program,
- have certification from the National Commission of Certification of Physician Assistants,

- be a graduate of the Army Flight Surgeon Course, and
- have the designated M3 (aeromedical PA) additional skill identifier.

Desired Skills and Attributes

Desired skills and attributes of the SERE PA include:

- prior operational experience as a PA,
- rank of captain,
- strong written and oral communication skills, and
- leadership experience.

Training

The Flight Surgeon Course educates health care providers in the area of aviation medicine and policies related to aviation personnel and their aeromedical qualification status.[9] Prior to assuming the position, the PA must attend and complete SERE-C, which allows for a better understanding of what the students will experience, and provides insight into their mindset and condition throughout the course. The opportunity to attend other SERE courses is available; there are multiple SERE courses throughout the Army that further delve into the specifics of evasion and resistance techniques. PAs can attend conferences such as those held by the Wilderness Medical Society, which offer a fresh perspective on issues related to field and survival training, and provide student teaching opportunities to facilitate their learning objectives.

Lessons Learned

The SERE PA position is not a clinical position; it is a medical director position. The mission is split into three major areas: screening, medical direction, and prevention. Most of the PA's time is spent screening medical packets to ensure they meet all admittance criteria. The next most important tasking is to provide mentorship and medical standards for the medical team to operate with. A SERE standard medical operating guideline has been created, but it requires refinement and continual updating from one PA to the next to ensure preventive strategies and treatments stay current. The success of the SERE PA relies on their involvement with all aspects of the course. This includes

working with the course registrar to have all packets completed at least a week prior to course start date, and attending all areas of the course to maintain current knowledge on how each section is operating. Finally, the SERE PA must be proficient and knowledgeable in diagnosing and treating a variety of medical conditions, most commonly dermatologic and musculoskeletal conditions. They also must determine when the soldier can continue in the course and when to send them for further care, which may mean that the soldier must be disenrolled from the course.

Tips for Success

- The SERE PA must be prepared to be challenged, both mentally and physically. The course itself is tough and will push the PA out of their comfort zone.
- The SERE PA must be present throughout all aspects of training. They must directly observe students during various phases; this will give the PA a unique perspective on students' overall health status. Injuries or illness are often concealed by students to avoid being dropped from training for medical reasons. The SERE PA must be ready to make the tough call to remove students from training when necessary.
- The SERE PA must work closely with the safety officer. Safety and medical personnel often work closely together to mitigate risk to the students and ensure safe training.

Conclusion

The SERE position at Fort Rucker is an extremely rewarding position. It allows the PA to expand their knowledge of military operational processes as well as impart medical skills to the students. The SERE medical team is highly motivated and prides itself on accomplishment of the mission. The team's goal is to ensure that each and every student successfully completes SERE school with knowledge of the potential dangers to their health, the skills to mitigate that risk, and the ability to return to duty upon graduation, and ultimately "return with honor."

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Chapter 59

ROLE OF THE ARMY PHYSICIAN ASSISTANT IN WEAPONS OF MASS DESTRUCTION CIVIL SUPPORT TEAMS

James A. Carroll, APA-C, DMSc, MPAS

Introduction

The National Guard Bureau has created a total of 57 weapons of mass destruction civil support teams (WMD CSTs). The WMD CST units assist, assess, advise, and facilitate support to local, state, and federal agencies in the course of chemical, biological, radiological, nuclear and explosive (CBRNE) incidents. The teams were formed to provide each state and territory with an on-call military CBRNE response unit available at all times. They also provide public safety support for significant events throughout the United States, including championship sports venues, international dignitary visits, and large-scale political events. The WMD CST Army physician assistant (PA) functions as the medical officer for the team.

Originally, the teams were referred to as Rapid Assessment and Initial Detection teams, consisting mostly of traditional National Guard members, and covered the 10 Federal Emergency Management Agency (FEMA) regions. Eventually, these units were converted to Active Guard Reserve status, and each state (versus each FEMA region) stood up fully funded teams with the new name. To date, New York, California, and Florida have two separate WMD CSTs. The US territories of Guam, Puerto Rico, and the US Virgin Islands also have WMD CSTs.

Medical Training

Initial training is provided at the Civil Support Skills Course, held at Fort Leonard Wood, Missouri. Thereafter, the WMD CST PA attends specific training unique to the CBRNE health care provider role. This includes multiple courses in radiation medicine, critical incident stress management, occupational health, and additional educational coursework detailing methods and protocols for the identification and treatment of chemical, biological, and radiation exposures. The comprehensive list of medical training for the WMD CST PA includes the full spectrum of life support certifications: Advanced Life Saver, Basic Life Support, Advanced HAZMAT [hazardous materials] Life Support, Advanced Burn Life Support, Advanced Trauma Life Support, Pre-Hospital Transport Life Support, and the Difficult Airway Course. Also, the PA must complete a trauma rotation on a recurring basis at one of several US locations. The trauma training frequency is dictated by the WMD CST medical section individual training requirements matrix as approved by the National Guard Bureau. In all cases, the WMD CST PA must also maintain HAZMAT Technician certification.[1]

The WMD CST PA occupies a multipurpose duty position, which calls for extensive training and expertise in emergency medicine, trauma medicine, occupational medicine, toxicology, and pre-hospital transport life support. To achieve expertise in toxicology, the PA must understand the chief CBRNE threats. This includes in-depth knowledge of biological agents at an advanced infectious disease level, an understanding of the medical effects of ionizing radiation, and the medical countermeasures for WMD chemical agent exposures. A crucial role for the WMD CST PA is the preservation of occupational safety for all team members in all environments. The seasoned WMD CST PA is a valued asset to the WMD CST commander if the response involves assessing clandestine laboratories or evaluating casualties. These two critical functions help in the identification of downrange CBRNE agents and the appropriate choice of required treatment protocols.

Personnel and Equipment

The WMD CST medical section is comprised of both medical and science components. There are four personnel. A medical operations officer, the team physician assistant, a nuclear medical science officer,

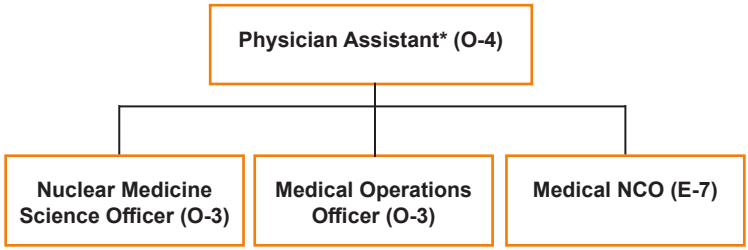


Figure 59-1. Weapons of mass destruction civil support team medical section organization, subject to senior-ranking team members in position.
*Senior officer positions can vary based on tenure.
NCO: noncommissioned officer

and a combat medic, who is usually certified as a paramedic (Figure 59-1). The section has two assigned vehicles, the medical recovery vehicle (MRV) and a mobile analytical laboratory system (ALS). The MRV provides a mobile platform for CBRNE customized prehospital medical support for WMD CST members. The ALS is a state-of-the art mobile laboratory designed to deliver on-scene identification of selected CBRNE threat agents.[1]

Garrison and Deployment

In garrison, the WMD CST PA directs the respirator-based occupational surveillance program for all team members. This includes the completion of the entry, annual, and exit physical exams, as well as maintaining compliance with immunizations required for CBRNE response. Also, the WMD CST PA serves the state community of first responders as a reach-back subject matter expert, and as a trainer to medical staff in both military and civilian hospital settings. As a subject matter expert, the WMD CST PA coordinates and collaborates with state health departments, the Centers for Disease Control and Prevention, the Federal Bureau of Investigation, and the Defense Threat Reduction Agency during missions and training. The role of the WMD CST PA as a medical trainer extends to federal, state, and local public safety personnel, as well as emergency medicine clinicians and emergency medical services providers.



Figure 59-2. (a) "Man-down" exercise, Maine, 2012. Decontamination of the level A (full encapsulation with splash, vapor, and respiratory protection) protective suit is completed prior to emergently removing the suit to further decontaminate the casualty.
Photograph courtesy of the 11th Weapons of Mass Destruction Civil Support Team unit historian photo files.



Figure 59-2. (b) Decontamination line, Florida coast, 2012. The decontamination line provides an organized sequence of decontamination procedures during doffing of personal protective equipment.
Photograph courtesy of the 11th Weapons of Mass Destruction Civil Support Team unit historian photo files.

Upon deployment, the WMD CST PA functions as the medical officer in a CBRNE response or as a contributing medical subject matter expert during joint HAZMAT assessment team missions at high-profile events. The WMD CST's typical site set-up includes a decontamination line delineating the area for casualty management and treatment. Rapid and focused decontamination measures ensure that an injured or exposed team member is quickly advanced to the cold zone (Figure 59-2). In the ever-changing landscape of homeland security requirements, the role of the WMD CST PA continues to evolve as the teams take on new missions, embrace cutting-edge technology, and regularly complete challenging missions.

Desired Skills and Attributes

The WMD CST PA requires a mastery of both the medical and scientific principles associated with CBRNE agents. The PA provides occupational medicine oversight for team members in action while also time serving as an onsite toxicology subject matter expert. These attributes contribute to both the safety of survey team members and prompt identification of CBRNE threats in the hot zone.

Lessons Learned and Tips for Success

The following are lessons learned and are tips for success that will enable the future WMD CST PA to succeed:

- Although the WMD CST program provides extensive medical and scientific training, the WMD CST PA must make an individual effort to master the immense amount of training course information and develop a broad understanding of the medical and scientific effects of CBRNE agents.
- A WMD CST PA on the scene of a CBRNE response must ensure that all survey team members are medically cleared for entry into the hot zone.
- Additionally, the PA must collate all available data associated with the mission response. This can include casualty information (signs and symptoms), law enforcement reports on downrange threats, various forms of intelligence, and background information on suspects.

Conclusion

The role of the WMD CST PA covers several medical and scientific disciplines, including toxicology, laboratory science, occupational medicine, pre-hospital and transport life support, and trauma medicine. The WMD CST medical officer position is a challenging and extremely rewarding career opportunity for the Army PA. With the multidisciplinary training required, the WMD CST PA develops a unique skill set. Once mastered, this knowledge empowers the WMD CST PA with the ability to influence the safe and successful outcome of a WMD CST response. Most importantly, the WMD CST PA ensures the safety of each team member who enters the hot zone.

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Chapter 60

ROLE OF THE WHITE HOUSE PHYSICIAN ASSISTANT (TACTICAL MEDICAL OFFICER)

James Jones, PA-C, PhD, MPAS; Travis Kaufman, PA-C, DMSc, MPAS; and Andrew Darrah, PA-C, MPAS

> "White House Physician Assistants are the tip of the spear, leading White House Medical Unit process improvement initiatives throughout the operations, clinical, and executive medicine mission."
>
> *—White House Medical Unit Director, State of the Unit, 2020*

Introduction

The joint service White House Medical Unit (WHMU) physician assistant (PA) has served as the senior medical planner and tactical medical officer (TMO) for the president, vice president, first family, and second family of the United States for the past 42 years. The first PAs from the Army, Navy, and Air Force joined the ranks of the WHMU in 1978.[1] At the position's inception, the White House PA performed hospital and site assessments to assist the physician to the president with medical planning.

Over the past 4 decades, trailblazers in the joint service WHMU PA position have expanded the initial role to include chief operations officer, deputy chief operations officer, officer in charge of five clinics, WHMU training officer, tactical medical officer, and PA to the physician to the president. Major Saibatu Mansaray-Knight was the first female Army PA to be assigned to WHMU.[2] She ultimately became the first medical officer to be selected as the Army military aide to the vice president of the United States.[2] Lieutenant Colonel James Jones was the first PA to serve as the deputy director of the WHMU and PA to the physician to the president. In 2017, Lieutenant Colonel Jones was awarded the Director's Lifesaving Citation for his efforts in treating a Secret Service agent while on mission in Peru.[3,4]

Roles and Responsibilities

PAs assist the White House physicians in providing comprehensive health care to the president, vice president, and their families. They also provide on-site medical response and urgent care for the president and vice president. White House PAs develop, coordinate, and direct comprehensive multiagency emergency plans for tactical, strategic, traumatic, and medical contingency scenarios worldwide. They independently conduct on-site and remote assessments of medical capabilities at White House travel destinations worldwide. The PAs also provide acute care to military personnel assigned to the White House and occupational health services to members of the White House staff and Secret Service.

"Tactical medical officer" is the official title of PAs assigned to the WHMU. As a TMO, White House PAs ensure the continuity of the Office of the President by developing and implementing protective medicine plans and procedures, managing executive health care, gathering global medical intelligence, performing contingency medical planning, and supporting travel medicine. Protective medicine procedures and travel medicine support include immunizations for endemic diseases, malaria prophylaxis, and guidance on protecting travelers from a variety of food-, water-, and insect-borne disease. White House PAs gather medical intelligence through on-site surveys of medical facilities and by conducting extensive research through a variety of approved online medical databases.

As part of contingency medical planning, White House PAs evaluate prehospital evacuation platforms, develop plans for all potential natural and manmade medical threats, and implement mitigation strategies to prevent injury or disease. White House PAs work with the Secret Service, other White House Military Office (WHMO) elements, other components of the Department of Defense (DOD) and local, state, federal, and international governments to plan and prepare for lifesaving medical interdiction involving serious injury or illness to the president or vice president. PAs also serve as the solo health care provider for the vice president and first lady of the United States.

Supervision

White House PAs are supervised by White House physicians, who are board-certified in emergency and family medicine. White House PAs collaborate directly with the physician to the president and are credentialed through Walter Reed National Military Medical Center.

Unit Structure

White House PAs belong to the WHMU, a vital branch of the WHMO. The WHMO provides direct military support to the president and vice president. The WHMO also oversees functions such as presidential food services, transportation, world-wide communications, medical support, emergency medical services, and hospitality services. WHMO supporting units include the White House Communications Agency, Presidential Airlift Group, Naval Support Activity Thurmont, Marine Helicopter Squadron One, Presidential Food Service, and the White House Transportation Agency.[5]

WHMU is a joint service unit comprised of physicians, PAs, nurses, psychologists, administrators, logisticians and medics/corpsmen, from the Army, Air Force, Navy and Coast Guard. Together, these personnel are responsible for the health care of the president, vice president, and their families. The unit also provides acute and emergency care services to over 3,000 military members assigned to presidential support, 6,000 members of the Executive Office of the President, the Secret Service, and the 1.5 million visitors to the White House annually. Together, WHMO and WHMU provide essential services to the president and help maintain the continuity of the presidency (Figure 60-1).

Leadership Opportunities

The leadership opportunities available to WHMU PAs include the following:

- **Chief of operations.** Works directly with presidential staff to develop the medical plan for travel. Responsible for primary hospital selection and medical package development; serves as the senior liaison for any issues that arise related to mission support.



Figure 60-1. White House Medical Unit with President Barack Obama in the State Dining Room, January 17, 2017.
Photograph courtesy of the White House.

- **Deputy chief of operations.** Responsible for the development of medical packages, medical divert information, and domestic and foreign travel requirements.
- **Senior PA.** Manages the PAs sponsorship program. Works with the PA training officer to make sure all TMOs are mission ready and deployable at all times.
- **Clinic officer in charge.** Manages physicians, PAs, nurses, and medics assigned to the clinic. Oversees medical care provided to those who support president and vice president.
- **PA training officer.** Manages the training for all PAs. Coordinates directly with DOD training units and civilian agencies for all initial and sustainment training for TMOs.

Required Skills and Desired Attributes

The required skills and desired attributes for this positions are:

- 6 years of active duty service, including a post-training utilization tour of at least 3 years as a PA, and a demonstrated record of sustained clinical excellence;
- proven track record of exemplary interpersonal skills, maturity, integrity, and character;
- graduate of an accredited PA program;
- certification from the National Commission of Certification of Physician Assistants;
- certification in Advanced Life Support;
- experience in Advanced Life Support principles;
- operational experience (preferred);
- rank of captain or junior major;
- graduate of the Captains Career Course (required) and Intermediate Level Education (preferred);
- outstanding written and oral communication skills; and
- must meet Army weight and physical fitness standards and be a nonsmoker.

Training

The training path to become a fully qualified TMO may take up to a year and is conducted during real world operations. A TMO will become fully qualified to develop contingency medical plans for the president and vice president after completing a contingency medical officer fellowship at the WHMU. The fellowship has objective training measures and guidelines on the number of missions needed for completion.

In addition to maintaining the required medical readiness training, PAs must complete the following additional training during the first year of assignment: Tactical Combat Medical Care Course, Management of Chemical and Biological Casualties Course, WHMO course, Radiation Emergency Assistance Center/Training Site course, Advanced Trauma Life Support, Advanced Cardiac Life Support, Basic Life Support, and Pediatric Advanced Life Support.[6] Other training is provided, as required, based on the PA's individual level of experience.

Key Factors

This position is typically 3 years in length. WHMU submits a formal request for candidates from the Office of the Secretary of Defense 15

months prior to the projected vacancy. It is DOD policy under Directive 5210.55[7] that only the most suitable and qualified individuals shall be selected for and retained in presidential support duties to ensure optimum presidential security and support. All candidates must be able to obtain a top secret and Yankee White clearance for presidential support duties in accordance with DOD Directive 5210.55,[7] and they must be selected through a competitive interview process.

Successful candidates will represent military medicine to the nation's senior leaders. Being a White House PA is a demanding yet rewarding position. The professional development and communication skills PAs develop at the White House are invaluable to the success of the WHMU mission.

Lessons Learned and Tips for Success

Before applying, those with a spouse or family must fully consider the impact of extensive short-notice travel requirements. Typically, temporary duty trip durations are 3 to 10 days, and occur four to six times per month; occasionally trips may last up to 14 days. PAs are occasionally sent from one mission to the next without the chance to return home. Travel notifications can be as short as 60 minutes during times of increased operational tempo. A robust family care plan is absolutely essential for a PA's success.

WHMU is unlike any military billet most PAs have ever held before. PAs operate in a civilian business environment and must be flexible and maintain discrete professionalism at all times. PAs will engage with patients of all ages and social stature. The daily uniform is business attire; service dress is worn occasionally. The operational camouflage pattern uniform is not worn when assigned to WHMU.

Conclusion

If selected to serve in this distinguished position, all candidates should be prepared to embark on a 12-month intensive training process. Although the overall framework is established, each PA's training path is unique, allowing them to focus on what interests them the most. The WHMU is seeking candidates who are flexible, innovative, and willing to learn. The most successful PAs at the WHMU are those who can accomplish the mission in any environment.

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Chapter 61

ROLE OF THE DEFENSE HEALTH AGENCY MEDICAL LOGISTICS DIRECTORATE

Victor Acevedo, PA-C, MPAS, and Keary Johnston, PA-C, MPAS

Introduction

The Defense Health Agency Medical Logistics Directorate (DHA MEDLOG), formerly known as the Defense Medical Materiel Program Office, located at Fort Detrick, Maryland (Figure 61-1), is a joint activity under the direction, authority, and control of the Defense Health Agency (DHA). Since the DHA MEDLOG's inception, its focus has been medical materiel standardization within the Department of Defense (DOD).[1] The DHA has tasked the MEDLOG with integrating and delivering medical logistics materiel, equipment, and services along the continuum of operational and institutional Military



Figure 61-1. The Defense Medical Logistics (MEDLOG) Center on Fort Detrick, Maryland, is home to the Defense Health Agency MEDLOG Directorate (2020).

Health System missions.[1] The DHA MEDLOG is supported by an office staffed with diverse clinicians and non-clinicians, including an Army physician assistant (PA), registered nurses, pharmacists, laboratory officers, biomedical equipment technicians, medical logisticians, information management staff, and support personnel representing all the services.

Job Duties and Responsibilities

The DHA MEDLOG PA serves as chief of the Clinical Product Analysis Office (Figure 61-2). This office's main role is to provide accurate and appropriate clinical input to the military medical logistics community. The chief is responsible for (*a*) providing input as a clinical subject matter expert to support current and new medical materiel and contingency readiness; (*b*) helping identify new requirements and processes within the DOD supply system to support joint and service

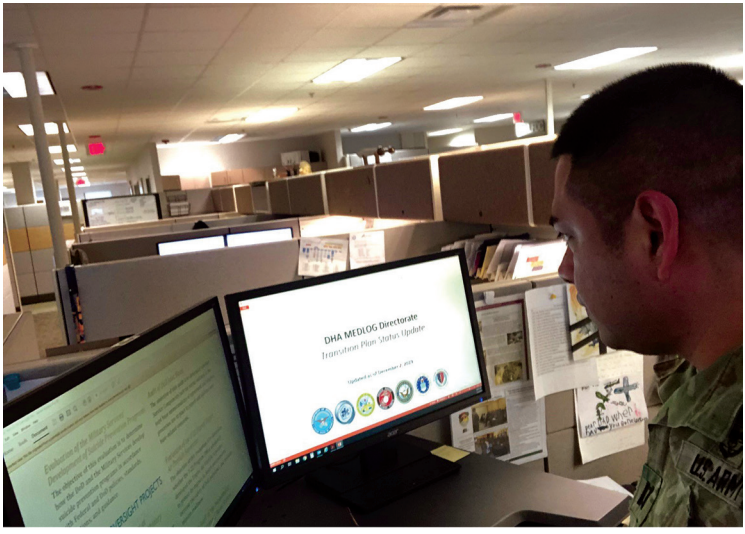


Figure 6-2. Captain Victor Acevedo performing daily duties as chief of the Clinical Product Analysis Office, Supply Management Division, Defense Health Agency Medical Logistics Center (2019).

operational requirements; and (*c*) leading joint initiatives and projects to optimize use of medical materiel across the services. Additionally, the chief serves as the DHA MEDLOG's National Stock Number management team officer in charge, responsible for (*a*) maintenance and new actions for over 100,000 medical materiel items in the Defense Medical Logistics Item Identification System (DMLIIS) database;[3] (*b*) evaluating medical materiel for quality and adjudicating product quality deficiency reports for the DOD;[4] (*c*) maintaining and updating the DOD's recommended personal protective equipment list for health care personnel;[5] and (*d*) working with joint developers, planners, researchers, and testing agencies to identify capability gaps for improving medical material interoperability, interchangeability, sustainability, and casualty survivability.

The DHA MEDLOG PA also provides clinical and operational insight to interservice and intergovernmental agencies, including the US Army Medical Materiel Agency, the Air Force Medical Evaluation Support Activity, the Air Force Medical Readiness Agency, and the Marine Corps Systems Command. Additionally, the PA represents DHA MEDLOG as a member of multiple clinical working groups, including the Committee for Tactical Combat Casualty Care and the Global Patient Movement Joint Advisory Board.

Requirements

The Army PA serving in this position must hold the rank of captain or above, have graduated from the Captains Career Course, and have clinical experience as a PA (civilian or military) and as an Army Medical Department officer. An overseas combat deployment experience is appropriate.

Skills and Attributes

The following qualities are helpful for excelling in this position: (*a*) a history of operational experience, in the wider readiness variety of units, the better; (*b*) recent deployment experience, preferably experience in multiple roles of care; (*c*) develop the basic knowledge of medical logistics and acquisition processes within the DOD; (*d*) basic knowledge of data processing and reporting; and (*e*) interest in medical equipment and medical product research.

Another very important skill is to be able to effectively lead working groups comprised ofclinicians, engineers, and logisticians from within the organization, other services, and outside entities such as the Defense Logistics Agency.

Training

The Defense Acquisition University online course, "Fundamentals of System Acquisition Management" (ACQ 101), should be completed within the first 6 months in this position. DHA MEDLOG and the Defense Logistics Agency provide general training to access medical logistics databases and tools such as the JMAR (Joint Medical Asset Repository), DMLIIS, MCRW (Medical Contingency Requirements Workflow), MMC (Medical Master Catalog), and MedPDB (Medical/ Surgical Product Data Bank). These systems contain information on medical supplies, devices, and equipment in use by the services.

Key Facts

This position is typically a 3-year tour and is coded for a 65D (PA area of concentration) O-3 (captain) with no other additional skill identifier requirements. The position title is expected to change upon approval of the new DHA MEDLOG organizational structure, which will grow in size and responsibility. The position is a staff rather than a leadership position, and is currently rated by the chief of Supply Management Division (immediate supervisor) and senior-rated by the director of the DHA MEDLOG. In this position, the PA is not responsible or expected to provide medical care or medical advice at work. However, to maintain clinical skills and provider bonus pay, the PA in this position is encouraged to volunteer at the Barquist Army Health Clinic at Fort Detrick. Historically, PAs assigned to this position are in clinic between 8 and12 hours per month. The credentialing military treatment facility is Fort Meade, Maryland.

Tips for Success

The PA in this position needs to think "joint" versus Army. Newcomers to DHA MEDLOG should become familiar with the directorate's

official public website, https://www.health.mil/About-MHS/ OASDHA/ Defense-Health-Agency, and pay particular attention to the publications and policy documents issued by Military Health Affairs and the DHA.

Conclusion

The PA serving as chief of the DHA MEDLOG Clinical Product Analysis Office will be involved in multiple aspects/groups that impact the Military Health System medical materiel and sustained contingency readiness. He or she will be expected to provide input about medical logistical needs and related matters of the joint operational field (roles of care 1–3), while collaborating daily with fellow service members and equities from the other service departments, DOD civilians, and government contractors.

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Chapter 62

ROLE OF THE PHYSICIAN ASSISTANT IN OCCUPATIONAL MEDICINE

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Introduction

The National Institute of Environmental Health Sciences defines occupational health as the identification and control of risks arising from (*a*) physical, (*b*) chemical, (*c*) biological, and (*d*) psychosocial workplace hazards in order to establish and maintain a safe and healthy working environment.[1] Additionally, the Occupational Safety and Health Administration (OSHA) directs that occupational health professionals apply the disciplines of occupational medicine, industrial hygiene, epidemiology, toxicology, preventive medicine, and statistics in collaborative multidisciplinary occupational health and safety teams that design, implement, and evaluate occupational health and safety programs.[2] OSHA's goals are to (*a*) enhance health, (*b*) improve safety, and thus (*c*) increase productivity.[2]

The US Army Occupational Health Program has adopted and adapted OSHA's standards, providing the support and resources necessary to achieve compliance in Army workplaces. The role of the occupational health physician assistant (OHPA) is critical in the occupational safety and health of soldiers, Department of Defense (DOD) civilians, and other beneficiaries who work with the Army, and thereby potentially encounter acute or chronic exposures to workplace hazards.

History of Occupational Medicine

Hazardous exposures that increase the risk of morbidity and mortality are not new in the workplace. Numerous diseases and injuries due to work-related exposures have been documented from Roman times through the present. One of the most cited is the account of Pliny the Elder, a Roman scholar who devised a face mask from an animal bladder to protect laborers working with zinc dust and sulfur fumes in the 1st century ad.[3] In other historical cases, Hippocrates documented miners with lead toxicity in the 4th century bce; Galen recognized lead poisoning and hazardous copper exposures among miners in the 2nd century ad; and Agricola, a German scholar, transcribed the first cases of pneumoconiosis-silicosis, a restrictive lung disease, in his 1556 book *De Re Metallica*. Percival Pott associated London chimney sweepers' exposure to soot with scrotal cancer in 1775; Alice Hamilton correlated worker illnesses and injuries to exposures to lead, carbon monoxide, and dangerous and repetitive industrial practices in the early 20th century[4]; and Rachael Carson's 1962 book, *Silent Spring*,[5] found the pesticide dichlorodiphenyltrichloroethane (DDT) detrimental to both birds and people (from consuming exposed produce and being sprayed during agricultural work). Joyce Egginton's *The Poisoning of Michigan* describes the 1970s dairy cattle contamination with the highly toxic chemical polybrominated biphenyl (PBB), which contributed to over 9 million residents ingesting contaminated milk and meat for almost a year.[6]

The true father of occupational medicine was the Italian Bernardo Ramazzini, who wrote a book in 1700 on occupational diseases, including military service exposures. He was credited with asking every patient, "What occupation do you follow?"[4] This practice is upheld today by all Army OHPAs, who are trained to ask every patient or soldier, "What is your military occupational specialty (MOS) or job in the Army?"

Workforce health and safety standards continue to evolve. In 1994, the World Health Organization developed a "Global Strategy on Occupational Health for All," and regular international conferences develop consensus action plans to address the large gaps between optimal occupational health services and the actual services available to most of the world's workforce.[7]

Background

The US Army's soldiers and civilian workforce have been exposed to a variety of occupational hazards since the Army's inception in 1775. Until the US Civil War (1861–1865), these exposures were an accepted risk of war and soldiering.[8] During the Civil War, several weapons systems, including the "Union repeating gun" (also known as the Ager gun) were returned to manufacturers after testing because of design flaws that injured soldiers (lead exposure was not known at that time to cause adverse health effects).[8] The invention of the tank in World War I added new hazards, prompting French military medical officers to study, report on, and mitigate carbon monoxide poisoning of tank crews from weapons propellant combustion inside sealed crew compartments.[8] New occupational hazards presented by new weapons and technologies prompted the Army Medical Department to establish the Armored Force Medical Research Laboratory at Fort Knox, Kentucky, in 1942.[8] This center studied the stressors placed on soldiers by the soldier–weapon system interface and recommended design modifications to improve effectiveness and safety of those systems.[8]

To protect workers in the gas defense production and ammunition plants of World War I and World War II, collaborative efforts arose that resulted in (*a*) the Army's taking responsibility for employee health; (*b*) expansion of industrial medical programs (including considerations for pregnancy, infectious disease, and overseas stationing); and (*c*) the establishment of the Army Industrial Health Laboratory in 1943. Originally located at Johns Hopkins University, the laboratory was relocated to Aberdeen Proving Ground, Maryland, and became the US Army Environmental Hygiene Agency after World War II.[4]

There was a lull in new Army occupational health programming between World War II and 1970, when the Occupational Safety and Health Act put the onus of responsibility for occupational injuries and illnesses on US employers and the military, forcing them to provide a safe and healthy workplace. The military then took on the responsibility to develop and publish (*a*) military standards, (*b*) an information management surveillance system, and (*c*) occupational health programs for both garrison and overseas.[4,9]

In the early 1980s, to improve occupational health services for soldiers and meet OSHA requirements, the Army Medical Department sponsored physician assistant (PA) training for master's degrees

in occupational and environmental health at the University of Oklahoma.[10] An Army OHPA who graduated from the program in 1984 began a pilot program at Fort Campbell, Kentucky, developing a survey that identified job-specific exposures resulting in ocular injuries and pulmonary diseases.[4] This resulted in the issuing of personal protective equipment to the identified workers, which mitigated occupational injuries and diseases.[11] Since 1984 the majority of the OHPA slots have been converted into civilian positions, but a few active duty OHPA slots remain (see Key Facts, later in this chapter).

Duties and Responsibilities

The OHPA assists the occupational medicine physician (area of concentration [AOC] 60D) or the preventive medicine physician (AOC 60C) in occupational and preventive medicine duties. OHPAs can perform the majority of the following types of examinations in accordance with DOD Manual 6055.05-M, *Occupational Medical Examinations and Surveillance Manual*[12]:

- qualification (per 5 CFR 339) and medical surveillance (per 29 CFR 1910), both preemployment and periodic
- return to work
- predeployment and postdeployment
- fitness to continue in current position (fit for duty)
- disability
- retirement
- surety medicine
- personnel reliability program
- security clearance
- termination
- respirator fit testing

In addition to the normal scope of practice, knowledge, skills, and behaviors required of PAs, the OHPA skill set duties include (*a*) assessing occupational health needs for active duty personnel and DOD civilians, (*b*) identifying hazardous occupational exposure and stress factors, (*c*) developing mechanisms to monitor soldier and civilian employee health trends, (*d*) conducting worksite evaluations and medical surveillance, (*e*) performing epidemiological studies, (*f*)

monitoring hearing conservation programs, (*g*) ensuring respiratory protection, (*h*) ensuring radiation protection, (*i*) enacting vision conservation programs, (*j*) conducting sexually transmitted disease surveillance, and (*k*) participating in collaborative industrial hygiene priority and support.[13]

Per Army Regulation 40-68, *Clinical Quality Management,* the duties and responsibilities of the OHPA specialty include (*a*) conducting job-related, fitness-for-duty, and health maintenance examinations for military and civilian personnel; (*b*) conducting occupational and non-occupational disease and injury prevention and treatment of military and civilian personnel; (*c*) conducting illness and injury MONITORING AND INVESTIGATIONS; (*d*) performing chronic disease surveillance, including tuberculosis and sexually transmitted diseases; and (*e*) providing occupational and environmental health education to soldiers and DOD civilian employees.[13] The OHPA's duties and responsibilities in conducting medical surveillance and exposure mitigation are fundamental to lowering future morbidity or mortality rates.

Requirements

Requirements for serving in OHPA positions are as follows:

- graduate of an accredited Master of Public Health (MPH) degree program in occupational health[10] (refer to current long-term health education and training [LTHET] information on the Army Human Resources Command website for updated requirements)[14];
- rank of captain or major; and
- graduate of Captains Career Course preferred.

Knowledge, Skills, and Attributes

OHPAs should maintain all military requirements and have the following knowledge, skills, and attributes:

- promotion potential for future service in broadening and operational assignments;
- professional knowledge and emotional maturity;
- critical thinking;

- interpersonal skills, including supervising, coaching, mentoring, and teaching;
- ability to function on a collaborative team and to work autonomously;
- leadership ability in promoting the OHPA specialty;
- motivation to work in research or public health settings;
- effective communication skills, both horizontally and vertically; and
- the occupational health skill set (acquired through LTHET).

Training

OHPA training encompasses LTHET and the following:

- Qualified PAs must attend an approved (by the Department of the Army and the Office of the Surgeon General) MPH program with an occupational health or environmental health concentration.
- The OHPA curriculum encompasses (*a*) didactics, (*b*) lectures, (*c*) conferences, (*d*) demonstrations, (*e*) seminars, (*f*) practical exercises, (*g*) academic subjects, (*h*) clinical applications, and (*i*) research.
- The goals and objectives of the training involve mastering concepts from the fields of (*a*) preventive medicine, (*b*) industrial hygiene, (*c*) toxicology, (*d*) epidemiology, (*e*) statistics, and (*f*) occupational medicine.
- Also recommended is the Army Training Requirements and Resource System (ATRRS) two-phase (online distributed learning and resident) Fundamentals of Occupational Medicine course (6H-F20).[15]
- After their MPH program, practicing OHPAs are encouraged to continue their specialty education to attain a Doctor of Medical Science (DMSc) degree with a concentration in the advanced professional practice of occupational preventative medicine, as completed by a military OHPA for the first time in 2020.[16]

Key Facts

Post-LTHET master's training involves a 2-year utilization tour in which the student practices as an OHPA, and incurs a concurrent additional duty service obligation of 4 years. There are currently six locations for OHPA utilization tours:

1. Ft Bragg, NC

2. Ft Hood, TX
3. Joint Base Lewis-McChord, WA
4. Pine Bluff Arsenal, AR
5. Ft Drum, NY
6. Watervliet Arsenal, NY

The active duty OHPA positions listed above, and over 90 civilian OHPA positions, are located in Army occupational health services across the United States and overseas. Active duty OHPAs should maintain both primary care and occupational health credentials. Primary care PA credentials are required for deployment (although there are no current OHPA deployment positions). Of the 1,415 US certified PAs in occupational medicine, only 7.2% (n=102) are federal government health care providers, both military and civilian, who work in federal government facilities, hospitals, and clinic settings, according to a 2018 specialty report by the National Commission on Certification of Physician Assistants.[17] Interestingly, the data suggest that the OHPA specialty is growing in the civilian sector and decreasing in the military setting.

Authorized List Positions

A few authorized list positions—jobs that are not part of the PA (65D or 65X immaterial) authorizations—have been filled by OHPAs in coordination with certain AOC consultants (such as occupational medicine physicians) and the Army Medical Specialist Corps management at Human Resources Command, including the following:

- Army Medical Center of Excellence (MEDCoE), deputy chief of the Preventive Medicine Branch, Department of Preventive Health Services, Joint Base San Antonio–Fort Sam Houston, TX
- Army Public Health Center, US Army Injury Program, Aberdeen, MD
- Army Public Health Center, OHPA, Aberdeen, MD
- National Training Center Command Surgeon, Ft Irwin, CA

Significant Contributions

OHPAs have continued to make enduring military medical contributions resulting from individual and collaborative research and public health practice, in areas ranging from basic combat training and combat morbidity to veteran mortality.[18–21] OHPAs have been nationally recognized for their significant medical contributions to military public health in practice and research. For example, a new LTHET graduate OHPA, after successfully completing the educational and examination requirements, and thereby demonstrating a mastery of the knowledge and skills relevant to contemporary public health, attained charter class recognition as the first military PA to be certified in public health (CPH) with the National Board of Public Health Examiners on October 24, 2008.[22] The OHPA was also inducted into the Delta Omega Honorary Society in Public Health,a national recognition for his contributions to military medicine.[23]

OHPAs have also contributed to a unique DOD predeployment and postdeployment study, which was collaboratively conducted by Sharp and colleagues at the US Army Research Institute of Environmental Medicine, Natick, Massachusetts; 1st Cavalry Division, Fort Hood, Texas; 10th Mountain Division, Fort Drum, New York; and the Army Center for Health Promotion and Preventive Medicine (now the Army Public Health Center).[18] The study's medical monitor and associate investigator was an OHPA.[18] Another study, on physical readiness training, also collaboratively conducted by an OHPA with staff from the US Army Research Institute of Environmental Medicine and the US Army Fitness School, resulted in the development of a new fitness training program by the Army Training and Doctrine Command, which has helped identify and significantly reduce injuries among Army personnel.[19,24] A third collaborative study, in which an OHPA was the primary investigator, resulted in an update to Army Pamphlet 385-63, *Range Safety*, and established the current US Army and Marine Corps range safety policy as well as a DOD lead (Pb) exposure medical surveillance program for outdoor ranges, indoor firing ranges, and shoot-houses.[21,25]

Challenges and the Way Ahead

Training and experience in epidemiology, injury prevention, preventive medicine, environmental health, soldier health care, and primary care provide the ideal skill set for OHPA utilization in division and corps headquarters surgeons' sections as division force health optimization officers. However, authorizations for officers in Table of Organization and Equipment (TOE) units are fixed, and an OHPA position does not exist in current TOE formations, specifically at the division and corps levels. With the current restructuring of medical forces in the Army as a result of the National Defense Authorization Act of 2017,[26] and the shortage of PAs to fill authorizations, it is unlikely that those positions will be realized. In the meantime, OHPA training supports collaboration with other specialists in the Army Medical Specialist Corps to bolster human performance optimization, focusing on (*a*) health readiness (with 65D PAs); (*b*) performance nutrition (with 65C dieticians); (*c*) exercise optimization, injury prevention, and rehabilitation (with 65B physical therapists); and (*d*) sleep, behavioral health optimization, and brain injury prevention and restoration (with 65A occupational therapists in their combat and operational stress control role). In the future, OHPA training may focus on preparing officers for research and epidemiology doctoral programs, or human performance optimization disciplines.

This multidisciplinary approach dovetails with the Army's new Holistic Health and Fitness (H2F) campaign, which replaces the previous Army Ready and Resilient Campaign. The H2F "doctrine directs leaders and Soldiers to use unit-level experts, facilities, and equipment to develop the physical and nonphysical components of Soldier readiness. . . . The H2F System is an immersive, comprehensive approach to readiness centered on brigade-owned H2F facilities and personnel."[27] OHPAs become familiar with community health promotion during their occupational health training programs, and are able to coordinate health promotion initiatives and programs in their formations.

Conclusion

Occupational health practitioners strive to optimize the health of workers, who make up half of the world's population. Improving the health of workers at their worksites, and preventing injuries and

illnesses associated with employment, increases productivity and decreases costs for employers. The US Army has embraced occupational health principles in protecting the uniformed and civilian workforce, the Army's most important asset. The application of the principles of occupational health improves worker performance and satisfaction, allows the Army to meet statutory requirements, and optimizes the productivity of soldiers and employees in support of the Army's mission—defending the nation. The Army is the DOD's largest employer, and Army occupational health serves a vital role within Army medicine, bridging the gap between employee workplace health and safety needs and employer resources, thereby preventing injuries and optimizing health in the Army's diverse work locations. Army PAs with an interest in research, epidemiology, public health, health readiness, soldier and worker performance optimization, and overall wellness and preventive medicine should consider specializing as an OHPA.

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Chapter 63

ROLE OF THE INSPECTOR GENERAL

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Introduction

The mission of all Army inspectors general (IGs) is to "Be the eyes, ears, voice, and conscience of the Army across the spectrum of operations. Conduct thorough, objective, and impartial inspections, assessments, and investigations. Provide assistance and training. Advise and assist Army leaders to maintain Army values, readiness, and effectiveness in the promotion of well-being, good order, and discipline."[1] Commissioned officers and warrant officers, including physician assistants (PAs), can be assigned as detailed IGs (Figure 63-1) in accordance with Army Regulation (AR) 20-1, *Inspector General Activities and Procedures*.[2] They must qualify for the detail under AR 614-100, Officer Assignment Policies, Detail, and Transfers.[3] Detailed IGs may serve in the capacity of deputy command IG or command IG at several locations where a general officer is commander (Figure 63-2); at the Department of the Army Inspector General office at the Pentagon (Figure 63-3); at any of the regional health commands; or at the Medical Command IG office in Fort Sam Houston, Texas (Figure 63-4). IGs provide relevant guidance to commanders on all topics affecting soldiers and Army civilians; however, PAs serving as IGs also provide expertise in issues related to health care and the health care system while conducting investigations, inspections, and training.

The Army IG's motto is *"Droit et Avant"*: "Be right and then go forward" (see Figure 63-1). Being an IG is a unique opportunity for PAs to showcase their talents not only based on their clinical knowledge but also as professional officers. Commanders often seek guidance



Figure 63-1. The US Army Inspector General seal with the motto "Droit et Avant."



Figure 63-2. Then-Major Dennison Segui (fourth from right) with Lieutenant General Nadja West, the 44th Army Surgeon General, in Sembach, Germany, 2018. Major Segui served as the RHC-E command inspector general. Left to right are Carlos Torres, Sergeant First Class Yomaira Adames-Santos, Lieutenant General West, Major Dennison Segui, Sergeant First Class Christopher Lane, Sergeant First Class Sheila Chase, and Master Sergeant Liza Shackelton.

from the regional health command IG office on profile limitations or adequate medical care for soldiers, and PAs in these positions may provide guidance to an entire region, educating both commanders and soldiers on medically relevant topics. The following are guidelines on the magnitude of the IG's responsibilities, as well as recommendations to help PAs transition to a generally nonclinical position that has tremendous impact on improving the Army.

How Does a Physician Assistant Become an Inspector General?

1. Review availability of IG positions in the Assignment Interactive Module (AIM), the Human Resources Command web-based officer management system (https://aim.hrc.army.mil/).
2. Ensure the following are up to date: curriculum vitae, officer evaluation reports, and officer record briefs.
3. Have an outstanding record.
4. Interview for the position if required.
5. Once selected, take the IG Basic Course (followed by the IG Advanced Course after a year of IG service).

Inspector General Functions

Assistance and Investigation

Soldiers, civilians, and family members reach out to the IG to seek assistance and investigate complaints. In order to provide these services, the IG must be skilled and well informed about issues affecting the command. Essential responsibilities are as follows:

- The IG must complete inspector general action requests (IGARs) in a timely manner and prepare accurate trend reports based on reported cases, to advise command on current and future courses of action. The IG Basic Course provides instruction on how to appropriately code IGAR elements. These codes are useful for reporting purposes, querying issues and allegations for trend reports and analysis, and providing guidance on IG-related complaints to a commander's area of responsibility.

- The process of documenting cases is a perishable skill when not used regularly or learned appropriately. Attending the IG Advanced Course will provide information on any updates pertaining to IGARs and timely topics that concern the Army IG.
- Also, the IG intranet (https://pentagon-p1.ignet. army.mil) is often updated and should be consulted regularly.



Figure 63-3. Then-Major Sharon Denson (right) with Lieutenant General David Quantock, the Army inspector general (IG), at the Department of the Army IG office in 2017. Major Denson served as a detailed IG and later competed for, and was selected as, the aide-de-camp for Lieutenant General Quantock in 2016.

- Additionally, IGs should keep up to date on S1 NET (https:// www.milsuite.mil/s1net), which provides information on human resources personnel updates; news from the Army Times; and local, national, and global news.

Inspections

The IG must develop and conduct systemic inspections that:

- Identify trends in performance and, if performance lags, identify the root causes.
- Identify the agent or proponent responsible for corrective action and provide recommendations on how the root causes of problematic issues should be addressed.
- Plan and conduct appropriate follow-up inspections to ensure continued compliance.



Figure 63-4. Then-Major Amelia Duran-Stanton (third from right) with Lieutenant General Patricia Horoho, the 43rd Army surgeon general, and the Medical Command (MEDCOM) inspector general (IG) team (left to right: Giovanni Veniciano, Sylvia Marchan, Colonel Jennifer Robinson, Lieutenant Colonel Jeffrey Marks, Lieutenant Colonel William Amsink, Lieutenant General Horoho, Urszula Nazarewicz, Major Duran-Stanton, Joyce Lugo-Beltre, and Sergeant Major Anthony Stevens). Major Duran-Stanton served as deputy chief of the MEDCOM IG inspection branch. Photograph courtesy of Sergeant Major (Retired) Anthony Stevens.

- Provide feedback to leaders at all levels.
- Teach and train Army systems, processes, and procedures.

The IG also assists the command G 3/5/7 (operations, readiness, plans, and training offices) with the unit's organization inspection plan. In writing inspection plans and reports, the IG must understand and apply critical thinking; must be able to apply, analyze, and evaluate information and create insightful summaries of this information; and must gain confidence in editorial decisions and edit for impact.

Teach and Train (During Investigations, Assistance, and Inspections)

The IG must teach and train unit personnel on policy and procedures at every opportunity; teaching is incorporated into all aspects of an IG's duties. The IG also needs to teach lessons learned and best practices observed during inspections, assistance visits, and teach-and-train sessions. Finally, the IG must ensure that leaders and their soldiers know how IGs contribute to mission accomplishment.

Working with the Commander

As the "eyes, ears, voice, and conscience" of the commander, the IG must maintain a direct relationship with the commander (see Figure 63-3). The IG needs to know the commander's guidance as well as his or her philosophy, vision, mission, policies, and directives. The IG must follow the commander's preferences for communication, reporting, and priorities. It is key to meet the commander as soon as possible after the role of IG is undertaken. A common operating picture of information requirements should be properly conveyed. The IG should find out the following:

- How will the IG be used? What will the role of the PA be in the IG office?
- What are the commander's expectations?
- What kind of access will the IG have to the commander?
- How often will the IG meet with the commander? How should the commander be updated and in what format?
- Who else needs to know the information the IG will be providing?
- What are the commander's critical information requirements? Some

examples are allegations against senior officers; chain-of-command abuse allegations; government misuse of funds; warrior transition unit concerns; suicide information (ideation, attempt gestures, completions); and reported sexual assaults. The IG must ask themselves, "Is there anything else that the commander or directing authority prefers to know?" This is why initial and routine meetings with the commander are critical.

- What inspections should be carried out in the current fiscal year, for example, barracks inspections, flagging actions, physical or combat fitness tests?

The IG also needs to discuss the IG administrative information flow with any aides, staff officers, and the commander's secretary. However, confidential IG matters are discussed only with the commander (conveying these matters to subordinate staff could derail trust and confidence in the IG system). The IG must have a working knowledge of who has access to the directing authority (the commander), especially when the command is not co-located with the IG. The IG will need to manage email, face-to-face communication, and video teleconferences with the directing authority and get access to the command calendar when away from the office. IGs must know their team (this may vary per location and may consist of the deputy IG, assistant IGs, the assistance and investigation team, and the inspection team) and their responsibilities.

Time Management

The IG should have a "battle rhythm" based on weekly, monthly, quarterly, and annual meetings to discuss issues and trends. A consistent schedule will help ensure that the IG presence is known. Examples are as follows:

- Weekly: commander's update brief, IG office huddle, newcomer's brief.
- Bi-weekly: commander/IG update meeting, command and staff call.
- Monthly: training, such as payday activities (eg, monthly checks on uniform, pay inspections, professional development opportunities, usually conducted the first Friday of the month) and unit status

report; sexual assault review board (trends and training statistics); commander's call; medical readiness reporting.
- Quarterly: training (IG-specific), Company Commander/First Sergeant Pre-Command Course (PCC), Battalion Commander PCC, Executive Officer/S3 Course, other courses on post.
- Annually: trends and reports.

Administrative Recommendations

- Know installation regulation and policies; and Department of Defense, Headquarters, Department of the Army, and higher headquarters regulations, directives, and policies.
- On a lower level, know staff policies, standard operating procedures, and guidance.
- Find out about operational law and how it affects the command.
- Read the IG bulletins.
- Meet the chief of staff, the command sergeant major, and subordinate unit commanders.
- Meet the staff judge advocate, the legal team, and the ethics counselor or advisor.
- Do outreach with local constituents; be proactive, informative, and visible (attend events, meetings, ceremonies, graduations).
- Provide avenues for input via telephone, email, interactive customer evaluations, bulletins, or flyers.
- Attend meetings and events with units (Officer Professional Development, Non-commissioned Officer Professional Development, Commander/First Sergeant Course, Basic Officer Leader Course, Captains Career Course, newcomers' briefings).
- Emphasize the organizational inspection plan.[4]
- Write and publish articles (have them reviewed for accuracy by the staff judge advocate and public affairs officer).
- Facilitate sensing sessions.

Lessons Learned Summary

- Maintain firm oversight of ongoing cases and investigations and the planning and execution of inspections.
- Set expectations early and maintain initial and periodic counseling with the directing authority and with any subordinates.

- Use staff experience within the office and regularly talk through the case with other staff.
- Be prepared for complainants to want to speak to an IG of the same race or gender.
- Be prepared to change the mindset of commanders, noncommissioned officers, and junior enlisted in relation to communicating with IGs. Many military personnel are unsure about what the IG can do for them and may be apprehensive.
- Be available to all commanders in the organization.
- Be aware and prepared that soldiers and family members may feel more comfortable coming to the IG instead of the chain of command.
- Be prepared to train other IGs on operation orders and staff action standards. Do not be afraid to delegate, but verify information gathered by others.
- Be prepared for cases to take longer at higher command IG offices, including the Department of the Army IG and Department of Defense IG.
- Have a good working relationship with the staff judge advocate.
- Use command products (unit-specific documents based on established policies and procedures that may vary depending on unit custom or the preference of the current command) whenever possible, but ensure that they address allegations completely before completing the report of investigation or report of investigative inquiry (ROI/ROII). IG reports must be worded and prepared properly in accordance with AR 20-1 and must be maintained even when using command products.
- Make sure investigating officers who serve as subject matter experts during IG investigations do their job correctly.
- Always offer help and tell commands and agencies what the IG can do for them.
- Do what is right by the standard.

Pitfalls to Avoid

- Undue influence (provide options, not orders).
- Always bringing bad news (bring positive news too).
- Incomplete electronic IGARs and DA 1559s (IGAR forms).
- Taking shortcuts (in preliminary analysis and fact finding).
- Looking the other way (will make the IG lose credibility).

- Failing to maintain training standards.
- Lack of timeliness (will be perceived as laziness).
- Failing to document (document everything you and other IGs do).
- Jumping to conclusions and failing to perform due diligence in researching information before providing guidance; prematurely or uncritically agreeing with a complainant (get all the facts first and make no promises; there is more than one side to every story).

Conclusion

The IG is expected to embrace and exemplify the highest standards of conduct, ethics, and professionalism within Army organizations. Maintaining these standards ensures the effectiveness of the IG system. IGs must display sensible character attributes and provide sound advice, assistance, and feedback to their directing authorities and fellow IGs every day. An IG is expected to "be right and then go forward" to support Army commanders, soldiers, and civilians. IGs must:

- Support the commander and chain of command.
- Provide assistance for soldiers, civilians, family members, and retirees.
- Conduct thorough inspections that recognize excellence and identify systemic deficiencies.
- Conduct investigations that meet the standard of thoroughness and fairness.
- Teach and train at every opportunity.

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Chapter 64

ROLE OF THE MEDICAL COMMAND ALLIED HEALTH OFFICER

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Introduction

The physician assistant (PA) assigned as the allied health officer (AHO) to the US Army Medical Command (MEDCOM) is the PA staff officer for health care delivery–clinical policy and services (HCD-CPS). The MEDCOM AHO is responsible for assisting with tasking, policy, and regulation development and review to ensure the maintenance of a healthy, mentally and physically fit, and medically protected force. The AHO provides policy guidance on PA education, credentialing, and scope of practice issues. They also act as the modified table of organization and equipment assigned personnel (MAP) medical augmentation manager for approximately 190 PAs to help the MEDCOM G33 (Current Operations Division), Forces Command (FORSCOM), and Human Resources Command (HRC) fill operating and generating force operational requirements. The AHO also acts as a subject matter expert and liaison with sister services, the Department of Veterans Affairs, and the US Public Health Service on PA-related issues, including responding to inquiries from the White House, Congress, Office of the Defense Secretary (Health Affairs), the Army's Office of the Surgeon General, major subordinate commands, and medical treatment facilities.

Supervision

There are multi-level direct and indirect supervision methods for this position. Direct supervision is through the chief of HCD-CPS and the

chief consultant to the surgeon general. Indirect supervisory guidance is through the PA consultant to the surgeon general, the Specialist (SP) Corps chief, and the HRC branch chief for PA policy development and talent management.

Unit Structure

This is a strategic developmental position within the MEDCOM general staff for the surgeon general.[1] The position is within the G-3/5/7 staff section for planning, training, and mobilization at Joint Base San Antonio–Fort Sam Houston, Texas.

Roles and Duties

The AHO assigned to this position assists in establishing relationships with all organizations throughout the Army Medical Department (AMEDD) and MEDCOM.[2] The AHO maintains active lines of communication with the Office of the Surgeon General, Medical Center of Excellence, FORSCOM, Special Operations Command, and all units currently deployed to theaters of operation. The AHO also communicates with other Department of Defense (DOD) branches, the Department of Veterans Affairs, and the Department of Homeland Security to ensure proper coordination for joint initiatives and education.

As the MAP medical augmentation manager for the 65D (PA) area of concentration (AOC), the AHO provides counsel and support to all levels of staffing requirements by working with the G33 desk officer for Central Command and various other tasking authorities within MEDCOM.[2] The AHO works with HRC to keep all 65D MAP requirements filled to 100%. The AHO also provides medical augmentees for deployments and last-minute replacements for SP Corps, Nurse Corps, and Medical Corps shortages in contingency areas of responsibility.

The MEDCOM AHO works to identify and exploit opportunities for growth for PAs and other AHOs in AOC 65 within the Army and the AMEDD by working in concert with the dietician, physical therapy, and occupational therapy consultants to the surgeon general.[3] The MEDCOM AHO should encourage the development of training opportunities for PAs and other AHOs for career enhancement and to support the surgeon general's priority initiatives and the AMEDD's transformation to a system of health.[4]

The MEDCOM AHO assists other members of the HCD-CPS staff with subject matter expertise to properly process relevant tasks and projects. For example, the AHO evaluates and provides revisions to numerous Army regulations, MEDCOM policies, executive orders, and other correspondence with clinical significance to the AMEDD. If the AHO is appointed as the deputy PA consultant to the surgeon general, he or she will have the additional duties of serving as the PA consultant in the consultant's absence. The AHO must maintain proficiency within their specialty. The consultant's duties may include, but are not limited to[3]:

- working closely with HRC and the Recruiting Command to manage the active duty and reserve component PA populations to ensure that requirements are filled for both the operational and generating forces;
- providing oversight for the AMEDD distribution plan and MAP deployments for the PA population;
- helping optimize the distribution of the other SP Corps AOCs to ensure mission success;
- serving as a member of the SP Corps Strategy Advisory Board and as the senior 65D advisor to the SP Corps chief on multiple lines of effort of the SP Corps strategy map that are synchronized with the MEDCOM strategy map; and
- serving as the PA consultant's representative on special review panels conducted by MEDCOM's Clinical Performance Assurance Directorate (formerly the Quality Management Division) for malpractice case reviews, providing subject matter expertise in cases involving PAs.

Desired Skills and Attributes

- Extensive experience as a PA and as an AMEDD and SP Corps officer.
- Rank of colonel, lieutenant colonel, or lieutenant colonel (promotable).
- Must be a graduate of Intermediate Level Education, and preferably Senior Service College.
- Must be an excellent role model with the desire to mentor others.
- Must have an interest in people and be able to encourage and assist others.

- Good speaking and communication skills.
- Strong multitasking capability.
- Strong work ethic.
- Solid writing techniques.
- Highly adaptable, flexible professional who embraces teamwork but also enjoys working independently.

Training

Training required for this position includes access to and familiarity with the Medical Operating Data System, which includes AMEDD human resources for HCD-CPS projections and MAP deployment decision tools; the AMEDD Resource Tracking System for MAP deployment taskings and management; and the Force Management System website for Army unit requirements and authorizations for personnel and equipment documentation. The AHO must also have access to the Soldier Management System, a web-based collection of data, applications, and tools to assist career managers and other human resource personnel in supporting active Army, Army Reserve, and National Guard soldiers, veterans, retirees, family members, and other stakeholders.

Key Factors

This is a key and developmental position, typically a 2- to 3-year tour, for a 65D in the grade of O-6 (colonel) with no additional skill identifier requirement. MEDCOM is currently located at Joint Base San Antonio. This position is primarily nonclinical; however, the AHO must maintain their credentials.

Lessons Learned and Tips for Success

The following are lessons learned and tips for success as a MEDCOM AHO:

- The strength of relationships make the difference between mission success and failure.
- The AHO should understand the mission, stakeholders, and unique operating environment.

- The AHO should share information with mission partners, safeguard sensitive information, and maintain frequent communication.
- The AHO should build and sustain credibility, trust, and positive relationships.
- Coordination and cooperation toward common objectives are essential to success, even if the participants are not necessarily part of the same command or organization, such as the Defense Health Agency or DOD.
- Best practices include establishing feedback mechanisms to identify lessons learned and successful techniques for use in future operations.
- The AHO should identify resources to combat staffing shortages.

Conclusion

The MEDCOM AHO role requires someone with exceptional communication and interpersonal skills, who can embrace teamwork but also enjoys working independently. The AHO is responsible for assisting with tasking, policy, and regulation development and review to ensure the maintenance of a healthy, mentally and physically fit, and medically protected force. The AHO must possess keen awareness of the strategic plan to transfer functions from MEDCOM to the Defense Health Agency, and be able to accomplish their duties while supporting the transition of both organizations. The AHO will regularly provide guidance to the field on management of the force, selection of personnel for deployment in support of combat operations, and oversight of military assigned personnel.

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Chapter 65

ROLE OF THE ARMY CAPABILITY MANAGER–ARMY HEALTH SYSTEMS PHYSICIAN ASSISTANT

Cleve B. Sylvester, PA-C, DSc, MPAS, and David Freel, PA-C, MPAS

Introduction

The mission of the Army Capability Manager–Army Health Systems (ACM-AHS), part of the US Army Medical Center of Excellence, is to understand and meet the needs of service members within the domains of doctrine, organization, training, materiel, leadership and education, personnel, facilities, and policy (DOTMLPF-P). ACM-AHS activities are intricately synchronized and integrated with those of the Capabilities Development and Integration Directorate and Fielded Forces Integration Directorate, with significant overlap in many cases. Army medicine is represented by a wide range of senior and experienced officers and noncommissioned officers, including the ACM-AHS physician assistant (PA) staff officer.

Responsibilities

The PA staff officer is one of the few colonel (O-6) authorizations for 65Ds (the PA area of concentration) in the Army. Considered a capstone assignment to a PA's professional development, this billet is personally rewarding. As an Army senior medical capability developer, the ACM-AHS PA staff officer is uniquely positioned to oversee the development of medical organizational and equipment capabilities to be employed for years to come. Using the Joint Capabilities Integration and Development System for development and acquisition, the ACM-AHS PA works to ensure that medical support to operational units meets the needs of the Army's future force. Consideration of future force capabilities must include any operating environment and missions everywhere soldiers might be asked to deploy, fight, and win.

User Representative

The ACM-AHS PA has many duties and responsibilities. The most important of these is as user representative to all other stakeholder organizations that enable the mission of the warfighter. In this capacity, the PA collaborates with product developers of medical materiel, equipment, pharmaceuticals, and knowledge products such as Clinical Practice Guidelines, from early basic research and discovery science, through US Food and Drug Administration approval, and finally through transition, resourcing, production, and fielding into Army units and medical sets, kits, and outfits. The total process to bring a new capability to fruition can take from 5 to 10 years, or even more.

Requirements Adjudication Team Member

Another responsibility for the ACM-AHS PA is that of a requirements adjudication team (RAT) voting member. RATs focus on gaps that may prevent Army medical operational forces from providing required support to combatant commanders and soldiers. Standards are constantly refined by lessons learned, medical research by organizations such as the Medical Research and Development Command (MRDC), Joint Trauma System initiatives, and efforts by the Council on Tactical Combat Casualty Care, the Armed Forces Medical Examiner, the Joint Trauma Analysis and Prevention of Injuries in Combat program (a Department of Defense program affiliated with MRDC), and civilian academia. The RAT studies input from these sources as it considers what the Army must do (required capabilities), what it needs to do but cannot (gaps), and what it can do to close these gaps (solutions).

Solutions can come in many forms. When the RAT determines that an identified gap is enduring and operationally significant, it may recommend changes in any of the DOTMLPF-P domains. “Enduring” means it applies to any operation or organization employed anywhere in the world now and for years in the future. An “operationally significant” gap, if not addressed, will result in high or very high risk of mission failure. The most significant inhibition to capability development is the Army’s fiscally constrained footing, which is expected to continue for the foreseeable future.

Clinical Subject Matter Expert

Another important responsibility of the ACM-AHS PA is serving as one of the few clinical subject matter experts in the directorate. All routine and periodic revisions of doctrine, clinical standards of care, materiel reviews, requirements for training and sustainment of medical skills, and policy are staffed by the clinical subject matter experts. This staffing process lays the foundation for the Army medical operational forces for years to come. In all respects, the ACM-AHS PA represents the future of Army medicine to the soldier. Getting it right, on time, every time, is paramount.

Lessons Learned

- The end users represented by ACM-AHS are at the level of the brigade combat team and below. It is important to understand the operational force, particularly point of injury/Role 1 through Role 3 operations, to be successful in this position.
- There are a few required courses for this position; the most important is the Capability Development Course. Taking this course beforehand is helpful, though it can also be taken after working in the position for several months.
- This is a very busy position. Being agile and flexible will make the job more enjoyable.
- Some civilian counterparts in the organization have been in their positions for several years, and often understand their areas of responsibility extremely well. Ego clashes will impede progress.

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Chapter 66

CONTINUOUS PROCESS IMPROVEMENT USING LEAN SIX SIGMA CONCEPTS

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Introduction

All Army physician assistants (PAs) must be involved in continually improving the organizations in which they serve. PAs demonstrate dedication and commitment to the organization through leading and participating in continuous process improvement (CPI) of their organization and its processes. CPI projects bring together subject matter experts with ideas to improve outcomes with potential for system-wide and even enterprise-wide implementation. Used by the Department of the Army as a CPI program, Lean Six Sigma (LSS), and the related Lean Daily Management (LDM) concept, is relevant to health care organizations (Figure 66-1). As of publication, the Army Medical Command (MEDCOM) LSS program is undergoing a transition to the Defense Health Agency (DHA). The DHA uses CPI, LSS, and high-reliability organization (HRO) concepts for its Quadruple Aim Performance Process (QPP) (Figure 66-2).[1] By completing LSS projects and training, including LSS certification, PAs can distinguish themselves from other officers, earn additional skill identifiers, implement cost reductions, increase profits, improve the quality of products, and use these skills at any duty station and in the civilian sector.[2] This chapter introduces several of the process improvement tools and methods being used in military medicine, especially by the DHA as it takes on more responsibility for providing care.



Figure 66-1. Department of the Army Lean Six Sigma logo.

Background

Every organization is driven by quality, cost, and speed considerations. Organizations may need improvement due to lengthy processing times, poor quality, or both. Continuous improvement is "the ongoing improvement of products, services and processes through incremental and breakthrough improvements."[3] LSS tools provide a framework to examine and meet organizational needs such as accelerating a product or service delivery, decreasing costs, and improving a product or service quality. Military medical treatment facilities (MTFs) and other health care organizations are using LSS and other models for CPI, and there is also room for LSS application in the operational environment. The

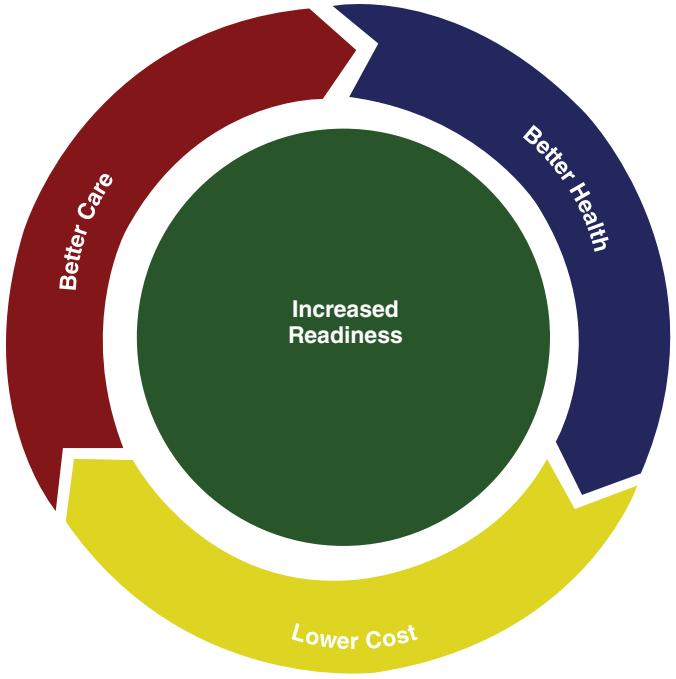


Figure 66-2. The Quadruple Aim Performance Process (increased readiness, better health, better care, and lower cost).

tenets of LSS can be applied anywhere to any process that needs some level of improvement to enable better outcomes.

Lean Six Sigma Process Steps

LSS consists of five process steps, signified by the acronym "DMAIC," that must be completed in sequential order. Each steps ends with a "gate review"—a collection of all the required components needed to fully complete each step and move on to the next. "DMAIC" refers to the following steps[4]:

1. **Define.** This step involves identifying the problem, the scope of the problem, the goals that the team wants to achieve to improve the situation, a validation of the problem through data sources or the process owner/business/customer, and the financial benefits. A project charter is completed in this step. Team members map out the process steps from start to finish and do their best to determine how long it takes between and at each step. During this step in the process, the team creates a communication plan, defining who will perform what actions during the process and by what means and how frequently the information will be communicated. In addition to this plan, a project plan lays out how long the team will spend working on each step in the process and the tentative deadlines.
2. **Measure.** This step helps identify the extent of the problem by collecting data. During this step, the team develops a value stream map, a data collection and analysis plan, baseline data, and other specific analyses in preparation for conducting the gate review.
3. **Analyze.** Key aspects in this step are determining whether the steps bring value to the process, calculating the process cycle efficiency and comparing it to the standard or recognized benchmark, analyzing the process map to find sources that impede the flow of work, and finding root causes of issues that create friction or constrain the process (lack of training, lack of resources, unclear procedures, etc).
4. **Improve.** In this step, the team explores potential solutions to the problem and develops a new process value stream map. The team also develops an implementation plan and pilots that plan. Upon the conclusion of the pilot, the team continues with a full implementation plan.
5. **Control.** This is the final step in the DMAIC process, whereby all the lessons learned are captured and applied to the process and actions to monitor the new plan are put into place. The intent is to check the process months later to analyze any outcomes and financial gains.

Lean Daily Management

LDM is an operating system with steps and tools that can be used to train leaders and teams to find and solve problems at the front line.

It can be used in both military and civilian health care organizations. Health care executives and leaders should understand LDM's relevance and be able to recognize the elements of LDM and its applications. In LDM, "lean" is the process of eliminating waste and driving productivity, commonly using CPI, with the goal of creating value using a set of principles, concepts, and techniques.[2] In a lean health care organization:

- The job of every frontline care team is to provide safe, quality care and to find and solve problems.
- The job of every other team is to support the frontline care team.[2]

High Reliability Organizations

MTFs have embraced the tenets of HROs, which are (1) leadership commitment to the ultimate goal of zero patient harm; (2) safety culture supporting high-reliability performance; (3) work toward creating robust process improvements; (4) "lean"; (5) "Six Sigma"; (6) change management; and (7) tiered huddle systems.[2] HROs "operate under very trying conditions all the time and yet manage to have fewer than their fair share of accidents."[3(p1)] "High reliability" means striving to get things right each and every time. The first three of these tenets are especially important for making substantial progress toward "high reliability":

1. *Leadership commitment to zero patient harm*. Leadership that is committed to zero patient harm will look closely at risk management outcomes, case reviews, patient safety reports (PSRs), and any other areas that can indicate patient harm.
2. *Incorporation of all principles and practices of safety culture throughout the organization*. Leadership that cares about safety will vocalize it and make it known that safety is important, so that everyone is on same page. Appropriate actions might include examining PSRs and ensuring that a culture of reporting PSRs is acceptable and encouraged to avoid future mishaps. PAs can report PSRs in their area and work with nursing staff who manage PSRs to investigate issues and identify solutions or quick wins. In in their own sections, PAs can ensure adherence to simple safety measures, such as avoiding alcohol before driving or keeping a weapon's safety on when it is not in use. A great determinant of

success is when simple, routine business involves risk assessment and safety at every step. If something more than a quick change is needed, a project could be the answer.

3. *Widespread adoption and deployment of robust process improvement tools and methods*. Using tools such as LSS and change management, leaders should note when something goes wrong (instead of avoiding the additional work involved, looking the other way, or leaving problems for the next person in charge). When everyone gets on board to conduct CPI and shares resulting information, there are always opportunities for improvement.

Total Quality Management

Another concept, total quality management (TQM), is the philosophy used to strategically improve quality in health care.[4] The DHA is using TQM principles during its efforts to become an HRO. The TQM principles are:

- customer focus,
- leadership,
- engagement of people,
- process approach,
- improvement,
- evidence-based decision-making, and
- relationship management.

The Quadruple Aim Performance Process

Human error in the care of patients is an increasing concern. The Institute of Medicine Committee on Quality of Health Care in America estimates that errors in patient care cause close to 200,000 deaths per year.[5] Harm is defined as "an impairment of structure or function of the body and/or any deleterious effect arising therefrom, including disease, injury, suffering, disability, and death."[6] Harm may be physical, social, or psychological, and either temporary or permanent. An adverse event is an injury directly caused by an error in care, and not due to a disease process. Clinical objectives seek to prevent all harm to patients. LSS principles can be a mechanism to accurately identify these problems, analyze each situation to get to the root causes of error, and implement

new or revised procedures to prevent future preventable harm. Based on the TQM philosophy, the military health system (MHS) transition to the DHA utilizes the QPP to get to "zero harm," the first goal of an HRO. The QPP is more than a plan; it is the process by which all staff engage the entire MHS to achieve breakthrough performance in pursuit of the "Quadruple Aim": increased readiness, better health, better care, and lower cost. Balanced across these four elements, its goals are to align the health care services and resources with MTF activities to enhance the MHS's integrated system of readiness and health, promote system learning and continuous improvement, support a smooth transition of administration and management of MTFs to the DHA, and enable enhanced enterprise performance.[2,4]

"A3" Thinking

Another method DHA had adopted for QPP is the "A3" problem-solving method, executed on a single sheet of A3-sized paper (a metric size close to 11" × 17", which is typically used).[2] This tool enables and encourages learning through the scientific method, with the following attributes:

- can be used be a team or individual;
- fosters consensus building;
- offers a simple systematic methodology for process improvement and complex problem solving;
- allows communication through a logical narrative;
- makes problem-solving visual; and
- tells a story (on a single page).

Lean Six Sigma Training

LSS courses provide valuable training, continuous learning points for officers in the Acquisition Corps (discussed in Chapter 44), promotion points for enlisted personnel, and additional skill sets and additional skill identifiers**.** Green Belt Courses and beyond are Army Training Requirements and Resource System (ATRRS) courses. (Note: The International Six Sigma Institute is NOT authorized to award promotion points). LSS courses must be reflected on a soldier's ATRRS transcript.

Additional Skill Identifiers

On May 23, 2006, the Army G-1 (manpower office) approved a proposal by the deputy undersecretary of the Army for business transformation to establish the following LSS skill identifiers[7]:

- Green Belt (1X)
- Black Belt (1Y)
- Master Black Belt (1Z)

Tips for Attending Courses

- Check the current schedule in ATRRS to see when courses are offered.
- Notify your chain of command and local deployment director (DD), and discuss potential projects with both (you cannot attend a Lean Leader, Green or Black Belt course without an approved project [charter]).
- Select a project approved by your chain of command and the DD.
- The DD will enroll you on ATRRS and align you with a Master Black Belt (MBB).
- Attend the course.
- Select your team.
- Follow instructions from the course.
- Keep your chain of command and DD informed of course status until completion.

Lessons Learned

- Project sponsors and leaders play critical roles. Their training, support, and engagement are imperative.
- Project identification, selection, and chartering must be completed upfront, before considering belt selection and training (ie, the candidate needs to discuss and identify their project with their leaders before they can attend a course).
- Belt candidates need dedicated time during didactics and project execution to stay on task.
- Coaching is critical to project execution, and MBB/BB mentors must be engaged.
- Periodic meetings with working groups are essential to getting diverse input as well as viewpoints on the problem and how to address it. Furthermore, working group selection is critical to ensuring there is a mix of personnel with experience of the problem as well as those without, who can provide a helpful perspective.

Discussion and Way Ahead

The MEDCOM alignment with DHA is well positioned for process improvement. As PAs get involved in making local improvements, their experiences and lessons learned should be fed through the DHA, MEDCOM, and MHS knowledge management process, and ultimately added to the DHA's knowledge base for process improvement, the Strategic Performance Improvement Data Repository.[8] Practitioners should share success stories, and nominate their successes for enterprise replication. Everyone should be an active part of the learning cycle.

Conclusion

LSS and LDM are important concepts to know and practice for maintaining relevancy in health care organizations, in both military and civilian settings. Following initial and subsequent steps using LSS and LDM tools, and all process improvement tools available, will enable the transformation of health care organizations. PAs must use their existing resources and continue striving to improve their skill sets as they participate in the alignment of MEDCOM with DHA, while also earning education credit and additional skill identifiers to remain competitive.

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Chapter 68

BARRIERS TO TREATMENT OUTSIDE THE CONTINENTAL UNITED STATES

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Introduction

The landscape of military medicine is evolving in an environment that is volatile, uncertain, complex, and ambiguous. The multi-domain battlefield, emerging diseases, disruptive technologies, and ever-changing regulatory environment present myriad opportunities and challenges.[1] Barriers to treatment outside continental United States (OCONUS) include a thinly spread force largely reliant on local resources; a limited internal medical logistic supply chain; and distances between areas of operation that are generally outside the range of most rotary-wing aircraft, extending transport times with transfer of patients at fixed-wing airfields.[2] Due to the unique nature of the overseas operational environment, health service support principles consist of conformity, proximity, flexibility, mobility, continuity, and control.[3]

Host Nation Medicine

The Military Health System is transforming to improve readiness and enhance the quality of care. One outcome may be a reduction in available services at overseas military medical treatment facilities (MTFs), requiring beneficiaries to visit host nation (HN) facilities for their health care. Most overseas military hospitals and clinics are staffed with patient liaisons to help patients navigate the overseas health care system, from the language barrier to insurance forms. The liaisons facilitate an easy and comfortable visit to an HN medical provider.

Culture differences may exist with outpatient and inpatient approaches to care and medical treatment. Differences may exist in medicines, treatment protocols, languages, or customs. It is important for physician assistants (PAs) to understand the variations in order to provide a smoother experience and advocate for the patients, when necessary. For example, the PA may need to explicitly request specific laboratory, radiological, or diagnostic tests as required for an evaluation instead of leaving it up to the HN health care provider to evaluate and treat the condition based on their education and training.

Medication is an area in which the PA may notice divergence from the standard military formulary. Overseas, more medications may be available over the counter and the pharmacists may have an expanded scope of practice to prescribe antibiotics and pain medication based on symptoms. PAs must become familiar with some of the commonly used medications at the local pharmacy and within the community.

If the MTF does not have the capability to provide treatment, Tricare beneficiaries must receive an International SOS (ISOS) authorization letter to the network provider before delivery of care. All medical notes and consult findings should be sent back to the MTF within 10 working days for routine consultation reports, or within 24 hours for urgent consultation reports. However, HN health care summary processing and translation from native language to English can take anywhere from 2 to 12 weeks. It is important for PAs working overseas to know the practices and processes for their MTF, especially those used to mitigate consultation report delays.

Tricare Overseas Program and International SOS

The Tricare Overseas Program provides health care to active duty service members and Department of Defense (DOD) beneficiaries who are OCONUS. The provider network may be limited, depending on location and available services. ISOS supports Tricare to fill this gap and ensue that beneficiaries receive the highest quality of care overseas.

ISOS provides a broad range of services such as a provider network for care, telephonic language assistance services, patient movement, and inpatient medical management.[4] ISOS screens all network providers to ensure they have practical knowledge and experience to deliver quality care. The added complexities associated with foreign health systems and variable quality of care requires more active patient

care management to ensure compliance with basic Tricare policy and expected US quality standards.[5] For all medical encounters, the ISOS telephonic language assistance services can provide over-the-phone, real-time translation when a patient receives medical care in non-English speaking countries. Services are available in over 200 languages and can be used at the time of any medical appointment. ISOS assists MTFs with the medical management of active duty service members and their families hospitalized in a medical facility. The organization performs continued stay reviews, status updates, and discharge information for the entire inpatient episode of care. They then assist in coordinating medical transfers back to the MTF. While beneficiaries may have to pay out-of-pocket when visiting non-network providers, they can file a Tricare claim for reimbursement. Typically, network providers file claims for beneficiaries, but this may be different in some overseas locations.

ISOS also assists the Defense Health Agency (DHA) in its role as a combat support agency. Through a comprehensive portfolio, including medical capability reports, health assessment planning, network development, and medical intelligence and surveillance services for moderate and high-risk overseas locations, ISOS assists the DHA and the combatant command with predeployment and strategic planning initiatives for operational support.[4]

Patient Movement

PAs must be prepared to treat, stabilize, and hold patients for up to 72 hours while awaiting evacuation to the next role of care, which varies from location to location. In Africa, evacuation was to a Role 2 facility, but in Europe, it may be to a Role 3 facility. The US Transportation Command (USTRANSCOM) surgeon serves as the Department of Defense single manager for the development of policy and standardization of procedures and information support systems for global patient movement.[6] USTRANSCOM's Theater Patient Movement Requirements Center (TPMRC) validates patient movement requests, coordinates transportation, and communicates between agencies to ensure mission execution. The TPMRC surgeon is the decision authority on where the patient is evacuated. If TPMRC cannot execute the mission, ISOS will evacuate the patient. ISOS conducts concurrent planning while awaiting TMPRC's decision.

PAs responsible for conducting or coordinating patient movement, which can be a very cumbersome process, should receive training on TRANSCOM Reporting and Command & Control Evacuation System (TRAC2ES). Flexibility and persistence is important with patient movement. For example, it can take over 24 hours to coordinate a routine movement from Italy to Germany. ISOS also establishes relationships with the TPMRC and the direct care referral facility, ensuring continuity of care if patient movement is required.[4]

Virtual Health

Virtual health brings the remote expert's knowledge and experience to the point of need. It can augment the capabilities of PAs working overseas using synchronous or asynchronous technology to optimize the care of patients who require specialist care or advanced level of care.[7] The military is currently developing a full spectrum of virtual health support options.

Credentialing and Privileging

All PAs must be credentialed and privileged to practice within their assigned environment. When PAs (including active duty and reserve components) are assigned temporarily for clinical practice (eg, MTF to MTF or MTF to deployed assignment), the base organization must convey all relevant credentials and privileging information to the temporary duty organization. The Inter-Facility Credentials Transfer Brief (ICTB) is the approved mechanism for conveying information between organizations in these cases. A provider with active privileges at a base organization should apply for clinical privileges at the temporary duty location. The temporary duty organization retains full responsibility and authority for making privileging decisions, but may request assistance from the base organization with respect to privileging decisions.

For routine temporary duty, annual training, or manning assistance, PAs should initiate the ICTB application at least 60 days in advance, completed by the provider and submitted to the temporary duty organization, whenever possible. PAs going on temporary duty to locations without Joint Centralized Credentialing and Quality Assurance System access must hand carry a hard copy ICTB.[8]

PAs are not recognized as health care providers in every country; therefore, it is important to check with the supporting organization and the US Department of State to learn the scope of the international practice and credentialing requirements for providing medical care to non-Tricare beneficiaries.

Medical Logistics

Overseas, the medical equipment and supplies may be slightly different than those used in typical MTFs in the United States. Due to increased delivery time in many locations, medical supplies should be ordered well in advance of need, depending on the stock level and procurement location. HNs may have many medications and supplies not found in the United States. PAs are resourceful and should discuss medication differences with the MTF pharmacist or explore the HN pharmacy to learn about medication treatment options or substitutions.

Training

When possible, PAs should train in the environment and with the type of equipment that will be used while overseas. PAs should look for training opportunities with the actual assigned unit. If that is not possible, PAs should look for a similar type unit that can provide necessary training. The following list represents commonly recommended training; in addition to Department of Defense Instruction 1322.24, *Medical Readiness Training*[9]; for overseas operational medicine or MTF assignments:

- Advanced Burn Life Support
- Advanced Life Support
- Advanced Trauma Life Support
- Pediatric Advanced Life Support
- Tactical Combat Casualty Care
- Tactical Combat Medical Care
- Global Medicine or Tropical Medicine course
- TRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES): https://trac2es.transport.mil/
- Defense Medical Logistics Standard Support Customer Assistance Module (DCAM)

- Theater Medical Data Store (TMDS)
- Medical Situational Awareness in the Theater (MSAT)
- Blood Inventory Management
- Electronic Medical Record
- Combatant Command Deployment Limiting Condition Guidelines: https://info.health.mil/hco/phealth/deployment_health/DeploymentHealthProductLine/Forms/AllItems.aspx
- Force Health Protection—field sanitation, hygiene, disease prevention and vector control; occupational and environmental hazard recognition, assessment, mitigation, and reporting
- Disease and Injury and tri-service reportable medical events reporting

American Academy of Physician Assistants Guidelines for International Practice

In 2001, the American Academy of Physician Assistants adopted policy HP-3700.3.1*, Guidelines for PAs Working Internationally*, outlining what PAs need to do when working globally.[10] Just as in the continental United States, PAs should establish and maintain an appropriate physician–PA team, accurately represent their professional credentials, and provide services within the scope their education and experiences. Most importantly, PAs should provide the best standards of care and strive to maintain quality while abroad.

Lessons Learned

These are some important lessons learned in working OCONUS. PAs should:

- learn and respect the culture, values, beliefs, and expectations of the patients, local health care providers, and HN;
- learn the language;
- understand the health service support plan, Tricare, and ISOS;
- prepare to advocate and play an active role in the case management of their patients;
- remain flexible; and
- enjoy the unique and rewarding experience.

Tips for Success

Along with lessons learned, the following tips will enable the PA working OCONUS to succeed beyond expectations. PAs should:

- recognize the strong link between health and security and get involved in global health engagement activities with the HN;
- take advantage of diverse training opportunities;
- be resourceful and know policy, regulations, authorities, and funding; and
- readily adapt to extraordinary medical crises or events.

Conclusion

Working OCONUS provides a unique and exciting opportunity for PAs. They are an integral part of the health system, involved with efforts to enhance communication, coordination, and integration of patient care, force health protection, and medical operations. Awareness and appreciation for OCONUS barriers to care will allow PAs to be engaged in research, clinical practice, and education to promote quality patient care.

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Chapter 69

SPECIAL PAY FOR ARMY PHYSICIAN ASSISTANTS

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Introduction

Special pay plans are available to enhance the Army's ability to shape the force by using monetary incentives as a means of recruitment and retention of health care professionals with critical wartime specialties and valuable experience. The Consolidation of Special Pay (CSP) programs are available tor Army health professions officers (HPOs) in all components. This chapter will describe the relevant types of special pay to Army PAs as of early 2020. The information will cover all components but focus on active duty.

Active Duty Special Pay

The HPO special and incentive pay plans are announced annually based on Department of Defense and Army policy. The Office of the Surgeon General (OTSG) disseminates changes through the Army Medical Department (AMEDD) special pay office.[1] The Army Active Component Health Professions Officer Special Pay Plan, effective January 1, 2020, contains the current active duty Army Medical Specialist Corps (AMSC) officer special pay incentives.[2] Three types of special pay are currently offered to PAs: (1) HPO board certification pay (HPOBCP), (2) HPO incentive pay (HPOIP), and (3) combined retention bonus/incentive pay (HPORB/IP). This plan is effective for all AMEDD HPOs in the active component or Active Guard Reserve (AGR), and for mobilized reserve component HPOs on active duty for 30 days or more.

US Army Reserve Component Special Pay

Reserve component special pay information is contained in the fiscal year 2020 US Army Reserve (USAR) Health Professions Special and Incentive Pay Plan and the USAR AMEDD incentives policy.[1] USAR incentives are subject to availability of funds and can be suspended at any time under the policy. To control the budget available for execution of contracts, the Army Reserve Headquarters-Fort Bragg issues an incentive control number for every incentive.

Eligibility

To be eligible for these special pay incentives, an Army PA must:

- be a commissioned officer on active duty status, including mobilized PAs and while attending unit assemblies;
- have a post-baccalaureate degree as a PA;
- be certified bythe National Commission for Certification of Physician Assistants (licensure is waived in accordance with Health Affairs Policy 04-002[3]);
- have completed the Army Officer Basic Course or received constructive or equivalent credit from the course proponent for the training (does not apply to USAR officers);
- meet Army height and weight retention criteria;[4] and
- not be subject to any unfavorable action.

Army National Guard (ARNG) PAs must also be credentialed, privileged, and qualified in the Joint Centralized Credentials and Quality Assurance System through the National Guard Bureau. Civilian credentialing and privileging does not meet this requirement.[5] Army PAs should contact their career manager for further information.

Types of Special Pay

Health Professions Officer Board Certification Pay

The Health Professions Officer Board Certification Pay (HPOBCP) consists of an annual $6,000 sum paid in monthly installments of

$500, noted as "SAVE PAY" on the Army leave and earnings statement (LES). All components offer HPOBCP for eligible PAs. Once a PA meets basic eligibility, they may apply for HPOBCP. Valid certification must be retained to continue receiving this pay. HPOBCP contracts are completed once and remain in effect until one of the eligibility criteria expire (eg, loss of certification, separation, or retirement). The ARNG offers HPOBCP at a 1/30th payment rate. In other words, 1/30th of $500 dollars is paid out monthly to ARNG PAs.[6]

Health Professions Officer Incentive Pay

The Health Professions Officer Incentive Pay (HPOIP) consists of an annual $5,000 sum paid in monthly installments of $416.66, and noted as "SAVE PAY" on the LES. If an officer receives both HPOBCP and HPOIP, they are combined in the same "SAVE PAY" entry on the LES as $916.66. The HPOIP requires meeting basic eligibility, being credentialed and privileged, and practicing a minimum of 40 hours per year at a facility designated by the Army. HPOIP requires an initial 1-year retainability agreement. Agreements are completed once and remain in effect until one of the eligibility criteria expire (eg, loss of certification, separation, or retirement from active duty), or when realigning with an HPORB agreement, which reduces the need for contract renegotiations every year. HPOIP contracts require renegotiation when a PA signs an HPORB contract.

Health Professions Officer Retention Bonus

The HPORB is a multiyear special pay bonus available for officers who agree to an extended period of service. Currently, the only HPORB contract offered is the 4-year retention bonus, paid at $20,000 annually, which includes a 4-year active duty service obligation (ADSO). The following basic eligibility criteria and retainability to serve the length of the HPORB contract are required:

- being credentialed, privileged, and practicing a minimum of 40-h/y at an Army-designated facility;
- not in a two-time non-selection status for promotion;
- meeting all Army fitness, height, and weight standards; and
- meeting retention criteria.

The incentive pay (HPOIP) of $5,000 is additional to the HPORB. The retention bonus is taxed at the time it is paid (noted in deductions on the LES). The retention bonus will be marked on the LES as "Nuc Med Bonus," and is paid as a lump sum annually on the anniversary of the contract's effective date or date of signature, whichever is later. Officers currently in another ADSO, such as those for completing the Interservice Physician Assistant Program or long term health education and training, are ineligible for the combined HPORB. A new contract may be requested up to 90 days prior to the completion of the current one, with an effective date the day after the completion of the current agreement.

For USAR officers, current incentives are the Reserve Component Health Professions Loan Repayment Program (RC HPLRP) ($20,000/year, $60,000 lifetime), Reserve Component Accession ($25,000) and Retention Bonuses ($25,000/year), incentive pay (IP), Board-Certified Pay (BCP). IP/BCP is professional specialty pay for AMEDD officers and is eligible during periods of active duty, battle assembly weekends, and annual training. The retention bonus requires a 2-4 year contract and the Army PA is not eligible in conjunction with RC HPLRP or the RC Accession Bonus. [6]

The traditional ARNG PA receives $5,000 per year as IP for the newly accessed PA and $25,000 per year as a retention bonus when eligible. The HPLRP and BCP are also available to ARNG PAs, but the HPLRP is not offered to AGR PAs.[6] For Title 32 and Title 10 ARNG PAs, the HPORB/IP has 2- and 3-year rates. This is an exception to policy for those ARNG officers in an AGR (Active Guard Reserve) status or one-time occasional tour status. The 2-year HPORB/IP is $10,000 per year, and the 3-year HPORB/IP is $15,000 per year.[6]

Application Process

To initiate the process of requesting special pay, active component PAs in a garrison environment should visit the special pay office in their credentialing military treatment facility. For most active duty officers, a special pay contract must be prepared in the Medical Operational Data System (MODS), AMEDD special pay module. Contracts may be submitted up to 90 days prior to the effective date and no later than 30 days after the effective date. Edited copies of someone else's contract will be rejected if submitted. The approval authority for special pay

agreements is the applicant's first line field-grade–level commander or the credentialing facility's commander or director. Any agreement outside the 120-day execution window will require a letter of lateness signed by the applicant's field-grade commander, or as designated by the commander in writing.

Once a contract is completed and reviewed, it is submitted, along with any supporting documentation, by the local special pay office to the OTSG AMEDD special pay office. The OTSG office in turn reviews the contract again, checking for errors, validating dates, and ensuring that any ADSOs have been satisfied with the assistance of the Army special pay office at the Army Human Resources Command. Upon final verification, the contract is submitted for upload to the officer's Army Military Human Resource Record (AMHRR) through the Interactive Personnel Records Management System (iPERMS) and forwarded to Defense Financing and Accounting Service (DFAS) for processing and disbursement of entitlements to the applicant. This process may take up to 90 days to complete, and inquiries on status of the process should be submitted to the point of contact who prepared the contract.

Eligible USAR officers can request IP and BCP via the Reserve Incentives Management Sub-System (RIMS).[6] Budget shortfalls affecting other incentive programs do not affect these types of pay. The Reserve Component Manpower System (RCMS) Request Incentive self-service website is https://selfservice.rcms.usar.army.mil/Selfservice/RequestIncentive. See instructions to activate this incentive on the US Army Reserve Physician Assistants milBook page at https://www.milsuite.mil/book/docs/DOC-723544).

Eligible ARNG officers can request IP and BCP through state incentive managers, who complete all the required documentation and submit it via the Guard Incentive Management System (GIMS) for review and approval.[5] The application process for the AGR PA is the same process as COMPO1 (active Army component).

Blended Retirement System

The blended retirement system (BRS) that went into effect January 1, 2018, reflects significant changes to the military retirement system. Service members entering service after that date are automatically enrolled under the new retirement system.[7] Those with 12 or fewer years of service as of January 1, 2018, had a transfer option to the BRS.[8]

Among the differences in pay for officers in the BRS is continuation pay (CP). This pay is not specific to PAs and available to service members enrolled in BRS. CP is an incentive to retain personnel beyond their 12th year of service with a one-time payment of 2.5 to 13 times their basic pay for active duty members, or 0.5 to 6 times the basic pay for reserve component members. Eligible regular Army officers will complete 11 years of service, but not more than 12 years of service, during calendar year 2020, as computed from their pay entry basic date (PEBD). The US Army's CP rate for 2020 is 2.5 times base pay for active component and 4 times base pay for reserve component, based on current pay grade and years of service. Agreement to receive CP incurs an obligation of an additional 4 years of service.[9] The service obligation commences upon approval of the CP request, and current implementation allows for concurrent obligation with any HPO special pay, including retention bonuses.

Points of Contact

For soldiers enrolled in BRS, contracts are generated for those interested in claiming CP by their organization's appointed official and routed by their S-1 (personnel office) to the local finance office.[8] There are many differences in BRS compared to the previous retirement system, and incentives are fluid. Officers seeking information should contact their local pay or finance office, or see https://militarypay.defense.gov/BlendedRetirement/. Officers may also contact the Army Medical Specialist Corps future readiness officer at the Human Resources Command. Other contact information is as follows:

- The OTSG AMEDD special pay office is located at the OTSG, Human Resources (DASG-HR-P), AMEDD Special Pay Branch, 7700 Arlington Boulevard, Suite 5144, Falls Church, VA 22042-5144. Phone: 703-681-1209; DSN: 471-1209; Fax: 703-681-0482.
- The point of contact for reserve special pay inquiries is the AMEDD incentives program manager, US Army Reserve, G-1, at 910-570-8784 or usarmy.usarc.usarc-hq.mbx.incentives@mail.mil.
- The point of contact for ARNG special pay inquires is National Guard Bureau Human Resource Management (HRM-I), AMEDD Incentives Office, 111 South George Mason Drive, Arlington, VA 22204, or ng.ncr.ngb-arng.mbx.amedd-incentives@mail.mil.

Exceptions to Policy and Special Cases

Backdated contracts that are requested with a date before the current fiscal year, or with any extenuating criteria beyond those mentioned above, may require submission to the Army Review Boards Agency for an Army Board of Correction of Military Records. For further information about this process, please refer to the agency's website at https://arba.army.pentagon.mil/abcmr-overview.html. Cases may be submitted on the advice of the OTSG AMEDD special pay office.

Conclusion

Various types of monetary incentives are available to PAs, from HPOBCP and IP early upon accession, to retention bonuses offered after initial service obligations. With the advent of the BRS, other options may also influence financial decisions made by Army PAs. The best way to maximize eligibility for these options includes careful career planning to integrate access to HPO special pay with ADSOs incurred by additional service incentives or training obligations. Policy guidance is continuously reviewed, so PAs must remain connected with Army leaders and peers to remain abreast of changes.

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Chapter 70

TRANSITIONING FROM THE MILITARY: LESSONS LEARNED FROM RETIRED ARMY PHYSICIAN ASSISTANTS

Pauline Gross, PA-C, MPH; W. Joseph Bowman, DSc, PA-C, EMPA; Christopher Montoya, PA-C, MPAS; and Christopher Sacheli, APA-C, MPAS

Introduction

Transitioning from the military is a process, not an event. There are many things to consider before "dropping the paperwork." Retirement transition for an active duty physician assistant (PA) is full of both opportunities and challenges. The high-demand and portable PA profession is easily adaptable to the civilian market in any number of clinical specialties and practice environments; however, the challenge faced by retiring Army PAs is to disengage from military leadership and clinical responsibilities in sufficient time to adequately prepare themselves for the transition. As dedicated professionals, Army PAs traditionally place the needs of others before themselves. This chapter will discuss specific timelines, lessons learned, and tips for success that may assist Army PAs during their retirement transition.

Preparation Timeline Prior to Retirement

The process of transition should begin about 2 years before the actual retirement date. Once the PA determines their retirement date, they can begin to backward plan for necessary personal, professional, and logistical events. This also allows the PA's command and Human Resources Command (HRC) enough time to find a replacement and establish a dedicated transition period. If they are lucky enough to be stationed in

the area where they plan to retire, there will be fewer challenges for the PA and their family as they prepare to leave the military.

Two Years Out

The active duty Army retirement timeline begins 24 months prior to retirement and ends 120 days after discharge (the deadline for health and life insurance conversions, as discussed below). At the 24-month mark, PAs should verify all active duty service time and obligations, time in grade, permanent change of station, and documentation for the Post-9/11 GI Bill. The overall military separation and transition process is geared toward an individual who does not already have a civilian job in place. The PA profession's reliance on HRC, the military board and promotions process, and local allocation of resources is markedly different than the civilian hiring process. The Army Soldier for Life Transition Assistance Program provides classes on resume writing, interviewing, and professional discourse (https://www.sfl-tap.army.mil/).[1] Participating in these courses is beneficial because most soldiers have not "interviewed" in the traditional sense for any clinical position or professional job during their time in the military. Retiring PAs need to polish their interviewing skills and prepare to sell themselves as a civilian PA. The transition assistance classes also cover what benefits they and their family will be eligible for in retirement, with discussions on TRICARE, the GI Bill, and other enduring programs. PAs may not be aware of all these benefits and programs, and may need to enroll before or soon after retirement.

Two Years to One Year Out

Between the 2-year and 1-year milestones, the Army PA should decide where they want to retire. Employment opportunities and family demands are characteristically the top two factors in determining where a PA leaving the military will establish themselves in retirement.

If the PA will be moving to another area, the mechanics of packing up a household and reestablishing it in a new location is the same as in every other military move. The challenge will be deciding on where to work, the area of medicine to practice in, and the preferred salary range to maintain their quality of life. If the PA is relocating to another city or state, will travel be necessary for job interviews or can

they be conducted virtually? Either way, it is advisable for the PA to take a pass or leave and travel to explore employment opportunities in the retirement location as early as possible. While securing a job 2 years before starting is unlikely, it is possible to begin a dialogue with employers and human resource departments. Emergency departments and urgent care practices have a high rate of turnover and are usually receptive to early inquiry about future positions. Specialty practices may be more challenging, and early professional dialogue with them is encouraged. When deciding on the area of medicine, will there be courses, additional certifications, or skill sets required for the positions? If terminal leave is an option, is it legal to work for the new employer prior to retirement?

If already located in the area where they plan to retire, it is advisable for the PA to work part-time at a civilian facility after obtaining permission for off-duty employment. Doing so will establish them as a credentialed civilian PA in the hospital system or clinical environment where they plan to work full-time after transition.

Twelve Months Out

A year before retiring, an Army PA must submit a retirement request and leave plan through their command and complete the pre-separation transition checklist (DD Form 2648). Final requests for permissive temporary duty and transition leave must be submitted 60 to 90 days taking it; depending on how much leave is requested and when it will be taken, requests may be submitted as much as 6 or 7 months before retirement. PAs must also obtain a secure Department of Defense (DOD) self-service (DS) logon that allows beneficiaries affiliated with the DOD or Veterans Affairs (VA) access to several websites using a single user name and password. This is also a good time to review personnel files and medical records, and gather all military records in one place. Relying on the Army Military Human Resource Record (AMHRR) digital record is not advisable, because access is limited after retirement. Having hard copy files, organized and readily available, is helpful and may be needed by the Retirement Services Office where the PA is outprocessing to complete the DD Form 214, Certificate of Release or Discharge from Active Duty. Copies of medical records should be requested from the appropriate patient administration department at this time. The PA must ensure their file contains records from all their assignments.

The VA Schedule of Ratings and Disabilities is used to determine if retiring officers will get tax-free monetary compensation for injuries and illnesses incurred during service. However, most medical officers do not seek out medical care throughout their career in the traditional sense. Instead, informal consults and orders placed by fellow providers allow officers to continue to work and deploy, which might cause problems for claiming retirement disability benefits. The Army PA should take as much time as they can spare to get any and all conditions documented in their medical records between the 1-year and 6-month milestones before retirement.

Six Months Out

This is a critical point to prepare for VA benefits and future employment. At the 6-month milestone, retiring PAs must complete their Separation History and Physical Examination (SHPE), so it can be used in any claim for VA disability compensation while the PA is still on active duty. Two copies of the SHPE record should be requested, one copy for personal records and the other for the VA disability application.

Civilian Employment Preparation. At about 6 months prior to retirement, PAs should be focused on securing full-time civilian employment. They should also contact the transportation/household goods office for an appointment to initiate any family or household moves. The local transition services office and transportation office will have stated timelines and submission deadlines that should not be missed. Depending on where the PA wants to work, there may be a significant amount of preparation required during the lead-up to the first day of work. Pre-employment tasks may include background checks, credentialing requirements, establishment of state licensure, and obtaining a Drug Enforcement Agency (DEA) registration number to allow them to write prescriptions for controlled substances. A good resource to consult at this point is the American Academy of Physician Assistants website (https://www.aapa.org/career-central/career-resources/), which has a wealth of information on such topics as "Prepare resume and curriculum vitae," "Negotiate your contract," "Licensure and certification," "Understand reimbursement," and "Malpractice insurance basics."[2]

Training and Education. Prospective employers may ask for diplomas, course certificates, and transcripts, and procuring

copies of these items may take time. PAs should take advantage of any opportunities available before separation to update required certifications such as Basic Life Support, Advanced Life Support, and Pediatric Advanced Life Support courses, to ensure these skills do not expire soon after separation and early on in their new career.

Contracts. How much experience does the PA have with contracts? Before signing, the PA should always ensure any bonuses, agreements, promises, malpractice coverage (during AND after employment) are clearly stated in the contract.

Curriculum Vitae. PAs should take the time to translate, as appropriate, military responsibilities, especially military-specific duties and leadership positions, into business-oriented language.

Credentialing. Military credentialing is fairly simple, and credentials are online. Providers review their files during in-processing to make sure they are complete and up to date, then wait for a month or less pending approval of the credentials committee. In civilian credentialing, the employer submits the provider's medical credential packet to all the medical insurance plans so the organization can be reimbursed (paid) for the provider's medical care. Until they are credentialed, providers will not be allowed to see patients. This process can take 90 to 120 days for certain contracts. Therefore, it is crucial for PAs to begin to job hunt 6 months before retiring, at the latest. Completing this process while on active duty alleviates the stress of not having clinical privileges during a PA's retirement transition, and will allow the PA to begin working full time as soon as they retire. Additionally, working part-time where the PA plans to get a permanent position, if possible, allows them to explore the organization's personalities and professional environment, and provides the opportunity to change course if there is not a good fit, before it becomes their full-time job. PAs should ask what information will be required at the new job to prove skill competency (eg, letters of certification, procedure logs).

Retirement Ceremony. This is a good time for a PA to decide if they want an individual retirement ceremony or would rather participate in an installation-led group ceremony. Planning for an individual ceremony can be simple or complex. While most PAs are quiet professionals who avoid recognition, a retirement ceremony is more about respecting the sacrifices their families have made throughout their service, and it is a great way to celebrate the cumulative accomplishments of a distinguished career. It also provides closure for a PA and their family

as they close the door on one chapter of life and move on to new adventures. If the PA decides on an individual ceremony, 6 months will give family members enough time to arrange travel and hotels as needed.

Six to Three Months Out

Between 6 and 3 months from retirement, PAs should verify their unit is completing their final officer evaluation report (OER) and retirement award. Most installations will require signed copies of leave forms and at least a draft OER before picking up their unit and installation clearance records.

Three Months Out

About 3 months before retirement/beginning of terminal leave, the PA should make an appointment with the Staff Judge Advocate office to update wills and power of attorney documents. In addition, the installation's transition class should provide information on what medical and dental care options are available for individuals and families; now is the time to choose among the options.

Two Months Out

About 2 months out from retirement/terminal leave, PAs should complete DD Form 2656 (Retired Pay Data/Survivor Benefit Plan). The Survivor Benefit Plan provides eligible beneficiaries an annuity (a monthly payment lasting the beneficiary's lifetime). Enrollment in an annuity plan is a decision that requires careful consideration; eligibility, costs, advantages and disadvantages, and limitations on leaving or changing coverage should be considered. More can be found at the Defense Finance and Accounting (DFAS) website: https://www.dfas.mil/retiredmilitary/provide/sbp.htm.[3]

Also, VA Form 21-526 (Service-Connected Disabilities) should be completed at this time. Form 21-526 is the VA application for compensation, used to make a claim for benefits that arise from disability or injuries sustained during military service. Most Army posts host a Disabled American Veterans or Veterans of Foreign Wars representative office next to the VA office; both organizations can help with submitting disability claims. PAs should use the VA Benefits Due at Discharge

(BDD) program, which combines the SHPE and the VA disability claim. The BDD process allows retirees found eligible to receive disability compensation immediately upon retirement. If they then have a rebuttal or amendment, they can submit additional documentation to the VA for up to 1 year and still receive expedited resolution of their claim. Any adjustment will be back-dated to their retirement date.

The VA claim examination process can take up to 45 days after initial submission. Temporary duty or personal travel should not be scheduled during this period because only one examination can be rescheduled, and most service members require multiple body system or specialty examinations to complete their claim. If their duty position requires them to continue with temporary duty, PAs might have to complete their VA disability claim and examinations after retirement. Once determination is completed, payments will be back-dated to their retirement date. More information can be found at https://www.va.gov/.[4]

One Month Out

At 1 month out from retirement/terminal leave, PAs should copy their important email contacts and back up important emails before their government email access terminates.

Retirement Day

Unit and installation clearance are usually done just before the initiation of terminal leave, unless terminal leave was not taken. As with any other permanent change of station or relocation, departing PAs must report to the installation out-processing center to complete installation clearing through Finance and Personnel, and receive their completed DD Form 214. Retirees must return to ID Card Services on or after their retirement date to turn in their active duty identification card and receive a retiree identification card.

Zero to Six Months After Retirment

PAs have up to 120 days after retirement to convert Servicemembers' Group Life Insurance to Veterans Group Life Insurance, if desired. The VA sends the application. Retirees must also sign up for a TRICARE plan within 120 days, which is not done automatically. If applicable,

PAs should compete DD Form 2860, Application for Combat-Related Special Compensation, but only after the VA has given the PA a disability rating.

Additional Lessons Learned and Tips for Success

A few additional lessons learned have been identified to help PAs, throughout their career, to set themselves up for success in retirement. Since joining the Army, the PA's mission has been to support the battalion and its soldiers. As Army PAs traverse their military duties, they are geared for many kinetic variables that are specified and detailed. However, nothing in their arsenal prepares them for the life-changing decision of exiting the military. In preparation for retirement, Army PAs must adjust their approach to support a different mission and focus on their own family and loved ones. With the new mission for retirement, PAs may lack some fundamental concepts that can hurt future job placement.

Training a Replacement

The Army PA must contact HRC to find out who their military replacement is, and get them onboard as soon as possible to allow for a good "left-seat, right-seat" transition. This will provide retiring PAs the flexibility to conduct their transition without a degradation of support to their command. Stepping away at the end of a career is the hardest thing most will do as Army officers.

Healthy Versus Sick Patients

Military providers see for the most part otherwise healthy patients with musculoskeletal injuries and, when deployed, combat injuries. Without caring for patients with morbid or chronic medical problems, an Army PA's primary care skills may become degraded. PAs should therefore be encouraged to seek work in the civilian community to become a more robust and effective clinician (they must first get approval for off-duty employment). For example, is the PA comfortable with treating a morbidly obese patient with diabetes, hypertension, and kidney failure who needs refills on blood pressure medications and wants phentermine? Working in the civilian community during off-duty hours will expand

the PA's medical knowledge base and make them more comfortable treating patients with multiple comorbidities.

Military Medical Benefits versus Insurance or No Insurance

When military providers treat soldiers, they do not need to worry about if, when, or how someone will pay for medications, treatments, or specialty care. Army PAs may lack basic knowledge of simple terms of commercial insurance, such as preferred provider organization, health maintenance organization, and exclusive provider organization. PAs must become familiar with these terms in the civilian community because every decision providers make can and does affect patients' pocketbook and time. Patients want the best care, but insurance providers will only approve of treatments within their plan, or fill medications that are in their formulary. It is very common for a small, healthy family to pay a monthly insurance bill of about $1,000, with a $5,000 deductible, and might still pay $17,000 in a calendar year before their insurance will cover their bills entirely.

Many clinics or organizations may not care if a PA was good at their military job or had saved lives; their reputation may not help them get paid for their patient care. Clinics and medical institution do care about the medical care they provide, but they want to be reimbursed by the insurance companies. PAs must have their credentialing requirements ready for submission for all the insurance plans. If PAs do not have this information ready or they let any certifications and licenses lapse, it will affect their employer's ability to generate revenue (no credentials, no job; no job, no money). Planning ahead and having copies of certifications and other documents will assist credentialing personnel complete the paperwork for PAs to enter the civilian workforce.

Customer Service

PAs must understand the relationship between customer service and patient care. They must be able to quickly evaluate their patient's situation, understand what the patient needs, and "sell" their diagnosis and treatment plan to the patient. If the patient thinks or feels their treatment is inappropriate, they will either let the provider know it in person, post it on social media, or contact state agencies. If a PA receives bad remarks or has bad experiences, regardless of whether they did the

right thing, the employer could terminate the PA's service if they think it will affect revenue. Again, the hard truth is that institutions want their reimbursements quickly, consistently, and without interruption.

Conclusion

PAs retire for many different reasons: they may have a mandatory retirement date, a family tired of moving, or another deployment coming up, or they may be considering excellent civilian salaries. Whatever the reason, PAs should plan early, do the research, stay flexible, and definitely be patient.

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Epilogue:
The Future of the Army Physician Assistant

The Army Physician Assistant (PA) profession was established for a noble purpose—to provide more accessible health care for soldiers in a turbulent world. Today, PAs have eclipsed that purpose, and are advancing medicine in ways never before envisioned. PAs serve as legislators, health system CEOs, hospital commanders, city officials, medico-legal experts, professors, education system leaders, and advisors to heads of state. The future of the profession is in adapting to an ever-changing health care industry.

The vision for the Army PA profession is to reinforce the spirit of innovation and performance in medical and readiness systems embodied by PAs to improve the deployability and survivability of our soldiers. PAs have too long been relegated to an obsolete force structure that does not encourage professional growth or validate the great breadth and depth of capability and experience our PAs bring to Army Medicine and commanders. Great opportunities have opened for PAs to collaborate and lead at all levels of Army Medicine. We must bolster Army Medicine by mentoring outstanding PAs to provide leadership and expertise throughout the Army and the Defense Health Agency. With great opportunity also comes great responsibility, and we must recognize that responsible mentorship and enforcement of quality and professional standards must be reinforced wherever PAs are posted. Army PA's training and credentialing must prepare and support them for the inevitable autonomy necessitated by the dispersed and multi-domain nature of current and future deployments. That autonomy must always be tempered with adherence to standards of care, scope of practice, self-restraint, and consultation to ensure PAs and Combat Medics have robust capabilities that meet the needs of commanders.

PAs serve as the face of Army Medicine. Together with Combat Medics, PAs are many times the first professional medical officers that Soldiers seek for medical readiness and care. The PA profession offers an avenue for outstanding combat medics and soldiers to become PAs, and we must always improve pathways to recruit Medics to the Interservice PA Program (IPAP) to retain the "From the Line, For the Line" character of the Army PA. As a product of that pathway, I charge all Army PAs to seek out excellent candidates for IPAP and direct commissioning,

and to facilitate their preparation to build a force of PAs with the depth of operational experience the Army, Department of Defense, and the world need for the future.

The *US Army Physician Assistant Handbook*, First Edition, collated the writings of the thought leaders of the Army PA profession. Only 2 years later, Army Medicine and the world have changed immensely. Because of all who have contributed to the first edition, we now have a snapshot in time of the opinions, challenges, and successes of those authors. Now, as the Military Health System continues to reform at a blistering pace along with the US civilian health system, current PA leaders continue to develop, lead, and share their hearts and opinions in this new addition. You are the real engine behind our positive energy! Thanks to all of you who enhance the PA profession and help others in the military and civilian communities. This publication is a true testament to all who have contributed and shared.

To all the individuals I have had the opportunity to serve with, be led by, or watch their leadership from afar, I want to say thank you for being the inspiration and foundation for the second edition of the *US Army Physician Assistant Handbook*. Without the experiences and support from peers and our teams, which touch on every aspect of military and civilian medicine, this book would not exist. You have given us all the opportunity to be surrounded by a great group of individuals. To be a leader among other great leaders is an honor. Thank you and special acknowledgements to COL Amy Jackson and LTC Amelia Duran-Stanton for their leadership, tenacity, and sustained unconditional support for the second edition of the *Physician Assistant Handbook*.

The associated dynamics of DOD and the recent organizational changes have presented many opportunities. The readiness growth and development experience is both internally challenging and rewarding as we continue to grow in support of our forces. I especially want to thank the individuals who helped make this happen and mentor those who will publish the next editions.

Colonel David Hamilton
The 9th Army Physician Assistant Consultant
to the Army Surgeon General

APPENDIX:
ARMY PHYSICIAN ASSISTANT DISTINCTIONS

Amelia M. Duran-Stanton, PA-C, PhD, DSc, MPAS, and
John F. Detro, PA-C, MPAS, MEd

Disclaimer: The distinctions listed here are based on access to available references, resources, and databases. It is not our intention to exclude anyone from the lists. Army physician assistant (PA) leadership should be notified for changes in future editions of this handbook.

In 2015, the Army Medical Specialist Corps divided the duties of the Area of Concentration (AOC) Branch Chief and Consultants, making these positions separate duties. Lieutenant Colonel Oliver and Lieutenant Colonel Detro were the first two PAs to serve in these new roles. In 2017, the PA Consultant was approved for two Deputy PA Consultants, one designated for Current Operations (CUOPS) and the other for Future Operations (FUOPS). Also in 2017, the AOC Chief was eliminated, and in 2018 the Consultants were formally authorized one Deputy PA Consultant to The Army Surgeon General.

Chief of the Army Medical Specialist Corps

2017–2021: COL John E. Balser

Deputy Chief of the Army Medical Specialist Corps

2018–2020: COL Jeffrey E. Oliver

Chief of the Physician Assistant Section, Assistant Chief of the Army Medical Specialist Corps

1992–1994: MAJ Jimmie E. Keller
1994–1998: LTC Patrick D. Feely
1998–2002: LTC Louis H. Smith, III
2002–2006: COL William L. Tozier
2006–2010: COL Michael A. Robertson
2010–2014: LTC John E. Balser
2014–2017: LTC Jeff Oliver

Physician Assistant Consultant to The Army Surgeon General

2015–2019: COL John F. Detro
2019–Present: COL David Hamilton

Deputy Physician Assistant Consultant to the Army PA Consultant Appointed by the Army Medical Specialist Corps Chief

2017–2020: LTC Amelia M. Duran-Stanton–CUOPS
2017–2020: LTC Sharon Rosser–FUOPS

Deputy Physician Assistant Consultant to The Army Surgeon General

2018–2020: LTC Amelia M. Duran-Stanton
2021–Present: LTC Sharon Denson

Awards for Valor or Secondary to Being Combat Wounded

The following Army PAs received awards for valor or secondary to being combat wounded. The descriptions of these awards can be found at https://www.military-ranks.org/decorations

Medal of Honor

The Medal of Honor is the US armed forces' highest and most prestigious military decoration that may be awarded to recognize American service members who have distinguished themselves by acts of valor. The medal is normally awarded by the President of the United States in the name of the US Congress. Because the medal is presented "in the name of Congress," it is also known as the Congressional Medal of Honor.

Louis Rocco

Distinguished Service Cross

The Distinguished Service Cross is the second highest award in the US Army. It is awarded for true gallantry and selfless action in combat against an armed enemy force. Actions must be more significant than those of other ribbons, medals, and decorations but do not merit the Medal of Honor. The Distinguished Service Cross is awarded to a service member who, while serving in any capacity with the Army, distinguishes himself or herself by extraordinary heroism. The action must occur while engaged in combat against an enemy of the United States. The actions of heroism must be notable and have involved great risk of life, so extraordinary as to set the individual apart from his or her comrades.

Bryan C. Anderson

Silver Star Medal

The Silver Star, officially known as the Silver Star Medal, is the US military's third-highest decoration for valor in combat. It is awarded primarily to members of the US armed forces for gallantry in action

against an enemy of the United States. The Silver Star is awarded for gallantry that does not meet the requirements for higher valor awards: the Distinguished Service Cross, the Navy Cross, or the Air Force Cross. The action must have taken place while engaged in combat against an enemy of the United States in which the United States is not a belligerent party.

Christopher Cordova	James B. Jones
Stephen M. DeLellis	Patrick Williams

Soldier's Medal

The Soldier's Medal is the highest honor a soldier can receive for an act of valor in a non-combat situation. A member of another military branch may be awarded the Soldier's Medal if they are serving alongside the US Army. It is considered to be equal to or greater than the level of heroism that would have justified an award of the Distinguished Flying Cross had such an act occurred in combat. Any enlisted American service member recipient who is eligible for retirement pay will receive an increase of 10% in retirement pay if the level of valor was equal to that which would earn the Distinguished Service Cross.

Dennis J. Brady	Johnny W. Paul
Mark Dedmon	Gary Reedy
Robert Howes	Troy Vaughn

Bronze Star Medal With "V" Device

The Bronze Star Medal with "V" device is a US military decoration awarded to members of the US armed forces for heroic achievement, heroic service, meritorious achievement, or meritorious service in a combat zone. The acts of heroism must be of a lesser degree than that required for the award of the Silver Star. The acts of merit or acts of valor must be less than that required for the Legion of Merit but must nevertheless have been meritorious and accomplished with distinction. The Bronze Star Medal is awarded only to service members in combat zones who are receiving imminent danger pay.

Robert S. Blough	Scott R. Leduc
Michael A. Broussard	John C. Maitha (three awards)

John F. Detro
Brian G. Gomez
James B. Jones (two awards)
Dawn L. Orta
Paul M. Schultz
James L. Shearer

Purple Heart

The Purple Heart is awarded in the name of the President of the United States to members of the US armed forces who have been wounded or killed after April 5, 1917. Individuals must be engaged in combat or undertaking any action with a known enemy of the United States where the United States is not the belligerent party. It may be awarded to individuals wounded during an international terrorist attack against the United States or a foreign nation friendly to the United States. It may also be awarded as a result of military operations that occur during peacekeeping missions that take place outside of the United States.

Bryan C. Anderson
Seamus P. Bradley
James P. Conner (two awards)
Stephen M. DeLellis
John F. Detro (three awards)
Kenneth J. Edwards
Andrew D. Fisher
Brett C. Gendron
Joseph N. Gomez
Sean Grimes
Jeffrey A. Hobbs
Corey J. Jenkins
James B. Jones
Andrew R. Kennedy
Daniel T. Knudsen
Garrett W. Larson
Laurencio C. Lopez
John C. Maitha
Jeremy A. McGuffey
Kane Morgan
Kevin M. Myirski
Antonio Narvaes (two awards)
Larry S. Pierce, Jr.
Michael A. Ramos
Michael A. Robertson
Alec Ross (two awards)
Renee A. Serell A.
Marion J. Smith III
Stephen M. Witte

Army Commendation Medal With "V" Device

The Army Commendation Medal (ARCOM) with "V" device is awarded to any member of the armed forces of the United States who, while serving in any capacity with the Army, distinguishes themselves by heroism, meritorious achievement, or meritorious service. Awards of the ARCOM may be made for acts of valor performed under circumstances described above which are of lesser degree than required for award of the

Bronze Star Medal. These acts may involve aerial flight. The ARCOM may be awarded for acts of noncombatant-related heroism that does not meet the requirements for an award of the Soldier's Medal.

Brian J. Ahern
Joseph R. Bongiorno
Seamus P. Bradley
Franklin G. Brown
Kyle A. Busby
Brandon J. Carroll
David J. Cantron
Nicholas R. Coffey (two awards)
John F. Detro (two awards)
Matthew J. Dower (two awards)
Kenneth J. Edwards
Brett C. Gendron
Jeffrey A. Hobbs
Garrett W. Larson
Daniel J. Maselli
Jeremy A. McGuffey
Antonio M. Narvaes
Roman R. Reyes
Marion J. Smith III (two awards)
Nickolas M. Willer

Joint Service Commendation Medal With "V" Device

The Joint Service Commendation Medal was authorized on June 25, 1963, and is awarded by or in the name of the Secretary of Defense to members of the US armed forces who distinguished themselves by meritorious achievement, valor, or service after January 1, 1963.

Franklin G. Brown
Daryl G. Hilyard
Joshua J. Lane (two awards)

Air Medal With "V" Device

The Air Medal is awarded to recognize gallantry or meritorious service over a period of time in a combat zone. The Air Medal recognizes those personnel who are on current crew member or non-crew member flying status, which requires them to participate in aerial flight on a regular and frequent basis in the performance of their primary duties. The US Army and Navy also awarded a "V" pin (valor device) that denotes special acts for heroism involving aerial contact with an enemy force.

Matthew J. Chandler
Robert S. Heath
Kevin E. Mayberry
Nathan C. Silvey (five awards)
Salvador M. Thorn
Caroline B. Vickers
William N. Vasios III

The Surgeon General's Physician Assistant Recognition Award

The Surgeon General's Physician Assistant Recognition Award (TSG-PARA) description can be found in Army Regulation 351-3. This annual award provides personal recognition by TSG to a PA who has made a significant contribution to military medicine. It is intended to increase PA motivation for exceptional job performance. The award program applies to all commands, agencies, installations, activities, and organizations having PAs assigned on a full-time basis.

1980:	Gerald T. Mlakar	2000:	Leonard Q. Gruppo, Jr.
1981:	Donald L. Parsons	2001:	James J. McIlwee
1982:	Keith B. Sunderlin	2002:	David L. Hamilton
1983:	William Donovan	2003:	Kevin W. Burnham
1984:	Stephen E. Brick	2004:	Christopher S. Van Winkle
1985:	Henry B. Sablan	2005:	John E. Hendricks
1986:	Samuel L. Jewett III	2006:	John F. Detro
1987:	Charles M. Russell	2007:	Patrick C. Williams
1988:	Patrick F. Roper	2008:	William C. Swaims
1989:	Judith E. Colver	2009:	Anthony J. Bohl
1990:	Terry L. Lewis	2010:	Andrew D. Fisher
1991:	Duane K. Paulus	2011:	Christopher Cordova
1992:	Michael K. Cavanagh	2012:	Manuel Menendez
1993:	John E. Hurley III	2013:	George A. Barbee
1994:	Peter A. Forsberg	2014:	Lindsey K. Faudree
1995:	Joseph F. Creedon, Jr.	2015:	John B. Robinson
1996:	Charles E. Solesbee	2016:	P. Jason Auchincloss
1997:	Jonathan R.C. Green	2017:	Kymberli Scruggs
1998:	Dale J. Rush	2018:	Johnny Paul
1999:	Anne M. Albert	2019:	Sean Donahue

Army Physician Assistants with "A" Designation

The "A" proficiency designator is the highest recognition for professional excellence in the Army Medical Department (AMEDD). Candidates for the honor must be eminently qualified to chair a department, division, or service, or have attained full professional status and national prominence in their field. This annual award can be given to eligible candidates in the AMEDD active component, Army National Guard, and US Army Reserve (USAR).

P. Jason Auchincloss
John E. Balser
David W. Broussard
George A. Barbee
Bruce J. Beecher
Thomas A. Bryant
Brian E. Burk
Aaron J. Cronin
Michael A. Davidson
Charles Day
Stephen DeLellis
Sharon D. Denson
John F. Detro
Mathew S. Douglas
Amelia M. Duran-Stanton
Colin T. Frament
Michael E. Franco
Pauline V. Gross
David L. Hamilton
Randolph "Scott" Harrison
Robert S. Heath
Owen T. Hill
George Horsley
Amy L. Jackson
Paul V. Jacobson
James J. Jones
Benjamin Kocher
Larry T. Lindsay
Roberto E. Marin
Jonathan D. Monti
Kane Morgan
Trisha A. McCracken
Jeffrey E. Oliver
Dawn L. Orta
James G. Pairmore
Christopher C. Pase
Johnny Paul
Dennison S. Segui
Kenneth Shedarowich
Erin J. Stibral
James T. Schumacher, Jr.
Patrick A Sherman
Cleve B. Sylvester
Mohamad A. Umar
Richard A. Villarreal
Michael P. Way
Patricia M. Williams
Larry A. Wyatt

Army Medical Specialist Corps Chief's Award of Excellence

The Army Medical Specialist Corps (SP) Chief's Award of Excellence provides personal recognition by the corps chief to active and reserve company-grade SP officers who have made outstanding contributions to the accomplishment of military medicine in their respective fields. This annual award is may be given to active duty company-grade occupational therapists, physical therapists, and dietitians, and reserve component company-grade occupational therapists, physical therapists, dietitians, and physician assistants.

2009: Kristy Linginfelter
2011: Michael Bell
2014: Brian Neurohr
2015: Erik Hanson
2016: Joshua Radi
2019: Alex Merkle (USAR)

Army Physician Assistant Iron Majors Award

The Army Medical Specialist Corps Chief's Iron Majors Award is a selection process to identify outstanding majors and captains promotable of the SP Corps who have displayed exceptional leadership skills, with the ability to mentor junior officers and foresee and participate in the future growth and potential of SP Corps officers. This annual award is bestowed upon selected recipients and culminates with the attendance of a senior leader development symposium in the National Capital Area, where invaluable exposure to strategic issues, interagency relations, and senior leader interaction at the Office of The Surgeon General level occur, building the foundation of future SP Corps strategic leaders.

2009: David Bauder
Robert Heath
James Jones

2010: George Barbee
Marni Barnes
Michael Franco
David Hamilton
Kane Morgan

2014: Christopher Pase

2015: Aaron Cronin
Ryan McGill
Sharon Rosser
Brian Savage (USAR)

2016: Anisa Garcia (USAR)
Maureen Giorio
Seth Holland

2011:	Stephen DeLellis		Benjamin Kocher
	Amy Jackson		Manuel Menendez
	Dawn Orta		
	Bill Soliz	2017:	P. Jason Auchincloss
			Sean Donohue
2012:	Michael Coote		Benjamin Vance (ARNG)
	Michael Davidson		
	John Detro	2018:	Ryan M. Rodriguez
	Amelia Duran-Stanton		Jodi Wernikoff (USAR)
	James Schmid		
	Bradley Warr	2019:	Andrew Kennedy
			Timothy Pekari
2013:	Roger Ball		
	Chad Cole		
	Owen Hill		
	Dustin Martin		
	Johnny Paul		
	Larry Wyatt		

The Junior Leadership Course Award

The Junior Leadership Course (formerly called the CJ Reddy Course and the Junior Officer Leadership Course) is an AMEDD event that starts with a nomination and selection process to identify outstanding active, reserve, and National Guard (ARNG) AMEDD officers, enlisted, and civilian employees who have consistently demonstrated the core Army values and warrior ethos and demonstrate the skills, attributes, and potential required of future leaders.

2015:	Garrett Larson	2019:	Matthew Dower
	Tammy Mayberry		Timothy Pekari
2018:	Roland Salazar	2020:	Terrence Canny
	Travis Kaufman		Jarrett Stark (ARNG)
	Dustin Stuart		
	Jill Rogers		
	Joshua Radi (ARNG)		

Army Medical Specialist Corps Mary Lipscomb Hamrick Research Awards

The Colonel Mary Lipscomb Hamrick (MLH) Research Award fund was established in March 1985 upon acceptance by LTG Quinn H. Becker, The 36th Army Surgeon General, of a $2,500 endowment tendered by BG (Ret) William A. Hamrick. BG Hamrick established a perpetual award recognizing outstanding SP Corps officers for their contributions to research or clinical investigations.

New Horizon Award

The MLH New Horizon Research Award recognizes outstanding junior researchers with less than 5 years of experience in the areas of research and clinical investigation.

2008: Amelia M. Duran-Stanton 2019: Brandon Carius

Lifetime Award

The MLH Lifetime Research Award recognizes an outstanding senior SP Corps officer who has accumulated significant research or clinical investigation contributions.

2017: Owen Hill 2019: Seth Holland

Manuscript Award

The MLH Manuscript Award recognizes outstanding published manuscripts.

2016: Brad Warr 2019: Nicole Lopez

Abstract Award

The MLH Abstract Award recognizes outstanding submitted abstracts.

2018: Matthew Douglas 2020: Brandon Carius

Army Medical Specialist Corps LTG Ledford Award

The LTG Frank Ledford Physician Assistant Award for postgraduates provides personal recognition to the most outstanding active duty physician assistant postgraduate DSc or PhD student.

2010: Jonathan L. Saxe
2011: Colin M. Dunderdale
2012: D. Alan Nelson
2013: Benjamin K. Kocher
2014: Joseph T. Costello
2015: Kurt Fossum
2016: Zebulon L. Wilkin
2017: Matthew S. Douglas
2018: James E. Huang
2019: Brandon Carius

USAREUR Physician Assistant of the Year Award

The USAREUR PA of the Year award is a unique representation of commitment and medical contribution to the US Army-Europe (USAREUR) mission. Its purpose is to recognize excellence and promote fellowship and esprit de corps among assigned USAREUR PA personnel.

2013: Zebulon Wilkin
2014: Marshall Healy
2015: Christina Carrigan
2016: Jon Christiansen
2017: Donald "Royce" Frazee II
2018: Militza Rivera-Cortes
2019: Jay O'Hara

Association of Military Surgeons of the United States Awards

Army Federal Physician Assistant of the Year Award

Every year between 1990 and 2009, the Association of Military Surgeons of the United States (AMSUS) awarded the Federal Physician Assistant of the Year Award, recognizing superior contribution, steadfast mission support, and accomplished technical performance. Four Army PAs have been honored with this accolade. From 2010 to present, the Federal PA of the Year Award was discontinued and the PAs were included in the Andrew Craige Allied Health Professional Award.

1991: Jimmie E. Keller
1992: Michael Champion
2006: John F. Detro
2009: Louis H. Smith III

Andrew Craige Allied Health Professional Award

This award recognizes the leadership role of federal allied healthcare professionals. The award is intended to recognize sustained excellence in the provision of allied healthcare, and to grant recognition and to promote awareness of federal allied healthcare practitioners who distinguish themselves in the provision of care. The professions that are eligible for this award are licensed healthcare provider in an allied health profession, including, but not limited to, pharmacists, physical, occupational, and recreational therapists; social workers; clinical psychologists; optometrists; physician assistants; dietitians; and veterinary practitioners.

2020: George Barbee

Rehabilitation Award

This award recognized a team or individual who has provided outstanding rehabilitative service or treatment to active duty personnel, transitioning personnel, or veterans in an inpatient or outpatient setting. This award is no longer given.

2018: Tyson Baynes

American Academy of Physician Assistants Awards

Military Service Award

This American Academy of Physician Assistants (AAPA) award honors veteran or active duty PAs who have demonstrated exemplary health care service to their community, to current members of the military or veterans, or to the medically underserved. Applicants must be current AAPA members in good standing.

2017: Pauline V. Gross
2018: John F. Detro
2019: David Hamilton
2020: Richard Villarreal

American Academy of Physician Assistants Preceptor of the Year Award

The AAPA Preceptor of the Year Award honors preceptors who have demonstrated a commitment to excellence in the clinical education of PA students as a mentor and instructor. PA applicants must be current AAPA members in good standing. Individuals who are preceptors to PA students but not PAs are not required to be AAPA members. This award is given in collaboration with the PA Education Association.

2013: Joseph Cohen

Henry Jackson Foundation Hero of Military Medicine Award

The Heroes of Military Medicine (HMM) Award honors outstanding contributions by individuals who have distinguished themselves through excellence and selfless dedication to advancing military medicine and enhancing the lives and health of our nation's wounded, ill, and injured service members, veterans, and civilians. The HMM Award is presented by the Henry M. Jackson Foundation for the Advancement of Military Medicine. Three awards presented at the HMM dinner are given to active duty military medical professionals from the Army, Navy, and Air Force, respectively. The Office of the Surgeon General for each service nominates the candidates for these awards, and the final honorees are chosen by the HMM Advisory Committee, comprised primarily of former surgeons general. In addition, one HMM Ambassador Award and one HMM Senior Leader Award are presented at each dinner.

2018: Andrew Fisher
2019: Stephen DeLellis
2020: George Barbee

LATINA *Style* Distinguished Military Service Award

The purpose of the LATINA *Style* Distinguished Military Service Award is to recognize women in the military and the Department of Defense (DoD) civilian workforce who, through their service, have enhanced the role of Latinas in their organization and the DoD.

2020: Kelly Guerra

Order of the Military Medical Merit Inductees

The Order of Military Medical Merit (O2M3) is a unique private organization founded by the commanding general of US Army Health Services Command in April 1982. Its purpose is to recognize excellence and promote fellowship and esprit de corps among AMEDD personnel. Contact O2M3 for a complete list of Army PAs awardees (https://ameddregiment.amedd.army.mil/merit/o2m3.html).

ABBREVIATIONS AND ACRONYMS

A

A: Airborne
AAC: Army Acquisition Corps
AAPA: American Academy of Physician Assistants
AATS: ARNG Aviation Training Site
ABLS: Advanced Burn Life Support
ABN DIV: airborne division
ABSITE: American Board of Surgery In-Training Examination
ACAT: acquisition category
ACE: ask, care, escort
ACEP: American College of Emergency Physicians
ACFT: Army Combat Fitness Test
ACGME: Accreditation Council for Graduate Medical Education
ACM: Army Capability Manager
ACR: armored cavalry regiment
ACU: Army combat uniform
AD: active duty
ADDIE: analysis, design, develop, implement, evaluate
ADP: AMEDD Distribution Plan
ADSO: active duty service obligation
ADTMC: algorithm-directed troop medical care
AFAB: assigned female at birth
AFRICOM: Africa Command
AFSCP: Army Flight Surgeon Course–Primary
AGR: Active Guard Reserve
AHA: American Heart Association
AHLTA: Armed Forces Health Longitudinal Technology Application
AHO: allied health officer
AHS: Army health system
AHSMS: Allied Health Sciences Military School
AI: associate investigator
AIM.2: Assignment Interactive Module Version 2
AIT: advanced individual training

ALARACT: All Army Activities message
ALP: accepted list position
ALS: Advanced Life Support
ALSE: Aviation Life Support Equipment (course)
AMA: American Medical Association
AMAB: assigned male at birth
AMEDD: Army Medical Department
AMEDDB: Army Medical Department Board
AMH: Army Medical Home
AMHRR: Army Military Human Resource Record
AMP: aviation medicine program
AMSC: Army Medical Specialist Corps
AMSMS: Army Medicine Secure Messaging Service
AMT: aviation medicine team
AO: action officer
AOC: area of concentration
AOR: area of responsibility
APA: aeromedical physician assistant
APA: American Psychiatric Association
APM: assistant program manager
APMC: AMEDD Professional Management Command
APPD: Army Medicine Personnel Proponent Directorate
AR: Army regulation
ARC: advanced resuscitative care
ARC: American Red Cross
ARC-PA: Accreditation Review Commission on Education for the Physician Assistant
ARMEDCOM: Army Reserve Medical Command
ARMS: Aviation Resource Management Survey
ARNG: Army National Guard
ARSOAC: Army Special Operations Aviation Command
ARSOF: US Army Special Operations Forces
ARTB: Airborne and Ranger Training Brigade
ASA: Assistant Secretary of the Army
ASAB: assigned sex at birth
ASAP: Alcohol Substance Abuse Program
ASBP: Armed Services Blood Program
ASBS: Army Selection Board System
ASCC: Army service component command

ASD: AMEDD Student Detachment
ASI: additional skill identifier
ASIMS: Aeromedical Services Information Management System
ASL: Army senior leader
ATAAPS: Automated Time and Assistance Production System
ATLS: Advanced Trauma Life Support
ATP: Aircrew Training Program
ATP: Army techniques publication
ATRRS: Army Training and Requirements Resources System
AUSA: Association of the US Army
AWC: Army War College

B
BAMC: Brooke Army Medical Center
BAS: battalion aid station
BCP: Board Certified Pay
BCT: brigade combat team; basic combat training
BCT3: Brigade Combat Team Trauma Training
BDD: Benefits Due at Discharge
BDE: brigade
BDE CDR: brigade commander
BDE SURG: brigade surgeon
BEST: Basic Endovascular Skills for Trauma (course)
BLS: Basic Life Support
BN: battalion
BOG: Boots on Ground
BOLC: Basic Officer Leader Course
BRS: blended retirement system
BSM: Bachelor of Science in Medicine

C
C2P2: Credentials Certification and Privileging Preparation
C4: Combat Casualty Care Course
C4I: command, control, communication, computers, and intelligence
CAC: common access card
CACO: congressional affairs contact officer
CAD: course administrative data
CAF: competency assessment file
CAMP: Career Acquisition Management Portal

CAPPMIS: Career Acquisition Personnel and Position Management Information System
CAQ: Certificate of Added Qualifications
CASEVAC: casualty evacuation
CASPA: Central Application Service for Physician Assistants
CATC: Combat Advisor Training Course
CBMH: Community-Based Medical Home
CBRNE: chemical, biological, radiological, nuclear, and explosive
C/B/T: company/battery/troop
CC: clinical coordinator
CC: corps chief
CCC: Captains Career Course
CC-DL: Common Core distance learning
CCMD: combatant command
CDID: Capabilities Development Integration Directorate
CENTCOM: Central Command
CES: Civilian Education System
CG: commanding general
CGHE: Center for Global Health Engagement
CGSC: Command and General Staff College
CGSOC-CC: Command and General Staff Officer Course–Common Core
CHCS: Composite Health Care System
CHRTAS: Civilian Human Resources Training Application
CIMPT: Center for Initial Military Training
CITI: Collaborative Institutional Training Initiative
CJCS: chairman of the Joint Chiefs of Staff
CJPA: Council of Junior Physician Assistants
CLINOPS: clinical operations
CLL: chief of legislative liaison
CLS: Combat Lifesaver
CME: continuing medical education
COCOM: combatant command
CoE: center of excellence
CONUS: continental United States
COP: combat outpost
CoS: chief of staff
CoTCCC: Committee on Tactical Combat Casualty Care
COVID: coronavirus disease

CP: continuation pay
CPD: citrate phosphate dextrose
CPG: Clinical Practice Guideline
CPI: continuous process improvement
CPP: Combat Paramedic Program
CPR: cardio pulmonary resuscitation
CR2C: Community Ready and Resilient Council
CR2I: command ready and resilient integrator
CSA: chief of staff of the Army
CSBPO: corps-specific branch proponency officer
CSHT: cross-sex hormone therapy
CSL: command selection list
CSM: command sergeant major
CSP: Consolidation of Special Pay (program)
CST: civil support team
C-STARS: Center for the Sustainment of Trauma and Readiness Skills
CTC: combat training center
CV: curriculum vitae
CWS: Certified Wound Care Specialist

D
DA: Department of the Army
DAC: Defense Acquisition Corps
DACM: Director of Acquisition Career Management
DA Pam: Department of the Army pamphlet
DAU: Defense Acquisition University
DCAM: DMLSS Customer Assistance Module
DCC: deputy corps chief; Direct Commission Course
DCCS: deputy commander for clinical services
DCG: deputy commanding general
DCG (M): deputy commanding general for maneuver
DCG (S): deputy commanding general for support
DCMT: Department of Combat Medic Training
DCR: damage control resuscitation
DCR: DOTMLPF-P change recommendation
DCSM: division command sergeant major
DD: Defense Department
DD: deployment director
DDT: dichlorodiphenyltrichloroethane

DEA: Drug Enforcement Agency
DEERS: Defense Enrollment Eligibility Reporting System
DFAS: Defense Financing and Accounting Service
DHA: Defense Health Agency
DHA-IHB: Defense Health Agency–Immunizations Healthcare Branch
DIV PA: division senior physician assistant
DIV SURG: division surgeon
DL: deployment-limiting
DMAIC: define, measure, analyze, improve, control
DMHRSi: Defense Medical Human Resources System internet
DMLIIS: Defense Medical Logistics Item Identification System
DMLSS: Defense Medical Logistics Standard Support
DMO: directed military overstrength
DMO: diving medical officer
DMRTI: Defense Medical Readiness Training Institute
DOD: Department of Defense
DODI: Department of Defense instruction
DODVPR: DOD Veterinary Pathology Residency
DOM: Directorates of Management
DoOM: Department of Operational Medicine
DOTD: Directorate of Training and Doctrine
DOTMLPF-P: doctrine, organization, training, materiel, leadership, personnel, facilities, and policy
DPAA: Defense Prisoner-of-War/Missing-in-Action Accounting Agency
DPMAP: Defense Performance Management and Appraisal Program
D-RAS: Disability Rating Activity Site
DREE: disaster relief exercise and exchange
DS: Department of Defense self-service
DSc: Doctor of Science degree
DScPAS: Doctor of Science in Physician Assistant Studies
DScPAS-EM: Doctor of Science in Physician Assistant Studies–Emergency Medicine
DScPAS-GS: Doctor of Science in Physician Assistant Studies–General Surgery
DScPAS-O: Doctor of Science in Physician Assistant Studies–Orthopedics
DSCU: Defense Security Cooperation University
DSM: Diagnostic and Statistical Manual of Mental Disorders
DSS: deputy state surgeons

DTIC: Defense Technical Information Center
DTM: directive-type memorandum
DTMC: DiLorenzo Troop Medical Clinic
DUI: driving under the influence

E
EBC: education branch chief
ED: emergency department
e-FAST: extended focused assessment with sonography in trauma
EHR: electronic health record
EIA: exercise-induced asthma
eMMPS: Electronic Medical Management Processing System
EMPA: emergency medicine physician assistant
EMR: electronic medical record
EMT: emergency medical technician
EMT-B: Emergency Medical Technician–Basic
ERT: emergent resuscitative thoracotomy
EUCOM: US European Command

F
FAST: focused assessment with sonography in trauma
FDA: Food and Drug Administration
FEB: flight evaluation boards
FEMA: Federal Emergency Management Agency
FERS: Federal Employees Retirement System
FHP: force health protection
FM: field manual
FMS: foreign military sales
FMSWeb: Force Management System website
FORSCOM: US Army Forces Command
FRAGO: fragmentation orders
FS: flight surgeon
FST: forward surgical team
FTE: full-time equivalent
FTX: field training exercise
FWB: fresh whole blood

G
GEARS: Global Electronic Approval Routing System
GEM: graduate education manager

GHE: global health engagement
GID: gender identity disorder
GME: graduate medical education
GOSC: General Officer Steering Committee
GRE: Graduate Record Examination
GS: general schedule
GSPA: general surgery physician assistant
GTMO: Guantanamo Bay Naval Base

H
H2F: Holistic Health and Fitness (program)
HAZMAT: hazardous materials
HBT: hospital-based training
HCD-CPS: healthcare delivery–clinical policy and services
HC-ITAB: Health Care Interservice Training Advisory Board
HELP: Health Experts OnLine Portal
HHBn: headquarters and headquarters battalion
HIPAA: Health Insurance Portability and Accountability Act
HLD: House Liaison Division
HMO: hyperbaric medical officer
HN: host nation
HPLRP: Health Professions Loan Repayment Program
HPO: health professions officer
HPOBCP: health professions officer board certification pay
HPOIP: health professions officer incentive pay
HPORB/IP: combined retention bonus/incentive pay
HQ: headquarters
HQDA: Headquarters, Department of the Army
HQ IMCOM: Headquarters, Installation Management Command
HR: human resources
HRC: US Army Human Resources Command
HRO: high-reliability organization
HSD: Health Services Division

I
IAW: in accordance with
ICD: International Classification of Diseases
ICTB: interfacility credentials transfer brief
ICTL: individual critical task list
ICU: intensive care unit

IDES: Integrated Disability Evaluation System
IDP: individual development plan
IET: initial entry training
IFAK: Individual First Aid Kit
IG: inspector general
IGAR: inspector general action request
ILE: Intermediate Level Education
IMCOM: Installation Management Command
IMT: initial military training
IP: incentive pay
IPAP: Interservice Physician Assistant Program
IPAT: integrated process action team
iPERMS: interactive Personnel Electronic Records Management System
IPPS-A: Integrated Personnel and Pay System–Army
IRB: institutional review board
ISAP: individual student assessment plan
ISOS: International SOS
ITRO: Interservice Training Review Organization
IUD: intrauterine device
IV: intravenous
I/W: instructor/writer

J

JBSA-FSH: Joint Base San Antonio–Fort Sam Houston
JC4I: Joint Command, Control, Communications, Computer and Intelligence
JCIDS: Joint Capabilities Integration and Development Systems
JDG: joint detention group
JIATF-S: Joint Inter-Agency Task Force–South
JMAR: Joint Medical Asset Repository
JMAU: Joint Medical Augmentation Unit
JMOC: Joint Medical Officer's Course
JOES: Joint Outpatient Experience Survey
JOPES: Joint Operation Planning and Execution System
JP: joint publication
JPEO: Joint Program Executive Office
JPME: joint professional military education
JRC-PA: Joint Review Committee for Educational Programs for the Assistant to Primary Care Physician

JRTC: Joint Readiness Training Center
JSAP: Joint Staff action process
JSOC: Joint Special Operation Center
JSOC: Joint Special Operations Command
JTDI: Joint Technical Data Integration
JTF: joint task force
JTIMS: Joint Training Information Management System
JTS: Joint Trauma System

K
KBAS: Kittery Beach Aid Station

L
LAHC: Lyster Army Health Clinic
LD: line of duty
LDB: Leader Development Branch
LDES: Legacy Disability Evaluation System
LDM: Lean Daily Management
LES: leave and earnings statement
LIN: line item number
L/MER: Labor/Management Employee Relations office
LOD: line of duty
LOE: line of effort
LRMC: Landstuhl Regional Medical Center
LSS: Lean Six Sigma
LTHET: long-term health education and training
LTOWB: low-titer group O whole blood
LTT: live tissue training

M
M3PT: Medical Materiel Mobilization Planning Tool
MAP: MTOE Assigned Personnel
MAR2: MOS administrative retention review
MARCORSYSCOM: Marine Corps Systems Command
MASCAL: mass casualty
MBB: Master Black Belt
MC: US Army Medical Corps
MCAHC: McDonald Army Health Clinic
MCDS: Medical Command Deployment Support

MCRW: Medical Contingency Requirements Workflow
MD: medical director
MDMP: military decision-making process
MDRE: medical dental readiness event
MEB: Medical Evaluation Board
MEDCoE: US Army Medical Center of Excellence
MEDCOM: US Army Medical Command
MEDDAC: Medical Activity
MEDEVAC: medical evacuation
MEDEX: medicine extension
MEDLOG: Medical Logistics Division
MEDO: medical operations officer
MEDOPS: medical operations
MEDPROS: Medical Protection System
MER: Medical Event Reporting
MES: medical equipment set
METC: Medical Education and Training Campus
MHA: Master of Healthcare Administration
MHA: Medical Health Assessment
MHS: military health system
MILPER: military personnel message
MLH: Mary Lipscomb Hamrick (research course)
MMAS: Master of Military Art and Science
MMC: Medical Master Catalog
MNG: Saudi Arabian Ministry of the National Guard
MoC: member of Congress
MODS: Medical Operating Data System
MOS: military occupational specialty
MOU: memorandum of understanding
MP: military police
MPAS: Master of Physician Assistant Studies
M&RA: Manpower and Reserve Affairs
MRB: medical recruiting brigade
MRBn: medical recruiting battalion
MRC: medical recruiting center
MRDC: Medical Research and Development Command
MRDP: medical retention determination point
MRO: medical regulating officer
MRS: medical recruiting station

MS: Medical Service Corps
MSAT: Medical Situational Awareness in the Theater
MSD: military service deposit
MSTC: Medical Simulation Training Center
MTF: medical treatment facility
MTOE: modified table of organization and equipment
MTT: mobile training team
MWDE: MEDPROS Web Data Entry
MWR: morale, welfare, and recreation

N
NARSUM: narrative summary
NATO: North Atlantic Treaty Organization
NBME: National Board of Medical Examiners
NC: Nurse Corps
NCCPA: National Commission on Certification of Physician Assistants
NCO: noncommissioned officer
NCOIC: noncommissioned officer-in-charge
NCQA: National Commission on Quality Assurance
NCR: National Capital Region
NCTH: noncompressible torso hemorrhage
NDAA: National Defense Authorization Act
NDS: National Defense Strategy
NGO: nongovernmental organization
NMS: National Military Strategy
NOVA: National Organization for Victim Assistance
NPDB: National Provider Databank
NREMT: National Registry of Emergency Medicine Technicians
NRP: Neonatal Resuscitation Program
NSN: national stock number
NSS: National Security Strategy
NTC: National Training Center

O
OCLL: Office of the Chief, Legislative Liaison
OCONUS: outside the continental United States
OC/T: observer controller/trainer
ODA: operational detachment alpha
OER: officer evaluation report

OHPA: occupational health physician assistant
OIC: officer-in-charge
OISD: operational, institutional, and self-development
OJSS: Office of the Joint Staff Surgeon
OML: order of merit list
OPA: orthopedic physician assistant
OPMD: Officer Personnel Management Directorate
OPM-SANG: Office Program Manager–Saudi Arabian National Guard
OPORD: operations orders
OR: operating room
ORB: officer record brief
OSHA: Occupational Safety and Health Administration
OSUT: one-station unit training
OT&E: operational testing and evaluation
OTSG: Office of the Surgeon General

P

PA: physician assistant
PA-C: physician assistant-certified
PACKRAT: Physician Assistant Clinical Knowledge Rating and Assessment Tool
PACU: post-anesthesia care unit
PAEA: Physician Assistant Education Association
PALS: Pediatric Advanced Life Support
PANCE: Physician Assistant National Certifying Exam
PANRE: Physician Assistant National Recertifying Exam
PATH: Pacific Asynchronous TeleHealth System
PCC: Pre-Command Course
PCF: practitioner's credentials file
PCMH: Patient-Centered Medical Home
PCS: permanent change of station
PD: program director
PEB: physical evaluation board
PEBD: pay entry basic date
PEBLO: physical evaluation board liaison officer
PETD: Professional Education and Training Department
PFC: prolonged field care
PFCCS: Pediatric Fundamentals of Critical Care Support
PI: performance improvement; primary investigator

PICO: patient or population, intervention or exposure, comparison or control, outcome
PME: professional military education
PMRM: Practice Management Revenue Model
PN: partner nation
POC: point of care
POG: Psychological Operations Group
POI: program of instruction
POW: prisoner-of-war
PPO: personnel proponency officer
PPRW: Program and Positions Requirement Worksheet
PROFIS: Professional Filler System
PRT: physical readiness training
PSR: patient safety report
PSV: primary source verification
PULHES: physical, upper, lower, hearing, eyes, psychiatric

Q
QA: quality assurance
QM: quality management

R
R2: Ready and Resilient
R2I: R2 Integration
RAPToR: Resuscitation Adjuncts: Prehospital Transfusion & REBOA (course)
RASP: Ranger assessment and selection program
RC: reserve component
RCMS: Reserve Component Manpower System
RDMS: Registered Diagnostic Medical Sonographer
REBOA: resuscitative endovascular balloon occlusion of the aorta
RIAT: Rapid Impact Assessment Team
RIMS: Reserve Incentives Management Sub-System
ROI/ROII: report of investigation or report of investigative inquiry
RSLC: Reconnaissance and Surveillance Leaders Course
RTB: Ranger training brigade
RTBn: Ranger training battalion
RVU: relative value unit

S

SA: self-assessment
SAAM: School of Army Aviation Medicine
SAB: Strategic Advisory Board
SAFM-BUL: secretary of the Army for financial management–budget liaison
SAPA: Society of Army Physician Assistants
SARC: sexual assault response coordinators
SATTOC: Security Assistant Team Training Orientation Course
SAV: Staff Assistance Visit (program)
SCMH: Soldier-Centered Medical Home
SEA: senior enlisted advisor
SECARMY: secretary of the Army
SERE: survival, escape, resistance, and evasion
SES: Senior Executive Service
SF: special forces
SFA: security force assistance
SFAB: Security Force Assistance Brigade
SFAC: Security Force Assistance Command
SFG: special forces group
SGL: small group leader
SGT: sergeant
SHPE: Separation History and Physical Examination
SKOs: sets, kits, and outfits
SMDR: structure manning decision review
SME: subject matter expert
SMEE: subject matter expert exchange
SMOG: Standard Medical Operating Guidelines
SMS: Soldier Management System
SMTS: Soldier Medic Training Site
SOAR: special operations aviation regiment
SOATB: Special Operations Aviation Training Battalion
SOC: special operations command
SOCM: Special Operations Combat Medic
SOF: US Army Special Operations Forces
SOP: standard operating procedure
SP: Army Medical Specialist Corps
SPMGTF: Special Purpose Marine Ground Task Force
SPPM: suicide prevention program manager

SQN: squadron
SRP: soldier readiness processing
SSC: Senior Service College
STAAR: Simulation Trainer for Arterial Access and REBOA

T
TAIR: Total Army Involvement in Recruiting
TAMMIS: Theater Army Medical Management Information System
TASS: Total Army School System
TCCC: tactical combat casualty care
TCMC: Tactical Combat Medical Care course
TCS: temporary change of station
TDA: table of distribution and allowances
TDY: temporary duty
TEWLS: Theater Enterprise-Wide Logistics System
TMDS: Theater Medical Data Store
TMO: tactical medical officer
TMT: Task Management Tool
TOC: tactical operations center
TOD: tour of duty
TOE: table of organization and equipment
TOMS: TRADOC Organic Medical Structure
TOPMIS: Total Army Personnel Management Information System
TPMRC: Theater Patient Movement Requirements Center
TQM: total quality management
TR: TRADOC regulation
TRAC2ES: Transportation Command Regulating and Command & Control Evacuation System
TRADOC: Army Training and Doctrine Command
TRANSCOM: Transportation Command
TRAP: training resource arbitration panel
TSG: the surgeon general
TSG-PARA: The Surgeon General Physician Assistant Recognition Award
TSOC: Theater Special Operations Command
TTD: transfusion-transmitted disease
TTPs: tactics, techniques, and procedures
TWI: training with industry
TXA: tranexamic acid

U
UAC: unit assemblage code
UCMJ: Uniform Code of Military Justice
UIC: unit identification code
UMR: unit medical readiness
UNMC: University of Nebraska Medical Center
USAACE: US Army Aviation Center of Excellence
USAFRICOM: US Africa Command
USAG: US Army garrison
USAMMA: US Army Medical Materiel Agency
USAMMDA: US Army Medical Materiel Development Activity
USAR: US Army Reserve
USARAF: US Army Africa
USARC: US Army Reserve Command
USAREC: US Army Recruiting Command
USARIEM: US Army Research Institute of Environmental Medicine
USASAM: US Army School of Aviation Medicine
USASOC: US Army Special Operations Command
USNH-GB: US Naval Hospital–Guantanamo Bay
USSOCOM: US Special Operations Command
USU: Uniformed Services University

V
VA: Department of Veterans Affairs
VC: Veterinary Corps
VH: virtual health
VVR: vasovagal reaction

W
WAATS: Western ARNG Aviation Training Site
WAMC: Womack Army Medical Center
WHINSEC: Western Hemisphere Institute for Security Cooperation
WHMO: White House Military Office
WHMU: White House Medical Unit
WHO: World Health Organization
WMDs: weapons of mass destruction

X
XO: executive officer

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