Commissioned Corps BULLETIN

Division of Commissioned Personnel • Program Support Center, DHHS

Vol. XV, No. 8 **August 2001**

Surgeon General's Column

"When we urge others to change their behavior, so as to protect themselves against infections, we must be ready to change our own behavior in the public arena. We cannot deal with AIDS by making moral judgments, or refusing to face unpleasant facts—and still less by stigmatizing those who are infected, and making out that it is all their fault."

—United Nations Secretary-General Kofi Annan

On Friday, June 29, we released the first-ever *Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior*. This is a tough topic for Americans to discuss, and while we are no strangers to difficult issues (e.g., the *Call to Action to Prevent Suicide and the Mental Health Report*), nothing compared to addressing the subject of sexuality.

The response since releasing the *Call to Action to Promote Sexual Health and Responsible Sexual Behavior* has been mixed but overwhelmingly positive. We have received letters from individuals and groups all across the country and numerous articles, editorials, and op-ed pieces in newspapers expressed support for the *Call*. Of course, there are those who disagree with certain parts of the report but, regardless of the position, we are pleased that the national dialogue has begun. The *Call to Action* was never intended to be the end of the discussion. Rather, it is intended to serve as the basis for beginning a dialogue which may someday lead us to that place in our sexual health that will ultimately lead to a healthier Nation.

The Public Health Imperative

This *Call to Action* applies the public health approach to address a major public health problem. It is not based on politics, religion or personal opinion—not even my own—only on the best available science.

It was developed out of concern for the public health problems related to sexual health in America, including sexually transmitted diseases, unintended pregnancies, and sexual violence and abuse. The data are alarming. In fact, 5 of the 10 most commonly reported infectious diseases in the United States are sexually transmitted diseases, and as recently as 1995, sexually transmitted diseases accounted for 87 percent of cases reported among those 10.

- More than 770,000 cases of AIDS have been reported to the Centers for Disease Control and Prevention since 1981; nearly two-thirds of them were sexually transmitted.
- Today, somewhere between 800,000 and 900,000 people are living with HIV. A third of them are aware of their status and are in treatment; one-third of them are aware but not in treatment; and one-third do not even realize they have the virus.

But AIDS is not the only problem.

- Approximately 12 million people in this country are infected with sexually transmitted diseases each year; millions of them adolescents.
- Nearly one-half of all pregnancies are unintended. The rates are highest among women 20 years of age and under, women 40 years of age and older, and low-income women.
- In 1996, more than 1.3 million women had abortions in the United States.
- One major study found that 22 percent of women and 2 percent of men have been victims of rape.
- We also estimate that 104,000 children are victims of sexual abuse each year.

Eliminating Disparities

What is also troubling is the fact that certain groups—underrepresented minorities, the socioeconomically disadvantaged, and women—are often disproportionately impacted by these problems, and eliminating health disparities is of great national importance. For example:

- Chlamydia infection is more common among women than men. Adolescent women aged 15-19 years have the highest rates; the rates for Black and Hispanic women are considerably higher than for White women.
- Gonorrhea rates are highest among women ages 15-19, and among minorities.
- While AIDS is no longer the overall leading cause of death in this country, it is still the leading cause of death

(Continued on page 2)

IN THIS ISSUE . . .

Commissioned Corps BULLETIN

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Director, DCP/HRS/PSC RADM R. Michael Davidson

Editor Mrs. Virginia Kapusnick

Surgeon General's Column

(Continued from page 1)

for African-American men between the ages of 25 and 44.

Most people would agree that *one* of the best ways to address these problems is to promote responsible sexual behavior on the part of individuals and communities. Community responsibility includes making information and sexual health and reproductive services available.

Areas of Agreement and Common Ground

While sexual health and responsible sexual behavior are not easy topics for Americans to discuss, they are even more difficult topics on which to reach common ground. Following the release of the report, we have found many areas of common ground.

- Most people agree that sexuality is an important part of life.
- Most people agree that parents are, and should be their child's first sexuality educators.
- Most people agree that there are individual and community responsibilities when it comes to protecting sexual health.
- Most people agree that if communities are going to live up to their responsibilities, schools must be the great equalizers in assuring that all children have a basic understanding of essential sexual health matters.
- Most people agree that there are certain risk and protective factors for sexual health and that there exists evidenced-based models of successful intervention to promote responsible sexual behavior.

Where We Go From Here

We have a long road ahead. Three fundamental strategies are outlined in the *Call*: increasing awareness, providing interventions, and continuing the research.

First, we must increase public awareness of issues relating to sexual health and responsible sexual behavior.

We hope this *Call to Action* will be the touchstone for this first strategy, as we begin a national dialogue on sexual health and responsible sexual behavior that is honest, mature, and respectful. That dialogue must take place at all levels of society and involve people from diverse and broad backgrounds. It must bring to bear the best available science in such a way that it informs and advances the discussion.

Additionally, in order to move toward equity of access to information for promoting sexual health and responsible sexual behavior, we must recognize that school sexuality education is a critical component of community responsibility. Sexuality education is not limited by venue and can take place in homes, schools, churches, or other community settings, but in order to assure equity of access to sexuality education, schools must be included.

But we must keep in mind that there is no replacement for the role of parents and families in sexuality education. With that in mind, this strategy suggests that sexuality education must start early, be thorough and broad, and continue throughout the life span. It must take into account the very special place that sexuality has in our lives, stress the benefits and value of remaining abstinent until involved in a committed and mutually monogamous relationship (with marriage as the best example), and it must assure awareness of optimal protection from sexually transmitted diseases and unintended pregnancy for those who are sexually active. Just as importantly, it must stress that there are no perfect forms of protection, except abstinence, and that condoms cannot protect against all sexually transmitted diseases.

Despite widespread anti-gay attitudes, existing science does not support the view that persons choose their sexual orientation or that sexual orientation can be changed.

We must also provide the health and social interventions necessary to promote and enhance sexual health and responsible sexual behavior.

This strategy involves improving access to sexual health and reproductive healthcare services, recognizing that some groups—particularly racial and ethnic minorities and the economically disadvantaged—have suffered disproportionately and may need targeted and tailored interventions. In so doing, we work to eliminate disparities in sexual health among racial and ethnic and economically disadvantaged groups.

At the same time, we must ensure that healthcare professionals are adequately trained to deal with sexual issues in their work and that they are culturally competent enough to meet the needs of diverse populations.

And, finally, we must invest in research related to sexual health.

There is available evidence to show the effectiveness of school-based sexuality education, but we must continue the research. We need to more fully understand sexual development, sexual health, and reproductive health. We need a better understanding of sexuality over the life span—from childhood to young adulthood all the way through to mid life and the later years.

The findings from this research would prove invaluable for developing, disseminating, and evaluating educational materials and guidelines for sexuality education that can be used by parents, clergy, teachers, and other community leaders.

VADM David Satcher
Surgeon General

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Commissioned Officer Training Academy

For information about the Commissioned Officer Training Academy, please visit the Division of Commissioned Personnel's web site—*http://dcp.psc.gov*—and select the 'Training' option.

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Medical Affairs Branch

TRICARE Prime Remote for Family Members

With passage of the National Defense Authorization Act (NDAA) for 2001, the TRICARE Management Activity is planning to implement a new benefit—TRICARE Prime Remote for Family Members (TPRFM).

Eligibility for TPRFM

Beginning April 2002, active-duty family members who reside with their TRICARE Prime Remote (TPR)-eligible sponsors will be eligible to enroll in TPRFM. Locations designated as TPR are generally more than 50 miles in distance or a 1-hour drive time from a military medical treatment facility. Family members can verify their sponsor's TPR eligibility on the TPR web site—www.tricare.osd.mil/remote

Cost Shares and Deductibles Waived

As an interim measure starting October 30, 2000, until the implementation of TPRFM, active-duty family members living in remote locations with their TPR-eligible sponsors are eligible to have their cost shares and deductibles waived. Sponsors and family members are encouraged to keep track of all fees paid from October 30, 2000, (the day the President signed the NDAA into law) until the implementation of TPRFM. This will enable them to apply for reimbursement once the program details are finalized.

Enrollment is Optional

Starting *April 2002*, enrollment in TPRFM will be optional. Active-duty family members who choose *not* to enroll can continue using the TRICARE Standard benefit. When the interim 'waive charges' benefit expires, family members choosing to use TRICARE Standard will again be responsible for TRICARE Standard deductibles and cost shares. Eligible active-duty family members choosing *to enroll* will enjoy a TRICARE Prime-like benefit. The TRICARE Prime access standards, cost shares, and other benefits will apply.

Note: Once the new pharmacy cost shares structure begins in spring 2001, the new pharmacy cost shares will no longer be covered as 'waive charges.'

Contact DEERS

Active-duty sponsors are encouraged to contact the Defense Enrollment Eligibility Reporting System (DEERS) to verify that information for themselves and their family members is correct. Eligibility for TPRFM will be based on DEERS data. Sponsors may call DEERS personnel at the Defense Manpower Data Center Support Office toll-free at 1-800-538-9552. Sponsors and family members can also update their addresses for DEERS on the Military Health System/TRICARE web site at—www.tricare.osd.mil/DEERS Address

Enrollment Location

The Beneficiary Medical Programs Section (BMP) of the Medical Affairs Branch, Division of Commissioned Personnel, has determined that there are officers who are enrolled in a different location than their dependents. The difference in the enrollment location will cause difficulties in acquiring the reimbursement for the cost shares and deductibles. BMP strongly recommends that every officer who plans to seek reimbursement for cost shares and deductibles, check their DEERS information and make necessary changes.

Web Sites / Phone Number

For verification of TPR location—www.tricare.osd.mil/remote

For DEERS information—www.tricare.osd.mil/DEERS Address or by calling the Defense Manpower Data Center Support Office toll-free at 1-800-538-9552.

Special Note—

Please see the letter below regarding "TRICARE Prime Remote for Family Members Waived Charges Benefit."

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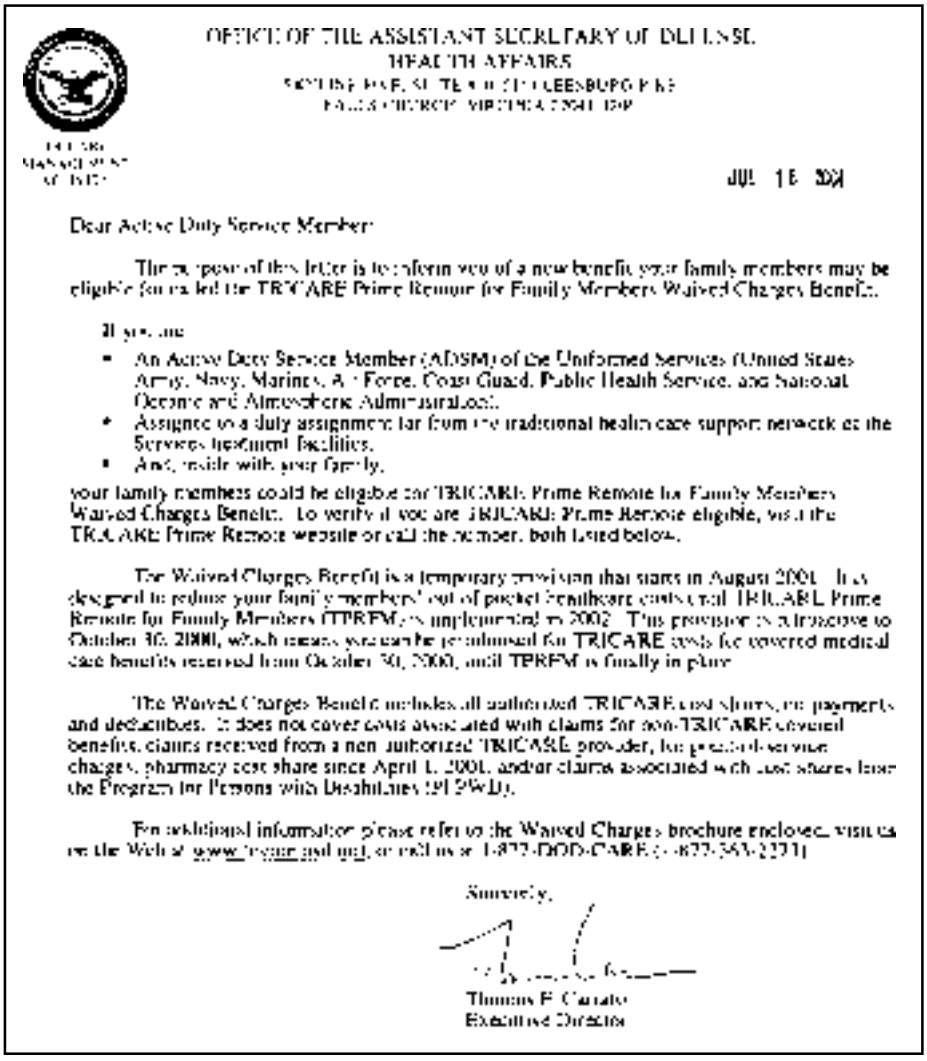

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

JUL 16 2001

Dear Active Duty Service Member:

The purpose of this letter is to inform you of a new benefit your family members may be eligible for called the TRICARE Prime Remote for Family Members Waived Charges Benefit.

If you are:

- An Active Duty Service Member (ADSM) of the Uniformed Services (United States Army, Navy, Marines, Air Force, Coast Guard, Public Health Service, and National Oceanic and Atmospheric Administration).
- Assigned to a duty assignment far from the traditional health care support network of the Services treatment facilities.
- And, reside with your family.

your family members could be eligible for TRICARE Prime Remote for Family Members Waived Charges Benefit. To verify if you are TRICARE Prime Remote eligible, visit the TRICARE Prime Remote website or call the number, both listed below.

The Waived Charges Benefit is a temporary provision that starts in August 2001. It is designed to reduce your family members' out of pocket healthcare costs until TRICARE Prime Remote for Family Members (TPRFM) is implemented in 2002. This provision is retroactive to October 30, 2000, which means you can be reimbursed for TRICARE costs for covered medical care benefits received from October 30, 2000, until TPRFM is finally in place.

The Waived Charges Benefit includes all authorized TRICARE cost shares, co-payments and deductibles. It does not cover costs associated with claims for non-TRICARE covered benefits, claims received from a non authorized TRICARE provider, for special service charges, pharmacy cost share since April 1, 2001, and/or claims associated with cost shares under the Program for Persons with Disabilities (PFPWD).

For additional information please refer to the Waived Charges brochure enclosed, visit us on the Web at www.tricare.osd.mil, or call us at 1-877-DOD-CARE (1-877-363-2273).

Sincerely,

Thomas F. Carrato
Executive Director

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
SKYLINE FIVE, SUITE 810, 5111 LEESBURG PIKE
FALLS CHURCH, VIRGINIA 22041-3206

TRICARE
MANAGEMENT
ACTIVITY

JUL 18 2001

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The Waived Charges Benefit includes all authorized TRICARE cost shares, co-payments, and deductibles. It does not cover costs associated with claims for non-TRICARE covered benefits, claims received from a non-authorized TRICARE provider, for point-of-service charges, pharmacy cost-share since April 1, 2001, and/or claims associated with cost-shares from the Program for Persons with Disabilities (PFPWD).

For additional information please refer to the Waived Charges brochure enclosed, visit us on the Web at www.tricare.osd.mil, or call us at 1-877-DOD-CARE (1-877-363-2273).

Sincerely,

Thomas F. Carrato
Executive Director

Original Surgeon General Publications Needed

The Office of the Public Health Service (PHS) Historian and the Office of the Surgeon General (OSG) are working to compile a complete archival set of *Surgeon General's Reports* and related publications for the OSG. They would also like to help the National Library of Medicine complete its collection of these publications as well.

Persons interested in donating their copies of such documents for these purposes are asked to contact:

Dr. John Parascandola
PHS Historian
5600 Fishers Lane, Room 18-23
Rockville, MD 20857-0001
Phone: 301-443-5363
Fax: 301-443-4193
E-mail: jparascandola@psc.gov

Dr. Parascandola will be happy to provide a list of the specific documents that are needed.

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Parklawn ID Card Issuing Office Will Be Closed September 6 and 7, 2001

The commissioned corps identification (ID) card issuing office in the Parklawn Building, Rockville, Maryland, will be closed Thursday, September 6, and Friday, September 7, for the installation of new hardware and training in its use.

Commissioned officers and/or their dependents needing new ID cards or Defense Enrollment Eligibility Reporting System (DEERS) services should plan to have these needs met either before or after the dates listed above.

Any questions regarding ID cards or DEERS should be directed to the Parklawn ID card issuing office at 301-594-3384 (or toll-free at 1-877-INFO DCP, listen to the prompts, select option #1, dial 43384).

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Scientist of the Year Awards

The Scientist Professional Advisory Committee's (SciPAC) 2001 Career Scientist Award and 2001 Young Scientist Award were presented to the following officers by Surgeon General David Satcher at the Commissioned Officers Association's (COA) annual meeting held May 28 through June 1, in Washington, D.C. Congratulations to these outstanding Scientist officers!

CAPT Derek E. Dunn Receives the SciPAC 2001 Career Scientist Award

CAPT Derek E. Dunn is the Associate Director for Science at the National Institute for Occupational Safety and Health (NIOSH). He has had two tours of duty at NIOSH. From 1972 until 1977, he served as a Research Audiologist. He returned in 1985, and served in many capacities from Section Chief to Division Director, to his present position. He conducted and published the landmark survey on hearing conservation, and directed pioneering research on the role of chemical exposure in occupational hearing loss. He assisted in the development of health criteria and standards pertaining to physical agents found in the workplace and was responsible for drafting the occupational noise-induced hearing loss objectives in Healthy People 2000. CAPT Dunn spearheaded the hearing loss protocol for the National Health and Nutrition Examination Survey, a nationally representative survey conducted by the National Center for Health Statistics. Under his leadership, NIOSH established critical partnerships with outside groups to conduct hearing loss prevention research, notably in the health effects of electric and magnetic fields.

CAPT Dunn served as the Special Assistant to the Director of NIOSH in the Washington, D.C. office. He also served as Executive Assistant to the Principal Deputy Assistant Secretary for Health, Office of the Public Health and Science, Office of the Secretary. He was the Chief Professional Officer for the Scientist Category for 5 years and was instrumental in advancing the *Scientist Category Handbook*, the Mentoring Program, Mentor and Leadership Skills Training Seminars, the Public Health Service (PHS) Bicentennial Calendar, the Scientist of the Year Awards program, and other noteworthy accomplishments.

He published more than 42 articles on factors associated with hearing loss, and teaches at the University of Cincinnati, the University of Miami of Ohio, and the University of Cincinnati Medical Center. He actively participates on 24 different organizational committees or groups, holding leadership roles in several.

CAPT Dunn is a regular corps officer who has received 18 PHS awards, several Distinguished Alumnus Awards, a NIOSH Supervisor of the Year award, and two SciPAC Certificates. For a large part of his career, CAPT Dunn has been active on the SciPAC and the COA, where he participated at the national and local levels.

LCDR Darin Weber Receives 2001 Young Scientist Award

LCDR Darin Weber, currently a Senior Regulatory Review Officer in the Food and Drug Administration's (FDA) Center for Biologics Evaluation and Research (CBER), received his B.S. degree in Molecular Biology in 1991, and his Ph.D. in Biochemistry and Biophysics in 1996.

LCDR Weber began his PHS career in CBER in 1996 as a Consumer Safety Officer in the Office of Therapeutics Research and Review where he later rose to Senior Regulatory Review Officer. He is responsible for developing regulatory science policy associated with the review of cellular and human tissue-based therapy products. His efforts have been instrumental in the development of Standard Operating Procedures and Policy for review of cellular products, a regulatory framework for oversight of human tissues, and the organization of an FDA Advisory Committee on the use of allogeneic pancreatic islets for the treatment of Type I diabetes. LCDR Weber is also a reviewer of product submissions.

He has authored 11 articles, with 6 in peer-reviewed journals, and 2 regulatory documents. He has received three PHS honor awards, two FDA/CBER Group Awards, a DC-COA Outstanding Service award, and the Field Medical Readiness Badge.

LCDR Weber served on the SciPAC for 3 years. He served a term each as Recording and Executive Secretary, was Editor of the category Charter and Standard Operating Procedures, member of the Recruitment and the PHS Bicentennial Calendar Committees, and was instrumental in the revision of the *Scientist Category Handbook*. LCDR Weber continues to serve as the category webmaster.

LCDR Weber is a participatory member in the DC-COA and serves as their current webmaster. He completed training in the Critical Reactions Aimed Toward Emergency Response (CRATER) under the aegis of the Commissioned Corps Readiness Force. He holds membership in the Association of Military Surgeons of the United States, Reserve Officers Association, and the American Association for the Advancement of Science.

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Basic Officer Training Course—5-day Version

The Commissioned Officer Training Academy (COTA), Officer Services Branch, Division of Commissioned Personnel (DCP), will initiate a pilot program for newly commissioned officers on extended active duty. The program is the Basic Officer Training Course (BOTC), 5-day version. It will be conducted frequently in the Washington, D.C. metropolitan area beginning in September 2001, and is available to officers called to duty on or after January 1, 2001.

Funds have been provided to the Program Support Center by agencies in support of the 5-day BOTC program. Participating officers will attend on temporary duty with travel orders generated by their respective duty sites. After completion of the BOTC and subsequent return travel, the individual officer will be reimbursed for expenses by his/her local duty site. DCP will reimburse the officer's duty site. Thus, there will be no permanent expense to the officer's local facility/duty site.

Officers attending the 5-day BOTC will receive an exposure to the commissioned corps personnel system, its diversity, Uniformed Service benefits, and more. Attendees will depart as a member of a great Service, and know it. Their graduation certificate will gain them immediate access to the Web-based Independent Officer Training Course, the Examination Series, and awarding of the Commissioned Officer Training Ribbon.

The 'more experienced' officers having been on duty prior to January 1, 2001, have similar yet slightly different options. These officers should attend a 2-day or 3-day BOTC. These shorter programs will continue to be conducted both in and out of the Washington, D.C. metropolitan area. Although the 2-day version is soon to be phased-out, the 3-day version will be continued. All officers, regardless of years of service, should attend a 3-day BOTC. A significant difference is that the local duty site does not receive reimbursement.

The first BOTC was completed in January 2000. Since that date, there have been 19 BOTC programs completed in 10 States from Alaska to Arizona and Washington to Maryland. They have been held in diverse surroundings, such as hotels, Indian Health Service area offices, hospitals, and three military bases. The weather varied from winter in Montana to summer in New Mexico. There has been rain, storms, and sun. But one thing they all had in common was the outstanding experience realized by the coming together of a group of Public Health Service officers. It has been truly memorable.

These programs are open to all officers, but the officer must select the proper BOTC based upon his or her call-to-duty date. All BOTC programs, both the 5-day version for officers called to duty since January 1, 2001, and the 3-day version for those more 'experienced,' are advertised with registration information on the COTA Web pages found at—http://dcp.psc.gov click on 'Training', 'COTA', 'BOTC.'

The COTA staff looks forward to seeing you in a class soon!

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AI/ANCOAC Presents 2001 Awards

The American Indian/Alaska Native Commissioned Officer Advisory Committee's (AI/ANCOAC) 2001 Leadership Award and 2001 Annie Dodge Wauneka Award were presented to the following officers in recognition of their outstanding contributions to improving the health status of American Indians and Alaska Natives.

CDR Greg A. Ketcher Receives the AI/ANCOAC 2001 Leadership Award

CDR Greg A. Ketcher is the Optometry Residency Director at the Lawton Indian Hospital in Lawton, Oklahoma, and is responsible for primary patient care and all administrative activities of the optometry program. He admirably performs his duties to the satisfaction of patients, coworkers, and management. He assures the services provided are of a scope, quality, and quantity consistent with Indian Health Service (IHS) policies and standards as demonstrated by internal performance improvement activities and by comparison with other programs of a similar nature. His dedication in furthering the mission of IHS and the Public Health Service (PHS) is evident in his attention to quality and details. His punctuality, ability to work with others, and professionalism enhances the overall efficiency of the program and positively influences other employees.

LTJG Celeste L. Davis Receives the AI/ANCOAC 2001 Annie Dodge Wauneka Award

LTJG Celeste L. Davis of the Yukon-Kuskokwim Health Corporation in Bethel, Alaska, was called to duty in April 1997. She assumed the responsibilities of the Acting Program Director in March 1998 and served in this capacity through July 1998. During this time, the program was understaffed by two environmental health officers and one engineer. LTJG Davis managed the entire program. She oversaw the budgets from five separate funding sources, supervised seven staff members, prepared grant applications and reports, advised State and Federal agencies, and represented the corporation at a variety of regional and State meetings. She accomplished these additional duties with efficiency while focusing a limited number of personnel on core public health problems. In addition to managing the program, LTJG Davis continued to provide direct environmental health services and technical assistance to seventeen remote villages within the Yukon-Kuskokwim Delta region of Alaska. LTJG Davis also received the PHS Achievement Medal for outstanding performance of duty during this period.

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WEB SITE ADDRESSES

U.S. Public Health Service Commissioned Corps—
http://www.usphs.gov

Division of Commissioned Personnel—
http://dcp.psc.gov

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Commissioned Corps Readiness Force

Tropical Storm Allison

Tropical Storm Allison moved onshore in the Galveston, Texas area, late Tuesday evening, June 5, 2001. Severe flooding from the heavy rainfall caused widespread damage to homes, businesses, and water and sewer systems in 28 counties of southeast Texas and southern Louisiana.

More than 30 inches of rain fell over the 3-week period. Flooding resulted in 23 storm-related deaths, and damages to the area are estimated to be in excess of 18 billion dollars. The President issued a Federal Disaster Declaration on June 9.

The city of Houston was especially hard hit. Two hospitals completely closed and health services at the remaining four hospitals were severely restricted by power and water issues, decreasing the number of available beds in the city by 1,700 beds. Emergency rooms were overflowing with patients waiting up to 21 hours for care.

The Office of Emergency Preparedness (OEP) deployed four Disaster Medical Assistance Teams (DMATs) as well as assets from the Commissioned Corps Readiness Force (CCRF). The CCRF provided a total of 14 personnel including two physicians, two pharmacists, and eight specialty nurses as well as two Emergency Operations Center support personnel.

The CCRF officers provided the following services:

- more than 1,400 emergency and primary care visits in one of three satellite clinics established at the Astrodome, the Houston Police Academy, and the Grayson Community Center;
- pharmacy services in the satellite clinics;
- critical care, pediatric intensive care, and emergency room care at four area hospitals; and
- Medical Officer for the OEP Management Support Team.

In addition to the long days under austere and extremely warm, humid temperatures, two of our officers distinguished themselves in a more unusual manner—they delivered Baby Ophelia. This is one instance where our officers were definitely in the right place at the right time and displayed yet again the dedication and professionalism that we have come to expect when CCRF officers deploy.

On June 18, following a particularly difficult 12-hour shift, LT Paul Gobourne and LTJG John Mallos witnessed a driver frantically pulling into the parking lot of the Lyndon B. Johnson Emergency Room, narrowly missing three large concrete pylons. The terrified driver exited the car shouting, "My wife is having a baby and it is slipping out now." The officers found the mother in the backseat of the car delivering an infant with its head and shoulders expulsed and the umbilical cord wrapped around its neck. They sprang into action summoning the help of two nearby civilian DMAT nurses and hospital staff. With the help of an emergency delivery kit, they ably assisted with the delivery, clamped the cord, and transported mother and baby safely into the hospital. A complicated situation resolved positively because officers with the right skills responded rapidly. Both mother and baby are doing well having benefitted from the expert, emergency care that they received.

CCRF Web Site

Please remember that CCRF members are responsible for keeping their data current. All CCRF members must login quarterly to remain roster-qualified. All members should remember to visit the CCRF Web site—http://oep.osophs.dhhs.gov/ccrf—frequently to check for news, upcoming events, training opportunities, and to update any changes to their personal information.

Any commissioned officer interested in applying for CCRF membership may apply online at the above Web site by simply clicking on the 'Apply' button and following the instructions. All interested parties are encouraged to subscribe to the CCRF Listserv in order to receive the most up-to-date CCRF news messages via e-mail. To do so, click on 'Listserv' on the Web site. The CCRF staff may be reached at—ccrf@osophs.dhhs.gov.

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Retirements - July

Title/Name	OPDIV/Program
MEDICAL	
CAPTAIN	
Allen R. Burkett	CG
Robert E. Johnson	CDC
Mitchell Singal	CDC
Kurt J. Stromberg	FDA
Bruce D. Broughton	IHS
Gary J. Kelloff	NIH
COMMANDER	
Jesus B. Carpio	IHS
DENTAL	
CAPTAIN	
Howard L. Kelley	OS
Daniel L. Pinson	BOP
NURSE	
CAPTAIN	
Melissa M. Adams	CDC
COMMANDER	
Jeffrey N. Burnham	IHS
Julio E. Garcia, Jr.	PSC
ENGINEER	
CAPTAIN	
Roy M. Fleming	CDC
William A. Heitbrink	CDC
James H. Jones	CDC
Kenneth J. Evans	IHS
SCIENTIST	
CAPTAIN	
David L. Conover	CDC
Philip E. Hamrick	NIH
ENVIRONMENTAL HEALTH	
CAPTAIN	
Byron L. Tart, Jr.	FDA
Douglas R. Akin	IHS
LIEUTENANT	
Don N. O'Neal	IHS
VETERINARY	
CAPTAIN	
Gerry M. Henningsen	EPA
PHARMACY	
CAPTAIN	
Mark D. Anderson	FDA
Robbin M. Nighswander	FDA
Allan S. Jio	IHS
Steven M. Wilson	IHS
THERAPY	
COMMANDER	
Selden D. Wasson	IHS
HEALTH SERVICES	
CAPTAIN	
Maruta Z. Budetti	HCFA
Eugenia Adams	HRSA
Duane R. Beckwith	IHS

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Physician Mentoring Program

The Physician Professional Advisory Committee (PPAC) is initiating a voluntary mentoring program for new and junior commissioned corps physicians. Initially this program will be limited to commissioned officers, but the goal is to expand it to civil service Public Health Service (PHS) physicians in the future.

The goal of the program is to promote professional growth and career development. New and junior physicians (protégés) with less than 2 years of service can be matched with more senior physicians (mentors) by Agency/Operating Division/Program, geographic area, or discipline.

Initially, the PPAC is recruiting senior commissioned corps physicians who are willing to serve as mentors. A senior commissioned corps physician is one with more than 5 years experience in the PHS and at the grade of O-5 or above. A description of the program and a mentor application is available at—www2.IHS.gov/ppac/Mentoring_Intro_page.htm. Information and applications can also be obtained from:

CAPT Dean Effler
401 Buster Road
Toppenish, WA 98948
Phone: 509-865-2102 ext. 224
E-mail: usuphsmentor@prodigy.net

Recent Deaths

The deaths of the following retired officers were reported to the Division of Commissioned Personnel:

Title / Name	*Date*
MEDICAL	
CAPT Anibal R. Valle	06/01/01
NURSE	
CAPT Mildred K. McDermott	02/04/01
ENGINEER	
CAPT Malcolm C. Hope	05/02/01
CAPT Robert E. H. Sheldon	06/11/01

Dental Professional Advisory Committee's Call for Nominations

The Dental Professional Advisory Committee (DePAC) seeks motivated commissioned corps and civil service dentists for terms beginning January 1, 2002. The DePAC provides advice to the Surgeon General and the Dental Chief Professional Officer on professional and personnel issues related to the Dental Category. The DePAC focuses on improving the Public Health Service (PHS) dental workforce by examining issues concerning awards/recognition, communications, promotions, retention/recruitment, clinical issues, and overall career development.

New DePAC members will be selected based on their commitment to improving the capabilities of the dental workforce in the PHS. Openings are available for new representatives for 3-year terms beginning January 1, 2002. The meetings are typically held in Rockville, Maryland, and members in the field are usually connected via teleconference if they are unable to travel to attend.

The DePAC needs you! Please consider this as an important step in your career and self-nominate today! Request a blank self-nomination form (which includes a space for supervisory approval) by using the Faxback feature of *CorpsLine*. You can reach *CorpsLine* at 301-443-6843. Listen to the menu and choose the option, "To retrieve documents through Faxback," and request document number **6539**.

Complete the self-nomination form and send it along with a current curriculum vitae and a cover letter describing how your experience and expertise will benefit the DePAC. The completed package must be submitted by **October 1, 2001**, to the address below:

LCDR Amanda L. Cramer
P.O. Box 160
Ft. Duchesne, UT 84026
Phone: 435-722-5122 ext. 6810
Fax: 435-722-2761
E-mail: Amanda.cramer@mail.ihs.gov

PHS Pharmacist Listserv

The Public Health Service (PHS) Pharmacist Professional Advisory Committee (PharmPAC) maintains a listserv that is intended to be the primary mechanism to distribute timely information, including PharmPAC minutes, to both commissioned corps and civil service pharmacists.

If you have not been receiving PharmPAC listserv messages already, it is probably because you are not subscribed. If you would like to subscribe for the first time, or if you would like to add any additional e-mail addresses to the PHS-Pharmacist listserv, please complete the Web-based form at—http://list.nih.gov/cgi-bin/wa?SUBED1=phs-pharmacists &A=1

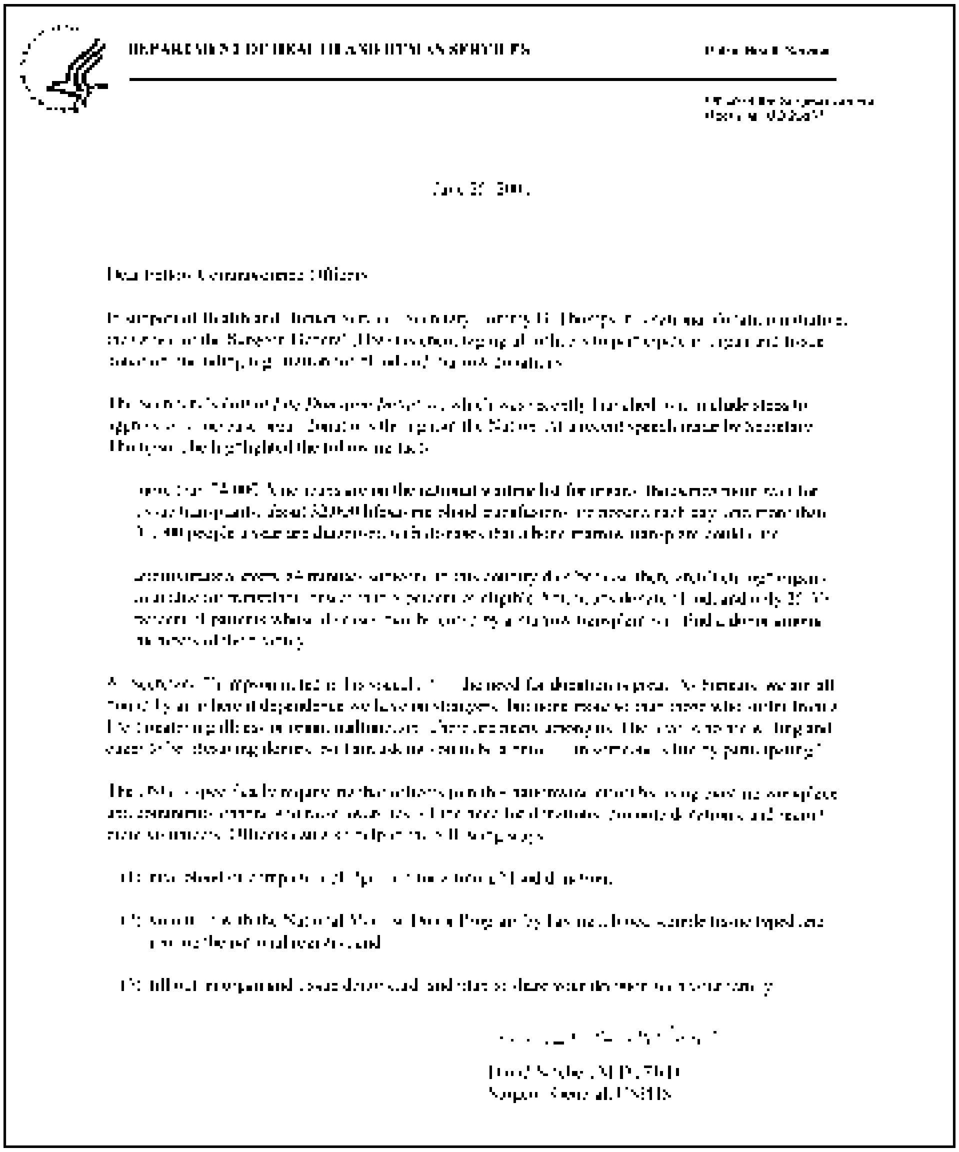
HEALTHY LIFESTYLES

Get Active—Your Own Way, Every Day, for Life

Overweight and obesity are the second leading causes of preventable death in the U.S. today, and pose a major public health challenge. This complex multifactorial problem develops from an interaction of social, behavioral, cultural, physiological, metabolic, and genetic factors.

An excellent resource for sorting out the facts from the fallacies of these conditions is the *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults* produced by the National Heart, Lung, and Blood Institute's Obesity Education Initiative in cooperation with the National Institute of Diabetes and Digestive and Kidney Diseases. It is available on the Internet at—http://www.nhlbi.nih.gov/guidelines/obesity/e_txtbk/index.htm

Letter from the Surgeon General Re: Organ Donation



CORRECTION!

Veterans Educational Assistance Program/ Montgomery GI Bill Mailing

The Division of Commissioned Personnel (DCP) recently completed a mailing to all active-duty Public Health Service (PHS) commissioned officers who participated in the Veterans Educational Assistance Program (VEAP) and were on active duty from October 9, 1996 through April 1, 2000. This mailing included PHS commissioned officers who originally enrolled in VEAP while serving with one of the Armed Forces. These officers are eligible to disenroll from VEAP and to enroll in the Montgomery GI Bill (MGIB).

PLEASE NOTE: *Unfortunately, that mailing reflected the maximum monthly benefit under MGIB as $650 when the actual maximum is $528 for full-time student status.*

Officers on active duty who meet the criteria listed above, but did not receive the mailed information, should contact the Officer Support Branch, Division of Commissioned Personnel, at 301-594-3384 (or toll-free at 1-877-INFO DCP, listen to the prompts, select option #1, dial 43384).

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Program Support Center
Human Resources Service
Division of Commissioned Personnel, Room 4-04
Rockville MD 20857-0001

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Office of the Surgeon General
Rockville, MD 20857

June 25, 2001

Dear Fellow Commissioned Officers:

In support of Health and Human Services Secretary Tommy G. Thompson's national donation initiative, the Office of the Surgeon General (OSG) is encouraging all officers to participate in organ and tissue donation, including registration for blood and marrow donations.

The Secretary's *Gift of Life Donation Initiative*, which was recently launched, will include steps to aggressively increase organ donations throughout the Nation. At a recent speech made by Secretary Thompson, he highlighted the following facts:

- more than 74,000 Americans are on the national waiting list for organs, thousands more wait for tissue transplants, about 32,000 lifesaving blood transfusions are needed each day, and more than 30,000 people a year are diagnosed with diseases that a bone marrow transplant could cure.

- approximately every 84 minutes someone in this country dies because there aren't enough organs available for transplant. Fewer than 5 percent of eligible Americans donate blood, and only 25-30 percent of patients whose diseases may be cured by a marrow transplant will find a donor among members of their family.

As Secretary Thompson noted in his speech, ". . . the need for donation is great. As humans, we are all bound by an inherent dependence we have on strangers; but none more so than those who suffer from a life-threatening illness or organ malfunction. There are many among us, I believe, who are willing and eager to be lifesaving donors. So I am asking you to be a hero . . . in someone's life by participating."

The OSG is specifically requesting that officers join this nationwide effort by using existing workplace and community channels to raise awareness of the need for donations, promote donations, and recruit more volunteers. Officers can also help in the following ways:

(1) give blood or complete a pledge card for a future blood donation;

(2) volunteer with the National Marrow Donor Program by having a blood sample tissue typed and joining the national registry; and

(3) fill out an organ and tissue donor card, and plan to share your decision with your family.

David Satcher, M.D., Ph.D.
Surgeon General, USPHS