Commissioned Officers Association

Each year at the Symposium I offer an analysis of COA membership and finances. Not everyone is able to attend this event, so the word does not reach every COA member. I thought I should devote a column to the sort of information I provide at the annual meeting, so here it is.

COA is a membership-based organization. This statement should be self-evident, but its validity apparently escapes some members of the Commissioned Corps. What do I mean by “membership-based”? The words really have three components. First of all, officers have to take a positive action to join COA. There is no automatic sign-up. We offer newly-commissioned officers a one-year free membership, and right now we’re not doing a very good job of persuading them to renew and pay for a second year of membership. Roughly one-fifth of free members renew without

see EXECUTIVE DIRECTOR on page 4

In a ceremony on October 25, 2017, Deputy Surgeon General RADM Sylvia Trent-Adams was presented with the prestigious Florence Nightingale Medal from the International Committee of the Red Cross/Red Crescent, the only 2017 medal recipient from the United States. The medal was described in a Red Cross press release as “the highest international honor of nursing contributions in the Red Cross/Red Crescent worldwide network, given for exceptional courage and devotion to victims of armed conflict or natural disaster.”

RADM Trent-Adams was recognized for her “outstanding contributions in public health, nursing and disaster response,” said Linda Maclntyre, chief nurse, American Red Cross. “Individuals and communities are at the heart of her work.” Her work with the Red Cross itself includes being an HIV-AIDs instructor, as well as teaching Red Cross Babysitting and community health classes for new mothers. She also volunteered with the Hampton Roads Red Cross, at the Walter Reed National Medical Center, and with the Red Cross in Lynchburg, VA.

RADM Trent-Adams participated in the USPHS Ebola mission to Liberia. She also worked with HIV/AIDS patients at Walter Reed National Medical Center.
COA Member Benefits

Capitol Hill Representation
Efforts on Capitol Hill continually support all Commissioned Corps officers – active duty and retired

Local Representation
COA Local Branches provide venues for meeting fellow officers and a forum for the discussion of issues within the Commissioned Corps

Frontline
Newsletter reports on monthly activities and items of interest about the Corps & COA

Insurance Programs
Low-cost insurance programs that may continue as long as your membership in COA remains current

$7,500 for Online Degrees
$7,500 scholarships to earn online degrees, which include:
- MPH@GW
- MHA@GW
- HealthInformatics@GW
- MBA@UNC
- MBA@Simmons
- HealthcareMBA@Simmons
- IRonline (American)
- MBA@American
- NYMC Online MPH
  50 percent discount for the online MPH and certificate programs

Scholarship Program
College scholarships for children and spouses of COA members

Ribbon
Authorized to be worn on the PHS uniform by members in good standing when attending COA functions

Legislative Update

A Look at Your Children’s Health Care

by Judy Rensberger

The Defense Health Board, a federal advisory committee, is finalizing a long-awaited evaluation of the pediatric care offered to 2.3 million children of uniformed services parents. A 200-page draft is being circulated among members of The Military Coalition’s Health Care Committee, of which I am a member. The draft report’s central finding is that pediatric care can and should be improved, especially for special needs children. Twenty-two specific recommendations address four overarching areas of care that were found wanting.

Key Findings

The report’s major (and unsparing) criticisms are these:

- The military health system does not consistently provide high-quality, coordinated care for children with chronic and complex conditions. These patients need integrated health care services, yet disruptions occur because of permanent changes in duty stations, deployments, or other geographic relocations.

- The military health system has no system-wide way to track and measure outcomes and other metrics related to quality, cost, and the actual experience of care for pediatric patients.

- Whether pediatric care is obtained at Military Treatment Facilities or in the community, it is not always aligned with evidence-based best practices.

- The military health system can be extremely difficult to navigate, especially for active-duty families with children.

Recommendations

The report’s twenty-two specific recommendations address each of these stated shortcomings. The draft report recommends improving communication with patients and families by including parents in working and policy groups “at all levels,” encouraging feedback from patients and families, creating a new “Patient Experience Office” within the Defense Health Agency, and permitting pediatric patients and their parents to access personal health records, “as has come to be expected by patients in the civilian healthcare system.”

Eight recommendations address the need to establish and use system-wide, reliable methods to collect, analyze, and report statistical data on the cost and quality of pediatric care. If the goal is to deliver evidence-based care consistently and safely across the system, then there must be a way to demonstrate that.

Acknowledging that pediatric care “is variable and not always aligned with
Five weeks into his tenure as the 20th Surgeon General, VADM Jerome M. Adams, MD, MPH spoke to a group of PHS Officers and Federal Physicians and healthcare personnel at the October 12, 2017, meeting of the Interagency Medical Council (IAMC) at the Department of Health & Human Services Headquarters (Hubert H. Humphrey Building) in Washington DC. Accompanied by Deputy Surgeon General RADM Sylvia Trent-Adams, audience members were delighted to hear from both the Surgeon General and the Deputy Surgeon General during this educational and collaborative day replete with PHS history, PHS culture as well as interagency collaboration. Senior PHS leaders also in attendance and in active engagement with PHS Officers throughout the day were RADM Joan Hunter (Director, Division of Commissioned Corps Personnel and Readiness) and RADM David Goldman (Chief Medical Officer, USPHS).

With origins dating back to shortly after 9-11, the IAMC was initiated for purposes of fostering interagency collaboration amongst physicians and medical personnel largely in administrative and leadership roles at various government agencies. An informal forum for enhancing shared knowledge of common medical challenges encountered across agencies, the IAMC has been meeting every six months since 2010 at the various agencies that constitute the council. Prior meetings of medical personnel have occurred at such as sites as the National Aeronautics and Space Administration (NASA), the Department of State, Peace Corps, Department of Homeland Security (DHS), Immigration and Customs Enforcement (ICE), Bureau of Prisons (BOP), and various other agencies throughout the greater Washington, DC, metro area.

The fall 2017 IAMC meeting was a day filled with a wealth of PHS history, education and the deployment experiences of various officers. Beginning with a comprehensive history of the PHS by RADM (Ret.) Fitzhugh Mullan, MD author of *Plagues and Politics, The Story of the United States Public Health Service*, the group then heard from 20th Surgeon General VADM Jerome Adams, MD, MPH. VADM Adams spoke about his priorities as the Surgeon General highlighting the clinical areas of focus such as the opioid epidemic, childhood obesity, mental illness as well as Institutional/transformational areas including developing better health through partnerships, bringing the business community into healthcare, the inextricable link between the nation’s prosperity and its health, and the crucial role that the Commissioned Corps has played and will continue to play in the health, prosperity and emergency response of the nation.

A visit to the Secretary’s Operations Center was followed by presentations of deployment experiences from Hurricane Katrina (CAPT Renee Joskow), Saipan (CAPT Sylvie Cohen), the Boston Marathon (CAPT Meena Vythilingham), and the West Africa Ebola mission (CAPT Jamal Gwathney).

PHS Officers from a number of agencies and departments were in attendance and enjoyed the opportunity to engage with and learn from not only other PHS Officers, but also federal medical personnel throughout the government.
our prodding them. We eventually get it up to slightly more than half
renewals, but it is clear that new PHS officers don’t understand what
COA does for them.

Second, we respond to our members. If you are a current member of
COA and have a problem or concern that affects your career or your
status as a Commissioned Corps officer, we welcome your call or email.
We can’t solve every problem, but we solve an awful lot of them. A
recent issue of Frontline recounted how we resolved a driver’s license
renewal for one of our members. Another recent success involved
working with DCCPR to allow an officer to transfer her GI Bill benefits to
a child. We give full credit to DCCPR for allowing this transfer to happen,
but we worked with the officer and with DCCPR on the case. We are
currently working—and have been working for quite some time—to help
our members who are assigned to BOP facilities. We have a meeting
scheduled with the new Director of BOP on 25 October.

If you go onto the COA website at http://www.coausphs.org/
advocacy/letters/, you can see letters we have written on behalf of
the Commissioned Corps, and I assure you that there are other, very
specific and targeted, letters that we have not posted. If you are a
current member and contact us about an issue, we will do our best to be
responsive.

Third, membership pays the cost of maintaining COA as an organization
representing you. COA has been representing the Commissioned Corps
since 1951. Just over seventy percent of the COA budget is derived from
member dues, so we need your membership support if we are going to
continue. As of 1 October we had 5850 active members in COA. Of this
number, 4370 were active duty officers, and 1580 were retirees. A total
of 1847 were Life Members. When officers pay for a life membership we
put the funds into a designated account, and we draw on them in an
actuarily-sound fashion.

The sad truth is that each year we have to beg, cajole, and otherwise
greatly bother officers to get them to renew their membership. As of
1 October of this year we had 999 active duty officers who had not
renewed their Fiscal Year 2018 membership. That’s almost one-third
of the total of active duty non-life member officers who were members
of COA at the end of FY 17. By 1 October we had already sent three
invoices to those who had not renewed, and we still had 999 who had
not renewed.

In the past week (I am writing this during the week of 9 October) we
have sent additional reminders to these non-paying officers, and the
memberships are gradually coming in. I ask you to think how much
time we are spending on this effort, time that we could be devoting
to advancing public health or lobbying Congress or reaching out to
executive branch figures who have an influence on the Corps. COA staff
devotes an enormous amount of time to this outreach because we can’t
survive as an organization if we don’t get members to renew.

We have about 1500 members whose dues are automatically deducted
from their pay every month. We used to offer this as an option, and it
was a popular one. Because of uncertainties in the entire Commissioned
Corps payroll system, we are unable to process additional officers
into the payroll deduction system. But even payroll deduction has its
challenges. We raised dues at the beginning of FY 17 (that was 1 July
2016) for the first time in eight years. Officers on payroll deduction were
contacted and sent a form that we need to send to DCCPR in order
to reflect the new dues amount. We have sent out no fewer than six
mailings, yet we still have over 300 officers who have not returned forms
to us. I sent an email to them just last week, and you might be amazed
at the number of respondents who said, “Really? This is the first I have
heard of it.” I don’t know what else to do. These officers are not current
on their dues, and they will not be allowed to sign up for the Symposium
at COA-member rates.

In the October issue of Frontline we suggested that COA members
direct their bank or credit union to debit their checking account once a
year and send their dues amount to COA. The same request is in this
issue. I suspect that every bank and credit union in the country offers this
service. All of my recurring bills are set up this way. I can have them paid
monthly, quarterly, yearly. I tell them who to pay, when to pay, and how
much to pay. So, I ask you, plead with you, beg you: please put your
COA renewal on an annual basis and have it automatically done.

What We Do for You

I was so disappointed this week to hear from one of our long-time
members who related a conversation he had with an officer who had
recently dropped his COA membership. “COA doesn’t do anything for
me,” was the reason the officer gave for dropping out of COA. Really?
COA doesn’t do anything for you? Where have you been?

If you wonder what we are doing for you and the Commissioned Corps
and public health in general, you should go to our website at http://www.
www.coausphs.org/ You’ll see much of what we do, though we also
work behind the scenes, especially when we join with members of
The Military Coalition. Even as I draft this column, COA Government
Relations Director Judy Rensberger is working with other TMC members
in an effort to gain more transparency from the Defense Health Agency
on TRICARE fees. This issue affects both active duty and retired PHS
officers. I suspect that all of you know about the GI Bill transferability that
COA put through the Congress a few years ago. No one else worked the
issue: not TMC not MOAA not HHS not OSG. It was completely COA’s
work. How many of you have used that law to save tens of thousands
of dollars in college costs? Or consider a much more mundane issue:
Disney World. It took us eighteen months, but we finally persuaded the
Disney Corporation to give you the same park admission prices that were
given to the military, and this discount includes both retirees and active
duty personnel.

Or consider the annual Symposium. In the year 2000 we created
the PHS Foundation for the Advancement of Public Health as a tax
deductible entity that sponsors the Symposium. Many of you attend the
Symposium every year and take advantage of the opportunity it affords
you to earn Continuing Education Credits. We don’t charge extra for
these credits, unlike some other organizations to which many of you
belong.

The Foundation also works to support Commissioned Corps officers
in other ways. Each year it awards college scholarships to children of
Corps officers. This year the total was $9000 in scholarship money. The
Foundation also provides Symposium registration scholarships to all
COA members at the O-3 or below level. That’s an average of 100 junior
officers a year who save some $350 each. Or consider the RADM Jerry
see EXECUTIVE DIRECTOR on page 8
Despite working long hours in support of response efforts to Hurricane Harvey, CAPT Aubrey Miller, MD, MPH, Senior Medical Officer to the Director of the National Institute of Environmental Health Sciences (NIEHS), gave of his personal time to participate in an impromptu educational session with graduate students from The University of Texas Health Science Center (UTHealth) School of Public Health (SPH). CAPT Miller was in Houston as part of the national response to the widespread and prolonged flooding resulting from Hurricane Harvey.

The students are members of the UTHealth SPH Student Epidemic Intelligence Society (SEIS) and they have an interest in both disaster response and possible careers with the Commissioned Corps. Many of these students participated in an epidemiologic study in one of the mega shelters that temporarily housed evacuees.

To the left of CAPT Miller in the photo is Dr. Janelle Rios, Director of Public Health Practice and Career Services and co-Director of the Prevention, Preparedness and Response (P2R) Academy. To the right of CAPT Miller is Dr. Robert Emery, former LCDR US PHS and current vice president of Safety, Health, Environment and Risk Management at UTHealth and co-Director for the P2R Academy. Pictured to the right of Dr. Emery is Dr. Mitch Rosen, Director of Public Health Practice at Rutgers University and a colleague within the NIEHS family of extramural activities. Not pictured are researchers from the Icahn School of Medicine at Mount Sinai to assist in the collection of preliminary physical and mental health status data.

The UTHealth SPH SEIS students were grateful for the real-life real-time boots-on-the-ground lessons from CAPT Miller and the ensuing discussion of the role of public health in disasters.

Verizon Wireless

Verizon has now agreed that PHS officers can send them the form generated on the Servicemembers Civil Relief Act website (https://scra.dmdc.osd.mil/scra/#!/single-record) to qualify for a 15 percent discount on cellular service. The letter from Verizon stating that such a discount is available to PHS officers can be found (and downloaded from) the COA website at http://www.coausphs.org/media/1678/letter-from-verizon-announcing-usphs-discounts-sep-2017.pdf
Why Attend the 126th Annual AMSUS Meeting

by COA Staff

COA had the honor of speaking with Vice Admiral Mike Cowan, MC, USN (Ret.), Executive Director of AMSUS, The Society of Federal Health Professionals. We spoke about the 2017 AMSUS Meeting, which will be held on November 28 to December 1, with pre-conference activities on November 27, in National Harbor, Maryland. The theme is “Force Health Protection: From Battlefront to Homefront.” Find more information at www.amsusmeetings.org.

On a side note, COA greatly appreciates the years of leadership Vice Admiral Cowan has provided for AMSUS. He will soon be stepping down as Executive Director of the organization. Bravo Zulu, sir!

Frontline: Thanks for the opportunity to talk with you regarding what the AMSUS meeting is all about. Let’s start with the overall theme of this year’s conference. What’s driving it this year?

VADM Cowan: The theme for 2017 is “Force Health Protection: From Battle Front to Home Front.” We structured this year’s meeting so that the first day will focus on battle front and pre-hospital and contingency issues. The next day will move to fixed facility care, and the last day will address long-term and rehabilitation issues. We’ll thus walk through the natural history of an illness or injury. We’ve asked the agency chiefs providing plenary presentations to look forward. This is their chance to tell people from all the other Federal agencies where their agencies are going in the future.

In the concurrent educational sessions, we have two sources: one is the abstract submissions that are coming in from individuals (there has been an exceptional response!), as well as topics that will be discussed by the subject matter experts in those areas that reflect the important topics of the day: suicide prevention, opioid avoidance and alternate means of pain maintenance, PTSD and TBI, and High Reliability Organizations (HRO), among others. We’re including updates on hurricane-affected populations among the Public Health Service. We selected the topics that are foremost on everybody’s minds and have subject matter experts who can speak authoritatively to those issues.

In the exhibit area, we have some really exciting things to showcase. Intuitive Surgical is bringing one of their robots called the da Vinci ® Surgical System to demonstrate remote surgery. In this scenario, a surgeon sits down at a designated station and a surgery actually happens via a remote robot. The process enables surgical procedures that humans couldn’t perform on their own.

The USIS Simulation Center will also demonstrate simulation devices. There are a lot of exciting things happening, and we think it’s going to be a very good conference.

Frontline: You mentioned the Public Health Service Officers who responded to the hurricanes this season – is this connected to the other services who responded like the National Guard, Reserve units, or is the focus on PHS?

VADM Cowan: The topic will likely be presented by PHS. Arrangements are still underway.

Frontline: What are some of the incentives
to encourage PHS officers to attend this year’s meeting?

VADM Cowan: You come to a meeting like this for several reasons. First, there’s the opportunity to accomplish that second mission of all in uniform – to act outside of our usual specialties. There are a range of things we have to know to do our jobs, and a body of knowledge that we have to familiarize ourselves with. This is a core goal of AMSUS.

Second, between the exhibits and the various people that are presenting, there are a number of advancements in healthcare to learn about.

Third, we all ought to be curious about what the agencies around us are doing. There’s not another place that you can go to find out what the Assistant Secretary of Defense, the DHA Director, and the Surgeons General will be up to for the next five years.

The final reason is simply about networking. Medical systems and professionals simply cannot thrive without going to meetings and sharing ideas outside of these kinds of professional networks. We need that opportunity.

The AMSUS annual meeting is a large unique, uniformed international medical conference. We expect the Surgeons General and other officers from 30+ different nations. We also offer the only national and international awards program that recognizes individual and organizational excellence.

Frontline: Will any PHS officers be on the podium for any of those awards?

VADM Cowan: Yes, there are several, including:

- The Dental Officer Award (CAPT Vicky Ottmers, USPHS)
- The Humanitarian Assistance Award (USPHS Rapid Deployment Team 3)
- Management and Administration Award (LCDR Jeffrey Ball, USPHS)

All awardees have been notified.

For future reference, I’d like to note that AMSUS is very proud to have a very simple awards nomination system, which consists of two short paragraphs based on two questions: what did this person do that was exceptional and why is that important?

Frontline: Any closing thoughts, especially for retired officers?

VADM Cowan: Most retired officers remain politically active or maintain interest in their profession in a variety of ways. I think the appeal of this conference is to attract professionals from all backgrounds. I personally go to these kinds of events because they serve as a “family reunion” of sorts. I appreciate the networking potential, because I think it’s important to foster relationships even into retirement. This is a good way to get out of the rocking chair!

The structure of the meeting is very much in support of the philosophy of comprehensive care from battlefront to home front. We recognize that treatment for an injury or disease is not done when the condition is cured. It’s only done when that patient’s family goes back to living their lives and the patient service member goes back to active duty or another career. One former patient once famously told me, “I used to be a wounded warrior.” That’s the goal for the health care system, and the message AMSUS hopes to help share at the upcoming meeting.
two days, and got the resolution introduced. It on, secured a Congressional sponsor in Representatives commending PAs. We took it on, and he asked us to see if we could get a resolution introduced into the U.S. House of Representatives commending PAs and other dignitaries. No group but COA could have gotten this done in such short order.

COA Dues

How do COA dues compare with those of other organizations to which you belong? Our dues are $105 per year for O-3 and below; $170 for O-4 and above, active or retired. Branch dues are extra, generally $5 to $10 per year. If you are “really retired,” your dues are $55 per year.

By comparison, American Public Health Association Dues are $220, with a rate of $105 for those whose income is below $45,000. (I ran what is called Regular Military Compensation on a DoD calculator [http://militarypay.defense.gov/Calculators/RMC-Calculator/] for an O-1 under 2 years of service, married, and came up with a total compensation figure of $70,439.33. This suggests that there is probably no one in the USPHS Commissioned Corps who would qualify for the lower rate at APHA.)

We’re not a labor union, but one of our nemesis (ask the folks who work in BOP facilities) is the American Federation of Government Employees (AFGE). They boast of 310,000 paying members, and their website says that their members pay between $468 and $572 per year in dues. Even at the lower rate, their yearly gross income is $145,080,000. AFGE gave almost $8 million to political candidates in 2016. (By way of contrast, I gave $4000 of my own money to members of Congress last year in an attempt to influence them favorably toward the Commissioned Corps. COA has no Political Action Committee). The amount of money that AFGE donates carries a lot of weight, and that’s who we’re up against as we fight for our members who work at BOP.

How about your professional association dues outside of COA? I asked some active duty COA members what they pay each year in dues to their various professional organizations other than COA. These figures often include dues to State and local organizations, as well as to specialty groups within their profession:

Veterinarian: $530 in yearly dues
Pharmacist: $1134 in yearly dues
Dentist: $929 in yearly dues
Nurse: $191 in yearly dues
Physician: $720 in yearly dues

COA Frugality

We do our best to spend your dues money wisely. In the three-plus years I have been your Executive Director, we have cut the following expenses:

- Rent: saved $40,000 per year
- Frontline: saved $30,000 per year
- Public Health Reports: saved $20,000 per year
- Lockbox with Wells Fargo: saved $10,000 per year
- Audit: saved $5000 per year
- Seven staff to six: saved $80,000 per year, including benefits
- Cable TV: saved $700 per year
- US Code Annotated pocket parts: saved $1000 per year

We are very frugal as we spend the money you entrust to us. We take the subway, rather than taxis, and unlike some Cabinet-level officials you could all name, we travel commercial economy class when we fly.

COA is sound financially at this time, and we want to keep it that way. If there are those of you reading this column who haven’t renewed for FY 2018, please do so. You can do it online at http://www.coausphs.org/membership/join-or-renew/ If you have a problem renewing, please call Donna Sparrow at 301 731-9080 or email her at dsparrow@coausphs.org

If you are on payroll deduction and haven’t sent in the form we need to increase the deduction to the correct amount, please contact Donna.

If you want to make it easy on yourself and us, please set up an automatic yearly dues payment through your bank or credit union.

I hope the officer who thinks that COA “doesn’t do anything” for them reads this column. As always, please contact me directly if you have any questions or concerns about anything I have written here.
LCDR Jacques, PT, DPT, OCS, CAHA, CSCS is a physical therapist (PT) with the Indian Health Service. She is the Clinical Director of Outpatient Physical Therapy (O-6 billet) within the Southcentral Foundation Rehabilitation Services in Anchorage and Wasilla, AK. In October 2015, her clinic employed two PTs, one PT assistant (PTA), and six Exercise Physiologists (EP). By July 2017, due to LCDR Jacques’ clinical leadership and direction, the clinic expanded to include eight PTs, three PTAs, and seven EPs. This expansion decreased the average wait time from 22 to 10 business days, increased their clinic’s productivity from 350 to 750 PT visits per month, and allowed them to provide the following services: orthopedic physical therapy, functional dry needling, sports rehabilitation, temporomandibular dysfunction and headache management, and pain neuroscience treatment and education.

In addition, LCDR Jacques hired a women’s health PT to her team, designated her as a Women’s Health Physical Therapy (WHPT) Champion for the department, and created a Women’s Health PT program. This program allowed the American Indian/Alaskan Native population statewide access to these high demand specialty services for the first time in over fourteen years. Moreover, LCDR Jacques has improved interdisciplinary care and communication regionally, including initiating a shadowing project with village providers in Anchorage. She established quarterly liaison meetings with the Primary Care Center, monthly meetings with Obstetrics and Gynecology department, and bi-annual meetings with the Pediatrics department. The interdisciplinary collaboration and relationship-building has increased referrals by 63%, as well as revenue, and has allowed same-day access for rural customers from Anchorage, the Matanuska-Susitna Borough, and other nearby villages.

In her free time, LCDR Jacques is enjoying spending time with her husband, Tim, and their newest addition, Naomi Evelyn, who was born in September. While she is on maternity leave, they are enjoying spending time outside walking with their two dogs, Chelly and Kobuk.

Meet LCDR Katie Jacques!

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Crunching Data for Healthy People

by COA Staff

Commander David Huang is with the CDC National Center for Health Statistics. COA spoke with him about his work on Healthy People, and why it matters. Find more information at https://www.healthypeople.gov/

Frontline: How long have you been in the Commissioned Corps?

CDR Huang: Since July of 2011.

Frontline: Why the Public Health Service? How did you know about it?

CDR Huang: I had heard about the Corps before I joined the CDC in 2009, but didn’t know enough about it until I started working with Corps officers. Wanting to do public service within the department for the duration of my career, joining the Corps made a lot of sense. One of the attractions was having the opportunity to deploy and serve the country.

Frontline: What is your current role entail?

CDR Huang: My branch and I work about 95 percent of the time on Healthy People initiatives, which are 10-year road maps in public health. Healthy People provides a framework for achieving the vision of allowing people to live long, healthy lives. Underlying this are 42 topic areas and 1,300 objectives, most of which have targets.

Frontline: How are the objectives and leading health indicators defined?

CDR Huang: A leading health indicator is a subset of the 1,300 objectives. These have been determined by the Department of Health and Human Services to be key indicators that we want to look at as a country to reduce mortality and morbidity.

Frontline: Are we becoming a healthier nation based on the data that’s coming in for Healthy People 2000, 2010, and 2020?

CDR Huang: We’re making improvements in a lot of areas and moving in the wrong direction in others. We are making improvements in infectious diseases. But in other areas there have been trends in the wrong direction—obesity, mental health (suicide and major concussive episodes).

Frontline: Are there connections between the goals the Surgeon General would select and Healthy People?

CDR Huang: The strongest connection between Healthy People and the Office of the Surgeon General is the National Prevention Strategy (NPS) which came out in 2011. When it was in development, OSG and folks working on Healthy People tried to harmonize the measures. The NPS is made up of seven priorities, and within those priorities are specific measures. In some cases, the NPS tweaked their measure to match the Healthy People measure. There were also some cases where Healthy People realized that there was an area that could be adjusted.

Frontline: Are you getting data from all 50 States? Do you trust the data coming in?

CDR Huang: A requirement for all of the data is that they be nationally-representative. The National Center for Health Statistics is responsible for a lot of the data systems used in Healthy People. Probably 40 percent of the objectives used are from NCHS. We are confident that the data coming out of NCHS are nationally-representative. We do our best to ensure that what we’re putting up is nationally-representative, but there have been cases where data sources have been rejected.

Frontline: What suggestion would you make to Frontline readers about how they can best follow what’s going on for PHS Officers?

CDR Huang: The data and objectives are now online, as are resources that people can use to look at things like disparity to create graphs and charts that can be pulled into presentations and reports. There has also been a push to highlight examples from the field of people who have moved the needle. I would point readers to the website to see examples of implementation tools/resources and evidence-based resources relevant to the objectives. There is also an archive of webinars and events, and of course, you can register for future events.
Physician Assistants, or “PAs,” started as a profession over fifty years ago when Dr. Eugene A. Stead, Jr., a professor at Duke University, took four former Navy Hospital Corpsmen and put them through a rigorous educational program based on the fast-track program for medical doctors that was started during World War II. From this modest beginning the PA profession has grown to over 115,000 PAs practicing in the United States and other countries.

On 12 October 2017, PAs who work at the National Institutes of Health (NIH) gathered for a celebration of National Physician Assistant Week. The ceremony was organized by former COA Board member and PA CAPT Josef Rivero and included several high-ranking dignitaries from NIH and PHS headquarters. CAPT Rivero served as master of ceremonies. RADM (Dr.) Richard Childs, Clinical Director of the National Heart, Lung and Blood Institute, offered introductory remarks. He was followed by Maj. Gen. (ret.) (Dr.) James Gilman, the first CEO of the NIH Clinical Center, who delivered the keynote address. He was followed by Chief Health Services Officer CAPT Jeanean Willis-Marsh, who read the text of the resolution that had been introduced into the United States House of Representatives by Rep. Karen Bass (D-CA), the only PA in the Congress. COA facilitated the introduction of this resolution by contacting Rep. Bass’ office and asking them to take on the task of shepherding the resolution through the House.

A cake-cutting ceremony was followed by remarks from Deputy Surgeon General RADM Sylvia Trent-Adams, who outlined the many qualities that Physician Assistants bring to the healthcare arena.

Commissioned Corps Officers working at NIH as Physician Assistants; CAPT George Carter, CAPT Josef Rivero; CAPT Janet Valdez, CDR Ulegen Fid

Cake cutting ceremony by the most junior PA Stefanie Bouma and the most senior PA CAPT George Carter

Call for Abstracts
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best practices," the report says the military health system should commit to standardizing care and adopting best practices so that pediatric care is timely, efficient, and equitable across the system. To address disruption and gaps in pediatric care, the report recommends integrating primary care and behavioral health care. It also proposes a "pediatric strategic initiative" that would incorporate telehealth technologies to minimize disruption and improve access and outcomes.

A Readiness Issue

Experts involved in developing the draft report explain that in the military health system the quality and accessibility of pediatric care should be considered a readiness issue. First, the well-being of uniformed services children directly impacts the readiness of the nation's fighting forces. Second, many uniformed services children go on to become uniformed services personnel themselves.

It's Not Easy

Modifying, updating, or expanding the TRICARE pediatric benefit is difficult, the draft report states. It is difficult because of the system's size, complexity, and changing statutory and regulatory requirements. Moreover, the military health system, unlike the civilian system, is both payer and provider of health care.

Looking Ahead

The draft report goes beyond current shortcomings and suggested fixes. A section titled “Additional Observations and Emerging Factors” describes several areas that the Defense Health Agency should begin to address. The first is childhood obesity. Overweight and obese children are at increased risk for a host of chronic diseases, the draft states, and so obesity among military children should be continually monitored. The draft praises a 2013 report, “Fit to Fight, Fit for Life,” and it proposes a demonstration project that would build on the evidence-based interventions and best practices discussed in that document.

The draft report also calls for new emphasis on the effects of adverse childhood experiences on health in later life. “Emerging research is now demonstrating that adverse childhood experiences among military populations may increase vulnerability, not resilience,” the draft states.

The draft report says that another emerging area in pediatrics is the study and treatment of gender dysphoria, including gender reassignment surgery. Finally, the report flags the issue of substance abuse among children and youth as an area that merits increased attention.

The draft cites 490 references, including peer-reviewed articles in medical journals as well as earlier evaluations of pediatric care in the military health system.

Defense Health Board

As an official advisory committee, the Defense Health Board is charged with providing independent, authoritative advice to the Defense Department on ways to improve the military health system. Its meetings are, by law, open to the public. At present, the Board consists of 19 experts in medicine and behavioral health. They serve on five subcommittees focused on health care delivery, public health, trauma and injury, neurological and behavioral health, and medical ethics.

The Board's draft report on pediatric care includes background information on the history of TRICARE, the complexity of the military health system, and the variability in care that beneficiaries experience. The report itself grows out of provisions in the 2017 National Defense Authorization Act (NDAA).

System Overview

The military health system's direct-care component includes 54 hospitals and 627 clinics staffed by 147,165 military and civilian personnel. Outside these military treatment facilities, health care for military families (including most of care for pediatric beneficiaries) is available through the TRICARE network. The Defense Health Board says that 47 percent of all health care providers in the U.S. are TRICARE-approved, and 80 percent of all non-mental health care providers in the U.S. are TRICARE-approved.

“"If you haven’t got charity in your heart, you have the worst kind of heart trouble.””

- Bob Hope

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**We Welcome**

**New Members of COA, October 1 to 31 2017**

- LT Aitor Andikoetxea (MT)
- LCDR Sarah-Blythe Ballard (GA)
- Ms. Renee Berg (MN)
- LT Jonathan Burgos (MD)
- LCDR Rebecca Chancey (GA)
- LT Stephanie Chiang (MD)
- Ms. Melissa Classon (MN)
- LCDR Jennifer Collins (GA)
- LT Keyana Crossley (VA)
- Ms. Lea Edwards (MN)
- Ms. Salena Ejuwa (MN)
- LT Leora Feldstein (GA)
- Ms. Ariel Field (MN)
- LT Temika Hardy-Lovelock (FL)
- LT Kathleen Hartnett (GA)
- LT Carolyn Herzig (NC)
- LCDR Elisabeth Hesse (GA)
- LT Omoye Imoisili (GA)
- LT Michelle Johnson (PA)
- LT Jasmeet Kalsi (MD)
- Ms. Johanna Katroscik (MN)
- ENS Jared Kavanaugh (AZ)
- LCDR Julia Majkrzak (CA)
- Ms. Tuesday McAuliffe Staehler (MN)
- LT Jennifer Mewshaw (TX)
- LT Pamela Mokoko (CA)
- LT Jolin Nguyen (TX)
- LT Gavin O’Brien (AZ)
- Mr. Benjamin Paolucci (MN)
- LTJG Schuyler Price (MD)
- ENS Uneeb Qureshi (MD)
- Ms. Julia Rumley (MN)
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- LT Khanh Vu (CA)
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Award Nominations Due By December 31

Health Leader of the Year
Local Branch of the Year (large and small)
Congressional Public Health Leadership
Civilian Outstanding Support of the USPHS Commissioned Corps
The Commissioned Corps’ newest advisory group – SOAGDAG (Sexual Orientation and Gender Diversity Advisory Group) – was signed into existence by the 19th U.S. Surgeon General VADM Vivek Murthy on 30 June 2015. SOAGDAG’s mission is to provide advice, consultation, and services to and on behalf of the United States Public Health Service (USPHS) Surgeon General on:

- Issues of interest to and concern of lesbian, gay, bisexual, and transgender (LGBT) officers, other sexual and gender minorities, and their allies in the USPHS Commissioned Corps;
- Issues relating to personnel policies and practices relevant to LGBT officers,
- Provision of LGBT-competent health care by Commissioned Corps healthcare providers.

Among its core functions, SOAGDAG aims to foster a community supportive of LGBT officers. SOAGDAG’s inception came from a desire for an LGBT group in the Commissioned Corps. The intent was to provide welcome support and visibility for officers. Before the 2010 repeal of Don’t Ask, Don’t Tell (DADT), the policy that barred lesbian, gay, and bisexual people from serving openly in the armed forces, it seemed inconceivable that such a group could exist. Now, for many PHS officers, the group has become a beacon of acceptance and hope.

SOAGDAG is currently comprised of up to twenty elected voting members who serve three-year terms and chair five committees (Awards, Communication, Education & Training, Membership, and Policy). Members come from diverse backgrounds and locations across the United States and represent many different professional categories. Any officer interested in furthering the mission of SOAGDAG may participate in the advisory group; one does not need to identify as LGBT to be a part of SOAGDAG.

Members have been working diligently to increase the visibility of SOAGDAG at recent conferences and outreach events:

- Volunteers have staffed a table at Officer Basic Course (OBC) Open Houses.
- On 2 May 2017, CDR Steve Morin (Communications Committee Chair) staffed a table at FDA’s 9th Annual U.S. Public Health Service Commissioned Corps Awareness Day.
- In June 2017, LCDR Sharyl Trail (Vice Chair) and LCDR Allen Applegate (Education and Training Committee Chair) presented SOAGDAG – The Commissioned Corps’ Newest Advisory Group

at the COF Symposium: “Addressing Health Disparities Among LGBT Americans: The Role of a Public Health Service Officer.” They addressed terminology pertaining to Sexual and Gender Minorities (SGM) to increase health literacy, including how to engage the LGBT community as a PHS officer, and they introduced the role of SOAGDAG. The presentation was very well received, with significant numbers in attendance.

Officers are invited to join and participate in SOAGDAG meetings. Monthly SOAGDAG meetings occur every fourth Tuesday at 1300 EST. Join by phone: (404) 553-8912. Conference ID: 5272483. In addition to participating in our meetings and various committees, we also want to encourage you to join our Listserv, as this is the primary way we communicate with our fellow officers. To sign up for the SOAGDAG Listserv, visit: http://go.usa.gov/xkSv9.
Junior Officer / Civil Servant Registration Scholarship

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Without the scholarship, I would not have been able to attend. I am in a remote location and travel alone was almost too much.”

“The scholarship alleviated some of the costs for the symposium, as I was not sponsored by my agency. I really appreciate it.”

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LCDR Jennifer J. Clements
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CAPT Tommy L. Mosely

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Interview with CDR Jennifer Adjemian

**Frontline:** What is your title at NIH, and what are you doing?

**CDR Adjemian:** I am a Senior Staff Scientist serving as the Deputy Chief of the Epidemiology Unit in the National Institute of Allergy and Infectious Diseases (NIAID).

At NIAID, there’s a focus on rare and infectious diseases – conditions that would otherwise be very challenging to research in an outside agency or in other groups due to their limited numbers (being very rare conditions) and the kind of financial support that’s available.

For me as an epidemiologist, I focus on population-level research. I’m looking for risk factors for rare infectious diseases and trying to identify ways to improve patient outcomes, whether through better treatment or changes in care management guidelines of patients. I like to call it clinical epidemiology, and I distinguish that from what’s done at an agency like CDC where there’s more of a focus on surveillance and public health response. We are working at more of a patient level by using population-level research that then feeds back into patient-level care.

**Frontline:** What types of diseases do you study?

Most of what we work on falls under the umbrella of one of two conditions. The first is antimicrobial resistance. There’s a growing awareness that we need more antibiotics to treat different bacterial infections. We look at what a clinician uses to treat a patient and whether they have a better outcome or not. On top of that, we do a lot of work around a disease called non-tuberculosis microbacterial disease. There’s a small subset of the population that’s very susceptible to developing a severe lung condition from this. NIH is very interested in anything where there’s that kind of intersection with environment and genetics.

I’ve worked on a lyme disease study. With the Rocky Mountain Laboratories, I’ve been helping with their Ebola patients. NIH had an Ebola treatment unit in collaboration with CDC during the outbreak in Liberia. Other studies I’ve worked with include the Lassa virus. We’ve also done a lot of work with rare fungal diseases.

**Frontline:** What were you doing before NIH that prepared you for this type of work?

**CDR Adjemian:** I worked at the Federal Bureau of Prisons leading an epidemiology research program. I also did CDC’s Epidemic Intelligence Service. I have a Ph.D. in epidemiology, so this experience came with lots of data, analysis, and quantitative training.

**Frontline:** Do you choose which diseases to focus on for your research or is there some flexibility to choose what you want to do?

**CDR Adjemian:** It’s very flexible here. NIH has an academic feel to it.

**Frontline:** Is it challenging?

**CDR Adjemian:** Yes, which is why I enjoy it.

**Frontline:** You’re a member of the scientist category of the Commissioned Corps working at NIH. Is there a desire or an expectation to publish what you’re doing?

**CDR Adjemian:** In the scientist category, there is this misconception that you must publish or you won’t be promoted. That really depends on your job description. We do like to see publications, but how that’s accomplished varies. In my role, there is definitely an expectation that you publish. With our academic environment, it’s the only way to get exposure in the field. We get anywhere from 5 to 10 scientific journal publications out each year.

**Frontline:** You just finished a tour as a chair of the SciPAC. Can you describe SciPAC and the priorities during your tenure?

**CDR Adjemian:** I first got involved in SciPAC shortly after commissioning, and I find it to be very fulfilling. We are a small category--only about 330 officers. We are very spread out,
and we’re very diverse. We have psychologists, epidemiologists, physicists, chemists, virologists, and others with more programmatic focused work (patent workers, for instance). Trying to find a way to make sure that everyone feels supported can be challenging. I made a point of reaching out to everybody to get a sense of where they felt the strengths and weaknesses were and to try to improve programs within our category.

I implemented a new program last year that focused on promotion-specific mentoring. I was overwhelmed by the feedback I received from people who were so desperate for that kind of help.

I think that’s definitely something that will continue to move forward, especially because it seemed to have made a big difference. We had people who were passed over for promotion (mainly O5s) as often as three to four times on average.

We’re surrounded with civilians who are going up in pay without having to deal with the added PHS processes. When you’re comparing yourself to your peers, it adds this layer of frustration. There are typically specific reasons as to why someone isn’t getting promoted, but for whatever reason, the person wasn’t getting that message or didn’t realize how they were coming through in their CV.

Frontline: Any advice for junior officers?

CDR Adjemian: Get involved right away with something you’re interested in related to PHS. SciPAC is always creating leadership opportunities. It’s really important to feel like you’re a part of the Commissioned Corps because you want to build your network and feel like you’re playing an active role, especially if you’re an officer in a more isolated position.

Also, get a mentor right away. I was shocked how many people didn’t have a mentor. It really makes a difference. If you don’t have a good mentor, get another one. Don’t be shy about it. You have to advocate for yourself.

DEPUTY SURGEON from page 1

RADM Trent-Adams served as Acting Surgeon General during the period between the departure of Surgeon General Vivek Murthy in April of this year and the swearing-in of Surgeon General Jerome Adams in September.

She received her Bachelor of Science degree in Nursing from Hampton University, a Master of Science in Nursing and Health Policy from the University of Maryland, Baltimore, and a Doctor of Philosophy from the University of Maryland, Baltimore County. She became a Fellow in the American Academy of Nursing in 2014.

The medal is named for the British nurse who ministered to wounded soldiers during the Crimean War in 1854 and later established what is recognized as the educational foundations of the modern nursing profession.

RADM Trent-Adams is a long-time member of the Commissioned Officers Association.