JOINT TRAUMA SYSTEM

The Unofficial Newsletter Recognizing the Efforts of the Joint Trauma System to Improve Trauma Care.

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Military Health System Recognizes Dr. Butler for Advancing Tactical Combat Casualty Care with Distinguished Service Award

As Committee of Tactical Combat Casualty Care (CoTCCC) celebrates 20 years of advancing combat medic training this year, the military medicine community celebrates the lifetime accomplishments of its chairman, Dr. Frank Butler. The Military Health System (MHS) presented Butler with the Distinguished Service Award at the MHS Research Symposium (MHSRS). The award is a lifetime achievement award recognizing an individual who contributed significantly to the success of MHS research and who demonstrates outstanding leadership.

"The name 'Frank Butler' is synonymous with prehospital trauma care, and rightly so," said JTS Director CAPT Zsolt Stockinger. "It is hard to think of a single person who has done more for the injured warfighter than he has over the last two decades. Many devices, procedures, and drugs have been developed, but Dr. Butler has placed into the hands of every deployed warrior the skills needed to ensure that if he or his comrades are injured, they have the best chance to leave that battlefield alive. There is a special place in heaven and in our hearts reserved for people like Frank."

Dr. Butler has facilitated, promoted and applied the results of military health system research in his roles as a founder of Tactical Combat Casualty Care (TCCC) and Director of the JTS Prehospital Care Branch. Dr. Butler is dedicated to ensuring medics are trained to the highest possible standard for combat medical providers and that they have the full support of their senior medical providers and line commanders.

Butler's vital contributions to prehospital interventions date back to 2007 when he was recruited to serve on the US Defense Health Board Trauma and Injury Subcommittee and joined CoTCCC as Chairman. The Tri-Service CoTCCC was founded in 2001 as a body of experts with the mission of maintaining and updating the TCCC clinical guidelines, ensuring new technologies and information is incorporated in prehospital trauma care. The CoTCCC has been the principle group responsible for the remarkable advances in battlefield (point of injury) trauma care made by the US Military in Afghanistan and Iraq – the breakthroughs being adopted by civilian trauma care providers.

Dr. Butler has been involved in medic training for 30 years. His work in trauma care was first recognized in 1996 when he co-authored a landmark paper in a supplement to the Military Medicine journal which introduced the concept of tactical combat casualty care as a guideline customized for use on the battlefield to address preventable causes of combat death by optimizing care rendered prior to arrival to a fixed medical facility. The TCCC guidelines were first adopted by US Special Operations Command, Navy Sea, Air and Land Team, Army Rangers, and Air Force Pararescue and endorsed by American College of Surgeons Committee on Trauma and National Association of Emergency Medical Technicians. The guidelines are followed by combat medics, forward operating bases, medical evacuation teams and surgeons in the military and civilian sectors in the US and abroad.

Butler has leveraged his prominent position as CoTCCC Chairman to ensure combat casualty care breakthroughs make their way to the civilian trauma care world. Butler has facilitated the research and testing of techniques, devices and pharmaceuticals for the purpose of improving trauma care to save lives of military and civilians. These include Tranexamic acid (TXA) to prevent or reduce bleeding, CricKey, surgical cricothyroidotomy device to precisely secure an airway, XStat, an expandable, multi-sponge wound dressing, Celox hemostatic gauze and the proper use of tourniquets. Butler is largely responsible for putting first responder trauma care into the national spotlight with the Stop the Bleed campaign sponsored by the White House.

Butler's influence is widespread. In addition to his TCCC work, he serves as co-chair of the Decompression Sickness and Arterial Gas Embolism Treatment Committee for the Undersea and Hyperbaric Medical Society. Butler also spent five years at the Navy Experimental Diving Unit in Panama City, FL, where he helped to pioneer numerous advances in SEAL diving capabilities. Later, as Director of the SEAL Biomedical Research Program for 15 years, his landmark projects included laser refractive surgery in the military, diving and hyperbaric ophthalmology, advanced diving procedures for Navy SEALs and the Naval Special Warfare decompression computer.

Dr. Mary Ann Spott, JTS Deputy Director, said "I have known Dr. Butler for many years, and I am continually impressed with his sustained passion for TC3, the patients and the providers. His is a living legend and a true American treasure."

Vice Admiral Raquel C. Bono, Director of the Defense Health Agency, presented Frank K. Butler, Jr., M.D. with the 2017 Distinguished Service Award.

Distinguished Service Award

- Recognizes individuals who, over the years or a career, have contributed significantly to the success of military health system (MHS) research.
- Recognizes substantial contributions above and beyond normal expectations to advance the growth and professional goals of the MHS research.

Award winners demonstrate outstanding leadership in pursuit of excellence for their country and service through research.

Dr. Butler Earns Notable Letterman Award for Exemplary Contributions to First Responder Care

The National Museum of Civil War Medicine has awarded CAPT Frank K. Butler, (USN ret), MD, the 10th Annual Major Jonathan Letterman Medical Excellence Award. Butler has served as a Navy SEAL, as an innovator and leader in Navy and civilian dive medicine, and most importantly as the driving force of Tactical Combat Casualty Care (TCCC). TCCC is a set of strategies for providing the best trauma care on the battlefield and guidelines to properly train non-medics to deal with the preventable causes of death in the field and now in the civilian world.

The Major Jonathan Letterman Medical Excellence Award honors an individual, program, or organization that has made an exemplary contribution to civilian or military medicine– continuing the legacy of Dr. Letterman. It is given to those who are leading innovative efforts in battlefield care, prosthetic technology, improving patient outcomes of the severely wounded, or leveraging cutting edge medical technology in new ways.

"In researching the career of Dr. Butler, it became obvious that he is indeed a 'Living Letterman,'" explains NMCWM Executive Director David Price, "Dr. Butler's accomplishments in the military, in the diving world, in ophthalmology and in civilian medicine are too numerous to list, however the singular achievement of his amazing career is conceiving and bringing to worldwide implementation of TCCC. He literally wrote the book on the guidelines to critical care in combat – just like Major Jonathan Letterman did during the Civil War. There are few more deserving of this award than Dr. Butler."

The civilian world is now impacted by Dr. Butler through the 'Stop the Bleed' campaign, which aims to teach citizens basic techniques in hemorrhage control so that an injured person has the greatest chance of surviving until they can reach a hospital.

"The potential impact of this initiative could rival the benefits of CPR and the Heimlich maneuver in the civilian world. Military medicine quickly translates to the civilian world – in this case through training people in the use of a tourniquet," observed Executive Director Price.

Dr. John Holcomb, the recipient of the 2016 Major Jonathan Letterman Medical Excellence Award, nominated Butler for the award. "Without any exaggeration, Navy SEALs are more lethal, military and civilian divers are safer and thousands of wounded combatants are alive because of his singular efforts," said Holcomb.

Harold Montgomery, JTS Operational Medicine Liaison to CoTCCC, expressed how all of the JTS feels about Butler's contributions to prehospital trauma care.

"Thank you, Dr. Butler, for your impact on a generation of medics and corpsman that you enabled to save hundreds, if not thousands, of lives. Your tireless work for nearly three decades to improve prehospital combat medicine has a empowered soldiers, sailors, airmen, and Marines with the capabilities to save lives on any battlefield."

"Your foresight and solutions has not only provided the U.S. military and partner nations, but also civilian EMS counterparts with well-founded concepts to save lives anywhere that trauma occurs including the streets of America," said Montgomery. "On behalf of those medics across the spectrum of care, thank you for everything you have done for us and our casualties."

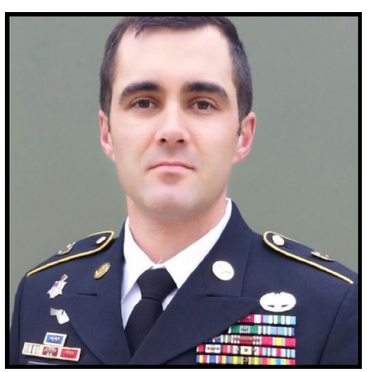
Betsy Estilow, President of the Board, National Museum of Civil War Medicine, presents Frank K. Butler, Jr., M.D. Photo courtesy of the National Museum of Civil War Medicine.

Frank K. Butler, Jr., M.D. with his wife, Deborah Lynn Butler.

CoTCCC Recognizes Those Dedicated to the Mission

In recognition of their medical leadership and excellence in battlefield trauma care innovation as well as the unparalleled advances made by the 75th Ranger Regiment in improving the delivery of TCCC to the wounded that their leadership has enabled, LTC Miles and MSG Conklin and the 75th Ranger Regiment are most deserving of the 2017 TCCC Award. The Ranger Regiment as a whole was included because it has become synonymous with well-trained and well-executed TCCC.

LTC Ethan Miles has been a 75th Ranger Regimental Surgeon and a Joint Special Operations Command Task Force Surgeon since 2013. He graduated from USUHS, trained in Family Medicine, and was a 75th Ranger Regiment Battalion Surgeon from 2006 until 2011. He then received a Masters Degree in Defense Analysis. LTC Miles has distinguished himself in Medical Leadership in the Ranger Regiment and across the DoD. With his Regimental Senior Medic , MSG Curt Conklin, they led the implementation of the Ranger Type O Low Titer Whole Blood Program. Not since the popularization of tourniquets by TCCC early in the recent conflicts has an innovation had such potential to change the face of operational medicine.



LTC Miles' leadership in developing the ability to provide whole blood in a systematic way during special force operations is so far reaching that it has the potential to require a redefinition of the term "non-survivable injuries." LTC Miles' leadership in the scientific development of this paradigm-changing technique, in partnership with the DoD's leading experts in transfusion medicine, and his creation of an effective program for training medics and operators to deliver this treatment on the "X" is a model for greatness for an operational physician.

MSG (P) Curt Conklin is nominated for his outstanding performance and key innovator as a member of the CoTCCC. MSG Conklin has been a critical team member of the TCCC Web-Mobile-Social Initiative with focus of "For Medics/By Medics." He was integral in the development of the TCCC website, mobile application, TCCC training videos, and social media activities. MSG Conklin has become the face of TCCC as he prominently appeared in the majority of the new TCCC instructional and procedural videos. As the Regimental Senior Medic for the 75th Ranger Regiment, MSG Conklin was pivotal in introducing new and innovative methods of training TCCC at unit level that can be emulated by units across the armed forces. MSG Conklin was instrumental in the development and establishment of the Ranger O Low Titer (ROLO) Whole Blood program which brings TCCC resuscitation methods at point of injury to an entirely new level and capability. MSG Conklin has also represented TCCC initiatives throughout the military by demonstrating and presenting the Ranger Regiment's success in reducing preventable combat death through its long-standing focus on TCCC for every unit member.

MSG (P) Conklin is a Special Operations Combat Medic, SO-Advanced Tactical Paramedic and National Registry Paramedic assigned to Joint Special Operations Command. He was the Regimental Senior Medic of the 75th Ranger Regiment from 2012-2017. Previously, he was the battalion senior medic/medical platoon sergeant for the 75th Regimental Special Troops Battalion from 2010-2012, and the senior medic and recon team medic in the Regimental Reconnaissance Company from 2005-2009. He served as a company senior medic and Ranger Platoon Medic in C Company, 3rd Ranger Battalion from 2002-2005. MSG (P) Conklin has several combat deployments to Afghanistan and Iraq.

COL Andre Cap , Research Director, Blood Research, for the US Army Institute of Surgical Research, received a TCCC Special Award for his outstanding leadership over the years in enabling US forces to use whole blood and blood products in the far-forward combat environment. He is also the DoD's leading expert in the use of TXA and other IV medications to promote hemostasis in bleeding casualties.

CoTCCC recognized MSG (R) "Monty" Montgomery, JTS Operational Medicine Liaison, for his outstanding work and for developing a TCCC website and enhanced TCCC educational products. He also established a social media presence for TCCC and the JTS. Montgomery received a coin, a letter of appreciation, and an award from his contracting company - Knowesis ,Inc. - for his superb work in developing the TCCC Quick Reference Guide which includes the first-ever TCCC Clinical Algorithms.

Director's Notes

CAPT Zsolt Stockinger, MC, USN, JTS Director

Are We There Yet? Moving Right Along...

Cynthia is killing me. It's like a long drive with the kids in the car -- "*Is it done yet? Is it done yet*?"

Of course, she is referring to the fabled *Director's Column* for the quarterly newsletter, which somehow always seems to get pushed to the back burner. There's always something that gets in the way: external deadlines, DHA transition meetings, budget issues, travel, the dog needs shots — the list of competing tasks is endless.

As the Director, naturally I have a full complement of delaying tactics. "I haven't seen the newsletter draft yet," "Have you finished formatting the article for the Military Medicine supplement," "Don't forget that the CONOPS is our first priority," "No one will read it until after the long weekend anyway," "I have Nintendinitis" (it's real, look it up!), "let's make sure the planet survives the eclipse first." And let's not forget "The dog ate it." But sooner or later I am run to ground and, as the Brits would say in their officer evals, "works well when cornered like a rat in a trap." So here we are.

For some reason, there has always been an impression that things slow down over the summer. Perhaps it is just that we'd all rather be outside playing, or that the summer torpor predisposes more to a languid afternoon on the porch than to a hectic day at the keyboard, but I've always found that summers are hectic at work. Perhaps THAT is because we have to cover for those on holiday, or that people love to empty their outboxes into our inboxes as they head out the door on vacation, but for whatever reason it remains busy. This summer at JTS was no exception.

One of the most visible events from an outsider's perspective was the annual Military Health System Research Symposium, where the "brain trust" of military medicine gets together to present all the cool things they've done for the year, in the hot sweaty environment that is Florida in August. JTS was there in full force, with months of your work culminating in no fewer than 12 presentations on a variety of topics, including high visibility presentations by Dr. Jud Janak on our preventable death project, and soon-to-be-Dr. Caryn Turner on combat surgical workload. None of these could have occurred without the full support of every member of the JTS team doing what they do every day to gather, abstract, and analyze combat casualty data. So an excellent showing by our team.

The Committee on Tactical Combat Casualty Care met here in San Antonio, doing its usual stellar work to improve point of injury trauma care. The Chairman, Dr. Frank Butler, was publicly embarrassed when his recent accolades were brought to light. First, he had received the Military Health System's Distinguished Service Award, which is a lifetime achievement award, for his many contributions to battlefield medicine. He then received the Letterman Award from the National Museum of Civil War Medicine. For those who aren't historians, Major Jonathan Letterman was appointed the Medical Director for the Army of the Potomoc in 1862 and reorganized trauma care for the Federal forces, saving innumerable lives on innumerable battlefields during the Civil War. As a former SEAL, CAPT (retired) Butler likes to stay under the radar, but not this time, Frank!

Also of note, two of our staff deployed to more a more local "battlefield," Hurricane Harvey relief in Houston. Kudos to our citizen-soldiers Patty Drouillard of the Texas Air National Guard, and Brian Miller of the Texas State Guard.

On the less visible side, there has been a great deal of work put into preparation for our transition to the Defense Health Agency, which I expect will occur sometime next summer. As this transition is primarily administrative, our goal is to create as little interruption in our daily work as possible. Despite any rumors that may abound, this is a transition and not a downsizing, and you'll have noticed that we've even brought a few new people on board because our workload always seems to increase.

So it's been a busy summer at JTS, and I anticipate we won't slow down over the holidays either. That's just not how things work around here. Not even the end-of-the-world-solar-eclipse can stop it!

JTS Sets Itself Up for Success in Expanded Role

Dr. Frank Butler, Chairman of the Committee of Tactical Combat Care recently commented on CAPT Stockinger's leadership during this landmark time in the JTS history.

"Both the 2015 Defense Health Board report on trauma care lessons learned in OEF and OIF and the 2016 National Academies of Science, Engineering, and Medicine report on the same topic have noted the remarkable contributions of the Department of Defense's Joint Trauma System in reducing the incidence of preventable death among US combat casualties. Congress responded to these reports by including language in NDAA 2017 that directed that the JTS become a permanent part of military medicine and reside at the Defense Health Agency," said Butler.

"CAPT Stockinger has been the Director of the JTS during the period of transition from it's long-term home in Army Medicine to the DHA. His leadership has helped the JTS to effectively address the many administrative challenges that this move entails and to ensure that the JTS will continue its lifesaving work without interruption at its new organizational location."

JTS Staffers Support Harvey Hurricane Recovery Efforts

While the world watched Harvey victims navigate their way to safety, service members everywhere were called to assist recovery efforts. Two of our JTS team, Patricia Drouillard (Performance Improvement Nurse Analyst) and Brian Miller (Database Manager) supported first responders.

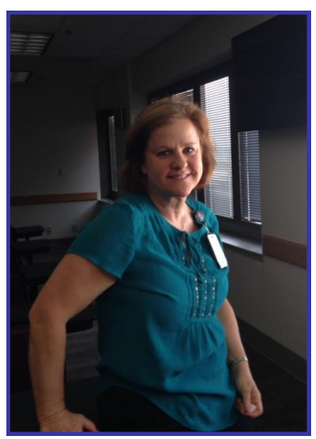
As a member of the Texas State Guard (TXSG), Miller helped the J6 information technology (IT) unit at the command headquarters at Camp Mabry in Austin. His primary role was to support the Texas State Guard's Readiness Management System (RMS). The web-application coordinates deployments, movement of teams and recovery efforts, availability of staff and personnel data for the Texas State Guard. In other words, the RMS tells who can do what when where and if the task is possible given the resources and personnel.

Miller stayed busy:

- Performing administrative functions for the RMS application.
- Providing SQL services for ad-hoc reporting against RMS.
- Providing on-site machine level support for TXSG members for general IT issues.

During his time at Mabry, Miller was also able to debug the RMS application and develop two bug fixes which were implemented.

On the other side of the Harvey recovery effort, Drouillard was boots on the ground in flood zones representing Texas Air National Guard. Drouillard and the crew spent a couple of days waiting for the high waters to subside before they could even drive into assigned areas. Drouillard eventually made her way to Beaumont, Texas with a pit stop at Katy High School in Katy, Texas (just east of Houston). Drouillard described the teachers and coaches as incredible as they provided clean clothes and fresh food around the clock for those in need. She said the constant flow of people dropping off donations at the high school was also impressive and encouraging. But sad reminders of the catastrophe were everywhere. Just across the street from the school shelter was a flooded neighborhood, houses stripped of their drenched belongings – lines of front yards filled with trash.



(left) Brian Miller and family at his TXSG swearing in ceremony.
(right) Patricia Drouillard at the JTS birthday social.

The drive to Beaumont was long, slowed by heavy traffic and high water – at times over half a foot – with foul water seeping into the trailers filled with supplies and equipment. They passed alligators swimming in the water next to the road. Halfway there, the team got a police escort, but the 1 ½ hour drive still took over 3 hours.

Drouillard and the others set up two emergency care tents in the parking lot of Beaumont's Memorial Hermann Hospital. The treatment tents were complete with all the equipment to run codes if necessary. What patients they couldn't handle, they sent to Memorial's Emergency Department which consisted of a skeleton crew. The hospital was operating without running water; generators kept the lights on. Critically sick patients were air lifted out.

The medical team consisted of 7 providers, 6 nurses, 20 med techs, 1 pharmacist, 3 biomet, 2 public health and 2 administrators. They saw 265 patients in 2 ½ half days and treated a variety of conditions from lacerations to broken bones. They were able to help the many people who found themselves without their prescriptions.

Drouillard was again impressed by how the community worked together. They slept on cots in the Beaumont airport lobby with other first responders. Drouillard said St. Elizabeth's Catholic Church from Port Neches took exceptional care of them, washing their clothes and making sure they ate a full breakfast before leaving for their 6am shift. The local Powerhouse Gym opened its doors for responders to shower. She thought it was funny they would shower at the gym, but they were too tired to work out.

The communities showed their gratitude for their service. She stressed that everywhere she went people anticipated their every need – food, toiletries, laundry. She didn't want for anything. "They were always available for anything we needed or requested, served incredibly great food, not just donuts and coffee. We didn't have to worry about too much," said Drouillard. "The people who we treated were so appreciative of everything we did for them."

Kudos to both Drouillard and Miller for going the extra mile to help Texans in crisis.

JTS Gets its Own Chief Financial Officer

After 21 months without an executive administrative officer, the JTS has found the perfect candidate—right here in our offices— to fill the substantial void left by Dom Greydanus. Dallas Burelison vacated his position as Education Branch Chief to lead the JTS as Chief Financial Officer. Burelison offers JTS the unique advantage of having served on both sides of the JTS mission: here in house and on the deployed side as a Joint Theater Trauma System coordinator.

His military experience gives him a well rounded understanding of the JTS operations here and abroad. While deployed in Bagram, Afghanistan, Burelison increased patient capture rate by 45% throughout Central Command area of operations for level II trauma database.

On the JTS home front, Burelison has implemented educational programs and led performance improvement initiatives. He has directed and coordinated a continuing education curriculum delivered on a global scale. He expanded continued education outreach capacity by 20% over a three-month period by developing new practices and delivery methods.

His master's degree in business will come in handy for his new duties.

Congratulations, Dallas!

En route committee Selects Chairman

By Dominick Sestito IV, USN (Ret), Senior Administrative Assistant

The Committee on En Route Combat Casualty Care has selected a Chairman to lead its efforts.

"The Joint Trauma System would like to welcome LTC Cord Cunningham, the new CoERCCC, to San Antonio," said Col Stacy Shackelford, JTS Chief of Education and Performance Improvement. "LTC Cunningham is an emergency physician and has completed an Emergency Medicine Services fellowship. His vast experience in prehospital and operational medicine will greatly strengthen the efforts of both the JTS CoERCCC and the Institute of Surgical Research (ISR) to improve prehospital trauma care. He joins the ISR as Deputy Task Area Leader for the new Prolonged Field Care task area.

Cunningham's extensive experience includes:

- **Command Flight Surgeon, 1st Air Cavalry Brigade,** Fort Hood, Texas, 6/2015-current
- **Fellow, EMS and Disaster Medicine,** San Antonio Uniformed Services Health Education Consortium, 7/2013-6/2015
- **Adjunct Assistant Professor, Dept of Emergency Health Sciences,** University Texas Health Sciences Center, 8/2013-8/2015
- **Chief, Dept of Emergency Medicine,** Carl R. Darnall Army Medical Center, 7/2011-6/2013

November conferences have received Final Approval from MRMC. ERC will commence 13-14, and SCC will follow 15-16th of Nov in San Antonio.

Conference will highlight presentations from deployed surgeons missions from LT Benjamin Miller from the Fleet Surgical Team onboard the USS Bataan, MAJ Mia DeBarros GHOST team in Operation Inherent Resolve, and Maj David "Marc" Northern on SOST in OIR. ERC will highlight deployed CCATT missions by Maj Eric Ball from 59MDW and a deployed medic presentation. VIP speakers will be Major General Iddins and VADM Pecha for ERC, and Major General Howell and MG Lein for SCCC.

Subcommittees Drive CPG Updates

ERC subcommittee and cadre of the Joint Enroute Care Course (JECC) is developing REBOA curriculum in order to respond to the increase in REBOA cases in Operation Inherent Resolve. This effort is being led by LCDR Erik Hardy with collaboration by Dr. John Holcomb (COL ret) and Col Shackelford of the JTS.

SCCC has aided in published CPG updates to REBOA for Hemorrhagic Shock and Airway Management of Traumatic Injuries (Jul 2017).

Traumatic Brain Injury Team Joins JTS

The JTS continues to expand the DoD Trauma Registry portfolio with the addition of a registry module for Traumatic Brain Injury (TBI). The team, which started in October, is led by Leslie DuBois, a Research Registered Nurse, formerly with Data Analysis/Special Projects.

The goals for the two–year project include:

- Create a comprehensive TBI module for data abstraction
- Abstract data into the TBI module
- Analyze the data

The trauma variables are already in the DoDTR. The TBI-specific module will facilitate collection of study-specific data without additional time and development costs.

The TBI team is expected to evolve into a branch like Military Orthopaedic Trauma Registry and Military En Route Care Registry groups did.

TBI research is moving to the forefront of popular science as evidenced by the recent widespread media coverage of chronic traumatic encephalopathy. Please welcome our TBI colleagues. See Hails & Farewells.

Pacesetter Niko Kypreos Helps JTS Capture Vital Operational Stats with JTS Manager Enhancements

Nikolaos "Niko" Kypreos, recipient of the JTS Pacesetter Certificate of Recognition for 3Q 2017, has been a pivotal player on the JTS team since fall of 2014 and even before that when he worked in the Information Management Office (IMO) in the Institute of Surgical Research.

Most people know Niko for his role as the creator of the JTS Manager. This year represented a major upgrade of the JTS application. Even since this spring when the newsletter covered the upgrade, Niko has added several more capabilities to keep up with our growing personnel and expanding role in Department of Defense.

"Niko is a quiet force in the JTS," said JTS Deputy Director Dr. Mary Ann Spott. "He has put together a software program that has enabled us to effectively demonstrate metrics to senior leaders and provide evidence on the true effort required to complete projects. This has enabled the JTS to acquire funding, secure assistance for support and change process practice. The JTS manager has become a critical daily tool for our use in managing and organizing the teams and the work of the JTS."

Niko has received nothing but praise and positive feedback from the branch chiefs for the new features. Thanks to Niko, JTS was able to capture system downtime hours which helped leadership make a case for escalating the network connectivity problems.

The latest line up of new JTS Manager features below illustrates the depth and breadth of Niko's work and his dedication to delivering a quality product.

- Added TBI workload module.
- Added PI workload module.
- Added SOP management module.
- Added publication management module.
- Expanded tracking capabilities of the agreements module.
- Added system downtime analytics.
- Added a library module for easy reference of CPGs, SOPs, agreements, etc
- Expanded menu of reports
- Added more search filters
- Minimized data going across VPN for better remote usability
- Fixed the digital signature problem with a better certificate selection process.
- Added an email notification system for when requests get assigned/completed to increase user feedback and user friendliness
- Integrated Role 2 as a separate launchable application
- Upgrading the personnel module to include training and certificates

When Niko wasn't enhancing JTS Manager, he was leading the IT Automation in its accreditation processes. Niko's prior documentation experience with the Certificate of Networthiness (CoN) process was instrumental in helping IT Automation navigate initial compelling evidence required for the media protections portion of the Risk Management Framework (RMF) process. Niko is credited with authoring the primary supporting documentation such as data flow diagrams and the configuration management plan. Niko's experience proved helpful to IMO when it was developing its cybersecurity methodology for standardizing security protocols within networks, servers, computers, and logical designs to enhance overall security, said James Mason, IT Automation Chief. He pointed out Niko's attention to detail and exemplary documentation were recognized by validators visiting IMO for the accreditation process.

JTS Manager enabled JTS to show how many hours JTS lost to network down time and how much it cost us. These vital numbers helped JTS draw attention to the problem which led to some resolution.

Mason says Niko's easy going nature and ability to go with the flow has come in handy in JTS' constantly changing (evolving) IT environment with increasing demands and issues which are often beyond our control. Niko is a calming voice of reason and always ready to assist.

JTS Director CAPT Stockinger presents Nikolaos "Niko" Kypreos, Senior Software Engineer, with the Pacesetter Certificate of Recognition.

What Niko likes about his job:

"The overwhelming team support I get in order to build software. It is really refreshing to be in an organization where everyone from management to co-workers is happy to help out and get the job done."

"Niko's contributions to JTS Manager enable the entire JTS organization to meet their mission requirements while working more efficiently, said Mason. "Niko deserves recognition by his managers and peers."

The Pacesetter Program recognizes and honors JTS staff members who set the pace for the organization's standard of excellence. Pacesetters lead by example, demonstrate a positive attitude when faced with challenges, and are known for their collaborative spirit. They take pride in their work and it shows in the product. Each quarter, JTS leadership selects professionals whose behaviors and work ethics support or further the mission, goals, values and initiatives of JTS.

ORISE Fellow Caryn Turner Raises Awareness of Combat Casualty Care Procedure Trends

COMBAT ABDOMINAL SURGERY DURING RECENT COMBAT OPERATIONS FROM 2002-2016

Caryn A. Turner, MPH, CAPT Zsolt T. Stockinger, MD, COL Jennifer M. Gurney, MD
Joint Trauma System, DoD Center of Excellence for Trauma, Joint Base San Antonio, Fort Sam Houston, Texas

Introduction

- Abdominal surgery constitutes approximately 13% of surgical procedures performed for combat injuries.[1]
- A study which compared the surgical procedures performed by surgical residents from 1998-2008 found a steady decline in major and routine open abdominal surgical procedures, with significant increases in laparoscopic procedures.[2]
- This demonstrated shift in surgical training shows residency training programs will produce capable general surgeons who have a different skill set than previous generations of surgeons and widens the gap between general surgeons and surgical specialists.[2]
- 70 percent of graduating general surgery residents immediately progress to subspecialty fellowships.[3]
- The paradigm shift in the U.S. from open to laparoscopic surgery, and the increasing sub-specialization within general surgery, may potentially negatively impact the ability of deployed military general surgeons to perform the full range of procedures traditionally required of surgeons in wartime.

Objectives

- Examine the frequency and type of abdominal surgical procedures performed in theater.
- Gain a more thorough understanding of abdominal surgical training gaps and personnel requirements.
- Compare these longitudinal data to the existing literature.

Methods

- Retrospective analysis of the Department of Defense Trauma Registry (DoDTR).
- Role 2 and Role 3 Military Treatment Facilities (MTFs) in Iraq and Afghanistan from January 2002 to May 2016.
- 270 ICD-9-CM codes were classified by SMEs as abdominal procedures.
- Procedures were grouped by anatomic location, with some subgroup analysis.
- 189,818 surgical procedures were identified
  - 26,537 classified as abdominal surgical procedures.

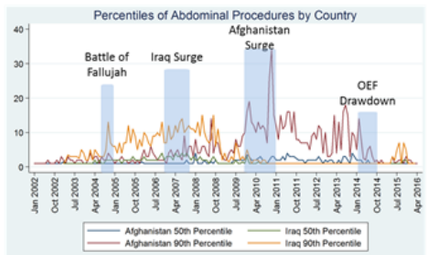
Acknowledgements

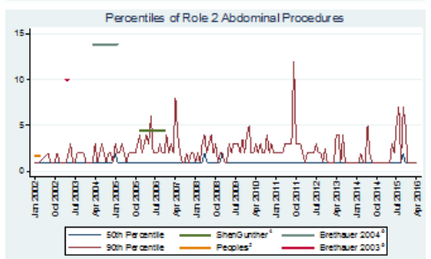
- The authors acknowledge the Joint Trauma System for providing the DoDTR data for this study and Ms. Susan West and the JTS staff for their assistance in preparing the data set.

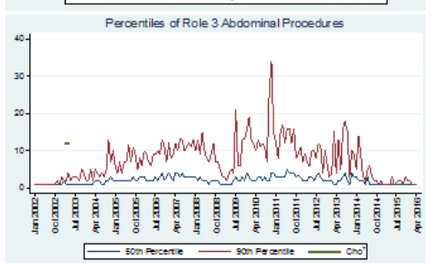
Results

- The majority of abdominal surgical procedures (22.2, 83.73%) were reported at R3 facilities.
- The most common surgical procedure at both R2 and R3 MTFs was Exploratory Laparotomy NOS.
- Only 18 laparoscopic procedures were reported, 14 of which were appendectomies.
- Only 12 gynecological surgical procedures were reported, 4 of which were Caesarean sections (R2:2 R3:10).
- Finally, abdominal caseload was extremely variable over the 15 year study period.

Abdominal	Role 2 N(%)	Role 3 N(%)	Total N(%)
Liver	131 (3.03)	637 (2.87)	768 (2.89)
Biliary	21 (0.49)	159 (0.72)	180 (0.68)
Spleen	238 (5.51)	798 (3.59)	1,036 (3.9)
Pancreas	51 (1.18)	140 (0.63)	191 (0.72)
Esophagus	6 (0.14)	33 (0.15)	39 (0.15)
Gastric	188 (4.35)	713 (3.21)	901 (3.4)
Bowel	1,604 (37.15)	6,789 (30.55)	8,393 (31.62)
Duodenum	25 (0.58)	79 (0.36)	104 (0.39)
Small Bowel	608 (14.08)	2,304 (10.37)	2,912 (10.97)
Colon	700 (16.21)	2,277 (10.25)	2,977 (11.22)
Rectum	31 (0.72)	162 (0.73)	193 (0.73)
Appendectomy	24 (0.56)	87 (0.39)	111 (0.42)
Ostomy	150 (3.47)	1,411 (6.35)	1,561 (5.88)
Bowel NOS	60 (1.39)	436 (1.96)	496 (1.87)
Feeding Tube	32 (0.74)	965 (4.34)	997 (3.76)
Anorectal	1 (0.02)	31 (0.14)	32 (0.12)
Renal	134 (3.1)	418 (1.88)	552 (2.08)
Bladder	135 (3.13)	793 (3.57)	928 (3.5)
Hernia	1 (0.02)	17 (0.08)	18 (0.07)
Adrenal	2 (0.05)	11 (0.05)	13 (0.05)
Gynecology	2 (0.05)	10 (0.05)	12 (0.05)
GI Endoscopy	152 (3.52)	1,776 (7.99)	1,928 (7.27)
Laparotomy NOS	1,060 (24.55)	4,935 (22.21)	5,995 (22.59)
Diaphragm	185 (4.29)	634 (2.85)	819 (3.09)
Other	380 (8.8)	3,394 (15.27)	3,774 (14.22)
Total	**4,317 (16.27)**	**22,220 (83.73)**	**26,537 (100)**
Laparoscopy			
Non-Laparoscopic	4,161 (99.9)	20,430 (99.93)	24,591 (99.93)
Laparoscopy	4 (0.1)	14 (0.07)	18 (0.07)
Total	**4,165 (16.92)**	**20,444 (83.08)**	**24,609 (100)**
Appendectomy			
Open	22 (91.67)	75 (86.21)	97 (87.39)
Laparoscopic	2 (8.33)	12 (13.79)	14 (12.61)
Total	**24 (21.62)**	**87 (78.38)**	**111 (100)**
Caesarean Section			
Caesarean Section	1 (50)	3 (30)	4 (33.33)
Other Gynecological	1 (50)	7 (70)	8 (66.67)
Total	**2 (16.67)**	**10 (83.33)**	**12 (100)**







Discussion

- Laparotomy NOS was the single most common surgical procedure at both Role 2 and Role 3, representing almost one quarter of all abdominal surgical procedures.
  - This may reflect the Damage Control Surgery practice of repeated exploration and washouts for complex abdominal injuries, insufficient procedural documentation within medical records, or imprecise procedural coding upon abstraction.
    - The last is unlikely given the >95 percent inter-rater reliability for DoDTR abstraction.
- In a 2008 survey, Cothren et al found only 9% of civilian Level I-III Trauma Centers have trauma surgeons that perform the full spectrum of vascular, thoracic and complex abdominal trauma cases.[5]
- Laparoscopy was almost nonexistent in the present study.
- Surgical procedural workload varied widely over the study period; published military literature almost exclusively reflected high op tempo periods and therefore cannot be taken as representative of typical deployment workload.
- However, as 90th percentile workload often exceeded the mean workload by several hundred percent, use of means for planning purposes could seriously underestimate surgical needs.

Conclusions

- Open abdominal surgical skills remain a necessity for deployed U.S. Military general surgeons.
- This necessity is at odds with the shifting paradigm from open to laparoscopic skills in stateside civilian and military hospitals, demonstrating an ever-widening training and sustainment gap for wartime surgical readiness.
- Fluctuations in military op tempo and casualty rates presumably led to variations in peak workloads, which makes planning to a median or mean inappropriate.

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An Analysis of Combat Orthopedic Procedures Performed During Combat Operations 2002-2016

Caryn Turner, ORISE Fellow, shared her recent work with MHSRS attendees. One study she presented as a poster (see left) and the other study she presented to conference attendees. Her presentation on US Military combat orthopedic surgical workload in Iraq and Afghanistan provides an understanding of orthopedic surgical training gaps. The issue is critical because orthopedics constitutes a significant proportion of deployed combat surgical procedures.

ORISE Fellow Caryn Turner, MPH, shares analysis with MHSRS attendees.

Turner identified the most common groups of Role 2 and Role 3 procedures in order to pinpoint surgical training shortcomings. A survey of 515 US Trauma Centers revealed that trauma surgeons do not regularly perform orthopedic procedures at civilian trauma centers. The majority of these procedures (debridement of open fractures, external fixation, fasciotomy, amputation) should fall within the skills set of the deployed general surgeon. Given this fact, the finding casts doubt on the centers' ability to provide military general surgeons with training or sustainment in skills which account for 26% of all surgical procedures downrange. Turner's analysis highlights the need to address how to ensure these orthopedic surgical skills are part of the Military General Surgeon's training.

Conclusions

- Open abdominal surgical skills remain a necessity for deployed U.S. Military general surgeons.
- This necessity is at odds with the shifting paradigm from open to laparoscopic skills in stateside civilian and military hospitals, demonstrating an ever-widening training and sustainment gap for wartime surgical readiness.
- Fluctuations in military op tempo and casualty rates presumably led to variations in peak workloads, which makes planning to a median or mean inappropriate.

Co-authors: COL Jennifer Gurney, MC, USA; CAPT Zsolt Stockinger, MC, USN

Col Shackelford Discusses Emergency Craniectomy & Effort to Author CPGs for Prolonged Field Care

Col Shackelford presented a JTS performance improvement initiative to study how to optimize the performance of emergency craniectomy by general surgeons in forward, resource-limited medical treatment facilities (MTFs). This is critical due to that fact that neurosurgical assets are limited in combat theaters and optimal management of brain-injured casualties is unknown.

The retrospective cohort and survey studies evaluated the following to address the gap in knowledge:

- Mortality in brain-injured casualties following emergency craniectomy procedures performed by non-neurosurgeons vs. neurosurgeons
- Survey responses from deployed general surgeons regarding their experience with emergency neurosurgical procedures

The study was able to establish:

- Roughly equal survival after emergency craniectomy, even without definitive neurosurgical assets
- The importance of head CT scans
- The need to document and account for the elapsed time from injury occurrence in the analyses

Suggestions for increasing comfort level include:

- 112 (54.6%) respondents suggested more neurosurgical-focused training
- 41% suggesting neurosurgeon mentored cadaver labs

The team aims to use its findings to inform future studies, training and CPGs to achieve to improved emergency craniectomy by general surgeons in forward, resource-limited MTFs.

Team: Deborah J. del Junco, Ph.D.; COL Jennifer Gurney, US Army, MC; LTC Tyson Becker, US Army, MC; CPT Jordon Guice, US Army, MC; LCDR Obinna Ugochukwu

Shackelford also briefed MHRS attendees on the recently published CPGs for Prolonged Field Care. These CPGs are: Analgesia; Burn Care; Crush/Rhabdo; General Care ; TBI; and Wound Care.

Conversation Continues about the Effect of Prehospital Transport Time on Survival of US Military Casualties

Russ S. Kotwal, MD, MPH shares his team's findings with MHSRS attendees.

Russ S. Kotwal, MD, MPH, presented a retrospective descriptive analysis of battlefield data of 34,623 US military casualties (Iraq: Mar 19, 2003 to Aug 31, 2010). The Effect of Prehospital Transport Time, Injury Severity and Blood Transfusion on Survival of US Military Casualties in Iraq continues to explore how decreasing time between injury and receiving required medical capabilities can mitigate morbidity and mortality in critically injured combat casualties. A previous analysis of prehospital transport of US military casualties during the Afghanistan conflict depicted time and treatment capability as important factors for casualty survival on the battlefield.

Data from the Iraq conflict were analyzed by mortality outcome (KIA, DOW, CFR) and compared to the Afghanistan conflict. Detailed data for 1,693 casualties who underwent prehospital transport were analyzed according to whether they occurred in 60 minutes or less versus more than 60 minutes. Detailed data for those who underwent prehospital transport were analyzed for effects of transport time, injury severity, and blood transfusion on survival. Mortality and morbidity outcomes and treatment capability-related variables were compared.

Conclusion

- Fatality rates varied between Iraq and Afghanistan conflicts, which warrant additional attention and detailed analysis.
- As transport times were shorter and less variable in Iraq, the impact of time on survival was not as meaningful as that observed in Afghanistan.
- Regardless of conflict, early delivery of blood transfusion was associated with increased survival.
- Thus, timely treatment capability was paramount for casualty survival on the battlefield of Iraq as it was in Afghanistan.
- Leaders must continue to mandate and enforce prehospital documentation and data collection for performance improvement.

Team: Laura L. F. Scott, MPH, MS; Jud C. Janak, PhD1; Bruce W. Tarpey, BS; Jeffrey T. Howard, PhD; Edward L. Mazuchowski, MD, PhD; Zsolt T. Stockinger, MD

Military Preventable Death Project Addresses Recommendations for Zero Preventable Deaths

Judson C. Janak, PhD, JTS Epidemiologist

Judson C. Janak, PhD, JTS Epidemiologist, presented the issues surrounding the preventable death challenge combat casualty care providers face. Preventable death is any death that might have been prevented if optimal care had been delivered. The primary issue is the DoD does not have a standardized prospective fatal battle injury surveillance system with formal preventable death guidelines and standard operating procedures.

There are three implicit criteria for preventable death:

- The injury or sequelae of injury must be survivable.
- Care delivered must be judged sub-optimal.
- Identified errors in the delivery of care must be directly or indirectly implicated in the demise of the patient.

The team will systematically review adult civilian and military trauma-related preventable death studies to facilitate, inform and guide future qualitative and quantitative studies. The ultimate goal is to come up with medical and non medical opportunities to improve combat casualty care and prevent future deaths from occurring. JTS and Armed Forces Medical Examiner System are working together to develop guidelines and standardized approaches to determine if the death of a service member was potentially preventable. Previous inconsistent and disparate methodologies must be resolved and replaced with novel methodology that is valid, reproducible and relevant in the unique context of battlefield trauma. Going forward JTS will need to know what's important and what's not and how the process is going to work. The team will need to figure out what information the experts in order to come up with a reliable conclusion — standard reliable methodology.

JTS Director CAPT Stockinger said the project will occupy the JTS for the next several years. "It is a potential game changer," said Stockinger. "If you think about it, the information reported out of this process will change how a battlefield commander executes his mission the next time based upon issues encountered this time. That commander will be able to create future medical plans to avoid demonstrated problems or mitigate known shortfalls, to reduce casualties and improve their survival."

Team: Zsolt T. Stockinger, MD; Edward L. Mazuchowski, MD; Mary A. Spott, PhD; Stacy A. Shackelford, MD; Frank K. Butler, MD; Harold R. Montgomery, NREMT; Russ S. Kotwal, MD; Jennifer M. Gurney, MD; Louis N. Finelli, MD; David J. Smith, MD

Epidemiology & Trends of Injury Among US Military Female Service Members in the Iraq, Afghanistan Wars

COL Jennifer Gurney, JTS Trauma System Development Chief, shared research identifying injury trends among female service members (FSMs) in recent wars. FSMs comprise 15% of the active duty forces in the US military and are now able to deploy in direct combat roles. However, there has not been a robust attempt to comprehensively describe the epidemiology of US female military casualties and the related-risk factors that are associated with their death and injury patterns.

Objectives

- Draw attention to this fast-growing population and contemplate adversities they face in combat
- Distinguish the classification, mechanisms, and dominant types of physical injuries sustained by women deployed during Iraq and Afghanistan wars
- Recognize patterns in injuries and mortality for women deployed to combat zones.

The study concluded that overall, the reported number of injuries for females decreased over time. Although female injury incidence slightly decreased from 2003 to 2014, there was a sharp increase between 2012 and 2013, the year the ban prohibiting females in battle was lifted. Identifying and understanding the causes, patterns and trends of injuries in the FSMs may guide targeted safety protections which reduce a preventable combat trauma during war time.

Case Records of the Joint Trauma System Panel continues to draw a great crowd and favorable feedback from attendees. "Excellent with outstanding panel members."

(left) COL (Ret) John Oh, MD, Clinical Instructor, School of Medicine, University of Texas Health San Antonio; Col Stacy Shackleford, Director, JTS Trauma Care Delivery ; CAPT Craig Shepps, MD, FACS (USN). (right) COL Martin Schreiber, MD, FACS, Professor of Surgery, Oregon Health & Science University and COL Jennifer Gurney, Chief, JTS Trauma Systems Development.

JTS Moves Its Mission to Social Media

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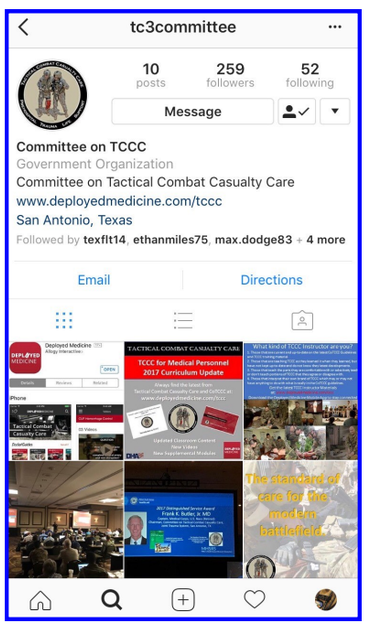

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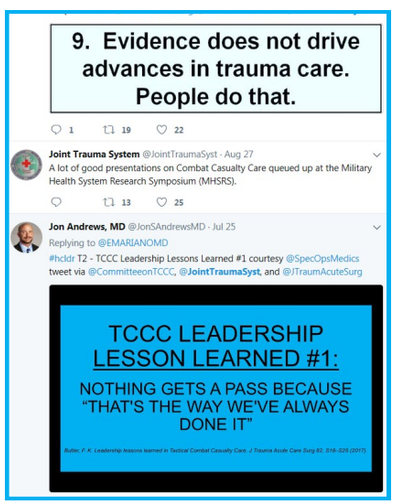

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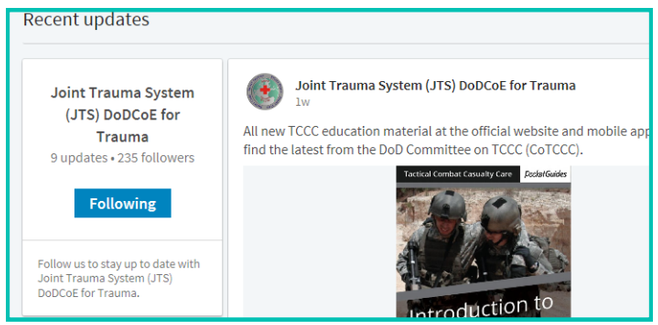

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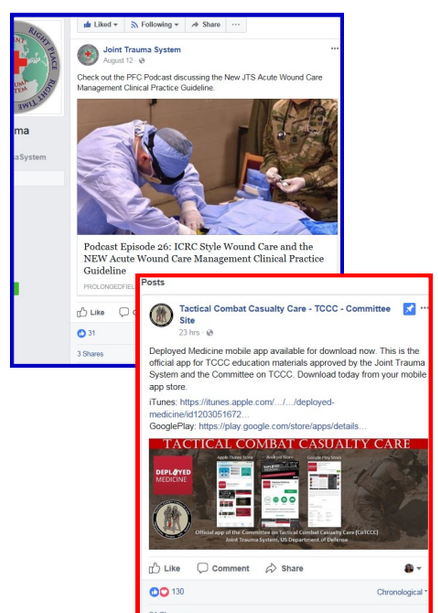

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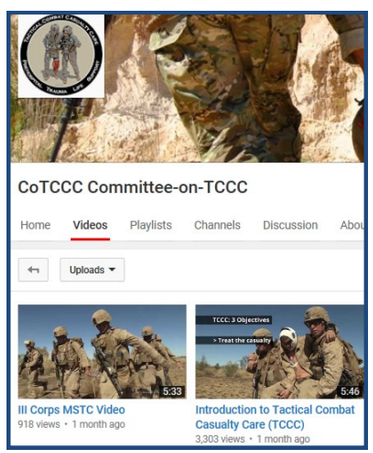
CoTCCC Committee-on-TCCC



CoTCCC Sets Goal to Optimize TCCC Training Military, Civilian Organizations

The following are excerpts from the September meeting of the Committee on Tactical Combat Casualty Care (CoTCCC)).

The recent 16 years of war in Afghanistan and Iraq have enabled the US Military to make remarkable advances in battlefield trauma care. Since the large majority of combat fatalities occur before the casualty ever reaches a medical treatment facility, the importance of prehospital care is paramount in reducing preventable deaths. TCCC has demonstrated great success in reducing preventable deaths and has become the standard for battlefield trauma care, both in the US Military and in the militaries of many allied nations.

In a moving presentation at the September meeting of the Committee on TCCC, US Army medic SSG Adam Hartswick described how his TCCC training saved his life when he was wounded by an improvised explosive device on a mission in Afghanistan in 2013. After this experience, in spite of the ongoing physical challenges from his wounds, he has now dedicated himself to training others in TCCC.

A 2013 letter from Secretary of Defense James Mattis to the Service Chiefs, written while he was the Commander of the US Central Command, highlights the importance of TCCC training. (Letter is shown at right.)

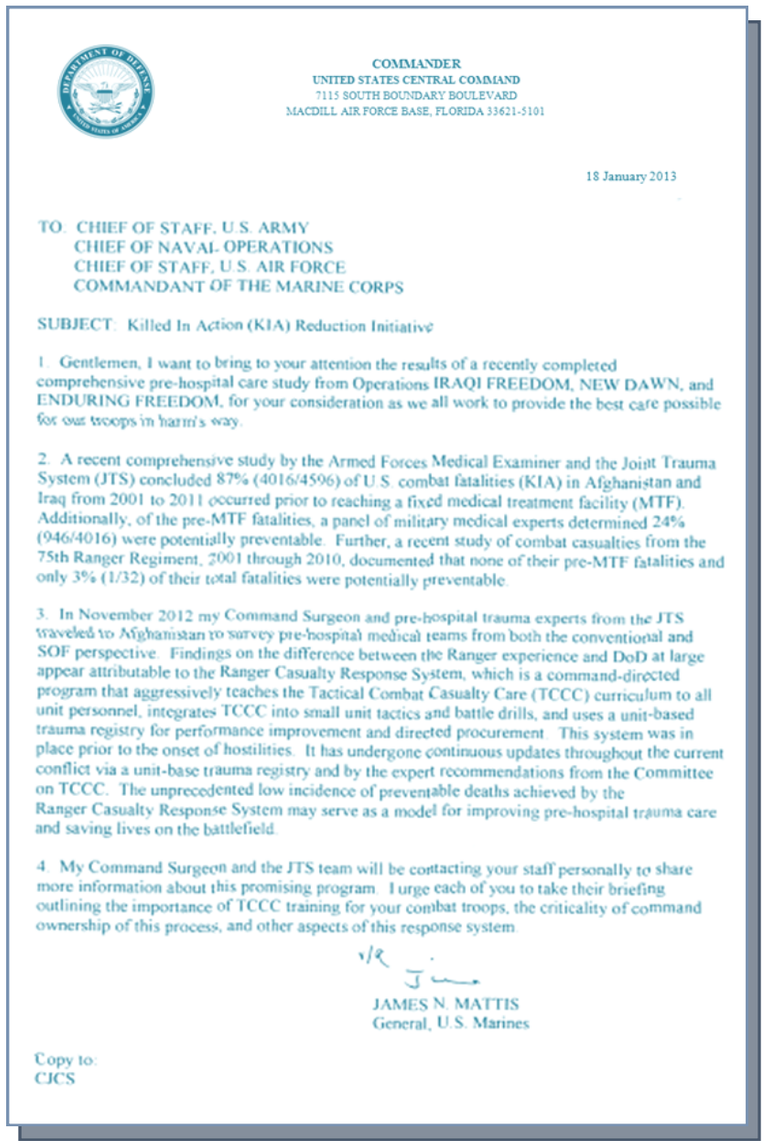
All of the US Armed Services have now endorsed TCCC concepts, but due to the divided authorities and distributed responsibilities in the DoD organizational structure, TCCC is still not being optimally trained or equipped in our combat forces. This training gap has been noted both in two recent surveys of prehospital trauma care in Afghanistan and in the Joint Trauma System's ongoing combat casualty care performance improvement process.

The need for better TCCC training was a major topic of discussion at the last CoTCCC meeting. Many courses that purport to train TCCC have been shown to contain incorrect messaging. This suboptimal training this has been directly responsible for adverse outcomes in our combat casualties. As recommended by the Director of the Joint Trauma System in a 2015 White Paper, TCCC training for medical personnel should be accomplished through the use of standardized, high-quality, internationally recognized TCCC-MP courses, such as those offered by the National Association of Emergency Medical Technicians (NAEMT).

There are adverse casualty outcomes as a result of incorrect messaging in training courses that were supposed to be teaching TCCC. TCCC has a 20-year strategic partnership with NAEMT, a civilian organization, which first began conducting TCCC training in 2009. As noted in his presentation, COL Jim Geracci, the former Army III Corps Command Surgeon, implemented the use of NAEMT TCCC-MP courses to train his command's physicians, Physician Assistants, and medics. Another perspective on the need for high-quality, standardized TCCC training was provided by CDR Carl Goforth when he was at the Marine Corps Combat Development Command.

Discussions are ongoing with the Uniformed Services University of the Health Sciences and the Defense Medical Readiness Training Institute and TCCC courses may be included in the course offerings of the Military Training Network in the near future.

Update provided by Frank K. Butler, MD, CAPT MC USN (Ret), Chairman, CoTCCC, and Chief, Prehospital Trauma Care, JTS.



COMMANDER
UNITED STATES CENTRAL COMMAND
7115 SOUTH BOUNDARY BOULEVARD
MACDILL AIR FORCE BASE, FLORIDA 33621-5101

18 January 2013

TO: CHIEF OF STAFF, U.S. ARMY
CHIEF OF NAVAL OPERATIONS
CHIEF OF STAFF, U.S. AIR FORCE
COMMANDANT OF THE MARINE CORPS

SUBJECT: Killed In Action (KIA) Reduction Initiative

1. Gentlemen, I want to bring to your attention the results of a recently completed comprehensive pre-hospital care study from Operations IRAQI FREEDOM, NEW DAWN, and ENDURING FREEDOM, for your consideration as we all work to provide the best care possible for our troops in harm's way.

2. A recent comprehensive study by the Armed Forces Medical Examiner and the Joint Trauma System (JTS) concluded 87% (4016/4596) of U.S. combat fatalities (KIA) in Afghanistan and Iraq from 2001 to 2011 occurred prior to reaching a fixed medical treatment facility (MTF). Additionally, of the pre-MTF fatalities, a panel of military medical experts determined 24% (946/4016) were potentially preventable. Further, a recent study of combat casualties from the 75th Ranger Regiment, 2001 through 2010, documented that none of their pre-MTF fatalities and only 3% (1/32) of their total fatalities were potentially preventable.

3. In November 2012 my Command Surgeon and pre-hospital trauma experts from the JTS traveled to Afghanistan to survey pre-hospital medical teams from both the conventional and SOF perspective. Findings on the difference between the Ranger experience and DoD at large appear attributable to the Ranger Casualty Response System, which is a command-directed program that aggressively teaches the Tactical Combat Casualty Care (TCCC) curriculum to all unit personnel, integrates TCCC into small unit tactics and battle drills, and uses a unit-based trauma registry for performance improvement and directed procurement. This system was in place prior to the onset of hostilities. It has undergone continuous updates throughout the current conflict via a unit-base trauma registry and by the expert recommendations from the Committee on TCCC. The unprecedented low incidence of preventable deaths achieved by the Ranger Casualty Response System may serve as a model for improving pre-hospital trauma care and saving lives on the battlefield.

4. My Command Surgeon and the JTS team will be contacting your staff personally to share more information about this promising program. I urge each of you to take their briefing outlining the importance of TCCC training for your combat troops, the criticality of command ownership of this process, and other aspects of this response system.

v/r

JAMES N. MATTIS
General, U.S. Marines

Copy to:
CJCS

Customer

Service

Make the customer the hero of your story.
~Ann Handley

By James Mason, IT Automation Branch Chief

I want to share with my thoughts on customer service. By the very nature of the service we provide to our colleagues, we are in the customer\professional service business. Often the duties and tasks we perform are not very glamorous; positive feedback, appreciation, or acknowledgement outside of our team or JTS leadership is minimal. However, what we do is crucial and vital to the success of JTS.

Nevertheless, without the needs from our JTS colleagues and internal and external partners, there is very little (if any) need for us. With that in mind, I want each of us to consider the following ways that we can enhance the experience of our colleagues when they work with us, and set a positive example for workplace interactions within the JTS.

Courtesy

Trust me when I say, I know first hand that there are people and times that try our patience. But at NO time is it okay to be discourteous when working with a customer. Likewise if a customer is not showing you the same level of courtesy, do not hesitate to let your manager. JTS does not entertain or tolerate discourteous colleagues in any way, shape, form or fashion.

Collaboration

We frequently collaborate on projects with other JTS Branches. Based upon their requirements or lack thereof, there is potential for documents to go back and forth, resulting in multiple iterations.

If you find yourself returning a document to a customer more than twice, you should consider involving a your manager to ensure you have answers to key questions and clarification. The goal is to reduce the back and forth without an agreement or clear direction and a well-defined path forward. Your time is very valuable; we want to keep projects moving forward and not get folks bogged down in documentation.

Quality and Attention to Detail

Just as our time is valuable, so is the time of our customers. We can reduce problems with collaborationby maintaining high standards of quality in our work products. A key component of quality is attention to detail, especially when following the customer's requirements. Frequent review and a final detailed check before sending the product (even if it's a draft) to the customer is essential to ensure that the product matches their requirements. Maintaining good communication with the customer can help. If questions about the requirements arise, be sure to discuss them with the customer as soon as possible, or raise the issue with me rather than send back a document that is incomplete. We need to maintain the high standards for quality for which we are known throughout JTS.

Respect

We work with internal and external customers at different levels of expertise, and at many different stages in their careers. As such, let's ensure we always remain respectful of others, even if their attitudes and opinions differ from ours. If at any time someone is disrespectful towards you, let your manager know.

Tone of Voice

Consider your tone of "voice" when speaking with our colleagues. I can't stress this enough especially when communicating over the phone or via an email. Something very simple can get blown WAY out of proportion simply because of perceptions conveyed not solely through the words expressed, but through the tone. Often times we might not recognize how critical our tone of "voice" is when communicating. If someone perceives our tone to be defensive, hostile, or dismissive of their concerns, we could easily go down the wrong path quickly. In those situations, getting back on track is more difficult, and the ability to address the issue or problem at hand is delayed or may even by severely compromised. I don't expect anyone to be overly passive. At the same time our tone should not be overly aggressive and should always be professional.

Communication

Tone is just one aspect of communication. Effective communication can help build strong and effective working relationships. The next page includes tips to help improve workplace communication. This is critical as our support for a more dynamic work environment increases.

Always give people more than they expect to get. ~ Nelson Boswell

Go beyond merely communicating to 'connecting' with people. – Jerry Bruckner

BUILD STRONG WORKING RELATIONSHIPS WITH EFFECTIVE COMMUNICATION

Effective communication strategies can help you build strong working relationships with team members, managers, and internal and external customers. Use the tips in the following list:

- Respond to requests by emphasizing what you can do to help meet them.
- Follow through and do what you say you'll do.
- Listen without passing judgment and don't rush in to give advice.
- When you have concerns, work them out with the source, not with others; if that doesn't work, ask leadership for help.
- Communicate with respect in every interaction regardless of whether you like the person.
- When others give you assistance or support, express appreciation for it.
- Focus on issues, not personalities, when you discuss work matters and problems.
- When differences in views or ideas occur, work first to understand them from the other person's perspective.
- Be direct and sincere as normal practices.
- Use humor in good taste.

Open, honest communication is the best foundation for any relationship, but remember that at the end of the day it's not what you say or what you do, but how you make people feel that matters the most. – Tony Hsieh

Don't find fault. Find a remedy. – Henry Ford

PITFALLS TO AVOID IN WORKPLACE COMMUNICATIONS

Effective communications includes choosing the proper method to communicate, the right time, and the relevant message. The pitfalls in the following list are ones to avoid:

- **Using e-mail to express concerns.** Instead, go to the source to work out problems in person.
- **Responding to requests by immediately saying it can't be done.** Instead, emphasize what you *can* do and *when* you can meet the request.
- **Saying yes when you really don't mean it.** Instead, express your concerns constructively and offer alternatives as to what you think will work better in the situation.
- **Sitting by quietly and passively when people discuss issues with you.** Instead, interact with the message you're hearing and provide verbal feedback to check your understanding of the message.
- **Dwelling on what's wrong or who's at fault when dealing with problem situations.** Instead, put your focus on working out solutions with others and on how to make the situation better.
- **Focusing on yourself — what you like and don't like — as you receive others' messages.** Instead, shift your focus from yourself to concentrating on your speaker's message and work to understand what that message means without passing judgment on it.

The most important thing in communication is hearing what isn't said. – Peter Drucker

Don't Kill the Messenger - Part 2

Back by popular demand: Random email pointers

⇒ Good email etiquette maintains that you do your best to respond to business communications as soon as possible. When you do not respond promptly, you come across as unorganized and unconcerned. Even if you are not able to attend to an email right away, writing a line back in acknowledgement that you have received it and will attend to it shows professionalism.

⇒ Include a subject line. I cannot stress this enough. This seems obvious, but blank subject lines are more common than you think. Use descriptive subject lines.

⇒ Use professional salutations.

⇒ Don't use laid-back, colloquial expressions like, "Hey you guys," "Yo" or "Hi folks."

⇒ Addressing a colleague by nickname is not a good idea since many professionals use their formal names in business communications. Same thing goes for shortening someone's name. Michael may prefer being called Michael over Mike.

⇒ Consider the relationship. Ask yourself: What's my relationship with the person I'm emailing?

⇒ Consider that people from different cultures speak and write differently. Some casual expressions may be misinterpreted, especially humorous phrases.

⇒ Be cautious with humor. Humor can easily get lost in translation without the right tone or facial expressions. In a professional exchange, it's better to leave humor out of emails unless you know the recipient well.

⇒ Limit the number of emails in a conversation thread between multiple parties. Start a new related "sidebar" conversation or summarize at the beginning of an email rather than referring everyone to the "below email." This will cut down on the confusion of following a rambling "upside down" discussion.

⇒ Nothing is confidential, so write accordingly.

⇒ Copy back salient points when replying to an earlier message to remind your correspondent about past relevant conversations about a matter.

⇒ It's difficult to reply to every email message ever sent to you, but you should try. This includes when the email was accidentally sent to you, especially if the sender is expecting a reply. A reply isn't necessary but serves as good manners, especially if this person works in the same company or industry as you.

⇒ Include a signature block...again. People rely upon them for phone numbers and titles, more than you think.

⇒ Avoid abbr. in biz email msgs. See how that works? It doesn't. Not professional looking.

⇒ Finally, most of us rely on email for business communications even though it may not be the best venue for a particular conversation. To determine the most effective mode to communicate your message, consider your audience and your goal. What do you want the other person to take away from the conversation? Are you sending an email to avoid a face-to-face conversation? If so, what's the cost of hiding behind the email?

ADOBE DC DIGITAL SIGNATURE FIX

If you encounter the above error message when digitally signing a PDF, then follow these directions. This error occurs when previous versions of certificates have not been removed from Windows.

1. Open Internet Explorer.
2. Open the Tools menu. Select Internet Options.
3. Choose the Content Tab and select Certificates. You will most likely see your three previous and possibly other users' certificates.
4. Remove the lower "CA" number certificates by selecting them and clicking Remove.
5. Close Internet Explorer.
6. Close any Adobe Acrobat documents.
7. Re-open the document you want to sign.

Warning: *Removing inactive certificates may result in older encrypted emails being inaccessible. Each encrypted email is tied to your active certificate at the time the email was received. Two options, do not remove all the old inactive signatures or if the email is important enough to save for an extended time convert it to pdf and move file in an appropriate folder. (Verify the attachments are available in the pdf. It may be necessary to copy them from the original email and place as separate files along with the PDF.)*

Hails & Farewells

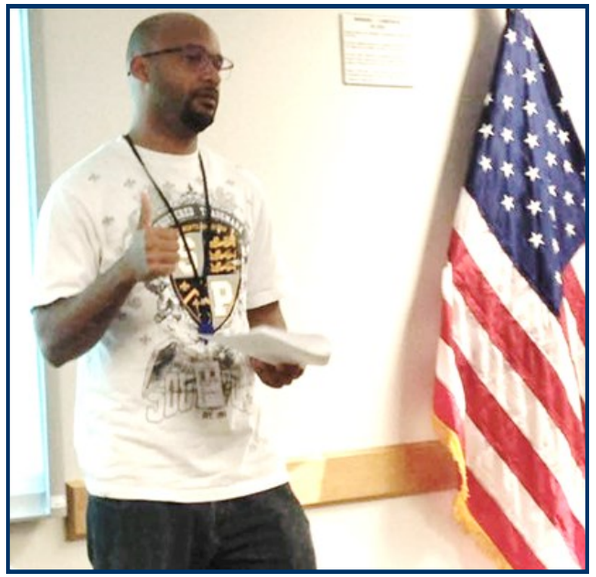
Welcome Newcomers

Jennifer Abilez	Health Information Management Coder (MOTR)	Jun 5
Elizabeth Lute	Trauma Nurse Abstractor (MOTR)	Jul 10
Julie Cutright	Clinical Nurse Abstractor (TBI) from MOTR	Sep 25
Trevor Maness	ORISE Fellow	Sep 11
Kamilah Buie	Health Information Management Special (TBI)	Sep 25
Leslie DuBois	Lead Trauma Registry Clinical Data Specialist (TBI) from DAB	Sep 25
Christian Magby	Trauma Registry Clinical Data Specialist (TBI)	Oct 2
Yvonne Olivarez	Health Information Management Specialist (TBI)	Oct 2
Derrick Kelly	IT Quality Assurance Engineer (TBI)	Oct 2
Darin Schwartz	Educational Branch Chief	Oct 16

Farewell & Best Wishes

Gerardo Pacheco	ORISE Fellow	Resigned Sept
Meredith Peiffer	Clinical Nurse Abstractor (MOTR)	Resigned Aug
Marc Ang-Abrigo	Nurse Analyst (MOTR)	Resigned Oct

Dustin Kinzinger, Clinical Nurse Abstractor, the 2Q Pacesetter receiving his certificate from JTS Director CAPT Stockinger (left).



At the last staff meeting, Christopher Wells, JTS IT support, discussed the requirements of telecommuting and what it takes to be a productive teleworker.

About The Joint Trauma System

Mission: Optimizing Combat Casualty Care

The Joint Trauma System (JTS) is the DoD Center of Excellence for Trauma. The JTS mission is to provide evidence-based process improvement of trauma and combat casualty care, to drive morbidity and mortality to the lowest possible levels, and to provide evidence-based recommendations on trauma care and trauma systems across the Department of Defense. JTS captures and reports battlefield injury demographics, treatments and outcomes using the DoD Trauma Registry (DoDTR), formerly known as the Joint Theater Trauma Registry. DoDTR captures trauma data from battlefield first responders to definitive care stateside, plus en route care for military and civilian personnel treated in US military facilities in wartime and peace-time.

The JTS vision is that every Soldier, Sailor, Airman and Marine injured on the battlefield or in any theater of operations will be provided with the optimum chance for survival and maximum potential for functional recovery.

Website: http://www.usaisr.amedd.army.mil/10_jts.html

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