



THE JUNIOR OFFICER CHRONICLES

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THE OFFICIAL JOAG MAGAZINE
DESIGNED FOR JUNIOR OFFICERS
BY JUNIOR OFFICERS



FROM the FRONTLINES

FEATURES

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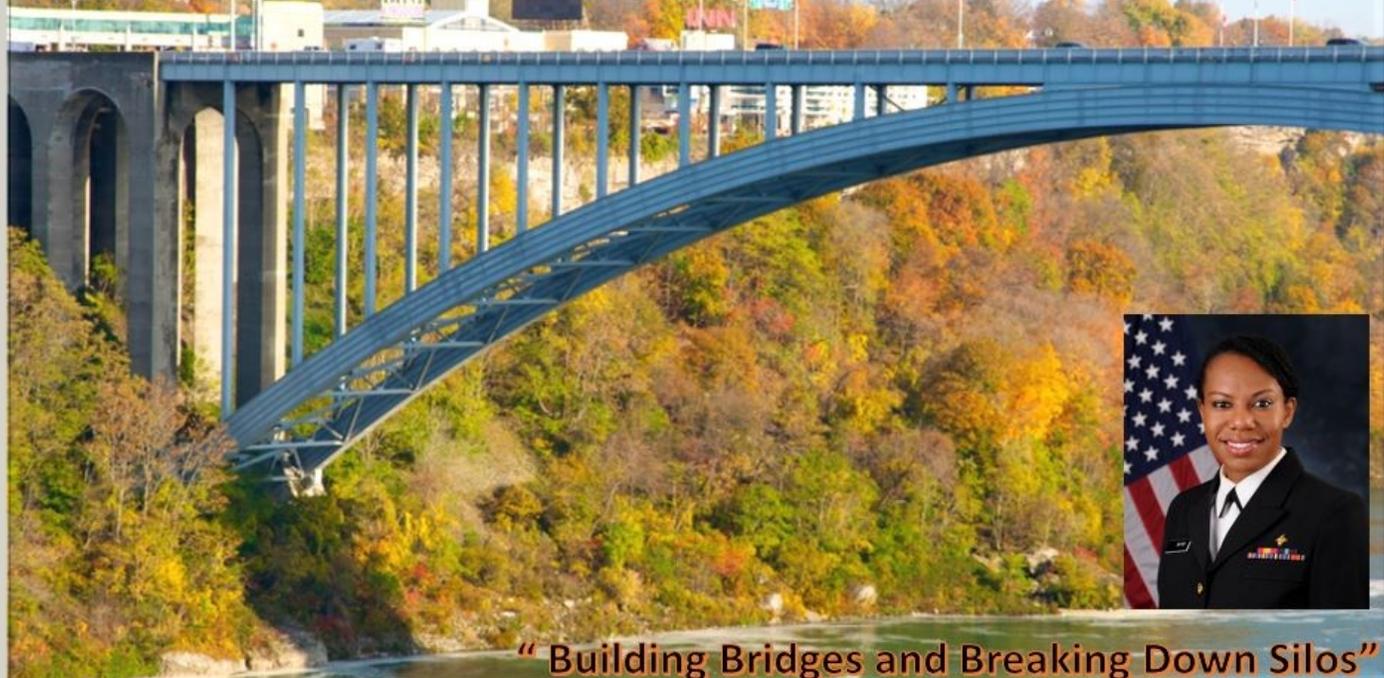
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JUNIOR OFFICER DIRECT

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- ◆ *The Junior Officer Advisory Group (JOAG) is a public health professional group whose purpose is to provide advice to other Corps and non-Corps entities on interests and concerns specific to junior officers in the United States Public Health Service (USPHS) Commissioned Corps.*
- ◆ *The Junior Officer Chronicles (JOC) is a quarterly publication produced by the JOAG Communications & Publications Committee (CPC) JOC Subcommittee. The 2017-2018 JOC Co-Leads are: LCDR Beth Wittry and LT Roseline Boateng. The CPC Co-Chairs are: LCDR Christine Corser and LCDR Beth Osterink and the Executive Committee (EC) Liaison is LCDR Mekeshia Bates.*
- ◆ *Send editorial comments and concerns to [LCDR Beth Wittry and LT Roseline Boateng](#).*
- ◆ *To contribute to a future edition, submit articles to [LCDR Beth Wittry and LT Roseline Boateng](#).*
- ◆ *Any opinions or thoughts presented in The Junior Officer Chronicles are solely those of the author and do not represent the USPHS, United States Department of Health and Human Services (HHS), or any other government agency.*

MESSAGE FROM THE CHAIR



Greetings Fellow Junior Officers,

Welcome to the Summer/Fall Issue of the Junior Officer Chronicles! On October 1, 2017, the new JOAG 2017-2018 operational year began and with that, the beginning of my term as JOAG Chair. It is with great delight that I have the opportunity to introduce myself to all of you and to let you know that I am sincerely honored to serve as your JOAG Chair. Currently, I am in my second term as a JOAG voting member. Last operational year, I served as the JOAG Chair-Elect and JOAG Policy and Procedures Committee Chair. Prior to those positions, I was Co-Chair of the Outreach Committee. I am a Nurse Officer stationed at the Health Resources and Services Administration, Bureau of Primary Health Care, Office of Quality Improvement in Rockville, MD. More specifically, I am a psychiatric nurse practitioner who enjoys working in continuous quality improvement and research.



As the JOAG Chair, I have the great pleasure of working with outstanding officers. The JOAG leadership is listed in the organizational chart found on page 18 and all of the voting members' and liaisons' contact information and biographies can be found on our website on the [JOAG Membership Roster page](#). However, I am compelled to share with you just a brief glimpse of the makeup of the 2017-2018 Voting Members. Voting membership consists of 21 junior officers representing all 11 categories and 10 different OPDIVs (BOP, CDC, DCCPR, EPA, FDA, HHS/ASPR, HRSA, IHS, USCG, and USDA). Additionally, officers are located in 9 different states (AK, AL, DC, GA, KY, MD, OK, MN, PA).



VADM Jerome M. Adams, 20th Surgeon General of the United States, shakes hands with LCDR Mekeshia Bates, 2017-2018 JOAG Chair.

With such diverse representation, JOAG provides junior officers with opportunities for networking, skillset enhancement, and leadership. For these reasons, this operational year is themed **“Building Bridges and Breaking Down Silos”**.

Our three main priorities for this year are:

- ◆ **Quality Assurance:** Reviewing all JOAG deliverables to ensure that they align with the Surgeon General’s priorities, are a value-add to junior officers, and that there are no duplication of efforts.
 - ◆ **Partnerships:** Effectively utilizing the JOAG Liaisons and working with the PAC Chairs and other PHS Chartered Groups’ Leadership to strengthen partnerships.
 - ◆ **Communication:** Improving communication within JOAG and with external partners.
- JOAG will be introducing its new yearly Operational Plan to ensure that these priorities and goals established by the committee co-chairs are met.

A vital part of the success of JOAG is the dedicated volunteers that work so very diligently. I encourage all junior officers to join a committee and become an active member in JOAG. We recognize the vast amount of experience and skills in our fellow junior officers and want to provide an opportunity for those talents to be shared and showcased.

I extend a heartfelt thank you to all of our previous members and once again welcome you all to this new operational year. I look forward to us **“Building Bridges and Breaking Down Silos”** together!

Respectfully,
LCDR Mekeshia Bates

The Road to 50 Miles

*Submitted by Officer Health & Fitness
Promotion Subcommittee*

Interviewee: LCDR Kenneth Chen

How/when did you get started running?

I started running short distances during high school. My motivation at the time was to meet physical fitness requirements for the service academies. I ended up receiving a four-year Army ROTC scholarship to Rutgers University and that was when I started running longer distances, and ran with the Army Ten Miler Team.

How many 5ks, 10ks, half marathons, and full marathons have you completed?

Tough question. If I had to guess, I've ran in approximately thirty 5ks, ten 10ks, around thirty-five half marathons, and exactly one full marathon over the course of 17 years.

Why did you decide to do a 50 mile race?

I first heard about the JFK 50 Miler when I moved to the state of Maryland. Before I thought, "Who would be crazy enough to run ultra distances?" Until last year, when a buddy of mine got me to run an 8-hour trail ultra, the Rick's Ultra Challenge in Greenbrier State Park, where I completed 6 of the 8 hours. The course was 5.22 miles (red trail) and you had to complete as many laps as you could within 8 hours.



LCDR Kenneth Chen (pictured above) running a race

There was only one aid station located at the start/finish line. After each lap, I stopped, chilled out, and grabbed a snack like boiled potatoes, gels, and sports drinks. Into my fifth lap, I started to get leg cramps so rather than pushing through it I decided to quit. After that race, I was hooked and wanted to push myself further. I was feeling strong (probably delusional as well) and told myself this was the year I'm going to run the JFK race.

FITNESS CORNER

The Road to 50 Miles (Cont.)

What is your training like during the week?

A normal week consists of strength/core training 2x a week. I am currently building base miles before the start of my 50 miler plan. I am running 5x a week and currently averaging 45 miles a week. I started to dabble a bit with barefoot running. I've added about 10-15 minutes barefoot sessions 3x a week after a regular running session. It's helped with correcting some form and cadence issues. Also, I'm on the foam roller a few times a week, which is helping me stay injury free.

What have been some struggles/obstacles you have encountered?

Injury prevention and time. Cross training is helping with injury prevention. Allocating time was difficult at first, I did not want to spend a half day on the trail and miss family time. I've started to wake up super early to hit the trails and finish up when my family is just waking up. That's worked out very well so far and my family has been super supportive, so that's helping me mentally.

What is your motivation and expectations for your upcoming 50 miler?

My number one motivation is maintaining a healthy lifestyle and challenging my body to go further and to finish.

Do you have any tips for someone who is interested in running longer distances?

My go to advice is work on form and cadence before diving into longer distances. You might have to set your pride aside while you work on these things, but the long term benefits are totally worth it.

What's next? 50 miles seems like a great accomplishment, are you planning for anything beyond?

Right now I'm too focused on training for 50 miles so I haven't thought of anything beyond that.

Share your fitness routine or secret to staying healthy!



LEADERSHIP & LESSONS

Officership & Perspective

Submitted by LCDR Daveta Bailey

Did you know that as junior officers you are the primary candidates for future leadership? You are a ripe and ready workforce that will be tapped to lead your agencies in the future. How you perform now will shape what type of leader you become.

Officership can be defined in several ways. There is no right or wrong way but for the purpose of this article we will pull from West Point Military Academy's description and substitute the words Army with PHS. Just to give you an idea of where to start.

Officership is the practice of being a PHS Officer. Commissioned Corps officers are leaders in the public health profession and are inspired by a unique professional identity. This identity is not only shaped by what PHS Officers KNOW and DO, but most importantly, by a deeply held personal understanding and acceptance of what it means to BE a PHS Uniformed Service Officer.

We learn a lot regarding officership at OBC, OMC, and other "Leadership Circles" currently available to officers at all agencies and levels. As our opportunities evolve, you must understand and reinforce that each individual wearing the uniform has some personal responsibility in creating a perspective for

a "Great Officer and an even better Uniform Service Leader."

Here are four principles of officership adapted from West Point's "Building a Capacity to Lead" that may help you shape and reinforce a positive perspective for **SERVICE**:

Physical Fitness – There have been major changes regarding basic readiness on the physical fitness and weight standards measurements recently. The guiding principle is this: Officers should maintain a physical capacity that allows them to meet and exceed all physical and mental demands associated with performing their daily public health duties and when called to perform emergency response deployment operations.

Character – It is important for officers to lead by example in all aspects. By displaying "true" character, you will earn the trust and influence of your superiors, stakeholders, colleagues, and public/professional networks.

Intellectual Capability – You must be in the habit of continual learning so that you are able to adapt and maneuver in the dynamic world of public health. This builds perspective, flexibility, and the willingness to generate solutions and innovate best practices facing our public health platforms today.

Service – You provide a service that society cannot provide for itself. When you take the Oath of Service, you are establishing a moral obligation to serve effectively, selflessly, and with an unwavering commitment to duty, honor, and integrity. When someone says "Thank you for your service" be sure you earned it day in and day out!

Reference: Building Capacity to Lead (<https://www.usma.edu/strategic/SiteAssets/SitePages/Home/building%20the%20capacity%20to%20lead.pdf>)

RECRUITMENT & RETENTION

READY RESERVE PROGRAM

Overview of the 2016 JOAG Ready Reserve Survey

Submitted by LCDR Matthew Deptola, LCDR Lauren Moulder and LCDR Richard Bashay III

The Affordable Care Act of 2010 assimilated PHS officers serving on active duty in the Reserve Corps into the Regular Corps. The Reserve Corps was subsequently replaced by the Ready Reserve. (RR). The RR was intended as a mechanism for the Surgeon General to call additional personnel to active duty on short notice to assist regular Commissioned Corps (CC) personnel to meet both routine public health (e.g., training) and emergency response missions. The RR has been a source of confusion and frustration for many officers called to active duty in the Centers for Disease Control and Prevention's Epidemic Intelligence Service (EIS) and pharmacy residency training programs, as it required the creation of new policy and procedures to maintain parity with other uniformed services and adhere to the drafted legislation.

The JOAG Recruitment & Retention Committee's Retention Subcommittee administered a survey in June 2016 to officers set to complete a pharmacy residency or an EIS training program. The objective of the project was to identify retention trends and concerns when transferring from the RR to Regular Corps. The data gathered may be useful in improving retention of these PHS officers while under the scope of the RR.

Between the two different training cohorts, we received a combined 21 responses out of 47 surveyed officers. Based on the results, 90% of the respondents re-applied with the Regular Corps. This survey also identified areas of concern related to communication and the re-application process. Almost 67% of the respondents surveyed were not satisfied with how the reapplication process was communicated. The vast majority of respondents (85%) felt that they would have benefited from hav-

ing a liaison or representative from the Division of CC Personnel and Readiness (DCCPR) guide them through the process of re-applying to the Regular Corps.

It is important to avoid interpreting an officer's intention to remain in the CC as an indicator of satisfaction with one's career. An officer may feel obligated for various reasons to remain on active duty despite being dissatisfied with multiple aspects of their PHS experience. Therefore, the findings from this survey should be used not only as a tool to improve retention of our officers, but also as a way to enhance career satisfaction for those initially entering through the RR. Improving career satisfaction will likely improve retention as well as recruitment of new officers. Given the limitations in any survey, the findings from our analysis should be combined with additional information from other sources to identify key areas of intervention where actions can be taken to improve the likelihood of RR officers transitioning into the Regular Corps.

One of the primary goals of this project was to disseminate information about the RR to PHS organizations so that there could be a better understanding behind its development and current processes. The survey results and JOAG's analysis was shared with the Deputy Surgeon General for further discussion with DCCPR and the PHS Chief Pharmacy Officer (CPO). The RR has the potential to be a great training experience that prepares officers for a career in the Regular Corps; however, this requires careful implementation and clear communication (i.e., control over the factors that we can control). Personnel Operations Memorandum (POM) 14-002 entitled *Transition from RR Corps to Regular Corps* was made available in June 2016. It was a step in the correct direction, but the Office of the Surgeon General (OSG) could benefit from more resources to support candidates who will go through the RR process. Future improvements have the potential to positively impact retention and increase the probability that officers from these training programs remain with the PHS. JOAG's full RR survey analysis can be found on Max.gov at <https://community.max.gov/pages/viewpage.action?pageId=1283490049>.

History of the USPHS Service Khaki

Submitted by LCDR Courtney Drevo

The service khaki is one of the most common working uniforms worn by the United States Public Health Service Commissioned Corps in day-to-day wear. The wearing of a khaki uniform can trace its origins to British Lieutenant Harry Lumsden and his "Corps of Guides," an infantry and cavalry regiment serving in Peshawar India around 1845. In order to develop a uniform that was comfortable in the heat and less conspicuous than their red or white uniforms, Lieutenant Lumsden experimented with various garments and dyes for his Corps. A muddy tan color, similar to local men's attire, was desired to hide dirt and blend in with the landscape. Locals called the uniforms *khaki*, from the Hindi and Urdu word *khak*,



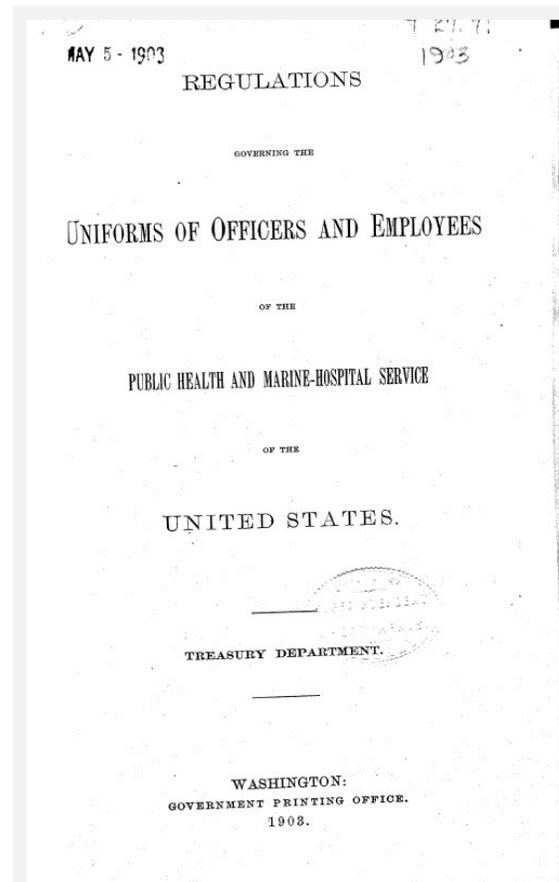
Photo 1. 2nd Battalion "The Queen's Own Corps of Guides" 1879, Peshawa, India.

meaning dust. Fellow British soldiers dubbed the Corps "mudlarks" because of their muddy color.

Lieutenant Lumsden dipped the material in mud to achieve the characteristic khaki color. While British soldiers initially scoffed at the uniform, the khaki's caught on and soldiers began to utilize mud, coffee and curry powder to soak and stain them the same khaki color, and thus the khaki uniform was born.

The debut of khaki's in the U.S. Navy can be traced to 1912, when they were first worn by naval aviators. The uniform was later adopted for use aboard submarines in 1931, and approved for on-station wear by senior officers in 1941. Chiefs and officers were authorized to wear khakis ashore on liberty soon after Pearl Harbor when white uniforms made

Figure 1. Original regulations describing wear of khaki uniform.



Uniform Corner Continued

officers conspicuous to the enemy.

For the Commissioned Corps, the khaki uniform indeed pre-dated that of the U.S. Navy and was authorized in Department Circular 45, dated May 1, 1902. The prescribed uniform authorized wear of a single breasted jacket with metal grade insignia, khaki trousers, and tan/brown shoes. The original khaki uniform was phased out and replaced in World War I by the “doughboy” olive drab uniform and was re-authorized prior to World War II modelling the Navy Service Dress Khaki uniform.

The modern day service khaki is made of 100 percent polyester Certified Navy Twill or 75/25 poly/wool. Both materials are approved for wear, but remember that the material must match between the shirt and slacks/skirt! Ladies, the color of your handbags must match the color of your shoes.

More info on khaki uniforms!

Following inquiries from fellow officers at the USPHS Scientific and Training Symposium JOAG Uniform Inspection Booth, here is more detail on the recently approved khaki over-blouse – thanks for your suggestions for topics! On April 29, 2014, the khaki over-blouse shirt was authorized for female officers in [Personnel Policy Memorandum 14-002](#). The over-blouse is also referred to as the untucked blouse or princess cut blouse. The over-blouse differs from the shirt as it is untucked and has no breast pockets making the proper placement of the name tag and ribbons more difficult. Proper wear of the over-blouse includes the following:

- ◆ All buttons must be buttoned;
- ◆ Shirt tails must not be visible when wearing the sweater, cardigan, or windbreaker;
- ◆ The name tag and ribbons should be centered between sleeve and button edge of the blouse (gig line); and
- ◆ The bottom of the name tag and ribbon bar should line up with the bottom of the first button.



Figure 2. Proper alignment for the khaki over-blouse.

Brown shoes approved for wear with service khakis are optional and were originally approved as tan leather in 1913 by the U.S. Navy. In 1922, the color changed to russet brown, which is the current color authorized for wear. Black shoes are also approved for wear with service khakis. For additional information on wear of shoes see the With Pride and Distinction article: https://dcp.psc.gov/osg/JOAG/documents/WPD_Vol8.pdf

For full details of the wear of male and female service khakis, see the following instructions from the Commissioned Corps Issuance System:

- ◆ Male: https://dcp.psc.gov/ccmis/ccis/documents/CC421_01.pdf
- ◆ Female: https://dcp.psc.gov/ccmis/ccis/documents/cc421_02.pdf

Picture Reference:

- ◆ <https://ccmis.psc.gov/Jarmanator/scientist/documents/2014-uniform-policy-updates.pdf>
- ◆ http://www.queensroyalsurreys.org.uk/time_line/khaki/khaki.shtml

Information Reference:

- ◆ <http://www.neatorama.com/2012/08/27/Khakis-A-Heat-Stroke-of-Genius/>
- ◆ CC Bulletin, Volume III, No. 11, September 5, 2007

POINT OF IMPACT

REPORT FROM THE RANKS

Suicide Prevention: Post Deployment

Submitted by
LCDR H. Voss

As officers of the United States Public Health Service Commissioned Corps, we take an oath to provide and support healthcare where needed at any given time. We are committed to a rotation of call for deployment on a bi-yearly basis, and as needed. We all have knowledge of when we are on call per our roster; however, we do not know what national, regional, or local state of emergency or support situation that we will be called

to support. Many of us have deployed to support public events with large crowds, national security events in Washington, DC, regional crises threatening the health of a small town, or supporting medical and mental health needs for those on Native American Reservations. The unknown is what can really affect an officer. Upon return from, what seemed to be an uneventful mission, officers may experience unexpected mental health effects. Officers often don't recognize the effect of deployment until they return to their normal routine. Mental health risks most often occur when stressors have

exceeded one's current coping abilities. Mental health risks, like depression, are the most common condition associated with suicide risk, and it is often undiagnosed or untreated. Conditions like depression, anxiety and substance problems, especially when unaddressed, increase risk for suicide. It is important to recognize risk factors that may occur post deployment.

For help, please call the National Suicide Prevention Lifeline:

1-800-273-TALK (8255)

Warning Signs Associated with Risk of Suicide

TALKS ABOUT...	BEHAVIOR	MOOD
◆ Being a burden to others	◆ Increased use of alcohol or prescriptions	◆ Depression
◆ Feeling trapped	◆ Acting recklessly	◆ Loss of interest
◆ Experiencing unbearable pain	◆ Withdrawing from activities	◆ Rage
◆ Having no reason to live	◆ Isolating from family and friends	◆ Irritability
◆ Killing themselves	◆ Sleeping too much or too little	◆ Humiliation
	◆ Giving away prized possessions	◆ Anxiety
	◆ Aggression	

POINT OF IMPACT

REPORT FROM THE RANKS

Remote Area Medical and the Corps: A Meaningful Partnership

*Contributed by LCDR Song Lavalais
Reviewed/Edited by CAPT Brandon Taylor*

Within the last year, a Memorandum of Understanding was formed between Remote Area Medical (RAM) and the Corps. RAM is a non-profit organization that sets up mobile clinics around the country to provide free, high quality healthcare to people in impoverished communities. Corps officers staffed most of the medical and dental clinic for

the RAM Oklahoma 2017 event that took place August 5th and 6th in Idabel, OK. In 2 days, 339 volunteers, which included 101 officers, served a total of 579 patients and provided \$249,762 in healthcare services.

For junior officers, RAM events provide a training opportunity to learn essential deployment skills, practice team camaraderie, and serve those in need. During the mission, the Incident Command System is employed to communicate within the team and coordinate operations with other agencies present. Officers are teamed up with their Section Leads, who serve as their first line in the chain of command. Accountability checks are conducted on a daily basis, which emulates the expectations of the



Inter-agency team, consisting of USPHS RDF-4 and Tier-3 augmentees, Remote Area Medical, and local charitable organizations, worked together to provide health care to the underserved population in Southeastern Oklahoma.

Continued on Page 13

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REPORT FROM THE RANKS

RAM continued

Office of the Assistant Secretary for Preparedness and Response to account for every officer on each shift during deployment. Billeting in a community style and eating every meal together, officers have numerous networking and team building opportunities. Whether sleeping on the hard floor of a high school gym or waiting in a long line for a shower at the end of a strenuous day, each challenge opens a door for building character and developing resilience. RAM targets communities that are underserved and these patients cannot afford to go see a healthcare provider. Without RAM and their efforts, they would never receive dental care or a new pair of glasses. When an officer witnesses patients lined up outside in the cold starting at midnight to be able to obtain a number to receive basic healthcare, it reinforces the reason why he or she joined the Corps. The mission of RAM to provide free quality healthcare to those in need align with the Corps' mission to protect, promote, and advance the health and safety of the nation.

Even if an officer is not in the dental or optometry category, there are many opportunities to serve in other areas. Officers are needed in Administration to arrange transportation and maintain team accountability, Planning to help prepare for the event and obtain important clinic data, and Logistics to manage resources. RAM staff members train officers to work as dental assistants, opticians, optometric technicians, and sterile processing technicians. At RAM Oklahoma this year, officers served new roles of educating patients about their medications, helping to conduct Hepatitis C screening, and working the Shoe Pantry to provide gently used shoes for adults and children. RAM events allow officers to put their deployment skills to practice and better prepare for future, longer deployments. Officer participation is highly encouraged because without the support of the Corps, who make up a notable portion of the clinicians, this great act of humanity and kindness would not take place.

Junior Officer Spotlight

Do you know of a deserving officer?

Do you know a junior officer that has a unique duty station? Is the officer a super star at work? Do they work tirelessly to support community endeavors, or just have a story to tell? We want to hear from you! Submit the officer's name and a short (50 words or less) narrative on why you think this officer's story should be shared. Submissions should be sent to: [LCDR Beth Wittry and LT Roseline Boateng](#). All submissions will be reviewed and one junior officer will be selected and showcased in the Winter 2018 Edition of the JOC.

POINT OF IMPACT

REPORT FROM THE RANKS

Seeking Trauma Certification? An Overview of Advanced Trauma Life Support

*Submitted by Kelly M. Fath, MSN, FNP-BC
IHS-TON, Tucson, AZ*

The Advanced Trauma Life Support (ATLS) Course was developed in 1980 as a collaborative effort between the American College of Surgeons (ACS) and the ACS Committee on Trauma. The first ATLS class was established in the United States in 1978 by an orthopedic surgeon from Nebraska who was involved in treating his family for injuries following a horrific plane crash in 1976. In collaboration with fellow orthopedic and trauma surgeons and emergency providers, the ATLS course was developed with national acceptance by the ACS Committee on Trauma.

The overall goal is to improve the quality of emergency care of surgical-trauma patients by conducting a rapid assessment and performing emergent procedures in an efficient, concise, and systematic approach. The “golden hour” or “window of opportunity” occurring after injury, is the time-frame when trauma patients are considered most vulnerable, where emergency life-saving treatments are most needed, and when these treatments can effectively reduce the morbidity and mortality associated with the injury. It is also the period of time when ATLS modalities can most improve outcomes that are highly beneficial and life-sustaining to the injured patient.

Today, this same course is taught in 63 countries; with contributing authors from Canada, Beirut, Netherlands, Hong Kong, Pakistan, and South Af-

rica. The course content encompasses information and advanced clinical skills that are universal and can be performed in a variety of clinical settings, from rural to pre-hospital to the trauma room.

The intense 2-day course includes lectures, skill demonstrations, diagnostic interpretation, and practicum skill stations managed by ATLS instructors. The students mostly consist of physicians, surgical residents, and trauma surgeons. Advanced pre-hospital providers (EMT’s, Paramedics, Flight medics) and nurses can audit the lectures and participate in the practice skill stations; however, since they are not granted a certification, these individuals are not included in testing stations nor the written test.

The ATLS outline includes two full-days of both lecture and practicum in the following topics: Initial Assessment, Airway-Ventilation Management, Shock, Thoracic/Abdominal/Musculoskeletal/Head/Spinal Cord Injuries and Trauma, Thermal Injuries, Pediatric/Geriatric Trauma, Pregnancy-Intimate Partner Violence, Transfer to Definitive Care, and Case Studies. The last day of the course, Day-3, consists of a written exam composed of 50-questions and rotating skill stations (in each category). In order to receive the certification, the exam must be passed with a score above 80%.

I enrolled in ATLS in 2014 at the university hospital in my hometown of Pittsburgh, Pennsylvania. With a passion for emergency and trauma, I had planned to audit the course in order to gain new skills and reinforce previous knowledge. I also believed this course could assist me in my role as a mid-level provider on deployments with the USPHS. To my surprise, the day before the course, I was informed by the program lead that, I too, would be sitting for the test and skill stations

POINT OF IMPACT

REPORT FROM THE RANKS

Integrating Mental Health Care into HIV Treatment Platforms: A Global Perspective

Submitted by LT Colin Smith, MD
Indian Health Service

One of my clinical and research interests as a resident in both Internal Medicine and Psychiatry at Duke University Medical Center, under the aegis of the Indian Health Service (IHS), includes integrating mental health services into HIV/AIDS treatment platforms in underserved groups. The evidence for integrating care in HIV is compelling considering that, globally, about 37 million people are currently infected.¹ Moreover, persons living with HIV are two to seven times more likely to develop major depressive disorder compared to the general population, resulting in increased disease progression, poor antiretroviral (ART) adherence and substantial economic burden. This is especially true in vulnerable populations, such as in sub-Saharan Africa, which is home to two-thirds of the world's cases of HIV/AIDS.²⁻⁴

In the spring of 2016, as a fourth-year medical student at the Uniformed Services University of the Health Sciences (USU), I was temporarily assigned to United States Agency for International Development (USAID) and sent directly by USU to Uganda in support of the President's Emergency Plan for AIDS Relief (PEPFAR) activities.

Since 2003, PEPFAR has worked in over 60 countries, providing over 11.5 million people with ART treatment, averting nearly 2 million mother-to-child HIV transmissions.⁵ There is now an effort underway to mitigate comorbid non-communicable dis-

eases, such as depression, in persons living with HIV in the form of the PEPFAR non-communicable disease project.⁶

At USAID, I worked in the Office of HIV/AIDS with partners in Uganda to develop a framework for implementing the World Health Organization's 2015 ART guidelines, recommending screening, and treating depression in all patients living with HIV. I was introduced to concepts such as community engagement, task shifting, and scaling up. I also attended the U.S. PEPFAR annual meeting, where I had the opportunity to hear Ambassador Birx, the U.S. Global AIDS Coordinator, deliver the annual address, emphasizing a commitment to the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 targets (i.e., 90% of people living with HIV tested and 90% of people tested accessing ART therapy).

In Uganda, I worked in the infectious disease ward of Mulago National Referral Hospital, assisting local healthcare personnel in delivering care to patients with HIV, tuberculosis, brucellosis, tetanus, schistosomiasis, and other infections. I also traveled to Kayunga, a rural site, and one of four implementing partners of the Makerere University Walter Reed Project, to provide medical and mental health services.⁷ Wards were often filled with patients on small cots, with family sleeping on the floor alongside their loved ones. Supplies were generally scant, and each decision was balanced with cost and availability of treatment. Patients were grateful for the care they were receiving, even during times of devastating illness. Local providers were skilled in their use of physical exam techniques relegated only to textbooks in the United States, and were necessarily resourceful. A humbling experience, for sure.

I also assisted in a clinical research project implementing group psychotherapy into existing treatment programs for people living with HIV in Uganda. A representative patient was a HIV positive

POINT OF IMPACT

REPORT FROM THE RANKS

ATLS (cont.) from page 14

and would also receive a certification if a passing score was achieved. This particular program permitted mid-level providers (physician assistants (PA) and nurse practitioners (NP)) to become certified as many are employed throughout their institution. My advice would be to check with the course lead upon registration, for clarification on certification.

As a newly graduated NP, with only nursing experience in an emergency department, my anxiety immediately escalated and the pressure to perform to the standard of my physician peers was overwhelming. The certification took on a whole new meaning after I found out that I was the only mid-level provider and nurse in the course!

However, I found ATLS to be intriguing; the instructors were very thorough, some even breaking down the information into concepts I could comprehend, and most of my fellow students were supportive and encouraging. I really learned a lot during those 2.5-days and although intense, the systematic approach to learning made the information much easier to retain. The course is very similar to the Emergency Nurses Association courses, taught mainly to nurses: Trauma Nurse Core Curriculum (TNCC) and Emergency Nurse Pediatric Course (ENPC).

Although initially overwhelmed, by the end of the first day, I truly was able to embrace the class and enjoy learning the advanced skills and concepts, networking and sharing my experiences with others. Leaving at the end of day-two, I felt totally exhausted and emotionally drained, along with a brain full of new knowledge. The following day, I walked out with pride in my accomplishments and with the prestigious certification as an Advanced Trauma Life Support Provider!

The ATLS certification lasts 4 years. More Information:

- <https://www.facs.org/quality-programs/trauma/atls>.
- <https://www.ena.org/education/ENPC-TNCC/tnc/Pages/aboutcourse.aspx>

Mental Health Care (cont.) from page 15

farmer, living in poverty with untreated depression. Many were also affected by the recent (2007) civil war carrying a significant history of trauma. Treatment included eight weeks of group therapy (in addition to ART) compared to standard HIV education.

These experiences at USAID and Uganda demonstrated to me both the challenge and excitement in tackling the problem of HIV and comorbid mental illness in vulnerable populations. I plan to use these tools in moving forward with my career as an officer in the IHS, as we are called to raise the physical, mental, social, and spiritual health of the American Indian/Alaska Native population.

References:

1. <https://www.aids.gov/hiv-aids-basics/hiv-aids-101/global-statistics/>
2. Hartzell JD, Janke IE & Weintrob AC (2008). Impact of depression on HIV outcomes in the HAART era. *Journal of Antimicrobial Chemotherapy* 62, 246–255.
3. Owe-Larsson B, Sall L, Salomon E, Allgulander C (2009). HIV infection and psychiatric illness. *Afr J Psychiatry* 12: 115–128.
4. Nakimuli-Mpungu E, Musisi S, Katabira E, Nachega J, Bass J (2011). Prevalence and factors associated with depressive disorders in an HIV positive rural patient population in southern Uganda. *Journal of affective disorders*. 135(1-3):160-7.
5. <https://www.pepfar.gov/about/270968.htm>
6. <https://www.fic.nih.gov/About/Staff/Policy-Planning-Evaluation/Pages/pepfar-ncd-project.aspx>
7. <http://www.muwrp.org/>

HEALTHY LIVING

Submitted by LCDR Daveta Bailey

BUILDING BASIC READY BODIES

MEAL Prepping 101

Healthy eating boils down to one thing. ...Preparation!

Part of being basic ready means you are making a daily commitment to get proper and plentiful rest, exercise (cardio and weight balanced), and to follow a good nutrition plan. Your body needs to be a well-oiled machine, but sometimes you have to provide it a little help to run smoothly.

Proper nutrition is not an easy task. We all have things that often stand in our way! Crazy work schedules, family obligations, continuing education courses, etc. Meal prepping helps to reduce the stress of:

- ◆ Choosing non-healthy food options; “Did I just eat that?!” remorse;
- ◆ Not having time to cook or trying to figure out what to cook due to a tight schedule; and
- ◆ Overspending at the deli, coffee shop, and during multiple grocery store runs.

Here is how to start a meal prepping plan. Start with planning for a week and then build your program as you see fit.

1. Rubbernecking – Check out your calendar and look at the week ahead.
 - This will help determine how many meals you need to prepare in advance.
 - This will also help determine your budget and how much you want to invest in the project.
2. Prime-Time – This is the fun part of meal prepping! Now that you know how many meals you need and how much you want to spend, it’s time to plan them! Need some inspiration? Try some of these awesome sites to help get you in the “Meal Prepper” state of mind.

<https://www.hsph.harvard.edu/nutritionsource/2017/03/20/meal-prep-planning/>

<http://damndelicious.net/category/meal-prep/>



<https://www.thirtyhandmadedays.com/100-meal-prep-ideas/>

If you have a fitness trainer, speak with them as he or she may have a meal plan to complement your current fitness program and weight management goals. In all your planning, try not to get carried away. K.I.S.S. (Keep it Simple Silly) is your friend. Remember you still have to cook, store, transport, and reheat these babies!

News Flash - Did you know mason jars can hold a salad fresh for five days? https://www.buzzfeed.com/carolynkylstra/mason-jar-salads?utm_term=.ry1mjDNv7G#.ndmnekJYKG

3. Prep & Pack – Now that you have a plan its time to light that “Meal Prep” fire!! Start by checking favorite stores or Sunday circular coupons. Also check the sites of your grocery store rewards programs. They often offer electronic coupons stored right on your card. Order or purchase BPA-free or microwave friendly containers ([Meal Prep Containers](#)).

Good luck and share your meal prep ideas with other junior officers. Send your recipes!

References:

1. <https://www.menshealth.com/nutrition/beginners-guide-to-meal-prep>
2. https://www.huffingtonpost.com/entry/meal-prepping-may-actually-be-sabotaging-your-diet_us_59512f64e4b0326c0a8d0a1f

QUOTE OF THE QUARTER



USPHS Scientific & Training Symposium
Ensuring Health for Generations to Come: Science Matters
Intercontinental Dallas on June 4-7, 2018



28 Nov - 1 Dec 2017 | Association of Military Surgeons in the United States (AMSUS) Annual Meeting

4 Dec 2017 | Deadline to submit abstracts for presentations during the scientific track sessions at the

2018 USPHS Scientific & Training Symposium

1 Dec 2017 | World AIDS Day

3 - 9 Dec 2017 | National Handwashing

Awareness Week

4 - 11 Dec 2017 | National Influenza Vaccination
Week

8 Dec 2017 | JOAG General Membership
Meeting at 1300 EST

16 Dec 2017 | Wreaths Across America Day

25 Dec 2017 | Christmas

31 Dec 2017 | New Year's Eve

1 Jan 2018 | New Year's Day

12 Jan 2018 | Journeyman Speaker Series

15 Jan 2018 | Martin Luther King Jr. Day

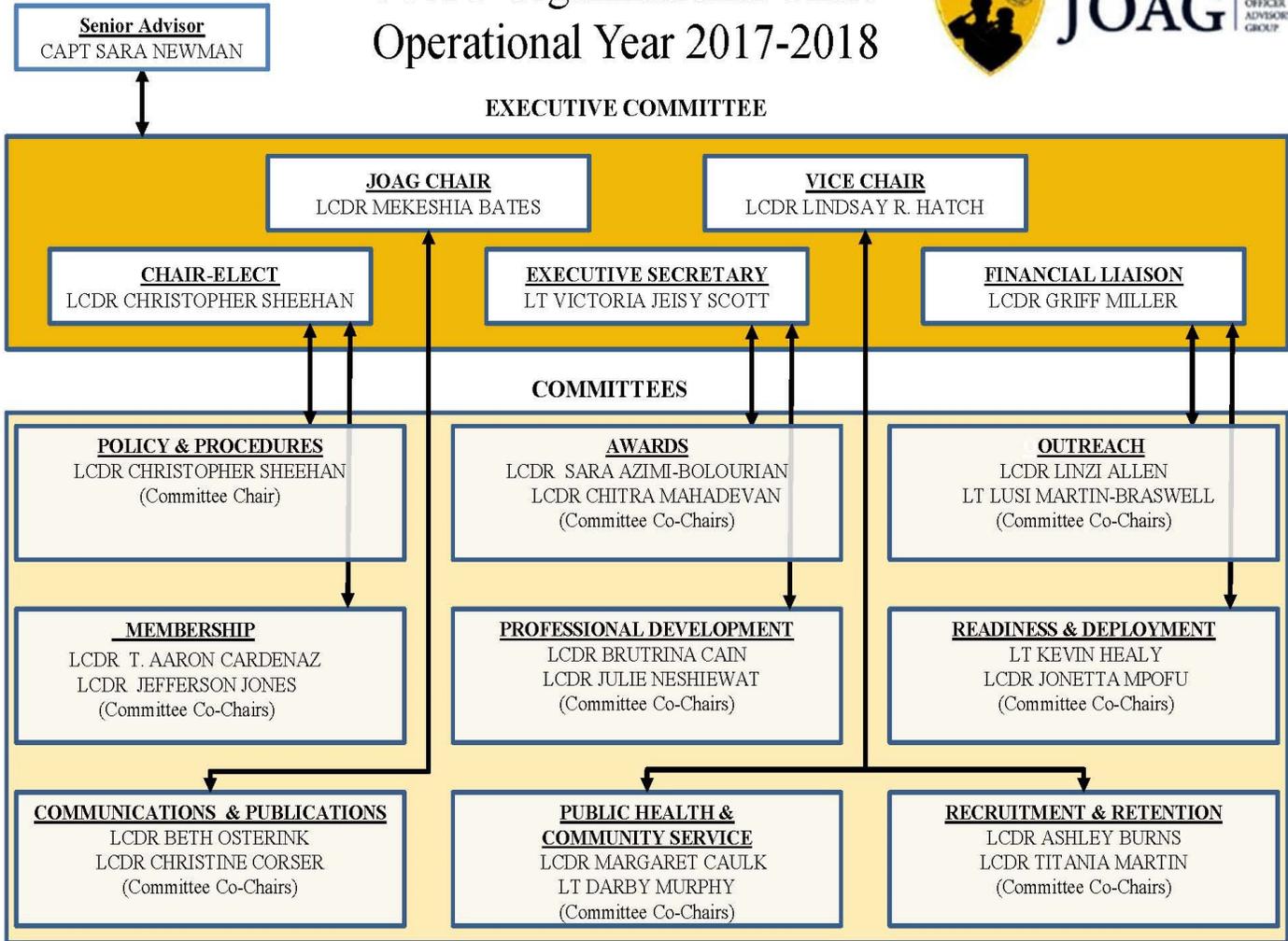
19 Feb 2018 | President's Day



Bravo Zulu to all officers who have deployed in support of Hurricane Harvey, Hurricane Irma, and Hurricane Maria.



JOAG Organizational Chart Operational Year 2017-2018



Executive Committee Liaisons are denoted by the arrows

THE JUNIOR OFFICER CHRONICLES

THE OFFICIAL JOAG MAGAZINE
DESIGNED FOR JUNIOR OFFICERS
BY JUNIOR OFFICERS