Medical Corps Newsletter

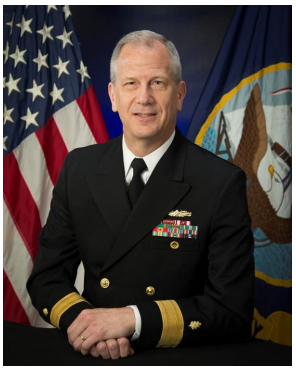
AUTUMN 2018

SPECIAL POINTS OF INTEREST:

- **Command Slate 2019**
- **Navy Informatics**
- **State Licensure Update**
- **Electronic Health Record**
- **Hometown Hero Program**
- **PERS Pearls**

INSIDE THIS ISSUE:

From the Corps Chief...



RDML Paul Pearigen

Medical Corps Colleagues,

As we have now transitioned into FY19, many of the much anticipated NDAA 2017 mandated changes to our organizational structure and practice have begun to take shape. I am immensely proud of the professionalism and dedication you have shown while navigating this time of uncertainty. Our senior leadership is capably pivoting towards our operational and readiness focus, while junior officers continue to advance their knowledge and skill in the practice of highly reliable medicine in the service of our nation.

Beyond the realm of health and healthcare, our Navy leadership is working to find efficiencies and develop new partnerships to advance our strategic defense plan. In that discussion, the pillars of the National Defense Strategy are:

i. Build a more lethal force
ii. Strengthen alliances and attract new partners
iii. Reform the Department for greater performance and affordability.

I would encourage every officer not yet familiar with this document, to read the summary that can be found at < https://dod.defense.gov/Portals/1/Documents/pubs/2018-National-Defense-Strategy-Summary.pdf >.

We contribute to our force lethality by providing for medical readiness and ensuring that every Soldier, Sailor, Marine, and Airman has the confidence to go into harm's way with complete trust that we will provide the needed medical support.

Our humanitarian missions and joint exercises go a long way in promoting modern medicine and advanced operational care. Indeed, at this moment USNS COMFORT is underway building the trust and confidence of our allies in the western hemisphere, with many of your physician colleagues aboard.

The third pillar involving 'greater performance and affordability' is not meant to be construed as 'doing more with less.' Rather, it's an honest recognition of limited resources and a need to prioritize missions while optimizing utilization of our assets.

As we remain a ready medical force and prepare to support the next battle, we must accurately predict what the needs of our Navy, Marine Corps and Joint teams will be. This strategic rudder must also be translated to all of our efforts in maintenance of that ready medical force – both as a team and as an individual. During this transition, much is unknown and we will not be able to anticipate every future challenge. However, our primary responsibility does not change. We must continue to ensure the delivery of high quality medical care for all those we support. I charge you to keep your focus on that enduring truth, even as there is change and uncertainty in our path.

A special congratulations to all of our newly selected Commanding Officers, Executive Officers, Chief Medical Officers, and Officers-in-Charge! Your recent selection was the result of deliberate and purposeful decisions you made throughout your career. You have been selected for your talent and experience. That foundation has prepared you for the leadership challenges of your new roles. For our junior officers, as physicians you are by definition leaders – no matter the future organization state – and your task does not change:

1) Master your specialty.
2) Seek out professional growth by accepting leadership roles of increasing scope and complexity.
3) Develop and mentor your subordinates – the higher your rank, the more of this you should do! I look to see you on future leadership slates and am looking forward to serving with you as we move forward into the next chapter of Navy Medicine!

I wish you all the happiest of holidays and hope it is filled with family, fun and peace as you reflect on our privilege of service. A heartfelt thanks to those that are deployed or standing the watch. Know that you are always in our thoughts, and we are grateful and proud to be your shipmates.

PDP

Readiness and the Reserves...

CAPT Jerry Dotson

It has been my distinct honor to serve the Medical Corps as Reserve Affairs Officer for the past two years. I want to thank RDML Tripoli for his keen insight and mentoring while we successfully navigated through some tough decisions. Additionally, thanks to RDML Pearigen, CAPT Pouget, and CAPT Quarles for their superior leadership in the Corps Chief office and making me part of the team. RDML Guldbek gave me an opportunity to serve the Dental Corps and provided great mentoring as well. My commitment will always be to advocate for our people, mentor them often, be present and available, and always ready to assist.

The heavy lifting in Reserve Medical Corps recruiting was accomplished under the watch of RADM Pecha and CAPT Eagleton. Their efforts increased manning from a low of 63% up to 93%. Through sustained effort, the Medical Corps has stabilized at 90%, largely due to retention pay. Commander Navy Reserve Forces Command (CNRFC) N112A (bonus shop) added a digitally signed retention pay request to expedite the quota process. A member can now execute a retention request from home, digitally sign it, and route it via email. N112A is working is to implement an online special pay process that is easily tracked by all stakeholders. One major accomplishment this year was getting the N112A to teleconference regularly with me. It allows me to review the bonus tracker and assure it is updated to reflect accurately where each members request is in the process of being paid.

Short lead times on mobilization taskers appear to be the new normal. To facilitate information transfer, I began advertising directly to officers in high demand specialties via email distribution lists the very same day the requirement was received. Our volunteer rate is about 55% for BSO-18 taskings. In my opinion, the Medical Corps has an impressive record of high-quality volunteerism.

The Reserve Affairs Officer is responsible for making changes in NOBC, SSP, and AQD in the official record for their community. We have a unique position where we see the new accessions as soon as they hit drill status. I started contacting all our new accessions to welcome them aboard. The early contact and mentoring provides important information for these officers to successfully integrate into our organization. I copied the Senior Medical Executive (SME), Specialty Leader (SL) and Commanding Officer in my welcome aboard messages. The electronic introduction gives the new SELRES key points of contact to integrate into the new unit. An old proverb reads, "It takes a village to

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OPERATIONAL OFFICER SPOTLIGHT

LCDR Garry reviewing MRI and Plain Film while in Vietnam.

Photo Credit: HM3 Jolijn Elsten

LCDR Conor Garry is an orthopaedic surgeon currently stationed at Naval Medical Center Portsmouth (NMCP). After graduating from Tufts University, he first completed flight training and served as a Naval Flight Officer, completing tours at VQ-1 and the Office of Naval Intelligence before transitioning into the Medical Corps. He graduated from Georgetown University School of Medicine, and completed his orthopaedic surgery training at Albert Einstein in New York prior to coming on active duty as a staff orthopaedic surgeon at Portsmouth. During medical school, LCDR Garry participated in numerous overseas medical missions and rotations, visiting Trinidad and Tobago, Ecuador, and Argentina.

Shortly after reporting to Naval Medical Center Portsmouth, LCDR Garry was assigned to the Continuing Promise 2018 mission, with the goal of providing civil and humanitarian assistance to our friends and neighbors in Latin America. He served as assistant surgical lead and expeditionary medical unit division officer, working with a team of highly skilled and motivated corpsmen, nurses, dentists, and medical officers to provide surgical care to host nation patients in Honduras and Guatemala both as guests in the host nation hospital system as well as within the U.S. Navy's expeditionary medical unit, a mobile surgical facility concept used for more than 80 surgical and dental procedures to benefit out Honduran and Guatemalan partners.

Following his excellent experience during Continuing Promise 2018, LCDR Garry volunteered to serve as the orthopaedic surgery representative on the inaugural Vietnam Integrated Trauma and Medical Readiness Exchange (ITMRE) and deployed to Hanoi, Vietnam at Viet Nam Hosptital 103 from June to August 2018 with an outstanding team of Navy Corpsmen, Nurses, and Doctors. During this mission the team conducted thousands of patient en-

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A Seat at the Table: Informatics and the Future

Submitted by: CAPT Hassan Tetteh, Chief Medical Informatics Officer, BUMED

"Who was that?" I asked. The surgeons appeared unusually excited to see the Executive and strained to get his attention when he entered the doctor's lounge. The gentleman had a presence. One surgeon was beguiled as the Executive approached, and another surgeon expressed earnest interest to secure a meeting. The man offered a polite response, hinted a meeting might happen soon, and then walked away. As he departed, I asked, "who was that?" Someone responded he is the CEO of Inova Fairfax, Dr. Reuven Pasternak.

My cardiothoracic surgery colleagues' reaction to Dr. Pasternak, the CEO, left an impression. Months earlier, I completed my thoracic surgery fellowship and through an agreement with Navy Medicine and the Inova Health System, had the unique opportunity to operate with and learn from highly skilled cardiac surgeons during the formative years of my surgical career. I absorbed their knowledge in and outside of the operating room. Months later, while consulting on a patient, I met Dr. Neal Chawla, a recently hired young emergency department doctor. We shared a mutual interest in information technology, I discovered he was appointed Associate Chief Medical Informatics Officer (CMIO) for Inova, and he casually related his 'obligation' to meet regularly with Dr. Pasternak and senior Inova leaders. "What?" He met regularly with the CEO and Inova leadership. Wow. It was my 'Pasternak moment.' As a Clinical Informaticist, Dr. Chawla applied his specialized knowledge to guide, influence, and contribute to the strategic direction of the organization; he had a seat at the table.

The Inova Health System purchased the Epic electronic health record software solution and was preparing to 'go-live.' The Epic solution was a significant investment for Inova and leaders were engaged. Dr. Chawla and his team led many initiatives. The informatics team cross-trained, communicated, and translated between basic informational sciences, the clinical community, and the Epic application. I observed and learned much through the process and witnessed an organizational transformation. An insatiable interest in informatics evolved. In the ensuing years, between cases, deployments, and clinical work, I studied informatics, concentrated on improving essential skills in communication, collaboration, and leadership, volunteered for health information and technology initiatives in military medicine, and completed the pathway culminating in board certification in the sub-specialty of Clinical Informatics under the American Board of Preventative Medicine (APBM).

Industry leaders use data, technology, and innovation to transform their businesses positively. The so-called FAANG, (i.e., Facebook, Amazon, Apple, Netflix, and Google) companies serve as information and technology vanguards. In healthcare, information and technology provide an inimitable competitive edge to organizations. Healthcare systems prioritize data analytics, and clinical and business intelligence. Increasingly, information and technology is leveraged to secure privacy and cybersecurity, improve patient outcomes and population health management, and ensure compliance and patient safety. Informaticists engage with clinical and business leaders and work to bring the tools of information and technology to life in their respective organizations. According to the 2018 Leadership Survey from the Healthcare Information and Management Systems Society (HIMSS), over 85% of hospitals and health systems hire senior clinical information and technology leaders to help guide and influence the strategic direction of their organizations.[1]

A new healthcare delivery paradigm exists. Today, the Navy faces threats and challenges that are trans-regional, multi-domain, and multifunctional. In response to this complex environment, Navy Medicine will need to

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counters, and the surgical team members assisted in hundreds of procedures focusing on the trauma related fields of general surgery, orthopaedic surgery, and neurosurgery. LCDR Garry took part in over 90 procedures, and provided over 20 hours of formal departmental instruction to the orthopaedics, trauma, and intensive care departments while assisting with research design. Together with his highly motivated enlisted and nursing colleagues, he helped introduce new operating room infection prevention protocols. LCDR Garry is continuing his relationship with Vietnam Hospital 103, and has submitted an IRB allowing deeper collaboration with our Vietnamese colleagues to ensure continued engagement and partnership.

Through missions such as the Vietnam ITMRE, LCDR Garry and his colleagues enable mutually beneficial exchanges that deepen US and US Navy engagement with our friends and partners in the global community. These exchanges deepen our understanding of our host nations while honing our wartime skills by dramatically increasing our exposure to blunt trauma. We benefit the host nation by familiarizing them with US best practices, as many of these nations lack the infrastructure and finances to independently support these changes. LCDR Garry is currently applying to become part of the US Navy's Global Health Engagement Community and will be presenting research related to his international experience in the coming months.

The 'Unrestricted License'… Understanding the purpose, background, and law.

CDR Melissa Austin, MC, USN, Plans and Policy Officer

Recent changes to the state of Nebraska's licensure policy ignited some heated debate about the need for military providers to have an unrestricted medical license and what that actually means. There are a number of states that make a military-specific license available that eliminates some or all of the fees or requirements associated with a regular unrestricted license; some military licenses are eligible for a waiver, and some are not. The Nebraska military license falls into the latter category, and let me take a moment to explain why and hopefully provide a broader context.

First, why are you required to have an unrestricted license when your state is perfectly willing to recognize your service and sacrifice as a military physician by reducing the financial or "hassle" costs of licensure? Much comes down to optics. The Military Health System must hold its providers to the same standards as our colleagues practicing in the private sector, and we must avoid even the appearance that we have a lower bar. Many of you have experienced veiled (or even overt) characterization of military medicine as "second class" – remember the US Family Health Plan ad that made the rounds in 2017? – so you can appreciate that even the best of intentions can be interpreted in a very negative light. Beyond this, complying with the full spectrum of licensure requirements is simply the right thing to do.

Licensure requirements for providers of all flavors are delineated in DoDM 6025.13 (29 Oct 2013) and BUMEDINST 6010.30 (27 Mar 2015). Physicians are required to have at least one current, valid and unrestricted state medical license as defined in Section 1094 of title 10, United States Code of Federal Regulations. "State" includes the District of Columbia and US commonwealths/territories for our purposes today. An unrestricted license "is not subject to limitation on the scope of practice ordinarily granted to other physicians for a similar specialty by the jurisdiction that granted the license." **Translation: if you cannot practice in the state giving you the license (excepting in federal facilities), then it is a restricted license.** DoDM 6025.13 states that an unrestricted license must include "…all the same requirements pertaining to clinical competency (e.g. education, training, national tests, continuing medical education, investigation and sanction authority of the license board) as the full scope category…", and waivers are prohibited for any requirement(s) pertaining to clinical competency.

BUMEDINST 6010.30 (Encl (7)) specifically states that a license that waives CE requirements is not eligible for a waiver. The waiver process is meant to relieve significant hardship associated with unrestricted (non-military) licensure. **ASD(HA) policy specifically states that a reduced fee associated with a military license, by itself, does not constitute grounds for a waiver.** Examples of appropriate justification for a waiver would be: (1) the unrestricted (non-military) license requires that the physician physically reside in the state; (2) the unrestricted (non-military) license requires the physician to pay into a medical injury compensation fund; or (3) the unrestricted (non-military) license requires the physician to maintain private malpractice liability insurance. One caveat: you may carry a restricted license in one or more states provided that you have an unrestricted license in at least one other state.

If you are discovered to have a medical license that does not meet DoD requirements, you will have to take action to bring yourself into compliance in order to avoid privileging repercussions. **Translation: you must drop everything and get a valid, unrestricted license or an approved waiver.** BUMEDINST 6010.30 (Encl(4)) states that providers lacking a valid unrestricted license or approved waiver "must be placed under a plan of supervision (POS) to participate in patient care activities" within 72 hours of identification and remain on that POS until you produce evidence of compliance. No one likes being hit with a POS, so it is in your best interest to proactively comply with the letter and spirit of the law.

The BUMED Centralized Credentials and Privileging Directorate manages the waiver process, but your local Privileging Authorities should be your first stop if you have questions about your license status or the waiver process.

NHC Annapolis mentors Midshipmen interested in service selecting US Navy Medical Corps! Opportunities included assistance with practice interviews, Red Cross volunteers, and of course pot-luck get-togethers...

Have a photo or brief story to share?

Email it to the Corps Chief's Office

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improve its healthcare delivery in every domain, especially in the operational realm. To ensure future success in this mission, Navy Medicine will need to provide the warfighter, clinicians, and the enterprise the information and technology frameworks needed to improve care, quality, patient safety, efficiency, and readiness anywhere and everywhere we operate in the world.

There is power in clinical informatics. Navy Medicine can harness this power to assist with our dynamic force deployment. Dr. Charles P. Friedman, the quintessential informaticist, defines the discipline as: "the relentless pursuit of making people better at what they do."[2] Indeed, this simple yet elegant definition embodies the work of a Clinical Informaticists. We use information and technology to help make people better at what they do. The cadre of Clinical Informaticists in Navy Medicine augment the warfighter and make Navy Medicine better at delivering world class care, anytime, anywhere.

Navy Medicine is in need of physician leaders and champions with interest and expertise in clinical informatics to amplify the voice of those that use information and technology to improve care. We need you to help build a specialized informatics workforce; increase expertise throughout the enterprise, bridge information, technology, leadership, administration, and clinical care to deliver the very best care in every domain to our Sailors, Marines, Services' men and women, and their families.

If you would like more information on training/certification pathways, obtaining the AQD, or becoming a CMIO, please contact CAPT Hassan Tetteh (hassan.a.tetteh.mil@mail.mil) or CDR Chris Tatro (christopher.r.tatro.mil@mail.mil).

About the Author: CAPT Hassan Tetteh serves as the Chief Medical Informatics Officer (CMIO) for Navy Medicine. Dr. Tetteh is triple-board certified in the specialty of general surgery, and sub-specialties of thoracic surgery and clinical informatics.

[1]2018 HIMSS U.S. Leadership and Workforce Survey, Accessed, Oct 18, 2018: https://www.himss.org/sites/himssorg/files/132196/2018_HIMSS_US_LEADERSHIP_WORKFORCE_SURVEY_Final_Report.pdf

[2]Friedman CP. What Informatics is and Isn't. JAMIA 2013;20:224-226.

Congratulations to the next generation of Navy Physician Leaders!

Commanding Officers:

CAPT Lisa Mulligan
NMC Portsmouth

CAPT David Webster
NH Pensacola

CAPT Shelley Perkins
NH Camp Pendleton

CAPT Lynelle Boamah
NH Twentynine Palms

CAPT David Krulak
USNH Okinawa

CAPT Steven Kewish
NHC Oak Harbor

CAPT Miguel Cubano
Kandahar Role III (Fall 2019)

CAPT Andrew Vaughn
NMRU San Antonio

Executive Officers:

CAPT(s) Jorge Brito
USNH Guam

CAPT Walter Dalitsch
USNH Sigonella

CAPT Manuel Alsina
USNH Yokosuka

CAPT H. Wesley Cho
NHC New England

CAPT(s) Kristie Robson
NHC Quantico

CAPT William Scouten
USNS Mercy (T-AH 19)

CAPT Frank Mullens
Kandahar Role III (Fall 2019)

CAPT Dennis Faix
NMRU Dayton

CAPT Brian Feldman
Naval Submarine Research Laboratory

Chief Medical Officer:

CAPT Christopher Chisholm
Navy Medicine West

CAPT Juliann Althoff
NMC San Diego

CDR(s) Julia Savitz
NH Beaufort

CDR Thomas Chung
NH Camp Pendleton

CDR Jami Peterson
NH Twentynine Palms

CDR Jacqueline McDowell
USNH Guam

CDR Jeffrey Martens
USNH Naples

CDR Kathy Kyser
USNH Okinawa

CDR David Paz
USNH Rota

CAPT(s) Bettina Sauter
USNH Sigonella

CDR Mark Lund
USNH Yokosuka

CDR Afshin Afarin
NHC Annapolis

CDR Jeffrey Gertner
NHC Charleston

CDR Thad Klimpel
NHC Cherry Point

CDR Michelle Perkins
NHC Corpus Christi

CDR Gregory Freitag
NHC Quantico

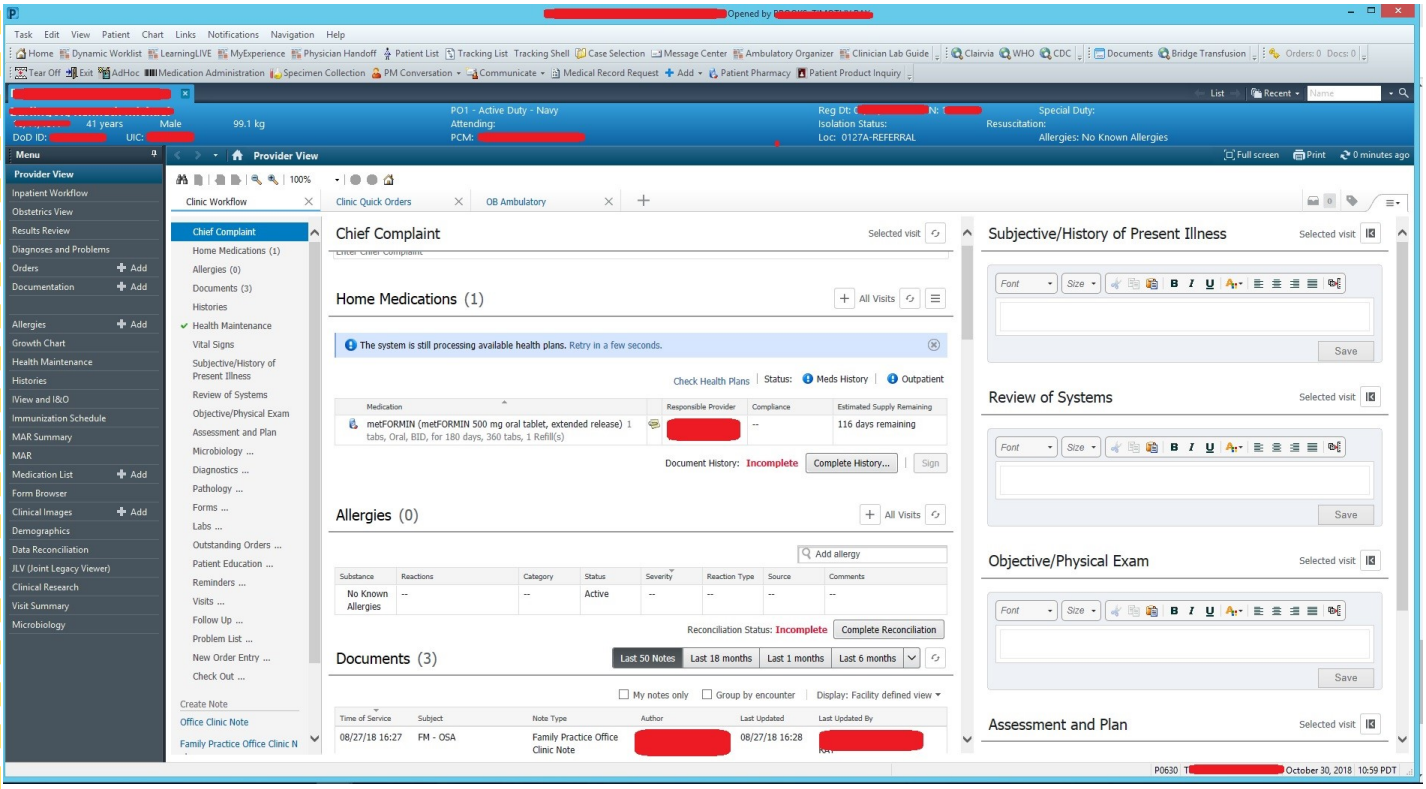
Officer in Charge:

NEPMU–7
CDR Tammy Servies

NBHC Port Hueneme
CDR Shannon Evans

EMR Update: Genesis in Action

LCDR Timothy Brooks MD, Naval Hospital Oak Harbor



Scrolling Facebook the other night, I saw one of our ENT colleagues in Virginia bemoaning her inability to leave clinic because two notes needed completion. AHLTA crashes were causing her simple task to take hours longer than necessary. At least it afforded her the time to share online!

This continues to be the reality for most of us in the MHS: an inefficient and sometimes unreliable amalgam of AHLTA, CHCS, ESSENTRIS, HAIMS, and even some departments paper charting. We all have existed in a state of learned helplessness knowing these deficits, finding workarounds, and making it work as best we can. This was my reality until April 2018 when I joined Naval Health Clinic Oak Harbor, one of the initial operating capability (IOC) sites of MHS GENESIS.

MHS GENESIS was rolled-out to PACNORWEST in summer 2017 with a multitude of challenges becoming immediately apparent. On the deck plates at Bremerton and Oak Harbor, people were stressed and just trying to keep up. These facilities and their staffs discovered quickly they were to be on the front lines of development: identifying system problems and submitting tickets that should lead to fixes and improvements. By the time I showed up in the spring of 2018, much had been accomplished. But news accounts were bleak, illuminating concerns for patient safety and reports of staff exits in frustration (Politico, May 2018).

The Politico story aside, there are many more positives to be had in this 21st Century platform. As a primary outpatient provider, my workflow is significantly improved over AHLTA. All the sections of a note are entered into text fields on the same screen. The days of holding your breath as your encounter transitions between the S/O and A/P modules are over. I reconcile medication lists and prescribe refills with the single click of a mouse. The double-negative text generated from clicking boxes in a review of systems or physical exam template are gone. We now easily build our own quick text ("dot phrases") templates for any component of our documentation. If my patient was admitted to Madigan Army Medical Center, I can easily see the inpatient notes as I do the outpatient follow-up. I can email patients their lab results as soon as I receive them, all documented in the chart with no need for Relay Health.

My experience is far removed from the struggles of those who were part of the initial deployment. There are still some ongoing issues. Problems include: inability to capture many metrics, clinical workflows still need to be improved, difficulty correcting some order sets, clinic schedule templates can be double stacked, and multiple alerts in orders that make no sense. These are just a few that affect me, but I am aware of more in other clinical settings.

We are moving in the right direction and vastly improved from just getting by with AHLTA/ESSENTRIS. There will continue to be challenges as MHS GENESIS is rolled out across the enterprise and each of us will feel a different type of growing pain from this. However, each successive MTF will benefit from the work and lessons learned from those before. With that in mind, our MTFs in the Northwest continue to identify deficiencies, submit trouble tickets, and find improvements building the EHR we have long been hoping for, so that we can give our patients the quality of care they deserve.

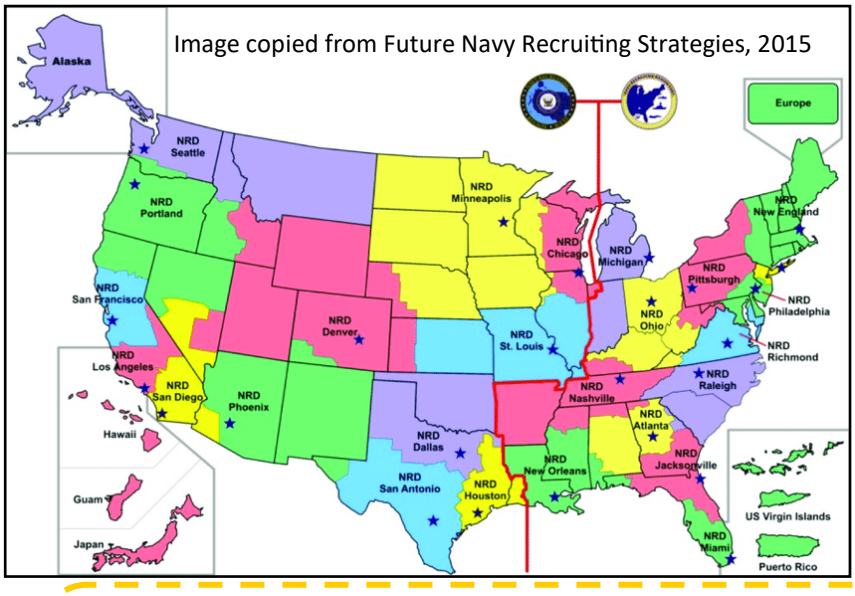
The Hometown Hero Recruiting Initiative

BLUF: *The Hometown Hero Initiative provides Medical Officers with the opportunity to take No-Cost TAD instead of leave, providing they liaison and assist local medical recruiters while TAD.*

The Navy Medical Corps Health Professions Scholarship (HPSP) program closed out FY18 by narrowly achieving its goal accession of 248 medical students. Quality indicators, including GPA and MCAT were on par with years past and the National Average for Medical School Matriculants. Unfortunately, there was a relative decrease in the number of applicants and a relative increase in the number of scholarship offers declined by the applicant. Navy Recruiting Command (NRC) is investigating the cause, but those who have been through the cycles of recruiting note that strong economies and increasing alternatives in paying for medical school may have been reflected in these numbers.

Discussions with the Medical Program managers at NRC note the challenges faced by recruiting districts, who are simultaneously recruiting several other specialized fields with their own career nuances. Interested Pre-Medical or Medical students are more likely to seek an HPSP Scholarship if they are able to connect with current medical officers to gain the proper insights into the opportunities available in Navy Medicine.

This is where every medical officer can become an ambassador. We currently have a need to increase interest amongst 1st year medical students who may be interested in a 3-year HPSP Scholarship. (Last year's relative shortfall has resulted in less 'carry-over' for the 3-year Scholarship recruiting numbers). We also have a need to generate maximum interest amongst pre-medical students who will be starting medical school this summer. By maximizing our application pool, we can ensure that the highest quality candidates are selected to serve in the Medical Corps.



The Medical Corps Chief's Office has started a 'Hometown Hero Initiative' to encourage high-performing, motivated medical officers to reach out to the Medical Recruiting leads as an asset to assist with interviews, mentorship, and recruiting. With the support of your chain of command, the Corps Chief's Office has encouraged local commanders to authorize Permissive ('No-Cost') TAD in order to facilitate the initiative. At the local commander's discretion, medical officers who reach out to the recruiting district of their choice and arrange to provide support to the recruiter (by talking to candidates, speaking at alma maters, etc.) can request permissive TAD orders en lieu of regular leave. This may be particularly advantageous to those who are visiting friends and family in areas where they have connections to assist recruiters.

For a list of Medical Recruiters and Recruiting Districts, please visit the Corps Chief Website. You can also email the centralized Medical Recruiter Inbox at MedicalVIP.fct@navy.mil (this is also a good email address to give to prospective applicants as a point of first contact).

(Continued from page 2, CAPT Dotson)

raise a child". Similarly, it takes a community of Navy leaders to mentor a junior officer.

Collectively, we must emphasize the purpose of our drill weekend and appropriately convey the necessity for active participation. With the exception of Marine Forces Reserve units (MARFORRES) and Tier 1 Expeditionary Medical Facilities, the standard Drill Weekend is used to ensure administrative readiness of personnel. The training conducted on these weekends is not to hone specialty skills, but rather completion of all relevant mobilization requirements. Medical and dental readiness, physical readiness, security clearances, urinalysis, and the myriad GMT topics, are but a few examples of mobilization checklist items. A comprehensive understanding of the depth and breadth of these requirements will go a long way toward improving unit and personnel readiness in support of the Navy mission. Ready Now, Anytime, Anywhere is our motto in the Navy Reserve.

As I return to SELRES status, my new billet is with 4th Medical Battalion. Filling the battalion's vacant general surgery (15C0) and emergency medicine (16P0) billets continues to be a problem. I encourage our 15C0 and 16P0 community to look to the "green side" to serve. Drilling at one of the commands detachments is required, and sacrificing an extra day each month to travel to drill may be necessary, but doing so reflects commitment. The friends made while serving in the 4th Medical Battalion, forged during field training exercises, deployments, and drill will be something I will always treasure. My time in the battalion, the officers that I engaged, the missions we accomplished, are the primary reason I have had a successful Navy Reserve career. Both of my EMF Commanding Officers were people whom I served with on the green side. The Battalion is poised to embark on a rigorous training plan this year to include OCONUS events in Australia, and the Philippine Islands, in addition to Global Medic at Fort McCoy. If you want to experience real operational medicine, come serve with the Marines.

Finally, thank you to all who serve. Your sacrifice is worthy of my utmost respect. I am proud to serve alongside you.

Quiz: Do you know about OPT-IN requirements for promotion?

Question: Who is required to OPT-In for promotion consideration?

1. All Officers
2. No one, you just get looked at when your number comes up
3. New Accessions who are In-Zone with less than one year on Active Duty

Correct Answer: Choice #3. If you are a New Accession or work with New Accessions, continue reading to learn the details of this requirement and process.

Who must OPT-IN for promotion consideration? This applies to individuals who are In-Zone for promotion but who have been on Active Duty for less than one year at the time the promotion board is held. In the Medical Corps community, we most often see this situation for our Lieutenants who have been in a reserve status (i.e., HPSP) while completing medical school and then go on to complete a long residency under the Navy Active Duty Delay for Specialist (NADDS) program. Typically, the residency must have taken at least 4 years to complete. This amount of time means the individual may now In-Zone for promotion consideration.

Why must the individual OPT-IN for promotion consideration? Officers in this category are automatically DEFERRED from promotion consideration. This is the Navy's method of protecting the Officer from a Failure to Select for promotion. Because they have been in the Navy for such a short time, their Navy personnel record does not contain much information and the individual may not compete well against his/her peers for promotion. The record likely will contain only one FITREP dtd 31 January (covering approximately 6 months after reporting for Active Duty). In order to be considered for promotion, the individual must OPT-IN.

How is the individual informed of this need to OPT-IN? All new accession orders contain verbiage directing the individual to determine their promotion eligibility status and what steps to take to OPT-IN. The verbiage reads as follows:

"- INFORM MEMBER THAT PLACEMENT ON THE ACTIVE DUTY LIST MAY HAVE RENDERED THE MEMBER ELIGIBLE FOR CONSIDERATION IN-ZONE OR ABOVE-ZONE FOR A PROMOTION SELECTION BOARD WITHIN ONE YEAR OF ENTERING ACTIVE DUTY, IN WHICH CASE MEMBER WILL BE AUTOMATICALLY DEFERRED FOR PROMOTION CONSIDERATION UNDER SECNAVINST 1420.1B, UNLESS MEMBER SPECIFICALLY REQUESTS TO BE CONSIDERED. POINT OF CONTACT IS PERS-802 DSN 882-4537 OR COMMERCIAL (901) 874-4537."

How do I find out if I am In-Zone for promotion? Annually, in December, the Navy will release a NAVADMIN detailing the promotion zones. Officers should go to the Navy Personnel Command NAVADMIN library website and check to see if given their lineal number, they are In-Zone for promotion. Officers should feel free to contact their respective Detailer for assistance.

NAVADMIN Library Link:

https://www.public.navy.mil/bupers-npc/reference/messages/NAVADMINS/Pages/default.aspx

How to Find your Lineal (Precedence) Number:

1. Log in to NSIPS.
2. Select View Personal Information.
3. Select Member Data Summary.
4. Look at the bottom of the page for your "Precedence Number."

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How would the officer OPT-IN for promotion consideration? Remember this is rare and only applies to a few individuals. Officers with less than one year of Active Duty service, once determining they are In-Zone or Above-Zone should call PERS-802 to request to be considered at this phone number (901) 874-4537.

Possible outcomes and considerations for accepting the deferment. Officers who accept the deferment (by taking no action) will simply not be considered for promotion. Their records will not be reviewed by the promotion board. Their record will NOT reflect any failure of selection. At the following year's board, the officer will be considered for promotion and if selected, will likely pin on rank earlier than peers because they will have more senior lineal numbers and be considered to have been Above Zone. While Medical Corps officers generally perform well at LCDR selection boards, officers may want to accept the deferment if they have not been able to update their personnel record, did not receive a very strong fitrep, or would like more time to strengthen their record.

Possible outcomes and considerations for OPTing-IN for promotion consideration. Officers who call PERS-802 and OPT-IN for promotion will be considered amongst the peer group. If selected, they will pin on the higher rank according to the promotion phasing plan. If not selected, their record will be marked as a "Failure to Select" and they will again be considered for promotion at the following year's board. In the event, they fail to select a second time, the officer may be either processed for resignation or retained on Active Duty to complete education/training obligations.

In general, Medical Corps officers do very well at a LCDR promotion board. Historically, the promotion opportunity has been 100% meaning, all eligible officers may be offered promotion. The precept historically instructs the board to promote all fully qualified officers. Officers who are able to update their records, and who have received a strong fitrep may want to consider Opting-In for promotion consideration.

How should an officer engage their senior leadership? Officers should discuss whether or not to OPT-IN with their senior leadership. If deciding to OPT-IN, ensure your leadership is aware and can work to write your FITREP in the strongest possible way that reflects your true performance and potential. Discuss with your leadership, Detailer, and mentors about whether or not you want to consider writing a letter to the board given the paucity of information in your record.

What should senior leaders do? Know the careers of the officers working for you. Remember, these are officers with approximately 6 months in the Navy, they likely do not understand the ins and outs of this Navy policy and promotion boards in general. Identify new accessions who may fall into this category of automatic deferment. Ensure they are educated on the situation and are informed about which decision to make. If the officer decides to opt-in pay careful attention to the details of the FITREP, it will likely be the only FITREP the board has available. Remember, these officers have done exactly what the Navy instructed them to do; that is, complete a residency and then report to Active Duty as a staff physician. Their records are compared against individuals who have done the same career track only through completion of a Navy residency and therefore have years of FITREPS on file. Other peer individuals under consideration have completed GMO/FS/UMO and likely have a robust record documenting performance.

As always, for any concerns regarding promotion or career management, officers should feel free to contact their Detailer.

Accessing the Corps Chief Homepage (if unable to hyperlink directly)

- Go to www.med.navy.mil
- Click on 'Internal Sites (CAC Enabled)' located on the top banner, far right
- Select either hyperlink option to access BUMED Sharepoint (the second option is more reliable if outside the DHHQ network). Use your CAC EMAIL certificate for access.
- Click the 'Surgeon General' dropdown menu located on the top banner and select 'M00C– Corps Chiefs'
- Click on 'Corps Sites' dropdown menu located on the top banner and select 'Medical Corps (M00C1)'
- Bookmark this site and please visit regularly for updates!

Medical Corps Challenge Coins

High-quality 1.75" coin with classic front and contemporary back, a wonderful memento, gift, or token of appreciation:

Suggested donation: **$10/coin**

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(varies by weight & zip code)

Please email **CAPT William Beckman <william.a.beckman.mil@mail.mil>** with the following information:

- **Order quantity**
- **Good mailing address (home is best)**
  - FPO AE/AP must include zip+4 & local phone for US Customs form

Once email is received, CAPT Beckman will confirm order, and advise of exact amount due, as well as specific check payment information (sorry, no credit card/PayPal option).

For further assistance, please feel free to contact us directly...

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