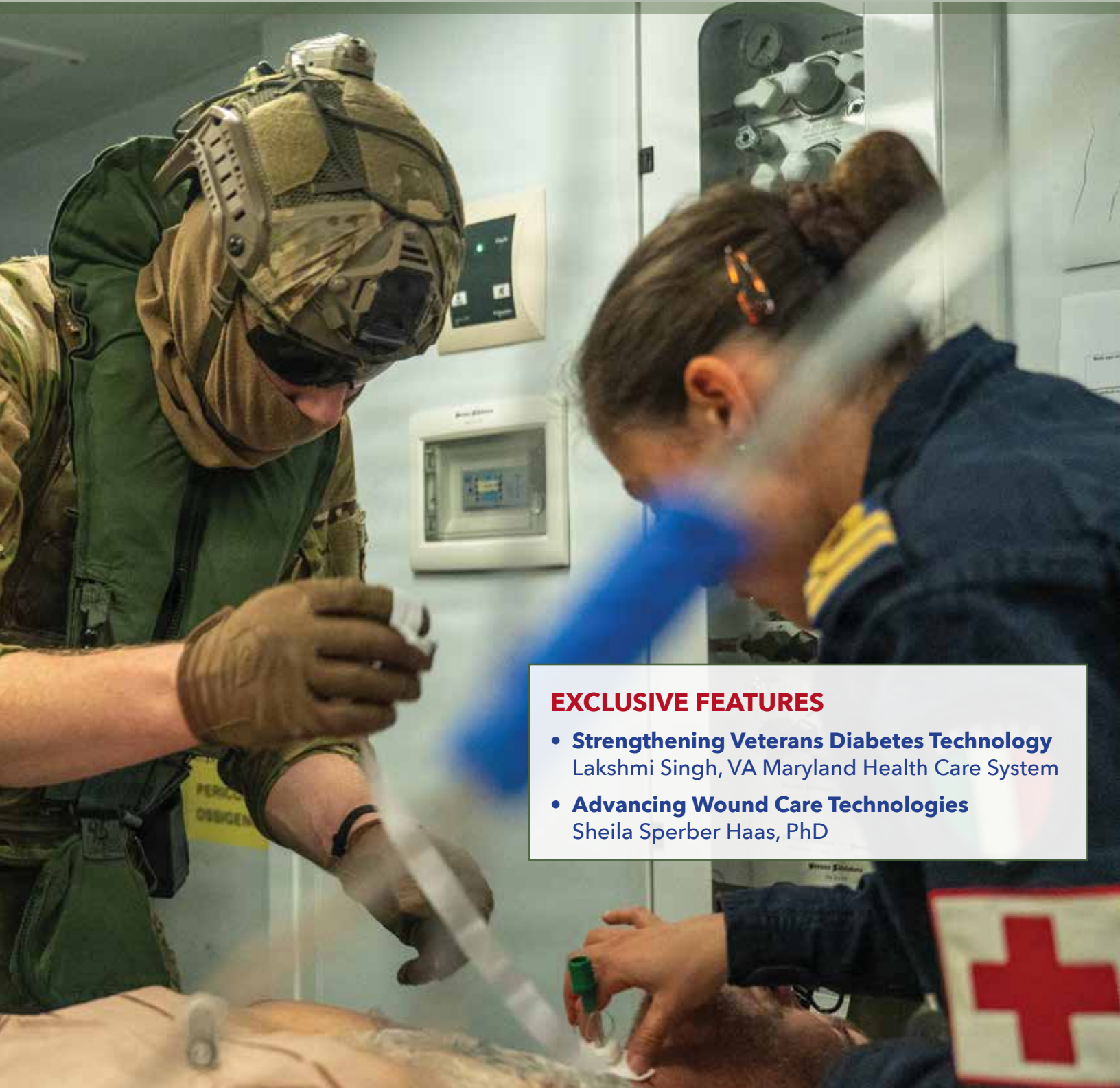


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2026



EXCLUSIVE FEATURES

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Lakshmi Singh, VA Maryland Health Care System
- **Advancing Wound Care Technologies**
Sheila Sperber Haas, PhD



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FOREWORD

Priorities for Military Health System: “Our Mission is Readiness”

By Robert Hammer, MHS Communications

The Military Health System must remain focused on its core purpose: ensuring warfighters are ready, lethal, and supported by a highly effective medical system.

Speaking at the 2026 MHS Conference in Dallas May 27, Keith Bass, the assistant secretary of war for health affairs, outlined his priorities to the capacity crowd of 2,600. While acknowledging that the MHS is one of the nation’s largest and most complex healthcare networks — serving 9.5 million beneficiaries on a \$68 billion budget — Bass made it clear that clinical metrics are not the ultimate measure of success.

“Most people say our main mission is to provide high-quality healthcare — but our mission is readiness,” he emphasized.

Since taking the oath of office Jan. 12, 2026, he has toured military hospitals, walked clinic hallways, and listened directly to the line personnel, senior leaders, and policy advisors who keep the system running. The feedback has been invaluable, he said, with funding and staffing at the top of the list.

With the costs of pharmaceuticals, care delivery, and deployment operations climbing, Bass sees his role as a fierce advocate to protect the MHS budget.

“We know the cost of medical care in general is high,” he noted. “So how do we continue to sustain our current operations with our current funding?”

The answer, Bass said, is working with senior leaders across the enterprise and Congress to prioritize funding to meet warfighter needs and determine efforts to enhance operational readiness.



Keith Bass, assistant secretary of war for health affairs, outlines his strategic priorities for the Military Health System, with funding and staffing at the top of the list to optimize warfighter readiness.

Staffing policies

With a worldwide workforce numbering about 130,000, staffing shortages rank high on his list, with the enterprise currently short about 28,000 personnel worldwide.

“We must bring the right people into the right jobs at the right time,” Bass stressed, noting the enterprise must contend more effectively with nonmilitary healthcare institutions — which can hire quickly and offer higher pay.

To help fix this, Bass called on leaders to change outdated policies, where possible, that stretch the onboarding process over months, causing the MHS to lose top-tier clinicians while they wait for paperwork to clear.

He also emphasized while recruiting matters, retention is just as important. Ensuring competitive pay, robust training, and a high quality of life are non-negotiable if the MHS expects to keep its world-class doctors, nurses, and medics, he said.

Facility upkeep

The MHS currently manages over 3,000 buildings spanning 84 million square feet. With an aging infrastructure and a \$17 billion backlog in deferred maintenance, physical plants are becoming operational liabilities. Bass noted that when he visits military hospitals and clinics, he has no interest in seeing freshly painted administrative spaces or prepped tour routes.

“Tell me what’s broke,” Bass said candidly. “What’s not working that we need to look



Shortly after his appointment in January 2026, Assistant Secretary of War for Health Affairs Keith Bass visited military hospitals and clinics around the world. In this photo, he is receiving a construction update at the future Rhine Ordnance Barracks Medical Center in Germany.

at.” He’ll push for a plan to improve infrastructure. “We owe it to our patients, and we owe it to our staff,” he said.

Partnerships and future readiness

To keep military medical skills sharp between conflicts, Bass highlighted the critical role of civilian-military partnerships. He pointed to successful initiatives like

the collaboration between Walter Reed National Military Medical Center and Kaiser Permanente, which allows military neurosurgeons to maintain high-repetition, complex skills by treating civilian patients in the Bethesda, Maryland, center.

“You don’t fight the next war like you fight the last war,” Bass said. “We have to adapt.

We have to make sure we’re ready, we’re prepared, and it should be a steady state of readiness.”

By driving strategic investments into combat support assets — including the blood program, the joint trauma system, and medical logistics — Bass said the No. 1 focus is ensuring the medical enterprise directly enhances the lethality of the joint force.

“You cannot separate lethality and medical capability from medical readiness,” he emphasized. “You have to have medical readiness to support lethality and military capability.”

Source: *The U.S. Military Health System*

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EXCLUSIVE

ENDOCRINOLOGY

Advancing Technology in Diabetes Care Management To Help Veterans

Exclusive interview with Lakshmi Singh, PharmD, Diabetes Technology Program Coordinator, VA Maryland Health Care System (VAMHCS)

By Thomas S. Adams III, Publisher, Military Veterans Health

Diabetes is one of the greatest health challenges facing Veterans today, and VA is truly on the forefront of advancing care within every aspect of this disease. It was my pleasure to speak with Dr. Singh about the work she and her colleagues are doing at the VA Maryland Health Care System, which has made life-saving differences in the Veterans they serve and their families.

The most encouraging developments in diabetes management recently remain with technology for monitoring and delivering insulin, which is Dr. Singh’s specialty. This stems from being a healthcare professional and a diabetes patient herself, living with type 1 diabetes for approximately 20 years. I began by asking about her training and current role within Maryland VA health care system.

“I’m a clinical pharmacist practitioner,” said Dr. Singh. “This is a pharmacist, who after graduation, does extra clinical residency training allowing us to work in clinical practice areas of the VA system, where we function similar to nurse practitioners and physician assistants. We can prescribe and manage chronic illnesses like diabetes, and we can also order tests, medications, and devices, plus provide education within the practice area. I’ve been with Maryland VA for 17 years now, and I started in primary care, doing chronic disease state management along with the primary care providers, and my interest in diabetes stems from my experience there as well as personally, I was diagnosed with type 1 diabetes almost 20 years ago. Just going through the experience firsthand and realizing how it impacts you, your family, and your life overall is something that I can really understand. This deepens my compassion for others who are similarly experiencing this disease or type 2 diabetes. As far as my specific role, from the point of when I was diagnosed, I knew I was going to find my way into a diabetes clinic, so I did everything to get to that point. And since I’ve been in the endocrinology diabetes service at the VA Maryland Health Care System, I’ve been focused heavily on the use of diabetes technology to help with diabetes management.”

This technology first entered the market about 40 years ago with extremely limited functions and limited infiltration of use. Its

awareness and use has also developed as a result of its improvement, and VA has been a leader within this advancement. Dr. Singh said, “More providers are aware of the technology now and are using it, but we’re still not as far as we could be when it comes to offering these interventions to those with diabetes as it was not as commonly used except if you were in specialty endocrinology and diabetes clinics,” she said. “For example, if you were an endocrine provider, then you would have that awareness and comfort to prescribe the devices and use them. However, diabetes is not all managed by specialists such as endocrinologists or diabetologists. Many of these patients are cared for by their primary care providers so it’s important that the use of these devices really goes beyond the specialty area because that’s where the majority of folks with diabetes are encountered,” she said.

Of the two types of diabetes known as type 1 and type 2, I asked Dr. Singh about the usefulness of technology as it related to both. “Typically, these devices are used for type 1 diabetes,” she said. “Type 1 diabetes is an autoimmune disease where patients who are diagnosed lose all ability to produce insulin, so insulin therapy is really the mainstay of management, and insulin pumps were originally studied and approved for type 1 diabetes. With that said, insulin pump companies are now working to become FDA approved for type 2 diabetes as well, and some of them have achieved those approvals over the last couple of years. This is very important because if patients can begin using technology earlier in the course of their experience with diabetes, it can help them achieve their goals and reduce their risk of complications and disease burdens much earlier than they might have otherwise. The other very important advancement in diabetes technology are continuous glucose monitoring systems or CGM’s, which are devices individuals wear that have a sensor on their arm or their abdomen that is constantly measuring glucose 24 hours a day and transmitting those readings to a device like a smart phone or other type of monitor they can carry with them. This allows the person with diabetes to know at all times what their glucose values are, plus it provides alarms to notify them if their glucose is low, which really can be life-saving for those who have low blood sugars overnight, for example, as that can be extremely

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dangerous. These advantages can make an incredible difference to the person's overall control, evidence suggests that just prescribing this device alone without making any medication adjustments can lower A1c by about half a percent, which is very meaningful. If you give the tools to the person with diabetes, to be able to better understand what they are doing day-to-day, what effect their medications have on their actual blood sugar value and what effects their dietary choices have, it really allows them to self-regulate better. I've seen even more than a half a percent reduction, for example, I've seen individuals with double digit A1cs at 11% for example, have poor insight into their disease and lifestyle choices. They are prescribed insulin, given a CGM device, and I've seen patients lower their A1c as much as 2%. And while that might not be the case for everybody, there's really no one that couldn't benefit from this device if they are able to safely and appropriately use it."

"The other devices I often use are insulin pumps; these devices can continuously deliver insulin to the person with diabetes through an embedded automated program (algorithm)." Initially, the technology was very basic, but in the last five years, it has proliferated to a point where the systems are game changers now. They take the management burden off the person and help patients achieve their goals. These automated insulin delivery systems can adjust insulin based on CGM data to tailor the dosing better and improve high and low blood glucose episodes. The devices can help providers solve very complex types of diabetes that they had not been able to manage before.

I asked Dr. Singh about the most common challenges in getting these devices to the patients who need them most.

"Unfortunately, right now, coverage options don't allow everybody with diabetes to have this device," she said. "Mostly it's for those who have an insulin prescription, but hopefully that will change as the technology continues to grow and coverage changes. There are some over-the-counter CGM devices that have become available for people to purchase without a prescription, but they do not possess all the same features as the FDA approved systems that require prescription. However, it is still a good sign as this indicates that they're becoming more accessible. They may not be affordable though for some, which is also a challenge. Aside from coverage and affordability limitations, providing a person with pre-diabetes a CGM device could then prevent them from developing the disease because they can implement interventions in their lifestyle to avoid progressing to a diagnosis of diabetes. It is important to think about future implications of the ability to prevent, and not just manage diabetes with the use of this device. Mainly the use of these technologies have expanded considerably, and it's important that we use them as early as possible when appropriate. Whenever I see a person newly diagnosed with diabetes who's on insulin, for example, one of the first interventions I would consider is to give them a CGM device along with any medication therapy as needed. Introducing this technology very early is a critical piece of support that we can provide to the individual with diabetes, and I think that's

important whether they are seen in a specialty diabetes clinic or primary care."

This point brings up an important factor in the collaboration between providers to communicate and work together for the most successful treatment of patients with diabetes. I asked Dr. Singh to elaborate more about her experiences at the Maryland VA with respect to this interdisciplinary approach.

"Some of the other interventions at our health care system were achieved through collaboration by a lot of wonderful providers and clinicians passionate about diabetes, including endocrinologists, primary care providers, nurse practitioners/nurses, diabetes educators, registered dietitians, clinical pharmacist practitioners, and everybody involved with caring for our Veterans. At our facility, together, we made an educational training program to expand the use of CGM devices across our health system outside just the specialty diabetes clinics. And beyond that, the VA has standardized national training modules which provide a wonderful opportunity to access training on CGM devices, what they are, and how they work. These training programs provide a foundation on how to prescribe them, how to use them, and interpret the data they generate for management. Other technology includes smart insulin pens. These smartpens guides the individual with diabetes on how much insulin to inject, prompt them with reminders so they do not forget their doses."

Most of us have no idea what our glucose level is until we get a blood test at annual checkup.. Then if there is an elevation of concern, our primary provider addresses it accordingly. The obvious advantage of CGM in the earliest stage of concern offers the greatest potential in not only treating the disease but possibly avoiding it altogether. I asked Dr. Singh at what stage she introduces this technology to her patients.

"Ideally, it's best is to give these tools as early on as possible," Dr. Singh said. If an individual with type 2 is being prescribed insulin, that's usually because that individual failed oral therapy or the disease is so severe that oral therapy is insufficient. Some people monitor their metabolic rates for just about everything, including sleep. There are smart watches and even rings with sensors available to do this because people want to know what's happening with their health; this includes individuals who don't have diabetes. This technology really can be leveraged for so many things. And instead of heavily weighing on treatments, which can become expensive, an array of new drugs are emerging that are impactful for type two diabetes and even allow people to get to their weight goals such as the GLP drugs. These are also game changers when it comes to diabetes, so it's both technology and medication therapy. Medications like SGLT2 inhibitors have profoundly changed the way we can prevent and treat kidney disease, heart failure, and various other conditions. Thus, there's a lot of advancements, but the question remains, are we getting to them early enough to make a difference in the person's life? For example, are we giving a person who is on insulin and eligible for CGM a prescription right away? Oftentimes we're not. If

you look at the population of insulin treated diabetes, it would not reflect that the majority have been prescribed CGM, and it just shows that it hasn't pushed forward into the market. For example, Metformin is one of the oldest drugs on the market for treating diabetes. It just needs to get to the point where we think of these drugs and these treatment options and prescribe device technology as soon as the patient becomes eligible for it. There's too much evidence to support them and not just stay within our own practice habits."

Early intervention makes all the difference compared to late stage, and while CGMs are still somewhat new I asked Dr. Singh about the lifespan of these devices and if it needs to be changed periodically.

"I can say from my own experience," she said, "which is a benefit of being a person with diabetes who's also working in diabetes, all of the sensors that you wear on the arm have a lifespan. Some are around 15 days. Some are 10 days, and some are one week. This means you must remove the sensor, throw it away, and replace it with a new one. Then the monitoring device, which is either software on your smart phone or a little proprietary device, usually last years. Usually, proprietary devices have a warranty for one year, and they do not require provider consent, so they are usually treated the same as medication refills at your pharmacy. Regarding the insulin pump devices, they also last for years but require supplies that must be changed or refilled every three days. Patients must fill the pump with insulin which is a little bit more tedious. If the patient requires an insulin pump, that usually means their situation is different, and they would be appropriately selected for being able to use that device. While that's not as straightforward as a CGM, which is just monitoring sugar, pumps actually deliver insulin."

I asked how the sensors respond to exposures like water, such as can a patient take a shower with them on, or go swimming?

Dr. Singh said, "With CGM, which is more widely used, you can take a shower with it on and you can also swim with on, but if you are far away from the receiving device such as a distance of 20 to 30 feet away, they can lose the signal to monitor. Once you get back in range, then it will reconnect and begin monitoring again. The only thing some patients are concerned with is the visibility of it. Sometimes they don't like to have it seen on their arm, so technically they can put it on their abdomen so it's not as easily seen. Outside of that, CGMs become a part of their normal everyday life, once they get used to it. The insulin pumps are a bit different because they have tubing which connects to your skin, and that has to be disconnected when you shower; a big part of educating a patient on an insulin pump and selecting a proper candidate is going through the care process for the device.. Making sure patients understand what it means to live with these devices is making sure they are committed to working with it properly. This is essential because it's only going to be successful if they're wearing it properly."

Clearly, educating the patient properly is crucially important to their success and safety. I asked if this was mostly done at the hospital facility, or if it can be done through outreach in a patient's own home.

"We can do it either way," she said. "VA has been really progressive for a while now, even before Covid, regarding outreach. We've been using tele-health services, and other technologies to help reach out to veterans who don't live near the main facility. These technologies have allowed us to also share data. For example, if we were to initiate a CGM for a patient living in a rural location that may have challenges traveling to come into the hospital, we can educate them through video visits during which either the patient or the caregiver or both participate. Sometimes it's a younger family member, like children or grandchildren who help if the Veteran is older and perhaps not as comfortable with using technology like setting up the app or logging in. Once everything is set up and working, the devices will share data through the cloud automatically, which goes into a web-based account that is accessible to any provider, and patients can link their devices to their clinic account. For example, I have a Veteran patient who uses an insulin pump and who lives on the eastern shore — three hours away. This patient is older and not very tech savvy, and he doesn't own a smart phone. But his wife does. We've been able to find solutions for that individual, who has type one diabetes and uses both an insulin pump and CGM device. I get access to his data automatically, so he doesn't have to make that three-hour trip for us to retrieve his data."

Many of the manufacturers themselves provide education suited specifically for their devices, so I asked Dr. Singh if the VA utilized their sources as well as their own, and how they incorporated it into their procedures.

"Yes. We utilize education from manufacturers, particularly when it comes to insulin pumps, because they require a certified pump trainer from the company who will meet the Veteran in a public place that's convenient for them," she said. "The VA provides training for CGM devices because it's far more straightforward. Really, it's about knowing all the options of who you can rely on in these situations and deploying them. One of the reasons we have been so successful with all of this is because the VA has a national advisory board for diabetes and endocrinology comprised of specialists from across the country who are experts in these fields. There's also a diabetes technology subcommittee with many members who represent information technology. These are clinical and administrative folks available to help support the technology across the entire health system. When you consider rural Veterans — these people give us the ability to have the software on our computers — they are making sure that all VA facilities can install the necessary programs to get the technology. Overall, I will say that it does require people on both sides who are passionate about this."

Having a team of incredibly qualified specialists and technologies from both VA and the private sector working together provides

our Veterans tremendous advantages with managing their diabetes and also preventing other associated health conditions such as vision and foot ulcers which often lead to amputation. This superior care is also proven by the number of Veterans who have successfully managed their diabetes for long periods of time. Dr. Singh has several patients who serve as outstanding examples of this, including some who have successfully managed diabetes for more than 50 years.

“I have a couple of patients who have lived more than 50+ years with type one diabetes,” she said. “That alone is an amazing accomplishment because it’s a difficult disease, and these people have seen the evolution of diabetes management firsthand. In the past five decades or more, they’ve gone from boiling insulin syringes and urinating on test strips to now finding out what their sugar is instantly on their phone. They’ve seen the advancement of seeing just color coding which only provides a general reading to an exact reading in real time. And this advancement is more appreciated by those who have had diabetes for a long time and who realize the improvements the most. Best of all, these new technologies increase the eligibility for more people to take part in them. There are no limitations such as age, literacy, socioeconomic background, or education level standing in their way.”

Naturally the question now is, where will this all go next? What could be the next advancement in diabetes care? I asked Dr. Singh this question, not from a point of development view, but from the aspect of care. What areas still present challenges that could be improved?

“Eventually the industry needs to develop an artificial pancreas,” she said. “This would be able to perform and control diabetes artificially as well as a natural healthy pancreas can. There is currently research and ongoing development that includes delivering insulin and glucagon, which is the other important hormone that a pancreas produces to properly control insulin levels. And then the other part of it is that they are working very hard on making all these devices as user-friendly as possible in terms of size.. The profile of these devices is important for patients because patients wearing them want low profile devices that are easy to use and easy to wear. Everything is moving toward making things more wearable, and that’s where it really needs to go as far as technology is concerned. Beyond that, it’s really looking at what will cure diabetes. It is a very good time, particularly for those who have lived with diabetes for five decades and who didn’t have what we have now. I really look up to them. I truly admire those who survived for so long with far less than those of us that were diagnosed after we had better technology. Even I’ve seen the evolution in my almost 20 years as a clinical pharmacist. And for those who are being diagnosed now, they would never know what it was like before, so that’s why it’s important to make things as easy as possible for people, because it really is a hard disease.”

Another great advantage to technological advancement is the positive mental attitude of encouragement that Veterans are also

getting from their healthcare providers, giving them a reason to take care of themselves. This is something the VA does a wonderful job at and should be commended for. I asked Dr. Singh about this in regard to her own background, when she was first diagnosed at 24 years old and in pharmacy school at the time, and how that led to her interest in work at VA.

“I went to the University of Maryland School of Pharmacy,” she said. “This sits nextdoor to the Baltimore VA Medical Center, so I had a rotation there in an anticoagulation clinic, monitoring for the blood thinner Warfarin. This needed close monitoring due to the many drug interactions. Here is where I saw how advanced the care was that pharmacist provided in the VA system. The federal law allows pharmacists to practice at a much higher level, whereas in most states, pharmacists’ roles are limited. Sometimes more can be done through collaborative practice agreements, but overall VA doesn’t have this limitation because it is innovative and utilizes many different types of disciplines that allows us to address the needs of a much larger population. This encourages us to lean on all their resources, and just seeing that alone and what I could potentially do in the VA is the main reason I choose to work at the Baltimore VA Medical Center. That, and the most important reason for choosing to work at the VA is that I love working with Veterans. I always joke that I’m going die in the halls of the VA somedaybecause I have never interacted with individuals who have given so much in their lives, such as the World War II Veterans whom I met when I used to work in the anticoagulation clinic. They just amazed me with their amount of experiences and sacrifice and commitment to the to their duty. Also, Veterans go through so much, and I’m deeply appreciative of them. I haveI gotten to know their families, and their life stories. Some of my patients — older Veterans passed way — I always I feel sad losing them because of having developed long-term relationships with them. These relationships are incredibly meaningful and the reason I came to the VA and why I will always stay at the VA. Those deep connections bring something else to mind: the importance of understanding mental health challenges and other barriers like depression, which plays a vital role in the management of individuals with diabetes. It’s important for everyone involved in the management of diabetes to understand the impact of their patients’ mental health status, and not to just quickly assume that someone’s non-adherent or noncompliant simply because they just don’t want to listen. Often, there are valid reasons for that, so within the VA we have behavioral mental health specialist, dietitians, case managers, and all sorts of supportive resources to help. Still, it takes the person managing the diabetes to identify and maybe spend a few minutes to figure out if there is an actual intervention that can be done and to identify any barriers for why they are not engaged in their healthcare, and then using those resources, This is personal to me. When I was first diagnosed, I was going to throw the insulin pens across the room as I was overwhelmed. Even when I was in pharmacy school, I didn’t take my insulin right away. The most important aspect: the manner in which someone is diagnosed and educated initially can change the trajectory of how they manage their disease.”



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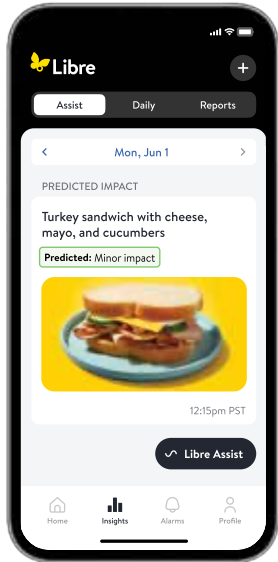
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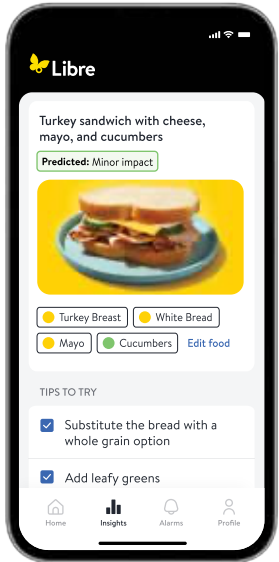
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SPECIAL FEATURES

6 Military Hospitals and Clinics Recognized as Centers of Excellence

By Andrew Ortuzar, Defense Health Agency Communications

Specialty Care Centers of Excellence are designed to enhance warfighter medical readiness and improve healthcare quality for all.

Defense Health Agency Director Vice Adm. Darin K. Via has formally established regional centers of excellence to deliver premier specialty care supporting critical warfighting capabilities.

Emerging in response to the National Defense Authorization Act for Fiscal Year 2023, the new Specialty Care Centers of Excellence are designed to enhance warfighter medical readiness and improve healthcare quality for all Military Health System beneficiaries, aligning with Via's Lines of Effort to reinforce DHA as a combat support agency.

In expanding the Centers of Excellence, DHA will mirror the successful models of established centers within the enterprise in oncology, traumatic brain injury, and ocular trauma. The new Centers of Excellence combine expertise, resources, and patient referrals to serve as specialized facilities providing "integrated, interdisciplinary care for complex medical and surgical conditions," said Dr. Chin Hee Kim, action officer for Specialty Care

Centers of Excellence and deputy chief of the medicine clinical service line at DHA. This effort underscores the agency's commitment "to modernizing the MHS through this now larger network of cutting-edge facilities," she added.

"We've had many years of experience with Centers of Excellence with a primary focus on research. This new initiative is focused on how we can optimize patient care delivery," she elaborated. Formal designation of these centers "helps us communicate and highlight the great work that's been going on for decades, so that our beneficiaries choose to receive care within military hospitals and clinics." The military hospitals and clinics receiving Center of Excellence designation are:

- Alexander T. Augusta Military Medical Center: Fort Belvoir, Virginia
- Brooke Army Medical Center: Joint Base San Antonio-Fort Sam Houston, Texas
- Madigan Army Medical Center: Joint Base Lewis-McChord, Washington
- Naval Medical Center San Diego: San Diego, California



A surgical team removes a brain tumor at Walter Reed National Military Medical Center in Bethesda, Maryland, March 4, 2026.
Photo credit Ricardo Reyes-Guevara

- Walter Reed National Military Medical Center: Bethesda, Maryland
- Wilford Hall Ambulatory Surgical Center: Joint Base San Antonio, Texas

In May 2026, fifteen military hospitals received an "A" from the nationally recognized Leapfrog safety assessment. Kim noted, "This formal designation validates all of the great work our military hospitals and clinics have been doing and also makes patients aware of the options they have."

The formally designated Centers of Excellence include specialties in:

- Amputations and prosthetics at WRNMMC, BAMC, and NMCS
- Burn injuries and wound care at U.S. Army Institute of Surgical Research co-located at BAMC
- Infectious diseases and preventive medicine at BAMC
- Maxillofacial restoration at NMCS and BAMC
- Ocular trauma previously designated in 2022 at BAMC, WHASC, WRNMMC, ATAMMC, NMCS, MAMC
- Oncology previously designated in 2012 at WRNMMC
- Orthopedic care at WRNMMC and ATAMMC
- Psychological health and traumatic brain injury previously designated in 2010 at WRNMMC
- Substance use disorder at BAMC
- Transplant surgery at WRNMMC

"Our Centers of Excellence provide the best possible care, convenience and cost savings to patients, empowering them to seek leading-edge, innovative care," said Dr. Paul R. Cordts, deputy assistant director for medical affairs at DHA. "Implementing the Centers of Excellence across military hospitals and clinics will advance care for warfighters to be safe, healthy, and fit to fight."

The expansion of the centers aims for service members and families to have access to first-rate, expert healthcare for any injury or illness, no matter the complexity, to bolster a ready medical force.

The strategic shift will ensure "all beneficiaries — past, present, and future — have more robust choices in access to timely, high-quality specialty care, leading to improved health outcomes and a stronger, healthier military community," Kim said.

Cost savings for patients, complex cases for providers

The new Specialty Care Centers of Excellence presents potential financial advantages for both patients and the enterprise.

"Beneficiaries have the choice to receive care at a world-class Center of Excellence within the MHS, which may reduce out-of-pocket financial impact," Kim said. Beyond individual savings, she noted that keeping complex cases inside the MHS lends further benefits "since providing healthcare is an inherent

requirement, treating patients within our Specialty Care Centers of Excellence allows us to maximize existing clinical talent to deliver excellent care and significantly reduce private-sector costs."

Treatment through Specialty Care Centers of Excellence attracts beneficiaries requiring complex multidisciplinary care to the MHS, which ensures military providers maintain their medical warrior currency and readiness for future operations. Kim noted consolidating multidisciplinary care teams for each specialty at the military hospitals and clinics will provide care teams with the capability and capacity to accept the most complicated cases within each discipline. "Centers of Excellence are uniquely positioned to treat complex diagnoses and conditions while supporting patient recovery across the continuum from diagnosis to rehabilitation."

The establishment of Centers of Excellence "positions the MHS as a global leader, particularly in fields like maxillofacial restoration where no civilian equivalent exists," Kim said, noting the agency's "commitment ensures service members receive treatments that minimize lifelong maintenance and maximize long-term health."

An example of benefits from a Specialty Care Center of Excellence, Kim said, is the pilot program in maxillofacial restoration demonstrating remarkable success. The study showed "94% of active-duty service members returned to full duty within 16 weeks of their operations," directly reducing nondeployable days.

Streamlined referrals and partnerships

To ensure this expansion is seamless for military hospital and clinic healthcare providers, as well as TRICARE network providers, standardized referral processes are being implemented, solidifying a joint warfighting effort through data sharing and clinical cohesion.

All referrals to the Centers of Excellence will be managed by central referral management centers, according to Kim. "Each specialty has developed specific referral eligibility criteria that will soon be available to providers, referral managers, and managed care support contractors."

The initiative also draws on flourishing partnerships between the Department of War and the Department of Veterans Affairs to share patient data, best practices, and clinical guidelines.

"Many beneficiaries we serve may transition at some point to the VA," Kim said. "There is synergy between the two systems to mutually refer patients based on which side has the right set of expertise and resources to provide the care."

At the foundation of the expansion is accessible, specialty care for the warfighter no matter the condition, she added. "This expansion will improve access because we're getting the right patients to the right location to get the right care that they deserve."

Source: The Defense Health Agency



SPECIAL FEATURES

Preparing for the Aftermath: How Navy Medicine Chaplains Fortify the Force

By Jennifer Goulart, Naval Medical Forces Atlantic

In his book “What It Is Like to Go to War”, American author and Vietnam War veteran Karl Marlantes reflects on the lasting moral and spiritual impact of combat. “Combat is a lot of things, but one of them is that it puts you in a different relationship with eternity... it changes... your sense of what matters and your understanding of what it means to be alive.”

Chaplain's have supported the spiritual and moral readiness of U.S. military forces since 1775. According to Naval Medical Forces Atlantic (NMFL) Chaplain, Capt. David Jeltma, the Navy defines spiritual readiness as, “strength of spirit that enables the warfighter to accomplish the mission with honor.”

“Spiritual readiness is not a check in the box or a one-time event,” he said. “It is a constellation of practices that help individuals understand who they are, why their work matters and how they contribute to something larger than themselves.”

As Navy Medicine has shifted its primary mission focus on healthcare delivery to operational capability and lethality — a mission centered on generating ready medical units for combat support — medical staff, like all operators, must be prepared, body, mind, and spirit.

Because of this, Navy Medicine leaders have placed a renewed emphasis on spiritual readiness as a critical component of warfighter resilience. This is particularly important as medical personnel prepare for operational environments where ethical decisions and human suffering can have lasting effects.

Central to the discussion is moral injury, a condition that can occur when individuals experience or witness events that conflict with their deeply held beliefs. “Moral injury is something all human beings are susceptible to,” said Jeltma. “But in military service, the intensity and frequency of those experiences are amplified.”



Capt. David Jeltma, Naval Medical Forces Atlantic (NMFL) Chaplain, blesses the hands of Rear Adm. Robert Hawkins, commander, NMFL, during a blessing of the hands ceremony held during National Nurses Week onboard Naval Support Activity (NSA) Hampton Roads - Portsmouth Annex, May 11, 2026. Photo credit Mass Communication Specialist Second Class Levi Decker United States Navy

Unlike physical wounds, moral injury often stems from ethical dilemmas, perceived failures, or exposure to trauma — including the loss of life — agonizing decisions made under pressure, or witnessing suffering. For Navy Medicine personnel, the risk can be uniquely complex. While medical providers may not be directly engaged in combat, they are routinely confronted with its consequences.

“Our medical Sailors are deeply involved in the aftermath,” Jeltma stressed. “Anguishing decisions about triage, limited resources, or who receives care first can be morally distressing in ways that differ from traditional clinical settings. These experiences can lead to long-term emotional and spiritual strain if not addressed.”

To best address such situations Jeltma emphasizes preparation — not just response — as key to reducing the impact of moral injury. According to him, research and operational experience show that discussing ethical challenges before deployment can strengthen resilience.

“Anticipating scenarios ahead of time is one of the most effective ways to prepare,” he said. “We would not send someone into combat without training them on their equipment. The same principle applies to spiritual and moral preparation, and we can’t just say it’s an individual responsibility.”

In fact, Jeltma believes spiritual and moral preparation is a collective responsibility. He emphasized that Navy Medicine leaders must make this a focus of their unit. This means integrating their chaplain into planning, ensuring spiritual readiness is addressed from the start.

“Marlantes said that the Marine Corps taught him to do maneuver warfare very well but left him unprepared spiritually,” said Jeltma. “And if a medical provider is going into a combat situation, we have to recognize there is great potential something

might happen that could be morally troubling, and we must prepare beforehand.” Another way the Navy addresses moral injury is to ensure military chaplains are properly trained to work in medical environments. Currently, every chaplain who works within Navy Medicine receives special training through the Pastoral Care Residency Program. This program is a year-long immersive, full-time healthcare ministry residency with structured clinical supervision, intensive group relations training, and advanced pastoral education.

“This program is designed to help us learn to suspend our personal stories and beliefs, to recognize our conscious and unconscious biases to ensure none of that interferes with the care we provide,” explained Jeltma.

“Our trained Navy Medicine chaplains are some of the finest in the world. This equips them to effectively minister within the complex environment of military medicine, serving the needs of patients, providers, and other military members.”

As Navy Medicine continues to grow their operational role and teams as well as support operational forces worldwide, strengthening spiritual readiness will remain essential to preserving both individual well-being and mission effectiveness.

“Spiritual readiness is a shared obligation,” said Jeltma. “I think we owe it to each other as a force to prepare for these realities together because how we face them as a team matters.”

As Marlantes wrote: “What happens in war is not simply an external event. It becomes part of who you are. The real battle afterward is learning how to live with what you have done and what you have seen.”

Source: *The United States Navy Bureau of Medicine and Surgery*



Capt. David Jeltma, Naval Medical Forces Atlantic (NMFL) Chaplain, leads a prayer before a blessing of the hands ceremony held during National Nurses Week onboard Naval Support Activity (NSA) Hampton Roads - Portsmouth Annex, May 11, 2026. Recognizing that medical Sailors are often deeply involved in the aftermath of combat, chaplains use practices like the Blessing of the Hands to strengthen their spiritual resilience. It represents their shared obligation to prepare the force for the emotional and ethical demands of military medicine. Photo credit Mass Communication Specialist Second Class Levi Decker United States Navy



SPECIAL FEATURES

Walter Reed Earns Military Health System Excellence in High Reliability Award; Providers Recognized for Exceptional Care

By Bernard S. Little, WRNMMC Hospital Communications

Walter Reed National Military Medical Center (WRNMMC) and two of its healthcare providers earned awards for high reliability and exceptional patient care during the 2026 Military Health System (MHS) Conference held May 26-29 in Dallas, Texas.

Walter Reed earned the MHS Excellence in High Reliability Award. Dr. Kip Hartman received the 2025 Award for the Advancement of Physicians in Civilian Medicine (MHS Federal Civilian Physician Leadership Excellence Award), and U.S. Army 1st Lt. Braden Damitz garnered the 2025 MHS Military Nursing Leadership Excellence Award in the junior category.

MHS Excellence in High Reliability

The MHS Excellence in High Reliability Award recognizes military treatment facilities and teams for “outstanding achievement in advancing high reliability practices driving continuous process improvement, safer patient care, patient engagement, and better outcomes,” according to MHS officials.

“Walter Reed is specifically being honored with the Large MEDCEN (medical center) Overall Excellence Award,” explained Dr. Paul Cordts, deputy assistant director for Medical Affairs at the Defense Health Agency (DHA) responsible for MHS clinical quality, patient safety, and risk management policies, procedures, and direction.

“This distinction is one of only 10 data-driven awards recognizing outstanding achievement in the Ready Reliable Care (RRC) Maturity Index-Model for 2025,” Cordts added. “The model measures progress and advancement of RRC capabilities across the organization, highlighting measurable excellence and sustained improvement.”

The Large MEDCEN award recognizes medical centers with more than 4,000 personnel that achieve the highest overall composite score on the inpatient maturity model in calendar year 2025. “This is a significant accomplishment that reflects disciplined execution, leadership engagement, and a culture

committed to continuous improvement,” Cordts stated.

“This exemplary achievement directly supports the DHA’s enterprise priorities by strengthening critical operational capabilities, driving improved performance across the system, and ultimately supporting warfighter readiness,” he added.

“We do this by following the principles of high reliability to achieve top outcomes despite operating in a complex, high-risk environment,” explained Bernadette Naquine, patient safety program manager in the Directorate of Quality at Walter Reed. “This includes improving standardization and reducing variability; mitigating errors to achieve zero harm; celebrating transparency and accountability; and valuing the contributions of all individuals, regardless of rank.”

Federal Civilian Physician Leadership Excellence

Hartman, a pediatric hematologist-oncologist at Walter Reed and John P. Murtha Cancer Center (MCC) at WRNMMC, is also a clinical professor of pediatrics at the Uniformed Services University (USU).

Cordts commended Hartman as the recipient of the Award for the Advancement of Physicians in Civilian Medicine, stating it’s “a testament to [Hartman’s] outstanding contributions and unwavering dedication to military medicine and commitment to our nation’s service members, their families, and our beneficiaries. To do so while also mentoring the next generation of military medical professionals is a remarkable achievement. Your leadership in guiding residents not only enhances their skills but also instills in them the values of excellence and compassion that are the bedrock of the MHS. This award recognizes your exemplary leadership, clinical expertise, and profound impact on the lives of your patients and colleagues.”

“I think that it is an honor to be able to provide personal medical care to pediatric patients and young adults with cancer and blood diseases,” said Hartman, principal investigator for Children’s Oncology Group Protocols at Murtha Cancer Center.

“At the Murtha, we provide care to children, adolescents, and young adults, including active-duty service members. We treat both cancer and blood diseases, such as sickle cell disease. Guiding patients and their families through their journey results in strong bonds and lifelong attachments. Our pediatric hematology-oncology team includes nurses, corpsmen, social workers, art therapists, volunteers, and administrators. Together, we work to give the best care we can for our patients.”

Hartman added that he also finds it rewarding to guide and mentor the next generation of military healthcare providers.

“I have been fortunate to be able to contribute to the development of over 40 pediatric hematology-oncology fellows, many of whom have gone on to leadership positions within the military,” he shared.

“The emphasis within the MHS is to be ready to provide medical support to the military mission. Pediatric hematology and oncology provide valuable training for young physicians and non-physicians in the treatment of disease and non-battle injury, including infectious diseases, chemical injuries, and radiation injuries, in very seriously ill patients. These skills are critical for robust support of the military medical mission,” added Hartman, who has worked in the MHS for nearly five decades.

MHS Military Nursing Leadership Excellence

Damitz, an emergency and trauma nurse at Walter Reed, earned the MHS Military Nursing Leadership Excellence Award for “demonstrating exemplary leadership, innovation, and commitment to advancing nursing practice.” He was also noted by MHS officials for “exceptional compassion and commitment to patients, colleagues, and the profession of nursing.”

“It’s rewarding caring for those in the military community and making a meaningful difference for patients and families during their most critical moments,” Damitz shared. “This gives purpose to the work we do every day. The opportunity to serve those who have sacrificed so much for our nation makes this profession especially meaningful.”

“This recognition reinforces the responsibility military nurses have to lead by example, invest in others, and provide exceptional patient care,” Damitz stated.

He added that he also focuses on mentoring, training, and supporting enlisted service members and students to enhance readiness in Walter Reed’s Emergency Department (ED).

“Serving on the Code Blue response and MEDEVAC (medical evacuation) teams while pursuing the Certified Emergency Nurse (CEN) credential helped strengthen the expertise and readiness required to serve our patients and mission,” he said.

“This recognition reflects the dedication, professionalism, and teamwork demonstrated throughout the ED every day. The military and civilian professionals who support our patients and mission continually set the standard for excellence, and contributing to that team remains a privilege,” Damitz said.

Leading by example is not new to Damitz. He was recognized as the Cadet of the Week while a nursing student and Army ROTC cadet at DeSales University in Pennsylvania. He also served as an emergency medical technician and volunteer firefighter there, where he was credited with helping save lives in a six-car pileup in the summer of 2020.

According to Dr. Stephen Ferrara, principal deputy assistant secretary of war for health affairs, those recognized with awards at the MHS conference are “excelling at their craft, rising stars, and innovators, but most of all — they are patriots; they are warriors.”

Source: The Walter Reed National Military Medical Center



Walter Reed National Military Medical Center photo courtesy of the Defense Health Agency



ADAPTIVE SPORTS

Marine Corps Opens 2026 Warrior Games with Strong Showing

By Yvonne Reed-Carlock, Marine Corps Wounded Warrior Regiment



Team Marine Corps competitors and coaches celebrate after the powerlifting event medal ceremony at the 2026 Warrior Games at the Henry B. González Convention Center in San Antonio, June 13, 2026. Team Marine Corps finished the event with two gold, four silver and four bronze medals. Photo credit Marine Corps Sgt. Anthony C. Ramsey Jr.

Team Marine Corps opened the competition at the 2026 Warrior Games June 13, with a strong showing in powerlifting and an exhibition pickleball competition, earning 10 medals and setting the tone for the week ahead.

The opening day featured a powerlifting competition at the Henry B. González Convention Center in San Antonio, where Team Marine Corps athletes captured two gold, four silver and four bronze medals.

Master Sgt. Stevan Ball earned a gold in the men’s 97-kilogram division, while Staff Sgt. Brett Meil captured gold in the men’s

107-kilogram division. For Meil, a Texas native, the victory came in front of a host of family members, including his wife and 20-month-old son.

Earlier this week, Meil said participating in the Warrior Games is important because of the sense of belonging he finds among fellow competitors, making his gold-medal performance especially meaningful, being close to home.

Ball, a communications chief recovering from multiple injuries, including a traumatic brain injury and dual hip surgeries, credits adaptive sports with helping to restore his purpose while also



Marine Corps Master Sgt. Stevan Ball, a communications chief assigned to the Wounded Warrior Regiment, prepares to bench press as family members, friends and service members cheer him on during the powerlifting event at the 2026 Warrior Games at the Henry B. González Convention Center in San Antonio, June 13, 2026. Photo credit Marine Corps Sgt. Anthony C. Ramsey Jr.

providing an avenue to display resilience throughout his recovery.

Silver medals were earned by Staff Sgt. Marshal Ivy, Staff Sgt. Morgan Rempel, veteran Giavanna Vicario and Lance Cpl. Calbert Martinez. Bronze medals went to Capt. Gabriela Ortiz, Maj. Kim Yen Soto, Master Sgt. Modesto Garcia and Pfc. Baltazar Torresjara.

In the women’s 55-kilogram division, Vicario and Ortiz shared the podium for Team Marine Corps. Every Team Marine Corps woman who competed in powerlifting earned a medal during the opening day of competition.

For Ortiz, the bronze-medal performance came during her first Warrior Games competition and in front of a hometown crowd. The San Antonio native was supported by her parents and members of her unit as she helped Team Marine Corps open the games with a strong showing.

“It was amazing,” Ortiz said. “All the females got a medal. That was the strongest thing I’ve seen.”

Vicario, competing in her second Warrior Games after earning

The Warrior Games bring together wounded, ill and injured service members and veterans from across the War Department to compete in adaptive sports while promoting recovery, rehabilitation and camaraderie.

11 medals during the 2025 competition, said medaling in the first competition of the week meant a great deal and helped set the tone for the remainder of the event.

Soto, Team Marine Corps’ captain, also opened the week on the podium with a bronze-medal performance, while Garcia earned bronze in the men’s 88-kilogram division.

In addition to powerlifting, Team Marine Corps athletes participated in the inaugural Warrior Games pickleball exhibition.

The team featured retired Gunnery Sgt. Gabriela Carbajal, Lance Cpl. Yates Cooper Jr., veteran Arion Klein and Staff Sgt. Jacob Wolfe, a Marine Corps reservist. The exhibition marked the introduction of pickleball to the Warrior Games, highlighting the continued evolution of adaptive sports opportunities available to wounded, ill and injured service members and veterans.



Marine Corps veteran Arion Klein, a member of Team Marine Corps, serves during the pickleball exhibition at the 2026 Warrior Games at the Henry B. González Convention Center in San Antonio, June 13, 2026. Photo credit Marine Corps Sgt. Anthony C. Ramsey Jr.

The day was not without adversity. Lance Cpl. Brandon Ndashi suffered an injury prior to the competition and was unable to participate. His teammates rallied around him while continuing to represent the Marine Corps with determination and competitive spirit throughout the day.

The Warrior Games bring together wounded, ill and injured service members and veterans from across the War Department to compete in adaptive sports while promoting recovery, rehabilitation and camaraderie.

Team Marine Corps athletes demonstrated those values throughout the opening day, experiencing recovery in real time while competing alongside fellow wounded, ill and injured service members and Veterans.

Source: The U.S. The Department of War



ADDICTION

Strength Under Pressure: Managing Stress and Rethinking Alcohol Use in the Military Community

By Rodney Jackson

As operational demands, family responsibilities and the pace of military life continue to challenge service members and their families, April’s dual observance of Stress Awareness Month and Alcohol Awareness Month highlights a critical connection: how stress is managed can directly impact long-term health, resilience and readiness.

In the military community, stress is often part of the mission. Long hours, frequent moves, deployments and the constant responsibility to remain mission-ready can weigh heavily on service members and their families.

“Stress is something we expect in military life, but how we respond to it is what really matters,” said Col. Amit Gupta, Fort

Hood director of psychological health and chief Mental Health at CRDAMC. “When stress builds up without healthy outlets, people may turn to quick fixes that may seem to help in the short term, but don’t actually solve the problem, and may even be harmful in the long term.”

One of those common “quick fixes” can be alcohol, said Mark Walls, a provider with the Substance Use Disorder Clinical Care Program, CRDAMC.

While drinking is often viewed as a way to relax or socialize, Walls cautions that using alcohol to cope with stress can have the opposite effect over time.

“Alcohol might feel like it’s taking the edge off in the moment, but it can disrupt sleep, increase anxiety, make it harder to manage stress in the long run and lead to possible dependence,” said Walls. “Before you’re aware it starts to impact not just personal health, but readiness and performance.”

In a military environment where camaraderie is essential, alcohol is often present at social gatherings and unit events. While these settings can strengthen bonds, they can also make it more difficult to recognize unhealthy patterns.

“It’s important for Soldiers and families to pause and ask themselves why they’re drinking,” Walls said. “Is it to connect with others, or is it to escape stress? That awareness is key.”

Leaders and healthcare professionals across the installation emphasize that building resilience starts with developing healthy coping strategies. Physical activity, consistent sleep and structured routines all play a major role in reducing stress.

“Something as simple as regular exercise or getting outside can make a significant difference,” said Maj. Michael Hurst, chief physical therapy, CRDAMC. “We want people to understand there are effective, accessible ways to manage stress that don’t come with negative side effects.”

Equally important is connection. Talking with trusted peers, family members or counselors can help reduce the stigma often associated with stress and mental health challenges.

“Reaching out for help takes a lot of courage,” Gupta added. “The earlier someone seeks support, the easier it is for them to take back control of their life.”

Resources are readily available across Fort Hood. Mental health services, Military and Family Life Counselors, chaplains and the Army Substance Abuse Program offer confidential support tailored to the unique needs of service members and their families.

Support is Always Available:

CRDAMC Mental Health Services: Counseling for stress, anxiety, and other concerns. Visit <https://darnall.tricare.mil/Health-Services/Mental-Behavioral-Health-Substance-Use-Disorder> for more information.

Military & Family Life Counselors (MFLC): Confidential, short-term counseling. MFLCs provide services to individuals, couples, families and groups. The MFLCs are available by appointment or on a walk-in basis at the Shoemaker Center, building 36000 Shoemaker Lane, or by calling 254-553-4705.

Chaplain Services: Confidential support for all faith backgrounds at <https://home.army.mil/hood/units-tenants/Garrison/> religious-support.



Ensuring a military member’s awareness of the limitations and consequences of alcohol abuse and driving under the influence can have on a career could prevent them from crossing the line of another drink or the decision to get behind the wheel. To learn more about the consequences of and alcohol abuse, call Alcohol, Drug Abuse Program and Treatment at 883-8373. U.S. Air Force photo illustration/Samuel King Jr.

ARMY SUBSTANCE ABUSE PROGRAM (ASAP) at <https://home.army.mil/hood/units-tenants/Garrison/directorate-human-resources/army-substance-abuse-program> or call 254-287-8868.

988 Suicide & Crisis Lifeline: Call or text 988 for free, confidential, 24/7 support.

Leaders also play a critical role in shaping the culture around stress and alcohol use. By encouraging open dialogue, modeling healthy behaviors and staying engaged with their teams, they help create an environment where seeking help is normalized.

“Taking care of your mental health is just as important as maintaining physical fitness,” Gupta said. “It directly impacts your ability to perform, lead and take care of others.”

As Stress Awareness Month and Alcohol Awareness Month are observed throughout April, the message for the military community is clear: managing stress in healthy ways strengthens not only the individual, but the entire force.

Understanding the connection between stress and alcohol use is a vital step toward building resilience—and ensuring service members and their families remain ready to meet the demands of military life.

Source: U.S. Army



The Navy Medicine Training Support Center’s Coalition of Sailors Against Destructive Decisions held a talent show to heighten awareness of its theme of “Substance Abuse, Drug and Alcohol Prevention and Awareness.” Navy photo by Petty Officer 1st Class Keegan Marcantel, Navy Medicine Training Support Center



AUDIOLOGY

Protect Your Hearing. Protect Your Brain.

Growing evidence suggests hearing loss may increase the risk of cognitive decline and dementia, including Alzheimer’s disease.

By Jean Graves, Bayne-Jones Army Community Hospital

Master Sgt. Justin Davis didn’t realize how much hearing loss was affecting his life until it began affecting the people closest to him. “My wife thought I wasn’t listening when I just couldn’t hear her,” Davis said. “I’m sure my kids felt it too. It’s frustrating for a kid to have to constantly repeat themselves.”

Davis’ experience illustrates a challenge facing millions of Americans. Untreated hearing loss can affect far more than a person’s ability to communicate. Growing evidence suggests it may also increase the risk of cognitive decline and dementia, including Alzheimer’s disease.

While hearing loss does not cause Alzheimer’s disease, researchers have identified it as one of the most significant potentially modifiable risk factors associated with dementia. Because hearing loss is identifiable and treatable, health experts say early intervention may support long-term brain health while improving communication and quality of life.

“It’s important to understand that hearing is actually a brain process, not just an ear process,” said Dr. Aimee Armetta, an audiologist at Bayne-Jones Army Community Hospital. “When hearing loss is present, the auditory system delivers less complete sound information to the brain,” she explained. “As a result, the brain must work harder to fill in the missing pieces of speech. When more cognitive resources are devoted to understanding speech, fewer resources may be available for memory, attention and other higher-level thinking skills.”

Researchers refer to this phenomenon as increased listening effort — the extra mental energy required to understand conversations when hearing is impaired.

Hearing loss can also reduce social engagement. “Social interaction provides important cognitive stimulation that helps maintain brain health,” Armetta said. “When individuals withdraw from those interactions, they may experience reduced mental stimulation, which has been associated with an increased risk of cognitive decline over time.”

Family members are often the first to recognize the signs of hearing loss. Frequently asking others to repeat themselves, increasing the television volume, difficulty understanding speech in noisy environments and withdrawing from conversations may all indicate it’s time for a hearing evaluation.

For Soldiers, protecting their hearing is also a matter of readiness. Military service routinely exposes Soldiers to hazardous noise from weapons systems, aircraft, tactical vehicles and heavy equipment.

Capt. Annika Zimmerman, hearing program manager and audiologist at BJACH, said protecting hearing begins long before hearing loss becomes noticeable. “Many young Soldiers don’t think about the long-term effects of hearing loss, but protecting your hearing starts now,” Zimmerman said. “The hearing damage we accumulate throughout our lives can have long-term consequences. Taking steps to protect your hearing today is an investment in your future health.”

Zimmerman said the Army Hearing Program emphasizes prevention, routine evaluations and early intervention to identify changes before they begin affecting communication and daily life. Those efforts help Soldiers preserve effective communication while supporting long-term readiness and quality of life.

For people experiencing hearing loss, treatment offers benefits beyond simply making sounds louder. “Hearing aids do much more than simply amplify sound,” Armetta said. “They improve access to speech and environmental sounds, allowing the auditory pathways and auditory cortex to receive clearer information.”

By reducing listening effort and improving communication, hearing aids help keep the brain actively engaged in conversations, relationships and everyday activities.

For Davis, seeking treatment changed more than his hearing. “The hearing aids have given me back my attentiveness,” he said. “At work and at home. I’ve been able to spend less time asking ‘huh?’ and more time enjoying the people around me.”

Looking back, Davis hopes others won’t wait as long as he did. “The stigma around seeking medical care is nonsense,” Davis said. “I won’t lie; I was that person for the first 14 or 15 years of my career. Don’t let pride get in the way of your health.”

Source: The Defense Health Agency

CARDIOLOGY

Landmark Cardiac Procedure at Mike O’Callaghan Military Medical Center Made Possible by DoW-VA Resource Sharing

By Robyn Stulgaitis

A physician from the Department of Veterans Affairs performed a landmark cardiac procedure at the Mike O’Callaghan Military Medical Center, the first time that it has been performed successfully in the state of Nevada. This achievement represents a significant step forward for local cardiac care and showcases the success of a resource-sharing agreement between two healthcare systems.

The procedure, a defibrillator implant using a new lead designed to provide both defibrillation and left bundle branch area pacing, marks a major evolution in how cardiologists treat heart rhythm problems. For decades, traditional pacemakers and defibrillators used leads implanted directly into the heart muscle. While effective in maintaining a life-sustaining rhythm, this procedure can generate abnormal and uncoordinated heart patterns.

The procedure performed at MOMMC uses next-generation technology. The surgeon places the pacing leads directly into the body’s natural conduction system, known as the left bundle branch. By using this more physiological approach, the heart can beat in a much more natural and synchronized fashion. This synchronization can prevent the weakening of the heart muscle that can occur with the traditional approach and can lead to significantly better outcomes, especially for patients with heart failure.

“I’m very proud to be part of a team that is proactive in the utilization of technology,” said Dr. Eric Mak, the VA cardiac electrophysiologist who performed the procedure. “My experience with MOMMC staff has been amazing. Everyone is friendly, experienced, and extremely capable.”

The seamless integration of a VA doctor into a Military Health System hospital underscores the powerful synergy created by DoW-VA resource-sharing agreements. The spirit of collaboration between the two facilities is a direct result of a unique history. After operating under one roof for nearly two decades as the nation’s first fully integrated joint DoW/VA medical center, the two systems transitioned to separate campuses. Years of integrated work have built a lasting partnership that makes today’s innovative procedures possible.

Beyond just a bureaucratic handshake, resource sharing in Southern Nevada can represent a lifeline for veterans and an invaluable learning opportunity for MOMMC medics. The goals are simple yet profound: improve patient access to care and maintain critical skills of military medical personnel. By allowing VA specialists like Dr. Mak to perform procedures at state-of-the-art facilities like MOMMC, the partnership provides veterans with



Members of Mike O’Callaghan Military Medical Center’s Cardiology team celebrate the first successful performance of a groundbreaking cardiac procedure in the state of Nevada. Pictured (from left): registered nurse Kai Howard, cardiac cath lab technologists Mel Uda and Will Henderson, registered nurse Grace Macadangdang, cardiac cath lab technologist Aaron Krucynski, and cardiac electrophysiologist Dr. Eric Mak.

access to advanced care while offering military medical staff vital opportunities to participate in a wider range of complex cases.

“Through this collaboration our team gains access to complex procedural opportunities while ensuring veteran and active-duty beneficiaries receive timely, high-quality cardiovascular care,” said Lt Col (Dr.) Shayef Gabasha, MOMMC’s Chief of Cardiology. “It enhances our team’s medical readiness and deepens clinical proficiency.”

Extending beyond cardiology, the resource-sharing agreement provides authorized veterans with access to a variety of other specialties and hospital services at MOMMC.

“Our relationship with the VA is mutually beneficial,” said Charlen Gray, MOMMC’s Joint Venture Coordinator. “It is a more cost-effective approach of the use of Federal health care resources and allows veterans with referrals to access care more quickly than they would in the community.”

Gabasha underscores the agreement’s impact on patients. “This partnership allows us to combine expertise, infrastructure, and clinical experience across systems,” said Gabasha. “Ultimately, it strengthens the care provided to the patients we are privileged to serve.”

Source: Tricare

FIELD MEDICINE

Evans Soldiers Compete for Best Medic, Best Squad Titles

By Gino Mattorano, Evans Army Community Hospital

Seven Evans Army Community Hospital Soldiers put their medical and Soldier skills to the test in the Medical Readiness Command, West Best Medic/Best Squad competition April 20-23.

For the first time ever, teams from every medical treatment facility in MRC, West are conducting their own competitions and will submit their scores to MRC, West. MRC, West will select winners who will compete in the upcoming U.S. Army Best Squad Competition in July and the Army Medical Command's CSM Jack L. Clark Best Medic Competition.

Master Sgt. Doreen Fajota, the NCO in charge of the competition, said that executing decentralized Best Medic and Best Squad competitions was a challenge, but that the EACH team tasked with executing the competitions did a great job.

"The meticulously structured sequence of events ensured competitors met time hacks with every movement to and from each event," MSG Fajota said. "We also conducted In-progress reviews weekly to sync our efforts with MRC, West and the other subordinate units. It also helped that the NCOs running our lanes were subject matter experts (SMEs), so that was also beneficial. I couldn't be more proud of the cadre team!"

The Best Medic Team was made up of two competitors, and there were five Soldiers on the Best Squad team. EACH competitor was evaluated in mental and physical tasks like a written Test, the Expert Physical Fitness Assessment, Obstacle Course, Combat Water Survival, M4 Weapons Qualification, Squad Tactics, and Tactical Combat Casualty Care.

Sgt. 1st Class Jerry Hawkins, the assistant NCOIC for the competition, said each competitor did great, thanks to the preparation they did in advance of the competition.

"A few months leading up to the competition, they dedicated time for train-up outside their work schedule and it was evident during the competition," Hawkins said. "They have represented themselves well in the MRC-West competition and I'm hopeful that some will get the chance to compete in the MEDCOM competition!"

While the EACH teams competed together, MRC, West will select the best individuals from across the command to represent MRC-West in the CSM Jack L. Clark Best Medic Competition, and the U.S. Army Best Squad Competitions.



1st Lt. Brendan Killian, left, a 66H Medical-Surgical Nurse, and Staff Sgt. John Baek, a 68W Combat Medic, perform simulated tactical combat casualty care on a mannequin during the Medical Readiness Command, West Best Medic/Best Squad competition April 23, 2026 at Fort Carson, Colo. Photo by Gino Mattorano

The EACH Best Medic/Best Squad competitors are:

Best Medic:

- 1st Lt. Brendan Killian, 66H –Medical-Surgical Nurse
- Staff Sgt. John Baek, 68W – Combat Medic

Best Squad:

- Staff Sgt. Kenneth Jenkins (Squad Leader), 68W-Combat Medic
- Sgt. William Griffin, 68A- Biomedical Equipment Specialist
- Sgt. Joseph Kim, 68A- Biomedical Equipment Specialist
- Cpl. Christopher Berard, 68D – Operating Room Specialist
- Cpl. Dreana Torres, 68D – Operating Room Specialist

Source: The U.S. Digital Visual Information Distribution System

INFECTION PREVENTION

It's a Welcoming Wash for NHB's Sterile Processing Department

By Douglas Stutz, Naval Hospital Bremerton

What started out as lighthearted recognition idea became a rinsing reality for Naval Hospital Bremerton's Sterile Processing Department.

SPD staff members — primarily Navy Nurse Corps officers and hospital corpsmen with surgical technologist specialty training in attendance — held a ribbon-cutting ceremony, May 7, 2026, to formally proclaim restoration of vital cart washer ability after a two-year outage of such a critical service.

No more time-consuming manual washing, cleaning and sanitizing. "Super excited with this," exclaimed Hospital Corpsman 2nd Class Megan Calderon, Main Operating Room surgical technologist. "I love it."

According to Cmdr. Marissa Hesse, NHB Surgery Department head, after jokingly suggesting that some type of recognition was needed to emphasize having the service back up and running, that notion lead to the ceremonial observance.

"The ribbon-cutting ceremony was held to highlight this critical return to full operational capability and recognize the resilience of our surgical staff," said Hesse.

It was several years ago when a surgical technologist identified a drain overflow associated with the previous cart washer. A subsequent safety investigation revealed severe hazards, including interior rusting and electrified water, necessitating an immediate and permanent shutdown to ensure worker safety.

"Since that time, our SPD personnel and surgical technologists have had to completely overhaul their daily workflows," noted Hesse. "For 24 months, they have successfully managed manual workarounds to ensure zero degradation in patient care or surgical readiness, despite the significant increase in physical labor and time required."

Hesse and others knowingly attest that with the Sterile Processing Department located away from the mainstream of daily hospital routine, the importance of having the new cart washer might not resonate to those who don't realize its significance.

"The cart washer is a critical piece of infrastructure for hospital infection control and surgical operations. Its return restores automated, high-level decontamination capabilities for surgical carts and equipment. This not only dramatically improves workflow efficiency and turnaround times for the operating rooms,



Naval Hospital Bremerton's Sterile Processing Department marked the restoration of vital cart washer ability after a two-year outage of such a critical service with a ribbon cutting ceremony, May 7, 2026. Official Navy photo by Mass Communication Specialist 2nd Class Jennifer Benedict, NHB/NMRTC Bremerton public affairs

but it also ensures the highest standard of patient safety and permanently resolves the occupational hazards our staff previously faced," explained Hesse.

The brief ribbon-cutting ceremony not only formally unveiled the new equipment but also provided the opportunity to publicly recognize the SPD and Main OR surgical technologist teams for their adaptability and hard work during the two-year outage.

"What an amazing morning. Moments like this are important. To solve this problem everyone worked together, with material management, facility management, your equipment folks, Main OR and SPD staff," said Capt. Karla Lepore, Naval Hospital Bremerton director and Navy Medicine Readiness Training Command Bremerton commanding officer.

"Celebrating a small moment like this is to acknowledge all that goes into the behind the scenes work to get this project done," added Hesse, noting that the new system back online is also a result of leadership's commitment to resolving critical staff safety and infrastructure issues, and demonstrates the command's enhanced medical readiness and infection control capabilities.

Hospital corpsmen with surgical technologist specialty skills handle Sterile Processing Department duties. A typical day for the surgical techs has them assisting in the Main OR during all surgical cases, followed by meticulous cleaning, disinfecting, and ensuring proper sterilization has taken place for all gear being used to eliminate risk of infection.

Source: The United States Navy



INFECTIOUS DISEASES

Invisible Threats, Visible Solutions for the Future of Military Environmental Health

By Wendy Li

The second annual Military Environmental Epidemiology Symposium advanced force readiness by combating invisible battlefield hazards.



Dr. Jennifer Rusiecki addresses the audience at the second annual Military Environmental Epidemiology Symposium. *USU Photo*

The second annual Military Environmental Epidemiology Symposium (MEES), held on April 30 at the Uniformed Services University (USU), brought together more than 300 attendees seeking to advance the science of environmental health and its impact on service member readiness.

Experts from advocacy groups and academic institutions shared existing research and had the opportunity to facilitate new collaborations. This event was made possible by a team from USU’s Department of Medicine, the Department of Veterans Affairs (VA), the National Cancer Institute (NCI), the Defense Centers for Public Health-Aberdeen (DCPH-A), and the Canadian Department of National Defense, reflecting the interagency spirit of the event.

The agenda of the symposium was built around three core pillars: resources for evaluating environmental and occupational exposures, exposure assessment within the military, and exposures of concern.

Dr. Laura Brosch, USU’s Interim Vice President for Research, opened the event by highlighting the profound impact of environmental epidemiology on mission success. “When our service

members deploy, they are prepared to face the kinetic effects of the battlefield, the threats,” she said. “However, history and science have shown us that some of the most pervasive and insidious threats are invisible. They are the air they breathe, the water they drink, and the soil on which they operate.”

A major highlight of the event was the emphasis on Job Exposure Matrices (JEMs) within the military. JEMs are epidemiological tools used to systematically link job titles with potential or relevant exposures to specific workplace hazards. Experts discussed how these tools can significantly enhance occupational exposure assessments, providing more precise data on the long-term health effects of service-related toxic exposures.

Dr. Jennifer Rusiecki, Professor of Medicine and chair of the organizing committee, noted that the MEES addresses a historical and critical absence of dedicated spaces for this type of research.

“This symposium bridges a significant gap in the field, providing a much-needed forum dedicated specifically to military environmental epidemiology. Looking back at our inaugural event last year, it’s incredibly clear how much our community has been craving a space like this to share research, tackle roadblocks, and network. Moving forward, we want to ensure we are lifting up the next generation of talent, which is why we’ve introduced lightning talks for junior investigators this year.”

Other sessions addressed compelling research examining how the serum concentrations of per- and polyfluoroalkyl substances are associated with glioma risk, as well as emerging areas vital to force protection, including the physiological effects of extreme heat and cold, the impacts of noise and ototoxin exposure, and the risks of ultrafine particulate matter air pollution.

The symposium culminated with an interactive session aimed at dismantling organizational silos between federal agencies and academic institutions. Participants identified significant potential for enhanced collaboration across the Military Health System, VA, and NCI — ensuring that cutting-edge research translates directly into improved health outcomes for both active-duty personnel and veterans.

Source: The Uniformed Services University

INFECTIOUS DISEASES

Update: Malaria among members of the U.S. Armed Forces, 2025



Malaria infection remains a potential health threat to U.S. service members located in or near endemic areas due to duty assignments, participation in contingency operations, or personal travel. This report summarizes findings from surveillance of malaria infections among U.S. service members in 2025 and analyzes trends for a 10-year period, from 2016 through 2025. In 2025, 36 cases of malaria were diagnosed among U.S. service members, representing a 12.5% increase from 32 cases reported in 2024. The majority of malaria cases occurred in service members who were male (94.4%), in the active component (80.6%), and serving in the Army (63.9%). Africa was the leading region of acquisition (n=14), primarily for *P. falciparum* infections. A significant 2025 finding is a shift in the predominant species to *P. vivax*, which accounted for 41.7% (n=15) of all cases, a notable increase from 10% of all cases in 2024. Most *P. vivax* cases (80.0%) were acquired in Korea. Seasonality of infection remained consistent, with 72.1% of cases diagnosed May through October. These findings underscore the critical need for continuous surveillance, strict command emphasis on personal protective measures, and region-specific prevention strategies to protect the health of the force and maintain military readiness.

What are the new findings?

Findings from 2025 indicate a 12.5% increase in malaria cases among U.S. service members compared to 2024, with a notable increase of new *P. vivax* cases. This change was driven almost entirely by *P. vivax* infections acquired in Korea, while Africa remained the principal source for *P. falciparum* cases.

What is the impact on readiness and force health protection?

The rise of *P. vivax* from Korea along with persistent *P. falciparum* infection from Africa not only directly affect force health protection

but demonstrate a dynamic, regionally specific threat that requires specialized prevention strategies to maintain military readiness.

Background

Malaria has long posed a significant risk to U.S. military service members and operations.¹ Before World War II, the disease was endemic across the southern U.S., prompting the 1942 establishment of the Office of Malaria Control in War Areas — an organization that would later become the Centers for Disease Control and Prevention — to mitigate vector-borne diseases around military installations.² While this campaign was successful in the elimination of malaria as a public health threat to the U.S. by 1949, the disease remains a persistent risk to the operational readiness of U.S. service members when deployed to endemic tropical and subtropical regions.³⁻⁵

The risk to military personnel is heightened by operational realities, the emergence of drug-resistant parasites, and inconsistent adherence to preventive measures such as chemoprophylaxis and personal protective equipment.⁶⁻⁹ Travel to malaria-endemic regions, especially for foreign-born personnel visiting their countries of origin, also presents a significant medical concern.¹⁰⁻¹¹ Studies have shown a significantly higher incidence of malaria in service members and their families with connections to malaria-endemic countries, particularly those from sub-Saharan Africa. This increased risk persists despite universal health coverage and access to pre-travel medical care for this specific population.¹¹ Most human malaria cases are caused by 4 *Plasmodium* species — *P. falciparum*, *P. vivax*, *P. malariae*, and *P. ovale* — with *P. falciparum* and *P. vivax* the most significant. *P. falciparum*, found predominantly in Africa, is the most dangerous species, accounting for over 90% of malaria-related deaths,¹² while *P. vivax* has the widest geographic distribution, with a high prevalence in Southeast Asia, the Western Pacific, and the Americas.¹³ These 2 species, *P. falciparum* and *P. vivax*, have distinct epidemiological profiles. A critical difference is the ability of *P. vivax* to cause relapses weeks or even months after initial infection,¹⁴ which occurs because the parasite can remain in the liver as hypnozoites, allowing dormant endemicity during the colder, mosquito-free seasons and extending its geographic range into temperate zones, such as the Korean peninsula.¹⁵

MSMR has published regular updates on malaria’s impact on service members since 1999. Current surveillance efforts include the differentiation of malaria types, such as the more lethal *P.*



falciparum and relapsing P. vivax. This sustained surveillance provides critical data to inform force health protection strategy, and this update continues that mission by describing malaria's epidemiological patterns among U.S. Armed Forces from 2016 through 2025.

Methods

The surveillance population for this report includes service members of the U.S. Army, Navy, Air Force, Marine Corps, Space Force, and Coast Guard. The surveillance period was January 1, 2016 through December 31, 2025. Records from the Defense Medical Surveillance System (DMSS) were searched to identify qualifying evidence of a malaria diagnosis from reportable medical events (RMEs), hospitalizations, outpatient encounters (in military and non-military facilities), and laboratory results from military facilities.

Case definition criteria for malaria included either 1) an RME record of confirmed malaria, 2) a hospitalization record with a primary diagnosis of malaria, 3) a hospitalization record with a non-primary diagnosis of malaria due to a specific Plasmodium species, 4) a hospitalization record with a non-primary diagnosis of malaria plus a diagnosis of anemia, thrombocytopenia, and related conditions, or malaria-complicating pregnancy in any diagnostic position, 5) a hospitalization record with a non-primary diagnosis of malaria plus diagnoses of signs or symptoms consistent with malaria in each diagnostic position preceding malaria, or 6) a positive malaria antigen test plus an outpatient record with a diagnosis of malaria in any diagnostic position within 30 days of the specimen collection date.¹⁶ The relevant International Classification of Diseases, 9th and 10th revisions (ICD-9/ICD-10) codes used to identify cases are shown in Table 1.

This analysis restricted each service member to 1 episode of malaria per 365-day period. When multiple records documented a

single episode, the date of the earliest record was considered the date of clinical onset. Records within 30 days of the clinical onset date were reviewed for evidence of a Plasmodium species.

Presumed locations of malaria acquisition were estimated with a hierarchical algorithm: 1) cases diagnosed in a malaria-endemic country were considered acquired in that country, 2) RMEs that listed exposures to malaria-endemic locations were considered acquired in those locations, 3) RMEs not listing exposures to malaria-endemic locations but reported from installations in malaria-endemic locations were considered acquired in those locations, 4) cases diagnosed among service members during or within 30 days of deployment or assignment to a malaria-endemic country were considered acquired in that country, and 5) cases diagnosed among service members deployed or assigned to a malaria-endemic country within 2 years before diagnosis were considered acquired in those countries. All remaining cases were considered to have acquired malaria in unknown locations.

Results

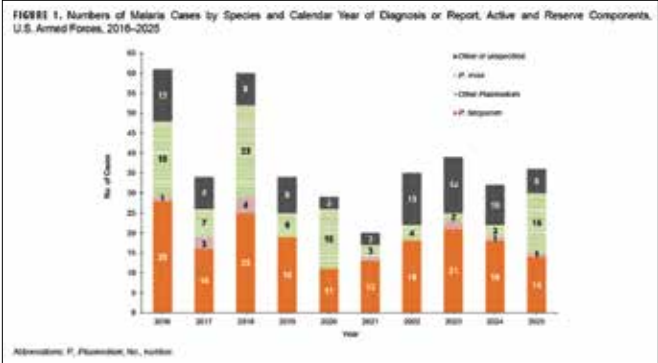
In 2025, a total of 36 U.S. service members were diagnosed with, or reported to have, malaria (Table 2). The annual total for 2025 represents a 12.5% increase in malaria cases from the 32 cases reported in 2024 (Figure 1). Twenty-eight (77.8%) of the 36 cases in 2025 were identified from RME records. The remaining 8 cases were identified through additional case definition criteria: 5 cases from hospitalization records with a defining diagnosis of malaria in the primary diagnostic position, 2 cases from hospitalization records with a case defining diagnosis of malaria in a non-primary diagnostic position due to a specific Plasmodium species or additional diagnoses for malaria-related conditions, and 1 case from a U.S. Department of War laboratory report of a positive malaria antigen test plus 1 outpatient medical encounter for a case-defining diagnosis of malaria in any diagnostic position within 30 days of the specimen collection date (data not shown).

TABLE 1. ICD-9 and ICD-10 Diagnosis Codes Used to Define Malaria Cases from Inpatient, Hospitalization Records		
	ICD-9	ICD-10
Malaria <i>Plasmodium</i> species		
<i>P. falciparum</i>	84.0	B50
<i>P. vivax</i>	84.1	B51
<i>P. malariae</i>	84.2	B52
<i>P. ovale</i>	84.3	B53.0
Unspecified	84.4, 84.5, 84.6, 84.8, 84.9	B53.1, B53.8, B54
Anemia	280–285	D50–D53, D55–D64
Thrombocytopenia	287	D69
Malaria complicating pregnancy	647.4	O98.6
Signs, symptoms, or other abnormalities consistent with malaria	276.2, 518.82, 584.9, 723.1, 724.2, 780.0, 780.01, 780.02, 780.03, 780.09, 780.1, 780.3, 780.31, 780.32, 780.33, 780.39, 780.6, 780.60, 780.61, 780.64, 780.65, 780.7, 780.71, 780.72, 780.79, 780.97, 782.4, 784.0, 786.05, 786.09, 786.2, 786.52, 786.59, 787.0, 787.01, 787.02, 787.03, 787.04, 789.2, 790.4	E87.2, J80, M54.2, M54.5, N17.9, R05, R06.0, R06.89, R07.1, R07.81, R07.82, R07.89, R11*, R16.1, R17, R40*, R41.0, R41.82, R44*, R50*, R51, G44.1, R53*, R56*, R68.0, R68.83, R74.0
Abbreviations: ICD-9, International Classification of Diseases, 9th Revision; ICD-10, International Classification of Diseases, 10th Revision; <i>P.</i> , <i>plasmodium</i> . * Indicates that any subsequent digit or character is included.		

TABLE 2. Malaria Cases by *Plasmodium* Species and Selected Demographic Characteristics, U.S. Armed Forces, 2025

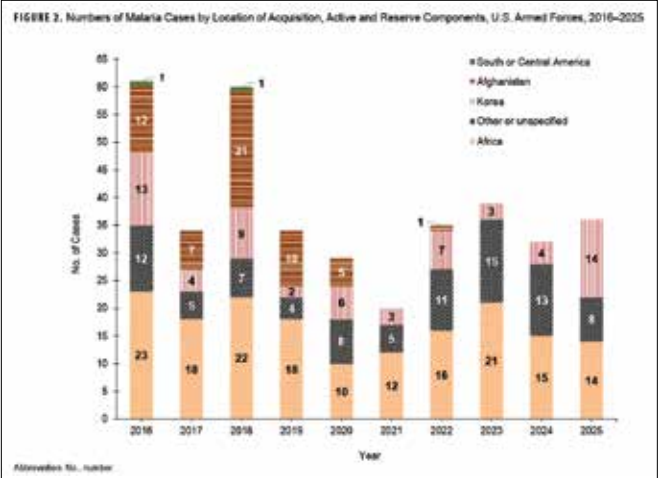
	<i>P. vivax</i>	<i>P. falciparum</i>	Other or Unspecified	Total	
	No.	No.	No.	No.	%
Total	15	14	7	36	100
Component					
Active	13	11	5	29	80.6
Guard, Reserve	2	3	2	7	19.4
Branch of service					
Army	12	7	4	23	63.9
Navy	1	4	0	5	13.9
Air Force	1	1	3	5	13.9
Marine Corps	1	2	0	3	8.3
Sex					
Male	14	13	7	34	94.4
Female	1	1	0	2	5.6
Age, y					
<20	2	0	1	3	8.3
20–24	7	2	2	11	30.6
25–29	3	3	2	8	22.2
30–34	2	5	0	7	19.4
35–39	1	1	1	3	8.3
40–44	0	1	1	2	5.6
45–49	0	1	0	1	2.8
50+	0	1	0	1	2.8
Race and ethnicity					
White, non-Hispanic	7	1	3	11	30.6
Black, non-Hispanic	0	13	3	16	44.4
Other	8	0	1	9	25.0

Abbreviations: *P.*, *Plasmodium*; DMSS, Defense Medical Surveillance System; y, years.



As in previous years, the majority of U.S. military members diagnosed with malaria in 2025 were men (94.4%), members of the active component (80.6%), and in the Army (63.9%). No cases were reported in the Space Force or Coast Guard. Non-Hispanic Black service members and individuals ages 20-24 years accounted for the most cases of malaria (44.4% and 30.6%, respectively) (Table 2).

Examination of the 28 malaria case records reported as RMEs in 2025 revealed that 5 of the case exposures were classified as deployment-related, 5 as duty-related (but not deployment-related), 10 were non-deployment and non-duty related, while 8 cases were missing exposure classification. Six of the 10 cases classified as non-deployment and non-duty related were documented as acquired in Africa (data not shown).



During the 2016-2025 surveillance period, malaria cases acquired in Africa (n=169, 44.5%) and other or unspecified locations (n=88, 23.2%) accounted for the largest numbers, followed by Korea (n=65, 17.1%), Afghanistan (n=56, 14.7%), and South and Central America (n=2, 0.5%) (Figure 2). Africa consistently reported the highest numbers of malaria cases throughout the period. Cases in Afghanistan peaked to 21 in 2018, thereafter declining to 0 cases during last 3 years of the surveillance period. Malaria cases were diagnosed or reported in 2025 from 21 different medical facilities: 14 facilities in the U.S., 3 facilities in the Republic of (South) Korea, and 1 facility each in Germany, Africa, and Japan, as well as 1 TRICARE Prime remote location (Table 3).

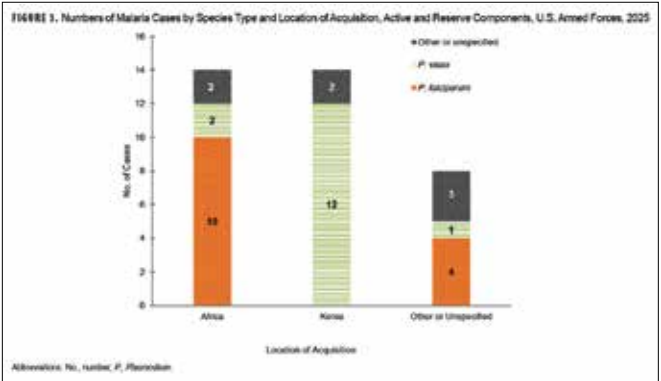


TABLE 3. Number of Malaria Cases by Geographic Location of Diagnosis or Report and Presumed Location of Acquisition, Active and Reserve Components, U.S. Armed Forces, 2025

Location Where Diagnosed or Reported	Korea	Africa	South or Central America	Other or Unknown Location	Total	
	No.	No.	No.	No.	No.	%
AHC Camp Casey, South Korea	9	0	0	0	9	25.0
ACH Camp Humphreys, South Korea	2	0	0	0	2	5.6
Irwin ACH, Fort Riley, KS	0	2	0	0	2	5.6
Madigan AMC, Joint Base Lewis-McChord, WA	2	0	0	0	2	5.6
NMC Portsmouth, VA	0	1	0	1	2	5.6
Travis AFB 60th Medical Group, CA	0	0	0	1	1	2.8
NMC San Diego, CA	0	0	0	1	1	2.8
Evans Carson ACH, Fort Carson, CO	0	1	0	0	1	2.8
NH Jacksonville, FL	0	1	0	0	1	2.8
MacDill AFB 6th Medical Group, FL	0	1	0	0	1	2.8
Robins AFB 78th Medical Group, GA	0	1	0	0	1	2.8
Walter Reed National Military Medical Center, MD	0	1	0	0	1	2.8
Womack AMC, Fort Bragg, NC	0	1	0	0	1	2.8
Alexander T. Augusta Military Medical Center, Fort Belvoir, VA	0	1	0	0	1	2.8
Fairchild AFB 92nd Medical Group, WA	0	1	0	0	1	2.8
Barquist AHC, MD	0	1	0	0	1	2.8
Landstuhl Regional Medical Center, Germany	0	0	0	1	1	2.8
Brian D. Allgood ACH, South Korea	1	0	0	0	1	2.8
NH Okinawa, Japan	0	0	0	1	1	2.8
Expeditionary Medical Facility, Djibouti	0	1	0	0	1	2.8
Pacific Tricare Prime Remote Facility	0	1	0	0	1	2.8
Location not reported	0	0	0	3	3	8.3
Total	14	14	0	8	36	100

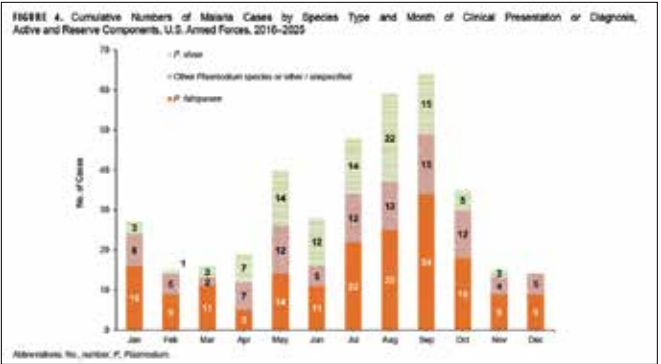
Abbreviations: No., number; AMC, Army Medical Center; ACH, Army Community Hospital; AHC, Army Health Clinic; AMC, Army Medical Center; AFB, Air Force Base; NH, Naval Hospital; NMC, Naval Medical Center.

Most U.S. service member malaria cases in 2025 were caused by *P. vivax* (n=15, 41.7%). Twelve of those 15 *P. vivax* cases were acquired in Korea. The remaining cases were attributed to *P. falciparum* (n=14, 38.9%) and other or unspecified types of malaria (n=7, 19.4%). Most cases acquired in Africa (n=14) were caused by *P. falciparum* (n=10, 71.4%) (Figure 3). The 14 malaria cases acquired in Africa were associated with several countries, including Djibouti (n=3), Ghana (n=3), Cameroon (n=2), Nigeria (n=2), Sierra Leone (n=1), Guinea (n=1), and Tanzania (n=1); 1 case was associated with an unknown African location (data not shown).



From 2016 to 2025, malaria caused by *P. falciparum* accounted for the greatest number of cases (183, 48.2%) followed by other or unspecified species (n=99, 26.1%), and *P. vivax* (n=98,

25.8%). Over the 10-year surveillance period, most malaria cases (n=274/380, 72.1%) were diagnosed or reported during the 6 months from the Northern Hemisphere middle of spring through the middle of autumn (i.e., May–October) (Figure 4). The proportions of malaria cases diagnosed or reported May–October varied by region of acquisition: Afghanistan (n=48/56, 85.7%), Korea (n=58/65, 89.2%), Africa (n=117/169, 69.2%), and South and Central America (n=1/2, 50.0%) (data not shown).



Discussion

The number of malaria cases among U.S. service members saw a modest increase in 2025, rising by 12.5% from the previous year. While the total number of cases remains relatively low, these malaria data reveal several key trends and a notable shift in the dominant parasite species, underscoring the persistent threat

of malaria to military personnel operating globally. Consistent with historical trends, the demographic profile of malaria cases in 2025 comprised predominantly young, male soldiers from the active component.³⁻⁵ The majority (77.8%) of cases were identified through routine RMEs, with the remainder captured through hospitalization and laboratory records, highlighting the importance of a multi-faceted surveillance strategy to ensure comprehensive case identification.

Geographically, Africa continues to be a primary region of acquisition for malaria infections, a consistent trend over the last decade.³ The majority of cases acquired in Africa were caused by *P. falciparum*, the most severe form of the parasite. Cases acquired in Africa were traced to at least 7 different countries, reflecting the widespread risk across the continent.

Perhaps the most significant finding from the 2025 surveillance data is the dramatic shift in the causative species. Nearly half of all cases were attributed to *P. vivax*, a stark contrast to 2024, when *P. falciparum* accounted for over half of cases — and *P. vivax* only 10%. This change is almost entirely driven by cases acquired in Korea, which accounted for 80% of *P. vivax* infections in 2025. This finding emphasizes the geographically distinct epidemiology of malaria and the specific risks associated with different operational theaters. This risk has long been documented since the Korean War, however, among U.S. and Korean Forces near the Demilitarized Zone.¹⁷

The seasonal pattern of malaria diagnoses remains consistent with previous findings, providing predictable opportunity for targeted force health protection measures. Over the 10-year surveillance period, a significant majority (72.1%) of cases were diagnosed May–October, coinciding with the warmer, wetter months that favor mosquito vector activity.¹⁸ This trend was particularly pronounced for cases acquired in Korea (89.2%), aligning with the established transmission season for *P. vivax* in temperate zones and reinforcing the need for heightened awareness and preventative measures during these months for personnel in those regions. Vector surveillance programs have shown a correlation between the number of *Anopheles* species positive for *P. vivax* sporozoites with the number of malaria cases and exposure of soldiers from the Republic of Korea soldiers from May through October.¹⁹ Even in Africa, where transmission can occur throughout the year,^{18,20} nearly 70% of cases were reported during this same period, underscoring its importance as a peak transmission season globally.

Limitations to this report should be considered when interpreting these findings. Malaria case reporting, especially for reserve components and non-deployment exposures, is likely incomplete, contributing to under-estimation of rates; some cases treated in deployed or non-U.S. military medical facilities may not have been reported or otherwise ascertained at the time of analysis. Malaria diagnoses documented only in outpatient settings without confirmatory testing and not reported as RMEs were not included in this report. Geographic location of malaria acquisition was estimated from reported information, with some



Photo courtesy of the U.S. Army



cases reporting exposures in multiple malaria-endemic areas and others with no relevant exposure information. Personal travel or deployment to malaria-endemic countries was not documented unless specified in RMEs. Limited information on species types in RME records emphasizes the need for more complete attention to documentation of reportable conditions.

These findings emphasize the need for continuous surveillance, regionally specific prevention strategies, and robust diagnostic capabilities to protect U.S. service members from this persistent infectious disease. While the overall burden of malaria within the U.S. military is not significant, 2025 data illustrate a dynamic and evolving threat, with the continued prevalence of *P. falciparum* in Africa posing a significant risk for severe disease and the sharp increase in *P. vivax* from Korea demonstrating a difference, but equally important, regional challenge.

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Disclaimers

The views expressed in this report reflect the results of research conducted by the authors and do not necessarily reflect official policy nor position of the Defense Health Agency, Department of War, or the U.S. Government.

The editors disclose use of an artificial intelligence (AI) language model in the preparation of this report. Assistance was provided by Gemini Enterprise, a large language model from Google, specifically optimized for Department of War mission support within an Impact Level 5 (IL5) environment. This AI application was used to assist with initial drafts of the discussion, to refine prose for clarity. *MSMR* editors directed all AI review and analysis, with subsequent editorial staff review and final edits. The editors assert full responsibility for the accuracy and integrity of the final content.

Source: *Then U.S. Military Health Service*

MENTAL HEALTH

59th Medical Wing Activates Mental Health Squadron, Advances Warfighter Readiness

By Brian Valencia 59th Medical Wing

The 59th Medical Wing officially activated the Lackland Mental Health Squadron during a ceremony June 25, marking a significant milestone in the organization's continued commitment to strengthening the readiness and resilience of Airmen while positioning the unit to meet the evolving demands of military medicine.

"Today isn't simply about standing up a new squadron," said Col. Shawn Garcia, commander of the Lackland Medical Group, who presided over the ceremony. "It's about ensuring our organizational structure reflects the critical role mental health plays in warfighter readiness. By standing up this squadron, we're strengthening our ability to care for Airmen, develop future leaders and continue evolving to meet the needs of the force."

The newly activated squadron traces its lineage to the 759th Medical Operations Squadron, first activated in 1998. It was redesignated as the 59th Mental Health Squadron in 2008 before becoming part of the 59th Medical Operations Squadron as a flight in 2013. Throughout its history, the organization has supported combat deployments, humanitarian operations, psychological research, trainee screening and behavioral health care for thousands of service members.

Now, this newly activated squadron carries that vision forward with a dedicated command structure designed to strengthen operational readiness, foster innovation and ensure Airmen receive the behavioral health care needed to remain mission ready.

Lt. Col. Elizabeth Najera, acting commander of the Lackland Mental Health Squadron, said the activation reinforces



U.S. Air Force Col. Shawn Garcia, commander of the Lackland Medical Group, and Chief Master Sgt. Codi Bowman, senior enlisted leader of the Lackland Mental Health Squadron, unfurl the squadron guidon during the unit's activation ceremony at Wilford Hall Ambulatory Surgical Center, Joint Base San Antonio-Lackland, Texas, June 25, 2026. Photo credit U.S. Air Force Senior Airman Matthew-John Braman

the Air Force's commitment to caring for the people who accomplish the mission every day.

"Every day, our team has the privilege of caring for the men and women who defend our nation," Najera said. "Standing up as a squadron allows us to sharpen that focus even further by strengthening our ability to support warfighter readiness, build resilient Airmen and continue evolving how we deliver behavioral health care to the force."

Chief Master Sgt. Codi Bowman, the squadron's senior enlisted leader, said the activation represents both a recognition of the unit's history and an investment in its future.

"Becoming a squadron again is a testament to the undeniable fact that mental health is a vital pillar of our warfighting

readiness," Bowman said. "We're honoring the great work this unit has done while starting a brand-new chapter. I'm incredibly proud of our team and look forward to providing even stronger support for our Airmen."

Najera will serve as the squadron's acting commander during the standup phase. Lt. Col. Nathan Howarth, the selected commander, is expected to assume command in the fall.

With its activation complete, the Lackland Mental Health Squadron is poised to build on more than two decades of excellence while advancing the mental readiness, resilience and warfighting capability of the Airmen it serves.

Source: *The Digital Visual Information Distribution System*



NEUROLOGY

Walter Reed’s National Intrepid Center of Excellence Leads War Department in Care, Research of Traumatic Brain Injury

By Bernard Little, WRNMMC Hospital Communications

When service members suffer a traumatic brain injury (TBI) or from post-traumatic stress, called the “invisible wounds of war,” many may think there’s no road to recovery. But the National Intrepid Center of Excellence (NICoE) at Walter Reed is there to make the road to recovery smoother for these service members and other Military Health System (MHS) beneficiaries through cutting-edge, holistic care and research to treat those invisible wounds.

NICoE is the Department of War’s Center of Excellence for TBI and related psychological health clinic care, research and education, bringing together expert providers under one roof to create care plans for each “brain warrior.” Providers and specialists at NICoE focus on an array of modalities, including brain fitness, restorative sleep, stress management, art therapies, social engagement, physical activity and nutrition to help battle TBI and mental health challenges.

“Beneficiaries are eligible for [care at] NICoE if they have suffered a TBI and have ongoing sequelae, especially if they require concomitant mental health care and/or rehab,” explained Army Col. (Dr.) Shannon Ford, NICoE’s director.

“We have 20 specialties under one roof to contribute to the interdisciplinary model that has been replicated across multiple civilian programs, and we are the lead and largest within the Defense Intrepid Network (DIN),” added Ford, a psychiatrist and a diplomate in psychiatry, consultation-liaison psychiatry, and geriatric psychiatry.

In 2008, the National Defense Authorization Act directed the Department of Defense (DOD) to establish a comprehensive plan for programs to prevent, diagnose, treat, and rehabilitate service members with TBI, PTSD, and other mental health conditions. Congress further instructed DOD to conduct research



Dr. David Williamson in 2023, medical director for the Neuropsychiatry/Traumatic Brain Injury unit at Walter Reed National Military Medical Center and his staff are breaking new ground in identifying and treating TBI and behavioral health challenges. Photo courtesy of Walter Reed National Military Medical Center



Walter Reed National Medical Center. Courtesy photo

to better understand TBI interventions and new therapies, and mandated dissemination of these practices. This came in the wake of 9/11 and the Global War on Terrorism when TBIs became the defining injury of the war.

With care from NICoE, which opened its doors on June 24, 2010, many service members who suffered a TBI are able to return to duty. NICoE now serves as the “hub” of the Intrepid Spirit Centers, located throughout the continental United States, and Overseas TBI and Brain Health Clinics at Joint Base Elmendorf-Richardson, Alaska, and Landstuhl Regional Medical Center in Germany. The centers make up the DIN.

Ford explained that unique components of the NICoE at Walter Reed include the Brain Fitness Center (BFC) and Arts in Health.

“The Brain Fitness Center is accessible to patients across the hospital, often used by oncology patients with cognitive concerns in addition to those who have experienced a TBI/concussion,” she shared. The BFC uses computer-based brain training, heart rate variability biofeedback, and mind-body techniques to improve memory, attention, and processing speed. Since it opened in 2009, more than 3,000 service members and beneficiaries have participated in the BFC program.

“Arts in Health has a monthly Cognitive Creations Art Therapy group at the BFC, in addition to weekly groups about communication, memory strategies, and nutrition for brain health,” Ford added.

The Arts in Health program at NICoE began in 2011 when NICoE partnered with the National Endowment of the Arts (NEA) to develop a creative arts therapy program. The collaboration has resulted in therapies and programs supported by visual art, music, dance, yoga and writing. Since the program began, nearly 4,000 service members and beneficiaries have been reached through the program.

A key component of the art therapy program is mask-making and other creative acts, allowing service members to visualize and process complex emotions to help tackle the challenges of invisible wounds. NICoE also has an Intensive Outpatient Program (IOP), a multi-week initiative for TBI patients that’s tailored treatment plans focus on the mind, body and spirit. Other programs include the Acute Concussion Clinic, Sleep Clinic, Pain Clinic, and Mind-Body Wellness Program.

Ford also discussed some of the recent research efforts of her NICoE team. NICoE’s Dr. Treven Pickett is currently a research leader in a study using teletherapy to improve emotional health after brain injury. The study is investigating how to strengthen emotional health and resiliency in people with mild TBI who experience alexithymia, a condition marked by difficulty recognizing and expressing emotions. The goal is to also lessen the challenges of post-traumatic stress, anxiety, depression, and anger.

The National Intrepid Center of Excellence (NICoE) at Walter Reed is there to make the road to recovery smoother for service members who suffer a traumatic brain injury (TBI) or from post-traumatic stress through cutting-edge, holistic care and research to treat these invisible wounds of war.

NICoE researchers are also looking into providing increased access to evidence-based moral injury treatment throughout DIN with train-the-trainer methodology and a goal of intervention delivered largely via telehealth.

Moral injury can happen when a person “perpetrates, fails to prevent, or witnesses acts that violate their personal ethics, often causing intense feelings of guilt, shame, anger, and betrayal.” In the military, moral injury is defined as “the deep psychological, ethical, and spiritual harm resulting from actions — or inactions — that violate deeply held moral beliefs during combat,” according to the National Center for PTSD. “Common in veterans, moral injury causes profound shame, guilt, and mistrust, distinct from the fear-based symptoms of PTSD. It often stems from killing, witnessing suffering, or following orders that conflict with personal ethics.”

“NICoE continues to excel in the delivery of patient-centered, interdisciplinary care to service members and veterans with TBI. Our efforts have been recognized across multiple fronts, most notably by our patients, who regularly share testimonials that our compassionate holistic approach heals warfighters and helps them overcome stigma and the challenges of moral injury,” Ford stated.

Source: Walter Reed National Medical Center



NURSING

United States Air Force Nurse Corps: 77 Years of Support to Mission Readiness, Patient Care

By Robert Hammer, MHS Communications

U.S. Air Force Nurse Corps celebrated its 77th anniversary in 2026. Through its mission, “Nursing Excellence, Anytime... Anywhere,” the nurses are dedicated to the health and safety of Airmen and Guardians.

A component of the Air Force Medical Service, the Nurse Corps was established July 1, 1949, with the transfer of 1,199 nurses from the U.S. Army Nurse Corps, two years after the creation of an independent U.S. Air Force.

U.S. Air Force General Order No. 35, established the AFMS and its six original corps components. Air Force Maj. Gen. Malcolm Grow, who would become the first U.S. Air Force surgeon general, convinced the U.S. Army and President Harry S. Truman, the U.S. Air Force needed its own specialized medical service.

Battlefield evolution needed specialized nurse corps

During World War II, U.S. Army Air Force nurses proved aircraft could move sick and injured troops safely over long distances. In January 1943, a specialized aeromedical nurse corps identity took shape as nurses and technicians began deploying overseas in medical air evacuation transport squadrons. Meanwhile, Army 2nd Lt. Elsie Ott, a nurse with no formal air evacuation training, escorted five seriously ill patients from Karachi, then part of India, to Walter Reed General Hospital in Washington, D.C, according to Judith Taylor, Air Force Medical Service senior historian. This first strategic evacuation mission demonstrated the need for trained flight nurses and validated the viability of long-distance aeromedical evacuation.



The U.S. Air Force Nurse Corps celebrates its 77th anniversary on July 1, 2026. From assisting in medevac during World War II to serving in military hospitals and clinics across the Military Health System today, discover the Nurse Corps’ decades-long commitment to the health and safety of Airmen and Guardians

Through its mission, “Nursing Excellence, Anytime... Anywhere,” the nurses are dedicated to the health and safety of Airmen and Guardians.

The U.S. Army Nurse Corps’ first formal class of trained flight nurses graduated Feb. 18, 1943, at Bowman Field, Kentucky. The honor graduate, Army 2nd Lt. Geraldine Dishroon received the first wings presented to a flight nurse and served on the first air evacuation team to land on Omaha Beach after the D-Day invasion in 1944.

The U.S. Army continued to support the medical needs of the U.S. Air Force after its creation on Sept. 18, 1947, until the establishment of the AFMS and the Nurse Corps in 1949.

Air Force Col. Verena Zeller, named the first chief of the Nurse Corps in 1949, had served in the U.S. Army Nurse Corps since 1936 and completed the flight nurse course in 1946. She was promoted to lieutenant colonel in 1950 and colonel in 1951.

Zeller led the corps through its first major test, the Korean War. At the time, only 181 of the corps’ 1,170 nurses were designated as flight nurses. Within a few weeks of the outbreak of hostilities, however, 200 Air Force nurses were actively engaged in the aeromedical evacuation of patients in the Zone of the Interior and overseas. With few fixed U.S. Air Force hospitals on the Korean Peninsula, nurses served mainly in aeromedical evacuation roles or in hospitals offshore in Japan. At the peak of the Korean War, almost 3,000 U.S. Air Force nurses served on active duty.

During the Vietnam War, more than 4,000 U.S. Air Force nurses served. U.S. Air Force nurses were instrumental in evacuating large numbers of those injured from Southeast Asia — including March 7, 1969, when 711 patients were evacuated from Vietnam on 12 missions. In 1973, flight nurses repatriated 591 American prisoners of war.

In support of the wars in Iraq and Afghanistan, the Nurse Corps played a pivotal role including at the peak of the Iraqi invasion between March and May 2003 with more than 2,000 aeromedical evacuations.

In 2026, nurses now serve in military hospitals and clinics, operational units, and mobility missions, including aeromedical evacuation and other settings where care must move with the force. They work across general medicine and numerous specialties, including clinical nursing, critical care, emergency and trauma nursing, flight nursing, mental health, obstetrics, and operating room nursing.

Landmark moments and historical figures of the Nurse Corps include:

- Air Force Brig. Gen. Ethel Ann Hoeffly became the first U.S. Air Force Nurse Corps chief promoted to brigadier general.
- Air Force Col. Regina Aune rescued children after the crash of the first Operation Babylift mission from Vietnam in 1975 and later became the first woman to receive the Cheney Award, a U.S. Air Force aviation award given for an act of valor, extreme fortitude, or self-sacrifices in a humanitarian interest.
- The first two nurses graduated from the aerospace nurse course at Patrick Air Force Base, Florida, in 1966.
- Air Force Capt. Mary T. Klinker died in the Operation Babylift crash and was the only member of the Nurse Corps and the last U.S. female service member killed in Vietnam. She was posthumously awarded the Airman’s Medal and the Meritorious Service Medal.
- Air Force Lt. Gen. Dorothy A. Hogg rose from nurse corps leadership to become U.S. Air Force surgeon general and the first surgeon general to support the U.S. Space Force.
- Air Force Brig. Gen. Robert J. Marks became the first male general officer and first male chief nurse of the U.S. Air Force Nurse Corps.
- Air Force Col. Gloria Hernandez became the first active duty nurse assigned as commander of an aeromedical evacuation unit, the 9th Aeromedical Evacuation Squadron at Clark Air Base, Philippines, in 1988.
- Air Force Brig. Gen. Linda J. Stierle became the first Air Force Nurse Corps chief, to serve as director of nursing services and medical readiness May 1, 1995.
- Air Force Col. Judith Hunt became the first nurse to command a military hospital or clinic, Byars Health Clinic at Pope Air Force Base, North Carolina.
- Air Force Col. Linda McHale was selected as command surgeon of the Air Reserve Personnel Center in 1999, becoming the first U.S. Air Force nurse selected to serve as a command surgeon.
- Air Force Maj. Gen. Barbara Brannon became the first Nurse Corps officer to achieve the rank of major general Aug. 1, 2003.
- Air Force Maj. Gen. Jeannine M. Ryder was the 18th chief nurse of the U.S. Air Force and is currently commander, Medical Readiness Command-Bravo, and director, Defense Health Network Continental.

More than seven decades after its creation, the Nurse Corps provides vital support to the Airman and Guardian with its vision

Source: *The U.S. Military Health System*



NUTRITION

Fueling the Force: Nutrition’s Role in Readiness

By Bernard Little, WRNMMC Hospital Communications

Fueling the body properly is essential to maintaining strength, endurance, and resilience across the force. According to experts at Walter Reed National Military Medical Center and the Consortium for Health and Military Performance, or CHAMP, at the Uniformed Services University (USU), “nutrition is a mission-critical component of warrior readiness driving physical performance, cognitive function and mental resilience.”

Proper nutrition helps service members “sustain energy, reduce injury risk, accelerate recovery from intense activity, enhance overall combat effectiveness, and prepare them for duty in challenging environments,” according to Robert Goldberg, a registered dietitian and certified diabetes care and education specialist in Outpatient Nutrition Services at Walter Reed, and officials at CHAMP.

March is observed annually as National Nutrition Month, and this year’s theme, “Discover the Power of Nutrition,” encourages people to consider the role protein plays in their diet.

“The role protein plays in a person’s diet is a hot topic these days and goes hand in hand with power and strength. People typically think they need more protein than they actually do,” said Goldberg.

New dietary guidelines from the U.S. Department of Agriculture (USDA) prioritize whole, nutritious foods, including “high-quality, nutrient-dense protein from both animal and plant sources, paired with healthy fats from whole foods such as eggs, seafood, meats, full-fat dairy, nuts, seeds, olives, and avocados.”

Goldberg noted that many food companies promote high-protein labels to make



The 2025–2030 Dietary Guidelines for Americans introduce a new inverted food pyramid focusing on “real food” and high nutrient density. Photo credit the USDA and U.S. Department of Health and Human Services

people believe that they need more to be healthy.

The USDA’s 2026 Real Food recommendations feature an updated and inverted pyramid guide emphasizing whole, nutrient-dense, and minimally processed foods. The model prioritizes daily intake of “whole, colorful, nutrient-dense” vegetables and fruits in their original “fresh form,” along with whole grains, healthy fats and proteins, while encouraging a reduction in added sugars and highly processed foods.

“Highly processed food has hollowed out our health, driving obesity, diabetes, heart disease, and early death. The truth is simple: real food restores health,” state USDA officials.

With increased attention on protein intake, Goldberg cautioned against overconsumption and stressed the importance of balance and hydration.

Some service members, many who train like athletes, believe they need massive amounts of protein and carbohydrates to build strength and endurance. However, consuming too much protein can increase

saturated fat intake and raise the risk of heart disease, while also contributing to digestive issues, dehydration, and cancer risk.

“Eating in an unhealthy manner can increase the risk for obesity, Type 2 diabetes, and heart disease,” said Goldberg.

“I’d recommend visualizing your meal-time plates as half of your plate being non-starchy vegetables such as broccoli, salad, cucumber, etc., along with fresh fruit; roughly ¼ of the plate with high fiber starch such as brown rice, whole grain bread, oatmeal, etc.; roughly another ¼ of the plate with lean protein; and an additional serving of low-fat dairy on the side.”

He added that drinking water throughout the day helps maintain hydration and supports both injury prevention and weight management.

A healthy diet rich in vitamins and nutrients directly impacts mental clarity, alertness, and the ability to manage stress, according to CHAMP. “Proper, sustained nutrition helps prevent burnout and supports immune function, important for maintaining long-term physical health and avoiding illness.” This contributes to force and warrior readiness.

“For those eligible, Walter Reed has several outpatient registered dietitian nutritionists (RDNs) that can help meet dietary goals and needs,” Goldberg added. “In order to schedule a one-on-one appointment with an outpatient RDN, a referral is not needed. Call the Outpatient Nutrition Clinic at 301-295-4065 to schedule an appointment.”

Source: Walter Reed National Military Medical Center



ONCOLOGY

Head and Neck Cancer among U.S. Active Component Service Members, 2010–2024

By Christa E. Goodwin, DMD, MS

This study utilized de-identified surveillance data to estimate the incidence of head and neck cancer among active component service members (Army, Navy, Air Force, Marine Corps, Coast Guard) from 2010 through 2024. This report updates the June 2021 MSMR analysis of oral and pharyngeal cancers (2007-2019) by expanding the case definition to include all head and neck cancers and extending the surveillance period through 2024. There were 549 cases of head and neck cancer diagnosed in the active component military during the 15-year period of analysis. The Army had the highest 15-year incidence rate (3.3 per 100,000 person-years) compared to the Navy (2.6 per 100,000), Air Force (2.6 per 100,000), Coast Guard (2.0 per 100,000), and Marine Corps (1.3 per 100,000). Service members ages 40 years and older had the highest overall incidence rate (12.3 per 100,000), which was 3.3 times the next highest rate observed among those ages 35-39 years. The 15-year male incidence rate (2.9 per 100,000) was greater than that among females (1.7 per 100,000). The parotid gland was the most common site of diagnosis, comprising 14.8% of cases.

What are the new findings?

From 2010 through 2024, 549 cases of head and neck cancer were diagnosed among U.S. active component service members. The branch of service, sex, and age group with the highest incidence rates were the Army, males, and those ages 40 years and older. The most common site was the parotid gland.

What is the impact on readiness and force health protection?

This report provides the most current head and neck cancer incidence data for active component service members from 2010 through 2024; it establishes baseline rates for monitoring of future trends and highlights specific high-risk populations (e.g., men, Army personnel, service members ages 40 years and older). Although head and neck cancer is the seventh most prevalent cancer worldwide, its incidence among active component service members is seldom reported. Head and neck cancer is often not diagnosed until it has metastasized. Significant physical limitations (e.g., difficulty chewing, speaking, and swallowing) and psychosocial effects (e.g., anxiety, depression, social isolation), compromising service member readiness, can accompany this type of cancer.

Background

Head and neck cancer (HNC), the seventh most prevalent cancer worldwide,^{1,2} is a collective term for cancers originating in the head and neck region including the lip, oral cavity, nasal cavity, paranasal sinuses, salivary glands, pharynx, and larynx. In 2022, there were over 940,000 new cases of HNC and 480,000 fatalities globally.^{1,2} Signs and symptoms may vary depending upon where specifically within the head and neck region the cancer originated. Cancer originating in the oral cavity may result in sores that do not heal, growth or swelling causing dentures to fit poorly, and unusual bleeding or pain.^{3,4} Alternatively, cancer that originates in the pharynx may cause difficulty with essential functions including breathing, speaking, and swallowing food.^{3,4} Various factors dictate the course of treatment including the location and stage of the tumor, as well as patient-specific factors, such as age and health history. Considering the complexity of this type of cancer and the numerous subsites, a multidisciplinary approach to treatment is required.⁵

Survival rates, like course of treatment, are strongly influenced by the location and stage at diagnosis. According to the National Cancer Institute’s Surveillance, Epidemiology, and End Results Program, the overall 5-year relative survival rate of oral cavity and pharynx cancer is 69.5%.⁶ When considering the stage at diagnosis, the 5-year survival rates for localized (i.e., confined to primary site), regional (i.e., spread to regional lymph nodes), and distant (i.e., metastasized) oral cavity and pharynx cancer are 88.4%, 69.4%, and 36.9%, respectively.⁶ Laryngeal cancer survival rates, however, are lower compared to oral cavity and pharynx cancer.⁷ The overall 5-year relative survival rate is 62.1%, and the 5-year survival rates for localized, regional, and distant laryngeal cancer are 79.3%, 49%, and 35.2%, respectively.⁷

Major risk factors of HNC include alcohol and tobacco use, betel nut chewing, and infection with human papillomavirus (HPV).⁸ HPV infections are usually asymptomatic and resolve naturally. However, long-lasting infections with high-risk strains of HPV (16 and 18) can cause various types of cancer (e.g., anal, cervical, oropharyngeal, penile, vaginal, vulvar).^{9,10} Remarkably, about 70% of oropharyngeal squamous cell carcinoma cases in the U.S. are attributed to HPV.^{8,10,11}



Additional risk factors of HNC include genetics, Epstein-Barr virus infection, radiation therapy, exposure to occupational or environmental carcinogens, and immunodeficiency.⁸ HNC is more likely to be diagnosed in those older than age 55 years and is more than twice as common in men compared to women.^{3,12,13} Moreover, a recent study determined that men are far more susceptible to HNC compared to women, regardless of tobacco and alcohol use.¹³

Numerous studies have explored the incidence of HNC among military veterans; the same cannot be said about active component service members (ACSMs). This is unsurprising, as the active component military population is considered a generally young population, and HNC is significantly more common among those older than age 55 years. A recent study investigated the incidence of the 16 most common cancers among ACSMs¹⁴; HNC was not included in that list. This type of cancer represents a small component of the overall cancer burden among this population and, consequently, may not often be explored. However, HNC is usually not diagnosed until it has metastasized. HNC can be accompanied by significant physical limitations (e.g., difficulty chewing, speaking, and swallowing) and psychosocial effects (e.g., anxiety, depression, social isolation), compromising service member readiness. Investigating its incidence among ACSMs is important and relevant. This report serves as an update to the June 2021 MSMR analysis on the incidence of oral cavity and pharynx cancers among ACSMs from 2007 through 2019, expanding the case definition to include all HNCs and extending the surveillance period to 2010–2024.¹⁵

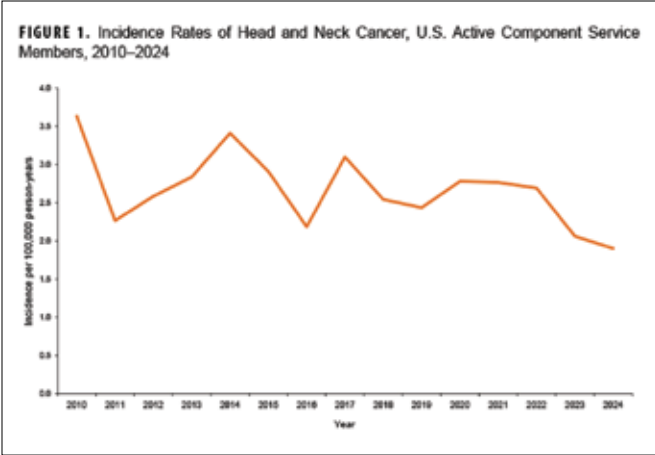
Methods

This investigation was completed at the Tri-Service Center for Oral Health Studies (TSCOHS), a center of the Uniformed Services University (USU), the nation’s federal health professions academy. The USU Human Research Protection Program approved this study, as protocol DBS.2025.827. Data were obtained from the Armed Forces Health Surveillance Division

(AFHSD), the central epidemiological health resource for the U.S. military.

The surveillance population included ACSMs of the U.S. Army, Navy, Air Force, Marine Corps, and Coast Guard diagnosed with HNC from the January 1, 2010 through December 31, 2024. Cases were identified by International Classification of Diseases, 9th and 10th revisions (ICD-9/ICD-10), codes for malignant neoplasms of the lip, oral cavity, pharynx, nasal cavity, larynx, and sinuses (Table 1). This report builds upon a prior 2021 analysis¹⁵ of the same population (with the addition of the Coast Guard) from 2007 to 2019 but uses a broader case definition. The prior study was restricted to malignant neoplasms of the lip, oral cavity, and pharynx.

For surveillance purposes, a case of HNC was defined by AFHSD as either 1 hospitalization with a case defining diagnosis of HNC (Table 1) in the first diagnostic position; or 1 hospitalization with a procedure code indicating radiotherapy, chemotherapy, or immunotherapy treatment in the first diagnostic position and a case-defining diagnosis of HNC (Table 1) in the second diagnostic position; or 3 or more outpatient medical encounters within a 90-day period, with a case-defining HNC diagnosis (Table 1) in the first or second diagnostic position. For those who met the case definition, the incidence date was the date of the first qualifying hospitalization or outpatient medical encounter with a case-defining HNC diagnosis. An individual was considered an incident case once per lifetime. Additional variables evaluated included branch of service, sex, year of diagnosis, and age at diagnosis. Annual incidence rates (IRs) were calculated for each service branch, sex, and age group, by dividing the number of cases in that subgroup by the number of ACSMs reported in the Defense Medical Epidemiology Database (DMED) for that subgroup and year. The ACSM population counts reported by DMED are the cumulative person years (p-yrs) contributed during the calendar year of interest for the population substratum.



Results

From 2010 through 2024, 549 cases of HNC were diagnosed among U.S. ACSMs. Yearly IRs ranged from 1.9 to 3.6 cases per 100,000 p-yrs (Figure 1) with an overall IR of 2.7 cases per 100,000 p-yrs. The number of HNC cases among male service members (n=492) was far greater than that among female service members (n=57) (Table 2). Likewise, the overall IR among men (2.9 per 100,000 p-yrs) exceeded that of women (1.7 per 100,000 p-yrs). As of 2024, male service members accounted for 82.2% of the active component and an even greater proportion (89.6%) of all identified HNC cases during the study period (Table 2).

The largest number (31) of cases occurred among service members who were age 43 years at diagnosis. When evaluated by age

TABLE 2. Counts, Rates, Percentages of All Head and Neck Cancer Cases, U.S. Active Component Service Members, 2010–2024, and Categorical Percentages of the Active Component, 2024

	No.	Rate ^a	% of Total Cases 2010–2024	% of AC 2024
Total	549	2.7	100	—
Sex				
Male	492	2.9	89.6	82.2
Female	57	1.7	10.4	17.8
Age group, y				
<20	3	0.2	0.5	6.6
20–24	61	0.9	11.1	30.0
25–29	74	1.5	13.5	23.4
30–34	61	1.8	11.1	16.7
35–39	89	3.7	16.2	12.9
40+	261	12.3	47.5	10.5
Branch of service				
Army	247	3.3	45.0	34.1
Navy	128	2.6	23.3	25.2
Air Force	127	2.6	23.1	24.8
Marine Corps	35	1.3	6.4	12.9
Coast Guard	12	2.0	2.2	3.1

Abbreviations: No., number; AC, active component; y, years.

^aIncidence rate per 100,000 person-years.

TABLE 1. ICD-9 and ICD-10 Diagnostic Codes Used to Identify Head and Neck Cancer Cases, U.S. Active Component Service Members, 2010–2024

ICD-9	ICD-10	Site
140.0–149.9	C00.0–C14.8	Malignant neoplasm of lip, oral cavity, and pharynx
160	C30.0	Malignant neoplasm of the nasal cavity
160.2–160.5	C31.0–C31.3	Malignant neoplasm of the maxillary sinus, ethmoidal sinus, frontal sinus, and sphenoid sinus
161.0–161.9	C32.0–C32.9	Malignant neoplasm of larynx

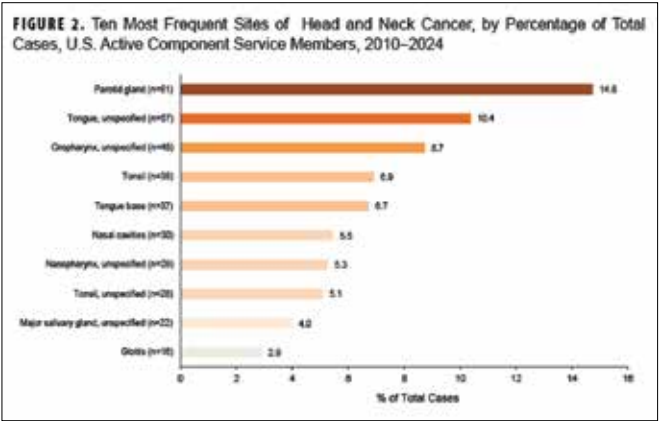
Abbreviations: ICD-9, International Classification of Diseases, 9th Revision; ICD-10, International Classification of Diseases, 10th Revision.



group, service members ages 40 years and older accounted for the largest proportion (47.5%) of HNC cases, with the largest overall IR (12.3 per 100,000 p-yrs) compared to the remaining younger age groups (Table 2). As of 2024, service members ages 40 years and older comprised only 10.5% of the active component; the majority (60%) of the active component is younger than age 30 years.

The Army had the largest number of HNC cases (n=247), followed by the Navy (n=128), Air Force (n=127), Marine Corps (n=35), and finally Coast Guard (n=12) (Table 2). The Army accounts for the greatest proportion (34.1% in 2024) of the active component and had an even greater proportion of all cases (45%). Likewise, the Coast Guard constitutes the smallest proportion (3.1% in 2024) of the active component and had the smallest proportion (2.2%) of all cases. The Coast Guard did not have the lowest overall IR, however, which was evidenced by the Marine Corps, with an IR of 1.3 cases per 100,000 p-yrs; the Army had the highest overall IR (3.3 per 100,000 p-yrs) (Table 2).

The 10 most frequent sites diagnosed with HNC are presented in Figure 2. ‘Unspecified’ indicates that the subsite was not documented. For instance, ‘tongue, unspecified’ signifies that the specific location of the tumor on the tongue (e.g., border, dorsal, base) is unknown. The greatest number of cases occurred in the parotid gland (n=81), accounting for 14.8% of all cases during the 15-year surveillance period. However, if combining cases diagnosed in the same primary location, the greatest number of cases (n=94, or 17.1%) occurred on the tongue (tongue, unspecified=57; tongue base=37).



Discussion

This study utilized de-identified surveillance data from AFHSD to estimate the incidence of HNC among ACSMs (Army, Navy, Air Force, Marine Corps, Coast Guard) from 2010 through 2024. This is the first time this group of cancers has been investigated by TSCOHS. These data can help guide military public health policy and future research into specific occupational or lifestyle risk factors within high-risk demographic groups.

In the general population, risk of diagnosis of HNC significantly increases with age; the same can be said for the military. Service members ages 40 years and older comprise the smallest

proportion of the active component, yet had the greatest proportion of cases and an IR 3.3 times the next highest IR, which was observed among those ages 35–39 years. Likewise, men in the general population are at a greater risk of developing HNC, which also applies to the military, as male service members had an IR 1.7 times that of female service members.

The 2021 study conducted determined the incidence of oral cavity and pharynx cancer among ACSMs from 2007 through 2019.¹⁵ While the present study expanded the 2021 study to include cancer in all locations considered HNC, in addition to the oral cavity and pharynx, very similar results were found. As with the present study, the 2021 investigation determined that the branch of service, sex, and age group with the highest IRs included the Army, men, and those ages 40 years and older.¹⁵ Furthermore, the most common diagnosed site in both studies was the parotid gland.¹⁵

The difference in IRs among the service branches may be due to the differing age distributions among them, as also suggested in the 2021 study.¹⁵ Service members with the greatest risk of HNC were those ages 40 years and older. The Marine Corps had the lowest overall HNC IR. Likewise, the proportion of service members ages 40 years or older is lowest in the Marine Corps (4.9%). Notably, this proportion is at least 2 times lower than that of any other service branch, ranging from 9.9% in the Air Force to 18.3% in the Coast Guard (DMED).

The small number of cases in this study precluded meaningfully stratified analysis due to limited statistical power to separate true trends from random fluctuations. The reliance on de-identified medical encounter data presented with additional limitations. Cancer diagnoses could not be independently verified, and thus, the results could be subject to misclassification errors leading to either an over- or under-estimation of cases. Individual risk factors could not be linked to diagnoses; differences in known contributing risk factors (e.g., tobacco and alcohol use, HPV infection) may explain the differences in IRs among the service branches. The Army had the highest IR, 2.5 times that of the Marine Corps, which might suggest higher rates of contributing risk factors in the Army. According to the 2018 Health Related Behavior Survey, however, both binge and heavy drinking were the highest among Marine Corps and Navy members.¹⁶ Furthermore, Marine Corps members were more likely to be current cigarette smokers, electronic cigarette smokers, and smokeless tobacco users compared to service members of all other branches.¹⁶

Certain military service members are subject to an added environmental hazard associated with HNC: burn pit exposure. The Department of Veterans Affairs has recognized HNC, in addition to various other cancers, as a “presumptive cancer” related to burn pit exposure among those who served in Iraq, Afghanistan, or certain other areas.¹⁷ As such, these individuals may be eligible for disability compensation.¹⁷

Risk of developing HNC is related to prolonged, repeated exposure to the known risk factors; this type of cancer can take years,



Head and neck cancer is the seventh most prevalent cancer worldwide, with survival rates strongly influenced by locus and stage at diagnosis. Photo courtesy of the U.S. Military Health System

even decades, to develop.^{3,4,8–12} Considering that HNC diagnosis may not occur until long after a service member has left service, numerous studies have evaluated HNC among the veteran population. Unfortunately, the prevalence of HNC among veterans is nearly twice that of the general population.^{18–21} Factors believed to contribute to this are the high rates of tobacco and alcohol use among this population, as well as low rates of HPV vaccination,^{22–26} which may not have been an option for some veterans, depending upon their ages.

HNC represents a small portion of the overall disease burden among ACSMs compared to other cancers such as breast cancer or melanoma.¹⁴ The significance of such a debilitating, albeit uncommon, disease should not be discounted, however. Early detection is paramount to improving prognosis, as is educating patients regarding the signs, symptoms, and risk factors for HNC.^{27,28} Military dentists contribute significantly to early detection. ACSMs are required to have a yearly dental examination which provides dentists with the opportunity to not only educate ACSMs about HNC but evaluate them for suspicious lesions in the head and neck region. This is consistent with the American Dental Association’s “Early Detection and Prevention of Oral and Oropharyngeal Cancer” policy, which recommends

cancer prevention education and a routine visual and tactile examination for all patients.²⁷ Nevertheless, given the implications of early detection, regular self-examinations for signs of HNC are equally vital.

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ONCOLOGY

USNH Yokosuka Cancer Screening Program Recognized as Best Practice across Pacific Rim Network

By Daniel Taylor - U.S. Naval Hospital Yokosuka

U.S. Naval Hospital (USNH) Yokosuka's proactive approach to cancer screening has been recognized by Defense Health Network (DHN) Pacific Rim leadership as a best practice, highlighting how targeted outreach, expanded access to care and a patient-centered approach to preventive medicine can improve health outcomes while supporting military readiness.

Over the past year, USNH Yokosuka achieved significant improvements across multiple cancer screening measures. Breast cancer screening rates increased from 69.0% in March 2025 to 82.8% in February 2026, exceeding the Defense Health Agency (DHA) goal of 78.64%. Cervical cancer screening rates reached 83.3%, surpassing a goal of 75.21%, while colorectal cancer screening rates climbed from 59.2% to 64.5%, approaching the DHA goal of 65.91%.

DHN Pacific Rim recently highlighted the hospital's operational approach as a model for other military treatment facilities across the region, recognizing its ability to increase participation in preventive screenings through collaboration, innovation and patient-focused access initiatives.

Lt. Christian Sanchez, staff internist, department head of Internal Medicine and USNH Yokosuka's Healthcare Effectiveness Data and Information Set (HEDIS) champion for breast, cervical and colorectal cancer measures, helped spearhead the initiative by coordinating outreach efforts, preventive health campaigns and process improvements across clinical and population health teams.

"Behind every percentage point is a patient who may have an

Lt. Christian Sanchez, staff internist, department head of Internal Medicine and U.S. Naval Hospital (USNH) Yokosuka's Healthcare Effectiveness Data and Information Set (HEDIS) champion for breast, cervical and colorectal cancer measures, poses for a portrait inside the Mammography Department at USNH Yokosuka. Photo credit Daniel Taylor/USNH Yokosuka United States Navy Public Affairs

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opportunity to detect cancer earlier, when treatment is often simpler and outcomes are better,” Sanchez said. “The numbers matter, but what mattered most was helping patients receive cancer screening before a problem developed.”

Hospital officials found that most patients were not declining screening exams but instead faced logistical challenges. Many were unaware they were overdue, struggled to schedule appointments, completed testing outside the Military Health System that was never documented, or lacked convenient access to services. To address those challenges, the hospital expanded self-referral mammography services, increased fecal immunochemical testing availability, offered walk-in preventive health events and implemented targeted outreach and reminder workflows.

“Most patients weren’t intentionally avoiding screening,” Sanchez said. “Many simply didn’t realize they were overdue or how to access the services available to them. Once we improved awareness and made the process easier, participation increased.”

While Sanchez focused on improving patient access, Cmdr. Brian Taylor, director for Health Care Business at USNH Yokosuka, said the hospital’s long-term success stemmed from creating a sustainable population health strategy.

“There wasn’t one thing that drove these improvements,” Taylor said. “Success came from creating a system that identified overdue patients, shared responsibility across the healthcare team and made it easier for patients to get the care they needed. When health screening becomes part of routine operations, improvements become sustainable even as personnel and leadership change.”

Hospital leaders say cancer screening is also an important component of military readiness. “Cancer screening is readiness medicine,” said Capt. Torrin W. Velazquez, director of U.S. Naval Hospital Yokosuka and commanding officer of U.S. Navy Medicine Readiness and Training Command Yokosuka. “Early detection creates opportunities to intervene before disease affects a service member’s health, deployability or long-term quality of life. Every completed screening represents an opportunity to preserve health, maintain readiness and ensure our force remains prepared to execute the mission.”

Velazquez noted that preventive care can be especially challenging to prioritize in an overseas military community where operational commitments, frequent moves and family obligations often compete for time and attention.

“Military families lead busy lives,” Velazquez said. “Deployments, permanent change of station moves, work schedules and the challenges of living overseas can make preventive care easy to postpone. Our responsibility is to remove as many barriers as possible so patients can access the care they need before a medical issue becomes more serious.”

Taylor said the recognition from DHN Pacific Rim reflects the strength of the hospital’s population health approach and

the collaboration required to sustain improvement across the organization.

“The recognition validates the work our teams have done to embed cancer screening into daily operations,” Taylor said. “What makes this approach effective is that it doesn’t depend on one clinic or one individual. It depends on teamwork and making care easier for patients to access.”

The hospital’s efforts support the DHA’s priorities of delivering warfighter medical readiness, providing exceptional patient care and building an integrated health system that emphasizes prevention and long-term health outcomes.

“We still have opportunities to reach more beneficiaries, especially those stationed farther from Yokosuka,” Taylor said. “Our goal is to continue making preventive screenings easier to access regardless of where beneficiaries live or work.”

Beneficiaries who are unsure whether they are due for breast, cervical or colorectal cancer screening are encouraged to speak with their primary care manager or contact the USNH Yokosuka Appointment Line at DSN 243-5352, commercial 046-816-5352 or from the United States at 011-81-46-816-5352. Patients can discuss recommended screenings during routine healthcare appointments and receive guidance on eligibility based on age, risk factors and current screening guidelines.

Eligible beneficiaries may also use USNH Yokosuka’s self-referral mammography program, which allows patients to schedule screening mammograms without a provider referral. To begin the process, beneficiaries can contact the USNH Yokosuka Mammography Department at DSN 243-3964.

For beneficiaries who may be overdue for a screening exam, Sanchez offered a simple message.

“Don’t wait until you have symptoms,” Sanchez said. “Many cancers develop silently for years before causing noticeable problems. A mammogram, Pap test or colorectal cancer screening may take only a small amount of time today, but it could have a life-changing impact tomorrow. Think of screening as an investment in your future, your family and your health.”

“When we make cancer screening more accessible, we are investing in both the health of our beneficiaries and the readiness of the force,” Velazquez said. “That’s a direct contribution to mission success.”

As USNH Yokosuka continues refining its population health programs, leaders hope the lessons learned will help more beneficiaries access timely preventive screenings, improve long-term health outcomes and strengthen the readiness and resilience of the military community throughout the Indo-Pacific region.

Source: United States Navy Bureau of Medicine and Surgery

OPHTHALMOLOGY

Clearing the Vision Barrier: Inside Walter Reed’s Refractive Surgery Program

By the Uniformed Services University News, originally posted by Ricardo Reyes-Guevara, WRNMMC Hospital Communications

Dr. Joseph Pasternak, a graduate of the Uniformed Services University and current director of the Refractive Surgery Center at Walter Reed, leads a team utilizing advanced laser technology to ensure warfighters and USU students meet rigorous military vision standards.



A surgeon at the Walter Reed National Military Medical Center Refractive Surgery Center performs a laser eye procedure. The center utilizes advanced technology like LASIK and PRK to help service members and USU students meet rigorous military vision standards. Photo courtesy of WRNMMC

As a U.S. Naval Academy midshipman in the early 1980s, Dr. Joseph Pasternak missed his chance to fly by a single line on the eye chart. He could see well with glasses, but the rule then was more unforgiving than it is now: U.S. Navy pilots needed to see 20/20 without them.

“I was off by a letter or two in one eye. That was it. If you weren’t 20/20 uncorrected, you could be a naval navigator but not a pilot,” he said.

Today, Pasternak, a retired U.S. Navy Captain, cornea specialist, and Uniformed Services University (USU) alumnus, is the director of Walter Reed National Military Medical Center’s Refractive Surgery Center, where a small team of surgeons and technicians uses advanced laser technology to help warfighters meet vision standards without the aid of glasses or contact lenses.

The clinic performs LASIK and PRK to correct common vision problems, including nearsightedness, farsightedness and

astigmatism. Both procedures use specialized lasers to reshape the cornea, but LASIK involves creating a surgical flap while PRK does not. Providers at Walter Reed choose between them largely based on how much correction a patient needs, with LASIK more common in higher-correction cases.

Pasternak said thousands of Naval Academy graduates have passed through the center while working to meet the vision standards for their chosen careers.

Midshipman 2nd Class Christian Basulto, a junior at the academy, came to Walter Reed hoping to turn a childhood dream of flying into a real possibility.

“It’s definitely a childhood dream to fly, and if service assignment was tomorrow, I would put Marine Corps pilot first, Navy pilot second,” he said. “I’m definitely sure that’s what I want to do.”

Basulto, who got his first pair of glasses in fifth grade and switched to contact lenses in eighth grade, said doctors at Walter Reed recommended PRK to correct his vision, clearing a major obstacle on his path to earning pilot wings.

“Even before I came to the academy, I knew PRK was a thing,” he said. “It’s something I’ve been looking forward to since [Induction Day]. I’m grateful this is hopefully the last step toward realizing that dream.”

On surgery day at Walter Reed, Basulto expected his nerves to catch up with him. They never did.

“I’m not somebody who’s necessarily calm about stuff like this, and I really wasn’t worried at all,” he acknowledged. “Even in the waiting room I thought maybe I’d start getting nervous, but it didn’t happen. At that point, I was kind of excited because it felt like that last step.”

Basulto said the detailed pre-surgery briefings made it much easier to relax.

“I mean the brief, even the virtual brief, really helped,” he said. “They walked us through all the steps, the possible complications, even the stats on how high the success rate is. It made it a lot easier to stay comfortable.”



Before patients step into the laser suite, they meet with optometrist Dr. Shayesteh Izaddoost, who handles pre- and post-operative visits and walks them through what the surgery does, how long it lasts and what to expect in the hours and days afterward. She said she focuses on setting clear expectations and practical instructions — down to what to bring on surgery day — because many midshipmen are away from home and navigating the process on their own.

“For our patients, it’s never just about getting rid of glasses,” Izaddoost said. “There’s a lot more at stake when you’re taking care of warfighters who need to see in the dark, underwater, in the desert — wherever they’re sent.”



Dr. Joseph Pasternak (standing, right), a USU alumnus and director of the Refractive Surgery Center, oversees a procedure at Walter Reed. In 2025, the center completed approximately 1,850 laser eye procedures for warfighters and students from across the force. Photo courtesy of WRNMMC

Walking out of the laser room, Basulto said he could see clearly without glasses for the first time since childhood. “I was looking around, and even now it feels like I have glasses on,” he said. “I thought, ‘Wow, I’m not wearing glasses right now.’”

Doctors said his vision was still expected to fluctuate in the days following PRK, but the immediate clarity marked a dramatic change from what he had known for most of his life.

At his six-day follow-up, Basulto reflected on the early days of his recovery.

“Tuesday, I had the surgery. I got back and honestly was feeling, at first, almost deceitfully well.”

He said the discomfort peaked over the next couple of days. “It kind of feels like you have soap in your eyes, but you can’t rub them. But that’s a small thing compared to the long-term impact, so definitely worth it.”

Doctors at the center said that pattern is typical for PRK patients. After several days of irritation while the surface cells heal, vision can fluctuate before gradually sharpening over the following weeks.

At six days, Basulto was seeing 20/30, already better than his pre-operative unaided vision of 20/60, roughly twice as sharp, with further improvement expected over the next month.

LASIK patients often experience a faster initial recovery, with noticeable improvement within the first day. However, both procedures are designed to achieve the same long-term visual outcome.

Basulto acknowledged the surgery doesn’t guarantee him a seat in the cockpit, but it ensures that an eye chart won’t keep him from getting a shot at it.

His experience reflects the readiness mission behind the refractive surgery program.

In a forward-deployed environment, service members are not permitted to wear contact lenses, yet many still do. Pasternak said he has seen as many troops sidelined by contact-lens-related corneal infections as by combat eye injuries.

He said every option carries some risk — even glasses can steam up or fall off at the worst moment — but significant problems after refractive surgery are uncommon, affecting roughly one eye in a thousand, and are usually treatable.

“For our patients, it’s never just about getting rid of glasses,” Izaddoost said. “There’s a lot more at stake when you’re taking care of warfighters who need to see in the dark, underwater, in the desert — wherever they’re sent.”

— Dr. Shayesteh Izaddoost

In 2025, surgeons at Walter Reed’s Refractive Surgery Center completed roughly 1,850 laser eye procedures, reflecting steady demand from across the force.

About 45% of patients were students at the U.S. Naval Academy, but the center also treats active-duty service members from all branches, cadets from West Point and the Coast Guard Academy, as well as students from the Uniformed Services University of the Health Sciences. All must receive command approval, with time-in-service requirements varying by branch.

“Our goal is for all warfighters to have access to this,” Pasternak said. “It’s a proven, safe and predictable surgery that’s been around for 25 years, and it’s only gotten better.”

Source: *The Uniformed Services University*

OPTOMETRY

Naval Hospital Twentynine Palms Hosts WesternU Optometry Students for Clinical Training

By Christopher Jones - Naval Hospital Twentynine Palms

Naval Hospital Twentynine Palms continues to strengthen the next generation of healthcare professionals in 2026 through its ongoing collaboration with Western University of Health Sciences (WesternU), providing optometry students with hands-on clinical training in a military healthcare environment while supporting patient care and medical readiness at the Marine Corps Air Ground Combat Center.

The partnership allows Doctor of Optometry students from WesternU to complete clinical rotations at Naval Hospital Twentynine Palms, where they work directly alongside Navy optometrists and gain experience caring for active-duty service members, beneficiaries, and family members under supervision.

Lt. Cmdr. Michael Squires, optometry department head at Naval Hospital Twentynine Palms, said the relationship between military treatment facilities (MTFs) and optometry schools plays an important role in preparing future healthcare providers while also benefiting military medicine.

“The relationship between optometry schools and MTF optometry clinics is crucial to maintain in order for students to gain critical clinical experience and for military optometrists to continue to train, mentor, and build the next generation of optometrists,” said Squires.

During his time assigned to Twentynine Palms, Squires has trained four students from WesternU and approximately 30 students from the university throughout his career. He explained that many MTFs maintain similar educational partnerships with optometry schools across the country.

While training at Naval Hospital Twentynine Palms, students perform eye examinations under the direct supervision of clinic optometrists and become integrated into the daily operations of the department. The experience exposes students to a wide range of patients and conditions while helping maintain access to quality eye care services within the military healthcare system.

Squires said hosting students also contributes to the hospital’s broader readiness mission.

“Having optometry students in the clinic helps us continue to deliver high-quality eye care for our patients, directly impacting our patients’ medical readiness,” he said.



Catherine Ortiz, a Doctor of Optometry student from Western University of Health Sciences, poses for a photo at Naval Hospital Twentynine Palms in April 2026. Ortiz completed a clinical rotation at the hospital through a partnership with WesternU that provides optometry students with hands-on clinical experience in a military healthcare environment. Photo credit Hospital Apprentice Evelyn Zermeno U.S. Navy

One of the most recent students to complete a rotation at the hospital was Catherine Ortiz, a Doctor of Optometry student from Ontario, California, who will graduate from Western University of Health Sciences in May 2026.

Ortiz said her path toward optometry began with a personal experience as a patient and a desire to pursue healthcare in a meaningful but less invasive setting.

“I always knew I wanted a career in healthcare because I enjoyed the idea of helping and caring for patients,” said Ortiz. “At the same time, I realized early on that I was not comfortable with blood or more invasive medical procedures, so I started looking for a healthcare field where I could still make a meaningful impact on patients’ lives in a different way.”

She said her interest in the profession grew after learning she needed glasses herself and seeing firsthand how vision care could improve a patient’s quality of life and confidence.



“From that point on, I knew optometry was the career I wanted to pursue,” Ortiz said.

Before entering optometry school, Ortiz completed undergraduate studies at California Polytechnic State University, majoring in biological sciences and minoring in accounting. She began her Doctor of Optometry program at WesternU in August 2022.

Ortiz said she arrived at Naval Hospital Twentynine Palms through her school’s clinical rotation assignment process and initially viewed the opportunity as both exciting and unfamiliar.

“When I first found out I would be training here, I felt both excited and nervous because it was such a unique environment,” Ortiz said. “However, the experience ended up being more rewarding than I expected.”

During her time at the hospital, Ortiz worked alongside Navy medical personnel while caring for a diverse patient population in a military healthcare setting. She said the experience helped her grow both clinically and professionally.

“I had the opportunity to work with diverse patients, learn in a military healthcare setting, and grow both clinically and professionally alongside a very supportive team,” she said.

Squires described Ortiz as a strong addition to the clinic team during her rotation.

“Catherine is a stellar student and will have a very bright future when she will very shortly be on her own,” said Squires. “She was able to help see patients and fully integrate into the optometry clinic team during her short time here.”

Ortiz said one of the most meaningful aspects of the rotation



Catherine Ortiz (right), a Doctor of Optometry student from Western University of Health Sciences, conducts an eye examination with Hospital Corpsman 2nd Class Emilio Matthew at Naval Hospital Twentynine Palms in April 2026. Ortiz completed a clinical rotation at the hospital as part of a partnership that provides optometry students with hands-on experience in a military healthcare environment. Photo credit Hospital Apprentice Evelyn Zermeno



Catherine Ortiz (right), a Doctor of Optometry student from Western University of Health Sciences, conducts an eye examination with Hospital Corpsman 2nd Class Emilio Matthew at Naval Hospital Twentynine Palms in April 2026. Ortiz completed a clinical rotation at the hospital as part of a partnership that provides optometry students with hands-on experience in a military healthcare environment. Photo credit Hospital Apprentice Evelyn Zermeno U.S. Navy

was the opportunity to work directly with service members while supporting their health and readiness.

“One of the most rewarding parts of this experience was working with Sailors, Marines, and occasionally their family members,” Ortiz said. “It was inspiring to care for patients from many different backgrounds and to contribute — even in a small way — to their readiness and overall health.”

She also credited the hospital staff for creating a welcoming and educational environment throughout her training.

“I also enjoyed working with my colleagues at Naval Hospital Twentynine Palms,” she said. “The team was incredibly supportive, welcoming, and dedicated to patient care, which made the experience both educational and memorable.”

Following graduation, Ortiz plans to begin practicing optometry in the corporate healthcare sector, where she hopes to continue developing professionally while providing comprehensive vision care to patients.

The collaboration between Naval Hospital Twentynine Palms and WesternU reflects the Defense Health Agency’s continued emphasis on partnerships that support healthcare education, patient care, and force readiness across military medicine.

Source: The United States Navy

ORAL HEALTH

Tri-Service Dental Team Earns First Place at National Orthodontics Competition

By Sharon Holland

A historic win highlights tri-service collaboration and the critical role of military graduate dental education in operational readiness.

For the first time in program history, a resident from the Tri-Service Orthodontic Residency Program (TORP) has earned first place at a national competition hosted during the American Association of Orthodontists Annual Meeting. This historic milestone, presented to Navy Lt. Cmdr. (Dr.) Miles Pedersen, reflects both clinical excellence and the impact of military graduate dental education.

The award was earned in the College of Diplomates of the American Board of Orthodontics (CDABO) Resident Case Display competition, an annual event that brings together top orthodontic residents from across the country to present their most complex and compelling patient cases. The competition provides a national platform for residents to demonstrate technical skill, clinical judgment, and the ability to communicate outcomes at the highest professional standard.

What set this year’s winning case apart was not just its quality, but the collaboration behind it.

The case represented a complete tri-service effort, showcasing the seamless interoperability that defines modern military medicine within the Military Health System (MHS). The complex care team brought together Pedersen, a Navy orthodontic resident, with multi-service faculty mentorship from Navy Cmdr. (Dr.) Drew Havard and Air Force Lt. Col. (Dr.) Duy Nguyen. Crucially, the execution of the treatment plan required close coordination with the surgical team, led by Army Maj. (Dr.) Charles A. Long, an oral and maxillofacial surgery resident. Together, the team delivered life-changing care through a combined surgical-orthodontic treatment approach, addressing a severe condition that affected both function and quality of life.

The orthognathic surgery (a type of corrective jaw surgery) component of the case was performed by Long under Havard’s supervision, showcasing one of the military’s primary surgical training platforms. These procedures — often correcting complex facial and jaw deformities — help refine the advanced surgical skills required in both peacetime care and combat casualty scenarios.

The orthodontic treatment, completed by Pedersen, underscores another critical mission: correcting severe malocclusions, restoring function, and ensuring service members and their families can maintain their health and focus on mission requirements.

All participants in the case are part of training programs that fall under the Uniformed Services University’s (USU) Postgraduate Dental College (PDC), the academic and research hub for the military’s dental education enterprise. Residents are simultaneously enrolled as graduate students, earning advanced degrees that integrate clinical expertise with research and critical thinking — skills essential to delivering high-quality care in both garrison and operational environments.

“This is exactly what military medicine is designed to do—bring together expertise across the services to deliver exceptional care while preparing providers for the demands of operational medicine,” said Dr. Drew Fallis, Executive Dean of USU’s PDC.

Beyond the clinical outcome, the competition itself plays an important role in preparing residents for board certification. The American Board of Orthodontics (ABO) recommends case display participation as a rigorous critical-thinking exercise, particularly as part of its scenario-based clinical examination format. Residents must present detailed documentation. This includes case management forms, discrepancy index scores, CRE evaluation metrics, and cephalometric analyses, while also reflecting on treatment decisions and outcomes.

Cases are evaluated by CDABO members with oversight from the ABO, and judged across several key areas: uniqueness, treatment quality, records quality, and the strength of the written manuscript. Top submissions may also be selected for publication consideration in leading orthodontic journals.

In an environment where readiness depends on both individual expertise and coordinated care, this achievement offers a clear example of what is possible when all three services come together with a shared purpose: delivering exceptional care and preparing the next generation of military medical professionals.

Source: The Uniformed Services University



PEDIATRICS

Tripler Army Medical Center Enhances Pediatric Cardiology Services across the Indo-Pacific

By Khinna Kaminske, Tripler Army Medical Center

A pediatric cardiology team from Tripler Army Medical Center held its biannual clinics at U.S. Naval Hospitals Okinawa Dec. 1-5 and Yokosuka Dec. 8-12. The team provided specialized care to children of active-duty service members, retirees, and Department of Defense Education Activity employees. The visit also helped the military treatment facilities strengthen their capabilities.

During the clinics conducted in Okinawa and Yokosuka, the team supported the professional development of local staff and achieved significant patient care outcomes:

- Total Patients Evaluated: 68
- Transthoracic Echocardiograms Performed: 51
- Fetal Echocardiograms Performed: 4
- Electrocardiogram Obtained: 61
- Ambulatory Electrocardiogram Monitors Placed: 6

Notably, 25 percent of the patients (17 out of 68) were found to have heart conditions requiring ongoing follow-up. This included three new diagnoses, one of which was hypertrophic cardiomyopathy, a disease in which the heart muscle becomes thickened and makes it harder to pump blood.

Tripler Army Medical Center’s Pediatric Cardiology team ensures seamless follow-up care and coordination through the Global Teleconsultation Portal (GTP), a secure web-based platform designed for exchanging medical advice and managing patient care across the military healthcare system. This platform serves as the initial point of contact for most patients, allowing the team to assess cases and recommend evaluations during clinic visits for non-urgent conditions. This approach is cost-effective and efficient, saving resources compared to transporting patients to Hawaii.

For routine cases requiring ongoing surveillance, follow-up care is typically scheduled during future clinics, which are held biannually in Guam, Okinawa, and Yokosuka. Between these visits, the team maintains close communication with patients’ primary care providers through GTP.

This continuous collaboration enables the team to address new clinical concerns, arrange additional testing such as

tele-echocardiography, electrocardiograms, or Holter monitoring, and conduct video consultations when necessary. By leveraging technology and fostering strong partnerships with local providers, TAMC ensures that patients receive high-quality, coordinated care regardless of their location.

“TAMC is at the forefront of delivering world-class pediatric cardiology care to military families throughout the Western Pacific,” said Col. (Dr.) Charlie T. Nguyen, TAMC pediatric cardiologist. “Through our biannual clinics, TAMC ensures that children with suspected or known cardiac conditions receive expert evaluations and treatment plans closer to home while fostering collaboration and training with partner MTFs.”

As the principal referral center for all MTFs in the region, TAMC has a rich history of providing support through tele-consultation and in-person clinics. The objectives of the Tripler Pediatric Cardiology service traveling clinics are to:

1. Deliver expert, in-person evaluations and tailored treatment plans for pediatric patients with suspected or known cardiac conditions through the “Cardiology Clinic in a Backpack” initiative.
2. Empower Navy cardiovascular technicians with hands-on training and mentorship to enhance year-round cardiac imaging capabilities for TAMC’s tele-echocardiography program at U.S. Naval Hospitals Guam and Okinawa.
3. Strengthen partnerships and foster professional growth by engaging directly with hospital staff, many of whom are early in their medical careers.

Through these efforts, TAMC provides a standard for military healthcare, ensuring that every child receives the specialized care they deserve, regardless of their location. These clinics not only provide specialty care to military families stationed overseas but also reinforce TAMC’s commitment to delivering exceptional healthcare and fostering readiness across the Indo-Pacific region.

“I would also like to highlight the contributions of my colleagues at TAMC who are equally committed to extending our reach across the Western Pacific,” Nguyen said. “I’m not the only one at TAMC conducting these clinics.”

In addition to the efforts of the Tripler Pediatric Cardiology team,



Strengthening partnerships for better health, (from left) U.S. Navy Cmdr. Brian Taylor , U.S. Naval Hospital Yokosuka (USNH Yokosuka) pediatrician and acting director for medical services; U.S. Navy Cmdr. Konstance Mackie, USNH Yokosuka pediatric nurse; U.S. Navy Lt. Laila Kong, USNH Yokosuka pediatric nurse; and U.S. Army Col. (Dr.) Charlie T. Nguyen, TAMC pediatric and cardiologist, collaborated with the TAMC Pediatric Cardiology team during a clinic at USNH Yokosuka on Dec. 8-12. Together, they provided essential cardiology services to children in need, underscoring their commitment to specialized care and the health of military families. Photo credit Khinna Kaminske

several other specialists from Tripler Army Medical Center have contributed to expanding access to care across the region. U.S. Army Maj. (Dr.) J. Ryan Hitt, a pediatric cardiologist, conducted a clinic at U.S. Naval Hospital Guam in November 2025, providing expert evaluations and treatment plans for children with cardiac conditions. U.S. Army Lt. Col. (Dr.) Sebastian Welsh, a pediatric pulmonologist, conducted a clinic at U.S. Naval Hospital Guam in January 2026, addressing respiratory health needs for pediatric patients. U.S. Army Col. (Dr.) Andrew Medendorp, a urology and urogynecology specialist, facilitated complex surgeries at U.S. Naval Hospital Guam in 2025, offering specialized care for urological and pelvic health concerns.

Their collective efforts underscore TAMC’s commitment to delivering high-quality, multidisciplinary care to military families stationed across the region.

“I hope that we can continue to make the case for the benefits of this enduring mission ,” Nguyen said, “Thank you all again for giving me the opportunity to participate in the care of your patients. We look forward to working with you again in the future!”

TAMC serves as the Department of War’s premier medical center in the Western Pacific Rim, providing comprehensive tertiary care to a diverse and geographically dispersed population. This includes over 264,000 local active-duty and retired military personnel, their families, and veteran beneficiaries. TAMC also extends its medical expertise to a regional population of 171,000, encompassing personnel from nine U.S.-affiliated jurisdictions and forward-deployed forces across more than 40 countries in the Indo-Pacific region.

Source: The Digital Visual Information Distribution System



PHARMACY

World-class Medicine: Inside Walter Reed’s Pharmacies

By the Walter Reed National Military Medical Center News

Walter Reed National Military Medical Center boasts one of the most innovative and comprehensive approaches to pharmaceutical care within the U.S. Military Health System. While many people dread a trip to the pharmacy, typically imagining having to stand in line to acquire their prescriptions, that is not the case at this flagship facility. Walter Reed’s pharmacy services are implementing an ever-expanding series of methods to streamline and improve their customers’ experience.

“We’ve listened to our customers and continue to work to incorporate changes and updates to our services that help them get the care they deserve,” said Lt. Col. Seth Mayer, Chief of Pharmacy Services for Walter Reed. “We’re at an interesting time in technology. Over the last three years we’ve rolled out the electronic health record, MHS GENESIS. We’ve added new pharmacy automation software, as well as adopting a new version of requesting pharmacy services via Q-Anywhere. All these changes we’ve implemented are critical in terms of meeting patients where they’re at.”

MHS GENESIS is a modern system that provides a single electronic health record for service members, retirees and their beneficiaries. The system is hosted on a secure website that is accessible 24/7 and provides several features, including allowing patients to schedule appointments, communicate with their care providers and request refills of their prescriptions.

The newly adopted automation software is a scalable enterprise suite designed to optimize the pharmacy’s supply chain. It provides comprehensive management and automated fulfillment workflows, ensuring patients receive accurate prescriptions through an efficient, quality-controlled process.

The Q-Anywhere remote queuing system allows patients to submit new prescriptions or renewal prescriptions at their most convenient Walter Reed pharmacy location. This allows them to essentially “get in line” virtually and pick up their prescription at their convenience. Even if their number is called prior to their arrival, their place is held and they can simply notify the pharmacy when they get there.

“I think people don’t realize Walter Reed has such a breadth and depth of pharmacy services,” said Dr. Elena Vagichev, assistant chief of Clinical Pharmacy Operations. “And people don’t realize the amount and volume of the medications we actually process.”

Walter Reed doesn’t have just one or two pharmacy locations. To serve the wide array of pharmaceutical requirements across the entirety of the hospital’s various departments and facilities, the hospital maintains several pharmacies that are responsible for managing the patients’ medication needs.

While there are two primary pharmacies — the Arrowhead facility and the America pharmacy, which serve both inpatient and outpatient prescriptions — there are several “smaller” pharmacy units that provide focused pharmaceutical support to specialty areas of the hospital. For example, the Hematology/Oncology pharmacy provides medications for all inpatient/outpatient cancer treatments, as well as supporting the infusion clinic.

There is also the Intensive Care Unit pharmacy, which covers the ICU, the surgical and medical ICUs, as well as the pediatric ICU. Then there are clinical pharmacists, who make rounds in the hospital units, the ICUs, and the clinics, coordinating with the medical teams to ensure each patient is receiving the proper medication.

Serving the prescription needs for all these different pharmaceutical focuses yields an incredible number of medications supplied. On average, Walter Reed’s pharmacies fulfill 50,000 outpatient prescriptions each month, with an additional 40,000 filled for inpatient needs. To manage all this pharmaceutical coverage, Walter Reed employs a team of more than 150 personnel.

“What is special about us is how we treat our staff; we treat each other like family,” said My Lan Tran, supervisory pharmacist. “And we carry that philosophy to the patient. We treat our patients just like one of our own family members.”

“There’s a shared understanding of who we serve and why we serve them,” said Mayer. “And that feeling is something that’s endemic to the people who work here. Over time, we have people that become stewards of [the culture], that allow that to continue. The person that sits in this chair is the person that’s going to make change, the civilians and people who work here, they create the continuity.”

Source: Walter Reed National Military Medical Center

PHYSICAL THERAPY

Building Readiness through Recovery: Bayne-Jones Army Community Hospital Occupational Therapy in Action

By Jean Graves

The sound of ping pong balls echoing through the Occupational Therapy Clinic at Bayne-Jones Army Community Hospital may seem like friendly competition, but behind each rally is a deliberate approach to recovery, resilience and readiness.

In recognition of Occupational Therapy Month, the clinic is hosting a month-long table tennis tournament, using the activity to highlight how occupational therapy helps patients regain the skills needed for daily life and duty.

“Occupational therapy helps people do the things they want to do, have to do and need to do,” said Capt. Carly Williams, chief of occupational therapy at BJACH.

Despite its name, OT is not limited to employment. In clinical practice, “occupations” refer to meaningful activities that occupy a person’s time — whether that is completing mission-essential tasks, caring for families, or maintaining independence at home.

In an outpatient setting like BJACH, Williams said OT focuses on restoring strength, endurance, joint integrity and injury prevention while reinforcing Army Warrior Tasks and everyday functional skills.

For Soldiers, those activities may include handling equipment, completing mission planning tasks or carrying a full load without pain. For others, it may involve returning to work, managing a household or recovering from surgery.

“Our mission is to help patients recover so they can fully participate in the roles that matter most to them,” said 1st Lt. Quinne Johnson, an occupational therapist at BJACH. “If a full return isn’t possible, we focus on problem-solving and helping them find new ways to live their lives to the fullest.”

From activity to recovery

At BJACH, the OT team incorporates meaningful, activity-based techniques into rehabilitation to improve outcomes and keep patients engaged.

“As part of the OT team, we try to make the rehabilitation process as comfortable and enjoyable as possible for our patients,” said Staff Sgt. Jason Cobb, occupational therapy specialist and noncommissioned officer in charge of the clinic.



Beatrice Hurey, a supervisor in Bayne-Jones Army Community Hospital’s military human resources department, performs a functional task during an occupational therapy session April 8 at the Joint Readiness Training Center and Fort Polk, Louisiana. Photo credit Jean Graves

Cobb said the OT team tailors activities to each patient’s injury and phase of recovery, often incorporating games to build strength and coordination in a functional way.

Ping pong has become a staple for patients recovering from upper extremity injuries, including wrist and elbow conditions such as carpal tunnel or cubital tunnel syndrome, wrist injuries and scaphoid fractures.

“It challenges both fine and gross motor skills,” Cobb said. “Holding the paddle and striking the ball improves hand-eye coordination, grip strength, dexterity and range of motion, while moving around the table improves balance, reflexes and overall coordination.”

The tournament, held during lunch hours to avoid disrupting patient care, also fosters morale and teamwork across the organization while raising awareness of OT and its role in recovery and readiness among staff.

OT specialists play a critical role in supporting both providers and patients throughout the rehabilitation process.

Sgt. Kayla Lowe, an occupational therapy specialist at BJACH said her role focuses on supporting both therapists and patients throughout the recovery process.



“We support the therapists by reinforcing treatment plans and helping patients stay engaged, both in the clinic and with their exercises at home,” she said.

Lowe added that activities like the ping pong tournament provide additional benefits beyond physical rehabilitation.

“It’s a fun way to work on coordination and build confidence,” she said. “You can see the difference in morale when patients are engaged and enjoying what they’re doing.”

Building resilience through movement

Beyond physical recovery, OT also strengthens cognitive performance and resilience.

Activities like ping pong require patients to track movement, plan responses and adjust force in real time — skills that directly support both daily function and operational performance.

From a Holistic Health and Fitness perspective, these activities help build resilience by training patients to respond appropriately under pressure in a controlled, low-risk environment.

“Soldiers need to be able to track, plan and react under pressure,” Williams said. “This is a low-threat way to train those skills.”

A patient’s path to recovery

While Occupational Therapy Month is being highlighted through activities like the clinic’s ping pong tournament, the impact of OT extends far beyond the table.

For Beatrice Hurey, a supervisor in BJACH’s military human resources department, OT has played a critical role in her recovery following multiple strokes earlier this year.

Although the outpatient clinic does not typically treat stroke patients, Hurey was accepted for care due to the clinical expertise of the team.

Williams brings specialized experience in brain injury and stroke rehabilitation, including advanced training and prior work in an inpatient rehabilitation setting focused on neurological recovery.

“We work to retrain neural pathways — or create new ones — so patients can return to performing tasks they were previously able to do,” Williams said.

Hurey said OT has helped her relearn how to perform everyday tasks many people take for granted. “It’s having my brain relearn how to operate with my arm and do the things I used to do without thinking,” she said.

After just a few weeks of therapy, she has already seen measurable progress. “My doctor said my left arm is reacting the same as my right,” Hurey said. “Occupational therapy has been amazing.”



1st Lt. Quinne Johnson, an occupational therapist at Bayne-Jones Army Community Hospital, applies neuromuscular electrical stimulation to Beatrice Hurey during a therapy session on April 9 at the Joint Readiness Training Center and Fort Polk, Louisiana. Photo credit Jean Graves

She said the impact goes beyond physical recovery. “They made me feel like I mattered,” Hurey said. “Every time I come here, there’s a laugh. They give you hope that you can get back to where you were.”

That process includes rebuilding coordination, cognitive function and the ability to perform multi-step tasks—skills essential to both daily living and overall readiness.

Strength through collaboration

OT at BJACH is part of a broader, collaborative effort to support patient outcomes and readiness.

“We work closely with primary care managers, physical therapy and orthopedics to ensure a cohesive recovery plan,” Johnson said. “Our specialties complement each other to help patients return stronger, safer and ready to perform.”

That teamwork extends throughout the clinic, where providers and specialists work together to deliver patient-centered care. “Our team is incredibly collaborative,” Johnson said. “We’re constantly learning from one another, and we all share the same goal — helping our patients succeed.”

Restoring function, rebuilding lives

For providers at BJACH, the success of OT is measured in everyday victories. “It’s not about one big moment — it’s about the small ones,” Johnson said. “When a patient can carry their child again, get dressed independently or return to training without pain — those are the wins that matter.”

At BJACH, OT is more than rehabilitation — it is a pathway to restoring independence, rebuilding confidence and ensuring patients can return to the activities that matter most.

Source: *The United States Army*



PULMONOLOGY
Twentynine Palms Sailors Earn Spirometry Certification to Safeguard Respiratory Health

By Christopher Jones, Naval Hospital Twentynine Palms

Sailors assigned to Navy Medicine Readiness and Training Command (NMRTC) Twentynine Palms completed National Institute for Occupational Safety and Health (NIOSH)-certified spirometry training on Feb. 26, expanding the command’s ability to detect occupational lung disease early and protect the respiratory health of service members and civilian personnel.

The three-day course provided hands-on instruction and certification for technicians responsible for conducting pulmonary function tests used to monitor respiratory health among personnel exposed to workplace hazards. Spirometry plays a critical role in occupational health programs by identifying lung function changes before symptoms develop, allowing for early intervention and improved outcomes.

Dr. Geoffrey Jacoby, occupational medicine physician at Branch Health Clinic Port Hueneme and course instructor, said the training focuses heavily on developing both technical proficiency and patient coaching skills necessary to obtain reliable results.

“The primary objective of the course instructor is to teach students how to coach patients through a complex set of respiratory maneuvers in a way that delivers accurate and reliable results,” Jacoby said. “Students learn to identify and correct testing errors, motivate patients to deliver their best effort, and help patients perfect their technique.”



Dr. Geoffrey S. Jacoby, an occupational medicine physician from Branch Health Clinic Port Hueneme, instructs Sailors during a National Institute for Occupational Safety and Health (NIOSH)-certified spirometry training course at Robert E. Bush Naval Hospital, Feb. 25, 2026. Photo courtesy of the Naval Hospital Twentynine Palms

Participants must complete the full three-day training and pass both a written and practical examination to receive certification as a NIOSH-certified spirometry technician, which remains valid for five years.

Jacoby’s background in occupational medicine spans decades of military service. During his Navy career, he supervised occupational medicine programs while serving as both a general medical officer and family medicine physician, later completing residency training in occupational and environmental medicine at the University of California, Irvine. He went on to serve in occupational medicine billets at Pearl Harbor Naval Shipyard, 3rd Marine Aircraft Wing and Naval Hospital Camp Pendleton before retiring from the Navy in 2020.

His experience across diverse military installations shaped his understanding of how workplace environments influence health risks. “I like learning about peoples’ jobs and the various hazards that are unique to each job and work location,” Jacoby said. “Each military base has unique functions that determine what types of personnel and hazards are present.”

Spirometry testing serves as an important screening tool in occupational medicine programs, particularly for personnel exposed to respiratory hazards such as smoke, chemicals, dust and industrial materials.

“Spirometry is a screening test that can detect occupational lung disease in its earliest stages, often before symptoms develop and when interventions are most effective,” Jacoby said. “It can also be used as a surveillance tool for groups of workers such as aircraft painters or firefighters for early identification of health effects potentially related to workplace exposures.”

For military treatment facilities, maintaining in-house spirometry capability ensures continuity of care and allows providers to monitor respiratory health over the course of a service member’s career.

“It is essential for commands to have their own certified personnel to perform these tests as part of a comprehensive occupational health evaluation,” Jacoby said. “Longitudinal monitoring of patients over time is an essential component. We have been tracking some of our patients for more than twenty years.”



Results from each test are documented in the electronic health record and compared with previous exams to identify potential changes in lung function. This continuity allows providers across the Department of War to review historical data when service members transfer or deploy.

Lt. Cmdr. Matthew Horch, occupational medicine physician and department head for occupational health at NMRTC Twentynine Palms, emphasized the operational importance of maintaining a certified spirometry program at the command.

“This training allows us to fully comply with federal and Defense Health Agency regulations for conducting spirometry,” Horch said. “Without this training, we can’t perform spirometry, which is a critical component of any occupational health program for early detection of work-related pulmonary disease.”

Horch attended the training alongside his staff to better understand the technical process and support quality assurance efforts within the clinic.

“I think it’s important to understand how to properly conduct spirometry so that I can provide oversight and quality control of the exams performed in the clinic,” Horch said. “I can also help troubleshoot and advise when any of my technicians are experiencing difficulty with the exams.”

Having multiple certified technicians also ensures the program remains operational despite the frequent personnel movements common within military commands.

“Having several NIOSH-approved technicians at the command allows us to meet the mission even when our active duty staff move to other departments, go on temporary additional duty or deploy,” Horch said. “Spirometry is a critical tool for early detection of occupational lung disease, which can have significant costs to the patient and the organization if it is not caught early—so always having certified technicians on-hand is crucial.”

For junior Sailors, the certification represents both a professional development opportunity and a chance to play a more active role in patient care.

Hospitalman Apprentice Hanna Parkos, an occupational health technician assigned to the command, said the course provided a deeper understanding of both the technical and patient-care aspects of spirometry testing.

“Spirometry training teaches corpsmen how to properly perform, analyze and interpret pulmonary function tests,” Parkos said. “One of the biggest things I learned during the course is how much accurate results depend on proper coaching and technique. Paying attention to detail and giving clear instructions to the patient is critical to getting reliable data.”

Parkos said the certification will allow her to apply those skills directly in supporting occupational health monitoring for

personnel working in environments where respiratory hazards may exist. “With this certification, I’ll be able to monitor lung function changes over time by ensuring tests are conducted accurately and consistently throughout a patient’s career,” Parkos said. “Tracking those changes helps identify potential issues early so they can be addressed before they affect someone’s ability to perform their job.”

Monitoring respiratory health is particularly important for personnel who routinely operate in environments where smoke, fumes or industrial materials are present. Early detection helps ensure individuals remain healthy and capable of performing their duties safely.

“Monitoring respiratory function for personnel exposed to workplace hazards helps ensure they remain healthy and fit to perform their jobs,” Parkos said. “It protects both the individual and the overall safety and readiness of the command they serve.”

Beyond its diagnostic value, spirometry also provides corpsmen with opportunities to strengthen their patient communication skills while developing confidence in clinical settings.

Jacoby said the collaborative nature of the test makes it especially valuable as a training tool for junior Sailors.

“Spirometry is an ideal test for developing communication skills because it requires staff members and patients to work together to get the best results,” Jacoby said. “For junior corpsmen it can be a great opportunity to have their own patient schedule in the occupational medicine clinic, become actively involved in patient care and develop their bedside manner.”

The certification also offers long-term professional benefits for corpsmen by expanding their clinical skill set and enhancing career opportunities.

“This certification allows technicians to function more independently and take ownership of their patients and clinic,” Horch said. “It can also help with advancement within the military and future employment outside the military because it makes them more attractive applicants to employers.”

For Parkos, gaining a specialized skill that directly contributes to protecting the health of service members reinforces the core mission of Navy medicine.

“As a corpsman I take pride in learning new skills that support and protect our service members,” Parkos expressed.

Through initiatives like spirometry certification training, NMRTC Twentynine Palms continues strengthening its occupational health capabilities—ensuring Sailors, Marines and civilian personnel remain medically ready to support operational missions around the globe.

Source: *The United States Navy*

RADIOLOGY

United States Naval Hospital Guam Installs New Computed Tomography Scanners to Boost Readiness and Patient Care

By Lt. Amanda Kundrat, U.S. Naval Hospital Guam

U.S. Naval Hospital Guam (USNH Guam) completed installation of a new 72 kilowatt computed tomography (CT) scanner Feb. 13, with a second unit scheduled for installation in the coming months as part of a planned modernization effort.

The new equipment replaces a legacy CT scanner that completed its scheduled service life. The upgrade ensures uninterrupted imaging capability and directly supports the command’s ongoing trauma capability efforts by minimizing potential downtime and reducing the need to divert emergency patients.

“Having a backup CT unit significantly strengthens our ability to maintain continuous emergency and trauma services,” said Cmdr. Carl Powell, director of clinical support services, which includes the radiology department. “This directly enhances patient safety and operational readiness”.

CT scans take highly detailed pictures of the inside of the body, helping doctors quickly find and treat injuries and illnesses. These new machines use advanced computer software to create sharper, clearer images while exposing patients to less radiation.

The new primary system has a wider opening and supports patients up to 675 pounds, expanding access for trauma and bariatric patients. The platform’s artificial intelligence-driven workflow reduces patient positioning time and overall exam duration,



Workers at U.S. Naval Hospital Guam (USNH Guam) install a new Revolution Ascend Plus 72 kilowatt computed tomography (CT) scanner, Feb. 13. Photo credit Hospital Corpsman First Class Clie Lester Guico U.S. Navy

speeding up the entire process, which is critical in emergency settings.

The second unit will further enhance cardiac and trauma imaging with its faster speed and sharper images, allowing USNH Guam’s medical team to make highly accurate diagnoses while using smaller, safer amounts of radiation and contrast dye.

Installation of the first unit wrapped up this week, with clinical protocol development and applications training scheduled for Feb. 18–27. The installation process for each scanner takes approximately two to three weeks. Patient care was not interrupted during the transition, as the previous unit remained operational throughout installation.

The modernization was coordinated by Lt. Cmdr. Jason Cole, radiation health officer, with Hospital Corpsman 1st Class Andy Kim assisting in day-to-day scheduling to ensure seamless delivery and installation of the new CT machine.

Upon completion of installation, Cole verified that the scanner functions safely, meets manufacturer specifications, and complies with Joint Commission standards while Lt. Cmdr. Kyle Keinath oversaw clinical integration and optimization for patient care. All radiology and CT technologists will receive on-site applications training to ensure flawless integration into clinical operations.

This investment, valued at more than \$1 million per unit, these systems are designed to save money and protect patient care. Keeping the equipment up and running avoids the high costs of transporting emergency patients elsewhere for scans. Additionally, the technology automatically monitors its own hardware to schedule maintenance before any technical issues can arise.

The new CT platforms meet Joint Commission standards and position USNH Guam to deliver high-quality, low-dose imaging in support of active-duty service members, retirees, and their families.

“These systems ensure we can provide reliable, advanced imaging anytime,” Powell said. “They strengthen our trauma capability and directly support the readiness of the force.”

Source: *The United States Navy*



RESEARCH

Naval Medical Research Command Scientist Selected for 2026 Dr. Delores M. Etter Top Scientists and Engineers of the Year Award

By Tommy Lamkin, Naval Medical Research Command

Kimberly Bishop-Lilly, a scientist with Naval Medical Research Command (NMRC), has been selected as a recipient of the Assistant Secretary of the Navy (Research, Development and Acquisition) 2026 Dr. Delores M. Etter Top Scientists and Engineers of the Year Award in the Individual Scientist category.

This award is used to recognize outstanding efforts that contribute to scientific development and operational capabilities in the U.S. Navy. The award is open to 35,000 scientists and engineers annually but only a few are selected.

Bishop-Lilly is one of five, Department of the Navy, researchers recognized in the Individual Scientist category for scientific achievements that advance naval readiness and support the Department of the Navy mission.

“This was something I never in a million years would have anticipated,” said Bishop-Lilly. “Once the shock started to wear off a little, it made me feel so good to know that the work my team and I are doing is valued.”

Bishop-Lilly’s research focuses on sequencing-based infectious disease and biothreat surveillance, helping identify and characterize emerging threats to service member health. Her laboratory serves as one of three core laboratories supporting the Global Emerging Infections Surveillance program’s Next-Generation Sequencing and Bioinformatics Consortium, providing technical expertise, training and reach-back support to Department of War laboratories around the world.

“My lab has been working on sequencing-based infectious disease and biothreat surveillance and supporting methodologies,” said Bishop-Lilly. “Detecting and characterizing novel pathogens is a special interest of ours.”

In addition to conducting sequencing and bioinformatics analysis, Bishop-Lilly’s team supports field-based genomic surveillance efforts, develops specialized software tools and maintains expertise in phage genomics.

While the award recognizes individual achievement, Bishop-Lilly emphasized the role of her team in receiving this award.

“Obviously, I couldn’t have done this without my team,” she said. “I am so fortunate to work with the most awesome team

of talented and hardworking people. Their work ethic, creativity and initiative are exemplary.”

“Selection for the Dr. Delores M. Etter Top Scientists and Engineers of the Year Award is among the highest honors a Navy researcher can receive,” said Capt. Eric Welsh, commander, Naval Medical Research Command. “Dr. Bishop-Lilly’s groundbreaking work in infectious disease surveillance and bioinformatics is advancing scientific knowledge while directly contributing to force health protection and operational readiness. On behalf of the entire Naval Medical Research Command team, I congratulate her on this outstanding achievement and thank her for her continued service to our nation’s military.”

According to Bishop-Lilly, the work performed at NMRC directly supports the health, readiness and operational effectiveness of Sailors, Marines and joint force personnel.

“We use sequencing and bioinformatics to detect and characterize threats to Sailors’ health and to assess or design countermeasures that can be used to protect them when they are deployed,” she said.

The annual Dr. Delores M. Etter Top Scientists and Engineers of the Year Awards recognize Department of the Navy scientists and engineers whose achievements demonstrate technical excellence and significant contributions to naval missions. Award recipients will be formally recognized during a ceremony at the Pentagon on July 29.

NMRC, headquarters of Navy Medicine Research & Development, is engaged in a broad spectrum of activity from basic science in the laboratory to field studies in austere and remote areas of the world to investigations in operational environments. In support of Navy, Marine Corps and joint U.S. warfighter health, readiness and lethality, researchers study infectious diseases, biological warfare detection and defense, combat casualty care, environmental health concerns, aerospace and undersea medicine, operational mission support and epidemiology.

Navy Medicine’s 44,000+ talented and ready forces optimize health readiness, deliver quality healthcare and provide global expeditionary medical support to warfighters.

Source: The United States Navy Bureau of Medicine and Surgery

SURGERY

Naval Medical Center San Diego Maxillofacial Restoration Program Designated Defense Health Agency Center of Excellence

By Regena Kowitz, Defense Health Network Pacific Rim

The Defense Health Agency has formally designated Naval Medical Center San Diego’s (NMCS) Maxillofacial Restoration Program as a Department of War Specialty Center of Excellence (CoE).

The designation, which is official as of May 18, establishes an enterprise-wide standard of care and regional center for treating service members and beneficiaries with complex facial trauma, head and neck cancer, and congenital or pathologic conditions of the face, mouth or jaw.

Alongside NMCS, the DHA has also designated Brooke Army Medical Center (BAMC) in San Antonio, Texas, as a CoE, creating a powerful, joint capability to scale this critical specialty across the Military Health System (MHS).

The establishment of the CoE is a direct response to the growing need for advanced restorative capabilities seamlessly integrating dentistry and reconstructive surgery. Given that maxillofacial (face, mouth and jaw) injuries account for 30-40% of casualties in recent global conflicts, the increasing prevalence of drone warfare elevates this into a critical readiness issue for the joint force in future fights.

The designation acknowledges NMCS’s unprecedented outcomes in maxillofacial restoration, including a 94% return-to-duty rate for active-duty service members and treatment timelines that significantly exceed civilian sector standards.

“This designation as a Center of Excellence reflects our commitment to delivering world-class specialty care to our warfighters and their families,” said Defense Health Network Pacific Rim



Cmdr. Daniel Hammer, left, maxillofacial surgeon and director of the Maxillofacial Restoration Program at Naval Medical Center San Diego, and Lt. Cmdr. Stephen Moreno, oral maxillofacial surgery residency program assistant director, check on U.S. Army Spc. Grant Dickerson in the intensive care unit two days after the performed his jaw-in-a-day surgery. Dickerson had the surgery to remove a tumor that had destroyed two-thirds of his lower jaw and rebuild the damaged portion. Photo credit Regena Kowitz, U.S. Department of War



Director Rear Adm. Kevin Brown. “NMCS D’s maxillofacial restoration team has revolutionized treatment protocols, achieving results that directly support force readiness while transforming the standard of care in facial reconstruction.”

The program has treated more than 70 patients since its inception, leveraging nine integrated clinical care pathways and a team of over 125 specialists across multiple disciplines. Notable achievements include:

- Hospital stays under 7 days, compared to the national average of 12-13 days
- Immediate oral feeding without feeding tubes upon hospital discharge
- Minimal pain medication requirements, with most patients managing post-operative pain using only over-the-counter medications
- Complete dental rehabilitation integration from day one
- Patients typically returning to full duty within 16 weeks

“This recognition validates the innovative spirit and dedication of our maxillofacial restoration team,” said Capt. Elizabeth Adriano, NMCS D director. “Their integrated approach transforms lives and directly sustains force readiness. Furthermore, by keeping these highly complex restorative cases within the MTF, we are advancing our core priorities — ensuring our military medical providers maintain the critical, high-acuity skills required to support the warfighter in future conflicts.”

The program’s success stems from its pioneering integration of nine clinical care pathways, including preoperative optimization leveraging telehealth, head and neck cancer care, advanced pain management protocols, nursing-led early recovery after surgery protocol, speech and swallow restoration, rapid dental restoration, mental health and wellness, comprehensive physical rehabilitation and deep focus on research, education and training.

This coordinated approach ensures that every aspect of a patient’s recovery is carefully planned and managed from day one, leading to superior outcomes and faster recovery times. In addition, the coordinated effort leads to medical force generation and readiness across all phases of patient care.

“This designation validates what we’ve known since establishing this program in 2020 — that our comprehensive, integrated approach to maxillofacial restoration is transforming lives and enhancing military readiness,” said Cmdr. Daniel Hammer, director of NMCS D’s Maxillofacial Restoration Program. “Our patient-centered approach integrates both physical and psychological recovery, ensuring complete restoration of function and well-being. We don’t just reconstruct faces, we restore lives, helping our patients face the world with confidence and our warfighters return to readiness.”

NMCS D’s program is unique in its integration of dental rehabilitation with surgical reconstruction, offering procedures like “Jaw in a Day” that provides immediate reconstruction with dental rehabilitation. The program has performed more than 35 of these procedures, including the Department of War’s first-ever immediate jaw reconstruction using 3D-printed teeth.

While the program’s primary mission is military readiness, its pioneering medical advancements are also making a profound impact on the local community.

“This transformative care has also strengthened collaboration with UC San Diego Health,” added Adriano. “Through clinical rotations at local San Diego hospitals, Cmdr. Hammer and the NMCS D team have performed these complex restorative procedures alongside surgeons at UC San Diego Health. The partnership allows Navy Medicine providers to sustain critical surgical proficiency while sharing innovative techniques pioneered at Naval Medical Center San Diego. By advancing the practice of maxillofacial reconstruction beyond the Military Health System, the collaboration demonstrates how military medical innovation can improve outcomes for both warfighters and the broader community.”

As Centers of Excellence, NMCS D and BAMC will serve as the primary referral centers for complex maxillofacial restoration cases across the MHS, scale best practices, and advance research and training in the field.

The program provides care and treatment for active-duty service members from all branches, veterans, retirees, and TRICARE-eligible beneficiaries. Treatment is provided at no cost to TRI-CARE-eligible beneficiaries.

For more information about NMCS D’s Maxillofacial Restoration Program, visit: <https://sandiego.tricare.mil/Health-Services/Specialty-Care/Maxillofacial-Restoration-Program>

About Naval Medical Center San Diego: The mission of NMCS D is to optimize health and enhance readiness. NMCS D employs more than 5,000 active-duty military personnel, civilians, and contractors in Southern California to deliver exceptional care afloat and ashore.

About the Defense Health Network Pacific Rim: Defense Health Network Pacific Rim (DHN-PR) is one of the Defense Health Agency’s nine networks of hospitals and clinics that deliver high-quality health care to more than 140,000 enrolled beneficiaries, supporting major operational units through the Indo-Pacific. The DHN-PR headquarters is located in San Diego, overseeing military hospitals and clinics along the U.S. West Coast and overseas in Guam and Japan.

Source: The United States Navy Bureau of Medicine and Surgery

TECHNOLOGY

Naval Medical Research Unit SOUTH Information Professional Receives Navy Medicine Lifetime Achievement Award

By the United States Naval Medical Research Command

Miguel Ramirez, head of information management/information technology at Naval Medical Research Unit (NAMRU) SOUTH, has been selected for the 2025 Captain Joan Dooling Information Professional Lifetime Achievement Award.

The award, which will be formally recognized during the 2026 Defense Health Information Technology Symposium Navy Service Day on August 10, recognizes outstanding contributions in information management, information technology and informatics.



Miguel Ramirez, head of information management/information technology at Naval Medical Research Unit (NAMRU) SOUTH. Ramirez was selected for the 2025 Captain Joan Dooling Information Professional Lifetime Achievement Award. Navy Medicine’s 44,000+ talented and ready forces optimize health readiness, deliver quality healthcare and provide global expeditionary medical support to warfighters. Photo courtesy of the United States Navy Bureau of Medicine and Surgery

Ramirez was selected in the lifetime achievement category for his sustained service and contributions to Navy Medicine and the NAMRU SOUTH mission. His contributions include leading major technology transitions, strengthening the command’s cybersecurity posture and ensuring mission continuity during periods of significant operational challenge for the command.

Ramirez leads a team of 13 information technology professionals in direct support of the NAMRU SOUTH scientific research

mission, supporting multiple research protocols annually, processing nearly 500,000 records and transforming research data into actionable scientific information.

“It has been 25 years serving the NAMRU SOUTH mission with honor and professionalism,” said Ramirez. “This is a recognition of an amazing IT team I have been working with since 2001. I am very proud of what we have accomplished so far, and this award is an incentive to continue serving with gratitude to our leadership, NMRC and BUMED for their guidance and support.”

During the COVID-19 pandemic and a country-wide lockdown in Peru, Ramirez helped deploy a telework infrastructure within 24 hours, allowing vital infectious disease research in support of U.S. service members to continue with minimal interruption.

He also played a key role in the command’s migration to the Medical Community of Interest network and supported a major facility renovation with no network downtime, helping ensure NAMRU SOUTH personnel could continue working through complex infrastructure changes.

“Mr. Ramirez’s recognition with a Navy Medicine lifetime achievement award is a proud moment for NAMRU SOUTH and a clear reflection of the mission impact our information professionals deliver every day,” said Capt. Hak Auth, NAMRU SOUTH commanding officer. “His leadership has helped safeguard the systems, data and operational continuity our scientists rely on, ensuring research can continue securely and without interruption, even during major transitions and global crises. We are proud to see his decades of service recognized across Navy Medicine.”

Navy Medicine’s 44,000+ talented and ready forces optimize health readiness, deliver quality healthcare and provide global expeditionary medical support to warfighters.

NAMRU SOUTH, part of Navy Medicine Research & Development conducts research and surveillance in the SOUTHCOM Area of Responsibility to prevent and treat infectious diseases in support of U.S. warfighter health and readiness.

Source: The United States Navy Bureau of Medicine and Surgery



TRAINING

United States Navy Ship Mercy Sailors, Marines Hold MERCEX 26-3, Strengthening Naval Medical Readiness

By Petty Officer 3rd Class Jason Afable, Naval Medical Center San Diego

U.S. Navy Sailors assigned to the hospital ship USNS Mercy (T-AH-19) conducted Mercy Exercise (MERCEX) 26-3 in San Diego, June 15-18. The quarterly exercise strengthened integration and readiness between reduced operating status (ROS) and full operating status (FOS) Sailors through training conducted at Naval Medical Center San Diego, Naval Base San Diego and aboard the Freedom-class littoral combat ship USS Fort Worth (LCS-3).

Sailors participated in a variety of training evolutions designed to reinforce core competencies among hospital corpsmen, medical providers and support personnel.

“This is an exercise where we ramp up our skills in all different areas,” said U.S. Navy Lt. Cmdr. Michael Gamboa, triage officer for the Mercy. “Everything from lab to triage to moving patients, and putting it all together into one exercise.”

Participants received familiarization training on several types of medical litters, including the Army TALON II 90C collapsible handle litter used with wheeled litter carriers, commonly known as rickshaws, and practiced moving patients through steep shipboard ladderwells using a Reeves sleeve stretcher. Although the skills may appear straightforward, proficiency with this equipment is critical during casualty scenarios where seconds can mean the difference between life and death.

For the first time, U.S. Marines assigned to 1st Marine Logistics Group and 1st Marine Division joined Navy instructors to facilitate the chemical, biological, radiological and nuclear (CBRN) portion of the exercise.

“The Marines involved in this exercise are MOS 5711 Marines [CBRN defense specialists],” said U.S. Marine Corps Warrant Officer Benjamin Train, CBRN response platoon commander, 1st Marine Logistics Group. “In addition to responsibilities like reconnaissance, sensitive site assessment and sensitive site exploitation, one of their specialties is decontamination, and that’s the expertise that we’re able to share in an exercise like this.”

Train said the joint training benefited both services.

“When we conduct trainings like this on our own, we often have to notionalize the roles of medical personnel,” he said. “Being able to integrate with the corpsmen and medical officers here,



U.S. Navy Sailors assigned to Navy Medicine Readiness Training Command San Diego participate in a shipboard litter bearer training aboard the Freedom-class littoral combat ship USS Fort Worth (LCS-3), June 16. Photo credit Petty Officer 3rd Class Jason Afable Mass Communication Specialist United States Navy

and to have that capability to triage, for instance, is a huge win for us. We’re able to get a better idea of how things would play out in a real-world scenario.”

Commissioned in 1986, USNS Mercy is a 1,000-bed hospital ship that, along with its sister ship USNS Comfort (T-AH-20), provides the U.S. military with afloat, mobile acute surgical medical capability. When not deployed, many of Mercy’s FOS Sailors are assigned to Navy Medicine Readiness and Training Command San Diego, where they maintain clinical proficiency while ensuring Sailors and Marines remain medically ready and deployable.

In addition to providing realistic deployment training, MERCEX strengthens integration between ROS and FOS personnel, enhances operational effectiveness and improves the Navy’s ability to deliver expeditionary medical support wherever and whenever it is needed.

NMRTC San Diego supports Navy and Marine Corps readiness by ensuring its medical forces are ready to deploy and provide medical support, ashore or at sea.

Source: The Digital Visual Information Distribution System

UROLOGY

Madigan Endourologist Named American Urological Association’s “Young Urologist of the Year”

By Sean Hall, Madigan Army Medical Center Public Affairs



Lt. Col. Ronald “RJ” Caras, a urologist at Madigan Army Medical Center, has been named the American Urological Association’s “Young Urologist of the Year,” representing the Society of Government Service Urologists and recognizing his clinical innovation and leadership in military medicine. Caras is a doctor of osteopathic medicine and an endourologist, which is a urologist with specialized training in endoscopic techniques to access the urinary tract. He is also an assistant professor of surgery at the Uniformed Services University. He serves as program director for the Madigan Urology Residency, where he oversees resident education, research initiatives and simulation-based surgical training. Caras previously served as chief of the Department of Urology at Madigan.

Photo credit Joseph Jones, courtesy of Madigan Army Medical Center

Lt. Col. Ronald “RJ” Caras, a urologist at Madigan Army Medical Center, has been named the American Urological Association’s “Young Urologist of the Year,” representing the Society of Government Service Urologists and recognizing his clinical innovation and leadership in military medicine.

Caras is a doctor of osteopathic medicine and an endourologist, which is a urologist with specialized training in endoscopic techniques to access the urinary tract. He is also an assistant professor of surgery at the Uniformed Services University.

He serves as program director for the Madigan Urology Residency, where he oversees resident education, research initiatives and simulation-based surgical training. Caras previously served as chief of the Department of Urology at Madigan.

“I’m humbled to be considered young,” joked Caras. “Honestly though, I think this is the product of working in a department with such excellent support. We have the best team in the hospital and a resident group that makes it easy to want to push the envelope and bring the best education we can.”

After completing his urology residency at Tripler Army Medical Center, Caras served as a general urologist at William Beaumont Army Medical Center in El Paso, Texas, and at Madigan before pursuing advanced fellowship training in endourology at Indiana University.

Upon his return to the Military Health System, Caras established the first Holmium Laser Enucleation of the Prostate program within the U.S. Army, expanding access to minimally invasive surgical care for service members and beneficiaries. He also led modernization efforts within urologic surgery at Madigan, securing advanced nephroscopes and resectoscopes, laser technologies and morcellation systems to support complex endourologic procedures.

In addition to his clinical work, Caras has held leadership roles within the Pacific Northwest Urologic Resident Collaborative, supporting multi-institutional research and regional academic planning.

The Young Urologist of the Year award recognizes early-career urologists who demonstrate outstanding contributions to clinical care, education and research.

The surgeons and staff of the Madigan Urology Service provide expert health care services for conditions of the urinary tract. Madigan provides comprehensive urologic care for eligible pediatric, adult, and geriatric patients at Madigan Army Medical Center. Madigan’s Urology Service is a state-of-the-art, 13,400 square foot clinic with the capability to perform the full range of diagnostic and therapeutic urologic procedures. Three urology procedure tables and four cystoscopy suites with full video capability allow providers to perform procedures and surgery in the clinic to include laser lithotripsy, flexible cystoscopy and ureteroscopy, transurethral surgery, prostate biopsies, urodynamics, and penile ultrasounds.

Source: The United States Army



WOMEN’S HEALTH

Army’s Newest Obstetrics and Gynecology Nurses Answer the Call to Provide Comprehensive Women’s Health Services

By Rodney Jackson

Ten Army nurses earned their Area of Concentration designator in obstetrics and gynecology after completing the Carl R. Darnall Army Medical Center’s Nursing Specialty Course, during a graduation ceremony Feb. 9.

The nurses were honored during the ceremony where they received their diplomas from Col. Brian Cahill, CRDAMC’s chief nursing officer. The graduates are Cpt. Hannah Lloyd, 1st Lt. Caitlin McCollom, 1st Lt. Anna Drury-Palermo, 1st Lt. Francesca Aviles-Winn, 1st Lt. Victoria Vinson, 1st Lt. Victoria McHale, 1st Lt. Zoie Walther, 1st Lt. Megan Harper, 1st Lt. Mikayla Fletcher and 1st Lt. Carren Matson.

The Nursing Specialty Course prepares registered nurses with the advanced knowledge and clinical skills to care for women across the lifespan. From prenatal care and labor support to postpartum recovery and gynecologic procedures, the training ensures nurses are ready to provide safe, high-quality care to Soldiers, retirees, and family members.

Over 16 weeks, the nurses engaged in classroom instruction, hands-on simulation training and clinical rotations within the hospital’s Labor and Delivery, Mother-Baby Unit, NICU, Newborn Clinic, and OB/GYN clinic. The curriculum emphasized evidence-based practice, fetal monitoring, obstetric emergencies, and patient-centered communication — critical components in



(bottom row) Lt. Col. Noelle Dove, deputy director OB-GYN nursing specialty course, 1st Lt. Mikayla Fletcher, Cpt. Hannah Lloyd, 1st Lt. Francesca Aviles-Winn, 1st Lt. Zoie Walther, (top row) Lt. Col. Bethany Gardner, director OB-GYN nursing specialty course, 1st Lt. Anna Drury-Palermo, 1st Lt. Megan Harper, 1st Lt. Zoie Matson, 1st Lt. Caitlin McCollom, 1st Lt. Victoria McHale, 1st Lt. Victoria Vinson the Army’s newest OB-GYN nurses, and said Lt. Col. Merry Fontenot, chief, department of women’s health pose for a photo after the Carl R. Darnall Army Medical Center’s OB-GYN Nursing Specialty Course graduation, Feb. 9. Photo credit Rodney Jackson

supporting military families who often face unique stressors such as deployments and frequent relocations, according to Lt. Col. Noelle Dove, deputy director of the OB-GYN nursing course.

“The goal is not only to strengthen clinical competence, but also to build confidence,” said Lt. Col. Bethany Gardner, director of the OB-GYN nursing course.

Simulation labs allowed nurses to practice responding to scenarios such as postpartum hemorrhage, preeclampsia, and neonatal resuscitation in a controlled environment before applying those skills in real-world settings.

“Our mission is readiness,” said Gardner. “When our nurses leave this course, they are prepared to step into high-acuity situations and provide exceptional care to our patients. That readiness directly supports the overall mission of Army Medicine.”



Lt. Col. Bethany Gardner, director OB-GYN Nursing Specialty Course, CRDAMC addresses the audience and the graduates during a ceremony for the Carl R. Darnall Army Medical Center’s OB-GYN Nursing Specialty Course, Feb. 9. Photo credit Rodney Jackson



Lt. Col. Merry Fontenot, CRDAMC’s chief of women’s health, addresses the Army’s newest obstetrics and gynecology nurses during a graduation ceremony for the Carl R. Darnall Army Medical Center’s OB-GYN Nursing Specialty Course, Feb. 9. Photo credit Rodney Jackson



(left) Col. Nickalous Korbut, commander and (right) Command Sgt. Maj. Andrew Colburn Medical Readiness Battalion, CRDAMC present Cpt. Hannah Lloyd, 1st Lt. Mikayla Fletcher, 1st Lt. Zoie Matson, with Army Achievement Medals for scoring an extremely difficult 95% on the physical fitness test while participating in the Carl R. Darnall Army Medical Center’s OB-GYN Nursing Specialty Course and during the graduation ceremony, Feb. 9. Photo credit Rodney Jackson

For many of the graduates, the training represents both professional growth and a deeper commitment to serving military families. Obstetric and gynecologic nursing requires not only technical skill but also compassion and adaptability.

“Today, you graduate equipped with the knowledge and skills to excel,” said Lt. Col. Merry Fontenot, chief, department of women’s health. “The Army needs leaders like you. Our profession is stronger because you chose to answer this call. As you step into your future, remember to be your authentic self and be compassionate, be the best at your job, and be present in every moment.”

Earning the 66G AOC designator marks a significant milestone in the nurses’ careers and strengthens not only CRDAMC’s ability to provide comprehensive women’s health services, but also all MTFs across Army Medicine as most graduates PCS from CRDAMC to serve the women’s health community across the United States and abroad. By investing in specialty training, the medical center continues to enhance patient safety, improve outcomes and ensure that Army families receive expert care at every stage of life.

“As these newly graduated OB/GYN nurses move forward in their assignments they carry with them the knowledge, confidence and commitment gained through the Nursing Specialty Course,” said Dove. “Their achievement reflects the Army’s dedication to professional development and its enduring promise to care for those who serve.”

McCollom’s next assignment is at Fort Benning, Georgia; Drury-Palermo, Aviles-Winn, and McHale at Tripler Army Medical Center, Hawaii; Lloyd at Fort Bragg, North Carolina; Vinson at Fort Leonard Wood, Missouri; Walther and Harper at CRDAMC; Fletcher at Fort Stewart, Georgia; and Matson at Fort Wainwright, Alaska.

Source: The United States Army



SPECIAL FEATURES

The Power of Spiritual Care in Supporting Homeless Veterans

By Shawn Liu, National Homeless Program Manager, VHA Homeless Programs Office

For Veterans experiencing homelessness, recovery goes beyond just securing housing — it also involves restoring meaning and a sense of purpose

When a Veteran loses their home, the world around them often narrows down to a search for the basics, such as a warm bed, a hot meal and a shower. It’s natural to assume a person must be fed and housed before they can even think about their spiritual and emotional well-being. But the reality is often the exact opposite.

For a Veteran experiencing homelessness, spiritual care isn’t a luxury to be addressed after they are housed; it is often the very anchor that helps them hold on during the hardest days of displacement. That is why VA does not treat spiritual health as a separate or competing priority, but instead views recovery as a circle, in which spiritual health is interwoven with every other aspect of care.

Understanding spiritual challenges in displacement

Homelessness often brings about specific spiritual wounds that medicine alone cannot always heal. VA views a Veteran’s journey to stability through a whole health approach and as a process that is interconnected, rather than a linear path.

By focusing on the physical search for a home, it can be easy to overlook the quiet, internal crisis that happens when a Veteran feels they no longer belong to a community. It is a specific kind of isolation — a feeling that their values, their purpose and their spirit have been sidelined while they struggle to survive.

Some of the most common challenges

Veterans experiencing homelessness may face include:

- **Abandonment:** A deep sense of isolation and loneliness that can leave a Veteran feeling forgotten by their country and their community.
- **Disconnection from self:** A loss of self-identity that occurs when a Veteran is forced to focus solely on survival, causing them to lose sight of their inherent value.
- **Value ruptures:** A painful disconnect between who the Veteran believes they are and the difficult reality of their current circumstances.

Spiritual care in practice

VA chaplains act as a bridge, helping Veterans restore their sense of connection, meaning and belonging — both within VA care and within their communities. A chaplain contributes to the care a Veteran receives at VA by addressing the spiritual, emotional and moral needs that support healing and resilience.

While a common misconception is that a Veteran has to be religious to seek the support of a VA chaplain, in reality, spirituality is much broader than any single faith. It is the way many of us find meaning, purpose and connection to something larger than ourselves.

Whether a Veteran identifies as religious, spiritual but not religious or simply a person looking for purpose, VA chaplains are trained to meet them where they are. With fewer than 900 chaplains nationwide, these professionals are among a small group of highly specialized clinical providers trained specifically in spiritual care within a health care setting. Their work is informed by

evidence-based practices rooted in deep listening and empathy. Their role is not to persuade or convert, but to help Veterans reconcile their self-understanding and find the strength to move forward.

Connecting Veterans to spiritual care

The road to finding stability is a journey of both the body and the spirit. If you are a friend, family member or supporter, you can play a vital role in connecting a Veteran with this care. Many Veterans do not realize that spiritual support is an earned benefit available to every Veteran eligible for VA health care.

If a Veteran you care about is struggling with their sense of worth or feeling abandoned, encourage them to talk to a VA chaplain. VA chaplain services are free, confidential and available regardless of religious belief, with support shaped by each Veteran’s individual needs and circumstances. Reaching out does not require a crisis or a specific belief — it can begin simply with a conversation.

If you’re a Veteran, family member or caregiver interested in meeting with a VA chaplain, please contact your local VA facility.

Learn about VA programs

If you are a Veteran who is homeless or at risk for homelessness or need to connect with a Veterans justice outreach specialist, call the National Call Center for Homeless Veterans at 877-424-3838. Visit the VA Homeless Programs website to learn about housing initiatives and other programs for Veterans exiting homelessness.

Source: The Veterans Health Administration

ADAPTIVE SPORTS

VA Announces \$16M in Disabled Veterans’ Adaptive Sports Grants

The Department of Veterans Affairs has made available \$16 million in grants for national, regional and community-based organizations that provide adaptive sports programs for Veterans and service members with disabilities.



Photo courtesy of the Veterans Health Administration

Adaptive sports programs offer Veterans supportive and recreational opportunities to improve their independence, well-being and quality of life. These programs include a variety of competitive and leisure activities — such as archery, skiing, cycling, wheelchair softball, hunting, fishing and many others — that enable Veterans to rehabilitate through recreation and encourage an active and healthy lifestyle.

Since the establishment of the Adaptive Sports Grant Program, VA has awarded over \$160 million to expand access to adaptive sports nationwide.

“Adaptive sports can be life-changing for disabled Veterans, improving strength and facilitating healing while building resilience through competition, camaraderie and achievement,” said VA Secretary Doug Collins. “These grants will create vital access to local adaptive sports programs to help Veterans stay active, engaged and connected with their communities and fellow Veterans.”

Eligible organizations have until May 13, 2026, to apply. For details about eligibility, priorities and application requirements for this year’s Adaptive Sports Grant Program, visit <https://grants.gov/search-results-detail/360391>.

For more information on the Adaptive Sports Grant Program and awardees, visit www.va.gov/adaptivesports and follow @Sports4Vets on social media.

The grant is just one of many ways the second Trump Administration is making VA work better for Veterans. For example, VA has:

- Enrolled more than 100,000 new Veterans in VA health care in 2026.
- Opened 34 new VA health care facilities since Jan. 20, 2025, Opening 34 new VA health care facilities expanding health care access for Veterans around the country.
 - Reduced the backlog of Veterans waiting for VA benefits by 67% since Jan. 20, 2025, after it increased 24% during the Biden Administration.
- Completed 82,083,918 direct care appointments in FY2025, up 4.1% from FY2024.
- Offered Veterans more than 2.3 million appointments outside of normal operating hours, giving Veterans more timely and convenient options for care.
- Permanently housed 51,936 homeless Veterans across the country in FY2025, the highest total in seven years.

Adaptive sports programs offer Veterans supportive and recreational opportunities to improve their independence, well-being and quality of life.

Source: The Veterans Health Administration



ADAPTIVE SPORTS

Spinal Cord Injury Team Helps Army Vet Keep Competing

By Kenneth Trotter Jr., Public Affairs Specialist, Rocky Mountain Regional (RMR) VA Medical Center

Strength, perseverance and the power of SCI rehabilitation

Army Veteran Mark Maloney suffered a spinal cord injury after falling off his bike six years ago. The resulting fall broke his neck, paralyzing him.

Maloney, now 90, had run marathons, competed in the Pikes Peak Ascent race in Colorado Springs, and had been a competitive runner for decades. He was physically active, out in the community, constantly challenging himself; all of that changed with just one fall.

After several years of painstaking rehabilitation and care with the Spinal Cord Injury (SCI) department at the Rocky Mountain Regional (RMR) VA Medical Center in Aurora, Maloney is back to doing what he loves: competing.

“I feel fantastic,” said Maloney. “When I was there, I wasn’t sure I’d be able to get out of bed. I didn’t know whether I’d be able to taste food again. I was unclear of my future, but the physical therapists got me out of bed, and it was a long process but eventually they helped me learn how to swallow food again.”

Maloney’s injury resulted in what is classified as C3 incomplete spinal cord injury, meaning his spinal cord injury starts at his C3 vertebrae.

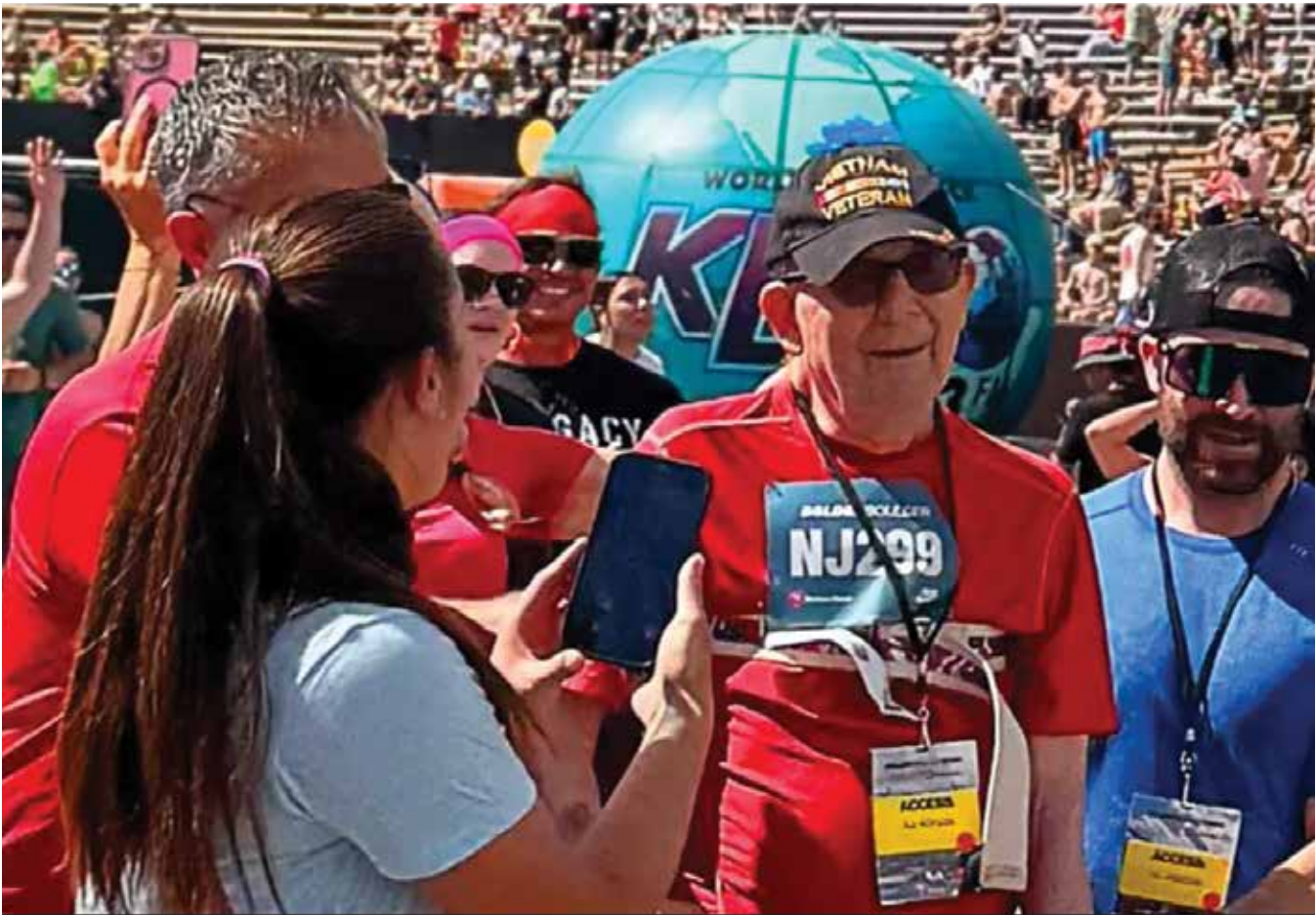


Photo courtesy of the Veterans Health Administration

“With any Veterans, we try to find things they have an interest in, and a love for, to help them. It’s important for Veterans to have a goal that has them physically active as possible.”

— Liam Kiernan, VA Eastern Colorado Health Care System (ECHCS) clinical specialist and physical therapist

“It’s really high (on the spinal cord) for any injury,” said Liam Kiernan, VA Eastern Colorado Health Care System (ECHCS) clinical specialist and physical therapist. “So, it has a big effect on his whole body. So, in his instance, there is a lot of dysfunctions with hands, trouble breathing, and goes all the way down to his legs. ‘Incomplete’ means there are some signals that are making it through the spinal cord down to his legs. If he was complete, he’d be on a ventilator, even more impaired than he is now. So, incomplete is generally a good thing.”

Though an incomplete spinal injury is better than a complete spinal cord injury, Maloney still had challenges he overcame to get to where he is now. And now, he is able to take part in races, such as the Bolder Boulder race that happened on May 25.

The SCI team at RMR helped him adjust to his new circumstances, working with Maloney to get back as many functions as possible.

“I had to pass tests to enable me to do that,” said Maloney. “I was able to eat food again and taste it rather than have a tube going into my stomach. So, even though I only stayed there for three months, they provided me with some exercise equipment, and I’ve been an outpatient now for almost five years. I’m a big advocate of VA.”

Finding purpose in helping other Veterans

During that time, going through inpatient care, Maloney worked with other Veterans who suffered spinal cord injuries, and to them he served as an empathetic ear, confidante and resource.

“When I arrived there, I didn’t know what questions to ask. I wasn’t in a clear state of mind,” he shared. “And what I’m doing now, I don’t do it as often as I would like, but when I have the opportunity, I go up and talk to either Veterans who have just arrived or who are just leaving. So, maybe I can answer the questions they might have in both cases.”

Kiernan echoed that sentiment.

“I think it means a ton,” said Kiernan. “This Veteran had a similar injury, and he was coming to terms with the fact life will never be the same, and his conversation with Mark gave him a little bit of hope.”

When recovering from such severe injuries, having a goal to motivate oneself is especially important. Maloney’s goal was to continue racing.

Motivation through racing

“I’ve been a competitive runner since the age of 55,” said Maloney. “I’ve ran marathons, triathlons. I’ve won in my age group. Hopefully, I’ll be able to make the one kilometer into the football stadium at Boulder. If I do make it to the end, it’s going to be tough. Probably one of the toughest things I’ve ever done.”

This type of motivation helps in the recovery process for those at the SCI Clinic as well. It helps them not only recover but come to terms with and cope with their current situation.

“With any Veterans, we try to find things for the Veterans they have an interest in, and a love for, to help them,” said Kiernan. “It’s important for Veterans to have a goal that has them physically active as possible.”

Maloney’s recovery hasn’t just been the individual effort of just one member. It has been a team process that has helped to get him to where he is today.

A team approach to recovery

“He has three or four different therapists,” said Kiernan. “Different people take turns working with him, a bunch of other physical therapists and occupational therapists who have worked with him to help him recover. I’ve worked with him for the past three or four years, working on his strength, balance. Between the three of us, we’ve gotten him to where he is today.”

Continuing to inspire others

With help from RMR SCI department, Maloney was able to compete in the Bolder Boulder, inspiring other Veterans who may be going through a similar situation.

“I’m hoping I can do and show others that if a 90-year-old guy can do it, maybe they can. I ran the race a few times before my accident. I (ran) in my age group. This will be another nice achievement for me. Not too long ago I was on the front page of the Colorado Springs Gazette, talking about what VA has done to help me. And I take any opportunity, like this one, to indicate that the support I have received from VA over the past five years has been outstanding.”

Find out about VA’s Spinal Cord Injuries and Disorders System of Care at <https://www.sci.va.gov/>

Source: The Veterans Health Administration



CARDIOLOGY

New Heart Procedure Brings Hope for Veterans

VA Palo Alto pioneers new heart valve treatment

By Steffany Lingad, Public Affairs Specialist, VA Palo Alto Health Care System

Staff at VA Palo Alto Health Care System opened a new chapter in heart care by successfully performing the first transcatheter tricuspid valve replacement (TTVR) in VA. This new heart procedure gives Veterans with severe tricuspid regurgitation (TR) — a heart condition where the heart’s tricuspid valve doesn’t close properly, allowing blood to leak backward — fresh hope and a safer path to recovery.

For years, Veterans diagnosed with this condition faced limited and often risky treatment options. Traditional open-heart surgery, while effective for some, can be too dangerous for older patients or those living with multiple health issues. That’s why the arrival of the Edwards EVOQUE TTVR system is such a milestone.

A safer alternative for tricuspid regurgitation

Instead of opening the chest, this procedure uses a thin tube (called a catheter) to replace the damaged valve through a vein, making it far less invasive and offering a smoother recovery.

The Veteran who received the first treatment is already recovering well and beginning to feel improvement, showing how powerful this new option can be.

“This is a big step forward in heart care for Veterans,” said Dr. Kang. “With new tools like the EVOQUE system, we can help more people who didn’t have good options before.”

The EVOQUE device received FDA approval in 2024 after studies showed it could significantly reduce symptoms and improve patients’ lives.

This breakthrough highlights VA’s commitment to ensuring Veterans have access to the latest medical advances. It also opens the door for more Veterans nationwide to benefit from this less-invasive, life-changing treatment.

Veterans interested in learning whether this therapy may be right for them are encouraged to talk with their cardiologist.

Source: The Veterans Health Administration



Photo courtesy of the Veterans Health Administration

EMERGENCY MEDICINE

Strengthening Emergency Care by Transforming Clinical Readiness

VA Texas Valley Coastal Bend Health Care System’s life-saving training recognized with perfect score

By Anaia Funtanilla, Public Affairs Specialist, VA Texas Valley Coastal Bend HCS

When a medical emergency unfolds, seconds matter, and preparation makes the difference in emergency care. At VA Texas Valley Coastal Bend Health Care System (VCB), a quiet but powerful transformation is happening behind the scenes, one that is strengthening clinical readiness and directly improving outcomes for the Veterans who depend on lifesaving care.

This year, that commitment to excellence was recognized nationally. During a recent site visit, the VA Simulation Learning, Evaluation, Assessment, and Research Network (SimLEARN) awarded VCB’s Advanced Cardiovascular Life Support (ACLS) and Basic Life Support (BLS) programs a perfect score: 24 out of 24. But for Program Director David Armor, the achievement is meaningful for one reason above all: “It elevates the safety and care Veterans receive when they need us most.”

Armor leads the facility’s resuscitation education efforts, which include quarterly simulation training and on-site mock codes conducted at every VCB campus. “Quarterly simulation training allows staff the proper preparation and skills to perform high-quality CPR during an actual emergency,” he explained.

The practice is frequent by design. By the time a real event occurs, staff have rehearsed the protocols, the teamwork and the critical decision-making required to act with precision under pressure.

How repeated practice transforms performance

The impact is measurable. “We have seen improvements in team response time, documentation, CPR skills, and use of equipment,” Armor said. Faster responses and better technical performance are not merely quality indicators, they are the factors that can determine whether a Veteran survives a code event.

Not all improvements can be captured in metrics, either. Some changes are personal. Armor recalls clinicians who were initially hesitant about moving from biannual to quarterly training. “Later, they came back and told me they were glad they practiced more,” he said. “They had much greater self-confidence and skills during the actual event.”

Those moments, when practice transforms into readiness, are central to the program’s mission. For Armor, this is what Veteran-centered care looks like in emergency medicine. “It means providing the right technology and practicing evidence-based



Photo courtesy of the Veterans Health Administration

processes with clinical staff to improve emergency care for our Veterans. Our goal is to ensure that when a Veteran needs immediate, lifesaving care, our teams are fully prepared.”

VCB’s innovations are gaining national attention. Armor’s internal, user-friendly BLS request platform caught the eye of leaders within the Resuscitation Education and Innovation (REdI) program, and they invited him to present his best practice to program directors across the country and consult on improvements to national Microsoft Teams channels. He hopes this momentum inspires broader change.

“I’d like to see the REdI program institute more mandatory national standards across VHA,” he shared. “That way, all clinicians can work toward the same evidence-based goals from facility to facility.”

While national recognition is meaningful, Armor keeps his focus close to home. If he could share one message with Veterans, he says it would be simple: “Our clinical staff at Valley Coastal Bend are excellent at handling emergencies with Veterans and practice high-quality lifesaving skills regularly.”

Behind that reassurance is a team that trains relentlessly, not for scores, not for accolades, but for the people who served. And when the moment comes when a Veteran needs help, the preparation happening quietly in VCB’s simulation rooms could be what saves a life.

Source: The Veterans Health Administration



ENDOCRINOLOGY

Pilot Program Combats Food Insecurity among Diabetic Veterans

By Michael Brock, Public Affairs Specialist, Bay Pines VA Healthcare System

Supporting diabetic Veterans facing food insecurity

At the Bay Pines VA Healthcare System, a new pilot program is taking shape to assist diabetic Veterans who are facing a growing challenge: food insecurity.

The Diabetes Emergency Food Bag Pilot Program aims to provide targeted nutrition support and education to Veterans who need it most, helping them better manage their health while addressing a critical social determinant of health.

The initiative was developed after recognizing a gap in targeted food support. While general food pantry resources exist, they are not tailored to Veterans managing chronic conditions like diabetes, where consistent access to appropriate foods is essential.

“This program started from a broader goal of improving food access for Veterans who screen positive for food insecurity,” said Bay Pines VA Nutrition and Dietetics intern Julia Marie Litherland. “We initially explored redistributing excess food from hospital operations, but after encountering barriers, we pivoted to a clinic-based approach that could realistically meet their needs.”

“This isn’t just about providing food, it’s about giving Veterans tools and knowledge they can use beyond just the food. Food is a basic need and no Veteran should have to choose between their health and access to food.”

— Julia Marie Litherland,
Bay Pines VA Nutrition and Dietetics intern

Improving food access to support diabetes management

During fiscal year 2025, staff at Bay Pines VA conducted more than 65,000 food insecurity screenings for all Veterans, with more than 1,300 Veterans identifying challenges accessing consistent, nutritious meals.

“Food insecurity directly impacts diabetes management,” Litherland continued. “When Veterans don’t have reliable access to balanced meals, it can lead to both low and high blood sugar, increased A1C levels, and even hospitalization. This program connects food



access directly with clinical care and nutrition education.”

Each food bag will include shelf-stable, diabetes-friendly items such as lean proteins, whole grains, low-sodium vegetables and low-sugar options. Veterans will also receive educational materials and simple, diabetes-friendly recipes to help support long-term self-management. The program will start by providing one food bag per month to Veterans, with goals to increase frequency based on the data collected and Veterans’ needs.

“This isn’t just about providing food,” Litherland explained. “It’s about giving Veterans tools and knowledge they can use beyond just the food. Food is a basic need and no Veteran should have to choose between their health and access to food.”

The program took approximately eight months to develop and involved collaboration across multiple departments, including dietitians, diabetes educators, Center for Development and Civic Engagement leadership, and volunteers.

“This initiative represents a collaborative effort to address a real and visible need among Veterans,” Litherland added. “It reflects our commitment to whole-person care, addressing not only medical needs, but also the social factors that impact health.”

Looking ahead, Bay Pines VA leaders hope to expand the model to support Veterans with other chronic conditions. Veterans who are facing food insecurity are encouraged to contact their primary care team for assistance.

Source: The Veterans Health Administration

Diabetes, Peripheral Arterial Disease, and Foot Ulcers

From the the National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases Practice Blog, April 7, 2021 interview with Edward J. Boyko, MD, MPH, professor of medicine and adjunct professor of epidemiology at the University of Washington and staff physician at the Veterans Affairs Puget Sound Health Care System in Seattle Washington, and Matilde Monteiro-Soares, DPM, MSc, PhD, research integrated member, Center for Health Technology and Services Research, and instructor at the Oporto University Faculty of Medicine, Oporto, Portugal.

When asked how common are PAD and foot ulcers among people who have diabetes, Dr. Monteiro-Soares stated, “While we don’t have exact numbers, and estimates vary in the literature, we know that many patients suffer from these complications. Recent research suggests that PAD affects up to 25% or 30% of people with diabetes. In earlier studies, ulcers were more common in people who had neuropathy but did not have ischemia, a lack of blood flow to the foot. However, both in our clinics and in available data, we’re seeing an increasing number of patients who have both foot ulcers and ischemia. For people who have diabetes, the lifetime risk of having a foot ulcer has been estimated at about 20% to 25%. However, updated research External link suggests that, as people with diabetes are living longer, the lifetime risk of diabetic foot ulcer may be as high as 34%.”

Question: For health care professionals caring for patients who have diabetes, what are the challenges involved in diagnosing and managing PAD?

Dr. Boyko replied, “Most patients with PAD are asymptomatic, and PAD can be difficult to diagnose in patients with diabetes. Health care professionals can diagnose PAD by measuring blood pressure in the

foot and calculating the ankle-brachial index (ABI). The blood pressure in the foot tends to be higher than in the arm; when blood pressure in the foot is much lower than in the arm, it suggests diminished circulation to the foot. However, diabetes may cause the arteries to become stiff and incompressible, which may falsely elevate foot blood pressure. If the pressure in the foot is falsely high, the ABI may not show that the patient has PAD. Another challenge for diagnosing and managing PAD is access to vascular surgeons. Today, vascular surgeons are very good at finding obstructions that can be treated, often with an intravascular procedure that expands the blood vessel narrowing and improves blood flow to the foot.”

Question: How can health care professionals help prevent diabetic foot ulcers and their complications in patients with diabetes, especially those with PAD?

Dr. Boyko stated, “The way to prevent diabetic foot ulcers is to prevent diabetic neuropathy and PAD by managing blood glucose levels. A number of trials have demonstrated that glycemic control reduces diabetes complications. We also advise patients who smoke to quit, as smoking is a major risk factor for PAD, and patients at higher risk for vascular disease to take statin medications to reduce this risk. Dr. Monteiro-Soares: Health care professionals, as a group, should focus on screening for diabetic foot disease. International recommendations should be adapted at the national level, and then at the hospital or clinic level, to create a more standardized and systematic approach to screening. Clear recommendations on prevention exist, although the evidence is still lacking in some cases. Also, establishing a way to classify patients with diabetic foot ulcers would improve communication at all the levels of care.”

Source: The National Institute of Diabetes and Digestive and Kidney Diseases

DIABETES, PAD & VETERANS

1 in 3
diabetic veterans over 50
has Peripheral Artery Disease

PAD is one of the most serious and most overlooked complications of diabetes in veterans. Most patients have no leg pain. Most have never been tested. And by the time a wound appears, limb loss may already be on the table.

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higher PAD risk in diabetic patients vs. the general population

Up to 50%
of PAD patients report no classic symptoms - silent until it's critical

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- ✓ Reliable in diabetics – PVR rapid exam and TBI both overcome calcified arteries
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GASTROENTEROLOGY

New Capsule Endoscopy Option for Easier GI Screening

By Tiara Z. Jones, Senior Public Affairs Specialist, Durham VA Health Care System

A more comfortable, convenient screening experience at Durham VA

Veterans at the Durham VA Health Care System now have access to a groundbreaking gastrointestinal (GI) screening technology, a capsule endoscopy that transforms the way GI testing is performed.

Durham VA is proud to be the first VA facility nationwide to offer this innovative procedure, giving Veterans the ability to complete their gastrointestinal screening from the comfort of their own homes.

“Being the first to try this new procedure is exciting,” said Howard Frisinger, Marine Veteran. “The best part is that I can go home and still have the rest of my day to enjoy.”



Photo courtesy of the Veterans Health Administration

How the capsule works

Veterans simply swallow a capsule about the size of a vitamin pill. Inside is a tiny camera that safely travels through the digestive tract, capturing up to 50,000 high-resolution images transmitted to a wearable recorder.

For Veterans managing iron deficiency or unexplained blood loss, this technology eliminates the anxiety and disruption often associated with GI procedures. There’s no need for sedation, and unlike traditional scopes, the capsule’s 12-hour recording time allows physicians to examine areas of the small intestine previously inaccessible.

This approach is far more comfortable and convenient than traditional methods.

“My dad didn’t have to go under anesthesia or worry about being uncomfortable,” said Sherri Frisinger, Howard’s daughter. “I’m excited that the capsule camera lets doctors see places they never could before.”

Improving access and comfort

Dr. Ziad Gellad emphasizes that this advancement expands access to care for Veterans who face travel challenges or sedation risks, while improving the detection of unreachable intestinal issues.

“Our main goal in introducing this new version of endoscopy is to give Veterans a safer, more convenient way to care for their health,” said Gellad. “With the capsule camera, we’re removing barriers; no sedation, no long hospital stays and no travel challenges. This innovation means Veterans can complete a critical GI screening in the comfort of their own homes while still getting the same high-quality results. It’s a game-changer for access and peace of mind.”

Quick results, less stress

After the capsule completes its journey, Veterans return the recorder. Physicians review the images promptly, and results are shared without requiring a hospital visit.

As the first Veteran to try the capsule camera, Frisinger expressed gratitude for the opportunity to participate in this innovative treatment.

“I feel great,” said Frisinger. “The capsule was so easy to swallow, just like taking a vitamin. The whole process was simple and stress-free, knowing that the doctors are getting the images they need.”

A new era of care for Veterans

Durham VA continues to lead the way in delivering advanced, Veteran-centered care, making procedures easier, safer and more accessible for those who served. This innovation is more than a medical breakthrough — it’s a step toward giving Veterans control, comfort and less worries.

Source: *The Veterans Health Administration*



HEPATOLOGY

Revolutionizing Cancer Treatment for Veterans

By Maureen Dyman, Communications Director, Michael E. DeBakey VA Medical Center

Ultrasound technology offers new hope at the Michael E. DeBakey VA Medical Center (MEDVAMC) in Houston, a groundbreaking new ultrasound technology called histotripsy is giving Veterans battling liver cancer new hope. This non-invasive approach to cancer care uses high-intensity ultrasound pulses to disrupt and destroy tumor cells. On Dec. 11, 2025, MEDVAMC made history as the first VA medical center in the nation to offer this cancer treatment, performing the groundbreaking procedure on Veteran Mark Schlegel.

A personal battle against cancer

Schlegel’s journey began in 2019 with a diagnosis of prostate cancer, a battle he fought with courage at a private hospital. Yet, when the cancer returned last year, spreading to his liver and leaving him with



Army Veteran Mark Schlegel. Photo courtesy of the Veterans Health Affairs



Photo courtesy of the Veterans Health Affairs

19 tumors, the prognosis felt grim. Despite being labeled terminal and put into palliative care, Schlegel was determined to fight. Together with his daughter, he explored integrative medicine options, and they ultimately found their way to MEDVAMC.

“The VA doctors were incredible,” Schlegel said. “They opened their hearts and minds to my needs, embracing integrative approaches to my diagnosis. I jumped at the opportunity to benefit from this new technology.”

In a state-of-the-art treatment room, Dr. Rayhan Hai, Dr. Jeffrey Jones and team of VA professionals prepared to deliver groundbreaking care. Using a mobile robotic arm and an ultrasound machine, they precisely targeted the tumors in Schlegel’s liver. Each brief ultrasound pulse created microbubbles, disrupting and eliminating the diseased cells with remarkable precision.

Precision in treatment

“This non-invasive treatment changes everything,” Hai said. “It allows us to precisely address tumors without the trauma

of surgery, enabling Veterans to recover much easier. We can break up tumors while preserving surrounding organs, truly transforming and often extending the lives of our Veterans.”

Dr. Darryl Smith, an interventional radiologist, recognized Schlegel’s determination from the start. “Mr. Schlegel’s resolve was evident,” he said. “He prioritizes his health, takes great care of himself, and expressed a fierce desire to live. Having this innovative technology at our disposal made all the difference.”

Schlegel’s wife of 42 years, Renia, and his two daughters Tammy and Mary, have been right by his side throughout his challenging cancer journey. Tammy says she is very grateful for the exceptional care her father received at the MEDVAMC, describing it as “impeccable” and “excellent.” “We placed our trust in God, and he led us to the MEDVAMC,” Tammy said. “VA doctors took the time to engage with us, discussing not just treatment but also our faith. My father felt a sense of peace and acceptance at VA... the doctors were truly with us every step of the way.”



Dr. Darryl Smith, interventional radiologist, got his first look at the Edison Histotripsy when it arrived at Houston VA in early December. Photo courtesy of the Veterans Health Affairs



Doctors at the Houston VA prepare to perform their first histotripsy on Army Veteran Mark Schlegel. Photo courtesy of the Veterans Health Affairs

A groundbreaking new ultrasound technology called histotripsy is giving Veterans battling liver cancer new hope. This non-invasive approach to cancer care uses high-intensity ultrasound pulses to disrupt and destroy tumor cells.

Expanding horizons in cancer care
According to Jones, another benefit of the new procedure is the potential of the histotripsy to stimulate the immune system to attack tumor cells. “This technology, together with recent advancements in immunotherapy, could potentially eradicate previously incurable cancers,” he said.

“Being the first medical center to offer this innovation means we are pushing the boundaries of cancer care, providing Veterans with unprecedented options and hope. They deserve nothing but the best, and we are honored to provide it.”

Schlegel now faces the future with gratitude and optimism. His recovery is progressing well, and his spirit is strong. “VA doctors gave me hope, compassion and understanding,” he said. “This technology gives me a chance to keep fighting. I thank God for placing the right people in my path... I really couldn’t ask for more.”

Source: Veterans Health Affairs

IT’S TIME TO SEE LIVER HEALTH IN A NEW WAY



Introducing the Mindray Hepatus Platform

Experience an ultrasound device dedicated to hepatology. A system that enables you to scan confidently, diagnose efficiently, and see liver disease in real-time.

The Hepatus is NexGen transient elastography that measures the attenuation and elasticity.

Plus it provides the exact location of the sample in a single non-invasive exam.

Mindray’s latest technology in liver care is a complete solution for non-invasive testing (NIT) for liver disease management utilizing NexGen transient elastography technology.

The Hepatus transient elastography diagnostic ultrasound system is ideally suited for early detection, staging, and surveillance of liver disease. This NexGen transient elastography provides clinicians with an easy-to-use and reliable solution for quantitative diagnosis of liver fibrosis and liver steatosis.

**INVESTING IN YOUR PATIENTS. INVESTING IN YOUR PRACTICE.
SCAN CONFIDENTLY. DIAGNOSE EFFICIENTLY.**



HEPATOLOGY

Atlanta VAHCS Achieves Major Milestone in the Fight Against Hepatitis C

By Gregory Kendall, Public Affairs Specialist

The Atlanta VA Health Care System is making a powerful impact in the fight against hepatitis C, with 1,804 Veterans now cured of the virus, an achievement that underscores the facility’s leader-ship in screening, treatment, and Veteran-centered care.

Hepatitis C often causes few or no symptoms, allowing the infection to go undetected for years. Left untreated, however, it can lead to serious and potentially fatal complications, including liver failure and liver cancer. Thanks to advances in medicine, highly effective oral treatments are now available that can cure the disease in most patients.

“At the Atlanta VA, we are committed to finding hepatitis C early and treating it aggressively,” said Emily Cartwright, Infec-tious Diseases Physician at the Atlanta VAHCS. “With today’s curative therapies, hepatitis C no longer has to be a lifelong or life-threatening illness. Our success shows what’s possible when screening, access to care, and follow-up are prioritized.”

Atlanta VAHCS’s proactive approach has led to exceptional screening rates. Currently, 80.5% of all Veterans in care in At-lanta have been screened for hepatitis C, surpassing both the VA

Southeast Network (VISN 7) average of 76.3% and the national VA average of 78%. Even more significantly, 100% of Veterans with untreated hepatitis C at the Atlanta VA have been offered treatment, when medically appropriate.

This comprehensive effort reflects a system-wide commitment to prevention, early detection, and cure. Care teams work closely with Veterans to provide education, testing, and streamlined ac-cess to treatment — often with minimal side effects and cure rates exceeding 95%.

“Every Veteran cured represents a life changed and future com-lications prevented,” Cartwright said. “Eliminating hepatitis C is not just a clinical goal, it’s about improving quality of life and ensuring Veterans can live longer, healthier lives.”

As a national leader in hepatitis C care, the Atlanta VA Health Care System continues to set the standard for how coordinat-ed, evidence-based care can deliver life-saving results for Veterans across the country.

Source: *The Veterans Health Administration*



Atlanta VAHCS staff members (left to right) Stacy Sorlie (Infectious Diseases), Nadine Harris (Infectious Diseases), Nora Oliver (Infectious Diseases), Emily Cartwright (Infectious Diseases), Sarah Reed (Nursing), Vian Farino (Pharmacy), and Kathy DeSilva (Pharmacy) all played a key role in the facility achieving a major milestone in the fight against Hepatitis C. Photo courtesy of the Veterans Health Administration



INFECTION PREVENTION

How Effective Hand Hygiene Helps Keep Everyone Safe

World Hand Hygiene Day highlights the importance of clean hands to prevent infections

By Suzanne Tovar, Infection Prevention & Control Specialist, VHA National Infectious Diseases Service

Like so many advancements in medicine, the modern history of hand hygiene to prevent infection can trace its way to battlefield medicine. During the Crimean War, the groundbreaking nurse Florence Nightingale made a discovery that hand washing, and basic hygiene, can save lives.

Until then, it was customary to expect that two soldiers would be lost for every one battlefield casualty. In many cases, it wasn’t the enemy that troops had to worry about; it was diseases like dysentery, diarrhea and typhoid. Nightingale was among the first to prioritize hand washing and general cleanliness in health care settings, saving countless lives and changing health care forever.

“We know that keeping your hands clean is one of the best ways to prevent the spread of germs and infection,” said Dr. Stephen Kralovic, acting National Program executive director of the Na-tional Infectious Diseases Service. “World Hand Hygiene Day is a reminder that simple actions can protect Veterans, families and the community.”

World Hand Hygiene Day is recognized every year on May 5. It’s a perfect time to highlight the importance of clean hands and the role each of us plays in preventing infection.

Why clean hands matter

Every day, our hands touch surfaces and objects, such as door-knobs, light switches, medical equipment, phones, patients, and computer keyboards, picking up germs along the way. These germs can make us sick or spread illness to others.

Germs that cause infections can spread easily through touch. When we don’t clean our hands, we can accidentally transfer these germs to our eyes, nose, mouth, open wounds and other people.

Keeping your hands clean helps you avoid getting sick and spreading germs to others, while keeping your family and com-munity healthy. Be a role model for others! Clean your hands of-ten, whether they look dirty or not, and encourage those around you to practice effective hand hygiene.

When to clean your hands

It is especially important to clean your hands before:

- Preparing or eating food.
- Caring for someone who is sick.
- Treating a cut or wound.
- Putting in contact lenses.

Clean your hands after:

- Using the bathroom.
- Touching body fluids such as blood, vomit or feces.
- Changing diapers or helping someone with toileting.
- Caring for someone who is sick.
- Blowing your nose.
- Coughing or sneezing.
- Touching an animal or handling pet items.
- Handling garbage, trash cans or drains.
- Treating a cut or wound.

Remember: Cleaning your hands often, whether they look dirty or not, can make all the difference!

Soap and water, or alcohol-based hand rub?

In most cases, using soap and water for at least 20 seconds to clean your hands is the best way to remove germs. If soap and water are not available, especially when hands aren’t visibly dirty, using an alcohol-based hand rub (hand sanitizer) is an effective alternative. When using the alcohol-based hand rub (hand sani-tizer), rub hand sanitizer into hands until completely dry.

You can make a difference

Make it easy to keep your hands clean and place hand sanitizer (hand rub) in common areas of your home, workplace, back-pack/purse and car. Encourage those around you, including your family and friends, work colleagues, and VA health care team to practice hand hygiene.

Hand hygiene is quick, easy and makes a big difference. Prac-ticing correct hand hygiene techniques help protect your family, your community and you.

Source: *The Veterans Health Administration*



INFECTIOUS DISEASES

Protecting Veterans: VA’s Commitment during Flu Season

Ensuring Veterans stay protected during flu season

By James Pernol, Public Affairs Specialist, VHA Office of Communications

Flu season is ramping up, and it’s not too late to get a flu vaccine if you haven’t done so already. As flu season is in full force, and flu-like activity in the U.S. is at the highest levels recorded in nearly 30 years, VA remains committed to protecting Veterans’ health. VA has been ready with flu vaccinations since September. To address new flu strains, VA ensures Veterans are offered the most current and effective flu vaccine available. Annual flu vaccines are one of the best defenses against serious illness, the need for hospital care or complications from the flu.

Easy access to flu vaccines for Veterans

Veterans have multiple convenient options to receive a flu shot:

- During routine appointments at VA facilities.
- At flu shot clinics and walk-in vaccination services offered by many VA facilities.
- At in-network community locations, such as retail pharmacies.

“Our goal is to make it as easy as possible for Veterans to get their flu shot,” said Amy Grant, a registered nurse at the West Texas VA Health Care System. “Prevention is always better than treatment, and just a few minutes today can help protect Veterans and their loved ones all season long.”

Convenience and confidence in care

Veterans often find getting a flu shot at VA facilities to be quick and easy process. “I literally walked right in, got my flu shot and was out the door all within 15 minutes,” said Navy Veteran Edward Covington. “VA couldn’t have made it any easier—the process was excellent.”

Flu shot clinics show VA’s commitment to maintaining Veterans’ health year-round. In addition to flu vaccines, VA offers various essential immunizations tailored to Veterans’ unique health needs.

Proactive health measures and staying updated

VA encourages Veterans to be proactive about their health, especially during flu season. This includes:

- Keeping up to date with recommended vaccinations.
- Washing your hands often.



Photo credit AdobeStock, courtesy of the Veterans Health Administration

- Eating a healthy diet.
- Drinking enough water to stay hydrated.
- Getting restful sleep.

Staying informed about health advisories

New flu strains can be risky, so it’s important for Veterans to get a flu shot each year. Vaccination protects both the individual and the community by reducing the spread of the virus.

Get your flu shot today

For Veterans enrolled in VA health care, the flu shot is part of their coverage. Flu shots are available at:

- VA medical centers.
- VA community-based outpatient clinics.
- Participating retail pharmacies.
- Participating urgent care centers.

Veterans are encouraged to use these resources to stay healthy and protected during the flu season. For more information or to find the nearest vaccination site, contact your local VA facility. Find a local VA facility on VA.gov.

Source: The Veterans Health Administration



NEPHROLOGY

Veterans: Make Kidney Disease Screening a Priority

By Tony Rosa, Communication Specialist, Office of Clinical Services

More than 1.4 million Veterans enrolled in VA health care are living with chronic kidney disease, a key focus during World Kidney Month

March is World Kidney Month. What better time to ask your VA provider about your risk for kidney disease? Most don’t “feel bad” until the later stages of kidney disease, so screening early can make a big difference.

Why Veterans are at greater risk

Military service can impact health in ways that show up years later. Veterans have higher rates of chronic kidney disease (CKD) than the general population. Certain health conditions that disproportionately affect those who have served increase CKD risk.

Risk factors include:

- Diabetes.
- High blood pressure.
- Heart disease.
- Occupational or environmental exposures.

More than half of all Veterans with CKD also have diabetes, about 7% have heart failure, and kidney disease is a risk factor for early death, regardless of other conditions.

If you have diabetes, high blood pressure, heart disease or a family history of kidney disease, talk to your VA provider about getting tested. The screening involves a simple blood test and a urine test.

VA is fighting for your kidney health

VA has been leading efforts in kidney health since 2019, when it created the first health system policy for CKD prevention, early detection and management.

This year, VA updated its joint clinical practice guidelines with the Department of Defense, with a specific focus on how military occupational exposures connect to kidney disease, an issue unique to the Veteran experience. The updated guidelines also emphasize shared decision-making, giving Veterans a stronger voice in their own care.

VA screens every enrolled Veteran for occupational and environmental exposures that can harm kidney function. For Veterans who may have an inherited kidney condition, VA offers genetic testing and counseling.

When it comes to treatment, VA has expanded access to home dialysis, so Veterans can manage their care independently. Integrated kidney care teams coordinate services across nephrology, nutrition, pharmacy, primary care and Whole Health programs. For those in rural or remote areas, VA’s Telenephrology Program offers virtual visits with kidney specialists, eliminating the need for travel.

VA has also built partnerships with the National Kidney Foundation, the American Kidney Fund and the American Association of Kidney Patients to ensure Veterans and their providers have access to the most current information and resources available.

What you can do right now

March is also National Nutrition Month, and nutrition is key to keeping your kidneys healthy. The main causes of kidney disease are diabetes and high blood pressure, which are strongly influenced by eating habits. Following a kidney-friendly eating plan, such as DASH or the Mediterranean diet, can help protect your kidneys. VA’s Nutrition and Food Services offers recipes and resources for kidney health. Visit with a dietitian at your VA for guidance on dietary adjustments to help manage your kidney disease.

What you can do this month to support your kidney health:

- Schedule a kidney screening.
- Know your blood pressure and blood glucose numbers.
- Review your medicines with your care team.
- Ask your provider about your personal kidney risk.
- Be proactive to keep your kidneys healthy.

To learn more or request a kidney health evaluation, contact your VA primary care team, visit the VA Kidney Medicine Program or log into MyHealtheVet.

Source: The Veterans Health Administration



NEUROLOGY

How VA TeleTBI is Connecting Veterans to Brain Injury Care

By Gwen McMillian, Communications Specialist, Digital Health Office

Closing the distance: Virtual visits connect Veterans to timely brain injury care

For many Veterans, getting care for a traumatic brain injury (TBI) can be hard, especially if they live far from a specialist. That's where VA Telehealth Services and TeleTBI are making a difference.

Dr. Mi-Hyon Cho, a brain injury specialist for the VA Hudson Valley Healthcare System, helped build VA Hudson Valley's TeleTBI program to provide TBI care to Veterans no matter where they live.

"We've been doing the TeleTBI program since 2017," she said. "I can be sitting in my office here in New York and am connecting with Veterans from wherever they are, at work or at home."



Photo courtesy of the Veterans Health Administration

Care regardless of distance

TeleTBI connects Veterans with specialists through VA Video Connect, VA's secure videoconferencing app. This means Veterans can get care faster, even if their local VA facility does not have a provider specializing in brain injury treatment. "Veterans love it," Cho shared.

What started as a small effort to support Veterans in Hawaii quickly grew into a nationwide program. Today, the program has helped more than 5,000 Veterans. Telehealth also helps VA facilities work together. If one site doesn't have a specialist, another VA facility can step in.

"If we can take care of Veterans and collaborate with other sites,

we can provide better care," Cho said.

This teamwork keeps Veterans within the VA system, where providers can see their full medical history and better coordinate care. Once a Veteran's local VA facility becomes fully staffed with a TBI specialty provider, the TeleTBI team ensures a smooth transition of care, including a warm handoff to support continuity and Veteran comfort.

How virtual care works

A comprehensive TBI evaluation via TeleTBI is completed through VA Video Connect, allowing clinicians to obtain a detailed history of the injury event and related symptoms, a Neurobehavioral Symptom Inventory (NSI), and a focused physical examination to determine whether the criteria for a TBI diagnosis are met. The care team then develops individualized treatment recommendations. The TeleTBI program then helps connect the Veteran to the right specialty providers, including virtual care or in-person care when available.

High satisfaction, real results

Veterans using TeleTBI report high satisfaction rates, often because care is easier to access and can be done from home. "We are nearing a 5 out of 5," Cho said.

The program also works hard to reduce missed visits. TeleTBI staff remind Veterans about appointments and help them stay engaged. "The Veteran is our center," she continued. "We need a strong support system to make this work."

A growing future for telehealth

All VA facilities now provide virtual services for TBI evaluation and ongoing care, ensuring Veterans can access specialized assessment and treatment regardless of their location. "Continuity of care is important," Cho added.

By connecting Veterans to the right providers, no matter the distance between Veteran and specialist, telehealth is helping Veterans get timely care and stay on track with their recovery.

Talk to your VA care team to learn more about TeleTBI. To learn more about telehealth at VA, visit the VA Telehealth Services website at <https://telehealth.va.gov/>

Source: *The Veterans Health Administration*



NEUROLOGY

First in VA to Receive Cutting-edge Epilepsy Treatment

By Maureen Dyman, Communications Director, Michael E. DeBakey VA Medical Center

A groundbreaking laser procedure offers a safer option for epilepsy treatment

Back in 1980, when Robert Lindemann decided to enlist in the Army National Guard at just 17 years old, he was following a proud family tradition.

His father and stepfather had both served in World War II, and for Lindemann, service in the military seemed like a calling.

That calling carried him through nearly 33 years in uniform, rising from enlisted soldier to officer before retiring in Texas. But in the years that followed, a quiet battle began brewing, one he didn't even fully recognize at first.

"I started having episodes where I would lose chunks of time and feel disconnected from what had happened around me," Lindemann shared. "I thought it might be sleepwalking or exhaustion, but looking back now, those moments were early warning signs that something neurological was happening. At the time I had no idea what was causing them."

Then, about five or six years ago, the situation became impossible to ignore. Lindemann had a major seizure and was diagnosed with focal epilepsy. He tried numerous medications, but he kept suffering seizures. After years of failed treatment, he was referred to the epilepsy center of excellence at Michael E. DeBakey VA Medical Center in Houston.

He underwent numerous tests, including implantation of electrodes into his brain to determine where his seizures were coming from. The seizures were originating from deep in his right temporal lobe. The normal surgical solution for this would be

a craniotomy to remove a large amount of his right temporal lobe.

"That's a scary procedure," he said. Understandably, Lindemann was not eager to have brain surgery that would remove a significant portion of his brain.

New option, new hope

Everything changed when Dr. Garrett Banks, a neurosurgeon at the Houston VA, approached Lindemann with a different path forward.

Banks told him he was an ideal candidate for a far less invasive procedure using a newer technology, Visualase. This technology has been used at a limited number of leading academic epilepsy centers but has never been used at any VA facility.

Last week, Lindemann became the first patient in the VA system to undergo the procedure, with Dr. Banks and Houston VA's neurosurgery, neurology and radiology teams working together to make history alongside him.

The Visualase V2 system delivers an extremely precise laser ablation through a slender fiber optic catheter placed through a 3.2mm hole in the skull, a hole smaller than a pencil eraser. Real-time MRI guidance allows surgeons to monitor tissue temperatures moment by moment, making immediate adjustments to protect surrounding brain structures while precisely targeting the problem tissue.

"This minimally invasive procedure isn't just about small incisions or faster recovery," Banks said. "It's about preserving the cognitive abilities, dignity and well-being of the Veteran patient. The Visualase system can treat focal epilepsy with very little

trauma, allowing people to return to their lives with less pain, fewer complications and greater confidence."

First-rate care, first-rate doctors

Two days after the procedure, Lindemann was discharged home, and four days after the procedure, he reported feeling great.

"At the Houston VA, I got first-rate care, by first-rate doctors, with the latest and greatest technology," he said. "You can't beat that."

The contrast with what he had expected — the lengthy recovery and significant risks of open brain surgery — was striking. The tiny incision, the shorter hospital stay, and the speed of his recovery all reflected exactly what the Visualase System was designed to deliver.

Expanding care for Veterans across the VA

Houston VA's successful first use of the Visualase V2 opens a new chapter in VA's neurosurgical capabilities, bringing a gentler but powerfully effective alternative to open surgery to the men and women who have served our country. "This is an expansion of what VA can offer to Veterans living with focal epilepsy, deep brain tumors and radiation necrosis across the country," Banks added. "We are thrilled to be able to offer Veterans this amazing technology and dramatically improve their quality of life."

For Lindemann, a soldier, an officer, a Veteran, and now a medical pioneer, it's one more mission accomplished.

Source: *The Veterans Health Administration*



NUTRITION

Healthy Summer Eating: Nutritious Ways to Enjoy the Season

By Amanda Breeden, Registered Dietitian, Mountain Home VA Health Care System

Nutritious recipes and tips for a summer of healthy eating

Summer brings sunshine, warm weather and plenty of opportunities to gather with family and friends. It also offers a great chance to enjoy fresh foods and healthy meals that help you feel your best. As you make the most of the season, here are a few ways to keep your summer eating nutritious and satisfying.

Stay hydrated

Most people don't drink enough fluids during the summer. Hot weather makes you sweat more, which means you lose more fluid. Drinking enough fluid helps keep your body temperature steady so that it feels cooler. Most people need about 64 ounces of water each day. You can get this from both drinks and foods with water.

Tips to stay hydrated:

- Add lemon, cucumber, mint and/or fruit to your water for extra flavor. Add strawberries, raspberries and blueberries for a refreshing red, white and blue touch.
- Eat hydrating fruits and vegetables like watermelon, peaches, cucumbers and tomatoes.
- Set alarms to remind you to drink water throughout the day.
- Carry a water bottle with you.
- Try a new refreshing recipe.

Become a grill master

Grilling is a heart-healthy way to cook because it helps limit fat intake. Next time you use your grill:



Photo courtesy of the Veterans Health Administration

- Try a Lamb-Vegetable Kabob.
- Use lean meats like 90% ground beef or ground turkey for burgers.
- Choose a whole-wheat bun and add it to the grill for a toasty flavor.
- Pile on toppings like lettuce, tomato and onions for extra fiber to keep you full.

To learn more about heart-healthy eating, explore other VA News articles, like Nourishing your heart.

Enjoy nutritious side dishes

No summer cookout is complete without side dishes. However, they are often high in calories. Add vegetables into your side dishes to keep them healthy:

- Freshen up your app table with pico de gallo and whole-grain tortilla chips.
- Try a lighter broccoli salad made with light Greek yogurt for extra protein.
- Amp up the flavor with this fiber-rich fresh corn and roasted red pepper salad. It includes anti-inflammatory ingredients like honey, ginger and turmeric.

Don't forget dessert

A favorite part of any gathering is the desserts. For healthier sweet treats:

- Keep portions small.
- Use lower-calorie ingredients for recipes.
- Add fruit to cakes, ice cream and puddings.
- Try Cherry-Peach Compote over vanilla ice cream.
- For a festive seasonal treat, try Berry Pudding Parfait with strawberries, blueberries and vanilla pudding. (Tip: freeze into popsicles for a cool twist!)

Whatever you prepare, we hope you have a safe and fun summer! For more recipe ideas, connect with your VA facility's Healthy Teaching Kitchen program, which helps Veterans learn to cook healthy meals. If you're interested in this or any other nutrition-related topic, contact your local VA to speak with a Registered Dietitian.

Source: The Veterans Health Administration



OPHTHALMOLOGY

Veteran Receives Next-generation Eye Care

By Gwen McMillian, Communications Specialist, Digital Health Office

Virtual eye care

At 56, Air Force Veteran Ben Parks thought he had seen it all when it came to eye care.

For 27 years, his community eye care providers had been monitoring a freckle in the back of his eye. He had been seeing his eye care provider regularly for checkups, which involved having his eyes dilated — a procedure he hated.

Then, six months ago, Parks moved to Livingston, Mont., and decided to enroll in VA health care. When his new primary care provider at the Travis W. Atkins VA Clinic in Bozeman referred him to the eye care services in their building, he was prepared for another typical eye visit: dilation and examination.

Instead, he met Amber Decamp, a VA Health technician with 29 years of experience in ophthalmology.

"The equipment at the Bozeman clinic is truly next generation," Parks said. "Amber explained that with the new equipment she has, we likely didn't need to do the dilation, and, in fact, we did not."

Connecting Veterans with specialty care

Decamp performed Parks' intake, ran the appropriate tests and reached out to his previous community providers for his records. She then let him know that a VA eye care provider would contact him with his results in the next few days.

Optometrist Grace Brown Bissonnette called him the very next day to explain his results, propose a treatment plan and answer his questions. "[The process] was super seamless for me," Parks shared.

The importance of virtual eye care

VA offers a wide variety of different programs that allow Veterans to receive eye care via telehealth, some which have been operational for more than 20 years. There are three main programs:

- Tele-Eye Screening: Screens for common diseases like diabetic retinopathy through eye pressure tests and photos.
- Technology-based Eye Care Services (TECS): Provides glasses and ocular health screens.
- Tele-Low Vision: Provide Veterans with rehabilitation to maximize their visual function.



Photo courtesy of the Veterans Health Administration

In total, VA Telehealth has more than 700 sites of eye care and covers >85% of the VA's network of hospitals and clinics, making it one of the largest and most robust telehealth deployments in the world.

The program highlighted here is Montana's TECS program, which provides routine vision exams, eyeglass prescriptions and monitoring/treatment for common eye conditions. TECS has been operating for more than 10 years and has more than 100 sites across the country. It is staffed by VA ophthalmologists and optometrists offering routine and specialty eye care to Veterans who live in areas that may not have any local eye care providers.

For Parks, it saved him from having to drive a long distance to another clinic in Montana.

"The fact that I can see a great eye care provider without having to travel even farther to Missoula or Helena to get care is great," he said.

Parks has also been taking advantage of VA's other virtual care resources. He uses the secure messaging service on My HealtheVet to refill prescriptions and schedule appointments.

The programs highlighted in this article, Technology-based Eye Care Services (TECS) and National Subspecialty Ophthalmology Network (NSON) were made possible because of funding by the VA Office of Rural Health through grant numbers #PROG-0000027 and #PROG-0000113.

Source: The Veterans Health Administration



ORAL HEALTH

Innovative Dental Treatments Advancing Veteran Care

By Nellie Mitchell, MS, RHIA, Program Analyst, Strategic Partnerships and Communications

Residents and providers learn to use the latest technology

Army Vietnam Veteran Anthony DiPrima lost all his teeth at 19 and avoided many foods and smiling for decades. After qualifying for VA dental care, DiPrima said a new dental implant transformed his life.

“The last year has been fantastic,” he said. “It used to be very hard smiling, and now, I’m the life of the party!”

Margaret Cochran Corbin VA has improved dental health for Veterans by training residents and providers in the latest state-of-the-art technology, expanding access to cutting-edge dental care.

Advanced dental treatments

The use of new dental technologies, including laser therapy and implant procedures, has become routine at the facility, with residents getting hands-on training in these innovations during their time with VA.

Assistant Chief of Dentistry Dr. Trevor Simmonds discussed how VA is using laser therapy and advanced lasers to treat gum tissue. “Laser treatment is a breakthrough in treating periodontal disease,” he said. Simmonds also noted it reduces bleeding, anxiety and has benefits for Veterans with complex medical conditions.

“Compared to the conventional approach, where we would have to cut and stitch [the gum], there is no cutting, no stitching,” said Simmonds. “It brings to the table in our field a minimally invasive approach for treating periodontal disease.”

Another innovative technology Margaret Cochran Corbin VA adopted is an implant technique called custom subperiosteal implant.

Dr. Gary Orentlicher, oral and maxillofacial surgeon, described the implants as a less-invasive, digitally designed, patient-specific procedure.

Approved in the U.S. within the last few years, Orentlicher said the technique has been used in 14 cases at Margaret Cochran



Photo courtesy of the Veterans Health Administration



Dr. Caroline Puskas provides dental care to Veteran patient at Margaret Cochran Corbin VA. Photo courtesy of the Veterans Health Administration

Corbin VA, primarily for Veterans 60 or older without enough bone for traditional implants.

“This implant is perfectly adapted to the patient’s anatomy, and it’s literally screwed into the patient’s jaw, making the implant exceptionally stable,” said Orentlicher. “It opens up an entire new treatment modality to patients with severe bone loss problems and just can’t have teeth conventionally.”

Most patients receive temporary teeth on surgery day and return later for permanent restorations, regaining function quickly.

Improving quality of life for Veterans

Marine Vietnam Veteran Thomas Mundy, a VA patient since 1968, described the dental care he receives as great with no complaints. “VA has been good to me in many ways,” said Mundy. “I couldn’t go wrong with the dental, either.”

Mundy said the new technology made procedures more comfortable and nearly pain-free. “I don’t have any pain at all no matter what they do,” said Mundy. “The scanning of the teeth, the machines that go back and forth to take the X-rays, it’s unbelievable.”

Mundy encouraged other Veterans who need services to reach out to VA. “Don’t hesitate to go in and start talking and asking,” said Mundy. “This is the payback — they are taking care of us.”

A training ground for advanced dental care

Training in these new technologies and procedures has given dental residents hands-on experience in implant placement, restorative care and laser treatment. Residents have treated a wide range of dental needs, reviewed cases with multidisciplinary specialists, and received in-depth instruction that would be hard to find elsewhere, according to third-year prosthodontics resident, Dr. Gustavo Lopez Gomez.

Gomez said he gained advanced experience at VA and found caring for Veterans deeply rewarding. “Exposure to implant cases here is extensive,” he said. “As I think to my future and how I will

be able to use these skills, I am one step ahead of colleagues of mine who may not get this experience,” Gomez said.

Dr. Alexia Blackhurst, a second-year endodontics resident and Navy Veteran, praised the supportive environment and training, noting that VA graduates are well prepared for real-world practice. “Working at VA, you see very complex dental cases, and you are working on cases you probably wouldn’t see in other residency programs,” said Blackhurst. “It is rigorous, but you are in a supportive environment with so many different faculty and specialties helping contribute to your education.”

“We are absolutely on the forefront”

Building on dental innovation, Dr. Lukasz Skomial, chief of dental service and a prosthodontist, explained that recent improvements in custom-designed implants have made these procedures more accurate and predictable.

“We are absolutely on the forefront,” said Skomial. “We give our Veterans the best technologies, the best products that are out there. And essentially, we are turning our patients around, making them believe that VA can provide them with the best possible care.”



Assistant Chief of Dentistry Dr. Trevor Simmonds provides laser equipment training to dental resident at Margaret Cochran Corbin VA. Photo courtesy of the Veterans Health Administration

By combining advanced technology, hands-on resident training and a whole-patient approach, the Margaret Cochran Corbin VA dental team broadens access to innovative procedures that restore health and confidence, reinforcing VA’s leadership in patient-centered dental care.

DiPrima said the benefits speak for themselves. “I chew a steak,” he said. “Being Italian, I have a piece of Italian bread with salami and cheese, and it’s no problem. I’m happy!”

Margaret Cochran Corbin VA dental residents are among the more than 124,000 trainees VA educates throughout the nation each year, making VA’s health professions education program the largest in the United States. These programs, overseen by the Office of Academic Affiliations, are shaping the next generation of health care professionals for VA and the nation.

Source: *The Veterans Health Administration*



PAIN MANAGEMENT

“My Pain is Barely a Comma Now”

Cheyenne VA pain management helps Veteran rethink pain

By Jesus Flores, Writer and Editor, VISN 19 Creative Task Force

Pain management at Cheyenne VA Health Care System (CVAHCS) began with a question for former Army officer Dominic Sansone.

“What is your goal with the pain team?” Sansone was asked. “I knew saying, ‘I wanna feel gooder’ wouldn’t work.”

So, he picked something smaller. Something specific: “I want to stand in front of the mirror and shave without stopping because of back pain,” he shared. “What I found out was that it was a trick question.”

Stopped expecting relief

Sansone enlisted in the Army, later earned a commission and then medically retired in 2016 after injuries from combat in Afghanistan.

After he left the Army, he went through procedures on his spine. He also tried care through VA.

None of it changed the way he understood pain. “Pain interfered with everything directly and indirectly, I just didn’t know it,” he said. “I let go of my hobbies and stopped working out.”

The hardest part for Sansone was not feeling the results he wanted. “Basically, I lost hope that anything would get better,” he said.

He and his wife, who is also a disabled combat Veteran, had stopped using VA services. After moving from Connecticut to Cheyenne in 2024, they gave VA another chance and both enrolled in pain management at CVAHCS.

Cheyenne asked a different question

Dr. Karen Jiles leads pain management at Cheyenne. She knows that chronic pain affects every part of a Veteran’s life.

“We are dedicated to transforming the way Veterans understand, experience and manage their pain,” Jiles said.

At Cheyenne, the team looks at sleep, movement, mood, nutrition and daily roles, not just the painful area. Then it builds a plan with the Veteran.

“Each Veteran receives a comprehensive evaluation. A combination of providers collaborates in real time,” she said. “It’s, ‘Here’s a plan created for you and with you.’”

Sansone noticed the difference at his first visit. “When I saw a team of medical professionals in a room, just like a brigade staff, all dedicated to support me and solve these problems, that’s when I knew they were listening,” Sansone said.

No other places had done that for him. “Other places treated my body but not my mind,” he said. “I never mentally adjusted until [I went to] Cheyenne VA.”

Seeing changes

The first change showed up at home. “We would sit in silence with our heads in devices. We used them to distract us from the pain,” he shared. “Now we talk like teenagers, and our bond is stronger.”

The pain is still there. He feels it when he shaves and when he walks with his wife.

“My pain is no longer the period at the end of the sentence,” he said. “It’s barely a comma. My mind is in control. I know it’s gonna hurt, but I have the tools to accept and mitigate the impact pain has on my life.”

Now he wants to help other Veterans

Sansone was accepted into the University of Denver’s master’s program in social work. He plans to become a licensed clinical social worker and wants to work with Veterans to help “bring the same familiarity and open freedom one Veteran has with another Veteran,” he added.

He nominated Cheyenne’s pain management team for the 2026 Dan Starks Award from the Wyoming Veterans Commission so other Veterans would know this kind of care exists at CVAHCS.

The Dan Starks Award is given each year to recognize outstanding service and innovation in caring for Wyoming Veterans.

Source: The Veterans Health Administration

PULMONOLOGY

A TelePulmonology Helps Veteran Receive Lung Care from Home

By Gwen McMillian, Communications Specialist, Digital Health Office

VA provides respiratory therapy through telehealth

When Air Force Veteran Robert Ordoyne was hospitalized earlier this year with coronary hypertension — a condition that puts added strain on both the heart and lungs — he wasn’t sure what his recovery would look like. Ordoyne, who served from 1983 to 1987, knew he was facing a health challenge that would require ongoing care.

After several days of inpatient care, his VA care team began planning for his long-term recovery. They wanted to make sure he could continue his treatment while avoiding the stress and fatigue of frequent trips for rehab sessions.

That’s when his respiratory therapist suggested VA TelePulmonology, a specialized respiratory care available through VA Telehealth Services. Using VA Video Connect, VA’s secure videoconferencing app, Ordoyne now meets twice a week with his respiratory therapist from the comfort of his own home.

“It makes it a lot easier for me,” Ordoyne said. “Not having to drive across town twice a week has been a big help.”



Photo courtesy of the Veterans Health Administration

Providing virtual lung care

Pulmonology focuses on diagnosing and treating diseases associated with the entire respiratory system, including the lungs and throat. VA’s TelePulmonology services, which are available in certain VA health care systems, virtually connect Veterans to

pulmonologists, respiratory therapists, and other lung health professionals.

This saves Veterans from having to travel to in-person appointments and enables Veterans who live far from the nearest specialist to get the care they need.

During Ordoyne’s biweekly sessions, he and his therapist review his progress, adjust his treatment plan as needed, and work through guided breathing and movement exercises that strengthen his lungs and support his heart health.

Pulmonary rehab exercises, from breathing techniques to light physical activity, have helped strengthen his lungs and cardiovascular health. Doing them from home means he can maintain a consistent routine and recover at his own pace.

Staying connected to care

TelePulmonology enables Ordoyne to stay connected to his care team. His respiratory therapist collaborates with other VA specialists to coordinate test results, recommendations and follow-up appointments. Ordoyne reviews his results and manages appointments through My HealtheVet on VA.gov, VA’s online portal.

Ordoyne’s therapy schedule is revised as needed, based on his weekly progress. He encourages other Veterans to ask about VA telehealth.

“If it’s available, give it a try. It saves you time and keeps your care on track,” he added.

Talk to your VA care team to see if TelePulmonology is available and right for you. For more information about telehealth resources for Veterans, visit VA Telehealth Services website at <https://telehealth.va.gov/>

Source: The Veterans Health Administration



TECHNOLOGY

Care without Limits: How VA Telehealth is Reaching Veterans Where They Are

By Gwen McMillian, Communications Specialist, Digital Health Office

VA telehealth satisfaction hits record highs for sixth straight year

Every Veteran has unique care needs, and VA strives to meet those needs with the highest quality of care possible. Telehealth is an important part of that mission, as VA is committed to expanding access to care and helping ensure that where a Veteran lives does not limit the services they can receive. Since the start of fiscal year 2026, 92.5% of Veterans who have received telehealth services reported being satisfied with their experience, a figure on track to increase for the sixth consecutive year.

For 68-year-old Veteran Gerry Pennington, telehealth made it easier for him to recover after he had major surgery. Having access to telehealth allowed Pennington to continue seeing his physical therapist without needing to drive to the nearest VA facility. In addition to saving him time and the discomfort of travel, telehealth helped him avoid the stress of dealing with a medical issue in public.

“It allowed me to maintain my dignity,” he said.

For another Veteran named Fullmer, who is 56, taking appointments from home made mental health care more accessible, and, as he described it, ‘eye-opening.’

“It’s a lot easier to talk when you’re in an environment you’re comfortable in,” Fullmer said.

Telehealth continues to play an increasingly important role in the delivery of care for Veterans nationwide. The growing use of telehealth reflects more than convenience alone; it also demonstrates that Veterans have confidence in the quality of care provided through virtual care.

Record-breaking satisfaction with telehealth

Between Oct. 1, 2025, and April 30, 2026, more than 2.3 million Veterans participated in more than 8.7 million episodes of care through telehealth.

The number of episodes of care reflects a 2.2% increase from the same time last year and puts VA on track to set a record for telehealth use.

“These results reflect VA’s ongoing efforts to ensure Veterans feel confident in and satisfied with the care they receive through



Photo courtesy of the Veterans Health Administration

telehealth,” said Dr. Kevin Galpin, executive director of VA Telehealth Services. “Whether through virtual appointments, mobile apps or secure messaging, VA will continue to expand and strengthen its use of telehealth to improve access, experience and outcomes for Veterans.”

One of VA’s most widely used technologies is VA Video Connect, VA’s secure videoconferencing app, which allows Veterans and their caregivers to meet with providers from anywhere in the United States through video appointments.

“For me, being able to sit in my chair and get help, instead of struggling to physically get to the appointment, makes all the difference,” said Jim Smith, an Army Veteran on using VA Video Connect for his health care appointments.

More ways to connect

VA offers Veterans multiple ways to engage with their healthcare services. More than 60 mobile apps are designed to help Veterans improve their health outside of a traditional clinical setting. And with My HealtheVet on VA.gov, VA’s modern digital health service, Veterans can now manage their prescriptions, appointments and medical records in the same place where they manage other VA benefits and services. Telehealth helps VA deliver critical mental health, primary and cancer care to Veterans.

Learn more about VA Telehealth Services at <https://telehealth.va.gov/>

Source: The Veterans Health Administration



UROLOGY

VA Augusta Offers Veterans a New Treatment for Overactive Bladder

By Megan Kon, Public Affairs Specialist, VA Southeast Network

A new bladder therapy is changing Veterans’ lives

For many Veterans living with overactive bladder and “urge urinary incontinence,” daily life requires extra planning, and with it comes feelings of anxiety from constant interruption. But at VA Augusta Health Care System, the Altaviva implant is rewriting that story and giving Veterans back the freedom they thought they’d lost.

Earlier this year, VA Augusta became the first hospital in Georgia, and the second VA Medical Center in the nation, to offer a new noninvasive therapy using a device that reshapes how the brain and bladder communicate. For Veterans receiving it, the change isn’t subtle. It’s life-altering.

‘I’m not waking up in the middle of the night’

For Bryant Murray, a 54-year-old Army Veteran who served four tours in Iraq, the therapy has meant reclaiming some of the simplest, yet most meaningful, parts of daily life.

After battling overactive bladder for more than a year and trying multiple medications, Murray said it was the first time he’d felt in control again.

“It was aggravating,” he recalled. “I would go to the bathroom but would have to sit there and wait 10 to 15 minutes sometimes to get it all out. The pressure would build up. It was painful.”

With the implant, that chapter is closing.

“I’m not getting excess leakage. I don’t have to wait. My flow is continuous. I’m not waking up in the middle of the night two to three times just to go,” Murray said.

Today, he describes life with a freedom he had almost forgotten, especially while driving.

“It’s a huge relief not having to worry, anymore,” he shared.

Small implant, big impact

The Altaviva device, cleared by the U.S. Food and Drug Administration in 2024, is placed near the ankle in a quick outpatient procedure using only local anesthesia. It sends gentle pulses to the tibial nerve, restoring the connection between brain and bladder, without requiring a spinal implant or trial phase.

Dr. Thomas Dykes, chief of urology at VA Augusta, performed the state’s first procedure.

“This therapy gives Veterans a less invasive alternative when medications or lifestyle changes aren’t enough,” Dykes said. “Being the first VA in the state to offer it means more Veterans can get the care they deserve without traveling long distances.”

For Murray, the procedure was surprisingly simple.

“It was nice and quick in the clinic. They numbed the area, made the incision, put the device in and programmed it,” he said. His device is scheduled to activate three times a week at 9 p.m.

‘Now I can drive two hours without stopping’

While Murray’s story is one of reclaimed rest and confidence, Navy Veteran Gayla Kunis describes something equally emotional: dignity restored.

A trailblazer as the first woman engineer in her department aboard the USS Canopus, Kunis spent nearly 20 years learning to manage, hide and endure her symptoms. It wasn’t easy.

“I have been known to pull over on the side of the road and go right there,” Kunis admitted. “I would bring an accident bag—underwear, pads, toilet paper, hand sanitizer. Six pads a day, sometimes more.”

Her mother, a retired nurse practitioner, saw a magazine article that finally connected the symptoms to the Altaviva therapy. Kunis became one of the first Veterans at VA Augusta to receive the new therapy, and the transformation, she said.

“Now I can drive all the way to my mother’s house in Anderson, South Carolina, about two hours, and not even need to stop.”

Around her home, she speaks with a mixture of disbelief and pride.

“In the house, I never have to wear a pad,” she said. “If I feel like I have to go, I can finish cooking, finish what I’m doing, then walk — not run — to the bathroom.”

Source: The Veterans Health Administration



WOMEN’S HEALTH

“I Never Let Breast Cancer Disable Me”

Navy Veteran diagnosed at 31 speaks candidly

By Bailey Breving, Public Affairs Specialist, VA Tennessee Valley Healthcare System

Heather Elliott was 31 years old when she was diagnosed with breast cancer, nearly three decades younger than the average age of diagnosis in the United States. Genetic testing showed no hereditary link, and with no family history to explain it, Elliott sought answers elsewhere. Years later, the possibility that toxic exposures during her deployment to the Gulf region may have played a role was considered. Finally, under the PACT Act, her breast cancer became recognized as service connected.

Elliott joined the Navy in 2002 right after high school and served aboard the USS John F. Kennedy. She deployed in 2004 in support of Operation Iraqi Freedom and Operation Enduring Freedom, traveling to Dubai, Bahrain, Spain and Italy. She left active duty in 2006 after four years of service.

More than a decade later, on Sept. 13, 2016, a CT scan and follow-up imaging intended to rule out complications from pneumonia revealed masses in both breasts. A biopsy confirmed ductal carcinoma, a type of breast cancer that develops early in the milk ducts, in her right breast.

Further testing determined her cancer was HER2-positive and not hormone-produced. Genetic testing came back negative. Without a hereditary explanation, Elliott was left with unanswered questions.

“It’s hard to determine where exactly your breast cancer came from or why you got breast cancer,” Elliott shared.

Elliott immediately underwent aggressive treatment beginning in October 2016, including multiple chemotherapy regimens, a double mastectomy in March 2017, additional chemotherapy, and 28 rounds of radiation. Her final reconstructive surgery was completed in March 2018. Despite the physical and emotional toll, she continued working and raising her two young sons.

“I knew I had to stay strong for my kids and my family,” she said. “I never let breast cancer disable me.”

Searching for answers

After beginning her career at VA in 2020, Elliott connected with other female Veterans and began sharing experiences. Over time, she noticed a pattern: Other women who deployed to the Gulf region in the early 2000s were also diagnosed with breast cancer at unusually young ages. They compared their stories and



Heather Elliott, a breast cancer survivor, poses for a portrait at the Alvin C. York VA Medical Center in Murfreesboro, Tenn. Elliott, who was diagnosed at age 31 and is now five years cancer-free, receives her care through VA Tennessee Valley Healthcare System and shares her experience to encourage other Veterans to take an active role in their health care. U.S. Department of Veterans Affairs photo by Bailey Breving

found common threads, including deployment locations, prolonged exposure to extreme heat, and concerns about potential toxic exposures.

Elliott connected with other female Veterans and began sharing experiences. Over time, she noticed a pattern — other women who deployed to the Gulf region in the early 2000s were also diagnosed with breast cancer at unusually young ages.

These conversations prompted Elliott and her oncologist to examine the environments where she had served, including Bahrain, and surrounding areas in the Persian Gulf.

In 2021, Elliott filed her first disability claim seeking service connection for her breast cancer.

“[The claim] was initially denied. But this was before the PACT Act,” Elliott said.

She began her appeal, working with her oncologist to write supporting letters. In late 2023, after the implementation of the PACT Act, her breast cancer was officially recognized as service connected.

The impact of the PACT Act

The PACT Act is a law that expanded VA health care and benefits for Veterans exposed to burn pits, Agent Orange and other toxic substances. It also added more than 20 presumptive conditions



After enlisting in the Navy in 2002, Heather Elliott deployed to locations in the Gulf region in support of Operations Iraqi Freedom and Enduring Freedom. These locations were later associated with toxic exposure concerns which would help establish her breast cancer as service connected. Photo courtesy of the Veterans Health Administration

linked to toxic exposures, making it easier for Veterans to connect certain illnesses to service without having to prove direct causation.

Under the PACT Act, VA toxic exposure screenings are more widely available to Veterans. Since 2024, more than 5.6 million Veterans have received these screenings designed to identify potential long-term health effects of exposure.

For Veterans like Elliott, who served in areas such as Bahrain and the Persian Gulf in the early 2000s, the law removed significant barriers that previously required extensive proof linking illness to service.

Now, Elliott receives her care at VA Tennessee Valley Healthcare System and is transitioning to an oncologist within the system.

Breast cancer awareness

For Elliott, early detection did not come through routine screening but through diagnostic imaging prompted by illness. Her story points to the importance of Veterans discussing their individual risk factors and deployment history with their providers.

“Even men can get diagnosed with breast cancer, too,” Elliott said.

According to the American Cancer Society, about 1 in 755 men will develop breast cancer in their lifetime; the disease is not limited to women only. Survival depends on the stage at diagnosis, just like in women. When caught early, outcomes are favorable. However, because men are often diagnosed later, mortality rates can be proportionally higher.

Today, Elliott marks a milestone.

“I have been cancer-free since 2020, meaning I’ve been cancer-free for five years,” she said.

She encourages anyone newly diagnosed to lean on their support systems.

“Don’t be ashamed to reach out if you need help,” she added.

Reflecting on over five years cancer-free, she says, “I feel stronger, wiser, and I don’t let the smallest things get me down anymore.”

Source: The Veterans Health Administration



WOUND CARE

Wound Care at Sheridan VA Gives 95-year-old Veteran a Second Chance

Veteran removed from hospice care at Sheridan VA after wounds heal

By Jesus Flores, Public Affairs Specialist, VA Rocky Mountain Network (VISN 19)

When 95-year-old Air Force Veteran Roy Clifton arrived at Sheridan VA Medical Center (SVAMC) in March 2025, he thought he didn't have much time left.

"I had a bone infection in both feet and could barely walk," he said. "Then I had a fall that caused a bleed in my brain. That's when I decided to call it quits and go to hospice."

Clifton was living in a community nursing home in Thermopolis, Wyoming, and had been seeing a community doctor when he chose hospice. He turned to the Sheridan VA Health Care System because they would cover the costs, and he knew he would be cared for with dignity.



Photo courtesy of the Veterans Health Administration

Treatment saved his life

Community doctors told Clifton he had only two options: amputate both legs or let the infections take their course. However, a wound care specialist Marta Ostler wasn't convinced; she examined Clifton and ran a Doppler test, using sound waves to check how well his blood was flowing through his arteries and veins.

"He had great blood flow," she said. "That told me we weren't dealing with wounds caused by poor blood flow."

What she did find was severe Stage 4 pressure ulcers on both of his heels. Stage 4 pressure ulcers are the most serious kind of bedsores. They happen when someone stays in one position too long, and the pressure cuts off blood flow to the skin and tissue.

Over time, the skin breaks down, and the wound can become so deep it exposes muscle, tendon or bone. These kinds of wounds can be painful, hard to heal and can become life-threatening if not treated properly.

Over time, Ostler removed damaged tissue from Clifton's feet to facilitate healing and coordinated with nurses to keep pressure off his heels. A VA podiatrist removed exposed bone, while nutrition staff provided meals to support his recovery.

Although both feet had exposed bones, and the injuries looked and smelled bad, Clifton's body was healing. His only job was to rest, eat and let the SVAMC staff do their work.

Clifton's condition improved so much, he was taken off hospice care.

"It made me feel great to survive hospice," he said, smiling. "They're all great. The staff took good care of me."

We're not giving up; you aren't either

As he healed, Clifton began showing up for meals, talking with staff and spending more time in his wheelchair. He smiled more and asked for updates on his progress.

"One day, we didn't put a dressing on his left heel, and he asked why," said Ostler. "I said, because it's healed. He couldn't believe it."

A second chance

Today, Clifton says he is focused on what matters most to him. He's preparing to move to a local community nursing facility, one where his spouse recently received care. The nursing home is working on a room for them to share.

"I'm very excited about seeing her," Clifton said. "We met in college on a blind date and have been together ever since."

He's grateful for the care he received and happy he gets to go back to the woman he's loved for 73 years.

Source: The Veterans Health Administration



WOUND CARE

Increasing Longevity and Quality of Life Through Healing Previously Unhealable Wounds

By Sheila Sperber Haas, PhD

Veteran Errett B. is a highly alert 76-year-old quadriplegic who bravely served our nation as a U.S. Marine fighter pilot. Approximately 37 years ago he sustained injuries to his neck from a car accident resulting in paralysis that left him with only minimal shoulder muscle control. Over the years, his immobility led to chronic pressure ulcer wounds (PUs) accompanied by chronic inflammation and substantial pain with the high risk of infection.

Fortunately, he was able to receive superb care in his own home from his daughter Brooke, a professional nurse with years of experience in wound prevention and chronic wound care for vulnerable patients like her dad, but after several decades of immobility, Errett finally found himself overwhelmed with the inevitable.

By the spring of 2025, he had been struggling with the burdens of multiple chronic wounds, 5 of them PUs (1 on the right heel, 1 on the left ankle, 1 on each hip, and

1 on his tailbone). The persistent wound in his left groin had developed 7 years earlier as the unintended consequence of an attempted soft tissue repair following a prior procedure in that area. Errett's tailbone wound had developed the previous year, and quickly became large enough to stick a fist into. The bone there had become infected at one point, but thankfully responded to IV infusion treatment.

The recently created permanent open wound on his right shin (a difficult-to-heal area in the best of circumstances, and further compromised by Errett's debilitated legs and aging skin) was the consequence of a "minor" skin cancer surgery.

Errett's spectrum of wounds were all seen biweekly by his medical wound-care team, and Brooke maintained "meticulous wound care" at home. "I had thrown everything but the kitchen sink at my father's wounds to try to get healing underway," Brooke emphasizes, "but it was fruitless."

This took a tremendous toll upon Errett, both physically as well as mentally. Concerned about life-threatening infection, he stopped leaving his house apart from going to medical appointments, and remained in bed almost all of the time.

Then he learned about the Crescel Skin Renewal Cream, and a truly amazing change began.

At first glance, the norm-shattering healing action ascribed to Crescel seemed too good to be true. So before using it on his pressure ulcer wounds, he and Brooke gave Crescel a 4-week trial run to see if it really works, and does no harm.

They applied Crescel twice daily to the weeks-old post-surgery wound on his right shin that showed no hint of beginning to heal. Just 4 weeks later, the degree of shrinkage astonished Errett, his family, and his doctors, and enabled the first steps in restoring Errett's quality of life.



Shin wound on May 25, 2025 — not healing 4 weeks after skin cancer removal.



Shin wound on August 31, 2025 — healed after 3 months of Crescel treatment.



Shin wound on January 15, 2026 — skin normalizing with continued Crescel use.





Left ankle PU on September 6, 2025 — before beginning Crescel treatment.



Left ankle PU on March 13, 2026 — fully healed after 6 months of Crescel treatment.



Right heel PU on August 20, 2025 – before beginning Crescel treatment.



Right heel PU on June 12, 2026 — fully healed, no scar, after 10 months of Crescel treatment.



Complex tailbone wound on Dec. 16, 2024 — prior to Crescel treatment, with size compared to a long Q-tip.



Complex tailbone wound on June 12, 2026 — after 8 months of Crescel treatment, it is smaller than a dime.

He treasured the diminishing discomfort and anxiety and sense of vulnerability, and spoke publicly of his gratitude and excitement. Brooke was preparing to add 4 of his 5 PUs to the Crescel treatment routine, eventually including his large and deep tailbone wound, and then hopefully the complex wound in his left groin as well.

“Crescel has given me more years with my father, and given him more quality years to his life.”
— Errett’s daughter and professional nurse, Brooke

After one year of treatment, his shin wound and ankle and heel PUs are fully healed, and the PU on his left hip is almost fully closed. The once-expansive and deep PU on his right hip has improved so significantly that nothing larger than a Q-tip can be inserted, and the threatening extensive tailbone wound, which was close to the length of a medical Q-tip and could incorporate a fist, is now smaller than a dime. His years-old large left-groin wound is at least half of its original size and depth, and daily care that used to take almost half and hour now takes only about 5 minutes. His daughter Brooke stated the only thing she regrets was not using Crescel everywhere exclusively from the very beginning.

Errett is now able to attend activities, visit relatives, and entertain family and friends at his home. “I feel so much more positive about life,” he states, “and like a normal person again. I no longer worry about whose schedule I’m impinging on, or if my wound dressings will last a full day. I don’t have to spend time with the wound vac. I feel more substantial and safer,” he exclaimed, “and I have returned to my normal life! The biggest change that Crescel has given me is that I get out of the house again and do things. I no longer just lie in bed or sit at home in a chair. I’m up and busy from 8 in the morning till 9 at night — and I have a level of confidence again that I can rely on. Crescel has been life-changing”.

Crescel is now becoming available to help Veterans and their wound care providers.

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