Chapter Fifteen

Revamping the Medical Department and Army Nursing

Another consequence of the Base Realignment and Closure process was the overall restructuring of the Army Medical Department (AMEDD) that transpired in the 1990s. The Quicksilver downsizing initiative, a part of the 1990 Base Realignment and Closure plan, recommended the elimination of Health Services Command (HSC) and its replacement by a new Medical Major Command (MACOM) commanded by The Surgeon General (TSG). This would ultimately restore the TSG's authority lost during the HSC reorganization in the early 1970s and render it commensurate with the position's responsibilities. It would also centralize accountability for all health care delivery in the Army with TSG. Original plans called for co-locating the MACOM within the Office of The Surgeon General (OTSG) in the National Capital Region (NCR). This did not materialize. Given a recent political controversy about the construction and bed size of a new Brooke Army Medical Center in San Antonio, Texas, and the Texas congressional delegation's concerns, planners deemed it unwise to shift assets from Fort Sam Houston, Texas, at that time. Additionally, constraints limited assigning additional manpower and resources within the NCR.[1] The new MACOM, the U.S. Army Medical Command (MEDCOM), thus located its headquarters at Fort Sam Houston, Texas.

On 1 July 1991, the Army officially authorized the organization of the U.S. Army Medical Department Center and School (AMEDD C&S), formerly known as the Academy of Health Sciences, at Fort Sam Houston. This was the first phase of the MEDCOM's reorganization within the changing Army.[2] The AMEDD C&S was the AMEDD's schoolhouse and think tank. A combined staff and faculty of 1,800 manned the institution and provided education for 31,000 resident students enrolled annually in some 150 courses. Another 25,000 students participated in correspondence courses each year. The AMEDD C&S also developed military medical doctrine, supported research, and was responsible for AMEDD personnel proponency.[3]

By 1 October 1993 the reorganization plan for the Medical Command (Provisional), as approved by Department of the Army, was in progress. The fully activated command commenced operations on 2 October 1994 and featured more precise lines of authority, more realistic spans of control, and improved use of resources in relation to the previous structure and function of HSC. The surgeon general became the principal medical adviser to the chief of staff of the Army and commander of the MEDCOM. A smaller OTSG staff, Army Staff, in the NCR, and a MEDCOM in San Antonio served as Army medicine's center of gravity.[4] The MEDCOM had a strategic focus, while the Medical Treatment Facilities' (MTFs') approach was tactical. Functioning between the MEDCOM and the MTFs were seven medical regions, originally called Health Services Support Areas (HSSAs) but later designated Regional Medical Commands (RMCs) in July 1996.[5] The HSSAs/RMCs had an operational focus and managed readiness, supervised education and training, and coordinated all health care delivery operations within each geographical region. The HSSAs strove to integrate the assets of the reserve components "into a seamless, combat-ready force." Since 70 percent of the AMEDD's assets were in the U.S. Army Reserve or the Army National Guard, this initiative allayed some of the readiness concerns that had surfaced during Operation Desert Storm.[6]

Army Nurse Corps officers held various staff positions in the HSSAs and added their unique clinical nursing perspective. Medical Center chief nurses typically served as chief nurses of the HSSAs and advised on the assignments of Army nurses to the HSSA, usually in the areas of coordinated care, education and training, and resource management, or wherever the HSSA need or health care mission dictated.[7] By 1 December 1993, seven HSSAs were operational at each of the seven Medical Centers.[8] By 1996 the RMCs were headquartered at Brooke, Eisenhower, Madigan, Tripler, Landstuhl, Beaumont, and Walter Reed Army Medical Centers.[9] The HSSAs or RMCs were Major Subordinate Commands of the MEDCOM along with the AMEDD C&S, the Dental and Veterinary Commands, and the Army Environmental Hygiene Agency, which became the U.S. Army Center for Health Promotion and Preventive Medicine in 1994 with responsibility for force health protection—physical fitness, health promotion, and preventive medicine.[10] The Medical Research and Materiel Command was another Major Subordinate Command. It subsumed the former Medical Research and Development Command and field operating activities whose functions were the development and acquisition of supplies and equipment, health facility planning, informatics, and the production and distribution of medical materiel. Table of Organization and Equipment and overseas units were also included under the MACOM.[11]

To enhance planning and review, refine the concept plan, and implement the transition of the proposed reorganization, Lieutenant General Alcide M. LaNoue established Task Force Aesculapius (TFA) in 1992 as one of his first objectives as surgeon general.[12] [Note: Aesculapius was a Greek god of medicine; his staff with a snake entwined around it is a symbol of the medical profession.] TSG directed the group to redesign the AMEDD's mission, function, and structures "into

a streamlined, flattened organization" to support its strategic mission. LaNoue also instructed TFA to prepare an implementation plan for the proposed transformation. TFA's guiding principles were to draft the organizational design with clear accountability linked with authority, have the right people implementing the proper tasks at the appropriate level, and avoid duplication and redundancy. The basis for the TFA effort was Elliott Jacques' untested theory, "requisite organization," that advanced the notion that organizational structure transcends personalities within a corporation, and a detailed focus on precise roles and responsibilities yields greater employee satisfaction and efficiency.[13]

The TFA process, however, often was difficult and represented some of the most challenging days within OTSG. TSG's mandate to avoid parochialism and the omnipresent need by individual corps representatives to strongly support the reorganization yet preserve their roles were countervailing forces that resulted in considerable acrimony among the task force members. The conflict contributed to some of the flawed TFA recommendations.

The group arrived at a number of puzzling conclusions whose implementation fundamentally changed the structure and function of the AMEDD and whose cost/benefit ratio seemed skewed. The unintended consequences of the changes were not always predominantly constructive. For instance, a TFA decision obliterated the Consultants' Division in OTSG, in which the Army Nurse Corps chief consultant was a key player with a strong voice, and replaced it with the Clinical Policy Division with minimal if any nurse input. Like her predecessors, the last chief nurse consultant, Colonel Bonnie Jennings, studied and often resolved a number of wide-ranging concerns with implications for nursing and improved patient care, such as case management, female hygiene during deployment, epidural analgesia for all deliveries, and anesthesiologist/anesthetist practice issues. When the chief nurse consultant position disappeared, resolution of such matters was undermined. Thereafter, "decisions were made [without] the input of nurses that had huge ramifications for nursing and patient care. The clinical voice of nursing was weakened."[14]

Another aftereffect emerged with the elimination of the chief nurse consultant position. The central figure to coordinate nursing innovations and a vital repository for ideas ceased to exist and function.[15] Previously, the Army Nurse Corps consultant had clinical oversight AMEDD-wide. Various Army MTFs transmitted new and successful ideas to the consultant, who investigated them and, if they proved valid and worthwhile, promulgated the information to Army facilities around the globe. After TFA recommendations were implemented and the "hub of the clinical wheel" disappeared, high-quality nursing practice in the Army became less homogeneous and standardized.[16] The negative effects of eliminating the chief nurse consultant position outweighed its cost-saving advantages. Although organizational efficiency and economy may have been enhanced, quality suffered in the long run.

Major General Girard Seitter originally led the TFA group.[17] After his retirement, Colonel Stephen Xenakis succeeded Seitter and then Brigadier General

Russ Zajtchuk led the group.[18] Colonel Mary Messerschmidt served as the Army Nurse Corps representative on TFA.[19]

As an integral component of the AMEDD, the Army Nurse Corps was a target for restructuring. Various plans proposed numerous organizational modifications, some of which were implemented. The intent of the proposed changes was to provide leadership experience to develop Army Nurse Corps officers' aptitude for future command and branch immaterial positions. An early proposal would have located the chief of the Army Nurse Corps away from the Washington, D.C., area. In 1992, an abortive plan surfaced to name the Army Nurse Corps chief as the deputy commandant at the AMEDD C&S in Texas. General Nancy Adams disagreed with this proposal because such a move would leave nursing in an obscure organizational element, diminish the effectiveness of the chief of the Corps, and disenfranchise the chief from health care's national policy-making levels. She added that such action ran counter to the congressionally encouraged movement toward jointness, or interservice collaboration, by hampering interface with the other military nurse corps chiefs whose positions were firmly entrenched in the NCR. Removing the Army Nurse Corps chief to Texas would also physically distance the Army Nurse Corps from the civilian professional organizations, most of which had offices in the Washington, D.C., metropolitan area. Surgeon general, LaNoue, accepted Adams' analysis and instead assigned another AMEDD general officer to the AMEDD C&S position.

At the same time, Adams also recommended that the Army Nurse Corps general officer serve as an assistant surgeon general for nursing, directly under the authority of the surgeon general. This would ensure that nursing remained identified as a separate functional element rather than one subsumed within other organizational entities. The position would call attention to nursing's vital organizational role in readiness, team building, and customer advocacy as well as allow availability for future additional functional roles for the Army Nurse Corps general officer.[20] The surgeon general approved this initiative in December 1992. By that time Adams wore three hats: (1) chief of the Army Nurse Corps, (2) assistant surgeon general for nursing, and (3) director of AMEDD Personnel.[21] This multifaceted role expansion was consistent with the AMEDD's changing vision of corps chiefs' responsibilities. By the 1990s, corps chiefs were increasingly assuming noncorps-specific corporate-level responsibilities while delegating the day-to-day operational management of their corps to their assistants at the colonel level.[22]

General Clara L. Adams-Ender observed that the corps chiefs' roles also were changing as a consequence of the reduction in the overall force that included a corresponding drop in the total number of general officers. The chief of staff of the Army directed that a general officer's functions, duties, and responsibilities "be in an operational position and not a personnel position like Chief of a Corps." Adams-Ender added that the line Army had functioned "this way for years because they had no specifically designated branch Chief positions in the law."[23]

In 1993, the surgeon general asked Adams to build the prototype HSSA, or the first region in his massive restructuring plan at Fitzsimons Army Medical Center.

She would then assume command of the Fitzsimons HSSA. Adams noted the limitations in this assignment, believing that in order to command the HSSA, she also needed to command the Fitzsimons Army Medical Center installation. Without this latter responsibility, Adams felt she would not establish command identity or credibility but would merely serve as a resource manager in a coordination/integration capacity that did not intrinsically reflect command authority. Additionally, General Gordon Sullivan did not approve this assignment for Adams, basing his decision on the notion that the AMEDD had not provided proper leader development for her to assume this command. Thus, a second plan to relocate the chief of the Army Nurse Corps away from the NCR did not come to fruition. Although Adams was not in favor of the HSSA assignment, she confided that she momentarily did regret the lost opportunity to command. However, she was consoled by the realization that in her existing tripartite role, she had ample opportunity to participate in the mainstream of AMEDD business and incorporate the agenda of the Army Nurse Corps into the transcending framework of the AMEDD.[24]

Adams' opportunity to command materialized in the summer of 1994, when she became the commander of the U.S. Army Center for Health Promotion and Preventive Medicine at Edgewood Arsenal, Maryland.[25] The function of this new command was to integrate health promotion and preventive medicine (a vital component of a trained and ready Army) with the existing environmental and occupational health responsibilities of the Army Environmental Hygiene Agency that it replaced.[26] Sullivan would not allow Adams to relocate to Edgewood Arsenal, so she commuted from the Washington, D.C., area one to two days weekly to do her U.S. Army Center for Health Promotion and Preventive Medicine work.[27]

Other changes related to the major AMEDD reorganization continued within the Office of the Chief of the Army Nurse Corps. By 1995, plans specified that the chief of the Army Nurse Corps would no longer be the assistant surgeon general for nursing but instead become an Army Staff general officer. The assistant chief of the Army Nurse Corps then became the assistant to TSG for nursing and served as the primary staff officer for all Army nurse operations at the corporate level. The Corps converted the Army Nurse Corps management fellow position into a nurse staff officer and eliminated the nurse consultant position, along with its responsibilities for multiple practice and patient care issues and its interface with the Department of Defense (DoD) and professional organizations. The Army Nurse Corps decentralized the consultant's functions to other elements such as the Army Staff, nursing subspecialty consultants, and quality assurance at the MEDCOM. Other OTSG nurse staff officer positions transferred to the MACOM, AMEDD C&S, Personnel Command, Forces Command, and the U.S. Army Recruiting Command.[28] Plans also called for eliminating the slots for Army Nurse Corps officers who dealt with community health nursing, drug and alcohol issues, coordinated care, manpower, and quality assurance within OTSG. The Army Nurse Corps procurement position consolidated with the U.S. Army Recruiting Command at Fort Knox, Kentucky. The Nursing Education Branch moved to the AMEDD C&S, and two Health Education and Training Division positions shifted

to Personnel Command in the Hoffman Building in Alexandria, Virginia.[29]

Nursing elements within HSC/MEDCOM also changed with the Army significantly reducing authorizations and assignments. The new organization, the MEDCOM, no longer showed a Nursing Division. In the spring of 1994, Colonel Bettye Simmons transitioned from being the chief of the Nursing Division into the new role of chief nurse, Clinical Operations Directorate, MEDCOM.[30] Several other positions disappeared with the reorganization from HSC to MEDCOM. The nurse staff officer and the Army nurses assigned to ambulatory care and the inspector general positions vanished from the organizational chart.[31]

The downsizing of the Army Nurse Corps and shrinking health care dollar left the organization of a number of MTFs along with their nursing elements in a state of flux. Departments of nursing at Moncrief Army Community Hospital (MACH) at Fort Jackson, South Carolina; General Leonard Wood Army Community Hospital at Fort Leonard Wood, Missouri; Munson Army Community Hospital at Fort Leavenworth, Kansas; Evans Army Community Hospital at Fort Carson, Colorado; and Ireland Community Hospital at Fort Knox, Kentucky, were undergoing change.[32] The organizational paradigm shift at MACH, for example, aimed to set up a matrix organization made up of three teams (Medicine, Nursing, and Administration) that would function with organizational parity in a flexible hierarchy.

With this framework, HSC approved a one-year pilot test beginning in May 1992 for MACH to reorganize its Department of Nursing. The concept envisaged the senior Army Nurse Corps officer without the title of chief nurse but instead claiming the position of the deputy commander for nursing, which later evolved into the deputy commander for hospital services, with authority and responsibility for all nursing activities, all hospital education and training, and hospital quality management.[33] The change refocused the role of the chief nurse from inward-looking departmental parochialism to an orientation encompassing the entire command and exemplified the trend of preparing selected Army Nurse Corps officers for future command and branch immaterial responsibilities. With this change came a metamorphosis for the assistant chief nurse (or chief, nursing administration, days), whose title became chief, Department of Nursing.

Other organizational changes at MACH eliminated the chief, Ambulatory Care Nursing Service, and the assistant chief wardmaster positions and substituted the chief, nursing administration for evenings and nights, position with a newly conceptualized role, the senior charge nurse on evenings and nights. The senior charge nurse performed clinical duties on a nursing unit when not carrying out supervisory responsibilities, such as resolving staffing issues, providing staff relief, furnishing emergency response, completing reports and administrative rounds, evaluating patient care, and resolving equipment and supply issues.

MACH plans also consolidated the chief positions for Medical Nursing and Surgical Nursing, eliminating the role of the special projects officer and changing the title of the clinical head nurse to unit nurse manager, which, it was thought, more accurately portrayed the job's responsibilities and levels of accountability. MACH nurses also established a Same Day Surgery Unit or Ambulatory Surgery

Unit that by September 1993 accounted for 54 percent of all surgical cases. Six nurse case managers were on staff by September 1993, and they developed their positional job descriptions; collected workload data on parameters such as cost abatement, length of stay, and readmissions; and created critical clinical pathways for procedures and diagnoses such as mastectomy, prostatectomy, bowel resection, reactive airway disease, and chest pain.

All the nursing staff practicing in the ambulatory setting were realigned from the Department of Nursing to positions under the chiefs of the departments under which they served—Medicine, Surgery, or Primary Care. Originators of the plan expected this change would enhance accountability, better define leadership responsibilities, and facilitate the implementation of coordinated care. It placed physicians in the nurses' rating chains, however, creating a need to educate the Medical Corps officers about performance evaluation procedures and priorities. Furthermore, it violated the long-standing principle that only a senior Army Nurse Corps officer should evaluate nurses' performance.

To evaluate the efficacy of the reorganization, the staff at MACH scrutinized productivity measures, including workload, cost, contract, and overtime data. It also considered risk management variables such as patient falls and medication errors. Findings revealed that personnel utilization was more consistent with workload and acuity demands. Moreover, many administrative nursing positions shifted to the hands-on clinical area. The architects of the plan viewed this flattening of the hierarchy as an auspicious change, but in fact, little improvement occurred in operating costs, and the manpower requirements remained unchanged. Similarly, numbers of unusual occurrences and patient complaints/concerns remained relatively stable.[34]

The team that implemented the restructuring saw the benefits of the new configuration in improved access to care, better staff development, more efficient management of patient care, the integration of Army nurses into multidisciplinary leadership roles, and more efficient actualization of case management. They identified lessons learned, including the need to implement the new structure in a series of carefully considered steps, evaluate outcomes sequentially before implementing further change, and mitigate title confusion.[35]

When Major General Richard Cameron, the commander of HSC, deputized the HSC Inspector General Team to evaluate the ongoing reorganization in MTFs—all based on patterns similar to MACH—their study uncovered similar pitfalls. The team found less-than-ideal communication patterns throughout the systems that caused "a high level of patient misunderstanding and staff aggravation." Cameron added that the absence of precedents for transformations intensified difficulties encountered in integrating the changes, as planners were navigating previously uncharted waters. Resistance to change was significant and the temptation to continue business as usual was widespread. Nonetheless, the accrued benefits seemed to outweigh the attendant problems. Cameron concluded that the overall advantages of the restructuring were twofold, specifically an expanded patient focus and a greater empowerment of those who delivered patient care.[36]

The senior leaders of the Army Nurse Corps expressed reservations about the remodeling of departments of nursing within certain MTFs' organizational structures as well. Adams echoed the thoughts of a visionary, Dr. Tim Porter-O'Grady, who predicted that nursing would not survive as a profession if its members did not soon publicly acknowledge and more authentically convey nursing values.[37] Adams reiterated his misgivings, emphasizing that, with the new organizational configurations, nurse leaders may have abdicated their allegiance and obligations to professional nursing to gain new, more impressive titles and widen the scope of their management duties. As a consequence, she cautioned, patient care could suffer. Adams warned that nurses should function as nurses and the patient care role should trump organizational roles. Colonel Terris Kennedy also succinctly advanced a parallel notion, remarking that Army nurses must not lose sight of what it is they do and who they are.

Doubtless referring to the notion of assigning nurses working in the ambulatory environment to the aegis of medical departments, Adams reaffirmed her stance that the medical model was not an appropriate paradigm to guide nursing practice and patient care responsibilities and reasoned that the traditional "nursing structure should not be replaced and subsumed by a medical organization (e.g., pediatric service, medical team, surgical team, etc.)."[38] Within a few years, however, this concept of aligning multidisciplinary teams along product lines that transcended the boundaries of inpatient and ambulatory settings of the organization became an accepted norm throughout the AMEDD.[39] A key difference with the product line model was that it provided nurses with the opportunity to be in charge, in contrast to multidisciplinary teams who previously had assumed the physician was in charge.[40] Similar patterns of change, revamping, and reorganization also surfaced in the civilian practice realms.

Despite rapid and sometimes chaotic change, the shift of patient workload from the inpatient to the ambulatory setting, the substantial cuts in numbers of nurses, and the painfully tightened fiscal resources, Army Nurse Corps officers found creative solutions to unprecedented challenges in whatever setting they practiced.

In a 1994 study that looked at the utilization of registered nurses in the ambulatory setting, investigators Colonel Carol Reineck, Lieutenant Colonel Donna Wright, and Captain Sheila Jones found that the nurses they polled were fulfilling some 17 roles, predominantly nontraditional for the AMEDD, at 10 selected MTFs. The most frequently cited positions were in the workplace setting of the Same Day Surgery Unit and Pre-Admission Unit. Other commonly reported roles among the 17, some unprecedented, some long-established, were as clinical case managers, coordinated care nurse, health care advisor, automation nurse, patient educator, and nurse researcher. A few nurses also were serving as project officers for new hospital construction, Joint Commission for the Accreditation of Healthcare Organizations preparation, with the Composite Health Care System, as a bed control manager or a third-party collection agent.[41] These nurses were fulfilling progressive roles in a variety of cutting-edge programs. Their assignments were another expression of the expanding boundaries that defined nursing, and they

served as leadership development activities and preparation for future branch immaterial roles.

Around the same time, as the locus of care shifted from the acute facility to the ambulatory setting, the Army Nurse Corps initiated a Primary Care Demonstration Project to support health care delivery and to pinpoint the Army Nurse Corps personnel requirements needed for the approaching transformations expected to emerge with the new AMEDD health care delivery model. The program featured a redistribution of Army nurses from inpatient to outpatient roles, thereby preserving Army Nurse Corps authorizations that had been predicted to disappear with the anticipated dwindling numbers of hospitalized patients. Primary care teams comprising a primary care physician and a nurse practitioner or physician assistant would meet the expected increased demand for primary health care at selected installations, such as Fort Belvoir, Virginia; Fort Bragg, North Carolina; and Fort Lewis, Washington.[42] A subsidiary study in part justified the new model, concluding that the physician, nurse practitioner, or physician assistant provider team combination was efficient. The investigation also revealed that all three categories of providers merged into an effective team capable of providing quality adult, non-obstetrical primary care. Patient outcomes were not adversely affected. Moreover, the model's use of lower-priced nurse practitioners and physician assistants cut expenses and was more cost effective when compared with an all-physician-provider arrangement.[43] Army Nurse Corps leaders judged that the use of a multidisciplinary primary care team resulted in better patient access to services, greater cost efficiency, preservation of quality care, and improved patient satisfaction.[44]

In 1989, the Department of Nursing at Tripler Army Medical Center (TAMC) in Honolulu, Hawaii, proposed a novel demonstration program and subsequently secured a total of $7.5 million in congressional appropriations for fiscal years 1990 to 1995 to underwrite what was termed the Nursing Productivity Study. The study's purpose was to test the belief that the augmentation of nursing staff with ancillary personnel would result in improved nursing productivity and job satisfaction and ultimately would enhance patient care. The proposal called for hiring escorts/couriers, custodial workers, supply clerks, ward clerks, dietary aides, and phlebotomists to do non-nursing tasks previously performed by nurses and, in theory, increase the amount of time professional nurses spend with patients.

Numerous difficulties and unanticipated variables plagued the study from its inception. Staff turbulence during Operation Desert Shield/Operation Desert Storm interfered with the progress of the study. A DoD hiring freeze thwarted the planned employment of ancillary staff. The simultaneous introduction of the Composite Health Care System, an automated patient health data system, at TAMC skewed the findings. With time, the researchers identified basic flaws in the study design. As the study progressed, the investigators consequently revamped the methodology, outcome variables, and study sample to improve the project's scientific merit and organizational relevance. All these circumstances profoundly invalidated the study outcomes.

The addition of the ancillary workers, however, did demonstrate that nurses had more time available to spend in direct contact with patients. A January 1990 pre-investigation baseline tabulated nurses spending 62.2 percent of their time with patients. By January 1991, with the supplementation of ancillary workers, that statistic increased to 75.5 percent. When the study concluded in 1995, nurses' contact time with patients had increased by some 12 percent.[45]

Another TAMC endeavor with more favorable outcomes was the Ambulatory Care Clinic, later called the Specialized Nursing Care Center. Among the first of its kind in the military health care system, the Ambulatory Care Clinic was established in 1991 as a multidisciplinary-staffed, nurse-managed unit that offered an alternative for selected patients who formerly would have required a hospital admission. The Ambulatory Care Clinic had virtually no patient waiting time and operated beyond normal duty hours seven days a week, making it convenient for patient access after work or school. It offered services on an outpatient basis that had previously been restricted to an inpatient venue, such as hydration, blood transfusions, chemotherapy, antibiotics administration, wound care, dressing changes, patient education, observation after selected procedures, and Pain Clinic support.[46] The clinic avoided more than 900 expensive inpatient bed days and served approximately 600 patients each month in 1994. The next year, the Specialized Nursing Care Center was supporting more than 650 patients monthly, with bed costs of $2.7 million averted that year. The Specialized Nursing Care Center recaptured $36,000 in health insurance reimbursements from civilian third-party payers during fiscal year 1995. This cost-effective, collaborative, customer-oriented effort resulted in better quality care and enhanced patient and staff satisfaction.[47]

The TAMC Pre-Admission Unit (PAU) was another cost-sparing, quality-enhancing, access-improving, nurse-managed initiative that opened its doors in 1992 as a collaborative effort of the TAMC departments of Nursing and Surgery. It had three components. The first, the preadmission multidisciplinary conference, screened all potential PAU patients and coordinated all pre-operative documentation and diagnostic procedures for all preadmission surgical patients with a one-stop customer service approach. The second, the Ambulatory Surgery Center (ASC), eliminated the need for hospitalization before and after minor surgery. Patients who took advantage of this service reported to the ASC on the day of their procedure, subsequently went to the operating and recovery rooms, then returned to the ASC for a further brief recovery period, and finally went home with an escort, all on the same day. The ASC saved a minimum of two occupied bed days, the pre- and post-operative days. The Same Day Admission Unit was the third component of the PAU. Planners designed it for patients who could be admitted on the day of surgery but required post-operative hospitalization. These patients were admitted to the Same Day Admission Unit and went that same day to the operating and the recovery rooms. Once cleared from the recovery room, they spent the requisite time on the inpatient nursing unit and at least one day later were discharged home. This option saved one occupied bed day, the day before surgery.

The PAU's nursing staff made post-operative follow-up contact by telephone with 98 percent of all patients who participated in the PAU's programs, completing the care cycle and contributing to a trouble-free convalescence.

The PAU exerted a positive effect on staff and patient satisfaction. Of all patients scheduled for surgical procedures at TAMC, 84 percent used some aspect of PAU services. The PAU also reduced waiting time for surgery by 55 percent, resulting in improved patient satisfaction and better access to care. The PAU's efficiency meant fewer cancellations of surgical procedures as a result of patient noncompliance. The PAU netted an impressive cost avoidance of more than $18 million in its first 30 months of operation.[48]

In 1991, the command group at Bassett Army Community Hospital (BACH) at Fort Wainwright, Alaska, inaugurated a Certified Nurse Midwives Service. The Army Nurse Corps promptly assigned two Certified Nurse Midwives (CNMWs) to BACH. These two officers provided nearly all routine antenatal and postpartum care, presided over approximately 50 percent of normal labor and delivery cases, and served as first assistants at caesarean sections. They established a well-woman clinic that met during evening hours and set up a nurse-led perinatal bereavement support group to provide counseling and follow-up care for patients and families who experienced the devastation of pregnancy loss. With this comprehensive level of support, medical officers were free to offer specialty consultation and concentrate on complex gynecological surgery. These measures resulted in significant paring of costs, expanded access to care, and enhanced quality of care. Annual cost avoidance generated by the Certified Nurse Midwives Service, for example, totaled $800,000. Surveys confirmed that the increased patient satisfaction was attributable to the care provided by CNMWs at BACH. Among other benefits accrued from the introduction of CNMWs at BACH was the improved level of maternal/child health in Alaska. The CNMWs sponsored and presented lectures for annual conferences in the community's civilian hospital and in a statewide midwifery conference. They provided obstetrical instruction in the interior of Alaska and furnished clinical mentoring for nurse midwifery students enrolled in an educational program affiliated with the Frontier Nursing Service and Case Western Reserve University.[49] The introduction of CNMWs at BACH was a noteworthy contribution not only to the welfare of the command's beneficiaries but also for prenatal health across the state.

The CNMWs and Women's Health Nurse Practitioners (WHNPs) at Blanchfield Army Community Hospital answered the call to broaden their existing range of ambulatory services by expanding their practice at Fort Campbell, Kentucky. They used two approaches, the Daily Walk-In Clinic and its subsidiary, the Active Duty Pap Program, to achieve their objectives. Each duty day, one assigned CNMW or WHNP conducted the Daily Walk-In Clinic and provided care for about 15 to 20 prenatal or postnatal patients with various health needs involving urinary, respiratory, neurological, musculoskeletal, or gastrointestinal problems, or other issues associated with pregnancy, and that needed to be addressed before the patient's next routine obstretrics/gynecology appointment. As patients arrived

at the clinic, receptionists inserted their charts in a box affixed to the nurse's door. On a very busy day, when many patients came to the clinic and the chart box was full, records were piled on a cart outside the nurse's door. This state of affairs became known as the "cart sign" and was the signal for all available CNMWs and WHNPs to assist with patients. One of the CNMWs noted that the positive spirit of teamwork unified the staff and improved the morale of both staff and patients. The Daily Walk-In Clinic also eased the workload in the hospital emergency department and provided patients with a more appropriate venue for dealing with their health concerns. The Active Duty Pap Program was another feature of the Daily Walk-In Clinic. Every active duty female soldier signing into Fort Campbell processed through a specified Troop Medical Clinic. One aspect of the process was a health record screen to verify the existence of a normal Pap smear within the past six months. If the soldier had no such documentation, the Troop Medical Clinic personnel referred the female soldier to the Daily Walk-In Clinic for assessment. This type of referral also provided the CNMW or WHNP with a timely opportunity to offer the female soldiers health education on contraception, disease prevention, and health promotion.[50]

Military nurses assigned to Landstuhl Regional Medical Center in Landstuhl, Germany, launched several innovations to improve quality of care, facilitate optimal functioning despite a more stringent budget, and expand access to care. They established a voluntary Mother/Baby Early Discharge Program in January 1995 that usually allowed the earlier hospital discharge of 41 percent of all patients from 24 to 48 hours after delivery. An Air Force nurse who was a perinatal clinical nurse specialist served as this program's case manager and educated expectant mothers, beginning at 34 weeks of gestation, on infant and postpartum care. This anticipatory guidance better prepared expectant families for impending labor and delivery and approaching parenthood. It doubtless eased prenatal fears and anxiety. The case manager routinely contacted new mothers one day after discharge to answer queries, gauge the family's state of well-being, and coordinate a pediatric follow-up for the infant at three days of age. Program evaluations revealed that the staff liked the concept, patient satisfaction exceeded 99 percent, and the small number of infant readmissions and emergency department visits affirmed the protocol's success. After a year, the program's estimated savings generated by reduced inpatient bed costs approached $750,000.

The Landstuhl nurses also began a Preadmission Clinic in January 1995. The clinic's two staff nurses and four paraprofessionals completed all preliminary diagnostic work required for patients scheduled for surgery, implemented preoperative teaching, and processed patients for admission through the Patient Administration Division. Nurse anesthetists also completed their pre-operative assessments in this setting. In its first year of operation, the Preadmission Clinic served 3,264 patients and avoided the expenditure of almost $4.4 million.[51]

Nurses serving in the Walter Reed Health Care System implemented innovative approaches in response to changing circumstances.[52] They opened an Ambulatory Procedure and Processing Center in January 1996 that provided preadmis-

sion services, day of surgery in-processing, and short-term recovery from conscious sedation. The Ambulatory Procedure and Processing Center coordinated with 18 in-house and two outlying clinics. By July 1997, Kimbrough Ambulatory Care Center at Fort Meade, Maryland, became the product line manager for same day surgeries in the Walter Reed Health Care System. The staff at Kimbrough Ambulatory Care Center streamlined the admission process; coordinated with pharmacy, laboratory, radiology and PAD services; cross-trained nursing personnel to improve effectiveness; simplified documentation; and developed a system for patient follow-up. Surgeons and staff members were highly satisfied with the program and, more important, patients rated the care they received as efficient, personalized, professional, and caring.

The Walter Reed Army Medical Center (WRAMC) nurses also established a Limb Preservation Clinic to aid patients with peripheral vascular disease or other conditions that threatened their extremities' viability. Based in part on the premise that reducing hospitalizations saved on operating costs, the clinic staff aimed to preserve the health of this population, maintain them as outpatients, and decrease the likelihood of complications that could lead to amputation. The goal of the resourceful, nurse-run Well Watch Clinic at WRAMC was to improve the accessibility of health services and to encourage cost avoidance through patient education and early detection of disease. The clinic furnished preventive health and clinical services such as patient's immunization review, health risk appraisal, health counseling by nurses, and self-help resources.[53]

At Madigan Army Medical Center (MAMC) in Tacoma, Washington, nurses played key roles in a unique, collaborative, interdisciplinary approach that centered around the patient rather than on the provider of services. This perspective led to improved patient outcomes and decreased costs by avoiding hospitalizations. MAMC Dialysis Unit physicians, nurses, and technicians offered an outpatient infusion service, administering blood products, antibiotics, and selected other medications to other than dialysis patients who in the past would have required hospital admission.

In another model endeavor, a nurse practitioner had charge of the multidisciplinary MAMC Congestive Heart Failure Clinic. This clinic focused on about 35 high-risk Congestive Heart Failure patients, all of whom had a history of repeated admissions with heart failure. Jennings, the MAMC assistant chief nurse, reported that—as a result of the clinic's aggressive approach—the patients' health status and quality of life were significantly improved and hospitalizations prevented.[54]

In the summer of 1997, nurse practitioners assigned to General Leonard Wood Army Community Hospital at Fort Leonard Wood, Missouri, established and managed a Health Promotion Clinic. Two nurse practitioners, a pharmacist, and a dietician managed a group of patients with diagnoses like diabetes, hypertension, or hyperlipidemia, and others on anticoagulant therapy. The generous appointment time of 30 to 45 minutes furnished the staff with the opportunity to reduce the complications resulting from these conditions. In its first six months of operation, the clinic cared for about 300 patients. Annually reviewed protocols

guided the staff's practice, while a medical officer reviewed about 10 percent of all charts for quality assurance. The Health Promotion Clinic was a subunit of the Health Promotion Center, an educational/marketing endeavor that offered classes and services on a variety of health issues such as self-care, stress management, smoking cessation, weight management, and back pain.[55] These strategies were an expression of the Army's emphasis on preventing disease and promoting health, designing initiatives to enhance quality of life, improving readiness, and saving fiscal and personnel resources.

In the early 1990s, the AMEDD encouraged multidisciplinary clinical case management in MTFs to support the provision of cost-effective, quality care. In the clinical aspect of managed care, nurse case managers dealt with high-risk, high-volume, or high-cost groups of patients to achieve optimal outcomes. The clinical case managers devised critical pathways (protocols with timelines or yardsticks to measure patient progress) that delineated intermediate goals for patients whose course of recovery was predictable. The critical pathway outlined steps as the patient progressed from a certain condition, procedure, or diagnosis along the road to regaining health and the best possible function. Variance analysis was another component of the AMEDD's clinical case management. This process involved identifying patients who failed to meet recuperation goals at predicted times and were possible candidates for individual case management. Case managers used this rigorous approach when a patient's course was unpredictable and complicated. An expert nurse case manager worked with other health care team members, the patient, and/or the family to assess, educate, plan, coordinate, and often deliver suitable care across the care continuum from hospitalization to ambulatory, outpatient status. Often the case manager made referrals when the patient relocated. The final phase of clinical case management evaluated predetermined goals such as better patient outcomes, improved quality, wider access, and/or reduced costs.[56]

By 1997, at least nine MTFs were actively using case management for high volume or long length-of-stay patients to avoid repeated hospitalizations and to contain costs. Their achievements were impressive. At Walter Reed Army Medical Center (WRAMC), the case management of four conditions, including percutaneous cardiovascular procedures, circulatory disorders, back and neck procedures, and medical back problems, led to $800,000 in cost avoidance by reducing bed days and disposition rates. At Keller Army Community Hospital at the U.S. Military Academy at West Point, New York, case management netted $12,000 in cost savings and $22,000 in cost avoidance. Both the WRAMC and the Keller Army Community Hospital cost avoidance strategies took place from 1995 through 1997. Of greater significance, however, were its other benefits. Patients enthusiastically endorsed the case management system and reported fewer complications as the intensity of required services plummeted.[57]

A new concept in the 1990s, telenursing was a convenient system that relied on two-way video technology. A personal computer and a camera in the patient's home allowed the nurse to both see and communicate with a patient without the nurse's leaving the health provider's office. Telenursing facilitated greater patient

access to health care, with features such as network chat, e-mail capability, and Internet access, as well as the visual/audio visits on 24-hour basis. In Hawaii, community health nurses at TAMC used the technology to decrease the potential for child abuse and neglect in combination with the DoD sponsored program, A Solid Parenting Experience Through Community Teaching and Support (ASPECTS). Telenursing augmented the existing ASPECTS Army Community Health Nurse home visitation program by adding two additional telehealth visits each month. Simultaneously, the program staff implemented a research project to measure the effects of the intervention. The study verified that the one-on-one support and surveillance provided by the ASPECTS and telenursing programs reduced the incidence of child maltreatment within the targeted high-risk population. The intervention also significantly increased new mothers' ego strengths and decreased their feelings of loneliness, rigidity, and unhappiness. It also reduced family problems. Other serendipitous outcomes were an increase in immunization rates, more appropriate access of services, and more patient interest and input into personal health care decisions.[58]

Nurses at Eisenhower Army Medical Center at Fort Gordon, Georgia, established a similar program. They relied on a comparable interactive network to assess patients who were at high risk for post-hospitalization complications and subsequent readmission to the hospital. In its first year, the program made more than 200 telenursing visits to more than two dozen patients. DoD, the Medical College of Georgia, Eisenhower Army Medical Center, and the Georgia Institute of Technology funded the endeavor.[59] Both programs saved a significant amount of staff time and spared health care funding while they notably improved patient outcomes. The use of telenursing technology spread to other MTFs.

Although not totally unprecedented, the joint staffing of a single MTF with multiservice personnel had been a rare event. In the 1990s, however, as military installations closed or realigned and DoD's managed care program, TRICARE, became the prevailing delivery model, the Assistant Secretary of Defense (Health Affairs) Stephen C. Joseph ordered the pooling of personnel resources in settings where two or more military services were closely situated.[60]

DoD previously implemented interservice collaboration in health care facilities at Fort Dix, New Jersey; and Charleston, South Carolina; and, according to Joseph, these first illustrations of joint operations set an example and furnished the services with the chance to grow and interact with other service personnel to improve health care delivery in those locales.[61] By 1995, the shared personnel initiatives had spread to TAMC, where Army, Air Force, and Navy nurses all had staffing responsibilities. TAMC also integrated Veterans Administration (VA) patients into its care network, allocating 10 of its 15 psychiatric beds to VA patients. The VA also built and began operation of an ambulatory care center, administrative offices, a parking garage, and a long-term care facility on the TAMC grounds. In 1997, the VA paid TAMC $9.5 million for space and services rendered. With the partnership, VA patients enjoyed greater access to care, and both TAMC and the VA profited as a result of the greater education and research opportunities.[62]

Certain aspects of military health care in the NCR also became joint efforts.

In 1993, Assistant Secretary of Defense (Health Affairs) Edward Martin issued a memo instructing all MTFs in the NCR to integrate their Graduate Medical Education and specialty services and eliminate duplication of programs. As a result, the National Capital Military Medical Education Consortium formed to make and implement plans. It recommended that the NNMC in Bethesda, Maryland, take on the area's military maternal-child mission with joint Navy and Army staffing. In a complementary move, WRAMC was to employ a joint Army/Navy staff to care for hospitalized adult psychiatric patients, while the Malcolm Grow Medical Center at Andrews Air Force Base was to accept the Alcohol and Drug Abuse Prevention and Control Program mission. The various MTFs implemented these recommendations. For a while, the NNMC operated an adolescent psychiatric unit but it proved to be cost prohibitive and Navy officials closed the program.

There were adjustment issues with the integration, many of which stemmed from the cultural and organizational differences that existed among the services. For instance, when mobilizing, the Navy Medical Department traditionally eliminated peacetime health care services to family members and retirees completely and referred all such patients to civilian sources of care, while the AMEDD continued to carry out both their peacetime and wartime missions with virtually no interruption. Also unlike the Army, the Navy did not have military companies for command and control of military members. The Navy instead decentralized this function in many instances to the head nurses who also had Uniform Code of Military Justice or disciplinary authority over their enlisted corpsmen. Another wrinkle to be ironed out focused on psychiatric practice. Unlike the Army, the Navy allowed nonlicensed providers of psychiatric nursing care to administer medications to psychiatric patients.[63] Further points of dissention had to do with issues such as career progression, leadership roles, rating schemes, staffing ratios and mix, policies, procedures and standard operating procedures, proof of competency, job descriptions, and educational variances.[64]

When it first appeared that the NCR integration actually would go forward, Colonel Janet R. Southby and Captain Carol Carney, the respective chief nurses of WRAMC and NNMC, met with the involved commanders, Major General Ronald Blanck and Rear Admiral Richard Ridenour. After they discussed the prospective merger extensively, Blanck stretched across the conference table and whispered to Southby, "make it happen" and, Southby recalled, "so we did." She confirmed that a cooperative spirit was somewhat lacking initially at the grassroots level among participating Army and Navy nurses. Differences focused on personnel issues such as "creative counting of workload and comments about safe nursing levels." But soon the participants transcended these disagreements and reached consensus about important matters. Southby ascribed the success of the implementation to the fact that she, Carney, and Colonel Joellen de Berg, chief nurse of Malcolm Grow, met regularly and communicated openly. Southby added that a climate of mutual trust prevailed and the triad had "great professional and personal respect for each other." To provide further support for the integration, Southby assigned Colonel Margaret Baird to oversee the exodus of maternal-child AMEDD staff to NNMC and appointed Lieutenant Colonel Victoria Ransom as the interim transi-

Pictured is Colonel Janet R. Southby, who served as chief nurse of Walter Reed Army Medical Center from December 1992 to September 1996.
Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.

tion coordinator. She also selected Sergeant First Class Rhonda Broberg, an Army non-commissioned officer, to coordinate and work full-time between all three institutions to facilitate seamless operations. A vanguard of nine Army nurses, of whom five were assigned to the nurseries and four as obstetrical nurses, transferred to NNMC on 5 June 1995.[65] The WRAMC Adolescent Psychiatric Inpatient Unit shifted to the NNMC on 1 August 1995 and simultaneously the NNMC Adult Psychiatric Inpatient Unit moved to WRAMC. Virtually all NCR pediatric services merged at WRAMC on 3 June 1996.[66] On 20 May 1996, six Navy Nurse Corps officers and seven Navy hospital corpsmen reported to WRAMC to support the neurology nursing services and eight reported for duty on the psychiatric units.[67] With time, the tri-service integration spread to other specialty areas until the only Graduate Medical Education and specialty services remaining discrete in both WRAMC and NNMC were general surgery, internal medicine, orthopedics, and the transitional internship.[68]

The assimilation of Air Force Nurse Corps officers into the staff at the U.S. Army Landstuhl Regional Medical Center in Germany in 1993 also was typical of other integrations of staff into the facilities of sister services. Initially, Army nurses resisted the change and expressed feelings of being invaded and overtaken by Air Force nurses. The Air Force nurses also were uncomfortable, feeling unwelcome and confused by the different Army staff positions, customs, terminology, and doctrine. To facilitate the integration, nursing leaders furnished regular familiarization and educational sessions, melded the two services' manning documents, made staff assignments based on qualifications irrespective of service so that each unit soon had a blend of Army and Air Force personnel, and mandated the battle dress uniform as the common duty uniform. With much hard work and a spirit of cooperation, nurses resolved the awkward state of affairs and the two services formed relationships and gained mutual understanding. Both groups recognized that flexibility and acceptance of differences were essential and that despite diversity, clinical nursing was the major commonality and a basic point of agreement. The staff reported learning four important lessons—(1) prior planning was paramount, (2) adaptability and a willingness to learn were essential, (3) full integration at every level was important, and (4) joint staffing can work.[69]

The previously described innovations were but a few of the hundreds of ingenious programs implemented by Army nurses across the AMEDD. Army Nurse Corps officers at fixed installations and those serving in combat or Operations Other Than War conceived, created, and participated in numerous similar programs and countless other unprecedented efforts that saved millions of dollars while maintaining access to quality health care services for soldiers, their families, the retired population, and their eligible family members. Their initiative was a testament to the creativity, professionalism, and dedication of Army nurses serving around the globe.

These same, typical Army Nurse Corps traits of resourcefulness, adaptability, collaboration, fiscal responsibility, and devotion to duty were but a handful of the many attributes that rendered Army nurses as ideal candidates for future unparal-

Colonel Margaret Baird, chief of the Maternal-Child Nursing Section at Walter Reed Army Medical Center, supervised the transition of health care services for obstetrics and pediatrics patients from her institution to the National Naval Medical Center in Bethesda, Maryland, in 1995.
Photo courtesy of Colonel Margaret Baird, Readfield, ME.

leled roles in the AMEDD. For it was at this point in the history of the Army Nurse Corps that formerly closed doors slowly but surely edged open to allow access to new opportunities for Army nurses in command and branch immaterial positions.

Notes

1. "Analysis of Alternatives," 12 March 1991, Draft Enclosure 2, in "Army Medical Department Realignment Study," n.d.; Thad A. Krupka, "Army Medical Department (AMEDD) Command and Control In Process Review (IPR)," Memorandum for Record, 1 August 1991; Mr. Yaglom, "Army Medical Department (AMEDD) Command and Control Realignment Update," Information Paper, 4 May 1992; and Alcide M. LaNoue, "Revised Concept Plan for Establishment of the US Army Medical Command," Memorandum, 16 July 1993 (all in Army Nurse Corps Collection [ANCC], Office of Medical History [OMH]). L. Martin Kaplan, Department of the Army Historical Summary Fiscal Year 1994 (Washington, DC: Center of Military History, United States Army, 2000), 114–15.

2. Mary Kay Jones, "U.S. Army Medical Department (AMEDD) Center and School (HSW3VZAA), Fort Sam Houston, TX 78234-6100," Permanent Orders 103-1, 15 July 1991; and Bruce T. Miketinac, "Abbreviated Concept Plan for U.S. Army Medical Department (AMEDD) Center and School," n.d. (both in ANCC, OMH).

3. Bettye H. Simmons, "Professional Development and Readiness Guide," 2-2, 7 May 1997, ANCC, OMH.

4. The plan effected a reduction in OTSG in the NCR from a staff of 500 to approximately 100. The former HSC staff was condensed into a MEDCOM organization of 400 staffers. Constance J. Moore, "Input for DA Historical Summary FY 1994," Information Paper, 16 March 1996; Bettye H. Simmons, "Professional Development and Readiness Guide," 2-1, 7 May 1997 (both in ANCC, OMH).

5. Jerry Harben, "Regional HSSAs Manage Health-Care Delivery," *The Mercury* 21 (January 1994): 1. "The MEDCOM," *The Mercury* (Fall 1996): 3. Bettye H. Simmons, "Professional Development and Readiness Guide," 2-1, 7 May 1997; and Terris E. Kennedy, "Minutes of the Regional Chief Nurses Conference," Memorandum, 2, n.d. (both in ANCC, OMH). John T. Greenwood and F. Clifton Berry, *Medics at War, Military Medicine from Colonial Times to the 21st Centur*y (Annapolis: Naval Institute Press, 2005), 170.

6. Nancy R. Adams, "Message from the Chief," Memo from the Chief, Army Nurse Corps (April 1993): 1; Nancy R. Adams, "Message from the Chief," Memo from the Chief, Army Nurse Corps (August 1993): 1; Constance J. Moore, "Input for DA Historical Summary FY 1994," Information Paper, 16 March 1996; Michael J. Foster, "Minutes of the Army Nurse Corps Staff Meeting on 6 October 1993," Memorandum for Record, 14 October 1993; Raymond T. Burden, "HSSA PAT Storyboard," Memorandum, 27 September

1993; and "Posture Statement by Major General John J. Cuddy, Deputy Surgeon General, United States Army, before the Committee on Appropriations, National Security Subcommittee, U.S. House of Representatives, 2nd Session, 104th Congress, Medical Overview," 24 April 1996 (all in ANCC, OMH). Alcide M. LaNoue, "Army Medicine: 'Caring Beyond the Call of Duty'," *Army* 46 (October 1996): 151–52, 154, 157.

7. Terris E. Kennedy, "Transition Plan for Army Nursing in Support of the AMEDD Reorganization and Restructure," 22 January 1994, Information Paper in Michael J. Foster, "Minutes of the Army Nurse Corps Staff Meeting on 1 February 1994," Memorandum for Record, n.d.; and Terris E. Kennedy, "Minutes of the Regional Chief Nurses Conference," Memorandum, 8, n.d. (both in ANCC, OMH).

8. Raymond T. Burden, "HSSA PAT Storyboard," Memorandum, 27 September 1993; and Alcide M. LaNoue, "Operational Level Guidance," Memorandum for Commanders, Health Service Support Areas (Provisional), 2 December 1993 (both in ANCC, OMH).

9. "The MEDCOM," *The Mercury* (Fall 1996): 5.

10. John T. Greenwood and F. Clifton Berry, *Medics at War, Military Medicine from Colonial Times to the 21st Century* (Annapolis: Naval Institute Press, 2005), 171.

11. Jerry Harben, "Plans for Revised AMEDD Near Completion," *HSC Mercury* 20 (June 1993): 1. Jerry Harben, "Top Leaders Briefed on New AMEDD Structure," *HSC Mercury* 20 (August 1993): 1. Jerry Harben, "New AMEDD Structures Kicks Off This Month," *HSC Mercury* 21 (October 1993): 1, 12. Jerry Harben, "Regional HSSAs Manage Health-Care Delivery," *HSC Mercury* 21 (January 1994): 1. Russ Zajtchuk "Command Name," Memorandum, 15 July 1994; and Alcide M. LaNoue, "Command Name," 8 September 1994 (both in ANCC, OMH). John T. Greenwood and F. Clifton Berry, *Medics at War, Military Medicine from Colonial Times to the 21st Century* (Annapolis: Naval Institute Press, 2005), 171.

12. Originally, TFA was named Project AMEDD Vanguard. Alcide M. LaNoue, "Charter for Project AMEDD Vanguard (Task Force Aesculapius)," Memorandum, 4 February 1993, ANCC, OMH.

13. Alcide LaNoue, "Information 'Wave' Embraced by Army," *U.S. Medicine* 32 (January 1996): 36, 38. "Posture Statement by Lieutenant General Alcide LaNoue, The Surgeon General, United States Army, for the Committee on Appropriations, Defense Subcommittee, United States Senate, 2nd Session, 104th Congress, DOD Medical Overview," 5 June 1996; United States Army, Medical Department, Reorganization, Volume I, Narrative, Task Force Aesculapius, January 1993–June 1995, Official Report; Alcide M. LaNoue, "Charter for Project AMEDD Vanguard (Task Force Aesculapius)," Memorandum, 4 February 1993; Russ Zajtchuk, "Army Medical Department Reorganization, January 1993–June 1995," 16 June 1995; and Bonnie M. Jennings, "Chapter Five Comments," August 2005 (all in ANCC, OMH). Jerry Harben, "Plans for Revised AMEDD Near Completion," *HSC Mercury* 20 (June 1993): 3. Jerry Harben, "New AMEDD Structure Kicks Off This Month," *HSC Mercury* 21 (October 1993): 1, 12. "The MEDCOM," *The Mercury* (Fall 1996): 4. Alcide M. LaNoue, "Army Medicine: 'Caring Beyond the Call of Duty'," *Army* 46 (October 1996): 151–52, 154, 157. Elliott Jacques, *Requisite Organization: A Total System for Effective Managerial Organization and Managerial Leadership for the 21st Century* (Falls Church, VA: Cason Hall & Company, 1998).

14. Bonnie Jennings to Author, E-mail Correspondence, 25 September 2005, ANCC, OMH.

15. Bonnie M. Jennings, "Chapter Five Comments," August 2005; and Terris E. Kennedy, Interview by Constance J. Moore, Transcript, 386–87, 31 October 1996 (both in ANCC, OMH).

16. Bonnie Jennings to Author, E-mail Correspondence, 25 September 2005, ANCC, OMH.

17. Alcide M. LaNoue, "Designation of Deputy Surgeon General and Assistant Surgeon General," Memorandum, 14 December 1992; Nancy R. Adams, "Message from the Chief," Memo from the Chief, Army Nurse Corps (August 1993): 1; and "Posture Statement by Lieutenant General Alcide LaNoue, The Surgeon General, United States Army, for the Committee on Appropriations, Defense Subcommittee, United States Senate, 2nd Session, 104th Congress, DOD Medical Overview," 5 June 1996 (all in ANCC, OMH).

18. Jerry Harben, "Plans for Revised AMEDD Near Completion," *HSC Mercury* 20 (June 1993): 1. Jerry Harben, "Top Leaders Briefed on New AMEDD Structure," *HSC Mercury* 20 (August 1993): 1.

19. Alcide M. LaNoue, "Charter for Project AMEDD Vanguard (Task Force Aesculapius)," Memorandum, 4 February 1993, ANCC, OMH.

20. Nancy R. Adams, "Proposed Reorganization, Our Discussion, July 1992, at Fort Sam Houston, Texas," Memorandum for Major General (P) LaNoue, 8 September 1992, OTSG Collection, OMH. Nancy R. Adams, "Concept Plan for Establishment of the US Army Medical Command (Provisional)," Memorandum, 25 September 1992; and Terris E. Kennedy, Interview by Constance J. Moore, Transcript, 300, 31 October 1996 (both in ANCC, OMH).

21. Alcide M. LaNoue, "Designation of Deputy Surgeon General and Assistant Surgeon General," Memorandum, 14 December 1992; Thomas Frank England, "Designation of Deputy Surgeon General and Assistant Surgeon General," Memorandum, 4 December 1992; Vahan Moushegian, "Designation of Deputy Surgeon General and Assistant Surgeon General," Memorandum, 4 December 1992; Nancy R. Adams, "Message from the Chief," Memo from the Chief, Army Nurse Corps (January 1993): 1; and Nancy R. Adams, "Message from the Chief," Memo from the Chief, Army Nurse Corps (August 1993): 1 (all in ANCC, OMH).

22. "Corps Chiefs," Typewritten Document (TD) , n.d., ANCC, OMH.

23. Clara L. Adams-Ender, Handwritten Notes on Draft Manuscript, 28 September 2005, ANCC, OMH.

24. Michael J. Foster, "Minutes of the Army Nurse Corps Staff Meeting of 7 May 1993," Memorandum for Record, 3, 11 May 1993; Nancy R. Adams, "Command of Fitzsimons Health Services Support Region," Memorandum for the Surgeon General, 11 June 1993; Nancy R. Adams to Gordon Sullivan, Draft, Unsent Letter, 1992; and Nancy R. Adams, "Message from the Chief," Memo from the Chief, Army Nurse Corps (December 1993): 1 (all in ANCC, OMH). Harry Noyes, "Nurse to Command Training Company," *The Mercury* 22 (February 1995): 6.

25. Constance J. Moore, "Input for DA Historical Summary FY 1994," Information Paper, 16 March 1996, ANCC, OMH. Jane Gervasoni, "CHPPM Becomes 'Official'," Army Health Connection 2 (Winter 1996): 1–2.

26. Nancy R. Adams, "Message from the Chief," Memo from the Chief, Army Nurse Corps (August 1994): 1; "Posture Statement by Lieutenant General Alcide LaNoue, The Surgeon General, United States Army, for the Committee on Appropriations, Defense Subcommittee, United States Senate, 2nd Session, 104th Congress, DOD Medical Overview," 8–9, 5 June 1996 (both in ANCC, OMH).

27. Nancy R. Adams, Handwritten Notes on Draft Manuscript, 11 July 2005, ANCC, OMH.

28. Terris Kennedy, "Transition of the Office of the Chief Army Nurse Corps and Subsequent Transitioning of Army Nurse Staff Officer Positions within Organizational Elements

of the Office of the Surgeon General," Information Paper, 30 November 1993; Terris Kennedy, "Office of the Chief," Memo from the Chief, Army Nurse Corps (April 1994): 2; Bonnie Jennings, "Nursing Consultant," Memo from the Chief, Army Nurse Corps (April 1994): 4; Terris Kennedy, Untitled Handwritten Note, 28 July 1995; Terris E. Kennedy, Interview by Constance J. Moore, Transcript, 345, 31 October 1996; and Constance J. Moore, "Input for DA Historical Summary, FY 1995," Information Paper, 20 May 1996 (all in ANCC, OMH).

29. "Reorganization ARSTAF and MACOM TDA's," Memorandum, n.d., ANCC, OMH.

30. Terris Kennedy, "Office of the Chief," Memo from the Chief, Army Nurse Corps (April 1994): 2, ANCC, OMH.

31. Nancy McFadin, "Transition of Nursing Division, Health Services Command," Information Paper, 3 January 1994, ANCC, OMH.

32. Carole A. Burke, "Proposed Position Paper on Deputy Chief Nurse," Memorandum, 6 February 1992; "Deputy Commander for Nursing," Position Paper, 25 February 1992; Carole A. Burke, "Proposed Position Paper on Deputy Chief Nurse," Memorandum, 6 February 1992; "Reorganization Department of Nursing, General Leonard Wood Army Community Hospital, Fort Leonard Wood, Missouri," Typewritten Paper, 16 April 1992; J.M. Cook, "Request for Deviation from Standardized Organization Structure of HSC 10-1," 20 April 1993; Thomas I. Clements, "Request for Deviation from Standardized Organization Structure of HSC 10-1," 20 April 1993; Claudia M. Mundy, "Quarterly Report on Test Project for Position of Deputy Commander for Patient Services," Memorandum, 30 June 1994; and "Satisfaction through Caring: More than Words. . . A Philosophy," n.d. (all in ANCC, OMH).

33. This position title at the Fort Knox, Kentucky, MEDDAC was deputy commander for patient services (DCPS). The officer holding the DCPS position was dual-hatted as chief nurse. J.M. Cook, "Request for Deviation from Standardized Organization Structure of HSC 10-1," 20 April 1993; Thomas I. Clements, "Request for Deviation from Standardized Organization Structure of HSC 10-1," 20 April 1993; Claudia M. Mundy, "Quarterly Report on Test Project for Position of Deputy Commander for Patient Services," Memorandum, 30 June 1994; and "Evans Army Community Hospital, Organizational Chart—Carelines," 23 June 1997 (all in ANCC, OMH). Originally, the DCN or DCHS was responsible for the Emergency Medical Service. Later, it added the Nutrition Care Division to its responsibilities. "Satisfaction through Caring: More than Words. . . A Philosophy," n.d., ANCC, OMH. At Evans Army Community Hospital at Fort Carson, Colorado, the DCHS managed nursing services, pharmacy services, nutrition care, the medical library, and the Education and Readiness Division. "Evans Army Community Hospital, Organizational Chart—Carelines," 23 June 1997, ANCC, OMH.

34. Karl S. Snyder, "Organizational Restructure," Memorandum, 17 April 1992; Philip L. Dorsey, "Organizational Restructure," Memorandum, 17 April 1992; Major Allen, "Moncrief Army Community Hospital Reorganization," Executive Summary, 17 April 1992; William P. Allen, "Request for Deviation from Standardized Organization Structure of HSC 10-1," Memorandum, 27 April 1992; Karl S. Snyder, "Reorganization of the Department of Nursing," Memorandum, 24 February 1993; Peggy A. Page, "Revision of the Highlights in the History of the Army Nurse Corps," Memorandum, 1 April 1993; Patricia A.H. Saulsbery, "Trip Report, Ft. Jackson, SC, 30 Aug–2 Sep 93," Memorandum, 2, 24 September 1993; "ANC Input for 1993 AMEDD Stockholders Report," n.d.; and "Moncrief Army Community Hospital, Nursing Reorganization, Information Briefing," Briefing Slides, n.d. (all in ANCC, OMH).

35. "Satisfaction through Caring: More than Words, . . A Philosophy," n.d., ANCC, OMH.

36. Richard D. Cameron, "Medical Treatment Facility (MTF) Reorganization Assessment," Memorandum, 12 September 1994, ANCC, OMH.

37. Tim Porter-O'Grady, "The Real Values of Partnership: Preventing Professional Amorphism," *Journal of Nursing Administration* 24 (February 1994): 11–15.

38. Nancy R. Adams, "Message from the Chief," Memo from the Chief, Army Nurse Corps (April 1994): 1; Nancy R. Adams, "Message from the Chief," Memo from the Chief, Army Nurse Corps (August 1995): 1; Terris E. Kennedy, Interview by Constance J. Moore focusing on "One Moment in Time," Briefing Slides, Transcript, 19–23, 11 February 1997; and Terris E. Kennedy, Interview by Constance J. Moore, Transcript, 371, 31 October 1996 (all in ANCC, OMH).

39. Bettye H. Simmons, Memo from the Chief, "Army Nurse Corps (1 August 1997):1, ANCC, OMH.

40. Nancy R. Adams, Handwritten Notes on Draft Manuscript, 11 July 2005, ANCC, OMH.

41. Carol Reineck, Donna Wright, and Sheila Jones, "Ambulatory Care Registered Nurse Utilization, A Pilot Study," 19 September 1994, ANCC, OMH.

42. "Primary Care Demonstration Project," Memorandum for Col. Terris Kennedy, 12 December 1994; "Primary Care Demonstration Project Overview," TD, n.d.; "Army Nurse Corps Project 'Primary Care'," Briefing Slides, 13 February 1995; Linda J. Stierle, "Report of the Federal Nursing Chiefs to the 1995 ANA House of Delegates," TD, 1, 11 May 1995; and Pew Health Professions Commission, "Health Professions Education for the Future: Schools in Service to the Nation," Printed Report, 30, 83–90, February 1993 (all in ANCC, OMH).

43. Debra Mark, "Primary Care Demonstration Project: Measurement of Provider Practice Styles and Client Outcomes," n.d.; Debra D. Mark, Mary Z. Mays, and Vicki L. Byers, "Primary Care Demonstration Project: Measurement of Provider Practice Style and Client Outcomes," Typewritten Report, 9 April 1997; "Statement by Brigadier General Bettye H. Simmons, Chief, Army Nurse Corps, Army Medical Department, before the Subcommittee on Defense, Committee on Appropriations, United States Senate, 1st Session, 105th Congress, DoD Health Care Programs," 4–5, 23 April 1997; and "Executive Summary," Enclosure 1, 1-2, in James W. Kirkpatrick, Primary Care Demonstration Project—Measurement of Provider Practice Styles and Client Outcomes, 25 November 1997 (all in ANCC, OMH).

44. Nancy R. Adams, Memo from the Chief, Army Nurse Corps (August 1995): 1, ANCC, OMH.

45. Edith Walsh, "Status of Demonstration Project," Information Paper, 19 March 1990; Bonnie Jennings, "Review of the Technical Report on the TAMC Nursing Demonstration Project," Memorandum, 10 February 1991; Lieutenant Colonel Maynard, "Demonstration Project, Nursing Satisfaction Outcomes, First Year—1990," Information Paper, 6 March 1991; Donna L. Patterson, "Status of Tripler Army Medical Center Nursing Demonstration Project," Information Paper, 6 March 1991; Edith Walsh, "Nursing Demonstration Project Funding Requirements for FY 92," Information Paper, 15 March 1991; Lieutenant Colonel Zurcher, "Nursing Shortage," Insert for the Record, Senate Appropriations Committee, 6 May 1991; Healthcare Strategy & Marketing Office, "FY92 Congressional Mark-up," n.d.; Sharon S. DeRuvo, "Status of the Congressional Demonstration Project," Memorandum, 12 January 1992; Linda Kirk and Donna Patterson, "Congressional Demonstration Project, Effects of the Restructuring of Nursing Practice to Effectively Use Ancillary Personnel," Typewritten Report, June 1992; Frederick N. Bussey to Daniel K. Inouye, Typewritten

Letter, 31 July 1992; Terris E. Kennedy, "Congressional Reports," Memorandum, 14 December 1992; Loretta Forlaw, "Nurse Demonstration Project," 3 May 1993; Loretta Forlaw, "Status of the Nurse Test Congressional Demonstration Project," Information Paper, 27 January 1995; and Loretta Forlaw to Iris West, E-mail Correspondence, 17 September 2004 (all in ANCC, OMH).

46. As of 1995, six TAMC nurses staffed a Pain Management Team 24 hours a day, seven days a week. In 1997, as cost-containment efforts expanded, the clinic hours fell to 16-hour days, five days a week, and the nurse staff downsized to three. The staff provided consultation for hospital staff and education and support for patients using patient-controlled analgesic devices and undergoing epidural analgesia. Michele L. Kohl, "Trip Report, Tripler Army Medical Center, Honolulu, Hawaii, 29 July–2 August 1996," Memorandum, 15 August 1996, ANCC, OMH. Diana L. Ruzicka and Don Daniels, "Implementing a Pain Management Service at an Army Medical Center," *Military Medicine* 166 (February 2001): 146–51.

47. Lisa Beckmann, "Tripler's Ambulatory Care Clinic," Information Paper, 9 March 1995; and Lisa Beckman, "Tripler's Specialized Nursing Care Center," Information Paper, 1 April 1996 (both in ANCC, OMH).

48. Barbara S. Stakk, "Pre-Admission Unit," Information Paper, 10 March 1995; and Michele L. Kohl, "Trip Report, Tripler Army Medical Center, Honolulu, Hawaii, 29 July–2 August 1996," Memorandum, 15 August 1996 (both in ANCC, OMH).

49. Alice L. O'K. DeMarais, "Certified Nurse-Midwifery (CNM) Service MEDDAC-AK," Information Paper, 22 May 1995, ANCC, OMH.

50. Laurie Davis, "Women's Health Advanced Practice," *The Army Nursing Newsletter* (December 1997): 13–14, ANCC, OMH.

51. "Landstuhl Regional Medical Center, Nursing Initiatives in Healthcare Delivery," n.d., ANCC, OMH.

52. The Walter Reed Health Care system incorporated a number of health care facilities in the mid-Atlantic region, such as those located at Carlisle Barracks, Pennsylvania, Fort Detrick, Maryland, Fort Meade, Maryland, Aberdeen Proving Ground, Maryland, Fort Belvoir, Virginia, Fort Myer, Virginia, the Pentagon, and Walter Reed Army Medical Center. http://www.wramc.amedd.army.mil/patientinfo/HealthCareSys.htm (accessed 20 September 2005).

53. Margaret M. Baird, "Input for BG Simmons' Congressional Testimony," Memorandum, 20 May 1996; and "Significant Army Nurse Corps UM/Best Practice Initiatives," Typewritten Briefing Outline, July 1997 (both in ANCC, OMH).

54. Bonnie Jennings to Diane Plemenik, E-mail Correspondence, 19 May 1996, ANCC, OMH.

55. Theresa M. Tominey, "General Leonard Wood Army Community Hospital (GLWACH) Health Promotion Center and Clinic," Information Paper, 11 February 1998, ANCC, OMH.

56. Bonnie M. Jennings, "Clinical Case Management in the Army Medical Department," Information Paper, 27 April 1993; Bonnie M. Jennings, "Clinical Case Management in the Army Medical Department," Information Paper, 24 February 1994; Bonnie M. Jennings, "Ideas on Case Management for the Senior Executive Coordinated Care Conference," Information Paper, n.d.; Kathleen Srsic-Stoehr, "Input on Ambulatory Care Initiative/Issues—Summary," Memorandum, 3, 3 March 1996; and Terris E. Kennedy, Interview by Constance J. Moore, Transcript, 347–50, 31 October 1996 (all in ANCC, OMH). Bonnie M. Jennings and Laura R. Brosch, "Clinical Case Management in the Army Medical Department," *Military Medicine* 159 (August 1994): 548–53. Joseph C. Kiser "Critical

Pathways Show Way to Success," *The Mercury* 26 (January 1999): 11.

57. "Significant Army Nurse Corps UM/Best Practice Initiatives," TD, July 1997, ANCC, OMH.

58. "DoD New Parent Support Program, Hawaii," TD, n.d.; Elizabeth Hill, Joann Hollandsworth, JoEllen Cerny, Anthony Ettipio, and Jillian Inouye to Gar Yip, TD, 29 January 1998; "Effects of Telehealth Augmentation of a Home Nursing Care Program for Women with Children at Risk for Child Abuse and Neglect," Typewritten Report, n.d.; and Susie Clark to Wendy Martinson, "Answer to Testimony Questions," E-mail Correspondence, 21 April 1998 (all in ANCC, OMH). Michelle J. Rowan, "Community Health Nurses Take Care Home," *The Mercury* 27 (June 2000): 8.

59. Susie Clark to Wendy Martinson, "Answer to Testimony Questions," E-mail Correspondence, 21 April 1998, ANCC, OMH.

60. Stephen C. Joseph, "Tri-Service Staffing of Tripler Army Medical Center (TAMC)," Memorandum, 1 November 1994, ANCC, OMH.

61. Stephen C. Joseph, "Tri-Service Staffing of Tripler Army Medical Center (TAMC)," Memorandum, 23 February 1995, ANCC, OMH.

62. "Statement by Brigadier General Nancy R. Adams, Chief, Army Nurse Corps, Army Medical Department, before the Defense Subcommittee, Committee on Appropriations, United States Senate, 1st Session, 104th Congress, Health Programs," 10, 13 June 1995; Janet R. Southby, "Walter Reed Army Medical Center, Department of Nursing," Briefing Slides, May 1996; Michele L. Kohl, "Trip Report, Installation Visited: Tripler Army Medical Center, Honolulu, Hawaii, 29 July–2 Aug 1996," Memorandum, 1–2, 15 August 1996; "Statement of Rear Admiral Joan Engel, Nurse Corps, Director, Nurse Corps, United States Navy, June 5, 1996, before the Subcommittee on Defense of the Senate Appropriations Committee," 4; and "Statement by Lieutenant General Ronald R. Blanck, The Army Surgeon General, on Health Care in the United States Army," TD, 23, n.d. (all in ANCC, OMH).

63. Earl Fauver, Interview by Author, 26 August 2005. Claudia Bartz and Gary Sadler, "Recommendation for Training Psychiatric Nurses and Medical Specialists to Practice in Interservice Settings," Memorandum, 1 August 1995, ANCC, OMH.

64. "Tri-Service Transitioning," presented at 4th Annual Leadership Seminar, 17 October 1995, ANCC, OMH.

65. Janet R. Southby to Author, E-mail Correspondence, 30 August 2005; and Janet R. Southby, "66D/66G Assignments to WRAMC," Memorandum, 26 June 1995 (both in ANCC, OMH).

66. Janet R. Southby and Carol A. Carney, "Nurse Staffing Arrangements between WRAMC and NNMC," Memorandum, 1 July 1996, ANCC, OMH.

67. C.A. Carney, "Nursing Service Personnel Transferred to Walter Reed Army Medical Center in Support of Neurology Nursing Services," Memorandum, 13 May 1996; and Ellen Buck to Kathy Tracy, "Staff Detailed to WRAMC," Memorandum, 19 May 1996 (both in ANCC, OMH).

68. Earl Fauver, Interview by Author, 26 August 2005. "Testimony of John R. Pierce, M.D., Colonel, Medical Corps, U.S. Army (Retired), BRAC Commission Hearing," 12, 7 July 2005, ANCC, OMH.

69. Glenn R. Ermer, Brenda J. McEleney, and Iris J. West, "An Oral History of the 'Joint' Nursing Experience at Landstuhl Regional Medical Center," *Military Medicine* 165 (February 2000): 131–34.