

United States Air Force



Presentation

Before the House Appropriations
Committee, Subcommittee on Defense

Defense Health Programs

Witness Statement of
Lieutenant General Thomas Travis
The Air Force Surgeon General

April 24, 2013

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BIOGRAPHY

UNITED STATES AIR FORCE

LIEUTENANT GENERAL (DR.) THOMAS W. TRAVIS

Lt. Gen. (Dr.) Thomas W. Travis is the Surgeon General of the Air Force, Headquarters U.S. Air Force, Washington, D.C. General Travis serves as functional manager of the U.S. Air Force Medical Service. In this capacity, he advises the Secretary of the Air Force and Air Force Chief of Staff, as well as the Assistant Secretary of Defense for Health Affairs on matters pertaining to the medical aspects of the air expeditionary force and the health of Air Force people. General Travis has authority to commit resources worldwide for the Air Force Medical Service, to make decisions affecting the delivery of medical services, and to develop plans, programs and procedures to support worldwide medical service missions. He exercises direction, guidance and technical management of more than 42,800 people assigned to 75 medical facilities worldwide.



General Travis entered the Air Force in 1976 as a distinguished graduate of the ROTC program at Virginia Polytechnic Institute and State University. He was awarded his pilot wings in 1978 and served as an F-4 pilot and aircraft commander.

The general completed his medical degree from the Uniformed Services University of the Health Sciences School of Medicine, where he was the top Air Force graduate, and in 1987 he became a flight surgeon. For more than three years, General Travis was Chief of Medical Operations for the Human Systems Program Office at Brooks Air Force Base, Texas. He later served as the Director of Operational Health Support and Chief of Aerospace Medicine Division for the Air Force Medical Operations Agency in Washington, D.C.

Prior to his current assignment, Gen Travis served as Deputy Surgeon General, Headquarters U.S. Air Force, Washington, D.C. The general has commanded the U.S. Air Force School of Aerospace Medicine; 311th Human Systems Wing at Brooks AFB; Malcolm Grow Medical Center and 79th Medical Wing, Andrews AFB, Md.; and the 59th Medical Wing, Wilford Hall Medical Center, Lackland AFB, Texas. He also served as the Command Surgeon, Headquarters Air Force District of Washington, and Command Surgeon, Headquarters Air Combat Command, Langley AFB, Va. He is board certified in aerospace medicine. A command pilot and chief flight surgeon, he has more than 1,800 flying hours and is one of the Air Force's few pilot-physicians. He has flown the F-4, F-15 and F-16 as mission pilot and, the Royal Air Force Hawk as the senior medical officer and pilot.

EDUCATION

1976 Distinguished graduate, Bachelor of Science degree in biology, Virginia Polytechnic Institute and State

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University, Blacksburg

1980 Master of Science degree in physiology, Virginia Polytechnic Institute and State University, Blacksburg
1986 Doctor of Medicine degree, Uniformed Services University of the Health Sciences School of Medicine, Bethesda, Md.

1991 Master of Science degree in public health, University of Texas Health Science Center, San Antonio, Texas

1996 Air War College, by correspondence

1999 Distinguished graduate, Master of Science degree in national resource strategy, Industrial College of the Armed Forces, Fort Lesley J. McNair, Washington, D.C.

2000 Medical Capstone, Walter Reed Army Medical Center, Washington, D.C.

2003 Federal Health Care Executive Course, Interagency Institute, George Washington University, Washington, D.C.

2005 Capstone, Fort Lesley J. McNair, Washington, D.C

ASSIGNMENTS

1. April 1977 - March 1978, student, undergraduate pilot training, Williams AFB, Ariz.
2. May 1978 - August 1978, student, fighter lead-in training, Holloman AFB, N.M.
3. August 1978 - February 1979, student, F-4 Replacement Training Unit, MacDill AFB, Fla.
4. February 1979 - June 1982, F-4 aircraft commander, 334th Tactical Fighter Squadron, Seymour Johnson Air Force Base, N.C.
5. August 1982 - May 1986, medical student, Uniformed Services University of the Health Sciences School of Medicine, Bethesda, Md.
6. July 1986 - June 1987, internship, Andrews AFB, Md.
7. July 1987 - July 1990, F-15 pilot physician, Langley AFB, Va.
8. August 1990 - June 1992, resident in aerospace medicine, Brooks AFB, Texas
9. July 1992 - April 1996, Chief, Medical Operations, Human Systems Program Office, Brooks AFB, Texas
10. April 1996 - June 1998, senior medical officer pilot, Royal Air Force School of Aviation Medicine, Farnborough, England
11. July 1998 - June 1999, student, National Defense University, Industrial College of the Armed Forces, National Defense University, Fort Lesley J. McNair, Washington, D.C.
12. July 1999 - July 2001, Director, Operational Health Support, and Chief, Aerospace Medicine Division, Air Force Medical Operations Agency, Washington, D.C.
13. July 2001 - February 2003, Commander, U.S. Air Force School of Aerospace Medicine, Brooks AFB, Texas
14. February 2003 - September 2005, Commander, 311th Human Systems Wing, Brooks City-Base, Texas
15. September 2005 - May 2006, Commander, 89th Medical Group, Andrews AFB, Md.
16. May 2006 - August 2006, Command Surgeon, Headquarters Air Force District of Washington, Bolling AFB, D.C., and Commander, 79th Medical Wing, Andrews AFB, Md.
17. September 2006 - August 2007, Command Surgeon, Headquarters Air Combat Command, Langley AFB, Va.
18. August 2007 - November 2010, Commander, 59th Medical Wing, Lackland AFB, Texas
19. November 2010 - July 2012, Deputy Surgeon General, Office of the Surgeon General, Headquarters U.S. Air Force, Washington, D.C.
20. July 2012 - present, Surgeon General, Office of the Surgeon General, Headquarters U.S. Air Force, Washington, D.C.

FLIGHT INFORMATION

Rating: Command pilot and chief flight surgeon

Hours: More than 1,800

Aircraft flown: F-4, F-15, F-16 and Royal Air Force Hawk

MAJOR AWARDS AND DECORATIONS

Distinguished Service Medal

Legion of Merit with oak leaf cluster

Meritorious Service Medal with four oak leaf clusters

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Aerial Achievement Medal
Air Force Commendation Medal
Joint Service Achievement Medal
Combat Readiness Medal
Air Force Recognition Ribbon

OTHER ACHIEVEMENTS

1994 Julian E. Ward Memorial Award, Aerospace Medical Association
1994 Unger Literary Award, Society of U.S. Air Force Flight Surgeons
1995 Paul W. Myers Award for outstanding contributions to Air Force medicine, Air Force Association
2003 Stewart Lecturer, Royal Aeronautical Society
2007 Marie Marvingt Award, French Society of Aerospace Medicine
2007 George E. Schafer Award, Society of USAF Flight Surgeons
2008 John D. Chase Award for Physician Executive Excellence, Association of Military Surgeons of the United States

PROFESSIONAL MEMBERSHIPS AND ASSOCIATIONS

Academician, International Academy of Aviation and Space Medicine
Member and former President, Society of U.S. Air Force Flight Surgeons
Member and former President, International Association of Military Flight Surgeon Pilots
Fellow, Aerospace Medical Association
Fellow and former Aerospace Medicine Regent, American College of Preventive Medicine
Life member, Association of Military Surgeons of the United States
Order of the Daedalians
Alpha Omega Alpha Honor Medical Society

EFFECTIVE DATES OF PROMOTION

Second Lieutenant June 2, 1976
First Lieutenant Dec. 2, 1978
Captain Feb. 25, 1982
Major Feb. 25, 1988
Lieutenant Colonel Feb. 25, 1994
Colonel May 31, 1998
Brigadier General Sept. 1, 2004
Major General June 2, 2007
Lieutenant General July 13, 2012

(Current as of July 2012)

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Chairman Young, Ranking Member Visclosky, and distinguished members of the Subcommittee, thank you for inviting me to appear before you today. U.S. military forces, now in the second decade of war, benefit from the vast achievements Army, Navy and Air Force medics have jointly made in deployed and en-route health care since 2001. With a 96 percent survival rate, we have never been better prepared to support our warfighters, and we owe a great debt to your support.

I joined the Air Force during the Cold War almost 37 years ago. The great majority of our military medics have joined the military during the current shooting war, and they have performed magnificently. War creates a readiness and training imperative and opportunity, and the current war, now beginning to wane, has put military medicine center stage as an incredibly effective part of this Nation's operational capability. This is a hard-earned and well-documented "identity" for military medics. After this war, while we rightly focus hard on cutting the cost of health care, we must continuously prepare for the next war, when our Nation will expect us to be just as good, if not better than we were in this one. And that the next war may be very different and present unique and significant challenges in a less permissive environment.

With the end of the war in Iraq and the draw-down of forces in Afghanistan, our real-time, real-world, theater hospital training opportunity is diminishing. While we are thrilled that patient movements have dropped significantly, we will soon face new challenges: How do we remain on the cutting edge of trauma care and aeromedical evacuation, ready for the next war, and ready to continue to provide "Trusted Care Anywhere?" What will we look like in the future?

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Clearly, our post-war medical forces must stay ready through their roles in patient-centered, state-of-the-art, full tempo health services that ensure competence, currency, and satisfaction of practice, while fostering innovation. The Air Force Medical Service (AFMS) is closely linked with our Defense, Army and Navy colleagues in efforts to achieve the Military Health System (MHS) Quadruple Aim through our goals of Readiness, Better Health, Better Care, and Best Value.

As medics, we must remain ready, current, trained, and equipped to provide care across a full spectrum of missions to include combat operations, stability operations, humanitarian assistance or disaster relief. To enhance our core competency on the ground and in the air, we're pursuing major modernization initiatives to maintain and improve our ready state.

In the past year, we've successfully tested and deployed our Expeditionary Medical Support Health Response Team (EMEDS-HRT), which replaces our former EMEDS Basic as the primary element of EMEDS capability. The HRT provides initial operating capability within 15 minutes, emergency room care within two hours, operating room capability within four hours, critical care within six hours and full operational capability within 12 hours. The HRT allows us to tailor clinical care to the mission, adding specialty care components for humanitarian assistance or disaster relief missions. Last summer the HRT was successfully exercised by our Langley AFB medics as they embarked on a humanitarian training exercise in Peru providing medical care to thousands of impoverished Peruvians. During this mission, the medics were fully operational in less than 12 hours. This operation successfully tested our enhanced capability and provided an important opportunity to pursue Global Health Engagement. Ten HRTs are now postured for deployment.

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Since 9/11, our forces have transported almost 182,000 patients, 98,000 from the CENTCOM Area of Responsibility, to include 8200, high acuity patients moved with Critical Care Air Transport Teams (CCATTs). These teams provide intensive care support in-flight to our high risk patients, and have significantly contributed to the lowest died-of-wounds rate in our Nation's history, while allowing the Department of Defense to maintain smaller theater medical footprints, a true revolution in deployed medicine.

Taking the next step toward raising the survival rate, the Air Force Medical Service (AFMS) has developed and deployed Tactical Critical Care Evacuation Teams (TCCETs) that provide advanced trauma care on rotary-wing aircraft beyond that provided by field and flight medical personnel. TCCETs represent the Air Force's initiative to close the critical care gap and ensure continuous en-route critical care from forward stabilization to definitive care venues. Two teams are now deployed in theater, allowing even more expeditious movement of critical patients between Level II and Level III facilities. We have plans to train more teams.

To keep our trauma and CCATT providers current and ready for the next mission, we will be relying even more upon the well-proven civilian partnering programs established at our Centers for the Sustainment of Trauma and Readiness Skills (C-STARS) in Baltimore, Cincinnati, and St. Louis. C-STARS are the hubs for advances in training and research. The cadre of specialists we place in these C-STARS platforms not only train our medical Airmen as they rotate through for trauma and high-acuity care training, but are also deployable as our most ready and capable trauma care teams.

The success of CCATTs in expanding the capabilities of the aeromedical evacuation (AE) system has led to dramatic changes in military medical force deployment and casualty care practices. We continue to collaborate with civilian partners in clinical care and research

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activities to provide a powerful platform for excellence in battlefield health. The AFMS and Battlefield Health and Trauma Research Institute (BHT) joined forces with the San Antonio University Health System to conduct research on spinal fractures, blood transfusion, sepsis, burns, hemorrhagic shock, and compartment syndrome. These partnerships continuously modernize our military and national health care systems.

The current war also presented us with trauma patients with life-threatening, severe respiratory failure requiring extracorporeal life support (ECLS, previously known as Extracorporeal Membrane Oxygenation [ECMO]) as rescue therapy in aeromedical evacuations. These devices allow the lungs to rest and heal. Until recently, Adult ECLS usage has been associated with high mortality rates. However, newer technology and equipment miniaturization has made it possible to apply this lifesaving measure during transport. Our teams at San Antonio Military Medical Center, Lackland AFB, Texas, and at David Grant Medical Center, Travis Air Force Base, California, continue to research the capabilities of a miniaturized ECLS system for use at altitude. The current study proposes to stabilize and capture micro emboli (small bubbles in the blood stream) when used in-flight. Airworthiness testing is pending and success of this research will help validate the utility of the ECLS closed-loop system. The device has gone from 800 pounds to 28 pounds, making it feasible as a mobile tool for use in various aircraft. The original capability of ECLS has improved since its inclusion in the Lung Team Package back in 2006. This past year alone, the Lung Team has been activated for 17 patient movements expanding our en-route care capability.

We are constantly identifying better technologies for more accurate patient assessment in flight and are employing research and development efforts to improve casualty care. On the horizon, the AFMS is pursuing the miniaturization of medical devices, such as a field-deployable

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light-weight vital sign monitor that would fit inside a cargo pocket; use of sensors to collect patient data; autonomous control of patient oxygen and ventilation via a closed-loop ventilation system to help reduce ventilator-induced lung injury and provide more efficient and precise oxygen therapy. Also under development, a video-assisted intubation device will provide caregivers visualization of the vocal cords and the endotracheal tube to confirm placement in the constrained, austere AE environment (in the aircraft, tarmac, during ground transport etc.).

Air Force Medical Service Research and Development (AFMS R&D) also centers on development of state-of-the-art training, such as the next-generation simulation training specifically designed for pararescue personnel. Another example is our virtual medical trainer program that provides an interactive, 360-degree internal view of the aircraft, which familiarizes the user with the aircraft's medical equipment, devices, supplies and best practices for patient loading and unloading.

One final example of the modernization of the AE platform are ongoing changes to our current Contingency Aeromedical Staging Facility operations towards a combined En-Route Patient Staging System (ERPSS) that allows for a flexible patient staging configuration and rapid response to a myriad of contingencies, and maintains the advantages of the building block approach for flexibility in bed size. This scalable response package was born out of lessons learned in this war, as well as disasters such as Hurricane Katrina.

As the way we fight wars evolves, the way we provide medical support for operators must also evolve. Airmen who are manning systems such as the distributed communication ground stations, space and cyber operations, or remotely piloted aircraft (RPA), and those who operate "outside the wire," such as Security Forces, Special Operations Forces, and Explosive

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Ordnance Disposal (EOD) specialists face distinct challenges. The types of injuries or stressors – both visible and invisible – to members and their families are also evolving. We must provide medical support in different ways than we have in the past to address the expanding definition of “operators,” and step up to our role as human performance practitioners, assuring Airmen are healthy and ready to perform their missions effectively. Not only will access and care be more customized for the mission, but so will prevention.

We are engaging in many human performance research initiatives across the AFMS to further this goal through a broad spectrum of clinical, information/technology and operational projects to ensure the care we provide remains state-of-the-art. We are studying the Remotely Piloted Aircraft mission and how this may be affecting our pilots and intelligence operators. Investigators assessed the main sources of occupational stress affecting performance, prevalence of suicidal ideation, clinical distress, PTSD, and high risk health behaviors. As a result of this study, we are embedding psychologists in remote warfare units to provide early intervention and care. Additionally, work shift schedules have changed to align with the recommendations of the study.

For better care, we must provide reliable access to safe, quality care for those we serve, promoting positive patient experiences and outcomes. To do this, we must be consistent and reliable in ensuring our staff focuses on patient safety first, and use evidence-based practices in the provision of quality care.

One way the AFMS is seeking to improve our patient safety efforts is by joining the national initiative, “Partnership for Patients,” which considers ways to reduce health-care acquired conditions (HAC). Our inpatient facilities have implemented nationally approved

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evidenced-based practice guidelines to help reduce HACs, and we continue to monitor and reevaluate our efforts along with the other Services and the DoD. Our patient safety programs are fully executed, with 90 contract full-time equivalents and one active duty director assigned across 75 Military Treatment Facilities (MTFs). Together with full contract support and 100 percent implementation of the Patient Safety Reporting system, we have demonstrated the same success that has been cited in the literature: The more near misses that are reported in the organization, the fewer harmful events occur. By utilizing this system we have noticed a 2.5 percent increase in near miss reporting and a 0.4 percent decrease in “harm” events over the previous year, demonstrating the importance of patient safety reporting and practices throughout our organization. We continue to collaborate with our sister Services, and this past year we led the first-ever interservice patient safety event analysis. Now, all sentinel event occurrences are shared among the services. Sharing information and full transparency helps prevent negative patient experiences throughout the Department of Defense.

The ability to promptly and effectively examine and treat sexual assault victims is a vital aspect of our better care initiatives. Every Air Force Military Treatment Facility has a Sexual Assault Forensic Exam (SAFE) process in place, and over the last three years we have quadrupled the number of trained medical personnel to care for victims. Our overseas and deployed locations all have trained SAFE/SANE (Sexual Assault Nurse Examiner) medical professionals on staff, with a minimum of two at any given facility. All deployed MTFs have SAFE capability, either within the unit or with another Service’s MTF nearby. Our proactive approach shows that our leaders are clearly focused on prompt, effective, and compassionate care for the victims.

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With more than 1 million patients enrolled, Air Force Patient-Centered Medical Home (PCMH) has made significant progress toward greater continuity of care and improved patient and provider satisfaction. Over the past year, patients have seen their assigned provider team over 90 percent of the time. This allows patients to become more active participants in their health care, and improves their care experience. For example, our clinic at Davis-Monthan AFB, Arizona, continues to be one of our top facilities for continuity of care. They have produced impressive improvements in patient health indicators, boasting a 21.6 percent increase in well child visits, a 4.9 percent increase in diabetes screening, a 9.0 percent increase in diabetes control, and a 48 percent decrease in urgent care referrals. These are prevention successes that also save money. We are also in the process of developing a Medical Home model for internal medicine clinics focused on improving care and better serving the special needs of this particular population of patients.

To support PCMH, we are implementing secure messaging. This technology is now deployed to a third of our MTFs, with the remainder coming on board this year. Secure messaging provides a private, online communication system that allows patients to contact their primary care clinics for medical advice, appointments, prescription renewal, and laboratory results. In the end state, will provide our patients with access to personal health records via secure messaging, making our patients partners in their health care.

Project ECHO (Extension for Community Healthcare Outcomes), a program that allows our family healthcare teams to care for more complex patients in the MTF, proves to be a valuable means for our providers to improve healthcare and continuity for patients. ECHO allows the MTF to keep patients in the direct care system by having primary care providers “reach back” to designated specialists for consultation, rather than referring them to the network.

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This platform uses information management/information technology systems to consult with specialists or experts remotely and this has reduced referrals to the TRICARE network.

Currently, 26 tri-service MTFs are participating in this service providing complicated diabetes management, chronic pain management, and traumatic brain injury care for our patients. This year we plan to add behavioral health, dermatology and international medical readiness into the program with plans to further expand in 2014.

As we focus on better health to reduce the need for care, we are encouraging healthy behaviors through a culture of resilience and performance, while reducing illness and injury. We are working hard with Air Force leadership to inculcate healthy behaviors in our Airmen and help them to cope with the mental stressors they experience. Comprehensive Airman Fitness focuses on building strength across physical, mental, spiritual and social domains. Our Airman Resilience Training provides a standardized but flexible approach to pre- and post-exposure training for deploying Airmen and reintegration education for redeploying Airmen. For our redeploying service members, the Deployment Transition Center (DTC) at Ramstein AB, Germany, has assisted 5,000 Airmen, Marines, and coalition partners who are in career fields at high risk for Post-Traumatic Stress Disorder (PTSD). Research from the Deployment Transition Center surveys show lower rates of post-traumatic stress, interpersonal conflict and alcohol use in attendees after returning home, presenting a model for improved warrior care.

We are also improving access to mental health care through initiatives such as the Patient Centered Medical Home-Behavioral Health (PCMH-BH) which embeds mental health providers within the primary care clinics of each Military Treatment Facility, and the Mental Health Integration Program, a demonstration project to evaluate placing full service mental health capability in PCMH at two of our MTFs. The deployment of video teleconferencing capabilities

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in our mental health clinics has also helped to reach the needs of our patients, while decreasing the stigma associated with seeking mental health assistance.

Providing quality mental health care with adequate staffing remains a top priority. To increase mental health manning as directed by the National Defense Authorization Act (NDAA) for Fiscal Year 2010, section 714, we continue to work toward increased recruitment and retention of mental health providers. We are near full staffing for psychiatrists, psychologists, social workers, and psychiatric nurse practitioners. However, the fully qualified numbers are lower because these specialties have members in training, or in the case of social workers and psychologists, they have finished their training but require supervision while they secure their licenses to become independent and fully qualified providers.

While the Air Force rate of deployment-associated TBI is lower than the other Services, we remain concerned about the consequences of TBI. We expanded clinical education for primary care providers who care for individuals at high risk for TBI and launched a pilot program at three of our bases where we have Explosive Ordnance Disposal (EOD) flights. Individuals at high risk for TBI were empanelled to a specific primary care team equipped to address the member's recovery needs. This program has been very well received at these locations, and we are now considering further expansion for other missions that may require customized care.

While Air Force rates of Post-traumatic Stress Disorder (PTSD) remain relatively low compared to the other Services, we continue looking for ways to prevent or minimize post-traumatic stress symptoms. In addition to providing pre- and post-deployment airman resilience training, we are reviewing recommended improvements to our curriculum and delivery strategies identified in a recent program evaluation. The AFMS uses evidence-based treatments for PTSD

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and offers ongoing provider training support from the Center for Deployment Psychology. We remain committed to safeguarding the well-being and mental health of our people and continue to work closely with Air Force leadership on airman resiliency efforts.

Research efforts on the horizon for TBI and PTSD include looking at prevention of mild TBI to determine if the ingestion of select dietary components at specific times will enhance resistance. We are also determining if there is a link between the effects of operational stressors (sleep-deprivation, immobilization) and increased susceptibility to brain injury.

Hearing loss is another frequent and invisible injury of war, with roughly 60 percent of those returning from Iraq and Afghanistan having this affliction. The AFMS remains vigilant in our efforts to mitigate hearing loss among service members. In 2013, the DoD Hearing Center of Excellence, a DoD, tri-Service and Department of Veterans Affairs (VA) organization under Air Force lead, will execute a hearing loss prevention campaign across the Department of Defense to increase military awareness of noise and the use of effective hearing protection. Clinical practice guidelines are published and in use to help primary care providers optimize diagnosis and treatment of the “dizzy” patient who may have sustained traumatic brain injury as a result of blast injuries. We are leading development of the Allied NeuroSensory Warrior Related Research Concept to identify a common research model to study the effect of polytrauma on comprehensive neurosensory systems and have upgraded the hearing conservation data surveillance platform to allow data sharing to smooth the transition of wounded warriors for care and disability processing. We are exploring an alternative for expedited auditory-related data capture by leveraging the Air Force’s Health Service Data Warehouse to capture clinical audiograms from 60 medical treatment facilities.

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The joint efforts of DoD and the VA to streamline the Integrated Disability Evaluation System (IDES) are paying off. To ensure a ready, fit force, the AFMS has implemented a centralized pre-screening process prior to referring a service member into the IDES. The intent of the prescreening process is to ensure the appropriateness for discharge consideration. The centralized process provides consistent application of medical retention standards across the Air Force. The goal is to reduce the number of personnel who may erroneously transit through the entire IDES process, only to receive a subsequent determination of "Return to Duty" (RTD) from the Physical Evaluation Board (PEB). The pre-screening initiative has shown success. Since the roll-out of the process in March 2012, of those active duty cases that underwent pre-screening and received final adjudication from the PEB, only 3.8 percent of the cases were returned to duty compared to an average of 25 percent in the six months prior to implementation. This means the Return to Duty determination was quicker for those Airmen, and we unburdened the IDES process of these types of cases. Improving the IDES process continues to be a significant priority for the Air Force Medical Service.

In addition to the challenges of military deployment and post-deployment medicine, we must be concerned with national health issues that impact our Airmen and their families just as in the civilian sector, such as the increasing rates of obesity and chronic illnesses. We continue to work with our Service counterparts and civilian partners to address these issues, through research, education and best practices.

The Air Force is united with our Army, Navy and Defense Department colleagues in reorganizing the Military Health System governance system. Implementation planning is underway to meet the NDAA 2013 requirements, to include consolidating and standardizing redundant processes and services. We are committed to full collaboration on shared services to

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lower health care costs and improve joint interoperability without relinquishing our important command relationships or specific Service doctrinal responsibilities.

Being prepared and proactive is vital to being ready for the next conflict, and we need to continue to fully invest in our most precious resource – our people. The state-of-the-art joint Medical Education and Training Campus (METC) helps us do just that and is now fully operational. The Medical Education and Training Campus offers our enlisted personnel more than 60 medical programs of instruction, and boasts 24,000 annual graduates. We continue to rely heavily on the Health Professions Scholarship program for the majority of our professional accessions, and the Uniformed Services University of the Health Sciences is the source of our highest retention rate, and military medicine’s academic home. Additionally, our Air Force graduate medical education (GME) programs continue to successfully recruit high-caliber physicians.

Through all of our successes, we continuously strive to find new and improved ways to get more return on our investments and be better stewards of the tax-payer dollar. We encourage innovative sharing agreements and joint initiatives that enhance our providers’ clinical currency and save federal dollars. One of our most significant partners in this endeavor is the Department of Veterans Affairs (VA). As a result of our efforts to encourage participation in the DoD-VA Resource Sharing Program, there are now 59 Air Force-VA sharing agreements with nine Master Sharing Agreements covering all available services at nine Air Force military treatment facilities. We currently have five joint venture sites with the VA and one multi-service joint venture site in Charleston, South Carolina, that involves collaboration between the Air Force, Navy, and the VA. We are looking at potentially adding two additional sites in the next few years. It is

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imperative that we continue to find ways to save federal dollars, enhance our providers' clinical skills, and become more efficient through collaborative sharing with our VA partners.

The AFMS continues to seek infrastructure improvement to better serve our beneficiaries. Our military construction projects offer greener buildings and state-of-the-art designs that help streamline the delivery of patient care and decrease our carbon footprint by increasing our energy star ratings. The AFMS has made significant investments in repairing, upgrading, and replacing infrastructure to address code compliance, patient and staff safety, mission continuity, and energy management.

One example is the McGuire Clinic in New Jersey. The facility is relatively new (11 years old) but consistently held a low energy star rating. Problems were identified and repairs were made resulting in over a nine-fold increase in energy star rating. Another prime example is the improvements made at the 1957 vintage clinic at Fairchild Air Force Base, Washington. The projects were completed in three phases and resulted in a 51.5 percent reduction in energy consumed. We currently have 7 Energy Star sites and are on target to obtain our 2015 goal of reducing energy usage by 30 percent. I'm proud to say that the AFMS has been selected as an Energy Star Partner of the Year for 2013 by the Environmental Protection Agency.

We support the President's budget and the proposed changes to the military health benefit. To slow the growth in military compensation while also fully supporting the all-volunteer force, we also request congressional support on limiting the basic military pay raise to one percent and allowing sensible TRICARE fee and pharmacy co-pay changes. I am confident that the recommendations included in the budget reflect the proper balance and the right priorities necessary to sustain the benefit over the long term.

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Our bottom line on efficiency is to ensure we have the best people working in the best facilities for the best patient outcomes; this vision guarantees that we provide health care at the best value.

Conclusion

In alignment with the MHS Quadruple Aim, we are committed to providing a ready force, better care, and better health at best value. Even in austere fiscal times, Readiness, Better Care and Better Health cannot be scoped solely on funding if we are to achieve and maintain a fit, healthy, ready, fighting force. Best Value means seeing a clear return on investments, which must be constantly measured, reported, and adjusted. We are heavily engaged in identifying the best practices, optimizing existing services, and pursuing continuous improvement to promote health and deliver care efficiently, effectively, and safely, while maintaining the readiness edge.

Building a solid, sustainable foundation for the way ahead, while recognizing that there is a cost to sustain readiness, is a crucial next step as we prepare for an uncertain future while establishing ourselves as an agile, versatile, and innovative medical force. The men and women of the Air Force Medical Service are dedicated to delivering “Trusted Care, Anywhere,” and we will continue to work with the other Services and DoD to improve readiness and provide the best care to our military members and their families. We anticipate exciting challenges in the delivery of military health care in the coming year, but I assure you that in my view, challenge creates opportunity, and we will remain fully committed to excellence. Again, I thank the Committee for your remarkable support to the Air Force Medical Service and military medicine.