D E P A R T M E N T O F T H E A I R F O R C E

PRESENTATION TO THE MILITARY PERSONNEL SUBCOMMITTEE

COMMITTEE ON ARMED SERVICES

U.S. HOUSE OF REPRESENTATIVES

SUBJECT: Medical Readiness

STATEMENT OF: Lieutenant General (Dr.) James G. Roudebush
Air Force Surgeon General

March 27, 2007

NOT FOR PUBLICATION UNTIL RELEASED
BY THE COMMITTEE ON ARMED SERVICES
U.S. HOUSE OF REPRESENTATIVES

BIOGRAPHY

UNITED STATES AIR FORCE

LIEUTENANT GENERAL (DR.) JAMES G. ROUDEBUSH

Lt. Gen. (Dr.) James G. Roudebush is the Surgeon General of the Air Force, Headquarters U.S. Air Force, Washington, D.C. General Roudebush 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 Roudebush 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 42,400 people assigned to 74 medical facilities worldwide.

The general entered the Air Force in 1975 after receiving a Bachelor of Medicine degree from the University of Nebraska at Lincoln, and a Doctor of Medicine degree from the University of Nebraska College of Medicine. He completed residency training in family practice at the Wright-Patterson Air Force Medical Center, Ohio, in 1978, and aerospace medicine at Brooks Air Force Base, Texas, in 1984. The general commanded a wing clinic and wing hospital before becoming Deputy Commander of the Air Force Materiel Command Human Systems Center. He has served as Command Surgeon for U.S. Central Command, Pacific Air Forces, U.S. Transportation Command and Headquarters Air Mobility Command. Prior to his selection as the 19th Surgeon General, he served as the Deputy Surgeon General of the U.S. Air Force.

EDUCATION

1971 Bachelor of Medicine degree, University of Nebraska at Lincoln
1975 Doctor of Medicine degree, University of Nebraska College of Medicine
1978 Residency training in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio
1980 Aerospace Medicine Primary Course, Brooks AFB, Texas
1981 Tri-Service Combat Casualty Care Course, Fort Sam Houston, Texas
1983 Master's degree in public health, University of Texas School of Public Health, San Antonio
1984 Residency in aerospace medicine, Brooks AFB, Texas
1988 Air War College, by seminar

1978 Residency training in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio
1980 Aerospace Medicine Primary Course, Brooks AFB, Texas
1981 Tri-Service Combat Casualty Care Course, Fort Sam Houston, Texas
1983 Master's degree in public health, University of Texas School of Public Health, San Antonio
1984 Residency in aerospace medicine, Brooks AFB, Texas
1988 Air War College, by seminar
1989 Institute for Federal Health Care Executives, George Washington University, Washington, D.C.
1992 National War College, Fort Lesley J. McNair, Washington, D.C.
1993 Executive Management Course, Defense Systems Management College, Fort Belvoir, Va.

ASSIGNMENTS
1. July 1975 - July 1978, resident in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio
2. July 1978 - September 1982, physician in family practice and flight surgeon, USAF Hospital, Francis E. Warren AFB, Wyo.
3. October 1982 - July 1984, resident in aerospace medicine, USAF School of Aerospace Medicine, Brooks AFB, Texas
4. August 1984 - September 1986, Chief of Aerospace Medicine, 81st Tactical Fighter Wing, Royal Air Force Bentwaters, England
5. September 1986 - July 1988, Commander, USAF Clinic, 81st Tactical Fighter Wing, Royal Air Force Bentwaters, England
6. August 1988 - June 1991, Commander, 36th Tactical Fighter Wing Hospital, Bitburg Air Base, Germany
7. August 1991 - July 1992, student, National War College, Fort Lesley J. McNair, Washington, D.C.
8. August 1992 - March 1994, Vice Commander, Human Systems Center, Brooks AFB, Texas
9. March 1994 - January 1997, Command Surgeon, U.S. Central Command, MacDill AFB, Fla.
10. February 1997 - June 1998, Command Surgeon, Pacific Air Forces, Hickam AFB, Hawaii
11. July 1998 - July 2000, Commander, 89th Medical Group, Andrews AFB, Md.
12. July 2000 - June 2001, Command Surgeon, U.S. Transportation Command and Headquarters Air Mobility Command, Scott AFB, Ill.
13. July 2001 - July 2006, Deputy Surgeon General, Headquarters U.S. Air Force, Bolling AFB, Washington, D.C.
14. August 2006 - present, Surgeon General, Headquarters U.S. Air Force, Washington, D.C.

FLIGHT INFORMATION
Rating: Chief flight surgeon
Flight hours: More than 1,100
Aircraft flown: C-5, C-9, C-21, C-130, EC-135, F-15, F-16, H-53, KC-135, KC-10, T-37, T-38, UH-1 and UH-60

BADGES
Chief Physician Badge
Chief Flight Surgeon Badge

MAJOR AWARDS AND DECORATIONS
Defense Superior Service Medal with oak leaf cluster
Legion of Merit with oak leaf cluster
Meritorious Service Medal with two oak leaf clusters
Air Force Commendation Medal
Joint Meritorious Unit Award
Air Force Outstanding Unit Award with oak leaf cluster
National Defense Service Medal with bronze star
Southwest Asia Service Medal with bronze star
Air Force Overseas Long Tour Ribbon with oak leaf cluster
Air Force Longevity Service Award with silver oak leaf cluster

Small Arms Expert Marksmanship Ribbon
Air Force Training Ribbon

PROFESSIONAL MEMBERSHIPS AND ASSOCIATIONS
Society of USAF Flight Surgeons
Aerospace Medical Association
International Association of Military Flight Surgeon Pilots
Association of Military Surgeons of the United States
Air Force Association
American College of Preventive Medicine
American College of Physician Executives
American Medical Association

EFFECTIVE DATES OF PROMOTION
Second Lieutenant May 15, 1972
First Lieutenant May 15, 1974
Captain May 15, 1975
Major Dec. 8, 1979
Lieutenant Colonel Dec. 8, 1985
Colonel Jan. 31, 1991
Brigadier General July 1, 1998
Major General May 24, 2001
Lieutenant General Aug. 4, 2006

(Current as of August 2006)

Mr. Chairman and esteemed members of the Committee, as the Air Force Medical Service's (AFMS) Surgeon General, it is a pleasure and honor to be here today to tell you about Air Force medical successes on both the battlefield and home front.

The Secretary and Chief of Staff of the Air Force set our priorities: Supporting the Global War on Terrorism, caring for Airmen and their families, and recapitalizing our assets. The AFMS fully supports these priorities by: taking care of joint warfighters and our Air Expeditionary Force; taking care of our Air Force family; and building the next generation of Air Force medics. And please note that when I say "medics," I am referring to all our Air Force medical personnel—officer and enlisted.

Upfront, I'd like to say, Air Force medicine is not simply about support, not simply reacting to illness and injury, and Air Force medicine is definitely not a commodity. Air Force medicine is a highly adaptive capability, a key part of Air Force expeditionary capabilities and culture. Our proactive and visionary work contributes heavily to a healthy fit force that is leveraged and designed, in fact, to prevent casualties. But…when there are casualties, we are there with world class care.

We provide the same quality of care – and access to care – for all of our nearly three million beneficiaries. Our stand out health care and health service support worldwide ensures total force personnel are healthy and fit before they deploy, while deployed, and when they return home. This is our hallmark, and the result is the lowest disease, non-battle injury and died of wounds rates in the history of war. We are committed to providing the very best health care to our Air Force and joint warfighters.

Taking Care of Our Expeditionary Force and Joint Warfighter

Our medical teams operate closer to the front lines than ever before, enabling us to provide warfighters advanced medical care within minutes. Without question, every day, Air Force medics save the lives of Soldiers, Sailors, Marines, Airmen and civilians; Coalition, Afghani and Iraqi; friend and foe alike. Underpinning this world-class health care for our joint warfighters is our system of en route care. We ensure joint warfighters receive seamless care through the continuum of care from first battle damage surgery to definitive care and recovery back in the United States. En route care relies on our unique capabilities in Expeditionary Medical Support (EMEDS) and aeromedical evacuation (AE).

Aeromedical Evacuation

Aeromedical evacuation is distinctly Air Force, and a critical component of the Air Force's global reach capability. We safely care for and transport even the most severely injured patients to definitive care.

Our expeditionary medical system and AE system combine to achieve an average patient movement time of 3 days from the battlefield to stateside care. This is remarkable when compared to the 10-14 days required during the 1991 Persian Gulf War or the average 45 days it took in Vietnam.

Our modern AE teams – which include active duty, Guard and Reserve forces – coupled with our innovative Critical Care Air Transport Teams (CCATT), operate flying intensive care units in the back of virtually any airlift platform. This success resulted from our shift to designated, versus dedicated, aircraft and training universally qualified AE crew members able to execute their AE mission on any airlift aircraft. This

transformation of AE has been repeatedly proven in the global war on terrorism, as evidenced by the safe and rapid transfer of more than 40,000 Operation ENDURING FREEDOM and Operation IRAQI FREEDOM patients from overseas theaters of operation to stateside hospitals!

To illustrate this capability, consider Marine Sergeant Justin Ping's story. As a result of a suicide bomber attack in Fallujah, Iraq, Sergeant Ping sustained severe burns to his face and hands, blast injuries to his right arm, and shrapnel embedded in his leg and right eye. Without immediate care, the shrapnel to his eye would have undoubtedly resulted in permanent loss of sight. After receiving superb first aid from his Navy corpsman immediately after injury, Sergeant Ping was flown from the battlefield to the Air Force Theater Hospital at Balad where his injuries were stabilized. It was quickly determined that Sergeant Ping's injuries would be best treated in the United States. Major (Dr.) Charles Puls, (a CCATT physician) provided full life support for Sergeant Ping during the 17-hour, 7,500 mile aeromedical evacuation flight from Balad to Brooke Army Medical Center, San Antonio, Texas. Major Puls said, "The patient was stable throughout flight…we cared for him prior to and during the flight," referring to his team comprised of Captain William Wolfe, a nurse, and Senior Airman Bertha Rivera, a respiratory therapy technician. His team ensured Sergeant Ping received the best en route care and most expeditious transport all the way back to definitive care. There is no doubt that this superb en route care saved Sergeant Ping's eyesight. Sergeant Ping is doing quite well today thanks to all the medics--Navy, Army, and Air Force--who were dedicated to his care.

Barbara Wynne, spouse of our very own Secretary of the Air Force, recently

expressed the importance of our capability when she wrote in a letter to all Airmen, "We visited the hospitals in Balad, Landstuhl, and at Walter Reed...The doctors, nurses and technicians are the cream of the crop. Their expertise, saving so many lives, is the silver lining to this conflict. It truly is the 'Miracle of Iraq and Afghanistan."

Commitment to Jointness

I am proud to say that the AFMS is all about "Joint." Not only do we run the renowned Air Force theater hospital in Balad, as well as smaller facilities in Kirkuk and Baghdad, 300 Air Force medics jointly staff Landstuhl Medical Center, Germany. Additionally, we assumed operational control of the theater hospital at Bagram Air Base in Afghanistan late January.

The AFMS has been deeply involved in establishing the most effective joint casualty care and management system in military history. Whether stabilizing a casualty, preparing a casualty for transport, providing continual care at stops along the way, or moving the patient in our AE system; what matters is providing the very best care possible to every injured or ill warfighter at every point in the care continuum. Everything medical in theater is designed to support moving casualties from the point of injury to the right level of care, at the right place, in the least amount of time.

To that end, we believe it is critically important to work closely with our sister Service medics in leveraging our joint capabilities. Working to improve our common "enabling" platforms—such as logistics, information management, information technology, and medical research and development—will serve to make all medics better prepared to support the Joint warfighter. Side by side with our Service counterparts, we recently concluded a 72-day

humanitarian and civic assistance deployment with the Navy on board the USNS Mercy. Yes, we are all about jointness and supporting the joint warfighter.

However, our focus is not just the war. Our Air Force medics are globally engaged in training our allies, supporting humanitarian missions or responding to disasters. To assist in this role, this year the Air Force built a new type of unit—the Humanitarian Operation Relief (HUMRO) Operational Capabilities Package (OCP)—a streamlined package of 91 medics and 133 base support personnel designed to support a humanitarian relief mission. This HUMRO OCP will provide a rapid and tailorable response to a disaster; and by leaving the deployable hospital and medical equipment, it will provide an enduring medical capacity for the host nation following redeployment of our U.S. Air Force personnel.

Delivering this remarkable medical care across the full spectrum of missions takes trained, clinically current physicians, nurses and technicians. The AFMS concentrates on joint medical education programs and has developed clinical training platforms providing surgical and trauma care experience. Our readiness training platforms, including training arrangements with Baltimore Shock Trauma, Cincinnati- Center for Sustainment of Trauma and Readiness Skills (C-STARS), and St. Louis- C-STARS, ensure our Air Force medics are the best trained in history.

Taking care of the expeditionary force and warfighter is job number one. But crucial to that mission is taking care of our Air Force family.

Taking Care of Our Air Force Family

When our Airmen join the Air Force, we make a commitment to them and their families that we will care for them throughout their period of service, and into retirement for career Airman, whether at their home station medical treatment facility (MTF), in a deployed MTF, or through private sector care TRICARE contracts. To that end, we have an integrated delivery system throughout our Air Force community to support our Airmen's health, including physical, mental, and dental needs. We work closely with the Department of Veterans Affairs and our TRICARE networks to provide seamless care.

Warfighter Fitness and Deployment Health

We begin by ensuring a fit and healthy force at home station. We maintain every warfighter's health and fitness through periodic assessments of their health and workplace, and support them with an effective physical fitness training and testing program. Before they deploy, we ensure they are medically ready.

In theater, our preventive aerospace medicine teams assess the austere environment to which our forces deploy, and continue to provide surveillance of their health and environment while deployed. If our Airmen and joint warfighters become ill or injured, we rapidly transport them with cutting edge en route medical care to expeditionary medical support and then to definitive stateside care.

Prior to deployment and upon redeployment home, we evaluate our Airmen's health—physical, mental, and emotional— through the use of a Pre- and Post-Deployment Health Assessment (PDHA). We then reevaluate at three to six months post deployment using the Post Deployment Health Reassessment (PDHRA) as the next link in the continuum of care. To date, 70 percent of required PDHRAs are completed. Thirty-eight percent of

them were considered positive due to a possible physical or emotional condition, with two percent reporting a Post Traumatic Stress Disorder (PTSD) symptom. Less than 0.5 percent have been positively diagnosed as actually having PTSD. Each positive finding is assessed by health care providers and appropriate treatment provided if required.

The AFMS is committed to providing our Airmen the most current, effective, and empirically validated treatment for PTSD. To meet that goal, we are training our behavioral health personnel to recognize, assess, and treat PTSD in accordance with the VA/DoD PTSD Clinical Practice Guidelines. Using nationally recognized civilian and military experts, we have trained 89 psychiatrists, psychologists, and social workers representing 45 Air Force installations. Our goal is to equip every behavioral health provider with the latest PTSD research, assessment modalities, and treatment techniques.

Caring for the families of our Airman has a mission impact. Assuring high quality and timely care for our family members at home gives our Airman the peace of mind they need to do a critical job in stressful and dangerous environments.

Partnerships

Our commitment to the health of our Airmen and their families also includes partnerships with leading civilian institutions. For instance, the AFMS and University of Pittsburgh Medical Center have teamed in collaborative efforts to prevent and/or delay type II diabetes, including associated complications, through education, early treatment modalities and community outreach. Other critically important efforts include the development of collaborative relationships with various Department of Veterans Affairs facilities and a robust TRICARE network. Throughout this continuum, we work closely with our sister Services and civilian counterparts to provide preventive health care,

interoperable surveillance, research and development, outreach, and treatment. Caring for our Air Force team and family also means taking care of our medics. We ensure that they are healthy and prepared for the mission they will face. With that in mind, our next priority involves taking care of our Air Force medics.

Taking Care of Each Other

The AFMS is committed to providing our Air Force medics the resources needed to perform the mission. To this end, we developed a new "Flight Path" to guide our organizational structure and the development of each of our Air Force medical personnel.

Professional Development

We created a clear “Flight Path” to match Air Force needs with individual professional growth requirements. The overall goal of the “Flight Path” is to develop a streamlined, consistent medical group structure, from clinic to medical center, that provides a ready and fit medical force in support of the Air Expeditionary Force. It assures military and functional medical competence; provides a power projection platform to deploy medics forward; and delivers high quality, cost-effective care.

The "Flight Path" fosters corps-specific force development, requirements-driven leadership opportunities, and balanced leadership teams within the MTF. It also assures compliance with military and civilian certification requirements, access to graduate medical education, and cost-effective mission support at home and when deployed.

In these ways, our “Flight Path” is helping us develop the next generation of Air Force medics. The way I view it, my charge is to ensure we recruit the best and brightest people, prepare them to expertly execute our mission, and retain them to support and lead these important efforts. Ideally, we do this in a way satisfying for them, and in a fashion

that enables a balance between duty and family.

Balance

An essential part of taking care of each other is to make sure our medics have the right balance in their lives between their professional duties and their families. We create better balance through staffing, finding the right mix of military, civilians and contractors, and by focusing our recruiting and retention efforts to maintain this mix. In these ways and others, we are recapitalizing our greatest resource, our people.

Air Expeditionary Force and Constant Deployer Model

We believe the Air Expeditionary Force (AEF) rotational construct is the right construct for the AFMS. It provides the predictability needed for planning, training, deploying and reconstituting our force that leads to an effective long-term strategy and, just as crucial, outstanding quality of life for our Airmen.

Another innovation geared toward taking care of our people is our Constant Deployer Model (CDM), which provides a continuous deployed capability with sustained access to care at home station as well as maintaining a balance between our people's deployed, professional and personal lives. This model has ensured access to care at home via contracted personnel and improved quality of care at deployed locations. We believe working in more efficient ways lends itself to taking care of each other.

Air Force Smart Operations for the 21st Century, AFSO21

An important tool—implemented Air Force-wide by the Secretary of the Air Force, Michael W. Wynne and the Air Force Chief of Staff, General T. Michael Moseley—is the Air Force Smart Operations 21 program. Using a variety of tools, including Lean and Six Sigma, AFSO21 is being used to streamline operations through process changes to improve

efficiency and reduce waste.

As medics, AFSO21 will make us more effective in supporting both the Air Force expeditionary mission and the joint mission. The use of process analysis and lean thinking will be essential in making sure that we are both relevant and cost-effective in support of our mission today, and tomorrow.

Challenges Ahead

Today we are faced with the most challenging of times. We must implement BRAC while we simultaneously support the global war on terrorism. The BRAC process has given us a tool to reposture several of our key MTFs. We are also creating efficiencies outside of the BRAC process, restructuring some MTFs to better meet today's demands.

Attracting and retaining the very best medics builds morale and trust to sustain the all volunteer force. Professional development, AEF rotations, AFSO21, BRAC, and military construction work together to recapitalize our Air Force Medical Service. Air Force medicine cares for our most treasured national asset—America's sons and daughters.

Summary

The talent and dedication of military medics ensures that an incredible 97 percent of the casualties we see in our deployed and joint theater hospitals will survive today. We safely aeromedically evacuated nearly 40,000 patients from theaters of operations since the beginning of Operations IRAQI FREEDOM and ENDURING FREEDOM, provided compassionate care to 1.5 million people on humanitarian missions over the past 6 years, and continued to care for 3 million patients annually all over the world.

Despite our successes, Mr. Chairman and members of the Committee, we are far from a position where we can rest on our laurels. I assure you we will continue to work hard with you in the months and years ahead to perfect the joint continuum of care for this fight, and the next! Thank you for your outstanding support.