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 COMMITTEE ON APPROPRIATIONS

SUBCOMMITTEE ON DEFENSE

UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: MEDICAL PROGRAM OVERVIEW

STATEMENT OF: LIEUTENANT GENERAL (DR.) JAMES G. ROUDEBUSH
AIR FORCE SURGEON GENERAL

February 28, 2008

NOT FOR PUBLICATION UNTIL RELEASED
BY THE COMMITTEE ON APPROPRIATIONS
UNITED STATES 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

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
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, it is my honor and privilege to be here today to talk with you about the Air Force Medical Service. The Air Force Medical Service exists and operates within the Air Force culture of accountability wherein medics work directly for the line of the Air Force. Within this framework we support the expeditionary Air Force both at home and deployed. We align with the Air Force's top priorities: Win Today's Fight, Take Care of our People, and Prepare for Tomorrow's Challenges. We are the Nation's Guardian—America's force of first and last resort. We get there quickly and we bring everyone home. That's our pledge to our military and their families.

Win Today's Fight

It is important to understand that every Air Force Base is an operational platform and Air Force medicine supports the war fighting capabilities at each one of our bases. Our home station military treatment facilities form the foundation from which the Air Force provides combatant commanders a fit and healthy force, capable of withstanding the physical and mental rigors associated with combat and other military missions. Our emphasis on fitness, disease prevention and surveillance has led to the lowest disease and non-battle injury rate in history.

Unmistakably, it is the daily delivery of health care which allows us to maintain critical skills that guarantee our readiness capability and success. The superior care delivered daily by Air Force medics builds the competency and currency necessary to fulfill our deployed mission. Our care is the product of preeminent medical training programs, groundbreaking research, and a culture of personal and professional accountability fostered by the Air Force's core values.

In support of our deployed forces, the Air Force Medical Service (AFMS) is central to the most effective joint casualty care and management system in military history. The effectiveness of forward stabilization followed by rapid Air Force aeromedical evacuation has been repeatedly proven. We have safely and rapidly moved more than 48,000 patients from overseas theaters to stateside hospitals during Operations ENDURING FREEDOM and IRAQI FREEDOM. Today, the average patient arrives from the battlefield to stateside care in three days. This is remarkable given the severity and complexity of the wounds our forces are sustaining. It certainly contributes to the lowest died of wounds rate in history.

Total Force Integration

Our Air Force Medical Service is already the model for melding Guard, Reserve and civilians with active duty elements. Future challenges will mandate even greater interoperability, and success will be measured by our Total Force and Joint performance.

A story that clearly illustrates the success of our Total Force and Joint enroute care is that of Army SGT Dan Powers, a squad leader with the 118th Military Police Company. He was stabbed in the head with a knife by an insurgent on the streets of Baghdad on July 3, 2007. Within 30 minutes of the attack, he was flown via helicopter to the Air Force theater hospital at Balad Air Base. Army neurosurgeons at the Balad Air Force theater hospital and in Washington DC reviewed his condition and determined that SGT Powers, once stabilized, needed to be transported and treated at the National Naval Medical Center, Bethesda, MD as soon as possible. The aeromedical evacuation system was activated and the miracle flight began. A C-17 aircrew from Charleston Air Force Base, SC, picked up SGT Powers with a seven-person Critical Care Air Transport Team and flew non-stop from Balad Air Base, Iraq, to Andrews Air Force Base, MD. After a 13-hour flight, they landed at Andrews AFB where SGT Powers was safely rushed to the National Naval Medical Center for lifesaving surgery.

As Sgt Powers stated, "the Air Force Mobility Command is the stuff they make movies out of…the Army, Navy, and Air Force moved the world to save one man's life."

We care for our families at home; we respond to our Nation's call supporting our warriors, and we provide humanitarian assistance to countries around the world. To execute these broad missions, the Services—Air Force, Navy and Army--must work jointly, inter-operatively, and interdependently. Our success depends on our partnerships with other federal agencies, academic institutions, and industry. Our mission is vital. Everyday we must earn the trust of America's all-volunteer force-- Airmen, Soldiers, Sailors and Marines, and their families. We hold that trust very dear.

Take Care of our People

We are in the midst of a long war and continually assess and improve health services we provide to Airmen, their families, and our joint brothers and sisters. We ensure high standards are met and sustained. Our Air Force chain of command fully understands their accountability for the health and welfare of our Airmen and their families. When our warfighters are ill or

injured, we provide a wrap-around system of medical care and support for them and their families – always with an eye towards rehabilitation and continued service.

Wounded Warrior Initiatives

The Air Force is in lock-step with our sister services and federal agencies to implement the recommendations from the President's Commission on the Care for America's Returning Wounded Warriors. The AFMS will deliver on all provisions set forth in the Fiscal Year 2008 National Defense Authorization Act and provide our warfighters and their families help in getting through the challenges they face. I am proud today to outline some of those initiatives.

Care Management, Rehabilitation, Transition

When a service member is ill or injured, the AFMS responds rapidly through a seamless system from initial field response, to stabilization care at expeditionary surgical units and theater hospitals, to in-the-air critical care in the Aeromedical Evacuation system, and ultimately home to a military or Department of Veterans Affairs (VA) medical treatment facility (MTF). With specific regard to our Airmen who are injured or ill, Air Force commanders, Family Liaison Officers, Airmen and Family Readiness Center representatives, in lock step with Federal Recovery Coordinators, and medical case managers, together ensure "eyes-on" for the Airman and family throughout the care process. For injured or ill active duty Airmen requiring follow-up medical care, they will receive it at their home station MTF. If no MTF is available, as is often the case for our Guard and Reserve Airmen, the TRICARE network expands options for follow-on care with case managers at the major command level overseeing the care. If transition to care within the VA is the right thing for our Airmen--Active, Guard, or Reserve--we work to make that transition as smooth and effective as possible. For those Airmen medically separated, care is provided through the TRICARE Transitional Health Care Program and the VA health system. The Air Force Wounded Warrior Program, formerly known as Palace Hart, maintains contact and provides assistance to those wounded Airmen who are separated from the Air Force for a minimum of five years.

The AFMS provides timely medical evaluations for continued service and fair and equitable disability ratings for those members determined not to be fit. We will implement DoD policy guidance on these matters and all final recommendations from the pilot programs to

improve the disability evaluation system. We have processes in place to ensure healthcare transitions are efficient and effective. Briefings are provided on VA benefits when individuals enter the Physical Evaluation Board process. Discharged members, still under active treatment, receive provider referral and transfer of their records. A key component of seamless transfer of care is a joint initiative by the VA and DoD, called the VA Benefits Delivery at Discharge (BDD) Program. Air Force MTFs provide the BDD advance notice of potential new service members and their health information through electronic transfer.

The Air Force Medical Hold Program is very different from our sister services. In the Air Force, those undergoing disability evaluation stay in their units. We work closely with wing commanders to ensure that our personnel receive timely disposition. The key to success in this process is comprehensive case management. Outpatients are managed by the home unit and major command case managers. The Air Force does not use patient holding squadrons for Air Force Reserve personnel in medical hold status since the majority of reserve members live at home and utilize TRICARE services. If members are outside the commuting area for medical care, they are put on temporary duty orders and sent to military treatment facilities for consultations for as long as needed for prompt medical attention. We are teaming with our Air Force manpower and personnel counterparts to initiate efforts to further reduce administrative time without downgrading the quality of medical care.

Psychological Health and Traumatic Brain Injury

Psychological health means much more than just the delivery of traditional mental health care. It is a broad concept that covers the entire spectrum of well-being, prevention, treatment, health maintenance and resilience training. To that end, I have made it a priority to ensure that the AFMS focuses on these psychological needs of our Airmen and identifies the effects of operational stress.

Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI)

Thank you for the opportunity to discuss these critical issues with you at your February 7th hearing. The incidence of Post Traumatic Stress Disorder is low in the Air Force, diagnosed in less than one percent of our deployers (at six months post-deployment). For every Airman affected, we provide the most current, effective, and empirically validated treatment for PTSD.

We have trained our behavioral health personnel to recognize and treat PTSD in accordance with the VA/DoD PTSD Clinical Practice Guidelines. Using nationally recognized civilian and military experts, we trained more than 200 psychiatrists, psychologists, and social workers to equip every behavioral health provider with the latest research, assessment modalities, and treatment techniques. We hired an additional 32 mental health professionals for the locations with the highest operational tempo to ensure we had the personnel in place to care for our Airmen and their families.

We recognize that Traumatic Brain Injury may be the "signature injury" of the Iraq war and is becoming more prevalent among service members. Research in TBI prevention, assessment, and treatment is ongoing and the Air Force is an active partner with the Defense and Veterans Brain Injury Center (DVBIC), the VA, the Center for Disease Control, industry and universities. The Air Force has very low positive screening for TBI —approximately one percent from Operation IRAQI FREEDOM (OIF) and Operation ENDURING FREEDOM (OEF).

Prevention

Several years ago the AFMS shifted from a program of head-to-toe periodic physical examinations for all active duty members and moved to an annual focused process, the Periodic Health Assessment (PHA). Through the use of the PHA, we identify and manage personnel readiness and overall health status, to include preventive health needs.

In addition, there are separate pre- and post-deployment health assessment/reassessment processes. Before deployment, our Airmen are assessed to identify any health concerns and determine who is medically ready to deploy. The Post-Deployment Health Assessments are completed at the end of their deployment and again at six months post-deployment. Of note, questions are embedded in the post-deployment assessments to screen for Traumatic Brain Injury. These cyclic and focused processes allow us to fully assess the Airmen's overall health and fitness. This allows commanders the ability to assess the overall fitness of the force.

Department of Veterans Affairs Sharing Initiatives

Our work with the VA toward seamless care and transition for our military members is a high priority, particularly as we treat and follow our Airmen redeploying from Operations OEF/OIF.

An important lesson learned from the care of our returning warriors is the need for a seamless electronic patient health record. After assuming command and responsibility for the Bagram and Balad hospitals, the Air Force successfully deployed a joint electronic health record known as Theater Medical Information Program Block 1. This revolutionary in-theater patient record is now visible to medical providers not only within the battlefield. Additionally, clinicians can access these theater clinical data at every military and VA medical center worldwide using the joint Bidirectional Health Information Exchange. This serves to improve the overall delivery of healthcare home and abroad for wounded and ill service members.

We are expanding our sharing opportunities with the VA, establishing a fifth joint venture at Keesler AFB Medical Center and the Biloxi VA Medical Center in Mississippi. This new Center of Excellence will optimize and enhance the care for DoD and VA patients in the area.

Our joint venture at Elmendorf AFB, Alaska, is another Air Force/VA success story. In 2007, the 3rd Medical Group at Elmendorf increased their access by more than 200 percent for veterans in areas such as orthopedics and ophthalmology. This effort enhanced readiness training for 3rd Medical Group medics, and increased the surgery capacity by 218 percent for the 3rd Medical Group and 239 percent for the VA. Sharing our medical capabilities not only makes fiscal sense and improves access to care for our patients, it helps to sustain our medics' clinical skills currency so we remain prepared for tomorrow.

Prepare for Tomorrow's Challenges

Our Medics

The demanding operations tempo at home and deployed locations also means we must take care of our Air Force medical personnel. This requires finding a balance between these extraordinarily demanding duties, time for personal recovery and growth, and time for family. We must recruit the best and brightest; prepare them for the mission and retain them to support and lead these important efforts in the months and years to come. We work closely with the Air Force Recruiting Service and the Director of Air Force Personnel to maximize the effectiveness of the Health Professions Scholarship Program (HPSP) and recruitment incentives. HPSP is our primary avenue of physician recruitment accounting for over 200 medical student graduates

annually. Once we recruit the best, we need to retain them. The AFMS is undertaking a number of initiatives to recapitalize and invest in our workforce. Enhancing both professional and leadership development, ensuring predictability in deployments, and offering financial incentives, are all important ways in which we will improve our overall retention.

Graduate Medical Education (GME)

Our in-house GME programs offer substantial benefits and are a cornerstone for building and sustaining our AFMS. The Air Force has 35 residencies in 18 specialties, and 100 percent of these are fully accredited compared to a national civilian average of 85 percent accreditation. This caliber of quality and commitment translates to a 95-98 percent first-time board pass rate for Air Force, Army and Navy program graduates which meets or exceeds the civilian national average for each of our specialties. Two of our GME programs, the Emergency Medicine and the Ophthalmology Residency Programs at Wilford Hall Medical Center TX, are rated among the top in the nation.

Centers for Sustainment of Trauma and Readiness Skills (C-STARS)

Job One is training our Expeditionary Airmen to be able to respond to any contingency. The C-STARS provides hands-on clinical sustainment training for our physicians, physician assistants, nurses, and medical technicians in the care of seriously injured patients. Our medics learn the latest trauma techniques and skills from leading medical teaching facilities, including the University of Maryland's R. Adams Cowley Shock Trauma Center in Baltimore, MD; the Cincinnati University Hospital Trauma Center; and the St. Louis University Trauma Center. These C-STARS sites offer an intense workload coupled with clinical experience that sharpens and refreshes our medics' trauma care. This training increases our knowledge and helps us care for the most critical injuries. We are developing plans to enhance training for our oral and plastic surgeons to better respond to facial trauma.

Medical Treatment Facility Recapitalization

Our recent experience re-emphasized that America expects us to take care of our injured and wounded in a quality environment, in facilities that are healthy and clean. I assure you that the Air Force is meeting that expectation. All 75 Air Force medical treatment facilities are

regularly inspected (both scheduled and unannounced) by two nationally recognized inspection and accreditation organizations. The Joint Commission inspects and accredits our Air Force medical centers and hospitals, while the Accreditation Association for Ambulatory Health Care inspects and accredits our outpatient clinics. These inspections focus on the critical areas of quality of patient care, patient safety, and the environment of care. All Air Force medical facilities have passed inspection and are currently fully accredited.

Telehealth

Telehealth applications are another important area of focus as we seek improvements and efficiencies in our delivery of healthcare. Telehealth moved into the forefront with the Air Force Radiology Network (RADNET) Project. This project provides Dynamic Workload Allocation by linking military radiologists via a global enterprise system. RADNET will provide access to studies across every radiology department throughout the AFMS on a continuous basis. Its goal is to maximize physician availability to address workload, regardless of location. We are aggressively targeting deployment of this capability in Fiscal Year 2009 to all Air Force sites.

Also scheduled for Fiscal Year 2009 deployment is the Tele-Mental Health Project. This project will provide video teleconference units at every mental health clinic for live patient consultation. This will allow increased access to, and use of, mental health treatment to our beneficiary population. Virtual Reality equipment will also be installed at six Air Force sites as a pilot project to help treat patients with post traumatic stress disorder. Using this equipment will facilitate desensitization therapy by recreating sight, sound and smell in a controlled environment.

Research and Development Initiatives

Our research initiatives advance delivery of care, training and disease surveillance for our Airmen. Our partnership between the University of Pittsburgh Medical Center and Wilford Hall Medical Center's Diabetes Outreach Clinic promotes advances in diabetes prevention and treatment. We are developing a program that can be implemented at all AFMS facilities worldwide.

A second example, the Virtual Medical Trainer, supports AFMS readiness skills by transforming textual, presentation-based training to more effective interactive, web-based tools.

The Virtual Medical Trainer allows medical personnel to acquire and refresh patient care skill sets using interactive training. Peripheral nerve block training is currently used, and training is being expanded to forensic dentistry and C-17 patient loading.

We also would like to highlight the capability of COHORT (Composite Occupational Health and Operational Risk Tracking). COHORT integrates information from disparate data sources for longitudinal studies and disease outbreak surveillance. All of these initiatives improve the health of our Airmen and allow us to proactively meet their needs.

Benefit adjustments

Increased health care demand combined with the current rate of medical cost growth is increasing pressure on the defense budget, and internal efficiencies are insufficient to stem the rising costs. Healthcare entitlements need to be reviewed to ensure the future of our high quality medical system and to sustain it for years to come.

Conclusion

In closing, Mister Chairman, I am intensely proud of the daily accomplishments of the men and women of the United States Air Force Medical Service. Our future strategic environment is extremely complex, dynamic and uncertain, and demands that we not rest on our success. We are committed to staying on the leading edge and anticipating the future. With your help and the help of the committee, the Air Force Medical Service will continue to improve the health of our service members and their families. We will win today's fight, and be ready for tomorrow's challenges. Thank you for your enduring support.