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 MILITARY QUALITY OF LIFE

AND VETERANS AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: Fiscal Year 2007 Defense Health Program

STATEMENT OF: Lieutenant General (Dr.) George Peach Taylor Jr.
Air Force Surgeon General

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Mr. Chairman and members of the committee, it is a pleasure to be here today to share with you stories of the Air Force Medical Service's success both on the battlefront and the home front.

The Air Force Medical Service (AFMS) continues to provide world-class health care and health service support anywhere in the world at anytime. This includes ensuring that active duty and Reserve component personnel of all Services are healthy and fit before they deploy, while deployed, and when they return home. It also includes providing the same quality of care – and access to care – for our 1.2 million TRICARE enrollees.

This year, our well-honed capabilities were important national assets in the medical response and evacuation of thousands of fellow Americans who were victims of Hurricanes Katrina and Rita. Our Total Force Airmen medics converged on the ravaged region twice in one month to work with Federal Emergency Management Agency (FEMA) medical teams to care for and transport thousands of ill patients. Overall, our Total Force medics provided health care for 7,600 people. Another 3,000, many of whom were critically ill, were safely aeromedically evacuated from the region.

During our response to these natural disasters, a senior physician in FEMA's disaster medical assistance team told me that one of the most impressive things about our people is that they treated every patient during that chaotic, crowded, and terrible time as if they were family, as if the person on the stretcher were their own father, mother, sister, brother, or child pulled from harm's way.

This catastrophic event, though, is something for which we are uniquely trained and equipped to perform. Obviously, the positive attitudes of our people and their collective competence go a long way toward ensuring that the AFMS successfully responds to and overcomes any disaster – natural, domestic or foreign.

To ensure we maintain these abilities and attitudes, Air Force Chief of Staff, General T. Michael Moseley, has outlined three major challenges for leadership to focus upon: fighting the Global War on Terrorism; preserving our culture of excellence through the training and development of our people, and breaking the vicious cycle of operating the oldest inventory in the history of the United States Air Force through recapitalization.

Global War on Terrorism

The Global War on Terrorism will be with us for years to come. Among the Air Force's most critical components in successfully fighting this war both overseas and here at home is considering how we plan for our long-term requirements.

Key in accomplishing this is reinforcing that the Air Force is one organization – not active-duty, Guard and Reserve "tribes." This philosophy necessarily extends to interoperating with all of our sister Services, a method of warfighting that has taken – and will continue to take – growing importance unmatched at any other time in our nation's history.

Most certainly, our light, lean and mobile expeditionary medical support – or EMEDS -- is the linchpin of our ground mission. As importantly, the Air Force Medical Service makes its unique contribution to the Total Force and joint operational environment through our aeromedical evacuation and en route care mission.

Significant as these two components are, we must also continually refine the Air Expeditionary Force deployment system; ensure the pre- and post-deployment health and fitness of our troops; and diligently work to maintain the technological edge over our enemies -- overseas and in the United States -- through the development of bio-surveillance and medical treatment capabilities.

EMEDS

EMEDS, especially at the Air Force Theater Hospital at Balad Air Base in Iraq, has validated the "golden hour" concept—the importance of delivering care in first 60 minutes after injury. This life-saving capability has proved its effectiveness, and no one illustrates the importance of its capability better than the joint troops who make it happen.

"If a patient requires surgery to survive, it will be done here," said Staff Sergeant Jalkennen Joseph, an emergency room medic. The reality and benefit of having a robust surgical capability forward has been key to the lowest casualty rate in the history of combat. Colonel (Dr.) Elisha Powell, former 332nd Expeditionary Medical Group (EMDG) Commander in Balad, supports this fact that "If you arrive here alive, you have about a 96 percent chance of leaving here alive."

We are proud of the teamwork between Air Force flight medics and the Army and Air Force medics on the ground in the patient administration office of our theater hospital as they prepare for the arrival of casualties. "I give all the credit in the world to flight medics…they do things you only see in movies or read about in books. They do it on a daily basis and they do it well." said Staff Sergeant Joseph. Moreover, although the Theater Hospital at Balad is largely staffed by the Air Force, the symphony of teamwork

is its cornerstone. Joseph continues, "We have all really clicked together…we run this place smooth, doing the same mission. We live by the hospital motto 'One team. One mission.'"

In this light, we foresee a continued need for this important capability to provide health care anywhere, and we will continue to refine this to meet joint warfighting medical requirements.

Our commitment to Joint operations cannot be overemphasized. As part of a joint team, we now have more than 600 ground medics in 10 deployed locations. In addition to Balad, we also operate two smaller hospitals in Iraq--one in Kirkuk and another at the Baghdad International Airport. Every day, Air Force medics in these theater hospitals are saving the lives of Soldiers, Sailors, Marines, Airmen, civilians, coalition and Iraqi forces, friend and foe alike. We treated over 12,000 patients in 2005 at Balad alone. These included U.S. forces, Iraqi Security Forces, U.S. and Iraqi civilians, as well as a combination of coalition forces, third country nationals and detainees.

Because our medical teams are operating closer to the front lines than ever before, patients are getting advanced medical care within hours, not days or weeks as they had in the past. However, as our experience in the past four years has shown us, as important as beds and forward deployed health care is, equally important is the ability to quickly move patients from the field to higher levels of care.

Aeromedical Evacuation

Aeromedical Evacuation (AE) crewmembers perform many of the same life-saving activities their peers accomplish in hospitals, but in the back of an aircraft at over 30,000 feet. The conditions are sometimes challenging as crewmembers work under the

noise of the engines or when flying through turbulence -- but there is no place else they would rather be.

"It is a great feeling of responsibility and a privilege to care for these patients," says Colonel (Dr.) Peter Muskat, director of clinical training at the Cincinnati Center for Sustainment and Trauma Readiness Skills (C-STARS), who has flown 15 missions from Balad. Without a shadow of doubt, casualties aboard AE flights are entrusted to warrior medics well trained to effectively perform under these conditions. Colonel Muskat: "From the point of injury in theater to the time the injured person is medevac'd to the states, most times within 72 hours, they receive care from medics who have been exposed to every potential problem a trauma patient may face on the ground and during that flight."

It is crucial to emphasize that of our approximately 400 AE personnel deployed today, the majority of them – almost 90 percent – are Guard and Reserve. A better example of fighting together in the Global War on Terrorism simply escapes me--the Reserve Component contribution to AE operations represents an undeniable hallmark of Total Force.

Occasionally, our AE crews transport patients who are so ill or injured that they require constant and intensive care. When that happens, our AE medical capability is supplemented by Critical Care Air Transport Teams, or CCATTs. These are like medical SWAT teams that fly anywhere on a moment's notice to treat and extract the most seriously injured troops.

Team members carry special gear that can turn almost any airframe into a flying intensive care unit within minutes. An in-theater EMEDS commander told me that CCATTs are a good news/bad news entity. He said, "The bad news is, if you see the CCATT team jumping on a plane, you know someone out there is hurt bad. The good news is, if you see the CCATT jumping on a plane, you know that someone will soon be in the miraculous hands of some of the best trained medics in existence."

No where in recent AE operations was this capability highlighted better than when three members of a CCATT, Major (Dr.) Linda Boyd, an emergency medicine physician, Major Denise Irizarry, a nurse, and Master Sergeant Jeffrey Wahler, a respiratory therapist, were aboard a C-17 Globemaster III from Ramstein Air Base, Germany, to Andrews Air Force Base, Maryland. They treated 30 casualties including ABC anchorman Bob Woodruff and cameraman Doug Vogt. Major Boyd said, "It was awesome…we did intubations and ventriculostomies—a procedure where a device is place into the ventricles of the brain when needed to drain spinal fluid and relieve pressure." On a regular basis, our AE warrior medics leverage superior training, commitment to excellence, and talent to uphold our requirements to support America's heroes who defend our great nation.

Overall, partnering with our critical care air transport teams, our aeromedical evacuation system has made it possible to move seriously injured patients in an astonishingly quick time, as short as 72 hours from the battleground to stateside medical care – unheard of even a decade ago.

Deployments

When I joined the Air Force in the 1970s, we planned, trained, and equipped our medics on the basis of the threats faced in two major operational plans of short duration. That construct is no longer valid, as can clearly be seen with the Global War on Terrorism.

Today's Air Expeditionary Force structure was created, in part, in response to this new construct. The AFMS needed to restructure itself, too, so that it could face multiple commitments overseas of both short and long duration. Our nation requires that medics field combat support capabilities that are very capable, rapidly deployable, and sustainable over long periods.

Medics must be placed at locations where they can maintain the skills they need for their combat medicine mission. It is also vital that these locations allow the medics to deploy easily without significantly interrupting the care they provide the base or TRICARE beneficiaries, especially at those locations with sustained medical education training programs.

This challenge is straightforward: create expeditionary medics who are focused on developing the skills for the field and eager to deploy for four of every twenty months. Currently, we assign medics at large facilities into groups of five so that one team can be deployed at any one time while the other four remain to work and train at home station. We also actively work the ratio of active-to-Reserve component medics to determine the proper mix of active duty and Reserve component to ensure the best balance between the ability to deploy quickly and the capability to surge forces when necessary.

We are also actively reviewing the total size of the AFMS to make sure that over the next few decades we can successfully fulfill our wartime mission while still providing the peacetime benefit to our members, retirees, and their families.

Finally, a vital part of our preparation is state-of-the-art training, such as our Coalition for Sustainment of Trauma and Readiness Skills, or C-STARS, where we partner with renowned civilian medical centers in Baltimore, St. Louis, and Cincinnati to allow our medics to receive trauma training. While our medics -- 300 in 2005 -- receive training that is unavailable in most of our stateside hospitals, we provide a service to the people of those cities – a mutually beneficial relationship that enhances preparedness both at home and abroad. Many students laud C-STARS as the best medical training they have received to prepare them for deployment.

Deployment Health

Collaborative arrangements among the medical, chaplain and family support communities support our claim the Air Force has personnel and processes in place to monitor and address health concerns before, during and after deployments.

Deployment Health Surveillance is a continuous process of Force Health Protection. From accession, through service, and into separation and retirement, the Air Force Medical Service is dedicated to ensuring the health of our Airmen. We maintain a robust Individual Medical Readiness program to ensure each Airman, active and reserve component, is assessed for deployability and mission capability. At the point of deployment, we conduct a tailored deployment health assessment to include appropriate immunizations, medications, and health communication of known threats in the deployment area. In OIF/OEF, these activities combined with continuous health support

in theater have resulted in the lowest disease/non battle injury rate ever experienced in combat operations.

Although some of these efforts are strictly medical in nature, others focus on specific and increasing needs such as mental health. To address the mental health needs of deployed airmen, the Air Force deploys two types of mental health teams: a rapid response team and an augmentation team. Mental health rapid response teams consist of one psychologist, one social worker and one mental health technician. Our mental health augmentation teams are staffed with one psychiatrist, three psychiatric nurses and two mental health technicians. Deployed mental health teams use combat stress control principles to provide consultation to leaders and prevention and intervention to deployed airmen.

I was involved in the medical combat service support laydown for Operations ENDURING FREEDOM and IRAQI FREEDOM, and one of my highest priorities was to ensure that the Air Force fielded mental health professionals early and as far forward as possible to not only treat casualties, but to put in place strong prevention and outreach programs. Today, the Air Force has 49 mental health personnel deployed for current operations, 36 of whom are supporting joint service requirements. We also position psychiatric nurses at our aeromedical staging facilities to better address emerging psychological issues for all troops being medically evacuated out of the combat theater.

The Air Force and the Department of Defense have enhanced efforts to monitor and address the health concerns of deploying service members. Airmen complete the post-deployment health assessment (PDHA) at the end of a deployment, and are now being assessed again 90-180 days after return from deployment via the post-deployment

health reassessment (PDHRA). These instruments provide an overall health assessment of our Airmen, with an emphasis on mental health.

A recent study published in the Journal of the American Medical Association examined the mental health problems reported by Army and Marine combat troops following deployments. We have examined the same data sets for Air Force personnel, and found that Airmen report significantly less mental health concerns following deployments than Army and Marine combat units. According to the report, while over 19 percent of Army and Marine personnel reported at least one mental health symptom after an OIF deployment, only 4.7 percent of Air Force OIF deployers reported at least one mental health symptom. Only about 1 percent of Air Force deployers were referred for mental health care following a post-deployment health assessment. The lower incidences of mental health problems for our Airmen are most likely attributable to both the type and length of Air Force missions. That said, we are closely scrutinizing deploying Airmen who may be at greater risk for mental health concerns, such as convoy personnel and medics.

The Air Force is also standardizing existing redeployment and reintegration programs to help Airmen and family members readjust following deployments. These programs are collaborative among the medical, chaplain and family support communities. Airmen and their families can also take advantage of *The Air Force Readiness Edge*, a comprehensive guide to deployment-related programs and services, as well as *Air Force OneSource*, a contractor-operated program that provides personal consultation via the web, telephone or in-person contacts, on matters that range from severely injured service member family impact to dealing with grief and loss to a myriad of other family related

matters. *Air Force OneSource* is available 24 hours a day, and can be accessed from any location.

Technological Edge

Terrorism confronts us all with the prospect of chemical, biological, and radiological attacks. Of those, one of the most disconcerting to me are the biological weapons. Nightmare scenarios include rapidly spreading illnesses so vicious that if we cannot detect and treat the afflicted quickly, there would be an exponential onslaught of casualties.

Medics have the capability to find, track, target, engage and defeat such biological threats, whether they are naturally occurring, like Severe Acute Respiratory Syndrome (SARS) and influenza, or man-made, like weaponized smallpox.

The rapidly advancing biogenetics field may provide the technology that allows us to identify and defeat these threats. Many consider the coupling of gene chip technology with advanced informatics and alerting systems as the most critical new health surveillance technology to explore -- and we are doing it now in the Air Force.

In 2005, an Epidemic Outbreak Surveillance project, an Air Force initiative, was successfully tested during a real-world exercise in Washington, D.C., that began shortly before the 2005 inauguration and ended after the State of the Union Address.

During the exercise, medical teams around the National Capital Region collected samples from patients who had fever and flu-like illnesses. The samples were transported to a central lab equipped with small, advanced biological identification units -- a "gene chip" -- that tested for common or dangerous bacteria and viruses. These results were known within 24 hours, not the days or weeks normally required. A web-based program

then tracked outbreak patterns, providing an additional mechanism to automatically alert medics and officials of potential epidemics or biological attacks. We continue to work with this technology to create better diagnostics for our normal clinical work as well as for early detection of a new disease, whether it be avian flu or a biological attack.

We are seeking techniques to convert common tap or surface water into safe intravenous solutions in the field. We are also developing the ability to generate medical oxygen in the field rather than shipping oxygen in its heavy containers into the field.

Telehealth is another fascinating technology that enhances the capabilities of our medics. It allows providers in Iraq to send diagnostic images such as X-rays through the Internet back to specialists located anywhere in the world for a near real-time consult. This ensures that each Soldier, Sailor, Airman or Marine in the field has access to one of our outstanding specialists almost anytime and anywhere.

In 2006, we expect to start transitioning another advancement -- our ability to create an unlimited number of cohorts of our beneficiaries using the Composite Occupational Health and Operational Risk Tracking (COHORT) initiative. This will provide occupational and medical surveillance from the time they join the Air Force until retirement or separation, regardless of where they serve or what job they perform. We will finally be able to tie together medical conditions, exposure data, duty locations, control groups, and demographic databases to globally provide individual and force protection and intervention, reducing disease and disability. These tools will work in near real time, and eventually will be automated to work continuously in the background, always searching for key sentinel events.

We are also proud of our collaborative efforts and pursuit of technogical advances that extend beyond threats of biological or epidemic concerns, to also include advancements in more common diseases such as diabetes.

In collaboration with the University of Pittsburgh Medical Center, the USAF is actively engaged in diabetes research. The emphasis of this research is on primary prevention, education, and lifestyle modifications. The "test bed" includes both urban and rural western Pennsylvania, the USAF's Wilford Hall Medical Center in San Antonio, Texas, and rural Texas. The ultimate goal is to develop a template for the development of Diabetes Centers of Excellence that can be utilized across America to include the military community and civilian resources for poor under-privileged regions. This research continuum and partnership will also add significantly to the development of a Diabetes Outreach Clinic at the Wilford Hall Medical Center that will ultimately serve the over 65-year old civilian community as well.

The program utilizes state-of-the art educational principles and tools as well as groundbreaking technology. Telemedicine applications, videos, specialized retinal cameras (to demonstrate pathology) are some of the high-tech educational tools. A computerized Comprehensive Diabetes Management Program designed to promote self-management will be tested as well. These educational efforts target both adults with Type II diabetes as well as at-risk children. Biochemical research involving platelet derived growth factors as related to wound healing (for diabetes related wounds) are also under study.

Diabetes has become a major healthcare crisis in the United States. Currently, over 20 million Americans have diabetes and that number is growing at 8 percent a year. In an effort to halt this unhealthy trend, this program will develop the Premier National Model for diabetes education and treatment. The program is well underway and remarkably, beneficiaries are seeing fruits of this labor already.

People

Almost half the people currently serving in the United States Air Force joined after Sept. 11, 2001. They knew what they were getting into, and there's no question that the military's medical personnel are a critical component of the Global War On Terrorism. As such, one of CSAF's key priorities -- get the right number of Airmen into the right jobs – takes on added significance.

The Air Force must have a balanced force of officer and enlisted Airmen. Force shaping is necessary to maintain the effectiveness of the Air Force and to maximize career opportunity for all Airmen.

Even so, the AFMS continues to face significant challenges in recruiting and retaining physicians, dentists, and nurses--the people whom we depend upon to provide care to our beneficiaries. The special pays, loan repayment programs, and bonuses to our active and Reserve component medics are helpful in retaining people. In fact, nearly 85 percent of nurses entering the Air Force say they joined in large part because of these incentives.

It's no secret that the military often pays significantly less than the private sector, the quality of life in uniform is more stressful, and in some cases the working conditions

in military hospitals and clinics could use improvements. The need to retain and recruit health care providers and specialists will grow as the military remains involved in the Global War On Terrorism for years to come.

As Assistant Secretary of Defense for Health Affairs Dr. William Winkenwerder, Jr., has said that the military medical community today is engaged "in a mission that, perhaps, has never before been so complex, challenging, or far-reaching as we find today."

Still, I am heartened by the caliber of the folks we continue to attract. One such person is Capt. (Dr.) An Duong, who, gave up her family medicine practice in Florida and came on active duty at Keesler Air Force Base, Miss., this year.

Doctor Duong was born in Saigon, South Vietnam, in 1971 and emigrated to the United States from the communist-held country at age 14 with her mother and two siblings. Now an American citizen, she said that part of the reason she joined was because of her early upbringing in a communist country. She said: "America adopted me and raised me. I owe her a lot."

She also said she was not fearful -- but willing -- to serve in a war zone. "I'm not intimidated about war. I was born into war -- a child of war."

As we work to balance the force with the right combination of active duty, reserve component, civilian and contract staff, we must keep in mind that we deploy people, not our hospitals and clinics. We take care of the nation's heroes, past and present, and it takes the finest of medical staffs to care for this country's finest.

We look forward to working with the Congress as we examine the various recruiting and retention programs for this our most precious asset, our people.

Recapitalization

We recognize the importance of maintaining a modern and effective infrastructure in our military treatment facilities, from clinics to medical centers. This is essential as we consider how the Air Force plans for its long-term requirements. The atmosphere in which our medics work is as important as any other retention factor. Our patients deserve not only the most brilliant medical and dental minds, but also first class equipment and facilities.

Though the TRICARE contracts create a strong civilian support system to augment the care we provide in our direct care medical treatment facilities, we continue to be challenged in maintaining top rate facilities. We are working to improve the quality of health care for the military, to invest and modernize key medical facilities, replace aging infrastructure, and to become more efficient in health care delivery.

When General Moseley recently stated that the Air Force is operating with the oldest inventory in the history of the Air Force, he was largely referring to our aircraft inventory. But that assessment also applies to medical facilities with the AFMS.

Our military construction budget has decreased for more than 15 years. We anticipate unusually high construction inflation through 2013. Right now, we can purchase 60 percent less square footage than in the mid-1990s. With an annual military construction budget of $60 million, we find that we have to phase any major construction over several years.

As an example, six percent of our current inventory is more than 50 years old; by 2025, it could grow to 35 percent. We've spent $30 million in less than two years to fix

structure failure at our 46-year-old facility at Tinker AFB, Okla. We've fixed safety code violations in five facilities, which ranged in age from 30 to 48 years.

This kind of budgetary pressure has changed the way we think about healthcare facilities. One initiative we are proud of is our clinic replacement at MacDill AFB, Fla. This 236,000 square foot new clinic will include a drive-through satellite pharmacy, which will consolidate 20 buildings and reduce our medical footprint by 25,000 square feet. Phase one of this project will cost $55 million in fiscal year 2007 and $32 million in fiscal year 2008. When completed, we will have replaced the oldest AFMS hospital in the United States; and we will provide $4 million annual savings to the Military Health System. But what is important to understand is that the specialists at MacDill will actually perform their inpatient work at the civilian medical center in Tampa.

As part of the recent Base Realignment and Closure (BRAC) process, DOD will operate on a more rational, modernized footprint. Through the combination of facilities, the closure of small hospitals, and the combination of similar educational and research activities, we will be able to take advantage of new partnerships, both inter-service and with our civilian and Department of Veterans Affairs partners. These BRAC decisions support strategies of reducing excess capacity and locating military personnel in activities where the workload is more diverse, providing them with enhanced opportunities to maintain their medical currency to meet combatant commander requirements. I strongly support the BRAC law and am fully committed to its complete implementation. It is right for military medicine and, as importantly, it is right for our patients and our staff.

We strive every day to ensure that the Military Health System is the best health care system for the dedicated men and women in uniform who sacrifice so much.

TRICARE

Across the services, we believe TRICARE is great health benefit and a superior program that supports the warfighter and the family at home. On behalf of the Department, General Granger, deputy director and program executive officer of the TRICARE Management Activity says, "We know we have a nation that is at war, and were going to continue to make sure that we maintain those superb benefits that we need to support this long and drawn out global war on terrorism."

The military health benefit has gained critical attention recently due to the Department's proposed initiative to control the long-term costs and hopefully sustain this important benefit for the future. Understand that we honor the service and sacrifice of our active duty members and retirees as well as their families. Because of their service and sacrifice the Department continually strives to provide a truly outstanding health benefit for them.

We must sustain this health benefit into the future; to do so, we have implemented management actions over the past few years and these continue. However, and this is critically important, these actions alone will not stem the rising costs of the military health benefit. Costs have doubled in five years from $19B in FY 01 to $38B in FY 06. Our analysts project these costs will reach $64B by 2015, over 12% of the Department's budget (vs. 4.5% in 1990).

Several factors contribute to this cost spiral: expansion of benefits, increased beneficiary usage, especially among retirees, healthcare inflation, and no increase in beneficiary cost-sharing since the TRICARE program began eleven years ago.

Our proposals to manage cost growth and sustain this valuable benefit encourage beneficiaries to elect medically appropriate cost-effective healthcare options. Significantly, our proposals, which seek to, as the Chairman of the Joint Chiefs of Staff put it, "re-norm" contributions to approach those when TRICARE was established in 1995, will continue the high level of access to care and quality enjoyed by our beneficiaries today. We are also recognizing differences in cost-sharing to be expected from retired officers versus enlisted personnel.

We strongly support the words of Chairman Pace and Secretary Rumsfeld and want to work closely with the distinguished members of this committee and all of Congress to sustain this great health benefit for the men and women of our Armed Forces. It is critically important to place the health benefit program on a sound fiscal foundation for the long term.

In so doing, together, we will also sustain the vital needs of the military to recruit, train, equip and protect our Service members who daily support our National Security responsibilities throughout the world, and keep our nation strong.

Summary

As we enter the fifth year of the Global War on Terrorism, we are engaged in combat and in humanitarian operations overseas and at home. From the Gulf of Mexico to the Persian Gulf, well-trained, dedicated, and compassionate medics from every service are making a difference in the lives of thousands of warriors and civilians. This

blending of increasingly interoperable talent and equipment has made the miracles of today's battlefield medicine possible.

In conclusion, a recent comment by General Moseley, perfectly describes our future and the challenges we face. "When someone asks you what the Air Force will be doing in the future, tell them this: We will do what we have always done. We will stand on the shoulders of giants. We will take care of each other and every member of this great fighting force. We will innovate. And … we will fly … we will fight … and we will win."