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Mr. Chairman and members of the committee, thank you for this opportunity to address the successes and challenges of the Air Force Medical Service (AFMS). The year 2001 was a year that changed our world forever. The threat we feared – an attack on the homeland -- became reality on September 11, 2001.

The AFMS swiftly rose to the challenge of September 11, and proved, once again, its commitment to rapidly and effectively meet any contingency that faces our country. Within hours, 71 personnel arrived at the Pentagon site from Andrews Air Force Base to provide emergency medical support. Four receiving hospitals were quickly identified within the National Capital Area to provide support as necessary.

Within 24 hours of the attacks, the AFMS deployed 500 medics to McGuire Air Force Base, New Jersey to respond immediately to any Federal Emergency Management Agency (FEMA) tasking for equipment and/or personnel needed at the New York City disaster. State-of-the-art medical emergency facilities were assembled, which included four Expeditionary Medical Support packages (light-weight modular systems that allow added bed sets as needed). Critical Care Air Transportable Teams (CCATTs), which provide emergency medical attention while in-flight, were quickly established at both the Pentagon and McGuire Air Force Base. Critical Incident Stress Management Teams conducted counseling to personnel assigned to recovery efforts at both locations as well.

Upon activation of the National Disaster Medical System, the AFMS also set up its aeromedical evacuation assets at both McGuire Air Force Base and Andrews Air Force Base. Overall, while little help was actually needed from the AFMS, it responded quickly and proactively with the help of several Air Force military treatment facilities.

Such a response is exactly what America needs to stand prepared for future terrorist threats, whether they occur on our shores or the shores of our allies around the world.

Our vision of global engagement supports an Air Force that is charged with responding to the full spectrum of contingencies throughout the world, and at a moment's notice. It also supports Joint Vision 2020, which states that today's joint force must be prepared to operate with multinational forces, government agencies, and international organizations. To achieve these ambitious visions, we know that we must consider our readiness and peacetime missions to be inextricably linked, and we must have a strategy that is durable, comprehensive and far-reaching. We do. This strategy is called the "Long View."

The Long View is an enterprise-based approach that emphasizes the realignment of readiness requirements, clinical currency and best practices, enabling the AFMS to provide high quality, cost effective health care and preventive services in all environments during peacetime and contingency operations. Crucial to success is the acceptance by each member of the enterprise that the needs of the AFMS outweigh those of the individual unit. By thinking and acting globally, we will ultimately strengthen our capabilities at the grassroots level and be able to respond effectively to the needs of our nation anywhere in the world.

Global Vigilance

The AFMS is committed to the Air Force Vision 2020 of "Global Vigilance, Reach, and Power." Our Long View is founded on this readiness triangle. One of the ways we are supporting global vigilance (to anticipate and deter threats) is through the Institute of Global Health (IGH), located at Brooks AFB, Texas. The IGH is a worldwide

educational program for medical providers to develop and improve their medical response skills. It develops and executes our international medical training programs, under the International Military Education and Training (IMET) and Expanded IMET (E-IMET) requirements implemented by the Defense Security Cooperative Agency. These medical training programs support the three components of the AFMS readiness mission, including humanitarian and civic assistance (HCA), medical response to disasters, and support of traditional wartime operations.

The objective of these "train the trainer" programs is to provide regional leaders a foundation for building disaster/trauma systems and improving their health systems and emergency response systems infrastructure by acquiring the necessary concepts and educational tools. Team training across specialties within healthcare, emergency response organizations, and regional partners (including hands on interactive educational techniques) have been tremendously popular with our international partners. At the same time, these mobile programs help shape the international environment by supporting the theater commander-in-chiefs (CINCs) engagement plans to promote democracy, stability, and collective approaches to disasters or medical threats to the region. Ultimately, we are partnering with our allies to protect our deployed forces in remote sites, that our troops might have the best possible care wherever they are.

Key components of these programs are that they are tailored to the host nation's infrastructure and resources and are taught on-site. Certainly, a primary outcome is the excellent training and experience the courses provide our own personnel.

Our prototype, "The Leadership Program for Regional Disaster and Trauma System Management," was established largely through initiatives begun at the Air

Force's Level-One trauma center, Wilford Hall Medical Center in San Antonio, Texas. These initiatives included a trauma refresher course for surgeons, a field surgery training course, Ecuador trauma symposiums, and clinical and field training for the new Air Force modular medical teams. The huge success of our prototype (taught to 25 countries since 1999; 16 scheduled for 2002) and the identified need for similar courses on other medical topics, such as the new "Hospital-Focused Approach to Biological Weapons and Toxins Course," has led to the requirement for a sustainable infrastructure to support our global medical initiatives – thus the Institute for Global Health.

The Air National Guard and Air Force Reserve have partnered with us to support these courses. In addition, we have partnered with the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), universities and international organizations in developing the IGH. We are excited about the future of the IGH and the opportunities it offers to enhance global health.

In 1998, former Air Force Chief of Staff Michael Ryan stated that, "to meet the needs of a complex global environment, Air Force officers would need specialized skills to operate in coalition with partners in the contingency arena." In response to this call, we developed the International Health Specialist (IHS) program. The program's focus is to build partnerships with other countries in peacetime, before disasters occur or assistance is needed. Then when disaster strikes, the medical networking is already in place and a more rapid and efficient response can occur.

AFMS members should be culturally aware and language proficient when deploying to increase mission effectiveness and force protection as we serve as instruments of national policy. This is important in the areas of Humanitarian Assistance

(HA) and Disaster Response (DR) as well as in war winning operational support. Clearly in the current Operation Enduring Freedom, coalition support and interoperability will grow best with cross cultural understanding and clear communications. In fact, we learned just how effective our IHS program really was when two French-speaking members of our Critical Care Air Transportable team worked successfully with French colleagues in response to the bombing of USS Cole in October 2000, providing the best possible care for the casualties.

Currently, there are four fully capable IHS teams, and they are aligned under Unified Commands: European Command, Pacific Command, Central Command, and Southern Command. There are also IHS team members located at the Uniformed Services University of Health Sciences and the U.S. Air Force School of Aerospace Medicine, and some serve as Special Operations medical planners. To ensure the AFMS Total Force synergy is optimized, the IHS program partners with the Air National Guard and Air Force Reserve. The IHS also has partnered with the Air Force Foreign Area Officer Branch to explore numerous language-training options with the goal of having our medics meet and sustain the Air Force goal of 10 percent of all officers proficient in a second language by 2005. Our language training opportunities do not stop at the officer level, however. The IHS Program has extended its language training opportunities to enlisted personnel as well through the Base Education Office Tuition Assistance Program and an IHS-funded enlisted opportunity for Language Area Studies Immersion experience.

Each team is composed of medics of all ranks and Air Force Specialty Codes. Its members are cultural and language experts in their Area of Responsibility (AOR) and

have humanitarian assistance/disaster relief and interagency and joint operations experience. In addition to the Unified Command-aligned teams, the IHS program office maintains a database of 300 AFMS members with varying degrees of cultural and regional medical experience who can serve as valuable assets for future missions. The language expertise represented by AFMS members includes more than 36 different languages. We are very excited about this program! The potential for IHS involvement and the return on its investment in the international arena is immeasurable: Today's commanders must be able to appraise health-related information and resources in a multi-national, multi-cultural context.

Strategic Reach and Overwhelming Power

While we are striving to support global vigilance, we are also thoroughly preparing our nation's ability for both strategic reach (to curb crises) and overwhelming power (to prevail in conflict and win America's wars). Part of this thorough preparation involves our continual development of state-of-the-art equipping and training initiatives. We continue to fine-tune our crisis response by ensuring we have the smallest, lightest, most flexible, and mobile system possible. We have nearly completed the transition from the Cold War legacy air transportable hospital to the Expeditionary Medical Support (EMEDS). The EMEDS system is a light-weight modular system that allows the AFMS to tailor our response to each situation, adding bed sets as needed and offering services that range from prevention and basic primary care to aerospace medicine support and sustained surgical operations. Collective protection has also been designed and is being fielded.

In June, we were asked to take our EMEDS to Houston to assist the flood-ravaged hospital system there. Our EMEDS treated over 1,000 patients, and our contribution was recognized by the mayor of Houston, the governor of Texas and the director of the Federal Emergency Management Agency (FEMA). As I noted previously, on September 11 we also activated four EMEDS upon the request from our Chief and Secretary to deploy EMEDS teams to McGuire Air Force Base, N.J., to provide additional medical capability to the medical group there in support of local authorities in New York City. Our strategy envisions placing EMEDS throughout the country to offer a regional quick response capability.

In partnership with our Army counterparts, the U.S. Air Force Medical Evaluation Support Activity (AFMESA) at Fort Detrick, MD., recently activated EMEDS-XTI (Experimental, Exercises, and Technology Insertion) as a "test bed" for expedited fielding of medical technologies and processes. EMEDS-XTI will help to better equip our medical providers for dealing with the medical challenges resulting from attacks on our homeland as well as the medical requirements to support our expeditionary forces. Using EMEDS-XTI, AFMESA will immediately focus on assessing, acquiring and fielding several key technologies, which include deployable medical oxygen equipment, chemical and biological decontamination, and biohazard surveillance systems. EMEDS-XTI also serves as an available response unit in the region in case of disaster.

Since the September 11 attacks, the concern regarding the threat of Weapons of Mass Destruction (WMD), particularly chemical and biological warfare attacks, has come to the forefront of our nation's most critical issues. For the AFMS, however, WMD has been a critical issue of concern and planning for the past few years – proof-positive of our

carefully prepared detection and response technologies and programs. A primary example of our latest technology is a state-of-the-art disaster response system called Lightweight Epidemiological Advanced Detection and Emergency Response System (LEADERS), which was designed to enhance the current medical surveillance process and provide the earliest possible detection of covert biological warfare incidents or significant outbreaks of disease.

LEADERS, also in use by some civilian organizations, such as the Centers for Disease Control and Prevention (CDC), is a modular web-based application that supports the collection, storage and analysis and distribution of critical sets of medical data to aid with rapid, effective response to natural disease outbreaks or overt/covert biological attacks within civilian populations or military forces. LEADERS is very deployable – it is based on an application model that requires little or no additional infrastructure for deployment.

The LEADERS system is organized into three primary customer modules, which include (1) Critical Care Tracking to facilitate the communication of bed availability between hospital departments and emergency response teams; (2) Medical Surveillance to detect and identify disease outbreaks using medical information stored in a database; and (3) Incident Management to enable a coordinated response of medical and non-medical personnel to potential or confirmed emergencies through a collection of command and control tools for situational awareness and response management. Together, these three modules allow multiple civilian and military applications, including identifying disease outbreaks, medical forensics, public health analysis, monitoring and improving clinical practice, monitoring medical fraud, improving infection control, and

comprehensive outbreak management and response. We will continue working with our civilian counterparts on development and fine-tuning of this technology over the coming year.

Other efforts underway to improve the AFMS's ability to respond to weapons of mass (WMD) destruction include the First Responder Pilot Program, which consists of 10 pilot bases that maintain a medical equipment list to support nuclear bio-chemical detection and provide decontamination capability at the MTF if appropriate. MTFs are required to scale requirements based on their local threat, vulnerabilities, mission capabilities and manpower, deliberate plans, and agreements with local first responders and providers to develop credible, supportable first response capability.

Another recent WMD initiative is the National Laboratory Response Network (NLRN), which provides an early warning network to detect covert release of pathogenic agents. Collaborators include local and state departments of health, Department of Defense medical laboratories, and the Federal Bureau of Investigation. The Air Force currently has 54 laboratories participating in this response network.

In addition to this network of laboratories, the AFMS has also assembled and trained 35 Biological Assessment Teams (BATS) that identify pathogen agents through the use of a commercial product called a Ruggedized Advanced Pathogen Identification Device (RAPID). RAPID quickly and accurately identifies a variety of pathogens, including conventional biological agents; it can accomplish tests in less than two hours from the time of the sample being received, a marked improvement over current pathogen identification technologies, which require the culturing of biological agents – taking as much as 48 hours for results.

In October, we responded to a request to send Air Force medics as part of joint Microbiology Augmentation Teams to New York City and the U.S. Capitol to assist staff from the Centers for Disease Control and Prevention and local authorities in the testing of samples for anthrax. We were delighted when our preliminary results completely correlated with the definitive cultures. Along with our sister Services, we are offering our services in whatever capacity is needed by local, state, and federal authorities during these tumultuous times.

The War on Terrorism in the United States will test the effectiveness of our technologies and training in many areas. To ensure we have the best the health care industry has to offer, we are partnering with our civilian counterparts whenever and wherever it makes sense. At the same time, we are sharing with them what we have to offer as well. One of our biggest milestones over the past year is the development of two Centers for Coalition Sustainment of Trauma and Readiness Skills – or CSTARS. The CSTARS concept creates unique learning opportunities in which civilian academic medical centers serve as training platforms to provide clinical experience to help sustain necessary readiness skills for our providers. The evolving strength of the CSTARS program is that it allows for the development of synergistic relationships and familiarity between academic medical centers and military medical assets (active, Guard, and Reserve), while simultaneously improving wartime readiness and homeland defense capability.

Our centers in Baltimore and Cincinnati have begun classes this year and will consist of full-time military medical personnel integrated into the facility of an academic medical center. Our partners are the University of Maryland School of Medicine and the

University of Cincinnati. The faculty will coordinate the rotation of military medical teams into the academic health center using patient care and didactic teaching sessions as the means of sustaining readiness skills. Additional CSTARS programs are being considered to ensure geographical distribution across the United States, with the goal of shortening the response time in homeland defense efforts.

Another way we are seeking to partner with the civilian community to reach our mutual goals is through a new partnership with the University of Pittsburgh Medical Center Health System to collaborate on the development of sophisticated telemedicine technology that will ultimately link specialists in pathology, radiology and dermatology with outposts at distant locations around the globe. Our goal is to strengthen the AFMS's expeditionary capability and provide state-of-the-art health care to our personnel everywhere.

As my examples have shown, the face of medical readiness has changed drastically in the past decade. Therefore, so too have our training requirements. Today Air Force medics are asked to provide a full spectrum of medical support, from caring for refugees requiring treatment for measles, dehydration or starvation to providing state-of-the-art trauma care in a disaster or wartime environment. Admittedly, until recently, few Air Force personnel have had the necessary experience in these or many other readiness-based care requirements. In support of our readiness case analysis and skills currency case analysis goals, we designed the Readiness Skills Verification Program (RSVP).

The RSVP will define the clinical tasks required of our deployable medics and build training programs targeted to keep our medics current. Individuals assigned to mobility positions are required to maintain currency in RSVP tasks through attendance in

formal training programs, ongoing clinical practice, and individual study. The RSVP consists of training task lists for every Air Force specialty. Today, all deployable medics – and soon, all Air Force medics – will focus their clinical training upon specific, measurable goals.

Where do we go from here? The Long View

Under the Long View, when we have built a solid foundation for readiness case analysis (RCA) and currency case analysis (CCA), we must then ensure a strong business case analysis (BCA) occurs in our decision-making. We are doing this through an effective corporate structure that reviews every major AFMS resourcing decision through a standardized process using the RCA-CCA-BCA model that allows input from every applicable party and measures each decision against objective criteria. This maintains the enterprise strategic view of a comprehensive plan, preventing local or urgent decisions from adversely affecting the AFMS. We are now planning far beyond the standard Program Objective Memorandum (POM) cycle to 10 years out and beyond. Our Primary Care Optimization (PCO) development and rollout was the first use of this model.

Primary Care Optimization

Central to the AFMS Population Health Plan is the reengineering of our primary care services under PCO. Sixty-five of our 75 Air Force medical treatment facilities (MTFs) focus almost exclusively on offering primary care services. The goal of PCO is to vastly improve the efficiency, effectiveness and quality of care delivered through our primary care platform. An important strategy within PCO is to recapture care from the private sector so that all enrollees can benefit and also to better manage the total financial risk of our health care system. Efficiencies are gained by improving clinical business

processes, by enhanced partnerships with civilian and other federal healthcare partners, by effectively utilizing support staff skills, and through robust information management that supports evidence-based health care decision-making. Critical to PCO success is Primary Care Manager by Name, which provides patients with continuity of care and allows providers and their teams to better manage their practice by knowing who their patients are.

Since we began our "Quick Start" training for PCO two years ago, we have seen some important returns on investment. Where teams are fully staffed, they are performing exceptionally well, and with great patient and staff satisfaction. Primary Care Manager by Name enrollment has been accomplished in 100 percent of our facilities. MTFs are proactively contacting patients regarding needed clinical preventive services.

Many other objective measurements continue to improve. Population health preventive measures are on a positive slope along with provider productivity. AFMS clinical quality measures, such as cervical cancer screening, breast cancer screening, and HbA1C annual testing for diabetics, are all above the 90 percent level for the Health Plan Employer Data and Information Set (HEDIS) national measures in all our Major Commands. There are very few health care organizations in the United States that can claim that type of preventive care success!

As we continue to improve PCO, our next step will be to pursue specialty care optimization. We are reviewing a limited number of AFMS product lines associated with surgical specialties in larger, bedded facilities: general surgery, obstetrics/gynecology, orthopedics, ophthalmology, otolaryngology, and anesthesia. As we implement our primary and specialty care optimization programs, the resourcing decisions arising from

the work of various functional panels will have full visibility at all levels of our corporate structure to ensure the Long View is the ultimate focus.

Manning the Mission

Of course a crucial factor in optimization is the ability to man our mission effectively, with the right number and mix of appropriately trained personnel at the right place and at the right time. We are working hard to do this, but it's been a very challenging time for medical force management in the Air Force. Many issues have been brought to the forefront, most importantly recruiting and retention and a high operations tempo with substantial deployment needs. Shortages in the Medical Corps, Dental Corps, Nurse Corps, Biomedical Sciences Corps, and Medical Service Corps have reached all-time highs and are expected to dramatically increase private sector health care costs as we are forced to shift health care downtown.

These staffing shortfalls led to our largest recruiting requirements in AFMS history for Fiscal Years 2000 and 2001. Centering our efforts around our RCA-CCA-BCA model, we've sought solutions, such as addressing promotion concerns, exploring special pay and investing additional resources in health professions scholarships for better and more stable long-term staffing growth. The success of these force management initiatives will enhance the future of our clinical capabilities and ultimately improve our readiness posture.

Population Health Initiatives

Optimizing our health care involves many factors, from training and equipping our providers, to modernizing our facilities, to effectively manning our mission. It also

means educating our patients to take responsibility for their health and giving them the tools to make it easier. This is a key tenet of population-based health care.

As the current chairman of the DoD Prevention, Safety and Health Promotion Council (PSHPC), I want to praise the personnel serving on the council for their outstanding efforts in many areas, but particularly in reducing tobacco use and alcohol abuse. In fact, our Tobacco Use Reduction Plan is nearly 80 percent complete. We still have a problem in the armed services, but proactive initiatives such as sensible pricing of tobacco and alcohol products in the commissaries and exchanges, better education of our troops, and research studies that will help us focus our efforts better are all means to reducing the problem.

I'm pleased to say that the PSHPC has now chartered the Suicide Prevention and Risk Reduction Committee to develop an action plan that will address suicide prevention across the DoD enterprise. The creation of both a DoD strategy and the national strategy developed under the United States Surgeon General are important steps in addressing this significant public health issue.

The Air Force Suicide Prevention Program has made a difference in the number of suicides in the Air Force, but, unfortunately, we continue to lose valuable personnel who needlessly take their own lives. As we move forward with our program, and in support of the DoD program, our primary goal within the Air Force is to better understand the causative factors involved with suicide and thus be able to implement the critical ingredients for effective suicide prevention.

Serving our Beneficiaries

The recent implementation of "TRICARE for Life" provided one of the missing links to our population-based health care strategy. Now we truly have the foundation to provide "whole life" care to our beneficiaries. Fiscal Year 2001 was a year of preparation and implementation of this and other significant health care provisions in the Fiscal Year 2001 National Defense Authorization Act.

The TRICARE Senior Pharmacy Benefit, which started Apr. 1, 2001, brought a robust pharmacy benefit to our senior patriots. The expanded pharmacy benefit was deployed with minimal problems and has been a tremendous success story for DoD and our beneficiaries. The Air Force continues to work with the other Services to minimize the impact of this enhanced benefit to ensure *all* of our beneficiaries are served.

TRICARE for Life, the program that makes TRICARE second payer to Medicare, and TRICARE Plus, the program that allows seniors to enroll in a primary care program at selected MTFs, both began concurrently on Oct. 1, 2001. We are delighted that these programs will enhance the quality of life for our retirees. We are also optimistic that TRICARE Plus will strengthen our medical readiness posture by expanding the patient case mix for our providers while reducing the government's cost to provide healthcare for these great Americans.

We are grateful to the committee and all of Congress for your support in adequately funding these programs. Your efforts have been crucial to their success, and they will provide the AFMS the ability to restore its in-house funding expenses (particularly for equipment, facility repair, and maintenance) to planned levels, and it will help ensure that our patients are provided quality care with state-of-the-art equipment.

Funding will also allow us to address numerous infrastructure requirements in medical facilities, particularly in the area of recapitalization. Additionally, we are excited about the opportunities provided by congressionally directed optimization funding, which will help us strike the balance in maintaining a high state of readiness, while providing efficient peacetime healthcare and investing in imperative modernization for the future.

VA/DoD Healthcare Resource Sharing

VA/DoD relationships continue to move forward as the VA/DoD Executive Council, which was reinvigorated in FY 2001 with increased accountability and leadership oversight, has established work groups to focus on a number of policy initiatives. The Air Force is pleased to participate in these work groups, which have achieved significant success in improving interagency cooperation in areas such as information management, pharmacy, medical surgical supplies, patient safety, and clinical practice guidelines. The AFMS continues to support the progress of our four successful joint ventures in Albuquerque, New Mexico; Las Vegas, Nevada; Anchorage, Alaska; and Fairfield, California.

At the Albuquerque site, which has operated effectively for more than 14 years, we recently established an agreement with the VA to provide professional VA psychologist oversight to our Air Force mental health services. We also recently established an agreement to reduce the veterans' colonoscopy procedures backlog while assisting Air Force personnel in the retention of critical skills.

In Las Vegas, our joint venture operates under common medical by-laws, allowing the VA and Air Force providers to address the needs of both Departments' beneficiaries. We collaborate with the VA to manage inpatient pharmacy services, and

we plan to manage the Intensive Care Unit in the same manner. This management "evolution" capitalizes on the experience of VA staff in inpatient operation of medical centers. In addition, the VA and the Air Force at the Las Vegas site are proposing to expand their existing emergency room to add a Step Down Unit and a secure recreation area for psychiatric inpatients.

In Anchorage, approximately 50 VA full-time employees work in the joint venture hospital. A recently established "Joint Venture Business Operations Committee (JVBOC)" was designed to provide structured communications and organizational continuity to the planning and implementation of issues relevant to the joint venture.

In Fairfield, California, a VA outpatient clinic is located adjacent to David Grant Medical Center (DGMC) on land leased from the Air Force. The VA actually purchases inpatient care from DGMC as well as other services that include specialty outpatient, emergency services, ambulatory surgery, and ancillary services. An Executive Management Team (EMT) manages this VA/DGMC joint venture, which consists of commanders, directors, and senior level staff of both agencies. The EMT provides oversight to a Joint Initiatives Working Group (JIWG), which identifies operational issues that need to be resolved and develops recommendations for the EMT.

We are extremely proud of the collaborative team efforts that all four joint ventures are engaged in, and we expect continued innovations in the areas of resource sharing in the future.

Customer Satisfaction

The Long View is built on metrics that show us how well we're doing in supporting DoD's missions. Customer satisfaction is one of the vital indicators of our

success or failure. I'm pleased to report that customer satisfaction in the Air Force continues to rise. According to DoD's latest Customer Satisfaction Survey Results, 90 percent of our enrolled beneficiaries indicate they would enroll or reenroll in TRICARE Prime if given the option. The overall satisfaction with clinics and medical care exceeds national civilian HMO averages. With the expanded senior benefit, improving access through primary care optimization, and our many population health initiatives, it should be no surprise that we are receiving high marks from our customers.

But the task is only begun. We will be working very hard in the months and years ahead to ensure we are ready if and when another "September 11th" arrives. The AFMS must keep the Air Force fit and healthy and be able to answer our nation's call whenever and wherever we are needed.