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 ARMED SERVICES

SUBCOMMITTEE ON MILITARY PERSONNEL

UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: Army Medical Action Plan and Support for Wounded Service Members from Other Services

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

February 15, 2008

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BY THE COMMITTEE ON ARMED SERVICES
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 43,131 people assigned to 75 medical facilities worldwide.

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

EDUCATION

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

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

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

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

BADGES
Chief Physician Badge
Chief Flight Surgeon Badge

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

Small Arms Expert Marksmanship Ribbon
Air Force Training Ribbon

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

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

(Current as of January 2008)

Madam Chairwoman 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 while 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.

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.

The Air Force Medical Service 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 transferred more than 48,000 patients from overseas theaters to stateside hospitals during Operations ENDURING FREEDOM and IRAQI FREEDOM. Today, the average patient movement 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**.

A story that clearly illustrates the success of 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 theater hospital and in Washington D.C. 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 C17 aircrew from Charleston Air Force Base, S.C., 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 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 2008 National Defense Authorization Act (NDAA) 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 AE system, and ultimately home to a military or Department of Veterans Affairs (VA) medical treatment facility (MTF). Commanders, Family Liaison Officers, Airmen & Family Readiness Center representatives, Federal Recovery Coordinators, and medical case managers together ensure "eyes-on" for the service member and family throughout the care process. If possible, those wounded and ill war fighters requiring follow-up medical care, receive it at the MTF nearest to where they live. If no MTF is available, the TRICARE network expands options for our wounded. If transition to care within the VA is the right thing for our Airmen, we work to make that transition as smooth and effective as possible. If separated from active duty, care is provided through the TRICARE Transitional Health Care Program and the Veterans Affairs health system. The AF 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 5 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 (PEB) 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. AF MTFs provide the BDD advance notice of potential new service members and their health information through electronic transfer.

The AF Medical Hold Program is very different from our sister services. In the AF, 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 AF 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 AF 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 (TBI)

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 identify the effects of operational stress.

Post Traumatic Stress Disorder (PTSD)

The incidence of Post Traumatic Stress Disorder is low in the AF, diagnosed in less than 1 percent of our deployers (at 6 month 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.

Traumatic Brain Injury

We recognize that Traumatic Brain Injury (TBI) 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 AF is an active partner with the Defense and Veterans Brain Injury Center (DVBIC), the VA, the CDC, industry and universities. The AF has very low positive screening for TBI —approximately 1 percent from OPERATION IRAQI FREEDOM and OPERATION ENDURING FREEDOM.

Screening for TBI occurs locally in theater, before transport of wounded service members stateside, and again at stateside hospitals as indicated. The Military Acute Concussive Evaluation (MACE) tool is administered in accordance with the Joint Theater Trauma System (JTTS) TBI Clinical Practice Guideline. U.S. Transportation Command (USTRANSCOM) policy dictates that all service members be screened for the signs and symptoms of TBI prior to transportation out of theater at either Landstuhl Regional Medical Center or at U.S. Air Forces Europe Aeromedical Staging Facilities. Follow up care for those with positive screens is conducted at US military treatment facilities and/or DVBIC's. The 59th Medical Group, Lackland AFB, Texas, is one of three DoD DVBIC Regional Centers that cares for TBI patients.

The AF is involved in several cutting edge research initiatives involving TBI. One in particular is the collaboration between the Air Force Research Laboratory and the University of Florida's Brain Institute. This research is focusing on the presence of biochemical markers in spinal fluid that is associated with TBI. In addition, the AF is utilizing a new mild TBI cognitive assessment tool, called HeadMinders. This internet-based tool is used to assist in determining which warfighter can safely return to duty following a concussion. Another is the Brain Acoustic Monitor, which detects mild TBI injuries and replaces invasive pressure monitors used to measure brain pressure for severe TBI cases.

Traumatic brain injury is an expanding area of study requiring close cooperation among the Services, the Department of Veterans Affairs, academic institutions and industry. It is vital that we better understand this disorder and clarify the long-term implications for our Airmen, Soldiers, Sailors, and Marines.

Suicide Prevention

The AF suicide prevention program is a commander's program. It has received a great deal of national acclaim and has achieved a remarkable 28 percent decrease in AF suicides since the program's inception in 1996. We continue to aggressively work our 11 suicide prevention initiatives using a community approach, and this year released the Frontline Supervisor's Course. This course further educates those with the most contact and greatest opportunity to intervene when Airmen are under stress. The Air Force integrates these prevention services through the Integrated Delivery System (IDS). IDS is a multidisciplinary team that identifies and corrects gaps in the community safety net. Leaders from the chapel programs, mental health services, family support centers, child and youth programs, family advocacy and health and wellness center are involved at each installation.

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 preventative health needs.

In addition, there is a separate pre and post deployment health assessment process. 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 at six months post-deployment. These are used to, once again, assess the Airmen's overall health and fitness. This allows commanders the ability to assess the overall fitness of the force. Recently, questions were added to the post deployment assessments to screen for Traumatic Brain Injury (TBI).

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 medics. 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 AF 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.

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 AF medical facilities have passed inspection and are currently fully accredited.

Electronic Health Records

As we prepare for tomorrow's challenges, it is essential to leverage the power of information and delivery it to our Airmen -- faster, easier, and cheaper. Information flow must be seamless between the services and the VA.

An important lesson learned from the care of our returning warriors is the need for a seamless electronic patient health record. After assuming operational control of the Bagram and Balad hospitals, the Air Force successfully deployed a joint electronic health record known as Theater Medical Information Program (TMIP) 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 (BHIE). This serves to improve the overall delivery of healthcare home and abroad for wounded and ill service members.

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 AF Radiology Network (RADNET) Project. This project provides Dynamic Workload Allocation (DWA) 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. It's goal is to maximize physician availability to address workload, regardless of location. We are aggressively targeting deployment of this capability in FY09 to all AF sites.

Also scheduled for FY09 deployment is the Tele-mental Health Project. This project will provide video teleconference (VTC) 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 (VR) equipment will also be installed at six AF 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. We are excited about these initiatives, not only for our returning deployers, but for all of our service members and their families.

Conclusion

In closing, Madam Chairwoman, 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 therefore we will 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.