

United States Air Force



Presentation

Before the Senate Appropriations
Subcommittee on Defense

Defense Health Programs

Witness Statement of
Lt. General (Dr.) Thomas Travis, USAF
Surgeon General of the Air Force

March 25, 2015



BIOGRAPHY



UNITED STATES AIR FORCE

LIEUTENANT GENERAL (DR.) THOMAS W. TRAVIS

Lt. Gen. (Dr.) Thomas W. Travis is the Surgeon General of the Air Force, Headquarters U.S. Air Force, Washington, D.C. General Travis 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 Travis 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 a \$6.6 billion, 44,000-person integrated health care delivery system serving 2.6 million beneficiaries at 75 military treatment facilities worldwide.



General Travis entered the Air Force in 1976 as a distinguished graduate of the ROTC program at Virginia Polytechnic Institute and State University. He was awarded his pilot wings in 1978 and served as an F-4 pilot and aircraft commander. The general completed his medical degree from the Uniformed Services University of the Health Sciences School of Medicine, where he was the top Air Force graduate, and in 1987 he became a flight surgeon. For more than three years, General Travis was Chief of Medical Operations for the Human Systems Program Office at Brooks Air Force Base, Texas. He later served as the Director of Operational Health Support and Chief of Aerospace Medicine Division for the Air Force Medical Operations Agency in Washington, D.C.

Prior to his current assignment, Gen Travis served as Deputy Surgeon General, Headquarters U.S. Air Force, Washington, D.C. The general has commanded the U.S. Air Force School of Aerospace Medicine; 311th Human Systems Wing at Brooks AFB; Malcolm Grow Medical Center and 79th Medical Wing, Andrews AFB, Md.; and the 59th Medical Wing, Wilford Hall Medical Center, Lackland AFB, Texas. He also served as the Command Surgeon, Headquarters Air Force District of Washington, and Command Surgeon, Headquarters Air Combat Command, Langley AFB, Va. He is board certified in aerospace medicine. A command pilot and chief flight surgeon, he has more than 1,800 flying hours and is one of the Air Force's few pilot-physicians. He has flown the F-4, F-15 and F-16 as mission pilot and, the Royal Air Force Hawk as the senior medical officer and pilot.

EDUCATION

1976 Distinguished graduate, Bachelor of Science degree in biology, Virginia Polytechnic Institute and

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State University, Blacksburg, Virginia
1980 Master of Science degree in physiology, Virginia Polytechnic Institute and State University, Blacksburg, Virginia
1986 Doctor of Medicine degree, Uniformed Services University of the Health Sciences School of Medicine, Bethesda, Maryland
1991 Master of Science degree in public health, University of Texas Health Science Center, San Antonio, Texas
1996 Air War College, by correspondence
1999 Distinguished graduate, Master of Science degree in national resource strategy, Industrial College of the Armed Forces, Fort Lesley J. McNair, Washington, D.C.
2000 Medical Capstone, Walter Reed Army Medical Center, Washington, D.C.
2003 Federal Health Care Executive Course, Interagency Institute, George Washington University, Washington, D.C.
2005 Capstone, Fort Lesley J. McNair, Washington, D.C.

ASSIGNMENTS

1. April 1977 - March 1978, student, undergraduate pilot training, Williams AFB, Arizona
2. May 1978 - August 1978, student, fighter lead-in training, Holloman AFB, New Mexico
3. August 1978 - February 1979, student, F-4 Replacement Training Unit, MacDill AFB, Florida
4. February 1979 - June 1982, F-4 aircraft commander, 334th Tactical Fighter Squadron, Seymour Johnson Air Force Base, North Carolina
5. August 1982 - May 1986, medical student, Uniformed Services University of the Health Sciences School of Medicine, Bethesda, Maryland
6. July 1986 - June 1987, internship, Andrews AFB, Maryland
7. July 1987 - July 1990, F-15 pilot physician, Langley AFB, Virginia
8. August 1990 - June 1992, resident in aerospace medicine, Brooks AFB, Texas
9. July 1992 - April 1996, Chief, Medical Operations, Human Systems Program Office, Brooks AFB, Texas
10. April 1996 - June 1998, senior medical officer pilot, Royal Air Force School of Aviation Medicine, Farnborough, England
11. July 1998 - June 1999, student, National Defense University, Industrial College of the Armed Forces, National Defense University, Fort Lesley J. McNair, Washington, D.C.
12. July 1999 - July 2001, Director, Operational Health Support, and Chief, Aerospace Medicine Division, Air Force Medical Operations Agency, Washington, D.C.
13. July 2001 - February 2003, Commander, U.S. Air Force School of Aerospace Medicine, Brooks AFB, Texas
14. February 2003 - September 2005, Commander, 311th Human Systems Wing, Brooks City-Base, Texas
15. September 2005 - May 2006, Commander, 89th Medical Group, Andrews AFB, Maryland
16. May 2006 - August 2006, Command Surgeon, Headquarters Air Force District of Washington, Bolling AFB, D.C., and Commander, 79th Medical Wing, Andrews AFB, Maryland
17. September 2006 - August 2007, Command Surgeon, Headquarters Air Combat Command, Langley AFB, Virginia
18. August 2007 - November 2010, Commander, 59th Medical Wing, Lackland AFB, Texas
19. November 2010 - July 2012, Deputy Surgeon General, Office of the Surgeon General, Headquarters U.S. Air Force, Washington, D.C.
20. July 2012 – present, Surgeon General, Office of the Surgeon General, Headquarters U.S. Air Force, Washington, D.C.

FLIGHT INFORMATION

Rating: Command pilot and chief flight surgeon
Hours: More than 1,800
Aircraft flown: F-4, F-15, F-16 and Royal Air Force Hawk

MAJOR AWARDS AND DECORATIONS

Distinguished Service Medal

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Legion of Merit with oak leaf cluster
Meritorious Service Medal with four oak leaf clusters
Aerial Achievement Medal
Air Force Commendation Medal
Joint Service Achievement Medal
Combat Readiness Medal
Air Force Recognition Ribbon

OTHER ACHIEVEMENTS

1994 Julian E. Ward Memorial Award, Aerospace Medical Association
1994 Unger Literary Award, Society of U.S. Air Force Flight Surgeons
1995 Paul W. Myers Award for outstanding contributions to Air Force medicine, Air Force Association
2003 Stewart Lecturer, Royal Aeronautical Society
2007 Marie Marvingt Award, French Society of Aerospace Medicine
2007 George E. Schafer Award, Society of USAF Flight Surgeons
2008 John D. Chase Award for Physician Executive Excellence, Association of Military Surgeons of the United States

PROFESSIONAL MEMBERSHIPS AND ASSOCIATIONS

Academician, International Academy of Aviation and Space Medicine
Member and former President, Society of U.S. Air Force Flight Surgeons
Member and former President, International Association of Military Flight Surgeon Pilots
Fellow, Aerospace Medical Association
Fellow and former Aerospace Medicine Regent, American College of Preventive Medicine
Life member, Association of Military Surgeons of the United States
Order of the Daedalians
Alpha Omega Alpha Honor Medical Society

EFFECTIVE DATES OF PROMOTION

Second Lieutenant June 2, 1976
First Lieutenant December 2, 1978
Captain February 25, 1982
Major February 25, 1988
Lieutenant Colonel February 25, 1994
Colonel May 31, 1998
Brigadier General September 1, 2004
Major General June 2, 2007
Lieutenant General July 13, 2012

(Current as of October 2013)

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Chairman Cochran, Ranking Member Durbin, and distinguished members of the Subcommittee, thank you for inviting me to appear before you today. After more than 13 years of war, in which the Military Health System (MHS) attained the lowest died-of-wounds rate and the lowest disease/non-battle injury rate in history, the Air Force Medical Service (AFMS) is envisioning future conflicts and adjusting our concepts of operations to prepare to provide medical support in situations that could be very different than what we have faced in the current long war. Among many efforts, we are focusing on enroute care to include aeromedical and critical care evacuation, expeditionary medical operations, and support to personnel during combat operations. Future contingencies may require longer transport times of more acute casualties without the benefit of stabilization in fixed facilities, as we have had in Iraq and Afghanistan. We have to consider worst case scenarios, which will prepare us well for less challenging circumstances. By enhancing clinical skills through partnerships with busy, high acuity civilian medical centers (such as our training programs in Baltimore, Cincinnati, St. Louis, and, most recently, Las Vegas), regular sustainment training for all team personnel, and developing new medical capabilities, we are committed to being just as ready or more ready at the beginning of the next war as we are in the current war. Our Nation expects no less – and our warriors deserve no less.

Since 9/11, we have logged over 200,500 patient movements, including 12,000 critical care patients. The 96% survival rate for U.S. casualties once they enter the Theater Medical System is a reflection of our commitment to the highest quality of care for our patients. As part of a remarkable Joint expeditionary health care system, deployed care has dramatically evolved during the wars and produced advances in scientific knowledge now in use across the U.S. to improve trauma outcomes.

Critical Care Air Transport Teams (CCATT) were developed in the late 1990s and have become the international benchmark for safe ICU-level patient movement. The AFMS adapted that capability to create the Tactical Critical Care Evacuation Team (TCCET), which consists of teams of medical personnel and equipment with specialized skills and training to meet Joint Staff requirements for intra-theater enroute tactical critical care transport of fresh and post-operative ICU-level casualties via rotary-

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wing or other tactical aircraft. Additionally, we recently developed a capability called Enhanced TCET (TCET-E), which is capable of short notice deployments performing surgical stabilization using interior of aircraft if required and supporting long-range patient movement. We have teams poised and ready to launch on C-130s or C-17s in the USEUCOM/USAFRICOM AOR today.

Our health response teams now include rapidly deployable, modular, and scalable field hospitals that provide immediate care within minutes of arrival. The Expeditionary Medical Support Health Response Teams (EMEDS-HRT), an evolution of our combat-proven and scalable Expeditionary Medical Support (EMEDS) teams, are now being deployed across our Air Force. They provide immediate emergency care within minutes of arrival, surgery and intensive critical care units within six hours, and full ICU capability within 12 hours of arrival. The HRT also helps tailor clinical care to the mission, adding specialty care such as OB-GYN and pediatrics for humanitarian assistance or disaster relief missions. This evolved expeditionary HRT capability has been successfully deployed and is on track to replace our previous generation of EMEDS by 2016.

In support of OPERATION UNITED ASSISTANCE in Liberia, an Air Force medical team quickly deployed and set up the first health care worker Ebola Virus Disease (EVD) treatment center utilized by the U.S. Public Health Service. The Air Force also provided 24 medical personnel to the Healthcare Worker Training Program, training over 1,500 health care workers in the proper procedures in dealing with Ebola infected patients. In support of Health and Human Services within the continental United States, the AFMS provided 12 personnel for USNORTHCOM's rapid response team that could respond to any city within the U.S. Additionally, the Air Force and USTRANSCOM developed the first Transportable Isolation System (TIS) to provide a capability to transport multiple contagious patients while mitigating/minimizing the risk of exposure to the aircraft and aircrew. While thankfully not needed in the recent EVD response, this is a capability which could prove useful in future infectious disease contingencies around the globe or here at home.

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Our medical forces must stay ready through their roles in patient-centered, full-tempo health care services that ensure competence, currency, and satisfaction of practice and foster innovation. In support of the MHS Quadruple Aim of Readiness, Better Health, Better Care, and Best Value; the AFMS is incorporating best practices such as Patient-Centered Medical Home (PCMH) and advanced surgical technology and techniques to ensure our staffs have the needed tools to care for patients at home or deployed. We can't separate care at home from readiness, as what we do and how we practice at home translates into the care we provide when we deploy. We have to augment our experience and training to be truly ready, as there is undoubtedly a difference between being prepared for downrange combat casualties and the type of every day medical care provided at in-garrison medical treatment facilities (MTF). We have a mature, combat-proven system for augmenting the clinical experience of our teams.

For well over a decade we have had a cadre of our best physicians, nurses, and technicians embedded in world-class Center for Sustainment of Trauma and Readiness Skills (C-STARS) facilities such as the University of Maryland's Baltimore Shock Trauma, University of Cincinnati, and St. Louis University. Hundreds of our medics have had elite trauma and critical care training through these facilities and remain prepared to deploy anywhere needed; whether to the AF-led theater hospitals in the USCENTCOM AOR, as CCATT team members, or to whatever location U.S. forces are deployed. We remain committed to the relationship we have with these civilian facilities, and rather than reducing training platforms as we come home from the current war, we intend to expand training opportunities to keep skills current and our team ready.

We are committed to expanding training opportunities for non-surgical and trauma related skills to ensure all our personnel remain ready and current. The AFMS continues its transition to a tiered, centrally managed training platform called Sustained Medical and Readiness Training, or SMART, which provides hands-on patient care of greater volume and complexity. Our first SMART course began recently at Nellis AFB, Nevada, in cooperation with the University Medical Center in Las Vegas, with plans for more than a dozen additional classes with students from all over the Air Force in the next year.

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As SMART requirements expand and the program matures, other local and regional partnerships will be developed to meet AFMS training needs, and we will establish a training “battle-rhythm” to provide deployable Airmen hands-on, high acuity care opportunities on a regular basis. This will further expand the system we have in place to identify training requirements and track completion of training events down to the individual.

Collaboration with the Department of Veterans Affairs (VA) through sharing agreements and joint initiatives enhances our providers’ clinical currency, saves federal dollars, and maintains readiness. As a result of our efforts to encourage participation in the DoD-VA Resource Sharing Program, we now have 49 Air Force-VA sharing agreements with 10 Master Sharing Agreements covering all available clinical services at nine MTFs. Our relationship with the VA extends to clinical currency opportunities for both entities. Our relationship with the VA extends to clinical currency opportunities for both entities.

One recently developed venture of this nature is with the Buckeye Federal Healthcare Consortium in Ohio. This consortium promotes health care resource sharing between Wright-Patterson AFB Medical Center and VA medical facilities in Dayton, Columbus, and Cincinnati, serving 158,137 enrolled veterans. A sharing agreement with Veterans Integrated Service Network 10, which supports veterans in three states, is currently being reviewed. Air Force-VA sharing agreements enhance access to specialty care for VA patients, allow VA physicians to use the MTF’s operating suites, and provide a great venue for our Air Force medics to hone their readiness skills in a high-acuity environment.

The United States Air Force’s core missions are Air and Space Superiority, ISR (Intelligence, Surveillance, and Reconnaissance), Rapid Global Mobility, Global Strike, and Command and Control. These are almost identical (but in different terms) to the missions the USAF had in 1947. But we now do these missions in three domains: air, space, and cyberspace. In the Air Force I grew up in, the “operators” were primarily pilots and navigators. There are many more types of “operators” these days, as Air Power is projected through the various domains in very new ways. Air Force Medicine is adapting and innovating to better support the Airmen who safeguard this country 24/7, 365 days a year. In that

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regard, Air Force Medicine is now focusing on human performance. This is not a huge shift for us. Since the AFMS began in 1949, Air Force medics have focused on occupational and population health and prevention. We are simply taking it to the next level. Our AFMS strategy embraces this, and to focus on this as a priority, we recently changed the AFMS vision to state: “*Our Supported Population is the Healthiest and Highest Performing Segment of the U.S. by 2025.*” This goal is focused on health rather than health care, and is clearly connected to the imperative to assure optimum performance of Airmen. Every Airman (or other-Service member) has human performance demands placed on them by virtue of their operational and mission tasks – and these demands have changed, rather than decreased, due to the technologies employed in current mission environments. This strategy will help to change culture, ultimately enabling our Airmen to not only strive to prevent or ameliorate disease, but to promote performance.

In view of our evolving Air Force, the AFMS is evolving to ensure that as many of our supported Service members are available to their commander as possible, able to perform the exquisite set of skills that are now required of them. Health in the context of mission equates to performance, and every medic or health care team must know how the mission might affect the health of the individual or unit, and how medical support affects the mission. I think this is just as relevant for other beneficiaries, to include family members and retirees, who also have performance goals in their day-to-day activities. Toward that goal, we have begun either embedding or dedicating medics to directly support missions such as special operations, remotely piloted aircraft, intel, and explosive ordnance disposal (EOD), which have had a clearly positive impact on those Airmen, their mission effectiveness, and their families. We are moving rapidly to make this “mission specific” support a more wide-spread practice.

At the clinic level, our intent is to provide customized prevention, access, and care for patients, recognizing specific stresses associated with career specialties. Our goal is to prevent physical or mental injuries where possible, and if unable to prevent, provide rapid access to the right team for care and recovery to full performance. As a result, mission effectiveness and quality of life should improve, and

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long-term injuries or illnesses should be mitigated to provide for a healthier, more active life, long after separation or retirement. Concordantly, long-term health care costs and disability compensation should also decrease.

Patient safety and quality care are foundational to supporting our beneficiaries in their quest for better health and improved performance. In order to improve both safety and quality we are committed, as part of the MHS, to become a high reliability health care system. This is a journey being undertaken by health care systems across the country. To achieve this goal we need a focused commitment by our leadership and staff, instilling a culture of safety and quality, constant measurement of the care we provide combined with robust process improvement at all levels. These key tenets will enable the AFMS to achieve the principles of high reliability seen in aviation and nuclear communities, and are aimed at eliminating medical errors. To that end, we are committed to strengthening our performance improvement programs and training all medics as “process improvers.” This will require advanced training for key leaders and staff, driving process improvement activities from the executive suite down to the front lines of our clinics and wards. A culture of safety requires that all AFMS members are empowered and understand their responsibility to report any unsafe condition or error, with the intent to make improvements and raise awareness across the enterprise.

In support of Human Performance and Enroute Care initiatives, our C-STARS faculty and civilian partners are comparing aeromedical evacuation timing and combat casualty outcomes to help medical teams determine ideal timing of evacuation to optimize treatment successes. While we have been very proud of our accomplishments in quickly transporting patients to higher levels of care, the decision of when to move a patient must be data-driven, and our experience in the current long war should help guide such future decisions, and may have great relevance in anti-access/area denial scenarios in future wars.

We also focus research on better care and health for Air Force families. Over the last few years we have teamed up the Wright-Patterson AFB Medical Center with the Nationwide Children’s Hospital

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and Dayton Children's Hospital in Ohio to identify autism spectrum disorder susceptibility genes, rare variants, and interventions to enable early intervention and treatment. This endeavor continues to support development of the Central Ohio Registry for Autism, which will enroll 150 families in the next phase of patient studies through September 2015, 50 percent of which are military families. Early intensive behavioral intervention with Applied Behavior Analysis (ABA) therapy offers promise. According to research, up to 20 percent of children diagnosed with autism before age 5 who receive ABA therapy "recover" from the condition. There are many Air Force families who could potentially benefit from this type of treatment, and we will continue this important collaborative effort.

With more than one million patients enrolled, Patient-Centered Home (PCMH) has made significant progress toward greater continuity of care and improved patient and provider satisfaction. Over the last year, patients have seen their assigned provider team 92 percent of the time, our highest continuity rating thus far. PCMH has increased primary care manager same day access, reduced local emergency room utilization, decreased the need for specialty care referrals, and improved patient experiences resulting in a remarkable health care satisfaction rating over 95 percent.

In concert with PCMH is our ongoing secure messaging capability called MiCare. The Air Force has now implemented MiCare at all 75 of its MTFs worldwide and averages over 220,000 messages per month. As of December 2014, there are over 412,000 Air Force registered users, allowing patients and providers to communicate on a secure network regarding non-urgent health care concerns. The network also allows our patients to view their health care record, make appointments, renew prescriptions, and receive important preventive care messages from their PCMH team. A recent secure messaging satisfaction survey demonstrated that 97 percent of over 13,000 survey respondents were satisfied with their secure messaging transaction and more than 86 percent agreed it helped them avoid a trip to an emergency room or an MTF for a medical problem.

Another important initiative concerning in-garrison care is our continued support of a robust Tele-Health program. Project ECHO (Extension for Community Health Outcomes) has evolved to cover

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eight long-term health care concerns and services to include complicated diabetic management, chronic pain management, traumatic brain injury, behavioral health, acupuncture, addiction, neurology, and dental disease. This Tri-Service effort builds specialty care capacity into a primary care clinic and participating ECHO providers comment on their increased clinical knowledge and confidence in patient management of these complicated diseases. Providers report an overall 95 percent approval rating in the ECHO's value to their practice. ECHO fits seamlessly into the PCMH model of health care delivery. During 2014, ECHO saw technological improvement by moving from the traditional VTC suite to the providers' desktop web-based video platform. In effect, we are using "new" technology to bring back the "old fashioned" curbside consult. Based on the University of New Mexico model, when fully matured, ECHO is projected to reduce referrals to the TRICARE network across 21 specialties over a seven-year expansion plan. This has the potential to enhance team-based care for chronic disease by incorporating the specialist into the team via digital connections.

The AFMS currently has two major health promotions initiatives. First, we're rolling out our "Health care to Health" program at six installations to better address adult and childhood obesity through proven patient and parent-focused interventions. Secondly, we're implementing a nutrition therapy Tele-Wellness at 15 smaller MTFs. This will allow those stationed at smaller locations access to one of our 31 dietitians stationed around the globe. We're also developing our Group Lifestyle Balance (GLB) and 5210 Healthy Military Children programs. GLB addresses the fastest growing problem facing our population today, pre-diabetes. It is geared towards helping participants lose five to seven percent of their body weight and increasing their physical activity level. The 5210 Healthy Military Children program is a primary prevention approach to childhood obesity with consistent messaging about healthy habits.

The wellness and resilience of our deploying Airmen remains a top AFMS priority. We have a new and improved Pre-Deployment Mental Health Training module designed to enhance an Airman's understanding of combat related stresses and how to mitigate the risk factors. The training has four platforms tailored to different target audiences -- leaders, medical and mental health providers, chaplains,

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and all other Airmen. Our redeploying Service members whose deployed role poses an increased risk for posttraumatic stress have been attending a two-day program at our Deployment Transition Center at Ramstein Air Base, Germany. Research demonstrates this initiative has reduced reported Post-Traumatic Stress (PTS), interpersonal conflict, and problematic alcohol use in our returning Service members. Each Airman is screened for PTS several times per deployment. When signs of PTS are detected, evidence-based treatments are provided in our MTFs. PTS rates continue to be low across the Air Force due in part to these combined efforts.

Airmen account for 14% of Service member traumatic brain injuries (TBI), only two percent of these cases are deployment related and 86% of those are mild concussion injuries. Though the incidence of TBI is low in the Air Force, we remain committed to providing quality care for our Airmen who have sustained these injuries. Our Air Force TBI clinic at Joint Base Elmendorf-Richardson maintains cross-Service support to optimize care within the DoD. For our more difficult cases we partner with the National Intrepid Center of Excellence for Psychological Health and TBI and Intrepid Spirit Satellites.

Air Force suicide rates remain lower than the U.S. and DoD average, but suicide awareness and prevention is a major concern for all Air Force leaders. Identified suicide risk factors continue to be relationship issues, financial problems, and legal problems. Our most “at risk” career fields continue to be security forces, aircraft maintenance, and intelligence. This year’s suicide prevention efforts will transition from computer-based training to a more personalized, face-to-face delivery method.

Supervisors and other mentor-leaders will facilitate small group discussions allowing more direct participation by Airmen. This will leverage our “Wingman culture” which is key to identifying and assisting Airmen. We are also adding an annual Frontline Supervisor Training refresher for our at-risk career field leaders to ensure their mentoring and awareness skills remain honed. Timely intervention utilizing counseling techniques learned during these training just may prevent future tragedies.

Counseling services are available to our Airman and their families from chaplains, Military Family Life Consultants at the Airman and Family Readiness Centers, mental health providers working in primary

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care settings, and of course, evaluation and therapy delivered in our mental health clinics. Suicide prevention in the Air Force relies on leaders and communities working together to bolster Airmen resilience and create a supportive environment where seeking help early is seen as a strength. We know what we do prevents some suicides, but we are not satisfied and will continue to focus hard on this issue.

We remain vigilant in our efforts to prevent hearing loss among Service members exposed to high intensity occupational noise. Often these exposures result in auditory and balance injuries, to include tinnitus (ringing in the ears) and hearing loss, currently the clear number one and two VA reimbursable health concerns. The DoD Hearing Center of Excellence (HCE) is a Tri-Service/VA collaboration with the Air Force serving as the lead agent. The HCE aim is to improve the auditory health of beneficiaries.

This year the HCE will implement the DoD Comprehensive Hearing Health Program designed to prevent and ultimately eliminate noise-induced hearing loss. A lofty but possible goal with outreach and awareness is essential to making this work. Identification of hazardous noise sources, effective and consistent hearing conservation methods, as well as monitoring hearing and proper hearing protection use are all education topics important to the HCE. This year also marks the beginning of the Baseline Audiogram (hearing test) at Accession Program for all Air Force members. This initiative ensures Airmen have a documented hearing screening prior to initial noise exposure, allows comparison of hearing ability over the course of a military career, provides better tracking ability of hearing loss trends throughout our Air Force, and when necessary, provides the capability to remove Airmen from hazardous noise exposure.

In 2015, the HCE will continue to develop the Joint Hearing Loss and Auditory System Injury Registry, a comprehensive effort to identify and track the incidence and care of auditory and balance system injury, facilitate research, develop best practices, and better educate Service members and veterans. The registry will improve the quality, reliability, and continuity of health care for Service members while they're on active duty and once they've transitioned to the VA. In addition to registry

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efforts, the HCE is focused on allowing Active Duty hearing conservation documentation to be shared with the VA to allow a smooth transition and continuity of care across the two departments.

Looking ahead, the AFMS is committed to working with our sister Services in continuing to shape the Defense Health Agency (DHA). We are optimistic that our efforts will result in efficiencies and cost savings across the MHS, as well as provide common solution sets to enhance interoperability at home and in a deployed setting. The ten shared services, such as IT and logistics, will standardize processes and reduce duplication across the MHS. Another example of our integration across the medical Services is our focus on enhanced multi-Service markets, or eMSMs, where we have large beneficiary populations and can target operational and business efficiencies, such as in the National Capital Region, Tidewater Virginia, San Antonio, Colorado Springs, Puget Sound, and Hawaii markets.

The AFMS joins with our sister Services as we transform, as part of the MHS, into a fully integrated system that consistently delivers quality health care while improving the health and readiness of our forces. With our vision of health and performance in mind, we are committed to providing the most effective prevention and best possible care to a rapidly changing Air Force, both at home and deployed. I am confident that we are on course to ensure medically fit forces, provide the best expeditionary medics on the planet, and improve the health of all we serve to meet our Nation's needs. I thank the Subcommittee for its continued strong support of Air Force medicine and the opportunity to testify at this hearing.