United States Air Force

Presentation

Before the Senate Appropriations Committee, Subcommittee on Defense

Defense Health Programs

Witness Statement of
Lt Gen (Dr.) Thomas W. Travis
Surgeon General, United States Air Force

April 9, 2014

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 more than 42,800 people assigned to 75 medical 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 State University, Blacksburg
1980 Master of Science degree in physiology, Virginia Polytechnic Institute and State University, Blacksburg
1986 Doctor of Medicine degree, Uniformed Services University of the Health Sciences School of Medicine, Bethesda, Md.
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 U., Washington, D.C.
2005 Capstone, Fort Lesley J. McNair, Washington, D.C

ASSIGNMENTS

1. April 1977 - March 1978, student, undergraduate pilot training, Williams AFB, Ariz.
2. May 1978 - August 1978, student, fighter lead-in training, Holloman AFB, N.M.
3. August 1978 - February 1979, student, F-4 Replacement Training Unit, MacDill AFB, Fla.
4. February 1979 - June 1982, F-4 aircraft commander, 334th Tactical Fighter Squadron, Seymour Johnson Air Force Base, N.C.
5. August 1982 - May 1986, medical student, Uniformed Services University of the Health Sciences School of Medicine, Bethesda, Md.
6. July 1986 - June 1987, internship, Andrews AFB, Md.
7. July 1987 - July 1990, F-15 pilot physician, Langley AFB, Va.
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, Md.
16. May 2006 - August 2006, Command Surgeon, Headquarters Air Force District of Washington, Bolling AFB, D.C., and Commander, 79th Medical Wing, Andrews AFB, Md.
17. September 2006 - August 2007, Command Surgeon, HQ Air Combat Command, Langley AFB, Va.
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
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 Dec. 2, 1978
Captain Feb. 25, 1982
Major Feb. 25, 1988
Lieutenant Colonel Feb. 25, 1994
Colonel May 31, 1998
Brigadier General Sept. 1, 2004
Major General June 2, 2007
Lieutenant General July 13, 2012

(Current as of July 2012)

Chairman Durbin, Vice Chairman Cochran, and distinguished members of the Subcommittee, thank you for inviting me to appear before you today. The Military Health System (MHS) is a world-class health care organization, and the Air Force Medical Service is proud to be a full partner. We have successfully overcome many significant challenges since we last met with the Subcommittee, and greatly appreciate your strong support.

As the war draws down and the focus shifts to in-garrison care, it is tempting to compare the MHS to civilian health care organizations. But there is a cost associated with being prepared to execute our readiness missions, and no civilian healthcare system in the world can do what we do – and have done -- when called upon to provide deployed and en-route care. That is the one key message I hope to leave with you today. The AFMS remains closely linked with our Army and Navy colleagues in our efforts to achieve the MHS Quadruple Aim of Readiness, Better Health, Better Care, and Best Value – but Readiness is first!

The AFMS is committed to supporting the Line of the Air Force mission -- our "True North" -- maintaining a medical force that is trained and ready to deploy at a moment's notice, but also aligned with our wings in support of their operational missions. We have logged an astounding 194,300 patient movements since 9/11, including transporting 7,900 critical care patients. We provided "care in the air" to more than 5,000 patients in 2013 alone, including almost 300 Critical Care Air Transport Team (CCATT) missions for the most seriously ill and injured. Recently, the Lung Team and one of our CCATTs transported the wife of a service member in need of a lung transplant on an Extracorporeal Life Support (ECLS) machine from Landstuhl, Germany to Joint Base Andrews, Maryland – the longest trip ever for transporting a critically-ill patient on ECLS who survived. Further research into use of the ECLS for the comprehensive treatment of combat casualties with single and multi-organ failure is underway at

the Joint Battlefield Health and Trauma Institute by Air Force investigators. Our CCATT capability has allowed us to advance our practice of transporting only stable patients to a paradigm of en-route patient treatment that has become integral to health service support in joint doctrine.

As we strive for even greater survival rates, we've evolved our CCATT capability point-of-injury response. This provides more capable care further forward and more sophisticated in-transit support. Our Tactical Critical Care Evacuation Teams (TCCETs) provide damage control resuscitation on rotary-wing, forward-deployed fixed-wing, and tilt-wing aircraft, and have accomplished more than 1,600 critical care patient movements since we began the program in June 2011, many from point of injury. In an effort to ensure these teams are fully trained to provide continuous en-route critical care, we have partnered with the University of Cincinnati (UC) Medical Center to develop a TCCET course at the same location as our CCATT training. We have dedicated Air Force Medics on staff at UC to provide this training. We have similar trauma training partnerships with Baltimore Shock Trauma and St. Louis University for our ground-based expeditionary medical teams. These partner universities are each a Center for the Sustainment of Trauma and Readiness Skills, or C-STARS.

Our health response teams 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) are successfully deployed as a part of our continuous evolution in medical response capabilities anywhere in the world. They provide immediate emergency care within minutes to hours of arrival -- surgery and intensive critical care units in place within six hours, and full capability established within 12 hours of deployment arrival.

The training course at Camp Bullis, near San Antonio, was updated to provide more realistic training scenarios to prepare for disaster and humanitarian missions that may require pediatric, women's health, and geriatric care while maintaining the ability to use this capability in a wartime setting. This evolved expeditionary HRT capability was successfully demonstrated in Peru in 2012, and is on track to be fully deployed as a replacement of our previous generation of EMEDS by 2016.

The success of TCCET, CCAT, and EMEDS-HRT in expanding our capabilities relies on collaboration with our civilian partners in the areas of research, education and training, and provider currency. We are involved in some amazing state-of-the-art research in our major thrust areas of En Route Care, Force Health Protection, Expeditionary Medicine, Human Performance and Operational Medicine.

One fascinating example is the Airborne Laser Sensor project, a collaborative effort with U.S. Customs and Border Protection that uses an AF-developed airborne sensor flown on Air Force aircraft to sense and detect laser illumination of aircrew to determine the occupational health hazard from laser exposure. Another example is our partnership with the Battlefield Health and Trauma Research Institute and the San Antonio University Health System to conduct research on spinal fractures, blood transfusions, sepsis, burns, hemorrhagic shock, and compartment syndrome. In support of Human Performance and Enroute Care, our C-STARS faculty and civilian partners are studying the timing of aeromedical evacuation on the clinical status of combat casualties to help medical teams determine the best timing of evacuation to optimize health outcomes. While we have been very proud of our success in quickly returning patients to higher levels of care when required, the decision of when to move a patient must be

data-driven, and our experience in the current long war should help guide such decisions in the future.

We also focus research on better care and health for Air Force families. For the past several years, Wright-Patterson AFB Medical Center, Nationwide Children's Hospital, and Dayton Children's Hospital in Ohio have teamed to develop protocols to identify autism spectrum disorder susceptibility genes and rare variants to allow early intervention, and have created the Central Ohio Registry for Autism. Many families have already benefitted from this ongoing research, and many more will.

Our C-STARS partnerships in Baltimore, Cincinnati and St. Louis provided critical trauma and CCATT training to our deploying medics during the war and will remain significant platforms. However, with the end of the war and drawdown of theater hospitals where readiness currency is at its highest, we need to expand our training opportunities in the pause between hostilities to ensure all of our personnel remain ready and current to care for our wounded warriors from point of injury to rehabilitation. We are transitioning to a layered, centrally managed platform emphasizing hands-on patient care, called Sustained Medical Airmen, Readiness Trained (SMART). SMART establishes a three-tiered approach where personnel at facilities of all sizes will train with a standardized curriculum using organic training opportunities, local training affiliation agreements with partnering hospitals, and, when necessary, regional currency sites to ensure required skills are preserved and staff is sustained in a trained and ready status. We anticipate our first class at a Regional SMART site to begin in September at Nellis AFB, Nevada, which is our alpha test site.

In another exciting new program, we have joined with the Uniformed Services' University of the Health Sciences (USUHS) to create an Enlisted to Medical Degree Preparatory

Program (EMDP2). The program is designed to help highly motivated active duty enlisted to complete the coursework necessary to apply for medical school while on active duty. This two-year program serves as one component in a comprehensive plan to recruit a student body that mirrors the diversity of our nation and expands the pool for future top-notch military clinicians, leaders, and scholars. The Air Force and the Uniformed Services University have selected the first five candidates, who will begin their studies later this summer.

In addition to education and training, human performance initiatives are critical to optimizing performance of our personnel, especially as the definition of the "warfighter" has evolved. For example, Remotely Piloted Aircraft (RPA) and Distributed Common Ground System (DCGS) operators execute their core missions in garrison, requiring a shift in how we view and provide medical support. We have customized our medical support to meet the needs of Airmen performing these very stressful missions. Our medics are becoming Human Performance Practitioners – actively seeking opportunities to sustain, enhance, and optimize performance of Air Force personnel.

Lessons learned in support of Special Operations Forces through the Preservation of Force and Families initiative have improved our support of other "Battlefield Airmen" (for example, Combat Search and Rescue, Tactical Air Control Party, and Explosive Ordnance Disposal Specialists). Tailored physical therapy support, psychological support, and by-unit Primary Care Manager empanelment for these Airmen have allowed prompt identification of physical and mental disease, rapid treatment and aggressive case management/care coordination to return these Airmen to their elite, high-performing state. We are teaming the right specialties and support agencies to keep our Airmen at the top of their game. To do this effectively, some of our medics possess the level of security clearance required for them to be fully read-in on

missions and challenges and, in some cases, to have office space where the missions are executed, which greatly improves access and trust.

Additionally, we are studying the operational and occupational health effects impacting personnel in Air Force-specific aircraft to determine risk of short term and potentially long-term neurocognitive deficits secondary to high altitude exposure and to develop methods to reduce prevalence of these injuries. Results of this work to date have directly impacted operational activities associated with the U-2 aircraft to mitigate health effects, and we will continue to monitor this population through ongoing research.

The success of our operational health initiatives relies on a strong foundation of in-garrison care. We continue to embrace the principles of Patient-Centered Medical Home (PCMH) to improve patient care, access and outcomes. We have attained all-time-high levels of provider and team continuity throughout 2013, while reducing emergency room utilization rates. We developed standardized support staff protocols to promote evidence-based practice, reduce variation, and enhance reliability by utilizing PCMH teams to their fullest capabilities. The protocols have also helped improve currency of our medics while creating access opportunities for our patients.

Likewise, we have achieved enhanced access through the continued deployment of secure messaging. This technology has now been launched throughout the AFMS and includes more than 305,000 enrolled users sending over 41,000 messages per month. This leading-edge communication tool provides an additional venue to meet patient needs without face-to-face appointments, and helps our patients partner with providers in the management of their care.

Last year we reported that we launched our telehealth initiative called Project ECHO (Extension for Community Health Outcomes) with one specialty (complicated diabetes

management) serving three military treatment facility (MTF) pilot sites. Now in our second year, we have added chronic pain management, traumatic brain injury, behavioral health, dermatology, ENT and acupuncture for a total of seven live ECHO specialty series and are on track to add four more specialties areas (Addictions, Infectious Disease, Neurology and Dental) this coming year. We have expanded participation to include all Services and the Department of Veterans Affairs (VA). In addition, continuing medical education accreditation was granted for six of the seven ECHOs. Participating provider response has been overwhelmingly positive with a 17 percent increase in provider knowledge and confidence level in their management of these complicated patients, and an overall 95 percent approval rating in the ECHOs' value to their practice. Project ECHO is postured for MHS-wide adoption under the new Defense Health Agency.

Our patient safety program continues to be the bedrock of our healthcare operations. Patient safety managers collaborate with subject matter experts in risk management, clinical quality, customer service, professional staff management, compliance and accreditation to ensure we provide the highest quality care in the safest environment possible for our beneficiaries. The "Partnership for Patients" initiative was implemented by the MHS in 2013 ensuring that each MTF develop processes and programs to reduce risk to our patients related to 10 Healthcare Related Conditions. We successfully rolled out all of the implementation guidelines last year and are pleased to report that the AFMS has fully implemented all 119 elements.

The high quality of our care in our inpatient facilities is monitored and validated by, the Joint Commission (TJC), the leading accreditor of health care organizations in America. This past year three of our hospitals earned top accreditation honors by TJC for exemplary performance and were named among the nation's Top Performers on Key Quality Measures.

The Joint Commission recognized these hospitals for their outstanding performance using evidence-based clinical processes that are shown to improve care for certain conditions, including heart attack, heart failure, pneumonia, surgical care, children's asthma, stroke and venous thromboembolism, as well as inpatient psychiatric services. Our facilities achieving top honors include the 96th Medical Group, Eglin Air Force Base, Florida; 48th Medical Group, RAF Lakenheath Air Base, England; and the 81st Medical Group, Keesler AFB, Mississippi.

World-class healthcare begins with disease prevention: We promote healthy behaviors and lifestyle choices to reduce illness and ensure a high quality of life for our Airmen and their families, resulting in a healthy, fit, resilient and productive force. We are targeting nutritional fitness, physical activity, healthy weight and tobacco-free living. Ten percent of active duty Airmen are obese. While this rate is much lower than the civilian average, we will continue to execute initiatives such as "Go For Green" – a food labeling system in military dining facilities that promotes healthy food choices. The Air Force has vigorously supported the National Prevention Council commitment to expand tobacco-free environments, and we are very encouraged by the results. Smoking in the Air Force has seen a steady decline; our current smoking prevalence of 14 percent is lower than the national average of 18 percent. But we will work to drive it even lower.

To increase resilience of deploying Airmen and reduce the likelihood of post traumatic symptoms, our Airman Resilience Training provides standardized pre- and post-exposure training and reintegration education, which we are now redesigning to be better tailored to specific groups of deployers. Even though Air Force rates of Post-Traumatic Stress Disorder (PTSD) remain relatively low compared to the other Services, we continue looking for ways to prevent or minimize symptoms.

We have formally trained the majority of our mental health providers and all new social work and psychology trainees on evidence-based treatments for PTSD, and the Center for Deployment Psychology at the Uniformed Services' University offers ongoing provider training support. The Air Force continues to actively participate in joint and collaborative research projects with the U.S. Army Medical Research and Materiel Command, STRONG STAR and Penn State, looking at the effectiveness of treatments, biomarkers and the future of PTSD treatment. We believe these efforts will continue to pay huge dividends in the future.

The mental health of our Airmen and their families' remains an important focus area for us. We are continually striving to improve access to mental health care through initiatives such as Patient- Centered Medical Home-Behavioral Health (PCMH-BH), which embeds mental health providers within the primary care clinics of each MTF to offer a lower-stigma mental health care option for beneficiaries. Another initiative is Mental Health Integration, a demonstration project at two of our MTFs to evaluate placing full-service mental health capability in Primary Care, promoting early intervention, improved access, and continuity of care within the MTF. The deployment of video teleconferencing capabilities in our mental health clinics has also helped to address the needs of our patients. We stood up six hubs for tele-psychiatry services throughout the AFMS, providing important psychiatric consultation to MTFs without on-site psychiatry. Each of these resources support increased access while reducing the stigma of seeking mental health assistance.

Fortunately, the incidence of deployment-associated traumatic brain injury (TBI) has remained low for the Air Force. However, we remain committed to ensuring appropriate care for our Airmen who have sustained TBI through referrals to the National Intrepid Center of Excellence for Psychological Health and Traumatic Brain Injury, and to the many TBI programs

throughout the Department of Defense (DOD). Our TBI Clinic at Joint Base Elmendorf-Richardson is engaged in cross-Service efforts to standardize and optimize TBI care within the DOD.

We remain concerned about suicides in the Air Force. In December 2013 we released an updated and refined version of "The Air Force Guide for Suicide Risk," based on research and published best practices over the last 10 years. This document provides a resource of state-of-the-art knowledge for the clinical management of suicide-related ideation and behaviors, allowing better standardization of clinical assessment and treatment of at-risk patients. The new version adds references for cognitive behavioral treatments for suicidal patients. This valuable resource will assist the ongoing training of our mental health personnel; improve the quality of care provided to those at risk of suicide, and support effective consultation to Air Force supervisors of Airmen at risk.

Airmen and their families are our most important resource and in an effort to improve the care provided to Air Force Families, we have recently completed a comprehensive examination of the relationship between deployments and subsequent rates of family violence. We found that among deployers, the rate of spouse abuse and child maltreatment is about the same before and after deployment. We have also identified a few specific situations that place military families at higher risk for family violence and are targeting family violence prevention efforts to those families at risk.

We are also committed to ensuring quality, compassionate care for victims of sexual assault, through the Air Force's Sexual Assault Prevention and Response Program. The Air Force has processes in place to perform Sexual Assault Forensic Exams (SAFE) either within the Air Force MTF, another nearby military medical facility, or through partnerships with civilian

experts in the local community. We utilize sexual assault forensic examination training programs that comply with the standards established in the Department of Justice "National Protocol for Sexual Assault Medical Forensic Examinations." In addition, we have designated executive level oversight at our MTFs, incorporated First Responder training requirements in the Major Command (MAJCOM) compliance inspection, and initiated a bi-directional information and communication link specific to sexual assault prevention and response, facilitating updates and answers to and from our MTFs. We stand ready to support every sexual assault victim with respect, compassion, urgency and professionalism.

Another area of concern is the impact of hearing loss on operational readiness and long-term quality of life. Hearing loss remains an easily overlooked occupational injury in service members and Veterans. As lead agent for the DOD Hearing Center of Excellence (HCE), the Air Force supports the efforts of the HCE to create better awareness of this pervasive injury through comprehensive hearing health programs. The HCE is finalizing the development of the Joint Hearing Loss and Auditory System Injury Registry and has established necessary agreements to access relevant DOD and VA data sources, standardize data collection, and manage data requirements. Initiatives are underway across the MHS and VA to improve hearing protection, standardize baseline and periodic hearing assessments across the Services, and establish engineering and acquisition best business practices that reduce hazardous noise at the source. Hearing loss is a mostly preventable disease, and both the operational and medical communities have a huge stake in preventing this injury.

The DOD Centers of Excellence are one of many areas where DOD and the Services work closely with the VA. As most of our military patients at some time pass through each other's doors, it makes sense to plan together and share resources where feasible. Our

relationship with the VA also expands clinical currency opportunities for both entities. We have had great success through the DOD/VA Joint Incentive Fund; 46 percent of all joint incentive fund projects include Air Force MTFs.

One of the most successful projects is the Joint Vascular and Endovascular Surgical Services project at David Grant Medical Center (DGMC), Travis AFB, CA. Working with the Northern California VA Health Care System, millions of dollars have been saved in only two years and more than 350 VA and DOD patients have stayed in in the federal care system. The vascular team at DGMC has embraced this initiative and enhanced their clinical skills with the increased patient load. In addition to efforts at DGMC, the Air Force has seen similar success at the Michael O'Callaghan Federal Medical Center (MOFMC), Nellis AFB, Nevada with their cardiac catheterization laboratory seeing both VA and DOD beneficiaries exceeding all early projections by approximately 20 percent. This project is only one of the sharing initiatives at this Joint Venture site.

Other successful sites include the 81st Medical Group at Keesler AFB, where their long list of Joint Incentive Projects include a Joint Cardiovascular Care Center that to date has seen a cumulative benefit of $9.4M and sustains the clinical currency of the Air Force providers with the continued influx of VA patients. This is only one of the successes at the 81st Medical Group; others include a joint business office function that has the common goal is to reduce duplication of services, capitalize on respective core competencies, and optimize volume to deliver services safer and more economically.

Throughout the Air Force Medical Service, DOD/VA sharing has been implemented and is continually emphasized as a way to enhance the clinical currency of our providers as well as provide economic, high quality health care for both DOD and VA beneficiaries. Recent efforts

at the 88th Medical Group, Wright-Patterson AFB, Ohio have resulted in a significant increase in the number of VA patients being seen at that location with anticipation that it will continue to grow in the future. Efforts at Eglin AFB, Florida are generating large increases in VA visits and surgeries and have made them the fifth largest sharing site in the AFMS. We will continue to push for more sharing at sites in close proximity to VA facilities and where there is an opportunity to care for VA patients in our MTFs.

The FY 15 President's Budget includes a proposal for a TRICARE Consolidated Health Plan along with modest increases in beneficiary out-of-pocket costs for active duty families, retirees and their families, and reserve component members and their families. These proposals reflect the Department of Defense's efforts to modernize and simplify the TRICARE program that will place the program on a stable, long-term footing.

Finally and importantly, the AFMS is united with our Army, Navy and DOD colleagues in support of the MHS governance reform efforts. The Defense Health Agency stood up in October 2013, and as of this date the first seven of 10 planned shared services have reached IOC. These include Facility Planning, Medical Logistics, Health Information Technology, TRICARE Health Plan, Pharmacy, Budget & Resource Management, and Contracting. The DHA is on target for the next group of shared services to reach IOC this year and full operating capability in October 2015. We remain fully committed to achieving reforms for best value and interoperability by seeking common solutions as we provide better care and better health to our beneficiaries.

In conclusion, despite the challenges we all experienced in the past year, the Air Force Medical Service continued to focus hard on providing operational support and high quality care around the globe, in-garrison and deployed, on the ground or in the air – that's what we mean by

"Trusted Care Anywhere!" I am honored to lead and serve with Air Force medics during this very important time. But I am just as honored to partner with my Army and Navy colleagues as we move forward together to build an even better Military Health System. Thank you for your continued support of our critical mission.