



Society of US Army Flight Surgeons

April 2006 * Volume 7, Issue 1

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Incoming President's Message

Welcome to the Spring 2006 edition of the SOUSAFS newsletter. We plan on a semiannual offering to keep you up to date on Army Aeromedical issues. If you have an interesting experience, a case study or anything you think would be of benefit to the Society membership, please feel free to submit to the secretary. We can even generate a "Letters to the Editor" section, if so desired. On February 14, 2006 at the annual business meeting in Galveston, I had the honor of being elected President of your society. In addition, the newly elected officers- VP- Major Justin Woodson, Secretary- LTC Stephen Bernstein, and Treasurer- Major Richard Roller, and I received a mandate for change from the society membership present. The areas for analysis and change include- society membership and organization, society role in the annual aeromedical problems course (OAP), society operations, and awards. Each of these areas will be reviewed and in the next year you can expect change in the Society Bylaws and function. Our goal is to make the Society of value to you, its members.

I would also like to highlight places to obtain aeromedical updates and to network with your colleagues. The US Army School of Aviation Medicine supports two websites:

by COL Monica Gorbandt

Home Page Web Address:
<http://usasam.amedd.army.mil>
AKO Web Address:
[https://www.us.army.mil/suite/portal.do?\\$p=144285](https://www.us.army.mil/suite/portal.do?$p=144285)

The new sites provide easy access to information on the activities and services of the School of Aviation Medicine, as well as links to a variety of locations that are valuable resources to the aero medical discipline.

For comments on the website contact:

imo.usasam@amedd.army.mil.
I encourage you to use the AKO site as a place to "chat" with your fellow aviation medicine professionals. We look forward to a great year in the Society and make plans now to join us at Moody Gardens in Galveston for the 2007 Medicine in Challenging Environments conference.

Reflections of Years Gone By

by COL John Campbell

I would like to take a few minutes and reflect on the year's gone by that I happily served the Society of US Army Flight Surgeons; most recently as the President and previously as the Vice President. I served at your (the members at large) selection since 1996.

First I would like to thank all the supporting members that allowed me to help guide and shape our society and secondly I would like to congratulate all the newly elected officers and board members. They need your support and involvement as we try to start some new initiatives and make some changes to the by laws to make a more functional society.

The 10 years have seen a lot of change in the world and definitely how we serve in our armed forces. Looking around at the 2006 OAP, I think at least 85-90% of the Flight Surgeons and APA's have done a combat tour, if not 2 or 3. This is unprecedented in over the last 30 years when most of us hadn't even started in medicine or the military. So needless to say, there are a lot of stories yet to be written and shared with the society to share with your peers.

I would like to thank USASAM, The Society and UTMB for hosting yet another great OAP. Over the last 10 years we have had the good fortune to partner with many professional organizations to bring you, the membership, the most current and pertinent data out in the field. This is no easy task. Once again we will need your help and thoughts as we push forward in the next few years

Finally, we have a great profession and I am proud to have served with each and every one of you and I look forward to even better times to come in the future!

And Now.... A Few Thoughts from AAMA

by LTC Stephen Bernstein

AAMA has been going through numerous changes since the last update was published. First thing to note is LTC Greig, MAJ Chhoue, and MAJ Thomas all PCS'd or ETS'd in the summer of 2005. LTC Brian Smalley filled in AAMA until my arrival in early August and LTC Valentin's arrival in late August. COL Baldwin was there for all the fun, stepping up to work more hours to help with covering the tasks. So, 3 out, 2 in, one would think life was okay, right? Well, the next big upheaval came in November with LTC Valentin moving to DCCS, leaving yours truly left since then.

Several tasks accomplished during the first few months including several APL updates and ATB changes. The first edition of BLUF Notes was posted in October outlining a number of changes. Summarizing some of these include removing the requirement for annual digital rectal exams, prostate exams, and stool guaiacs on Abbreviated flight physicals as well as no longer requiring a new AMS for those receiving an exception to policy who remain stable and in compliance with annual waiver requirements. APL's updated or added include Metabolic Syndrome, Allergic Rhinitis for Information Only criteria, and Corneal Refractive Surgery for Information Only criteria. And then there was tackling the backlog of overdue AMS's awaiting disposition—the backlog is any encounter that is beyond 30 days since submission for review and disposition—which was at 950 encounters on 30 JUNE 2005.

After the personnel reshuffling, the second quarter was spent focusing on a few areas. The second edition of BLUF Notes was recently posted on the

homepage and in the download section of AERO as well. The FDME Checklist, one-page version, has been updated and posted. The final posting of Corneal Refractive Surgery and an updated policy for SSRI's for the field to follow. And yes, there was the beating down of the backlog (it's a theme here) which is currently at an all-time low of 91 and forecasted to be exhausted in the third quarter of this FY. The goal is to maintain review and disposition within AAMA without having any encounters in a backlog state.

AAMA has tried to maintain its open and receptive posture for questions, comments, consultation, and dialogue in ensuring the aeromedical health of our population. The push for AERO continues and is highly encouraged for all to utilize. Rates of AERO submission have climbed to an all-time high of 78%. The goal is to keep pushing this higher as it is becoming well obvious that physicals returned are often for missing things readily obvious from AERO. Despite some of the initial work upfront in the flight surgeon's office to learn and adapt to using AERO, field flight surgeons will quickly see the utility in time reduction with dealing with incomplete submissions.

References that flight surgeons and APA's should maintain and use are the link to the AAMA homepage—<http://usasam.amedd.army.mil/AAMA/index.htm>, and the email address for help and assistance is aama@amedd.army.mil. The phone number is 334-255-7430 (DSN 558) and fax is 334-255-7606 or -7030 (DSN 558).

Election Results and 2006 SoUSAFS Awards

2006 Election Results

President: COL Monica Gorbandt
 Vice President: MAJ Justin Woodson
 Secretary: LTC Stephen Bernstein
 Treasurer: MAJ Richard Roller

Board of Governors

Army NG: MAJ Doug Little
 Army Reserve: COL Regina Curtis
 Aeromedical PA: LTC Michael Gaffney
 Past President: COL John Campbell

General: LTC Eric Olins
 COL Joseph McKeon
 LCDR Dana Thomas (USCG)
 CAPT Mark Tedesco (USCG)

Awards:

Flight Surgeon of the Year: CPT Sara Anderson
 Outstanding Achievement (APA): CPT Tripp Baldwin
 Order of Aeromedical Merit: COL (Ret.) Wade D. Baldwin

Thank you all for your participation and congratulations to our new officers.

Order of Aeromedical Merit Recipient

COL Baldwin was born in Oklahoma in 1936. He went to undergraduate at Oklahoma State University and graduated from medical school at the then Kansas City College of Osteopathic Medicine in 1962. After completing his internship, he went straight into Orthopedic Surgery at Oklahoma Osteopathic Hospital. He went on to a successful private practice in Albuquerque and Tulsa until 1978 when he decided to enter the US Army, serving his first tour at Fort Sill. He went on to serve at Fort Knox, Fort Sheridan, and Fort Rucker before entering the Residency in Aerospace

Medicine. He completed his MPH at Tulane and training at Brooks AFB. From there, he went to command the 43rd MASH at Camp Humphries, DCCS at Fox (Fort McClellan, AL), and command 98th General Hospital (Frankfort, Germany) and Patch Barracks (Stuttgart, Germany). He returned to Fort Rucker as Deputy Chief of AAMA until his retirement in 1998, and then stayed on at AAMA providing initial review of flight physicals and processing waivers and suspensions to this day. His involvement in Army Aviation Medicine has been long and extensive and

continuous, for longer than many have been on active duty. Although slowed by health issues for the past two decades, he still has the dedication and love of doing service for his country, the Army, his fellow colleagues, and the Army aviation population. He was nominated for and unanimously approved for this honor by his peers and proudly represents the core values of aviation medicine, dedication to duty, and honor. It gives the Society great pleasure to award COL (Ret.) Wade D. Baldwin the 2006 Order of Aeromedical Merit.

2005 Army Aviation Medicine Trends

The United States Army School of Aviation Medicine surveyed and assisted 96 Army Aviation units in the area of Aviation Medicine in conjunction with Forces Command's Aviation Resource Management Survey (ARMS) program in 2005. The surveyed units were members of both the Active Component (AC) and Reserve Component (RC) and ranged in size from detachments to brigades. The survey results varied as much as the unit sizes and locations, but several trends in both the clinical and non-clinical aspects of the programs emerged.

The 2005 ARMS Aviation Medicine checklist is comprised of three sub-functional areas. The first sub-functional area, Command Factors, consisted of 27 questions evaluating the level of Aviation Medicine integration into the unit safety, training, and flying programs. Trends in this area largely centered on the lack of Flight Surgeon availability to support programs at the unit level. The demand for physicians (AC and RC) in support of operational deployments left many units without organic or dedicated Flight Surgeon support. In many cases units or Flight Surgeons were not completing accident prevention surveys in the area of Aviation Medicine (annually for RC and semi-annually for AC units and support facilities). This prevented the detection of Aviation Medicine program shortcomings in many cases. Often it was common for Flight Surgeons to not fly in the types of airframe supported or even maintain flying hour minimums in accordance with AR 40-501. This seemed to be directly linked to the lack of Flight Surgeons available. Commanders were often forced to choose between the Flight Surgeon using time to support required, but often ancillary, programs or to ensure

that the unit's crewmembers possessed current flight physicals. Using this logic the units' required medical training for crewmembers, Flight Records (DA Form 4186 and waiver letters), and pre-accident plans suffered.

The Clinical Duties sub-functional area determines unit compliance with Army regulations concerning Health Records and flight physical procedures and administration. In the Clinical Duties sub-functional area there seemed to be a split between the performance of RC and AC units. Twenty percent of National Guard units failed the Clinical Duties area where all AC units passed this area. These results had nothing to do with the competence of the medical personnel supporting the Guard versus the AC, but had everything to do with resources. In most cases units that failed this area failed because their Health Records were not maintained, secured, or accounted for. For most Guard units the Health Records were stored by Aviation detachments, companies or battalions who were not authorized medical personnel. In some cases Guard records were maintained at the State or at the Army Aviation Support Facility. In these cases the records were generally well maintained, but neither the Flight Surgeon nor the Soldier had access to the records. The AC units were supported by Health Records technicians who are trained and experienced in such matters. The same issue held true for much of the flight physical administration. Guard units rarely had the luxury of a dedicated Aviation Medicine section. The exceptions to this rule did very well in the ARMS. However, in many cases flight physicals were sent to the Army Aeromedical Activity (AAMA) by unit or support facility personnel. The personnel who

by MAJ Guy Gierhart

used the Aeromedical Electronic Records Office (AERO) were able to accurately track physicals and follow up on missing or disqualifying information. AERO has been a definite force multiplier for the National Guard aviation units. AC units often had the advantage of full time Aviation Medicine staffs and were using AERO as well.

The last sub-functional area is Aeromedical Evacuation Units. This area applied only to MEDEVAC companies and detachments or to aviation units with a MEDEVAC mission. Trends in this area included a lack of Flight Surgeon support in the training of Flight Medics and a lack of Semi-Annual Combat Medic Skills Validation and Testing (SACMS-VT). The Flight Surgeon support issue in most cases was due to the lack of Flight Surgeon availability as discussed above. The lack of SACMS-VT was largely the result of rapid turn-around deployments for MEDEVAC units and a lack of documentation. However, most MEDEVAC units are no onboard with this training. Units who had Flight Surgeon involvement in protocols, training, and who flew with the units were overall successful in this area.

After summarizing the negative trends identified during the 2005 ARMS it would only be fair to remind everyone that prior to the ARMS out-brief the ARMS Team Chief states, "During this brief you will hear many more negatives than positives. This is because we don't have time to talk about all the good things that we see." This is true, and there are many out there doing great things in support of their Soldiers and crewmembers.

arms.usasam@amedd.army.mil

News from the School of Aviation Medicine

Greetings from the U.S. Army School of Aviation Medicine (USASAM). As a short review, the U.S. Army School of Aviation Medicine located at Fort Rucker, Alabama is the center for rotary wing aeromedical training, education, and consultation in direct support of all Army rotary wing and fixed wing aviators, flight surgeons, flight medics, aeromedical evacuation pilots, and all DoD aeromedical psychologists deployed worldwide. USASAM is also the Army's center for all Army hypobaric training. USASAM offers the following courses for the Army and joint forces; Flight Surgeon Course, Flight Medic Course, Aeromedical Psychology Course, Joint En Route Care Course, Medical Evacuation Doctrine Course, Aviation Physiology, Air Ambulance Company Pre-Command Course, and assists in Aviation Resource Management Survey (ARMS) inspections.

USASAM changed leadership with COL Monica Gorbandt assuming the helm as the Dean from COL John Campbell on 5 August 2005. 1SG Carl Martin assumed First Sergeant responsibilities from 1SG Jayme Johnson on 3 June 2005. LTC Vince Carnazza assumed duties as assistant Dean on 16 January 2006 after Major Frank Paulino assumed the duties for an interim period.

In response to the mission requirements and lessons learned from OIF/OEF, USASAM recently developed the Joint En Route Care Course (JECC) and provided mobile training team support to train Navy helicopter pilots on medical evacuation doctrine.

The Joint En Route Care Course (JECC) focuses on skills and knowledge in the area of

specialized clinical care management of critically injured/ill casualties during tactical conditions on medical evacuation platforms, both ground and air, and the appropriate preparation to limit the stressors encountered in the transport environment. USASAM recently completed two joint pilot courses and was approved by MG Weightman on 11 October 2005 as an official AMEDD&C course. Enrollment is open to all DoD and DHS components.

The Medical Evacuation Doctrine Course (2C-F7), a two week course focusing on the proper application of medical evacuation doctrine tactics, techniques, and procedures continues to play a vital role in preparing our MEDEVAC pilots for OIF/OEF. In addition to our residence course, USASAM provides a mobile training team to MEDEVAC units throughout our Army and now for the Navy. USASAM is in its second course iteration training Navy pilots in San Diego, California on Army medical evacuation doctrine in support of the Navy's future MEDEVAC role in OIF.

USASAM is working diligently to increase our ability to project current aeromedical information and doctrine to the aeromedical healthcare team. USASAM launched two new websites- both public and AKO - as part of this effort.

Home Page Web Address:

<http://usasam.amedd.army.mil>

AKO Web Address:

<https://www.us.army.mil/suite/portals.do?sp=144285>

USASAM is pleased to present the newly redesigned USASAM website and the new AKO website with knowledge centers.

by COL Monica Gorbandt

USASAM's focus is on deployment readiness, relevant training, relevant knowledge and on the mission of the organization. The new sites provide easy access to information on the activities and services of the School of Aviation Medicine, as well as links to a variety of locations that are valuable resources to the Aeromedical discipline.

Among the information provided on our site:

- USAAMA Policy Letters and Technical Bulletins
- Medical Evacuation Proponent Information and Links
- Keys documents on Army Resource Management Survey's
- Aeromedical course information
- DL Courses
- Directory for contact information

We hope these sites are useful and welcome feedback. Help us to make these sites your Aeromedical focal point (portal).

For comments on the website: imo.usasam@amedd.army.mil

History and Current Capabilities of IqAF Aeromedical Program

The Iraq aeromedical system started in the mid of 1950's with the first 2 Iraqi flight surgeons graduating from Brooks Air Base School of Aerospace Medicine in 1966. Additionally from 1970 to 1976, 6 Iraqi flight surgeons graduated from U.K. In 1986 4 Iraqi flight surgeons graduated from Egypt. After the first Gulf War, Iraq turned inward for all its military medical education needs with flight surgeons receiving their training at the physiology department in Baghdad Medical College followed by 6 months of additional training at the Iraq Air Force hospital in Rustimiyah. These graduates provided medical services to the Air Force, Army Aviation and Civil Aviation. More than 20 physicians graduated from this program. In 2001, a new Aerospace Medicine 4 year residency program started with one year spent in public health, occupational medicine, ophthalmology, internal medicine, ENT, rheumatology, or pathology. Unfortunately the program was discontinued due to the destruction of the aerospace medical center during the Iraqi Freedom Operation. In 2005, the Iraq Ministry of Higher Education and the United States FAA agreed to continue the training of Iraqi Civilian Flight Surgery residents in Oklahoma. Currently there are 32 trained Iraqi Flight Surgeons, of which 31 are civilians including 2 females. However, many of these civilian flight surgeons are currently serving outside of Iraq or retired leaving a gap between services needed and current capabilities. All civilian flight surgeons are employed by the Minister of Health. Most serve at Baghdad International Airport while a few serve as administrators within the MOH offices.

In July 2004, I was asked to reestablish the new Iraqi military aeromedical program. This request came from the Surgeon General of the Iraq Armed Forces, Brigadier General Samir. I worked closely with the Multi National Security Transition Command (MNSTCI) to help develop the foundation upon which the Iraq Air Force would care for our flyers and ground personnel. Of particular importance were the relationships built with the MNSTCI Air Cell and the USAF medical advisor to BG Samir.

My goal was to reestablish aerospace medicine department according to the size and number of squadron and air bases.

The Iraqi Air Force's roles will include the policing of international borders and surveillance of national assets. Air capability will also allow Iraq to rapidly deploy its developing Army. The Iraqi Army Air Corps will focus primarily on troop and logistics movements as well as air medevac for life-threatening and casualty-producing situations. Since January 2004, the Coalition Professional Authority (CPA) has trained both helicopter and transport pilots and planned to field the first operational squadrons in the summer of 2004.

The Iraqi Air Force (IqAF) consists of helicopter and transportation squadrons totaling 1000 personnel, with the number projected to double by 2007. The aerospace medicine department will not exceed 7% the total number of the Air Force. Currently the Iraqi air force operates 2 air bases in BIAP and Tadjji.

The AL-Munthana air base, located in BIAP hosts the 23rd Transport Squadron's three C-130E aircraft, the 12th squadron's five Jet Ranger helicopters, the first aerospace medical facilities, and the IqAF operation head quarters. The AL-Munthana clinic currently sees 30-40 patients daily and is staffed with a physician and support staff. This facility contains a trauma section, 3 rooms for flight surgeon exams, a patient reception administration section, pharmacy, dentistry, public health, laboratory, ENT, audio logy booth, and optometry. In addition to acute care, the clinic performs screening exams on pilot candidates before they go to the US and Britain for training. AL-Munthana shares the same runway with collation force aircraft.

Tadjji AB hosts the 2nd and 4th Squadrons, which fly 16 UH-1H's (being upgraded to Huey II). Tadjji serves primarily as an Army training base for over 30,000 soldiers and contains 3 army clinics, one of which houses the Aerospace Medicine Department. Similar to AL-Munthana, this base shares the runway with US Army. Currently all clinic staffing is with

by Col Muntadhar Hassan Flayh

Iraq Army personnel due to a shortage of IqAF flight surgeons and staff.

Two additional squadrons are present in Kirkuk and Basrah at the American and British bases, respectfully. These squadrons work cooperatively with their coalition partners and share runways but do not have Iraqi Aerospace Medical facilities. The Kirkuk base hosts the 3rd squadron, which flies Comp Airlift and Bell Jet Rangers. Their mission is air surveillance to protect the strategic oil pipelines. Aeromedical support is provided by the Kirkuk Air Base USAF EMEDS. Eventually, this base will need IqAF Aerospace support at Iraqi capabilities as mission tempo increases. Basrah hosts the 70th Squadron, flying 2 Seekers and 2 CH-2000 aircrafts. The 70th squadron does not receive medical support from the British hosts at Basrah, and thus, it was necessary to hire one Iraqi Navy physician (non-aeromedical) and two medics on a short term basis until more flight surgeons are available. These men work out of the 70th Squadron building in a single room with limited medical equipment.

Part 2—Iraqi Aerospace Medicine Program

Having reviewed the history of Aerospace Medicine in Iraq and the current resources, I will now state my plans and challenges for the future of Aerospace Medicine in a free and democratic Iraq for the next 2-5 years.

Needed Aerospace Medical Facilities:
BIAP (AL-Munthana Air Base)

- Aerospace Medicine Clinic with Level 3 Trauma Center
- Selection and Recruitment Medical Center
- Bio-Environmental Engineering and Public Health Facilities
- Flight Physiology Department (to include altitude, hyperbaric chambers)
- ATC Gyro Lab.

(Continued on next page....)

KIRKUK:
 Aerospace Medicine Level 2 Clinic
 BASRA:
 Aerospace Medicine Level 2 Clinic
 TADJI:
 Aerospace Medicine Level 2 Clinic

Responsibilities and scope of care:
 To care for the flyers and carry out Aerospace Medicine examinations according to regulations for flyers and aircrew.
 To carry out occupational medicine examinations and issue certification for performing hazardous work for PSN on the base and report to appropriate authorities.
 To carry out selection for a new student pilot and air aviator crew.
 Vaccination programs.
 Establish Medical Emergency Response and contingency plans for the airfield and local threats.
 Using USAF Medical Standards and Procedures, provide basic charting, surveillance, medical clearance and health maintenance for pilots and ground crew.
 Establish centralized selection center for aviators.

Challenges:
 Insufficient support of USAF SG office to Iraqi aerospace medicine

department. Most support has come through USAF officers within MNSTCI. Iraqi air cell headquarter misunderstandings and misinterpretation as to the responsibilities and capabilities of the Aerospace Medicine department. Shortage in the number of military physician due to insurgency and unstable security. This includes the refusal of prior IqAF flight surgeons to return to active duty. Development of IqAF standard of medical care for pilots and ground crew. Age and health of many pilots will require medical waivers consistent with basic medical standard of care while maintaining mission effectiveness. Lack of aerospace medical equipment. Development of aero medical evacuation system to support army and air force units given limited resources. Training a new generation of flight surgeon, flight nurse, flight medics, and technicians in medical flight aspect. Enhancement of aviator's human systems performance.

Suggestions for developing the aeromedical program:

Increase the role of USAF aerospace medicine specialty to develop the Iraqi aerospace medical program. Creation of training program for new IqAF Team Aerospace Medicine WITHIN Iraq to expedite the training process by having USAF flight Surgeons come to Iraq to provide the training for a large groups of physicians. This can be coordinated with US Army aviation medicine training due to the large helicopter presence in the IqAF. Increase the recruitment of new Team Aerospace Medicine members by offering the following-
 Opportunity to fly
 International opportunities, meeting, training, and travel.
 The department must work independently with full support from both air force cell and army SG, with private annual budget.
 Physician and Flying bonus pay
 Research opportunities
 Create an esprit de corps within Aerospace Medicine using flight wings, special patches, and call signs.

By Col N. Flayh, with editing assistance from MAJ Justin Woodson and LTC Stephen Bernstein

Aeromedical Electronic Resource Office (AERO) Update

by Mr. Martin Quattlebaum

Congratulations to the USAAMA Team on winning the Surgeon General's Excalibur Award. The USAAMA Team has updated the version of the AERO to 4.0.1.0. This includes a complete upgrade, update and migration of the AERO application, software and hardware. AAMA has implemented the ATB update and Metabolic Syndrome "Change Package" via recent Aeromedical Policy Letters (APL) changes. This and following-on 'change requests' have been beta tested and moved into the AERO production environment. Recent APLs, including the 2006 Comprehensive Package, are updated and posted via AERO download section. The AERO user *Password* feature tool has been updated per AR25-2. AKO username/password authentication is coming this summer. Users will login and authenticate via AKO (CAC login) for access to AERO (more updates to follow).

The USAAMA New web *page* site debuts this summer (URL to follow). New features will provide for AAMA, AERO, APL, Processing features and updates including *paperless* user account requests and reporting. Additionally, the web page site will allow for suggestions for improving AERO via an electronic version of the 'change request form' processed via the AERO Configuration Control Board (CCB) disposition. We are completing the new AERO Training CD and should be able to provide the sections via download from the new Web page site.

AAMA has started the *initial* Interface for AERO ↔ AHLTA (CHCS II). This work is being conducted via grant funding from the AMEDD Advanced Medical Technology Initiative (AAMTI) and Telemedicine and Advanced Technology Research Center (TATRC). This will be a real time system interface at the data element layer. The *initial* interface should be completed by FY07. The Military Vaccine funded AERO web based Data Warehouse is in beta test version transition.

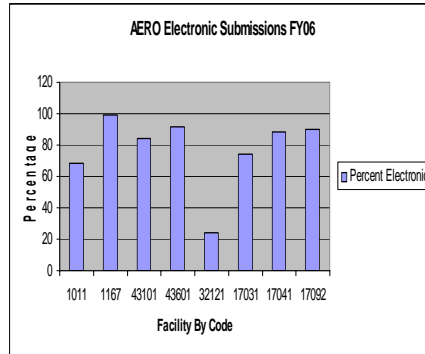
Upcoming presentations at the American Telemedicine Association conference in San Diego, CA will include the AERO Web Based Data Warehouse and the AERO Automated Disposition Feature.

AERO needs volunteers for beta testing from the field including Flight Surgeons, APAs, NCOICs and data clerks. As we develop application 'Change Packages' for AERO, we need the enhancements tested by internal and external USERS. POC for this effort is: martin.d.quattlebaum@us.army.mil. (Continued on next page....)

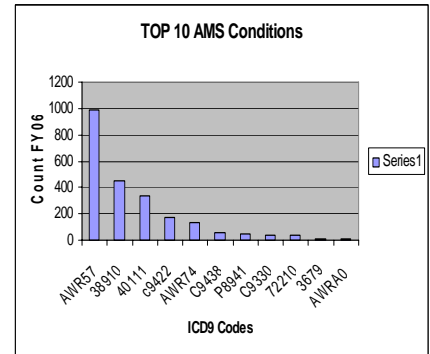
Below are some current charts and trends with AERO usage and its value to AAMA, flight surgeons, and the aviation community. To summarize, we are approaching 80% submission rate, which greatly is noticeable in those FDME/FDHS returned due to being incomplete. AAMA is continuing to process almost 2500 encounters monthly. Some facilities are doing great with embracing AERO.

AERO production for FY06: AERO production for electronic usage has been on the increase this fiscal year. We are approaching 80% electronic submissions monthly.

The following are Electronic Submission for several Facilities per code:



TOP 11 AMS conditions submitted to AAMA:



- AMS57 Corneal Refractive Surgery
- 38910 Hearing Loss
- 40111 Hypertension
- C9422 Hyperlipidemia
- AWR74 Medications
- C9438 GI Meds (Reflux)
- P8941 Stress Test/GXT (Level 1 failures)
- C9330 Allergic Rhinitis and medications
- 72210 HNP/Intervertebral Disc Disease
- 3679 Cycloplegic Failure
- AWRA0 Retained Hardware

AERO Backlog Stats: All encounters (flight physicals and aeromedical summaries) should be reviewed and given a disposition within 30 days from submission. Those not are referred to the Backlog. Statistics show the backlog dropping significantly since June 05. Current backlog is at 91 and soon to be at an acceptable threshold level of less than 30 days old. This has been the result of the AERO application tool, Business Processing Re-engineering policies and the Director, USAAMA reviewing and providing disposition.

