BIOGRAPHY

UNITED STATES AIR FORCE

LIEUTENANT GENERAL DOROTHY A. HOGG

Lt. Gen. Dorothy A. Hogg is the Surgeon General, Headquarters U.S. Air Force, Arlington, Virginia. General Hogg serves as functional manager of the U.S. Air Force Medical Service. In this capacity, she 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 Airmen. General Hogg 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. She exercises direction, guidance and technical management of a $6.1 billion, 44,000-person integrated healthcare delivery and readiness system serving 2.6 million beneficiaries at 76 military treatment facilities worldwide. Prior to her current assignment, General Hogg served as Deputy Surgeon General and Chief, Air Force Nurse Corps, Office of the Surgeon General, Falls Church, Virginia.

General Hogg entered the Air Force in 1984 and has commanded at the squadron and group level, and served as the deputy command surgeon for two major commands. She has deployed in support of operations Enduring Freedom and Iraqi Freedom.

EDUCATION

1981 Bachelor of Science degree in Nursing, University of Southern Maine, Portland
1986 Squadron Officer School, by correspondence
1987 Women's Health Nurse Practitioner, School of Healthcare Sciences, Sheppard Air Force Base, TX
1992 Master of Public Administration, Troy State University, Troy, AL
1996 Air Command and Staff College, by seminar
1997 Master of Science in Nursing, Sigma Theta Tau, Medical University of South Carolina
2002 Air War College, by seminar
2007 Executive Development Intern, SDE in-residence equivalent
2010 Interagency Institute for Federal Healthcare Executives
2012 Joint Medical Executive Skills Medical Executive Skills Capstone Course
2014 Capstone, Fort Lesley J. McNair, Washington, D.C.

ASSIGNMENTS

1984 – 1986, Staff Nurse, OB/GYN Nursing Unit, U.S. Air Force Regional Hospital, Eglin AFB, FL
1986 – 1987, Nurse Practitioner Student, School of Healthcare Sciences, Sheppard AFB, TX
1987 – 1989, Women's Health Nurse Practitioner, 410th Medical Group, K.I. Sawyer AFB, MI
1989 – 1992, Women's Health Nurse Practitioner, 52nd Medical Group, Spangdahlem Air Base, Germany
1992 – 1996, Women's Health Nurse Practitioner, 18th Medical Group, Kadena AB, Japan
1996 – 1997, AFIT Master's Student, Medical University of South Carolina, Charleston, SC
1997 – 2001, Maternal-Infant Flight Commander, 366th Medical Group, Mountain Home AFB, ID
2001 – 2002, Family Practice Flight Commander, 314th Medical Group, Little Rock AFB, AR
2002 – 2004, Clinical Medicine Flight Commander, 314th Medical Group, Little Rock AFB, AR
2004 – 2006, 22nd Medical Operations Squadron Commander/Chief Nurse Executive, McConnell AFB, KS
2006 – 2007, Executive Development Intern, Manpower and Organization/SDE equivalent, Headquarters U.S. Air Force/SG, Bolling AFB, Washington, D.C.
2007 – 2008, 79th Medical Operations Squadron Commander, 79th Medical Group, Andrews AFB, MD
2008 – 2010, 9th Medical Group Commander, Beale AFB, CA
2010 – 2012, Deputy Command Surgeon, Air Force Central Command, Shaw AFB, SC
15. June 2012 – July 2013, Deputy Command Surgeon, Air Force Materiel Command, Wright Patterson AFB, OH
16. July 2013 – September 2014, Chief, Air Force Nurse Corps/Assistant Surgeon General, Medical Force Development, Office of the Surgeon General, Falls Church, VA
2014 – 2015, Chief, Air Force Nurse Corps/Director, Medical Operations and Research Office of the Surgeon General, Headquarters U.S. Air Force, Falls Church, VA
2015 – 2018, Deputy Surgeon General/Chief, Air Force Nurse Corps, Office of the Surgeon General, Falls Church, VA
2018 – Present, Surgeon General, Headquarters U.S. Air Force, Arlington, VA

MAJOR AWARDS AND DECORATIONS

Defense Service Medal
Legion of Merit
Bronze Star
Meritorious Service Medal with silver and two oak leaf clusters
Air Force Commendation Medal with two oak leaf clusters

CURRENT NATIONAL CERTIFICATIONS

Women's Health Nurse Practitioner National Certification Corporation

EFFECTIVE DATES OF PROMOTION

Second Lieutenant Dec. 29, 1983
First Lieutenant Jan. 14, 1986
Captain Jan. 14, 1988
Major Aug. 1, 1995
Lieutenant Colonel June 1, 2001
Colonel Nov. 1, 2006
Major General Aug. 9, 2013
Lieutenant General June 4, 2018
(Current as of June 2018)

United States Air Force

Presentation

Before the House Appropriations Committee, Subcommittee on Defense

Defense Health Program

Witness Statement of

Lieutenant General Dorothy Hogg
Surgeon General of the Air Force

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Chairman Visclosky, Representative Calvert, and distinguished members of the Subcommittee, thank you for this opportunity to testify before you today.

The Air Force Medical Service celebrates its 70th anniversary this year. Since separating from the Army Medical Department in 1949, Air Force Medicine has been an innovative force in the medical community, developing and implementing new ways to deliver ever higher levels of care in challenging environments, from remote, austere battlefields to the back of a plane at 30,000 feet.

Today, the Air Force Medical Service supports a beneficiary population of more than 2.5 million from 63 clinics and 12 hospitals across the country and around the world. More than 850 Air Force medics are currently deployed in an operational theater worldwide, an increase of nearly 20 percent in the past two years. These deployed medics are backed by 29,000 active duty medics and a total medical force of 40,550 personnel, including civilians and contractors.

The Air Force Medical Service employs the greatest patient movement system in history. This system developed gradually, driven by the evolving requirements of delivering medical support in shifting battlefield environments, and improves continuously. Our current capabilities are tailored to our current and recent conflicts, and must be adjusted to meet anticipated future requirements. Expanding our aeromedical evacuation capacity and enhancing its versatility is vital to preparing for future conflicts that may involve more casualties than current operations.

The Air Force of tomorrow must be able to compete with peer militaries; deter rogue states and opportunistic aggression; defeat terrorist threats wherever they arise; and defend American interests in air, space, cyberspace and other domains. As the Air Force looks to increase the number of operational squadrons, the Air Force Medical Service will remain a vital

part of supporting and sustaining the effectiveness of those units. To accomplish this goal, the Air Force Medical Service must modernize and transform to stay aligned with a changing Air Force and our Joint partners.

Our operational squadrons depend on the entire Air Force to ensure they are lethal, resilient and ready to fight. Today's combat environments require our forces to operate seamlessly across all domains with our Joint and allied partners. Medical integration and Joint training are critical, for while the human body is the same no matter what uniform it wears, the platforms, techniques, terminology and equipment vary. We do our medics a disservice when they have to learn unfamiliar systems on the fly during a deployment. The Air Force Medical Service is committed to relentlessly working with our Army, Navy and Defense Health Agency partners to increase Joint training and duty opportunities to minimize this challenge. Strengthening these bonds furthers the vision of an integrated, innovative, flexible, efficient and modern medical service that is responsive to the needs of combatant commanders.

Last year, we told the Senate Subcommittee that the Air Force Medical Service was at a crossroad. That crossroad is now in our rearview mirror. The Air Force Medical Service is already moving quickly down the path that will define the next decade or more of Air Force medical support. We are undertaking multiple lines of readiness-focused reform simultaneously, including:

- Transitioning health care delivery at our Military Treatment Facilities to the Defense Health Agency;
- Restructuring our headquarters and field operating agencies;
- Reorganizing our Military Treatment Facilities to focus on Airmen availability;

- Creating Operational Medical Readiness Squadrons;
- Revising and expanding the practice and training for flight medicine to additional provider types; and
- Evolving our deployable medical platforms to meet the needs of our combatant commanders.

The National Defense Strategy makes restoring readiness the top priority for our nation's armed forces. Each of the reform efforts underway in Air Force Medicine seeks to improve readiness. As we make our plans for the future and evaluate the courses of action available to us, our readiness mission is at the forefront of every discussion, matched by our commitment to providing our patients with high quality care.

Using the National Defense Strategy and the Secretary of the Air Force's priorities as guidelines, the Air Force Medical Service unveiled a strategy map last summer outlining three goals to drive our future efforts – Achieve Full Spectrum Medical Readiness, Strengthen Joint Warrior Medical Teams and Drive Air Force Medical Service Transformation. Each goal aligns to the broader vision of the Department of Defense and the Secretary.

Air Force medics are not "trigger-pullers" or "bomb-droppers" or even intelligence analysts, weapon system designers or cargo-movers. Our job is to make sure that the Airmen who execute those critical functions can most effectively accomplish their mission, contributing to the lethality of the force. We optimize their physical and mental health, and work to heal and return them to duty if they become ill or injured. We are the maintainers of the human weapon system.

Our single biggest driver of change remains the readiness needs of combatant commanders. As the global security landscape evolves, the Air Force Medical Service must also evolve to ensure we deliver the medical support required to conduct global operations.

In the last 20 years, the Air Force Medical Service has tailored our operational medical support to relatively small-scale and asymmetric conflicts. We built a world-class patient movement system that gets casualties from the frontline to higher levels of care in a remarkably short time. Since September 11, 2001, we have conducted nearly 340,000 global patient movements, saving many lives and contributing to an unprecedented 98 percent survival rate for U.S. service members injured in Iraq and Afghanistan.

Sustaining and improving this high-level of support for tomorrow's conflicts will be difficult and requires adapting our force composition and our deployment, training and readiness models. As the Air Force Medical Service implements the reforms coming from Congress, the Department and the Air Force, these evolving operational readiness requirements are the prism we use to determine the best way forward.

There is no better example than our efforts to implement the various medical reforms outlined by Congress in recent National Defense Authorization Acts.

The Air Force is committed to the vision of a single, integrated Military Health System laid out in the fiscal year 2017 NDAA, and we have moved smartly to adopt these reforms. We are working hand-in-hand with the Defense Health Agency and our sister services to design a model that effectively transitions the authority, direction and control of the health care benefit at Air Force Military Treatment Facilities to the Defense Health Agency, as detailed in section 702 of that act. The resulting standardization and efficiencies will allow the Air Force Medical

Service to focus our efforts on supporting the readiness of operational Airmen, and organizing, training and equipping deployable medical Airmen in support of combatant commander requirements.

In October 2018, the first four Air Force Military Treatment Facilities – Keesler Air Force Base in Mississippi, Joint Base Charleston in South Carolina, and Seymour Johnson Air Force Base and Pope Field in North Carolina – transitioned to the Defense Health Agency. We are also in the process of transitioning initial headquarters functioning to the Defense Health Agency, including the Quadruple Aim Performance Plan (a tool to quantify resources required for Military Treatment Facility readiness activities), health plans and pharmacy operations.

The run-up to and handover of the phase-one Military Treatment Facilities has not been without challenges. This is to be expected in any organization undergoing major structural and cultural change, and we do have noteworthy success stories. Participating in the collaborative transition Intermediate Management Organization with Army, Navy and the Defense Health Agency led to invaluable information sharing and gave the Air Force an opportunity to provide input as the Defense Health Agency built its processes.

The Defense Health Agency and the Air Force Medical Service worked together to overcome some unanticipated challenges at phase-one Military Treatment Facilities. Keesler Medical Center experienced a shortfall in funding soon after the Oct. 1 transition. The transition Intermediate Management Organization worked with Keesler to revise its estimated funding requirements to cover all civilian workforce and nearly all contract requirements in one day, allowing Keeler to sustain normal business operations without interruption.

In early March, a burst pipe flooded a building at Joint Base Charleston, affecting the mental health clinic, resource management office, and education and training facilities for the 628th Medical Group. The Medical Group worked with the Air Force Medical Operations Agency, the Defense Health Agency and the transition Intermediate Management Organization to secure funding for disaster management, flood restoration and the eventual facility repair and renovation, and reopen mental health services in a temporary facility.

These examples demonstrate the potential the Military Treatment Facility transition provides – a resilient, flexible organizational structure with greater resources and a narrowed focus on administration, management and patient care. The structure we developed allowed us to overcome many of the initial hiccups presented by the transition. Significant strategic and operational challenges remain as we move toward transitioning more Military Treatment Facilities and additional headquarters functions to the Defense Health Agency. These future steps will be taken with the benefit of lessons learned from this first phase, but we will have challenges to overcome – some already identified, and some not foreseen.

As we transition more organizational roles and move new structures from concept to operation, the key to ongoing success will be maintaining strong lines of communication with the Defense Health Agency and other partners and stakeholders. Only through close coordination and collaboration will we achieve the goal of an integrated Military Health System while maintaining the same commitment to readiness, continuity of care, and high level of service to our patients.

The next phase of transition begins October 2019 with additional CONUS Military Treatment Facilities moving to the Defense Health Agency. We are fully engaged with the

Defense Health Agency, affected Military Treatment Facilities, their wings and Major Commands to prepare for this action. Additional headquarters functions, including medical facility administration, and medical logistics will also transition to the Defense Health Agency during this phase. We are simultaneously communicating to Military Treatment Facilities in future phases to help them adapt to the coming changes.

Concurrently, the Air Force Medical Service is preparing to implement section 703 of the fiscal year 2017 NDAA. Our team is evaluating ways to restructure Military Treatment Facilities in order to maintain appropriate support for their host wing's mission and ensure our providers have the opportunity to practice and maintain the essential skills needed to provide care down-range. Our teams are currently in the process of assessing each Air Force Military Treatment Facility, analyzing their current mission requirements, clinical performance, and ability to integrate care with network partners. We will build comprehensive assessments of each facility based on these criteria, which will inform our re-scoping recommendations, and be included in reports due to Congress.

The Air Force Medical Service has also made significant progress reorienting our internal organizational structure in support of our full spectrum readiness mission. We are preparing to stand-down our two current Field Operating Agencies, the Air Force Medical Operations Agency and the Air Force Medical Support Agency, and replace them with the Air Force Medical Readiness Agency.

The creation of the Air Force Medical Readiness Agency facilitates our renewed focus on the operational readiness of our Airmen and our medical forces, and will help us coordinate with the Defense Health Agency to align readiness requirements and avoid duplication. We have draft

plans for the composition and location of the Air Force Medical Readiness Agency and will reach initial operating capacity this summer, with full operating capacity expected in autumn 2020.

This new headquarters structure highlights our renewed readiness focus and commitment to efficiency. As the Defense Health Agency on-boards additional functions, the Air Force Medical Service is taking a careful look at which parts of our organization will no longer be required, and which of these resources can be realigned to other parts of the Air Force. A more streamlined Air Force Medical Service supports the Secretary's plan to expand the Air Force's operational squadrons.

This reorientation towards readiness goes far beyond headquarters. We are restructuring Air Force Military Treatment Facilities in support of the readiness mission, and to clearly demarcate full spectrum readiness activities from health care delivery to non-active duty patients. We anticipate that these changes will help the Air Force meet its 95 percent medical deployablity and 90 percent fully mission-capable goals by reducing the number of Airmen deemed non-deployable due to preventable illness or injury.

Per guidance issued by Secretary in February 2019, many Air Force Military Treatment Facilities will soon reorganize based on a model implemented in 2018 by the 366th Medical Group at Mountain Home Air Force Base, Idaho. The Air Force Medical Service Reform Model divides Military Treatment Facility staff into new squadron types, each with a distinct focus. Medics assigned to Operational Medical Readiness Squadrons will only treat active duty patients, while medics assigned to Health Care Operations Squadrons will only treat non-active duty patients. At larger Military Treatment Facilities, a third squadron type, Medical Operations

Support Squadrons, will provide ancillary health services like laboratory, x-ray, and administrative functions. The Medical Operations Support Squadrons squadron will support both active duty and non-active duty patients.

This new model will enhance our organizational readiness culture by allowing medics who treat active duty patients to focus on that patient population and their readiness needs. Over an initial six-month period in 2018, employing the Air Force Medical Service Reform Model at the 366th MDG contributed to a 20 percent reduction in the percentage of Airmen deemed non-deployable at Mountain Home AFB at a time when the rest of the Air Force maintained a constant rate. We anticipate this will have similar effects at future sites.

We are on track to implement the Air Force Medical Service Reform Model at 43 Military Treatment Facilities this summer. Some facilities will be exempt, including larger hospital facilities, overseas Military Treatment Facilities, some smaller Military Treatment Facilities, and Graduate Medical Education platforms.

Airmen will be empaneled to Operational Medical Readiness Squadrons by unit. This allows providers to build relationships with squadron leaders and individual Airmen, and focus on squadron-specific needs to return Airmen to duty. The Air Force Medical Service Reform Model will allow our providers to get to know their active duty patients better, understand the challenges they face, prevent more injuries and illnesses, and return Airmen to full duty status more quickly.

This structure will also allow medical groups to be more responsive to the shifting operational mission requirements of their wings. The Air Force Medical Service is working closely with the Defense Health Agency as we plan this reform, as it overlaps and complements

the transition of health care delivery to that organization. Our partnership with the Defense Health Agency is vibrant and vital, and its strength will contribute greatly to the future successes of these efforts.

The Air Force Medical Service is also modernizing its approach to aerospace and operational medicine capabilities. The definition of an operator has evolved over the years but flight medicine has not. We will use the traditional flight medicine model to reach the rest of our operational medics such as security forces, explosive ordinance disposal and intelligence, surveillance and reconnaissance operators. The traditional flight medicine model will remain as part of our operational medical readiness model and it will expand to include nurse practitioners and physician assistants as flight surgeons. This expands the pool of flight medicine-qualified practitioners, increasing our deployable medical assets and capability to ensure Airmen are mission ready.

Another critical readiness component the Air Force Medical Service continues to develop is the concept of Integrated Operational Support. Integrated Operational Support embeds medical assets directly into operational units, enhancing access, building relationships and improving performance, fitness and overall health. In particular, embedded medics help in preventing and rapidly diagnosing musculoskeletal injuries. Integrated Operational Support has long been a staple of Air Force Medical Service support to operational squadrons, but we are developing new platforms to push the envelope.

One such platform, the Operational Support Team, is designed to act as a “strike team” to deploy into units at the request of the commander to analyze and recommend solutions for medical and mental health issues that may impact the mission. These teams are typically

composed of a physical therapist, a psychologist, two nutritionists, an exercise physiologist, and a human performance integrator. Working in partnership with squadron commanders, the Operational Support Team evaluates the unit as a whole, determining what behaviors or conditions may contribute to illness or injury, and recommending strategies for the unit to avoid or address preventable health issues.

We rolled out the Operational Support Team model at two sites in 2018, Whiteman Air Force Base in Missouri and Joint Base Elmendorf-Richardson in Alaska. It will deploy to 15 additional sites in the Air Force in 2019, and we plan to continue rolling this model out Air Force-wide in coming years. These efforts aligns closely with the Secretary's goal of revitalizing the Air Force at the squadron level, our core unit, making them more lethal, resilient and ready.

Even as we realign our medical support to the Air Force of the future, the Air Force Medical Service must recommit to training, nurturing and supporting our own medical personnel. One of the primary objectives in the new Air Force Medical Service strategy map is strengthening our Joint Warrior Medical Teams. The move towards an integrated Military Health System mirrors the Joint nature of most line deployments. It is increasingly more common for Airmen to serve side-by-side with Soldiers, Sailors, Marines, Coast Guardsmen, National Guard and Reserve members outside deployments. We need to do a better job of preparing medical Airmen for these Joint environments. We also need to create career and professional opportunities that reflect that new normal and contribute to the recruiting and retention of qualified, valuable military medical personnel.

Along these lines, the Air Force Medical Service is refining our career pyramids to align with future Joint training and fully develop an Air Force Medical Service continuum of learning

to establish a clear framework for career evolution for medical Airmen. Throughout that process, it is vital for us to listen to our medical force to ensure we are meeting their needs as members of the military and medical professionals. This will also support our need to recruit, develop and retain the highest quality practitioners. We are committed to building a talent management structure for each of the seven officer, enlisted and civilian Air Force medical corps to meet current and future requirements.

We are designing the plan to help us achieve these goals, and we know that making the proper investment of time, energy and resources today will pay off as we develop service and Joint leaders equipped to meet emerging challenges. Our goal to strengthen our Joint Warrior Medics is flexible and adaptive. We will continue to collaborate with our partners at Defense Health System and the other Services to find innovative ways to improve training and allow members to plot their professional and Joint development.

Another major change affecting the Air Force Medical Service is the adoption of MHS GENESIS, the integrated, enterprise electronic health record for the Military Health System. MHS GENESIS was first fielded by the 92nd Medical Group at Fairchild Air Force Base, Washington, in February 2017. MHS GENESIS will deploy in a series of waves over the next several years, with Wave One sites coming in 2019. Air Force locations in Wave One include Travis and Mountain Home Air Force Bases.

Electronic Health Record usage is a critical component of modern medicine, and replacing legacy electronic health records with MHS GENESIS is a significant additional mission for medical Airmen. Adoption requires broad systems and network improvements, as well as business process changes to achieve standardization and culture change. Fairchild

provided a critical template and testing ground for MHS GENESIS adoption, and for the change management and systems processes needed to successfully implement it across the Military Health System.

One key lesson from Fairchild's implementation of MHS GENESIS is that the transition to a new network has to happen at the Military Treatment Facility well in advance of actual MHS GENESIS training and Go-Live events. We are now implementing network updates at least six months prior to these events at all future adoption sites. This significantly alleviates many of the technical problems that affected Fairchild's MHS GENESIS implementation. Another key lesson from Fairchild is the need to overhaul our training approach. Immature workflows limited training effectiveness for the entire staff, beyond the designated MHS GENESIS "super-users" who were tasked to help other members learn the system. We developed a new training approach in coordination with the Defense Health Agency, informed by the challenges and solutions from Fairchild and the other early sites.

Although the 92nd Medical Group did suffer a temporary but significant decrease in productivity as their staff learned MHS GENESIS, Fairchild did not lose readiness capability during this period. 92nd Medical Group leadership prioritized that mission, another critical lesson for future Military Treatment Facilities. Access levels at Fairchild decreased during MHS GENESIS adoption, but rebounded by December 2018. We expect the duration of this decrease to shrink as our experience implementing MHS GENESIS grows. However, the readiness mission cannot and will not be allowed to suffer during implementation.

We also learned that Fairchild's manning structure was insufficient in some areas to support MHS GENESIS workflows. Adoption of MHS GENESIS will require on-site program

management and additional resources. As the number of sites using MHS GENESIS increases, the normal military cycle of permanent changes of station will find experienced MHS GENESIS users already working at Military Treatment Facilities as they begin implementation. This will provide a cadre of experienced users at new sites, easing transition.

It has been more than two years since we started electronic health record modernization in the Military Health System, and that time has reaffirmed the knowledge that it requires significant collaboration between the services and the Defense Health Agency to effectively accomplish this modernization. We have learned a lot and the product has been improved greatly in that time. We will continue to strive towards standardizing and optimizing our use of MHS GENESIS and look for ways to streamline our business processes.

Even while these transformation activities are underway, the day-to-day mission of the Air Force Medical Service continues. Our medical Airmen remain resolute in their commitment to our culture of Trusted Care, wherever they serve. Above all else, we are focused on our patients, whether they are an Airman getting ready for deployment, a mother and newborn child at a hospital stateside, or an injured service member en route home from a faraway battlefield. I am always humbled and amazed by the incredible work medical Airmen do every day.

Alongside the structural and organizational changes to the Air Force Medical Service outlined above, we continue to refine and grow our expeditionary medical and aeromedical evacuation platforms. These efforts are aligned with and in response to the requirements of our combatant commanders, with a strategic eye towards the next generation of conflicts. While this process is continuous, the past year saw significant progress in evolving our capabilities to support a global or regional peer-level conflict.

In fiscal year 2018, the Air Force Medical Service initiated the Ground Surgical Team program to upgrade and enhance the capabilities of the Mobile Field Surgical Teams. This was accomplished by modifying training, equipment and personnel assigned and revising the tactics, techniques and procedures for employment. These enhancements provide ground force commanders with enhanced capabilities for damage control resuscitation, combat damage control surgery, life, limb and eye-sight saving care, and post-op critical care. When the transition is complete, the Air Force Medical Service will field a total of 65 Ground Surgical Teams.

This new platform offers several improvements over the previous iteration. Ground Surgical Teams are designed to be flexible platforms that undergo robust training and have a scalable, modernized equipment augmentation package with enhanced capabilities to meet combatant commander requirements. While staging out of an Expeditionary Medical Support System near the front lines, these small, agile teams can drop into remote, austere locations to save lives. This forward deployable medical asset can prolong survivability for injured service members in denied environments, where typical patient movement and en route care is inaccessible.

At this time, 92 percent of active duty Ground Surgical Team positions have been filled, with 63 percent of those individuals fully trained. We are currently on schedule to have the remaining positions manned and trained by the end of fiscal year 2019.

Ground Surgical Teams form the core capability of the Expeditionary Medical System, which we are also making more flexible to support new requirements. A key component of the revised Expeditionary Medical System tactics, techniques and procedures is the addition of a

second Ground Surgical Team to each Expeditionary Medical System +25 package. This will allow one team to forward deploy as a surgical element without rendering the entire Expeditionary Medical System non-mission capable.

We are also growing our Critical Care Air Transport Team capability, which can turn an aircraft into a flying Intensive Care Unit, expanding our global patient movement capability. We are taking short- and long-term steps to build this capability by training additional active duty, Guard and Reserve Critical Care Air Transport Team crews, with plans to nearly double our current baseline of 124 crews to 221 crews by the end of fiscal year 2020. Increasing our Critical Care Air Transport Team capability was identified as a requirement in the 2017 Air Force Aeromedical Requirements Analysis Study, and as a needed improved/enhanced medical mission in the deliberate planning process for existing Air Force Operation Plans.

The Air Force Medical Service responded to this requirement by taking immediate and long-term steps to increase our Critical Care Air Transport Team capability. First, we increased the number of crews in our training pipeline. Second, we identified the lengthy and repetitive training process as a potential impediment to future growth. The 711th Human Performance Wing and the U.S. Air Force School of Aerospace Medicine at Wright-Patterson Air Force Base in Ohio unveiled a streamlined Critical Care Air Transport Team course in 2018, making it more efficient at training new crews and maintaining skills for existing crews. This allows the Air Force Medical Service to sustain our increased Critical Care Air Transport Team capability, and grow it further should this requirement arise.

In addition to training more Critical Care Air Transport Team crews, the Air Force is expanding our standard aeromedical evacuation fleet. We are working to certify the C-5M Super

Galaxy for regular aeromedical evacuation missions. The C-5M is currently used for emergency aeromedical evacuation missions, but certifying it for scheduled missions makes our aeromedical evacuation fleet larger and more flexible. The C-5M can accommodate up to 300 patients, with a mix of ambulatory and litter cases. Because this capacity is so large, we are also in the early planning stages of increasing our ground staging capability to take full advantage of the C-5M.

Our commitment to restoring readiness exceeds the areas outlined above. I recently issued a new vision and guidance to the Air Force Medical Service that positions Full Spectrum Medical Readiness as our top priority and aligns with the Air Force's vision. We are institutionalizing our Comprehensive Medical Readiness Program, which establishes standards for a ready medical force at the individual Airman level, enabling Commanders to manage to those standards. We are clarifying and standardizing the readiness roles of our Major Command Surgeons, Air Force Medical Service headquarters staff and Military Treatment Facilities commanders.

We are also taking another look at our readiness training exercises. This means reemphasizing the importance of medical participation in wing-level readiness exercises. We are recommitting to "training how we fight" by conducting realistic and challenging training and exercises to ensure our medical personnel are ready perform to across a multi-domain environment. We are bringing back our readiness training exercises, known as "Medical Red Flag" to give medics additional training in battlefield casualty management. We want to ensure our medics are ready to "fight tonight" when called on.

Working with our combatant commanders, we have also updated our medical resourcing to revise some of our deployable medical platforms. This includes configuration for Air Force

Theater Hospitals, the Expeditionary Medical System, and the aforementioned increase in Critical Care Air Transport Team crews across our Total Force. These efforts allow us to improve our capability mix through cost-effective modernization, facilitate Joint operations, and build a more flexible operational medical force.

Implementing these numerous, concurrent transformation efforts commanded an enormous amount of time, energy and attention. As a leader, it is my responsibility to help manage the natural concerns and anxieties Air Force Medical Service members are experiencing during this time. Author Robin Sharma says “Change is hardest at the beginning, and messiest in the middle, and easiest at the end.” We are in the middle of our change and it’s messy and we are working are way through it.

Many Air Force Medical Service members perceive the various ongoing transformations with concern and trepidation about how it will impact their careers, personal lives and, of course, patients. It is also a testament to the incredible talent, resiliency and character of our Airmen that we have made so much progress transforming the Air Force Medical Service in such a quick time. Despite the challenges and anxieties created by transformation, there is also a broad recognition of the opportunity before us. By renewing and recommitting our focus on operational medical readiness, we will build a stronger, more flexible, and healthier Air Force than ever before.

As the Air Force Medical Service continues down the road of multiple, simultaneous modernizations, efficiencies and reforms, we will continue to innovate new ways to push medicine forward on the battlefield, higher into the sky, and improve it in traditional clinical settings. I regularly call on each and every medic, irrespective of rank, to be disruptive

innovators in their workspace. This means finding new solutions that upend the established way of doing things. To take risks, to try new ideas, to think without a box. This spirit will see the Air Force Medical Service through this tremendous change, and will lead to an even stronger organization.

Chairman Visclosky, Representative Calvert, thank you again for the opportunity to address you today. I hope that my testimony gives a complete picture where Air Force Medicine is going, and the challenges we are overcoming to get there. Building an integrated Military Healthy System, focused on supporting the readiness and operational medical needs of U.S. Armed Forces, will take time and significant efforts from all involved, but I am confident we are on the right path to achieve that vision. None of this would be possible without the remarkable contributions, hard work and constant sacrifices made every day by the men and women of the Air Force Medical Service.

I look forward to answering your questions.