United States Air Force

Presentation

Before the House Armed Services Committee, Subcommittee on Military Personnel

Military Health System Reform

Witness Statement of

Lieutenant General Dorothy Hogg
Surgeon General of the Air Force

December 5, 2019

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)

Chairwoman Speier, Ranking Member Kelly, and distinguished members of the Subcommittee. Thank you for this opportunity to update you on our progress implementing the numerous reforms underway in the Air Force Medical Service.

The Air Force Medical Service provides a unique and critical set of medical capabilities to our warfighters. Our specialty is aerospace and operational medicine, most notably aeromedical evacuation. Delivering this vital support to those who defend our nation remains our primary mission, even as we engage in ongoing Military Health System reforms. Air Force Medicine must continue to promote fit, healthy, medically ready Airmen postured to fly, fight and win in air, space and cyberspace.

Air Force medics answer the call across a broad spectrum of operational, humanitarian, and disaster response missions. In August, our medics participated in a life-sustaining aeromedical evacuation mission, transporting a critically injured Soldier directly from Bagram Air Base, Afghanistan to Brooke Army Medical Center in San Antonio. This dedicated team provided en route care for the entire 8,000 mile, 20-hour non-stop flight, sparing no effort to bring this Soldier home, alive. While the distance and duration of the flight were exceptional, this is the level of care and expertise Air Force medics deliver on a daily basis. We are proud of our 98% survivability rate and we do whatever it takes to get our wounded warriors back to their loved ones.

In fall 2017, devastating hurricanes hit the Virgin Islands and once again our Air Force medics were at the forefront. A 23-person team from the 375th Medical Group at Scott Air Force Base were among the first medical personnel on the ground in St. Croix to administer aid

and evacuate injured victims. The team quickly established an En Route Patient Staging facility, supporting nine aeromedical evacuation missions over seven days and evacuating 135 patients. The deteriorating conditions in St. Croix demonstrated Air Force medics' agility and adaptability in executing our mission under the most challenging circumstances.

To best support the Air Force Medical Services' renewed focus on operational readiness, this summer I deactivated our Air Force Medical Support Agency and redesignated our Air Force Medical Operations Agency as the Air Force Medical Readiness Agency. This brings us into compliance with section 712 of the 2019 National Defense Authorization Act, which requires the military department surgeons general to restructure their headquarters organizations to undertake statutory duties supporting readiness. We reduced headquarters management redundancy while improving our ability to execute our medical readiness mission in support of Air Force operational requirements.

The Air Force Medical Readiness Agency delivers operational medical capabilities to support combatant commander requirements while providing oversight of strategic medical readiness initiatives at Air Force installations. Additionally, it will directly support readiness, aerospace and operational medicine activities at military treatment facilities, downrange, and throughout the Air Force. We designed the organizational structure to deliver the operational medical capabilities the Air Force needs now and in the future.

The Air Force Medical Service also reorganized our military treatment facilities with the goal of modifying how we deliver mission support to our operational forces. The Air Force Medical Reform Model, launched this summer, optimizes the medical readiness of our Airmen

and the delivery of healthcare to our beneficiaries. Based on a 2018 pilot conducted by the 366th Medical Group at Mountain Home Air Force Base, the model reorganized our military treatment facilities into two squadron types, an Operational Medical Readiness Squadron, serving our active duty beneficiaries (including Guard and Reserve) and a Healthcare Operations Squadron, serving our non-active duty beneficiaries. At larger military treatment facilities, a third squadron, the Medical Support Squadron will continue to provide ancillary health services such as laboratory, X-ray, and administrative functions for both active and non-active duty patients.

The new two squadron model delivers a more focused approach to ensure Airmen are fully mission-capable and rapidly returned to duty. The initial roll out of this model has been completed at 41 military treatment facilities in the United States, plus the pilot location, with remaining facilities projected to transition by summer 2020. This phased approach allows us to identify any potential challenges and refine the model accordingly. We will continue to work closely with the Defense Health Agency during initial implementation to ensure we are collectively supporting readiness and the delivery of healthcare.

Under the new construct, operational squadrons are empaneled to a single provider team. This facilitates better relationships between patient and provider, and allows the provider to develop a better understanding of Airmen's medical needs. This also enables medical teams to work hand-in-hand with wing and Squadron leadership to gain a better understanding of the physical and mental stressors for each unit. Medics assigned to the Operational Medical Readiness Squadron devote time each week to proactive case

management of Airmen with limiting medical restrictions to maximize their employability and availability.

In today's Air Force, we must prepare for peer competitors while continuing to deter and defeat rogue states and terrorist threats across multiple domains. In support of these strategic objectives, the Air Force Medical Service is aggressively enhancing our ability to operate in these highly contested environments. A major initiative underway is the MedicX program, which expands the basic clinical capabilities of all Air Force medics. MedicX develops multi-functional medics who can perform some clinical functions beyond their primary job duties. For example, when we deploy an Expeditionary Medical Support System (a modular field hospital) to a contingency area, a significant portion are non-clinical positions such as logistics, administrative, and lab personnel. We need to strengthen this cohort's clinical skills so that in the event of a mass casualty or all-hands-on-deck scenario, they are equipped to perform skills beyond their primary job.

The Ground Surgical Team platform recently replaced our Mobile Field Surgical Teams, offering enhanced capabilities. Designed to be flexible platforms that undergo robust training and have a scalable, modernized equipment augmentation package, Ground Surgical Teams 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. As forward deployable medical assets, their mission is to improve survivability for injured service members in denied environments without access to higher levels of care.

Increasing our Critical Care Air Transport Team capability, which turns an aircraft into a flying Intensive Care Unit, was identified as a requirement in the 2017 Air Force Aeromedical Requirements Analysis Study. We are taking short-term and long-term steps to expand this capability by training additional active duty, Guard and Reserve Critical Care Air Transport Team crews. We grew from 130 authorized teams in fiscal year 2018 to 196 in fiscal year 2019 and expect to have 221 teams by the end of fiscal year 2021. Supporting these emerging requirements presents resourcing, posturing and training hurdles, but we have made significant strides in overcoming these obstacles. It takes considerable time to recruit, train and equip new Critical Care Air Transport Team crews, but I view this as an essential long-term investment in our aeromedical evacuation capabilities.

The Air Force participated in the tri-service working group that led efforts to implement section 703 of the 2017 National Defense Authorization Act which required a systemic review of military treatment facility readiness support requirements at military treatment facilities. A final report to Congress, with the recommendations of that working group should be released soon. Analysis of Air Force military treatment facilities was grounded in guidance from Congress found in section 703, and a standardized processes to gather and validate data developed by the working group. A critical component in assessing the appropriate scope for these facilities is the capacity of the local TRICARE network to take on additional patients. Many Air Force installations are located in communities with limited health care resources where expanding the local network capacity would be challenging.

It is crucial to sustain and strengthen our partnerships with civilian, educational and other government health systems to ensure our maintain medics maintain their currency and competency in their primary specialty. Military treatment facilities are our primary readiness platforms, but their typical case mix is not always adequate to sustain the skills our teams require in a deployed environment. Partnerships with hospitals, like the Level I Trauma Center at the University Medical Center of Southern Nevada, the R Adams Cowley Shock Trauma Center in Baltimore, and the St. Louis University Hospital, are increasingly important for preparing our surgical teams to treat complex combat injuries. In addition to these national level partnerships, medical group commanders are empowered to pursue partnerships with local health facilities. This allows commanders to adaptively build the necessary partnerships needed to maintain the clinical currencies and skills appropriate for their facility in conjunction with their mission. This is critical as we evolve our medical force and possibly decrease the scope of care we deliver in military treatment facilities.

Recent months have seen the Military Health System achieve significant milestones in implementing section 702 of the fiscal year 2017 National Defense Authorization Act. In October, military treatment facilities in the U.S. moved under Defense Health Agency management. The Air Force Medical Service is working closely with the Defense Health Agency and sister services to ensure the success of these efforts. The Defense Health Agency is still building its headquarters structure and capabilities. Until this process is complete, and the Defense Health Agency can begin to assume day-to-day management responsibilities, it is premature to judge the long-term success of the transition.

Earlier this year, the services and Defense Health Agency took a clear-eyed look at our progress and identified significant risks in the geographically phased approach of previous implementation plans. We needed clearer communication and adjudication channels, and plans to build out the Defense Health Agency functional capabilities and markets, which were underdeveloped and did not have a mechanism to validate their maturity. Jointly, we assessed these risks necessitated a new implementation plan to meet the intent of the law without harming our readiness and patient care missions.

In response, the Defense Health Agency, with significant input from the services, developed what we call “Plan 3”, which included highly developed implementation plans and annexes for building Defense Health Agency functional capabilities and the market construct, including an outline for the human capital strategy required to bring them online. Critically, it laid the blueprint for developing quantifiable, specific metrics to evaluate and validate when the Defense Health Agency is ready to take on aspects of military treatment facility management from the services.

Plan 3 called for the Defense Health Agency to assume administration of all U.S. military treatment facilities in October 2019. We are supporting the Defense Health Agency in executing administration through a direct support memorandum of agreement. Once Defense Health Agency functional capabilities meet conditioned-based metrics, we will discontinue the memorandum. Today, we retain many of our existing military treatment facility support functions. The phone numbers have not changed, nor in most cases, have the people answering the phone. We will provide this continuity while the Defense Health Agency develops its own

management capabilities. This will ensure a smooth transition and reduce risk of mission failure in both our readiness requirements and delivery of the benefit.

This relationship is very much like the relationship between an instructor and student pilot. The more experienced pilot keeps their hand on the stick, as the less experienced pilot demonstrates that they are ready to take the controls. We are helping to guide the Defense Health Agency as it takes on a new mission set. Once they develop the organizational capability to manage a large, complex and geographically diverse direct care system, we will step back and they will take on full day-to-day management activities. The culminating point of this transition will be a system where the services and the Defense Health Agency mutually support one another in our complimentary readiness and health benefit missions.

We are working closely with the Defense Health Agency, Army and Navy to develop a highly reliable Military Health System. In 2015, Air Force Medicine began our Trusted Care journey to being a Highly Reliable Organization, evolving into a continuous learning and improving organization that partners with patients and families in a single-minded focus on safety and Zero Harm. Since then, we have achieved a 50% reduction in serious patient safety events in the 30 months prior to October 2019. We will blend our Trusted Care culture with our sister services and the Defense Health Agency patient safety cultures to take what works best from each service, and apply it enterprise-wide. Trusted Care will remain our culture as we shift our focus to readiness and operational medicine.

In September, MHS GENESIS, the new Military Health System electronic health record was deployed to the 60th Medical Group at Travis Air Force Base and the 366th Medical Group

at Mountain Home Air Force Base. The Defense Health Agency and the Defense Healthcare Management Systems Program Executive Office deployment team applied the many lessons learned from our initial operating sites to deliver a much smoother launch. Travis and Mountain Home report accelerated adoption of MHS GENESIS by their staff and a significant reduction in time spent using the electronic health record per patient. We have also seen a 50% drop in remedy tickets compared to the earlier waves. In addition, Travis and Mountain Home have nearly returned to their pre-"go live" levels of productivity in just eight weeks. The next deployment wave of MHS GENESIS will impact many Air Force sites starting in June 2020, I am pleased the Defense Health Agency is already surging additional IT staff to help with implementation.

The capabilities offered by MHS GENESIS help position the Air Force Medical Service and the entire Military Health System to better accomplish our Quadruple Aim goals (Better Health, Better Care, Lower Cost, Improved Readiness) over the long term. We continue to work with the Defense Health Agency to evaluate staffing requirements for deploying MHS GENESIS and will mature the manning requirements to ensure timely and successful rollouts.

As we continue down the road of simultaneous reforms and modernizations, we will work closely with our partners in the Defense Health Agency, Army Medical Command, and Navy Bureau of Medicine and Surgery to develop the best possible medical system for our warfighters and beneficiaries. We will continue to innovate and find new ways to push the limits of what is possible in military medicine. Medical Airmen are incredibly talented and totally dedicated to their missions and their patients. I hear their remarkable stories every day,

like the flight nurse on a trans-Pacific aeromedical evacuation flight who held an oxygen mask up to a 5-year old burn victim for seven hours because wearing the mask irritated her burns; or about the New Horizons Medical Readiness Training Exercise, where Air Force medics treated 9,575 Guyanese patients while practicing vital deployment skills; or the Air Force International Health Specialist in Uganda who applied his clinical skills to save a tourist who was mugged and assaulted with machetes, then stayed in touch and coordinated follow-up visits and travel home. These stories, and many more like them, are emblematic of what makes Air Force Medicine, it's what makes military medicine a national treasure.

Chairwoman Speier, Ranking Member Kelly, thank you again for the opportunity to address the Subcommittee. I hope my testimony gives the committee a clear picture of your Air Force Medical Service and the challenges we face. It will not be easy to meet these goals but I don't know anyone who signed up to be in medicine or the military because it would be easy. Our success will be a result of the hard work and tireless resolve of medics at all levels of the Military Health System. Their talent, skill and commitment to our patients, in uniform and out, inspires me every day.

I look forward to your questions.