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

March 5, 2020

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
2012 – 2013, Deputy Command Surgeon, Air Force Materiel Command, Wright Patterson AFB, OH
2013 – 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 February 2020)

Chairman Visclosky, Representative Calvert, and distinguished members of the Subcommittee, it is my honor to testify on behalf of the 54,600 active duty, guard, reserve, and civilian Airmen who comprise the Air Force Medical Service. It is a privilege to represent these Airmen who are wholeheartedly committed to our mission.

Today, Air Force medics are deployed around the world in support of wartime contingencies, natural disasters, humanitarian relief, and global health engagement with U.S. allies. These deployed medics, like those at home station, must be ready at a moment's notice to deliver life-sustaining care under the most challenging circumstances.

Air Force medics provide a broad continuum of care and treat patients in every environment imaginable. Sometimes they have access to the full array of modern medical technology, other times they are happy to have sterile water and battery power. To prepare medics for the unknown, their training must simulate the rigors, unpredictability and stressors of combat. As the Air Force Surgeon General, my job is to prepare our warrior medics to do the job combatant commanders require, no matter the conditions.

WHY WE NEED A MILITARY HEALTH SYSTEM

Recently, this responsibility was driven home by the story of a young medic, Senior Airman Colleen Mitchell. In January, Airman Mitchell was on her first deployment when Al Shabab militants attacked the airfield at Manda Bay, Kenya, taking the lives of three Americans. Airman Mitchell, a medical technician from Wright-Patterson Air Force Base, Ohio, was awakened by the ensuing chaos. Still in her pajamas, she immediately established a triage point. As her supervising physician assistant coordinated patient movement, Airman Mitchell

assumed the role of lead medic, spending hours triaging and treating patients. She directed a team of fire fighters, a Staff Sergeant from the base contracting office, and contract employees to care for the injured. Airman Mitchell and her makeshift team treated a variety of injuries, including shrapnel wounds, severe burns, and combat stress.

As the lead medic, Airman Mitchell also monitored her care team for signs of combat stress, shock, and dehydration. Once the attack ended and the injured had been treated and released or evacuated, Airman Mitchell turned to the solemn task of preparing the remains of the three Americans who lost their lives. She performed well above her paygrade and demonstrated the very best qualities of what we value in our Airmen – skill, diligence, innovation, and commitment to her patients and mission.

Airman Mitchell's experience reminds me of what makes our medics so remarkable. She did not have a hospital full of trained professionals, nor access to a fully stocked pharmacy, or an abundant blood supply. Against all odds, Airman Mitchell stabilized her patients and prepared them for transport to the next echelon of care. I take very seriously my responsibility to prepare Airman Mitchell, and every other Air Force medic, to succeed along the entire continuum of care to return service members to the fight or bring them safely home. They must be prepared to treat patients from point of injury to rehabilitation.

Approximately 30% of the care provided in the deployed environment goes towards trauma injuries. The other 70% tackles disease and non-battle injuries to keep our deployed forces healthy and ready to complete their mission. These injuries include sports and occupational injuries, dehydration, dental problems, mental health issues and anything else you

would see in a military treatment facility. Having medics along this entire continuum, from point of injury to rehabilitation, is vital to ensure our Airmen and joint partners are fit for duty when and where needed.

Each of the three uniformed medical Services specialize in medicine that uniquely supports its operational mission. The Air Force specializes in aerospace medicine and aeromedical evacuation. Aerospace medicine focuses on the occupational health needs of crewmembers and passengers on air and space vehicles, as well as individuals who maintain those vehicles. They specialize in the physiological effects of altitude, pressure, and noise. They also understand the physical and mental requirements it takes to operate an aircraft at optimal efficiency, and know the challenges maintainers must overcome to keep our aircraft safe and ready to fly.

Because the Air Force fights originate from our bases, many of our deployments are not located inside a combat zone. Remotely piloted aircraft operators, intelligence analysts, cyber warriors, and others may be located far from the front, but execute front line operations. That means stateside aerospace medicine is synonymous with combat medicine. Many aerospace medical providers are embedded in operational units, working with crews and maintainers day-in and day-out. The specialized aerospace medicine our providers deliver is comparable to sports medicine practiced in professional sports. It is high cost, high maintenance and highly specialized, but unlike professional athletes, our Airmen have no offseason to rest and recover.

The Air Force's other medical specialty is aeromedical evacuation, providing en route care for patients moving to higher echelons of care. Since September 11, 2001, the Air Force

has conducted more than 340,000 global patient movements and 13,500 Critical Care Air Transport missions. We convert the back of an aircraft into a flying intensive care unit. We deliver a broad spectrum of "care in the air" and operate patient staging facilities where we hold and prepare them for transport.

Over the past 20 years, we developed a robust and variable aeromedical evacuation capability to support the evolving needs of our operational forces. Our aeromedical evacuation forces must be capable of operating anywhere air operations occur. Aeromedical evacuation crews require specialized training for each airframe, in addition to preparing them to deliver care during flight. This means we train our medics to treat patients in a loud, dark, unsteady, non-temperature controlled, high-altitude environment, and develop special equipment to mitigate these challenges. Things that providers take for granted on the ground, like verbal communication with patients and staff, are often not possible in the back of an airplane. Opportunities for training in these conditions are rare or inaccessible in the civilian medical community, but vital for Air Force Medicine to accomplish our mission.

READY MEDICAL FORCES

Our military treatment facilities remain our primary readiness platform. The scope of practice at these facilities is necessary to maintain the skills and currency across the broad spectrum of care needed to meet our requirements. However, military treatment facilities alone cannot sustain currency in every skillset. Our beneficiary population tends towards young, healthy patients, offering few complex cases to support currency of our more specialized providers. We pursue partnerships with civilian, educational, and other

government health organizations, including international partners, to keep our medics proficient. Fostering these partnerships is a critical part of getting our medics the proper caseload and patient mix needed to sustain their skills. Partnerships with major civilian trauma centers are increasingly important for preparing our surgical teams to provide damage control care at the point of injury and treat complex combat injuries. As we re-scope the direct care system, our reliance on these partnerships will be critical to the currency of all our provider types, from the trauma team to nurses, medical technicians and other medics.

The 2014 Ebola outbreak in West Africa highlighted the need for advanced infectious disease control training. In 2018, the Air Force Research Laboratory established a partnership with the University of Nebraska Medical Center in Omaha to train Air Force medics to care for patients with infectious diseases. These diseases require expert knowledge and specialized training to safely treat patients while mitigating risk to our operations. This partnership allows medics to learn from instructors with decades of expertise in biocontainment care and research. Air Force infectious disease physicians and infection prevention specialists take courses covering disease recognition, diagnosis, treatment, patient transport, infection prevention, personal protective equipment, waste management, and communication.

The ongoing 2019 novel coronavirus health crisis drives home the importance of this partnership. The director of the C-STARS Omaha team is a member of the University of Nebraska Medical Center Biodefense team preparing to treat evacuees from China. Delivering this care in a civilian setting gives the Air Force valuable experience for future contingency operations.

In addition to our national-level focus, medical group commanders are empowered to pursue partnerships with local health facilities. This allows commanders to maintain the clinical currencies and skills appropriate for their unique missions. This is critical as we evolve our medical force and re-scope our medical treatment facilities.

MILITARY MEDICAL REFORM

Our partnership with the Defense Health Agency will be critical to our continued success. I am pleased with the collaboration between the Air Force Medical Service and the Defense Health Agency as we implement section 702 of the fiscal year 2017 National Defense Authorization Act. In 2019, this partnership helped us reach important milestones in transitioning authority, direction and control of military treatment facilities to the Defense Health Agency, including the transfer of all U.S.-based military treatment facilities October 1, 2019. Through a memorandum of agreement, the Air Force Medical Service is providing direct support to the Defense Health Agency while it stands up its headquarters and works toward achieving full operational capability.

Recognizing the challenges of merging four discrete health systems, we are working closely with the Defense Health Agency, Army and Navy, to maintain a highly reliable Military Health System. In 2015, Air Force Medicine began our Trusted Care journey to being a Highly Reliable Organization, with a single-minded focus on patient safety. Since then, we have achieved a 50% reduction in serious patient safety events. We will blend our Trusted Care culture with our sister Services' and the Defense Health Agency's patient safety cultures to take what each Service does best and apply it enterprise-wide.

In 2018 and 2019, the Air Force participated in a tri-Service working group to implement section 703 of the 2017 National Defense Authorization Act, which required a systemic review of military treatment facility readiness support requirements. Analysis of Air Force military treatment facilities encompassed a standardized process to gather and validate data developed by the working group. A critical component to "right-sizing" these facilities was the local TRICARE network's capacity to take on more patients. Many Air Force installations are located in communities with limited health care resources. Those facilities were not considered for re-scoping.

Fiscal year 2020 will also see changes to the medical force as we convert 4,684 uniformed medical positions to meet other Air Force operational requirements. Proposed uniformed medical billet reductions were based on our Critical Operational Readiness Requirement model. Pending the report required by section 719 of the fiscal year 2020 National Defense Authorization Act, planned reductions to uniformed medical personnel will be gradual in order to minimize negative impacts to patient care and our ability to accomplish the readiness mission.

FUTURE OF AIR FORCE MEDICINE

The most significant driver of change in Air Force Medicine remains the evolving requirements of our combatant commanders. As our armed forces pivot away from small, asymmetric conflicts to global conflicts with peer or near-peer adversaries, our medical capabilities must follow. This requires us to enhance our current capabilities while developing

new ones. Our current conflicts allow us to prioritize patients at greatest risk of death, leading to an unprecedented 98% survival rate for U.S. and coalition forces wounded in action.

However, in our next conflict we will face very different challenges. In a peer conflict with limited resources and casualty evacuation capability, the highest priority patients are those we can return to the fight quickest. In this mass casualty scenario, the sobering reality is that we will not be able to save every patient. It will be hard for our medical personnel to mentally adjust to this battlefield reality. To prepare for this challenge, we have begun reorienting our training doctrine to teach medics to make these hard choices.

To prepare our medical force for the next decade and beyond, we will expand our ability to operate in a denied environment, where we may not have access to functioning airfields or electronic equipment. This means growing our aeromedical evacuation capacity while broadening the baseline clinical skills of every medical Airmen, including those in non-clinical roles. We are preparing for this unpredictable future while supporting today's requirements.

We are warrior medics first and foremost. Our core mission is to deliver medical support to our operational forces, keeping them fit to fight and returning them to the fight as quickly as possible. We keep our skills current by delivering the health benefit at our military treatment facilities and through our partnerships. These activities augment our core readiness mission, but that mission takes precedence when necessary.

The talent, adaptability and dedication of Air Force medics shines through in the stories I hear every day. For example, an off-duty Tech. Sergeant from the 459th Aeromedical Staging Squadron on an international flight who treated an unconscious woman with anemia. A 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 the straps irritated her burns. A dental assistant who saw a major traffic accident and saved the life of a victim by applying a tourniquet to their severed leg. The 2019 New Horizons Medical Readiness Training Exercise where Air Force medics treated 9,575 Guyanese patients provided vital deployment skills. And of course, Senior Airmen Mitchell, going above and beyond to care for personnel injured in the Manda Bay attacks.

These are just a few examples of remarkable Air Force medics and the service and sacrifice they make every day defending our nation. They are what make military medicine irreplaceable, and they are why we will succeed in reforming military health care to meet whatever challenges the future brings.

I thank the Committee for this opportunity, your steadfast support of Air Force Medicine, and your dedication to the welfare of Airmen, Soldiers, Sailors, Marines, Coast Guardsmen, veterans, and their families.