UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

SEP 15 2021

The Honorable Jack Reed
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The Department's final response to section 708(d) of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114-328), "Joint Trauma Education and Training Directorate," is enclosed. Section 708(d) requires the Secretary of Defense to establish a personnel management plan for specified wartime medical specialties.

Previously submitted interim reports satisfied all elements of section 708, parts a-e, with the exception of two remaining sub-tasks in section 708(d) pertaining to the personnel management plan. A working group comprised of the Office of the Assistant Secretary of Defense for Health Affairs, the Military Departments, the Defense Health Agency, and the Joint Staff completed work on those two remaining sub-tasks. This report contains the results of the working group, the required accession plans, and the number of critical wartime medical specialties (CWS) as specified within section 708(d).

The report includes an overview of the Department of Defense (DoD) processes used to define the total force manpower requirement for CWS and an analysis of manpower gaps. Additionally, it provides a DoD-level review of the various mechanisms common to all Military Departments for the recruitment, production, and retention of CWS, including crucial organizational and operational assignments and career pathways common across all Military Services.

Thank you for your continued strong support for the health and well-being of our Service members, veterans, and families. I am sending a similar letter to the House Armed Services Committee.

Sincerely,

Gilbert R. Cisneros, Jr.

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

SEP 15 2021

The Honorable Adam Smith
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Department's final response to section 708(d) of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114-328), "Joint Trauma Education and Training Directorate," is enclosed. Section 708(d) requires the Secretary of Defense to establish a personnel management plan for specified wartime medical specialties.

Previously submitted interim reports satisfied all elements of section 708, parts a-e, with the exception of two remaining sub-tasks in section 708(d) pertaining to the personnel management plan. A working group comprised of the Office of the Assistant Secretary of Defense for Health Affairs, the Military Departments, the Defense Health Agency, and the Joint Staff completed work on those two remaining sub-tasks. This report contains the results of the working group, the required accession plans, and the number of critical wartime medical specialties (CWS) as specified within section 708(d).

The report includes an overview of the Department of Defense (DoD) processes used to define the total force manpower requirement for CWS and an analysis of manpower gaps. Additionally, it provides a DoD-level review of the various mechanisms common to all Military Departments for the recruitment, production, and retention of CWS, including crucial organizational and operational assignments and career pathways common across all Military Services.

Thank you for your continued strong support for the health and well-being of our Service members, veterans, and families. I am sending a similar letter to the Senate Armed Services Committee.

Sincerely,

Gilbert R. Cisneros, Jr.

Enclosure:
As stated

cc:
The Honorable Mike D. Rogers
Ranking Member

Report and Final Implementation Plan for Congressional Armed Services Committees

September 2021

Final Report and Implementation Plan in response to Section 708 of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114–328)

"Establishment of Joint Trauma Education and Training Directorate"

The estimated cost of this report or study for the Department of Defense (DoD) is approximately $18,000 in Fiscal Years 2019 - 2021. This includes $0 in expenses and $18,000 in DoD labor.

Generated on 2021Feb03 RefID: B-1C5C087

Table of Contents

EXECUTIVE SUMMARY 3

1. INTRODUCTION 5

2. TRAUMA-RELATED WARTIME MEDICAL SPECIALTY MANPOWER REQUIREMENTS OVERVIEW [SECTION 708(D)(1) ELEMENTS (A)-(F) AND 708 (D)(2) ELEMENT (B)] 6

2.A. OVERVIEW OF THE DOD MEDICAL MANPOWER REQUIREMENTS DEVELOPMENT PROCESS 6

2.B. ANALYSIS OF CURRENT CWS MANPOWER GAPS 7

2.C. FUTURE CONSIDERATIONS FOR WARTIME MEDICAL SPECIALTY MANPOWER AUTHORIZATIONS 10

3. TRAUMA-RELATED WARTIME MEDICAL SPECIALTY SHORTAGE MITIGATION PLAN [SECTION 708(D)(2) ELEMENTS (A), (C), AND (D)] 11

3.A. OVERVIEW OF WARTIME SPECIALTY SHORTAGE MITIGATION PLAN 11

3.B. ACCESSION AND PRODUCTION OF WARTIME SPECIALTIES IN THE ACTIVE COMPONENT 12

3.C. ACCESSION AND PRODUCTION OF WARTIME SPECIALTIES IN THE RESERVE COMPONENT 14

3.D. RETENTION OF WARTIME SPECIALTIES 15

3.E. CRUCIAL ORGANIZATIONAL AND OPERATIONAL ASSIGNMENTS AND CAREER PATHWAYS FOR WARTIME SPECIALTIES 18

4. SUMMARY 21

APPENDIX A. REFERENCES 23

APPENDIX B. ACRONYMS 24

APPENDIX C: DEPARTMENT OF THE ARMY CORRECTIVE ACTION PLAN FOR WARTIME SPECIALTIES (NOTE: CURRENTLY IN EXECUTION) 25

APPENDIX D: DEPARTMENT OF THE NAVY CORRECTIVE ACTION PLAN FOR WARTIME SPECIALTIES (NOTE: CURRENTLY IN EXECUTION) 72

APPENDIX E: DEPARTMENT OF THE AIR FORCE CORRECTIVE ACTION PLAN FOR WARTIME SPECIALTIES (NOTE: CURRENTLY IN EXECUTION) 85

APPENDIX F: MILDEP PLANS FOR CIVILIAN TRAUMA CENTER PARTNERSHIP EXPANSION 90

EXECUTIVE SUMMARY

This final report is in response to section 708 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017 (Public Law 114–328) and provides additional information about the Department of Defense (DoD) personnel management plan for trauma-related and other critical wartime specialties (CWS) in accordance with subsection (d). This report is a complement to the February 2018 interim Report to Congress (RTC) that provided the final implementation plan for establishing the Joint Trauma Education and Training Directorate (JTETD) in accordance with subsections (a)-(c). This report completes the July 2018 and February 2019 interim RTCs that provided the preliminary information about the DoD personnel management plan for specified trauma-related CWS in accordance with section 708(d). This final RTC provides updated data and contains the Department's final implementation plan to satisfy all 708(d) requirements.

The congressional requirement within section 708(d)(1)(A)-(F) mandated assessment of five specialty areas: Emergency Medical Services/Prehospital Care, Trauma Surgery, Critical Care, Anesthesiology, and Emergency Medicine, as well as any other wartime medical specialties the Secretary of Defense (SecDef) determines appropriate. These broad categories were further divided based on the data categories utilized by the DoD Health Manpower Personnel Data System (HMPDS): Trauma Surgery (including General Surgeon, Cardiothoracic Surgeon, Orthopedic Surgeon, Critical Care/Trauma Surgeon, Vascular Surgeon, and Operating Room Nurse); Critical Care Medicine (Critical Care Physician and Critical Care Nurse); Anesthesiology (Anesthesiologist and Nurse Anesthetist); Emergency Medicine (Emergency Medicine Physician and Emergency/Trauma Nurse); and Prehospital Care (Family Practice Physician and General Medical Officer). Analysis of specialties with historical fill rates below 80 percent suggested that one additional specialty deserved consideration in this report, Psychiatry. Together, these 14 specialties were the focus of this report.

Under their authorities to organize, train, and equip, the Secretaries of the Military Departments remain responsible for recruiting the force, including the military medical specialties described in this plan. Representatives of the Military Departments (MILDEPs) contributed to this report by validating current authorizations and shortages, and by defining implementation measures to close the gap between on-hand, trained personnel and authorized end-strength in these CWS by FY 2023.

This report is divided into two sections. The main body of the report contains the overarching DoD-level personnel management plan elements. This includes an overview of the DoD processes used to define the total force manpower requirement for CWS and an analysis of FY 2019 CWS manpower gaps. It also provides a DoD-level review of the various mechanisms common to all MILDEPs for the recruitment, production, and retention of CWS, including crucial organizational and operational assignments and career pathways common across all Services. Finally, it provides DoD-level initiatives to improve retention of CWS.

The appendices contain detailed corrective action plans (CAPs) from each MILDEP to close the gaps in CWS. These CAPs were provided to Congress in the September 2019 RTC, "Additional Actions Needed to Address the Gaps in Military Physician Specialties." These CAPs provide detailed Service plans to increase or decrease the end-strength requirements for all specialties,

including the CWS that are the focus of this report, and include each Service's specific plan for detailed annual graduate medical education (GME) starts required to reach these targets. Each of these multi-year CAPs is currently being executed by the MILDEPs. Morever, the CAPs are reviewed on an annual basis and updated, when necessary, to ensure they remain on course to meet established targets. With most critical wartime specialties requiring 3 to 8 years of specialized training, the Services will not realize their end strength gains until 2023-2028. Additionally, the appendix contains the MILDEP plans for rapidly expanding the number of partnerships at civilian trauma centers in order to increase the exposure to complex trauma cases necessary for DoD critical wartime specialists.

Collectively these initiatives form the comprehensive DoD strategy focused on increasing the generation, sustainment, and retention of these CWS.

1. INTRODUCTION

This final report is the final implementation plan submitted to the Committees on Armed Services of the the Senate and the House of Representatives as described in the July 2018 and February 2019 interim RTCs that provided the preliminary information about the DoD personnel management plan by the SecDef for fourteen specified trauma-related and other CWS the SecDef determined appropriate for purposes of this plan in accordance with section 708(d)(1)(A)-(F) of the NDAA for FY 2017.

Trauma-related and other critical wartime specialists possess a complex and perishable set of knowledge, skills, and abilities (KSAs) that take years of education, training, and operational experience to develop. Adding to this complexity, trauma-related and other critical wartime specialists do not work alone and must function as part of a cohesive multi-disciplinary team. Due to the highly specialized nature of these individuals, as well as the length of time it takes to develop and maintain these skills, there is a critical need for DoD longitudinal accession, skill development, and career field sustainment planning.

The combination of a national shortage of health care professionals and ongoing challenges in recruiting and retention requires an aggressive DoD approach to personnel management in this specific area. Multiple recent Government Accountability Office (GAO) and congressional reports have documented these challenges. The FY 2019 HMPDS data analysis conducted for this report validated these prior findings, noting that DoD continues to experience challenges meeting accession and retention goals for many trauma-related force projection requirements. Finally, this report contains the individual MILDEP CAPs to close the CWS gaps, as well as the broader DoD actions to improve sustainment and retention of these specialists.

Identification of personnel requirements and establishing strong and consistent accession, career management, and retention plans are all essential components of readiness of the United States Armed Forces. The SecDef directed the MILDEPs to evaluate their accession, training, and career management processes for each trauma-related and other CWS and propose MILDEP and DoD policy and legislative changes forming the departmental strategy to reduce gaps in fill rates for these specialties. Based on this data, this report describes the SecDef-approved implementation plan for the DoD's personnel management plan for CWS. The plan establishes SecDef direction over the recruiting and retention of trauma-related and other CWS by the MILDEPs and includes the MILDEP specific multi-year CAPs to close the gaps in these specialties by FY 2023.

2. TRAUMA-RELATED WARTIME MEDICAL SPECIALTY MANPOWER REQUIREMENTS OVERVIEW [SECTION 708(D)(1) ELEMENTS (A)-(F) AND 708 (D)(2) ELEMENT (B)]

Consolidated DoD requirements for trauma-related and other CWS are the outcomes of deliberate DoD manpower planning processes. The following sections describe the DoD medical manpower requirements development process (2.A), analysis of the current DoD wartime medical specialty gaps based on FY 2019 data (2.B), and projected changes occurring within the DoD and the Military Health System (MHS) that may drive future changes to these trauma-related wartime medical specialty manpower requirements (2.C).

2.A. Overview of the DoD Medical Manpower Requirements Development Process

Under the authority, direction, and control of the SecDef, recruiting the force is a function assigned to the MILDEPs by law. Accordingly, the three MILDEPs have different processes for determining the number of annual CWS manpower authorizations and recruiting targets. This section details the various DoD processes to ensure the MILDEPs' CWS manpower authorizations align in support of the total force manpower authorizations required to support the National Military Strategy (NMS).

The number of consolidated DoD authorizations for trauma-related and other CWS is the end result of the annual Planning, Programming, Budgeting, and Execution process. These requirements are aligned with the NMS and are derived primarily from Defense Planning Guidance (DPG) force sizing constructs to identify specific trauma-related and other CWS personnel requirements. Combatant Command and operational plan casualty estimates and first responder, medical evacuation, patient stabilization, and definitive care requirements are translated by the MILDEPs into medical specialty-specific expeditionary personnel requirements. These joint and expeditionary-focused guidance documents serve as primary drivers of MILDEP manpower models developed to ensure the provision of required personnel for generating and operating forces in diverse specialties.

These MILDEP-specific total force manpower models and processes include the Total Army Analysis (TAA) model for the Army; the Required Operational Capabilities (ROC) Projected Operational Environment (POE) for the Navy; and the Management Engineering Program (MEP) for the Air Force. These models and processes are informed by and contribute to respective MILDEP medical manpower readiness requirements. The Army uses a medical objective force model nested within the TAA line personnel model. The Navy uses the Medical Manpower All Corps Requirements Estimator (MedMACRE) model. The Air Force uses the Critical Operational Readiness Requirement (CORR). These MILDEP force requirement estimates are subject to change, based on changes in the National Defense Strategy (NDS) and review by the Office of Cost Assessment and Program Evaluation (CAPE).

In recognition that the total force baseline information is based on 3- to 5-year projected personnel requirements, additional inputs are used to provide the most up-to-date accession goals and objectives to forecast and meet those personnel requirements. For example, military medical

specialty leaders and advisors to the Surgeons General provide updated projections for medical personnel retirements and separations annually in order to adjust the MILDEP accession targets.

These MILDEP model estimates are designed to ensure the availability of ready trauma-related and other medical capabilities to meet projected global expeditionary contingency requirements. The MILDEPs use additional processes to stratify these total force requirements between the Active and Reserve Components, as well as by-grade requirements to guide recruitment and medical education authorizations. The end result is the DoD total force requirement for CWS with distribution of these specialists between the Active and Reserve Components of the three MILDEPs (Figure 1).

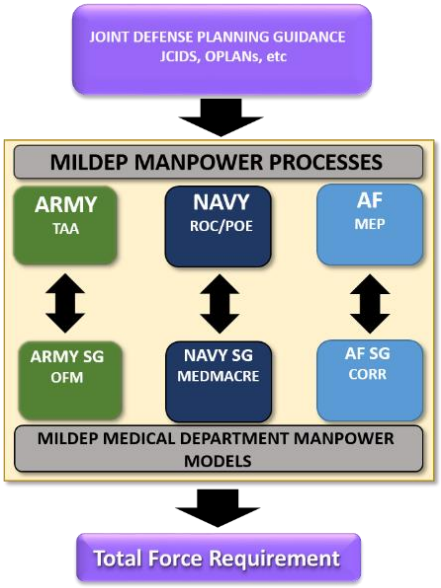


Figure 1: Overview of Military Medical Manpower Requirement Determination

JCIDS – Joint Capability Integration Development System, OPLAN – Operational Plans in Complete Format, TAA – Total Army Analysis, MEP – Management Engineering Program, ROC – Required Operation Capabilities, POE – Projected Operational Environment, OFM – Objective Force Model, CORR – Critical Operational Readiness Requirements model, MedMACRE –Medical Manpower All Corps Requirements Estimator

2.B. Analysis of Current CWS Manpower Gaps

This report analyzed all CWS based on FY 2019 HMPDS data. For the purposes of this report, critically short wartime specialties are defined as having a total force current fill rate below 80 percent of the force requirements submitted by the MILDEPs. Based on this methodology, the Active Component was analyzed to assess their CWS status (Table 1). Based on this analysis, the Active Component across the MILDEPs was assessed as generally meeting manpower authorization targets; however 4 of 14 specialties are experiencing critical shortages: Cardiothoracic Surgeons (79 percent), Critical Care Physicians (49 percent), Emergency/Trauma Nurses (62 percent), and Psychiatrists (76 percent).

Category	Specialty	Requirements	End-Strength	% Fill
Trauma Surgery	General Surgeon	365	326	89%
Trauma Surgery	Cardiothoracic Surgeon	34	27	79%
Trauma Surgery	Orthopedic Surgeon	358	335	94%
Trauma Surgery	Critical Care/Trauma Surgeon	44	41	93%
Trauma Surgery	Vascular Surgeon	38	41	108%
Trauma Surgery	Operating Room Nurse	732	752	103%
Critical Care Medicine	Critical Care Physician	78	38	49%
Critical Care Medicine	Critical Care Nurse	750	1070	143%
Anesthesiology	Anesthesiologist	324	312	96%
Anesthesiology	Nurse Anesthetist	532	478	90%
Emergency Medicine	Emergency Medicine Physician	497	523	105%
Emergency Medicine	Emergency/Trauma Nurse	1073	662	62%
Prehospital Care	Family Medicine/General Medicine	1562	1419	91%
Psychiatry	Psychiatrist	421	318	76%

Table 1: FY 2019 Active Component Critical Wartime Specialists

The data demonstrates the Active Component has the ability to meet most of the CWS accession targets; however, this is only part of the CWS total force requirements. The Reserve Component of the MILDEPs contains authorizations for a significant portion of the total force requirements for many of these specialties (Table 2):

Category	Specialty	% of Total DoD End-Strength Requirement in the Reserve or Guard Component
Trauma Surgery	General Surgeon	60%
Trauma Surgery	Cardiothoracic Surgeon	68%
Trauma Surgery	Orthopedic Surgeon	52%
Trauma Surgery	Critical Care/Trauma Surgeon	12%
Trauma Surgery	Vascular Surgeon	16%
Trauma Surgery	Operating Room Nurse	38%
Critical Care Medicine	Critical Care Physician	50%
Critical Care Medicine	Critical Care Nurse	61%
Anesthesiology	Anesthesiologist	38%
Anesthesiology	Nurse Anesthetist	67%
Emergency Medicine	Emergency Medicine Physician	52%
Emergency Medicine	Emergency/Trauma Nurse	24%
Prehospital Care	Family Medicine/General Medicine	46%
Psychiatry	Psychiatrist	34%

Table 2: FY 2019 Reserve Component Critical Wartime Specialists Percentages of the Total Force

The Reserve Component was analyzed to assess its respective CWS status (Table 3). Based on this analysis, the Reserve Component across the MILDEPs is experiencing deeper challenges than the Active Component, with 8 of the 14 specialties experiencing critical shortages: General Surgeons (49 percent), Cardiothoracic Surgeons (19 percent), Orthopedic Surgeons (25 percent), Critical Care Nurses (77 percent), Nurse Anesthetists (58 percent), Emergency Medicine Physicians (70 percent), Prehospital Specialties (Family Medicine and General Medicine) (53 percent), and Psychiatrists (61 percent).

Category	Specialty	Requirements	End-Strength	% Fill
Trauma Surgery	General Surgeon	540	262	49%
Trauma Surgery	Cardiothoracic Surgeon	72	14	19%
Trauma Surgery	Orthopedic Surgeon	389	97	25%
Trauma Surgery	Critical Care/Trauma Surgeon	6	11	183%
Trauma Surgery	Vascular Surgeon	7	8	114%
Trauma Surgery	Operating Room Nurse	440	526	120%
Critical Care Medicine	Critical Care Physician	78	155	199%
Critical Care Medicine	Critical Care Nurse	1197	920	77%
Anesthesiology	Anesthesiologist	200	176	88%
Anesthesiology	Nurse Anesthetist	1071	618	58%
Emergency Medicine	Emergency Medicine Physician	536	377	70%
Emergency Medicine	Emergency/Trauma Nurse	339	329	97%
Prehospital Care	Family Medicine/General Medicine	1305	694	53%
Psychiatry	Psychiatrist	218	134	61%

Table 3: FY 2019 Reserve Component Critical Wartime Specialists

The total DoD CWS manpower picture is produced by combining data from the Active and Reserve Components. This data demonstrates significant shortages for the following seven CWS (Table 4): General Surgeons (65 percent), Cardiothoracic Surgeons (39 percent), Orthopedic Surgeons (58 percent), Nurse Anesthetists (68 percent), Emergency/Trauma Nurses (70 percent), Prehospital Specialties (Family Medicine and General Medicine) (74 percent), and Psychiatrists (71 percent).

Category	Specialty	Total Force Requirements	End-Strength	% Fill
Trauma Surgery	General Surgeon	905	588	65%
Trauma Surgery	Cardiothoracic Surgeon	106	41	39%
Trauma Surgery	Orthopedic Surgeon	747	432	58%
Trauma Surgery	Critical Care/Trauma Surgeon	50	52	104%
Trauma Surgery	Vascular Surgeon	45	49	109%
Trauma Surgery	Operating Room Nurse	1172	1278	109%
Critical Care Medicine	Critical Care Physician	156	193	124%
Critical Care Medicine	Critical Care Nurse	1947	1990	102%
Anesthesiology	Anesthesiologist	524	488	93%
Anesthesiology	Nurse Anesthetist	1603	1096	68%
Emergency Medicine	Emergency Medicine Physician	1033	900	87%
Emergency Medicine	Emergency/Trauma Nurse	1412	991	70%
Prehospital Care	Family Medicine/General Medicine	2867	2113	74%
Psychiatry	Psychiatrist	639	452	71%

Table 4: FY 2019 Total DoD Wartime Medical Specialist Manpower Authorizations and Gaps

This data represents the current DoD CWS total force requirements as requested in section 708(d)(2)(B) of the NDAA for FY 2017. These manpower authorization levels were reviewed by CAPE as part of section 721 of the NDAA for FY 2017 work. They are also being reviewed

by the Office of the Joint Staff Surgeon as part of the Joint Medical Estimate. The outcome of these initiatives could substantively alter the total DoD CWS manpower authorizations.

2.C. Future Considerations for Wartime Medical Specialty Manpower Authorizations

It is important to note that the number of DoD authorizations required for wartime specialties is dynamic and fluctuates from year to year. While most specialties experience relatively minor changes in total authorizations from year to year, DoD can experience substantial shifts in total authorizations within extremely short timeframes. Multiple factors may contribute to these shifts, including changes to total DoD end-strength, changes in NMS or DPG, or changes to Service-specific concepts of operations for medical support of deployed operations.

For example, and in response to the 2018 NDS, DoD is shifting focus to near peer conflict and great power competition. Preparation for these scenarios involves medical casualty estimates substantially higher than the current steady state conflicts DoD has known over the last 2 decades.

Additionally, the DoD is considering the conversion of several thousand medical positions into line positions to increase combat power and lethality in line with the 2018 NMS. While most of these conversions will not include the specialties that are the focus of this report, these changes, if approved and executed, could potentially impact some of the CWS total authorizations.

Finally, the MHS is currently undergoing a period of unprecedented and historic change with some authorities previously exercised by the MILDEPs now transferred to DHA. Multiple complex issues are being resolved, with the potential to cause further dynamic fluctuations in the FY 2020 authorization numbers for CWS forming the foundation of this report.

3. TRAUMA-RELATED WARTIME MEDICAL SPECIALTY SHORTAGE MITIGATION PLAN [SECTION 708(D)(2) ELEMENTS (A), (C), AND (D)]

Strong and consistent accession, career management, and retention plans are all essential components of readiness of the United States Armed Forces. In preparing this report, the SecDef directed the MILDEPs to evaluate their accession, training, and career management processes for each trauma-related and other CWS and propose MILDEP and DoD policy and legislative changes that form the DoD strategy to reduce gaps in fill rates for these specialties. The following sections describe an overview of the DoD CWS shortage mitigation plan (3.A), the Active Component's process for CWS accession and production (3.B), the Reserve Component's process for CWS accession and production (3.C), the status of CWS retention (3.D), and crucial CWS organization assignments and career pathways (3.E). Given their title 10 authority to organize, train, and equip these CWS, the MILDEPs' respective CAPs to close the gaps in CWS are included as Appendix C (Army), Appendix D (Navy), and Appendix E (Air Force).

3.A. Overview of Wartime Specialty Shortage Mitigation Plan

The DoD manpower models identify core personnel requirements necessary to meet projected global expeditionary force mission needs. Effective recruitment, retention, career management, and development measures are necessary to achieve and sustain manpower goals for each critical wartime medical specialty. The DoD has encountered challenges meeting manpower model projections for select medical specialties.

Although meeting personnel strength requirements is essential for all CWS, this personnel management plan focuses on those specialties with less than 80 percent total force fill rates (Table 5).

Category	Specialty	Total Force Requirements	End-Strength	% Fill
Trauma Surgery	General Surgeon	910	582	64%
Trauma Surgery	Cardiothoracic Surgeon	113	42	37%
Trauma Surgery	Orthopedic Surgeon	737	438	59%
Critical Care Medicine	Critical Care Physician	311	115	34%
Critical Care Medicine	Critical Care Nurse	2285	1789	78%
Anesthesiology	Nurse Anesthetist	1463	1060	72%
Prehospital Care	Family Practice/General Medicine	2867	2113	74%
Psychiatry	Psychiatrist	725	450	62%

Table 5: Total Force CWS Below 80% Critical Fill Rate

All of these specialties are highly competitive and require years of extensive training to achieve full qualification. These specialties are also highly sought in the civilian marketplace, partially explaining the difficult time the DoD has in accessing and retaining these fully-trained specialists.

There are unique challenges in accession and retention between the Active and Reserve Components, which drive different approaches and tools to solving their respective critical

shortages. Understanding where a specialty is critically short is therefore paramount to developing strategies to reach the desired end-strength. Table 6 delineates which Component is contributing to these shortages (Active, Reserve, or both). For the purposes of calculating "contribution" to the overall shortage, a Component was deemed as contributing if less than 90 percent of the total end-strength authorization was filled within the Component.

Category	Specialty	DoD Total % Fill	Contributing Component
Trauma Surgery	General Surgeon	64%	Both
Trauma Surgery	Cardiothoracic Surgeon	37%	Both
Trauma Surgery	Orthopedic Surgeon	59%	Reserve
Trauma Surgery	Critical Care/Trauma Surgeon	114%	
Trauma Surgery	Vascular Surgeon	109%	
Trauma Surgery	Operating Room Nurse	101%	
Critical Care Medicine	Critical Care Physician	34%	Both
Critical Care Medicine	Critical Care Nurse	78%	Both
Anesthesiology	Anesthesiologist	89%	Reserve
Anesthesiology	Nurse Anesthetist	72%	Reserve
Emergency Medicine	Emergency Medicine Physician	92%	
Emergency Medicine	Emergency/Trauma Nurse	106%	
Prehospital Care	Family Practice/General Medicine	74%	Reserve
Psychiatry	Psychiatrist	62%	Both

Table 6: Location of Critical Shortages in Wartime Medical Specialties

In order to close the gap between authorized and filled positions, the MILDEPs will need to increase accessions and/or increase retention rates for these trauma-related and other CWS. In development of this personnel management plan, the MILDEPs were directed to analyze the following elements for each specialty identified, for both the Active and Reserve Components:

a. Current fill rate;
b. Current accessions per year;
c. Accessions per year required to achieve and maintain a fill rate of 100 percent;
d. Changes to MILDEP policy that will be made to increase accessions and retention;
e. Funded and unfunded initiatives, changes to DoD policy, or legislative relief required to increase accessions and retention; and
f. Timeline to achieve a fill rate of 100 percent with identified milestones.

The following sections provide analysis of the challenges for accessing and retaining CWS, as well as organization/operational assignments and career pathways to reduce these personnel gaps in the Active and Reserve Components.

3.B. Accession and Production of Wartime Specialties in the Active Component

The MILDEPs have two mechanisms for assessing CWS: direct accession of fully trained specialists from the civilian market and scholarship programs that assess officers at the start of medical school.

Historically, despite financial incentive programs (such as signing bonuses or loan repayment programs) and other recruiting methods, direct accession of fully trained medical specialists has not been a significant source of physicians for the DoD. The direct accession mechanism, however, could serve as the most agile way for the DoD to adjust to CWS shortages. This failure of direct accession of fully trained specialists is due to three primary factors. First, even with specialty bonuses that are the maximum allowed by law, the DoD offers these critical wartime specialists a lower salary compared to national averages for that specialty. The recent GAO RTC 20-165 found for 21 of the 27 physician and dental specialties, the maximum cash compensation was less than the private sector civilian median within all four officer pay grades (O-3 to O-6). The report also found that the total salary compensation package offered by DoD for several CWS is less than half of their national specialty average (cardiothoracic surgery, neurosurgery, orthopedic surgery). Second, these specialists experience a loss of individual control over practice location and type of practice due to the military permanent change of station (PCS) requirements. Finally, the patient population enrolled in the direct care system administered by the MHS is predominantly young and healthy and does not generate enough diversity in surgical and critical care-related cases, making recruitment and retention more difficult. Due to these challenges, historically less than 5 percent of DoD physicians enter active service as fully trained specialists through the direct accession mechanism.

Due to its inability to direct assess significant numbers of trained wartime specialists, DoD has instead relied upon medical student scholarship programs that require extended military service commitments through either the Health Professions Scholarship Program (HPSP) or attending the Uniformed Services University of the Health Sciences (USU). Over 95 percent of active duty physicians enter military service through these programs. The Department assesses approximately 1,200 Active Component physicians per year through USU (170 physicians) and HPSP (1,000 physicians). The active duty service obligations incurred range from 3-4 years for HPSP to 7 years for USU education. Due to the length of time it takes to complete medical school (4 years) and specialty training for CWS (3-7 years), any change in accession requirements by the MILDEPs may take between 5-10 years to be reflected in the end-strength of physician CWS.

Each year, the MILDEPs attempt to adjust for shortages of critical wartime specialists within a shorter timeline by adjusting the number of specialty training slots for the upcoming year. This is done in accordance with DoD Instruction 6015.24, "DoD Graduate Medical Education Program," April 9, 2021, and SecDef Memorandum, "Graduate Medical Education," November 3, 2020, which prioritize the generation of operational medical specialties within the MHS that are critical to aligning manpower requirements with the NDS and posturing the Department for Great Power Competition. For example, the Air Force is currently recommending an increase within GME Emergency Medicine starts through FY 2023 (Table 7). Such a move would enable the Air Force to meet its projected increase in requirements for both Critical Care Air Transport Teams and Ground Surgical Teams in response to NMS and DPG shifting to near peer conflict. If approved, these additional training slots cannot be met by the fixed number of military-specific GME program slots, and instead rely on military students being accepted to civilian GME training programs. Although acceptance to these programs is not under DoD control, historically military students have successfully competed for these slots, and DoD has been able to successfully utilize this mechanism to make changes in the CWS end-strength within a shorter 3-5 year timeframe.

	FY 19	FY 20	FY 21	FY 22	FY 23
Projected Inventory	154	160	165	172	178
Accession Number	32	38	38	40	40
Retention Target	122	122	127	132	138

Table 7: Air Force Accession Strategy to Achieve FY 2023 Emergency Medicine Specialist Target

All three MILDEPs utilize this process as the primary method to increase production of critically short specialties within a 3-5 year timeline. The MILDEPs have each submitted their respective CAPs for inclusion in this report (Appendices C-E). These CAPs were also recently provided to Congress in the September 2019 RTC, "Additional Actions Needed to Address the Gaps in Military Physician Specialties" (response to the GAO-18-77 report). These reports provide detailed MILDEP plans to increase or decrease the end-strength requirements for each specific wartime specialty, as well each MILDEP's specific plan with detailed annual GME starts required to access these targets. Each of these multi-year CAPs is currently being executed by the MILDEPs. Moreover, the CAPs are reviewed on an annual basis and updated, when necessary, to ensure they remain on course to meet established targets. Given the 3-8 year length of training timeline for these specialties, DoD will be unable to make an assessment of the impact of these CAPs on the final CWS end-strength until these physicians graduate from training in FY 2023-2028.

This report also identified two nursing specialties meeting the definition of critically short (Emergency/Trauma Nurse 70 percent and Nurse Anesthetist 68 percent). Nursing specialties rely on the same direct accession or internal production mechanisms described above and similar specialty bonus programs to attract and retain critically short specialties. The main difference lies in the length of time it takes to produce nursing specialists, with an average of 2-3 years compared to 7-12 years for many of the physician wartime specialties, providing the MILDEPs greater agility to respond to CWS nursing shortages.

3.C. Accession and Production of Wartime Specialties in the Reserve Component

The Reserve Components of the MILDEPs are a critical part of the total authorizations for wartime specialists (Table 2). The preponderance of challenges driving critically short manning at the DoD level are rooted in low Reserve Component manning (Table 6). Many physicians in the Reserve Component started service in the Active Component and transitioned to the Reserve Component when their Active Duty service obligation was complete. However, physicians in trauma-related and other CWS transition to the Reserve Component at disproportionately low rates. Two recent studies of Army general surgeons note extremely low Reserve Component personnel fill rates relative to authorized end-strength. The Reserve Components of the MILDEPs face additional challenges because they do not have all of the mechanisms described previously that are utilized by the MILDEPs to keep pace with attrition. Most notably, the Reserve Components do not have the ability to produce specialists through DoD GME programs, requiring a greater reliance on the difficult task of assessing trained, practicing health care professionals in trauma-related specialties.

Additionally, deployment of Reserve Component health care professionals has increased markedly in the past 2 decades. Low manning in the Reserve Component places additional stress

on the Active Component to fill required deployments, further increasing the challenges of retaining experienced personnel.

Beginning in FY 2017, the Army initiated a focused effort to address Army Reserve physician shortages. Understanding that many direct accession physicians required multiple waivers (age, grade/constructive credit), concrete actions were taken to appropriately delegate waiver authorities to decrease lengthy accession timelines. Additionally, the U.S. Army Recruiting Command applied additional resources to the Army Reserve physician recruitment mission. This has resulted in an increase from 149 to 225 direct accession physicians, for a 33 percent increase when comparing FY 2017 to FY 2019 recruitment data.

3.D. Retention of Wartime Specialties

Section 3.B. described the process by which the MILDEPs access and produce critical wartime specialists in the Active Component. Although the mechanism lags by several years, the MILDEPs have been successful in annually modulating the number of GME starts to match projected CWS production needs falling below the 80 percent threshold, meeting increased production targets largely through civilian GME platforms. While this process is complicated and relies heavily on prediction models, it has generally met accession goals, as demonstrated by Table 1. However, while the MILDEPs have utilized this mechanism to successfully adjust production of critical wartime specialists, the MILDEPs have historically struggled to keep them.

A 2019 Military Medicine article titled, "Factors Associated with U.S. Army Physician Service After Obligation Completion," conducted detailed analysis of the number of Army physicians choosing to serve beyond their initial service obligation. The data revealed the median length of service for HPSP graduates, as measured by physician available time (service while not in a training status), was 4.3 years (interquartile range of 4.0-7.3 years). Given over 80 percent of active duty physicians enter service through the HPSP mechanism, this data suggests that the vast majority of our force leaves service at the earliest opportunity.

The MILDEPs have historically utilized the mechanism previously described to fluctuate the GME starts in a given year in order to keep pace. Comparing MILDEP accession/production targets with average length of service suggests that the DoD needs to plan on 15-20 percent turnover annually in many of these programs, which is reflected in the GME yearly starts for most specialties.

While the tactic to match turnover with large yearly GME starts has historically produced enough physician specialists to meet accession targets, it does not provide a long enough length of service for most physicians to become fluent in the art of military medicine (Figure 2). For most physicians, the first 2 to 4 years following residency are still a time of growth, where physicians learn to apply their specialty knowledge on their own, without the supervision of attending physicians. For military physicians, the first deployed experience is similarly a critical step in understanding their specialty in the military context, because it is the first experience with the deployed operational environment and the first exposure to military wounding patterns, such as blast and high velocity injuries, something rarely experienced in U.S.-based GME training locations. With a median length of post-training service of only 4.3 years, most military physicians barely achieve these milestones (Figure 2).

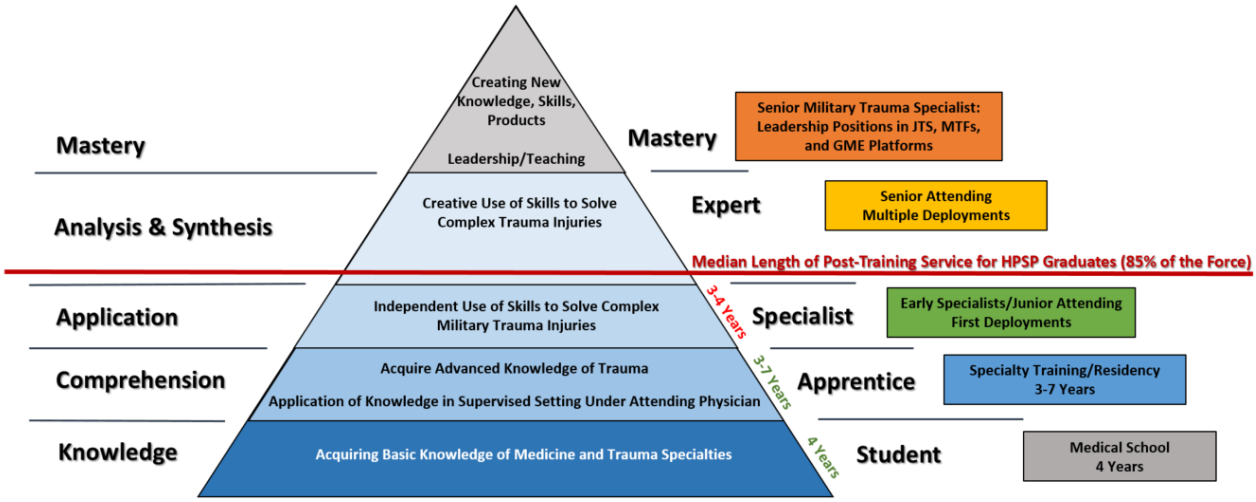
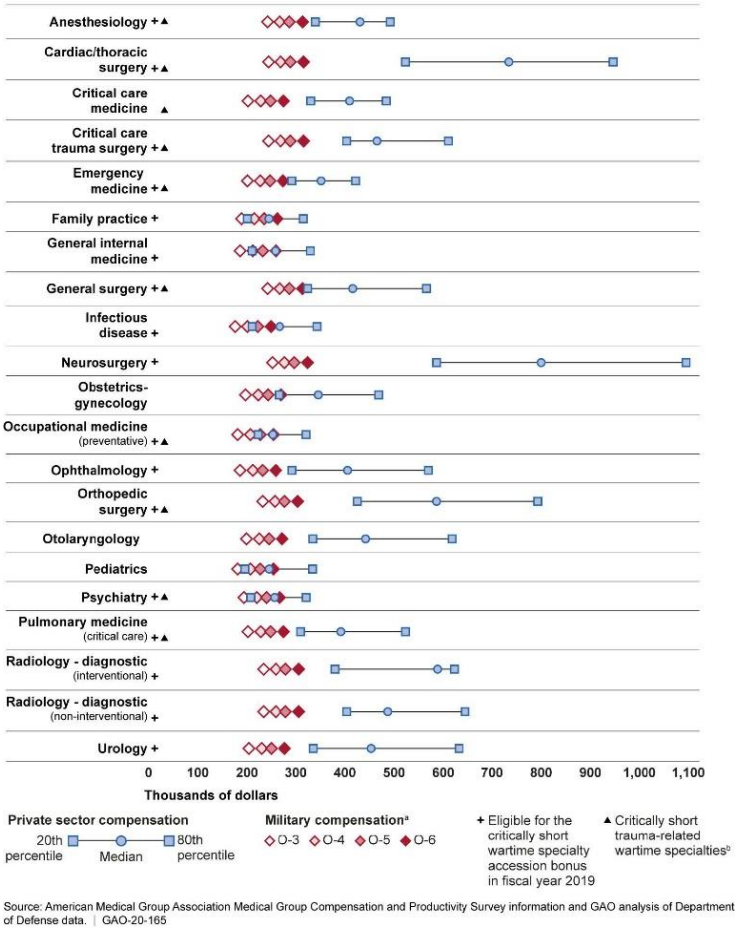


Figure 2: Skills Hierarchy for Military Trauma Specialists with Median Length of Service Overlay

Although the next section will detail a career progression plan with key operational and organizational assignments, with a median service of 4.3 years physician available time, many military physicians exit the service before they can follow it. Understanding the reasons why such a high percentage of our trained military physicians leave the service at the earliest opportunity is therefore paramount.

As part of this report, the general surgeon specialty consultants for the MILDEPs conducted a survey to delineate the reasons underlying this retention data. Three primary reasons emerged: substantial pay gaps between the military and civilian markets, concern over the impact of low volume and low acuity of patients in military medical treatment facilities (MTFs), and fatigue with the military deployment and PCS cycles.

Multiple studies have highlighted the substantial gap between the private sector and military salary compensation for CWS. The most study recent was published in January 2020: Figure 3 from GAO Report 20-165 demonstrates the magnitude of this gap.



Source: American Medical Group Association Medical Group Compensation and Productivity Survey information and GAO analysis of Department of Defense data. | GAO-20-165

Figure 3: Maximum Military Physician Cash Compensation and Private Sector Civilian Compensation for Selected Military Specialties 2017 (From GAO 20-165 Figure 4)

This GAO report noted, "all nine specialties DoD identified as critical trauma-related wartime specialties in 2019 were less than the 20th percentile" for cash compensation compared to the civilian sector.

Further, while the total DoD O-6 compensation package for some specialties begins to approach the 20th percentile of the civilian sector, this is not the key battleground for the DoD. Since the majority of DoD's trained physicians are leaving military service at median of 4.3 years post-training, the target cohort is the O-3 and O-4 group. Despite offering many of these CWS the maximum retention bonus allowed by law, Figure 3 demonstrates this group falls substantially below their private sector peers. In response to this disparity, in section 612 of the NDAA for FY 2020 (Public Law 116-92), Congress authorized an increase to special and incentive pays for officers in the health professions. These changes increased the retention bonus maximum for CWS from $75,000 to $150,000, and, to varying degrees based upon speciality, reduce current compensation gaps. The effect of this legislation on retention rates for CWS will be assessed in the coming years.

The second major reason identified is a concern amongst critical wartime specialists that most DoD MTFs lack the case volume and complexity to maintain clinical currency in their

specialties. This is due to the relatively young and healthy population of active duty Service members and their dependents, coupled with the fact that the vast majority of DoD MTFs lack intensive care units, trauma center designation status, or other support services to allow complex cases. The end result is that many specialists feel their specialty skills are tarnishing while on active duty. Data from the newly developed DoD KSA metric for surgeon clinical currency verifies this lack of diversity and complexity of cases.

The MILDEPS have several ongoing lines of effort to address this gap, including efforts by all three MILDEPs to increase partnerships with civilian trauma centers. Various models are being pursued, an example of which provides critical wartime specialists with rotational trauma experiences through partnerships with civilian trauma centers. Another model involves embedding trauma teams within civilian centers on a more permanent assignment basis. The MILDEPs are aggressively working to expand these opportunities and will substantially increase these platforms over the next 2-3 years. Appendix F details each MILDEP's specific partnership models, targets, and planning timelines.

The third major reason identified is a strain on military families caused by a combination of deployment and PCS fatigue. Many of these CWS are deployed at a high rate, with deployment to home station time (or dwell time) ratios below the desired 1:2 ratio. Closely related is PCS fatigue, with the normal 3-4 year military PCS cycle having negative impacts on family/school stability; and the ability to moonlight (i.e., practice their medical specialty during off-duty hours) at local trauma centers to gain access to higher acuity cases. Attaining full CWS end-strength through the MILDEPs' multi-year CAPs contained in this report will relieve some of the deployment fatigue. Additionally, as the MILDEPs increase the portion of their force embedded in civilian trauma center partnerships, they should simultaneously pursue efforts to add PCS stability for these specialists. Such stability will ensure critical wartime specialists are able to build their local professional status and ensure adequate referral volume for high acuity cases, both of which often take years to establish.

While DoD production of CWS may meet targets, improving CWS retention is paramount to ensuring DoD has not only the required end-strength but also the optimal mix of expert and mastery level experience in critical wartime specialists.

3.E. Crucial Organizational and Operational Assignments and Career Pathways for Wartime Specialties

The most important assignment criterion is that critical wartime specialists must be assigned to venues that have adequate patient volume and diversity of cases in order to maintain those skills required to execute trauma-related and other critical wartime medical missions. The DoD is defining the joint clinical competencies required for these specialists and developing metrics to measure adequate clinical experience for CWS as part of the ongoing KSA initiative. The KSA program is a critical step to being able to assess MTFs and civilian partnerships in providing adequate clinical caseload and experience for CWS.

Within the direct care portion of the MHS, medical centers in major metropolitan areas offer the greatest opportunity to maintain the required skills for trauma-related and other CWS. Initial KSA analysis suggests MTFs alone cannot meet the clinical currency requirements of all MHS

critical wartime specialists. In MTFs where sufficient patient workload does not exist within the direct care system, the DHA, in coordination with the MILDEPs, is establishing agreements for the maintenance of clinical competencies with other Federal and non-Federal institutions as directed in section 708(c) of the NDAA for FY 2017. It will likely take DoD several years to enter into the number of partnerships required to provide adequate clinical experience for all MHS CWS. Appendix F details each MILDEP's plan for military-civilian partnerships.

The career progression for CWS is the same across all three MILDEPs, with specialists progressing through three stages of development throughout their career. In the tactical phase, they gain increasing proficiency in their wartime specialty; in the operational phase, they gain expertise and mastery of their wartime specialty; and in the strategic phase, they reinvest in future generations through leadership and education. Figure 4 depicts the relative proportions of personnel in each stage of development.

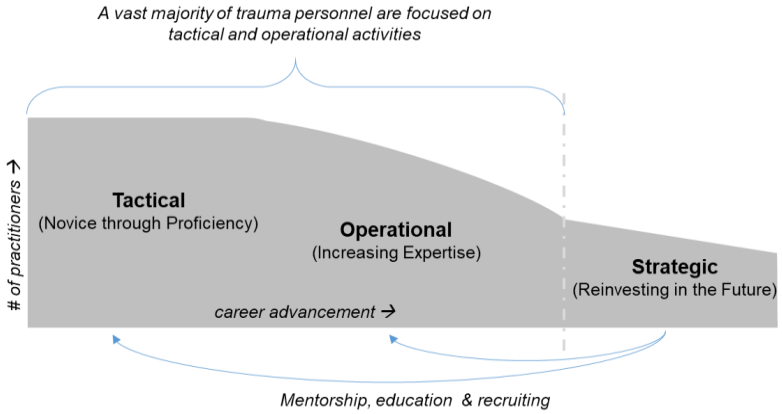


Figure 4: Proportional Overview of Career Progression

The vast majority of trauma-related specialists, though fully qualified to meet operational demands, are in the early stages of their clinical and leadership development while under initial training-related service obligations. Strategic level health care leaders provide an invaluable return on investment through extended service and through mentorship and teaching of junior specialists. Examples of progressive crucial assignment pathways for trauma-related specialists within this construct include:

Tactical: Surgery GME residency; trauma or critical care GME fellowships; master's degree student; nurse anesthesia student; staff surgeon; staff trauma/critical care physician/nurse

Operational: Assistant trauma director; trauma nurse coordinator; intensive care unit medical director/nurse coordinator; civilian trauma center embedded team or section leader; deployed theater of operations specialty leader

Strategic: Joint Trauma System staff; Service Specialty Consultant to the Surgeon General

The MILDEPs each have service-unique, mission-specific requirements for the differing deployment roles of their critical wartime specialists. These Service-specific roles drive differing requirements for operational assignments and experiences needed to become well-rounded wartime specialists supporting the Service's deployment mission. For example, exposure to shipboard medicine is a critical operational assignment for Navy medical personnel, while exposure to medical support for a brigade combat team is a critical operational assignment for Army medical personnel. Because of these differences, the MILDEPs have subtle differences in organizational and operational assignment plans related to their development of deployment ready critical wartime specialists.

Despite these subtle differences, all of these plans have a common architecture. Figure 5 provides a high level career pathways map for trauma-related and other CWS containing crucial assignments in accordance with elements (C) and (D) of section 708(d)(2) of the NDAA for FY 2017. Features of this common pathway include intentional development of clinical competence from novice to greater levels of expertise and leadership skill sets that begin at the tactical level and are developed to execute at a strategic level providing maximal impact for the enterprise. In recognition of the varied length of primary and advanced clinical training, these milestones are achieved at different lengths of service depending on the medical specialty. The shared commitment to developing high functioning clinicians, academicians, and military medical officer leaders, is applicable to all. This career map solidifies a pure clinical pathway throughout the career of trauma-related specialists culminating with service in key clinical leadership positions charged with leading and educating the next generation of specialists.

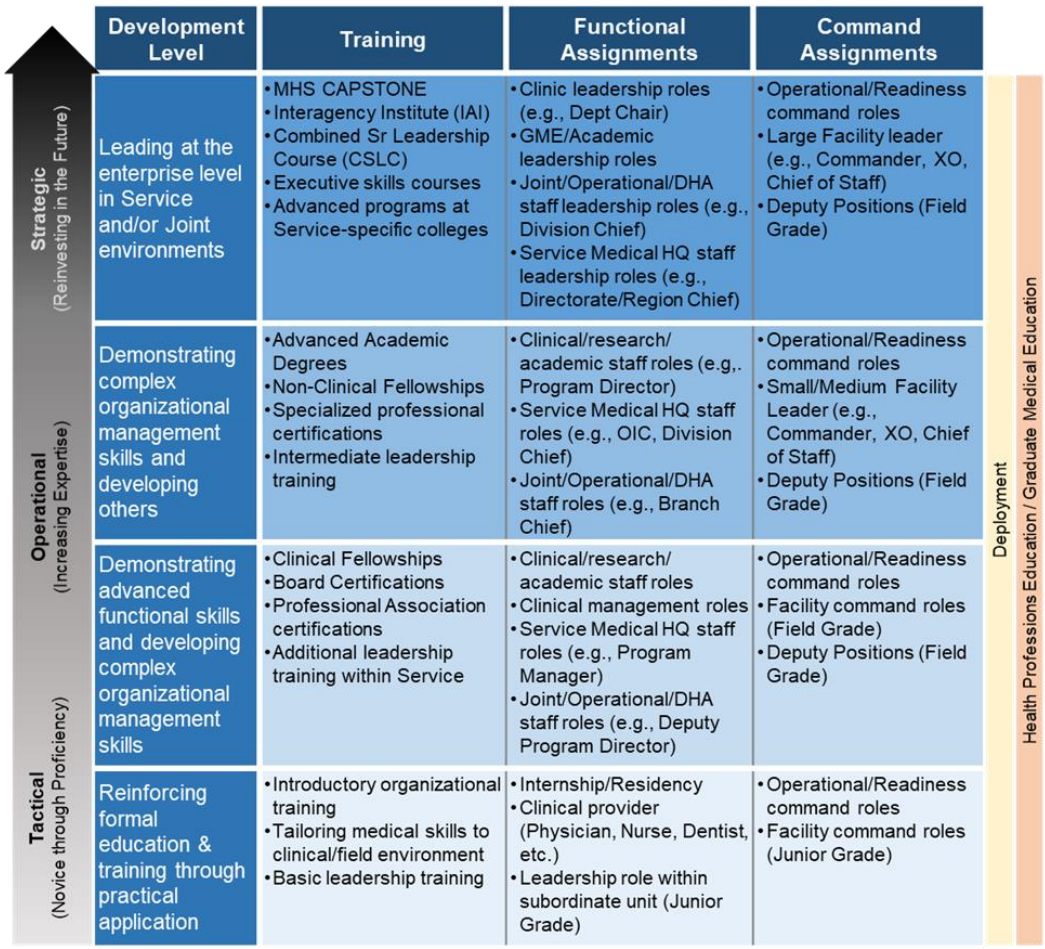


Figure 5: Career Pathways for DoD Trauma-related Personnel

4. SUMMARY

This final report for section 708 of the NDAA for FY 2017 (Public Law 114–328) provides additional information about the DoD personnel management plan for trauma-related and other CWS in accordance with subsection (d) and serves as the final implementation plan required by subsection (e). This report is a complement to the February 2018 interim RTC that provided the final implementation plan for establishing the JTETD in accordance with subsections (a)-(c). This report completes the July 2018 and February 2019 interim RTCs that provided the preliminary information about the DoD personnel management plan for specified trauma-related wartime medical specialties in accordance with section 708(d). This final RTC provides updated data and final recommendations to satisfy all 708(d) requirements.

The congressional requirement within section 708(d)(1)(A)-(F) mandated assessment of five specialty areas: Emergency Medical Services/Prehospital Care, Trauma Surgery, Critical Care, Anesthesiology, and Emergency Medicine. These broad categories were further divided based on the data categories utilized by the DoD HMPDS: Trauma Surgery (including General Surgeon, Cardiothoracic Surgeon, Orthopedic Surgeon, Critical Care/Trauma Surgeon, Vascular Surgeon, and Operating Room Nurse); Critical Care Medicine (Critical Care Physician and

Critical Care Nurse); Anesthesiology (Anesthesiologist and Nurse Anesthetist); Emergency Medicine (Emergency Medicine Physician and Emergency/Trauma Nurse); and Prehospital Care (Family Practice Physician and General Medical Officer). Analysis of specialties with historical fill rates below 80 percent suggested that one additional specialty deserved consideration in this report, Psychiatry. Together, these 14 specialties were the focus of this report.

Under their authorities to organize, train, and equip, the Secretaries of the Military Departments remain responsible for recruiting the force, including the military medical specialties described in this plan. MILDEP representatives contributed to this report through a chartered subject matter expert working group by validating current authorizations and shortages, and by defining implementation measures to close the gap between on-hand, trained personnel and authorized CWS end-strength by FY 2023.

The final overarching DoD personnel management plan is presented in the body of this report, with the three individual MILDEP CAPs included as appendices. These multi-year CAPs are currently in execution and reviewed on an annual basis, with updates made to ensure they remain on track to meet established targets. These individual MILDEP CAPs collectively represent the DoD strategy to change MILDEP physician accession programs in order to close the gaps between on-hand, trained personnel and authorized end-strength. The Office of the Assistant Secretary of Defense for Health Affairs will evaluate these analyses and assessments annually to determine if the initiatives need revision to optimize the generation, sustainment, and retention of a ready medical force capable of providing trauma-related and other critical wartime medical capabilities.

The DoD is committed to ensuring personnel management is efficient and singularly focused on maintaining an always ready medical force uniquely qualified to provide Combatant Commands and expeditionary global forces the full spectrum of joint health services from predeployment individual medical readiness to point-of-injury and illness treatment through rehabilitation.

APPENDIX A. REFERENCES

DoD Instruction 6015.24, "DoD Graduate Medical Education Program," April 9, 2021

GAO-18-77 RTC Feb 2018 Military Personnel: Additional Actions Needed to Address Gaps in Military Physician Specialties

GAO-19-206 RTC Feb 2019 Defense Health Care: Actions Needed to Determine the Required Size and Readiness of Operational Medical and Dental Forces

GAO-19-338 RTC Mar 2019 Defense Health Care: DoD's Proposed Plan for Oversight of the Graduate Medical Education Program

GAO-20-165 RTC Jan 2020: Defense Health Care: DoD Should Collect and Use Key Information to Make Decisions about Incentives for Physicians and Dentists

Health Manpower Personnel Data System Fiscal Year Statistics 2019

Military Medicine July/August 2019: Factors Associated with U.S. Army Physician Service After Obligation Completion

Public Law 114-328, "National Defense Authorization Act for Fiscal Year 2017," December 23, 2016

Public Law 116-92, "National Defense Authorization Act for Fiscal Year 2020," December, 20, 2019

Report to Congressional Armed Services Committees; Senate Report 115-262, Page 219 to Accompany the S. 2987, John S. McCain National Defense Authorization Act for Fiscal Year 2019, "Additional Actions Needed to Address Gaps in Military Physician Specialties," September 2019

Secretary of Defense Memorandum, "Graduate Medical Education," November 3, 2020

APPENDIX B. ACRONYMS

CAP	corrective action plan
CAPE	Cost Assessment and Program Evaluation
CORR	Critical Operational Readiness Requirement
CWS	critical wartime specialty(ies)
DHA	Defense Health Agency
DoD	Department of Defense
DPG	Defense Planning Guidance
FY	Fiscal Year
GAO	Government Accountability Office
GME	graduate medical education
HMPDS	Health Manpower Personnel Data System
HPSP	Health Professions Scholarship Program
JCIDS	Joint Capability Integration Development System
JTETD	Joint Trauma Education and Training Directorate
KSA	knowledge, skills, and abilities
MedMACRE	Medical Manpower All Corps Requirements Estimator
MEP	Management Engineering Program
MHS	Military Health System
MILDEP	Military Department
MTF	military medical treatment facility
NDAA	National Defense Authorization Act
NDS	National Defense Strategy
NMS	National Military Strategy
OFM	Objective Force Model
OPLAN	Operational Plan
PCS	permanent change of station
POE	Projected Operational Environment
ROC	Required Operational Capabilities
RTC	Report to Congress
SecDef	Secretary of Defense
TAA	Total Army Analysis
USU	Uniformed Services University of the Health Sciences

APPENDIX C: DEPARTMENT OF THE ARMY CORRECTIVE ACTION PLAN FOR WARTIME SPECIALTIES (NOTE: CURRENTLY IN EXECUTION)

Subject: Follow-up Status on GAO-18-77, MILITARY PERSONNEL: Additional Actions Needed to Address Gaps in Military Physician Specialties, February 18, 2018 (GAO Project Number 101138)

Recommendation #1: The Secretary of the Army should develop targeted strategies for using its recruitment, training, and retention programs collectively to address key military physician gaps in a coordinated manner, and metrics that would monitor the effectiveness of its programs collectively in reducing gaps.

Army Position: Concur. The Army will conduct a review of recruitment, training, and retention programs to determine what changes should be made to improve recruitment and retention of military physicians.

Status Update: In fiscal year 2019, the DoD and Army took several actions, including creating a 6-year health professions officer retention bonus for critically short physician specialties; increased the number of Armed Forces Health Professions Scholarship Program scholarships to help decrease the overall physician shortfalls; and added a recruiting mission using Financial Assistance Program scholarships to help decrease the physician shortfall in critical specialties. Lastly, the Army has monitored its recruitment and retention efforts and plans to continue to monitor its efforts annually.

Estimated Completion Date: All required actions completed and GAO considers this recommendation to be successfully implemented.

Corrective Action Plan (CAP):

Key Corrective Actions	Estimated Completion Dates	Actual Completion Date	Measure(s) Capturing Demonstrated Results	Clarifying Comments
OSD(HA) increased the Physician Critically Short Wartime Specialty Accession Bonus (CSWSAB) Rates.	1 Oct 18	1 Jan 19	Based on a specialty specific mission, the number of USAREC CSWSAB agreements executed with new accessions.	Army implemented OSD(HA) CSWSAB higher rates for the USAREC missioned specialties as published in the Army Active Component Health Professions Officer Special and Incentive Pay Plan Effective 1 January 2019.
OSD(HA) created a Higher Rate 6-year Health Professions Officer Retention Bonus (HPO RB)	1 Oct 18	1 Jan 19	Number of officer 6-year HPO RB agreements	Army implemented OSD(HA) HPO RB 6-year authority for specific specialties as

for Critically Short Physician Specialties.			executed.	published in the Army Active Component Health Professions Officer Special and Incentive Pay Plan Effective 1 January 2019 (attachment 1).

Increase the number of Health Professions Scholarships Program (HPSP) scholarships to help decrease the overall physician shortfalls.	1 Oct 19	1 Feb 19	Review actual numbers of accessions at the end of each scholarship window; revise annually as required.	OTSG authorized over accession of FY18 HPSP Scholarship participants, and provided increases to the FY19 and FY20 missions via OTSG G-1/4/6 input to Army G-1 Mission letter increased the HPSP Scholarships as follows: 5 Additional 3 Year 25 Additional 4 Year This guidance was signed on 26 July 2018 (attachment 2). The Army G-1 has not yet published the FY19/20 Mission Letter. Continued increases at the current level will be dependent upon future program funding.
Implement a recruiting mission using Financial Assistance Program (FAP) scholarships to help decrease the physician shortfall in critical specialties.	1 Oct 19	1 Feb 19	Review actual numbers of FAP participants at the end of each FY; revise annually as required.	OTSG provided for a FAP mission beginning in FY20 and an over production mission for FAP in FY19. FAP is a new mission for USAREC and requires an adjustment to their operations to develop the market strategy. G-1/4/6 input to Army G-1 Mission letter added a mission of 10 FAP Scholarships

				This guidance was signed on 26 July 2018 (attachment 2). The Army G-1 has not yet published the FY19/20 Mission Letter. It is currently in draft form. Continued increases at the current level will be dependent upon future program funding.

Subject: Follow-up Status on GAO-18-77, MILITARY PERSONNEL: Additional Actions Needed to Address Gaps in Military Physician Specialties, February 18, 2018 (GAO Project Number 101138)

Recommendation #4: The Secretary of the Army should track complete, accurate, and accessible information on the qualifications, performance, and progress of Army AFHPSP medical students.

Army Position: Partially concur. As GAO notes in the report, the Army has a process to track data on student qualifications and performance and uses the information to make improvements as needed. However, we will review current processes and make necessary improvements to ensure data is complete and accurate

Status Update: In July 2018, the Army issued a memorandum requiring quarterly review of key data fields and requirements for completeness and accuracy of data. Further, retraining of data entry technicians has been performed and records are now routinely reviewed by the program manager for accuracy.

Estimated Completion Date: All required actions completed and GAO considers this recommendation to be successfully implemented.

Corrective Action Plan (CAP):

Key Corrective Actions	Estimated Completion Dates	Actual Completion Date	Measure(s) Capturing Demonstrated Results	Clarifying Comments
Issue memorandum advising technicians of initiation of quarterly review of key data fields and requirements for completeness and accuracy of data.	1 August 2018	13 July 2018		Memorandum was issued on 13 July 2018 (attached), and is now part of the quarterly appraisal counselling for all technicians.
Begin quarterly reviews of selected student data entries to ensure completeness and accuracy of key data fields.	1 October 2018	13 July 2018		Quarterly review of data with responsible technicians began in July 2018, and now occurs on a quarterly basis. However, review of data on individual records is performed daily by the Program Manager as each record is entered and validated by the technicians.
Retrain technicians as needed to correct any	1 October 2019	13 July 2018		As of 13 July 2018, quarterly

significant identified deficiencies with data quality.				performance evaluation of all technicians include quality expectations for data entry. New records are reviewed daily by the Program Manager for accuracy, and additional training is provided when performance does not adequately meet expectation. Additional training is annotated on the quarterly appraisal counseling form.

This is a memorandum from the Surgeon General of the Army, dated July 26, 2018, Subject: Modified FY 2019 and Tentative FY 2020 Active Component Army Medical Department (AMEDD) Accession Mission.

[= THE ARMY OFFICE OF THE SURGEON GENERAL 5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3258

26 JUL 2018

MEMORANDUM FOR DEPUTY CHIEF OF STAFF, G-1, ATTN: DAPE-MPA

SUBJECT: Modified Fiscal Year (FY) 2019 and Tentative FY 2020 Active Component Army Medical Department (AMEDD) Accession Mission

1. This memorandum transmits the modified FY19 and the tentative FY20 Active Component accession mission for the AMEDD. The FY19 modification reflects the final determination based on the accomplishments of the FY18 mission and known changes in strength and/or future force structure. The FY20 accession mission is based on the current force structure models for each Corps and may be modified later in FY19. Individual Corps program accession requirements represent the total requirements from all sources.

2. The table below represents the projected total program requirements for entry onto active duty (AD) and entry into student programs not on AD in FY19 and FY20 for each of the AMEDD Corps:

Corps	Accession to AD		Students not on AD	
	FV19	FY20	FY19	FY20
AN[1]	285	289	40	40
DC	102	104	95	95
MC	371	375	315	325
MS[2]	323	330	28	28
SP[3]	162	169	100	100
VC	41	43	33	33
TOTAL	1284	1310	611	621

Notes:

1. Students not on AD includes AMEDD Enlisted Commissioning Program (AECP).
2. Accessions to AD does not include requirements for USUHS entrants.
3. IPAP students are AD officer and enlisted but retain current branch until completion.

3. Enclosures 1 through 6 provide a detailed breakout for each Corps showing sources of total program requirements for entry on AD, specific direct recruitment requirements, and student recruitment requirements to meet the above stated requirements.

4. Army Nurse Corps: There is a distinction in the Army Nurse Corps Mission between the USA Cadet Command Commission Mission as reflected in Enclosure 4 of the Department of the Army G-1 mission memo and the Accession Mission as reflected in Enclosure 1 to this memorandum. Enclosure 1 reflects accessions to active duty which normally includes cadets that have been actually commissioned in previous FYs. These are reflected as "roll overs'; and should not influence the numbers actually commissioned annually by USACC.

5. Behavioral Health: Continued demands on the behavioral health professions make accomplishment of the stated mission for these skill sets especially critical. Missions for Psychiatrists, Clinical Psychologists, Social Workers and Psychiatric Nurse Practitioners should receive special attention.

a. Recruitment requirements for Social Work officers remains a high priority. Recruitment will focus on two avenues:

1) Master of Science in Social Work program at the AMEDD Center and School. This program is viewed as critical to meet the behavioral health needs of the Army. Detailed guidance regarding the program for FY19 is contained in at forthcoming MILPER Message.

2) Social Work Internship Program (SWIP) provides individuals who have already attained a Master's Degree in Social Work from a Council on Social Work Education (CSWE) accredited institution the opportunity to complete the necessary requirements to become a licensed clinical social worker. Interested individuals should also have successfully completed the License Master Social Work (LMSW) examination prior to entry into SWIP.

b. The Clinical Psychology recruitment remains a high priority, and multiple programs will be used to access the numbers required to meet the current authorized levels.

1) Internship Program is a program of particular concern. The applicants to this program must match to the Army program in order to be entered on to active duty for an internship.

2) HPSP Scholarships for students in Clinical Psychology programs has increased for both 1 and 2 year scholarships. USAREC must ensure that sufficient numbers of applicants are available to meet the scholarship mission requirements.

3) Beginning in FY 2019 USAREC will board and select fully-qualified applicants.

4) Beginning in FY2019 USAREC will offer the Financial Assistance Program (FAP) to up to 3 applicants per year for post-doctoral Fellowships. USAREC will coordinate with the Clinical Psychology Consultant to The Surgeon General for specific qualifications for entry into FAP.

6. Addendum 1 to Army Structure (ARSRTUC) Memorandum 2020-2024, dated 08 December 2017 adds 130 spaces for Physical Therapists (658) and Dieticians (65C) to support the Holistic Health and Fitness (H2F) initiative. This requires a significant increase in the recruitment and accession of 658 and 65C officers over prior recruitment years. These increased requirements are reflected in the mission numbers for FY19 and FY20. These increases are anticipated to endure beyond FY20. In addition, it is anticipated that there will be an increased need for the accession of fully-qualified Occupational Therapists (65A). Due to lack of budgeted end-strength for 65A, the accession numbers remain unchanged from FY 2018. However, USAREC should be prepared to over-produce on the mission of fully-qualified 65A in order to meet anticipated demand.

7. Based on the number of foreign veterinary colleges which have gained accreditation from the American Veterinary Medical Association (AVMA), the waiver of the requirement in paragraph 1(11)c(1)(d), AR 351-101, continues throughout this accession period. This waiver is necessary in light of the fact that the AVMA policies exempt graduates of accredited foreign colleges from taking the standard Educational Commission for Foreign Veterinary Graduates (ECFVG). Graduates of non-AVMA accredited foreign veterinary schools continue to require the ECFVG.

8. Utilization of the Critically Short Wartime Specialty Accession Bonus (CSWSAB) results in a mission which delineates specific skills to be recruited utilizing the bonus amount established by Assistant Secretary of Defense (Health Affairs) (ASD(HA)). The FY19 dollar amounts of the accession bonus have increased for selected critical skills as published in the FY19 pay plan. A determination as to availability in FY20 has not yet been made.

a. The CSWSAB may be utilized for Army Nurse Corps officers recruited as CANA (66F).

b. The CSWSAB may be utilized for Medical Corps officers recruited in the skills listed in the Medical Corps enclosure for FY19 only.

c. The CSWSAB may be utilized for Dental Corps officers recruited as Oral Surgery (63N), Prosthodontics (63F), Comprehensive Dentistry (63B), Endodontics (63E) or General Dentistry (63A).

e. The CWSAB may be utilized for fully-qualified Medical Service Corps Officers in Clinical Psychology (738) only.

9. There are standard accession bonuses (AB) available for selected specialties as described below.

a. The standard AB may be utilized for Army Nurse Corps in FY19 for all specialty trained direct accession applicants. This does not include Medical Surgical Nurses (66H).

b. The standard AB may be utilized for accession of qualified direct accession Dental Corps officers in any specialty not listed as a CWSAB specialty.

c. The standard AB may be utilized for Army Medical Specialist Corps beginning in FY 19 for the recruitment of fully-qualified Physical Therapists (658) and Dietitians (65C) to assist in meeting the H2F increases. The AB may also be utilized for any Physician Assistants (650).

d. The standard AB may be utilized for accession of qualified Medical Service Corps officers in Pharmacy (67E) and Social Worker (73A).

e. The standard AB may be used Veterinary Corps applicants.

10. The AD Health Professional Loan Repayment Program remains funded at a level to support 175 new enrollees within the program in FY19. A decision regarding FY20 availability of funds has not yet been made. This program may be utilized as required to accomplish the established direct accession mission for all specialties, except Medical- Surgical Nurse (66H).

11. MAVNI should be considered a tool to assist USAREC in the accomplishment of the assigned direct accession mission. Limitations have been placed on the use of MAVNI in some of the Corps. These limitations are contained within the specific Corps enclosures.

12. Fiscal and strength considerations make adherence to the year group distribution of the Health Professions Scholarship Program (HPSP) mission critical. No deviation from the established year group mission will be permitted without direct coordination with DASG-HR or as indicated in the specific Corps enclosure.

13. There will be required modifications to this mission letter during the execution year caused by academic drops from schooling, changes in force structure, and additional external factors. I request authorization for direct coordination between the Office of The Surgeon General (OTSG) and Health Services Directorate, USAREC, during the year of execution in the following instances.

a. Changes in the Health Professions Scholarship/Financial Assistance Program Mission and the Health Professions Loan Repayment Program.

b. Activation of alternates from selection boards.

c. Reductions in direct accession missions.

d. Requests to overproduce in non-missioned AOCs.

e. Modification of available recruitment incentives based on funding constraints.

14. Additions to the direct mission in the year of execution and any change where there is no agreement between the Human Resources Directorate, OTSG, and Health Services Directorate, USAREC will be routed through DAPE-MPA for adjudication.

15. Our point of contact for this action **is Ms.** Cara Weldyt DASG-HR, 703-681-3197, email cara.a.weldy.civ@mail.mil.

FOR THE SURGEON GENERAL:

Encls

Colonel(P), US Army
Deputy Chief of Staff, Support (G-1/4/6)

CF:
Chief, Health Services Directorate, HRC
Director, AMEDDPersonnel Proponency Directorate, AMEDDC&S
Dean, AMEDDCS

Expected Accession Capability as a Result of Prior Recruitments

Specialty		AOC	Program	Category	FY19	FY20
Registered Nurse[1]		66H	ROTC	Current FY Commissions	120	120
Registered Nurse[1]		66H	ROTC	Prior FY Commissions	**45**	**45**
Registered Nurse		66H	AMEDD Enlisted Commissioning	Projected Graduates	**25**	**25**
Nurse Anesthetist		66F	Health Professions Scholarship	Projected Graduates	0	1
Family Nurse Practitioner		66P	Health Professions Scholarship	Projected Graduates	1	0
Psychiatric Nurse Practitioner		**66R**	Health Professions Scholarship	Projected Graduates	1	0
Nurse Midwife		66W	Health Professions Scholarship	Projected Graduates	0	1
TOTAL					**192**	**192**

Recruitment Requirements for Current FY **Accessions**

Specialty	AOC	Program	Category	FY19	FY20
Registered Nurse[2]	66H	Direct Accession	Fully-Qualified	20	20
Registered Nurse[3]	66H	AMEDD **Registered** Nurse Enlisted Commissioning	Fully-Qualified/OCS Graduate	0	0
Nurse Anesthetist[4]	66F	Direct Accession	Fully-Qualified	5	5
Nurse Anesthetist	66F	Direct Accession	Student Program	**25**	25
Familv Nurse Practitioner[4]	66P	Direct Accession	Fully-Qualified	10	10
Psychiatric Nurse Practitioner	66R	Direct Accession	Fully-Qualified	3	7
Critical Care Nurse	66S	Direct Accession	Fully-Qualified	10	10
Critical Care Nurse[5]	66S	Direct Accession	Student Program	15	15
Emergency Nurse	66T	Direct Accession	Fully-Qualified	4	4
Nurse Midwife	66W	Direct Accession	Fully-Qualified	1	1
TOTAL				**93**	**97**
TOTAL EXPECTED ACCESSIONS FROM ALL SOURCES				***285***	***289***

Recruitment to Student Programs for Accession In Future Fiscal Years

Specialty	AOC	Program	Category	FY19	FY20
Registered Nurse (to be 66H)		AMEDD Enlisted Commissioning	Student	35	35
Nurse Anesthetist, Famity Nurse Practitioner or Psychiatric Nurse Practitione[6]r	00E	Health Professions Scholarship	Student	5	5
TOTAL				**40**	**40**

NOTES:

1. ROTC numbers reflect projected accession to active duty from all commissioning years and should not be confused with Cadet Command Commission Mission. Desired Reserve Officer Training Corps Commission Output is 165 which is the combination of current and prior year commissions.
2. Distribution of the 66H recruitment mission is 10 fully-qualified with <2 years of experience and 10 with 2-4 years of experience. Deviations must be coordinated with DASG-HR.
3. AMEDD Registered Nurse Enlisted Commissioning Officer Candidate program will be boarded as needed based upon fiscal year requirements.
4. Over-accession of fully-qualified 66F and 66P direct accessions is authorized.
5. Applicants for the 66S Student Program must possess a minimum of 2 years of medical-surgical nursing experience in order to be considered.
6. HPSP accessions are capped at 5 in any combination of Nurse Anesthetist (66F), Family Nurse Practitioner (66P) or Psychiatric Nurse Practitioner (66R).

ADDITIONAL GUIDANCE:

MAVNI accessions are not generally appropriate for nurse accessions and coordination must be made with OTSG prior to boarding any MAVNJ applicant.

Over-accessions of fully-qualified nurses except as noted above require DASG-HR approval.

Expected Accession Capability as a result of Prior Recruitments

Specialty	AOC	Program	Category	FY19	FY20
General Dentist	63A	Health Professions Scholarshlp (HPSP)	Projected Graduates	75	81
General Dentist	63A	ROTC and USMA/HPSP	Education Delay	5	1
TOTAL				**80**	**82**

Recruitment Requirements for Current FY Accessions

Specialty	AOC	Program	Category	FY19	FY20
General Dentist	63A	Direct Accession	Fully-Qualified	15	15
Oral Surgeon	63N	Direct Accession	Fully-Qualified	5	5
Prosthodontist	63F	Direct Accession	Fully-Qualified	2	2
TOTAL				**22**	**22**
TOTAL EXPECTED ACCESSIONS FROM ALL SOURCES				***102***	***104***

Recruitment to Student Programs for Accession in Future Fiscal Years

Specialty	AOC	Program	Category	FY19	FY20
Dental School Student	0OE	Health Professions Scholarship	FY20 Graduation	0	0
Dental School Student	ODE	Health Professions Scholarship	FY21 Graduation	0	0
Dental School Student	00E	Health Professions Scholarship	FY22 Graduation	20	20
Dental School Student	00E	Health Professions Scholarship	FY23 Graduation	75	75
TOTAL				**95**	**95**

NOTES:

1. Military Accessions Vital to the National Interest (MAVNI) will not be utilized to recruit 63A (General Dentists).

2. All direct accessions should have less than 10 years constructive credit or current grade held of MAJ. Individuals with 10 or greater years constructive credit or current grade held higher than MAJ must be approved by Chief, Dental Corps (or his designated representative) prior to recruitment/accession.

3. USAREC has "automatic authority" to enroll any additional one year HPSP Scholarships; DASG-HR will be notified if executed.

4. Over-accessions of Dental HPSP may be allowed with coordination and approval of OTSG.

ADDITIONAL GUIDANCE:

Fully qualified applicants, other than those missioned, should be forwarded to the appropriate consultant for Curriculum Vitae (CV) review and determination of the current needs of the Dental Corps.

Positions will be available for the one-year Advanced Education in General Dentistry to officers entering active duty through all accession sources other than Financial Assistance Program (FAP). USAREC must contact OTSG Medical Education to confirm prior to execution.

-

Specialty	AOC	Program	Category	FY19	FY20
Field Surgeon	62B	Uniformed Service University	Projected Graduates	65	60
Field Surgeon	628	Health Professions Scholarship	Projected Graduates	266	275
Field Surgeon[1]	628	Financial Assistance	Projected Graduates	0	0
Field Surgeon	628	Early Commissioning	Projected Graduates	0	0
TOTAL				**331**	**335**

Recruitment Requirements for Current FY Accessions

Specialty	AOC	Program	Category	FY19	FY20
Preventive Medicine	60C	Direct Accession	Fully-Qualified	2	2
Anesthesia	SON	Direct Accession	Fully-Qualified	4	4
Pediatrician	60P	Direct Accession	Fully-Qualified	0	0
Psychiatrist	60W	Direct Accession	Fully-Qualified	8	8
Internal Medicine	61F	Direct Accession	Fully-Qualified	2	2
Infectious Disease	61G	Direct Accession	Fully-Qualified	2	2
Family Practice	61H	Direct Accession	Fully-Qualified	2	2
General Surgery	61J	Direct Accession	Fully-Qualified	10	10
Emergency Medicine	62A	Direct Accession	Fully-Qualified	10	10
TOTAL				**40**	**40**
TOTAL EXPECTED ACCESSIONS FROM ALL SOURCES FOR FY 2019				***371***	***375***

Recruitment to Student Programs for Accession In Future Fiscal Years

Specialty	AOC	Program	Category	FY19	FY20
Medical School Student	00E	Health Professions Scholarship Student	1-Year Scholarship	0	0
Medical School Student	00E	Health Professions Scholarship Student	2-Year Scholarship	0	0
Medical School Student	00E	Health Professions Scholarship Student	3-Year Scholarship	25	25
Medical School Student	00E	Health Professions Scholarship Student	4-Year Scholarship	280	290
Medical School Student[1]	00E	Financial Assistance	1+ Years Grant/Stipend	10	10
TOTAL				**315**	**325**

Overproduction of Direct Accessions Authorized in Following Specialties to Fill Vacancies

Specialty	AOC	Program	Category		FY19	FY20
Preventive Medicine	60C	Direct Accession	Fully-Qualified		20	20
Anesthesia	60N	Direct Accession	Fully-Qualified		25	25
Psychiatrist	60W	Direct Accession	Fully-Qualified		No Limit	No Limit
Internal Medicine	61F	Direct Accession	Fully-Qualified		50	50
Family Practice	61H	Direct Accession	Fully-Qualified		No Limit	No Limit
General Surgery	61J	Direct Accession	Fully-Qualified		No Limit	No Limit
Neurosurgery	61Z	Direct Accession	Fully-Qualified		No Limit	No Limit
Emergency Medicine	62A	Direct Accession	Fully-Qualified		No Limit	No Limit

NOTES:

1. FAP mission will be restricted to the Areas of Concentration listed in the direct accession, fully-qualified mission requirements listed. The direct accession mission will not be reduced based upon recruitment of any FAP participant. Deviations from this instruction must be coordinated with DASG-HR.

2. Direct accession of any specialty not listed may be processed by exception. Prior coordination with DASG-HR is required. Forward in accordance with established procedures

-

Specialty	AOC	Program	Category	FY19	FY20
Health Care Admin	70B	United States Military Academv	Projected Graduates	20	20
Health Care Admin[1]	708	ROTC	Current FY Commissions	140	150
Health Care Admin[1]	708	ROTC	Prior FY Commissions	0	0
Health Care Admin[2]	70B	OCS	Projected Graduates	0	0
Optometry	67F	HPSP	Projected Graduates	12	11
Pharmacy	67E	HPSP	Projected **Graduates**	1	0
Pharmacy	67E	ROTC	Education Delay	0	0
Biochemist	71B	ROTC	Education Delay	0	0
Social Work Officer	73A	ROTC	Education Delay	0	0
Clinical Psychology	73B	HPSP	Projected Graduates	**8**	13
Clinical Psychology	73B	ROTC	Education Delay	1	1
Clinical Psychology	73B	FAP	Projected Graduates	3	3
TOTAL				**185**	**198**

Recruitment Requirements for Current FY Accessions

Specialty	AOC	Program	Category	FY19	FY20
Health Care Admin[3]	70B	Direct Accession	Fully-Qualified	0	0
Microbiologist (MS)	71A	Direct Accession	Fully-Qualified	1	1
Microbiologist (PhD)	71A	Direct Accession	Fully-Qualified	4	4
Biochemist	718	Direct Accession	Fully-Qualified	7	7
Clinical Lab Off	71E	Direct Accession	Fully-Qualified	7	7
Research Psychologist	71F	Direct Accession	Fully-Qualified	3	3
Nuclear Med Science	72A	Direct Accession	Fully-Qualified	**8**	6
Entomologist	728	Direct Accession	Fully-Qualified	4	4
Audiologist	72C	Direct Accession	AEP or Fully-Qualified	6	6
Environmental Science (BS/MS Level)	720	Direct Accession	Fully-Qualified	**13**	9
Environmental Science (ASI N4 Qualified)	72D	Direct Accession	Fully-Qualified	4	4
Social Work Off	73A	MSW Training Program	Student	22	22
Social Work Off	73A	Internship	Student	5	5
Social Work Off	73A	Direct Accession	Fully-Qualified	**5**	5
Clinical Psychology	738	Internship Program	Student	**24**	**24**
Clinical **Psychology**	738	Post Doc Supervision	Fully-Qualified	3	3
Clinical Psychology	73B	Direct **Accession**	Fully-Qualified	3	3
Pharmacy	67E	Direct Accession	Fully-Qualified	13	13
Optometrist	67F	Direct Accession	Fully-Qualified	2	2
Podiatrist	67G	Surgery Residency	Student	2	2
Podiatrist	67G	Direct Accession	Fully-Qualified	2	2
TOTAL				**138**	**132**

TOTAL EXPECTED ACCESSIONS FROM ALL SOURCES ***323*** ***330***

Specialty	AOC	Program	Category	FY19	FY20
Medical Student	70B	F. Edward Herbert School of Medicine	Future MC Accession	63	63
Clinical Psychology	738	PhD Long Term Training	Board Select Students	3	3
TOTAL				**66**	**66**

Recruitment to Student Programs for Accession In Future Fiscal **Years**

Specialty	AOC	Program	Category	FY19	FY20
Optometry	00E	Health Professions Scholarship	(1-Year Scholarship)	2	2
Optometry	00E	Health Professions Scholarship	(2-Year Scholarship)	6	6
Optometry	00E	Health Professions Scholarship	(3-Year Scholarship)	4	4
Optometry	00E	Health Professions Scholarship	**(4-Year** Scholarship)	0	0
Clinical Psychology	00E	Health Professions Scholarship	(1-Year Scholarship)	B	B
Clinical Psychology	00E	Health Professions Scholarship	(2-Year Scholarship)	5	5
Clinical Psychology[7]	00E	Financial Assistance Program (FAP)	1-Year FAP	3	3
TOTAL				**28**	**28**

NOTES:

1. Desired Reserve Officer Training Corps Commission Output is **150.**

2. Officer Candidate School accessions will be by exception with coordination. Desired number of accession is 10 per fiscal year.

3. Direct accession mission for administrative AOCs is restricted to 708 with no constructive credit. Requests for application must be forwarded thru the Office of the Chief, Medical Service Corps for approval prior to boarding.

4. Substitution allowed for 71A. An additional PhD applicant may be accepted in lieu of a Masters applicant. Total number of fully-qualified direct accession 71A may not exceed 5.

5. Pharmacy Accession Bonus remains fully funded.

6. The accession requirement to support Uniformed Services University of Health Sciences is not included in the **stated** Accession Requirement. This recruitment is managed solely by USUHS. USAREC program manager will however, include these individuals In their reporting process.

7. Clinical Psychology FAP will be used to fund applicants matching to post doctoral Fellowships outside of DoD.

ADDITIONAL GUIDANCE:

Based on the results of the ROTC Branching Board and the academic credentials of those selected, the direct accession missions for Allied Science officers may be decreased.

Expected Accession Capability as a result of Prior Recruitments

Specialty	AOC	Program	Category	FY19	FY20
Occupational Therapy	**65A**	ROTC	Education Delay	0	0
Physical Therapy	658	ROTC	Education Delay	3	0
Dietician	65C	ROTC	Education Delay	1	0
Physician Assistant	650	ROTC	Education Delay	0	0
Physician Assistant	650	Interagency Physician Assistant Program **IPAP)**	Projected Graduates	90	95
TOTAL				**94**	**95**

Recruitment Requirements for Current FY Accessions

Specialty	AOC	Program	Category	FY19	FY20
Occupational Therapy	65A	Direct Accession	Fully-Qualified	9	11
Physical Therapy[1]	658	Direct Accession	Fully-Qualified	9	9
Physical Therapy	658	Baylor PT Doctoral	Student	20	24
Dietician[2]	65C	Direct Accession	Fully-Qualified	**B**	**B**
Dietician[3]	65C	Graduate Program in Nutrition	Student	15	15
Physician Assistant[4]	65D	Direct Accession	Fully-Qualified	7	7
TOTAL				**68**	74
TOTAL EXPECTED ACCESSIONS FROM ALL SOURCES				***162***	***169***

Recruitment to Student Programs for Accession in Future Fiscal Years

Specialty	AOC	Program	Category	FY19	FY20
Physician Assistant [5]	00E	Interagency Physician Assistant Program 'IPAP)	Student Trainee	**100**	**100**
TOTAL				**100**	**100**

NOTES:

1. The fully-qualified applicant for 658 will have experience or training as specified below. Any deviations from these must be coordinated with DASG-HR.
   a. Qualified doctorate in physical therapy (DPT) from a CAPTE accredited program.
   b. Current unrestricted license to practice physical therapy in any state.
   c. Three to six years of clinical experience as a licensed physical therapist.
2. For applicants to fully-qualified direct accession65C, please refer applicants CV or equivalent to the consultant prior to boarding to ensure they meet requisite education, license and/or certification to practice.
3. Applicants with a completed 8atchelor's degree may access to the GPN with or without a completed internship, appropriate constructive credit will be awarded based upon experience.
4. PA direct accession should be in the grade of Captain or below. Accessions above that grade will be coordinated with the Corps Chief and DASG-HR.
5. Officer students entered into the !PAP program will be assigned as 00E.
6. Any over-accession of GSA, **658,** or GSC will be coordinated with DASG-HR.

Expected Accession Capability as a result of Prior Recruitments

Specialty	AOC	Program	Category	FY19	FY20
Field Veterinary Service Officer	64A	Health Professions Scholarship (HPSP\	Projected Graduates	21	30
Field Veterinary Service Officer	64A	Health Professions Scholarship Program Delav	Education Delay	3	3
TOTAL				**24**	33

Recruitment Requirements for Current FY Accessions

Specialty	AOC	Program	Category	FY19	FY20
Field Veterinary Service Officer	**64A**	Direct Accession	Fully-Qualified	17	10
Veterinary Preventive Medicine Officer[1]	648	Direct Accession	Fully-Qualified	0	0
TOTAL				**17**	**10**
TOTAL EXPECTED ACCESSIONS FROM ALL SOURCES				**41**	**43**

Recruitment to Student Programs for Accession in **Future Fiscal Years**

Specialty	AOC	Program	Category	FY19	FY20
Veterinary School Student	COE	Health Professions Scholarship	1-Year Scholarship	0	0
Veterinary School Student	OOE	Health Professions Scholarship	2-Year Scholarship	0	0
Veterinary School Student	OOE	Health Professions Scholarship	3-Year Scholarship	33	33
Veterinary School Student	OOE	Health Professions Scholarship	4-Year Scholarship	0	0
TOTAL				**33**	**33**

NOTES:

1. Based on critical shortage, USAREC has blanket authority to over-access anyone qualified as a 64B, Veterinary Preventive Medicine Officer. DASG-HR will be notified of any occurrence.

The next attachment is Army's Active Component Health Professions Officer Special and Incentive Pay Plans Effective 1 January 2019.

Army Active Professions Officer
Special and Incentive Pay Plan
Effective 1 January 2019

Index:
Para 1 - Purpose
Para 2 - Definitions
Para 3 - General Policy
Para 4 - Evaluation of Eligibility
Para 5 - Health Professions Officer (HPO) Accession Bonus (AB) and HPO Critically Short Wartime Specialty Accession Bonus (CSWSAB)
Para 6 - HPO Board Certification Pay (BCP)
Para 7 - HPO Incentive Pay (IP)
Para 8 - HPO Retention Bonus (RB)
Para 9 - Automatic Voluntary Retention
Para 10 - Agreement Procedures and Approval Authority
Para 11 - Termination of Special Pays
Para 12 - Recoupment of Unearned Payments
Para 13 - Administration of Authorization Data
Para 14 - Payment Procedures
Para 15 - Special Pay for Mobilized Reserve Component (RC) HPOs
Table 1 - HPO AB and HPO CSWSAB Authorized Specialties and Rates
Table 2 - HPO BCP Authorized Specialties, Boards, and Rates
Table 3 - HPO IP and HPO RB Specialties, Boards, and Rates

1. **Purpose**. This pay plan applies to all Army Medical Department (AMEDD) Active Component (AC) Health Professions Officers (HPOs), as well as title 10 USC and title 32 USC Active Guard Reserve (AGR) HPOs, and mobilized Reserve Component (RC) HPOs on Active Duty 30-consecutive days or more. The pay plan enhances the ability to size, shape, and stabilize the force by using a monetary incentive to support the recruitment and retention of health care professionals with critical wartime specialties and valuable experience crucial to Army mission success today and readiness tomorrow. This pay plan enacts the Consolidation of Special Pays (CSP) statute and Department of Defense (DoD) plan, and includes the HPO Accession Bonus (AB), HPO Critical Wartime Skills Accession Bonus (CSWSAB), HPO Board Certification Pay (BCP), HPO Incentive Pay (IP), and HPO Retention Bonus (RB). The CSP special pays are categorized as discretionary and are not an entitlement. This pay plan is effective 1 January 2019, and does not expire unless superseded.

2. **Definitions**.

a. Health Professions Officer (HPO). Any health profession performed by officers who are in the Medical Corps of a Uniformed Service or designated as Medical Officers; in the Dental Corps of a Uniformed Service or designated as Dental Officers; in the Medical Service Corps of a Uniformed Service or designated as Medical Service Officers; in the Medical Specialists Corps of a Uniformed Service or designated as

Medical Specialists; in the Nurse Corps of a Uniformed Service or designated as Nurses; in the Veterinary Corps of a Uniformed Service or designated as Veterinary officers.

b. Specialty. A health profession specialty for which there is an identifying Army specialty skill identifier; also called an Area of Concentration (AOC). The Additional Skill Identifier (ASI) can further designate the HPO specialty.

c. Health Care Provider (HCP). A military HPO granted privileges to diagnose, initiate, alter, or terminate health care treatment regimens within the scope of his or her license, certification, or registration. Includes physicians, dentists, advance practice registered nurses (APRN) – {family nurse practitioners, psychiatric/behavioral health nurse practitioners, nurse anesthetists, nurse midwives, clinical nurse specialists}, physical therapists, podiatrists, optometrists, clinical dietitians, social workers, clinical pharmacists, clinical psychologists, occupational therapists, audiologists, speech pathologists, physician assistants, or any other person providing direct patient care as may be designated by the DoD.

d. Initial Education and Training Active Duty Obligation. As recorded on officer's initial order to active duty, it is an obligation incurred for participating in a pre-commissioning and/or commissioning program. This includes, but is not limited to, an accession bonus (AB/CSWSAB), Reserve Officer Training Corps (ROTC), U.S. Military Academy (USMA) or equivalent, Uniformed Services University of the Health Sciences (USUHS), Accession Health Professions Loan Repayment Program (HPLRP), Armed Forces Health Professions Scholarship Program (HPSP), Interagency Physician Assistant Program (IPAP), Financial Assistance Program (FAP), Registered Nurse Enlisted Commissioning Program (RNECP), Educational Delay, Social Work Internship Program (SWIP), Clinical Psychology Internship Program (CPIP), Graduate Professional Education (GPE) i.e. MSW or other initial specialty education, training, and/or other commissioning programs.

e. Credentialed. A qualification held by a health professions officer constituting evidence of qualifying education, training, licensure, experience, current competence, etc.

f. Privileged. Permission/authorization for an independent provider to provide medical or other patient care services in the granting institution. Clinical privileges define the scope and limits of practice for individual providers and are based on the capability of the healthcare facility, the provider's licensure, relevant training and experience, current competence, health status, and judgment.

g. Legacy Special Pays. Pertains to all special pays in title 37 USC Chapter 5, Sub Chapter I, §301d through §303b, to include: Accession Bonus (AB), Critical Wartime Skills AB (CSWSAB), Variable Special Pay (VSP), Optometry Duty Pay (ODP), Veterinary Duty Pay (VDP), Board Certification Pay (BCP), Non-Physician BCP (NPBCP), Medical Additional Special Pay (MASP), Dental Additional Special Pay

(DASP), Incentive Special Pay (ISP), Multi-year ISP (MISP), Oral and Maxillofacial Surgeon ISP (OMFS ISP), Certified Registered Nurse Anesthetist ISP (CRNA ISP), Registered Nurse ISP (RNISP), Pharmacy Officer Special Pay (POSP), Optometry Retention Bonus (ORB), Multi-year Special Pay (MSP), and Dental Officer Multi-year Retention Bonus (DOMRB).

3. **General Policy**.

a. Upon implementation of this plan, all remaining HPOs not already under a CSP agreement will transition from Legacy to CSP.

b. The HPO must have sufficient retention to complete the Active Duty Obligation (ADO) incurred by the agreement.

c. All HPOs must possess a current, valid unrestricted license from a State, U.S. Commonwealth, or territory, or an approved waiver if a HCP. An approved waiver must be consistent with DoD Manual 6025.13 and AR 40-68.

(1) AR 40-68, paragraph 4–6: Guidance on licensure requirements. Professionals directly accessed from a training program who require a license, certification, and/or registration to practice must obtain such authorizing documents within 1-year of the date when all required didactic and clinical requirements are met; within 1-year of completion of postgraduate year 1 (PGY–1) for physicians; and within 2-years after award of the doctoral degree for clinical psychologists.

(2) Physician Assistants/AOC 65D licensure is waived in accordance with Health Affairs Policy 04-002/15 January 2004, who must be certified by the National Commission on Certification of Physician Assistants (NCCPA).

d. All agreements will be executed up to 90-days in advance, but no later than 30-days after the agreement effective date; otherwise, the date of signature is the agreement effective date. Any request for exception to this 120-day window of execution policy must include Command endorsement explaining the extenuating circumstances for the delay in agreement execution.

e. HPOs will only sign linked IP and RB agreements for one specialty, even if the HPO holds qualifications in two or more specialties. Subspecialties or ASI of the primary specialty are included under the primary specialty. The linked IP and RB agreements must be for the same specialty and the same effective date.

f. All HPOs in a multi-year Legacy agreement due an annual installment in or after Fiscal Year 2019 will remain in those agreements, and the agreement is amended as an HPO RB. Amended agreements will not incur any additional ADO.

g. Delayed payments: All agreements will be paid directly by the Defense Finance and Accounting Service - Indianapolis Center (DFAS-IN) and could experiencea delay in payment of up to 90-days upon receipt by DFAS-IN. The Leave

and Earnings Statement (LES) entries may include the terminology "Save Pay" for BCP and IP payments, or possibly "Nuc Off Pay" for RB payments. HPOs should read LES remarks for further details.

4. **Evaluation of Eligibility**.

a. In general, a special pay recipient will be an HPO who has demonstrated performance and warrants retention of that officer on Active Duty. Denial of special pay based on other than failure to satisfy the eligibility criteria must be substantiated with documentation. Circumstances must clearly indicate that actions have been or will be initiated which would deny the HPO further practice, specialty designation, or continued Active Duty.

b. Individual responsibility: The success of the special pay program is paying only those HPOs who are authorized to receive it. It is the responsibility of the requesting HPO to ensure data is correct to support their eligibility for special pays.

c. Commander's expanded responsibility: Entrants and reentrants into the special pay program will be reviewed for participation. It is incumbent upon the Commander to remain constantly aware of the status of those HPOs for whom they serve as special pay agreement approval authority. The Commander will evaluate each requesting HPO for satisfaction of all eligibility criteria. A recommendation to terminate authorization to the pay may be made at any time based on failure to satisfy qualifying criteria or significant evidence that the HPO should be denied further practice as an HPO, or further retention on Active Duty. Submission of a recommendation to terminate authorization may be done at any time and is not restricted to the period immediately prior to the entry into a new agreement.

5. **HPO Accession Bonus (AB) and HPO Critically Short Wartime Specialty Accession Bonus (CSWSAB)**.

a. Eligibility. To be eligible for the AB or CSWSAB, an individual must:

(1) Be a graduate of an accredited school in his or her clinical specialty (see pertinent section of Table 1).

(2) Be fully qualified to hold a commission or appointment as a commissioned officer in an Active Component of the AMEDD Officer Corps.

(3) Be fully qualified in the specialty to which appointed.

(4) Have a current, valid, unrestricted license; NCCPA; or approved Army waiver.

(5) At the time of commission or appointment, have completed all mandatory service obligations if financial assistance was received from the DoD in order to pursue a course of study to become an officer, or pursue a course of study leading

towards appointment in the Corps/specialty. This includes, but is not limited to, participants and former participants of a Military Service Academy, ROTC, HPSP, FAP, USUHS, and other commissioning programs.

(6) Execute a written agreement to accept a commission or appointment as an Army officer and serve on Active Duty for a specific period. An individual who holds an appointment as an officer in either the Active or Reserve Component is not eligible for an AB or CSWSAB. A former officer who no longer holds an appointment or commission, and is otherwise qualified and eligible must have been honorably discharged or released from uniformed service at least 24 months prior to executing the written agreement to receive an AB or CSWSAB.

b. Procedures.

(1) Specialties authorized the AB or CSWSAB must be in accordance with the current Office of the Deputy Chief of Staff, G-1, Army Accession Mission memorandum. The Health Services Directorate, U.S. Army Recruiting Command (USAREC) manages the AB/CSWSAB program, and authorizes AB/CSWSAB written agreements to authorized specialties that meet the eligibility criteria and the Army Accession Mission Memorandum to serve on Active Duty.

(2) Individuals who meet the eligibility criteria and are authorized the AB or CSWSAB on the Army Accession Mission Memorandum, are eligible for an AB or CSWSAB in the amounts established by DoD in the pertinent section of Table 1.

(3) During the discharge of the service obligation associated with AB or CSWSAB, individuals are eligible for the IP and BCP, as applicable. Any additional obligation incurred by these pays shall be served concurrently. During the discharge of the service obligation associated with the AB or CSWSAB, individuals are not eligible for a RB.

c. The AB or CSWSAB will be terminated upon separation from Active Duty, death, or if the conditions of this agreement are not fulfilled. Reasons for termination include, but are not limited to: loss of privileges, court-martial conviction, violations of the Uniform Code of Military Justice, failure to maintain required certification or licensure, unprofessional conduct, failure to demonstrate proficient medical skill, or reasons that are in the best interest of the Army. The Army Surgeon General is the termination authority for all agreements.

d. Any failure to fulfill the conditions specified in the AB or CSWSAB agreement may result in termination of the agreement and the repayment of any unearned portion of the AB or CSWSAB in accordance with title 37 USC §373 and Chapter 2 of Volume 7A, DoDFMR 7000.14-R, as amended. As indicated in title 37 USC §373, a discharge in bankruptcy under title 11 USC does not discharge an officer from a debt arising from this agreement.

6. **HPO BOARD CERTIFICATION PAY (BCP)**.

a. Eligibility. To be eligible for the BCP, an HPO must:

(1) Execute a BCP agreement, and have at least one-year retainability on Active Duty beginning on the effective date.

(2) Have a post-baccalaureate degree (Master's Degree or higher) in the HPO's clinical specialty/AOC.

(3) Be certified by an approved recognized clinical specialty professional board (not a State board) in the clinical specialty/AOC as listed in the pertinent section of Table 2.

(4) Maintain Diplomate, certification, or board status, to include meeting the Maintenance of Certification (MOC) requirements, in the professional board of designated clinical specialty/AOC for the duration of receipt of BCP.

(5) The HPO must possess a current, valid, unrestricted license; NCCPA; or approved Army waiver under the provisions of AR 40-68, with applicable interim changes, without prejudicial restriction to the standards of the specialty for which the award is made, as a prerequisite and for the duration of receipt of BCP.

b. Agreement Effective Date. The effective date of the BCP agreement is the latter date of meeting all of the following:

(1) The date of entry on Active Duty,

(2) The date the post-baccalaureate degree in the HPO's clinical specialty/AOC is awarded,

(3) The date the HPO becomes board certified in the clinical specialty/AOC.

c. Procedures.

(1) BCP is paid on a prorated monthly basis; subject to the availability of funds, for the duration of the agreement. Payment of BCP is applicable to only one board certification, even if the HPO has multiple board certifications. Any previous payments of BCP or NPBCP will be stopped, and any overlapping payments will be adjusted and recouped as necessary.

(2) All AC and AGR HPOs must execute a written BCP agreement as prepared in the Medical Operational Data System (MODS) special pay module, with a copy of the board certificate or a copy of the board letter of

notification of certification, and a copy of their current, valid, unrestricted license; NCCPA; or approved Army waiver.

(3) RC HPOs serving more than 30-consecutive days on Active Duty, and not for training, must meet the same eligibility criteria and documentation, but no BCP agreement is required. See paragraph 15.

(4) Commanders will verify the HPO's eligibility, endorse the BCP agreement, and forward the endorsed BCP agreement to the AMEDD Special Pay Branch, OTSG.

(5) The AMEDD Special Pay Branch, OTSG will verify eligibility criteria provided with the BCP agreement and the MODS special pay module transaction data. All BCP agreements are subject to acceptance and may involve additional coordination with the pertinent AMEDD Officer Corps Branch at Health Services Division, Human Resources Command (HRC) to verify eligibility.

d. The BCP will expire when Diplomate, certification, or board status expires unless there is a submission of recertification or MOC documentation with a new BCP agreement. The HPO is responsible to repay all payments received beginning on the day after the expiration date of Diplomate, certification, or board status. Additionally, it is the HPO's responsibility to inform the AMEDD Special Pay Branch, OTSG to initiate stop-payment and recoupment action upon loss of eligibility, loss of license, or loss of certification. Payments received during the ineligible period will be recouped.

e. The BCP will be terminated upon separation from Active Duty, death, or if the conditions of this agreement are not fulfilled. Reasons for termination include, but are not limited to: loss of privileges, court-martial conviction, violations of the Uniform Code of Military Justice, failure to maintain required certification or licensure, unprofessional conduct, failure to demonstrate proficient medical skill, or reasons that are in the best interest of the Army. The Army Surgeon General is the termination authority for all agreements.

f. Any failure to fulfill the conditions specified in the BCP agreement may result in termination of the agreement and the repayment of any unearned portion of BCP in accordance with title 37 USC §373 and Chapter 2 of Volume 7A, DoDFMR 7000.14-R, as amended. As indicated in title 37 USC §373, a discharge in bankruptcy under title 11 USC does not discharge an officer from a debt arising from this agreement.

7. **HEALTH PROFESSIONS OFFICER INCENTIVE PAY (IP)**.

a. Eligibility. To be eligible for the IP, an HPO must:

(1) Execute an IP agreement, and have at least one-year retainability on Active Duty beginning on the effective date.

(2) If a HCP, AC and AGR HPOs must be currently credentialed, privileged, and practicing a minimum of 40-hours/year at a facility designated by the Army, in the specialty for which the IP is being paid.

(3) The HPO must possess a current, valid, unrestricted license; NCCPA; or approved Army waiver under the provisions of AR 40-68, with applicable interim changes, without prejudicial restriction to the standards of the specialty for which the award is made, as a prerequisite and for the duration of receipt of IP.

b. Agreement Effective Date. The effective date of the IP agreement is the latter date of meeting all of the following:

(1) No earlier than upon completion of qualifying training plus 3-months,

(2) Date of privileging as a HCP.

c. Procedures.

(1) IP is authorized at the annual rate as listed in the pertinent section of Table 3, and is paid on a prorated monthly basis; subject to the availability of funds, for the duration of the agreement. Any previous payments of IP or Legacy special pays will be stopped, and any overlapping payments will be adjusted and recouped as necessary.

(2) All AC and AGR HPOs must execute a written IP agreement as prepared in the MODS special pay module, and provide a copy of their current, valid, unrestricted license, or approved Army waiver. An HPO will only sign one IP agreement for one specialty, even if the HPO holds qualifications in two or more specialties.

(3) RC HPOs serving more than 30-consecutive days on Active Duty, and not for training, must meet the same eligibility criteria and documentation, but no IP agreement is required. See paragraph 15.

(4) Termination of a current IP agreement can only be performed in conjunction with meeting the eligibility for a new higher rate IP, or when linking IP with a 2, 3, or 4-year RB agreement.

(5) If entering an RB agreement, the HPO shall also enter a new IP agreement for the same specialty at the linked IP rate listed in conjunction with a 2, 3, or 4-year RB (see pertinent section of Table 3). The HPO would continue IP eligibility at that rate for each active year of the 2, 3, or 4-year RB agreement.

(6) Any specialty or rate change would require the existing RB agreement period to be completed. After expiration of that RB and after meeting the completion of qualifying training plus 3-months, the officer would require a new IP and RB agreement executed with a new effective date, and an equal or longer 2, 3, or 4-year RB obligation at the specialty rates in effect at the time the new agreement is signed.

(7) Commanders will verify the HPO's eligibility, endorse the IP agreement, and forward the endorsed IP agreement to the AMEDD Special Pay Branch, OTSG. The Commander may approve agreements, on a case by case basis, for IP payments to HCPs assigned to positions requiring a substantial portion of time performing military-unique duties under adverse conditions, or in remote locations outside the United States, or that preclude the ability to spend appropriate time in a clinical setting.

(8) The AMEDD Special Pay Branch, OTSG will verify eligibility criteria provided with the IP agreement and the MODS special pay module transaction data. All IP agreements are subject to acceptance and may involve additional coordination with the pertinent AMEDD Officer Corps Branch at Health Services Division, HRC to verify eligibility.

d. The annual IP agreement and rate will not expire unless the officer no longer meets the eligibility criteria. It is the HPO's responsibility to inform the AMEDD Special Pay Branch, OTSG to initiate stop-payment and recoupment action upon loss of eligibility, loss of license, or other pertinent disqualifying information. Payments received during the ineligible period will be recouped.

e. The IP will be terminated upon separation from Active Duty, death, or if the conditions of this agreement are not fulfilled. Reasons for termination include, but are not limited to: loss of privileges, court-martial conviction, violations of the Uniform Code of Military Justice, failure to maintain required certification or licensure, unprofessional conduct, failure to demonstrate proficient medical skill, or reasons that are in the best interest of the Army. The Army Surgeon General is the termination authority for all agreements.

f. Any failure to fulfill the conditions specified in the IP agreement may result in termination of the agreement and the repayment of any unearned portion of IP in accordance with title 37 USC §373 and Chapter 2 of Volume 7A, DoDFMR 7000.14-R, as amended. As indicated in title 37 USC §373, a discharge in bankruptcy under title 11 USC does not discharge an officer from a debt arising from this agreement.

8. **HEALTH PROFESSIONS OFFICER RETENTION BONUS (RB)**.

a. Eligibility. To be eligible for RB, an HPO must:

(1) Be below the grade of O-7.

(2) Have completed either:

(a) Any Active Duty service commitment incurred for participating in a pre-commissioning and/or commissioning program, as indicated on initial active duty orders or amendments; completed from officer's entry on active duty date.

(b) The ADO for AB, CSWSAB, or HPLRP paid as an accession incentive. An individual may not decline the AB or CSWSAB and accept the RB.

(3) Have completed specialty qualification for which the RB is being paid, but no earlier than 3-months after completing qualifying training.

(4) If a HCP, AC and AGR HPOs must be currently credentialed, privileged, and practicing a minimum of 40-hours/year at a facility designated by the Army, in the specialty for which the RB is being paid.

(5) The HPO must possess a current, valid, unrestricted license; NCCPA; or approved Army waiver under the provisions of AR 40-68, with applicable interim changes, without prejudicial restriction to the standards of the specialty for which the award is made, as a prerequisite and for the duration of receipt of RB.

(6) Officer must not be in a two-time non-selection status for promotion (2XNS), with the following exceptions:

(a) Officers below the grade of O-5 in a selective continuation (SELCON) status, may only execute the RB for an obligation that does not extend past their SELCON date.

(b) Officers in the grade of O-5 or O-6 may only execute the RB for an obligation that does not extend past their MRD.

(7) At the time of the agreement effective date, the HPO must have no Suspension of Favorable Personnel Actions (SOFPA/FLAG), and have passed the Army Physical Fitness Test (APFT) and Army Body Composition Program (ABCP) standards within seven months.

(8) Additional RB eligibility criteria for Army Nurse Corps (ANC) Officers.

(a) The 2, 3 or 4-year RB is available to all designated specialty ANC officers in the grade of O-5 and below. Only ANC officers in the grade of O-5 /P and O-6, with the AOC 66F and assigned as an AOC 66F, are authorized to execute a 2-year RB agreement.

(b) The ANC officer must have completed specialty qualification via a TSG approved specialty, AOC, and/or ASI producing course or graduate program, and must have professional board certification in the clinical specialty/designated AOC for which they are receiving RB.

(c) The ANC officer is not eligible to execute an RB while in a Long Term Health Education and Training (LTHET) program.

(d) The ANC officer is eligible to execute a RB one-year after successful completion of a non-APRN AOC producing course.

b. Procedures.

(1) Annual payment amounts for the 2, 3, or 4-year RB agreements shall be in the amounts established by DoD in the pertinent section of Table 3. Payments will be made upon agreement effective date and annually thereafter on the anniversary of the agreement effective date, subject to the availability of funds. Any previous payments of RB or Legacy multi-year special pays will be stopped, and any overlapping payments will be adjusted and recouped as necessary.

(2) All AC and AGR HPOs must execute a written RB agreement as prepared in the MODS special pay module, with a copy of their current, valid, unrestricted license; NCCPA; or approved Army waiver.

(3) If entering an RB agreement, the HPO shall also enter a new IP agreement for the same specialty at the linked IP rate listed in conjunction with a 2, 3, or 4-year RB (see pertinent section of Table 3). The HPO would continue IP eligibility at that rate for each active year of the 2, 3, or 4-year RB agreement.

(4) Any specialty or rate change would require the existing RB agreement period to be completed. After expiration of that RB and after meeting the completion of qualifying training plus 3-months, the officer would require a new IP and RB agreement executed with a new effective date, and an equal or longer 2, 3, or 4-year RB obligation at the specialty rates in effect at the time the new agreement is signed. At the time the RB expires, the HPO must execute both a new IP and RB, or convert to the annual rate IP.

(5) Commanders will verify the HPO's eligibility, endorse the RB agreement, and forward the endorsed RB agreement to the AMEDD Special Pay Branch, OTSG. The Commander may approve agreements, on a case by case basis, for RB payments to HCPs assigned to positions requiring a substantial portion of time performing military-unique duties under adverse conditions, or in remote locations outside the United States, or that preclude the ability to spend appropriate time in a clinical setting.

(6) The AMEDD Special Pay Branch, OTSG will verify eligibility criteria provided with the RB agreement and the MODS special pay module transaction data. All RB agreements are subject to acceptance and will involve additional coordination with the pertinent AMEDD Officer Corps Branch at Health Services Division, HRC to verify eligibility.

c. The RB agreement will be terminated if the officer is promoted to the grade of Brigadier General (O-7), upon separation from Active Duty, death, or if the conditions of the RB agreement are not fulfilled. Reasons for termination include, but are not limited to: loss of privileges, court-martial conviction, violations of the Uniform Code of Military Justice, failure to maintain required certification or licensure, unprofessional conduct, failure to demonstrate proficient medical skill, or reasons that are in the best interest of the Army. The Army Surgeon General is the termination authority for all agreements.

d. Any failure to fulfill the conditions specified in the IP agreement may result in termination of the agreement and the repayment of any unearned portion of IP in accordance with title 37 USC §373 and Chapter 2 of Volume 7A, DoDFMR 7000.14-R, as amended. As indicated in title 37 USC §373, a discharge in bankruptcy under title 11 USC does not discharge an officer from a debt arising from this agreement.

e. ADO.

(1) Any ADO for education and training incurred on Active Duty, and previous MP or RB agreements, shall be served before serving new RB ADO (consecutive obligation). The RB recipient with a remaining education and training ADO should be explicitly aware that in many cases the RB payments and ADO may not be synchronized.

(2) During the discharge of the ADO associated with the HPLRP paid as a retention incentive, individuals are eligible for an RB; however, the RB ADO is consecutive to all HPLRP obligations regardless of when the HPLRP is taken.

(3) If the RB agreement is executed on or before the start date of GPE training, and no other education and training ADO exists, the RB ADO shall be served concurrently with the RB agreement period. However, if the RB agreement is executed after the start date of GPE training, the HPO is obligated for the full GPE period and the RB ADO shall begin 1-day after the GPE ADO is completed. The ADO to be served is consecutive or an additive obligation.

(4) When no new education and training ADO exists at the time of an RB agreement execution, the RB ADO shall be served concurrently with the RB agreement period, and all non-education and training ADOs.

(5) Once an HPO has begun to serve an RB ADO, they shall serve it concurrently with any existing obligations or future ADOs, including education and training obligations incurred after the RB effective date for the length of that particular RB agreement.

(6) Obligations for an RB will be served concurrently with BCP, IP, promotion, non-clinical master's degree, non-clinical doctorate degree, and non-medical military schooling.

9. **Automatic Voluntary Retention**.

a. Participation in the HPO Special and Incentive Pay Plan constitutes a voluntary retention program. Unless a waiver is obtained, an HPO participating in these special pays will not be released from Active Duty before fulfilling the term of continuous Active Duty agreed to by execution of an agreement, even if that ADO will extend the HPO beyond 20 years of active federal service. Requests for resignation, release from Active Duty, or voluntary retirement will be disapproved except when considered to be in the best interest of the Army. An offer to repay the full sum of the special pays does not constitute a basis for early termination of an agreement.

b. An agreement may not extend beyond a legislated mandatory separation or retirement date for age or service, unless the HPO's separation or retirement has been deferred in advance of the agreement effective date. An agreement executed without prior deferment is erroneous and subject to full recoupment.

10. **Agreement Procedures and Approval Authority**.

a. The MODS special pay module will prepare the automated BCP, IP, and RB agreements based on the data extracted and/or entered into the agreement creation module. Any adjustment to the agreement or deviation to content, will result in the agreement being returned without action.

b. Commanders will approve the agreement if they determine that the HPO meets all eligibility criteria as discussed above. If Commanders determine that the eligibility criteria have not been met, they will disapprove the agreement and will indicate the reason for disapproval.

c. The Commander, Acting Commander, or the written special pay appointed approval authority of the HPO must be a Field Grade officer (Major/O-4 or higher). Where the Commander is a Company Grade officer, the next Field Grade Commander in the chain of command will serve as the approval authority.

d. The approval authority may be branch immaterial. The advice of a senior AMEDD officer should be obtained with regard to required privileging and patient care duties.

e. The Branch Chief of the HPO's Corps Branch, Health Services Division, HRC will be the approval authority of agreements for HPOs for whom no other appropriate authority can be identified.

f. All special pay agreements upon approval/disapproval by the appropriate authority, will be transmitted to the AMEDD Special Pay Branch, OTSG via email (usarmy.ncr.hqda-otsg.mbx.otsg-special-pay@mail.mil) to coordinate verification of eligibility, authorized rates, voluntary retention program, and ADO. Upon verification of agreement data, authorization for payments will be transmitted to DFAS-IN for disbursement.

11. **Termination of Special Pays**.

a. Automatic termination:

(1) All special pays in this plan will be terminated upon death, or upon separation from Active Duty where approved or directed by the Army.

(2) All special pay agreements in this plan may be disapproved by the Commander or terminated by The Surgeon General if the HPO fails to meet the eligibility requirements of the special pay agreement either upon execution or during the agreement period.

b. Optional termination.

(1) The Surgeon General has the authority to disapprove or terminate authorization to BCP, IP and/or RB at any time. Terminations are accomplished through review proceedings approved by The Surgeon General.

(2) A Commander who receives an agreement for approval, but is aware of potentially disqualifying information pertaining to an HPO, will disapprove the agreement and if required, initiate action recommending immediate termination of all other existing agreements for review proceedings by The Surgeon General.

(3) Reasons for termination include, but are not limited to: loss of privileges, court-martial conviction, violations of the Uniform Code of Military Justice, failure to maintain required certification or licensure, unprofessional conduct, failure to demonstrate proficient medical skill, or reasons that are in the best interest of the Army.

c. Procedures for termination:

(1) The Commander will notify the HPO in writing and provide 10-calendar days to submit a rebuttal.

(2) The recommendation and rebuttal, or a statement that the HPO does not intend to rebut, will be forwarded to the AMEDD Special Pay Branch, OTSG.

(3) The Commander will also submit the data upon which the evaluation is based to include any objective data available in regard to privileges, practice within the specialty, or other criteria leading to the recommendation for termination of authorization.

(4) The effective date of termination of authorization will be the date on which The Surgeon General approves the recommendation. The decision of The Surgeon General is final.

12. **Recoupment of Unearned Payments**.

a. Alignment or termination of BCP, IP, and RB agreements may incur a pro rata recoupment of Legacy or CSP special pays already paid that overlap, or of an obligation that has not yet been served. Recalculation of the remaining BCP, IP, and RB agreement ADO may occur.

b. As an exception, recoupment is waived under the following circumstances:

(1) Death or disability that is not the result of misconduct or willful neglect and not incurred during a period of unauthorized absence.

(2) Separation from the Army by operation of law or regulation of DoD or the Army, or when a waiver of recoupment was approved by the Secretary of the Army.

c. The repayment of any unearned portion is in accordance with title 37 USC §373 and Chapter 2 of Volume 7A, DoDFMR 7000.14-R, as amended. As indicated in title 37 USC §373, a discharge in bankruptcy under title 11 USC does not discharge an officer from a debt arising from this agreement.

13. **Administration of Authorization Data**.

a. AMEDD Special Pay Branch, OTSG will:

(1) Maintain eligibility rosters in MODS for BCP, IP, and RB agreements based on data as received from the Total Army Personnel Data Base (TAPDB).

(2) Verify BCP, IP, and RB agreements approved by the HPO's Commander for eligibility and correct rates, and authorize release for disbursement.

(3) Provide DFAS-IN with applicable pay data upon verification of an approved BCP, IP, and RB agreement.

b. Health Services Division, HRC will:

(1) Ensure the Total Officer Personnel Management Information System (TOPMIS) has documented the officer's education and training, board certification, initial and incurred ADO dates for training (TOPMIS Code: DTMSO) and special pay (TOPMIS Code: DTMSPO).

(2) Provide coordinated review of BCP, IP, and RB agreements for eligibility and extended ADOs, as required.

(3) Forward all provided BCP, IP, and RB agreements and enclosures to the Interactive Personnel Electronic Records Management System (iPERMS) for filing.

c. Health Services Directorate, USAREC will:

(1) Include in the Active Duty orders for each HPO direct accession any AB or CSWSAB authorization.

(2) Provide fiscal data on all approved AB and CSWSAB authorizations.

14. **Payment Procedures**.

a. The BCP and IP shall be paid on a prorated monthly basis. The RB shall be paid in annual installments for the length of the agreement, and AB may be paid in a lump sum or annual installments as determined by the agreement amount or officer's request. The total amount paid under the agreement shall be fixed during the length of the agreement.

b. Payment by DFAS-IN may take up to 90-days upon their receipt of authorization. The initial annual installment will be authorized after approval of the

agreement. Payment of subsequent installments will be authorized on the anniversary of the agreement effective date.

c. New IP and/or RB agreements involve an audit and possible recoupment of the HPO's military pay account, and could experience a delay in payment of 90-days upon receipt by DFAS-IN. The individual LES entries may include terminology "Save Pay" for BCP and IP payments, or possibly "Nuc Off Pay" for RB payments. HPOs should read LES remarks for further details.

15. **Special Pay for Mobilized Reserve Component (RC) HPOs**:

a. Mobilized RC HPOs are eligible for BCP and/or IP if they are serving more than 30-consecutive days on Active Duty and not for training, at the rates specified in this plan.

b. Mobilized RC HCPs must be credentialed by the use of the Inter-facility Credentials Transfer Brief (ICTB) in the specialty for which the special pay is being paid.

c. Payments shall be paid monthly and amounts shall be prorated for periods less than 30-days. RC HPOs are not required to execute a written agreement to remain on Active Duty for at least 1-year.

d. Requests for special pay must include Active Duty orders and ICTB for all HPOs. Forward consolidated documentation via email to the AMEDD Special Pay Branch, OTSG mailbox: usarmy.ncr.hqda-otsg.mbx.otsg-special-pay@mail.mil

e. AMEDD Special Pay Branch, OTSG determines eligibility based on criteria and rates specified in this plan, providing individual rates authorized to RC DFAS-IN for payment. RC DFAS-IN disburses special pays on a prorated basis starting after the first 30-consecutive days, retroactive to Active Duty tour entry date.

Table 1:

Specialties authorized the Accession Bonus (AB) or Critically Short Wartime Specialty Accession Bonus (CSWSAB) by USAREC must be in accordance with the current Office of the Deputy Chief of Staff, G-1, Army Accession Mission Memorandum.

Medical Corps CSWSAB[1]

Medical Specialty	CSWSAB 4-Year ADO Total Rate
Aerospace Medicine	$200,000
Anesthesia	$400,000
Cardiology	$325,000
Cardio-Thoracic Surgery	$400,000
Diagnostic Radiology	$375,000
Emergency Medicine	$300,000
Family Practice	$275,000
General Surgery	$400,000
Internal Medicine	$250,000
Infectious Diseases	$200,000
Neurosurgery	$400,000
Ophthalmology	$225,000
Orthopedics	$400,000
Otolaryngology	$252,000
Preventive Medicine	$225,000
Psychiatry	$275,000
Pulmonary Medicine	$300,000
Trauma/Critical Care Surgery	$400,000
Urology	$300,000
Vascular Surgery	$400,000

[1] Must be a graduate of an American Medical Association (AMA) or American Osteopathic Association (AOA) accredited school of medicine, and possess a Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) degree.

Table 1: (continued)

Dental Corps CSWSAB[2]

Dental Specialty	CSWSAB 4-Year ADO Total Rate
General Dentistry	$150,000
Comprehensive Dentistry	$300,000
Endodontics	$300,000

Oral and Maxillofacial Surgery	$300,000
Prosthodontics	$300,000

[2] Must be a graduate of an American Dental Association (ADA) accredited school of dentistry and possess a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) degree.

Nurse Corps CSWSAB[3]

Active Duty Obligation	CSWSAB 4-Year ADO Total Rate
Specialty Specific 3-Year	$20,000
Specialty Specific 4-Year	$30,000
CRNA Only 4-Year	$250,000

[3] Must be a graduate of a school of nursing accredited by the National League for Nursing Accrediting Commission (NLNAC) or the Commission on Collegiate Nursing Education (CCNE) that conferred a baccalaureate degree or higher in nursing.

Specialty Accession Bonus (AB) or CSWSAB[4]

	One-Time Lump Sum Rate	
Specialty AB	**3-Year Obligation**	**4-Year Obligation**
Dietician		$30,000
Pharmacist		$30,000
Physical Therapist		$30,000
Physician Assistant	$37,500	$60,000
Social Worker	$18,750	$30,000
Veterinary Officer		$20,000
Specialty CSWSAB	----------	----------
Psychologist	$37,500	$60,000

[4] Must be a graduate of an accredited school in the clinical specialty.

Table 2:

HPO Board Certification Pay (BCP) Rate

1-Year Rate (prorated monthly)	$6,000

General/Flag Officers at the rank of O-7 and above, that meet the eligibility criteria, are eligible for the HPO BCP.

Medical Corps Recognized Boards for HPO BCP

American Board of Medical Specialties – ABMS
American Osteopathic Association Specialty Certifying Boards – AOA
Note: See the MODS Special Pay Module 'About' Page for a listing of all current boards

American Board of General Dentistry - 63B	American Board of Periodontology - 63D
American Board of Endodontics - 63E	American Board of Prosthodontics - 63F
American Board of Dental Public Health - 63H	American Board of Pediatric Dentistry - 63K
American Board of Orthodontics - 63M	American Board of Oral and Maxillofacial Surgery - 63N
American Board of Oral and Maxillofacial Pathology - 63P	American Board of Orofacial Pain Any AOC (Requires DC Branch, HRC Review)

Dental Corps Recognized Boards for HPO BCP

Table 2: (continued)

Nurse Corps Recognized Boards for HPO BCP (Graduate Degree Required)

Nurse Specialty AOC	Qualifying Graduate Program	Recognized Boards for HPO BCP
Public Health Nurse 66B	1. Community Health CNS (MSN) 2. Master's or Doctorate Public Health (MPH/DNP)	1. ANCC Public or Community Health Nursing (APHN-BC or PHCNS-BC) 2. National Board of Public Health Examiners (NBPHE)
Clinical Nurse Specialist 66E7T	Clinical Nurse Specialist (MSN/DNP)	1. AACN's Acute Care CNS - Adult - Gerontology (ACCNS-AG) (formerly called CCNS by AACN) 2. ANCC's Adult Gerontology Clinical Nurse Specialist (AG-CNS-BC)
Nurse Anesthetist 66F	Nurse Anesthetist (MSN/DNP)	National Board on Certification/Recertification for Nurse Anesthetist (NBCRNA)

Clinical Nurse Specialist 66G7T	Clinical Nurse Specialist (MSN/DNP)	1. NCC's Maternal Newborn (RNC-MNN) 2. NCC's Inpatient Obstetric Nursing (RNC-OB)
Clinical Nurse Specialist 66H7T	1. Critical Care CNS (MSN/DNP) 2. Adult/Med Surg CNS (MSN/DNP)	1. ANCC's Clinical Nurse Specialist in Adult Health (ACNS-BC) 2. ANCC's Adult - Gerontology Clinical Nurse Specialist (AGCNS-BC) 3. AACN's Clinical Nurse Specialist Adult - Gerontology (AACNS-AG) 4. AACN's Clinical Nurse Specialist for Adult - Acute Care Nursing (CCNS)
Family Nurse Practitioner 66P	Family NP (MSN/DNP)	1. ANCC's Family Nurse Practitioner (FNP-BC) 2. AANP's Family Nurse Practitioner (FNP-BC)
Psychiatric/ Behavioral Health Nurse Practitioner 66R	Psych Mental Health NP	1. ANCC's Adult Psychiatric Mental Health Nurse Practitioner (PMHNP-BC) 2. ANCC's Psychiatric -Mental Health Nurse Practitioner (PMHNP-BC) 3. ANCC's Family Psychiatric Nurse Practitioner (FPMHNP-BC)

Specialty/AOC	Sponsor	Certification Agency	Recognized Boards
Audiology/Speech Pathology 72C	American Speech-Language Hearing Association	Council for Clinical Certification in Audiology and Speech-Language Pathology	1. Audiology (CCC-A) 2. Speech-Language Pathology (CCC-SLP)
	American Board of Audiology	Clinical Certification Board	1. Audiology 2. Advanced Certification with Specialty Recognition (various)
Biochemistry 71B	Commission on Accreditation in Clinical Chemistry	American Board of Clinical Chemistry	Fellow of the Academy of Clinical Biochemistry
Dietetics 65C	Academy of Nutrition and Dietetics	Commission on Dietetic Registration	1. Pediatric Nutrition 2. Renal Nutrition 3. Metabolic Nutrition 4. Sports Dietetics 5. Gerontological Nutrition 6. Oncology Nutrition 7. Advanced Practice Certification in Clinical Nutrition

	American Society for Parenteral and Enteral Nutrition	The National Board of Nutrition Support Certification	Certified Nutrition Support Clinician
	National Certification Board for Diabetes Educators	National Certification Board for Diabetes Educators	Certified Diabetes Educator
	National Commission for Health Education Credentialing	National Commission for Health Education Credentialing	1. Certified Health Education Specialists 2. Master Certified Health Education Specialist
	American Board of Sports Medicine	American College of Sports Medicine	1. Registered Clinical Exercise Physiologist 2. Certified Exercise Physiologist 3. Certified Clinical Exercise Physiologist
Medical Physicist 72A	American Board of Radiology	American Board of Medical Specialties	Subspecialties of nuclear medical physics, diagnostic medical physics, therapeutic medical physics

Nurse Specialty AOC	**Qualifying Graduate Program**	**Recognized Boards for HPO BCP**
Critical Care Nurse 66S7T	1. Critical Care CNS (MSN/DNP) 2. Adult/Med Surg CNS (MSN/DNP)	1. ANCC's Clinical Nurse Specialist in Adult Health (ACNS-BC) 2. ANCC's Adult-Gerontology Clinical Nurse Specialist (AGCNS-BC) 3. AACN's Acute Care Clinical Nurse Specialist (Adult-Gero) (ACCNS-AG) 4. AACN's Critical Care CNS (CCNS)- Legacy board for renewal only
Emergency Nurse 66T7T	1. Critical Care CNS (MSN) 2. Adult/Med Surg CNS (MSN) 3. Emergency Trauma CNS (MSN)	1. ANCC's Clinical Nurse Specialist in Adult Health (ACNS-BC) 2. ANCC's Adult-Gerontology Clinical Nurse Specialist (AGCNS-BC) 3. AACN's Acute Care Clinical Nurse Specialist (Adult-Gero) (ACCNS-AG) 4. AACN's Critical Care CNS (CCNS)- Legacy board for renewal only
Nurse Midwife 66W	Certified Nurse Midwife (MSN/DNP)	American Midwifery Certification Board (AMCB)

Table 2: (continued)

Specialty Recognized Boards for HPO BCP (Graduate Degree Required)

Specialty/AOC	Sponsor	Certification Agency	Recognized Boards
Occupational Therapy 65A	American Occupational Therapy Association (AOTA)	AOTA Board for Advanced and Specialty Certification	1. Gerontology 2. Mental Health 3. Pediatrics 4. Physical Rehabilitation
	Hand Therapy Certification Commission	Hand Therapy Certification Commission	Certified Hand Therapist
	Board of Certification in Professional Ergonomics	Board of Certification in Professional Ergonomics	1. Certified Professional Ergonomist 2. Certified Human Factors Professional 3. Certified User Experience Professional
	Academy of Certified Brain Injury Specialists	Academy of Certified Brain Injury Specialists	Certified Brain Injury Specialist Trainer
Optometry 67F	American Academy of Optometry	American Academy of Optometry	Fellow in the American Academy of Optometry
Pharmacy 67E	American Pharmacists Association	Board of Pharmacy Specialties	Any
Physical Therapy 65B	American Physical Therapy Association	American Board of Physical Therapy Specialists	1. Cardiopulmonary 2. Clinical Electrophysiology 3. Geriatrics 4. Neurology 5. Orthopedics 6. Pediatrics 7. Sports 8. Women's Health
Physician Assistant 65D	National Commission on Certification of Physician Assistants	National Commission on Certification of Physician Assistants	National Commission on Certification of Physician Assistants
Podiatry 67G	American Podiatric Medical Association	Council on Podiatric Medical Education	1. American Board of Podiatric Medicine 2. American Board of Foot and Ankle Surgery
Psychology 73B	American Psychological Association	American Board of Professional Psychology	Diplomate
Social Work 73A	American Board of Examiners In Clinical Social Work	American Board of Examiners In Clinical Social Work	Diplomate in Clinical Social Work

	National Association of Social Workers	Competence Certification Commission	Diplomate in Clinical Social Work
Veterinary Officer 64-Series	Any American Veterinary Medical Assoc. Board	Specific Specialty Board	Any

Table 3:

Medical Corps HPO IP[1] & HPO RB Rates

[1] General/Flag Officers at the rank of O-7 and above, that meet the eligibility criteria, are eligible for the General Medical Officer (GMO) HPO IP rate only.

MEDICAL CORPS	Incentive Pay (IP) only 1-year rate (prorated monthly)
INTERNSHIP (FYGME)- ANY AOC	$1,200
INITIAL RESIDENCY (PGY2)- ANY AOC	$8,000
GENERAL MEDICAL OFFICER (GMO)-62B	$20,000

POST RESIDENT or FELLOW GRADUATE	Fully Qualified IP only 1-Year Rate (prorated monthly)	OR	Fully Qualified IP rate paid with a Retention Bonus (RB) (prorated monthly)	RB 2-Year Rate (paid annually)	RB 3-Year Rate (paid annually)	RB 4-Year Rate (paid annually)	RB 6-Year Rate (paid annually)
AEROSPACE MEDICINE (RAM) - 61N (See Note 0)	$43,000		$43,000	$13,000	$19,000	$25,000	
ANESTHESIOLOGY - 60N	$59,000		$73,000	$25,000	$40,000	$60,000	$75,000
CARDIOLOGY - ADULT - 60H /PEDS	$59,000		$64,000	$21,000	$34,000	$51,000	
DERMATOLOGY - 60L	$43,000		$43,000	$17,000	$25,000	$38,000	
EMERGENCY MEDICINE - 62A	$49,000		$53,000	$17,000	$26,000	$40,000	$55,000
FAMILY PRACTICE - 61H	$43,000		$43,000	$17,000	$25,000	$38,000	
GASTROENTEROLOGY - ADULT - 60G / PEDS	$49,000		$52,000	$22,000	$33,000	$50,000	
GEN INTERNAL MEDICINE - 61F	$43,000		$43,000	$13,000	$23,000	$35,000	
GENERAL SURGERY - 61J	$52,000		$73,000	$25,000	$40,000	$60,000	$75,000
NEUROLOGY - ADULT - 60V / PEDS - 60R	$43,000		$43,000	$13,000	$19,000	$25,000	
NEUROSURGERY - 61Z	$59,000		$83,000	$25,000	$40,000	$60,000	
OBSTETRICS-GYNECOLOGY - 60J	$54,000		$54,000	$17,000	$25,000	$35,000	
OPHTHALMOLOGY - 60S	$51,000		$53,000	$13,000	$19,000	$25,000	
ORTHOPEDICS - 61M	$59,000		$73,000	$17,000	$33,000	$50,000	$70,000
OTOLARYNGOLOGY - 60T	$53,000		$58,000	$17,000	$25,000	$33,000	
PATHOLOGY - 61U	$43,000		$43,000	$13,000	$20,000	$30,000	
PEDIATRICS - 60P	$43,000		$43,000	$13,000	$20,000	$30,000	
PHYSIATRIST/PHYSICAL MEDICINE - 61P	$43,000		$43,000	$12,000	$13,000	$20,000	
PREVENTIVE/OCCUPATIONAL MEDICINE - 60C / 60D	$43,000		$43,000	$13,000	$20,000	$30,000	
PSYCHIATRY - ADULT - 60W / PEDS - 60W8Z	$43,000		$43,000	$17,000	$28,000	$43,000	$58,000
PULMONARY MEDICINE - ADULT - 60F / PEDS, AND FELLOWSHIP TRAINED CRITICAL CARE (M4), OR INTENSIVE MEDICINE SPECIALIST - ADULT / PEDS	$46,000		$49,000	$21,000	$31,000	$45,000	$60,000
RADIOLOGY - 61R / 61Q	$59,000		$65,000	$25,000	$40,000	$60,000	
UROLOGY - 60K	$51,000		$51,000	$20,000	$30,000	$45,000	
SUBSPEC CAT I (Note 1)	$59,000		$80,000	$23,000	$36,000	$55,000	$75,000
SUBSPEC CAT II (Note 2)	$51,000		$51,000	$12,000	$18,000	$27,000	
SUBSPEC CAT III (Note 3)	$46,000		$49,000	$12,000	$17,000	$25,000	
SUBSPEC CAT IV (Note 4)	$43,000		$43,000	$13,000	$19,000	$25,000	
SUBSPEC CAT V (Note 5)	$59,000		$64,000	$21,000	$31,000	$45,000	

NOTE 0: RAM Residents after completing the Aerospace Medicine portion of residency (2d year), may apply for the RAM IP/RB IAW Pay Plan policy.

NOTE 1: REQUIRES PRIMARY SPECIALTY IN GENERAL SURGERY - 61J OR AS LISTED: CARDIO-THORACIC SURGERY - 61K, COLON-RECTAL SURGERY, ONCOLOGY SURGERY, PEDIATRIC SURGERY, PLASTIC SURGERY - 61L, ORGAN TRANSPLANT, TRAUMA/CRITICAL CARE SURGERY (DESIGNATOR: FN), VASCULAR SURGERY - 61W, AND FELLOWSHIP

NOTE 2: NUCLEAR MEDICINE INTERNISTS ONLY - 60B.

NOTE 3: INTERNAL MEDICINE/PEDIATRIC FELLOWSHIP SUBSPECIALTIES IN ALLERGY, ALLERGY/IMMUNOLOGY - 60M, NEPHROLOGY - 61A, HEMATOLOGY/ONCOLOGY - 61B, AND NEONATOLOGY.

NOTE 4: ALL INTERNAL MEDICINE AND PEDIATRIC SUBSPECIALTIES NOT LISTED IN SUBSPECIALTY CATEGORY I, III, OR LISTED SEPARATELY-- INFECTIOUS DISEASE - 61G, RHEUMATOLOGY - 61D, GERIATRICS FELLOWSHIP TRAINING, ENDOCRINOLOGY - 61C, CLINICAL PHARMACOLOGY - 61E, DEVELOPMENTAL PEDIATRICS.

NOTE 5: PHYSICIANS WHO ARE FELLOWSHIP TRAINED IN OPHTHALMOLOGY - 60S, OTOLARYNGOLOGY - 60T, OB/GYN - 60J, AND UROLOGY - 60K.

Table 3: (continued)

Dental Corps HPO IP[2] & HPO RB Rates

[2] General/Flag Officers at the rank of O-7 and above, that meet the eligibility criteria, are eligible for the fully qualified General Dentistry HPO IP rate only.

DENTAL CORPS	Fully Qualified IP only 1-Year Rate (prorated monthly)	OR	Fully Qualified IP rate paid with a Retention Bonus (RB) (prorated monthly)	RB 2-Year Rate (paid annually)	RB 3-Year Rate (paid annually)	RB 4-Year Rate (paid annually)	RB 6-Year Rate (paid annually)
Advanced Clinical Practice (ACP) - 63A: General Dentistry, Exodontia, Endodontics, Periodontics, Prosthodontics	$25,000		$25,000	$18,000	$27,000	$35,000	
Comprehensive/Operative Dentistry - 63B	$25,000		$25,000	$25,000	$38,000	$50,000	$65,000
Dental Research (PhD Level)	$25,000		$25,000	$25,000	$38,000	$50,000	
Endodontics - 63E	$25,000		$25,000	$25,000	$38,000	$50,000	
General Dentistry - 63A	$20,000		$20,000	$13,000	$19,000	$25,000	
Oral Maxillofacial Surgery - 63N	$55,000		$75,000	$25,000	$38,000	$50,000	$65,000
Oral Pathology/Oral Diagnosis/Oral Medicine - 63P	$25,000		$25,000	$25,000	$38,000	$50,000	
Orthodontics - 63M	$25,000		$25,000	$25,000	$38,000	$50,000	
Pedodontics - 63K	$25,000		$25,000	$25,000	$38,000	$50,000	
Periodontics - 63D	$25,000		$25,000	$25,000	$38,000	$50,000	
Prosthodontics - 63F	$25,000		$25,000	$25,000	$38,000	$50,000	$65,000
Public Health Dentistry - 63H	$25,000		$25,000	$25,000	$38,000	$50,000	
Temporomandibular Dysfunction (TMD)/Orofacial Pain (PhD Level)	$25,000		$25,000	$25,000	$38,000	$50,000	

Nurse Corps HPO IP[3] & HPO RB Rates (See Recognized Training and Boards)

[3] General/Flag Officers at the rank of O-7 and above, that meet the eligibility criteria, are eligible for the fully qualified HPO IP rate only.

NURSE CORPS	Fully Qualified IP only 1-Year Rate (prorated monthly)	RB 2-Year Rate (paid annually)	RB 3-Year Rate (paid annually)	RB 4-Year Rate (paid annually)	RB 6-Year Rate (paid annually)
Public Health Nurse - 66B		$10,000	$15,000	$20,000	
Psychiatric/Beha vioral Health Nurse - 66C		$10,000	$15,000	$20,000	
Perioperative Nurse - 66E		$10,000	$15,000	$20,000	
Clinical Nurse Specialist - 7T (66E,G,H,S,T)		$10,000	$15,000	$20,000	
Nurse Anes theti st (CRNA) - 66F	$15,000	$10,000	$20,000	$35,000	$50,000
Obstetrics/Gynecology Nurse - 66G		$10,000	$15,000	$20,000	
Family Nurse Practitioner (NP) - 66P		$10,000	$15,000	$20,000	$35,000
Psychiatric/Beha vioral Health NP - 66R		$10,000	$15,000	$20,000	$35,000
Critical Ca re Nurse - 66S		$10,000	$15,000	$20,000	$35,000
Emergency Nurse - 66T		$10,000	$15,000	$20,000	
Nurse Midwife - 66W		$10,000	$15,000	$20,000	

Table 3: (continued)

Nurse Corps Recognized Training and Boards for HPO IP and/or HPO RB

Nurse Specialty AOC	TSG Appd AOC Crs.	Qualifying Graduate Program	Recognized Boards for HPO IP or RB
Public Health Nurse 66B	Yes	1. Community Health CNS (MSN) 2. Master's or Doctorate Public Health (MPH/DNP)	1. ANCC Public or Community Health Nursing (APHN-BC or PHCNS-BC) 2. National Board of Public Health Examiners (NBPHE)
Psychiatric Behavioral Health Nurse 66C	Yes	Psychiatric Behavioral Health Course	ANCC's Psychiatric-Mental Health RN-BC
Perioperative Nurse 66E	Yes	Perioperative Nursing Course	CCI's Certified Nurse in the Operating Room (CNOR)
Clinical Nurse Specialist 66E7T	Yes	Clinical Nurse Specialist (MSN/DNP)	1. AACN's Acute Care CNS - Adult - Gerontology (ACCNS-AG) (formerly called CCNS by AACN) 2. ANCC's Adult Gerontology Clinical Nurse Specialist (AG-CNS-BC)
Nurse Anesthetist 66F	NA	Nurse Anesthetist (MSN/DNP)	National Board on Certification/Recertification for Nurse Anesthetist (NBCRNA)
Obstetric and Gynecologic Nurse 66G	Yes	Obstetric/GYN Nursing Course	1. NCC's Maternal Newborn (RNC-MNN) 2. NCC's Inpatient Obstetric Nursing (RNC-OB)
Clinical Nurse Specialist 66G7T	Yes	Clinical Nurse Specialist (MSN/DNP)	1. NCC's Maternal Newborn (RNC-MNN) 2. NCC's Inpatient Obstetric Nursing (RNC-OB)

Table 3: (continued)

Nurse Specialty AOC	TSG Appd AOC Crs.	Qualifying Graduate Program	Recognized Boards for HPO IP or RB
Clinical Nurse Specialist 66H7T	Yes	1. Critical Care CNS (MSN/DNP) 2. Adult/Med Surg CNS (MSN/DNP)	1. ANCC's Clinical Nurse Specialist in Adult Health (ACNS-BC) 2. ANCC's Adult-Gerontology Clinical Nurse Specialist (AGCNS-BC) 3. AACN's Clinical Nurse Specialist Adult-Gero (AACNS-AG) 4. AACN's Clinical Nurse Specialist for Adult - Acute Care Nursing (CCNS)
Family Nurse Practitioner 66P	NA	Family NP (MSN/DNP)	1. ANCC's Family Nurse Practitioner (FNP-BC) 2. AANP's Family Nurse Practitioner (FNP-BC)
Psychiatric/ Behavioral Health Nurse Practitioner 66R	Yes	Psych Mental Health NP	1. ANCC's Adult Psychiatric Mental Health Nurse Practitioner (PMHNP-BC) 2. ANCC's Psychiatric -Mental Health Nurse Practitioner (PMHNP-BC) 3. ANCC's Family Psychiatric Nurse Practitioner (FPMHNP-BC)
Critical Care Nurse 66S	Yes	Critical Care Nursing Course	1. AACN's Critical Care Registered Nurse (CCRN) 2. AACN's Critical Care Registered Nurse-Knowledge (CCRN-K)
Critical Care Nurse 66S7T	Yes	1. Critical Care CNS (MSN/DNP) 2. Adult/Med Surg CNS (MSN/DNP)	1. ANCC's Clinical Nurse Specialist in Adult Health (ACNS-BC) 2. ANCC's Adult-Gerontology Clinical Nurse Specialist (AGCNS-BC) 3. AACN's Acute Care Clinical Nurse Specialist (Adult-Gero) (ACCNS-AG) 4. AACN's Critical Care CNS (CCNS)-Legacy board for renewal only
Emergency Nurse 66T	Yes	Emergency Nursing Course	BCEN's Certified Emergency Nurse (CEN)

Table 3: (continued)

Nurse Specialty AOC	TSG Appd AOC Crs.	Qualifying Graduate Program	Recognized Boards for HPO IP or RB
Emergency Nurse 66T7T	Yes	1. Critical Care CNS (MSN) 2. Adult/Med Surg CNS (MSN) 3. Emergency Trauma CNS (MSN)	1. ANCC's Clinical Nurse Specialist in Adu Health (ACNS-BC) 2. ANCC's Adult-Gerontology Clinical Nur Specialist (AGCNS-BC) 3. AACN's Acute Care Clinical Nurse Specialist (Adult-Gero) (ACCNS-AG) 4. AACN's Critical Care CNS (CCNS)- Lega board for renewal only
Nurse Midwife 66W	Yes	Certified Nurse Midwife (MSN/DNP)	American Midwifery Certification Board (AMCB)

Specialty HPO IP[4] & HPO RB Rates

[4] General/Flag Officers at the rank of O-7 and above, that meet the eligibility criteria, are eligible for the fully qualified HPO IP rate only.

SPECIALTY	HPO IP Rate/Year with or without HPO RB (prorated monthly)	HPO RB 2-Year Rate (paid annually)	HPO RB 3-Year Rate (paid annually)	HPO RB 4-Year Rate (paid annually)	HPO RB 6-Year Rate (paid annually)
Optometrist - 67F	$1,200			$10,000	
Pharmacist - 67E				$15,000	
Physician Assistant - 65D	$5,000			$20,000	
Psychologist - 73B	$5,000	$10,000	$15,000	$20,000	$35,000
Social Worker - 73A				$10,000	
Veterinarian - 64-Series	$5,000	$2,500	$3,750	$5,000	

Finally, this is a memorandum for record that Army issued to ensure accuracy of student qualifications and performance data entry

APPENDIX D: DEPARTMENT OF THE NAVY CORRECTIVE ACTION PLAN FOR WARTIME SPECIALTIES (NOTE: CURRENTLY IN EXECUTION)

DEPARTMENT OF THE NAVY
OFFICE OF THE ASSISTANT SECRETARY
(MANPOWER AND RESERVE AFFAIRS)
1000 NAVY PENTAGON
WASHINGTON, D.C. 20350-1000

JAN 30 2019

MEMORANDUM FOR DIRECTOR, DEFENSE HEALTH AGENCY

SUBJECT: Follow-up on Final Report, GAO-18-77, MILITARY PERSONNEL: "Additional Actions Needed to Address Gaps in Military Physicians Specialties," dated February 28, 2018 (GAO Code 101138)

The Department of the Navy (DON) Corrective Action Plans (CAPs) in response to recommendations of Final Report, GAO-18-77, MILITARY PERSONNEL: "Additional Actions Needed to Address Gaps in Military Physicians Specialties," dated February 28, 2018 (GAO Code 101138) is provided. The DON CAP includes 2018 efforts to identify and correct gaps in recruiting and retaining highly qualified physicians to address critical wartime specialties. The CAP for GAO recommendation two has been initiated with ongoing actions for full implementation, while the CAPs for recommendations five and eight have been fully implemented. The DON's full CAP and supporting documents are provided as attachments.

My point of contact for this matter is Commander Lakesha Chieves at 703-693-0238, or Lakesha.chieves1@navy.mil.

Russell W. Beland
Deputy Assistant Secretary of the Navy
(Military Manpower and Personnel)

Attachment:
As stated

ACTION MEMO

January 23, 2019

FOR: DEPUTY CHIEF, TOTAL FORCE

FROM: CAPT Valerie Morrison, Director for Military Personnel Policy, Plans, and Special Pays (M13)

SUBJECT: FOLLOW-UP ON GAO FINAL REPORT, GA0-18-77. MILITARY PERSONNEL: "ADDITIONAL ACTIONS NEEDED TO ADDRESS GAPS IN MILITARY PHYSICIAN SPECIALTIES," DATED FEBRUARY 28, 2018

- TAB A is the coordinated response reflecting an updated Corrective Action Plans through calendar year 2018.
- TABB is Office of Secretary of Defense (Health Affairs) Memorandum, dated December 27, 2018.
- The Corrective Action Plans (CAPs) were updated to demonstrate recruitment and retention efforts to improve manning in key Medical Corps specialties. The Navy Medicine CAP for recommendation 2 have continued ongoing actions. The Navy Medicine CAP for recommendations 5 and 8 have been fully implemented.
- Recommendations for policy changes to aid in recruitment and retention of critical Medical Department specialties are outlined.

RECOMMENDATION: Deputy Chief approve TAB A.

Approve  Disapprove__

COORDINATION: TAB C

ATTACHMENTS:

As stated

Prepared By: CAPT Valerie Morrison, Ml 3, (703) 681-9256

Subject: Follow-up Status on Report No. **GAO-18-77, "Military Personnel: Additional Actions Needed to Address Gaps in Military Physician Specialties". February 2018.**

Recommendation# 2: The Secretary of the Navy should develop targeted strategies for using its recruitment, training, and retention programs collectively to address key military physician gaps in a coordinated manner, and metrics that would monitor the effectiveness of its programs collectively in reducing gaps.

DoD Position: Deputy Chief, Navy Medical Corps, Office of the Corps Chiefs

Status Update: Key Corrective Actions listed.

Estimated Completion Date: FY30

Corrective Action Plan (CAP): Accession/retention in each specialty as below to meet target goal.

Key Corrective Actions	Estimated Completion Dates	Actual Completion Date	Measure(s) Capturing Demonstrated Results	Clarifying Comments
AC Residency in **Aerospace Medicine**	30 Sep 22	TBD	100% manning	Access 10 yearly, maintain loss rate below 16%
TIS Training Plan	30 Sep 18 30 Sep 19	30Sep18 30 Sep 19	10 Gains FYI 8 Projecting 13 Gains FY19	Manning increased from 72% to 82% (FYI 7 to FYI 8). Projecting 90% manning FYI 9
Loss Projections	30 Sep18 30 Sep 19	30 Sep18 30 Sep19	13.7% 5-yr loss rate	3 Losses FY18 Projecting 8 Losses FY19
Special Pays Incentives	30 Sep 18	30Sep18	RB Takers increased from 31 to 36 FYI 7 to FY18	36 RB Takers

				(IP $43,000, 4 yr RB $25,000, BCP $6,000) Note: Many Aerospace Medicine physicians have completed a residency in another specialty. As some of these specialties offer a higher RB rate, they may preferentially take the RB for that specialty. Of the 36 RB takers 6 are under the AeroMed RB,and 30 are under the RB for other specialties.
AC Cardiothoracic Surgeon	30 Sep 26	TBD	100% manning	Access 3 fellows yearly, maintain loss rate below 10%
FTIS Training Plan	30 Sep 18 30Sep19	30 Sep 18 30 Sep 19	0 Gains FY18 Projecting 1 Gain FY19	Manning decreased from 71% to 60% (FYI 7 to FYI 8) Projecting 67% manning FYI 9
Loss Projections	30 Sep 18 30 Sep 19	30Sep18 30 Sep 19	7.7% 5-yr loss rate	1 Loss FY18 Projecting O Losses FY19
Special Pays Incentives	30 Sep 18	30 Sep 18	RB Takers remained unchanged from FYI 7 to FY18 with 4 takers each year	4 RB Takers (IP $59,000 w/o RB $80,000 with RB, 6 yr RB $75,000, BCP $6,000) The RB was increased in FY19

				with the implementation of the 6 yr RB
AC General Surgery	Unknown	TBD	100% manning	79%manned
FY18 Direct Accession FYI 9 Direct Accession	30Sep18 30 Sep 19	30Sepl8 30 Sep 19	I attained TBD	Goal: 3 Goal: 4
Total Accessions (including FTIS/FTOS, NADDS, etc).	30 Sep 18 30 Sep 19	30Sepl8 30 Sep 19	30 Gains Total FY18 Projecting 26 Gains FY19	Manning decreased from 81% to 79% (FYI 7 to FYI 8). Projecting 79% manning FYI9
Loss Projections	30Sep18 30 Sep 19	30 Sep 18 30 Sep 19	11.9% 5-yr loss rate	31 Losses FYI 8 27 Projected Losses FY19
Special Pays Incentives	30Sep18	30Sep18	RB Takers decreased from 30 to 29 (FYl 7 to FY18)	29 Total RB Takers (IP $52,000 w/o RB $73,000 with RB, 6 yr RB $75,000, BCP $6,000) The RB was increased in FY19 with the implementation of the 6 yr RB
RC Anesthesiology	30 Sep 23	TBD	100% manning	Currently 104% manned
Direct Commission	30 Sep 18 30 Sep 19	30 Sep 18 30 Sep 19	6 attained TBD	FY18 Goal: 6 FYI 9 Goal: 1-2
Loss Projections	30Sep18	30 Sep 18	Maintain loss rate below 14%	

Special Pays Incentives			# RB Takers	Increased RC retention pay to $40,000/year in FY19
Training Medical Specialties (TMS) Program eligible			#TMS Takers	Recruitment program that offers residents $2,000/month, with payback obligation of 1 year for every 6 months of pay received.
RC Cardiothoracic Surgery	30 Sep 26	TBD	100% manning	Currently 78% manned
Direct Commission	30 Sep 18 30 Sep 19	30Sep18 30 Sep 19	2 attained TBD	FY18 Goal: 0- 1 FY19 Goal: 2
Loss Projections	30 Sep 18	30 Sep 18	Maintain loss rate below 14%	
Special Pays Incentives			# RB Takers	Special Pay: $50,000/year
Training Medical Specialties (TMS) Program eligible			#TMS Takers	Recruitment program that offers residents $2,000/month, with payback obligation of 1 year for every 6 months of pay received.
RC Critical Care Medicine	30 Sep 30	TBD	100% manning	Currently 14% manned
Direct Commission	30 Sep 18 30 Sep 19	30Sep18 30 Sep19	0 attained TBD	FY18 Goal: 0- 2 FY19 Goal: 8-10
Loss Projections	30Sep18	30 Sep 18	Maintain loss rate below 14%	
Special Pays Incentives			#RB Takers	Increased RC retention pay to

				$50,000/year in FY19
RC General Surgery	Unknown	TBD	100% manning	Currently 68% manned
Direct Commission	30 Sep 18 30 Sep 19	30Sep18 30 Sep19	5 attained TBD	FY 18 Goal: 18 FY19 Goal: 22 - 25
Loss Projections	30 Sep 18	30 Sep 18	Maintain loss rate below 14%	
Special Pays Incentives			#RB Takers	Increased RC retention pay to $50,000/year in FY18 and FY19
Training Medical Specialties (TMS) Program eligible			#TMS Takers	Recruitment program that offers residents $2,000/month, with payback obligation of 1 year for every 6 months of pay received.
RC Orthopedic Surgery	Unknown	TBD	100% manning	Currently 62% manned
Direct Commission	30 Sep 18 30 Sep 19	30 Sep 18 30 Sep 19	2 attained TBD	FY18 Goal: 9 FY19 Goal: 9 - 11
Loss Projections	30 Sep 18	30Sep18	Maintain loss rate below 14%	
Special Pays Incentives			#RB Takers	Increased RC retention pay to $50,000/year in FYI 8 and FYI 9
Training Medical Specialties (TMS) Program eligible			#TMS Takers	Recruitment program that offers residents $2,000/month, with payback obligation of 1 year for every 6

				months of pay received.
RC Preventive Medicine Direct Commission Loss Projections Special Pays Incentives	30 Sep 20 30 Sep 18 30 Sep 19 30Sep18	TBD 30Sep18 30 Sep 19 30 Sep 18	100% manning 0 attained TBD Maintain loss rate below 14% #Accession Bonus Takers	Currently 80% manned FY18 Goal: 0 FY19 Goal: 0 - 1 Accession/Affiliation Bonus of $1OK available. No special pay offered
Medical Education Policy Council Publication of Annual Training Plan	June 2018	Board Results Pending	100% fulfillment of Graduate Medical Education Selection Board (GMESB) Quotas	Meets quarterly, translates strategic needs into an annual training plan
CNRC participation at Medical Conferences: -American Academy of Orthopedic Surgeons -Academy for Orthopedic Surgery and Sports Medicine -American Association for the Surgery of Trauma -American College of Emergency Physicians -American College of Surgeons	Mar 2018 July 2018 Sept 2018 Oct 2018 Oct 2018	Mar 2018 July 2018 Sept 2018 Oct 2018 Oct 2018	# Leads/# Engagements	~14,000 Attendees ~5,500 Attendees ~6,000 Attendees ~9,000 Attendees ~12,000 Attendees

CNRC Emails/Mail-Outs -Orthopedic Surgeons -General Surgeons	 July 2018 July2018	 July 2018 July 2018	 # Leads/# Engagements	 10,000 sent 10,000 sent
Hometown Heroes Program	Dec 2018	Ongoing	# Leads/# Engagements	Supportive effort to improve access/availability of MC Officers to Medical Recruiters on request. Sends MC officers on no-cost TAD to their hometown to participate in recruiting efforts.
MC Informational Pamphlet	Mar 2018	TBD	TBD	Supportive effort to provide informational handout to offer prospective HPSP applicants.
Bi-Weekly CNRC Synchronization Meeting	Jan 2018	Ongoing	# Professional Review Board (PRB) approved candidates/Total #PRB candidates	Supportive effort to provide real-time feedback on quality of applicants at PRB and assist in efforts to meet goal accession timelines.

Subject: Follow-up Status on Report No. **GAO-18-77 "Military Personnel: Additional Actions Needed to Address Gaps** in **Military Physician Specialties", February 2018.** GAO Project Number GAO-18-77.

Recommendation# 5: The Secretary of the Navy should track complete, accurate, and accessible information on the qualifications, performance, and progress of Navy AFHPSP medical students.

Key Corrective Actions	Estimated Completion Dates	Actual Completion Date	Measure(s) Capturing Demonstrated Results	Clarifying Comments
Submit a Systems Change Request (SCR) to SPAWAR to add an undergraduate GPA (grade point average) data field to Navy Standard Integrated Personnel System (NSIPS). Undergraduate GPA will be obtained from Navy Recruit Command (CNRC) as part of the gains package and entered into NSIPS.	June 2019	November 2018	Data fields have been added and are functional (see screenshot).	The additional data fields in NSIPS will allow all objective performance measures to be tracked in a single data base. NSIPS allows system queries and ad hoc data pulls for detailed analysis. Other medical school performance measures are already being tracked and recorded in NSIPS.
Submit an SCR to SPAWAR to add a Medical College Admissions Test (MCAT) score data field to NSIPS. MCAT Score will be obtained from CNRC as part of the gains package and entered into NSIPS.	June 2019	November 2018	Data fields have been added and are functional (see screenshot).	Adding these data fields to NSIPS will allow all objective performance measures to be tracked in a single data base. NSIPS allows system queries and ad hoc data pulls for detailed analysis.
Utilize the "add value" option in NSIPS to activate a field for COMLEX/USMLE Step 3 scores. COMLEX/USMLE Step 3 scores will be obtained from the Graduate Medical Education (GME) Office and entered into the activated data field for PGY 1 residents. Willores will be obtained from the	June 2019	TBD	Observing the activated data field in NSIPS (see screen shot).	COMLEX/USMLE Step 3 is already an option in NSIPS to track COMLEX/USMLE Step 3 scores for Navy Active Duty Delay for Specialists (NADDS) and Financial Assistance Program (FAP)

Graduate. Will need to work with GME Office for a process for tracking the in-service COMLEX/USMLE Scores.				participants. Activating this field for all PGY 1 residents, will capture the scores for all PGY 1s in the Navy. Will have to collaborate with GME Office on a process to obtain in-service USMLE/COMLEX Step 3 scores. Will also have to collaborate with NSIPS support to have access to in-service resident pages for entering and tracking data. This is a more complex undertaking and involves at least 2 other offices. NSIPS allows system queries and ad hoc data pulls for detailed analysis. Other objective medical school performance measures are already being recorded and tracked in NSIPS.

Subject: Follow-up Status on Report No. **GAO-18-77, "Military Personnel: Additional Actions Needed to Address Gaps in Military Physician Specialties". February 2018.**

Recommendation# 8: The Secretary of the Navy should use information on medical student performance to evaluate medical accessions programs.

DoD Position: Head of Student Programs, Accessions Department, Total Force

Status Update: Key corrective actions listed

Estimated Completion Date: November 2018 (Note: GAO currently monitoring USN progress with implementing recommendation over multi- year period before officially closing out action).

Corrective Action Plan (CAP): See below.

Key Corrective Actions	Estimated Completion Date	Actual Completion Date	Measure(s) Capturing Demonstrated Results	Clarifying Comments
Utilize the analytic ad hoc capability of NSIPS to do information queries and data pulls on performance measures at any stage in training and any point after graduation. This data can be pulled, reviewed and analyzed for a broad range of potential questions.	November 2018	Ad hoc function is currently available for all data present in HPIP Maintenance realm of NSIPS. This is completed for all recorded data in NSIPS. (Note: GAO is currently monitoring implementation of recommendation prior to officially closing out.)	The system can be queried to pull requested pre-matriculation and medical student performance measures.	GPA and MCAT data fields data fields are now present and functional. The COMLEX/USMLE "add" function is available. NSIPS can be a single database to record and track all recorded, objective performance measures. The data can easily be queried, pulled, and analyzed. This information can be used to assess the performance of medical students from recruitment, through medical school and through their Post Graduate Year (PGY) 1. The addition of the new data fields in combination with

				the data fields already in place, will offer a plethora of information to query, analyze and assess various aspects of the accessions programs data fields are now present and functional. The COMLEX/USMLE "add" function is available. NSIPS can be a single database to record and track all recorded, objective performance measures. The data can easily be queried, pulled, and analyzed. This information can be used to assess the performance of medical students from recruitment, through medical school and through their Post Graduate Year (PGY) 1. The addition of the new data fields in combination with the data fields already in place, will offer a plethora of information to query, analyze and assess various aspects of the accessions programs.

APPENDIX E: DEPARTMENT OF THE AIR FORCE CORRECTIVE ACTION PLAN FOR WARTIME SPECIALTIES (NOTE: CURRENTLY IN EXECUTION)

Follow-up Status and Corrective Action Plan
For Implementing GAO Recommendations

Subject: GAO Report No. GAO-18-77, "Additional Actions Needed to Address Gaps in Military Physician Specialties", February 28, 2018, (GAO Project Number 101138).

Recommendation 3: The Secretary of the Air Force should develop targeted strategies for using its recruitment, training, and retention programs collectively to address key military physician gaps in a coordinated manner, and metrics that would monitor the effectiveness of its programs collectively in reducing gaps.

DoD Position: Concur

Status Update: Correction action plan identified (specifics in chart). In July 2018, we conducted a 3-day "Influencer Tour" with the Air Force (Air Force) Recruiting Service highlighting critically-manned wartime specialties to premedical advisors, medical school admissions/financial aid officers, and graduate medical education leads to excite interest in the AF Medical Service (AFMS) mission.

To improve interest in the career field and help students prepare more competitive applications, separate teleconferences (TCONs) were conducted for each of the following specialties since the GAO report was released: family medicine, emergency medicine, aerospace medicine, surgery and anesthesia/Critical Care Air Transport Team (CCATT)/Special Operations. During the TCON, the AF Surgeon General Specialty Consultant marketed their career field (including operational tempo, career paths/assignments), explains specifics on each residency platform and the selection board. These TCONs are recorded and available in a mobile-friendly format for the students to access throughout the year. A schedule was established to conduct/record each specialty annually.

Estimated Completion Date: December 31, 2021

Corrective Action Plan (CAP): Identify key corrective actions planned to fully implement the recommendation.

Key Corrective Actions	Estimated Completion Dates	Actual Completion Date	Measure(s) Capturing Demonstrated Results	Clarifying Comments
Develop a sustainable process for improved marketing of key specialties to students: mobile-friendly, recorded specialty teleconferences, recurring news stories shared with the Facebook community, and online mentors.	31 Aug 2018	1 Aug 2018	Numbers utilizing services (TCON participation, frequency of news stories). For example, TCON participation: Emergency Medicine >80. Anesthesia >100. For the week of 29 Jul, 3 news stories on key specialties shared on Facebook.	Over 2500 members in our closed group, active Facebook community.
In coordination with AF Recruiting Service, develop a process to educate civilian leaders that have influence over potential AFMS recruits. Develop a CONOPS for a multi-day "Influencer Tour" with hands-on demos & conduct the 1st tour.	31 Jul 2018	15 Jul 2018	Survey of civilian participants: 100% very impressed with tour & all articulated plans to share the "AFMS story" when they return home.	Demos included hospital tours, CCATT training flight on a C17 aircraft, educational panels & meeting 1:1 with AF physicians.
Expand AF Health Professions Scholarship Program (HPSP) quotas as indicated in the GAO report.	4th Qtr CY18	8 Jan 2019	# of approved AF HPSP accession quotas per year. Fill rate and average GPA/MCAT	Overproduction approved for FY18 quotas. The Medical Corps FY19 HPSP quotas were increased by 16. ECD set for 4th Qtr to

			scores for FY18 accessions.	allow us time at the end of this FY to analyze the percent filled & quality of accessions to track the impact of increased production.
Expand military-sponsored Graduate Medical Education (GME) opportunities for key specialties.	2nd Qtr CY19	TBD	# of additional trainees with these new programs	Currently working the following new military/civilian GME partnerships: Aerospace Med, Emergency Med, Family Med, and Internal Med (via USAFSAM) and Orthopedics (at Travis AFB).
In coordination with A1 and the Air Force Personnel Center, analyze challenges & opportunities (using subject matter experts) through a Physician Retention Task Force and implement process improvements.	4th Qtr CY19	TBD	TBD by Task Force	

Recommendation 6: The Secretary of the Air Force should track complete, accurate, and accessible information on the qualifications, performance, and progress of Air Force AFHPSP medical students.

DoD Position: Concur
Status Update: Correction actions identified. Completeness and accuracy of data submitted by AF recruiters has improved as noted and verified in the second initiative below.
Estimated Completion Date: August 31, 2021
Corrective Action Plan (CAP): Identify key corrective actions planned to fully implement the recommendation.

Key Corrective Actions	Estimated Completion Dates	Actual Completion Date	Measure(s) Capturing Demonstrated Results	Clarifying Comments
Partner with Army and Navy to secure a tri-service database to track students' performance across the continuum of learning (from accession to post-residency). Secure funding to modify the already-existing MODS database for the three Services to manage Undergraduate Medical Education (UME) and GME personnel.	2nd Qtr CY19	Aug 2021		Based on systematic limitations to the current Medical Operational Data System (MODS) currently managed under the Defense Health Agency, we propose this recommendation be closed.
Update AF Recruiting Service guide to emphasize requirement for accurate/complete reporting of accession data to include undergraduate metrics (GPA/MCAT) for all HPSP scholarship recipients.	30 Sep 18	1 Aug 18	Review of 2018 HPSP scholarship recipients accession data showed 100% capture of GPA and MCAT	

Recommendation 9: The Secretary of the Air Force should use information on medical student performance to evaluate Air Force accession programs.

DoD Position: Concur
Status Update: Correction actions identified.
Estimated Completion Date: December 31, 2021
Corrective Action Plan (CAP): Identify key corrective actions planned to fully implement the recommendation.

Key Corrective Actions	Estimated Completion Dates	Actual Completion Date	Measure(s) Capturing Demonstrated Results	Clarifying Comments
Annually track & analyze the qualifications of HPSP and Uniformed Services University accessions (including GPA and MCAT scores).	4th Qtr CY18 (then yearly thereafter)	August 2018	GPA and MCAT scores	Changes in recruiting strategies have resulted in more collaboration between USU and AF HPSP. This has led to improved HPSP recruiting numbers (increased scholarship awardees to 326 with higher avg GPA/MCAT – 3.77/508
Annually track matriculation of medical students progressing to the next year of training.	3rd Qtr CY 18 (then yearly thereafter)	September 2018	Progression rate thru medical school and on-time (4 year) graduation rate	USAF HPSP has a higher on-time 4 year medical school completion rate than civilian MD and DO schools and a 96% program completion rate.
Annually analyze the very small number of students that do not matriculate successfully to the next year of training.	4th Qtr CY18 (then yearly thereafter)	TBD	Rate of non-progression, source, and contributing factors	Available records of the non-medical losses to the HPSP program are being collected and evaluated to look for potential risk factors in this population to assess if there are factors that could inform future scholarship selections and lower the attrition rate.

APPENDIX F: MILDEP PLANS FOR CIVILIAN TRAUMA CENTER PARTNERSHIP EXPANSION

1. **Army Plan**
2. **Navy Plan**
3. **Air Force Plan**

DASG-HCO
16 December 2019

SUBJECT: Army Medicine Skills Sustainment Program (AMSSP)

1. Purpose: Provide information to Secretary of the Army regarding the current Military-Civilian Partnerships, geared towards delivering vital medical skills sustainment capabilities and opportunities to support the Total Force.

2. Facts:

a. TSG's guidance, MEDCOM OPORD 18-78, and NDAA 2017, Section 708(c), authorize the establishment of skills sustainment partnerships with civilian Level 1 Trauma Centers.

b. In 2018, the MEDCOM G-3/5/7 chartered Army Medical Department Military-Civilian Trauma Team Training (AMCT3) Task Force to explore the feasibility of leveraging partnerships to build trauma skills proficiency.

c. In January, 2019, leveraging early success, the MEDCOM G-3/5/7's AMSSP Program Office (G-3/7 Readiness and Training Division) assumed management of two primary lines of effort (LOE) aimed at medical skills sustainment opportunities by partnering with civilian trauma centers and hospitals.

d. LOE One is the Strategic Medical Asset Readiness Training (SMART) LOE provides tri-service, all COMPO medics, 'hands-on' skill sustainment opportunities in civilian medical centers (2-week rotations, quarterly execution). The program is successfully operating in Ohio and two sites in New Jersey, expanding to Laredo, TX and San Juan, Puerto Rico in CY20.

e. To date the SMART program has trained 153 low density Medical Occupational Specialties (MOSs), to include one 70B Healthcare Administrator, across three sites.

f. Future SMART sites include, Oklahoma University Medical Center, OK, Queens Medical Center, HI, Rush University Medical Center, IL, as well as leveraging current and future AMEDD Military-Civilian Trauma Team Training, for co-location of SMART program.

g. LOE Two is the AMEDD Military-Civilian Trauma Team Training (AMCT3), which complies with the NDAA 2017, 708(c), by embedding select trauma team members into premier level-one trauma centers for a duration of 2-3 years. The goal of AMCT3 is to build and sustain critical trauma skills that are ready to support the globally deployed medical force.

h. OTSG has three fully executed AMCT3 Medical Training Agreements (MTA) with Cooper University Health System in Camden, NJ, Oregon Health and Science

University in Portland, OR, and the Medical College of Wisconsin, where six-seven person trauma teams are embedded.

i. OTSG has three signed MTAs with Vanderbilt University Hospital, TN, Harborview Medical Center, WA and University Chicago Medical College, IL. The AMSSP continues to build military civilian relationships and capacity for skill sustainment in the civilian healthcare sector.

j. Future AMCT3 sites include, Virginia Commonwealth University Hospital Health System, VA, University of North Carolina Medical Center, NC, and Grady Memorial Hospital, GA, to name a few.

k. The AOCs presently participating in the AMCT3 are 61J General Surgeon, 62A Emergency Physician, 61Z Neuro Surgeon, 66F Certified Registered Nurse Anesthetists, 66S Intensive Care Unit Nurse, 66E Perioperative Nurse and 66T Emergency Room Nurse. Currently there are 17 MEDCOM personnel embedded at the three sites. The program will include other AOCs as it scales in capacity and location.

l. AMCT3 can expand to train Role 2 and 3 personnel, also to afford refresher and just-in-time training to COMPOs 2 and 3.

m. There are currently 15 General Surgeons (61J) in surgical-critical care fellowships (trauma) and 5 more selected at this years' Joint Selection Graduate Medical Education Board. These are two year programs.

LTC Jon Camp Acting Dir. AMSSP/(703)681-9549
Approved by: COL Laurel Neff, MCCO Deputy Chief

Joint Partnership Register, *Ongoing Draft Updated 5SEP19*

Army

Status	Civilian Partner	Military Partner	Active Date	Region	City	State	Level	Type
Complete	Cooper University Health Care	OTSG / MEDCOM		East	Camden	NJ		AMCT3 Model
Complete	Medical College of Wisconsin	OTSG / MEDCOM		Midwest	Wauwatosa	WI		AMCT3 Model
Complete	Oregon Health & Science University	OTSG / MEDCOM		West	Portland	OR		AMCT3 Model
Pending	Baylor University Medical Center	OTSG / MEDCOM		Midwest	Dallas	TX		AMCT3 Model
Pending	Grady Health System	OTSG / MEDCOM		East	Atlanta	GA		AMCT3 Model
Pending	Hartford Hospital	OTSG / MEDCOM		East	Hartford	CT		AMCT3 Model
Pending	University of Chicago Medical Center	OTSG / MEDCOM		Midwest	Chicago	IL		AMCT3 Model
Pending	University of North Carolina School of Medicine	OTSG / MEDCOM		East	Chapel Hill	NC		AMCT3 Model
Pending	University of Washington Medical Center, Harborview	OTSG / MEDCOM		West	Seattle	WA		AMCT3 Model
Pending	Vanderbilt University Medical Center	OTSG / MEDCOM		East	Nashville	TN		AMCT3 Model
Pending	Virginia Commonwealth University Medical Center	OTSG / MEDCOM		East	Richmond	VA		AMCT3 Model

Navy Trauma Partnerships EXSUM

BACKGROUND:

National Defense Authorization Act (NDAA) 2017, Joint Requirements Oversight Council Memorandums Document Change Recommendations on Forward Resuscitative Care in Support of Dispersed Operations, and the Defense Trauma Enterprise set the legal and Departmental requirements for trauma efforts to meet the challenges of future conflict.

The Navy Bureau of Medicine and Surgery (BUMED) developed the Navy Medicine Trauma Strategy and established the Trauma Strategy Management Office (TSMO). The TSMO's mission is to "implement the strategy and provide a ready, rapidly deployable and combat effective Naval medical force to improve warfighter survivability in a joint environment." The TSMO's vision is to "achieve zero preventable deaths after injury and minimize trauma-related disability through the provision of world-class trauma care for the warfighters." One of the key responsibilities of the TSMO is to support Navy's trauma partnerships.

CURRENT STATE:

The largest, most mature partnership is the Navy Trauma Training Center (NTTC) at LA County/University of Southern California. NTTC offers just-in-time individual and team-based training for 18 Role 2 and Role 3 surgical/resuscitation teams across PACOM, CENTCOM, AFRICOM, and SOCOM. Annually, NTTC trains approximately 264 Navy clinicians. Cadre assigned to NTTC are able to operate in their full-scope of practice, sustaining their clinical currency and strengthening the partnerships.

There are dozens of local, part-time partnerships for skills sustainment. These include the University of Maryland Shock Trauma System with Naval Medical Research Command (NMRC), Eastern Virginia Medical School with Naval Medical Center (NMC) Portsmouth, Vidant Medical Center with NMC Camp Lejeune, UC San Diego with NMC San Diego, and Sacred Heart Health System with Naval Hospital Pensacola, along with several smaller partnerships.

Navy Medicine established a six-week rotational trauma training program for the sustainment of the lifesaving skills of the enlisted clinicians. The Hospital Corpsman Trauma Training program (HMTT) provides corpsmen with hands-on exposure in clinical and trauma environments at Stroger Hospital of Cook County, a Level I trauma center in Chicago, IL and the University of Florida Health Jacksonville. 157 students have completed the training since October 2017, with 96 graduates in FY19. An additional partnership site has been established with University Hospitals Health System Cleveland Medical Center which is scheduled to begin in January 2020.

Internationally, Global Health Engagement (GHE), BUMED M52, is participating in Central Command's trauma, burn, and rehabilitation Medicine initiative in the United Arab Emirates with continued engagement with trauma system development in Vietnam.

FUTURE STATE:

A key lesson learned from current partnerships is that several distinct types of partnerships will be needed to fulfill the training/sustainment requirements of physicians, nurses, and corpsmen, as there is no all-encompassing source. The Navy Surgeon General approved in December 2019 the development and launch of a proof of concept for embedding trauma teams with the University of Pennsylvania Health System, Penn Medicine. TSMO is working closely with the University of Pennsylvania to establish the Navy's first strategic military civilian partnership.

Joint Partnership Register, Ongoing Draft Updated 5SEP19								
Navy								
Status	Civilian Partner	Military Partner	Active Date	Region	City	State	Level	Type
Current	Stroger Cook County Hospital	FHCC Great Lakes, BUMED, NMOTC		East	Chicago	IL	Level I	HMTT Model
Current	University of Florida, Shands Medical Center	NH Jacksonville		East	Gainesville	FL	Level I	HMTT Model
Current	University of Maryland Shock Trauma System	Walter Reed National Military Medical Center and Naval Medical Research Center		East	Baltimore	MD	Level I	Part-time Model
Current	Eastern Virginia Medical School and Sentara Norfolk General Hospital	NMC Portsmouth		East	Portsmouth	VA	Level I	Part-time Model
Current	Vidant Medical Center	NMC Lejeune		East	Greenville	NC	Level I	Part-time Model
Current	University of California San Diego	NMC San Diego, 1st Medical Battalion	JAN19	West	San Diego	CA	Level I	Part-time Model
Current	University of California Irvine	1st Medical Battalion		West	Irvine	CA	Level I	Part-time Model
Current	Palomar Medical Center	1st Medical Battalion		West	San Diego County	CA	Level II	Part-time Model
Current	Riverside Medical Center	Naval Surface Forces Pacific		West	Riverside	CA	Level II	Part-time Model
Current	Sacred Heart Health System Pensacola	NH Pensacola		East	Pensacola	FL	Level II	Part-time Model
Current	Womack Army Medical Center	NMOTC and Naval Special Operations Medical Institute		West	Fort Bragg	NC	Level III	Part-time Model
Current	Los Angeles County & University of Southern California Medical Center	NMOTC		West	Los Angeles	CA	Level I	Training Model
Current	St. Francis Medical Center	Naval Surface Forces Pacific	SEP18	West	Lynwood	CA	Level II	Part-time Model
Future	Vidant Medical CenterEastCare	NMC Lejeune		East	Greenville	NC	Level I	En Route Care Model
Future	University of California Irvine	NMC San Diego		West	Irvine	CA	Level I	Part-time Model
Future	Penn Medicine, University of Pennsylvania			East	Philadelphia	PA	Network (Level I or Level II)	Embedded Sustainment Model
Future	Riverside Regional Medical Center			East	Newport News	VA	Level II	Embedded Sustainment Model
Future	Vidant Medical Center East Care			East	Greenville	NC	Level I	En Route Care Model
Future	University of Pittsburgh			East	Pittsburgh	PA	Level 1	En Route Care Model
Future	Maryland State Trooper			East		MD		En Route Care Model
Future	University of Maryland, Prince George's County Hospital Center			East	Cheverly	MD	Level II	
Future	University of Wisconsin Hospital and Clinics			East	Madison	WI	Level I	
Future	University of California at Irvine			West	Irvine	CA	Level I	
Future	Scripps Mercy	NMC San Diego		West	San Diego	CA	Level I	
Future	Palomar Medical Center			West	Escondido	CA	Level II	
Future	University Medical Center New Orleans			East	New Orleans	LA	Level I	
Future	Scripps Memorial			West	La Jolla	CA	Level II	
Future	Naval Hospital Guam			OCONUS	Hagatna	Guam	NA	

AF Plan for Medical Personnel Opportunities in Civilian Centers

Background: The AFMS manages the clinical currency and readiness of the medical force principally through the Comprehensive Medical Readiness Program (CMRP). This program establishes career-field specific requirements, measures, and sources for training, retraining, and sustainment activities. The clinical activities managed are typically performed in a health care setting and the location of training is determined through agreements with certification or accreditation bodies or in accordance with the AFMS Sustained Medics and Readiness Trained (SMART) concept of operations. The concept directs commanders to employ personnel first within the MTF and progressively through local and regional civilian partner settings to ensure that appropriate clinical experience is achieved in accordance with readiness requirements. It builds on two decades of experience with regional partnerships known as the Centers for Sustainment of Trauma and Readiness Skills (C-STARS) where select AF personnel are assigned as instructor cadre to support pre-deployment and currency training of rotating personnel. Based on experience and success of these programs, AF MTF commanders have subsequently established partnerships to expand activities within the MTF or establish partnerships with local health-care entities to provide clinical opportunities required under the CMRP program. The result of this approach includes MTF integration into the civilian trauma system (i.e. SAMMC, planned for Nellis), DoD/VA partnerships that allow for specialty care of veterans within the MTF (DGMC, Keesler, Nellis, Eglin, Wright-Patterson, JBER), and local civilian partnerships that allow AF personnel to perform clinical activities outside of the MTF. Medical personnel not assigned to an MTF (i.e. AF Special Operations Surgical Teams) also utilize civilian partnerships for sustainment training.

Overview of current civilian partnerships:

1. Initial training agreements that are part of a formal program and grant a degree or certification for a medical specialty:

Physician*	Nurse*	Technician*	Other*	Total Civilian Sites
48	14	18	27	81

*Note: Many sites include multiple professions

2. Local training affiliation agreements between individual Air Force facilities and local civilian partners for sustainment training:

Physician*	Nurse*	Technician*	Other*	Total Civilian Sites
108	72	118	68	191

*Note: agreements with some sites may include multiple professions

3. Regional Currency Sites: US Air Force School of Aerospace Medicine (USAFSAM) personnel are embedded as cadre and fully integrated into clinical practice at the civilian site(s). They function as instructors and facilitators for additional personnel that rotate through centrally funded 2-week training programs. Cadre and rotating personnel include surgeons, physicians, nurses and technicians. For FY19 the following attended:

Civilian Site	Physicians	Nurses	Technicians	Total
University of Maryland, Baltimore Shock Trauma	57	66	133	256
St Louis University	60	64	127	251
University of Cincinnati	54	62	56	172
University of Nevada Las Vegas	14	56	55	125
TOTAL	185	248	371	804

Ongoing efforts: The AFMS is seeking to further refine and expand existing programs and partnerships. Efforts are being led and coordinated through the Air Force Medical Readiness Agency and will include the following.

1. Refinement of the CMRP will include incorporation of joint readiness reporting measures and KSA metrics and assessments as they are developed and validated.
2. Expansion of partnerships will be focused on establishing additional programs for nursing and technician specialists, expanding opportunities for pre-hospital clinical care experience, and incorporating personnel from the Reserve and Guard Components into existing or novel programs.
3. The AFMS will collaborate with both DHA and civilian partners to expand clinical activity reporting and analysis in order to optimize personnel activities in alignment with currency and readiness requirements and health care operations demands.
4. The AFMS will address challenges at the enterprise level that have hindered the effectiveness of individual military civilian partnerships in the past, including::
    a. Military medical enlisted personnel scope of practice frequently exceeds that of civilian counterparts resulting in limited sustainment training opportunities for those personnel at civilian sites.
    b. Limits to licensure portability results in additional administrative and financial barriers to personnel participation.
    c. The capability to monitor and report nursing and technician clinical activity is insufficient to guide management of these personnel.

Joint Partnership Register, Ongoing Draft Updated 5SEP19								
Air Force								
Status	Civilian Partner	Military Partner	Active Date	Region	City	State	Level	Type
Complete	Singer River Hospital System	Keesler AFB		East	Pascagaoula	MS		Part-time Model
Complete	Merit Health	Keesler AFB		East	Biloxi	MS		Part-time Model
Complete	South Texas Spinal Clinic, P.A.	Lackland AFB		Midwest	San Antonio	TX		Part-time Model
Complete	University of Texas Health Science Center At San Antonio	Lackland AFB		Midwest	San Antonio	TX		Part-time Model
Complete	Georgetown University Medical Center	Langley AFB		East	Washington	D.C.		Part-time Model
Complete	University of Maryland School of Medicine - Cadaver Lab	Langley AFB		East	Baltimore	MD		Part-time Model
Complete	Barnes Jewish Hospital	Langley AFB		Midwest	St. Louis	MO		Part-time Model
Complete	Tampa General Hospital	MacDill AFB		East	Tampa	FL		Part-time Model
Complete	Bay Pines VA Hospital	MacDill AFB		East	St. Petersburg	FL		Part-time Model
Complete	University Medical Center of Southern Nevada	Nellis AFB		West	Las Vegas	NV		Part-time Model
Complete	Emergency Medicine Physicians of Clark UMC MCCOURT PLLC	Nellis AFB		West	Las Vegas	NV		Part-time Model
Complete	Bellevue Medical Center LLC	Offutt AFB		Midwest	Omaha	NE		Part-time Model
Complete	Norfolk & Norwich University Hospital	RAF Lakenheath		OCONUS	Norfolk	United Kingdom		Part-time Model
Complete	West Suffolk Hospital	RAF Lakenheath		OCONUS	Suffolk	United Kingdom		Part-time Model
Complete	Cambridge University Hospital	RAF Lakenheath		OCONUS	Cambridge	United Kingdom		Part-time Model
Complete	Royal London	RAF Lakenheath		OCONUS	London	United Kingdom		Part-time Model
Complete	Nuffield Hospital, Cambridge	RAF Lakenheath		OCONUS	Cambridge	United Kingdom		Part-time Model
Complete	Cardinal Glennon Childrens Hospital	Scott AFB		Midwest	St. Louis	MO		Part-time Model
Complete	San Francisco VAMC	Travis AFB		West	San Francisco	CA		Part-time Model
Complete	Sacramento VAMC	Travis AFB		West	Sacramento	CA		Part-time Model
Complete	University of Califronia, Davis Medical Health Center	Travis AFB		West	Sacramento	CA		Part-time Model
Complete	University of California, San Francisco Medical Center	Travis AFB		West	San Francisco	CA		Part-time Model
Complete	Northbay Healthcare Group	Travis AFB		West	Fairfield	CA		Part-time Model
Complete	UC Health University of Colorado Hospital	US Air Force Academy		West	Aurora	CO		Part-time Model
Complete	Kettering Medical Center - Kettering Health Network	Wright Patterson AFB		Midwest	Dayton	OH		Part-time Model
Complete	Dayton VAMC	Wright Patterson AFB		Midwest	Dayton	OH		Part-time Model
Complete	University of Cincinnati Medical Center	Wright Patterson AFB		Midwest	Cincinnati	OH		Part-time Model
Complete	Miami Valley Hospital	Wright Patterson AFB		East	Miami	FL		Part-time Model
Complete	Cincinnati Childrens Hospital Medical Center	Wright Patterson AFB		Midwest	Cincinnati	OH		Part-time Model
Complete	University of Maryland Shock Trauma Center	Wright Patterson AFB		East	Baltimore	MD		Part-time Model
Complete	Saint Louis University Department of Orthopedic Surgery	Wright Patterson AFB		Midwest	St. Louis	MO		Part-time Model
Complete	University of Nebraska Medical Center	Wright Patterson AFB		Midwest	Omaha	NE		Part-time Model
Complete	RA Cowley Shock Trauma	USAFSAM		East	Baltimore	MD		C-STARS Model
Complete	Saint Louis University Barnes	USAFSAM		Midwest	St. Louis	MO		C-STARS Model
Complete	University of Cincinatti	USAFSAM		Midwest	Cincinnati	OH		C-STARS Model