



Defense Health Agency

PROCEDURAL INSTRUCTION

NUMBER 1025.04

May 18, 2022

DAD-MA

SUBJECT: Graduate Medical Education

References: See Enclosure 1.

1. PURPOSE. This Defense Health Agency-Procedural Instruction (DHA-PI), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (s), establishes the Defense Health Agency (DHA) procedures for the oversight, establishment, and governance of Graduate Medical Education (GME) programs pursuant to Reference (r) and Sections 702, 706, 717, and 749 of Reference (f).
2. APPLICABILITY. This DHA-PI applies to the DHA, DHA Activities (under the authority, direction, and control of DHA), and the Military Departments (MILDEPs).
3. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to References (a) through (j), that DHA must:
 - a. Establish procedures for oversight of GME through the governance of a Military Health System (MHS) GME Oversight Advisory Council (OAC) and MHS GME Integration Advisory Board (IAB).
 - b. Develop GME processes to include the evaluation of GME programs for opening, expanding, restructuring, realigning, or closing the programs.
 - c. Develop a process that ensures that the assignment of faculty, support staff, and trainees within GME programs are coordinated among the MILDEPs.
 - d. Establish processes that will assist with DHA review and oversight of existing programs to ensure MILDEP operational needs are met and programs meet national accrediting body requirements.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosure 3.

6. PROPONENT AND WAIVERS. The proponent of this publication is the Deputy Assistant Director (DAD), Medical Affairs (MA). When Activities are unable to comply with this publication the activity may request a waiver that must include a justification, to include an analysis of the risk associated with not granting the waiver. The activity director or senior leader will submit the waiver request through their supervisory chain to the DAD-MA to determine if the waiver may be granted by the Director, DHA or their designee.

7. RELEASABILITY. **Cleared for public release**. This DHA-PI is available on the Internet from the Health.mil site at: <https://health.mil/Reference-Center/Policies> and is also available to authorized users from the DHA SharePoint site at: <https://info.health.mil/cos/admin/pubs/SitePages/Home.aspx>.

8. EFFECTIVE DATE. This DHA-PI:

a. Is effective upon signature.

b. Will expire 10 years from the date of signature if it has not been reissued or canceled before this date in accordance with Reference (c).

9. FORM. The DHA Form 165, "Graduate Medical Education Final Evaluation," is available at https://info.health.mil/cos/admin/DHA_Forms_Management/DHA_Forms1/DHA%20165.pdf.

/S/
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ENCLOSURE 1

REFERENCES

- (a) DoD Directive 5136.01, “Assistant Secretary of Defense for Health Affairs (ASD(HA)),” September 30, 2013, as amended
- (b) DoD Directive 5136.13, “Defense Health Agency (DHA),” September 30, 2013, as amended
- (c) DHA-Procedural Instruction 5025.01, “Publication System,” August 24, 2018
- (d) DHA-Procedures Manual 6025.13, “Clinical Quality Management in the Military Health System,” August 29, 2019
- (e) DHA-Multi Service Regulation 6025.02, “The Care and Use of Animals in DoD Research, Development, Test, and Evaluation (RDT&E) or Training Programs,” June 18, 2019
- (f) Public Law 114-328, “National Defense Authorization Act for Fiscal Year 2017,” Sections 706 and 749, December 23, 2016
- (g) DoD Instruction 6015.24, “DoD Graduate Medical Education Program,” April 9, 2021
- (h) DoD Instruction 3216.01, “Use of Animals in DoD Conducted and Supported Research and Training,” March 20, 2019
- (i) DoD Instruction 3216.02, “Protection of Human Subjects and Adherence to Ethical Standards in DoD-Conducted and -Supported Research,” April 15, 2020
- (j) DoD Instruction 4000.19, “Support Agreements,” December 16, 2020
- (k) Army Regulation 351-3, “Professional Education and Training Programs of the Army Medical Department,” October 15, 2007
- (l) Army Regulation 600-9, “The Army Body Composition Program,” July 16, 2019
- (m) Air Force Instruction 41-117, “Medical Service Officer Education,” March 25, 2015, as amended
- (n) Air Force Instruction 41-110, “Medical Health Care Professions Scholarship Programs,” December 23, 2020
- (o) Air Force Instruction 36-2905, “Air Force Physical Fitness Program,” December 11, 2020
- (p) BUMEDINST 1524.1C, “Graduate Medical Education Programs,” November 21, 2018
- (q) OPNAVINST 6110.1J, “Physical Readiness Program,” July 11, 2011
- (r) 10 U.S.C. §1073c
- (s) Report on Oversight of Graduate Medical Education Programs of Military Departments Final Report dated July 13, 2018

ENCLOSURE 2
RESPONSIBILITIES

1. DIRECTOR, DHA. In accordance with reference (g), the Director, DHA will:
 - a. Establish policy, procedures, and direction of the DoD GME Program and GME in military medical treatment facilities (MTFs).
 - b. Establish procedures to ensure that GME programs are conducted jointly, to the extent practicable, and focus on operational medical force requirements.
 - c. Coordinate with the Secretaries of the MILDEPs to assign current Active Duty Service members to GME programs, including faculty, support staff, and trainees necessary to operate GME programs.
 - d. Provide sufficient resources, including educational materials and personnel to augment the personnel provided by the MILDEPs, as required, to maintain national operational readiness and GME program accreditation or certification.
 - e. Establish policy and procedures to enter into Federal and non-Federal partnerships and agreements to fulfill civilian accrediting body and GME operational requirements.
 - f. As established in this Instruction, conduct the Joint GME Selection Board annually in conjunction with the Secretaries of the MILDEPs.
 - g. Conduct a review of GME programs at least once every two years and provide a report to the Assistant Secretary of Defense for Health Affairs (ASD(HA)), through the Deputy ASD for Health Services Policy and Oversight with an assessment of the DoD GME program and recommendations for improvement.
 - h. Approves or closes GME programs. Approval or disapproval may be delegated, but no further than the DAD-MA.

2. ASSISTANT DIRECTOR (AD), HEALTH CARE ADMINISTRATION (HCA). The AD-HCA will:
 - a. Establish priorities for health care administration and management.
 - b. Establish policies, procedures, and direction for the provision of direct care at MTFs.
 - c. Establish priorities for budgeting matters with respect to the provision of direct care at MTFs.

d. Establish policies, procedures, and direction for clinic management and operations at MTFs.

e. Establish priorities for information technology at and between the MTFs.

f. Ensure the planning, direction, and management of MTFs result in adequate resources, personnel, and procedures to support GME, as described in this DHA-PI, by implementing policies that affect healthcare delivery and administration as well as providing cross-functional support to the DHA Direct Reporting Organizations (DRO) and managing the TRICARE Health Plan.

3. DAD-MA. The DAD-MA will:

a. Be responsible for policy, procedure, and direction of MHS GME.

b. Monitor compliance with the guidance outlined in this DHA-PI through the MTFs where GME occurs.

c. Serve as Chair of the GME-OAC.

d. Provide recommendations, updates, or action requests to Director, DHA, through the AD-HCA, from work completed by the GME-OAC and/or GME IAB.

4. DEPUTY ASSISTANT DIRECTOR-HEALTHCARE OPERATIONS (DAD-HCO). The DAD-Healthcare Operations will:

a. Collaborate with DAD-MA to ensure DRO and MTF standard healthcare operations processes are established to support sufficient patient volume and complexity to fulfill the requirements of this DHA-PI.

b. Collaborate with DAD-MA and DRO Directors to provide guidance on financial, budget, quality, and/or strategy proposals to ensure the requirements of this DHA-PI are met.

5. DIRECTOR, EDUCATION & TRAINING (J-7). The Director, J-7 will:

a. Provide oversight to J-7 directorates across the enterprise and support GME training programs in collaboration with DAD-MA and MILDEPs' Surgeons General (SGs).

b. Provide feedback to the Director, DHA on training and educational programs affecting GME in collaboration with DAD-MA.

6. DHA, GME DIRECTOR. The DHA, GME Director will:

- a. Serve as GME expert for the DHA when implementing this instruction.
- b. Develop and refine DHA GME guidance and procedures to implement this instruction.
- c. Provide analyses and recommendations for any other DHA policies and procedures that affect GME as per this instruction.
- d. Assist MILDEP GME Directors, Designated Institutional Officials (DIO)/Directors of Medical Education (DME), GME Program Directors (PDs), and Specialty Leaders/Consultants in the implementation of this instruction.
- e. Collect, analyze, and report data for MHS GME processes and outcomes as required in this instruction.
- f. Organize and oversee the planning and coordination of the Joint Graduate Medical Education Selection Board (JGMESB).
- g. Chair the GME-IAB.

7. SECRETARIES OF THE MILDEPS. The Secretaries of the MILDEPs will:

- a. Appoint MILDEP GME Directors as per MILDEP policy.
- b. As provided for in Reference (g), and in coordination with Director, DHA, ensure that MILDEP GME Directors comply with, oversee, and execute the procedures outlined in this DHA-PI.

8. MILDEP GME DIRECTORS. The MILDEP GME Directors will:

- a. Lead MILDEP GME platform as per MILDEP policy.
- b. Establish or refine MILDEP-specific GME policy as per MILDEP policy.
- c. Provide analyses and recommendations for any other DHA and/or MILDEP policies and procedures that affect MILDEP GME as per this instruction.
- d. Oversee and/or assist DIOs/DMEs, GME PDs, and Specialty Leaders/Consultants in the implementation of this instruction.
- e. Assist with the collection, analysis, and reporting data for MHS GME processes and outcomes as required in this instruction.
- f. Oversee and administer the JGMESB as per DHA and MILDEP policy.
- g. Serve on the GME-IAB.

- h. Oversee MILDEP-specific Military-Unique Curriculum (MUC).
 - i. Ensure the GME-IAB reviews all MILDEP-specific GME programs within MTFs and with non-Federal partners.
9. DIRECTORS, DRO. Directors of DROs will:
- a. Collaborate with Directors of MTFs and the DRO GME liaisons to ensure GME Programs within the DRO have the personnel, funds, equipment, and patient load/case mix necessary to meet the educational and readiness needs of the GME programs.
 - b. Designate GME Liaisons within the DRO.
 - c. This does not include Defense Health Agency Regions.
10. DIRECTORS, MTFs. Directors, MTFs will:
- a. Ensure GME programs meet the standards and criteria of this instruction, as well as the standards of national accrediting bodies.
 - b. Plan and provide, in conjunction with DRO Director and MILDEPs, personnel, funds, equipment, and patient load/case mix necessary to meet the educational and readiness needs of the GME program(s) under their MTF.
 - c. Review and approve DIO, DME, and PD appointments in accordance with DHA and MILDEP policy.
 - d. Ensure DIO and/or DME is positioned at appropriate level in organizational structure (e.g., as member or an ad hoc member of the MTF Leadership/Board of Directors) to facilitate appropriate representation of GME issues in MTF meetings and decisions.
11. DIO/DME. The DIO and/or DME will:
- a. Ensure the sponsoring institution (SI) is conducted in accordance with the Accreditation Council for Graduate Medical Education (ACGME) institutional requirements.
 - b. Represent GME issues in MTF-level meetings and decisions. Appoint individuals as needed to represent GME issues in institutional committees.
 - c. Ensure that the assigned GME program(s) is/are conducted in accordance with the ACGME, and/or specialty-specific accrediting bodies, as applicable.

- d. Ensure all GME programs are conducted in accordance with the MILDEP and institutional policies and procedures.
- e. Ensure GME programs include MUC to meet operational needs of the MILDEPs.
- f. Prepare and submit reports and budget requirements necessary to support educational programs as required by this instruction and accrediting bodies.
- g. Inform the DHA GME Director, affected MILDEP GME Director, and/or GME-IAB of changes in the SI's or GME program's status as described in this instruction (Refer to Enclosure 3, paragraph 10).
- h. Oversee and maintain training records for program participants in accordance with ACGME and MILDEP policy as well as this DHA-PI.
- i. Create a local orientation program for individuals entering GME. Assist all PDs to develop an appropriate orientation.
- j. Oversee PD selection.

12. GME PD. The GME PDs will:

- a. Conduct assigned GME programs in accordance with ACGME policy, and/or specialty specific accrediting bodies, as applicable and institutional GME policy.
- b. Develop program curriculum, performance standards, and staffing plans/scheduling in accordance with DHA GME policy, ACGME and/or specialty specific accrediting body policies, and specialty specific policy.
- c. Oversee and maintain training records for program participants in accordance with ACGME and MILDEP policy as well as this instruction.
- d. Provide updates to DIO and/or DME on performance of trainees and any areas of concern for review and action, as needed.
- e. Participate in preparation for the JGMESB; attendance will be determined by MILDEP policy.
- f. Implement MUC to meet operational needs of the MILDEPS.
- g. Approve and assign faculty to educational roles and committees as required by ACGME and MILDEP policy.

ENCLOSURE 3

PROCEDURES

1. GENERAL PROVISIONS

a. Purpose. The purpose of GME is to generate Medical Corps (MC) Officers who are expert clinicians and leaders, trained to the scope of practice required in the operational force, acculturated in the MC and key aspects of military practice, and ready to support wartime and related operational missions. After completion of GME, these MC Officers will form the MC component of the MILDEPs' Ready Medical Force. All procedures in this DHA-PI are intended to achieve this purpose.

b. Accreditation. All MHS GME programs will seek and maintain ACGME accreditation in designated specialty/subspecialty areas where ACGME provides accreditation.

(1) The ACGME is the body responsible for accrediting nearly all GME training programs (i.e., internships, residencies, and fellowships) for physicians in the United States.

(2) ACGME accreditation provides assurance that MHS GME programs meet the quality standards (i.e., Institutional and Program Requirements) of the specialty or subspecialty practice(s) for which it prepares its graduates.

(3) All MHS SI, as defined by the ACGME, will ensure that local policies and procedures meet at least the minimum ACGME program requirements. Non-ACGME physician training programs will meet the minimum ACGME common program requirements.

c. Oversight. The goals of GME oversight are to ensure high quality programs while meeting the requirements of Reference (f):

(1) To the extent practicable, programs focus on operational medical force requirements and are conducted jointly between MILDEPs.

(2) Minimizing [unwarranted] duplicative programs among the MILDEPs.

(3) Coordinating among the MILDEPs the assignment of faculty, support staff, and students by the MILDEP.

(4) Optimizing of resources by appropriately using MTFs as training platforms to the maximum extent practicable.

(5) Reviewing and, if necessary, restructuring or realigning of programs to sustain and improve medical force readiness.

2. OVERSIGHT PROCESS

a. GME IAB

(1) Purpose and Responsibilities. GME-IAB, under the direction and control of the GME-OAC, will coordinate GME across the MHS and provide a forum for sustained communication, collaboration, and joint strategic planning for military GME. The IAB develops GME policy recommendations directed by the GME-OAC and ensures that, to the extent practicable, GME military operations are integrated and conducted jointly across the MILDEPs and DHA.

(2) Reporting Structure. The GME-IAB reports to the GME-OAC.

(3) Composition

(a) Principal members (voting)

1. DHA GME Director–Chair
2. Army GME Director
3. Navy GME Director
4. Air Force GME Director

(b) Advisory members (non-voting)

1. Office of the ASD(HA) GME Representative
2. DHA J-7 representative
3. A representative from the San Antonio Market and a representative from the National Capital Region Market
4. A representative from multi-specialty medical centers and a representative for MTFs with a small number (e.g., one or two) of GME programs
5. Uniformed Services University of the Health Sciences (USUHS) representative
6. Ad-hoc members (i.e., military members or Federal civilian employees), as determined necessary by the Chair

(c) Ad hoc non-voting advisors.

(4) Functions

- (a) Recommend a common operational model for GME in the MHS.
- (b) Work with ASD(HA), the MILDEPs, and DHA to develop overarching DoD GME policies to be recommended for approval through the GME-OAC.
- (c) Organize the annual JGMESB with an enhanced focus on common issues, needs, and joint integration opportunities.
- (d) Consolidate each MILDEP's training plan to develop an annual Joint Training Plan to align available training resources with validated MILDEP readiness and accreditation requirements.
- (e) Standardize and manage reporting across all MHS GME programs.
- (f) Perform an annual review of the MHS GME platform.
- (g) Review new training programs and any proposed additions, realignments, or closures of existing programs.
- (h) Serve as the point of contact for external inquiries and requests for information related to MHS GME platform.

b. GME-OAC

(1) Purpose and Responsibilities. The GME-OAC provides advice and assistance to the Director, DHA on issues involving GME. The ultimate goal of this Council is to establish a joint oversight body that assists the Director, DHA with optimizing military GME to sustain and improve medical force readiness.

(2) Reporting. The GME-OAC reports to the Director, DHA through the AD-HCA.

(3) Composition.

(a) Principal members (voting)

- 1. DAD-MA–Chair or Designee
- 2. Chief, Army MC or Designee
- 3. Chief, Navy MC or Designee
- 4. Chief, Air Force MC or Designee

(b) Advisory members (non-voting)

- 1. Office of the ASD(HA) GME representative

2. DHA J-7 representative
3. Chair, GME-IAB
4. USUHS representative
5. Ad-hoc members (i.e., military members or Federal civilian employees), as determined necessary by the Chair

(c) Ad hoc non-voting advisors.

(4) Functions

- (a) Focus on medical force readiness.
- (b) Review MILDEP-specific training plans to ensure, to the greatest extent practicable, training is conducted jointly.
- (c) Evaluate recommendations for policy, procedures, and direction of GME, as developed by the GME-IAB.
- (d) Provide recommendations on joint reports to Congress and responses to other external inquires.
- (e) Oversee implementation of a standardized annual MHS GME platform review.
- (f) Provide recommendations to Director, DHA in regards to policy, procedure, and direction of the MHS GME platform, and ensure support of GME PDs and SIs.

3. TRAINING PLAN DEVELOPMENT FOR GME

- a. Per 3.1, Section 3 of Reference (g), each MILDEP independently develops and submits their annual GME training plan that is based on operational medical force requirements of the MILDEPS and listed by specialty and number, for the Fiscal Year Defense Program to DHA prior to 1 July annually.
- b. DoD specifies, in Section 1 of Reference (g), that the MILDEPs base these plans on the primary guidance of their deployment Concept of Operations, which determines their operational requirements. The MILDEPs then consider the requirements to support the Combatant Commands, particularly outside the continental United States and remote sites, and support for force generation. The sum of these considerations determines the number and location of training positions for each specialty.
- c. The DHA GME-IAB will consolidate the inputs from the MILDEPs' training plans by specialty, location, and number to be trained.

(1) This combined training plan will be the basis to optimize the MHS GME platform, ensuring adequate training opportunities within the MHS or in partnership with non-DoD GME programs (refer to Enclosure 3, paragraph 4 for additional details).

(2) During the annual Joint GME Selection Board, the MILDEPs' SGs will select the applicants for GME positions in accordance with the annual training plan.

(3) When evaluating the number of training positions in individual programs, the GME-IAB will ensure that the number of trainees will meet the program approved training complement and accreditation requirements.

(4) Alterations in the numbers and mix of specialties are permitted during the Selection Board, but the MILDEPs and the Under Secretary of Defense for Personnel and Readiness will be briefed on any changes to the numbers and mix of specialties made by the Board. Upon mutual agreement of affected MILDEP, SI, and PD, training complement increases (subject to ACGME approval) may occur to accommodate trainees in individual programs.

4. EVALUATION OF NUMBER AND SIZE OF GME PROGRAMS

a. Types of Clinical Training Programs

(1) MHS SI

(a) These programs are hosted by a military SI and are largely conducted at MTFs.

(b) All trainees who are primarily assigned to these programs are military trainees, trainees from the Public Health Service, or civilian employees funded by the U.S. Department of Veterans Affairs (VA). There is no authority for civilian trainees funded by the MHS to be assigned to these programs. However, this may change, so personnel contemplating such training should check with DHA Office of General Council to determine whether this authority is now available.

(c) All rotations are designed, organized, and funded by the MHS SI.

(d) Programs are required to have appropriate Training Agreement (TA) if there are training experiences outside of the SI and/or the program has non-military trainees. If all rotations are in the SI, then there is no training agreement required.

(2) MHS SI that includes non-Federal trainees

(a) These programs are hosted by a military SI and have an enduring relationship with a geographically co-located non-Federal facility, where the non-Federal facility funds at least one trainee to be part of the program.

(b) Trainees from the program include military and non-Federal trainees. The military trainees are selected via the JGMESB and the non-Federal trainees are selected through the standard civilian match process. The primary PD is active duty and reports to the military SI. There is also a non-Federal associate PD who oversees the civilian match process in coordination with the military PD.

(c) Rotations are designed by the military program. The civilian associate PD provides input into any requirements that are unique to the civilian trainees.

(d) Primary oversight is provided by the military SI.

(e) Programs are required to have an appropriate TA and comply with standard training objectives and maintain accreditation in accordance with ACGME standards.

(3) Non-DoD SI with enduring affiliated relationship.

(a) These programs are hosted by non-DoD SIs and have established a long-term commitment to train military trainees within their program. The military trainees may or may not have rotations at a geographically collocated MTF.

(b) Trainees from the program include non-DoD (including non-Federal) and military trainees. The non-DoD trainees are selected through the standard civilian match process and military trainees are selected via the JGMESB. The PD is typically a non-federally employed civilian. If military trainees have rotations at a geographically collocated MTF, then the MTF will also have a military associate PD to oversee the military aspects of training, to include, but not limited to, military unique curriculum and rotations at the MTF.

(c) Rotations are designed by the non-DoD program. If military trainees do not have rotations at a geographically collocated MTF, the DHA and/or MILDEP GME office will provide input to the PD for the curriculum necessary to develop the trainees' military-specific scope of practice.

(d) Primary oversight is provided by the non-DoD SI.

(e) Programs are required to have an appropriate TA and comply with standard training objectives and maintain accreditation in accordance with ACGME standards.

(4) Non-DoD programs without an enduring relationship where military trainees are selected via a civilian match or other processes outside the match.

(a) Sponsored – Contingent upon the availability of billets, federal funding, and applicant competency.

(b) Non-Sponsored – Contingent upon applicant competency and training requirement without federal support authorized.

(c) Programs are required to have an appropriate TA.

b. Comparison of MHS GME capacity to MHS GME operational training requirement

(1) At least biennially, the GME-IAB will review each specialty to determine if there is unwarranted duplication of programs and/or the program capacity is sufficient, insufficient, or excessive based upon MILDEPs' operational training requirements. For specialties that have sufficient or excessive capacity, the GME-IAB will evaluate for unwarranted duplication. For programs with insufficient capacity, the GME-IAB will evaluate for expanding or opening programs.

(2) Unwarranted duplication exists when all of the following are met:

(a) There is excess training capacity above the operational requirements of the MILDEPs.

(b) At least one program may be closed as the remaining program(s) have either sufficient ACGME-approved complement that can be utilized to meet the operational requirements of the MILDEPs or can successfully receive approval for increased ACGME complement levels as there is sufficient faculty, space, patient volume, clinical experiences, etc. to support such a request.

(c) At least one program may be closed and not adversely affect the ACGME accreditation requirements of other co-located ACGME-accredited programs that also meet operational requirements.

(d) Program closure(s) would not adversely affect MILDEP-specific operational training requirements.

(e) Program closures would not adversely impact strategic non-DoD partnerships relating to critical wartime readiness of GME trainees and faculty, as per Section 706 of Reference (f).

(3) For specialties with either insufficient capacity or unwarranted duplication, the GME-IAB will ask the impacted program's PD(s), DIO/DMEs, Consultants/Specialty Leaders, and DRO GME Liaisons to submit the operational focus, academic, and market criteria identified below. After receiving that information, the GME-IAB will appoint a working group to conduct an analysis and generate courses of action to submit to the GME-OAC.

(a) Operational Focus Criteria:

1. Operational curriculum/scope of practice relating to operational knowledge, skills, and abilities (KSA)

2. MILDEP strategic planning

3. Impact to the treatment facility and other supported missions

(b) Academic Criteria:

1. Board pass rate, as reported by specialty board

2. Accreditation status/history

3. Size of programs

4. Depth of faculty experience/breadth of sub-specialties

5. Scholarly activity, as reported on annual ACGME report

6. Support to other GME programs

7. Support to non-GME health training

8. Support to undergraduate medical education

9. Support from the SI

(c) Market Criteria:

1. Geographic factors/market assessment

2. Strategic non-DoD including VA partnership opportunities

3. Resourcing

4. Case volume/mix in relation to ACGME requirements

(d) Options to increase training capacity where there is a long-term operational training requirement that exceeds current capacity in training programs:

1. Expand current programs, if feasible

2. Evaluate for new partnerships when one or more of the following is present:

a. Availability and suitability (for example, ACGME accreditation) of non-DoD including VA partners.

KSAs

- b. Likelihood of meeting scope of practice criteria relating to operational
 - c. Ability to train in MUC
 - d. Ability to meet long-term operational readiness training requirements
 - e. Market analysis is supportive
- 3. Use of the civilian match is generally supported when one or more of the following is present:
 - a. Short-term need
 - b. Low-volume need
 - c. Opportunities/availability in the civilian sector
 - d. No other option to meet the operational need
- 4. Open new program(s):
 - a. If considering opening a new program, present to OAC and, if approved, initiate full analysis and provide recommendation(s) for OAC and MHS Governance decisions.
 - b. Evaluation Criteria for Opening New Program(s):
 - (1) Patient potential to support training, and operational requirements, and operational KSAs for currency
 - (2) Facility space
 - (3) Breadth of faculty, including sub-specialty trained
 - (4) Ancillary personnel/services
 - (5) Availability of interdependent residencies
 - (6) Funding
 - (7) Availability of required clinical rotations
 - (8) Impact of other GME locations/MTFs (adequate faculty, resident availability in other specialties)
 - (9) Availability of appropriate simulation support

research (10) Availability of appropriate infrastructure to facilitate the conduct of

(11) Medical staff support and GME infrastructure

(12) Long term operational readiness training requirements need

(13) Market analysis

(14) Cost to include facility improvement and staffing increases

(15) Ability to obtain ACGME accreditation

(16) Potential for non-DoD including VA collaboration where the non-DoD facility has an independent ACGME accredited program in place.

(17) Impact on other training programs

c. Program Closure

(1) As discussed above in paragraph 4.b.(2) of this enclosure, if a specialty/subspecialty is determined to have unwarranted duplicative training capacity, all programs in that specialty/subspecialty will be evaluated to identify a program for potential closure.

(2) Input from Specialty Leaders/Consultants, MILDEP GME Directors, PDs, and DIO/DMEs will be requested.

(3) Courses of action will be generated by the GME-IAB to decide which program(s) to potentially close and send to the GME-OAC for formal recommendation to the Director, DHA. Service GME-OAC principal members will represent their respective MILDEP SGs.

(4) Closure procedures, if approved by the Director, DHA:

(a) The DHA Director notifies ASD(HA) and copies all MILDEP SGs.

(b) DHA GME office develops strategic communication.

(c) DIOs of the affected program(s) notify the accrediting and specialty bodies, as applicable.

(d) DIOs and PD(s) of the affected program(s) notify the affected trainees.

(e) All trainees of closing program(s) will be supported in completing their training as per current ACGME and respective board certification guidelines.

d. Realignment of GME Programs

(1) During biennial program evaluation, programs within a specialty will be evaluated for realignment (e.g. increasing the size of a program at one location and decreasing the size of a program at another location).

(2) The GME-IAB will evaluate programs to determine if programs are correctly sized.

e. Change in Trainee Complement

(1) Permanent changes in ACGME complement will be evaluated based on the operational requirements compared to the existing MHS training capacity, as detailed above.

(2) All requests for permanent changes in trainee complement must first be approved by the SI and reported to the MILDEP GME Director for IAB review. Institutions may not request permanent changes in complement without GME-IAB approval.

(3) If no additional resources are required and the changes do not disrupt the MILDEPs' ability to meet operation requirements, the GME-IAB may approve the request. The SI DIO will follow local procedures, submit the change request to the ACGME, and notify the GME-IAB when the ACGME makes its determination.

5. TRAINEE SELECTION

a. JGMESB

(1) The JGMESB is convened annually to evaluate and recommend applicants for training positions in military GME programs and non-DoD training positions with DHA sponsorship.

(2) The JGMESB is convened under the authority of the ASD(HA), DHA, and the MILDEP SGs.

(a) The ASD(HA) will publish annually the Rules of Engagement for conduct of the board, to include:

1. Board membership
2. Dates and locations
3. Procedures
4. Administrative support

(b) The DHA will host the JGMESB annually:

1. Publish the JGMESB convening notice.

2. Coordinate administrative responsibilities with MILDEP GME offices.

(c) The MILDEPs will annually publish instructions and guidance on its Service-specific conduct of the board, to include:

1. Appointment of MILDEP board president
2. Policies and procedures for filling training slots left vacant at the conclusion of JGMESB
3. MILDEP-specific eligibility requirements

(3) At the JGMESB, the MILDEPs' SGs or their designees will select applicants for GME positions in accordance with their annual training plan.

(a) Alterations in the specific numbers for each specialty are permitted during the JGMESB, but MILDEPs' SGs and the Under Secretary of Defense for Personnel and Readiness will be briefed on any changes to the numbers and mix of specialties made by the board.

(b) Application process

1. Applications for GME positions will be submitted as directed by MILDEP instructions. Submission of applications, including, but not limited to, information required to be submitted and timeline for being submitted, will be in accordance with MILDEP instructions.

2. If directed by MILDEP instructions, applications will be submitted to non-DoD programs via the Electronic Residency Application Service or other systems as directed by civilian residency match authorities. Acceptance to a non-DoD program does not guarantee placement in the non-DoD program; placement will be subject to needs of the MILDEP as determined by the JGMESB.

3. The MILDEP instructions will include guidance for the conduct of applicant interviews, including, but not limited to, what documentation may/may not be provided, what information may/may not be requested, and what questions are specifically prohibited, if any.

b. Trainee Eligibility

(1) Current MC Officers, with or without an Active Duty Service Obligation (ADSO), are eligible, subject to MILDEPs' eligibility requirements.

(2) Current medical students or graduates of a school within the United States and its territories that is accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation Service are eligible if they have a current ADSO from Reserve Officer Training Corps, Military Academy, Health Professions Scholarship Program, USUHS, U.S. Public Health Service, and/or other MC accession program.

(3) If desired, the MILDEPs may permit, as a new accession to its MILDEP, any physician who has successfully completed at least one year of GME at an ACGME-accredited program to be eligible in accordance with MILDEP-specific accession policy. If applicable, candidates must be certified by the Educational Commission for Foreign Medical Graduates.

6. SI

a. An SI is the organization or entity that assumes the financial and academic responsibility for a GME program consistent with ACGME institutional requirements.

(1) SIs and participating sites may encompass inpatient and outpatient settings including, but not limited, to universities, medical schools, teaching hospitals, etc.

(2) In the MHS, this is generally the MTF or a consortium of geographically co-located MTFs within a single DRO.

b. The DIO is the academic leader for GME at the SI. Some SIs have more than one facility. If desired, SIs may appoint DMEs to assist the DIO, e.g., one at each MTF under an SI.

c. Each SI must have a Graduate Medical Education Committee (GMEC), in accordance with ACGME Institutional Requirements. The GMEC provides an organized administrative system to oversee all GME at the SI.

(1) A GMEC may use subcommittees to directly advise the DIO.

(2) SI may also choose to use the GMEC to oversee all Graduate Health Professions Education (e.g., Psychology, Dental, Nurse-Anesthetist), as per locally established policy.

(3) GMEC membership consists of the following:

(a) The DIO (Chair)

(b) Any personnel required by ACGME institutional requirements.

(c) Any personnel required to oversee non-physician training, if these responsibilities are added by the SI.

(d) Any personnel as per the SI.

(4) The GMEC is responsible for activities as described in current ACGME institutional requirements.

(5) If the GMEC also oversees other Graduate Health Professions Education programs as per local policy, the GMEC will be responsible for oversight activities as described in these programs' accreditation requirements.

d. SI and DIOs will develop policies and procedures to maintain compliance with ACGME SI requirements, as appropriate.

e. The SI must identify a governing body, which is the single entity that maintains authority over and responsibility for the SI and each of its ACGME-accredited programs. Membership of the governing body must meet current ACGME guidance.

7. DIO/DME SELECTION

a. The selection of the most qualified candidate to become the DIO/DME of a MHS SI is essential to producing a quality clinical learning environment and in training graduates that will meet the MILDEPs' operational needs.

b. Each DIO/DME selection will be conducted in accordance with local policies and procedures with the utmost transparency and fairness, in full accordance with all DoD values, including equal employment opportunity, diversity, equity, and inclusion principles. Additionally, this process will ensure conformity with applicable accrediting body requirements, such as those of the ACGME.

c. The SI DIO/DME will notify the MILDEP GME office(s) and the DHA GME office of their intention to leave the DIO/DME position. Ideally, this should occur early in the academic year that the DIO/DME intends to depart the position.

d. For military DIO/DME positions that become available, the site will determine, in coordination with the appropriate MILDEP GME office(s), specific criteria for the position and advertise the position through these offices. The MILDEP GME office(s) may assist in managing applications, notifying the site of qualified applicants and approving any applications if there is no MILDEP billet at the site.

e. For civilian DIO/DME positions that become available, the same process as above applies, but must also be done in coordination with the appropriate civilian personnel office. This office must review any civilian applicant's eligibility to apply for the position and subsequently perform the hiring action for the selected individual.

f. The site will notify the MILDEP GME office(s) that a selection has been made.

g. For military DIOs/DMEs, the tenure will ordinarily be for a minimum of five years to allow for necessary continuity and an optimal training environment.

8. PD SELECTION

a. The selection of the best candidate to become the PD of a DoD GME program is essential to producing graduates that will meet the MILDEPs' operational need.

b. Each PD selection will be conducted with the utmost transparency and fairness, and in full accordance with all DoD values, including equal opportunity (EO), equal employment opportunity, diversity, and inclusion principles. In addition, this process will ensure conformity with applicable program accreditation body requirements, such as those of the ACGME.

c. The following will be adhered to for the selection of all MHS PDs:

(1) Current PD will notify the SI DIO/DME of intent to leave the PD position. Ideally, this should occur early in the academic year that the PD intends to depart the position.

(2) The SI DIO/DME will consult the GMEC and others in the SI leadership per local policy to determine whether the PD search should be restricted to only the MILDEP (s) with billets at the SI or open to all MILDEPs.

(3) The SI DIO/DME will notify the appropriate MILDEP office(s) and the DHA GME office. The MILDEP's office will be the office designated by the MILDEP, e.g., Corps Chief or GME office, to manage applications. The MILDEP office must approve, as per policy, to permit applications when there is no MILDEP billet at the SI. If a SI DIO/DME would like to request civilian PD applicants, the request must be approved by the GME IAB. Military applicants will fill these positions unless a qualified military applicant is unavailable. Additionally, local personnel offices will need to review any civilian applicants to ensure eligibility to apply for the position.

(4) Within 10 business days of official notification or within a mutually agreed upon time frame, the effected MILDEP GME office(s) and the SI DIO/DME will co-develop a PD job announcement.

(a) The announcement will include at a minimum the position title, location, expected start date, eligibility criteria (to include specialty specific ACGME qualification requirements), and application submission instructions.

(b) Instructions for submitting an application will include at a minimum the required submission of a letter of intent, curriculum vitae, recent MILDEP-specific Officer Record Brief, and an endorsement from the applicant's Specialty Leader/Consultant of meeting the minimum requirements. Additional materials may also be submitted (e.g., letter of recommendation) as per SI policy.

(c) Letters of intent will include the rationale for applying for the position and perceived strengths, a statement of intention to serve four years or the length of training plus one year (whichever is longer for that specialty), and a statement that the applicant will accept the position if selected.

(d) All application materials will be submitted to the applicant's MILDEP office. Applicants will have a minimum of 10 business days to submit the application package.

(5) The MILDEP office will collect all application packets from their MILDEP, review for completion, and then forward to the respective Specialty Leader/Consultant and others (e.g., Human Resources Command) as per MILDEP policy. Within 10 business days, each MILDEP office will complete reviews of all applicants from his/her MILDEP. The MILDEP office will determine which applicants are or are not qualified based on the following criteria:

(a) Academically qualified, as per ACGME or other accrediting body criteria where applicable. Applicants with small deviations from the ACGME criteria will be permitted to continue, as the ACGME may occasionally grant waivers.

(b) Eligible for Permanent Change of Station to the PD position, as the officer is both authorized to Permanent Change of Station and a MILDEP-specific billet will be available.

(c) Appropriate for significant leadership positions, as per MILDEP-specific record review and Specialty Leader/Consultant endorsement.

(d) If the applicant is selected, he/she is able to serve for four years or the length of the training program plus one year (whichever is longer for that specialty). For applicants whose ADSO is less than the duration of being a PD, it will be assumed at this stage of analysis that the applicant will extend on active duty, unless the extension will take the applicant beyond mandatory retirement.

(6) Once all reviews are completed, MILDEP offices will forward the packets of all qualified applicants to SI DIO/DME. This notification should include any reservations from the Services. Service offices will inform unqualified applicants that they will not be considered for the position. Services are not obligated to submit any applicants.

(7) Once the SI DIO/DME has received the application packets, he/she will select the new PD via local policy. This policy must adhere to the following:

(a) Compliance with ACGME requirements.

(b) The SI DIO/DME must use a selection committee to generate an Order of Merit List (OML). The SI DIO/DME or designee must appoint the committee. This committee must consist of a committee chair, at least one faculty member from the SI, a local leader in the specialty (the faculty member and local Specialty Leader may be the same person), at least two academic leaders outside the department, and at least one peer-selected trainee. The committee chair can fulfill more than one role. The DIO/DME and outgoing PD may be members of the committee. The two academic leaders outside the department may be from within or outside the institution. The peer-selected trainee(s) must come from the program unless the SI DIO/DME determines it would be more appropriate for a trainee outside the program to be a committee member. Last, there should be a member of the committee of the same MILDEP for each applicant.

(c) All applicants must be reviewed. A record-only review may be used if the selection committee has objective criteria established (e.g., a minimum number of publications

for programs where the ACGME has PD scholarly activity requirements) prior to review of the applicant's packets to decide whom to interview.

(d) The selection committee's work must be approved by the SI GMEC and SI Governing Body (or designee) as per local policy.

(8) Within 10 business days of approval of the selection, the DIO/DME will inform each MILDEP office that provided an applicant and the DHA GME office of the selection. The MILDEP of the selectee will then follow MILDEP policy to adjust personnel records, generate orders, etc., as appropriate. The minimum appointment will be the length of training plus one year, with a minimum of four years for programs less than three years in length.

(9) In the event a newly selected PD is unable to start or must step down soon after starting the position, the selection committee's OML is valid for six months from the date of approval of the selection. The SI DIO/DME would then present the next person on the OML for approval as above, with an additional request to the MILDEP for re-evaluation of the new selectee's eligibility to take the position.

9. PD LENGTH OF DEPLOYMENT

a. Participation in deployment by PDs and other faculty is valuable for the successful execution of operational missions and ensures that experiences obtained from missions are incorporated into each MUC.

b. The length of time PDs are deployed will be in accordance with the parent MILDEP policies and procedures.

c. PD deployment length should be kept to the minimum amount of time possible so as not to disrupt the training program.

d. PD deployment should not be so frequent as to disrupt continuity of program leadership and training.

e. Designation of an Interim PD will be at the discretion of the SI DIO/DME.

10. SI REPORTING REQUIREMENTS TO MILDEP GME DIRECTOR AND GME-IAB

a. Circumstances requiring reporting:

(1) Change of leadership: DIO/Dean

(2) Any accreditation decision other than continued accreditation.

(3) If the institution invokes the ACGME Disaster/Extraordinary Circumstances or similar Policy due to natural disaster or other catastrophic event such as loss of The Joint Commission accreditation.

(4) Notification of formal complaints received by the ACGME that require a response. Details of the complaint will not be shared with the GME-IAB if not appropriate, such as an ongoing investigation.

(5) ACGME Letters of Notification: Institutional or Program Citations

(6) Shortages in the number of faculty or type of subspecialty faculty that result in program being below the minimum number of required faculty that cannot be resolved at the SI level.

(7) Significant loss of funding from MILDEP/DHA that can impact accreditation status.

(8) Death of a Trainee or PD.

(9) Other communications which in a SI DIO/DME's judgment would be important/appropriate to refer to the MILDEP GME Director and GME-IAB.

b. Process and Standards for Reporting:

(1) Communication with the GME-IAB through the MILDEP GME Director(s) should take place prior to communicating with the ACGME or other accrediting body in the following cases:

(a) Permanent complement changes:

1. Voluntary request by program to permanently reduce trainee complement.
2. Requests for permanent increase in complement.

(b) Requests for new programs (GME accredited and GME non-accredited).

(2) Reporting by the DIO/DME to the GME-IAB through the MILDEP GME Director(s) should occur within 14 calendar days.

(3) The GME-IAB will provide guidance and assistance to the affected DIO, as appropriate.

(4) The GME-IAB will inform the GME-OAC of significant findings appropriate for their oversight.

11. ASSESSMENT OF PROGRAMS

a. Individual GME Program assessments

(1) The ACGME, the American Board of Medical Specialties (ABMS), and other accrediting bodies will conduct assessments in accordance with their policies and procedures.

(2) Results of any accrediting body decisions of program accreditation status must be sent to the GME-IAB through the MILDEP GME Director(s). The GME-IAB will determine the specific data elements and frequency of reporting.

(3) DIOs/DMEs or designees may perform additional reviews of programs.

(4) PDs will conduct annual reviews of their programs as per ACGME policy.

(5) PDs will conduct reviews of their programs' TAs no less than midpoint or near the anniversary of its effective date in its entirety as per Reference (j).

b. SI assessments

(1) The ACGME (e.g., Clinical Learning Environment Review and accreditation site visits) and MILDEPs will conduct assessments as per their policies and procedures.

(2) Results of any accrediting body decisions of SI accreditation status must be sent to the GME-IAB through the MILDEP GME Director(s). Non-DoD SIs must report this information through the market GME liaison, and this requirement must be described in the TA. The GME-IAB will determine the specific data elements and frequency of reporting.

(3) DIOs will conduct an Annual Institutional Review as per ACGME policy.

c. Ad hoc Assessments. The GME-IAB may conduct additional assessments of programs and institutions as deemed necessary.

12. DIVERSITY, EQUITY, AND INCLUSION

a. MHS SI and GME programs will engage in practices that focus on mission-driven, on-going, systematic recruitment and retention of a diverse inclusive workforce of trainees, faculty members, senior administrative staff members, and other relevant members of the academic community.

b. MHS GME programs must have activities that support advancing diversity, equity, and inclusion in the program.

13. STATE OF EMERGENCY

a. DIOs/DMEs of facilities impacted by a state of emergency caused by a natural disaster or other catastrophic event will inform DHA/MILDEP GME leadership and ACGME as soon as reasonably possible. Non-DoD SIs must report this information through the market GME liaison, and this requirement must be described in the TA.

b. MILDEP GME leaders and affected DIOs/DMEs will conduct an analysis and discuss at the GME-IAB.

c. If it is necessary to relocate trainees, the affected DIO/DME, in conjunction with the GME-IAB and MILDEP of the affected trainees, will develop a plan that allows the trainees to complete their training while simultaneously supporting the trainee and their family, supporting MILDEP preferences, and following accreditation policies.

d. The GME-IAB will brief the GME-OAC on the long-term impact of the state of emergency, if any.

14. CURRICULUM

a. The PD will be responsible for the development of a progressive, comprehensive curriculum. Each program's curriculum must have overall aims that describe the desired distinctive capabilities of its graduates as MC Officers.

b. The curriculum must meet the ACGME, ABMS, and/or other governing body requirements, as applicable.

c. Each educational experience must have competency-based goals and objectives designed to promote progress on a trajectory to autonomous practice, in accordance with accrediting body requirements.

d. MUC describes the integrated educational activities for trainees to learn and apply their specialty expertise to the scope of practice required for expeditionary medicine and unique issues of the MHS patient population. This also includes key administrative aspects of military medicine and acculturation into the MC.

(1) All GME programs are required to have a MUC. The contents of the curriculum are MILDEP and specialty specific.

(2) MUC curriculum may require training outside of an MTF for satisfactory completion. Training can be accomplished through military training courses, specialized training laboratories (e.g., anatomical labs), or civilian programs with appropriate patient population and TA.

e. For some programs, it may be necessary for trainees to travel for clinical rotations and/or experiences required to meet ACGME and/or MUC requirements. When PDs identify a need

and the GMEC confirms that outside clinical rotations and/or experiences are required to meet ACGME requirements, Directors must budget and provide the funds for this travel.

15. RESEARCH/SCHOLARLY ACTIVITY

a. Research/scholarly activity is a requirement for ACGME accredited programs.

b. ACGME defines evidence of research/scholarly activity as the following: publication with a PubMed identification number, other publications, conference presentations, other presentations, textbook chapters, grant leadership, leadership or peer-review role, and formal courses.

c. Programs are encouraged to align research/scholarly activity projects to address issues of military importance.

d. Research/scholarly activity conducted by trainees must be performed under the supervision and direction of qualified faculty.

e. Research/scholarly activity must follow all applicable MHS and MILDEP research regulations as per Reference (i).

f. Animal use for research is governed by References (e) and (h).

(1) GME training programs and trainees will comply with policies, procedures, and responsibilities for the care and use of animals as specified in Reference (e).

(2) The use of live animals in GME, whether for research or for training, will be minimized in accordance with References (e) and (h) and only used when alternatives such as commercial training simulators, manikins, and moulaged actors and cadavers are deemed insufficient for the required training or not available as specified in References (e) and (h).

g. Program trainees and faculty are encouraged to prepare research/scholarly activity project results for publication in peer reviewed journals and presentation at educational conferences as per ACGME and ABMS requirements.

16. TRAINEE SUPERVISION

a. All trainee activities must be supervised in accordance with the TA, ACGME standards, and institutional and program policies. The attending physician is ultimately responsible and accountable for the care of the patient.

b. DIO/DME and PDs are responsible for ensuring a safe learning environment for trainees, faculty, staff, and patients.

c. The ACGME definitions written below for the levels of supervision are current as of 1 July 2020. In the event these definitions are changed by the ACGME, but before this DHA-PI is updated, the newest ACGME version will supersede the definitions written below.

(1) Direct supervision: The supervising physician is physically present with the resident during the key portions of the patient interaction; or the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

(2) Indirect supervision: The supervising physician is not providing physical or concurrent visual or audio supervision, but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.

(3) Oversight: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

d. Post-graduate year (PGY)-1 trainees must be directly or indirectly supervised unless otherwise explicitly specified by the individual specialty training requirements of the ACGME.

e. Direct supervision can be provided by a more senior trainee or a physician/privileged provider as specified in the program-specific ACGME Program requirements. Supervision at a non-DoD SI must be in accordance with the TA.

f. To promote oversight of resident supervision, while providing for graded authority and responsibility, PDs must establish which level of supervision, as defined above, is appropriate for a particular educational experience. Institutions and PDs must balance the need for increasing autonomy that residents require to eventually achieve independent practice with the need for safe patient care and appropriate resident supervision.

g. PDs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).

17. CLINICAL AND EDUCATIONAL WORK HOURS

a. Institutions and programs must develop and abide by policies that are consistent with current accreditation requirements.

b. Compliance will be monitored by PDs and the SI.

c. Follow applicable MILDEP policy with respect to off-duty employment by trainees.

18. INDIVIDUAL TRAINEE EVALUATIONS AND RECORD MANAGEMENT

- a. MILDEP-specific officer performance evaluation (e.g., Officer Evaluation Report, Fitness Report, or Training Reports) will occur in accordance with MILDEP regulations to document job performance, officership, and military career progression.
- b. Academic evaluations will occur in accordance with ACGME Common Program Requirements.
- c. PDs will appoint Clinical Competency Committee(s) (CCC) to assist in trainee evaluations in accordance with ACGME guidelines.
- d. Communication of evaluations to trainees will be conducted in person when reasonably possible and documented, with trainee acknowledgment, in the trainee's training record.
- e. Trainee records will be stored in a secure area to prevent loss and to ensure confidentiality.
- f. Trainee records will be retained in accordance with MILDEP policy, ACGME requirements, and state laws, as applicable.
- g. Final Summative Evaluation must be completed by the PD at the conclusion of any period of training using the DHA Form 165, Graduate Medical Education Final Evaluation.

19. PHYSICAL FITNESS AND BODY COMPOSITION STANDARDS

- a. Trainees serving in active duty GME programs are required to maintain physical fitness standards as determined by MILDEP affiliation (see References (l), (o), and (q)).
- b. Military trainees serving in non-DoD facilities may be required to pass MILDEP-affiliated fitness standards in accordance with associated MILDEP regulations.
- c. Actions for trainees that do not meet physical fitness and/or body composition standards are deferred to the MILDEPs.

20. LICENSING EXAMINATIONS AND MEDICAL LICENSES

- a. The requirement for and timing of passing licensing examinations (United States Medical Licensing Examination or Comprehensive Osteopathic Medical Licensing Examination) is deferred to the MILDEPs. The consequences for trainees who do not complete a licensing examination as per MILDEP policy is deferred to the MILDEP.
- b. The requirement for and timing of obtaining an unrestricted medical license is deferred to the MILDEPs in accordance with Reference (d). The consequences of trainees who do not obtain an unrestricted medical license as per MILDEP policy is deferred to the MILDEP.

c. Trainees may be required to obtain a medical training license as per state laws and/or regulations.

21. TRAINEE AND FACULTY PROFESSIONAL DEVELOPMENT

a. Professional Meetings and Courses

(1) Attending courses and training permit faculty and trainees to learn new skills and/or present original research. When attending meetings, conferences, courses, or when on orders, faculty and trainees must adhere to MILDEP policy when wearing military uniform.

(2) Directors must budget and fund travel for these activities to the extent required to meet the ACGME and ABMS scholarly activity requirements of the program(s).

(3) Directors are strongly encouraged to budget and fund for travel to national conferences that will increase the visibility and leverage the reputation of their GME programs, even if the minimal scholarly activity requirement has been met.

b. Faculty Development. DIOs/DMEs and PDs must plan for faculty development as per current ACGME requirements. If funding is needed, Directors must budget for it.

22. LEAVE, PASSES, AND LIBERTY

a. The background for leave, passes, and liberty considerations consist of the following:

(1) Trainees must be actively training for a specified number of weeks per year in order to meet the requirements of the training program, board certifying bodies, and/or accrediting bodies to develop competency in the specialty.

(2) Trainees must be permitted vacation time and sick leave each year as part of their personal wellness.

(3) Some trainees will have health or personal issues that require additional time away from training.

(4) Trainees will abide by their MILDEP's leave and liberty policy.

b. The ABMS has specialty-specific standards for what experiences count toward training and how many weeks per academic year trainees must be actively training.

c. Activities that count as in training and progressing toward completion of training include: clinical rotations, research rotations, attendance at medical conferences, military medical training (e.g., Combat Casualty Care Course), and normal days off as part of a rotation. Days off during federal holidays and training holidays count as time in training, unless the trainee has requested

leave. A pass/liberty during a federal/training holiday is considered in training, unless the rotation would have required duty during those days.

d. Activities that count as out of training consist of sick days, vacation leave, emergency leave, parental leave, permissive Temporary Additional Duties/Temporary Duty Travel for non-training purposes (e.g., house hunting), and leave of absence. As above, a pass is considered out of training only when the days missed are typical working days of the rotations.

e. The procedures for leave, passes, and liberty consist of the following:

(1) Final approval remains with the local Command as per current MILDEP regulations.

(2) Processes for requesting and taking leave, passes, and liberty must be described by the Command, SI, and Program.

(3) When considering these requests, PDs must ensure that trainees meet the ACGME and ABMS clinical experience and procedural standards to become board-eligible upon graduation.

(4) PDs must notify the trainee in writing if the leave requested would likely result in extension of training as the trainee would not be able to meet the ACGME and or ABMS standards to become board-eligible without an extension in training.

(5) PGY-1: All trainees must be actively training for at least 48 weeks per year, regardless of specialty.

(6) PGY-2 and above: The amount of time actively training is determined by the ABMS specialty-specific standards. If no ABMS standard is described, the minimum actively training time is 48 weeks per year.

(7) Any leave requests beyond four weeks per year, except emergency, maternal, or paternal leave, is solely at the direction of the PD or designee to authorize (and the Command to approve).

23. ABSENCE FROM TRAINING

a. Definition. An absence from training is a period in which the trainee remains within the program but is not actively training and not progressing toward graduation. They are not adverse academic actions. Leave, passes, and liberty are not included in the definition of absence from training. There are two types of absences from training: health related and administrative related.

b. Health-Related Absence from Training (HRAFT)

(1) A HRAFT is a period in which the trainee remains within the program but is not actively training and not progressing toward graduation. It is used for trainees when they have a

health condition (medical, psychiatric, and/or substance use disorder) that impairs their ability to safely care for patients and/or fully participate in the academic aspects of the training program.

(a) Brief periods of illness should be taken as sick leave, not a HRAFT, with notification of the PD or designee as per local policy.

(b) A HRAFT is to be used for an extended absence, such as when a trainee may require an extension in training to meet program requirements due to a health condition.

(2) A trainee must be under the care of an attending physician or an independently privileged provider not in training status in order to be placed on a HRAFT. The trainee maintains the right to privacy, beyond the specified restrictions to patient care, except as required by MILDEP regulation. To place a trainee on a HRAFT, a PD would make a recommendation to the DIO, who has the approval authority.

(3) Once on a HRAFT, trainees must have a recommendation from a treating provider (which can be communicated directly from the treating provider, via an impaired provider committee, or via the trainee's primary care provider) to return to full-time training. To remove a trainee from a HRAFT, a PD would make a recommendation to the DIO, who has the approval authority.

(4) DIOs must inform the MILDEP GME office when trainees are placed on and complete a HRAFT, including changes in graduation dates, as appropriate.

(5) Health conditions that may render the trainee unfit for service may be subject to a fitness for duty evaluation resulting in a medical evaluation board for determination of continued service, as per MILDEP regulations. If trainees are discharged from their Service due to a health condition, they are removed from training as well. This removal from training is non-adverse.

(6) The maximum duration of a HRAFT is one year (365 days). Trainees will automatically be removed from training should the HRAFT reach one year, unless a waiver is granted by the MILDEP GME office. This one year is cumulative of all HRAFT until the trainee has one consecutive year (365 days) without being placed on a HRAFT.

(a) For example, if a trainee is on a HRAFT for nine months, returns to training for one month, and then is placed back on a HRAFT, the trainee will be removed from training if the second HRAFT is longer than three months.

(b) Trainees who are being removed from training as their HRAFT exceeds one year may appeal to the DIO. DIOs must consult with the MILDEP GME office as part of the appeal. Removal from training due to reaching the maximum duration of HRAFT is non-adverse. The MILDEP GME office must be informed of the trainee's removal.

c. Administrative Related Absence from Training (ARAFT)

(1) An ARAFT is a period in which a trainee remains within the program but is not actively training and not progressing toward graduation. It is used when a trainee does not meet DHA or MILDEP-specific regulations/policies that require a temporary removal from training or a personal circumstance where ordinary leave would not be appropriate, such as when a trainee does not meet physical fitness standards, is awaiting outcome of legal decisions, is undergoing investigation, is attending to a prolonged illness in a family member, etc.

(a) When a trainee presents a potential danger to themselves, others, and/or their patients, PDs will place them on an ARAFT. While on this ARAFT, the trainee is removed from active participation in the program to include direct patient care, academic activities, and/or research activities. The ARAFT ends when an evaluation of the events concludes it is now safe for the trainee to resume participation in the program.

(b) If the evaluation results in an adverse academic action (academic probation or termination), then this ARAFT is termed a suspension.

(2) To place a trainee on an ARAFT, a PD would make a recommendation to the DIO, who has the approval authority. MILDEP GME offices may require DIOs to place a trainee on an ARAFT as per MILDEP policies. DIOs must inform the MILDEP GME office when trainees are placed on and complete an ARAFT, including changes in graduation dates, as appropriate.

(3) To remove a trainee from an ARAFT, a PD would make a recommendation to the DIO, who has the approval authority. For those trainees who were placed on ARAFT as per MILDEP Policy, DIOs must seek guidance from the MILDEP GME office prior to removal from ARAFT.

(4) The maximum duration of an ARAFT is one year (365 days), unless a MILDEP regulation or policy permits a longer ARAFT. Trainees will automatically be removed from training should the ARAFT reach one year. This one year is cumulative of all ARAFT until the trainee has one consecutive year (365 days) without being placed on an ARAFT.

(a) For example, if a trainee is on an ARAFT for nine months, returns to training for one month, and then is placed back on an ARAFT, the trainee will be removed from training if the second ARAFT is longer than three months.

(b) Trainees who are being removed from training as their ARAFT exceeds one year may appeal to the DIO. DIOs must consult with the MILDEP GME office as part of the appeal. Removal from training due to reaching the maximum duration of ARAFT is non-adverse. The MILDEP GME office must be informed of the trainee's removal and must be consulted prior to removal from training due to not meeting a MILDEP Policy.

24. ACCOMMODATIONS FOR TRAINEES WHO ARE PREGNANT OR LACTATING

a. The physical demands of GME may exceed what is recommended for a pregnant trainee at certain stages of her pregnancy. These include, but are not limited to, length of work shift, heavy

lifting, standing for long periods of time, exposure to infectious agents, and exposure to chemotherapy or radiation.

(1) DIOs/DMEs/PDs must develop a safe work schedule for the pregnant trainee by balancing MILDEP regulations, ACGME requirements, and clinical guidelines for the management of pregnancy per the trainee's provider and the trainee's goals.

(2) A pregnant trainee must always consider not only the health of herself and her fetus(es) but also her ability to safely provide patient care. Should she notice that she cannot deliver safe patient care within the current work conditions, she is required to notify her PD or designee immediately so that her work conditions may be adjusted.

(3) PDs must provide adequate time and patient care coverage for a pregnant trainee to attend clinical appointments related to her pregnancy.

b. Some trainees will choose to breastfeed their newborn. PDs will support lactating trainees in accordance with DHA/MILDEP regulations and ACGME requirements.

25. TRAINEE PROGRESSION TOWARD PROGRAM COMPLETION, INDIVIDUALIZED LEARNING PLANS, AND IMPROVEMENT PLANS

a. PDs will monitor trainees' progress toward acquiring the requisite KSAs to achieve program completion, as outlined by the program's curriculum, as well as MILDEP, ACGME, ABMS, and other certifying body(s) requirements.

b. GME is primarily based on the experiential learning model. This model requires trainees to reflect on experiences, make changes and/or reinforce effective behaviors, and improve over time to successfully complete their training program.

c. Periodic feedback is provided to trainees throughout the training program to improve performance and assist in program completion. GME trainees should receive corrective and reinforcing feedback throughout the individual educational experiences, at the end of the education experience (or the minimum frequency required by ACGME) and at least semiannually in formative feedback sessions by the PD or designee. Evaluations and feedback at the end of educational experiences and after formative feedback sessions by the PD or designee must be documented and acknowledged by the trainee.

d. To assist trainees in completing the curriculum and requirements while incorporating feedback, all trainees are required to have an individual learning plan (ILP). Each trainee and their PD or designee will develop and periodically update their ILP.

e. Trainees' knowledge, skills, and/or abilities may, at some point during their training, be below an expected milestone for their level.

(1) DIOs, DMEs, and PDs must recognize that their duty is to society first, in that graduates of MHS programs must be able to provide safe, appropriate care to their patients in their future practice.

(2) To address these issues, there is generally a step-wise approach. This begins with corrective feedback, followed by an update to the ILP, and then an improvement plan. However, depending on the nature of the issue(s), it may be appropriate to go directly to ARAFT, probation, or termination as the initial action.

(3) For trainees with performance problems, it is common that a health condition (e.g., medical, psychological, substance use) or external stressors (e.g., family, social, financial issues) could be potential contributing factors. PDs should advise any trainee being considered for a written individualized improvement plan or adverse academic action of available resources to assist with any such contributing factors, should the trainee wish to pursue assistance.

(4) For trainees being considered for an improvement plan or adverse academic action, PDs may implement changes in clinical supervision and/or evaluations of the trainee at any time, regardless of whether or not an improvement plan or adverse action has been drafted, proposed, or approved.

(5) The MILDEPs retain responsibility for processing trainees due to any alleged Uniform Code of Military Justice violations.

f. An improvement plan is an augmentation to a trainee's ILP designed to improve a trainee's performance that may or may not be on a trajectory to meet program milestones and/or graduation requirements. As it is part of the normal feedback process, it is neither a condition nor a restriction beyond what is generally associated with training at an MHS GME program. The intent is to assist trainees who, if they do not improve, might be at risk of probation, termination, or failure of specialty board examination after training. Ultimately, this process, using structured, written feedback, is designed to provide a supportive learning environment to improve the trainee's performance.

(1) The PD and/or designee will develop an improvement plan that identifies what is necessary for a trainee to improve performance. PDs and/or designees are encouraged to collaborate with the trainee to develop the improvement plan, where appropriate. The improvement plan must document what areas are in need of improvement, what support will be provided, what is required of the trainee, the timeline, and the metrics that will be used to determine success of the improvement plan. A copy of the improvement plan, signed by both the program representative and the trainee, will be kept in the trainee's training file.

(2) As improvement plans are augmentation to ILPs, there is no limit to the number of times a trainee can be placed in one, nor is there a set duration. Should the improvement plan be completed successfully, it is not required to be reported at any level above the program. An improvement plan is not considered a negative report in the trainee's file. Should the trainee not meet the metrics of successful completion of the improvement plan, the PD or designee and CCC must discuss whether to continue the improvement plan or consider an adverse academic action.

(3) As improvement plans are part of the normal feedback process of an MHS GME program, trainees may not appeal being placed in an improvement plan.

g. If the trainee cannot meet the requirements to graduate on time due to hospital system factors, (e.g., lack of clinical cases, temporary or permanent closure of the medical facility) the trainee may be extended in training without an adverse academic action.

(1) This training extension is non-adverse.

(2) Whether or not this extension is accompanied with an additional ADSO is deferred to the MILDEP.

26. ADVERSE ACADEMIC ACTIONS: CHANGES IN ACADEMIC STANDING

a. Defined. An adverse academic action is a change in academic standing that is reportable to outside agencies on the DHA Form 165. There are three types of adverse academic actions: probation, suspension, and termination.

b. Probation

(1) Probation is a formal, reportable action beyond what is generally associated with the training in a MHS GME program. Probation is typically considered after a trainee is not successful at completing an improvement plan or performance reverts to unacceptable levels after successfully completing an improvement plan. However, a PD may recommend probation without an improvement plan for a single incident of gross negligence or willful misconduct. PDs should recommend probation when deficiency(s) due to unsatisfactory academic performance, clinical progress, and/or disciplinary problems are to the degree that, if they are not corrected, will likely result in the trainee not completing the training program. See Enclosure 3, paragraph 27 for the process to place a trainee on probation.

(2) The duration of probation will normally be for three to six months, but may be longer.

(3) PDs may extend the trainee's time required for program completion for any amount of time up to the duration of the probationary period. The PD may also determine that no extension is required for program completion. An extension could result in an additional ADSO.

c. Suspension

(1) As stated in Enclosure 3, paragraph 23, one example of when a PD will place trainees on an ARAFT is when the trainee presents a potential danger to themselves, others, and/or their patients while an investigation is conducted.

(2) If the circumstances of that investigation ultimately result in an approved academic probation or termination, the ARAFT is classified as a suspension and is a reportable event on the

DHA Form 165. In addition, the MTF Director may need to consider a clinical adverse action (removal from practice) if the trainee meets criteria in accordance with reference (d).

d. Termination

(1) Termination is removal from the training program prior to program completion. This occurs when events are grievous to the extent it is determined the trainee's continuation in the training program is not conducive to safe medical practice in that specialty. Causes for termination include, but are not limited to, performance below expected levels, ethical issues, safety concerns, failure to promote, and/or unprofessional conduct.

(2) Termination generally occurs when a trainee has had at least one episode of probation/suspension without tangible evidence of remediation by the trainee to perform at a satisfactory level. Termination may also be recommended in the case of a single incident of gross negligence or misconduct without having gone through a period of an improvement plan, probation, and/or suspension (See Enclosure 3, paragraph 27 for details).

(3) The SI DIO/DME will immediately notify the trainee's parent MILDEP GME Director within two business days of a trainee termination from training.

(4) Trainees terminated from a GME program may be subject to an ADSO as per regulation and contract agreement of respective MILDEP.

(5) In addition, the MTF Director may need to consider a clinical adverse action (removal from practice) if the trainee meets criteria in accordance with reference (d).

27. DUE PROCESS FOR ADVERSE ACADEMIC ACTIONS

a. The SI DIO/DME will develop and follow a comprehensive Due Process policy as described below.

b. Adverse academic actions (i.e., probation, suspension, and termination) typically begin when a program's CCC reviews a trainee's educational record and makes a recommendation to the PD. Such recommendations will classify all deficiencies within the context of ACGME competencies.

c. If the PD concurs with the CCC's recommendation for an adverse academic action, the PD will submit proposals for adverse academic actions to the GMEC.

d. The entire GMEC, or subcommittee of the GMEC per SI policy, has the authority to approve or reject adverse academic action proposals made by PDs. At least one trainee representative must be on the committee and present for the voting. The DIO/DME may be a voting member of the committee, but is not required to be. For SIs with more than one program, the committee must include at least one PD not involved in the case.

e. All adverse academic action proposals or plans will be applied in a uniform and fair manner by the GMEC or designated subcommittee in order to avoid any arbitrary or capricious actions.

f. PDs will provide trainees with written notification of a proposed adverse academic action. The written notice must include language indicating that suspension with a conclusive investigation, probation, and/or termination is an adverse academic action and a reportable event.

g. With exception of voting deliberations, trainees have the right to be physically or virtually present. Trainees have the right to provide a written or oral statement during the GMEC or designated subcommittee's review of an adverse academic proposal.

h. DIO/DMEs will specify in SI policy deadlines for trainee response to adverse academic action proposals and scheduling of GMEC or designated subcommittee's review of an adverse academic proposal.

i. Probation proposals will consist of the following elements: deficiencies that are comprehensive, specific, and linked to ACGME competency(s); expectations for improvement that are ACGME competency based; what is needed to make improvement; consequences if goals are not achieved; and timeline for improvement.

(1) If the probation proposal is not approved by the GMEC, the PD will consult with the program's CCC and formulate an alternative plan, as appropriate.

(2) If the probation proposal is approved, the trainee's progress in an approved probation plan will be evaluated by the GMEC or designated sub-committee. The GMEC or designated subcommittee will determine successful completion of the probation plan and when the trainee will return to normal academic training status.

(3) If conditions are not met within the probation time or performance worsens on probation, the PD will consult with the program's CCC and make a proposal for an additional period of probation or termination to GMEC, as appropriate.

(4) As the trainee had the opportunity to participate in the GMEC's or subcommittee's review of the probation proposal, all decisions for probation are final.

j. Regarding suspension, an ARAFT for an investigation can only be labeled a suspension if accompanied by an approved probation or termination action, as described previously in paragraph 26.c of this enclosure. Such investigations will be conducted promptly with the guidance of the DIO/DME, and/or military chain of command, as appropriate.

k. Termination proposals will consist of the following elements: deficiencies that are comprehensive, specific, and linked to ACGME competency(s), summary of previous efforts to improve performance (if applicable), and analyses of why further training in the specialty is not appropriate.

(1) If the termination proposal is approved by GMEC or subcommittee, the recommendation for termination will be forwarded to the head of SI or other final approval authority, as per SI policy.

(2) If the termination proposal is not approved by the GMEC, the PD will consult with the program's CCC and formulate an alternative plan, as appropriate.

(3) Trainee may appeal the decision to the Chair of the SI Governing Body or designee, as per SI policy.

(4) If confirmed, the PD will complete the trainee's final summative evaluation.

(5) The trainee's follow-on assignment is determined by the respective MILDEP.

1. GMEC or subcommittee review hearings for adverse academic action proposals are not bound by the formal rules of evidence or a strict procedural format. The GMEC or subcommittee members may question witnesses and examine documents as necessary. The DHA Office of General Council will provide a non-voting legal advisor to the GMEC.

(1) Trainee rights for review hearing:

(a) Right not to participate in the hearing and/or remain silent.

(b) Right to obtain notice of the grounds for the action

(c) Right to obtain copies of documents to be considered by the GMEC

(d) Right to know who will testify at the hearing

(e) Right to seek military defense counsel or to secure civilian defense counsel at his/her own expense. NOTE: The presence of counsel at the hearing is not an absolute right. Legal Counsel may advise the trainee during the session, but only the trainee may address the GMEC and/or witnesses. Legal Counsel may be excluded from the hearing if counsel's presence unduly impedes the hearing, as per the panel chair's judgment.

(f) Right to present evidence at the hearing

(g) Right to ask questions to those testifying at the hearing

(h) Right to make an oral or written statement in his/her own behalf, if they so choose.

(2) The DIO may authorize a review hearing to be held without the trainee, if the trainee declines being present or does not respond within the SI's timeline to a hearing being scheduled. In this case, all of the same rights apply, except the following:

(a) The right to present evidence is limited to providing written documentation prior to the meeting.

(b) There is no right to ask questions to those testifying at the hearing.

(c) Right to make a statement in his/her own behalf is limited to a written statement provided prior to the meeting.

(3) The trainee will receive notice of these rights; such information will be delivered to the trainee in-person, by official e-mail, or by registered or certified mail, with a return receipt requested.

(4) A record of the summary of the proceeding will be drafted and maintained by the DIO/DME's office. The trainee may request a copy of this summary.

(5) After evidence has been reviewed, the voting members of the GMEC will deliberate confidentially. For probation, the action is approved by a simple majority vote. For termination, the action is sent forth to the higher authority by a two-thirds majority vote.

m. If, during the consideration of probation, suspension, or termination, there are concerns of reckless, malicious, and/or criminal activity by the trainee, the DIO/DME will refer to Reference (d) for guidance.

28. RESIGNATION FROM TRAINING

a. Trainees who wish to resign from their GME program must send a written request to their PD in order to do so. This written request must include the following:

(1) The desire to resign

(2) The proposed date of the resignation. This may be immediately or any date through the end of the trainee's current PGY of training.

(3) Statement that if the resignation is approved, it is irrevocable. The trainee may only re-enter GME through a re-application via MILDEP-approved processes.

(4) Any other language as required by the member's MILDEP

b. The PD is responsible for ensuring the trainee understands the potential for recoupment will be as per the trainee's training contract.

c. The PD will review the trainee request, and then send that request and an assessment to the DIO/DME. This assessment must include the following:

(1) The circumstances of the resignation.

(2) Whether the PD supports the trainee's request, including the proposed date of resignation.

(3) Whether the trainee's performance has been satisfactory up to the time of resignation.

(4) How many months of training have been successfully completed by the trainee.

(5) Whether the trainee will be recommended for future training in the same specialty, a different specialty, or not at all.

d. The DIO/DME will review the trainee request and PD's assessment and mediate any disagreements, if necessary. The DIO/DME may approve the resignation or seek GMEC or GMEC subcommittee guidance.

e. DIOs will provide written notification to the respective MILDEP GME Office of trainees who resign. MILDEP-level GME policy will be reviewed for guidance regarding additional requirements that need to be met for GME program resignation.

f. Trainees who resign may/may not be eligible for further GME in accordance with MILDEP needs and policy.

g. For trainees who resign after being given written notice of a proposal for an adverse academic action, the resignation will be annotated on the summative evaluation as "resigned after receiving written notice of a proposal for suspension, probation, or termination".

29. GRIEVANCE PROCEDURES

a. Trainees may have concerns other than training status. SIs must have a policy and procedure for addressing trainee grievances per ACGME requirements. These procedures should attempt to address the grievances at the lowest level first.

b. MILDEP-specific issues will be addressed via Service-specific channels (i.e., the chain of command).

c. Grievances of an EO nature must be addressed via the servicing EO office (i.e., usually at the local institution), as per MILDEP regulations.

30. REPORTS AND METRICS

a. Reports. DME/DIO will submit reports as required in Enclosure 3, paragraph 10 of this DHA-PI.

b. **Metrics.** The GME-IAB will collect annual metrics of accreditation status, first-time board pass rate of graduates, and other metrics if approved by the GME-OAC.

c. Review of GME Programs. The GME-IAB will conduct a review of GME programs, which must include an assessment of the DoD GME program and recommendations for improvement at least once every 2 years, as per Reference (g). The report will be sent to the ASD(HA), through the Deputy ASD for Health Services Policy and Oversight; the Director, DHA; AD-HCA; and the GME-OAC.

d. Annual training plan. The GME-IAB will collect and consolidate the MILDEPs GME training plans that will be submitted to DHA by 1 July annually, as per Reference (g).

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

| | |
|---------|--|
| ABMS | American Board of Medical Specialties |
| ACGME | Accreditation Council for Graduate Medical Education |
| AD | Assistant Director |
| ADSO | Active Duty Service Obligation |
| ARAFT | Administrative Related Absence from Training |
| ASD(HA) | Assistant Secretary of Defense for Health Affairs |
| CCC | Clinical Competency Committee |
| DAD | Deputy Assistant Director |
| DHA-PI | Defense Health Agency-Procedural Instruction |
| DIO | Designated Institutional Official |
| DME | Director of Medical Education |
| DRO | Direct Reporting Organizations |
| EO | equal opportunity |
| GME | Graduate Medical Education |
| GMEC | Graduate Medical Education Committee |
| HCA | Health Care Administration |
| HRAFT | Health-Related Absence from Training |
| IAB | Integration Advisory Board |
| ILP | individual learning plan |
| J-7 | Education & Training |
| JGMESB | Joint Graduate Medical Education Selection Board |
| KSA | knowledge, skills, and abilities |
| MA | Medical Affairs |
| MC | Medical Corps |
| MHS | Military Health System |
| MILDEP | Military Department |
| MOA | Memorandum of Agreement |
| MTF | military medical treatment facility |
| MUC | Military-Unique Curriculum |
| OAC | Oversight Advisory Council |

| | |
|-------|--|
| OML | Order of Merit List |
| PD | Program Director |
| PGY | post-graduate year |
| SG | Surgeon General |
| SI | Sponsoring Institution |
| TA | Training Agreement |
| USUHS | Uniformed Services University of the Health Sciences |
| VA | U.S. Department of Veterans Affairs |

PART II. DEFINITIONS

Annual Training Plan. A plan made annually by each Military Department listing the number and types of each specialty of physician to be trained.

Complement. The maximum number of trainees approved by a specialty/subspecialty's ACGME Review Committee per year and/or per program based upon availability of adequate resources.

DRO. Small Market and Stand-Alone Medical Treatment Facility Organization, Defense Health Agency Regions.

GME. Didactic and clinical education in a medical specialty or subspecialty that follows the completion of undergraduate medical education and prepares physicians for the independent practice of medicine in that specialty or subspecialty. This education is also referred to as residency or fellowship education. Completion of this education typically results in board eligibility and certification by the national accrediting body for that specialty or subspecialty. This definition also includes other physician graduate professional education in clinical settings that incur an ADSO.

Sponsoring Institution. An entity that oversees, supports, and administers a certain set of ACGME-accredited residency/fellowship programs.

Trainee. The physician participating as a student in the GME program, often referred to as an "intern", "resident", or "fellow", or designated by the year of participation in the program (e.g., "PGY-1).

Unwarranted Duplication. Many specialties have more than one training program across the MHS. Unwarranted duplication of training programs exists when there is excess training capacity above the operational requirements of all three Services, and whose further consolidation is not prevented due to interdependency requirements, limitations on increasing the

ACGME-approved complement level (such as faculty, space, patient volume, or clinical experience) or is not counter to Section 706 of Reference (f).