1. A more comprehensive plan on how many MCs with the informatics ASI were needed in the MC, number currently present and the projected attrition rate. In short, I think they wanted greater justification of the number of people needed per year (perhaps training 2 per year for a specified period of time, then going down to one with a possibility of two) This was both from our command group and John Powers.
	1. The initial manpower assessment to establish the N2 skill identifier set the basic need at 30 personnel (based on officers working in actual, not necessarily TDA authorized, positions in MTFs, MEDCOM and MHS positions. The MC, AN and MS Clinical Corps supported 10 officers for the basic need, knowing that as the skill set matured and was integrated into the organization (AMEDD, MHS) there would be additional officers needed and justified to add to TDA documents. With the establishment of CMIOs at MEDCOM, Regions and MTFs, the need has grown. The number of N2 qualified physicians is 3-4. Based on existing utilization and cross leveling Regions and MRFs, the need is:

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Regional CMIO |  | MTF: |  |  |  | OTSG | JTF CAPMED | MHS |
| ERMC | 1 | 1-LSL | 1-Bavaria |  |  | 1 to 2 | 2 to 3 | 2-3 |
| SRMC | 1 | 1-DDEAMC | 1-BAMC | 1-MACH |  |  |  |  |
| WRMC | 1 | 1-MAMC | 1-EACH | 1-DMC | 1-WBMC |  |  |  |
| NARMC | 1 | 1-WOMAK | 1- |  |  |  |  |  |
| PRMC | 1 | 1-TAMC |  |  |  |  | Total: | 24-27 |
|  |  |  |  |  |  |  |  |  |
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 In addition to the other Corps (nursing is the most robust in terms of staff on hand as well as programmed training). To date, MS clinical personnel are not filling slots to my knowledge.

2) The OTSG GME office wanted to ensure that this wasn't filled with fresh residents and specifically - Paragraph 4(a)(3) should contain verbiage such as "individual should have practiced as an independent provider in board certified specialty for at least as long as it took to complete training, exclusive of internship". That was right from John Powers, so I'd definitely consider adding this.

I believe we stated that the preference would be to have senior Majors, LTC and COL applicants who were seasoned clinically and leaders in their clinical specialties-will check the submission.

3) John Powers suggested a block diagram of the 2 year curriculum as a visual aid, which seemed reasonable.

Will ask CAPT Marshall to flesh this one out as he has a curriculum template.

4) I was very surprised when John Powers said he thought he might be able to scrape up funds for the 22.5K/year/fellow for tuition (he said on another occasion the Long Term Health Education budget was frozen with no increases, even for inflation). He still stated the program director duties and other expenses need to come out of MAMC. The command was hesitant about hiring a GS-15 program director. My sentiment is that given the amount of away learning and the level of maturity of the fellows, if you can find a qualified civilian or military person working for the military now, maybe asking for a number like 0.2 FTE of an existing employee might be palatable and no additional secretarial support needed would be enough to get the command to buy off - all they'd need to contribute at that point is an office for the fellows and a touch of loss of productivity - easier sell. Then you can keep a formally trained fellow here to be the new director.

This is where the correlation to the Faculty Development Fellowship is helpful as they have an assigned director. While we are looking at Army ascensions, the other branches are interested in sending fellows as well (at least the Air Force). There is a position for a continuity CMIO who could establish and run the fellowship that the command has committed to.

 