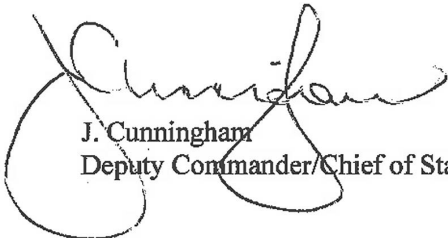


DEPARTMENT OF DEFENSE
HEADQUARTERS, UNITED STATES MILITARY ENTRANCE PROCESSING COMMAND
2834 GREEN BAY ROAD, NORTH CHICAGO, ILLINOIS 60064-3091

USMEPCOM Regulation
No. 40-2

Effective: March 4, 2019
Medical Services
Provider Quality Management Program

FOR THE COMMANDER:



J. Cunningham
Deputy Commander/Chief of Staff

DISTRIBUTION:

Unlimited. This Regulation is approved for public release.

Executive Summary. This regulation encompasses current policy and regulatory guidance for the United States Military Entrance Processing Command (USMEPCOM) Medical Program, Provider Quality Management Program (PQMP). This regulation prescribes USMEPCOM Forms [40-2-1-E \(Medical Provider Initial Application\)](#), [40-2-2-E \(Malpractice and Clinical Privileges History Questionnaire\)](#), [40-2-3-E \(Provider Clinical Assessment and Qualification\)](#), [40-2-4-E \(Contract Provider Quality Management Form\)](#), and [40-2-5-E \(CME Conference/Training After-Action Report\)](#).

Applicability. This regulation applies to all personnel assigned or attached to Headquarters (HQ) USMEPCOM and the Military Entrance Processing Stations (MEPS).

Supplementation. Supplementation of this regulation is prohibited without prior approval of HQ USMEPCOM, ATTN: J-7/MEMD, 2834 Green Bay Road, North Chicago, IL 60064-3091.

Suggested improvements. The proponent agency of this regulation is HQ USMEPCOM, ATTN: J-7/MEMD. Users are invited to send comments and suggested improvements on [Department of the Army \(DA\) Form 2028 \(Recommended Changes to Publications and Blank Forms\)](#) directly to HQ USMEPCOM, ATTN: J-7/MEMD, 2834 Green Bay Road, North Chicago, IL 60064-3091.

Internal control process. This regulation contains internal control provisions and provides an internal control evaluation checklist, in [Appendix E](#), for use in conducting internal controls.

*This regulation supersedes USMEPCOM Regulation 40-2, March 24, 2017.

Summary of Changes

Major revisions have been made to this USMEPCOM Regulation (UMR), changes are in red text. Information that is obsolete and will be deleted is in red text with ~~strikethrough~~.

Incorporating changes effective March 4, 2019

This major revision addresses updates and clarification related to the initial training program and quality maintenance arm of the regulation for the Chief Medical Officers

- Throughout: Changed the word certification to qualification in all areas where certification is referring to the initial training qualification visit in order to standardize the terminology throughout the regulation
- Chapter 4: Addition of a chapter delineating categories of Provider Quality Management Program quality assessments, for Chief Medical Officers (CMO)
- Chapter 5: Clarification added to the initial training program for CMOs
- Chapter 5: Additional naming for the initial training program components for CMOs to include part 1 (training to DPC 2 and DPC 3, 15 day training) and part 2 (qualification visit)
- Throughout: All references to the New CMO Initial Training SOP have been changed to the new title-PQMP SOP where the information resides
- Throughout: Reference to the FBP Initial Training SOP and changed to PQMP SOP, Chapter 8 where this information resides currently
- Chapter 6: Additional details added for the data collection, tracking and reporting for the PQMP components reporting for the Annual Quality Review for CMOs
- Chapter 6: Clarification regarding requalification requirements for CMOs
- Paragraph 6-4: Removal of National Peer Review program reference that was being coordinated by J-7/MEMD, as it has been placed on hold. Clarification added that the local peer review program has been and continues to be active at the MEPS. The Peer Review SOP on SPEAR has been revised and will replace the current SOP and placed on SPEAR with references to the national program removed and minimum requirements added for standardization of the program across the MEPS, but allowing for local accommodations based on variances in the MEPS.
- Chapter 4: Specific requirements for completion of Grand Rounds, Medical Leadership Training Symposium and annual knowledge assessment have been added for CMOs
- Paragraph 7-4: Addition of FBP Quarterly training guidance, formerly in UMR 40-1 has been placed into UMR 40-2
- Appendix G: Addition of abbreviations for Focused Clinical Assessment (FCA) and Ongoing Clinical Assessment (OCA) and addition of qualification visit definition in *Section II Terms*

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Chapter 1 General

1-1. Purpose

The purpose of this regulation is to establish policies and procedural guidance for executing the USMEPCOM Medical Program, Provider Quality Management Program (PQMP) which provides technical management and quality oversight of the USMEPCOM medical provider pool. The PQMP includes an initial professional review prior to a medical provider being hired by USMEPCOM or hired under a contract to work at a MEPS; training of medical providers to provide accession medical services in the specialized area of accession medicine; and maintenance of quality performance.

1-2. References

References are listed in [Appendix F](#).

1-3. Abbreviations and terms

Abbreviations and terms used in this regulation are explained in [Appendix G, Glossary](#).

1-4. Responsibilities

a. J-7 Medical Plans and Policy (J-7/MEMD) Director, will:

(1) Exercise primary staff responsibility and develop policies and procedural guidance for the PQMP.

(2) Ensure the execution and quality of the PQMP and medical provider pool in accordance with (IAW) Commander, USMEPCOM policies.

(3) Approve Defined Provider Category (DPC) levels which define accession medical services a provider is authorized to perform based on demonstrated skill set or competency.

(4) Chair the PQMP Provider Review Panel (PRP) when convened.

b. J-7/MEMD Deputy Director will:

(1) Manage PQMP policies and procedural guidance.

(2) Supervise J-7/MEMD personnel in the execution of the PQMP.

(3) Ensure policies set forth in this regulation are complied with across the Command.

(4) Provide technical subject matter expertise and guidance to all providers subject to the provisions of the PQMP.

(5) Ensure timely completion of all PRP actions.

(6) Sign PQMP technical documents for the Director when absent, sign clinical documents for the Director when both the Director and Clinical Operations Division Chief are absent.

(7) Sign clinical documents when delegated in writing by the J-7 Director.

c. J-7/MEMD Clinical Operations Division Chief will:

- (1) Provide clinical subject matter expertise to the PQMP.
- (2) Manage clinical review of provider initial qualification documents.
- (3) Manage execution of initial and quality maintenance provider review and training including but not limited to review of new/updated qualification documents as well as development of curriculum for medical training seminars, Grand Rounds, and J-7 Director required medical training during MEPS Chief Medical Officer (CMO) Medical Department quarterly training and USMEPCOM Training Days.
- (4) Manage clinical assessment of provider performance issues.
- (5) Coordinate with Sector Deputy Commanders on government provider performance issues requiring command and control oversight from Sector, Battalion, and MEPS Commanders.
- (6) Coordinate with J-1/Human Resources Directorate (J-1/MEHR) on government provider performance issues requiring civilian personnel subject matter expertise and/or intervention.
- (7) Review and update recommended PQMP policies and procedural guidance, as required.
- (8) Manage PRP clinical presentations.
- (9) Sign PQMP clinical documents for the Director when absent, technical documents for the Director when both the Director and Deputy Director are absent.
- (10) Ensure policies set forth in this regulation are complied with across the Command.

d. J-7/MEMD Accession Medicine Branches (AMBs) providers will:

- (1) Provide clinical support to the PQMP.
- (2) Review and assess provider initial clinical qualification documents and recommend provider DPC levels.
- (3) Support MEPS Commanders in hiring actions by reviewing prospective CMO curricula vitae (CV), participating as indicated in candidate interview and providing qualification recommendation to MEPS Commanders.
- (4) Manage and perform PQMP provider training.
- (5) Manage and perform PQMP quality review and performance maintenance.
- (6) Provide clinical expertise for the management of provider performance issues.
- (7) Manage submission of annual clinical performance assessments on CMOs to MEPS Commanders for use in annual appraisals.

(8) Coordinate with MEPS Commanders on government provider performance issues requiring performance improvement plans.

(9) Ensure policies set forth in this regulation are complied with across the Command.

e. J-7/MEMD Clinical Quality Division Chief will:

(1) Provide technical subject matter expertise to the PQMP.

(2) Manage technical and contractual review of provider initial qualification documents and preparation of credentials packages.

(3) Manage development and maintenance of PQMP policies and procedural guidance.

(4) Manage logistics of initial and quality maintenance provider training.

(5) Coordinate with Sector Deputy Commanders on contract provider performance issues requiring command and control oversight from Sector, Battalion, and MEPS Commanders.

(6) Coordinate with J-4/Facilities and Acquisition Directorate (J-4/ MEFA) on contract issues requiring acquisition and contract subject matter expertise input.

(7) Manage PRP technical and contract presentations.

(8) Ensure policies set forth in this regulation are complied with across the Command.

f. J-7/MEMD Clinical Management Branch will:

(1) Prepare and manage government provider PQMP packages.

(2) Provide contracting officer's representative (COR) support to the PQMP including but not limited to ensuring vendor submissions meet contractual requirements, preparing and managing contract provider PQMP packages, and managing contract provider performance issues.

(3) Research credential policies, procedures, and information for applicability/non-applicability for PQMP use.

(4) Develop recommended PQMP policies and procedural guidance.

(5) Provide technical support for medical training including but not limited to management of continuing medical education (CME) credits.

(6) Provide COR and technical support for PRP meetings, including minutes to document actions taken.

(7) Ensure policies set forth in this regulation are complied with across the Command.

g. USMEPCOM Staff Judge Advocate will:

- (1) Serve as the USMEPCOM Commander's principal legal advisor for PQMP.
 - (2) Perform legal reviews for negative DPC decisions and provide results to J-7/ MEMD.
- h. J-1 Human Resources (J-1/MEHR) Director, will:
- (1) Serve as the USMEPCOM Commander's principal civilian personnel advisor for PQMP.
 - (2) Perform civilian personnel reviews for negative DPC decisions for government providers and provide results to J-7/MEMD.
- i. J-4 Facilities and Acquisitions Director, will:
- (1) Serve as the USMEPCOM Commander's principal contract advisor for PQMP.
 - (2) Perform contract reviews for negative DPC decisions and provide results to J-7/ MEMD.
- j. Sector Medical Officers (SMOs) will:
- (1) Serve as the Sector Commander's technical advisor regarding daily medical processing operations for their Sector.
 - (2) Serve under the clinical oversight of the USMEPCOM Command Surgeon/J-7 Medical Plans & Policy Director and will execute functions at the DPC-5 level identified in Section 2-2f.
 - (3) Ensure MEPS personnel comply with this regulation; provide assistance and guidance by articulating published policies but does not interpret policies; forwards new or further interpretation questions/issues to J-7/MEMD for resolution.
 - (4) Serve as a member of all MEPS CMO/Assistant Chief Medical Officer (ACMO) hiring panels.
 - (5) Oversee completion of initial CMO/ACMO/Fee Basis Provider (FBP) at the MEPS level; for FBPs requiring initial training at MEPS with no government providers, SMOs will coordinate with J-7 FBP COR for training scheduling and will not directly contact the FBP vendor.
 - (6) Be clinically evaluated by J-7/MEMD physicians, using UMF 40-2-3 at least annually or more often as determined by the Director, J-7/MEMD. All UMF 40-2-3s will be submitted to the J-7/MEMD Director for review/assessment and inclusion in the provider's credential file.
 - (7) Conduct new CMO ~~certification~~ **qualification** visits after completion of regional trainer initial training and report results using UMF 40-2-3. All UMF 40-2-3s will be submitted to the J-7/MEMD Director for review/assessment and inclusion in the provider's credential file.
 - (8) Clinically evaluate MEPS CMOs at least once every 1-3 years using UMF 40-2-3 or more often as determined by both the Sector Commander and J-7/MEMD Director. All UMF 40-2-3s will be submitted to the J-7/MEMD Director for review/assessment and inclusion in the provider's credential file.

(9) Evaluate the MEPS Medical Department for regulatory compliance when a MEPS visit is made and results will be documented per UMR 25-32 Trip Report format and submitted to both the appropriate Sector Commander and J-7/MEMD Director for review/assessment and inclusion in the provider's credential file.

(10) Collaborate with J-7/MEMD to ensure the quality and standardization of the USMEPCOM Program.

(11) Nominate Regional Trainer candidates and coordinate approval with J-7/MEMD Director; jointly train Regional Trainers with J-7/MEMD staff.

(12) When required by Sector Commander and/or J-7/MEMD Director, evaluate MEPS FBPs for contract compliance; any contract deviations/performance issues will be documented using UMF 40-2-4 and be submitted to the J-7 FBP COR for processing within J-7/MEMD and forwarding to the contracting officer and vendor.

(13) Oversee MEPS local peer review programs to ensure each MEPS executes a viable program.

(14) Manages Annual Quality Review sub-program of PQMP and works with MEPS Commanders within their Sectors to provide clinical inputs/expertise for MEPS CMO civilian employee appraisal processes.

(15) Assists J-7/MEMD with training at the annual Medical Leadership Training Seminar.

(16) Focus on performance/process improvement throughout the USMEPCOM Medical Program, working in collaboration with J-7/MEMD.

k. MEPS Commanders will:

(1) Ensure MEPS personnel comply with this regulation.

(2) Hire CMOs and ACMOs through the local servicing civilian personnel activity IAW the medical requirements of this regulation.

(3) Ensure J-7/MEMD is notified of projected CMO/ACMO vacancies, hiring actions, candidate interview schedules, and projected start dates.

(4) Supervise MEPS CMOs and ensure CMOs are supervising any ACMOs and the MEPS Medical Non-Commissioned Officers in Charge (NCOICs)/Supervisory Medical Technicians (SUP MTs). When Service-specific policies prohibit the CMO position from supervising the NCOIC, the CMO will then supervise the lead medical technician.

(5) Ensure FBP training and administrative requirements are met before allowing an FBP to conduct accession medical services.

(6) Establish and execute a MEPS PQMP Peer Review Program led by the MEPS CMO as described in the PQMP Peer Review Program Standard Operating Procedure (SOP).

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(7) Ensure medical provider initial qualification, training, and performance documents are maintained locally by the MEPS Medical Departments as required in this regulation.

(8) Ensure medical providers are assigned a DPC level and only provide accession medical services in the MEPS IAW their assigned DPC.

(9) Coordinate with SMOs for completion of annual clinical assessments for use in CMO appraisals.

(10) Coordinate with J-7/MEMD AMBs and SMOs on medical provider performance issues to include obtaining clinical inputs for any CMO performance improvement plans.

l. MEPS CMOs will:

(1) Ensure MEPS medical providers comply with this regulation.

(2) Comply with initial medical training requirements directed by J-7/MEMD through the PQMP, as directed by J-7/MEMD in order to obtain DPC-4 as a designated profiling officer to perform physical examinations, evaluations, and profiling of applicants for fitness to enter military service and ~~certification~~ **qualification** visit completed. (See [Paragraph 2-2](#) for information on DPC levels)

(3) Comply with PQMP initial medical training requirements to ensure approved medical providers are fully trained as directed by J-7/MEMD through the PQMP.

(4) Execute the PQMP Peer Review Program for MEPS medical providers, including development of the local process and procedures for implementing peer review locally as outlined in the PQMP Peer Review Program SOP, reviewing the plan with the MEPS Commander, and submitting the plan and any changes to J-7/MEMD for review and approval in meeting PQMP objectives.

(5) Supervise any ACMOs and the MEPS NCOICs/ SUP MTs. When Service-specific policies prohibit the CMO position from supervising the NCOIC, the CMO will provide supervision for the lead medical technician.

(6) Document FBP performance issues and submit to the FBP COR for processing.

(7) Ensure other FBP contractual requirements are met as directed by J-7/MEMD.

m. MEPS Medical NCOICs/SUP MTs will:

(1) Assist the MEPS Commander and CMO/ACMO in implementing PQMP requirements.

(2) Ensure OSHA requirements are met for all medical personnel.

(3) Schedule medical provider on-the-job training and crosswalks.

(4) Ensure FBP contractual requirements are met as directed by J-7/MEMD.

(5) Establish FBP six part folders for all FBPs assigned to their MEPS FBP pool.

- (6) Complete all required taskings within the established time period.

1-5. Internal Control Checklists

This regulation establishes the use of an internal control evaluation checklist at [Appendix E](#). Users of the checklists will use [Department of the Army \(DA\) Form 11-2-R, Internal Control Evaluation Certification](#) to document internal control evaluations.

Chapter 2 PQMP Composition

2-1. Overview

The PQMP consists of three major program areas which are as follows:

a. Initial Professional Review Program.

The Initial Professional Review Program provides the qualification process resulting in a provider being granted tiered permissions and responsibilities to provide accession medical services designated by DPC levels. Qualification includes official review and acceptance of an individual's professional credentials as certified by a national agency or association deemed acceptable to USMEPCOM in order to assure the public that the medical professional has successfully completed an approved educational program and is professionally licensed to practice medicine in at least one state. Providers qualified as DPC-1 (entry level) are eligible to be hired into government CMO or ACMO positions or if seeking to work as a contract provider are now acceptable to work under the FBP contract for their employer once the provider signs a personal services contract associated with the FBP contract.

b. Initial Training Program.

The Initial Training Program provides standardized training for new CMOs, ACMOs, and FBPs in order to educate the new provider in accession medical services. Clinical Operations Division physicians will document training requirements in PQMP Training SOPs located on the USMEPCOM intranet [Sharing Policy Experience and Resources \(SPEAR\)](#), which include but are not limited to, training on policies in [DoD Instruction \(DoDI\) 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services](#); [USMEPCOM Regulation \(UMR\) 40-1, Medical Qualification Program](#); [UMR 40-8, Department of Defense \(DOD\) Human Immunodeficiency Virus \(HIV\) Testing Program and Drug and Alcohol Testing \(DAT\) Program](#); and [UMR 40-9, Blood-borne Pathogen Program](#).

c. Quality Performance Maintenance Program.

The Quality Performance Maintenance Program provides recurring reviews, assessments, feedback, and sustainment training to ensure a quality medical program and continued quality performance of the USMEPCOM medical provider pool.

2-2. Defined Provider Category

a. DPC Overview. DPC levels are a sequential process whereby providers are assigned performance levels based on provider experience, knowledge, and ability. There are five DPC levels of assignment which are granted. Levels range from DPC-1 through DPC-5.

b. DPC-1

(1) Applies to new providers working under the direct supervision of a government physician during initial accession medicine training. A provider must be approved for DPC-1 prior to working at a MEPS. Approval for DPC-1 is based on a J-7/MEMD review of a provider's professional credentials.

(2) When working in a DPC-1 status, the provider's performance will be under close review by his/her clinical supervisor for clinical competence as well as for compliance with the MEPS policies and procedures.

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(3) Once the DPC-1 training and evaluation is completed, requests for assignment to DPC 2 shall be submitted to J-7/MEMD as described in [Chapter 5](#).

c. DPC-2

(1) Providers completing DPC-1 training are qualified for DPC-2. Supervising government physicians will seek approval from J-7/MEMD for progression from DPC-1 to DPC-2 by submitting a request to J-7/MEMD. Providers designated as DPC-2 may include physicians, certified nurse practitioners, and physician assistants who are capable of performing medical history interviews and accession physical examinations without supervision. DPC-2 providers are not qualified to assess medical accession standards in order to assign applicant profiles, and they cannot serve as a Fee Basis CMO (FB-CMO) under the FBP contract.

(2) Certified nurse practitioners (CNPs) and physician assistants (PAs) cannot independently assign applicant profiles so can only qualify for DPC-1 or DPC-2. DPC-2 Physicians are qualified to proceed with training to sequentially obtain DPC-3 and DPC-4 levels. Even though CNPs and PAs are not allowed to independently assign applicant profiles, they are expected to have full knowledge and understanding of all regulatory profiling policies to determine and recommend an accurate profile. This ability is essential to their role by ensuring the CNPs and PAs are able to examine and document the needed components in order for the profiler to make an accurate decision. CNPs and PAs will normally learn the profiling policies within six months after initial training.

(3) For physicians, DPC-2 is normally a temporary assignment of six months or less in which the provider, newly trained in accession medical services, gains proficiency in performing accession physical examinations, and learns the elements of accession medical standards.

(4) Once the DPC-2 training and evaluation is completed as outlined in [Chapter 5](#), requests for assignment to DPC 3 or 4 shall be submitted to J-7/MEMD per [Chapter 5](#).

d. DPC-3

(1) Physicians designated as DPC-3 are qualified to profile applicants by applying accession medical standards to determine applicant medical qualifications. DPC-3 does not include supervisory responsibilities associated with CMO, ACMO, and FB-CMO roles.

(2) FBP physicians are expected to become proficient in the application of accession medical standards to determine suitability of applicants for military service, and progress from DPC-2 to DPC-3 during their initial six month period of employment with a minimum of 80 hours of FBP service. FBPs who are unable to assimilate and master profiling abilities and remain at DPC-2 for more than six months will be evaluated by the MEPS CMO and receive a performance evaluation advising either retraining or other employment recommendations in order to meet the terms of the FBP contract. MEPS will submit documentation to the J-7/MEMD FBP contract COR for all performance issues.

e. DPC-4

(1) Government Physicians assigned DPC-4 have received their initial **certification qualification** visit with results documented using UMF 40-2-3 and approved by the J-7 Director. All MEPS have CMO positions and some of the MEPS have ACMO positions, determined by size and/or workflow. These positions are considered permanent and are normally filled with physicians hired through servicing civilian

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personnel offices as GP employees. Clinical supervision under PQMP is separate from a CMO's personnel responsibilities documented in the CMO position description. Contract physicians granted DPC-4 can contractually serve as a FB-CMO when government CMOs/ACMOs are not available at the MEPS. An FB-CMO attends local inter-service recruiting council meetings as required by the MEPS Commander in order to discuss MEPS specific medical issues. The FB-CMO provides technical advice and guidance to the MEPS medical department when requested by the MEPS Commander of medical staff.

(2) The supervising government physician may recommend advancement of a DPC-3 FBP to DPC-4 status by submitting a request to J-7/MEMD, asking approval from J-7/MEMD for progression from DPC-3 to DPC-4. Under the FBP contract, DPC-4 FBPs can be scheduled as FB-CMOs. During vacancies or absences of the CMO and the ACMO, as applicable, a FB-CMO provides medical expertise to the MEPS as the on-site clinical expert.

(3) DPC-4 duties include compiling medical histories; conducting physical screening examinations; reviewing medical test results, documents, and consultations; and serving as the subject matter expert for medical questions, including providing technical advice and guidance to the MEPS Commander and all medical staff to achieve the ultimate level of quality and service in processing applicants for military service. DPC-4 physicians will consult with J-7/MEMD physicians for assistance with applicant processing when regulatory guidance does not provide clear solutions.

f. DPC-5

(1) DPC-5 providers are assigned to USMEPCOM in North Chicago, IL, J-7/MEMD and Sectors. Duties and responsibilities include establishing and maintaining premier quality accession medical services throughout USMEPCOM. DPC-5 providers develop policy recommendations, review PQMP documents, and provide guidance and accession medical consultative services to all MEPS providers, identify training needs, and develop and provide focused training.

(2) DPC-5 physicians conduct periodic evaluation of all MEPS providers based on review of medical examination documentation and/or on-site observation of provision of services.

(3) As directed by the J-7/MEMD Director, DPC-5 physicians may travel to any MEPS and assume CMO duties to maintain continuous operations. DPC-5 Physicians may conduct applicant medical examinations and assume supervisory responsibilities of the MEPS Medical Department. DPC-5 physicians may also be tasked to support MEPS as a temporary CMO in situations where the CMO position is vacant, there is no ACMO, no FB-CMO is available, or when government oversight is determined necessary for a designated period of time to ensure continuation of standardized, quality applicant medical processing.

(4) J-7/MEMD Director will review and determine training required for providers currently or newly hired for HQ USMEPCOM and SMO physician positions who have previous PQMP training and/or USMEPCOM experience (either government or under the FBP contract.) All newly hired HQ USMEPCOM and SMO providers (no previous provider experience at the MEPS), will be required to go through the full initial CMO training per PQMP and be recommended to DPC-4 before approval to a DPC-5 will be granted. J-7/MEMD Director will determine any additional training requirements required of DPC-5 candidates, such as a crosswalk visit with another DPC-5 provider.

2-3. Provider Review Panel

a. The PRP supports the PQMP by providing a panel normally consisting of three J-7/MEMD physicians but no less than two, along with non-physician technical subject matter experts in order to review and assess provider credentials and/or performance.

b. The three physicians are normally the J-7/MEMD Director, J-7/MEMD Clinical Operations Division Chief, and one AMB physician. Technical experts consist of Clinical Quality Division personnel along with HQ experts in legal, contracting, and civilian personnel matters.

c. The PRP is chaired by the J-7/MEMD Director who approves DPC assignments. Other members make DPC recommendations based on review of applicable PQMP documentation.

d. The PRP is normally an informal process that includes routing of applications meeting regulatory documentation requirements and there are no issues and routine performance issues through the panel members for review based on [Appendix A](#) requirements. For the Initial Professional Review Program, J-7/MEMD physicians will complete a routine review of initial documentation. This review and the approval of DPC-1 for packages having no issues can be done electronically or by reviewing the application through a fast-track process with in-box to in-box processing. The general routing will be from the Clinical Management Branch, to an AMB physician, to the Clinical Operations Division Chief, to the J-7/MEMD Director. If during this review process, confusing or contentious issues (e.g. multiple malpractice payouts, arrest incidents, etc.) are discovered, PRP panel members, the J-7/MEMD Deputy Director, appropriate Clinical Management Division personnel, and HQ technical experts will be brought into the process to provide relevant input to the J-7/MEMD Director prior to final disposition. When concerning issues are identified that cannot be easily reconciled, PRP members will interrupt the informal review process and call for a formal meeting to discuss a provider candidate's qualifications.

e. Initial packages with known or potential issues, or those discovered during informal review as described above, will normally be addressed during formal PRP meetings where the Clinical Management Branch will record and publish minutes of the proceedings. In addition, if issues arise at any time during the electronic routing of an application, a formal PRP meeting will convene to address the issues.

f. When an initial package is disapproved for a government or FBP provider candidate, a Clinical Operations Division physician will write a memorandum documenting the reason(s). The Clinical Management Branch will create a staff package and route through the supervisory chain to the J-7/MEMD Director for release to the USMEPCOM Commander's HQ subject matter experts including the MEJA, J-1/MEHR, and J-4/MEFA. If there is concurrence on the action, the Clinical Management Branch will maintain the documentation. If there is not concurrence, the Clinical Management Branch will schedule a decision brief with the USMEPCOM Commander and Deputy Commander/Chief of Staff to resolve the issue. J-7/MEMD is responsible for notifying the applicable civilian personnel office for provider candidates applying for CMO/ACMO positions and the FBP vendor for FBP candidates. The civilian personnel office and FBP vendor are then responsible for notifying the candidates.

g. For both the Initial Training and Quality Performance Maintenance Programs, the PRP will make recommendations to the J-7/MEMD Director for assignment of DPCs or downgrade/removal of DPC level. Modifications or downgrades/removals of DPC levels are administrative actions and are not necessarily reportable to state licensing boards. Government providers being considered for a downgrade or removal of their DPC level will be provided notification from J-7/MEMD in writing as to when the PRP will meet, the allegation(s) being considered and provide options for the provider to present a written and/or oral

statement to the panel. MEJA and J-1/MEHR will provide supporting expertise to the PRP for any meetings which may result in removal of a provider's qualification/no DPC level assigned.

h. If it is apparent that a government provider is involved with commission of egregious actions warranting potential notification at the state or national level, J-7/MEMD will consult with appropriate HQ organizations (e.g. MEJA, J-1/MEHR, and J-4/MEFA) and may consult with the Army Medical Command to consider the issue and arrange submission to the appropriate agency, and/or report the issue directly to the provider state licensing activity. Criminal acts, such as sexual misconduct will be reported to appropriate legal and professional authorities.

If similar issues arise with contract providers, J-7/MEMD will notify the FBP contracting officer (KO) and the FBP vendor. The vendor, as the FBP employer, is responsible for administrative processing of allegations of improper activities of vendor employees.

i. Other services the PRP may be involved in include:

(1) Providing physician support to MEPS Commanders and medical staff.

(2) Providing feedback and training to address provider performance issues.

2-4. Centralized Credentials Quality Assurance System

When directed through the Command Message System, USMEPCOM will implement use of Centralized Credentials Quality Assurance System (CCQAS). CCQAS instructions will be included on [SPEAR](#) at the time of implementation. J-7/MEMD Clinical Management Branch will manage providers that are participating or have participated in the CCQAS Program while serving in the military at another duty station.

Chapter 3 Initial Professional Review Program

3-1. Hiring CMOs and ACMOs

a. The MEPS Commander maintains hiring authority for the CMO and ACMO positions through the local servicing civilian personnel activity. A SMO, J-7/MEMD physician or other J-7/MEMD-designated member of the USMEPCOM medical staff normally participates in candidate interviews, and makes selection recommendations to the MEPS Commander for hiring.

b. CMO or ACMO candidates must meet PQMP Initial Professional Review Program requirements in [Appendix A](#) before being hired and be DPC-1 qualified by the PRP before they begin working at a MEPS. Primary Source Verification (PSV) will be completed by J-7/MEMD per [Appendix B](#) for documents requiring PSV. Candidates with previous USMEPCOM PQMP training and/or experience can be hired at a higher DPC level based on a credentials file review and approval of the J-7/MEMD Director.

c. J-7/MEMD Clinical Management Branch personnel will work with MEPS CMO or ACMO candidates to obtain PQMP Initial Professional Review required documentation. It is critical for the MEPS to work closely with J-7/MEMD in the hiring process to ensure this part of the PQMP is completed in a timely and efficient manner.

d. Ideally, CMO or ACMO candidates will submit required documentation electronically to the Clinical Management Branch via the J-7/MEMD group email address:
osd.north-chicago.usmepcom.list.hq-j7-memd-government-apps@mail.mil.

e. When CMO or ACMO candidates are currently FBPs and the MEPS Commander selects the FBP for the government position, J-7/MEMD will complete [USMEPCOM Form \(UMF\) 40-2-3-E, Provider Clinical Assessment and Qualification](#) which may include a records review, visit, etc. Instructions for completing this form are included at [Appendix C](#), J-7/MEMD will review the provider's existing credential file and account for [Appendix A](#)-required documents and identify those that require updating such as Licensure, Certification and BLS. Note - Letters of Recommendation do not need to be re-submitted. The credential file also includes the performance write ups which will be taken into consideration before the offer is finalized. J-7/MEMD will obtain updated credential documents and reports as required.

f. The MEPS will notify J-7/MEMD of existing or anticipated CMO/ACMO vacancies and start dates for newly hired CMOs/ACMOs via the J-7/MEMD group email address:
osd.north-chicago.usmepcom.list.hq-j7-memd-pqmp-government@mail.mil.

3-2. Contract FBPs.

a. FBPs are contracted by their employer, the vendor who was awarded the FBP contract. However, FBPs must still meet the PQMP Initial Professional Review Program requirements in [Appendix A](#) and have a signed personal services contract with the FBP contract vendor before working at a MEPS. Any documentation requiring PSV will be completed by the FBP vendor per [Appendix B](#). The MEPS must be notified in writing by J-7/MEMD that an FBP has met these requirements before the FBP is permitted to work at a MEPS.

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b. The FBP vendor is responsible for working with FBP candidates to obtain PQMP Initial Professional Review and Approval required documentation. The FBP vendor submits these documents directly to the J-7/MEMD COR.

c. All FBPs performing services under the FBP contract shall comply with the Health and Immunization requirements as instructed by the vendor at the time of their documentation submission to J-7/MEMD for PQMP initial professional review and approval.

d. When a government provider resigns and then seeks employment with the FBP vendor, J-7/MEMD will review the provider's existing credential file and account for Appendix A required documents and identify those that require updating such as Licensure, Certification, and BLS. J-7/MEMD will obtain updated credential documents and reports as required by contract. Letters of Recommendation do not need to be re-submitted. The credential file also includes performance assessments which will be taken into consideration before the J-7/MEMD Director can grant the FBP's initial DPC level.

3-3. Malpractice Liability

a. The federal government is a self-insuring entity which provides protection to certain physicians against medical malpractice claims. This protection is conferred by statute, not via a malpractice insurance policy. The relevant statutes are [10 US Code](#) §1089 and §1091, known respectively as the Medical Malpractice Immunity Act and the Gonzalez Act.

b. The Gonzalez Act protects civil servants, members of the Armed Forces, and personal services contractors in the MEPS who perform services actually covered by the contract. If a provider under contract to the vendor renders services in a MEPS outside of those described in their contract (i.e., is not paid by the "contractor" for these services), he/she is not covered for malpractice.

c. To be covered under the Gonzalez Act a provider must:

(1) be in a valid status which means authorized military status, federal civil service employee, or working pursuant to a personal services contract with the Department of Defense.

(2) be working within the scope of the provider's employment.

(3) be working whereby the incident must have occurred within a MEPS or other authorized location which means inside a MEPS or other location authorized by HQ USMEPCOM (for example, a National Guard Armory in Micronesia while on USMEPCOM-sanctioned travel).

Chapter 4

Categories of Quality Assessments for Chief Medical Officers

4-1 Categories of Quality Assessments for Chief Medical Officers

a. Clinical quality monitoring of the CMO and the quality of the medical processing that the CMO oversees includes evaluations and general competency assessments to validate and support quality in the following areas (but not limited to):

- (1) Medical Processing
- (2) Medical/Clinical Knowledge
- (3) Clinical Based Learning and Improvement
- (4) Interpersonal and Communication Skills
- (5) Professionalism
- (6) Systems-based knowledge and execution

b. All clinical quality performance assessments for the CMO under the PQMP fall into one of the following categories: Focused Clinical Assessment (FCA) and Ongoing Clinical Assessment (OCA). Figure 1 at the end of this chapter delineates which PQMP components fall under which clinical assessment category and also additional evaluations that may occur. Details of process and methods for each assessment type is detailed in this chapter.

4-2 Focused Clinical Assessment- FCA

a. Focused Clinical Assessment (FCA) is a performance based evaluation that occurs during initial training of new CMOs and can also be triggered when quality medical processing is in question. FCA has two sub-categories a) FCA-1 is the process of going through and completing the initial training program and b) FCA-2 is J-7/MEMD directed, triggered when there is a question regarding medical processing quality of the providers, including moderate to significant findings from an OCA or inability to complete FCA-1 in the standard timeframe due to clinical performance concerns.

b. Breakdown of sub-categories of FCA:

- (1) Sub-category 1/ FCA-1: Initial Provider Training
 - (a) Part 1 Initial training program for the CMO with a Regional Trainer (DPC1-DPC 3).
 - (b) Part 2 Initial training-Qualification Visit (DPC 4) conducted by the Sector Medical Officer (SMO) or J-7 Designee.
- (2) Sub-category 2/ FCA-2: J-7/MEMD Directed- may be conducted when the following occurs (including but not limited to):

(a) When a new provider does not meet the standard training timeline due to clinical performance concerns during the FCA-1 (part 1 or 2 initial training program). Rationale is documented on UMF 40-2-3-E along with a recommendation for FCA- 2.

(b) When a question arises regarding a CMOs ability to conduct quality medical processing at the MEPS anytime throughout the CMOs employment with USMEPCOM.

(c) When clinical competency is in question in relation to significant and/or recurrent errors identified through Ongoing Clinical Assessment (OCA) such as Existed Prior to Service (EPTS) cases, Congressional inquiry, peer and chart review.

(d) Clinical quality concerns related to MEPS provider medical processing in general versus concerns with a specific provider (e.g. from J-7/MEMD, Sector, MEPS CDR).

(e) Questions from accession partners, regarding standardized quality medical processing of a CMO and other MEPS providers.

(f) Questions from J-7/MEMD or Sector on general provider medical processing quality at the MEPS that warrant validation.

(g) New process/policy is implemented for quality improvement, an FCA evaluation is used to validate the process has been adopted and validate the quality improvement.

c. Data Collection and Analysis

(1) FCA-1 (Initial Training) is mandatory for all new CMOs. Data tracking includes, but is not limited to: date of submission of training documentation (UMF 40-2-3-E and supportive training guide) to J-7/MEMD and training start and end date to track compliance of training documentation completion and reason for variances in training completion in relation to the standard timeline.

(2) FCA-2 will include, but not limited to, tracking of reason the FCA-2 was initiated and follow up/close out dates to ensure clinical concerns are being managed and closed out. Data will be reviewed by J-7/MEMD to determine impact to the Command and, if needed, develop an action plan or policy adjustment based on the data.

d. Methods

The type of evaluation and data collection is based on the category of FCA and is individualized based on specific quality concerns and the best ways to evaluate them. The recommendation for a FCA is finalized by routing the UMF 40-2-3-E detailing the recommendation, followed by routing of the UMF 40-2-3-E through J-7/MMD and signature by the J-7 Director or designee. Feedback is then provided to the SMO for situational awareness or to follow up as indicated.

(1) FCA-1: Methods for conducting an FCA-1 is the process of completing the standardized PQMP Initial Training Program IAW UMR 40-2 and PQMP SOP including training on associated regulations related to MEPS Medical Department.

(2) FCA-2: Methods for conducting the J-7/MEMD Directed FCA -2 involves use of one or a combination of evaluation methods and is individualized based on the quality concern that triggered the FCA. Below are some of the methods that can be used:

(a) Focused chart review of provider or MEPS (either remote or in person review as part of PQMP visit).

(b) In person evaluation with specific evaluation methods described to evaluate the issue in question.

(c) Simulation.

(d) Observation.

(e) Remote evaluation methods as determined by the J-7 Directorate.

(f) Utilization data of FBPs.

(g) Monitoring quality measures as delineated by J-7.

(h) Monitoring medical processing patterns such as rates of qualification, disqualification, open for records, requests for tests or consultations.

(i) Proctoring.

(j) Discussion with others involved in the medical processing related to the quality concern.

(k) Additional PQMP training with a Regional Trainer, SMO or AMB physician or J-7 Director designated physician.

(l) Other methods as determined by the J-7 Director or designee.

e. Duration

(1) FCA-1 follows a standard timeline. Part 1 of initial training to DPC 3 generally occurs around weeks 3-5 from the new providers start date (15 days total). Part 2 of the training entails the DPC 4 evaluation and occurs around week 10 from the start date or 7 weeks from the end of part 1 initial training completion.

(2) FCA-2 timeline is individualized based on the specific quality concern.

f. Action

(1) FCA-1

(a) Part 1 and part 2 of initial training completion is documented on the UMF 40-2-3E. Documentation should include support for the DPC recommendation. If clinical performance concerns are

noted and the expected DPC level is not recommended by the trainer (DPC 3 for part 1 and DPC 4 for part 2- qualification visit), but the provider trainer feels that additional training time will remediate the problem, the recommendation of additional training time should be documented on the UMF 40-2-3-E along with the full evaluation from the completed training and will be reviewed by J-7/MEMD who makes the final decision. Additional training may be granted and will stay in the FCA-1 sub-category.

(b) If the CMO trainer has significant concerns regarding the new provider's clinical performance, or after completion of additional training, the trainer is unable to recommend a DPC 3 at the end of part 1 of the training, the findings should be documented on UMF 40-2-3-E with FCA-2 recommendation and action plan for remediation and sent to J-7/MEMD for review and disposition.

(c) Management when a CMO is not awarded a DPC 3 after completing part 1 of initial training:

Note: If the CMO returns to their home MEPS for an interim period before remediation plan is executed (detailed in a. and b.), should include direction by the J-7 Director to address profiling oversight. Documentation of this plan can be included in the additional recommendations by the J-7 Director on the UMF 40-2-3-E or Memorandum for Record (MFR) and included in the final disposition and communication.

(2) FCA-2

(a) FCA-2 Initial Recommendation

When a quality concern warrants an FCA-2, the observer of the quality concern-Regional Trainer, SMO or J-7 designee documents the findings and recommendations in an objective and comprehensive manner on the UMF 40-2-3-E. If the quality concern originates from concern that was not directly observed during a PQMP visit and is related to quality medical processing concern of the MEPS CMO or the MEPS medical department, the concern should be communicated to the J-7 Chief, Clinical Operations Division (COD). If an FCA-2 is warranted, the J-7 Chief, COD will recommend documentation on a UMF 40-2-3-E of an FCA-2 recommendation. The UMF 40-2-3-E is routed to and reviewed by J-7/MEMD and final signature and disposition is by the J-7 Director or designee. The final disposition is then communicated to the SMO or designee to oversee the execution of the plan, with details of the FCA-2 to include a specific plan and timeline for completion of the FCA-2. Once the FCA-2 is executed, findings should be documented on a UMF 40-2-3-E and submitted to J-7/MEMD.

(b) Completed FCA-2

After the FCA-2 is executed, if quality concerns have resolved or quality is validated through completing the FCA-2 plan, the evaluator should complete the UMF 40-2-3-E with the summary of findings and recommendation for close out. The J-7 Director will review the recommendation from the evaluator (SMO or designee) and sign the UMF 40-2-3-E to close out the concern. If serious concerns (e.g. recommendation of down grading DPC level) are validated by the FCA-2, the evaluator should document their findings on a UMF 40-2-3-E and the J-7 Director will schedule a Provider Review Panel and work with the SMO, MEPS CDR and J-1 Human Resources to determine next course of action as the findings from an FCA-2 can lead to personnel action. All finalized UMF 40-2-3-Es must be kept in the CMOs credential file in J-7/MEMD and when applicable in the CMOs first line supervisor's CMO personnel file at the MEPS.

4-3 Ongoing Clinical Assessment-OCA

a. Ongoing Clinical Assessments (OCA) are ongoing assessments of the quality of the medical processing of the CMO and their associated MEPS to validate quality and to identify areas that may impact

quality MEPS medical processing. The OCA is a continuous assessment process for all CMOs and their associated MEPS. [Figure 4-1](#) at the end of this chapter highlights some of the specific areas of PQMP that fall into the OCA category.

b. Data Collection

Select quality data is collected in the following areas for OCA (this is not an all- inclusive list and one or multiple data or processes may be used):

(1) CMO Attendance at Grand Rounds and Medical Leadership Training Seminar (MLTS) or completion of the alternative pathway described in Chapter 6.

(2) Requalification visit findings.

(3) Annual knowledge assessment completion and findings.

(4) Consult utilization.

(5) Fee Basis Provider oversight and utilization.

(6) Medical processing quality measures.

(7) Peer and chart review – appropriateness of medical processing and documentation.

(8) Medical processing performance measures (example- prescreen efficiency or standardization in records requests).

(9) Documentation and timeliness.

(10) Trends in ordered testing.

(11) Other monitoring as directed by the J-7 Director.

c. Methods

The information may be acquired through the following methods (one or more may be used):

(1) Periodic chart review (remote or during a PQMP visit by J-7 or SMOs)

(2) Direct observation

(3) Monitoring patterns of utilization of consults

(4) Monitoring utilization of FBPs

(5) Monitoring diagnostic ordering trends

(6) Simulation

(7) Peer and or Chart Review

(8) Discussions with others involved with the applicant case (example-other providers, medical staff)

(9) Proctoring

(10) Other methods as determined by J-7 Director

d. Action

(1) Select data from OCAs are collected, analyzed and reviewed by J-7 and SMOs and aggregated annually for the MEPS CDR as a component of the Annual Quality Review through the quality scorecard (see [Chapter 6](#)) for CMOs. These components include, but are not limited to:

(a) Grand Rounds and MLTS attendance or completion of the alternative pathway.

(b) Requalification.

(c) Annual Knowledge Assessment participation.

(2) Data trends from OCAs may also be used for quality improvement.

(3) Documentation of findings on a UMF 40-3-4-E for OCA occur at the following specific evaluations by SMO or J-7 Director designee:

(a) Requalification Visit (or alternative pathway defined in Chapter 6–e.g. summary of remote chart review results).

(b) Annual Quality Review for the MEPS Commander.

Note: Includes summary of data from OCA components and scorecard data (e.g. attendance at MLTS and Grand Rounds. An example of the CMO scorecard is found in Chapter 6.

(c) When OCA findings trigger a Focused Clinical Assessment (FCA-2) recommendation, the OCA findings that support the recommendation for an FCA-2 should be clearly documented in a UMF 40-2-3-E.

(4) [Figure 4-2](#) at the end of this chapter shows a decision algorithm for management of OCA results based on the level of the findings. Minor quality concerns that can be corrected at the local level should be documented on UMF 40-2-3-E to include a summary of the findings, remediation that occurred and close out of the issue. For moderate to significant findings, quality concerns identified that require additional action by J7/MEMD or SMOs should include Focused Clinical Assessment (FCA-2) recommendation, method, duration and a follow up date for re-evaluation and documentation on the UMF 40-2-3-E.

4-4. Chart Review

a. Chart reviews to evaluate the quality of CMO or MEPS medical processing to include oversight of FBPs may be part of an OCA or FCA. Routinely, SMOs and J-7 providers or designee will request charts to be scanned and sent to a specified address through encrypted email or other PII protected avenue for remote chart reviews conducted by SMOs or J-7 providers. For planned chart reviews that will be conducted during PQMP visits, a randomized chart list will be sent to the MEPS to retrieve prior to the visit. The random chart list contains PII and must be sent via encrypted email to the MEPS. A standard chart review worksheet is used by J-7/MEMD or SMOs when conducting the chart reviews and is located on the PQMP SPEAR page.

b. Some examples of chart reviews are as follows, but not limited to:

(1) Chart review as part of an OCA: Chart reviews are conducted as part of the requalification visit detailed in the requalification guide located on SPEAR. Other categories of OCA may entail an action plan that includes a chart review in coordination with a visit or remote chart review as part of the evaluation.

(2) Chart review as part of an FCA-1: FCA chart reviews are routine part of FCA-1, initial training with the Regional Trainer and the qualification visit with the SMO or J-7 provider.

(a) Part 1 initial training: A standard part of training oversight of the initial training process as the CMO trainer reviews the charts for accurate documentation and processing throughout the course of training.

(b) Part 2 initial training-qualification visit: The qualification visit guide located on SPEAR has specifications for the chart review parameters for the provider conducting the visit (SMO or J-7 provider).

(3) Chart review as part of FCA-2: FCA-2 chart review may be conducted in coordination with a PQMP visit or done remotely. FCA-2 recommendation should include specific parameters for chart review if this avenue for evaluation is chosen, to include how it will be conducted- remotely or in coordination with a visit, number and type of charts to be reviewed, frequency of the reviews (weekly, monthly) and duration of time for the reviews. (e.g recommendation for an FCA-2 is documented on the UMF 40-2-3-E with an action plan that includes a remote chart review with 10 MEPS charts weekly for 90 days).

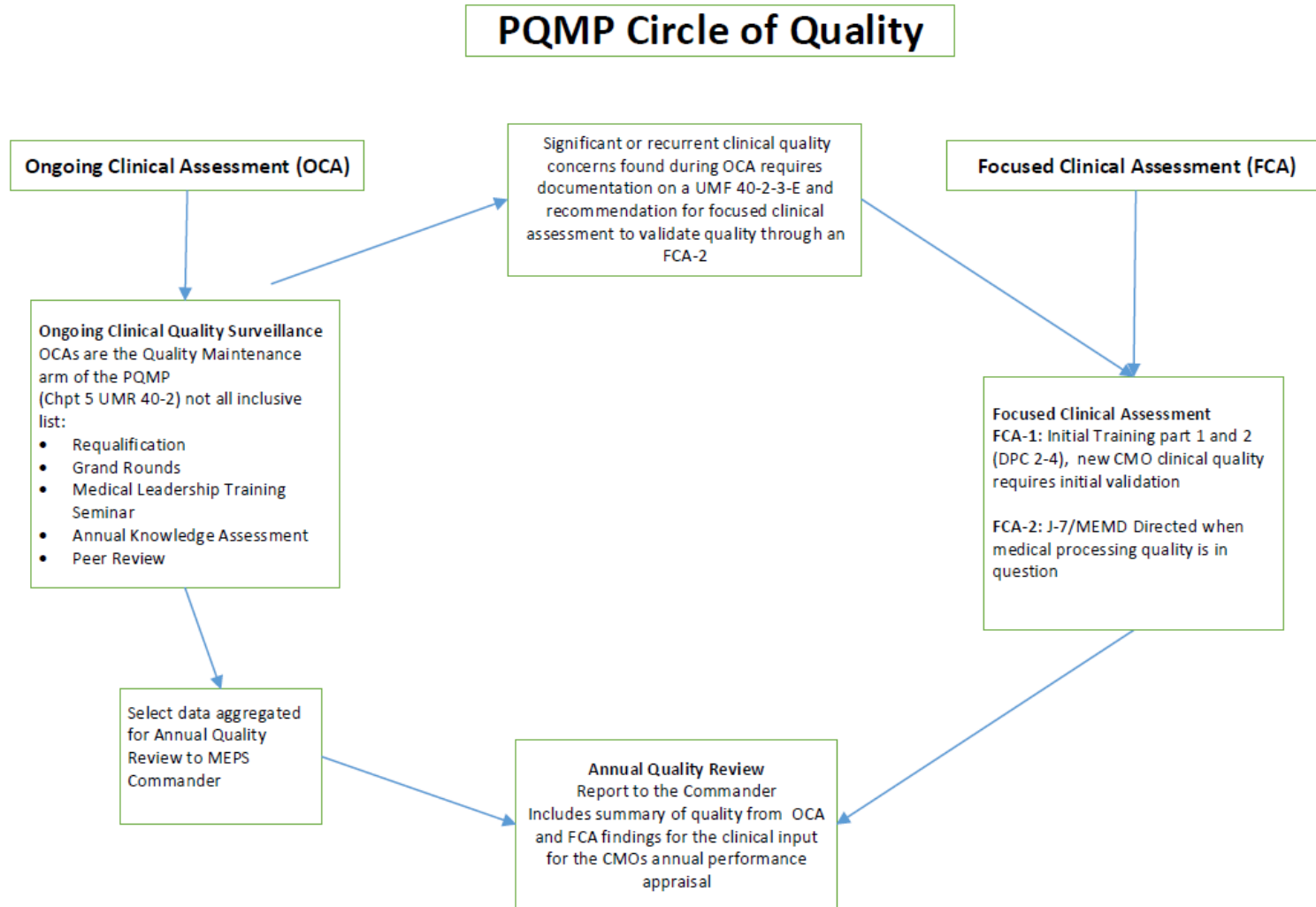


Figure 1- The circle of quality summarizes PQMP clinical quality assessments and how they inform the Annual Quality Review

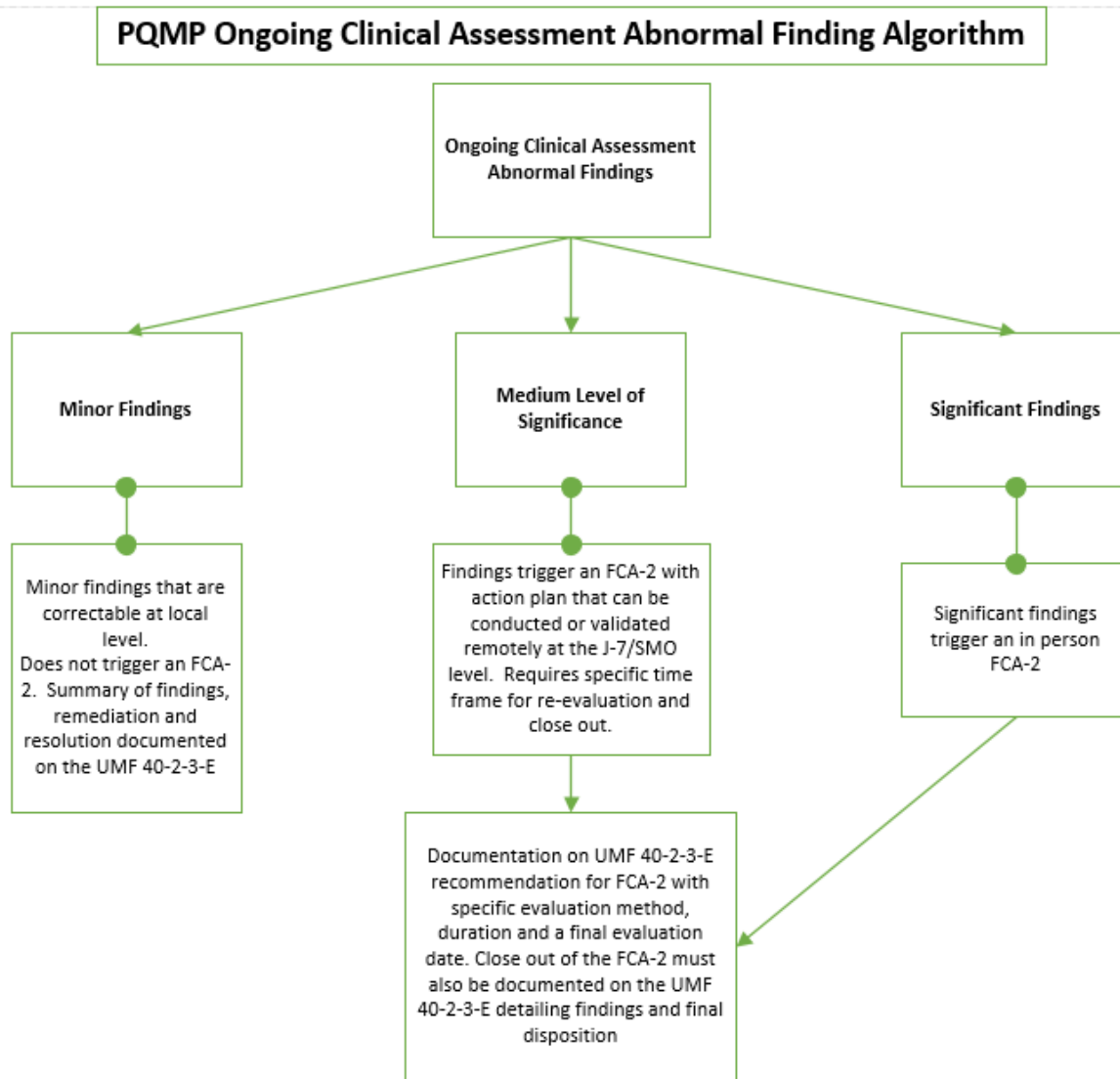


Figure 2-Decisional Algorithm for Management of Ongoing Clinical Assessment (OCA) Abnormal Findings

Chapter 5 Initial Training Program

5-1. Government Provider Initial Training

c. a. New CMOs and ACMOs assigned to DPC-1 must complete J-7/MEMD directed training as documented in the USMEPCOM PQMP SOP (standard training timeline is detailed in PQMP SOP Chapter 4). ~~New CMO Initial Training Program SOP~~ located on SPEAR, [J-7/MEMD, Provider Quality Management Program](#). Training includes learning the regulatory requirements for the USMEPCOM Medical Program and hands-on training. CMOs are also required to train on USMEPCOM supervisory tasks required of their position.

b. Normally, medical department specific in-processing is completed during the first two weeks of the CMO employment. The week 1-2 training guide on the PQMP SPEAR page is used to guide priority training for this time period. Priority training includes mandatory medical department training and in-processing tasks that are time sensitive and completion of highlighted components are required before PQMP part 1 of initial training can start.

c. Initial Training Part 1: 15 day training program

(1) The initial training program for CMOs is classified as an FCA-1

(2) A new CMO will perform “crosswalk” training at another MEPS with an experienced, DPC-4 CMO (regional trainer) for up to 15 workdays ~~and ideally around weeks three to five from their start date,~~ to observe and then participate in medical processing. The SMO in coordination with the J-7/MEMD Director, Battalion Commander, and advice from the J-7/MEMD Clinical Operations Division, will select one or more MEPS to be visited either in their Battalion or with coordination, in another Battalion. The medical NCOIC/SUP MT will assist the CMO with ensuring appropriate travel arrangements are made for the CMO. The new CMO “crosswalk” training will include an assessment by the regional trainer using [UMF 40-2-3-E](#). Instructions for completing this form are included at [Appendix C](#). ~~In addition to UMF 40-2-3-E, the CMO Initial Training Guide found on the PQMP SPEAR page is used during the training and must be submitted to J-7/MEMD as supportive documentation of training completion. The goal of this training is for a new CMO to complete DPC 2 and 3 training objectives and meet core competencies as outlined in the CMO Initial Training Guide located on the PQMP SPEAR page. The standard training timeline is up to 15 days with an end goal of a DPC-3 level recommendation, which approves the MEPS provider to profile applicants. and thus can independently conduct medical examinations and profile an applicant correctly.~~

d. Initial Training Part 2: Qualification Visit

(3) (1) All new CMOs receive a qualification visit by a SMO and/or a J-7/MEMD physician approximately ~~two months after starting~~ six weeks after completing part 1 of initial training. Details of the qualification visit can be found in the PQMP SOP ~~New CMO Initial Training SOP~~ located on SPEAR, [J-7/MEMD, Provider Quality Management Program](#). The goal of the visit is to observe the CMO functioning in their role at their home MEPS and provide additional support and training for DPC 4 level responsibilities. The Qualification Visit Training Guide on SPEAR is used to conduct the visit. UMF 40-2-3-E and the training guide is completed and sent to J-7/MEMD. The expected outcome of the qualification visit is DPC 4 recommendation. If it is determined the CMO ~~requires~~ does not meet DPC 4

criteria by the end of the qualification visit, but will be successful as a CMO with additional training ~~after the qualification visit, a J-7 Physician will prescribe the training~~, the SMO or J-7/MEMD physician conducting the visit will document findings and recommendation for FCA-2 and document the specific remediation plan and follow up date on the UMF 40-2-3-E. Final qualification, when additional training is required, should take place within 90-days of identification of the need for the additional training and a specific date for the 90 day follow up evaluation should be detailed in the FCA-2 recommendation on UMF 40-2-3-E for tracking purposes and to ensure a timely follow up evaluation ~~training completion~~. If qualification is not achieved, the CMO may be subject to separation IAW applicable civilian personnel regulations and procedures. The qualification visit is normally conducted at the CMO's MEPS. The new CMO qualification visit will include an evaluation using [UMF 40-2-3-E](#). Instructions for completing this form are included at Appendix [C](#).

(4) (2) Alternative pathways for the qualification visit will be utilized in circumstances where a J-7/MEMD physician or other provider designated by the J-7/MEMD Director are unable to make a visit to the CMO's MEPS detailed in the PQMP New CMO Initial Training SOP, Qualification Visit Chapter located on SPEAR, [J-7/MEMD, Provider Quality Management Program](#).

e. The new CMO may not profile any applicant until approval is granted by the J-7/MEMD Director for the appropriate DPC rating. Note: CMOs are expected to reach and maintain a DPC-4 level designation ~~IAW the standard training timeline~~.

f. J-7/MEMD will determine an individualized training program for new CMOs/ACMOs with previous USMEPCOM PQMP training and/or USMEPCOM experience. Providers originally trained under PQMP and/or have USMEPCOM experience may be modified to attend less than three weeks of initial training with a Regional Trainer as approved by the J-7/MEMD Director. Note – based on the Regional Trainer's assessment, additional training could be authorized by the J-7/MEMD Director.

5-2. Contract Provider Initial Training

a. The FBP cannot work at the MEPS until the J-7/MEMD Director has approved DPC-1 or higher and the MEPS has received official notification from J-7/MEMD that a personal services contract has been signed. New FBPs assigned to DPC-1 or higher will undergo a training period of up to 40 hours (ideally consecutive workdays) under the supervision of the CMO. The period of instruction is determined by the CMO. New FBPs with previous USMEPCOM PQMP training and experience are likely candidates for a training period that is less than 40 hours.

b. CMOs are responsible for conducting and documenting FBP initial training as directed in the USMEPCOM PQMP ~~FBP Initial Training SOP, Chapter 8~~ located on SPEAR, [Headquarters, J-7/MEMD, Provider Quality Management Program](#). Requirements ~~will~~ include completing [UMF 40-2-4-E](#) and use of ~~FBP DPC specific training guides found on SPEAR, Headquarters, J-7/MEMD, Provider Quality Management Program~~ to guide the visit and use as ~~supportive documentation of the training~~.

c. CMOs must actively participate in new FBP training. The Medical NCOIC/SUP MT should make the CMO unavailable in the FBP Application so a FB-CMO is authorized (when there is no ACMO) or FBP is authorized (when there is an ACMO). The CMO will oversee all applicant medical examination processing by the new FBP during this time in order to effectively evaluate the FBP's performance. The CMO will forward to J-7/MEMD a recommendation for the J-7/MEMD Director to assign the FBP to a higher DPC level as appropriate for the training successfully completed and based on the clinical assessment

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documented IAW the USMEPCOM PQMP ~~FBP Initial Training~~ SOP, **Chapter 8** located on SPEAR, [Headquarters, J-7/MEMD, Provider Quality Management Program](#).

d. If a CMO makes an assessment that a new FBP is not capable of being approved for DPC-2, the CMO must document reasons, with examples of performance problems on [UMF 40-2-4-E, Contract Provider Quality Management Form](#). [UMF 40-2-4-E](#) will be submitted to the J-7/MEMD FBP COR for processing using the J-7/MEMD FBP COR group email address: osd.north-chicago.usmepcom.list.hq-j7-memd-FBP-COR@mail.mil.

5-3. OSHA Initial Training

All government and contract providers will complete current [OSHA Standard 1910.1030](#) and [UMR 40-9](#) training within 10 working days of beginning work at the MEPS. Medical NCOICs/SUP MTs will document training by memorandum for record and file training documents IAW guidance prescribed in [UMR 40-9](#).

5-4. USMEPCOM Glove Use Policy Training

All government and contract providers must complete current USMEPCOM glove use policy training located on SPEAR, [Headquarters, J-7/MEMD, Medical Examination Chaperone Policy](#) prior to conducting any applicant physical screening examinations. Medical providers observed not strictly adhering to the glove use policy will be reported immediately to J-7/MEMD. Non adherence to this policy may result in downgrade of a provider's DPC level with subsequent removal from the MEPS Medical Department.

5-5. USMEPCOM Chaperone Policy Training.

All government and contract providers must also complete current [USMEPCOM Chaperone Policy](#) training prior to conducting any applicant physical screening examinations. Medical examiners not strictly adhering to the USMEPCOM Chaperone Policy will be reported immediately to J-7/MEMD. Non-adherence to this policy may result in downgrade of a provider's DPC level with subsequent removal from the MEPS Medical Department

5-6. Establishment of FBP Six Part Folder and Training Procedures

a. MEPS are required to keep copies of PQMP documents for each of their FBPs. Maintaining duplicates will help decrease the possibility of lost FBP documents required for re-qualification review.

b. MEPS are to purchase a box of Classification File Folders, NSN 7530-00-990-8884, via government purchase card from the DoD Email (URL: <https://dod.emall.dla.mil/acct/>).

c. Folder requirements are included in [Appendix D](#).

d. The folder should be updated accordingly when a new FBP training requirement is announced via the Command Message System and documented training should be placed in the appropriate file folder section. Upon notification from the J-7/MEMD that the FBP no longer works for the FBP vendor and has been archived, the six part folder will be retained under Record Number 1aa4/800D, "Employee Records – FBP Qualification and Training File". Upon transfer or termination of individual, keep in office file for 3 months, or no longer needed for conducting business, but not longer than 6 years, then destroy.

Chapter 6 Quality Performance Maintenance Program – Government Providers

6-1. Overview

The PQMP Quality Performance Maintenance Program is a multifaceted program for both government and contract medical providers. The goal of the program is to ensure ongoing quality of applicant medical processing throughout USMEPCOM. This chapter provides policies and procedural guidance for government providers. As civilian employees, CMOs/ACMOs must be provided a reasonable opportunity to demonstrate acceptable performance. ~~J-7/MEMD will assist~~ SMOs will assist the MEPS Commanders by providing clinical performance inputs using [UMF 40-2-3-E](#). Instructions for completing this form are included at [Appendix C](#). When an adverse action that may impact a civil service provider is being worked, the employee relations specialist (Civilian Personnel Office) must be consulted before any action is taken. This consultation is required to ensure preservation of employee rights and to ensure that civilian employee guidelines are met.

6-2. Annual Quality Review

a. The Annual Quality Review (AQR) is a routine process conducted annually to assess government provider continued proficiency in the provision of accession medical services. The process also certifies that government service providers continue to meet USMEPCOM civilian employee requirements for employment.

b. The MEPS Commander supervises the CMO, and is responsible for providing periodic constructive counseling and evaluation. SMOs will support the MEPS Commander by providing a summary of assessment of clinical performance and recommendations for improvement (if any) annually prior to July 15 to inform the annual performance appraisal process. ~~The AQR summary includes data from OCAs and, if applicable, FCAs throughout the year.~~ Assessments will evaluate each provider's quality based upon ~~clinical quality performance~~ data from, but not limited to, select components of the Quality Maintenance Program (see [Figure 6-1](#) for an example of the AQR CMO scorecard that will be added to the UMF 40-2-3-E as part of the report to the MEPS CDR) ~~the PQMP CMO Peer Review Program~~. CMOs will also have the opportunity for self-assessment through an annual knowledge assessment administered by the J-7/Clinical Operations Division. The AQR written assessment of clinical performance input will be ~~prepared and documented by the SMO on a UMF 40-2-3-E, to include the AQR scorecard and~~ sent to the MEPS Commander by the ~~SMOs J-7/Clinical Operations Division physicians~~. **Note:** Due to start-up actions required for AQR; full implementation of the AQR will occur the ~~performance year after implementation of the PQMP~~ performance period July 1, 2019-June 30, 2020. Also, when the assessment is provided to the MEPS Commander will be determined by J-7/MEMD/SMO and not necessarily after the end of the civilian performance period based on, for example, the provider's start date. ~~Data tracking for the AQR is a collaborative effort between Sector and J-7/MEMD, roles and responsibilities are established through internal SOPs.~~

c. CMOs supervise ACMOs and will provide periodic constructive counseling and evaluations of ACMO clinical performance during the normal civilian performance plan feedback and appraisal processes. CMOs will conduct PQMP Peer Review for their ACMOs. ~~SMOs and/or J-7/MEMD physicians, as determined by the J-7 Director,~~ will assist with PQMP Peer Review as needed for MEPS with a vacant CMO position depending on the situation.

6-3. PQMP Requalification

The purpose of requalification is to provide recurring credentials and performance reviews and assessments to ensure a quality medical program and continued quality performance of the USMEPCOM medical provider pool. J-7/MEMD will continually review expiration dates for documents such as license and BLS certification and request updated documents from providers. J-7/MEMD, every two years, will request providers complete [USMEPCOM Form 40-2-2-E \(Malpractice and Clinical Privileges History Questionnaire\)](#) and J-7/MEMD will obtain appropriate medical community updates such as National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank (NPDB) and American Medical Association (AMA) updates. The original authorization a provider signed for USMEPCOM to obtain documents will be used to obtain updates.

SMOs will conduct PQMP requalification visits for CMOs every 1-3 years. J-7/MEMD physicians are also authorized to perform requalification visits for SMOs and for CMOs/ACMOs when directed by the J-7/MEMD Director. Periodicity of requalification visits ~~is determined by J-7/MEMD in coordination with SMOs and Sector by the PRP,~~ based on ~~review of Peer Review Program data, and other~~ quality review indicators ~~including recommendations summarized in the UMF 40-2-3-E forms from OCAs and FCAs.~~ Prioritization will include coordination of requalification with Staff Assistance Visit (SAV) when possible. All new CMOs should have a 1 year requalification visit recommendation on the UMF 40-2-3-E documentation from the qualification visit, unless strong support is documented for rationale why a 1 year requalification visit for the new CMO is not needed. ~~Routinely, the PRP will~~ The J-7/MEMD Director may designate a CMO from another MEPS to perform J-7/MEMD physician and SMO assessment duties if J-7/MEMD and SMO physician resources are limited or if individual provider characteristics and abilities require it. J-7/MEMD requalification functions may also be carried out virtually in select cases, utilizing video teleconferencing or other electronic communication modes to assess a CMO's performance.

~~The requalification guide located on the PQMP SPEAR page is used to conduct the requalification visit and includes an OCA chart review. Periodically, SMOs and J-7 providers or designees will request applicant records from the MEPS Medical Department to conduct remote chart reviews as part of the requalification process (see [Chart Review](#) detailed in Chapter 4).~~

~~In years a requalification visit is conducted, the SMOs will use a summary of the findings from the requalification visit for the AQR to the MEPS CDR. For new CMOs, the summary of findings from the qualification visit will be used for the AQR.~~

DPC-5 providers will medically process applicants on a periodic basis as determined by the J-7/MEMD Director. Requalification assessments will be accomplished by a J-7/MEMD Director-assigned HQ provider. All USMEPCOM provider assessments will be documented using [UMF 40-2-3-E](#). Instructions for completing this form are included at [Appendix C](#).

6-4. Peer Review Program

a. The PQMP Peer Review Program is an ongoing quality review process implemented throughout USMEPCOM. ~~CMOs are required to participate by anonymously reviewing another CMO's work. J-7/ Clinical Operations Division is responsible for this program and will facilitate quarterly peer reviews of CMO work. CMOs are encouraged to use the information to improve their performance. If an individual CMO is not improving, J-7/MEMD physicians will provide retraining during site visits and in some instances may work with the MEPS Commander to implement a performance improvement plan. Details of this critical program are included in the Peer Review Program SOP located on SPEAR.~~ The National

Peer Review Program, a program previously detailed in the PQMP Peer Review SOP on SPEAR, has not been implemented and is currently on hold. The National Peer Review program is a separate program from the current and active Local Peer Review Program.

b. **Local Peer Review:** CMOs will develop local procedures to conduct ~~“daily”~~ local peer review with assigned ACMOs and FBPs. The CMO will also participate in the ~~daily~~ local peer review program. Medical providers will review each other as part of their normal ~~daily~~ work flow. **Minimum requirements and suggested formats for this part of the peer review program are contained in the Peer Review Program SOP on SPEAR, [Headquarters, J-7 MEMD, Provider Quality Management Program page](#). Note: ~~“Daily” peer review is the goal especially for medium and large MEPS; there may be days, especially for small MEPS, where there is not a “peer group” available.~~ All MEPS must adhere to the intent of the peer review program to have a professional review and ~~small~~-MEPS, ~~for example,~~ will coordinate with J-7/MEMD if there are issues completing recurring peer review IAW with Local Peer Review SOP minimum requirements in order to determine a solution.**

6-5. Annual Medical Training Seminar

Attendance at Annual Medical Leadership Training Seminar (MLTS), when conducted, is mandatory for CMOs at MEPS without ACMOs. Exception to policy (ETP) for non- attendance can only be granted by the J-7 Director or designee. For MEPS with ACMOs, attendance is mandatory for one physician (either CMO or one ACMO) and encouraged for the second (CMO or ACMO) depending on the ability of the MEPS to have competent FB-CMO medical coverage in the MEPS during the training seminar. **For CMOs who are unable to attend the conference, completion by an alternative method is mandatory. The method for alternative pathway completion will be announced via the Command Message system as a Tasking message each year after MLTS. The message will include details of the alternative pathway method that will primarily include reviewing the slides, completing any associated knowledge assessments and turning required documentation as proof of completion to the POC listed in the message. Completion of this activity is tracked as part of the CMO annual scorecard and included as part of the AQR for CMOs. The goal is 100% completion by either in person attendance or alternative pathway unless an ETP to not complete either has been granted by the J-7 Director.**

6-6. Grand Rounds

J-7/MEMD periodically conducts Grand Rounds sessions which are announced via the Command Message System. MEPS Commanders will ensure MEPS CMOs are available to participate, barring unforeseen medical mission requirements for applicant medical processing. Participation for the FBPs will be announced via the Command Message System. **Grand Rounds provides regular updates to the field on issues impacting the Medical Department and supports quality and standardized medical processing. Attendance to the live Grand Rounds or by an alternative method is mandatory for all CMOs. For the CMOs who are unable to attend the live Grand Rounds, a method for alternative pathway completion will be available and announced through the Command Message System Tasking message following Grand Rounds. Completion by the alternative pathway requires an ETP from the SMO and should not exceed 20% of the total Grand Rounds for the performance year. The alternative pathway method will often include reviewing the Grand Rounds presentation and audio once posted to SPEAR and completing any associated knowledge assessments when applicable. FBP coverage is authorized when needed to support attendance for Grand Rounds or alternative pathway completion. Completion of this mandatory requirement is tracked monthly and reported as part of the AQR CMO scorecard. 100% completion is required and the annual goal for all CMOs unless ETP to not complete either method, for any of the sessions, is on file with the SMO.**

6-7. Continuing Medical Education Courses

Subject to funding and staffing availability, one annual, professional medical training course within the continental United States may be approved for CMOs and ACMOs. Prior approval by J-7/MEMD is required. All requests for CME must be submitted in writing to the J-7/ Clinical Operations Division. The MEPS must consider the most cost efficient training location for courses offered in multiple locations and provide training/TDY cost information with requests. Upon completion of the CME course, the attendee will provide a copy of the CME certificate showing the number of credits earned and a course evaluation using [USMEPCOM Form 40-2-5-E, CME Conference/Training After-Action Report](#) to the J-7/MEMD Clinical Operations Division for inclusion in the PQMP file. File the CME certificate in CMO/ACMO training folders and FBP six part folders, in the training section.

Figure 6-1. CMO Scorecards

Example of CMO “Scorecard” for Annual Quality Review. Data compiled from tracking conducted by J-7 and Sector,

Provider Name	Grand Rounds Attendance or Alternative Pathway % (Goal 100% completed >80% attended <20% as ETP alternative pathway)	Medical Seminar Attendance or Alternative Pathway (Goal- 100%completed)	Requalification/FCA-1/FCA-2 (Goal: Completed, summary documented on the UMF 40-2-3 E for Annual Quality Review)	Annual Knowledge Assessment (Goal:100% completion)
CMO Name Here	% Attended % completed via alternative pathway	Example 1: Attended Example 2: Completed through alternative pathway Example 3: Did not complete, no ETP on file Example 4: Did not completed, ETP on file	SMO to indicate in this box which category is used in the summary. Example 1 Requalification visit completed in this performance year. Example 2 The CMO started in this performance period, FCA-1 (initial training part 1 and 2) Example 3 FCA-2 was conducted in this performance period, a summary of the outcome/findings Example 4 document no requalification visit, FCA-1 or FCA-2 were conducted	Example 1: Completed at MLTS Example 2: Completed through Grand Rounds

The scorecard will be included as an attachment to the UMF 40-2-3E that is completed by the SMO for the MEPS CDR for the annual quality review for the CMOs. In addition to the data in the scorecard, summary of qualification or requalification visit findings and any additional information related to quality is included in the summary documented on the UMF 40-2-3- E. Examples of additional items include- presented at Grand Rounds or MLTS, contributed to best practice adapted by J-7 for the Command, serves as Regional Trainer (document number of providers trained throughout the performance period)

Figure 6-1. CMO Scorecards

Chapter 7

Quality Performance Maintenance Program – Contract Providers

7-1. Overview

This chapter provides policies and procedural guidance for managing contract providers under PQMP to ensure maximum quality and efficiency of the provision of accession medical services in USMEPCOM. Specific implementation procedures for the Peer Review Program are in the PQMP Peer Review Program SOP located on SPEAR, [Headquarters, J-7 MEMD, Provider Quality Management Program page](#).

7-2. Fee Basis Provider Performance Issues

a. Emergency Situations.

(1) Emergency situations are defined in the contract as issues generating “reasonable suspicion that clear and present danger of physical harm exists” to an applicant, FBP, government personnel, or authorized visitor. These situations will immediately be addressed by the MEPS Commander in coordination with the CMO as described below.

(2) In situations of imminent danger, the MEPS Commander will follow the Emergency Management Assistance Plan to ensure the safety and well-being of everyone in the MEPS. If there is no imminent danger and the MEPS Commander/CMO believes that a FBP should be removed from the MEPS, the MEPS Commander will contact the FBP COR at J-7/MEMD immediately.

Note: Per the FBP contract, the COR is the person who will notify the vendor if the decision is made by J-7/MEMD to remove the vendor’s employee from the MEPS.

(3) After the emergency situation has been secured, the MEPS Commander, in coordination with the CMO, will complete an FBP Performance Report and forward it to the FBP COR. In the subject line of the email list the MEPS name, followed by “FBP-PR”, followed by the last name of the provider. For example: Albany MEPS FBP-PR, Jones. The FBP COR will staff the report to an **AMB** physician to complete the report within 24 hours of receipt. The FBP COR will coordinate the report with appropriate HQ and Sector personnel and submit when appropriate to the FBP KO.

b. Non-Emergency Situations.

(1) For FBP performance issues observed while conducting routine applicant medical processing, the CMO, in coordination with the MEPS Commander, will address the performance issues by verbally notifying the FBP of the performance issue(s).

(2) When applicable, provide the FBP additional training so he/she has the opportunity to correct the performance issue(s).

Document the issue(s) on [UMF 40-2-4-E](#) every time an issue occurs. Use encrypted email and send the report to ([OSD North Chicago USMEPCOM List HQ-J7-MEMD-FBP-COR](#)) within 3 business days for review. The subject line of the email should include the MEPS name, followed by FBP-PR, followed by the last name of the provider. The FBP COR will staff the report to an **AMB** physician to complete the report within 24 hours of receipt. The FBP COR will coordinate the report with appropriate HQ and Sector personnel and submit when appropriate to the FBP KO. When the performance problems are not corrected

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through additional training and continue to the extent a DPC level change is contemplated, then a [UMF 40-2-4-E](#) must be completed with a DPC level change recommendation.

c. All FBP performance issues shall be coordinated with appropriate J-7/MEMD leadership, Sector leadership, Staff Judge Advocate, and J-4/MEFA personnel, as appropriate and necessary.

(1) If an action implicating a contract employee is contemplated, the FBP COR will consult with the KO. Suspension of the provider's services will be conducted IAW this regulation using [UMF 40-2-4-E](#) to document withdrawal of approval for the provider to perform accession medical services within USMEPCOM. If the MEPS Commander or CMO/ACMO feels that a provider is not performing to contractual standards, accurate and complete documentation is mandatory. The decision to reduce a provider's DPC level is made by the PRP using the PQMP process.

(2) Staff Judge Advocate, Sector leadership, and J-4/MEFA personnel must be consulted as appropriate and necessary prior to proceeding with FBP performance issues. This will ensure compliance with due process, including conducting investigations/inquiries, removing a provider from the MEPS, and issuance of notification letters.

d. The provider's six part folder will be maintained in a secure manner under Record Number 1aa4/800D, "Employee Records FBP Qualification and Training File". Upon transfer or termination of individual, keep in office file for 3 months, or no longer needed for conducting business, but not longer than 6 years, then destroy. Folders will be maintained in a clearly identified locked file cabinet, or locked desk drawer, in the MEPS medical department accessible only to medical staff designated by the MEPS CMO and/or SUP MT. Providers may review their folder, but may not remove the folder from the control of MEPS medical staff.

7-3. Fee Basis Provider Requalification

J-7/MEMD will continually review expiration dates for documents such as license and BLS certification and request updated documents from providers. J-7/MEMD, every two years, will request providers complete [USMEPCOM Form 40-2-2-E \(Malpractice and Clinical Privileges History Questionnaire\)](#) and J-7/MEMD will obtain appropriate medical community updates such NPDB and AMA updates. The original authorization a provider signed for USMEPCOM to obtain documents will be used to obtain updates.

7-4. Fee Basis Provider Quarterly Training

FBP training will be accomplished during any fiscal year by:

- a. J-7/MEMD directing the method and subject of quarterly training
- b. The MEPS directing which of the two options will be used

(1) Option 1 (Group Training): With the approval of the MEPS Commander, up to four hours of a *USMEPCOM Training Day* can be blocked for medical training where the FBPs can be invited (requested to attend but not compelled to attend) to participate at the MEPS for group training/formal presentations. If this option is used, a training plan must be written and approved by the MEPS Commander which documents specific training that will be accomplished so the hours are efficiently used. This time will not be used for "team building" type activities, it must be used for specific medical training. This option assumes MEPS will only schedule training to last as long as necessary- if only 2.5 FBP hours are needed, schedule the FBPs for 2.5 hours. If an FBP cannot attend a training session, there is no make-up option; important information will need to be passed to providers through readable products/on normal processing

days. Follow J-7/MMD guidance for requesting providers participate in training and for documenting work hours for payment of providers.

(2) Option 2 (Individual Training): The intent of this option is to allow MEPS who have been training “on-the-job” in the past, to continue this practice for one quarter each fiscal year. On regular processing days, where FBPs are scheduled to work conducting physicals, the CMO can training individual FBPs and have an additional FBP work up to four hours that day to conduct physical examinations instead of the CMO. Follow J-7/MMD guidance for requesting the additional FBP. If training is missed there are no make-up options. To provide individual training, this will take multiple days during the quarter to accomplish, but the number of additional FBPs requested should not exceed the number of FBPs in the MEPS FBP pool. MEPS must use this option in a cost efficient manner; for example, if there are two FBPs only needing two hours of training, have the additional FBP work four hours, spend the first two hours with one provider and the other two hours with the other provider.

(3) The CMO preparing and conducting training during two quarters within the normal processing day and without using additional FBP contract dollars. CMOs will determine how to conduct this training. Examples include providing the FBPs a one page summary on a specific topic for reading during the normal processing day, reviewing medical section equipment during the normal processing day, and the CMO highlighting something specific to their MEPS by demonstrating a procedure during a physical.

Appendix A

Initial Professional Review Documentation Requirements

A-1. Documentation Submission

The documentation listed in this Appendix must be submitted to J-7/MEMD for review and consideration. CMO and ACMO candidates will submit documentation directly to J-7/ Clinical Management Branch. FBP candidate documentation will be submitted to J-7/MEMD by the FBP vendor.

A-2. Curriculum Vitae/Resume.

Information current and accurate, all pages initialed with the last page signed and dated by the provider submitting the CV. CV must contain, at a minimum, a list with the name of organization/institution of previous professional employment in chronological order, the location of the organization/institution by city and state (if outside the United States, give city and country), the clinical area assigned, inclusive dates (year and month for each assignment), and a short summary of duties/responsibilities. **Note:** Any gaps in work history must be accounted for and explained. If no history of professional employment, state “None”.

A-3. Current Active and Unencumbered State License(s) and Past License(s)

a. Providers must possess and maintain an active, current, valid, and unrestricted license from a U.S. jurisdiction before practicing independently within the defined scope of practice for the MEPS defined as:

(1) active - characterized by present activity, participation, practice, or use.

(2) current - not revoked, suspended, or lapsed.

(3) valid and unrestricted - not subject to state imposed stipulations or restriction pertaining to the scope, location, or type of practice ordinarily granted to all other applicants for similar licensure in the granting jurisdiction.

b. The license must be identified and presented by the provider and not subject to restriction pertaining to the scope, location, or type of practice ordinarily granted to other applicants for similar licenses.

c. The active license must be one allowing independent level of practice and granted by the recognized licensing agency of that State, the District of Columbia, the Commonwealths of Puerto Rico, Guam, or the Virgin Islands.

d. As a term of employment, providers are required to have one valid active medical license which is unrestricted and unencumbered from any state or territory identified above. The provider must, however, provide an explanation for any other current or past encumbered license(s). All other licenses, past or present, must be identified for review. Past license(s) must have been either in good standing at the time they lapsed or expired, or a written explanation must be provided.

e. The FBP vendor is responsible for providing written PSVs for FBPs on all past and present state licenses by submitting copies of the verifications with supporting documentation, as needed, to J-7/MEMD FBP COR. J-7/MEMD Clinical Management Branch personnel will PSV CMO and ACMO candidate licenses. If PSV is not possible due to closure of the original issuing facility or other plausible reason, the vendor will proceed in order through the three additional steps listed in Appendix [B](#).

A-4. Professional School Diploma, Degree, and/or Completion Certificate

- a. All providers must supply copies of original diplomas or certificates indicating completion of training specific to their profession in Medical School, Nursing, or Physician Assistant programs.
- b. Both nursing degree and/or diploma, and advanced nursing diplomas/certificates must be provided for nurse practitioners. Submitted documents must be PSV'd directly from the issuing organization, or verified by pursuing in order the alternative methods listed in Appendix [B](#).
- c. If a document is not in English, it must be translated by an official translator (University linguistics department, consulate officer, individual certified to be competent as translator, etc.). Translator's credentials must also be supplied (name, organization, position, contact information, and a statement as to why the person is qualified to translate the document).

A-5. Educational Council for Foreign Medical Graduate or 5th Pathway Certification

A copy of the provider's Educational Council for Foreign Medical Graduate (ECFMG) or 5th Pathway certificate is required for providers who are foreign medical graduates after 1958, not including graduates from Canadian or Puerto Rican medical schools. Foreign language (excluding Latin) documents must be translated into English. ECFMG documents that are from 1985 or earlier must be translated into English and the qualifying foreign medical degree must be PSVd with the issuing institution. The only exception is if the qualifying foreign medical degree is from 1986 or later because the ECFMG PSVs these documents.

A-6. Postgraduate Training Certificates

- a. The provider must submit his/her postgraduate training certificate(s), whether it is an Internship, Residency, or Fellowship. The training must be PSVd from the issuing organization and not from a third party.
- b. ACOMO and FBP physician providers must have at a minimum 12 months of post-graduate clinical training (internship) verified by certificate of completion.
- c. The training must have been received in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or Osteopathic Graduate Medical Education (OGME).
- d. All of a provider's postgraduate training must be submitted and PSVd.

A-7. Verification of Board Certification

Specialty board certificates will be PSVd. This will be done directly with the certifying board or by using one of the approved sources:

- a. For the American Board of Medical Specialties (ABMS), the following are identified and approved as the designated official display agents for Board Certification: CertiFACTs Online, Elsevier BoardCertifiedDocs, AMA Physician Profile, and AMA Master File. Therefore, the ABMS Board Certification information provided by these entities is considered a designated equivalent source in regard to credentialing standards. (Reference [American Board of Medical Specialties](#)).

(1) Verifications through ABMS or American Osteopathic Association (AOA) apply only to those specialty boards that are members of the ABMS or AOA. Certification by non-ABMS or AOA boards must be verified directly with the respective board.

(2) It is not necessary to delay the award of DPC level pending verification of board certification, because board certification is not an USMEPCOM requirement for employment.

b. National Certification for Nurse Practitioners. Nurse Practitioners must possess either an American Nurse's Credentialing Center (ANCC) or American Academy of Nurse Practitioners (AANP) certification in order to be qualified to work as a provider with USMEPCOM. Certifications must be PSV'd.

c. National Certification for Physician Assistants. Physician Assistants must possess a National Commission on Certification of Physician Assistants (NCCPA) certification in order to be qualified to work as a provider with USMEPCOM. Certifications must be PSV'd.

A-8. American Medical Association Master File or American Osteopathic Association Master File. J-7/MEMD will obtain these files for CMO and ACMO candidates. The FBP vendor will obtain these files and submit to J-7/MEMD for FBP candidates.

A-9. National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank. J-7/MEMD will obtain an NPDB result for CMO and ACMO candidates. The FBP vendor will obtain an NPDB result and submit to J-7/MEMD for FBP candidates. The NPDB request will include all name variations including maiden name for a provider along with the provider's social security number. The FBP vendor will submit an NPDB result to J-7/MEMD every two years for providers approved to work under the FBP contract. Physician Assistants will provide their continuing medical education credits every two years.

A-10. Basis Life Support. CMO and ACMO candidates will submit Basis Life Support (BLS) completion certificates to J-7/MEMD. The FBP vendor will submit BLS completion certificates to J-7/MEMD for FBP candidates. All FBPs shall be recertified every two years at the vendor's expense and completion documentation provided to J-7/MEMD.

A-11. Social Security Card. A copy of the provider's social security card.

A-12. Photo Identification. A copy of a federal or state-issued photo identification such as driver's license, military identification card, etc.

A-13. Letters of Recommendation.

- a. Two current Letters of Recommendation (LORs) must be submitted.
- b. Letters must address clinical competency, quality of work, professional standing, and character.
- c. Letters must contain contact information for the person providing the recommendation with the person's name, address and phone number.
- d. Medical Doctors (MD) and Doctors of Osteopathy (DO) candidates must submit two letters from their peers.
- e. Certified Nurse Practitioner (CNP) and Physician Assistant (PA) candidates will submit one letter from their peer and one letter from either an MD or DO.

f. LORs must be dated and must have been written within the past year and signed. Form letter LORs will not be accepted.

A-14. Standard Request Letter and Information Release.

a. There are two required standardized letters, one requesting official participation in accession medical services with USMEPCOM and a second which is an “authorization for information release.” These letters are not to be written on MEPS letterhead unless it is for a current Government employee. FBP letters may be submitted on FBP vendor letterhead. Providers are to print and sign their name.

b. Sample participation letter:

REQUEST FOR HQ USMEPCOM, ATTENTION J-7/MEMD, 2834 GREEN BAY ROAD, NORTH CHICAGO, IL 60064-3091

I am requesting to provide accession medical services at the _____ Military Entrance Processing Station (MEPS) as a _____ (Chief Medical Officer, Assistant Chief Medical Officer, Fee Basis Provider).

I hereby authorize and consent to the release of information to or by USMEPCOM or its staff to or from other physicians or references, professional schools or training programs, medical associations, clinics or hospitals and their staff, or other employees on request regarding any information the sources may have concerning me, as long as the release of information is done in good faith and without malice. I hereby release all parties, including USMEPCOM and its members, for doing so.”

Print Full Legal Name

Date: MMDDYY

Signature

c. Sample release letter (for FBP letters, the FBP vendor can be listed in the second paragraph of this letter along with USMEPCOM):

RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize all who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated healthcare organization, its staff, and agents. These include individuals, institutions, and entities of organizations with which I am currently or have associated and all professional liability insurers with which I have had or currently have professional liability insurance.

I agree to release and hold harmless from any liability the United States Military Entrance Processing Command (USMEPCOM) and any and all persons who participate within the scope of their duties in good faith and without malice in the review of any action or recommendation relating to my application.

A-15. [USMEPCOM Form 40-2-1-E, Medical Provider Initial Application](#). This form is to be filled out in its entirety as follows:

SECTION A – IDENTIFICATION

Item 1a, Full name: List the provider’s current full legal name.

Item 1b, (Maiden Names & Aliases, as applicable): List all previous names including maiden names and permutations of legal name used by the provider for but not limited to licensing, education, training, and work history records. Use Section E on the back side of the form to ensure all names are provided.

Item 2, National Provider Number (NPI): Self explanatory.

Item 3, Date of Birth: Self explanatory using the format MMM DD, YYYY.

Item 4, Function: Candidates for MEPS CMO positions will check the CMO option, candidates for MEPS ACMO positions will check the ACMO option, and FBP contract candidates must only check the FBP option.

Item 5, MEPS: Name of local MEPS where the government candidate applied for a position or the local “home” MEPS where an FBP provider will be assigned.

SECTION B – PROFESSIONAL MEDICAL EDUCATION

Item 6a, Name of Professional School: List professional schools attended in chronological order starting with earliest first.

Item 6b, Type of Degree: List specific degree obtained.

Item 6c, Degree Completion Date: The month day, year the degree was completed in the format MMM DD, YYYY.

SECTION C – POSTGRADUATE TRAINING AND LICENSING

Item 7a, Name of Hospital or Institution: List name of hospital or institution where postgraduate training was performed. List multiple programs in chronological order with the earliest listed first.

Item 7b, Location: List location of the hospital or institution by city and state. If done outside the United States, give city and country.

Item 7c, Type of Program: List the type of post-graduate training, e.g., internship, residency, fellowship, practicum.

Item 7d, Date Completed: List the month day, year completed in the format MMM DD, YYYY.

Item 8a, State: List the state licensure states(s) for all active/current and past/inactive state licenses. List all active/current licenses first followed by the past/inactive licenses.

Item 8b, Status: List the state licensure status (es) for all state licenses using the words active or inactive (it is not necessary to state revoked or expired, just inactive)

Item 8c, Expiration Date: List the state licensure expiration date(s) for all active/current state licenses only.

Item 9a, Signature of Medical Provider Candidate: Self-explanatory.

Item 9b, Date: Annotate date (MMM DD, YYYY format) application was signed.

SECTION D: HEADQUARTERS REVIEW AND APPROVAL: for internal USMEPCOM use.

SECTION E: ADDITIONAL INFORMATION/COMMENTS: for use by the medical provider candidate to continue providing applicable application information.

Item 12a, Signature of Individual Providing Additional Information/Comments: Self-explanatory.

Item 12b, Date Signed: Annotate date (MMM DD, YYYY format) application was signed.

A-16. [USMEPCOM Form 40-2-2-E, Malpractice and Clinical Privileges History Questionnaire.](#) This form is to be filled out in its entirety as follows:

Item 1, Name: List the provider's current full legal name.

Item 2, National Provider Number (NPI): Self-Explanatory.

Item 3, Date of Birth: Self-Explanatory using the format MMM DD, YYYY.

Item 4, Function: Candidates for MEPS CMO positions will check the CMO option, candidates for MEPS ACOMO positions will check the ACOMO option, and FBP contract candidates must only check the FBP option.

Item 5, MEPS Name: Name of local MEPS where the government candidate applied for a position or the local "home" MEPS where an FBP provider will be assigned.

Item 6a-m: Check box for appropriate answer to each question. All questions must be answered.

Note: If yes is answered to any of the questions, please explain in Item 7. If more room is needed, please use the back of the form or attach a typed explanation to the form which is signed and dated by the provider.

Item 7, Comments: Use this box to explain any "yes" answers.

Item 8a, Signature of Applicant: Self-Explanatory.

Item 8b, Date Signed: Self-Explanatory.

Appendix B

Primary Source Verification

B-1. Primary Source Verification

The PQMP requirements include the PSV of medical license, education, and training as documented in Appendix [A](#). Primary source is the original source of a specific credential that can verify the accuracy of a qualification reported by a provider or licensed individual.

B-2. Primary Source Verification Requirements

Documents required by the PQMP can be verified by one of the following methods, listed in order of preference. Each step must be attempted in order; if documents are incapable of being PSVd, each attempt must be described and recorded in a memorandum for record, and submitted along with the provider's documents in the request for certification.

a. Written confirmation from the issuing authority in the form of a letter or an email. For emailed letter, the institution must be clearly identified. In the case of qualifying degrees, certified copies of the final college transcripts are acceptable if the type of degree and the date it was conferred are included on the transcript and the document came directly from the issuing authority.

b. Verbal telephone confirmation from the issuing authority. This confirmation must be annotated on the copy of the document being verified or on a separate memorandum.

- (1) The verification annotation will indicate the date of the conversation,
- (2) agency contacted for the verification,
- (3) agency phone number,
- (4) name and title of the individual at the agency who verified the information,
- (5) the specific information provided,

(6) and the signature and signature block of the person who performed the verification. The signature block of the person requesting verification will include full name, title, and organizational address and phone number.

c. By obtaining an AMA Master file or American Osteopathic Association (AOA) Master file.

d. Internet or website Verifications. The use of a professional organization's website is permitted for PSV of credentials by Headquarters and vendor's credentials verification coordinator if:

- (1) The information is obtained directly from the professional organization's website.
- (2) Use of the website of another recognized professional organization is permitted if it is used as the platform to reach the intended site. The Headquarters and when applicable the vendor's credential coordinator, must confirm the website used is the professional organization's official website, e.g. National Clearing House.

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(3) The information on the website contains all of the information required for the PSV process of the specific credential, to include, sufficient information to properly identify the applicant. For example, name alone might not be sufficient to distinguish the applicant.

(4) Headquarters and when applicable the vendor credential coordinator, must know the currency of information on the website. Information on the website that is supplemental to the information undergoing PSV, such as a state licensing board's website including information on the individual's specialty, is not to be used as PSV data, although it may be useful in evaluating the overall package of information gathered by an individual on the provider.

(5) Headquarters and/or the vendor must assure itself that the source website, when not located at, and under the direct control of the professional organization, receives its information directly from the professional organization's database through encrypted transmission and it is protected from alteration by unauthorized individuals.

(6) The fact that adverse information is not presented on the website does not deter the Headquarters or vendor credential coordinator from contacting the professional organization by telephone or written correspondence if the other information gathered by the organizations warrants it or if there is a discrepancy between what the applicant provided and the information on the website.

(7) The signature block of the person completing verification, along with the date, will be placed on the website printout or other record of information and will include the individual's full name, title, and organizational address and phone number.

e. Least preferred, Touchtone Telephone PSV. Touchtone telephone PSV (in which the caller does not speak with an actual person; instead, the caller electronically accesses a database) is acceptable only if the other methods listed above are not possible and must be annotated as such.

B-3. Primary Source Verification Chain of Transmission

The chain of transmission of the document or information is what distinguishes PSV from secondary source verification. The document or information must come directly from the issuing authority to be considered a PSV. Documents delivered and/or provided directly from the provider still require PSV.

B-4. Document Copies

Copies of diplomas, certificates, licenses, etc. are NOT considered PSV, even if one personally makes the copy from the original document.

B-5. Primary Source Verification Attempts

A reasonable attempt to PSV a document is defined as making a second attempt to solicit the necessary information. If still unsuccessful, annotate the effort, file documentation in the credential package and identify the problem in writing.

B-6. Equivalent Sources

The following are considered designated equivalent primary source verifications:

a. The AMA Physician Master file may be used for PSV of US medical school graduation and US residency program completion.

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b. The AOA Master file may be used as PSV for US medical school and US residency program completions for osteopathic physicians.

c. The ECFMG for verification of physician's graduation from a foreign medical school.

Note: If unable to obtain verification due to destruction of original documents by fire or natural disaster, annotate the reason the PSV could not be completed and attempt to, at least, secondary source verify the information.

B-7. Credential Document Authentication

Annotating authentication true and valid copy of a credentialing document is not an acceptable method of PSV.

B-8. Actions Following Initial Verification

As long as the provider is continually employed by the DoD or an FBP under a personal services contract, the following apply:

a. Licenses, registrations, and certifications must be re-verified as described above.

b. Specialty board certifications with expiration dates must be re-verified (PSV) at time of reissue.

c. Credentials which do not expire or require reissue, such as a qualifying degree, do not need to be re-verified as long as the provider is continually employed by the DoD or the FBP is employed under a personal services contract.

B-9. Inability to Obtain Necessary Credentials Primary Source Verification

Inability to obtain necessary credential verification will be considered when recommending the award of DPC level and may result in a modification of DPC level or failure to award DPC level.

Note: If unable to obtain verification due to destruction of original documents by fire or natural disaster, annotate the reason the PSV could not be completed and attempt to verify the information from a secondary source.

**Appendix C
Provider Clinical Assessment**

[USMEPCOM Form 40-2-3-E, Provider Clinical Assessment and Qualification](#). This form is to be filled out in its entirety as follows:

SECTION A – PROVIDER’S IDENTIFICATION

Item 1, Full Name: List the provider’s current full legal name.

Item 2, National Provider Number (NPI): Self-Explanatory.

Item 3, Current DPC Level: List the provider’s current Defined Provider Category Level (e.g. DPC-1, DPC-2, DPC-3, DPC-4)

Item 4, Function: Self-explanatory

Item 5, Assessment Period: Time frame for the assessment provided in a From: MMM DD, YYYY To: MMM DD, YYYY format.

Item 6, List of Current and Active State Licenses Only: Current and active licenses are listed, a provider does not have to list past, inactive licenses.

SECTION B – CLINICAL ASSESSMENT AND COMMENTS

Items 7-13 and 15: Each medical service assessment will be evaluated and comments provided. In situations where an area is not assessed, please annotate “n/a” and when comments are not used, please annotate “None”. Comments are normally required. Item 8 includes but is not limited to assessing the provider’s professional attitude and appearance. Item 13 includes but is not limited to assessing the provider’s ability to establish rapport with applicants. Item 15 includes but is not limited to assessing the provider’s relationship with colleagues, cooperation with personnel, oversight of fee basis providers, and professional conduct.

Item 14, Name: List the provider’s full name.

Item 16, Additional Comments/Remarks: Annotate comments for use in the evaluation and review of the provider. Annotate comments as to why a DPC level change in Item 17 is being requested along with any justification or remarks for the J-7/MEMD staff to review.

SECTION C – DEFINED PROVIDER CATEGORY (DPC) LEVEL

Item 17a-f: Annotate what category is being requested.

Item 18a-c, Assessment Method: Annotate all methods used in the assessment.

Item 19a, Provider’s Signature: Self-Explanatory.

Item 19b, Date: Date signed.

Item 20a, Assessment Conducted by: Print the name of the person doing the assessment, the person's title, have the person sign and provide the date the person signed.

Item 20b, Overall Assessment: The person signing in Item 20a will provide an overall clinical assessment of the provider being evaluated.

SECTION D – FUNCTION MODIFICATION

Item 21, Select Change, if Applicable: Use this section only when there is a government provider changing functions to an FBP, if an FBP is changing their function and is being hired as a government provider (e.g. CMO or ACMO), or if a government provider changes functions (CMO to ACMO or ACMO to CMO)

SECTION E – ASSESSMENT CERTIFICATION

Items 22-24: For internal J-7/MEMD use only.

SECTION F – MEPS COMMANDER ACKNOWLEDGEMENT

Item 25: MEPS Commander, Acknowledges Receipt: MEPS Commanders will print their names, title, sign, and date the form when it is received and return a copy to J-7/MEMD for filing in the provider's PQMP file.

SECTION G- CONTINUATION SHEET

Additional documentation is placed here. The Item number that corresponds to the continuation documentation should be placed in the section prior to the documentation.

Appendix D
Six Part Folder Requirements

D-1. Folders should be set up in the following manner.

a. Part 1 - Mandatory PQMP Documentation

- (1) [USMEPCOM Form 40-2-1-E, Medical Provider Initial Application.](#)
- (2) [USMEPCOM Form 40-2-3-E, Provider Clinical Assessment and Qualification](#) (when applicable).
- (3) [Use of Gloves During MEPS Medical Examination.](#)
- (4) [Chaperone Training Checklist.](#)
- (5) [USMEPCOM Form 40-2-4-E, Contract Provider Quality Management Form](#) (if applicable).

Note: If a form is in the PRP requalification process, you may place a copy of the form in the folder until receipt of the signed form from the PRP. Only current PQMP documentation shall be kept.

b. Part 2 - contains a copy of the FBP's current Basic Life Support card and current license.

c. Part 3 - Medical Training Requirements Documentation.

- (1) Point of Care Testing for Occult Blood Training Checklist
- (2) DoD Instruction 6130.03 Training Checklist

d. Part 4 - Non-Medical Training Requirements Documentation.

- (1) Cyber Awareness Challenge DoD Version
- (2) Personal Identifiable Information (PII)

e. Part 5 - FBP occupational physical examination certificate.

f. Part 6 - Miscellaneous Documentation, e.g.:

- (1) DD Form 2875, System Authorization Access Request.
- (2) USMEPCOM Training Day Documentation.
- (3) Other PQMP Documentation.
- (4) Bloodborne Pathogen (initial and annual) training and Hepatitis B/declination statement will remain in the FBPs individual record.

D-2. Whenever an FBP requests a change to the FBP's local "home" MEPS and J-7/MEMD approves the request, J-7/MEMD will notify the current MEPS in writing (normally an email from a J-7/MEMD FBP COR) to send the six part folder to the gaining MEPS. Instructions for sending the folder will be included in the email.

D-3. The six part folder will be retained in a secure manner, accessible only to medical staff designated by the MEPS CMO and/or SUP MT, under Record Number 1aa4/800D, "Employee Records – FBP Qualification and Training File". Upon transfer or termination of individual, keep in office file for 3 months, or no longer needed for conducting business, but not longer than 6 years, then destroy.

Appendix E**Internal Controls Evaluation Checklist – MEPS Medical Department**

E-1. Function. The functions covered by this checklist are procedures for MEPS medical departments to implement the PQMP.

E-2. Purpose. The purpose of this checklist is to assist Commanders and medical departments in evaluating key internal controls listed below. It is not intended to cover all controls.

E-3. Instructions. Answers must be based on actual testing of key internal controls (e.g., document analysis, direct observations, sampling). Answers that indicate deficiencies must be explained and corrective actions indicated in the supporting documentation. These controls must be evaluated at least every two years. Certification that the evaluation has been conducted will be done on [DA Form 11-2, Internal Control Evaluation Certification](#). File completed DA Form 11-2 under RN 11-2a3/800B, “Management Control Program”, keep in office file until next management control evaluation, not more than 6 years, then destroy.

E-4. Questions

a. Are government medical providers assigned DPC-1 before being hired by the MEPS Commander? ([UMR 40-2, ch. 3](#))

b. Are contract medical providers assigned DPC-1 before being allowed to train at the MEPS? ([UMR 40-2, ch. 3](#))

c. Are medical providers only performing accession medical services based on their DPC level? ([UMR 40-2, ch. 2](#))

d. Is the MEPS notifying J-7/MEMD of vacancies, hiring actions, interview dates, start dates, and departure dates for CMOs and ACMOs? ([UMR 40-2, ch. 1](#))

e. Is all required initial training completed and documented? ([UMR 40-2, ch. 4](#))

f. Does the CMO have a peer review program for the local MEPS medical providers? ([UMR 40-2, ch. 5](#))

g. Are all medical providers actively participating in the local peer review program? ([UMR 40-2, ch. 5](#))

h. Is the CMO ensuring peer review program documentation is being completed? ([UMR 40-2, ch. 5](#))

i. Are there six part folders for all FBPs that are organized correctly? (UMR 40-2, [ch. 4](#) and Appendix [D](#))

j. Is recurrent training (e.g. glove use, chaperone, standard precautions, bloodborne pathogen, etc.) properly documented?

E-5. Comments

Users may submit comments to HQ USMEPCOM, ATTN: J-7/MEMD, 2834 Green Bay Road, North Chicago, IL 60064-3091

**Appendix F
References**

Section I

Publications referenced in or related to this publication

OSHA Standard 1910.1030

Blood-borne Pathogens.

DoD Instruction (DoDI) 6130.03

Medical Standards for Appointment, Enlistment, or Induction in the Military Services.

AR 11-2

Managers' Internal Control Program.

USMEPCOM Regulation 40-1,

Medical Qualification Program

USMEPCOM Regulation 40-8

Department of Defense (DoD) Human Immunodeficiency Virus (HIV) Testing Program and Drug and Alcohol Testing (DAT) Program.

USMEPCOM Regulation 40-9

Blood-borne Pathogen Program.

USMEPCOM Regulation 690-13

Civilian Personnel Management Program

USMEPCOM Regulation 601-23

Enlistment Processing

Section II

Forms referenced in or related to this publication

DA Form 11-2-R

Internal Control Evaluation Certification

DA Form 2028

Recommended Changes to Publications and Blank Forms

USMEPCOM Form 40-2-1-E

Medical Provider Initial Application.

USMEPCOM Form 40-2-2-E

Malpractice and Clinical Privileges History Questionnaire.

USMEPCOM Form 40-2-3-E

Provider Clinical Assessment and Qualification.

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USMEPCOM Regulation 40-2

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USMEPCOM Form 40-2-4-E

Contract Provider Quality Management Form.

USMEPCOM Form 40-2-5-E

CME Conference/Training After-Action Report.

Appendix G
Glossary

Section I
Abbreviations

AANP
American Academy of Nurse Practitioners

ABMS
American Board of Medical Specialties

ACGME
Accreditation Council for Graduate Medical Education

ACMO
Assistant Chief Medical Officer

AMA
American Medical Association

AMB
Accession Medicine Branch

ANCC
American Nurse's Credentialing Center

AOA
American Osteopathic Association

AR
Army Regulation

ACRS
Army Consolidated Records Schedule

AQR
Annual Quality Review

BLS
Basic life support

CCQAS
Centralized Credentials Quality Assurance System

CME
Continuing Medical Education

CMO

Chief Medical Officer

CNP

Certified Nurse Practitioner

COR

Contract Officer Representative

CV

Curriculum Vitae (plural)/Curricula Vitae (singular)

DA

Department of the Army

DO

Doctor of Osteopathic Medicine

DoD

Department of Defense

DoDI

Department of Defense Instruction

DPC

Defined Provider Category

ECFMG

Educational Council for Foreign Medical Graduates

FB-CMO

Fee Basis Chief Medical Officer

FBP

Fee Basis Provider

FCA

Focused Clinical Assessment

HQ

Headquarters

IAW

In Accordance With

J-1/MEHR

J-1/Human Resources Directorate

J-4/MEFA

J-4/Facilities and Acquisition Directorate

J-7/MEMD

J-7/Medical Plans and Policy Directorate

KO

Contracting Officer

LOR

Letter of Recommendation

MD

Doctor of Medicine

MEPS

Military Entrance Processing Station

NCCPA

National Commission on Certification of Physician Assistants

NCOIC

Noncommissioned Officer in Charge

NPDB

National Practitioner Data Bank

OCA

Ongoing Clinical Assessment

OGME

Osteopathic Graduate Medical Education

OSHA

Occupational Safety and Health Administration

PA

Physician Assistant

PQMP

Provider Quality Management Program

PRP

Provider Review Panel

PSV

Primary Source Verification

SMO

Sector Medical Officer

SOP

Standard Operating Procedure

SUP MT

Supervisory Medical Technician

USMEPCOM

United States Military Entrance Processing Command

Section II***Terms***

Accession Medicine. A phrase coined by J-7/MEMD to epitomize the activities of USMEPCOM centered on evaluating the suitability of the moral, physical, and mental condition of prospective applicants for entry in to military service. Accession medicine is unique to the USMEPCOM medical departments for performing accession medical services. USMEPCOM accession medicine physicians ensure accession standards as defined in the Department of Defense Instruction (DoDI) 6130.03 are applied appropriately for each applicant.

Accession Medical Services. USMEPCOM medical services provided during the medical examination processing of applicants for the Armed Services. Medical services include but are not limited to prescreen reviews of applicant medical history, medical history interviews, physical screening examinations, reviews of medical test results, determinations of whether an applicant does or does not meet accession medical standards, physical inspections, and overseeing MEPS medical department regulatory compliance.

Annual Quality Review (AQR). The AQR is a routine process conducted annually to assess government provider continued proficiency in the provision of accession medical services. The process also certifies that government service providers continue to meet USMEPCOM civilian employee requirements for employment.

Assistant Chief Medical Officer (ACMO). Government civil service physician located at larger MEPS in the medical department. The ACMO uses their professional training and judgment to apply medical qualification standards set forth by the Department of Defense policy. The ACMO is supervised by the CMO, but the Commander has complete authority, within the rules and regulation of USMEPCOM, to direct the ACMO regarding administrative matters. After initial training, ACMOs are expected to be DPC-4 providers. ACMOs are subject to review by HQ USMEPCOM and SMO physicians.

Chief Medical Officer (CMO). Government civil service physician responsible for medical operations at each MEPS or processing facility. The CMOs use their professional training and judgment to apply medical qualification standards set forth by the Department of Defense policy. The CMO is supervised by the MEPS Commander who has complete authority, within the rules and regulation of USMEPCOM, to direct the CMO regarding administrative matters. After initial training, CMOs are expected to be DPC-4 providers. CMOs are subject to review by HQ USMEPCOM and SMO physicians.

Contracting Officer (KO). A person with authority to enter into, administer, modify, or terminate contracts. Make related determinations and findings on behalf of the government.

Note: The only individual who can legally bind the government.

Contracting Officer's Representative (COR). An employee of the U.S. Government appointed by the contracting officer to monitor contractor performance. Such appointment shall be in writing and shall state the scope of authority and limitations. This individual has authority to provide technical direction to the Contractor as long as that direction is within the scope of the contract, does not constitute a change, and has no funding implications. This individual does NOT have authority to change the terms and conditions of the contract.

Credentials. Documents that constitute evidence of qualifying education, training, licensure, certification or registration, experience, current competence, health status, and other qualifications of medical providers.

Defined Provider Categories (DPC). A sequential process whereby providers qualified by the Provider Review Panel are assigned provider levels based on provider experience and competence, and organizational requirements.

Fee Basis Chief Medical Officer (FB-CMO). An FBP (contract employee) who is assigned for a specified work day as the "temporary CMO" when the CMO is absent and the MEPS does not have an ACMO available. An FB-CMO must be a physician with a DPC-4 assignment (is assigned to profile) approved by USMEPCOM. FB-CMOs will accomplish medical histories; physical medical examinations; reviews of required medical tests and documents pertaining to consultations and medical histories; assessing applicant medical documentation and rendering their medical opinion on an applicant's medical qualification for serving in the Armed Forces. FB-CMOs apply set DoD medical standards when determining medical qualifications. When medical standards are unclear or ambiguous regarding the medical qualifications of an applicant the FB-CMO will consult with a HQ USMEPCOM physician.

Fee Basis Provider (FBP). Medical Doctor (MD) or (Doctor of Osteopathy (DO), Physician Assistant (PA), or Certified Nurse Practitioner (CNP), all of which are contract employees, who conduct enlistment physical medical examination screenings at a MEPS. FBPs will accomplish medical histories; physical examinations; reviews of required medical tests and documents pertaining to consultations and medical histories; assessing applicant medical documentation to render a medical opinion on an applicant's medical qualification for serving in the Armed Forces by using qualification standards set forth by Department of Defense policy under the general supervision of the MEPS CMO or designated representative.

FBP Non-Profiler Physician. FBP physician that does not have profiling privileges granted and cannot render a medical opinion on an applicant's medical qualification for serving in the Armed Forces. FBP will accomplish medical histories, physical examinations, and reviews of required medical tests and documents pertaining to consultations and medical histories. Normally physicians will become profilers.

FBP Non-Profiler Non-Physician. FBP Physician Assistant or Certified Nurse Practitioner that is at DPC-2 and cannot render a medical opinion on an applicant's medical qualification for serving in the Armed Forces. FBP will accomplish medical histories, physical examinations, reviews of required medical tests and documents pertaining to consultations, and medical histories.

Initial Professional Review Program. Provides a qualification process resulting in a provider being granted the permissions and responsibilities to provide accession medical services which are represented by DPC levels.

Initial Training Program. Provides standardized training for new CMOs, ACMOs, and FBPs in order to indoctrinate the new provider in accession medical services.

Medical Non-Commissioned Officer In Charge (NCOIC)/ Supervisory Medical Technician (SUP MT). Individual (Government employee) responsible for the administrative operation of the MEPS medical department and general supervision of paraprofessional staff (lead medical technicians, medical technicians) conducting physical screening examinations.

Medical Provider. Medical practitioners providing accession medical services within USMEPCOM. Includes government and contracted physicians, certified nurse practitioners, and physician assistants.

Military Entrance Processing Station (MEPS). DoD activity responsible for administering aptitude tests, medical examinations, and administrative processing of Armed Forces applicants.

Non-Profiler. FBP who does not sign for physicals, known as profiling. Non-profiler's do not hold as much responsibility as Profilers.

Peer Review Program. Ongoing quality review process implemented throughout USMEPCOM where medical providers assess the quality of accession medical services in order to improve performance in providing these services.

Primary Source Verification (PSV). Verification for clinical staff required by the organization or state to have a license, registration, or certification. Examples include medical school (for qualifying degree), graduate medical education program (for residency training), and state medical board (for license). A reasonable effort must be made to verify, with the primary issuing authority.

Profiler. Government physician or FBP physician who has been granted either DPC-3 or DPC-4.

Profiling. A system for classifying individuals according to functional abilities. It is based primarily upon the function of body systems and their relation to military duties. It is applicable for physical exams for enlistment, appointment or induction, and is used to specify whether an applicant meets the relevant physical standards or not.

Provider Quality Management Program. USMEPCOM comprehensive program which provides technical management and quality oversight of the USMEPCOM medical provider pool. The PQMP includes an initial professional review prior to hire; training of medical providers in the unique specialty of accession medicine; and maintenance of quality performance.

Qualification. Qualification includes official review and acceptance of an individual's professional credentials as certified by a national agency or association deemed acceptable to USMEPCOM in order to assure the public that the medical professional has successfully completed an approved educational program and is professionally licensed to practice medicine in at least one state.

Qualification Visit: The qualification visit is part 2 of the initial training program for CMOs and includes a review and assessment of a new CMOs performance approximately 6 weeks after the completion of part 1 of initial training. The visit is conducted by a SMO or J-7 AMB physician or J-7 Director designee for the CMO. CMO are expected to achieve a DPC 4 designation at the end of this visit.

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Quality Performance Maintenance Program. Provides recurring reviews, assessments, feedback, and sustainment training to ensure a quality medical program and continued quality performance of the USMEPCOM medical provider pool.

Regional Trainer. A DPC-4 CMO who has been certified by J-7/MEMD to provide training to new CMOs. Regional Trainers will be trained by J-7/MEMD staff on training requirements.

Requalification. Periodic review and assessment of a provider's credentials and performance in providing accession medical services within USMEPCOM.

U.S. Military Entrance Processing Command (USMEPCOM). Major command responsible for ensuring the quality of military accessions during peacetime and mobilization in accordance with established standards and consists of a Headquarters, two Sector Headquarters, 12 Battalions, 65 Military Entrance Processing Stations, and one remote processing unit (RPU).

USMEPCOM Provider. A physician, nurse practitioner, or physician assistant qualified through the Provider Quality Management Program to provide assigned accession medical services in the MEPS.