Chapter 5

US ARMY OCCUPATIONAL HEALTH PROGRAMS AND SERVICES

TIMOTHY M. MALLON, MD, MPH*; M. DEBRA PARKER, JD, MSN†; JENNYLYNN BALMER, RN, MPA‡; DAVID P. DEETER, MD, MPH¥; AND JANET M. RUFF, RN, MPH§

*Colonel (Retired), US Army; Adjunct Assistant Professor, Department of Preventive Medicine & Biostatistics, Uniformed Services University of the Health Sciences, Bethesda, Maryland 20814

†Colonel (Retired), US Air Force; formerly, Senior Occupational Health Nurse Consultant, Occupational and Environmental Health Portfolio, Army Public Health Center (Provisional), Aberdeen Proving Ground, Maryland 21010

‡Occupational Health Nurse Consultant, Occupational and Environmental Health Portfolio, Army Public Health Center (Provisional), Aberdeen Proving Ground, Maryland 21010

¥Lieutenant Colonel (P), US Army; Director, Occupational and Environmental Health, and Director, Occupational Medicine Residency Program, US Army Environmental Health Agency, Edgewood Area, Aberdeen Proving Ground, Maryland 21010-5422; formerly, Occupational Health Consultant to the Surgeon General

§Senior Occupational Health Nurse Consultant (Retired), Occupational and Environmental Medicine Division, US Army Environmental Hygiene Agency, Aberdeen Proving Ground, Maryland 21010-5422

INTRODUCTION

This chapter is being published as an update to Chapter 3, US Army Health Programs and Services, in the previous edition of this textbook.[1] Much of the chapter has been revised to reflect the new policies and programs that affect the occupational health program at the installation level. The references have been updated as well.

This chapter describes the Army Occupational Health Program (OHP), which promotes health and protects civilian and military personnel from workplace hazards. The OHP's mission is to protect the health of the worker through prevention of injuries and illnesses; to ensure the organization complies with federal, state, and local laws; and lastly to keep workers' compensation medical and disability costs as low as possible through prevention of workplace injuries and management of injured workers' cases to ensure their timely return to work while minimizing long-term disability. For OHP to be effective, the senior leadership in the organization must actively support the program. The OHP manager must coordinate and communicate directly and frequently with other members of the safety and occupational health team, both internal and external to the organization and Army, to develop and maintain a successful program.

Soldiers frequently perform work separate from their combat duties, during which they encounter hazardous exposures similar to civilian exposures. In this context, the military must address the potentially harmful effects of soldiers' work and work conditions, just as these are addressed for civilian employees in the federal government and private-sector workforce. The challenge for military occupational health is to work with commanders to ensure that soldier exposures are evaluated, that health risks are identified and prevented if possible, and that outcomes are documented in the soldier's medical record.

Department of the Army (DA) civilian employees are eligible to be seen in the occupational health clinic for job-related health services including work-related immunizations, work-related injury and illness care, health promotion and wellness education, preplacement and post-hire physical examinations, periodic physicals, and disability retirement physicals. Civilian employees can be seen in the emergency room for emergency care and for minor non-occupational illnesses in Army Medical Department facilities. In deployed settings, federal civilian employees are eligible to use the military medical treatment facility (MTF) for work-related injuries and illnesses and emergency care.

In 1974, the Health Services Command stood up and took command and control of all installation clinics, nursing offices, and occupational health clinics. The responsibilities for managing civilian employee healthcare were assigned to Army preventive medicine services. In 1994, the Army Medical Department reorganized under the Army surgeon general, and the US Army Medical Command (MEDCOM) was formed. Under MEDCOM, there are currently four regional health commands (RHCs), two in the United States (Eastern and Central) and two outside the United States (Europe and Pacific). The Pacific RHC also encompasses Alaska, Hawaii, and Washington state. The four RHCs have command and control over the MTFs in their respective regions.

LAWS, REGULATIONS, AND GUIDANCE

Several laws and regulations protect the health and promote the effectiveness of all federal employees—military and civilian. The guidance provided is intended to serve as the professional minimum criteria for program performance to help occupational health providers and managers implement the OHP and self-assess their programs' performance.

Public Law 79-658

The first law that authorized access to care for federal civilian employees was Public Law 79-658.[2] This law authorized federal agencies to establish health service programs to promote and maintain the physical and mental fitness of their employees, but it limited health services to the following:

- on-the-job illness and injury treatment,
- emergency dental care,
- physical examinations for employment, and
- health promotion services.

The Occupational Safety and Health Act

Public Law 91-596, the Occupational Safety and Health Act (OSHA),[3] requires that all employers provide a safe and healthy working environment for their employees. Executive Order 12196[4] requires that all federal agencies comply with the law. OSHA issued regulations under 29 CFR 1960,[5] Basic Program Elements for Federal Employee Occupational Safety and Health Programs, that require federal agencies to establish an occupational safety and health program.

OSHA regulations under 29 CFR 1910[6] provide the legal requirements for medical surveillance regarding lead, noise, asbestos, and a number of other hazards. Another important OSHA regulation, 29 CFR 1904, Recording and Reporting Occupational Injuries and Illnesses,[7] establishes recordkeeping requirements for agencies. These are often difficult to meet, particularly the requirement for keeping records for 30 years past employment.

Federal Employees' Compensation Program

The Federal Employees' Compensation Act (FECA)[8] was passed in 1916. FECA provides medical and disability benefits to employees who have an injury or illness at work (see Chapter 9, Federal Workers' Compensation Programs, for more detail). The law also includes death benefits for anyone who dies as a result of a work-related injury or illness. The Department of Labor's Office of Federal Workers' Compensation Programs administers FECA benefits, and its regulations are published in 20 CFR.[9] The Office of Workers' Compensation Programs, through its Division of Federal Employees' Compensation, has issued guidelines on filing FECA claims for employees and supervisors.[10,11] Claims by non-appropriated fund employees who are injured on the job are managed by the Division of Longshoremen's and Harbor Workers' Compensation,[12] which handles workers' compensation claims for employees paid with non-tax dollars. Department of Defense (DoD) regulations for FECA claims processing and program management are followed at the installation level.[13]

Regulations and Guidance Applicable to Occupational Health

DoD instructions direct implementation of the occupational safety and health program for military and civilian DoD employees. Guidance is defined in DoD Instruction (DoDI) 6055.01, *DoD Safety and Occupational Health Program*[14]; DoDI 6055.5, *Occupational and Environmental Health*[15]; and DoDI 6055.05-M, *Occupational Medical Examinations and Surveillance Manual*.[16] Army Regulation (AR) 40-5[17] and DA Pamphlet (PAM) 40-11,[18] both called *Preventive Medicine,* provide service-specific implementing instructions for healthcare providers regarding the preventive medicine program, including occupational medicine.

To ensure effective management of the OHP, staff must develop and maintain administrative documents. A good administrative structure is critical to providing effective occupational health services and managing the program. In addition to the laws and regulations that have already been discussed, other Army directives include (*a*) an installation occupational health regulation, (*b*) an OHP document, (*c*) standard operating procedures (SOPs), and (*d*) medical directives for occupational health nurses.

Installation Occupational Health Regulation

The installation occupational health regulation defines policy and guidance as it applies to a particular installation. This regulation should discuss the scope of the mission, including who is eligible for services within the occupational health clinic. It should spell out the responsibilities of occupational health, industrial hygiene, and safety staff; supervisors; and employees, both military and civilian. The regulation should be staffed through all the organizations listed above to ensure support for the regulation and make sure all stakeholders have visibility of the applicable requirements. Once the occupational health regulation is published, it must be kept current through annual or biennial reviews and updates. The occupational health provider and the occupational health nurse must contribute to any installation directive that involves occupational health, from its initial development through the staffing stages.

Program Document

Commanders of medical centers (MEDCENs) and Medical Department activities (MEDDACs) must take responsibility for the OHP document, which details the available occupational health services for the supported units. The program document should include performance goals for each program element, target dates for the accomplishment of each objective, and the methods planned to achieve the objective. The OHP status report (OHPSR) is the tool used to collect program performance data for each element of the OHP, and this data is collected from each installation for an annual performance assessment of the Army OHP. The OHP document should be part of the preventive medicine program document for the installation. The OHP manager and staff should review the document annually. The installation and MTF mission, priorities, and resources should drive the goals and objectives of the OHP document.

Frequently, the manager of the occupational health clinic will be called upon to (*a*) defend the program against reductions in the budget, personnel, and space; (*b*) justify requests for more resources; and (*c*) assure the commander that the clinic is contributing to accomplishment of the installation's mission. An up-to-date, meaningful program document, representing both a

plan for the future and a report on past performance, will be invaluable in these situations. The success of the OHP depends on having a well-developed program document and business plan, as well as highly motivated and resourceful occupational health staff who skillfully execute the mission. The quality of the program depends on a commitment to excellence and caring and compassionate providers who will ensure the health and wellbeing of the soldiers and civilian employees assigned to the installation. Further, the OHP manager must be able to convey information about the program's quality to the senior installation and medical leadership using objective metrics of performance.

Standard Operating Procedures

The occupational health clinic benefits from having well-written SOPs that give detailed step-by-step operating instructions for accomplishing program-specific clinical tasks. The SOP, which is internal to the occupational health clinic, is designed to inform physicians, nurses, nurse practitioners, and physician assistants about routine procedures that standardize practice throughout the clinic. It serves as a training tool so that everyone is familiar with the scope and depth of practice expected for clinical encounters. The SOP is designed to help new providers quickly learn how things are done in the clinic, as well as providing continuity during staff and leadership changes. SOPs are valuable only when they are utilized, and they should be updated annually or more frequently if program elements change due to new OSHA, National Institute for Occupational Safety and Health, or Centers for Disease Control and Prevention guidance.

Medical Directives

The occupational medicine physician or primary care physician supporting the OHP manager can write medical directives that serve as written orders to the occupational health nurse for administering treatment. The directives are very specific, usually covering one type of encounter that details the extent of the history, physical exam, and treatment the nurse is authorized to perform. Medical emergencies do arise when the occupational medicine physician is not available, and the medical directives afford the occupational health nurse an opportunity to provide medical care during these incidents. Further, the medical directives permit occupational health nurses to perform medical screening and surveillance examination elements (blood draws, immunizations, etc) that do not require the presence of a physician.

Medical directives should be tailored to the scope of occupational health services provided at the installation and the competencies of the individual occupational health nursing staff. The directives should be prepared collaboratively by the physician, the occupational health nurse manager, and chief nurse of the MTF. The physician must ensure that the services provided are within the scope of the nursing license for the state and that the nurses are competent to provide the services before signing the directives. All parties who participate in the development of the medical directives should co-sign the final version. The medical directives should be reviewed annually by the occupational medicine physician and the occupational health nurse. It should be signed and dated after each review.

Occupational Health Business Plan

The OHP manager should develop a business plan that includes an assessment of the requirements needed to maintain worker health given the hazards at the worksite. The business plan should:

- state program mission and responsibilities,
- identify individuals and organizations covered by the program,
- determine the requirements of both individuals and organizations,
- ensure the OHP is capable of meeting mission requirements with existing resources,
- identify unmet needs for local OHP requirements,
- determine what additional activities and resources are needed to fulfill OHP requirements, and
- identify ways to obtain needed resources internal and external to the organization, including personnel, financing, supplies, and equipment.

Marketing

The marketing of occupational health services on the installation is necessary to provide visibility for the OHP and to make stakeholders aware of the potential benefits of using available services. It will also aid in predicting what future services will be needed by both management and employees. Through marketing, the OHP can reach out to identify customers' needs and then develop a service that satisfies these needs consistent with the business plan. To satisfy the customers' needs, the OHP manager must invest time and effort to understand:

- customers' level of satisfaction with existing services,
- whether customers have any unmet needs for services,
- the best methods to provide these services,
- whether OHP resources allow for providing these services,
- the timeline for when the additional services may be provided, and
- who the bill payer will be for the additional services.

Marketing is a continuous, systematic process with formal and informal targets of opportunity. Visibility of the OHP can be increased through networking at professional organizations and participating in community activities and regular committees with safety and occupational health professionals. Most importantly, the OPH is marketed by demonstrating and documenting cost effectiveness and customer satisfaction, and communicating to all stakeholders that the OHP is an important and value-added service. OHP staff should take advantage of social media and use brochures that can be distributed to the human resources office, safety personnel, installation headquarters, and the commissary.

Occupational Health Program Evaluation

All federal agencies are required to collect occupational injury and illness data and record it in the OSHA 300 Log of Federal Occupational Injuries and Illnesses.[7] The installation's safety officer usually has the primary responsibility for collecting data and maintaining the log. The safety officer must coordinate with occupational health staff and the installation compensation specialist to ensure that the data are complete. The safety office should report all of the following in the log:

- occupational illnesses,
- job-related injuries that resulted in death or disability,
- job-related injuries that caused employees to lose time at work (other than the day on which the injury occurred), and
- job-related injuries that require medical care.

A review of the OSHA log is one indicator of the effectiveness of the occupational health and safety programs.

AR 40-5[17] and DA PAM 40-11[18] require OHP managers to perform an annual OHP self-assessment and submit an annual OHPSR for their program to the OHP manager at the US Army Public Health Center (USAPHC). These documents also require an external program assessment every 3 years performed by the RHC, MEDCOM, or USAPHC. The use of annual self-assessments and triennial external evaluations offer standardized processes to evaluate the effectiveness of OHPs, identify strengths and significant problem areas, and set priorities for improvement.

ORGANIZATION OF THE ARMY'S OCCUPATIONAL HEALTH PROGRAM

The Army operates more than 80 occupational health clinics around the world. OHP needs vary from installation to installation, so the program's structure and scope vary by location. Army occupational health clinics either work directly for MEDCOM, or they work for and support the Army Material Command (AMCOM).

When working under a MEDCEN or MEDDAC, an occupational health clinic is part of the preventive medicine service. When the clinic works on an installation supported by AMCOM, Training and Doctrine Command (TRADOC), or Forces Command (FORSCOM), it is part of an Army health clinic. MEDCOM Organization and Functions Regulation 10-1[19] prescribes the organization and functions of clinics under MEDCOM command. AR 40-1, *Composition, Mission, and Functions of the Army Medical Department*,[20] describes the operations of Army health clinics and occupational health clinics that are not under MEDCOM command and control. AR 40-5[17] provides additional guidance for the management of OHPs in both situations. AR 40-400, *Patient Administration*,[21] and AR 40-3, *Medical, Dental, and Veterinary Care*,[22] specify who has access to occupational health services and under what circumstances the occupational health clinic may provide care.

Medical Center or Medical Activity Occupational Health Clinic

When occupational health is part of the preventive medicine service, the chief of preventive medicine oversees and supervises the chief of occupational health. The OHP manager is responsible for the day-to-day operation of the administrative and clinical aspects of occupational health. The MEDCEN or MEDDAC supports the OHP by providing laboratory and radiology services required for medical surveillance examinations and treatment of work-related injury and illnesses.

The occupational health clinic is usually staffed by an occupational health nurse, an occupational health technician, a records clerk, and an administrative staff member, depending on the size of the population served and the occupational health services provided. There is a clinical provider who may be a physician, physician assistant, or nurse practitioner. The provider or the occupational health nurse serves as the OHP manager. In the absence of an occupational medicine physician, the chief of preventive medicine often provides clinical support for the OHP if resources do not permit hiring a provider. At some locations, the occupational health clinic may be part of family medicine and primary care. In this case, a provider from the family medicine clinic may provide the clinical support for the OHP.

Army Health Clinic Occupational Health Program

AMCOM, TRADOC, and FORSCOM installations have an employee health clinic that is part of the Army health clinic on the installation. The Army health clinic is under the control of the local installation commander, yet the medical mission for occupational health is directly overseen by the preventive medicine service or department of primary care and family medicine at the supporting regional MEDCEN or MEDDAC. Army health clinic staff usually include one or two providers (either military or civilian), several civilian nurses, and other administrative and support personnel. A provider is usually appointed as the officer-in-charge of the clinic. The Army health clinic usually has in-house laboratory and radiology capability, or employees are sent off base for these services. The mission of the Army health clinic includes providing clinical care to both civilian employees and active duty military personnel on base, as well as family members and retirees.

Patients who require referral to a specialist may be sent to the supporting MEDDAC or MEDCEN, but only after prior coordination with the specialty clinic. Alternatively, patients may be referred to a local specialist. However, such a referral must be approved by the deputy commander for clinical services at the supporting MEDDAC or MEDCEN before an appointment is scheduled. Often financial arrangements for referral of civilian employees to see specialists for work ability determinations must be coordinated in advance through resource management at the MTF and the USAPHC, particularly for compliance with AR 190-56, *The Army Civilian Police and Security Guard Program*.[23]

The staffing and support of Army health clinics by MEDCOM has historically been a challenge, causing problems for installation commanders who want the best care available for personnel on the installation. Army health clinic staffing dramatically improved when MEDCOM and DoD approved the budget plan for 2010 to 2014, which provided $50 million for Army occupational health and industrial hygiene programs over the 5-year period. The OHP manager must coordinate with the USAPHC if personnel or resources are deemed insufficient to execute the mission.

An Army health clinic OHP manager—either the occupational medicine physician, nurse practitioner, physician assistant, or senior occupational health nurse—should be designated in writing. In clinics without an occupational medicine physician or other provider, one of the primary clinic providers should be assigned the responsibility of providing clinical support for the OHP.

Occupational Health Program Staffing

The size and type of the staff of an occupational health section depend on the population to be served, type of installation, range of occupational health services provided, and availability of resources. All OHPs require at least one full-time civilian occupational health nurse, either a full-time or part-time provider, and clerical support. The OHP can request USAPHC staff assistance to run the Automated Staffing Assessment Model for Preventive Medicine[24,25] to document shortfalls in staffing and to request additional staffing. This model, developed by the MEDCOM Manpower Division, is a multivariate model that determines staffing requirements for preventive and occupational medicine. The model inputs include workload, population served, impacts on productivity, cost savings and cost avoidance, and established best practices for preventive and occupational medicine.

Credentialing and Privileging

Credentialing is how an MTF determines what procedures may be performed or which conditions may be treated by each healthcare professional. Credentialing for each provider is based on relevant education, training, experience, and each state's licensing board and the scope of practice permitted by the licensing board. Credentialing may be defined as the process of assessing and validating the qualifications of a licensed professional to provide health services. Per the Joint Commission,[26] each facility should have professional criteria as the basis for granting initial or renewed/revised clinical privileges. These criteria must pertain to, at a minimum, evidence of current licensure, relevant training and/or experience, current competency, and health status.

Privileging is the process MTFs use to determine the specific procedures and treatments that each licensed independent healthcare professional may perform. The provider credentials packet includes the requirements to begin the privileging process and is based upon AR 40-68, *Quality Assurance Administration*.[27] Once professional and technical personnel are assigned to the clinic, each individual is responsible for maintaining current licensure and certification according to legal and professional requirements.

Occupational Health Providers

The occupational health provider may be a military or civilian physician, physician assistant, or nurse practitioner. The qualifications of a civilian physician and military physician may vary somewhat. The MEDCEN or MEDDAC credentialing committee must approve the occupational health provider's clinical privileges as an occupational health physician, physician assistant, or nurse practitioner. Civilian occupational medicine physicians or other civilian providers must meet the minimum qualifications of the Office of Personnel Management (OPM)[28] to be selected for the position. In addition, training or prior experience in the field of occupational health is needed. The occupational health provider can be assigned as a part-time or full-time member of the occupational health clinic staff, based on staffing requirements. Part-time support is seldom adequate because these providers also have clinical duties in the primary care clinic, which limits time spent on occupational health duties.

Occupational Health Nurses

The Army employs civilian occupational health nurses, who are usually registered nurses, to work in the occupational health clinic. These nurses must meet the minimum OPM qualifications and hold a current state license to practice nursing. MEDCEN or MEDDAC clinical privileges are not required for occupational health nurses who practice within the scope of nursing practice for their state license. Occupational health nurses may seek additional training beyond a bachelor's degree by earning a master's degree in occupational health nursing. This additional training is often thought necessary to become a certified occupational health nurse. The master's-level coursework usually includes management principles; industrial toxicology; the cause, prevention, control, and treatment of occupational injuries and illnesses; principles of industrial hygiene and epidemiology; concepts and practices of job-related medical surveillance; and legal and regulatory aspects of occupational health. A course in biostatistics is also helpful for the occupational health nurse manager who is performing health surveillance on specific worker populations.

Industrial Hygienists

The industrial hygienist assists the occupational health clinic staff by providing information on industrial hygiene program efforts to support and maintain a safe and healthful workplace, as mandated by OSHA,[3] DoDIs,[14–16] ARs,[17] and DA PAM 40-503, *Industrial Hygiene*.[29] The industrial hygienist should provide the clinic with copies of worksite visit reports that identify and quantify occupational health hazards. These reports should also recommend appropriate medical surveillance enrollment when the action level specified in OSHA regulation is half the permissible exposure level (PEL), or when the American Council of Governmental and Industrial Hygienists (ACGIH) threshold limit value (TLV) is exceeded. When workplace chemical exposures exceed the OSHA PEL or ACGIH TLV, the industrial hygienist, in conjunction with the site supervisor and safety manager, conducts an investigation to identify the source of the exposure, characterize the degree of exposure, and write a summary report that documents for those workers involved the chemicals involved, the exposure levels encountered, and duration of exposures. The industrial hygienist also provides the clinic results of air sampling, wipe sampling, or noise dosimetry surveys. He or she reviews plans and blueprints for modifications to and construction of new worksite facilities or operations to ensure adequate planning for heating, ventilation, and air-conditioning systems, making sure the ventilation planned for workplace hazards will protect worker health and safety. The industrial hygienist also collaborates with occupational health, safety, and human resources to provide employee health education, and participates on the installation safety and occupational health and FECA working groups.

Safety Personnel

Safety personnel collaborate with occupational health and industrial hygiene staff to ensure that civilian employees and soldiers follow safe work practices, use appropriate personal protective equipment, and report work-related injuries and illnesses. Occupational health providers and staff should be aware of the numerous Army safety regulations and pamphlets, including AR 385-10,[30] DA PAM 385-1,[31] and DA PAM 385-10,[32] to ensure occupational health coordination of efforts and participation as appropriate in safety and OHP activities. Coordination on worksite visits, the

FECA program, and injury and illness reporting and investigation of accidents are but a few of the many issues that require occupational health providers and safety staff to work together.

Supervisors

Supervisors must ensure that personnel comply with all safety and occupational health requirements, such as attendance at medical surveillance and screening exams, training, use of personal protective equipment, safe work practices, and respirator fit testing. Supervisors also play a large role supporting the FECA program when they review the circumstances surrounding an employee's claim for compensation benefits for a work-related injury. The supervisor must sign the claim form attesting to the facts as presented by the civilian employee, or check that the claim should be controverted if the facts in the case are different than what was reported.

Employees

Employees must follow safe and healthful work practices, use personal protective equipment when required, and make note of and report suspected unsafe or hazardous work situations to their supervisor. Employees must also comply with the requirements of the OHP and participate in medical surveillance programs when required by OPM[33] and ARs.[17] Employees should report any work-related injury to their supervisor at the time of occurrence or no more than 72 hours later, and report to the occupational health clinic in compliance with the installation commander's "clinic-first" policy. This will ensure the circumstances related to the injury are documented in the employee's medical record in the occupational health clinic and help to ensure timely completion of claim forms that will initiate continuation of pay and medical benefits.

MEDICAL RECORDS MANAGEMENT

The civilian employee medical record (CEMR) contains all records pertaining to occupational health physical examinations, workers' compensation records, and administrative reports. The purpose of the CEMR is to document the medical history of the patient and medical care provided for injuries and illnesses. The CEMR records in chronological order any work-related changes in health status, comprehensive health histories, workplace exposure records based on sampling conducted by industrial hygiene staff, a healthcare professional's written medical opinions regarding workplace examinations and whether the employee developed injuries or illnesses related to the job, and a record or all medical conditions, medications, and treatment for all work-related conditions.

OPM owns the CEMR and delegates its custody to the MTF commander. The chief of the MTF's Patient Administration Division acts on behalf of the commander in matters that involve medical records. Periodically, the chief of the Patient Administration Division or their representative inspects the employee health records to ensure compliance with AR 40-66 recordkeeping requirements[34] and make sure medical encounters are properly coded using ICD-10.[35] Upon request, the patient administration division will provide training on coding rules and guidelines for all providers.

The CEMR and active duty treatment record should be maintained separately and each record marked appropriately to facilitate identification. If the civilian employee has dual status as a National Guard member or Reservist, or they retired from the active duty military, then the service member's outpatient treatment record should not be consolidated into the CEMR. It is strongly recommended that the OHP manager ask civilian employees who hold dual status to sign both the Privacy Act[36] and the Health Insurance Portability and Accountability Act (HIPAA)[37] notice giving informed consent that information in their health record may be utilized and included in the medical history section of the occupational health record. This will prevent problems later if questions of work ability arise when HIPAA may limit access to the information in the military treatment record unless an informed consent was signed by the employee.

OPM's *Guide to Personnel Recordkeeping*[38] and AR 40-66[34] direct how the CEMR should be maintained, and all entries into the CEMR must be made. The Report of Medical History (DD Form 2807-1) is used to obtain a health history from all civilian employees and to initiate a medical record upon employment. Once the medical record is initiated, the form should be kept in the Service Member Treatment Record (DA Form 3444) or in the CEMR folder (SF 66-D). DA and DoD forms are the only approved forms for use in the medical record. The MTF commander may approve the use of any forms that were developed locally. Office of Workers' Compensation forms related to medical treatment (CA-1, CA 15, CA-16, and CA 17) may also be maintained in the medical record. The CEMR should be sent to the civilian person-

nel office of the gaining unit when the employee transfers to another agency, or sent to the National Records Center when the employee retires.

Small radiographs (8.5 × 11″ or smaller) should be placed in the CEMR and retired or forwarded to the gaining unit. However, larger chest radiographs (larger than 8.5 × 11″) should be maintained at the MTF for 30 years beyond the termination of employment. The CEMR must have a copy of the written radiologist's findings, the last known location of the radiograph, and how the plain film can be obtained. If the employee is transferring to another federal agency, the large films must be forwarded to the gaining agencies' supporting occupational health clinic.

Like any other medical record, the CEMR must be maintained in accordance with the Privacy Act[36] and HIPAA.[37] Both OSHA and National Institute for Occupational Safety and Health personnel must be given access to the CEMR when they are investigating workplace exposures to toxic materials or harmful physical agents such as radiation and noise.

OCCUPATIONAL HEALTH PROGRAMS AND SERVICES

OHPs provide medical, dental, and veterinary personnel with clinical preventive and occupational health services. Occupational health staff conduct work-related medical surveillance and perform various administrative medical examinations, as well as educating employees about health hazards in the workplace. The occupational health clinic conducts medical screening of civilian employees who have been absent from work, and also provides immunizations for at-risk employees to prevent workplace infections. Clinic staff also conduct worksite visits to evaluate the workplace for hazardous conditions. Occupational health providers may conduct epidemiological studies of workplace injuries or illnesses to target at-risk workers with countermeasures to reduce injuries and illnesses. Finally, employees can be seen in the occupational health clinic for emergency treatment of work-related illnesses and injuries and non–work-related minor illnesses and injuries.

Medical Surveillance

Job-related medical surveillance consists of systematically and periodically collecting and analyzing health data on groups of employees for the purpose of early detection of an increased risk or actual presence of job-related health effects. Medical surveillance is prospective and ongoing in nature. Designing a medical surveillance program requires identification of employees with a potential exposure to job-related hazards. Medical surveillance is covered in detail in Chapter 10 of this book.

Administrative Medical Examinations

Managers need to know whether employees are able to perform the essential duties of their job safely, without undue risk to themselves or others, in order to make employment decisions. Administrative medical examinations will determine if the employee can perform the job safely and efficiently. The occupational health provider's role is to assess whether any medical or psychological conditions exist, and if so, determine whether the condition is stable and whether the individual's ability to perform the essential functions of the job is impacted by the condition. OPM has established medical standards and physical requirements for only a limited number of jobs (refer to Chapter 8, Agency Medical Evaluations, for a more in-depth discussion of OPM's existing regulations and requirements for employee medical examinations).

The occupational health clinic performs a variety of administrative physical examinations that include preplacement/post-hire physical examinations, periodic medical examinations, fitness-for-duty examinations, and retirement disability examinations. The occupational health provider performs the preplacement/post-offer physical examination to assess the employee's abilities to do the job, and also to establish a baseline medical assessment against which future assessments regarding workplace exposure can be compared. OPM mandates medical examinations for civilian employees only when the job has physical standards, the workplace involves hazardous exposures, or the employing agency requires a physical.

The Civilian Personnel Office usually forwards the job description and the OF 178, Certificate of Medical Examination, or DA Form 3437, Non-Appropriated Funds Certificate of Medical Examination, to occupational health clinic staff for completion by the examining provider. The OF 178 lists the specific job's physical requirements and the environmental factors that the employee will encounter on the job. Though not required by OPM, applicants for positions with duties that are sedentary or moderately active should complete a DD Form 2801-1, Report of Medical History, and take advantage of baseline screening, such as for blood pressure, vision, and hearing.

Periodic administrative examinations are performed to evaluate an employee's continuing ability to perform the job. OPM requires personnel in only a few positions to undergo periodic medical examinations. It is considered a standard of practice for occupational health providers to perform periodic examinations on selected groups of employees who have OPM medical examination requirements. The frequency of the periodic examination is specified in the appropriate AR: AR 190-56, *The Civilian Police and Army Security Guard Program*,[23] requires periodic examinations for police and security; AR 600-55, *The Army Driver and Equipment Operator Standardization Program (Selection, Training, Testing, and Licensing)*,[39] requires periodic examinations for drivers of commercial vehicles; and AR 50-6, *Nuclear and Chemical Weapons and Materiel, Chemical Surety*,[40] and the corresponding DA PAM require periodic physicals for employees in the chemical surety program. OSHA regulations also provide guidance regarding medical surveillance examinations for specific workplace exposures, particularly carcinogens, and the National Fire Protection Association Standard 1582[41] provides guidance for firefighter examinations.

Fitness-for-Duty and Disability Retirement Examinations

Per 5 CFR 339, OPM allows agencies to direct an employee in writing to undergo a medical examination provided there is sufficient reason to believe they are unable to perform the essential duties of the position due to physical or mental impairment.[33] The agency must inform the employee in writing of the reasons for the examination and notify them of their right to have a physician submit needed medical documentation to address work ability. Further, the agency must pay for medical examinations employees are directed to undergo.

Supervisors may request a fitness-for-duty examination for an employee by asking the human resources office to direct the employee to undergo the exam. Human resources staff will then issue the employee a letter directing them to report to the occupational health clinic for the exam at a specified time. The occupational health clinician will complete the examination and note in writing the employee's capability to meet the physical or medical requirements of a position. The agency may also offer a psychiatric evaluation to help establish the employee's work ability. An employee who submits a request for medical accommodation under the Americans With Disabilities Act,[42] as amended, or the Family and Medical Leave Act[43] must submit supporting medical documentation.

Worksite Evaluations

Occupational health staff conduct worksite evaluations annually and when operations change. These evaluations can be performed independently or with safety and industrial hygiene staff. Occupational health clinic staff should conduct worksite visits because it allows the provider to gain an understanding of organization work practices and hazards, and how well the employees comply with requirements to use personal protective equipment. During the visits, staff should encourage employees to take full advantage of the services offered by the occupational health clinic, including health promotion and health hazard training.

Health Hazard Education

OSHA mandates that employees receive training on workplace hazards in 29 CFR 1910.1200, Hazard Communication.[44] Supervisors are primarily responsible for ensuring that employees get mandated training and that the training meets OSHA requirements. The safety and occupational health team has a role in ensuring the training is a success. Occupational health providers train employees about the signs and symptoms of exposure, what medical surveillance is done to identify worker exposure, and what potential health outcomes might occur as a result of workplace exposures. In addition, the provider should indicate when emergency treatment is needed for an acute exposure and identify what clothing and equipment is needed to protect against the hazard. Occupational health clinic staff may provide job-related health education individually during job-related health evaluations, or train groups of employees who are exposed to the same hazards. Documentation of the education is required in the CEMR.

The occupational health clinic can also provide health promotion and wellness classes to assist employees in achieving optimal health. This education is usually given when the employee receives healthcare or approaches clinic staff with questions or problems. Providers may supplement the health education provided in the clinic by making educational pamphlets available to employees or publishing health information in the installation newspaper for dissemination to the workforce.

Monitoring Absences Due to Illness

The occupational health provider can help keep employees healthy, which minimizes lost work time and helps supervisors maintain productivity. This will also reduce the burden on supervisors and the

Civilian Personnel Office in terms of tracking work absences. Illness absence monitoring ensures that employees are well enough to perform the job safely; however, the identification and control of abuse of leave benefits is a supervisory and Civilian Personnel Office responsibility.

The installation occupational health regulation should include processes for monitoring absences due to illness that involve evaluating and treating employees who become ill or are injured during duty hours, or referring them to their treating provider. This will ensure the appropriate disposition of ill employees, permit the occupational health clinic staff to provide health education, increase awareness of health problems, and increase the staff's ability to detect sentinel health events.

Employees who treat patients and those who handle food must report to clinic staff for evaluation after any illness or injury. Generally, if other employees are out for 3 days, they should also be asked to be evaluated at the clinic. Occupational health providers should determine the appropriate duration of work absences, and they must decide whether civilian employees can return to work safely after a work absence due to illness and ensure they are well enough to work. If employees cannot perform their full duties, they may be able to return to work with limitations or work elsewhere for a limited period of time. An evaluation after a work absence due to a job-related illness is essential to document the accident particulars and note the work ability of the employee.

Injured workers should also report to the occupational health clinic so that a medical evaluation can be performed to assess their work ability. These evaluations may require only a review of medical reports, or they may call for a directed physical examination. The occupational health physician should request specialty consultation when indicated.

Immunizations

Research laboratories using certain biological warfare agents and clinical laboratories using live bacteria and viruses that require biosafety level 2 or higher protection pose a potential health risk for their employees. Some of these hazards are also found in hospitals, medical and dental clinics, and animal-care facilities. Employees who travel to certain foreign countries may also be at increased risk.

Army immunization guidance is published in AR 40-562, *Immunizations and Chemoprophylaxis*.[45] The immunization program provides appropriate immunizations for healthcare personnel who are at risk. AR 40-562 mandates that military and civilian healthcare providers who are at risk for blood-borne pathogen exposure be immunized against hepatitis B.[45(p12)] The occupational health clinic also offers rubella, tetanus, and influenza immunizations for medical and dental personnel; rabies prophylaxis for veterinary staff and animal handlers; and special vaccinations for staff in research medical laboratories. The occupational health clinic screens high-risk dental, medical, and veterinary personnel for active tuberculosis as well.

Clinic staff also provide immunizations to civilian personnel against illnesses such as influenza to prevent communicable disease outbreaks and reduce work time lost to illness. Staff must assess whether the available immunization is sufficient to effectively control the threat. The Advisory Committee on Immunization Practices provides guidance for healthcare providers, published on the Centers for Disease Control and Prevention website.[46]

Epidemiological Investigations of Occupational Illnesses and Injuries

Occupational health clinic providers should conduct an epidemiological investigation when an occupational illnesses or a cluster of occupational injuries in the same worksite occurs. For example, five lower back strain cases in a short period of time at the same location should prompt an investigation into the cause.

Any factors at the worksite that may have contributed to the condition are the subject of the epidemiological investigation. The scope of the investigation should extend beyond individual cases to include all those at risk of illness or injury. The investigation should include members of safety, industrial hygiene, and preventive medicine services, as well as supervisors and human resources staff.

An epidemiological investigation can be a simple investigation of exposure at the worksite, or it can be a detailed assessment that includes sample collection and analysis of suspected agents, medical examinations, test results and diagnosis, and a literature review. The occupational health team may also contact the USAPHC for assistance with the epidemiological investigation through command channels.

Health Promotion

The Army Health Promotion Program is designed to promote and maintain the health and well-being of both military and civilian personnel. Health promotion and wellness programs have improved employee morale and reduced absenteeism and presenteeism (being at work without being productive). Army

installations must establish a wellness council that meets the requirements of AR 600-63, *Army Health Promotion*.[47] All employees are encouraged to participate in fitness and exercise programs. However, ARs permit only employees in jobs with physical fitness requirements, such as police and firefighters, to be granted regular time off to participate in fitness training. Other employees may receive only a one-time grant of no more than 3 hours of administrative time per week, for 6 to 8 weeks, to participate in command-sponsored physical fitness programs. Occupational health providers may provide medical examinations to clear employees for participation in the physical fitness program.

Emergency Treatment of Illnesses and Injuries

Civilian employees are eligible for diagnosis and treatment of occupational injuries and illnesses in the occupational health clinic[21,22]; they may sometimes be seen for non-occupational illnesses and injuries as well. Civilians may be seen in the emergency room for emergent, non–work-related conditions to prevent the loss of life or limb, or to relieve suffering until they can be seen by their private physician. Some civilian contractors may be seen for work-related and non–work-related conditions if specified by the terms of their contract. This is usually permitted only in locations where civilian treatment facilities are not available, such as a deployed setting or other remote location. Finally, civilian employees may be seen in the occupational health clinic for non-occupational injuries or illnesses of a minor nature for first aid or palliative care that would enable the employee to complete the work shift before they see their physician. Civilian employees may also ask to be seen for minor treatments such as suture removal or for blood pressure monitoring, which will be supported if space is available and the occupational health clinician supports it to minimize lost work time.

SUMMARY

The OHP Army mission is to promote health and to provide job-related, occupational healthcare services for civilian employees and active duty service members, including the operation of 80 occupational health clinics worldwide. This chapter has reviewed the basic structure and program guidance for the OHP. OHP staffing, resources, and programs were reviewed to give providers an awareness of the scope and complexity of the program. The pertinent OSHA, DoD, and Army regulations were reviewed in a comprehensive fashion to show how the regulations and policy guidance apply in the occupational health setting.

The occupational health clinic provides core occupational health services, including job-related medical surveillance, administrative medical examinations, health hazard education, monitoring of absences due to illness, immunizations, health promotion, and treatment of work-related injuries and illnesses. The ARs relating to the provision of occupational health services provide guidance on who has access to occupational health services. The occupational health provider must be aware of military personnel who have workplace hazards and may require periodic medical surveillance like their civilian counterparts. In such cases, the occupational health clinician must include these personnel in periodic medical surveillance because their primary care providers may be unfamiliar with the workplace hazards.

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