DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
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BUMEDINST 5100.13G
BUMED-N44
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BUMED INSTRUCTION 5100.13G

From: Chief, Bureau of Medicine and Surgery

Subj: NAVY MEDICINE SAFETY AND OCCUPATIONAL HEALTH PROGRAM

Ref: (a) through (x)

Encl: (1) References
(2) Critical Path Reporting
(3) Navy Medicine Guidelines for Hearing Conservation Program Management

1. Purpose. To issue Bureau of Medicine and Surgery (BUMED) policy regarding the Navy Medicine (NAVMED) Safety and Occupational Health (SOH) Program, per references (a) through (w). This is a complete revision and should be reviewed in its entirety.

2. Cancellation. BUMEDINST 5100.13F.

3. Scope and Applicability. Applies to all NAVMED activities.

4. Background

a. This instruction provides roles and responsibilities for the NAVMED SOH Program as well as services provided in support of Department of the Navy (DON) organizations and activities. The provisions of references (a) through (x) apply to all NAVMED activities and assigned personnel. The NAVMED SOH program includes safety, occupational and environmental medicine (OEM), occupational audiology (OA), hearing conservation (HC), industrial hygiene (IH), and environmental health (EH) disciplines and services.

b. NAVMED's Safety Management System (SMS) will follow the framework and structure for how safety risks are managed to maintain compliance while focusing on performance. Reference (a) establishes organizational responsibility to successfully implement an enterprise SMS aligned with the principles of the Navy's SMS.

c. Reference (b) provides procedures for mishap and safety investigations, reporting, and recordkeeping. The Hazard Review Board process will be implemented to effectively identify, communicate, and account for organizational risks.

d. Reference (c), is the single-source guide for all Department of Defense (DoD) activities for injury compensation program management under the Federal Employees Compensation Act.

5. Policy. Per reference (a), establish an effective NAVMED SOH Program to improve risk management in support of the NAVMED SMS policy.

6. Action. These actions are required in addition to the requirements outlined in references (a) through (s):

a. SOH Responsibilities

(1) BUMED Public Health and Safety (BUMED-N44) will:

(a) Oversee comprehensive program management of Safety, IH, OEM, HC, and EH disciplines within their authority and scope per references (a) through (r).

(b) Develop and issue policies along with strategic goals and objectives applicable to SOH programs within their authority and scope.

(c) Conduct formal onsite triennial Safety and Occupational Health Management Evaluations (SOHMEs) of echelon 3 NAVMED commands.

(d) Oversee annual metrics to measure enterprise-wide SOH program performance at echelons 3 and below.

(e) Establish operational risk management (ORM) policy and integrate with high reliability organization (HRO) principles.

(f) Establish and manage the SMS to align with NAVMED principles and setting processes focused on continuous improvement that is aligned with HRO principles.

(g) Evaluate SOH performance, per references (a) through (s), and SMS policy.

(h) Oversee organization and staffing of the SOH program are accomplished, per reference (a). The IH staffing standard will be implemented per reference (t).

(i) Ensure NAVMED high risk training (HRT) policy and procedures are aligned with references (e) through (g).

(j) Implement and ensure effective execution of the Hazard Review Board process. Review and approve all Class A and B mishaps reported in the Risk Management Information Streamlined Incident Reporting (RMI SIR) system.

(k) Provide self-assessment guidance for NAVMED SOH and HRT activities, per references (a) and (e) through (g).

(l) Represent NAVMED for SOH councils, working groups, and meetings to maintain an enterprise-wide perspective to program implementation.

(m) Prepare and report enterprise-wide Safety metrics using the Enterprise Safety and Applications Management System (ESAMS) and RMI SIR in combination with SOHME results and other evaluative data.

(2) Commanders, NAVMED Echelon 3 Commands will:

(a) Provide leadership, oversight, and management to support the implementation of the comprehensive SOH Program at all BUMED commanded activities under their authority per references (a) through (r). Regional SOH Program Management includes a multidisciplinary team of SOH professionals comprised of Safety, IH, OEM, HC, and EH disciplines.

(b) Oversee a comprehensive NAVMED SOH Program per the references in this instruction. Ensure risk is managed through the NAVMED SMS at all activities under their cognizance.

(c) Develop, implement, and manage SOH programs that meet the goals and objectives as outlined in their corresponding strategic plans.

(d) Facilitate NAVMED SOH policy development and improvement. Establish and implement regional SOH Program business rules.

(e) Conduct formal onsite triennial SOHMEs using standardized procedures at subordinate echelon 4 activities. Review and assess SOH program components and benchmarks.

(f) Provide informal technical assist visit (TAV) program assistance and program reviews. Review TAV requests from subordinate activities to determine whether the appropriate NAVMED region or echelon 4 commands can provide the necessary assistance.

(g) Provide advice, TAVs, and representation on working groups as requested by BUMED and higher authorities.

(h) Encourage inter-departmental and intra-departmental communication and cooperation among all professional disciplines of SOH programs.

(i) Track the NAVMED activity's full use of ESAMS until complete migration to RMI SIR. Until RMI SIR is mature enough to manage, ensure ESAMS is used to record deficiency tracking, HRT program specific requirements, self-assessment results, hazard abatement, medical surveillance and training, traffic safety, and motorcycle rider training.

(j) Monitor and take action to ensure adequate resources and staffing to execute and sustain acceptable performance measures at all BUMED commanded activities under their authority. Implement the IH staffing standard and utilize the calculator per reference (t).

(k) Monitor and take action to ensure SOH training and continuing education adequately supports existing program and credentialing requirements to allow staff to fulfill assigned duties and responsibilities. Provide evidence for educational initiatives (i.e., gap analysis) which include the desired future state for skills, experience, credentials, or education to address critical business areas that will benefit from performance improvement. When planning to assess a new training requirement, collaborate with BUMED stakeholders (i.e., BUMED-N44, BUMED-N7, and BUMED-N8), Naval Safety and Environmental Training Center, subject matter experts (SME), and other pertinent stakeholders.

(l) Provide consultative services and subject matter expertise for HRT program implementation and informing relevant policy development.

(m) Ensure OEM program managers provide installation support including, but not limited to:

1. Act as direct consultants to Navy commands to ensure all OEM services being provided meets Navy requirements.

2. Work with tenant commands Human Resources Offices to ensure preplacement request using the DD-864 functional and environmental factors are appropriate and to advocate for standardization of the request(s).

3. Engage the major command stakeholders to identify compliance issues and weaknesses of OEM deliverance.

4. Engage and communicate at the regional, fleet, and installation level (e.g., supervisors, safety, IH, and managers) regarding status of medical surveillance, qualification enrollment, and occupational health (OH) issues.

5. Review installation metrics to provide recommendations for improving medical surveillance compliance.

6. Obtain regional access to RMI SIR for all installations to identify areas of delinquent medical surveillance, data analysis, and compliance of OEM programs.

7. Inclusion in appropriate work groups and committees.

8. Work with the regional level workers compensation personnel to clearly identify overall trends.

(3) Commanders, Commanding Officers (CO), Officers in Charge (OIC), Echelons 4 and 5 NAVMED Activities will:

(a) Support BUMED's comprehensive SOH Program, per references (a) through (r) to manage risk through the NAVMED SMS at all activities. Establish and maintain an effective SOH program using the requirements set forth in references (a) through (s) and within the framework of the SMS. SOH Programs incorporate Safety, IH, OM, OA/HCP, and EH, along with a multidisciplinary team of qualified SOH professionals who implement, support and manage these programs.

(b) Leverage the SOH Program personnel requirements, using the SMS principles, to build change management processes for the identification, evaluation, prioritization, and mitigation of hazards and risks.

(c) Utilize ESAMS and RMI SIR to manage safety programs.

1. Fully use ESAMS to record deficiency tracking, HRT program specific requirements, self-assessment results, hazard abatement, medical surveillance and training, traffic safety, and motorcycle rider training.

2. Full participation in ESAMS by supervisors, work centers, and departmental safety representatives is required for assignment of duty tasks, medical surveillance and medical qualification tracking, safety training, and entering required demographic information in ESAMS.

3. All staff members will have an active ESAMS account with appropriate access assigned by the safety professionals and duty task(s) assigned by their workplace supervisor.

4. All personnel must complete required safety web-based training and in-person training upon initial assignment to the command and enrollment in ESAMS.

5. As RMI SIR is developed and matured, ESAMS usage, reporting, and program management will transfer to RMI SIR.

(d) Utilize RMI SIR to manage mishap data, per references (a), (b), (e), (f), and (i). On-duty mishaps at military treatment facilities (MTFs) are reported by the organization supervising their day-to-day duties and accessible by the CO, Navy Medicine Readiness and Training Command (NAVMEDREADTRNCMD). Off-duty mishaps are reported in the RMI SIR system and input by the collateral duty safety officer (CDSO).

(e) Conduct effective mishap and safety investigations, reporting, and record keeping, per reference (b), as well as this instruction. All mishap reports must be recorded in the RMI SIR system. To facilitate accurate mishap reporting, all commands must have a designated user administrator with an active RMI SIR account.

(f) Submit TAV requests to the appropriate NAVMED Region.

(g) Maintain inter-departmental and intra-departmental communication and cooperation among all professional disciplines of SOH programs.

(h) Ensure full utilization of Defense Occupational and Environmental Health Readiness System (DOEHRS) for IH, EH, and HC to document and evaluate OH hazards and related assessments and potential community exposures, per references (b) and (i).

(i) Implement tracking tools to adequately document program requirements and support activities not available in DOEHRS (i.e., training, design reviews, etc.).

(j) Staff and organize safety offices as outlined in references (a) and (h). Align the safety department so the safety manager or CDSO reports directly to the CO as a special assistant. For commands that have civilian safety managers or staff, the safety manager and staff will be assigned to the executive officer and must not be delegated lower in the organization. Those activity safety offices tasked with managing other program elements not included in reference (a) minimum core requirements (e.g., fire prevention, life safety, environmental program, emergency management, and laser safety) must consider this as an additive function, and ensure additional resources are provided to support these additional functions.

(k) Appoint CDSOs for a minimum of 1 year with a rank of E-6 or above. Primary and alternate CDSOs, at a minimum, will complete Introduction to Naval SOH (Ashore) Global Online Course Identification Number (CIN): A-493-0550; Mishap Investigation Course CIN: A-493-0078; and Introduction to Hazardous Materials (Ashore) Global Online CIN: A-493-0331. Additional training will be required to manage other specific safety programs and program support.

(l) Establish a Safety and Occupational Health Council (SOHC) or support the installation SOHC. The SOHC should include representatives from safety, OEM, IH, and HC, and must meet quarterly to address SOH issues with the goal of preventing occupational illnesses and injuries. SOHCs can be included in other command meetings.

(m) Conduct technical review of SOH notifications, correspondence, and reports by SMEs.

(n) Consider delegating “By direction” authority to qualified IH department heads.

(o) Report critical information to BUMED within the time periods listed in enclosure (2).

(p) Prepare annual budget plan for SOH programs and associated priorities to include staffing, equipment, supplies, training, travel, and reference material requirements and costs.

(q) Coordinate closely with the regional program managers to ensure optimal integration and alignment across the enterprise.

(r) Provide requests for technical and managerial assistance from the supporting region when needed.

(s) Utilize SOH program evaluation tools to perform annual assessments (i.e., IH Program Self-Assessment Checklist). Participate in external audits to document program effectiveness and make improvements to the program.

(4) Commander, Navy and Marine Corps Force Health Protection Command (NAVMCFORHLTHPRTCMD) will:

(a) Provide support and subject matter expertise in such areas as OEM, IH, EH, HC, risk assessment, risk communication, and toxicology. Support is provided to Navy echelons 2 through 5 commands (primarily NAVMED commands), Navy and Marine Corps acquisition, and operational program managers.

(b) Provide consultative support to Navy environmental programs and technical representation to working groups and committees as tasked by BUMED or higher authority.

(c) Maintain a comprehensive organization of OH and preventive medicine (PM) expertise in support of the Navy and Marine Corps.

(d) Specific examples of the support NAVMCFORHLTHPRTCMD provide includes:

1. Ensure SMEs in fields listed in subparagraph 6a(3)(a) are available to provide consultation and technical field support to DON where appropriate and following internal procedures to process request accordingly.

2. Publish and maintain technical manuals and all associated medical matrix data on the subject matter listed in subparagraph 6a(3)(a). This includes but is not be limited to OEM field operations manual, reproductive hazards manual, IH field operations manual, HC program procedures manual, blood-borne pathogen exposure prevention manual, heat and cold stress NAVMED P-5010-3, and the OEM Surveillance Procedures Manual and Medical Matrix,

with its companion software product Medical Matrix Online. NMCPHC-TM OM 6260, Medical Surveillance Procedures Manual and Medical Matrix, reference (p), is located at: https://www.med.navy.mil/Portals/62/Documents/NMFA/NMCPHC/root/Occupational%20and%20Environmental%20Medicine/mmo_web/content/forms/MedicalMatrix.pdf.

3. Manage the Navy Asbestos Medical Surveillance Program (AMSP) to include receiving and managing AMSP data, monitoring B-reading radiograph quality, ensuring B-reading report accuracy, ensuring AMSP elements conform to current Occupational Safety and Health Administration (OSHA) requirements, and maintaining currency with advances in technology and related issues of data integrity and privacy. Provide program trend analysis and reports when requested by higher authority. Utilize NAVMED 6260/5 and NAVMED 6260/7 to meet Federal, DoD, and Navy asbestos medical surveillance history, physical, and B-reading reporting requirements and to maintain currency with technology. OEM providers will use these forms to document asbestos medical surveillance examinations and radiographic interpretations, respectively. Instructions and forms are located at: Asbestos Medical Surveillance Program (AMSP) (navy.mil).

4. Serve as the NAVMED conduit with the Defense Health Agency (DHA) Epidemiology Data Center (EDC) with its ability to provide descriptive and multi-level analyses for cluster investigations, disease and injury risk, public health assessments, and business case analysis from a variety of clinical data sources. The EDC designs and conducts occupational and environmental studies for IH, EH, and HC; and provides reports periodically as requested by higher authority.

5. Ensure the use of medical treatment reports by the EDC, in coordination with Naval Safety Command, to identify mishap-related injuries of active-duty military and civilian personnel authorized treatment from the MTF. Medical treatment data provides the first-line notification of a potential mishap-related injury. Linking medical and safety reporting systems is vital to reducing the number of unreported mishaps involving active-duty military personnel.

6. Provide funded audiometric calibration services limited to screening audiometers, sound level meters, dosimeters, and calibrators used in the Hearing Conservation Program (HCP). This service does not include tympanometers, diagnostic audiometers, otoacoustic emissions meters, middle ear analyzers, or other equipment utilized within the diagnostic audiology clinical centers.

7. Ensure analytic and consultative services are provided by the comprehensive IH laboratories to Navy and Marine Corps IH field personnel. As arranged with hospitals and clinics, comprehensive IH laboratories also provide analytic services in support of biological monitoring and occupational screening examinations conducted by hospitals and clinics.

8. Provide IH, OEM, HC, EH, and PM services to operational Navy and Marine Corps activities and units through the Navy Environmental Preventive Medicine Units.

9. Develop and administer a series of annual professional awards to recognize individuals for sustained professional excellence and significant contributions through their service that have enhanced IH, OEM, HC, and EH for Navy and Marine Corps. Awards should cover as applicable, both junior and senior individuals in the respective fields in this subparagraph.

10. Maintain currency of DATAGRID 6260/8, Occupational Exposures of Reproductive or Developmental Concern – Supervisor's Statement, and DATAGRID 6260/9, Occupational Exposures of Reproductive or Developmental Concern – Worker's Statement. These data grids are available at: Technical Manuals and Guidance (navy.mil). Reference (s), NMCPHC TM-6260.01D, Reproductive and Developmental Hazards: A Guide for Occupational Health Professionals, provides additional guidance on the use of these data grids and is available at: 2NMCPHC_TM-6260.01D_(May2019)_ReproductiveAndDevelopmentalHazards.pdf (SECURED) (navy.mil).

11. Maintain OEM records review checklists, or "chart validation sheets," which are currently available at the NAVMCFORHLTHPRTCMD Web site.

12. Provide assistance to activities, offices, and commands concerning the health aspects of pollution sources or pollution control equipment, including development of medical monitoring programs, human health risk assessment, health and safety considerations, toxicology, and risk communication.

13. Determine, validate, and establish health-related criteria and standards not available through Federal, State, or local laws and regulations. Conduct research and analyses to support updates to SOH policy and verify procedures accurately meet program requirements, including published DoD Issuances.

14. Establish and publish appropriate medical surveillance guidance for Navy, Marine Corps and joint base (when applicable) water systems and provide public health advice and consultative services to Commander, Navy Installations Command, Marine Corps Installation Command, Navy, Marine Corps, and other Service commands for drinking water quality.

15. Coordinate with Agency for Toxic Substances and Disease Registry concerning their legally mandated health related activities, including public health assessments, public health consultations, health surveys and investigations, toxicology databases, emergency response, and health education and review for comment.

16. Develop and facilitate the OEM fundamentals and OH nursing fundamentals courses with adequate frequency such that newly assigned staff with no previous OH training can receive training within 12 months of assignment.

17. Develop and facilitate National Institute for Occupational Safety and Health - approved spirometry courses with adequate frequency such that personnel that are required to perform spirometry in Navy clinics are able to obtain and maintain certification.

18. Provide instructors for the IH techniques and exposure monitor training for introductory level instruction of a broad range of subject matter: policy and regulatory requirements, fundamentals of toxicology, sampling methods, sampling equipment and media, and common IH calculations. Act as curriculum manager to ensure training is conducted in an economical and effective manner.

19. Generate reports and dashboards, develop new reports and reporting tools, and strive to improve effectiveness as well as competitive advantage of those reporting solutions.

20. Participate in Navy working groups to solicit end user feedback on design and performance aspects of developed applications and reporting tools.

21. Engage continuously to learn and incorporate future strategic objectives as it relates to technical solutions.

22. Liaise with BUMED echelon 2 and below to ensure that the SOH functional requirements are being maximized.

(e) Serve as the executive agent responsible for all DOEHRS functionality for shore, afloat, and deployed units. NAVMCFORHLTHPRTCMD must:

1. Coordinate with Navy SMEs for the development, implementation, and maintenance of all DOEHRS functionality and routinely provide reports, queries, and metrics to BUMED.

2. As assigned, serve as lead on various SOH related DOEHRS project or process teams.

3. Serve as the Navy DOEHRS SME, and coordinate with BUMED, other Services, and DHA in the development, review, analysis, and maintenance of the DOEHRS-IH, EH, and HC and approve and prioritize DOEHRS change requests for the Navy.

4. Develop and facilitate training on DOEHRS-IH and EH to Navy personnel and contract staff with adequate frequency, so newly assigned staff (with no previous DOEHRS training) can receive training within 6 months of assignment. Provide basic and refresher training on DOEHRS-IH to cover basic data entry, advanced user training, and system administrator training. Advanced training methods will include train the trainer model to educate the workforce on improved business practices (i.e., master schedule, data warehouse, etc.). Develop and deliver tailored training to reflect new functionality and capabilities.

5. Act as DOEHRS account service level administrators, pick-list administrators for the Navy, and approve DOEHRS accounts for Navy personnel.

6. Construct recommendations to BUMED on the DOEHRS-enhanced EH and IH implementation policy for deployed units and in-garrison units to include any expansion of DOEHRS contract support and incorporation of training into applicable curriculums.

7. Provide support and coaching to DOEHRS end users while assimilating feedback to formulate successful queries and understanding the data contained in the DOEHRS data warehouse and transactional reporting to increase end-user productivity and reduce administrative efforts.

8. Provide support with respect to data integrity for system entries within the databases and reports through data quality management plan(s).

9. Provide monthly DOEHRS-IH and DOEHRS-EH metrics to facilitate program management review, assess performance, and for analyses, models, visualizations.

10. Provide visualization tools to drive strategic planning and improve decision-making processes by leveraging technical expertise in business objects and business intelligence to develop integrated software solutions to support the configuration and deployment of workflows and interfaces for program requirements and monitoring enterprise-wide performance to include business capabilities solutions for DOEHRS-IH.

(f) Conduct formal onsite triennial SOHMEs using standardized procedures developed by subordinate echelon 5 activities.

(g) Provide occupational toxicology expertise to establish toxicological profiles, develop health based occupational exposure levels and inform relevant policy matters.

(h) Provide toxicology SMEs to participate on the Tri-Service Toxicology Consortium, Emerging Chemicals Working Group, and additional working groups as directed by higher echelons.

(5) NAVMED Activities with IH, OEM, OA, HC, and EH, and services will:

(a) Implement centralized operational and technical management of safety, IH, OEM, OA, HC, EH, and PM services under their command that are organizationally aligned within a Directorate of Public Health (DPH) or a Director of Warfighter Optimization (DWO). The DPH or DWO must have specialization and expertise in at least one of the public health disciplines. Activities must ensure appropriate technical management and oversight of IH, OH, OA, HC, EH, and PM personnel and programs, especially at Navy Medicine Readiness and Training Units (NAVMEDREADTRNUNIT) and those locations without a DPH. When IH, OH, OA, HC, EH,

and PM staff are assigned to the Director for Branch Clinics, the NAVMEDREADTRNUNIT OIC, DPH, and Director for Branch Health Clinics must work collaboratively to ensure operational and technical mission requirements are met. In particular, close collaboration by all parties must occur when: (1) IH, OH, OA, HC, and EH, staff are administratively assigned under NAVMEDREADTRNUNIT OICs; (2) hiring professional IH, OH, OA, HC, and EH, staff at NAVMEDREADTRNUNIT (must include the senior MTF or NAVMEDREADTRNUNIT SME in the selection process); (3) assessing and providing cross leveling staff requirements to ensure the mission is met; and (4) determining and establishing resource requirements and approval for equipment and training. Activities will consult with NAVMED regional SOH program managers when questions or concerns arise.

(b) Ensure operational and technical management that is overseen by qualified SOH professionals, per references (a), (b), (l), and (n), and includes as a minimum:

1. Standardization of business practices across the entire activity.

2. Assignment and performance evaluation of professional and technical personnel.

3. Leadership support and advocacy for these mandated, regulatory-driven SOH product lines (IH, OEM, OA, HC, and EH services) throughout the geographic area of responsibility (AOR) of the parent activity.

4. Ensure SME technical review of SOH notifications, correspondence, and reports using an effective document review and tracking system. Recommend activities consider delegating "By direction" authority to qualified IH department heads to expedite the publishing and distribution of IH surveys and required correspondence to supported customer commands.

(c) All NAVMED activities that deliver OEM services will have oversight by a board-certified OEM physician. If one is not billeted at that activity, an agreement with another activity is required to include a minimum of one onsite visit per year. Oversight will include peer medical record reviews and records will be retained for 5 years.

(d) Ensure peer medical record reviews for all licensed independent practitioners (physicians, physician assistants, nurse practitioners, and audiologists) are completed to meet competency and privileging requirements. OEM peer review is required by certified or board eligible OEM physicians or physicians with a minimum of 5 years of experience working in an OEM clinic to meet credentialing requirements.

(e) Ensure the DOEHRS for IH, EH, HC, and various SOH programs is fully utilized to document and evaluate OH hazards and related assessments and potential community exposures, per references (b) and (i).

(f) All NAVMED activities that deliver IH program services will:

1. Provide technical expertise to preserve health and enhance medical readiness by anticipating, recognizing, evaluating, and recommending controls to prevent both acute and chronic exposures to OH hazards that may impair health arising in or from the workplace where military members and civilian employees work, including permanent installations and deployment locations.

2. Ensure minimum knowledge and skills are demonstrated for developmental military and civilian industrial hygienists and technicians to successfully execute their duties and improve upon existing skillsets. Refer to IH department personnel competency standard to ensure requisite technical competencies are readily available to support the IH mission using reference (u), available at: IH_Personnel_Competency_Standard.pdf (navy.mil). Training must be provided to employees who do not meet the competencies. The preferred method of demonstrating expert level of competence is achieving the certified industrial hygienist (CIH) credential.

3. Align employee performance goals and measures with strategic objectives. Complete individual development plans to ensure IH staff can fulfill assigned duties and responsibilities. Identify and prioritize improvement areas using the guidance in reference (u).

4. Follow data quality and standardization efforts when implementing the eight steps of the DoD exposure assessment model. Exposure assessments will follow a comprehensive strategy to achieve the primary objectives outlined in the IH Field Operations Manual, per reference (r), chapter 4.

5. Perform adequate quality reviews of technical reports by a senior industrial hygienist with advanced competencies to properly review for accuracy. Signatures of technical reports by senior industrial hygienists will serve as verification of sufficient review. Therefore, IH program managers should possess an active CIH credential or at a minimum, be eligible for certification, and actively working to achieve the certification.

6. Verify the accuracy and completeness of all exposure assessment data entered in DOEHRS-IH via experienced civilian and military industrial hygienist personnel entrusted with quality assurance (QA) permissions. Follow established QA procedures to ensure data integrity and quality. Do not grant QA permissions to any contractors.

7. Generate born-digital and digitized records. Document owners are responsible for ensuring that documents are properly marked, indexed, and filed in their AOR with oversight by IH program managers and records management staff.

8. Utilize DOEHRS-IH to assemble, compare, evaluate, and store non-classified information to establish comprehensive longitudinal exposure records for recordkeeping and reporting, per references (a), (h), (i), and (j).

9. Complete basic DOEHRS-IH training within 6 months of assignment for personnel that have received no formal training (military and civilian).

10. Follow the DOEHRS-IH Student Guide and User Manual standardization in the most recent business practices established in standard operating procedures.

11. Collect personally identifiable information for military, civil service, and foreign national employees as part of normal Navy IH business procedures during field support per the Privacy Act and DoD Privacy Program (DoD Directive 5400.11). Request low risk personally identifiable information such as the individual's full name and DoD identification from the corresponding manpower department. Authorized personnel must have and maintain the appropriate training requirements including: Information Assurance; Health Insurance Portability and Accountability Act; and Privacy Act.

12. Define and establish similar exposure groups (SEG) which will be populated with data from the IH survey and results of exposure monitoring. Use personnel rosters to properly account for Navy personnel and assign them to appropriate workplaces as part of the individual's longitudinal exposure record. Priority must be given for establishing similar exposure groups in Priority 1 shops and subsequently Priority 2 shops. Calculate the exposure assessment priorities for unacceptable exposures with additional guidance provided in reference (r).

13. Use the master schedule to plan, schedule, and record industrial hygienist surveys and workplace monitoring tasks per established guidance which may be supplemented by regional management directions.

14. Strive to maintain chronological records of significant contacts with high priority workplaces to include the date, individual contacted, method and reason for the contact, and a brief summary of any pertinent information communicated. One option includes the use the "Observations and Notes" section within DOEHRS-IH.

15. Utilize the Navy transactional reporting business common services to generate routine survey reports. Upload signed routine and special survey reports to DOEHRS-IH to maintain continuity using the document library as described in NAVMCFORHLTHPRTCMD DOEHRS User Guide.

16. Use NAVMED 6000/5 Medical Record - Supplemental Medical Data to facilitate any transfer of employee exposure data via scan or upload into the employee's electronic health records in coordination with military treatment facility depending on available resources. As necessary, prioritize individuals in SEGs with recommendations for relevant hazard-based medical surveillance program.

17. Develop support agreement(s) to reflect recurring IH services being provided to external organizations per reference (w). Coordinate the development of proposed agreement with IH managers at the local level. Submit proposed agreement to NAVMED regions for SME review of the terms and factual circumstances to verify no adverse impact to current mission and compliance with current policies, procedures, and strategic goals. Evaluate if the NAVMED activity is funded to provide requested service to external organization. If not funded, assess any extra workload, estimate personnel offset, and develop justifications to transfer funded manpower authorization(s). Approval of any support agreement does not negate nor supersede existing program requirements for compliance with statutory, regulatory, and higher authority guidance from DON. Monitor performance throughout the duration of the agreement to ensure Navy IH services do not experience any significant degradation of performance to assigned Navy and Marine Corps commands, units and activities within the AOR. Per reference (w), manage and amend if additional work is necessary beyond the scope of the original agreement.

18. Ensure IH survey reports and field notes of submarines do not aggregate Controlled Unclassified Information which generates classified Naval Nuclear Propulsion Information for both paper and electronic records. Provide awareness-level training to all staff responsible for providing IH services to submarines beforehand to understand the importance of not aggregating three elements as defined in chapter 1 of reference (x). Seek clarification when uncertainty exists with local security personnel or appropriate field representative overseeing the submarine naval nuclear propulsion plant.

19. Ensure junior industrial hygiene officers have the opportunity to complete the following training courses before transferring to an afloat assignment where scheduling and resourcing allows: Afloat Safety Officer (ASO; CIN A-4J-0020), Respiratory Protection Program Manager (RPPM; CIN A-493-0072), and Afloat Environmental Protection Coordinator (AEPC; CIN A-4J0022).

b. NAVMED SOH Program Requirements

(1) SOH Program Assessment

(a) BUMED will issue SOH program evaluation guidelines and metrics requirements annually.

(b) SOHMEs will be conducted at least every 3 years, per reference (a), or as determined by cause of all subordinate commands. SOHMEs will be conducted per a standard operating procedure developed by BUMED. Copies of the final reports will be forwarded to BUMED Public Health and Safety (BUMED-N44) and BUMED Medical Inspector General (BUMED-N00IG) within 45 calendar days of the SOHME out-brief.

(c) The evaluations must include an assessment of the SMS functionality and effectiveness.

(d) All NAVMED echelon 4 activities must prepare annual self-assessments, quarterly and annual metrics, and improvement plans for their respective SOH programs, as applicable. A summary report of these items must be submitted annually to the regional commands and routed to BUMED, per the NAVMED SMS or regional guidance reflected in their Safety Management Plan.

(e) Program self-assessments, annual metrics, and improvement plans will be compiled during the first quarter of each fiscal year (assessing the previous fiscal year's performance). Start and completion dates will be determined annually by BUMED. Regional program managers may designate an earlier due date for review and approval before submission to BUMED.

(f) Quarterly safety metrics will be submitted to the regional safety program managers the 10th day following the end of each fiscal year quarter after review by command CO. Regional safety program managers will route a consolidated regional metrics through the region headquarters deputy commander for review before sending to BUMED by the end of the month following the quarter. Echelon 4 commands will include metrics from each of their echelon 5 activities. A separate fourth quarter metrics is not required due to the annual metrics requirement.

(g) SOH program managers must brief command leadership on their annual self-assessments, quarterly and annual metrics, and improvement plans. The activity commander, CO, OIC, executive officer, or senior leadership council must review and concur with program assessments, improvements plans, and annual BUMED SOH metrics. Program assessments, metrics, and improvement plans, and all validating documents, must be retained within the command for a minimum of 6 years for review by appropriate SOH inspection authorities.

(h) Guidance for the self-assessments and improvement plans is provided in reference (d) and by separate correspondence issued annually by BUMED.

(i) OH clinics should complete OEM program assessment tools annually for the programs they manage. These tools are available at the NAVMCFORHLTHPRTCMD Web site: Technical Manuals and Guidance (navy.mil). Area OH nurse program manager should assess all OEM clinics and their OEM programs in AOR annually via review and an on-site visit. Additional monthly metrics may be required to be submitted as needed.

(j) All records for the SOH program assessments noted subparagraph 6b(1)(a) through 6b(1)(i) will be maintained for 5 years.

(2) SOH Training

(a) BUMED will participate as a member of SOH training groups, per reference (a), or as assigned by higher authority.

(b) As outlined in reference (a), chapter 6, NAVMED activities must support professional development and continuing education of assigned SOH personnel. All SOH professionals as defined in reference (a), which include all professionals serving in the IH program, will receive a minimum of 5.0 continuing education units per year. OEM physicians must annually receive at least 25 hours of continuing medical education, consisting of at least 10 maintenance of certification hours (or the equivalent for osteopathic OEM specialist physicians), plus any additional continuing medical education necessary to meet the minimum annual requirements for State or territory licensure.

(c) Naval Safety and Environmental Training Center provides SOH courses for military and civilians with most focusing on safety: General Industry Standards; Introduction to Navy Occupational Safety and Health; Mishap Investigation; Respiratory Protection Program Manager; Ergonomics; and Noise and Hearing Conservation. Additional courses for consideration include Competent Person for Fall Protection; Asbestos Inspector and Supervisor; Emergency Asbestos Response Team; Hazardous Material Control and Management; Fall Protection Program Manager; Fire Protection and Life Safety; Construction Safety Standards; and Machinery and Machine Guards.

(d) Additional training for IH skill acquisition needs to be sought out externally to achieve and sustain intermediate to advanced skills.

(e) Professional certification of individuals in their specialty is encouraged, highly desirable, and fully supported by BUMED. Activities will budget accordingly to provide training necessary to maintain professional certification. Guidance on payment of professional board certifications and licenses for military and civilian personnel is available respectively in reference (o).

(3) Hazardous Material Control and Management

(a) BUMED will coordinate assistance and oversight to ensure compliance with Navy Hazardous Material Control and Management programs and initiatives.

(b) BUMED will coordinate with NAVMCFORHLTHPRTCMD or other organizations for any needed technical advice or support.

(4) Hazard Abatement Program. All activities will work diligently to identify and quickly abate hazards. All Navy facilities will use the NAVMED system of record to record and track safety hazards and deficiencies. Record and track deficiencies from assessments, self-assessments, inspections, SOHMEs, and evaluations to closure in the NAVMED enterprise system. See reference (a) for more information on hazard abatement.

(5) Mishap Investigation, Reporting and Recordkeeping

(a) NAVMED will conduct an aggressive mishap investigation program and use RMI SIR for mishap management. A Safety Investigation Board (SIB) will be established as necessary to perform special investigations of on-duty Class A and certain Class B mishaps as directed by BUMED. All classes of mishaps will be investigated and reported per the requirements of references (b) and (i). Class C mishaps will be reviewed and approved by BUMED. Most events that result in damage, injury, or illness that fall below the minimum reporting threshold of Class D for on-duty events and Class C threshold for off-duty events are specifically exempt from mishap reporting and do not require a safety investigation or report. However, some events trigger mandatory safety reporting requirements no matter the damage, injury, or illness. These event types are clearly explained and must be reported per reference (b) paragraph 218 and can be found in the tables in chapter appendices 2-A through 2-E. Commands are authorized to direct the reporting of events below the minimum thresholds if it will further their mishap prevention efforts. Ensure this is stated in writing.

(b) NAVMED activities must telephonically or electronically (OPREP-3 or RMI SIR initial reporting) notify the Naval Safety Command, their NAVMED region or echelon 3 command, and BUMED within 8 hours of all (military and civilian) on-duty Class A mishaps, military off-duty Class A mishaps and any Class B mishaps that result in the inpatient hospitalization of three or more people. Reference (a) provides further details.

(c) The cognizant NAVMED region, unless otherwise directed by BUMED, must convene a mishap SIB and initiate an investigation within 48 hours of notification of a mishap of the types noted in reference (b) and any other significant accidents as directed. The convening authority, BUMED-N44, or NAVMED region, will arrange funding of the investigation board and coordinate required access for the investigation team members.

(6) Emergency Preparedness and Response. Activities will develop emergency preparedness procedures, per reference (n). As part of this planning, activities must define the expected role of SOH personnel (safety, EH, IH, OH, and OA/HC in emergencies and ensure they are appropriately equipped and trained to meet the defined roles). These roles may vary from activity to activity based on local conditions and the expertise of command personnel.

(7) Respiratory Protection Program (RPP)

(a) BUMED will provide guidance necessary to implement the Navy RPP throughout NAVMED and ensure its implementation, per references (a) and (k).

(b) NAVMED regions will include RPPs as part of their oversight evaluations and ensure the establishment of comprehensive, effective RPPs, per references (a) and (k) at all activities under their cognizance.

(c) Activities with duty tasks requiring respiratory protection must establish and maintain an RPP, per references (a), (k), and (p).

1. Each activity must identify which tasks require respiratory protection and ensure personnel performing those tasks receive appropriate medical clearance, training, and fit-testing prior to being issued a respirator and performing the task. ESAMS must be used to record medical surveillance, respirator training, and fit-testing until replaced by RMI SIR.

2. Activities must identify tasks and use ESAMS to record which tasks require respiratory protection in unique or non-routine circumstances (e.g., pandemic influenza or chemical biological radiological and nuclear incident). Activities must include a strategy in the emergency management plan that will ensure an adequate cadre of qualified personnel in the RPP to meet initial circumstances and to ensure the necessary surge capacity for an emergency management incident. Those individuals identified as highest risk for needing a respirator should be maintained in the RPP at all times. The accommodation of others should be planned for in emergency response plans. It is neither necessary nor recommended to maintain all personnel in an RPP who use an N-95 filtering face piece respirator when their exposure is minimum and the use of the N-95 filtering face piece is not required. Personnel on designated response teams must be identified in the RPP and comply with all requirements, per references (a), (k), and (p).

(8) Safety Awards Programs

(a) NAVMED regions will submit nominations for the BUMED Medical Safety Excellence Award, per the criteria provided. This award must recognize NAVMED activities that have demonstrated exceptional and sustained safety excellence in their employee safety programs. The objectives of the awards program are to encourage increased mission readiness by mishap and hazard reduction; to promote full integration of risk management principles; and to foster a sound safety culture throughout all NAVMED commands and activities.

(b) Selection criteria will include exceptional success in improving safety programs, performance, and culture; identifying and mitigating safety hazards; or integrating safety to support mission throughout their organization. The focus of this award is improvement and results.

(c) BUMED submissions will be considered for the Chief of Naval Operations shore safety awards, per reference (a) and potentially the Secretary of the Navy Safety Excellence Awards, per reference (d).

(d) Activities may also submit Chief of Naval Operations safety award nominations for individual(s), per reference (d). These nominations must also be endorsed by their respective regional command and forwarded to BUMED by 30 November of each year.

(9) ORM. NAVMED regions, echelon 3 commands and activity leadership at all levels are responsible for the integration and application of ORM and for incorporating risk-based assessment and decision-making principles and attributes of ORM into all aspects of these SOH programs, per reference (e).

(10) Base Operating Support Safety Services. NAVMED commands without a full-time safety officer (e.g., GS 0018) at Navy installations may use the Base Operating Support to provide safety services where safety support is unavailable. Contact BUMED-N44 for additional information.

(11) High Risk Training (HRT)

(a) Per references (e) through (g), HRT is defined as training that exposes personnel to the potential risks of death, permanent disability, or loss during training. References (e) through (g) identify the method to determine if training is high risk as well as the mitigation requirements.

(b) As identified in references (e) through (g), NAVMED commanders, COs, and OICs are responsible for the identification of high-risk training courses based on the deliberate risk assessments. Refer to references (e) through (g) for additional information.

(c) When a HRT course has been identified, the control measures required to be implemented are noted in references (f) and (g). These control measures include emergency action plans; screening; qualifications and training; oversight; inspections; curriculum reviews; and equipment maintenance.

(d) Complete annual self-assessments for all HRT courses and enter high risk training deficiencies into the NAVMED system of record.

(12) Information Management

(a) ESAMS is the standard data management NAVMED system of record that monitors, assesses, and measures these safety programs: employee duty task(s); safety training; and workplace inspection results for safety and high-risk training. ESAMS provides a mechanism for management to ensure compliance with applicable directives, conducts analysis using real-time data, and is a system for the SMS performance assurance elements.

(b) RMI SIR is a DON system of record to capture safety performance data. The RMI is expected to mature with the needs of the Navy to support the pillars of SMS noted in reference (a). The RMI SIR is used by NAVMED as the system of record for reporting and management of mishaps to include capturing data for analysis, tracking corrective actions,

reporting causal factors, developing lessons learned, and verifying effective risk mitigation. RMI safety program management will eventually replace ESAMS and will be used to manage various safety and high-risk training programs.

(c) DOEHRS is the information management system for maintaining a comprehensive record of occupational hazards, exposures, exposed populations, audiology data such as individual audiometric results and threshold shifts, longitudinal exposure recordkeeping and reporting, and EH inspection records.

1. DOEHRS-HC

a. Per reference (o), HC audiograms must be administered using the DOEHRS-HC software application and data must be exported daily to the DOEHRS Data Repository web application.

b. Diagnostic audiology evaluation results must also be manually entered into DOEHRS-HC when provider certification numbers and audiometer specifications are known.

c. DOEHRS-HC data will be examined by echelon 4 program managers or designees at least quarterly to guide local and strategic program management efforts, assess program effectiveness, monitor hearing readiness, and validate compliance with OSHA recordkeeping requirements.

2. DOEHRS-EH

a. Per reference (k), DOEHRS-EH must be used to document and report EH and PM workload data with QA review within required instructional timeframes.

b. All newly assigned EH personnel (military and civilian) that have no formal DOEHRS-EH training will receive initial training.

c. DOEHRS-EH is to be implemented and utilized at NAVMEDREAD-TRNCMD and NAVMEDREADTRNUNIT facility, as applicable.

3. DOEHRS-IH

a. Per reference (a), BUMED IH program offices will utilize DOEHRS-IH as the sole information management system for recordkeeping and reporting purposes.

b. Monthly reports will facilitate regional program management review to assess performance. Business intelligence and data management applications using the SAP Business Objects platform or future modernization platform will be developed for analyses and visualizations.

7. Records Management

a. Records created as a result of this instruction, regardless of format and media, must be maintained and dispositioned per the records disposition schedules located on the Department of the Navy Assistant for Administration, Directives and Records Management Division portal page at https://portal.secnav.navy.mil/orgs/DUSNM/DONAA/DRM/Records-and-InformationManagement/Approved%20Record5%Schedules/Forms/AllItems.aspx.

b. For questions concerning the management of records related to this instruction or records disposition schedules, please contact the local records manager or the OPNAV Records Management Program (DNS-16).

8. Review and Effective Date. Per OPNAVINST 5215.17A, BUMED-N44 will review this instruction annually around the anniversary of its issuance date to ensure applicability, currency, and consistency with Federal, Department of Defense, Secretary of the Navy, and Navy policy and statutory authority using OPNAV 5215/40 Review of Instruction. This instruction will be in effect for 10 years, unless revised or cancelled in the interim, and will be reissued by the 10-year anniversary date if it is still required, unless it meets one of the exceptions in OPNAVINST 5215.17A, paragraph 9. Otherwise, if the instruction is no longer required, it will be processed for cancellation as soon as the need for cancellation is known following the guidance in OPNAV Manual 5215.1 of May 2016.

9. Forms and Information Management Control

a. The reports required in subparagraphs 6a and 6b of the basic instruction, enclosure (2), enclosure (3) subparagraph 2c through 2e, enclosure (3) paragraphs 3 through 5, enclosure (3) paragraph 8 of this instruction are exempt from reports control per SECNAV M-5214.1 of December 2005, part IV, subparagraph 7k.

b. Forms

(1) NAVMED 6000/5 Medical Record - Supplemental Medical Data is available at https://www.med.navy.mil/Directives/NAVMED-Forms.

(2) The following DD Forms are available at: https://www.esd.whs.mil/Directives/forms/dd2000_2499/

(a) DD Form 2214 Noise Survey

(b) DD Form 2215 Reference Audiogram

(c) DD Form 2216 Hearing Conservation Data

(d) DD Form 2217 Biological Audiometer Calibration Check

(e) DD Form 3126 Hearing Protection Fit-Test Record

(3) SECNAV 5100/1 Supervisor's Medical Surveillance and Certification Exam Referral is available at: https://www.secnav.navy.mil/doni/nfol/forms/allitems.aspx?rootfolder=/doni/nfol/secnav/secnav+forms&folderctid=0x012000365d27b574a66144834c11a9cdabb889

(4) NAVMCFORHLTHPRTCMD IH forms are available at https://www.med.navy.mil/Navy-and-Marine-Corps-Force-Health-Protection-Command/Environmental-Health/Industrial-Hygiene/Program-Support/Industrial-Hygiene-Field-Operations-Manual-IHFOM/.

(a) NMCFHPC Form 5100/17 Industrial Hygiene Noise Survey Form.

(b) NMCFHPC Form 5100/18 Industrial Hygiene Noise Dosimetry Form.

D. K. VIA

Releasability and distribution:
This instruction is cleared for public release and is available electronically only via the Navy Medicine Web site, https://www.med.navy.mil/Directives/

REFERENCES

(a) OPNAVINST 5100.23H of 5 Jun 2020 and OPNAV M-5100.23 of 20 Sep 2023
(b) OPNAVINST 5102.1E
(c) DoD Instruction 1400.25, Vol 1800 of 17 July 2023
(d) SECNAVINST 5100.10L
(e) SECNAVINST 3900.39E
(f) OPNAVINST 1500.75D
(g) BUMEDINST 1500.35
(h) DoD Instruction 6055.05 of 11 November 2008
(i) DoD Instruction 6490.03 of 19 June 2019
(j) 29 CFR 1910
(k) BUMEDINST 6240.12A
(l) DoD Instruction 6055.01 of 14 October 2014
(m) BUMEDINST 1500.20A
(n) BUMEDINST 3440.10B
(o) DoD Instruction 6055.12 of 14 August 2019
(p) NMCPHC TM 6260.9A
(q) NMCPHC-TM 6260.51.99-3
(r) NMCPHC-TM 6290.91-2
(s) NMCPHC TM-6260.01D
(t) BUMED ltr 5320 Ser M1/11UM1116 of 28 Feb 2011 (NOTAL)
(u) Industrial Hygiene Department Personnel Competency Standard
(v) BUMEDINST 7050.IB
(w) OPNAVINST N9210.3

CRITICAL PATH REPORTING

This enclosure defines additional guidance to ensure critical information is reported to leadership within an actionable time frame to identify risks to mission and force. The commanding officer is to report to the Bureau of Medicine and Surgery duty officer.

Reportable Condition	Time to Report After Discovery
Building or Site Evacuations	4 hours
Fatalities: On-Duty	4 hours
Fatalities: Off-Duty	8 hours
Hospitalization (overnight): On-Duty	8 hours
OSHA Inspections	24 hours
OSHA Non-compliances	48 hours

NAVY MEDICINE GUIDELINES FOR HEARING CONSERVATION PROGRAM MANAGEMENT

The objectives of Occupational Audiology (OA) and the Hearing Conservation Program (HCP) are to prevent occupational noise-induced hearing loss through proactive implementation of outreach, education and prevention activities, and to preserve and enhance hearing capability by adhering to regulatory measures, implementing program guidelines, and applying technological advances. Program managers must use this guide as a standardized framework to ensure effective HCP management and oversight.

1. Purpose. The purpose of the Navy Medicine Guidelines for HCP Management is to provide supplemental regulatory guidance to the Occupational Safety and Health Administration (OSHA), Department of Defense (DoD), and Office of the Chief of Naval Operations (OPNAV) 5100 series of instructions for the consistent and effective implementation of the Navy and Marine Corps HCP.

2. Responsibilities

a. Bureau of Medicine and Surgery (BUMED) Audiologist. Establishes policy and procedures to implement and manage a comprehensive Department of the Navy (DON) HCP.

(1) Serves as the subject matter expert for hearing conservation-related matters for activities under the command and control of Chief, BUMED.

(2) Coordinates the exchange of hearing conservation information between headquarters commands to ensure familiarity with BUMED policies and procedures and that they are implemented consistently across Navy Medicine.

b. Regional Hearing Conservation Program Manager (HCPM). Regional HCPMs serve as the senior occupational audiology and hearing conservation subject matter experts for the Navy Medicine regions and are responsible for management oversight and ensuring program implementation of Navy and Marine Corps HCPs at subordinate commands throughout the region.

(1) Establishes regional business rules and benchmarks and facilitates policy development and improvement.

(2) Formally evaluates the HCPs of echelon 4 subordinate activity Navy Medicine Readiness and Training Commands (NAVMEDREADTRNCMD) at least every 3 years as part of the Safety and Occupational Health Management Evaluation (SOHME) per this instruction. At the discretion of the regional HCPM or the request of an NAVMEDREADTRNCMD, technical or informal program assist visits may be provided.

(3) Collaborates with Medical Inspector General (MEDIG) safety and occupational health inspectors to ensure quality, stable, sustainable, effective programs and promote standardization of best practices across the enterprise.

(4) Facilitates occupational audiologist cross-leveling support coverage at NAVMEDREADTRNCMDs within the region. When NAVMEDREADTRNCMDs have gapped occupational audiologist billets, regional HCPMs work to identify and designate another occupational audiologist within the region (military or civilian) to temporarily backfill a gapped position. When there is no available occupational audiologist within the region to support the gapped billet, the regional human resources or manpower office forwards the cross-leveling support request to the other Navy Medicine region or to the Navy audiology specialty leader to identify a potential candidate to provide temporary coverage to the requesting command.

(5) Briefs prospective commanding officers and prospective executive officers on the status of the NAVMEDREADTRNCMD's HCP.

(6) Upon completion of each fiscal year, Regional HCPMs review HCP self-assessments from each of the NAVMEDREADTRNCMDs under their purview to evaluate the status of each NAVMEDREADTRNCMD's program and (when possible) provide support and resources to facilitate improvements at commands where weaknesses or challenges exist.

(7) Reviews and consolidates NAVMEDREADTRNCMD HCP metrics and forwards to BUMED-N44 at the end of each fiscal year.

c. NAVMEDREADTRNCMD HCPM. A NAVMEDREADTRNCMD HCPM will be designated by appointment letter. The senior NAVMEDREADTRNCMD occupational audiologist is the appropriate professional to serve as NAVMEDREADTRNCMD HCPM. In the absence of an occupational audiologist, the regional HCPM will assist the NAVMEDREADTRNCMD commanding officer in identifying an individual within the NAVMEDREADTRNCMD's area of responsibility (AOR) to provide local program management and an occupational audiologist to provide program oversight support via memorandum of agreement (MOA). NAVMEDREADTRNCMD HCPMs are responsible for implementing the Navy medicine components of the HCP for noise hazard commands within the NAVMEDREADTRNCMD AOR.

(1) Ensures standardization of patient care and business practices across the NAVMEDREADTRNCMD AOR. Provides centralized oversight, operational management, and technical supervision of OA and HCP personnel, services, and resources within the NAVMEDREADTRNCMD, branch clinics, and mobile facilities. Convenes at least semi-annual documented meetings or training with HCP staff to facilitate effective leadership, communication, and program and process improvement efforts.

(2) Ensures adequate staffing, equipment, supplies, operating target, and access to OA and HCP care and services at NAVMEDREADTRNCMDs in the AOR. The BUMED occupational audiology staffing model will be used as a guide to determine appropriate staffing levels.

(3) Oversees staffing issues to include initiating, participating, and facilitating in hiring actions and orientation of occupational audiologists and HCP personnel. Facilitates training, certification, and continuing education for HCP staff.

(4) Provides technical review of HCP notifications, correspondence, and reports.

(5) Conducts medical record reviews, mentoring, and performance and competency evaluations for HCP staff.

(6) Monitors and evaluates Defense Occupational and Environmental Health Readiness System - Hearing Conservation (DOEHRS-HC) data quality from HCP point of care sites and resolves discrepancies. Ensures all HCP workload is appropriately captured in patient electronic health record (EHR) systems and all time spent performing HCP functions is accurately captured in the Defense Medical Human Resource System - Internet (DMHRSi) under the "FBN" Medical Expense and Performance Reporting System (MEPRS) code.

(7) Manages NAVMEDREADTRNCMD HCP equipment inventory, maintenance, calibration schedules, and clinic space needs. Coordinates with leadership on facility design of new and renovated spaces and the relocation of OA and HCP personnel. Consults with the regional OA HCPM prior to purchasing new audiometric booth(s).

(8) Completes annual HCP self-assessment and metrics. Annually briefs NAVMED-READTRNCMD leadership on overall HCP status, self-assessment findings, metrics, and plans for improvement. Submits assessment and metrics data to the cognizant Navy medicine regional HCPM per established timelines.

(9) Maintains HCP preparedness across the NAVMEDREADTRNCMD enterprise for SOHME and Navy MEDIG inspections. Resolves all formal findings.

(10) Maintains a comprehensive list of all HCP enrolled commands and contact information for corresponding command safety managers and officers. Updates this list at least semi-annually.

(11) Participates in ongoing communication and collaboration with noise hazard commands to evaluate HCP effectiveness and work toward the common goal of hearing loss prevention.

(12) Monitors and tracks program effectiveness of all supported activities. Provides documented annual HCP performance reports to supported commands and activities and maintains these documents for at least 5 years for inspections, audits, or epidemiological trending.

(13) Ensures that formal hearing injury notifications are provided to employees and their supervisors within 21 days of OA confirmation of permanent threshold shift (PTS) or OSHA recordable hearing loss.

(14) Conducts quarterly review of DOEHRS data entry integrity and DOEHRS Data Repository (DR) uploads for all DOEHRS users in the AOR. Analyzes DOEHRS data quality and addresses and corrects data integrity issues. Reviews DR accounts and archives inactive users quarterly.

d. Occupational Audiologist. For the purpose of HCP Management, the occupational audiologist must maintain a close collaborative relationship with command leadership and safety managers of supported noise hazard commands, in addition to NAVMEDREADTRNCMD industrial hygiene (IH) and occupational and environmental medicine (OEM) professionals.

(1) Occupational audiologists will allocate no more than 50 percent of the OA work schedule toward patient care to enable the proper distribution of efforts toward the primary mission of hearing loss prevention. Patient care responsibilities include:

(a) Reviewing referrals and determining disposition.

(b) Providing comprehensive diagnostic audiology care and services to referred patients.

(c) Conducting medical qualification assessments on HCP enrollees that meet criteria for further audiological and fitness for duty evaluation.

(2) Occupational audiologists will allocate at least 50 percent of the work schedule to hearing loss prevention outreach efforts, program oversight, and management functions. Occupational audiologists must maintain objective tracking documentation on how this time is spent. This includes:

(a) Maintaining a current, comprehensive directory of supported noise hazard commands within the NAVMEDREADTRNCMD AOR. For each supported command and in collaboration with the safety officer and work area supervisor, minimum documentation must be maintained: Unit identification code (UIC), HCP enrollment numbers, estimated program compliance data, PTS hearing injury rates, and contact information for key HCP stakeholders. The directory must be updated at least semi-annually. Collaborative partnerships with IH personnel and the ability to access noise surveys and shared files is essential for maintaining current HCP directory information.

(b) Prevention Outreach. Each full-time occupational audiologist must complete a minimum of 12 documented HCP training or hearing loss prevention events per fiscal year with supported noise hazard commands. Prevention outreach must be tracked in Excel or other effective database tracking system and kept on file for at least 5 years. The objective of these events is to provide tangible program assistance and hearing loss prevention services that yield effective outcomes and return on investment (i.e., reductions in hearing injury and risk, greater awareness of noise hazard impacts, and hearing protection use and fit improvements). Prevention outreach may include:

1. Worksite Assessments. Worksite assessments include a walk-through of the noise hazard worksite area(s) and review and evaluation of overall program compliance, worksite noise hazards, noise hazard signs or labels, hearing protection options and availability, employee communication requirements and challenges, potential for engineering controls and noise hazard reduction, and providing professional expertise and consultation on hearing loss prevention and HCP improvement initiatives. A worksite assessment report is sent to the command leadership and safety manager upon completion.

2. Risk-Based Intervention and Support. Conduct more detailed, customized, and targeted hearing loss prevention initiatives by prioritizing assistance to commands with the highest hearing injury rates and assess possible worksite elements, work practices, and employee habits that influence injury risk. Work collaboratively with safety, IH, and other professionals to implement processes and procedures that mitigate risk.

3. Group HCP Education. Conduct group HCP training or other substantial knowledge-based interactive hearing loss prevention activities for noise exposed personnel, supervisors, command leadership, or unit Safety personnel. Group training services may be captured as encounters in the EHR.

4. HPD Consultation, Selection, Fitting, and Fit-Checks. Provide group consultation on hearing protective device (HPD) selection to include advanced or custom protection options or conduct HPD fit check assessments. HPD fittings and fit-check services must be captured as encounters in the EHR.

5. Base Safety Council meetings. Provide or present HCP information and statistics, such as noise hazard command program performance data (estimated compliance, hearing injury PTS), HPD options, samples, fitting demonstrations, new technology, HCP self-assessment checklist items, literature on available HCP services, and OA/HCP contact information.

(c) Networking and Relationship building. Maintain documented monthly e-mail communications with 100 percent of noise hazard command safety managers and officers in the AOR. Establish systematic contact and on-site collaborative meetings with noise hazard command safety managers in the AOR to develop proactive communication and facilitate reciprocal cooperative relationships in the prevention of occupational hearing loss.

(d) Clinic Assist Visits. Occupational audiologists who provide oversight to multiple HCP points of service locations must visit and assess each site quarterly. Clinics outside a 120-mile radius must be visited at least annually (more often, if needed). An After-Action Report is provided to the clinic officer in charge. Technician refresher training is encouraged during visits. See the Navy and Marine Corps Force Health Protection Command (NAVMCFORHLTH-PRTCMD) Web site for the clinic assist visit checklist. Infection control protocol will be reviewed as part of the clinic assist visit. See the NAVMCFORHLTHPRTCMD Web site for infection control guidance.

(e) Hearing Conservation Technician (HCT) Certification Courses. Periodic standardized hearing conservation technician certification courses are conducted to maintain adequate staffing and credentialing of certified technicians in the AOR. Course frequency is commensurate with local demands. Occupational audiologists must maintain current hearing conservation Course Director credentials through Council for Accreditation in Occupational Hearing Conservation (CAOHC).

1. Courses are required to be coordinated, scheduled, and canceled with NAVMCFORHLTHPRTCMD no later than 1 week prior to the end of the preceding month the course is being held. This can be done via e-mail to the NAVMCFORHLTHPRTCMD information systems and training specialist. Information required includes: Start date, location, course director, DOEHRS-HC instructor, and confirmation of CAOHC certification and CAOHC course number (if applicable). Also, NAVMCFORHLTHPRTCMD has an inventory of available training equipment that can be provided (based on availability) to support courses. Course directors will submit the request for training equipment at the time of scheduling the HCT Certification Course. Training equipment will be shipped back to NAVMCFORHLTH-PRTCMD no later than the first business day after course completion.

2. Course directors must follow the standardized 5-day HCT Certification Course curriculum that entails a written test, practical test, and oral patient counseling exam in order to meet certification requirements. There is a limit of one student per computer, audiometric hardware, and DOEHRS-HC software training set. It is recommended that course directors have students print manuals locally prior to class.

3. For the course to be closed out and certifications to be approved by NAVMCFORHLTHPRTCMD student rosters and student course critiques must be submitted within 3 business days of course completion.

(f) Annual Technician Competency Evaluations. The provision of audiometry and other hearing conservation support services is accomplished under the supervision of an audiologist, otolaryngologist, OEM physician, or other qualified physician. Technician proficiency in audiometric test instructions, administration, patient education, and HPD fittings is evaluated and documented at least annually as part of the certification maintenance process using the standardized form that can be found on the NAVMCFORHLTHPRTCMD Web site or from

the regional HCPM. Technician competency evaluations are completed on all active certified technicians in the AOR. Active technicians are those who have administered audiograms within 1 year. Newly certified technicians are considered fully qualified, and a competency evaluation is not required until 1 year from certification date.

(g) Hearing injury notification reports. Formal notification is provided to the patient and his or her supervisor within 21 days of an occupational audiologist's confirmation of a work-related PTS or OSHA recordable hearing loss. A sample report is located on the NAVMCFOR-HLTHPRTCMD Web site and in the OA standard operating procedure (SOP) manual.

(h) HCP Performance Reports. Annual fiscal year HCP performance reports are provided to supported commands and must include estimated compliance and PTS hearing injury rates. The NAVMCFORHLTHPRTCMD Web site and OA SOP provide templates for the HCP performance report.

(3) Audiology Equipment. The NAVMEDREADTRNCMD or regional HCPM must be involved in all audiology equipment purchases and installations. Prior to submitting a procurement package, consult the cognizant regional HCPM on all audiometric test booth purchases for review.

(4) Peer Review. Occupational audiologists will complete the peer review process per local command credentials protocol. In the absence of a qualified occupational audiologist to provide peer review services, the regional HCPM will assist with coordinating a viable peer review process.

e. HCT

(1) Educates HCP enrollees on the components, requirements, and benefits of the HCP.

(2) Reviews ear and hearing information from patient's medical record. Obtains patient history on conditions that may contribute to loss of hearing sensitivity, or that may affect hearing test results. Documents any significant patient history in the medical record.

(3) Performs otoscopic examination of ear canals to ensure there are no medical contraindications to testing, such as excessive ear wax, foreign bodies, evidence of infection or disease or other conditions that may affect hearing or the insertion of earplugs. When contraindications to testing are noted, the HCT refers the employee to appropriate provider for evaluation, treatment, and disposition.

(4) Prepares patients for hearing tests. Gives clear, concise test instructions. Administers air conduction audiometric tests. For HCP enrolled patients, compares annual hearing test results to the most current DD Form 2215 Reference Audiogram in the patient's medical record to determine if a significant threshold shift (STS) exists. Reviews audiogram results with patients. Enters test results in the patient's medical record.

(5) Schedules and performs follow-up tests, tympanometry, HPD checks and fittings, or other procedures, as required. Refers patients with STS on final follow-up test to the occupational audiologist. Consults with occupational audiologist on referral and disposition of patients with asymmetrical hearing loss, low frequency loss, or unusual and abnormal test results. Adheres to referral guidelines.

(6) Ensures fit of issued HPDs, demonstrates proper use, and discusses advantages, limitations, and possible consequences of misuse or non-use. Educates on proper care and maintenance of hearing protective devices. Determines special hearing protective needs based on patient needs, concerns, and work environment.

(7) Ensures proper maintenance of audiometric equipment. Prior to daily patient testing, performs a functional and a biological calibration check of the equipment. Records results on a DD Form 2217 Biological Audiometer Calibration Check or stores results in microprocessor. Follows infection control guidelines found on the NAVMCFORHLTHPRTCMD Web site for cleaning patient headphones and patient exam areas.

(8) Electronically transmits hearing conservation test result data to the DOEHRS DR daily. Prepares and submits other hearing conservation reports as needed or as requested by the occupational audiologist.

f. Navy Environmental and Preventive Medicine Unit (NEPMU) Audiologist. Provides HCP oversight and consultation to supported operational platforms.

(1) Conducts shipboard technical assist visits for specified commands (per local agreements) to monitor HCP compliance and provide trend analysis.

(2) Supports readiness for fleet safety and medical inspection requirements, such as the Board of Inspection and Survey, Naval Safety Center Survey, Medical Readiness Inspection, and Afloat Training Group Inspection.

(3) Conducts annual HCT competency evaluations for shipboard HCTs.

(4) Provides support to remote active-duty service members receiving HCP audiograms outside of the NAVMEDREADTRNCMD. Support includes reviewing audiograms, inputting audiograms into DOEHRS-HC, and recommending follow-up testing as needed.

3. Elements of the HCP

a. Noise Abatement and Control. Engineering controls constitutes the primary method for preventing occupational hearing loss. Removing or reducing hazardous noise from the source is the most effective method for preventing occupational hearing loss and creating a safe sound environment. Every effort must be made to eliminate or reduce identified noise hazards through

the systems engineering and systems safety process. Industrial hygienists, occupational audiologists, command leaders, facilities managers, and safety managers collaborate on appropriate engineering controls. Noise hazard commands must apply processes for eliminating or reducing the noise, where possible.

(1) Administrative control of exposure time is required in cases where noise control is not possible and HPDs provide insufficient attenuation to reduce the employee's effective exposure level below 85 dBA time weighted average (TWA). Implementation of administrative controls must be accomplished under strict supervisory control and in consultation with safety, IH, or OA.

(2) If hazardous noise exposure cannot be sufficiently eliminated or reduced through engineering and administrative controls, appropriate HPDs should be fitted for each individual exposed.

b. HCP Enrollment. Military and civilian personnel working in hazardous noise areas will be identified by their parent activity and enrolled in the HCP. Subsequently, these employees will undergo hearing protection fitting and issue, annual hearing loss prevention education, and annual audiometric testing. Per Marine Corps Order 6260.3A, all active duty and reserve Marine Corps personnel are enrolled in the HCP. Civilian personnel should not be enrolled in the HCP if there is documented evidence that they do not meet enrollment criteria, as this introduces potential for unwarranted liability and compensation claims and adds undue burden onto government and medical systems.

c. HCP Enrollment Criteria

(1) Noise hazard exposure criteria that requires enrollment in the HCP:

(a) $\geq$85 dBA TWA continuous and intermittent noise for 1 day or more per year. TWA calculation is based on an 8-hour workday with a 3 dB exchange rate.

(b) $\geq$140 dBP SPL impulse noise for 1 day or more per year.

(2) Exposure assessments should be made to determine hazardous noise areas and operations. Assessments include noise measurements performed per NAVMCFORHLTHPRT-CMD IH Field Operations Manual, which will determine personnel enrollment in the HCP. Assessments should be made initially and reassessed whenever operations have changed based on the risk management process in DoDI 6055.05. In addition, noise surveys should be performed when a ship has undergone a major repair availability, had significant work to existing engineering systems, or has new equipment installed. Acquisition and new system development should incorporate noise measurements during the test and evaluation stage per OPNAV M-5100.23. When insufficient noise data is available to determine risk, personnel may be enrolled in the HCP based on the sampling of SEG.

(3) All active-duty and reserve Marine Corps personnel and all active-duty and reserve Navy personnel serving with or supporting Marine Corps units are enrolled in the HCP, regardless of noise exposure levels. All civilian personnel occupationally exposed to hazardous noise will be enrolled in the HCP according to the criteria listed under subparagraph 3c(1) of this enclosure.

d. HCP Enrollment Responsibilities and Actions

(1) Medical Department IH personnel are responsible for identifying noise hazardous areas and equipment within a command during baseline and periodic noise hazard surveys and during select noise exposure monitoring events. Formal IH survey reports are subsequently provided to commands detailing the noise hazard areas and operations.

(2) Commands are responsible for identifying the personnel who work in noise hazard areas or operations, enrollment of personnel into the HCP, removing personnel from the HCP when they no longer work in hazardous noise, and semi-annually updating HCP enrollment rosters and databases.

(3) Visitors to hazardous noise areas are required to wear hearing protection but are not required to be enrolled in the HCP, have their hearing tested, or be included on a roster of noise exposed personnel.

4. Hearing Protection

a. HPD Use. HPD use is mandatory when personnel are occupationally exposed to noise levels at or above 85 dBA or 140 dBP. HPDs and earplug carrying cases are provided to and worn by personnel working in potentially hazardous noise. Areas or equipment where the sound pressure levels are 104 dBA or greater, or 165 dB peak or greater must be labeled and require the use of double hearing protection (earplugs and circumaural muffs). Personnel who are not in compliance with the mandatory and appropriate use of hearing protection in noise-hazardous areas (double protection where required) are subject to administrative or disciplinary action. All personnel exposed to weapons fire regardless of a simulated or live training event must wear HPDs. Commanders will determine the use of HPDs in combat based on mission requirements, impact on communication, and situational awareness.

b. Hearing Protection Product Selection. Noise hazard commands are advised to consult with NAVMEDREADTRNCMD occupational audiologists or industrial hygienists on product selection to assure that selected devices are appropriate and effective for the noise environments. Commercial HPD product noise reduction rating (NRR) values are not representative of real-world attenuation. Field attenuation estimation systems, commonly referred to as a fit-test system are a best practice method for determining attenuation. If fit-testing is not available, the NAVMCFORHLTHPRTCMD IH Field Operations Manual describes calculation methods for determining more authentic product noise reduction capability to help facilitate appropriate HPD

selection. HPD attenuation measurements conducted by government labs (and government approved labs) reflect accurate noise reduction values and can be relied on when selecting HPD devices.

(1) Considerations for hearing protection are found on the NAVMCFORHLTHPRTCMD Web site.

(2) Information and guidance on NRR, ordering information, custom molded hearing protection, and other HPD products is available on the NAVMCFORHLTHPRTCMD Web site.

(3) The user should be permitted some freedom of choice in the selection of HPD type, unless the selected protector is medically contraindicated or inappropriate for a particular noise hazardous area or operation. Pre-formed and hand-formed earplugs, as well as other HPD options should be available at all times for personnel in the HCP. Hand-formed disposable earplugs must be available for visitors to noise-hazardous areas.

(4) OA consultation is recommended in instances of HCP enrollee significant hearing loss, high intensity noise exposures (TWAs in excess of 104 dBA or 165 dBP impulse or impact), auditory fitness for duty (AFFD) concerns, or communication-critical situations.

c. Specialized Hearing Protection Products and Communication Devices

(1) Use of custom hearing protection devices is authorized. HCP enrolled personnel have the option to use custom hearing protection to effectively reduce excessive noise exposure and maintain or enhance communication ability. Only audiologists, otolaryngologists, or trained aviation physiologists or technicians may take impressions of the ear necessary to make the custom earplugs. Consult the local audiologist for custom ear impression guidance and protocols.

(2) Procurement of Tactical Communication and Protection Systems or other advanced electronic devices that enhance or improve communication and reduce noise exposure should be coordinated with the NAVMEDREADTRNCMD occupational audiologist who can provide product selection advice, device fitting, training support, and attenuation assessments.

d. HPD Fitting Procedures

(1) While the command or activity is required to purchase, provide, and maintain hearing protection for its employees, non-disposable and specialized hearing protectors require accurate sizing and fitting by medically trained personnel. Before any such device is placed in an ear, a well-lighted visual inspection is necessary to determine whether any condition is present that would make insertion inadvisable, such as, observable pathology or excessive earwax. Each ear canal will be inspected and sized separately.

(2) HPD fit is a critical factor in preventing noise-induced hearing loss. The quality of the fit significantly influences the amount of protection provided by the device. Fit-testing is a best practice method for determining attenuation. It is required on all DoD personnel at the initial reference audiogram, or before initial routine duty in hazardous noise areas, or as soon as possible after employment begins when the occupational exposures are at 85 dBA or greater, 8 hour time weighted average for at least one day. Additionally, fit testing is required when a confirmed PTS is identified on the periodic audiogram. Fit-testing will be conducted at the frequencies of 500, 1000, and 2000 Hz. It should be performed by a trained safety professional, occupational audiologist, occupational health nurse or technician, or corpsman.

(3) Provision of personal hearing protection of any sort requires basic instruction as to use and care. All personnel required to wear hearing protection will receive adequate and effective training in the proper use and care of HPDs. Medically trained personnel must examine the fit and condition of preformed, specialized, and custom earplugs at initial fitting and at least annually, preferably in conjunction with the annual hearing test.

(4) Recreational listening devices must not be used in place of or in conjunction with approved hearing protectors. Hearing aids or amplification devices must not be used in noise hazard areas, unless specifically approved by an audiologist. Hearing aids must not be used in place of or in conjunction with an approved hearing protector unless approved for that purpose by an audiologist. Any decisions to waive or alter the use of HPDs must be made and documented by an occupational audiologist.

e. HPD Purchase and Procurement. As with all personal protective equipment, purchase and provision of hearing protection and communication devices is a responsibility of noise hazard commands. Hearing protection and earplug carrying cases are considered safety supply items, not medical items. NAVMEDREADTRNCMDs must also maintain a supply of a variety of HPDs and carrying cases for the purposes of educating command safety representatives, employee supervisors, and employees on available and appropriate HPD options and current technology.

5. Audiometric Monitoring

a. Audiometric Testing and Diagnostic Audiology Services. The Navy Medical Department is responsible for the provision of all required HCP evaluations to include diagnostic audiology evaluations and medical qualification and AFFD evaluations. All hearing evaluation results must be captured and maintained in the EHR. On joint service and sister service bases, medical surveillance and diagnostic hearing evaluations may be obtained through certified technicians and audiologists from supporting Services. Navy and DoD occupational audiologists are the subject matter experts on federal regulations and military guidance regarding occupational hearing standards and requirements for AFFD determination.

b. Audiometric Equipment and Software Requirements. Audiology equipment must be replaced once it has exceeded its life cycle expectancy.

(1) For HCP medical surveillance audiometric testing:

(a) Certified audiometric test chamber (audio booth).

(b) Benson Medical CCA-200 mini microprocessor audiometer for each station with accompanying headphones and patient response button (provided by NAVMCFORHLTH-PRTCMD).

(c) Benson Medical BAS-200 Acoustic Simulator for each station (provided by NAVMCFORHLTHPRTCMD).

(d) Current version of DOEHRS-HC software.

(e) Hearing protection fit-check equipment.

(2) For diagnostic audiology assessments:

(a) Certified audiometric chamber that meets diagnostic test attenuation requirements (recommend double-walled booth).

(b) Enterprise Clinical Audiology Application (ECAA) compatible diagnostic audiometer with accompanying headphones, bone oscillator, and patient response button.

(c) ECAA compatible middle ear analyzer.

(d) Otoacoustic emission equipment.

(e) Diagnostic otoscope.

(f) Device for administering recorded speech tests.

(g) Hearing protection fit-check equipment.

(h) Custom earmold impression equipment and supplies.

(i) Current version of ECAA software.

(j) Virtual audiology equipment (optional or recommended for supporting remote clinics).

(3) Audiology Booth Installation and Certification Requirements

(a) Audiometric test chambers (audio booths) must be certified annually with a Type 1 octave band analyzer meter with a 1-inch microphone, meeting the requirements of the most recent version of American National Standards Institute (ANSI) standards. Recertification is also required when a chamber, including Mobile Occupational Hearing Conservation Audiometric Truck, is relocated and whenever there is a significant change in ambient noise levels that could affect hearing testing.

(b) Certification is performed by an industrial hygienist, audiologist, or others meeting guidelines established by NAVMCFORHLTHPRTCMD. An approved booth certification form with instructions for conducting a booth certification is provided on the NAVMCFORHLTHPRTCMD Web site. Current booth certifications must be posted in the area where audiometric testing is performed.

(c) New booth purchases or relocation of existing booths must be coordinated through the Defense Health Agency (DHA) and the local occupational audiologist. The regional HCPM must be consulted to ensure the appropriate size and type of booth is selected. Adequate space planning and preparation is required when determining facility location for audiometric testing services. Sound-treated audiometric chambers occupy a significantly large footprint. The designated room must also accommodate audiometric medical equipment, office furniture, and patient counseling area. Sound attenuation is critical for obtaining valid audiometric results; therefore, careful pre-planning is required prior to booth purchase and installation. Audiometric testing locations should be designated in areas away from known noise sources, such as conference rooms, break rooms, auditoriums, ambulance bays, and other significant outdoor noise sources, intercom systems, ventilation systems, and heavy patient traffic areas.

(4) Equipment Use, Maintenance, and Calibration Requirements

(a) Medical Surveillance Audiometric Equipment. All NAVMEDREADTRNCMD hearing conservation audiometric testing sites must use the DoD designated microprocessor audiometer with the most recent version of the DOEHRS-HC software for all hearing conservation testing. The most current version of DOEHRS-HC software is available at the DOEHRS-DR Web site for those with active accounts or may be obtained by contacting the Military Health System (MHS) Help Desk at 1-800-600-9332 or e-mail: help@mhs-helpdesk.com. Software maintenance updates must also be downloaded on a monthly basis. These updates are located at the DOEHRS-HC DR Web site. After logging onto the Web site, HC updates are found under the DOEHRS-HC menu.

(b) An exception to using microprocessor-based DOEHRS-HC audiometry includes patients who require manual audiometry (tinnitus patients, hard-to-test patients, and referrals to the audiologist). In these instances, the manual audiometer test results will be manually entered into the DOEHRS-HC software and uploaded to the DOEHRS-HC DR to ensure the central data

repository remains current on all hearing conservation test results. Each audiologist will have the DOEHRS-HC software loaded onto their desktop to allow entering of re-established baseline or periodic audiograms.

(c) Audiometric Equipment Calibration

1. Calibration of clinical and diagnostic audiology equipment is the responsibility of the NAVMEDREADTRNCMD and is conducted onsite by a NAVMEDREAD-TRNCMD contracted vendor. Calibration for clinical and diagnostic audiology equipment is required to be completed by or before the calibration due date indicated on the equipment. Daily calibration checks are not required for diagnostic audiology equipment.

2. Medical surveillance microprocessor audiometers will be calibrated by physical methods at least annually for compliance with the most recent version of ANSI standards. Calibration and repairs affecting calibration are provided by NAVMCFORHLTH-PRTCMD at no cost for all DOEHRS-HC microprocessor audiometers used in the HCP. The calibration of clinical or diagnostic audiometers used in otolaryngology or audiology clinics are not part of the NAVMCFORHLTHPRTCMD service.

3. Preventive and minor maintenance of medical surveillance audiometers which does not affect calibration is accomplished by the local NAVMEDREADTRNCMD biomedical equipment maintenance and repair staff. A local pool of audiometers for loan may be maintained for branch clinics and fleet activities, where necessary, to be used for exchanging defective units which cannot be immediately repaired locally. The local HCPM will control this pool. Guidance concerning the pool or for assistance with audiometer repair, calibration, or loan may be obtained by contacting the audiometer calibration and repair staff at the NAVMCFORHLTH-PRTCMD.

4. Problems with DOEHRS-HC software must be reported to the MHS Help Desk by e-mail to servicecenter@dha.mil or by phone (CONUS: 1-800-600-9332 or OCONUS: 1-866-637-8725). These e-mails cannot be encrypted and must not include protected health information or personal identifying information. E-mails should include a brief, but detailed description of the problem including screen captures (if possible), error messages, software version being used, and user or facility contact information.

5. A functional listening check and biological calibration check is performed each day the medical surveillance microprocessor is used. An acoustic simulator or normal hearing listener with pre-recorded baseline thresholds will be used to complete the daily biologic calibration check. Biological calibration results are electronically recorded on a DD Form 2217. Daily biologic calibrations must be maintained and available for review for 5 years. If the daily calibration test results differ from the calibration baseline audiogram by more than +/- 5dB at 500 - 4000 Hz or more than +/- 10 dB at 6000 Hz, an alternate normal “listener” with a reference audiogram on file must be tested and results compared against recorded reference hearing values

for that listener. Listeners are not interchangeable once calibration baselines are established immediately after annual electro-acoustic calibration. An audiometer must be removed from service and repaired or recalibrated if it fails the calibration check.

c. Audiometric Test Types

(1) There are four types of audiograms: reference (baseline) audiogram, medical surveillance monitoring audiogram, non-HCP audiogram, and diagnostic audiogram.

(2) All personnel enrolled in the HCP are required to obtain reference (baseline) and annual medical surveillance hearing tests which consist of pure tone, air conduction hearing threshold measurements at test frequencies of 500, 1000, 2000, 3000, 4000, and 6000 Hz. Each ear is tested separately and unaided. All audiometric assessments must be permanently retained in individual health records. All required data fields can be found on a copy of the DOEHRS-HC Demographic Data Intake Form (sample provided on NAVMCFORHLTHPRTCMD Web site).

(a) Reference Audiograms are recorded on DD Form 2215. The reference hearing test will not be administered unless the individual has been free from exposure to occupational and non-occupational noise above 80 dBA for at least 14 hours. This requirement cannot be met by wearing hearing protection devices. Five types of reference audiograms are used in the HCP.

1. Type 0 (Manually entered) Reference is manually entered into DOEHRS-HC when the reference audiogram is not electronically available. It is entered to conduct a comparison with the periodic audiogram DD Form 2216 Hearing Conservation Data. This data will only be transcribed from a DD Form 2215 from the employee's medical record.

2. Type 1 (Baseline) Reference is administered prior to (within 30 days) an employee beginning initial work assignment in occupational noise. All active-duty military personnel must receive a Type 1 reference audiogram at their first duty station. Civilians who are enrolled in the HCP must receive a Type 1 reference audiogram upon HCP enrollment. Diagnostic audiology evaluations are required when Type 1 reference audiogram results are abnormal.

3. Type 2 (Baseline) Reference is administered after exposure to hazardous noise, such as when the original reference audiogram is lost or never established. Diagnostic audiology evaluations are required when Type 2 reference audiogram results are abnormal.

4. Type 3 (Re-established) Reference is administered as the result of follow-up completion and is used to re-establish the baseline due to a confirmed (negative or positive) PTS. Only an audiologist or HCPM can authorize the re-establishment of a baseline after a positive (hearing gets worse) PTS. A certified HCT can re-establish reference audiograms when a negative (DD Form 2216 results are significantly better than the current reference) STS has been verified and previous audiometric history has been reviewed.

5. Type 4 Reference is administered when there is a change in service component. A Type 4 Reference is used for patients who are former active-duty military and are now a civil service employee or when a former civil service employee enters active-duty service or there is a break in service. In the case of civilians transferring between DoD service and components (i.e., a worker employed by the Army transfers to Navy employment), the baseline remains the same. Diagnostic audiology evaluations are required when Type 4 reference audiogram results are abnormal.

(b) Medical Surveillance Monitoring Audiograms are recorded on DD Form 2216. Monitoring hearing tests are used to detect incremental changes in hearing and identify potential problems before the hearing loss begins to interfere with verbal communication, job performance, or safety. Comparison is made between the most current monitoring audiogram with the most current reference audiogram to determine whether significant changes in hearing have occurred. A follow-up monitoring audiogram is required if results indicate a significant change in hearing in order to validate the results. All follow-up audiograms must occur within 30 days for civilian personnel or 90 days for military personnel to be considered valid. If follow-up testing is not obtained during this time frame, the monitoring sequence starts over. A referral to the occupational audiologist is required when a significant decrease in hearing is detected on the final follow-up test.

1. The monitoring audiogram may be conducted at any time during the work shift and does not require a noise-free period beforehand. Follow-up tests require the patient to be free from occupational and non-occupational noise (less than 80 dBA) for 14 hours prior to testing. This requirement cannot be met by wearing HPDs.

2. Termination Audiograms are also recorded on DD Form 2216. Military personnel will receive a termination audiogram 6 months prior to leaving military service, regardless of noise exposure history. Civilian personnel who have been routinely exposed to hazardous noise and were enrolled in the HCP will receive a hearing test within 12 months of termination of employment. Additionally, all civilian personnel who no longer require inclusion in the HCP due to removal from hazardous noise duties will have a termination audiogram to document auditory status at the time of reassignment.

3. Pre/Post Deployment Audiograms are not required to be administered for DON personnel before and after deployment unless specifically indicated as part of a pre or post deployment physical. Pre or post deployment audiograms are recorded on a DD Form 2216.

(c) Non-HCP Audiograms are used to record audiometric test results for non-hearing conservation purposes or for personnel not enrolled in the HCP.

(d) Diagnostic audiology evaluations are administered by NAVMEDREADTRN-CMD privileged audiologists for referred patients.

d. Coordination of Medical Surveillance Audiometric Testing

(1) Employee supervisors are responsible for ensuring that HCP enrolled personnel report to the supporting NAVMEDREADTRNCMD for all annual and required follow-up hearing tests and diagnostic evaluations.

(2) SECNAV 5100/1 Supervisor's Medical Surveillance and Certification Exam Referral Form is used to communicate and coordinate HCP care and services between the NAVMEDREADTRNCMD and supported commands. Employee supervisors are responsible for initiating and submitting this form to the supporting NAVMEDREADTRNCMD. Close collaboration between the NAVMEDREADTRNCMD occupational audiologist or HCPM and supported noise hazard command safety officers is crucial to the success of the program. Commands with personnel in the HCP must provide the NAVMEDREADTRNCMD HCPM or occupational audiologist with safety officer contact information, denominator or enrollment data, UIC for Navy, UIC or monitored command code or reporting unit code for Marine Corps, and program specifics to ensure effective program management and success.

(3) HCP enrolled personnel are required to bring their personal hearing protectors to the audiometric testing location in order to verify fit and effectiveness.

e. Medical Surveillance Audiometric Testing Outcomes

(1) STS. A STS is defined as a change in hearing threshold relative to the current reference audiogram of an average of 10 dB or more at 2000, 3000, and 4000 Hz in either ear. The STS may be either positive (poorer hearing) or negative (better hearing). A change of 15 dB or greater in either ear at any test frequency from 1000 to 4000 Hz is considered an early warning of potential future STS, requiring verbal counseling and assurance of appropriate hearing protection for the individual. Per DoD Instruction 6055.12, an age correction factor cannot be applied when determining STS.

(a) Positive STS

1. If the STS is positive, that is, the hearing levels of the monitoring audiogram are significantly poorer than the reference audiogram, a 14-hour noise-free (less than 80 dBA) follow-up test must be administered on a subsequent day to determine if the decrease in hearing is permanent.

2. If the results of this first follow-up test do not indicate a STS, no additional follow-up testing is required and the individual is counseled and returned to annual monitoring.

3. If the positive STS persists on the first follow-up and if frequencies below 3000 Hz are involved, then it is efficient and necessary to rule out an obvious conductive (mechanical) or medically significant basis for the shift before proceeding to the second

follow-up. The preferred method to rule out conductive hearing loss is through otoscopy and technician-administered screening tympanometry. Normal otoscopy, in conjunction with a normal tympanogram, is a quick and accurate indication that the threshold shift was likely not the result of an acute medical condition. A health record entry is made to document the tympanometry and otoscopic findings. If the tympanogram is abnormal, then evaluation by a health care provider (medical officer, nurse practitioner, physician's assistant, or independent duty corpsman) must be obtained and documented and the individual followed until cleared medically. If tympanometry is not available, the test sequence is continued. Further guidance concerning local procedures are provided by the audiologist or physician responsible for case management.

4. Perform a second follow-up audiogram if otoscopy, tympanometry, or medical evaluations are within normal limits. This follow-up test may be administered on the same day as the first follow-up. If the STS persists on the second follow-up, the patient is referred to the NAVMEDREADTRNCMD occupational audiologist or designated DoD provider for the review of results, determination of PTS, and disposition.

(b) Negative STS

1. If the STS is negative, that is, the hearing levels of the monitoring audiogram are significantly better than the reference audiogram, a retest will be conducted on the same day.

2. If the results of the follow-up audiogram are not significantly different from the reference audiogram (meaning no STS is present), no further testing is required. The individual is counseled on the test results and returns in 12 months for the next annual test (if enrolled in the HCP).

3. If the results of the retest remain significantly improved from the reference audiogram, establish the retest as the new re-established Reference (Type 3) audiogram. No Audiology consult is needed.

(2) Hearing Injury or Positive PTS and OSHA Reportable Hearing Loss Notifications

(a) PTS. A positive PTS is defined as a 10dB average decrease in hearing at 2000, 3000, and 4000 Hz in either ear when compared to the baseline or reference audiogram that is confirmed by an audiologist. A positive PTS is a potentially recordable illness or injury and is reported to the command safety office for entry on OPNAV 5102/7 (Log of Navy Injuries and Occupational Illnesses) or equivalent. Upon confirmation of a PTS, the reference audiogram will be re-established as a Type 3 audiogram on a DD Form 2215.

(b) OSHA Recordable Hearing Loss. All test results for civilian HCP enrollees are reviewed for evidence of an OSHA-Recordable STS. For an STS to be considered OSHA recordable, three criteria must be met: a confirmed positive PTS; average hearing threshold levels at 2000, 3000, and 4000 Hz is 25dB HL or greater; and the PTS is determined to be work related. OSHA recordable STS is not applicable to active-duty personnel.

(c) PTS and OSHA Recordable Hearing Loss Notification. All PTS results must be reviewed by an occupational audiologist or HCPM for validation. The HCP manager is responsible for notifying the HCP enrollee, his or her supervisor, and safety manager in writing within 21 days of determination of a positive PTS or OSHA recordable hearing loss. The HCP enrollee's signature on the DD Form 2216 serves as an appropriate formal written notice of a PTS to the individual. A sample notification letter to the HCP enrollee's command is provided on the NAVMCFORHLTHPRTCMD Web site and in the OA SOP.

(d) Hearing Injury, PTS, and OSHA Recordable Hearing Loss Tracking. The employee's command is required to document and track employee STS and PTS through Medical Readiness Reporting System (MRRS), Enterprise Safety Applications Management System, or other established system. For civilian HCP enrollees with a PTS that are also categorized as an OSHA recordable loss, the command is required to document the injury on the OSHA 300 log. For active-duty HCP enrollees with a PTS it may be required to enter the injury into RMI SIR. An OSHA or RMI SIR recordable hearing loss is recorded as a Class D mishap. A progressive hearing loss is typically recorded as an illness; an acoustic trauma from an instantaneous event such as weapon fire or impulse and impact noise is recorded as an injury.

(e) Hearing Injury, STS/PTS, or Mishap Investigation. Monitoring audiograms do not prevent hearing loss but serve as a gauge of HCP success. Once a hearing injury has occurred, it is imperative that the command take action to address and prevent future injury. Intervention effort should be made at the earliest indication of decreased hearing. Early Warning Shifts and STS incidence are the initial precursors of impending hearing injury and are the most opportune time to intervene. Upon notification to the commanding officer or safety officer of a PTS occurrence, the command safety officer must provide follow-up action to prevent further hearing loss. Recommended actions may include the evaluation of the worksite, review of potential noise hazard engineering and administrative controls, assessment of the adequacy and availability of appropriate hearing protectors, and review of the effectiveness of hearing loss prevention training. For active-duty and civilian HCP enrollees with an occupationally related PTS, noise hazard commands will:

1. Document the PTS as an illness and investigate as a Class D mishap when the PTS is determined to be a gradual and progressive change in hearing.

2. Document the PTS as an injury and investigate as a Class B mishap when the PTS is determined to be a result of an acute acoustic trauma from an instantaneous event, such as weapon fire, explosion, or other significant impulse or impact noise.

f. Audiology Referral Criteria

(1) Abnormal results on initial baseline DD Form 2215 audiograms as indicated in block 18 of form.

(2) Positive STS on final follow-up audiogram on DD Form 2216.

(3) Asymmetrical hearing loss. Individuals whose hearing thresholds at any test frequency differ by 40 dB or more between ears cannot be tested by a technician and must be referred to an audiologist, as masking is required. In addition, any patient with an asymmetry of 20 dB or more at two consecutive frequencies will be referred to an audiologist.

(4) Abnormal pre-placement audiograms. Civilian employee applicants undergoing pre-placement evaluations are referred to the supporting NAVMEDREADTRNCMD occupational audiologist for review of any pre-existing hearing loss for the purposes of assisting medical qualification determination.

(5) Significant Hearing Loss. A significant hearing loss exists when the average hearing thresholds in either ear at 500, 1000 and 2000 Hz exceeds 30 dB and/or individual thresholds in either ear exceed 35 dB at 3000 Hz and 45 dB at 4000 Hz per DoD Instruction 6130.3, Medical Standards for Appointment, Enlistment, or Induction into the Military Services.

(6) Fitness for Duty 270 Rule. Any individual who has hearing loss in which the sum of thresholds at the frequencies of 3000, 4000, and 6000 Hz in both ears equals or exceeds a sum total of 270 dB will not be assigned to duties involving exposure to hazardous noise without a medical qualifying evaluation and clearance.

(7) Three PTS Rule. Individuals monitored under the HCP who have their reference audiogram re-established due to deteriorated hearing on three separate occasions must obtain clearance from an audiologist, otolaryngologist, or OEM physician before returning to duties involving hazardous noise. These individuals are considered to be at high risk for developing further hearing loss and require comprehensive diagnostic audiology evaluations and medical qualification determination.

(8) Auditory Complaints. Personnel enrolled in the HCP reporting significant occupational hearing loss, bothersome tinnitus, or difficulty understanding verbal communication should be referred to the audiologist for evaluation. Employees who experience any occupational illness or injury should be instructed to report these problems to their immediate supervisor.

g. Medical and Otolaryngology Referral Criteria

(1) Patients with abnormal screening otoscopy and tympanometry results.

(2) Individuals not responding to treatment of ear canal occlusion, persistent ear pain, or ear canal drainage.

(3) Significant aural pathology, dizziness, severe and persistent or unilateral tinnitus, or sudden onset of hearing loss warrants immediate otolaryngology consultation.

(4) Upon completion of assessment/treatment, periodic monitoring hearing testing can resume, and a diagnostic audiology evaluation may be warranted to determine if a PTS has occurred.

h. OA Evaluation. Comprehensive OA evaluations involve a detailed diagnostic audiological assessment and are allotted for a 60-minute appointment slot. ECAA software will be used to electronically capture diagnostic audiology assessment results which will be transferred into the EHR at each location where an Audiologist is assigned. Patients referred for a comprehensive OA evaluation will undergo:

(1) Extensive review of patient audiological and relevant medical history, to include: occupation and description of work, noise exposure (past and current), number of previous threshold shifts, hearing protection required/used, workplace communication demands and potential consequences of miscommunication, need for situational awareness, localization, and other related communication skills.

(2) Comprehensive diagnostic evaluation of both ears to include pure tone air conduction testing at 250-8000 Hz, bone conduction testing at 500-4000 Hz, speech reception thresholds, word recognition testing in quiet using recorded speech, tympanometry, and ipsilateral acoustic reflex testing. Optional tests, as applicable, include otoacoustic emissions, contralateral acoustic reflexes, reflex decay, and phonetically balanced rollover. As indicated, further diagnostic testing or magnetic resonance imaging may be warranted.

i. Medical Qualification and AFFD Determination

(1) Federal hearing standards for specified occupations will guide medical qualification and AFFD determination cases. The NAVMCFORHLTHPRTCMD Web site provides a chart that summarizes applicable Federal and DoD Hearing Standards. The 270 Rule will guide medical qualification and AFFD determinations in the absence of Federal hearing standards or other higher guidance.

(2) In cases where an employee's audiological evaluation reveals pure tone hearing thresholds that exceed the applicable hearing standards, an AFFD evaluation must be conducted. This evaluation will include all items listed in subparagraph 5h of this enclosure and a speech-in-noise test, except when the Federal and DoD Hearing Standards for a specified occupation exclude speech-in-noise testing. Speech-in-Noise test options include Speech Recognition in Noise Test (SPRINT), QuickSIN, Hearing in Noise Test (HINT), and Words-in-Noise (WIN), and Military Occupational Hearing Test (MOHT) for active duty service members, etc..

(3) The AFFD evaluation should include a functional on-site assessment of the worksite and a formal Job Capability and Safety Analysis (JCSA) in cases where there is concern about the employee's ability to conduct the essential job functions with the degree of hearing impairment incurred, or concern about the employee's personal safety risk or risk to others. In

these cases, AFFD determination must be a collaborative effort between OA, medical, and key personnel from the employee's command (i.e., employee supervisor, safety representative, Human Resources).

(a) The functional on-site assessment of the employee's worksite should evaluate the employee's ability to perform essential job functions and requirements while working in the noise environment, critical communication demands, noise exposure levels, availability and use of protective equipment, workplace safety concerns, and potential for reasonable workplace accommodations. This assessment and final AFFD determination(s) should be documented on the JCSA worksheet, available on the NAVMCFORHLTHPRTCMD Web site.

(b) Before the final medical qualification and fitness for duty determination is made for civilian employees, Human Resources and applicable legal representative(s) should be consulted to review pertinent issues specific to the case and provide guidance on the appropriate course of action.

(4) The role of the occupational audiologist is limited to determining whether the individual meets physical standards and requirements of the position and can, from a medical standpoint, perform the job capably and safely. Occupational audiologists offer administrative recommendations to the employee's chain of command, but the command makes the final decision as to what action to take. Waivers and employment-related decisions are fundamentally managerial, not medical.

(5) Final AFFD determinations include: Medically qualified, not medically qualified, or medically qualified with limitations. Final determination decisions will be forwarded to the appropriate authorities for action.

(a) Active-Duty Service Members

1. Those deemed medically qualified will be verbally notified during the AFFD assessment, and results will be placed in the EHR.

2. Findings of medically qualified with limitations or not medically qualified, along with any recommendations for administrative controls or placement in an alternate work environment free or limited from hazardous noise (which may require a change of occupational specialty), will be forwarded to the Service member's command leadership or supervisor, safety officer, or appropriate physician for consideration regarding a medical evaluation board.

(b) Civil Service Employees

1. Those deemed medically qualified will be verbally notified during the AFFD assessment, and results will be placed in the EHR.

2. Findings of medically qualified with limitations or not medically qualified, along with any recommendations for administrative controls or placement in an alternate work environment free or limited from hazardous noise, will be forwarded to the employee's supervisor, safety manager, and Human Resources Office.

j. Provider Credentials

(1) Military and civilian occupational audiologists supporting the HCP must be credentialed and privileged through the NAVMEDREADTRNCMD and must be certified as a course director by CAOHC. All HCP audiometric testing will be supervised by the cognizant NAVMEDREADTRNCMD's occupational audiologist or HCPM.

(2) HCTs or nurses providing medical surveillance audiometric testing must be certified in occupational hearing conservation. Successful completion of a Hearing Conservation Certification Course authorized by NAVMCFORHLTHPRTCMD is required for certification. This training is provided by military and civil service audiologists who are CAOHC-certified course directors. Navy HCP course locations, dates, and contact information are available on the NAVMCFORHLTHPRTCMD Web site.

(a) Equivalent training sponsored by other military services may be utilized with prior permission from NAVMCFORHLTHPRTCMD.

(b) HCTs obtaining initial certification should observe audiometric testing in a HCP clinic for at least 1 day prior to the HCT Certification Course. After completing the HCT Certification Course, the HCT should be supervised the first 3-5 days of initial hands-on experience and before conducting hearing testing independently. Technicians who have been inactive for more than 6 months should be supervised to ensure competency prior to conducting hearing testing independently. Those providing the supervision should ensure HCTs possess the knowledge and skills associated with DOEHRS-HC procedures and data accuracy, HCP procedures and regulatory requirements, and electronic medical record applications.

(c) Recertification training is required every 5 years. Certification extensions may be granted on a case-by-case basis from NAVMCFORHLTHPRTCMD.

(d) An annual on-site HCT competency assessment (sample on the NAVMCFOR-HLTHPRTCMD Web site) must be conducted on all active certified HCTs by an occupational audiologist, HCPM, or lead technician. Competency assessments for lead technicians will be conducted by an occupational audiologist. Active technicians are defined as those who have used the DOEHRS-HC system within 1 year. HCTs will be evaluated on test instructions, administration, patient education, fitting of hearing protective devices, and DOEHRS-HC and DOHERS-DR use skills. This evaluation will be documented at least annually to maintain certification. Documentation of successful competency evaluations must be maintained in technician training files and tracked by the HCPM for 5 years.

(e) At the discretion of the NAVMEDREADTRNCMD HCPM, DOEHRS-HC accounts may be locked or archived for technicians who have not successfully completed the annual technician competency evaluation, have demonstrated lack of skills and competency, or are non-compliant with requirements.

(f) Annual in-service refresher training is recommended during on-site visits.

(g) Quarterly group meetings with all HCP staff are recommended to provide targeted training on issues and trends identified during technician competency evaluations, improve HCP implementation and management, and facilitate mentorship and open communication among OA providers and technician staff.

k. Provider Workload Capture. HCP patient care services provided by audiologists and certified technicians must be captured in the EHR and coded as a special program service in an F-MEPRS clinic (FBN). Accuracy of workload captured will be monitored by the HCPM.

l. Medical Diagnosis and Procedure Coding. Occupational audiologists and HCTs will adhere to the MHS and Hearing Center of Excellence (HCE) guidelines for medical coding.

6. Employee Hearing Loss Prevention Training

a. Training Requirements

(1) Initial hearing conservation training must be provided prior to assignment to duties in hazardous noise and annually thereafter. Civilians enrolled in the HCP should obtain initial training from the command during an orientation module. Uniformed personnel should obtain initial education during basic training.

(2) Provision and documentation of initial and annual training is the responsibility of the employee's command. Commands are encouraged to seek NAVMEDREADTRNCMD OA subject matter experts to assist with providing effective, meaningful training.

b. Training Content

(1) Initial and annual training must be sufficiently comprehensive to ensure familiarity with the following training elements:

(a) Physical and psychological effects of noise environments and hearing loss.

(b) Recognition of posted noise-hazardous spaces and environment.

(c) Audiometric testing and its purpose.

(d) Proper selection, fitting, use and care of HPDs.

(e) Roles and responsibilities in the prevention of hearing loss.

(f) Awareness training as to the hazards of non-occupational noise exposure during recreational activities.

(g) Impact of hearing loss on job performance and AFFD.

(h) Disciplinary actions for HCP non-compliance.

(2) Other than successful noise abatement operations, nothing is more important to the successful prevention of noise-induced hearing loss than motivating personnel to wear hearing protectors appropriately and ensuring compliance with personal protective and medical surveillance requirements. Personnel must understand why they need to protect themselves, when and how to do so, resources available for hearing protection and communication, and the consequences of carelessness or deliberate non-compliance.

(3) Successful education at all levels of the command is vital. As HCP subject matter experts, Navy Medicine occupational audiologists assist noise hazard commands in providing annual hearing conservation training and in educating leadership on HCP compliance and the appropriate tools and technology for hearing loss prevention.

(4) Occurrences of technician-administered refresher training is documented in the medical record when provided in conjunction with the annual audiogram.

c. Training Resources

(1) Sources of training support include OA and HCP staff at Navy NAVMEDREAD-TRNCMDs and NEPMUs. Upon request, these subject matter experts can provide assistance with HCP training, as schedules permit.

(2) Sources for hearing conservation training materials and information may be found on the NAVMCFORHLTHPRTCMD Web site or DHA HCE Web site at: https://hearing.health.mil/Resources/Training. A Hearing Education and Readiness course (DHA-US097) is recommended and available on the Joint Knowledge Online Web site. The course length is 30 minutes with a course certificate provided upon completion. The target audience for this course includes military and civilian employees, supervisors, and safety personnel.

7. Record Keeping

a. Hearing Conservation Data

(1) All hearing conservation data will be recorded using the forms in subparagraphs 7a(1)(a) through 7a(1)(d) of this enclosure:

(a) DD Form 2215 Reference Audiogram.

(b) DD Form 2216 Hearing Conservation Data.

(c) DD Form 2217 Audiometer Biological Calibration Check.

(d) DD Form 3126 Hearing Protection Fit-Test Record.

(2) Employee Health Record. A hard copy printout of DD Form 2215 and 2216 is placed in Part 1 of an individual's health record or is scanned into the EHR. The health record of each individual identified by command for inclusion in the HCP will contain the original baseline/reference audiogram on DD Form 2215; re-established reference audiogram(s), if different from original baseline audiogram; and all monitoring audiograms on the DD Form 2216. Diagnostic OA evaluation results will be captured in the ECAA software and saved into the EHR.

(3) DOEHRS-HC. Audiometric testing sites that are connected to local-area network (LAN) lines will export (upload) to the DOEHRS DR each day that the system is used to administer audiometric testing. Testing sites that are not connected to LAN lines will export DOEHRS data at least weekly. Information concerning exporting data is available at NAVMCFORHLTHPRTCMD, DOEHRS-HC, and DR Web sites.

(4) A current electronic backup of the local audiometric database must be maintained for purposes of resolving data corruption and integrity issues and restoring lost data. Electronic backups must be conducted at least weekly and preferably daily.

b. Individual Noise Exposure. Individual dosimetry results must be recorded in the employee medical record. Documentation of exposure may be based on actual exposure or SEG data associated with the individual's job code (i.e., Navy Enlisted Classification, Military Occupational Specialty, Service Duty Occupation Code) and may not be readily available in the medical file. Avoid selection of a specific noise exposure choice on the DD Forms 2215 and 2216 without documentation of the actual exposure.

(1) NMCFHPC Form 5100/17 Industrial Hygiene Noise Survey Form.

(2) NMCFHPC Form 5100/18 Industrial Hygiene Noise Dosimetry Form.

c. Medical Department Documentation. These records are maintained:

(1) Current number (denominator) of personnel enrolled on the HCP, as provided by the supported commands. This number will be updated at least every 6 months.

(2) Results of noise surveys. (Survey data for individual commands may not be available.) Noise survey data and files must be made accessible to OA and OEM Department personnel.

(3) Results of daily Audiometer Biological Calibration Checks on the DD Form 2217.

(4) Results of annual audiometric test booth certifications.

(5) Records of competency evaluations and in-service training of HCTs.

d. Retention of Records

(1) Results of hearing tests performed for hearing conservation, as well as exposure documentation, will be a permanent part of an individual's health record.

(2) Noise exposure data, recorded on a DD Form 2214 Noise Survey, NMCFHPC Form 5100/17, or NMCFHPC Form 5100/18, will be kept for a minimum of 40 years.

(3) All other hearing and noise-related documentation will be retained for 5 years.

e. HCP Workload Reporting

(1) All OA and HCP patient care workload will be recorded in the EHR under the FBN MEPRS code per current MEPRS guidance. FBN is used to document hearing conservation services to active-duty service members and DoD civilians enrolled in the HCP. FBN is also used to document diagnostic audiology services: hearing loss evaluations for worker's compensation, hearing readiness and fitness for duty, STS, acoustic trauma, and difficult to test patients (non-organic behavior or response).

(2) All NAVMEDREADTRNCMD personnel performing OA or HCP activities will record this work time under FBN in the DMHRSi application.

8. Program Evaluation and Management

a. NAVMEDREADTRNCMDs are required to track metrics by fiscal year. Metrics will be reported through annual HCP self-assessment and metric submissions to the cognizant Navy Medicine region and annual HCP status briefings with NAVMEDREADTRNCMD leadership. This data will also be reviewed during SOHME evaluations. The metrics in subparagraphs 8a(1) through 8a(6) of this enclosure are required.

(1) Noise hazard command HCP enrollment, estimated compliance, and hearing injury rates.

(2) Hearing loss prevention outreach initiatives (minimum of 12 per full-time occupational audiologist per fiscal year).

(3) Technician competency evaluation rate (benchmark = 95 percent).

(4) Clinic assist visits (benchmark = 100 percent).

(5) Submission of annual HCP performance reports to noise hazard commands in the NAVMEDREADTRNCMD AOR (benchmark = 100 percent).

(6) Submission of hearing injury reports (within 21 days) to noise hazard commands in the NAVMEDREADTRNCMD AOR (benchmark = 100 percent).

b. HCP Metrics. The key to a successful HCP is to ensure that all personnel who are exposed to hazardous noise in the workplace are enrolled in the command's HCP, receive annual audiometric evaluations, and active measures are taken to prevent occupational hearing loss (i.e., noise control, HPD use). While Navy Medicine is responsible for management of the medical components of the program, ultimately it is each command's responsibility to ensure its personnel receive proper medical surveillance to include annual audiograms. Navy Medicine does not have control over the number of individuals reporting for annual required testing.

c. The DOEHRS DR offers both standard and ad hoc queries against all centrally maintained data. Guidance in utilizing the DR can be provided by NAVMCFORHLTH-PRTCMD. Incomplete reporting, either through the HCP enrollee roster or DOEHRS data entry and uploads, or non-compliance with annual testing requirements negatively impact the data integrity and usefulness of HCP trend analysis through the centralized DOEHRS-HC database and the DOEHRS DR.

(1) Audiogram compliance and hearing injury rates are important data points for measuring HCP success. Command safety officers and work area supervisors manage and track HCP implementation and compliance. The safety officer and work area supervisor are responsible for establishing and maintaining the roster of HCP enrolled personnel, semi-annually providing the cognizant medical facility with the total program enrollment number, ensuring medical surveillance compliance is met by coordinating appointments with the supporting NAVMEDREADTRNCMD, and ensuring personnel complete required appointments. Because the safety officer manages and tracks HCP implementation, it is their compliance metrics that will be reported for annual audiogram compliance. The HCPM at the NAVMEDREAD-TRNCMD is subject to periodic assessment to ensure technical management of OA services. As a part of that assessment, the HCPM will be asked to present efforts made to monitor annual audiogram compliance.

(a) Accurate HCP enrollment numbers are necessary for calculating compliance.

(b) Compliance = the number of individuals enrolled in the HCP who have a current audiogram (dated within 12 months) divided by the number of individuals enrolled; # in HCP with current audiogram x 100 = % HCP compliance.

1. Calculating Annual Audiogram Compliance. The denominator in the compliance calculation is the number of personnel enrolled in the HCP. The accuracy of this number can be susceptible to HCP enrollee roster availability from safety officers or work area supervisors and roster updates, especially with the transient nature of military personnel moving to different assignments. The numerator in the compliance calculation is the number of personnel enrolled in the HCP that received their annual audiogram. Numerator accuracy is contingent on correct data entry into DOEHRS-HC and successful routine (daily or weekly) uploading of the audiogram test results into the DOEHRS DR by the HCT.

2. Reporting Annual Audiogram Compliance. The Navy reports the percentage of compliance of annual audiograms based on self-reported data from echelon 2 commands submitted to the Naval Safety Command and consolidated into the Medical Surveillance Command Report. Marine Corps annual audiogram compliance is collected, consolidated, and reported via MRRS. The accuracy of the Navy and Marine Corps compliance data for annual audiograms is a result of shared efforts made at local levels between noise hazardous commands and NAVMEDREADTRNCMD HCP personnel. It is the responsibility of the safety officer and work area supervisor to ensure personnel enrolled in the HCP receive appropriate medical surveillance testing; and the HCTs properly conduct, record, and routinely (daily or weekly) upload audiometric testing. It is the responsibility of the OA and HCPM to monitor the upload schedule and data integrity issues.

(c) Injury Rate

1. Incidence of STS = the number of positive STSs (poorer hearing) on annual monitoring tests (minus follow-up exams for the same individual) in the latest fiscal year divided by the number of individuals monitored; # of STS detected x 100 = % incidence STS.

2. Incidence of PTS = the number of PTSs (poorer hearing) in the latest fiscal year divided by the number of individuals tested during that period; # PTS detected x 100 = % incidence PTS.

3. STS rate metrics guide: $\leq$5% = Green, 6-9% = Yellow, $\geq$10% = Red

(2) Population Measures of Effectiveness (MOE)

(a) Annually, the DoD Hearing Conservation Working Group; Defense Public Health Agency – Dayton, Public Health and Preventive Medicine Department, Epidemiology Consult Service Division; and DHA HCE collaborate to provide information on the effectiveness of the DoD HCPs. A report is developed on service-level MOEs on HCP metrics.

1. MOE 1 examines the potential hearing injuries or illnesses by calculating the percentages of tested individuals who had results of STS, PTS, and temporary threshold shift.

2. MOE 2 examines the STS follow-up testing compliance for individuals with STS on the annual audiogram.

3. MOE 3 focuses on the measure of the proportion of individuals in the HCP population who have hearing impairment versus the proportion of those with normal hearing in the HCP population.

4. MOE 4 calculates the percentage of Service members who might qualify for Department of Veterans Affairs based only on auditory threshold disability criteria per 38 CFR §3.385, disability due to impaired hearing.

(b) The MOEs serve as a standardized operational demand signal that is actionable from the unit commander through the chain of command and serve as an enterprise tool to assess efforts made to minimize preventable hearing loss across the DON.

(c) Requests for ad hoc queries should be directed to the regional HCPMs.