DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO
BUMEDINST 5100.13E
BUMED-M44
14 Mar 2012

BUMED INSTRUCTION 5100.13E

From: Chief, Bureau of Medicine and Surgery

Subj: BUREAU OF MEDICINE AND SURGERY SAFETY AND OCCUPATIONAL HEALTH PROGRAM

Ref: (a) through (w) see enclosure (1)

Encl: (1) References
(2) Acronyms
(3) Policy Guidance for Providing Occupational Health Services to Personal Services Contract Workers
(4) Department of Navy Bureau of Medicine and Surgery Safety Excellence Award In Medical Safety Improvement Criterion and Nomination Process

1. Purpose. To establish policy and procedures to implement and manage the Department of the Navy's (DON's) Bureau of Medicine and Surgery (BUMED) Safety and Occupational Health (SOH) Program in accordance with references (a) through (w). This is a complete revision and must be read in its entirety.

2. Cancellation. BUMEDINST 5100.13D and BUMED memo of 5 Sep 2006 "NAVMED Policy memo 06-012."

3. Scope. This applies to all BUMED command activities.

4. Discussion

a. Reference (d) establishes organizational responsibility and provides implementing guidance for the Navy SOH Program. Reference (e) provides procedures for mishap and safety investigations, reporting, and recordkeeping.

b. This instruction clarifies guidance in references (d) and (e), and explains the roles and responsibilities for the BUMED SOH Program both internally within BUMED and in support of DON organizations and activities with occupational medicine (OM), occupational nursing, occupational audiology (OA), and industrial hygiene (IH) services.

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

d. The provisions of references (c) through (g) apply to all BUMED activities and assigned personnel.

5. Policy. An effective BUMED SOH Program will be established in accordance with reference (d) and this instruction. Navy Medicine (NAVMED) Region and activity leadership at all levels are responsible for the integration and application of Operational Risk Management (ORM), and for incorporating risk-based assessment and decision-making principles and attributes of ORM into all aspects of the BUMED SOH programs in accordance with reference (v).

6. Action. The following actions are required in addition to the requirements outlined in references (d) through (g):

a. SOH Program Organization

(1) BUMED will:

(a) Establish a comprehensive SOH program in accordance with reference (d), chapters 2 and 3 and reference (j). Reference (d), paragraph 0302, delineates these duties and responsibilities.

(b) Serve as the liaison for SOH and The Joint Commission Environment of Care safety and health-related matters for activities under the command and control of Chief, BUMED.

(c) Coordinate the exchange of SOH information between headquarters commands to assure assigned forces are familiar with BUMED policies and procedures and that they are implemented consistently across NAVMED.

(d) Ensure organization and staffing of the SOH program are accomplished in accordance with reference (d), chapter 3. The NAVMED IH Staffing Standard developed by NAVMED Support Command (NMSC), NAVMED Management Analysis Team (NMAT) has been approved for implementation by reference (n). This standard adequately predicts IH staffing needs on a regional basis, but tends to underestimate required staff for small or remote activities while overestimating required staff for larger activities. IH staffing will be determined by applying the standard to individual medical treatment facility (MTF) IH departments but will be subject to modification by NAVMED Regions where deemed appropriate. NAVMED Regions will ensure that the individual MTF modifications do not result in regional IH total staff exceeding that calculated for the NAVMED Region using the NMAT staffing standard.

(2) NAVMED Regions will:

(a) Establish comprehensive, effective SOH programs in accordance with reference (d) at all activities under their cognizance. The regional SOH program should include a multidisciplinary team of both SOH professionals.

(b) Ensure Enterprise Safety Applications Management System (ESAMS) is used to record safety actions such as, but not limited to, training, inspections, mishap reporting, and medical surveillance and any required follow-up, at all activities under their cognizance.

(c) Review consultative assist visit requests from subordinate activities to determine whether the NAVMED Region can provide the necessary assistance. If not, forward the request to BUMED for resourcing assistance in accordance with reference (d), section 0806.

(d) Provide advice, technical reviews, and representation on working groups as requested by BUMED and higher authority.

(e) Ensure consistent implementation of Hearing Readiness and Preservation (alternatively known as Hearing Conservation Program (HCP)) requirements within their area of responsibility (AOR).

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

(g) Ensure effective incident reporting, Occupational Safety and Health Administration recordkeeping, Web Enabled Safety System (WESS) entries, as well as collaborative on-site investigation and/or intervention.

(3) Navy and Marine Corps Public Health Center (NMCPHC) will:

(a) Maintain a comprehensive organization of occupational health (OH) and preventive medicine expertise that provides unique technical support to the Navy and Marine Corps, particularly when such support may be outside the scope or capabilities of local MTFs.

(b) Provide specialized consultative support and subject matter expertise in such areas as IH, OM, ergonomics, hearing readiness and preservation (HRP) to the Chief, BUMED, NAVMED Region commanders, and Navy and Marine Corps Operational Forces, as well as acquisition and operational program managers. Provide technical representation to working groups and committees as tasked by BUMED or higher authority.

(c) Specific examples of the type of unique support the NMCPHC may provide include, but are not limited to, the following:

1. Maintain the Epidemiology Data Center with the 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 Epidemiology Data Center will design and conduct occupational and environmental studies, as well as routinely review and report studies utilizing the Defense Occupational and Environmental Health Readiness System (DOEHRS) for IH, environmental health (EH), and HRP, and provide reports periodically as requested by higher authority.

2. The Epidemiology Data Center, in coordination with Naval Safety Center shall ensure use of medical treatment reports to identify mishap-related injuries of active duty military and civilian personnel authorized treatment from 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.

3. Ensure subject matter experts in EH, IH, OA, OH, OM, and preventive medicine provide Navy and Marine Corps requested consultation and technical field support.

4. Publish and maintain technical manuals on IH and OM subjects including the Medical Matrix for medical surveillance, OM field operations, reproductive hazards, IH field operations, HRP, and heat and cold stress.

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

6. Provide IH laboratory services to Navy and Marine Corps industrial hygienists through the NMCPHC Comprehensive IH Laboratories.

7. Provide IH, OM, HCP, and ergonomic services to operational Navy and Marine Corps activities and units through the Navy Environmental Preventive Medicine Units (NEPMUs).

(4) BUMED Activities

(a) Conduct an aggressive and continuing SOH program applying the requirements of references (a) through (m) and, where applicable, the Joint Commission standards.

(b) Ensure ESAMS, the standard data management system to record, monitor, assess, and measure safety programs, is implemented and used to record safety actions throughout the command. ESAMS will accommodate safety program components such as, but not limited to, training, workplace inspections, job hazard analyses, employee reports of unsafe or unhealthful working conditions, hazard abatement, respiratory protection program, mishap investigation, reporting, recordkeeping, and medical surveillance. Some mishaps, depending on class and category, may require direct entry into the Navy WESS.

(c) The DOEHRS is the information management system for longitudinal exposure recordkeeping and reporting in accordance with references (d), (o), (p), and (q) and its use is mandatory. All personal exposure sample results and Consolidated IH Laboratory samples will be entered into DOEHRS.

(d) Staff and organize SOH offices as outlined in reference (d), chapter 3. Those activity SOH offices tasked with managing other program elements not included in reference (d) minimum core requirements (e.g., fire prevention, environmental protection, patient safety, environment of care, and other Joint Commission-specific programs) must consider this as an additive function, and ensure additional resources necessary to support this function are allocated.

(e) As required by reference (d), implementation of the safety program is considered a command special assistant staff level function and must not be delegated lower in the organization. The SOH program is an inherent responsibility of the command and includes legal obligations for the commander, commanding officer (CO), officer in charge (OIC), and the SOH manager. Accordingly, the SOH manager will report directly to the commander, CO, and OIC and have regular unimpeded communications with the CO and senior leadership regarding SOH program status, problems, resource needs, etc. In activities with less than 400 employees, the safety manager position may be a collateral duty performed by an appropriately trained individual with special assistant status for SOH matters. In activities with a Director of Public Health (DPH), the safety organization may be administratively aligned with the DPH, but only if the safety manager is placed no lower than the department head level administratively and has unfettered communication with the commander, CO, and OIC as a special assistant. The safety organization may not be aligned with any other directorate.

(f) Activities will ensure centralized technical management of IH, OM, and HRP services under their command, preferably within a DPH. As specified in reference (t), technical management must be performed by qualified OH professionals. This technical management is to include as a minimum:

1. Standardization of business practices.

2. Assignment and evaluation of professional and technical personnel.

3. Prioritization of IH, OM, OA, safety, and healthcare support services throughout the geographic AOR of the MTF and NEPMU.

4. Technical document review. For all IH technical reports, a documented review by an experienced IH subject matter professional (e.g., IH department head) is required to ensure technical accuracy and report format consistency. Individuals selected to manage and supervise IH programs should be certified in the comprehensive practice of IH by the American Board of IH or at a minimum, eligible for certification, and working to achieve it. Signatures of IH technical reports will ensure this technical review was accomplished.

5. Medical record review. For all licensed independent practitioners (physicians, physician assistants, nurse practitioners, and audiologists) peer medical record reviews are required to meet competency and privileging requirements.

OM peer review is required by a board eligible OM/certified occupational and environmental medicine physicians or physicians with a minimum of 5 years experience working in an OM clinic to meet credentialing requirements. Peer review for OAs must be done by another licensed audiologist.

(g) MTFs must provide OH and workers compensation program support services in accordance with references (d), chapter 8 and (f).

(h) Navy MTFs will provide OH services for personal services contract workers, in accordance with reference (g) and enclosure (3).

(i) MTFs will ensure that OH providers (specifically OM physicians, OM physician assistants, OAs, and OH nurses) visit, at least annually, the DoD workplaces of personnel enrolled in medical surveillance programs. It is encouraged to the maximum extent possible to leverage subject matter expertise of professions that visits be done jointly with industrial hygienists, OAs, and safety specialists. Site visits are within the scope of practice for OH providers and are a necessary part of injury prevention, risk communication, and incorporating exposure assessment into clinical practice.

b. SOH Program Assessment

(1) BUMED will issue SOH program assessment guidelines and metrics annually.

(2) NAVMED Regions must conduct on-site compliance evaluations of SOH program effectiveness and efficiency at all subordinate activities. NMSC will continue to provide Safety and Occupational Health Management Evaluations (SOHMEs) and other related services to the three NAVMED Non-Regional Echelon 3 commands in accordance with reference (w). These SOHMEs will be conducted at least every 3 years as required by reference (d), paragraph 0904 or as directed by BUMED. SOHMEs will be conducted in accordance with a standard operating procedure developed by BUMED and posted on the BUMED SOH Web site. Copies of evaluations and reports will be forwarded to BUMED Safety and Occupational Health (BUMED-M44), BUMED Deputy Chief, Medical Operations (BUMED-M3), and BUMED Medical Inspector General (BUMED-M00IG).

(3) All BUMED activities must prepare annual program self-assessments and improvement plans for their internal SOH program.

(a) A summary roll-up report of these self-assessments must be provided in accordance with annual BUMED guidance. All activities shall incorporate the Navy Safety Vision as part of their safety program self-assessments. Guidance for the safety roll-up report, self assessments, and improvement plans is provided in reference (d), chapter 5 and by separate correspondence issued annually by BUMED.

(b) MTFs must also prepare separate annual safety, IH and OM program assessments and improvement plans. Program self-assessments shall be completed no later than 15 October each year.

(c) The activity commander, CO, OIC, executive officer, or senior leadership council must review and concur with program assessments, improvement plans, and annual BUMED SOH metrics. Program assessments, improvement plans, metrics, and all validating documents must be retained in-house for a minimum of 3 years for review by appropriate SOH inspection authorities.

c. SOH Training

(1) BUMED will participate as a member of SOH training groups in accordance with reference (d), or as assigned by higher authority.

(2) As outlined in reference (d), chapter 6, BUMED activities must support professional development and continuing education of assigned SOH personnel. All full-time journeyman level and higher industrial hygienists, IH officers, OH nurses, OM providers, OAs, and safety specialists and managers shall receive an equivalent of 4 continuing education units (CEUs) or 40 hours of professional development training annually. All full-time SOH personnel in a training status shall receive an equivalent of 8 CEUs or 80 hours of professional development training annually.

(3) ESAMS should be used to record safety training, in accordance with reference (d), chapter 6.

(4) Activities must identify and submit annual SOH training needs to BUMED. Guidance for submitting this information will be provided by BUMED annually.

(5) 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 are available respectively in references (k) and (l).

d. Hazardous Material Control and Management (HMC&M)

(1) BUMED will coordinate assistance and oversight to ensure compliance with Navy HMC&M programs and initiatives.

(2) NMCPHC will provide technical advice to Navy commands as directed by BUMED.

e. Hazard Abatement Program. All activities will work diligently to identify and quickly abate hazards. Use ESAMS to record and track SOH hazards. Large SOH hazard abatement projects will be validated, prioritized, and submitted in accordance with reference (d), chapter 12 and as directed by the Naval Facilities Engineering Command.

f. Mishap Investigation, Reporting, and Recordkeeping

(1) BUMED will conduct a thorough and timely mishap investigation program and use ESAMS for appropriate recordkeeping. An investigation board will be established as necessary to perform special investigations of on-duty Class A and certain Class B mishaps in accordance with references (d) and (e).

(2) BUMED activities must telephonically notify the Naval Safety Center, their respective NAVMED Region, and BUMED within 8 hours of all on duty civilian Class A mishaps, all on and off duty military Class A mishaps, and any Class B mishaps that result in the inpatient hospitalization of 3 or more people. Reference (d) chapter 14 and reference (e) chapter 3 provide further details.

(3) The cognizant NAVMED Region, unless otherwise directed by BUMED, must convene a mishap investigation board and initiate an investigation within 48 hours of notification of a mishap of the types noted in paragraph 6f(2) above and any other significant accidents as directed. The convening authority, BUMED-M44 or NAVMED Region, will arrange funding of the investigation board and coordinate required access for the investigation team members.

g. Emergency Preparedness. Activities will develop emergency preparedness procedures in accordance with reference (m). As part of this planning, activities must define the expected role of safety, IH, and OH personnel 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.

h. Respiratory Protection Program (RPP)

(1) BUMED will provide guidance necessary to implement the Navy RPP throughout NAVMED and ensure its implementation in accordance with references (a) and (d).

(2) NAVMED Regions will include RPPs as part of their oversight evaluations and ensure the establishment of comprehensive, effective RPPs in accordance with reference (a) and (d) at all activities under their cognizance.

(3) Activities with job tasks requiring respiratory protection shall establish and maintain an RPP in accordance with references (a), (d), and (m).

(a) Each activity shall 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 shall be used to record respirator fitting and training data.

(b) Activities shall also 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 (CBRN) incident). Activities shall include a strategy in the Emergency Management Plan that will ensure an adequate cadre of personnel is in the RPP to meet initial circumstances and to ensure the necessary surge capacity for an incident such as pandemic influenza. Those individuals at 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 desirable to maintain all personnel who have the potential to need an N-95 filtering face piece respirator in the RPP at all times.

(c) Personnel on designated CBRN response teams must be identified in the RPP and comply with all requirements of references (a), (d), and (m).

(d) Unless specified otherwise by contract, MTFs that employ personal service contract workers and non-personal service contract workers must abide by enclosure (3).

i. Safety Awards Programs

(1) BUMED's regional activities will nominate for DON BUMED medical safety improvement awards program in accordance with reference (c), and reference (d) chapter 32. This award shall recognize NAVMED activities that have demonstrated exceptional and sustained safety excellence both in patient and employee safety programs. The objectives of the awards program is 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, activities, and MTFs.

(2) BUMED winners shall be entered in competition for the Secretary of the Navy Safety Excellence Awards in accordance with reference (u).

(3) Criteria and nomination process for submitting a nomination is delineated in reference (u) and enclosure (4). Patient safety works to eliminate preventable patient harm by empowering patients and engaging, educating, and equipping patient care teams, including the patient, to institutionalize evidence-based safe practices.

(4) Selection criteria will include exceptional success in improving safety programs, performance, and culture, identifying and mitigating medically unique safety hazards, and/or integrating safety into the medical mission throughout their organization. The main focus of this award is improvement and results.

j. Information Technology

(1) The DOEHRS is the information management system for longitudinal exposure recordkeeping and reporting as stated in paragraph 6a(4)(c). In accordance with reference (q), NMSC is the executive agent responsible for all DOEHRS functionality. Under the direction of Commander, NMSC, the CO, NMCPHC shall allocate sufficient resources to:

(a) Coordinate Navy subject matter experts for the development, implementation, and maintenance of DOEHRS functionality.

(b) Approve and prioritize DOEHRS change request for the Navy.

(c) Serve as a DOEHRS consultant to Occupational and Environmental Health Integrated Process Team Navy membership.

(d) Facilitate and perform training of DOEHRS to Navy personnel.

(e) Approve DOEHRS accounts for Navy personnel.

(f) Construct recommendations to BUMED on the DOEHRS-Enhanced Environmental Health implementation policy for deployed units and in-garrison units to include any expansion of DOEHRS contract support and incorporation of training into applicable school curriculums.

(2) The ESAMS is the standard data management system to record and monitor, assess, and measure safety programs and shall be the safety and emergency management preparedness information system. It is a web-based risk management information system that facilitates multi-level program management and provides aggregate reporting, tracking, and trending of electronic data. ESAMS provides a mechanism for management to ensure compliance with applicable directives, and conduct analysis using real-time data.

7. Reports. The reporting requirements for this instruction are authorized by the report control symbols established in references (d) and (e).

8. Records Management. Records created as a result of this instruction, regardless of media and format, shall be managed in accordance with reference (x).

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https://www.med.navy.mil/directives/Pages/default.aspx

REFERENCES

(a) 29 CFR 1910
(b) DoDINST 6055.1 of August 19, 1998
(c) SECNAVINST 5100.10J
(d) OPNAVINST 5100.23G
(e) OPNAVINST 5102.1D
(f) DoD 1400.25-M, Subchapter 810 of April 12, 2005
(g) NAVMED Policy Memo 06-012 of 5 Sep 2006 Policy Guidance for Providing Occupational Health Services to Personal Services Contract Workers
(h) MCO 5100.29B of 28 Jul 2011
(i) NAVMC 5100.8 of 15 May 2006
(j) CNICINST 5100.3
(k) BUMEDINST 1500.18C
(l) BUMEDINST 7042.1A
(m) BUMEDINST 3440.10
(n) Chief, BUMED ltr 5320 Ser M1/11UM 1116 of 28 Feb 2011 (NOTAL)
(o) DoDI 6055.05 of November 11, 2008
(p) DoDI 6490.03 of August 11, 2006
(q) BUMED Memo 6240 Ser M3/5/10UM358150 of 20 Dec 2010 (NOTAL)
(r) DoD 6010.13-M of April 7, 2008
(s) SECNAVINST 5430.57G
(t) BUMEDINST 5430.8A
(u) SECNAVINST 5305.4B
(v) OPNAVINST 3500.39B
(w) BUMEDINST 5450.165B
(x) SECNAV Manual 5210.1 of Nov 2007

ACRONYMS

AOR	Area of Responsibility
BUMED	Bureau of Medicine and Surgery
CBRN	Chemical Biological Radiological and Nuclear
CEU	Continued Education Unit
CO	Commanding Officer
COR	Contracting Officer's Representative
DoD	Department of Defense
DOEHRS	Defense Occupational and Environmental Health Readiness System
DON	Department of the Navy
DPH	Director of Public Health
ESAMS	Enterprise Safety Applications Management System
HC	Hearing Conservation
HCP	Hearing Conservation Program
HCW	Healthcare Workers
HMC&M	Hazardous Material Control and Management
HRP	Hearing Readiness and Preservation
IH	Industrial Hygiene
MTF	Medical Treatment Facility
NAVMED	Navy Medicine
NEPMU	Navy Environmental Preventive Medicine Unit
NMAT	Navy Medicine Management Analysis Team
NMCPHC	Navy and Marine Corps Public Health Center
NMLC	Navy Medical Logistics Command
NMSC	Navy Medicine Support Command
NOTAL	Not to All
NPSC	Non-personal Service Contract
OA	Occupational Audiologist
OH	Occupational Health
OIC	Officer in Charge
OM	Occupational Medicine
PPE	Personal Protective Equipment
RPP	Respiratory Protection Program
SOH	Safety and Occupational Health
SOHME	Safety and Occupational Health Management Evaluation
WESS	Web Enabled Safety System

POLICY GUIDANCE FOR PROVIDING OCCUPATIONAL HEALTH SERVICES TO PERSONAL SERVICES CONTRACT WORKERS

Ref: (a) 10 U.S.C. § 1091
(b) BUMEDINST 4200.2B
(c) DoDI 6055.1 of 8 Aug 1998
(d) SECNAVINST 5100.10J
(e) OPNAVINST 5100.23G
(f) NMCPHC-TM OM-6260, Occupational Medical Surveillance Procedures Manual and Medical Matrix (Edition 10)
(g) NMCPHC-TM OM-6260.96-2, Occupational Medical Field Operations Manual (2006)
(h) NAVMED P-117, Manual of the Medical Department (MANMED)
(i) BUMEDNOTE 6230 of 22 Dec 2004
(j) BUMEDINST 6224.8A

This enclosure serves as policy and procedural guidance for personal services contract (PSC) workers at Navy medical treatment facilities (MTFs). References (a) through (j) of this enclosure defines PSC workers and provides instruction and guidance on occupational health (OH) programs and requirements. Contracts fall into two types PSCs and non-personal services contracts (NPSC).

1. PSC workers are always healthcare workers (HCWs) who are involved in direct patient care or clinical services. Most HCWs are currently PSCs but not all, so it is important to know the contract type. Examples of NPSC include housekeeping and food services.

2. Respiratory Protection Program (RPP). Due to the nature of PSCs, in which the Government is assuming the liability risk for the worker, the Government will provide the same personal protective equipment (PPE) (respirator, gloves, etc.) to the PSC worker as to a civil service employee performing the same duties. In general, PSCs are also treated the same as direct civil service employees with respect to RPP services. They should be fit-tested by Navy Medicine (NAVMED) staff and provided respirators as though they were direct employees. They should be fit-tested by our staff and provided respirators as though they were direct employees. Perhaps the only difference in the RPP with respect to PSCs is their medical qualification. PSCs must provide their own pre-placement health assessment (including respirator qualification if appropriate) before hire rather than getting a pre-employment physical from our OH clinic. Follow-up periodic medical certification for respirators can come from their own medical provider or our OH clinic. A direct civil service employee would have to get their periodic medical certification for respirators from our OH clinic.

3. NPSCs. In general, NPSC workers receive all their PPE and RPP support from their employer. Our OH clinic and safety office would not provide medical screening, respirator

fit-testing, respirators, or other PPE. The contract should have a statement regarding the contractor's obligation to meet safety and health standards and provide their employee PPE as necessary. There may be exceptions however, so it is always wise to check the contract.

4. PSC Worker Coordination with the Contracting Officer's Representative (COR)

a. OH services for PSC workers require close coordination between the MTF OH clinic staff, the COR, and the contracting officer at the applicable contracting office. In all cases, contract specifications take precedence over this policy memorandum.

b. The implicit employer-employee relationship existing between the Government and PSC workers may warrant the Government assuming some OH care responsibilities for PSC workers not assumed for NPSC workers. Programs include:

(1) Pre-placement Health Assessment. PSC workers complete a pre-placement health assessment before beginning MTF clinical services in accordance with their contract. Pre-placement health assessments are performed by a licensed physician who documents the worker's ability to safely perform functional requirements of the position with or without accommodation and documents all immunizations required by contract. The pre-placement health assessment is forwarded by the MTF COR to the MTF OH clinic and becomes part of the employee's MTF occupational medical record. Pre-placement assessments will not be performed at the MTF unless the PSC worker is an eligible beneficiary.

(2) Functional Requirements. Functional job requirements for each category of PSC worker within the MTF must be the same or similar to those required by DON civilian jobs. Standard lists of functional requirements are part of the solicitation process. Certification is the responsibility of the contractor and the contractor's medical agent.

(3) Immunizations and Tuberculosis Screening. Prior to employment, PSC workers must provide documentation of adequate immunizations. Documentation is retained in the PSC worker's MTF occupational medical record. The Naval Medical Logistics Command (NMLC) is responsible for ensuring consistency and accuracy of immunization requirements in all Bureau of Medicine and Surgery (BUMED) health care services contracts. NMLC and BUMED Medical Operations (BUMED-M3) will review and update immunization and other OH requirements annually. The MTF OH clinic will maintain an occupational medical record for each PSC worker. When pre-placement documentation is received, the OH clinic staff will screen the record for any medical contraindications to the Government.

1. PSC workers may request copies of all or part of their occupational medical record during and on termination of employment.

2. PSC workers are indistinguishable from military and Federal civilian workers for IH surveys and sampling.

c. The following services may be provided by the Government for PSC workers: medical certification examinations, medical surveillance examinations, occupational injury/illness care on a reimbursable basis, emergency care occurring on duty, urgent care on a reimbursable basis, and limited follow-up care. If the PSC worker is absent for 3 or more consecutive unplanned days, the commander, commanding officer (CO), or officer in charge (OIC) may require written documentation from a qualified health care provider that the PSC worker is free from communicable disease. The Government reserves the right to examine and/or re-examine a PSC worker who meets this criterion. OH clinic staff should consult with COR regarding return to work requirements and with PSC worker supervisors for optimum coordination.

d. The Government, via the MTF commander, CO, or OIC reserves the right to determine PSC worker fitness for duty. Any PSC worker demonstrating impairment will be evaluated. Fitness for duty evaluation is conducted at the MTF by a licensed provider authorized to perform these examinations. An unfit for duty finding requires prompt consultation with the COR. The Government reserves the right to examine and/or re-examine any PSC worker cleared by an outside agency or provider.

5. Categories of Impairments

a. Drug/Alcohol-Related Impairment. The Government reserves the right to require evaluation of any PSC worker who appears to be impaired by drugs and/or alcohol. PSC workers determined to be impaired by drugs and/or alcohol will be removed from the workplace. PSC workers are not eligible for Federal Employee Assistance Programs.

b. Other impairment. The Government reserves the right to require evaluation of any PSC worker who demonstrates an impairment which interferes with state workplace practices or fulfillment of contractual obligations. Examples of such impairments include, but are not limited to, physical impairments precluding performance of required tasks or mental/emotional dysfunction threatening staff or patient safety. This does not pertain to individuals granted reasonable accommodation under the Americans with Disabilities Act or due to work-related injury.

6. The above summary is designed to help safety and OH personnel understand existing contracts. It does not amplify, supersede, or otherwise change any contract provision. If in doubt, contact COR.

7. NAVMED commanders, COs, and OICs will disseminate guidance on OH services to ensure consistent and appropriate services for PSC workers.

DEPARTMENT OF NAVY
BUREAU OF MEDICINE AND SURGERY
SAFETY EXCELLENCE AWARD IN MEDICAL SAFETY IMPROVEMENT
CRITERION AND NOMINATION PROCESS

A fundamental element of SECNAVINST 5100.10J is the continuous improvement of safety and OH of all Naval personnel. Critical components of this are the integration of safety into everything we do and the design of safety into systems and processes up front. Safety and effective risk management should be engrained early in processes and be intrinsic to the medical culture of continuous improvement. Toward this end, Chief, Bureau of Medicine and Surgery (BUMED) will present the annual Medical Safety Improvement Award to a command, team, or office that has demonstrated exceptional success in improving safety programs and culture; identifying and mitigating medically unique safety hazards; and/or integrating safety into the medical mission throughout their organization.

1. Eligibility. All Navy Medicine activities are eligible for nomination for the Chief, BUMED's Medical Safety Improvement Award.

2. Criteria and Nomination Process. Annually the Regional SOH program managers as well as appropriate Patient Safety and Risk Mangers shall meet and establish minimum standards of performance for this award

a. Each nomination package should provide a brief description of the improvement and the results achieved by implementing the improvement. The package should address as many of the following criteria as applicable:

(1) Culture. How was the command or team's culture changed to better integrate safety and focus on early identification and resolution of safety issues?

(2) Patient Safety. How has patient safety worked to eliminate preventable patient harm by empowering patients and engaging, educating, and equipping patient care teams, including the patient, to institutionalize evidence-based safe practices?

(3) Improvement Identification. How was this particular improvement identified as a priority?

(4) Engineering. How were safety engineering principles, methodologies, and rigor integrated into the program, system, or process, and how did that lead to overall safety improvement? How were safeguards to protect personnel, equipment, and environment improved?

(5) Hazard Mitigation. How were hazard mitigation strategies for safety issues identified and developed?

(6) Barriers. What barriers, such as cost constraints, schedule drivers, and performance parameters, were overcome to develop and implement this safety improvement?

(7) Future Impact. How can this safety improvement be exported to other processes, programs, and commands, etc.?

(8) Documentation and Monitoring. What documentation and ongoing monitoring is the team or office implementing to support continuation and expansion of this improvement?

b. Nomination packages should include the following:

(1) Endorsement of the nominee via their chain of command.

(2) A cover page that includes the program/improvement name; nominating command(s); name/position title, address, telephone number, and e-mail of the team or office leader; and names and positions of all members involved in integrating safety into the program.

(3) A Microsoft Word document or portable document format that addresses the criteria above. The document should be no longer than 1,000 words. Up to three pages of attachments may also be included if they substantially clarify achievements.

(4) Achievements should be supported by quantitative and qualitative data, wherever possible.

(5) Achievements should be explained in a way that can be easily understood and appreciated by the general public; generalities, acronyms, and excessive use of superlatives should be avoided.

3. Submission of Nomination Packages. Packages must be submitted from the nominating command via e-mail to bumed.safety@med.navy.mil no later than close of business 1 March to the BUMED Safety Program Manager. Confirm receipt via separate e-mail.

4. Information. For additional information, e-mail the BUMED Safety Program Manager at bumed.safety@med.navy.mil.