DoD Medical Case Management Working Group

White Paper

April 2004

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Executive Summary

The DoD Prevention, Safety, and Health Promotion Council (PSHPC) chartered the Medical Case Management (MCM) Working Group to (1) conduct a business case analysis of MCM based on DoD and private industry data and (2) develop specific policy and programmatic recommendations that could be implemented within one year.

Business Case Analysis Findings

- Between 2001 and 2003, the Military Services lost 4.6M hours of productive work time to occupational injuries and illnesses. This is equivalent to losing approximately:
  - 2660 full time equivalents (FTEs)
  - 1.2 Marine Expeditionary Units
  - 88% of an Army Brigade
  - 1 embarked Navy Air Wing
  - 50% of a mid-size Air Force Fighter Wing

- Although there are significant differences between workers' compensation systems for private industry and the Federal workers' compensation system, many of the best practices used in private industry can be easily applied in the DoD. Some of these best practices are already in place in many DoD installations, though none of the DoD installations evaluated for this analysis has implemented all the best practices.

- Between 1996 and 2003, 14 sites with some form of MCM best practices were able to avoid $46M in workers' compensation costs when compared with their appropriate Service average. If all DoD sites had performed like the average examined best practice sites, DoD could have avoided $421M in workers' compensation costs during this time period—enough funding for 10,300 GS-07 employees or approximately 98 M-1 tanks.

Policy and Program Recommendations

- Request the Deputy Undersecretary of Defense (CPP) act on the proposed DoD 1400.25-M revision to (1) include role for designated medical case manager from the occupational health (OH) clinical staff and (2) implement return-to-work (RTW) teams.
- Revise DoDI 6055.1 to strengthen the OH clinic role in injury care and case management.
- Publish Health Affairs policy memo to (1) clarify authorization for access to medical treatment facility (MTF) medical care and (2) recommend prioritization status for injured workers to receive treatment after active duty military and ahead of other beneficiaries.
- Endorse publication of the proposed DoD 6055 Manual on MCM.
- Address issue of resourcing the MTFs to provide injury care (including specialty, diagnostics, and physical therapy/occupational therapy) and MCM. Consider financial incentives for providing on-site care.

- Task the Workers' Compensation Task Force to:
  - Develop and implement a DoD RTW policy and program that includes positions for long-term roll claimants and cross-service placement options.
  - Identify the targets for the proposed metrics of Average Annualized COP Lost Day Rate and PR Case Rate, including whether there should be DoD targets, Service-specific targets, or reduction by a percentage against self-baseline figures.
- Engage DoD Inspector General to measure impact of costs due to Department of Labor (DOL) Office of Workers' Compensation Programs (OWCP) administrative delays.
- Propose DoD-OWCP partnership program under the Safety, Health and Return-to-Employment (SHARE) Initiative.
- Include MCM in the scope of the Occupational Medicine, Injury Prevention and Mitigation Task Force for further action and development.
- Request Defense Manpower Data Center (DMDC) provide a report on their DoD Lost Workday Web site to show average annualized continuation of pay (COP) lost workday rate (COP days lost per 100 FTEs per year).
- Request Civilian Personnel Management Service (CPMS) include PR (long-term) case rate as a statistical report option on its Defense Portal and Analysis Center (DefPAC) Workers' Compensation Web site.

Conclusion

The successes at the DoD best practice sites present a compelling argument for the application of best practices across the DoD. Although many of the described best practices overlap with injury compensation program administrator functions, sites that implemented a team approach with medical personnel showed significant improvements with very modest financial resources. This white paper provides a foundation and impetus for decision and policy makers to improve the way DoD does business through medical support to workers' compensation case management.

Marianne Cloeren, MD, MPH
Chair, DoD Medical Case Management Working Group

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1. INTRODUCTION.

a. **Objectives.** On 28 August 2003, the Prevention, Safety and Health Promotion Council (PSHPC) announced the formation of the Department of Defense (DoD) Medical Case Management (MCM) Working Group. The working group was instructed to assess applying an MCM approach within DoD and to develop recommendations for consideration (see Appendix A). The working group convened for the first time on 17 October 2003. This white paper is the result of the working group's efforts to satisfy the following objectives:

(1) Define workers' compensation MCM.
(2) Conduct a business case analysis.
(3) Recommend a staffing decision model.
(4) Develop policy and program recommendations.
(5) Identify performance metrics.
(6) Deliver a white paper and draft DoD policies and guidance.

b. **Membership.** Marianne Cloeren, MD, MPH, chaired the working group. Members included personnel, safety, ergonomics, and occupational health (OH) representatives from the Office of the Assistant Secretary of Defense (OASD) and each of the Services (see Appendix B).

c. **The Challenge.**

(1) The working group recognized that DoD lost-time rates are comparable to, or lower than, those for other civilian and Federal employers. Nevertheless, between 2001 and 2003, the Military Services lost 4.6M hours of productive work time to occupational injuries and illnesses. This is equivalent to losing approximately 2660 full time equivalents (FTEs). The associated costs are as profound as the impact on productivity and include:

- Wage replacement costs for injured employees.
- Cost for medical treatment and rehabilitation.
- Overtime costs of the current staff to cover the injured workers' time.
- Costs of recruiting and training replacement workers.

(2) In addition, the President, Secretary of Labor, and Secretary of Defense have each challenged DoD to reduce workplace injuries and illnesses.

- President's Safety, Health, and Return to Employment (SHARE) Initiative. On January 9, 2004, President George W. Bush, in a memo to the Heads of Executive Departments and Agencies, established a safe workplace initiative for fiscal years 2004-2006 (see Appendix C). The initiative focuses on four goals: "lower workplace injury and illness case rates, lower lost-time injury and illness case rates, timely reporting of injuries and illnesses, and fewer lost days resulting from work injuries and illnesses."
- Secretary of Labor's Memorandum Implementing SHARE. On January 15, 2004, Secretary of Labor Elaine Chao issued a memorandum describing how the

Department of Labor (DOL) will measure and report the agencies' progress in meeting the four goals outlined in the President's SHARE initiative (see Appendix D). Secretary of Labor Chao also assigned metrics to the President's goals and stated that the government should be able to (1) reduce total injury case rates and lost-time case rates by 3% each year, (2) increase the timely filing of claims by 5% each year, and (3) reduce the rate of lost production days due to injury by 1% each year. Each agency was also tasked to work with DOL to set its own goals for the 3-year period.

- Secretary of Defense's Memorandum Calling for a Reduction in Preventable Accidents**.** Secretary of Defense Donald Rumsfeld, in a memorandum dated May 19, 2003, challenged the military departments to reduce the number of mishaps and accident rates by at least 50% during the following 2-year period (see Appendix E).

(3) The working group focused on these challenges as they performed their task to assess applying an MCM approach within DoD. This white paper provides a foundation and impetus for decision and policy makers to improve the way DoD does business through medical support to workers' compensation case management.

d. **Legal and Regulatory Mandate.** Medical support in the injury compensation process is the civilian employee's entitlement under Federal statutes and DoD regulations. Federal government employees who are injured while performing their duties are entitled to medical "services, appliances, and supplies" furnished by or on the order of U.S. medical officers and hospitals.[1] U.S. Army, Navy, and Air Force medical officers and hospitals are included in the statutory definition of "U.S. medical officers and hospitals."[2] Responsibilities of DoD medical officers are described in DoD's Civilian Personnel Management Service's Manual 1400.25-M.[3] See Information Memorandum at Appendix F for a detailed account of legal and regulatory mandates for medical officers.

2. DEFINITIONS.

a. **Workers' Compensation Case Management.** The working group defined workers' compensation case management as a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an injured worker's health needs through communication and coordination of care to minimize delays in diagnosis, treatment, and return-to-work (RTW).

(1) Expected outcomes are to retain the skills of a valued worker, reduce injury severity, prevent future injury to the employee and others, reduce lost workdays, and reduce overall compensations costs. Effective case management requires collaboration among the injury compensation program administrator (ICPA), who has overall responsibility for the installation's workers' compensation program, the occupational health clinic (OHC) staff, supervisors, Personnel, the treating

[1] Title 5, U.S. Code, Chapter 81, section 8103.
[2] Title 5, U.S. Code, Chapter 81, section 8101(20).
[3] DoD 1400.25-M, subchapter 810, Injury Compensation Policy.

physician, Safety, Ergonomics, Industrial Hygiene (IH), and DOL, which has the ultimate authority for determining case disposition.

(2) The medical contribution to case management, as defined in DoD 1400.25M, includes:

- Review all occupational illness cases; recommend action; and, if requested by ICPA, provide medical report for submission to the Office of Workers' Compensation Programs (OWCP).
- Communicate with the treating physician to clarify medical evidence if the attempts of the ICPA fail.
- Conduct a medical review of controversial and complex cases.
- Participate in RTW process; recommend appropriate assignments.
- Assist the ICPA in communicating issues to the local medical community.
- Facilitate on-site care such as physical therapy.
- Participate in the Federal Employees' Compensation Act (FECA) Working Group.

(3) MCM includes the above functions, but with a more proactive and organized approach, and includes:

- Advise the ICPA, Safety, and management of potential claims and management policies that may increase claims.
- Facilitate access to appropriate care, whether on-site or off-site, and help the ICPA network with community providers.
- Address work area hazards to prevent progression of symptoms to illnesses and injuries resulting in claims.
- Use clinic visit, claim, and lost day data to identify trends that need to be addressed through prevention.
- Use standardized disability guidelines to identify expected duration of disability.
- Participate in RTW team meetings.

b. **Integrated MCM Team.** The Integrated MCM Team (sometimes called RTW team) is composed of the ICPA, OH physician, medical case manager (usually an OH nurse), and other command-designated personnel such as Safety/Ergonomics/IH, as needed. This team meets frequently to discuss and make plans to facilitate safe and early RTW for employees with recent injuries, and to identify RTW opportunities for employees with long-standing partial disabilities. Individual case management planning includes development of short, intermediate, and long-term medical goals using disability guidelines, as well as determining necessary communications with the treating physician, OWCP, claimant, and supervisor.

3. CURRENT DOD CASE MANAGEMENT ISSUES. The working group identified and investigated policy, program, and process limitations that contribute to suboptimal outcomes.

a. **Military Treatment Facilities (MTFs).** There is wide disparity in the use of MTFs across the DoD. Some MTFs offer a full range of services, including physical therapy, diagnostic imaging, and specialty care. Other MTFs, with similar resources on-site, do

not offer any treatment beyond first aid and emergency care for occupational injuries. The root causes for this disparity include:

(1) MTFs providing comprehensive services to injured and/or ill employees absorb the cost of employee care. DoD policy prevents billing OWCP for these services and there is no reimbursement mechanism (see Appendix L). Competition for resources leads to prioritizing care for services that can be billed, resulting in some MTFs using OH physicians for primary care services for TriCare and other beneficiaries.

(2) Current DoD policies related to using the MTFs for MCM are nonexistent.

(3) A lack of understanding exists about when an employee may be required to report to the OHC for evaluation.

- DOL and DoD regulations prohibit requiring employees to visit the agency physician for evaluation before they have the opportunity to visit their physician of choice.
- DOL and DoD regulations do not prohibit requiring employees to visit the OHC for follow-up evaluations; however, Office of Personnel Management (OPM) provisions apply.

b. **Communication Gaps.** The Electronic Data Interchange (EDI) has improved the filing of DOL claims, but it does not notify key installation personnel (e.g., the supervisor, ICPA, OHC staff, and safety/ergonomics/IH staff) when an injury occurs. Prompt reporting of injuries to key personnel was identified as a critical factor in case management. DoD is currently developing an addition to the DoD EDI reporting system that will generate an OSHA report that will be available to safety managers.

c. **OWCP Delays.** There are long delays in decisions and responses from OWCP, including decisions on second opinion examinations, functional capacity evaluations, authorizations for surgery or proposed RTW assignments. Occupational illness claims typically take months to adjudicate (determine whether accepted or denied), during which time the claimant may not proceed with definitive care.

d. **Integrated MCM Team Development.** Civilian Personnel Management Service (CPMS) offers annual training on administrative case management to the ICPA and makes it available to other employees with FECA program responsibilities. Training on occupational injury care and the OH role in workers' compensation MCM is not routinely provided to the OHC staff, supervisors, or safety/ergonomics/IH staff. Although RTW teams were a common feature at sites with successful programs, training in the integrated MCM team process is not addressed in any currently available training or policy guidance.

e. **Limited RTW Employment Alternatives.** In general, installations provide temporary modified duty assignments early in a claim for those injured employees able to work in some capacity. Many installations do not provide permanent modified assignments for employees whose injuries result in permanent restrictions. Such employees are routinely separated and eventually placed on the periodic rolls (PRs). Many installations do not offer RTW options for former employees whose medical statuses have improved and who could RTW in some capacity. The root causes include:

(1) Disincentives to return employees to work. With some exceptions, commanders do not bear the financial burden for the cost of wage replacement for employees who have been separated by the installation because the chargeback bill is paid at a higher level.

(2) No DoD policy directing the rehiring of former employees who are able to work. DoD 1400-25M only directs that maximum effort be made to:
- Keep injured employees on the job and that light duty positions are made available (SC810.3.4.4); and,
- Restructure positions for employees who have been permanently or partially disabled because of a job-related injury or illness (SC810.3.4.5).

(3) No DoD incentive programs (e.g., for temporary subsidization of salaries or ability to hire across services) for Commanders to hire employees with disabilities. Although the Assisted Reemployment Program administered by DOL encourages cross hiring practices by subsidizing the hiring agencies with partial reimbursement of the salary provided through the losing organization, this program is not often used in DoD.

(4) Claimant financial disincentives to RTW due to generous OWCP payments (for those employees with dependents, OWCP payments at 75% of regular pay, tax-free, may be larger than their regular take-home pay).

f. **OWCP Quality Case Management Program.** The OWCP offers a Quality Case Management Program for traumatically injured workers losing time from work. Table 1 presents the timeline for assigning a DOL field nurse to a case, the necessary coordinated agency efforts in illness and injury claims, and the many "gap" periods when there is limited or nonexistent DOL MCM.

Table 1. Timelines for Illness and Injury Case Management

Timelines	DOL Nurse Quality Care Management Services*	Integrated MCM Team Best Practices**
Illness: Day 1 through claims adjudication (usually 90+ days)†	Not routinely offered Individual cases may be referred for advice/assistance or vocational rehabilitation.	• Maintain contact with ill worker, supervisor, and/or treating physician pending claim adjudication. • Facilitate needed diagnostic testing and collection of medical and exposure data needed for adjudication. • Coordinate limited duty assignments and needed work area corrections.
Illness: Adjudication to maximum medical improvement (MMI)†	Not routinely offered Individual cases may be referred for advice/assistance or vocational rehabilitation	• Maintain contact with ill worker, supervisor, and/or treating physician. • If claim is accepted, facilitate needed care, if MTF selected. • Review medical progress reports and recommendations. • Coordinate limited duty assignments and needed work area corrections. • Participate in long-range planning for duty assignments if permanent partial disability

Timelines	DOL Nurse Quality Care Management Services*	Integrated MCM Team Best Practices**
		results after MMI reached. • If claim is denied, assist employee and personnel with reasonable accommodations issues under Americans with Disabilities Act/ Rehabilitation Act of 1973.
Non-Lost-Time Injury†	Not offered	• Coordinate safe light duty assignment, appropriate medical care, and eventual return to regular duties.
Lost-Time Injury: Day 1 - Day 14†	Not routinely offered	• Contact injured worker, supervisor, and treating physician to facilitate care and RTW planning. • In catastrophic cases, help injured employee obtain necessary care and follow-up; assist in claim filing by helping gather needed medical documentation.
Lost-Time Injury: Day 15 - Day 44†	**Identification Phase** (Cases identified for intervention) • Usually limited to telephone contact with claimant, agency, and treating physician.	• Coordinate on-site treatment, if selected. • If off-site treatment is selected, communicate with treating physician (within DoL guidelines) for medical restrictions and available on-site referral services, and with supervisor for limited duty assignments. • Support the DOL nurse, if assigned during this period.
Lost-Time Injury: Day 45 - Day 119	**Monitoring/Assessment Phases** • Per OWCP manual, this is ideal time for DOL nurse intervention. Assignment may occur during these phases. • Telephone and face-to-face interviews, treatment plan updated/modified, determination if RTW is feasible.	• Support the DOL nurse if assigned. • Coordinate on-site treatment, if selected. • If no DOL nurse assigned, communicate with treating physician (within DoL guidelines) for information on medical restrictions and with supervisor for limited duty assignments.
Lost-Time Injury: Day 120+ (approx.)†	**Discharge Planning Phase** (Outcome of intervention assessed) • If claimant returns to work, follow-up for 60 days. • If claimant has not returned to work, case is referred back to claims examiner with recommendations.	• Support the DOL nurse if assigned. • Coordinate on-site treatment, if selected. • Once closed by DOL nurse, resume communication with treating physician (within DoL guidelines) for information on medical restrictions and with supervisor for limited duty assignments. • Participate in RTW team meetings for long-term placement options.

*Source: DOL Program Guidelines, Part 3, Medical, Ch. 3-0201, Staff Nurse Services.
**Source: Appendix G
† Indicates "gap" periods when there is no or limited DOL MCM.

4. INDUSTRY BEST PRACTICES, RESEARCH, AND OUTCOMES. A detailed analysis of industry sector best practices strategies, components, and outcomes was conducted (see Appendix G). These best practices primarily focus on effective proactive administrative oversight and integration of the care process, communication, and RTW management. The industry MCM programs using these best practices demonstrated strong and compelling results. Despite differences in workers' compensation systems, these same industry best practices are being applied successfully within DoD.

5. DOD BEST PRACTICES.

a. DoD civilian lost-time injuries, illnesses, and associated medical and compensation costs are major targets of the Secretary of Defense and Defense Safety Oversight Council (DSOC). These injuries and illnesses result in reduced productivity, increased production costs, and decreased financial and manpower resources to meet mission demands. Fortunately, approaches and programs in several DoD installations have demonstrated dramatic decreases in lost days and medical and compensation costs through a variety of injury/illness management initiatives and best practices.

b. The working group conducted a detailed program and business case analysis of current DoD best practices initiatives and outcomes. Fourteen DoD installations (see Table 2) were examined and data from these sites were used for the business case analysis. Supporting data was collected through site visits, extensive interviews with key personnel, and review of workers' compensation data and trends.

Table 2. Target DoD Sites for Best Practices Analysis

Air Force	Army	Marine Corps	Navy
• Robins Air Force Base, Georgia • Tinker Air Force Base, Oklahoma • Wright-Patterson Air Force Base, Ohio	• Anniston Army Depot, Alabama • Corpus Christi Army Depot, Texas	• Marine Corps Logistics Base, Albany, Georgia	• Norfolk Naval Shipyard, Virginia • Command Navy Region Southeast: o Naval Station Charleston, South Carolina o Naval Station Gulfport, Mississippi o Naval Station Jacksonville, Florida o Naval Station Key West, Florida o Naval Station Kings Bay, Georgia o Naval Station Mayport, Florida o Naval Station Pascagoula, Mississippi

c. Several DoD installations have integrated selected MCM best practices into their FECA management programs. Although these best practices were not uniformly or consistently implemented and coordinated across the analyzed sites, all of the DoD best practices translated successful civilian sector initiatives into DoD-relevant processes, policies, and activities. Specifically, the DoD best practices addressed command support (table 3), an integrated MCM team approach (table 4), training for key personnel (table 5), effective communications (table 6), case closure (table 7), medical care and coordination (table 8), information system solutions (table 9), and a dynamic RTW program (table 10). These proven DoD business best practices provide an excellent operational template for all DoD installations.

d. Most of the DoD best practice sites initiated an MCM program with very few additional resources. Some of the recommendations involve cost, including the provision of needed software for tracking and disability guidelines, as well as increasing the availability of the MTFs for care. However, the analysis demonstrated the effectiveness of low-cost approaches that can be implemented immediately at most DoD sites. Program successes were attributed to the improved team approach, coordinated communications, focused emphasis on RTW, and Command support. One of the bases reported dramatic improvements in the program outcomes following a Command mandate to establish a functional and cooperative team consisting of representatives from Personnel, OH, Safety, IH, managers, and line supervisors. The successes at the DoD best practice sites present a compelling argument for the application of these best practices across the DoD. The economic and productivity impact alone far exceed any program start-up expenses. But it is the avoidance of "hidden costs" associated with losing skilled and productive manpower that ultimately improves DoD readiness.

Table 3. Command Support Best Practices and Recommendations

DoD Sites Best Practices	Related Industry Best Practices	Recommendations
• Require an integrated, coordinated, and cooperative case management effort among Personnel, Safety, OH, IH, Ergonomics, and all levels of management. • Demonstrate Command support through policy, accountability, and resource allocation. • Establish an early injury reporting process that is supported by and visible to the Commander.	• Establish an effective multidisciplinary case management team, to include the occupational medicine physician, nurse case manager, a safety rep, and an ergonomist. • Commit necessary resources to the process, requiring accountability, implementing sound recommendations, and encouraging safety and wellness.	The Commander should: • Establish and chair the FECA Working Group to: o Meet at least quarterly to review established metrics for injuries, illnesses, lost days and costs, and RTW program progress. o Develop strategies to prevent injuries and illnesses, as well as to reduce lost days. • Establish policies requiring: o Same day reporting of injuries. o Mandatory offer of temporary light duty positions. • Establish a program for placing employees and former employees with permanent restrictions back to work.

Table 4. Integrated MCM Team Best Practices and Recommendations

DoD Sites Best Practices	Related Industry Best Practices	Recommendations
• Involve ICPA, Safety, IH, OH, and Ergonomics on the FECA committee. • Establish regular RTW team meetings to discuss open cases, cases that may not have been reported to the supervisor or installation OHC, placement issues, accommodation issues, and job modification issues. • Establish regular meetings between selected installation team members and supervisors or work area representatives.	• Use a medical case manager or managed care program. • Establish coordinating team of key players, who meet regularly to share information on the claim and medical status of injured workers. • Include need for preventive interventions in scope of case management team responsibilities.	• Expand FECA working group membership to include IH and ergonomics expertise as needed. • Establish an effective multidisciplinary medical case management team to include the ICPA, occupational medicine physician, and nurse case manager. Include expertise in safety, IH, or ergonomics as needed to facilitate safe RTW. • Use this team to review and discuss: o All new cases requiring care beyond first aid, including-- - Discrepancies warranting controversion. - Medical care needs of the injured worker. - Documentation needed for agency response to OWCP. o All illness cases. o All lost-time cases. o All prolonged temporary light duty cases. o Old cases on an annual basis, to define current medical status and identify opportunities for RTW.

Table 5. Training Best Practices and Recommendations

DoD Sites Best Practices	Related Industry Best Practices	Recommendations
• Provide comprehensive integrated training for installation ICPA, OHC staff, Safety, IH, and Ergonomics points of contact. • Provide intermediate-level training for production supervisors and team leaders. • Provide annual information and program overview training for shop and office civilian employees. • Develop information publications and fact sheets on the program and the required FECA forms for supervisors and civilian employees.	• Regularly train key personnel on multidisciplinary case management team in: ○ prevention ○ early recognition ○ evaluation ○ treatment ○ accommodation requirements ○ ergonomic concerns ○ rehabilitation of acute injuries and WMSDs • Fund short- and long-term formal and informal training opportunities for key workers' compensation team members, supervisors, employees, and providers of services.	• Provide regional resident and national nonresident integrated training for key personnel (e.g., installation ICPAs, OHC staff, Safety, IH, Ergonomics, and supervisors), including use of the DoD databases. • Provide appropriate-level training for first-line supervisors and RTW team leaders (i.e., ICPAs) on the role of MCM in the case management and RTW processes. • Provide training for civilian employees on the availability of on-site treatment and services in the event of an injury. • Design and develop an MCM technical guide to standardize DoD MCM processes and procedures. • Provide training in workers' compensation case management and use of disability guidelines for OH personnel; consider offering case management certification.

Table 6. Communication Best Practices and Recommendations

DoD Sites Best Practices	Related Industry Best Practices	Recommendations
• Establish a good working relationship between the installation OHC and the surrounding medical community providers. • Establish process for injured employees to obtain necessary forms for the treating physician. • Monitor and track medical restrictions. • Establish process for early notification of the ICPA, Safety, IH, and OH of any incident, injury, or accident. • Develop a follow-up system with civilian employees not placed on temporary assignment ("Stay in Touch Program"). • Maintain regular contact with injured employees, supervisors of the injured employees, and RTW employees and their supervisors. • Schedule follow-up visits to the FECA office after each medical appointment.	• Communicate with the treating physician before and after every visit. • Implement a missed-appointment protocol that requires a nurse to follow-up with the employee within 2-3 days of a missed appointment. • Conduct workplace based rehabilitation meetings (between employer, employee, case manager and ergonomist/ occupational therapist) to reach a consensus on early rehabilitation and return to work plan.	• Establish a network between the OHC and community providers, using introduction letters, catalog of services available on site, and open houses to meet the community providers. • Provide injured workers with packets including program information and necessary forms. • Consider use of a simple first report of injury system to notify key parties of an injury event. • Fax information about installation points of contact and RTW policy and options to the selected treating physician.

Table 7. Case Closure Best Practices and Recommendations

DoD Sites Best Practices	Related Industry Best Practices	Recommendations
• Implement specific forms and tracking to support case management process. • Follow up with civilian employees placed on the PRs to identify changes in medical status that may afford opportunities for RTW. • Use team approach to review current medical status on old claims and identify necessary interventions, e.g. request for second opinion exam, formal job offer, etc.	• Track action plan, actions taken, results, referrals, approval, scheduling, and appointment status. • Attempt RTW with the original employer first by accommodating the work restrictions. • Use independent medical evaluations and functional capacity evaluations to identify permanent restrictions. • Consider early (within 90 to 120 days) use of vocational rehabilitation.	• Establish system of tracking and reviewing old claims on an annual basis (or every 3 years for claims with PN status). • Obtain current medical status using multiple means: o Requests to OWCP. o Requests to the claimant. o Requests to the treating physician of record (with appropriate consent from the claimant on file). • Use OHP to review current medical information and the integrated MCM team to identify opportunities for case closure through RTW, vocational rehabilitation, or termination of benefits.

Table 8. Medical Care and Coordination Best Practices and Recommendations

DoD Sites Best Practices	Related Industry Best Practices	Recommendations
• Use OHC staff to help injured workers obtain needed appointments. • Offer full range of medical care at MTF. • Use OHC staff to obtain clarification of restrictions from medical provider. • Use standardized disability guidelines to predict duration of disability. • Monitor and track medical restrictions. • Review medical documentation for consistency between claimed condition, mechanism of injury, and planned care. • Visit work areas to identify needed improvements to allow safe RTW.	• Offer on-site medical care. • Coordinate referrals and off-site care. • Establish working relationships with community providers, including specialists. • Use standardized disability guidelines to plan care and RTW options.	• Co-locate the ICPA with the OHC, when feasible, to facilitate communication and medical case management, and for the convenience of the injured workers. • Offer full range of services at the MTF. • Use OH staff expertise early and often, in all cases requiring ongoing evaluation or care, to help coordinate care, identify medical discrepancies, and facilitate safe RTW. • Request the DSOC Occupational Injury Prevention and Mitigation Task Force compare the merits of commercial standardized disability management software programs for use by OHCs and ICPAs. Two commonly used systems are the *Official Disability Guidelines* and the *Medical Disability Advisor*. In addition to these two systems, identify other similar systems, and provide recommendations for DoD adoption.

Table 9. Information System Solutions Best Practices and Recommendations

DoD Sites Best Practices	Related Industry Best Practices	Recommendations
• Report injuries to key personnel immediately. The Army developed a first report of injury program as part of a demonstration project. This system collects just the basic facts (what, when, who, where, how) and pushes out an immediate e-mail notification to the ICPA, Safety, and OH. • Use EDI for prompt claim filing and better injury data accuracy.	• Use software systems (many proprietary and off-the-shelf systems are available) that allow: o Early identification of new work-related injuries and illnesses. o Team member access to create and review updated information. o Tracking of claim, medical and RTW status. o Real-time information.	• Request the DSOC Occupational Injury Prevention and Mitigation Task Force review the Army, Navy, and any other similar DoD injury reporting systems (including the Defense Injury/Unemployment Compensation System (DIUCS) database) for possible DoD-wide adoption of an administrative software program that will offer the following features:— o Provide a coordinating infrastructure to manage the cases and RTW process. o Track claim and medical progress. o Alert ICPA, OHC, Safety, and IH of injuries and incidents immediately. o Prompt and document an investigation. o Trend or analyze metrics. • Enforce use of mandated EDI for prompt claim filing across DoD.

Table 10. Return-to-Work Best Practices and Recommendations

DoD Sites Best Practices	Related Industry Best Practices	Recommendations
• Develop a process for Safety, IH, OH, or Ergonomics to validate the job placement assignment and job and equipment modifications and accommodations. • Establish an agreement among regional installations to assist with RTW assignments. • Establish an RTW team of key players (e.g., ICPA, OHP, medical case manager, safety rep, and ergonomist) to meet regularly and discuss and plan actions related to RTW problems. • Create positions for use for returning partially disabled former employees to work.	• Establish early RTW programs, light duty assignments, work modifications, and accommodations. • Track the medical care and medical clearances; respond quickly to implement planned actions. • Conduct an initial job analysis/RTW meeting with the employee and supervisor to establish targets and an action plan. • Conduct ergonomic assessment of the current and potential alternative work assignments. • Monitor employee progress and performance.	• Have the DSOC Workers' Compensation Task Force strengthen the DoD RTW policy to address motivating commanders to find assignments for employees with permanent restrictions, and placing former employees who are found able to work into jobs. • Endorse the proposed DSOC Workers' Compensation Task Force proposal for funding a fixed number of RTW positions for one year. • Establish integrated MCM teams to identify RTW opportunities and review proposed assignments for appropriateness. • Require medical officers to actively participate on the RTW teams and to use standardized disability guidelines to assist the ICPA in case management by providing expected medical outcome benchmarks

6. BUSINESS CASE ANALYSIS. The objective of the business case analysis was to quantify the economic and productivity impact of occupational injuries on DoD.

a. **Economic Impact.** Analysis of workers' compensation data between 1996 and 2003 for 14 sites with some form of MCM indicates that they avoided $46M in workers' compensation costs, when compared with the appropriate service average. If all DoD sites had performed like the average of the 14 analyzed sites, the Services could have avoided $421M in workers' compensation costs—enough funding for 10,300 GS-07 employees or 98 M-1 tanks. See Appendix H.

(1) Definition of Cost Avoidance: All reductions in future resource requirements, not in an approved program, because investment in some needed program/project will not have to be made.[1] For example, Anniston Army Depot established shared responsibility for program elements between Personnel, Safety, and Security, without additional resources, relying on existing personnel. The Anniston program was very successful, avoiding $12.7M between 1996 and 2003 when compared to the Army average costs.

(2) Definition of Benefit/Cost Ratio (Return on Investment): The ratio of the total benefits (savings and cost avoidances) divided by the total costs.[1] Using Robins AFB as an example, the base was able to avoid $4M in compensation costs from 2000-2003 based on a benchmark comparison with the Air Force average costs. The total investment in the program was $240,000 over a 4-year period. The Benefit/Cost Ratio was 16.7 over a 4-year period with the breakeven point occurring in year two (2001).

b. **Calculations for Estimating Economic Impact.**

(1) The working hypothesis for the business case analysis was that MCM has the greatest impact on compensation costs. The case statuses most likely to have compensation costs are:

- Periodic Roll (PR)
- Periodic Roll No Wage Earning Capacity (PN)
- Reduced Compensation (PW)
- Daily Roll (DR)
- Under Development (UD)
- Cases coded Medical Only (MC)

(2) Therefore, the cost data for these case statuses were chosen for analysis. Cases coded "medical only" were included for analysis because they accounted for more than $300M in compensation costs for the period of study. The analysis compared average costs per claim for each of the analyzed sites with their respective Service counterparts.

[1]Department of the Army Cost Analysis Manual from the US Army Cost and Economic Analysis Center (July 1997).

(3) Average Compensation Costs per Claim.

- This calculation represents the average compensation cost per claim at the installation for the year, including long-term cases and cases coded "medical only."

$$\frac{\text{Sum of Compensation Costs}}{\text{Total Number of Cases}}$$

- It is an important calculation because an effective MCM program will impact compensation costs through early identification, case tracking, and RTW programs. It also provides a very conservative estimate of the impact of the program, as it includes long-term cases. Historically, long-term cases have diluted the effect of program outcomes. Long-term cases often function as "outliers," pulling averages in a negative direction and masking the effects of prevention and intervention programs. Any positive trend reflects a very effective program.
- Base Realignment and Closure Commission (BRACC) cases were included in the cost data. However, data from the Command Navy Region Southeast indicate that the impact of these cases on the estimated cost avoidance is very small. In 2002, the region administered 12 cases for closed bases out of 1,800 cases examined in the study, or less than 1 percent. In 2003, six cases were administered out of a total of 2,000, or less than 1 percent. Data from the Army Materiel Command (AMC) also show minimal impact from closed base cases. In 2002, 2.6 percent of the cases administered by AMC were from closed installations. In 2003, the percentage of closed installation cases fell to 2.3 percent. Costs related to the closed base cases have very little effect on the overall analysis and the potential cost avoidance.

(4) Average Medical Costs per Claim. This calculation represents the average medical cost per case for cases at the installation for the year, including long-term cases. In general, medical costs are expected to remain relatively stable and are not affected by MCM programs. The analysis supports this assertion. All estimated cost avoidance resulted from avoiding compensation costs. If the analysis was limited to compensation costs alone, the cost avoidance analysis presents an even more compelling argument for MCM, with a total potential compensation cost avoidance of approximately $489M.

$$\frac{\text{Sum of Medical Costs}}{\text{Total Number of Cases}}$$

c. **Productivity Impact on Available Manpower.** Between 2001 and 2003, the Military Services lost 4.6M hours of productive work time to occupational injuries. This is equivalent to losing:

(1) 2,660 FTEs
(2) 1.2 Marine Expeditionary Units
(3) 88% of an Army Brigade
(4) 1 embarked Navy Air Wing
(5) 50% of a mid-size Air Force Fighter Wing

d. **Calculating Productivity Impact on Available Manpower.** The objective of the business case analysis was to quantify the impact of occupational injuries on productivity. Lost workday data was analyzed to estimate the impact of occupational injuries on productivity. Lost workdays were converted to lost work hours in order to estimate lost FTEs. FTEs measure productivity or level of effort and are defined by each of the Services in Service specific manpower staffing standards.[1-3] The Army FTE definition was used in this analysis. Air Force and Navy FTE definitions are very similar.

$$\frac{\text{Sum of Lost Workdays X 8 Hours}}{\text{1740 Hours/FTE}}$$

7. STAFFING DECISION MODEL. Identification of the resources needed for effective case management should take into account current personnel and OH resources at the installation, opportunities for regional efficiencies, and workload factors. The working group recognized that identification of right resources is an issue that will take longer than the one-year timeframe for recommended initiatives. There are on-going Service initiatives to develop staffing decision models.

8. METRICS

a. **Information Systems.** Information systems provide data that can act as numerators and denominators for metrics. The working group identified one DOL and three DoD information systems relevant to MCM, and two disability guideline systems used within some parts of DoD.

(1) The DoD Lost Workday Web Site (https://www.dmdc.osd.mil/ltwi/owa/ltwi) uses timecard data to count lost workdays during the continuation of pay (COP) period, lost days after this period, and lost days in claims not entitled to COP (occupational illnesses). This site is available to all military computer users, and provides useful data but does not link data to individual claims to allow analysis of days lost by type or cause of injury.

(2) The DIUCS provides detailed data on individual and aggregate claims, but is not flexible in its sort options, and access is password-protected. Limited safety views are available to safety and OH personnel via application for access to the CPMS.

[1]Army Regulation 570-5 (June 1989).
[2]Air Force Peacetime Civilian Man-Hour Availability Factor Update (August 2002).
[3]OPNAV Instruction 1000.16J (January 1998).

(3) The Defense Portal Analysis Center (DefPAC) is a tool provided by CPMS at https://icucweb.cpms.osd.mil/cognos. The statistical data reports contained in DefPAC are Web-based reporting tools designed to support injury and unemployment compensation, safety, and OH administration in gathering data necessary to identify areas to improve within each program, and developing program initiatives to manage programs more effectively at all organizational levels. This site contains a Web portal with updates from CPMS, easy access to regulations and policies, and statistical reports on claims and costs. Access is available via application to CPMS for password. At present, the site does not allow drill-down to the individual claim level. This is planned in the future, but access to this level will be restricted by password to the ICPAs. Data do not include populations, therefore rates are not provided.

(4) The Agency Query System (AQS) is a DOL case management system that provides information on individual claims, including adjudication decisions. This system is only available to ICPAs, via application through CPMS.

(5) The *Official Disability Guidelines* and the *Medical Disability Advisor* are standard references that are used regularly in private industry to estimate expected duration of disability for a given injury. These Web-based guidelines are infrequently used by DoD personnel, but when referred to they provide useful standardized information for planning, and communicating with treating physicians and the OWCP.

b. **Current Metrics.** There are three current DoD metrics for measuring effectiveness of injury prevention and case management:

(1) Total lost workdays—

- Reflects both case management and personnel practices related to separation of disabled employees with long-term claims.
- Uses total lost days rather than rates to identify outliers and penalizes installations with larger populations, preventing a fair and stable basis for comparison and targeting. As an example, the top 40 graphs at the DoD Lost Time Due to Work Injuries Web Site (https://www.dmdc.osd.mil/ltwi/owa/cop) identify larger installations as problem sites. It is inappropriate to assess the results of injury prevention efforts or hold Commanders accountable for the number of lost days without consideration of the population size.

(2) Lost-time injury rate—

- Is a relevant measure of injury prevention activity as well as case management effectiveness since coordinated efforts to return employees to work the day of an injury prevent it from being coded as a lost-time injury at the time of submitting the claim to OWCP.
- Undercounts true lost-time cases significantly.
  - Counts claims losing time at the time the claim is filed.
  - Counts neither the injury claims that start losing time after claim filing nor many occupational illness claims losing time.
    - Employees who initially RTW after a traumatic injury, but are then subsequently placed off work by their treating physicians, are lost-time

cases missed by the system since OWCP does not recode the claim that was recorded at the time of filing as no lost time.
- The extent of injury code used to identify lost time is not routinely used in occupational illness claims, which tend not to lose time until months after filing, when the claim has been approved and surgical intervention takes place (e.g., carpal tunnel surgery). Although significant time may be lost, such claims are not always counted as lost-time claims.

(3) Timeliness of filing claim—
- Is a relevant measure for performance in both claims administration and agency injury reporting procedures.
- Does not, in itself, ensure effective integrated case management and RTW efforts.

c. **Recommended Metrics.** The working group recommends adopting two additional metrics:

(1) Average Annualized COP Lost Workday Rate (COP days lost per 100 FTE per year).

$$\frac{\text{Number of COP days lost for past 26 pay periods} \times 200{,}000 \text{ (hrs worked by 100 FTE/yr)}}{\text{Civilian hours worked over past 26 pay periods}}$$

- This metric reflects both injury prevention efforts and attention to cases early in the claims process. Lower COP lost workday rates are expected at sites with effective case management. This rate is obtained by taking a rolling average of the COP lost workday rate for the past 26 pay periods. This data is available at the DoD Lost Workday Web Site, though not presented with rolling averages.
- Although this is not the exact metric used in the business case analysis, which used manpower staffing standards for the denominator and calculations, the proposed metric gives figures that are proportional to that used in the business case analysis. More importantly, the data are readily available at https://www.dmdc.osd.mil/ltwi/owa/cop, using this proposed formula.
- Numerator Data Source (Number of COP days lost for past 26 pay periods): Time card data from the Defense Finance and Accounting Service (DFAS) provides the most accurate information on COP days lost. Currently, this data is downloaded to the Defense Manpower Data Center (DMDC) every pay period and is included in the DoD Lost Time Due to Work Injuries Web Site.
- Denominator Data Source (Civilian hours worked over past 26 pay periods): Time card data from the DFAS provides the most accurate estimate of hours worked. Currently, this data is downloaded every pay period to the DMDC and is posted on the DoD Lost Time Due to Work Injuries Web Site.
- All of the data needed to calculate this metric is currently transferred to the DoD Lost Time Due to Work Injuries Web Site. Calculation of this metric may be done manually with data at the site; however, presentation of this metric as an available option at the Web site could be accomplished with minimal reprogramming.

(2) PR Case Rate.

$$\frac{\text{Number of PR cases for the previous year} \times 100}{\text{Average civilian population for the year (average of the 12 monthly population counts)}}$$

- This metric reflects past case management practices as well as past claim rates. A low PR case rate is expected to reflect effective case management or a conversion of PR cases to PN cases. Where case management is effective, a low PR case rate is expected to be accompanied by a low or stable PN case rate. Caveat: Differences in PR rates between installations also relate to the nature of work performed at the installations, therefore installations with higher risk work would be expected to have a higher PR case rate than those where injury risk is low. Note also that the PR case rate would be expected to be higher in installations where there are few or no RTW opportunities due to base closure or reduction in force. Although these issues should be considered in making comparisons, this metric is useful in measuring case management successes over time (comparison with self over time) and for targeting installations where RTW programs may need support.
- Numerator Data Source (number of PR cases for the previous year): The number of PR cases in a current chargeback year is available at https://icucweb.cpms.osd.mil/cognos. The Web site does not show the number for past years, nor does it show population figures needed for obtaining rates. Unless this changes, this metric must be generated manually with population data from the DMDC and updated annually.
- Denominator Data Source (average civilian population for the year): Population data from the DMDC provides the most accurate information.
- Currently, this metric must be generated manually with population data from the DMDC and updated annually.

d. **Other Metrics.** See Appendix I for a list of lagging and leading indicators that could also be considered from both the corporate and local levels.

9. POLICY AND PROGRAM RECOMMENDATIONS.

a. **DoD Instruction 6055.1 (DoD Safety and Occupational Health Program).**

(1) Discussion. There is a need for improved approaches to management of occupational injury and illness claims, both from a medical care and a claims administration standpoint. The OHC has a large, mostly unrealized, role to play in the reduction of lost days due to occupational injuries and illnesses, both in provision of evaluation and treatment, and in provision of MCM support to the workers' compensation program.

(2) Recommendation. Amend DoDI 6055.1 to update the roles and responsibilities of The Surgeons General and management with regard to MCM. See Appendix J for proposed language.

b. **DoD 1400.25-M (DoD Civilian Personnel Manual).**
   (1) Discussion. Experience at installations in all Services has illustrated the benefit of assigned medical case managers to support the FECA program. Estimates indicate that the Air Force may have reduced their lost-day rate by 50% or more due to an aggressive MCM program. The Navy has regional medical case management programs to review documentation, assist the ICPAs, and provide support to the OHCs.
   (2) Recommendation. Request the Deputy Undersecretary of Defense (CPP) act on the proposed DoD 1400.25-M revision to clarify role of FECA Working Group and establish an integrated MCM team and the role for the medical case manager. See Appendix K.

c. **DoD Policy Memorandum: Treatment of Injured Federal Employees at Military Treatment Facilities.**
   (1) Discussion. The working group determined that a memorandum with consistent language for all the Services should be issued to clarify the type of treatment and services that Federal employees could expect to receive from MTFs, when they could receive such services, and the priority of the treatment for Federal employees. Optimizing the use of the MTF reduces the medical costs for outside care but, more importantly, provides more convenient services to injured employees and supports agency RTW efforts.
   (2) Recommendation. Publish the proposed DoD Health Affairs memorandum to the military departments encouraging MTF Commanders to provide care to injured civilians, ensuring they receive priority for care after active duty military personnel. See Appendix L for the proposed memorandum.

d. **RTW Policy.**
   (1) Discussion. DoD should expand on its current RTW policy in DoD 1400.25M to clarify what is entailed by requiring that agencies must make every effort to return injured employees to work. While this policy has resulted in widespread use of temporary light duty assignments for employees recovering from an injury, it does not effectively challenge commanders to find assignments for employees with permanent restrictions, nor does it address job placement for former employees found able to work.
   (2) Recommendation. Request the DSOC Workers' Compensation Task Force address strengthening the DoD RTW policy to address these gaps.

e. **DoD 6055.99 Manual (Medical Case Management Procedures).**
   (1) Discussion. The working group found that inconsistent policies and procedures exist throughout DoD in the OH community. Although DoD 1400.25M provides detailed guidance on claims administration and administrative case management, there are no DoD guidance documents addressing MCM procedures. The working

group developed the Medical Case Management Technical Guide to address this need.

(2) Recommendation. Adopt the draft DoD MCM procedural guidelines and develop as a DoD manual. The table of contents for the manual is at Appendix M.

10. RECOMMENDED ACTIONS. The DoD MCM Working Group requests the DSOC take action to implement the following recommendations:

a. Forward to the Deputy Undersecretary of Defense (CPP) the proposed DoD 1400.25M revision to (1) include role for designated medical case manager from the occupational health (OH) clinical staff and (2) implement return-to-work (RTW) teams. See Appendix K.

b. Revise DoDI 6055.1 to strengthen the OH clinic role in injury care and case management. See Appendix J.

c. Publish Health Affairs policy memo to (1) clarify authorization for access to medical treatment facility (MTF) medical care and (2) recommend prioritization status for injured workers to receive treatment after active duty military and ahead of other beneficiaries. See Appendix L.

d. Endorse publication of the proposed DoD 6055 Manual on MCM. See Appendix M.

e. Address issue of resourcing the MTFs to provide injury care (including specialty, diagnostics, and physical therapy/occupational therapy) and MCM. Consider financial incentives for providing on-site care.

f. Task the Workers' Compensation Task Force to:
   (1) Develop and implement a DoD RTW policy and program that includes positions for long-term roll claimants and cross-service placement options.
   (2) Identify the targets for the proposed metrics of Average Annualized COP Lost Day Rate and PR Case Rate, including whether there should be DoD targets, Service-specific targets, or reduction by a percentage against self-baseline figures.

g. Engage DoD Inspector General to measure impact of costs due to DOL OWCP administrative delays.

h. Propose DoD-OWCP partnership program under the Safety, Health and Return-to-Employment (SHARE) Initiative.

i. Include MCM in the scope of the Occupational Medicine, Injury Prevention and Mitigation Task Force for further action and development.

j. Request DMDC provide a report on their DoD Lost Workday Web site to show average annualized COP lost workday rate (COP days lost per 100 FTEs per year).

k. Request CPMS include PR (long-term) case rate as a statistical report option on its DefPAC Workers' Compensation Web site.

Marianne Cloeren, MD, MPH
Chair, DoD Medical Case Management Working Group

APPENDIX A. DoD Medical Case Management Working Group Charter

Medical Case Management Working Group
Instructions

The goal of this group is to conduct a business case analysis of medical case management based on internal DoD and external industry data and to develop specific policy and programmatic recommendations for DoD. The group should limit recommendations to those actions which can be realistically taken immediately or in within one year.

Define Workers' Compensation Medical Case Management

- Analyze current case management processes, describe lanes of responsibility and conduct a linked lane-based process analysis.
  - Include health, safety and personnel roles and responsibilities.
- Develop an agreed-upon definition of medical case management.
  - Include administrative and clinical aspects.
  - Describe the necessary training and experience for medical case managers.

Conduct Business Case Analysis

- Review DoD, Federal Sector and industry literature, demonstration projects and programs.
  - Identify current DoD medical case management projects expected to provide additional relevant return on investment evidence and the timelines for completion of these projects.
- Compare data on lost workdays, costs and claims between DoD sites with medical case managers and comparable sites without case managers.
- Define costs for existing medical case managers and estimate the return on investment.
- Develop a return on investment model based on the evidence and apply the model to the DoD and the individual Services and Agencies.
  - Document assumptions and limitations of the model.
  - Provide different scenario analyses using the model.

Recommend Staffing Decision Model

- Recommend approaches for determining staffing levels for medical case managers and related staff.
- Use existing data sources and information.
  - Parameters may include claim volume, costs, number of personnel, geographic separation between installations, case managers and personnel offices.

Develop Policy and Program Recommendations

- Provide draft language for specific DoD regulations and guidance documents.
- Identify and describe realistic actions that could be taken immediately or within one year.
  - Include process change recommendations to improve efficiency and effectiveness based on the linked lane-based process analysis.

Identify Appropriate Performance Metrics

- Define key process (leading) and outcome (lagging) metrics relevant to the core objectives of medical case management to benchmark and evaluate program effectiveness.
- Use existing data sources.
- Identify data gaps and limitations and develop short-term recommendations to improve data sources.
- Ensure identified metrics are consistent with DoD Lost Work Time Civilian and Military metrics.

Working Group Deliverables

- Short "White Paper" detailing the business case analysis, points for consideration and recommendations.
- Decision briefing for the PSHPC, no longer than 20 minutes.
- Draft language for specific DoD regulations and guidance documents.

APPENDIX B. DoD Medical Case Management Working Group

The following list shows participants over time. Participants were selected to represent the personnel, safety, and OH communities of OASD and all the military departments.

DoD

- COL Mary Lopez, PhD, Chair, DoD Ergonomics Working Group
- COL David Louis, MD, Chair, Occupational Health Working Group
- MAJ Lourdes Moore, TRICARE Management Activity
- Ralph Slighter, Civilian Personnel Management Services, Injury Compensation Unemployment Compensation Division

Army

- Denise Bane, Installation Management Agency, Human Resources Division
- Marianne Cloeren, MD, MPH, Occupational Medicine Program, US Army Center for Health Promotion and Preventive Medicine (CHPPM)
- Connie Fox-Samson, JD, Occupational Medicine Program, CHPPM
- Franklin McClanahan, Safety Manager, Plans & Programs Division, US Army Safety Center
- Katharine Neufeld, Preventive Medicine Resourcing Team, CHPPM
- Katherine Secor, RN, Army Materiel Command Case Manager
- Candace Shupay, RN, Civilian Personnel Office, Walter Reed Army Medical Center
- Taiwanna Smith, HQDA, Civilian Personnel Policy
- MAJ Eugene Thurman, MS, Chief, Plans & Programs, US Army Safety Center

Navy

- Kathleen Edwards, RN, Naval Medical Center, San Diego
- Carlos Saavedra, Office of Civilian Human Resources, Department of the Navy
- Carla Treadwell, CIH, CSP, Bureau of Medicine and Surgery
- CDR Robin Wilkening, MC, USNR, Occupational Medicine Program Manager, Navy Bureau of Medicine and Surgery
- Richard Wright, Director, Safety and Occupational Health, ODASN (Safety)

Air Force

- Kathy Dean, RN, BSN, MED, EdS, COHN-S/CM, CRRN, Occupational Nurse Case Manager, Robins Air Force Base
- Diane Erickson, RN, Wright-Patterson Air Force Base
- R. Michael Imphong, PhD, Headquarters, US Air Force, Directorate of Personnel Policy
- George Rhymes, Headquarters, US Air Force, Safety

APPENDIX C. President's Safety, Health, and Return to Employment (SHARE) Initiative

the White House
President George W. Bush

For Immediate Release
Office of the Press Secretary
January 9, 2004

Memorandum for the Heads of Executive Departments and Agencies

SUBJECT: The Safety, Health, and Return-to-Employment (SHARE) Initiative

The cost of Federal workplace injuries, when measured by workers' compensation losses, is more than $2 billion and 2 million lost production days annually. In fiscal year 2003, the Federal workforce of almost 2.7 million filed more than 168,000 injury claims. Behind these numbers lie pain and suffering by workers and their families. Clearly, Government agencies should strive to do more to improve workplace safety and health and reduce the costs of injury to workers and taxpayers. Many workplace injuries are preventable.

Therefore, I am establishing SHARE: Safety, Health, and Return-to-Employment Initiative, a safe workplace initiative for fiscal years 2004-2006. The initiative's four goals cover the most important elements of a strong safety and health management program: lower workplace injury and illness case rates, lower lost-time injury and illness case rates, timely reporting of injuries and illnesses, and fewer lost days resulting from work injuries and illnesses. The Secretary of Labor will lead the SHARE Initiative and will measure the performance of each department and agency against the goals. I direct all executive branch departments and agencies to participate in SHARE for this 3-year period.

Each department and agency will collaborate with the Department of Labor to establish challenging annual goals based on its current performance in the four areas. The Department of Labor will measure and track agency performance, and will report to me annually on each agency's progress towards meeting its goals. The Department of Labor's Occupational Safety and Health Administration and Office of Workers' Compensation Programs will also work with Federal departments and agencies to develop new workplace strategies to improve safety and health at high injury rate sites, assist them in improving the timeliness of reporting claims through electronic and other means, and guide them in providing suitable work and tools for injured and disabled employees.

Federal supervisors and managers must focus management tools and resources on eliminating unsafe and unhealthy working conditions. Federal employees should be encouraged to perform their jobs safely, effectively, and alertly to remain injury- free. Dedication to ensuring our Government workforce family is safe and healthy preserves the resources of Government and helps promote the delivery of Government services to the American people.

GEORGE W. BUSH

APPENDIX D. Secretary of Labor's Memorandum Implementing SHARE

SECRETARY OF LABOR
WASHINGTON

JAN 15 2004

MEMORANDUM FOR THE HEADS OF EXECUTIVE DEPARTMENTS AND AGENCIES

FROM: ELAINE L. CHAO

SUBJECT: Safety, Health and Return-to-Employment (SHARE) Initiative

To demonstrate his Administration's commitment to worker safety and health, and to reduce the personal and financial cost of accidents in our Federal workplaces, the President has directed the Department of Labor to lead a major new initiative, SHARE, to promote Safety, Health and Return-to-Employment of Federal workers injured on the job.

SHARE is a new, more forward-looking initiative to replace "Federal Worker 2000," an initiative which began in 1999. The critical target areas of SHARE are similar to the goals of Federal Worker 2000. SHARE builds on the successes of the old, and reinforces this Administration's interest in safe and healthful workplaces and costs savings to taxpayers.

The cost of federal workplace injuries, when measured by workers' compensation losses, exceeds two billion dollars annually. In Fiscal Year 2003, the nearly 2.7 million federal employees filed more than 168,000 new workers' compensation claims, which resulted in over two million days lost from work. Even these striking numbers do not include the pain and inconvenience suffered by injured workers, and in many cases, the profound disruption of their lives. Nor do they count the losses in productivity, diminished responsiveness, and quality of service to the taxpayer because of diverted resources and lost workdays.

The President has directed all Executive Branch departments and agencies to participate in SHARE for three years, beginning with FY 2004. The Department will measure and report agencies' progress in four critical areas against their performance in the baseline year FY 2003, and will assist agencies in meeting their annual goals in each area.

The President asks that we set goals in the following areas:

- % Reduction in total case rates for injuries and illnesses
- % Reduction in case rates for lost time injuries and illnesses
- % Improvement of the timeliness of filing notices of injury and illness
- % Reduction in the rates of lost production days due to injuries and illnesses.

We believe that it is reasonable for the government as a whole to accomplish at least the following: reduce total injury case rates and lost time case rates by 3% each per year; increase the timely filing of claims by 5% per year; and reduce the rate of lost production days due to injury by 1% each year.

We know that some agencies have set more challenging goals for themselves, and indeed, many agencies can make greater strides in accomplishing these objectives. To accommodate these variations, the President has asked that each agency work with the Department of Labor to set for itself challenging annual targets for the three years of the initiative. By January 30, 2004, each agency should notify John L. Henshaw, Assistant Secretary of Labor for Occupational Safety and Health (202-693-2000) of its annual targets for the three years of the initiative in each of the four measures. Department of Labor staff in our Occupational Safety and Health Administration and Office of Workers' Compensation Programs will provide baseline performance data, assist in goal-setting, and work with you and your staffs during the year as you evaluate your status, adopt strategies to meet your targets, and check your progress.

As Federal agencies organize and function to ensure our security at home and abroad, we must maintain our focus on improving worker safety and health, reducing the costs of workplace injuries and illnesses and enhancing workforce productivity. As the President stated, many if not all, workplace injuries and illnesses can be avoided.

We at the Department are inspired and energized by the President's commitment to improve workplace safety and health beginning with our own establishments. I am completely committed to improving the Federal workplace by achieving the goals of SHARE, and I look forward to working with each of you to achieve these critical results.

APPENDIX E. Secretary of Defense's Memorandum Calling for a Reduction in Preventable Accidents

THE SECRETARY OF DEFENSE
1000 DEFENSE PENTAGON
WASHINGTON, DC 20301-1000

May 19, 2003

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARIES OF DEFENSE
DIRECTOR, DEFENSE RESEARCH AND ENGINEERING
ASSISTANT SECRETARIES OF DEFENSE
GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE
INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE
DIRECTOR, OPERATIONAL TEST AND EVALUATION
ASSISTANTS TO THE SECRETARY OF DEFENSE
DIRECTOR, ADMINISTRATION AND MANAGEMENT
DIRECTOR, FORCE TRANSFORMATION
DIRECTOR, NET ASSESSMENT
DIRECTOR, PROGRAM ANALYSIS AND EVALUATION
DIRECTORS OF THE DEFENSE AGENCIES
DIRECTORS OF THE DOD FIELD ACTIVITIES

SUBJECT: Reducing Preventable Accidents

World-class organizations do not tolerate preventable accidents. Our accident rates have increased recently, and we need to turn this situation around. I challenge all of you to reduce the number of mishaps and accident rates by at least 50% in the next two years. These goals are achievable, and will directly increase our operational readiness. We owe no less to the men and women who defend our Nation.

I have asked the Under Secretary of Defense for Personnel and Readiness to lead a department-wide effort to focus our accident reduction effort. I intend to be updated on our progress routinely. The USD(P&R) will provide detailed instructions in separate correspondence.

APPENDIX F. Legal and Regulatory Mandates for Medical Officers

MCHB-TS-MOM

INFORMATION MEMORANDUM

1. References.
   a. Title 5, United States Code, Chapter 81, section 8101, *et seq., Federal Employees' Compensation Act (FECA)* (Encl 1).
   b. Title 20, Code of Federal Regulations, Subchapter B, Part 10, subchapter D, §10.300, *Claims for Compensation Under the FECA* (Encl 2).
   c. Department of Labor (DOL) Procedures Manual (PM), Chapter 3 (Encl 3).
   d. DoD Civilian Personnel Management Service(CPMS), 1400.25-M, Subchapter 810, Injury Compensation Policy (December 1996) (Encl 4).
   e. Memorandum, MCSM, 14 April 2003, subject: Medical Treatment Policy for Federal Civilians, quoting the language in 5 USC §8303(a) regarding an employee's entitlement to care and allowing federal employees to use Army healthcare for treatment (Encl 5).

2. Purpose. To provide legal and regulatory authority for the military services' medical case management activities, including a DoD Working Group, chartered by the Prevention, Safety, and Health Promotion Council, to address medical case management issues.

3. Summary. The DoD Working Group is authorized by federal law, federal regulation, and DoD policy to address medical case management issues within the military services. Federal statute authorizes the provision of "services, appliances, and supplies by or on the order of United States medical officers and hospitals" for federal government employees with occupational injuries. Therefore, the delivery and management of medical services by the military departments are mandated under federal law.

4. Discussion.
   a. Medical support in the FECA process is sanctioned by federal law, DOL and DoD regulations, and individual military service policies.
   b. Although "medical case management" is not a specific term used in the statutes and regulations, the responsibility for medical care and delivery of services is assigned to the OHC in DoD regulations.
   c. The charter of the DoD Working Group is to study the issue of medical case management in workers' compensation and to identify approaches within the scope of the OH responsibilities that have been shown to be effective in assisting with the President's and Secretary of Defense's goals to reduce lost work days and associated costs for injured and ill federal employees.
   d. The recommendations of the DoD Working Group emphasize the need to follow DoD and DOL policy regarding the injury compensation program administrator's authority for FECA program management.

The DOL offers a Quality Case Management Program, with assigned nurses, for certain phases of certain claims. However, the following areas of need or "gaps" in medical case management are not routinely met by the program.

- Non-lost-time injury cases.
- During the first 15 days of a lost-time claim before a DOL telephonic nurse case manager is assigned.
- From day 15 - 120 of a lost-time claim before a case is identified for intervention and a DOL nurse is assigned to assess and monitor the claim.
- During the period after a nurse case manager has completed the assignment and the employee has not returned to work (within 120 days from filing the claim).
- During the period after the employee returns to work, but is in a temporary modified duty assignment.
- Whenever older PR and PN cases that are not eligible for DOL case management services but still need medical scrutiny.
- Whenever nurse case managers are not assigned to illness claims because of the length of time to adjudicate such claims (90+ days).

5. POCs for this action are Dr. Marianne Cloeren, 410-436-1011, and Connie Fox-Samson, Esq., 410-436-6145.

5 Encls
1. 5 USC § 8103
2. Title 20, CFR
3. DOL PM, Ch. 3
4. DoD CPMS 1400.25-M
5. Army policy memorandum

Title 5, United States Code, Chapter 81, section 8103 provides that:

§8103 Medical services and initial medical and other benefits

(a) The United States shall furnish to an employee who is injured while in the performance of duty, the services, appliances, and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of the monthly compensation. These services, appliances, and supplies shall be furnished--

(1) whether or not disability has arisen;

(2) notwithstanding that the employee has accepted or is entitled to receive benefits under subchapter III of chapter 83 of this title or another retirement system for employees of the Government; and

(3) by or on the order of United States medical officers and hospitals[4], or, at the employee's option, by or on the order of physicians and hospitals designated or approved by the Secretary.

The employee may initially select a physician to provide medical services, appliances, and supplies, in accordance with such regulations and instructions as the Secretary considers necessary, and may be furnished necessary and reasonable transportation and expenses incident to the securing of such services, appliances, and supplies…

Enclosure 1

[4] See 5 USC § 8101(20). "United States medical officers and hospitals" includes medical officers and hospitals of the Army, Navy, Air Force, Department of Veterans Affairs, and United States Public Health Service, and any other medical officer or hospital designated as a United States medical officer or hospital by the Secretary of Labor.

Title 20, Code of Federal Regulations, Subchapter B, Part 10, subchapter D.

§ 10.300 What are the basic rules for authorizing emergency medical care?

(d) The employer should advise the employee of the right to his or her initial choice of physician. The employer shall allow the employee to select a qualified physician, after advising him or her of those physicians excluded under subpart I of this part. The physician may be in private practice, including a health maintenance organization (HMO), or employed by a Federal agency such as the Department of the Army, Navy, Air Force, or Veterans Affairs. Any qualified physician may provide initial treatment of a work-related injury in an emergency.

§ 10.310 What are the basic rules for obtaining medical care?

(a) The employee is entitled to receive all medical services, appliances or supplies which a qualified physician prescribes or recommends and which OWCP considers necessary to treat the work-related injury. The employee need not be disabled to receive such treatment.

(b) Any qualified physician or qualified hospital may provide such services, appliances and supplies.

Enclosure 2

DOL PROCEDURES MANUAL, CHAPTER 3-0201 – [DOL] STAFF NURSE SERVICES

Definition. In its broadest scope, [DOL nurse] case management is a comprehensive approach to minimize the length and perhaps the extent of disability in some compensation cases. In this process, [DOL staff] nurses will play a vital role by participating in the early, aggressive medical management of cases. The primary focus of the nurses' activities will be to encourage recovery and the RTW through direct interventions with the claimants, treating physicians, and employing agencies.

3-0201-6 Preliminary Steps

6. Preliminary Steps. Nurse intervention early during the period of disability is one of the major components of the quality case management procedures. This section details all the important aspects and steps in this process.

(1) Traumatic Injury Cases. Although the ideal time for nurse intervention is from 45-90 days after the day of injury, the CE may refer traumatic injury cases for nurse intervention regardless of the time elapsed…
(2) Occupational Illness Cases. These cases ordinarily require more than 90 days to adjudicate, thus placing them outside the optimum time frame for nurse intervention.

Enclosure 3

DoD Policy: CPMS 1400.25-M, Subchapter 810, Injury Compensation Policy

SC810.3.5. Activity Medical Service

"*SC810.3.5.1. **Medical Officers**. Medical officers review all reported cases of occupational illness and take or recommend action. Upon the ICPA's request, they provide medical information to be sent to OWCP to support or to controvert a claim for an occupational illness or work-related injury. They also:*

SC810.3.5.1.1. As necessary, communicate with the employee's personal physician to clarify medical evidence when ICPA's attempts fail;

SC810.3.5.1.2. Conduct a medical review of controversial and complex cases;

SC810.3.5.1.3. With the treating physician's recommendations, participate with the CPO/HRO in returning employees to duty as soon as medically feasible;

SC810.3.5.1.4. Assist the ICPA in informing the local medical community of FECA program and problems being experienced;

SC810.3.5.1.5. Review, evaluate, and recommend light-duty or limited-duty assignments and make recommendations on employee placements involving work limitations;

SC810.3.5.1.6. Advise the attending physician that the medical facility may give supportive treatment such as physical therapy, under his or her direction (arrangements should be made with the concurrence of the employee and attending physician); and,

SC810.3.5.1.7. Provide a representative to actively participate in the activity FECA Working Group. "

"*SC810.5.1.2. **Activity Responsibility**. Occupational illness or disease cases require special effort and extensive documentation. ICPAs should use all resources available in acquiring information. Normally, this will include medical records and opinions, co-worker statements, information obtained from the official personnel folder and activity medical records, documentation from the occupational health and safety officers, and information regarding the feasibility and availability of alternate employment.*

SC810.5.1.2.1. It is important that the ICPA ensures that the evidence submitted in occupational illness or disease cases is clear, concise, and factual and includes all required documentation. As appropriate, the supervisor, occupational health official, audiologist, safety and medical officers, and other interested parties submit their respective portions of the documentation to the ICPA for review and forwarding to OWCP."

Enclosure 4

DEPARTMENT OF THE ARMY
HEADQUARTERS, U. S. ARMY MEDICAL COMMAND
2050 WORTH ROAD
FORT SAM HOUSTON, TEXAS 78234-6000

REPLY TO
ATTENTION OF

MCSM

14 APR 2003

MEMORANDUM FOR Commanders, MEDCOM Major Subordinate Commands/ Installations/Activities

SUBJECT: Medical Treatment Policy for Federal Employees

1. The Federal Employees' Compensation Act USC 8103 authorizes medical services needed to provide treatment or to counteract or minimize the effects of any condition which is causally related to factors of Federal employment.

2. Federal employees are entitled to all services, appliances, and supplies prescribed or recommended by qualified physicians which, in the opinion of the Office of Workers' Compensation, are likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation. Medical care includes examination, treatment, and related services such as hospitalization, medications, appliances, supplies, and transportation incident to securing them.

3. Initial Choice. An employee is entitled to initial selection of physician for treatment of an injury or occupational illness. He or she may choose any licensed physician in private practice who is not excluded, or he or she may choose to be treated at a government facility where one is available.

4. Agency personnel may not interfere with the employee's right to choose a physician, nor may they require an employee who claims an injury to go to a physician who is employed by or under contract to the agency before going to the physician of the employee's choice. Thereafter, the agency may refer the employee to the Occupational Health Clinic for evaluation of their duty status.

5. In addition, it is MEDCOM policy that all employees with an on the job injury or illness be encouraged to utilize Army healthcare for treatment. Leaders at all levels, occupational health personnel and health care providers should ensure all personnel are made aware of and support this policy of in-house medical treatment of employee injuries and/or occupational disease. Additionally, medical commanders will make every effort to accommodate employees by scheduling them in a timely manner to ensure they return to work as soon as possible.

FOR THE COMMANDER:

KENNETH L. FARMER, JR.
Major General
Chief of Staff

Enclosure 5

APPENDIX G. Medical Case Management Best Practices, Research, and Outcomes

Introduction

The Secretary of Defense issued this challenge to all members of the Department of Defense (DoD): "World class organizations do not tolerate preventable accidents. Our accident rates have increased recently, and we need to turn this situation around. I challenge all of you to reduce the number of mishaps and accident rates by at least 50% in the next two years. These goals are achievable, and will directly increase our operational readiness. We owe no less to the men and women who defend our Nation."[1]

DoD civilian lost-time injuries and illnesses and associated medical and compensation costs are among the primary targets of the Secretary of Defense and the Defense Safety Oversight Council (DSOC). These injuries and illnesses result in reduced productivity, increased production costs, and decreased financial and manpower resources to meet mission demands. Fortunately, recent research investigations have demonstrated dramatic decreases in lost days and medical and compensation costs through a variety of injury and illness management initiatives and best practices. These industry best practices primarily focus on efficient and effective proactive administrative oversight and integration of the care process, communication, and return-to-work (RTW) management.

Best Practices Strategies

Best practices strategies for reducing lost time due to work-related injuries and illnesses consistently include the following elements in an integrated and focused medical case management (MCM) program[2-10]:

- Administrative case management
- Use of a medical case manager or managed care programs
- Establishment of a coordinating team of key players
- Early identification of employees with work-related injuries or illnesses
- Involvement and collaboration among the employee, supervisor, and the team
- Training for key personnel
- Effective communication mechanisms
- Timely and coordinated medical care
- Information support system and database
- Proactive preventive measures (safety engineering and ergonomic controls)
- Early rehabilitation programs for injured workers
- Early RTW programs, light duty assignments, work modifications, and accommodations

Most of the MCM best practices involved a dynamic, coordinated team approach with the occupational physician/nurse case manager coordinating the care management process, including the prevention of accidents and facilitated RTW. The key team members included representatives from safety, human resources, ergonomics, occupational and physical therapy, and medical specialties such as orthopedics and neurology.[2-8]

Several best practice process changes were implemented to improve outcomes[7]:

- Administrative process changes included timely accurate and complete communication to all team members, supervisors, and employees which reduced the time required to identify new injuries and develop and approve plans.
- Patient care efficiencies were realized by taking a sports medicine approach that included early and specific diagnosis and timely and effective medical, surgical, and rehabilitation interventions.
- RTW management processes focused on communication with line managers to identify work duties that matched each injured worker's residual functions rather than communicating work restrictions to an administrator with limited knowledge of the essential job functions of available jobs.

Best Practices Components

a. **Key Medical Care Management Players and Functions.** Establishing an effective multidisciplinary care management team has been shown to be the key element of a successful program. Each team member must have a basic knowledge in the prevention, early recognition, evaluation, treatment, accommodation requirements/ergonomic concerns, and rehabilitation of acute injuries and work-related musculoskeletal disorders (WMSDs).

(1) Occupational Medicine Physician. The occupational medicine physician provides primary medical care, oversight of referrals, coordination with other providers, and oversight of the care management process and RTW plan.[3 5]

(2) Nurse Case Manager. The nurse case manager maintains contact with health care providers, coordinates communication, maintains documentation, and tracks the progress of patients who have been referred to specialty providers or those patients who have elected to use a private physician.[4,5,7]

(3) Safety. The safety professional is primarily responsible for assessing workplaces and environments in which accidents and acute or cumulative trauma injuries occurred. The primary safety focus is on preventing future accidents and injuries. In some cases, the safety professional may work with the nurse case manager, supervisor, and employee to facilitate early RTW and provide recommendations on workplace, task, or tool modifications and alternate work assignments.[4,5]

(4) Ergonomist. Ergonomics support may be provided by a trained ergonomist or an occupational therapist, an industrial hygienist, or a safety professional. The ergonomics element provides the essential detailed job analysis, risk assessment, hazard identification, and engineering design recommendations for workplaces, tasks, and tools necessary for accommodation, light duty assignments, and RTW. The ergonomist works with the nurse case manager to facilitate agreements between supervisors and employees on task limitations and accommodations. The ergonomist can design the gradual reduction of job accommodations up to the resumption of full job duties.[2,4,6]

b. **Communication.**

(1) Effective, timely, and complete communication must be promoted for a successful program. Some best practices programs established routine team meetings such as[2-6,8]:

- Bi-weekly Medical Management Workgroup responsible for coordinating treatment plans for each injured worker.
- Monthly Workers' Compensation Claims Management Workgroup (nurse manager, safety, human resources, and administrator) meetings that formulated a plan for each lost-time injury case.
- Bi-weekly administrative meetings (nurse case manager, primary and specialty care physicians, OHC's nurse manager, claims office manager, and safety) to share information on the status of individuals who are out of work or have work restrictions. During these sessions, each employee who has job restrictions is discussed and his/her work status is monitored.
- Bi-weekly multidisciplinary workgroup meetings twice a month to develop a coordinated treatment plan for each injured worker.
- Workplace based rehabilitation and adaptation meetings (employee, employer, case manager, and ergonomist/occupational therapist) to coordinate and reach consensus on early rehabilitation and RTW plan.
- Weekly disability management team meetings to present selected cases to the team and design or modify the care management and RTW plan.

(2) In addition, most programs included frequent (e.g., daily) communication between the occupational medicine physician or nurse and the workers' compensation office to ensure timely and effective use of modified duty and the early RTW program, and with supervisors to facilitate more effective use of the modified duty program. If the employee was receiving therapy or being evaluated or treated by a specialist, the occupational medicine physician or nurse established a contact schedule to discuss the case, worker restrictions, and types of modified duty available.[2-6,8]

(3) Finally, the best practices programs included a missed appointment protocol that required nurse follow-up with the employee within 2-3 days of a missed appointment. This follow-up was very important as the employee was aware that the employer was still interested in his care and the occupational medicine provider was well informed on the medical progress of the patient. The missed appointment protocol dramatically reduced the chances of the patient becoming lost to follow and it allowed timely use of modified duty.[2-6,8]

(4) These communication activities are consistent with the DoD approach recommended by the Civilian Personnel Management Service (CPMS) recognizing that the injured employee might be unaware that the agency may be able to accommodate their condition and bring them back to the job. There is a clear need to establish early and sustained contact with the injured employee and to communicate and work with employee and supervisor to accommodate any duty limitations.[11]

c. **Information System Solutions.** Every best practices program had an existing administrative software program to manage claims and payments; however, these systems proved inadequate to manage the cases and the RTW process. Several key system requirements were identified in the best practices programs. Specifically, the

supporting information system must provide a coordinating infrastructure for the program that[4-6, 8]:

- Allows early identification of new work-related injuries and illnesses.
- Allows input, maintenance, and team member review of information related to an employee work-related injury or illness, case management plan and status, and investigation results.
- Provides a single database that integrates all elements of the program.
- Allows user role definitions, specifically limiting each participant to entering or viewing only those portions of the system that relate to their discipline.
- Tracks action plan, actions taken, results, referrals, approval, scheduling, and appointment status.
- Allows a coordinated flow of information between providers, supervisors, safety, workers' compensation administrators, therapists, ergonomists, and medical specialists.
- Provides "real-time" information about each case, including initial identification of a work-related injury or illness; environmental conditions; health, safety, and ergonomic investigation results; restrictions imposed by physicians; RTW plan status; accommodations plan; and status and regular reports.
- Allows e-mail team notifications of a new injury or illness case, a significant change in a case, requests for health and safety investigations, specific team actions, and suspenses.

d. **Early RTW Program and Accommodation.** Early RTW was a key element of all of the best practices programs. Early RTW and accommodation programs result in fewer lost days and faster return to work.[3-8] These programs focus on a rapid, team-oriented response once a case becomes a lost-time case. Typically, the RTW process involves[3-8]:

(1) Close tracking of the medical care and medical clearances. Action planning can occur prior to the medical clearance, but once the clearance is received, the team responds quickly to implement planned actions.

(2) An initial job analysis/RTW meeting with the employee and supervisor to establish RTW targets and an action plan. The supervisor provides information on the specific job tasks and activities required for the essential elements of the job; the employee provides detailed information on how he/she performs job tasks; and the nurse case manager answers medical questions related to any restriction placed on the employee.

(3) Ergonomic assessment of the current and potential alternative work assignments that allow injured employees to perform work activities that meet their current capabilities. These activities are designed to accommodate limitations such as restrictions in lifting, standing, walking, or sitting.

(4) Close monitoring of employee progress and performance to ensure that the employee was allowed adequate time to become acclimated to the job, that necessary accommodations and modifications had been made, that required tools were satisfactory, and that the employee is functioning at his or her peak capacity in a productive job.

e. **Ergonomic Assessment.**

(1) Most injured employees return to work with a duty restriction. The ergonomic job task assessment provides valuable information about the physical, perceptual, and cognitive demands of both the employee's current job and potential alternative work assignments. The identified job demands are compared to the medical restrictions and guidance. Any gaps between the job demands and the medical restrictions (e.g., lifting restrictions) present opportunities for engineering design changes. These design changes usually focus on the design of the workplace, tasks, tools, and equipment to minimize ergonomic risk factors.[3-8]

(2) The assessment may also include the identification of psychosocial stressors. These stressors can contribute to the injury or illness and can interfere with the RTW and accommodation process.[5] In some cases, evaluations of the employee's functional capacity are conducted to provide information to the treating physician, but also identify differences between work demands and work capacity.[4]

Regulatory and Procedural Issues

Many of the best practices programs encountered challenges with the workers' compensation regulations and procedures that made it difficult to control medical and compensation costs, injury rates, and care management.

Regulations for Federal employees include several particularly challenging features[4], which are also common to some state workers' compensation systems:

- Free choice of treating physician by the injured worker.
- Limitations on communication with outside treating physicians.
- Unlimited third party medical and indemnity payments with no deductibles or co-payments.
- Medical care and disability duration determined by the treating physician.
- A highly litigious system that is claimant biased.
- Federal OWCP wage replacement frequently exceeds the employees' regular take-home pay for employees with dependents (75% of their pay tax free).

Some states have passed legislation that resolves many of these challenges and facilitates managed care and RTW programs (e.g., Arkansas, Florida, California).[2] However, most of the best practices programs were established in states without enabling legislation. It is important to note that, although legislative change can facilitate the implementation of best practices, significant savings were achieved in states that required employee free choice of physicians for the initial evaluation and subsequent treatment.[2-8] These results demonstrate that an integrated case management process can work in the Federal sector and the states even without enabling managed care legislation.

Outcomes

All of the best practices programs demonstrated strong and compelling positive results (Table G-1). Most of the programs identified lost workday rate, lost workday case rate, and cost as primary outcome metrics. Lost workday rate decreases ranged from 27% to 77%, with most of

the programs reporting around a 50% reduction.[3-5, 7, 8] The lost-time case rate reductions ranged from 46% to 73%.[3-6] Cost reductions ranged from 23% to 59%.[2,3,5,6] When statistical analyses were applied, highly significant differences were found when comparing lost days, RTW rates, and costs between the intervention and control groups.[2,7]

Several best practices reports discussed the program elements that led to these dramatic reductions in rates and costs. The reduction in the overall number of lost days was attributed to the increased use of modified duty and workplace accommodations. The reduction in lost-time and medical only claims was associated with both the use of modified duty and the continuous assessment and improvement of work areas where injuries occurred.[2-8] One report acknowledged that there was a state-wide decrease in lost-time claims at the same time; however, the rate of decrease in lost-time claims in the best practices program was approximately three times greater than the decrease observed state-wide.[4]

Conclusions

Traditional cost control strategies, administrative management, and fraud investigations have had limited success in reducing lost workdays and costs associated with work-related injuries and illnesses.[5] Recent studies have consistently shown that a well-structured, proactive, and focused team approach to care management, early RTW, and accommodation are integral components of a comprehensive effort to control lost workdays and costs.

Most importantly, all of the identified best practices consist of elements already present in the DoD. These low-cost best practice process changes can be successfully implemented in the DoD with cooperative commitment and coordinated effort among the key administrative, health, and safety players.

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Table G-1. Best Practices Programs

Location	Population (N)	Best Practice(s)	Metrics	Outcomes
Sweden	Workers with MSD Injury (137). Intervention Group: 65 Control Group: 72	Early workplace interventions focused on ergonomics and accommodation compared to traditional case management.	• Total mean number of sick days (lost time) • RTW • Total compensation reimbursement • Cost-Benefit Ratio based on direct cost savings	• Significant differences (<.01) between intervention and control group mean number of sick days • Odds Ratio of 2.5 (95% CI 1.2-5.1) for returning to work in the intervention group • Significant differences (<.05) between intervention and control group payments • Cost-Benefit Ratio of 6.8 (direct cost savings)
Large university hospital (including two hospitals, a cleaning service, a security company and a research university)	All covered employees (24,486)	Occupational medicine physician and nurse manager team with an in-house PPO network (orthopedics, neurosurgery, physical medicine and rehabilitation). Bi-weekly Medical Management Workgroup meetings developed coordinated treatment plans for each worker. Monthly Workers' Compensation Claims Management Workgroup (nurse manager, safety, human resources and administrator) meetings formulated a plan for each lost-time injury case.	• Per capita compensation expenses • Lost time case rate • "Medical only" case rate • Temporary total disability lost days rate • Per capita cost for temporary total disability	• Per capita costs reduced 23% • Lost time case rate reduced from 22 cases/1000 to 12-14 cases/1000 • Medical only case rate reduced from 155 cases/1000 to 96 cases/1000 • Temporary total disability lost days rate reduced from 163 days/1000 to 70 days/1000 • Per capita costs for total temporary disability reduced from $53 to $26
Large university hospital	All covered employees (28,518)	Employee and supervisor training and job accommodation; ergonomics to facilitate placement of individuals with work restrictions.	• Lost workday case rate • Lost workdays rate • Restricted duty days rate *(increase desired – indicates increased placement and RTW focus)*	• Lost workday case rate decreased 55% from 19.8 per 100 employees to 10.0 per 100 • Lost workdays rate decreased from 26.3 days per 100 employees to 12.0 days per 100 employees • Restricted duty days rate increased from 0.63 days per 100 employees to 13.4 days per 100

Location	Population (N)	Best Practice(s)	Metrics	Outcomes
Large university hospital	All covered employees (39,000)	Integrated workers' compensation claims management system. The system allows safety, administrators, medical and nursing personnel to collaborate in preventing and efficiently assessing, treating and returning individuals to work. Software program implemented to integrate all elements of the program.	• Lost time claims rate • Medical claims rate • Total workers' compensation expenses per $100 of payroll • Medical costs per $100 of payroll	• Lost time claims rate decreased 73% from 22 cases per 1000 to 6 cases per 1000 • Medical claims rate decreased 61% from 155 cases per 1000 to 61 cases per 1000 • Temporary total disability lost days rate decreased 77% from 163 per 100 to 37 per 100 • Total workers' compensation expenses per $100 of payroll decreased 54% Medical costs per $100 of payroll decreased 44%
Self-insured university hospital	All covered workers (6,000) incurring a new work-related injury or illness	Early RTW and modified duty assignments, injury prevention programs, internal administration of legal cases, case management and provider training.	• Compensation indemnity costs • Lost time cases • Accepted claims	• Compensation indemnity costs decreased 41-59% • Lost time cases decreased 46-67% • Accepted claims decreased 10-15%
All business clients of a managed care organization and a hospital system	All covered employees with a work-related injury or illness in the one-year study period (608 workers participated)	Integrated workers' compensation managed care organization and OHC and emergency department.	• Lost workdays • Days until medical release to RTW	• Lost work days reduced 27% - 64% (P<.001) with integrated care management when compared to traditional loosely managed and optimally manage case management • Medical release to RTW reduced 78% - 89% under integrated care management
Automotive manufacturing organization	All covered employees	Multifaceted disability management program including case manager, job placement coordinator and medical director team.	• Total disability leave rate • Extended disability leave rate • Workers' compensation leave rate	• Total disability leave rate decreased 50% • Extended disability leave rate decreased 50% • Workers' compensation leave rate decreased 75%

APPENDIX H. Cost Avoidance Data

Table H-1. Cost Avoidance Analysis – Air Force

	1996	1997	1998	1999	2000	2001	2002	2003
Comp Costs/Case								
Avg of Analyzed Sites	$14322	$14866	$14670	$14322	$13156	$10796	$9257	$8726
Svc Avg	$14144	$14171	$14057	$13275	$12461	$11445	$10544	$10316
Difference	-$178	-$695	-$613	-$1047	-$695	$648	$1286	$1589
Medical Costs/Case								
Avg of Analyzed Sites	$3354	$3342	$4951	$3762	$3768	$3545	$3240	$3325
Svc Avg	$3201	$3059	$3581	$3245	$3486	$3463	$3204	$3527
Difference	-$154	-$282	-$1371	-$517	-$281	-$82	-$36	$201
Total								
Difference	-$332	-$977	-$1984	-$1564	-$976	$566	$1250	$1791
Svc Case Count	3596	3856	4253	4752	5554	6551	7388	7761
Cost Avoidance	-$1,192,156	-$3,769,049	-$8,436,008	-$7,431,951	-$5,419,092	$3,709,846	$9,237,929	$13,896,755

Total Potential Costs Avoided: $596,276

Table H-2. Cost Avoidance Analysis – Army

	1996	1997	1998	1999	2000	2001	2002	2003
Comp Costs/Case								
Avg of Analyzed Sites	$9741	$10302	$9517	$7682	$7597	$6385	$6150	$5663
Svc Avg	$14547	$14344	$13991	$13381	$12620	$11239	$9924	$9857
Difference	$4806	$4042	$4474	$5699	$5023	$4854	$3774	$4194
Medical Costs/Case								
Avg of Analyzed Sites	$4172	$3931	$4827	$3662	$3884	$3807	$2983	$2976
Svc Avg	$3042	$2878	$3190	$3130	$3352	$3189	$3214	$3407
Difference	-$1130	-$1053	-$1637	-$532	-$532	-$618	$231	$432
Total								
Difference	$3675	$2989	$2836	$5167	$4491	$4236	$4005	$4625
Svc Case Count	5048	5323	5793	6426	7281	8769	10475	10937
Cost Avoidance	$18,553,920	$15,907,979	$16,431,707	$33,202,385	$32,698,918	$37,142,452	$41,955,366	$50,587,885

Total Potential Costs Avoided: $246,480,612

Table H-3. Cost Avoidance Analysis – Navy

	1996	1997	1998	1999	2000	2001	2002	2003
Comp Costs/Case								
Avg of Analyzed Sites	$10807	$9987	$10494	$9823	$10133	$8001	$7280	$7794
Svc Avg	$11869	$11975	$12167	$12105	$11734	$10991	$10190	$10074
Difference	$1062	$1988	$1673	$2281	$1601	$2989	$2911	$2280
Medical Costs/Case								
Avg of Analyzed Sites	$3105	$2864	$2865	$3613	$3612	$3604	$2782	$3208
Svc Avg	$2772	$2532	$2643	$2726	$3015	$3165	$2934	$3001
Difference	-$334	-$332	-$223	-$887	-$598	-$439	$151	-$207
Total								
Difference	$728	$1655	$1451	$1395	$1004	$2550	$3062	$2073
Svc Case Count	9402	9838	10119	10532	11495	12913	14726	15239
Cost Avoidance	$6,846,601	$16,284,585	$14,678,052	$14,687,582	$11,539,615	$32,934,003	$45,092,578	$31,596,755

Total Potential Costs Avoided: $173,659,771

APPENDIX I. Other Metrics for Consideration

Lagging Indicators for the Corporate Level. Lagging indicators are those metrics that measure relevant outcomes. The following corporate metrics could be measured centrally:

a. **Average Compensation Costs per Case.** Data to calculate this are available at the Civilian Personnel Management Service (CPMS) Injury and Unemployment Compensation (ICUC) Defense Portal Analysis Center (https://icucweb.cpms.osd.mil/cognos). Reflects overall case management approaches, including diligence with old claims. This metric should not be used as a stand-alone measure since one very expensive claim in a small installation can greatly affect the average compensation costs per claim.

b. **Average Medical Costs per Case.** A lower average is expected for those sites where much of the medical care is provided at the site medical treatment facility (MTF). A lower average is also expected at sites with proactive case management, including reviews of proposed treatment for appropriateness.

c. **Compensation Costs per Case/Medical Costs per Case.** Data to calculate this are available at the CPMS ICUC Defense Portal Analysis Center (https://icucweb.cpms.osd.mil/cognos)**.** A lower ratio is expected at sites where care is well-managed. However, a high denominator (due to treating mostly off-site) could skew this toward a lower number as well, so this circumstance will need to be considered.

d. **Compensation Costs/Lost Workday Case.** Data to calculate this are available at the CPMS ICUC Defense Portal Analysis Center (https://icucweb.cpms.osd.mil/cognos). Measures the costs related to the more serious cases, by eliminating those cases that are first aid only or non-lost time at the outset.

e. **Periodic Roll No Wage Earning Capacity (PN) Case Rate.** Reflects management of oldest claims, since it usually takes some time for a case on the periodic roll (PR) to be designated PN. The expectation is that a high PN case rate will be seen in sites with persistent or past inattention to case management. A low PN rate means that case management has been effective over the long-term. The numerator, number of PN cases in a current chargeback year, is available at https://icucweb.cpms.osd.mil/cognos. However, the Web site does not show the number for past years, nor does it show population figures needed for obtaining rates. Unless this changes, this metric would need to be generated manually with Defense Manpower Data Center (DMDC) population data and updated annually.

f. **Daily Roll (DR) Case Rate.** Measures the rate of DR cases, those cases that are recent and losing time, and have not been placed on the periodic rolls yet. Reflects current case management practices and should correlate with the continuation of pay (COP) lost day rate. A high rate is expected to reflect problems with case management early in a claim, but may also reflect higher injury risk. The number of DR cases in a current chargeback year is available at https://icucweb.cpms.osd.mil/cognos. However, the site does not

show the number for past years, nor does it show population figures needed for obtaining rates. Unless this changes, this metric would need to be generated manually with population data from the DMDC and updated annually.

g. **Periodic Roll, Wage Reduction in Place (PW) Case Rate.** Reflects attention to vocational rehabilitation opportunities late in older claims. Claims with a PW status are those whose claimants are either working in a lower wage job, or whose benefits have been reduced following vocational rehabilitation assessment and identification of ability to work in some capacity. A higher PW rate is expected to reflect *better* case management practices when coupled with lower PR rates. The number of PW cases in a current chargeback year is available at https://icucweb.cpms.osd.mil/cognos. However, the site does not show the number for past years, nor does it show population figures needed for obtaining rates. Unless this changes, this metric would need to be generated manually with population data from the DMDC and updated annually.

Leading Indicators for the Local Level. Leading indicators are those that measure processes that affect outcomes. They cannot at this point be measured centrally, but are offered as suggested metrics for consideration at the local level.

- Percentage of people filing claims who visited the clinic for evaluation.
- Percentage of people filing claims who selected the on-site clinic for medical care.
- Lag time between initial injury and initial evaluation.
- Percentage of new claims that resulted in safety or industrial hygiene (IH) visits for workplace evaluation.
- Percentage of PR claims receiving review by medical personnel once a year.
- Percentage of claims with emergency room visits that were followed up by the occupational health clinic (OHC) within one business day.
- Average time between release to return to work (RTW) and actual RTW.

APPENDIX J. Proposed Additions to DoDI 6055.1

PROPOSED ADDITIONS TO DoDI 6055.1

References (Add the following two references):

(w) Section 8101 et seq. of title 5, United States Code 8101, *The Federal Employees' Compensation Act.*

(x) Chapter 1, subchapter B, part 10 of Title 20, *Code of Federal Regulations*, *Employees' Benefits*.

5. RESPONSIBILITIES (Add the following responsibilities):

5.5 The Surgeons General of the Military Services shall:

5.5.1 Execute and provide oversight of occupational health and preventive medicine programs, as outlined in this instruction.

5.5.2 Develop medical care and case management policies to prevent and manage disabilities caused by occupational injuries and illnesses.

E.3. ENCLOSURE 3. DoD SOH PROGRAM REQUIREMENTS AND PROCEDURES

E.3.1. General Administration.

E3.1.1. Management Responsibility. …Military and DoD civilian officials at each management level shall:

- Advocate a strong SOH program.
- Provide their personnel safe and healthful working conditions.
- Provide education and training that will enable [them] *personnel* to prevent accidents, injuries, and occupational illnesses.
- *Offer, with a right of refusal, civilian employees an occupational health evaluation at the time the employee reports an occupational illness or injury.*
- *Require an occupational health evaluation whenever new job restrictions are imposed or whenever accommodations are requested, for employees whose job descriptions include physical requirements. (Note that failure of an injured employee to comply with this requirement would not necessarily jeopardize FECA benefits, since this is not a FECA requirement, however, noncompliance may result in disciplinary or adverse action, according to 5 Code of Federal Regulations 339.102(c)).*

- *Provide occupational health services with a copy of completed and signed Department of Labor (DOL) forms.*
- *Refer civilian employees who have a work-related injury or illness and who occupy a position that has medical standards or physical requirements to the supporting occupational health services for a determination of medical limitations that may affect job placement decisions, according to 5 Code of Federal Regulations 339.301(c).*
- *Ensure the availability of limited duty positions for partially disabled civilian employees.*
- *Consider position restructuring for employees who are permanently partially disabled due to a job-related injury or illness.*
- *Ensure regular team meetings among installation SOH personnel and injury compensation program administrators, according to DoD 1400.25-M, Civilian Personnel Manual, to review and analyze FECA costs, injury and illness trends, plans, activities and outcomes, and develop cost-containment initiatives.*

Performance evaluations of those responsible DoD Component officials shall reflect…

E.3.1.3. SOH Staffing. Qualified Safety and Occupational Health personnel shall be designated at levels of command consistent with the DoD component's organizational structure, including installation and unit levels, to serve as principal command SOH advisors, accident prevention policy and program developers, *medical case managers*, performance monitors, and points-of-contact for SOH matters.

E.3.1.6. Dissemination of Information.

E3.1.6.1. Component programs shall ensure that all personnel have access to and are informed of, the location, availability, and procedures to obtain SOH information *and medical care for occupationally-related injuries and illnesses.*

E3.3. SOH Training, Education, and Qualifications.

E3.3.1.2. Supervisors. Train supervisors in the management skills needed to implement the DoD Component's SOH policies and programs. These skills include: fostering a workplace where hazards are identified and risks managed; identifying and being able to teach subordinates to identify hazards and employ controls; safety motivation; accident reporting and investigation; *referring civilian employees with work-related injuries and illnesses for medical examination or treatment in accordance with DOD 1400.25M*, development of other skills needed to implement the Component's program at the working level; and enforcement action to ensure subordinate compliance.

E3.5.3. DoD Workplace Visits.

E3.5.3.1 General.

At least annually, qualified SOH personnel shall visit every installation workplace. The exact nature of the visit is at the discretion of the local senior SOH professional or as directed by that official's higher headquarters. Visits are to be conducted more frequently based on factors such as the exposure to and potential severity of hazards, actual accident experience, special emphasis programs, changes in the organization's staffing or workplaces, or other event that increases risk of accidents and occupational illnesses. *Qualified SOH personnel (e.g., industrial hygiene, medical, ergonomic, and safety) shall assist with workplace assessments in the evaluation of OWCP claims and to facilitate safe return-to-work initiatives.* Military personnel and DoD…

E3.10. Councils and Conferences.

E3.10.1. DoD SOH Councils.

E3.10.1.2. …Although these Councils or Committees are established under this Instruction primarily to address on-the-job personnel safety and health matters, the scope of their considerations should be expanded to include other safety, health, and accident prevention concerns of the command, *such as reducing civilian injury and illness rates and associated costs.* Components will establish procedures to form Joint Labor Management Committees or SOH Councils at the installation level. SOH personnel shall not chair these Committees or Councils. *Instead, they will be chaired by the appropriate-level commander or commander's representative who will schedule regular meetings and special meetings, as necessary.*

APPENDIX K. Proposed Changes to DoD 1400.25-M

PROPOSED CHANGES TO DoD 1400.25-M

SC810.3.4. The Activity Commander. This person ensures that:

SC810.3.4.6. The FECA Working Group meets periodically (usually quarterly) to *review and* analyze FECA costs*, injury and illness* trends, plans, [~~etc.~~] *activities and outcomes*, and develop cost-containment initiatives. FECA Working Groups shall consist of *representatives from* management, safety, personnel, *finance, logistics, security, legal, environmental*, medical, *ergonomics, industrial hygiene as needed*, and investigative services staffs. FECA Working Groups will be mandatory for any installation whose claims exceed $1M *and recommended for all installations*.

SC810.3.4.7. The return-to-work team (consisting of the Occupational Health Physician and the Medical Case Manager, among other command-designated personnel), led by the ICPA, meets frequently (typically biweekly or monthly), as determined by team goals and caseload, to plan short-, intermediate-, and long-term medical case management goals and plans for specific cases.

SC810.3.5. Activity Medical Service

SC810.3.5.1. Medical Officers. Medical officers review all reported cases of occupational illness and take or recommend action. Upon the ICPA's request, they provide medical information to be sent to OWCP to support or to controvert a claim for an occupational illness or work-related injury. They also:

SC810.3.5.1.8. Actively participate in the activity return-to-work team by reviewing medical reports, planning communications with the treating physician regarding accommodation and modified-duty options, recommending whether to request a second opinion exam, independent medical exam, vocational rehabilitation evaluation or other intervention from OWCP, and comparing individual cases with standardized disability guidelines to recommend expected medical outcome benchmarks.

SC810.3.5.2. Occupational Health Officials (Industrial Hygiene, Public Health, Epidemiology, *Environmental Health, etc.)* shall:

SC810.3.5.3. Medical Case Manager. A medical case manager, appointed from the Activity Medical Service, shall assist the ICPA by

SC810.3.5.3.1. Coordinating medical reviews, medical reports, medical services, and relevant communications with medical providers.

SC810.3.5.3.2. Facilitating medical care for injured employees.

SC810.3.5.3.3. Participating in the return-to-work team meetings.

APPENDIX L. Draft Memorandum for Medical Treatment Policy for Federal Employees

Office Symbol

MEMORANDUM FOR

SUBJECT: Medical Treatment Policy for Federal Employees

1. References.
    a. 5 United States Code section 8101, *et seq.,* Federal Employees Compensation Act.
    b. Title 20, Code of Federal Regulations, Subchapter B, Subchapter B, Part 10, subchapter D, §10.300, *Claims for Compensation Under the FECA*.
    c. Department of Labor (DOL) Procedures Manual (PM), Chapter 3, Medical Claims.
    d. DoD Civilian Personnel Management Service (CPMS), 1400.25-M, Subchapter 810, Injury Compensation Policy (December 1996).
    e. Health Affairs Policy 97-035, March 5, 1997, subject: Policy for Billing Occupational Health or Workers' Compensation Cases for Department of Defense Employees in Military Treatment Facilities (enclosed).

2. Federal employees are a critical asset for essential function in the Department of Defense, particularly in light of the smaller "right-sized" forces. Conservation of this important asset is critical to our Nation's defense.

3. The Federal Employees' Compensation Act, 5 USC 8103 *et seq*., authorizes medical services needed to provide treatment or to counteract or minimize the effects of any condition that is causally related to factors of Federal employment.

4. Federal employees are entitled to "all services, appliances, and supplies prescribed or recommended by qualified physicians which, in the opinion of the Office of Workers' Compensation Programs, are likely to cure, give relief, or reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation. Medical care includes examination, treatment, and related services such as hospitalization, medications, appliances, supplies, and transportation incident to securing them."

5. The injured worker is entitled to his/her choice of physician. Whenever possible, MTF Commanders are encouraged to provide timely access to high quality care at their facilities to minimize the health and productivity losses to the worker, the agency and the Department of Defense. Federal workers with work-related injuries should receive treatment priority just after active duty military, and ahead of all other beneficiaries. Workers with occupational illnesses should have an approval from the Office of Workers' Compensation Programs before any definitive treatment is commenced.

Enclosure SIGNATURE BLOCK

HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, DC 20301-1200

MAR 5, 1997

MEMORANDUM FOR: ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (MRAI&E)

SUBJECT: Policy for Billing Occupational Health or Workers' Compensation Cases for Department of Defense Employees in Military Treatment Facilities

This memorandum clarifies our billing policy for occupational health or workers' compensation cases in military treatment facilities. Emergency medical care (including initial treatment after on-the-job injury or illness) provided Department of Defense (DoD) employees injured on the job, whether appropriated or nonappropriated fund, will not be billed. Nonemergent or follow-up occupational health or workers' compensation care for nonappropriated fund employees will be billed to the employer at the interagency rate.

I recognize that appropriated fund DoD employees are governed by the Federal Employees Compensation Act (FECA), nonappropriated fund employees are governed by the Longshore and Harbor Workers' Compensation Act, and that military treatment facilities are legally authorized to collect from nonappropriated fund instrumentalities for all occupational health or workers' compensation care. However, due to the potential impact of this action on service morale, welfare and recreation programs, I am establishing this policy to forego collections for emergency medical care. I am taking this action under the authority of 10 U.S.C. 1074 (c) to establish, by regulation, the limited entitlement to emergency medical care.

The point of contact is LCDR Pat Kelly at (703) 681-8910 or pkelly@ha.osd.mil.

Stephen C. Joseph, M.D., M.P.H.

cc:
Surgeon General of the Army
Surgeon General of the Navy
Surgeon General of the Air Force

HA POLICY 97-035

Enclosure

APPENDIX M. Proposed DoD Manual on MCM Procedures

MEDICAL CASE MANAGEMENT PROCEDURES
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Appendix N. Impact of Overtime on Productivity

Overtime is often used as a solution for personnel shortages or to meet peak production demands and schedules. Although management may view overtime as a temporary solution, it often becomes a standard way of managing work demands. In many instances, the extended overtime hours approach the same hours worked in a 12-hour shift system; however, the use of overtime is applied with little consideration to the consequences of this work pattern or the scheduling of rest days. The worker fatigue resulting from extended work hours is very costly in terms of worker health, performance, and morale.

The health effects of extended work hours are well documented and include an increased risk for:

- cardiovascular disease
- sleep disorders
- depression
- ulcers
- gastrointestinal dysfunction and disorders
- breast cancer
- complications of existing medical conditions such as diabetes and epilepsy

These health effects become even more apparent in older workers. In addition, extended hours reduce the available time to spend quality time with family members and meet family care demands, leading to increased levels of stress, irritability, and feelings of isolation. The risk of substance abuse also increases as workers resort to caffeine, stimulants, and tobacco to stay awake and alcohol and depressant drugs to fall asleep. Workers who consistently work under an extended hours schedule report high levels of concern that these extended hours are affecting their health and longevity. Typically, excessive use of overtime is accompanied by a characteristic increase in absences for sickness and accidents.

The productivity and performance costs are often not apparent to management, but these costs can far exceed the direct costs of overtime. The worker fatigue resulting from extended hours leads to increased errors and accidents, decreased concentration, slower reaction time, failure to perceive and react to critical signals, impaired motor skills and coordination, decreased ability to handle stress, reduced problem-solving and decision-making abilities, and increased risk-taking behavior.

Dramatic examples of fatigue-related accidents include the chemical spill in Bhopal, India; the nuclear accidents at Three-Mile Island and Chernobyl; and the Exxon Valdez oil spill. Driving is a serious concern. A recent study found that fatigued drivers perform worse than those with a blood alcohol level of .05 percent. Finally, productivity levels and work output do not increase in proportion to the hours worked. In fact, extending the workday often causes the tempo of work to slow down and the hourly output to decrease, especially in physically demanding jobs.

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