NATIONAL TRANSPORTATION SAFETY BOARD

Office of Research and Engineering
Washington, DC

Medical Factual Report

June 12, 2017

Nicholas Webster, MD, MPH
Medical Officer

A. **ACCIDENT: DCA17FR002**

Accident Type:	Train did not stop at the Atlantic Terminal and collided with the end of track
Location:	Brooklyn, New York
Date:	January 04, 2017
Time:	8:18 a.m. EST
Vehicle:	Long Island Rail Road (LIRR) train (No. 2817) with 6 passenger cars

B. **GROUP IDENTIFICATION:**
No investigative group was formed.

C. **RELEVANT REGULATIONS, PROTOCOLS AND MEDICAL CONDITIONS**

Per Title 49 *Code of Federal Regulations* (CFR) Part 240.121, triennially, railroad engineers are required to meet the following criteria:

> (b) *Fitness requirement.* In order to be currently certified as a locomotive engineer, except as permitted by paragraph (e) of this section, a person's vision and hearing shall meet or exceed the standards prescribed in this section and appendix F to this part.

Per 49 CFR 242.117, triennially, railroad conductors are required to meet the following criteria:

> (g) *Fitness requirement.* In order to be currently certified as a conductor, except as permitted by paragraph (j) of this section, a person's vision and hearing shall meet or exceed the standards prescribed in this section and Appendix D to this part.

Federal regulations do not require railroad engineers or conductors to report a medical history, describe their use of medications, or undergo any other physical examination, additional testing or review of their health.

New York MTA / LIRR Medical Protocols

Long Island Rail Road (LIRR) along with MetroNorth and New York City Transit (NYCT) are passenger transportation subsidiaries of New York State's Metropolitan Transportation Authority (MTA). Each of these subsidiaries has managed their occupational medical programs independently. In November 2015, the MTA developed a strategy to transition each of the subsidiaries Occupational Health Services functions, previously managed independently by a 3rd party service provider, to a centralized function at the MTA. This consolidation was planned to ensure a uniform approach to health and wellness across the MTA agencies and allow for the application of medical best practices at each of the agencies. This integrated approach required the recruitment of medical staff and the development of protocols. Metro-North Railroad (MNR) was integrated under the new MTA Medical Director on January 3 of 2016 and at the time of this report it was anticipated that the LIRR would be integrated by July 2017. (Attachment 1)

According to correspondence from LIRR, medical evaluations of safety sensitive personnel are conducted in accordance with LIRR Corporate Policy and Procedures, Medical Assessment Policy MED-001 (Attachment 2), 49 CFR 240.121, and 242.117. Federal mandates require Locomotive Engineers and Conductors have triennial hearing and vision exams. LIRR Medical Services conducts these exams on a biennial basis, recording the results on a spreadsheet in the occupational medicine records. Additionally, for triennial LIRR corporate mandated periodic physical examinations the company uses LIRR MD-10 medical form. (Attachment 3) There are no LIRR guidelines concerning the conduct of the examination. Based on the LIRR occupational medicine examination form, examiners are expected to review the employee's medical conditions and medications, obtain vital signs, and perform a physical examination in addition to the Federal Railroad Administration (FRA) required vision and hearing tests. However, the employee is not asked to fill out any information directly and no screening for sleep disorders is included. Following a fatal rail accident in the Bronx in 2013 in which undiagnosed Obstructive Sleep Apnea (OSA) was implicated, MetroNorth began an OSA screening program in January 2015 for its rail engineers and since then has expanded the program to include its conductors. At the time of this accident, the MTA had plans to include LIRR in the OSA screening program but had not yet implemented the change. (Attachment 4)

Obstructive Sleep Apnea

OSA is a chronic disease in which patients experience episodes of airway obstruction while sleeping. During each episode, the person stops breathing for a period of time which causes oxygen levels to drop and carbon dioxide levels to rise. When the buildup of carbon dioxide gets too high, the brain detects it and the person arouses or awakens in order to breathe. The end result is fragmented sleep. Risk factors for OSA include, male gender, age, obesity, hypertension, large neck circumference (greater than 16 inches in women and 17 inches in men), a waist to hip circumference ratio of greater than 1 for men and 0.85 for women, and snoring.[1,2,3,4,5] A task force created by the American Academy of Sleep Medicine developed

[1] Peppard PE, et al. Increased prevalence of sleep-disordered breathing in adults. Am J Risk factors for obstructive sleep apnea in adults Epidemiology. 2013;177(9):1006-14.
[2] Seidell JC. Waist circumference and waist/hip ratio in relation to all-cause mortality, cancer and sleep apnea. Eur J Clin Nutr. 2010;64(1):35-41.
[3] Young T, et al. Sleep Heart Health Study Research Group. Predictors of sleep-disordered breathing in community-dwelling adults: The Sleep Heart Health Study. Arch Intern Med. 2002;162(8):893-900.
[4] Olson LG, et al. A Community Study of Snoring and Sleep-disordered Breathing Prevalence. Am J Respir Crit Care Med 1995; 152:711-6.
[5] Young T, et al. Risk factors for obstructive sleep apnea in adults. JAMA. 2004;291(16):2013-6.

a Clinical Guideline for the Evaluation, Management, and Long Term Care of Obstructive Sleep Apnea in Adults which was published in 2009.[6] The task force reached consensus that patients with obesity, congestive heart failure, atrial fibrillation, treatment refractory hypertension, type 2 diabetes, stroke, nocturnal dysrhythmias, pulmonary hypertension, those who were members of high-risk driving populations (such as commercial truck drivers), and those being evaluated for bariatric surgery were either at increased risk of having OSA, having serious complications of OSA, or having undiagnosed OSA complicate their medical care. Patients with any of these conditions or situations were identified as "high risk," suggesting increased vigilance for the diagnosis. Of note, persons with OSA have a significantly increased risk of motor vehicle crashes and other occupational injuries.[7,8,9]

D. DETAILS OF INVESTIGATION

Purpose

This investigation was performed to evaluate the train's crew for any medical conditions, use of medications/illicit drugs, or the presence of any toxins. Additionally, the investigation evaluated the conduct and oversight of LIRR occupational medicine evaluations of safety sensitive personnel.

Methods

The crews' LIRR occupational health records and FRA post-accident toxicology reports, as well as the Locomotive Engineer's pre- and postaccident medical treatment records were reviewed. Additionally, MTA / LIRR occupational medicine policies and procedures for evaluation of OSA in safety sensitive personnel were reviewed.

Locomotive Engineer

LIRR Medical File

According to LIRR occupational medical records ranging from March 1999 to November 2016, the 50-year-old male Locomotive Engineer was first found medically qualified for employment March 29, 1998. His most recent federally mandated hearing and vision examination was dated November 14, 2016. The examination signed by a nurse recorded a vision and hearing evaluation on a spread sheet. No disqualifying abnormalities were noted on this examination and testing recorded the Locomotive Engineer's uncorrected distant vision as 20/20 in right eye and 20/20 left eye.[10] It did not include a health history or sleep apnea risk questionnaire, complete physical examination, measurement of height, weight, BMI or neck circumference. No abnormalities were found in visual field or color vision testing. No comments about his qualifications for duty were made and a note

[6] Adult Obstructive Sleep Apnea Task Force of the American Academy of Sleep Medicine. Clinical Guideline for the Evaluation, Management, and Long Term Care of Obstructive Sleep Apnea in Adults. J Clin Sleep Med. 2009;5(3): 263-276.

[7] Mulgrew AT, et al. Risk and severity of motor vehicle crashes in patients with obstructive sleep apnea/hypopnea. Thorax. 2008; 63(6):536–541.

[8] Lindberg E, et al. Role of snoring and daytime sleepiness in occupational accidents. Am J Respir Crit Care Med 2001;164 (11): 2031–2035.

[9] Basoglu OK, Tasbakan MS. Elevated risk of sleepiness-related motor vehicle accidents in patients with obstructive sleep apnea syndrome: a case-control study. Traffic Inj Prev. 2014;15(5):470-6.

[10] According to 49 CFR 240.121(c), Each person shall have visual acuity that meets or exceeds the following thresholds: (1) for distant viewing either,

(i) Distant visual acuity of at least 20/40 (Snellen) in each eye without corrective lenses or

(ii) Distant visual acuity separately corrected to at least 20/40 (Snellen) with corrective lenses and distant binocular acuity of at least 20/40 (Snellen) in both eyes with or without corrective lenses.

documented he was advised to follow up with his PMD [personal medical doctor] for a mild hearing deficit.

The Locomotive Engineer's earlier complete corporate mandated periodic physical examination was dated October 14, 2014. At that time, his height was recorded as 5 feet 11 inches and his weight as 223 pounds. Although the examiner did not calculate a BMI, this correlates to a calculated body mass index (BMI) of 32.5 kg/m^2.[11] His health history did not record any active chronic medical conditions or use of any prescription medications and an examination did not find any significant medical conditions.

Personal Medical Records

Personal medical records from primary care providers dated from December 2010 to January 26, 2017 were reviewed. Clinical notes dated prior to the accident documented the Locomotive Engineer had been evaluated for minor respiratory infections and orthopedic issues but had no chronic medical concerns. No screening for sleep disorders was performed during this time.

An examination by a nurse practitioner dated January 9, 2017 (5 days after the accident), documented the Locomotive Engineer routinely worked midnight to early morning hours and he generally felt fatigued. He admitted to snoring but was unable to confirm gasping or choking as his sleep patterns and hours differed from his wife. The health care provider documented the Locomotive Engineer reported having had an episode of unconsciousness before the accident. No specific medical findings were identified on further history or physical examination. He was referred for neurologic and cardiac evaluations, seeking the cause of the Locomotive Engineer's self-described period of unconsciousness. He was also referred for a sleep evaluation.

Neurology Evaluation

According to records from a neurology evaluation following the accident, the Locomotive Engineer 's neurologist documented a normal exam and an EEG was read as normal. His diagnosis was documented as "transient alteration of awareness."

Cardiology Evaluation

Records from the Locomotive Engineer's evaluation by a board-certified cardiologist following the accident including an electrocardiogram, Holter monitor, exercise stress test, stress echo, and carotid ultrasound did not find any disease. The Locomotive Engineer's documented height was 5 feet 10.5 inches, weight was 282 pounds, BMI was 39.89 and the physician documented morbid obesity (a BMI between 35-40) but did not identify a cause for his episode of altered consciousness.

Postaccident Sleep Study

According to sleep medicine clinic records from January 2017, the Locomotive Engineer's recorded height was 5 feet 10 inches, weight was 275 pounds, BMI was 39.5 kg/m^2, and neck circumference was 18.5 inches.[12] Additionally, he scored 12 of

[11] National Institute of Health, National Heart, Lung and Blood Institute BMI Calculator. https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm Accessed 03/03/2017

[12] According to the National Institute of Health https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmi_dis.htm a BMI of between 35 and 39.9 kg/m^2 indicates obesity and places the patient at very high risk of Type II diabetes, high blood pressure, cardiovascular disease.

24 points on the Epworth sleepiness scale.[13,14] On January 16, 2017, he underwent a non-invasive polysomnographic evaluation (sleep study) in a sleep center. Testing results included an apnea-hypopnea index (AHI) of 101.3 episodes per hour with and average oxygen saturation during testing of 95%, dropping to as low as 73%.[15] The sleep medicine specialist diagnosed severe OSA and prescribed continuous positive airway pressure (CPAP) as treatment.[16]

Toxicology

FRA post-accident toxicology testing of blood and urine collected at 12:02 and 12:15 p.m. respectively was conducted by the Quest Diagnostic Forensic Toxicology Laboratory. Testing was negative for tested-for-drugs and alcohol.[17]

Conductor

LIRR Medical File

According to LIRR occupational medical records ranging from August 1998 to March 2016, the 46-year-old female Conductor was first found medically qualified for employment August 28, 1998. Her most recent examination was dated March 01, 2016. The exam consisted of a verbal history, a complete physical examination including measurement of height, weight, vision and hearing evaluation but did not include a sleep apnea risk questionnaire or measurement of neck circumference. The exam documented she was 5 feet 9 inches tall and weight was 177 pounds. Although the examiner did not calculate a BMI, this correlates to a calculated body mass index (BMI) of 26.1 kg/m^2. No disqualifying abnormalities were noted and the Conductor was found medically qualified.

Toxicology

FRA post-accident toxicology testing of the Conductor's blood and urine collected at 12:35 and 12:45 p.m. respectively was conducted by the Quest Diagnostic Forensic Toxicology Laboratory. Testing was negative for tested-for-drugs and alcohol.

Assistant Conductor

LIRR Medical File

According to LIRR occupational medical records ranging from February 2007 to August 2016, the 51-year-old male Assistant Conductor was first found medically qualified for employment February 14, 2007. His most recent examination was dated August 17, 2016. The exam consisted of a verbal history, a complete physical examination including measurement of height, weight, vision and hearing evaluation but did not include a sleep apnea risk questionnaire or measurement of neck

[13] The Epworth sleepiness scale is a subjective measure of the potential to fall asleep. It is administered as a questionnaire. Generally, a score of 10 or higher is considered an excessive amount of sleepiness depending on the situation.

[14] Johns MW. Reliability and Factor Analysis of the Epworth Sleepiness Scale, Sleep, 15(4):376-381

[15] An apneic episode is the complete absence of airflow though the mouth and nose for at least 10 seconds. A hypopnea episode is when airflow decreases by 50 percent for at least 10 seconds or decreases by 30 percent if there is an associated decrease in the oxygen saturation or an arousal from sleep. The apnea-hypopnea index (AHI) sums the frequency of both types of episodes. An AHI of less than 5 is considered normal. An AHI of 5-15 is mild sleep apnea; 15-30 is moderate sleep apnea and more than 30 events per hour is considered severe sleep apnea.

[16] CPAP is a treatment for OSA that uses a machine to generate positive air pressure that is delivered though a mask the covers the nose or nose and mouth to keep the airways open during sleep.

[17] Quest Laboratory tested urine specimens for amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, MDMA/MDA, methadone, opiates/opioids, phencyclidine, tramadol, brompheniramine, chlorpheniramine, diphenhydramine, doxylamine, and pheniramine. Blood was tested for alcohol.

circumference. The exam documented he was 6 feet tall and weight was 165 pounds. Although the examiner did not calculate a BMI, this correlates to a calculated body mass index (BMI) of 22.4 kg/m^2.[18] No disqualifying abnormalities were noted and the conductor was found medically qualified.

Toxicology

FRA post-accident toxicology testing of the Assistant Conductor's blood and urine collected at 1:03 and 1:45 p.m. respectively was conducted by the Quest Diagnostic Forensic Toxicology Laboratory. Testing was negative for tested-for-drugs and alcohol.

E. LIRR Transit Actions concerning OSA Screening Following the Accident

According to correspondence with the MTA Medical Director, LIRR started screening locomotive engineers during their FRA recertification testing using the MTA OSA screening program on April 17, 2017. As of Monday May 15, 2017, 34 of 432 (7.8%) of locomotive engineers had been screened. 8 of the 34 (24%) had screened positive and had been referred for more testing. Additionally, one locomotive engineer reported OSA and had already been treated with CPAP. (Attachments 5, 6)

F. SUMMARY OF FINDINGS

The 50-year-old male Locomotive Engineer had no documented acute or chronic medical conditions but was found to be morbidly obese with a postaccident weight of 275 pounds and a BMI of 39.5 kg/m^2. His postaccident primary care, neurology, and cardiology evaluations did not identify any concerns but a sleep evaluation including polysomnography documented an AHI of 101.3 episodes per hour and the Locomotive Engineer was diagnosed with severe obstructive sleep apnea.

Review of the 46-year-old female Conductor’s and 51-year-old male Assistant Conductor's occupational records found that they were both medically certified for the safety sensitive positions they held.

At the time of the accident, MTA / LIRR had planned for but had not started an OSA screening program. Since the accident, MTA / LIRR have started a program to screen LIRR safety sensitive personnel for OSA.

[18] The recorded weight is documented to be from a patient report.

Memorandum

Metropolitan Transportation Authority
State of New York

Date: November 6, 2015

To: Agency Heads

From: Thomas F. Prendergast, Chairman and Chief Executive Officer

Re: **Reorganization of Occupational Health Services**

As we continue to raise the bar on our safety performance and standards, it has become increasingly clear that the next challenge we will face is in the area of occupational health and wellness and how those issues affect our workforce in performing their jobs. I cannot emphasize enough how important I consider the role of occupational health management in maintaining fitness standards for our operational personnel.

Therefore, to facilitate a more uniform approach to medical issues such as sleep apnea that are common to all MTA agencies, and to do so as efficiently and effectively as possible. I have asked Anita Miller, MTA's Chief Employee Relations and Administrative Officer, to begin the task of integrating the management of occupational health services for all MTA employees. As a first step in this process, the management of the Occupational Health Services (OHS) unit that serves New York City Transit (NYCT) and MTA Bus Company employees will report directly to Ms. Miller.

John Crisci, NYCT's Corporate Occupational Health Officer will report directly to Anita. John is a seasoned executive with over 34 years of operating and occupational health management experience at NYCT, including leading NYCT's OHS for the last 8 years. John and his team have already successfully assumed the provision of occupational health services to MTA Bus Company employees in 2012 from a vendor. They are uniquely qualified to assist Anita in the implementation of this mission critical effort.

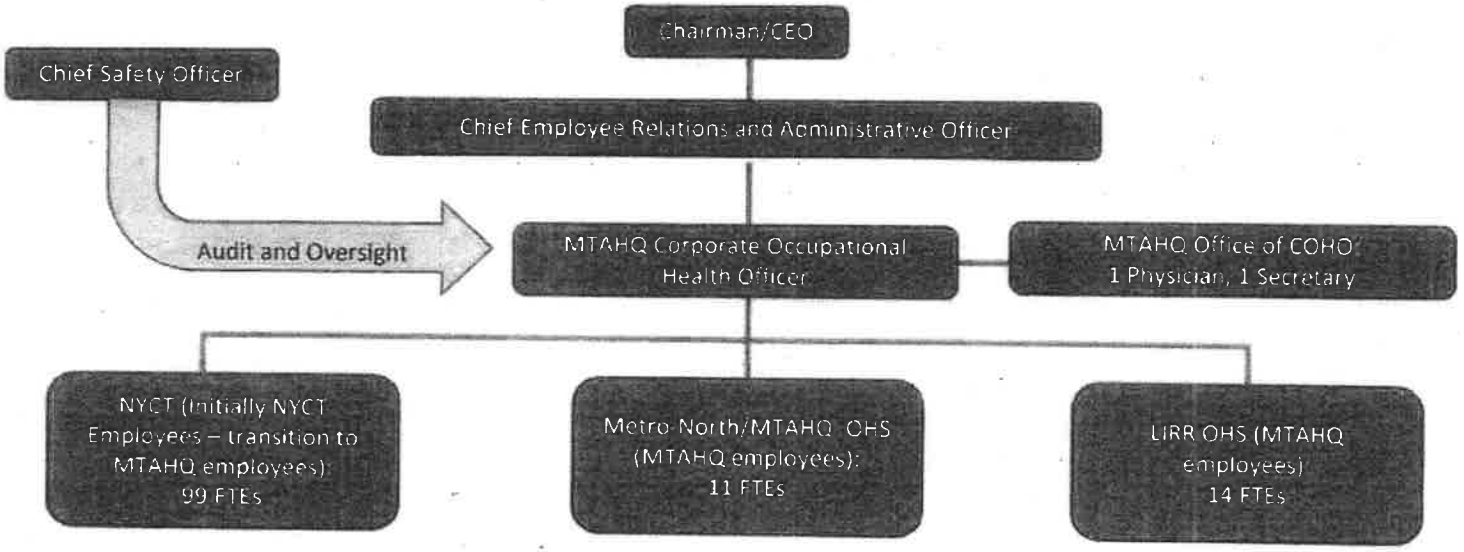
The next step in the transition will be for Occupational Health Services taking responsibility for the medical services for Metro-North Railroad employees and MTA Headquarters staff during 2016.

Please extend your full cooperation to Anita and her team during the undertaking of this challenging new responsibility.

cc: D. Evans
A. Miller
J. Crisci

HQ Centralization Contract Model

- Step 1: NYCT OHS senior management (3 employees) to become HQ employees to manage centralized operation; other NYCT OHS staff remain at NYCT reporting to HQ Corporate Occupational Health Officer (COHO); potential for transition of NYCT OHS staff to HQ employment at a later time
- Step 2: After 6 months to hire up new staff as HQ employees, COHO takes responsibility for MNR/MTAHQ from Take Care Health
- Step 3: Upon termination of LIRR's Take Care Health contract (end of 2016) COHO takes responsibility for LIRR using new staff of HQ employees
- Step 4: Assume responsibility for B&T through the NYCT OHS office at a time to be determined
- HQ to enter into MOUs with each of NYCT, LIRR, MNR, and B&T addressing cost accounting, service levels, oversight, and liability.



Long Island Rail Road

Corporate Policy & Procedure

MEDICAL ASSESSMENT POLICY **MED-001**

I. PURPOSE

The purpose of this Corporate Policy and Procedure (Policy) is to set forth the MTA Long Island Rail Road (LIRR) medical assessment program.

II. SCOPE

This Policy applies to all LIRR employees and job candidates.

III. DEFINITIONS

A. Leave Status Classifications for the purposes of this Policy consist of:

1. **Disabled/Accident (D/A)** – Time lost by an employee as a result of an injury/disability received in the performance of duty.
2. **Disabled/Sick (D/S)** – Time lost by an employee as a result of a non-job-related sickness/illness or injury.

B. Work Status Classifications

1. **Full Duty** – A determination by the LIRR Medical Department (Medical) that an employee is medically and physically **able** to perform all of the essential duties of his/her job with or without reasonable accommodation.
2. **No Work** – A determination by Medical that an employee is medically and/or physically **unable** to perform the essential duties of his/her job with or without reasonable accommodation.

C. Accident/Incident – An event or occurrence related to a LIRR operation that is required to be reported, including: fatality, injury or illness; collision, derailment, and similar events involving the operation of on-track equipment that resulted in monetary damage in excess of the current reporting threshold; and impact between rail on-track equipment and highway users at crossings.

IV. ESSENTIAL FUNCTIONS

A. Senior Director – Human Resources

Oversee the administration of this Policy.

B. LIRR Medical Department

1. Assess the medical and physical abilities of employees and prospective employees to safely perform essential functions of a position with or without reasonable accommodation.
2. Develop and maintain current job related medical and/or physical standards.

C. Assistant Director – Employee Services

Manage the day-to-day operation of this Policy.

D. Employees

Comply with this Policy.

E. Department Heads

Ensure compliance with this Policy.

F. Labor Relations Department

Assist as needed with application and interpretation of Collective Bargaining Agreements.

G. Safety & Training Department

Ensure lost time is reported to Federal Railroad Administration (FRA) in accordance with 49 CFR 225.

H. Department Medical Liaison (To be determined by Department)

1. Serve as liaison between his/her department and Medical on all medical-related matters.
2. Ensure that employees are instructed to report to Medical in accordance with this Policy.
3. Follow up to ensure appointments are kept and take appropriate action if employees fail to report as directed.
4. Coordinate as needed with the Assistant Director - Employee Services or designee and other departments regarding all medical matters.

V. PROCEDURES

A. Physical Abilities Screening (PAS)/Medical Assessments

The LIRR Medical Staff will conduct medical examinations and/or PAS to determine an employee or applicant's ability to perform the essential functions of a job, with or without reasonable accommodation. If PAS is required for a position, it must be performed no more than 60 days prior to start of employment, job change, or return to duty.

B. Pre-Employment/Job Title Changes Medical Assessments

1. Medical assessments will be performed only after the applicant for employment or promotion has been determined to be otherwise qualified for employment and has been made a conditional offer of employment, subject only to a satisfactory medical assessment. Medical Staff will perform medical assessments of an applicant to determine his/her fitness to perform the essential functions established

for that job as specified by the medical standards. Medical assessments will not be required for positions with no established medical standards.

2. If the Medical staff has reason to believe a medical condition exists that prevents the applicant from performing the essential functions of the job, the applicant may be required to provide medical records for the Medical to make a final recommendation. The medical assessment will be valid for 90 days.
3. If a position requires a Department of Transportation (DOT) or Safety-Sensitive drug test, a valid drug and/or alcohol test must be performed no more than 30 days prior to employment, job change, or return to duty.
4. If it is determined that an applicant cannot perform the essential functions of the job due to a disability, the Reasonable Accommodations Policy (CP&P MED-003) should be referenced and serve as a basis for employment decision.
5. In the event the applicant has not requested a reasonable accommodation, and the medical assessment indicates the applicant does not meet the medical and/or physical standards of the job, he/she will be evaluated to determine whether a reasonable accommodation is needed or available to permit the applicant to perform the essential functions of the job, in accordance with LIRR ADA (Americans with Disabilities Act) Policy guidelines. (CP&P MED-002)

C. Post Accident/Incident

1. Reporting to Medical by Employee Injured on Duty (D/A)

Responsibilities of Employee, Supervisors and Department – It is the responsibility of an employee involved in an on duty accident/incident to request medical attention if necessary, and:

a. Immediately report the occurrence to his/her supervisor or to the appropriate reporting location as designated by Department's rule, as soon as practicable, but no later than the end of the employee's tour of duty. Failure to comply may result in discipline and/or loss of benefits.

b. If the employee is unable to perform his/her duties due to the accident/incident, the employee must report to Medical within twenty-four (24) hours from the time of the accident/incident. If Medical is not open, then the employee must report as soon as Medical is open.

c. If an employee is unable to report to Medical as required under Paragraph (b) above, the employee must immediately notify his/her supervisor and supply medical proof acceptable to Medical to justify the reason for his/her failure to so report. Failure to comply may result in discipline and/or loss of benefits.

d. It is the responsibility of the employee's supervisor and Department to obtain medical attention for the employee, if necessary, and to thoroughly complete and distribute the AR-1 and AR-20/AR-21 Reports of Employee Accidents/Incidents, as required by the Employee Safety Policy (SAFE-005).

2. **Medical will:**

   a. Check the Accident Control System (ACS) for information about the accident/incident. If no information is in the ACS, Medical will contact the employee's department to find out the status of the accident/incident.

   b. Examine the employee for purposes of assessing his/her fitness for duty, and to give the employee a Work Status Classification as soon as practicable after the employee reports to Medical.

3. **Recurrence of Pain**

   An employee who loses time for a recurrence of pain for a previously documented accident/incident must follow the same procedure mentioned in Section 1 above.

D. Other Medical Assessments

1. Periodic medical assessments of all incumbents will be performed for those employees covered by FRA and/or Federal Motor Carrier Safety Administration Policies to determine their fitness to perform the essential functions of their job as specified in the medical standards for the position. These periodic medical assessments include, but are not limited to, locomotive engineer and conductor certifications, commercial driver's license/HAZMAT Medical Examinations, asbestos exposure medical examinations, respiratory fitness medical examinations, and periodic physicals.

2. If LIRR Medical Staff has identified the need for ongoing monitoring of a medical condition of an employee, the LIRR Medical Staff shall advise the employee of the requirement to submit periodic reports on the status of the condition from the employee's personal physician or report to Medical for assessment. Medical Staff will provide the employee with the form(s), which must be completed by his/her physician.

3. A department may submit a written request (email, memo, etc.) to Medical for a fitness-for-duty medical assessment when, in the department's view, based on observed, articulable facts, the employee may be unfit to perform his/her job duties. The Physician-in-Charge will determine whether a medical and/or physical assessment is warranted in these instances.

E. Return to Work

1. When required to do so by labor agreements, represented employees shall report to Medical when they are ready to return to work after having been absent. Employee shall provide Medical Staff, at the time of the assessment, with documentation concerning the medical condition, injury or illness and current medical status.

2. The Medical Staff shall perform a medical and/or physical assessment, based on the physical standards of the employee's position, to determine the status of the employee's condition, illness or injury, to determine whether the employee is fit for duty and shall apprise the Department Medical Liaison whether the employee is fit

to return to work with or without reasonable accommodation. If PAS is required for the position, it must be performed if the employee has been absent (for any reason) for 60 days or more.

F. Dispute Procedure

For represented employees, in the event of a dispute or disagreement between Medical and an employee's physician, a medical panel, if requested, will be scheduled as soon as possible pursuant to the applicable Collective Bargaining Agreement. If a panel is requested, it is the responsibility of Medical to: set up the panel; arrange for the change of the employee's Leave Status Classification, as appropriate; notify the Labor Relations Department and the Human Resources Department; and track pertinent information regarding such disputes.

G. Physical Therapy Evaluation

The Physician-in-Charge or designee will determine if a Physical Therapy Evaluation (PTE) is to be performed by Medical's Physical Therapist on an employee who has recovered from an accident/incident or sickness to determine if the employee has recovered sufficiently to return to duty or ever return to his/her previous job function.

H. Functional Capacity Evaluation (FCE)

The Physician-in-Charge or designee will determine if a comprehensive Functional Capacity Evaluation (FCE) is to be performed by Medical's Physical Therapist on an employee who has recovered from an accident/incident or sickness to determine if the employee has recovered sufficiently to ever return to her/her previous job function and, if not, what physical abilities are demonstrated that might relate to other job functions.

I. Confidentiality of Medical Records

1. All records of medical assessments and of other medical information provided by applicants and employees shall be maintained in secure files within Medical. Only authorized persons may access or receive confidential medical information concerning an applicant or employee.
2. Communications from Medical Staff, concerning an employee's medical assessment, shall indicate the employee's status for work without disclosing confidential medical information.

J. Compliance

1. If an employee is unable to report to Medical or consulting physician on a scheduled appointment date, the employee shall make every effort to provide at least 24 hours advance notice to Medical. The employee's Department Medical Department Liaison shall recommend that appropriate disciplinary action is taken if the employee fails to attend scheduled visits without providing appropriate justification, including requested documentation.

2. Employees are on notice that if they fail to comply with this Policy or provide untimely, false and/or incomplete medical information, they may be subject to disciplinary action, up to and including termination and loss of benefits.

VI. FORMS & ATTACHMENTS

None

VII. RELATED POLICIES

MED-002 - Americans with Disabilities Act (ADA)
MED-003 - Reasonable Accommodations Policy
SAFE-005 - Employee Safety Policy & Procedure
MED-005 - Alcohol & Substance Abuse

VIII. REVISION TRACKING

January 2001
October 2012
December 2014 - The Policy was scheduled for review per CP&P BPM-001 – Issuance of Corporate Policies and Procedures.
- Added clarification of time frames for drug testing.

MTA Long Island Rail Road

MEDICAL EXAMINATION

MD-10 FORM 7/12/06

DATE: _____
TIME: _____

EXAMINATION TYPE:
☐ PRE-PLACEMENT ☐ JOB CHANGE
☐ PERIODIC ☐ RETURN TO DUTY _____

Telephone #: _____ 1ST DAY OUT: _____

NAME: Last First Middle	OCCUPATION EXAMINED FOR:	DATE OF BIRTH	EMPLOYEE NO./SSN

Height: _____ Weight: _____ Temperature: _____ Pulse Rate: _____ Resp. Rate: _____ Blood Pressure: _____

Eyes: DISTANT VISION: NEAR VISION: Color Vision: _____
Without glasses: RE _____ LE _____ Without glasses: RE _____ LE _____ Field of Vision: _____
With glasses: RE _____ LE _____ With glasses: RE _____ LE _____ Contact Lenses: _____
Comments: _____

Hearing: AUDIOGRAM ☐ Comments: _____

General: _____

H.E.E.N.T.: _____

_____

Neck: _____ Thyroid: _____

Chest: _____ Lungs: _____

Heart: _____ EKG: ☐

Abdomen: _____ Hernia: _____

Extremities: _____

Musculoskeletal: _____

_____

Neurological: _____

_____ Reflexes: _____ Romberg: _____

Urine Dipstick: PH _____ Blood _____ Sugar _____ Albumin _____ Other _____

Specimen No.: _____ Saliva: _____

Tobacco: _____ Alcohol: _____

Past Medical History:	Past Surgical History:

Allergies: _____

Current Medication(s): _____
(Include PRN Meds)

_____

Plan: _____

_____

CONTINUED ON REVERSE SIDE ☐ YES ☐ NO

Examiner's Signature: _____ Print: _____ Date _____

☐ MEDICALLY QUALIFIED ☐ NOT MEDICALLY QUALIFIED ☐ MEDICAL HOLD DATE: _____

Physician's Signature: _____ Print: _____ Date _____

MTA Press Releases

Press Release April 19, 2016

MTA Headquarters IMMEDIATE

Governor Cuomo and Senator Schumer Announce Expanded Sleep Apnea Screening for MTA Employees

Screenings For Employees in Safety-Sensitive Positions Will Identify Those Deemed At Risk and Provide Them With Treatment

Governor Andrew M. Cuomo and Senator Charles E. Schumer today announced the expansion of a successful sleep apnea testing program for MTA employees. Testing was first begun as a pilot program in January 2015 to screen Metro-North Railroad train engineers, and now the MTA will make the program permanent at Metro-North and bring it to other agencies in the MTA family, including the Long Island Rail Road.

“This program helps us identify workers who may be at risk for sleep apnea, ensure they receive appropriate treatment, and ultimately create a safer MTA,” said Governor Cuomo. “A healthy workforce is crucial to the MTA’s success and, with the expansion of this successful program, we will continue to build a stronger transportation system and keep New York moving forward.”

“Addressing the dangerous risks of sleep apnea requires a blanket policy of both testing and treatment across the MTA,” said U.S. Senator Charles Schumer. “Today’s news that the MTA will soon implement this critical effort within the LIRR is the right move and the safest one. I’ve argued that it shouldn’t take a Long Island Rail Road crash for the MTA to institute NTSB recommendations and test LIRR engineers for sleep disorders. I’m glad the call to make this testing a priority was heeded. Time and again, the NTSB’s common-sense recommendations have taken far too long to enact, or were carried out in a piece-meal way. So, today’s news of real action by the MTA to address this dangerous situation should help commuters rest a little easier.”

Under the program, screenings for obstructive sleep apnea that have already been underway for Metro-North Railroad locomotive engineers will be expanded to Metro-North conductors, Long Island Rail Road train crew members, and be available to other MTA agencies.

Sleep apnea is a medical disorder in which breathing repeatedly stops and starts while a person is sleeping when the patient’s throat muscles intermittently relax and block his or her windpipe. This results in insufficient sleep. Left untreated, someone with the disorder functions with reduced alertness and may involuntarily fall asleep. Those who are at risk for sleep apnea will be referred to medical treatment that can ensure they can do their jobs safely.

The MTA issued a Request for Proposals today to seek a medical firm or firms to conduct the sleep apnea testing for MTA personnel. The proposal may be found by searching the New York State Contract Reporter (www.nyscr.ny.gov). Proposals are due within 30 days.

Metro-North began a pilot program in January 2015 through which 438 locomotive engineers and locomotive engineer trainees underwent an initial screening for obstructive sleep apnea by the Railroad’s Occupational Health Services Department. Medical personnel used body mass index, neck circumference, and other medical information to determine which employees were at risk for sleep apnea, and referred these employees for additional testing. Those referred for additional testing were given a take-home overnight sleep test administered by a medical firm that specializes in sleep disorders and was selected through an earlier Request for Proposals to participate with Metro-North for its pilot program.

Based on the results of the sleep test, some employees were required to undergo medical treatment for sleep apnea, which is generally treated through the use of masks that deliver continuous positive airway pressure, or oral devices that keep the airway open, either of which is worn at home during sleep.

Initiation of a sleep apnea screening program was a recommendation made by the National Transportation Safety Board in October 2014. The NTSB found that the derailment of a Metro-North Hudson Line train on December 1, 2013, occurred because the train’s engineer, who was later found to have had an undiagnosed case of severe obstructive sleep apnea, fell asleep while operating the train and therefore did not comply with a 30-mph speed restriction leading into a curve in the Spuyten Duyvil section of the Bronx.

MTA Chief Safety Officer David Mayer said: “Although it is not required by regulation, the MTA recognizes the safety benefits of sleep apnea screening and treatment. Our pilot program worked well at Metro-North Railroad, and because of this success we are looking forward to extending this safety program to employees elsewhere within the MTA.”

Employees will be screened regularly as part of their existing routine medical re-evaluations.

Webster Nicholas

From: Lim, Suzanne [redacted] >
Sent: Wednesday, March 22, 2017 7:25 PM
To: Webster Nicholas
Cc: Turpin Ted; Garcia Anne; Meilick, Kathy; Centauro, Mary Lou; Driscoll, Daniel; Ebbighausen, Loretta; Wishnuff, M.D., Dr. Mark; Yodice, Christopher; Crisci, John
Subject: RE: DCA17FR002 - LIRR Atlantic Terminal, Brooklyn, New York, January 04, 2017

Attachments: OHS Health Questionnaire Sleep Questions.docx; MTA Obstructive Sleep Apnea Screening and Referral Program 3 9 17 final.docx; OSA FAQ 3 9 17 final.docx

Dr. Webster,

Please see the attached documents that have been developed for the MTA OSA program. The screening for LIRR Locomotive Engineers will start on April 10, 2017 for those being seen by Occupational Health Services (OHS) clinical staff for periodic and return to work examinations.

- The screening criteria were originally developed as part of updated medical standards for New York City Transit by a contractor from New York University Hospital Center.
- Initial screening using the OHS Health Questionnaire Sleep Questions document (attached) and measurement of BMI and neck circumference will be done by OHS clinical staff who will decide which employees need to have further evaluation for sleep disorders. They will generally be allowed to continue working for 90-100 days during the initial evaluation/treatment process.
- The MTA now has contracts with four large network vendors who will be expediting provision of home sleep tests, evaluations by certified sleep specialists and provision of any further testing or prescribed equipment such as CPAP
- Employees will be able to choose a vendor who has specialists and sleep centers close to their home or work location
- Vendors will be issuing periodic reports to MTA OHS which include tracking compliance of employees for prompt return of home sleep study, delayed or missed appointments with sleep specialists and usage compliance reports for those needing treatment such as CPAP. Those who have reported issues will be contacted by agency management
- The sleep test results, sleep specialist evaluation and if applicable, usage compliance reports covering at least 30 days of treatment must be submitted to the LIRR OHS unit for review within 90 days of diagnosis. Those who are not compliant with the testing/evaluation process or treatment at that time will be taken out of active service and recalled to OHS. They will not be returned to any safety sensitive duties until satisfactory compliance is documented.
- Employees requiring treatment will need to provide at least another 60 days of compliance data after six months and thereafter at least 90 days annually in order to remain in service
- MTA OHS will be monitoring and tracking the results of all those who have been referred to the OSA screening program at LIRR and the other MTA agencies and reporting these to upper MTA and LIRR management.

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OHS Health Questionnaire - Sleep Screening

	Yes	No
1. In the past 5 years, has a spouse or bed partner commented that you snore?	____	____
2. In the past 5 years has a spouse or bed partner commented that you make noises such as gasping while sleeping?	____	____
3. In the past 5 years, has a spouse or bed partner commented that you stop or pause in your breathing while sleeping?	____	____
4. Have you ever been referred to a sleep specialist or had a sleep study (at home study or overnight study at a sleep lab)?	____	____
5. Do you use or have ever been prescribed to use any equipment (such as CPAP, BiPAP, APAP or oral device) while you sleep?	____	____
6. Have you felt sleepy during your scheduled work shift even after having at least four hours of rest?	____	____
7. Have you had any motor vehicle or other accidents or "near-misses" due to being sleepy during your scheduled work shift?	____	____

Epworth Sleepiness Scale:

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the **most appropriate number** for each situation:

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (such as a theatre or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Signature: _____ **Date: _____**

Print name: _____

FOR COMPLETION BY OHS STAFF

	Yes	No
1. Epworth Sleepiness Scale total score _____. Score of 11 or greater	____	____
2. Positive answer(s) to a sleep related question	____	____
3. BMI > 35 and neck circumference> 17" for males or >16" for females	____	____
4. BMI > 35 or neck circumference> 17" for males or >16" for females	____	____

plus any of the following:

- Loud snoring
- Observed apneas
- Diagnosed hypertension requiring medication
- Diagnosed diabetes or glucose intolerance

_____ Needs evaluation by sleep specialist

_____ Has previously diagnosed sleep disorder, must bring evidence of satisfactory treatment

_____ Does not need sleep specialist evaluation

Signature: _____ **Date: _____**

Print name: _____

Metropolitan Transportation Authority

MTA Obstructive Sleep Apnea (OSA) Screening and Referral Program

The MTA's Obstructive Sleep Apnea (OSA) screening program is one element in an overall effort to ensure operational safety and improve health and wellness among MTA employees. Alertness, along with healthy sleep management, is a major factor in our wellbeing and contributes to safety in the workplace. This document describes the process and protocols in place for addressing sleep disorders, in particular, Obstructive Sleep Apnea (OSA).

Screening of safety sensitive employees such as locomotive engineers and conductors has been strongly recommended by the National Transportation Safety Board and the Federal Railroad Administration. To facilitate this OSA screening program, the MTA has contracted with multiple vendors to assist employees in the diagnosis and treatment of OSA.

Initially, employees who are directly involved in train or bus movement will be screened for OSA risk factors. The screenings will eventually be expanded to include employees who operate heavy machinery or company vehicles, where there may be an impact on public safety. These screenings will be conducted by Occupational Health Services (OHS) physicians during their periodic medical evaluations, or when an employee comes for a revisit for conditions such as hypertension or diabetes, or during a Return to Work examination.

As the program develops and our overall wellness efforts evolve, additional employees will also be required to undergo this screening and possible testing and treatment for OSA.

Employment applicants for those safety sensitive titles who require pre-placement medical evaluations will also have to qualify using the same screening and compliance criteria.

Any employee having concerns for their own safety and wellness may voluntarily be screened for OSA risk factors through their personal physician and a referral to a sleep specialist or one of the all-agency contracts.

The key to a successful program requires honesty and mutual trust between the employee and employer. It is critical to identify as quickly as possible, those with obstructive sleep apnea and get them the treatment they need in order to support and sustain a healthy lifestyle.

MTA Obstructive Sleep Apnea (OSA) Screening and Referral Program

Screening

The following criteria/risk factors in conjunction with sound medical judgement will be utilized to refer employees for testing and evaluation:

The screening criteria are based on reviews of other Industry criteria and medical expert guidance. Parameters considered during this screening will be a review of medical history, results of a screening questionnaire and other physical criteria described below.

Screening Questionnaire

- Enhanced health questionnaire will include questions on inappropriate sleepiness during the day (or work shift), history of any motor vehicle crashes or near misses due to drowsiness AND
- Epworth Sleepiness Scale, a frequently used and well validated questionnaire. A score of 11 or greater would warrant additional evaluation
- The enhanced questionnaire is very similar to one currently used by the Metro-North Railroad program to screen their Locomotive Engineers

Physical criteria

- BMI>35 and neck circumference >17" for men or 16" for women OR
- BMI>35 OR neck circumference >17" for men or 16" for women plus any of the following:

  Loud snoring
  Observed apneas
  Diagnosed hypertension requiring medication
  Diagnosed diabetes or glucose intolerance

Referral Process

I. If an OHS representative, in their medical judgement, deems an employee is at risk for OSA, the employee will be referred to a MTA Sleep Medicine vendor for a take-home and/or laboratory sleep test. Before leaving OHS, the employee will receive a packet of material explaining the program and their responsibilities for testing and follow-up with a sleep physician; and the employee will fill out and sign any necessary forms and HIPAA releases.

II. OHS will provide a referral and relevant medical history to the vendor after the employee has been referred. All efforts will be made to schedule an employee with a vendor that serves their home or work location.

III. The employee will communicate with the vendor by telephone or e-mail within 48 hours of the referral by OHS.

IV. The employee has the responsibility to (1) take the sleep test on the date established, usually the night before a relief day or scheduled day off, (2) if given a home test, return the testing equipment to the vendor within 48 hours of taking the test using the provided packaging, and (3) scheduling and attending the appointment with the sleep specialist.

V. Any follow up visits would require the employee using his/her own sick leave time.

VI. An employee who is prescribed OSA therapy, will contact the vendor within 48 hours after the date of the appointment with the sleep specialist to begin the process of ordering any needed medical equipment, scheduling an appointment for fitting, etc., and/or keeping the vendor up-to-date concerning the next steps in his/her treatment.

VII. Durable Medical Equipment (DME) – replacement parts (e.g. tubing, filters, masks) for Positive Airway Pressure machines are available via prescription from the treating sleep specialist and through employee health insurance plans.

Medical Clearance and Compliance Monitoring

- Any safety-sensitive employee who is determined by OHS to need further evaluation must bring the results of the sleep specialist evaluation including test results and any treatment recommendations. In general, employees will be allowed to work during the evaluation process and given 90 days after diagnosis to provide satisfactory documentation of treatment compliance. However, applicants will need to demonstrate compliance before being hired.

- An employee in a safety-sensitive title with diagnosed moderate or severe OSA is required to show acceptable levels of compliance with the treatment recommended by their sleep specialist. There must be documented efficacy of the recommended method of treatment.

- Those using devices such as CPAP (continuous positive airway pressure) must provide reports of satisfactory compliance with use for at least 30 days. The revisits to monitor continued compliance are scheduled at least every six months.

- Employees with moderate or severe OSA who do not demonstrate satisfactory compliance with treatment within 90 days of diagnosis are restricted from performance of safety-sensitive duties.

Metropolitan Transportation Authority

MTA Obstructive Sleep Apnea Program
Frequently Asked Questions

What is Obstructive Sleep Apnea?

Obstructive sleep apnea (OSA) in adults occurs when a person's airway becomes partially or completely blocked many times during sleep. The result of this interrupted breathing pattern is severely fragmented sleep, as the individual must wake up enough to regain muscle control in the throat and to reopen the airway. This constant awakening means that people with apnea do not get sufficient or good quality sleep, resulting in sleepiness and/or fatigue. But, because OSA sufferers typically do not gain full consciousness when they wake after apnea episodes, they often do not know the cause of their sleepiness and/or fatigue. Along with sleepiness and/or fatigue, OSA can cause significant physiological and psychological distress. OSA is a treatable disorder and, with proper diagnosis and treatment, many people have complete resolution of their symptoms.

What are we doing about OSA?

We are beginning a program to screen and treat employees for a sleep disorder that can affect health and safety. The purpose of this document is to provide information that will help explain this program and answer questions that you might have.

Why are we doing this?

It's the right thing to do for the safety of our customers, employees and, the general public; and, it truly will be a life changer for those diagnosed and treated for OSA.

Sleep apnea can increase your risk of heart disease, stroke, and other ailments. Diagnosis and treatment can be a life saver.

What job titles are affected by this?

Right now, positions responsible for train and bus movement at the Railroads and TA. Others will include CDL operators. We will continue to review risk factors of OSA and the impact on safety. As we address positions of most concern, we will identify others. Do I have to participate?

If your agency has identified your job title for participation, then, yes, you must participate. We are also developing processes for a voluntary program for those job titles not immediately identified at your agency. This is a public safety issue, but the screening also benefits our employees. Sleep apnea can increase your risk of heart disease, stroke, and other ailments. Diagnosis and treatment can be a life saver.

How common is OSA?

OSA is fairly common and affects millions of Americans. Some sufferers may not be aware they have it.

MTA Obstructive Sleep Apnea Program
Frequently Asked Questions

What are the safety risks of OSA?

Many people with OSA are excessively sleepy. This can make it difficult to work, and can even lead to job loss. If you have OSA you might fall asleep while driving a car, watching television, reading, talking on the telephone, or even while eating a meal. People with OSA might not complain of sleepiness; they may just think that they are "slowing down" and getting more tired as they get older.

What are the health risks of OSA?

Studies suggest that having OSA raises the heart rate and increases blood pressure, placing stress on the heart. This may be because apneas frequently reduce blood oxygen levels, activating the branch of the nervous system responsible for increasing heart performance. In addition, levels of chemicals in the blood that cause inflammation and promote elevations in blood sugar rise. Such inflammation can damage the heart and blood vessels. Both hypertension and diabetes increase the risk for heart disease, and the likelihood of being diagnosed with one of these illnesses increases as a result of OSA.

Why are you characterizing this as a wellness program?

This is one aspect in an overall approach to wellness at the MTA. Treatment of OSA can benefit you in many ways. It is likely that employees being treated for OSA will likely have an easier time controlling diabetes and hypertension. Most people with OSA see increased energy levels and alertness. That increase in energy will make it easier to develop healthier lifestyles and even lose some necessary weight.

How is OSA diagnosed?

Screening is a two-step process. The first is to identity employees who are at risk. The condition is more common in men over 40 with a high body mass index (BMI), the ratio of weight to height. Chronic snoring, morning headaches, daytime fatigue and memory lapses are among the typical indicators.

Following the initial assessments, employees who are at risk for sleep apnea will be given a take-home test to monitor breathing and sleeping patterns. In some cases, employees will visit a sleep laboratory for a sleep study. The most common treatment includes wearing a breathing mask while sleeping.

How is OSA treated?

Positive airway pressure (PAP) is a treatment in which a small mask or nose tubes (also known as nasal pillows) are placed over the nose or nose and mouth and compressed air is blown into the lungs to keep the airway open. PAP therapy is the most common treatment for OSA and can be successful for most people.

Severity of obstructive sleep apnea (OSA) is often highly correlated with obesity. For people who are obese, major weight reduction can reduce the severity of OSA and, in some cases, eliminate OSA

altogether. Weight loss should be a priority for all who are overweight or obese and have OSA. Treatment with positive airway pressure may help you lose weight.

What happens if I am referred for a sleep study?

The MTA has contracted with 4 sleep vendors to assist with the logistics of obtaining a sleep study and working with a sleep specialist to determine your treatment plan, if needed. You will need to sign a medical release that allows the MTA to share relevant medical information with the sleep vendor and sleep specialist and allows them to provide the MTA OHS with testing and treatment information.

What happens if I am diagnosed with OSA?

You will need to follow up with a sleep specialist. The Vendors can assist you with finding someone in your network that can see you quickly. Once diagnosed, you will have 90 days to work with the vendor and OHS to come into compliance with a prescribed treatment plan. As long as you are working with OHS and the vendor and no other medical risk factors are involved, you will continue to work during that time.

What if I am a borderline case?

If you have a mild case of sleep apnea, the sleep specialist will work with you to determine if there are ways, like losing weight, to keep the OSA at that level or eliminate it completely. You will be monitored by OHS to ensure your risk factors, like weight and neck circumference. If those increase, you may be asked to repeat a sleep study to ensure your OSA has not worsened.

Will I be held out of service if I have OSA?

The intent of this program is to keep employees working. To do so, it is important to comply with the evaluation and/or treatment process with Occupational Health Services and the sleep vendors.

I think I might have OSA, should I wait for my periodic medical, or is there anything I can do now?

You should not wait. The sooner you get treatment, the better you will feel. There are options available to you. At this time, you could see your own physician, or you can contact one of the sleep vendors directly. (Note: we are trying to work out a process to allow employees to contact the vendors separately and have visits, tests and/or treatment billed through their insurance.)

Is this required by regulations?

No, not at this point, but the Federal Railroad Administration (FRA) has issued an advisory recommending that certain jobs regulated under the FRA, be screened and tested for OSA. The FRA advisory recommends that employees be withheld from service if diagnosed with OSA, but we have worked with them and educated them as to our approach to keep employees working so that we can treat them quicker and get them healthier. Guidelines established by the Federal Motor Carrier Safety Administration have also been used to inform the development of our program.

Attachment 6 - Medical Factual Report - DCA17FR002

From: Lim, Suzanne
To: Webster Nicholas
Cc: [redacted]
Subject: RE: DCA17FR002 - LIRR Atlantic Terminal, Brooklyn, New York, January 04, 2017 - Obstructive Sleep Apnea.
Date: Thursday, May 18, 2017 6:06:12 PM

Dr. Webster,

The OSA screening program actually began for the LIRR locomotive engineers on April 17, 2017. Screening is being performed when the engineers come to the Occupational Health Service for their FRA recertification testing.

As of this Monday, May 15, 2017 we have screened 34 engineers out of a total of 432 (7.9%). Eight (24%) have been referred for further testing/evaluation.. As I indicated in my previous response, these employees have up to 90 days after diagnosis to provide their test results, sleep specialist reports and proof of 30 days of compliance with any prescribed treatment so none of those referred have reached that deadline yet. One engineer admitted to having already been diagnosed with OSA about a year ago and has prescribed CPAP; he is supposed to provide a compliance report within the next two weeks.

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