

Integration of Occupational Health Services in the Federal Sector

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SUMMARY. Federal Occupational Health (FOH) is a federal sector model of the integration and collaboration of occupational health (OH) programs that includes on-site health clinics, and environmental health as well as EAP, work-life, and wellness/fitness programs. This article reviews several aspects of integration at various levels of this public health organization.

The broad objectives of occupational health programs are to promote, support, and provide a healthy and productive, highly functioning workforce to the employer. FOH staff has special expertise and knowledge related to federal procedures, regulations and agency culture, as well as the OH disciplines. With its mission to provide occupational health services to federal agencies and federal employees, FOH has the unique opportunity to provide integrated OH services, thereby providing a more comprehensive approach to the occupational health care of the individual employee, as well as a more comprehensive approach to the health and productivity efforts of the federal agencies.

Although we have made strides and engage in continuing efforts to promote integrated programs and care, a number of additional program enhancements are in discussion and/or in process. FOH is a unique entity

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and the largest provider of comprehensive OH services within the federal government. It has achieved some notable success with the integration of its services across various levels of the organization with different federal organizations. Efforts have been particularly successful in bringing a coordinated response to various crises and emergency situations. With increasing knowledge and data on the benefits of integration, FOH is working to reduce both internal and external organizational barriers to bring integration of services to their maximum potential. [Article copies available for a fee from *The Haworth Document Delivery Service: 1-800-HAWORTH*. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2005 by *The Haworth Press, Inc.* All rights reserved.]

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INTRODUCTION

Over the past few years, employee assistance program (EAP) and work-life researchers, program evaluators, and practitioners have published a number of articles and studies focusing on the integration of EAP and work-life programs, as well as EAP and wellness/health promotion programs (Herlihy, Attridge, Turner, 2002; Mulvihill, 2003; Erfurt, Foote, Heirich, 1992; Herlihy, 2002; Derr, Lindsay, 1999). Looking at the broader scope of occupational health (OH) programs that includes on-site health clinics, and environmental health as well as EAP, work-life, and wellness/fitness programs, provides an opportunity to analyze other models of integration. This article focuses on such a model in the federal sector, and reviews several aspects of integration at various levels of this public health organization.

The broad objectives of occupational health programs are to promote, support, and provide a healthy and productive, highly functioning workforce to the employer. Many employers offer a variety of occupational health programs, as well as employee benefits, in order to support that effort. Although it has been common practice to offer these programs for several decades, such programs may not be integrated either in evaluation of cost-benefit to the employer, in integration of care of the employee, or in administration of the occupational health programs within the organization. Offering integrated programs increases both the viability and the visibility of the individual programs and provides a

more comprehensive approach to health and productivity management for the employer.

There has been a recent explosion of research addressing the quantification of employer costs for employees' mental and physical problems and risks. The *Journal of Occupational and Environmental Medicine* recently devoted a supplemental issue to the effects of disease on workplace activity. The research moves us significantly forward in our scientific understanding of the monetary impact of health issues in the workplace. Health and productivity management (HPM) literature and research over the past several years provides a structure that allows for the cost benefit analysis of intervention programs that could address any of the occupational health arenas, or a combination of occupational health programs. Offering an integrated OH program gives employers a unique opportunity to implement the workplace-based components of HPM to improve employee quality of life while promoting the organization's business objectives.

FEDERAL OCCUPATIONAL HEALTH MODEL— AN ORGANIZATION OFFERING A FULL RANGE OF OCCUPATIONAL HEALTH SERVICES

The U.S. Department of Health and Human Services (DHHS) has been charged with promoting the health and wellness of U.S. citizens and is engaged in two special initiatives, the HealthierUS presidential initiative and Steps to a Healthier US. A component of DHHS, the National Institute for Occupational Safety and Health (NIOSH), is the federal agency responsible for conducting research and making recommendations for the prevention of work-related injury and illness, and has unveiled the Steps to a Healthier US Workforce initiative to encourage workplace safety and health programs throughout all U.S. businesses. FOH Service, a unit within DHHS' Program Support Center and a component of the U.S. Public Health Service, is the DHHS agency responsible for encouraging and supplying workplace health and wellness programs within federal agencies for federal employees. FOH's mission is to work in partnership with its customers, that is, other federal agencies, to deliver comprehensive occupational health solutions that improve the health, safety, and productivity of the federal workforce. FOH's catalogue includes a broad array of clinical, wellness/fitness, employee assistance program (EAP), work/life, and environmental health (EH) services.

FOH is a unique entity within the federal government in that it is a fully reimbursable entity and receives no appropriations from Congress. This means that FOH essentially must cover its operating costs solely through its revenues, and must act like an entrepreneurial business within the government. Other federal agencies “contract” with FOH through interagency agreements to provide occupational health services and consultations. Agencies pay FOH as they would any other public or private organization. FOH must compete with the private sector for this government business and has nearly sixty years of experience providing these services exclusively to federal agencies. FOH is the largest provider of occupational health and safety services to the federal government, serving 377 federal departments and agencies, reaching more than 1.5 million federal employees, and generating over \$150M in revenue in fiscal year 2004. FOH provides these services in major cities and towns all across the country as well as in some of the most remote corners of the United States and territories in the South Pacific. In addition, the organization’s EAP and work-life services are available to federal employees and their families stationed in more than 100 countries overseas. The support and services FOH provides enable agencies to promote health, wellness, and safe work environments for their employees as well as maintain compliance with Occupational Safety and Health Administration (OSHA) and other federally mandated standards.

Organizationally, FOH has three primary lines of service or divisions: clinical services, employee assistance (e.g., workplace behavioral health), and environmental health. A brief summary of the functions and services of each can be found in Appendix A.

Integration at the Organizational Level

Prior to 1996, like many federal agencies, FOH was organized regionally, providing occupational health services through teams consisting of employee assistance, environmental health, clinical and wellness/fitness professionals. Although this model promoted integration of the different occupational health services for federal agencies within the regions, generally consisting of three to six states, it was not conducive to implementing, managing, and evaluating programs for federal agencies on a nationwide scale. To meet growing customer demand for nationwide program consistency and administration, FOH restructured and organized by product line and service, resulting in the current divisions: employee assistance, environmental health, and clinical services. This structure has enabled FOH to deliver standardized services at standard-

ized prices across the country and was a key factor in its growth. Today, over two-thirds of its revenues are generated through national agreements with its customer agencies, with the remaining revenue derived through agreements with local, regional, or other agency components.

While organizing by product or service has had enormous benefits to FOH and its customers, avoiding the creation of silos between these units has been and continues to be a challenge. In order to address this, FOH has taken steps at several levels to reduce isolation and promote communication among lines of service. These include: formation of a standing advisory committee made up of representatives of each of the divisions to develop strategic planning, recommend policy changes, and review cross-service line issues; creation of a time-limited task force consisting of a large number of management and line staff from all segments of the agency to make recommendations on future organizational changes, focusing on integration and promotion of services; and interdisciplinary work groups designed to address specific needs, problems or issues. These interdisciplinary work groups have worked on such topics as HIPAA compliance, blood borne pathogen policy, guidelines for nurses on handling the inebriated employee, and an assessment tool for wellness/fitness coordinators to assist them in making appropriate referrals of clients to the EAP counselor. The decision to develop an integrated FOH-wide service tracking software system, enabling systematic tracking of accounts covering all lines of service, gives staff a concrete vehicle for the promotion of integrated agreements and care for our serviced agencies.

Also, FOH has maintained staff from each of the service lines in major regional cities. At these area offices, the employee assistance consultants, the nurse administrators, the environmental health managers, the wellness/fitness managers, and other FOH employees meet together regularly for staff meetings, hear updates about each other's projects, address local issues, and share ideas about how to further integrate programs to the benefit of the customer agency and its employees. This close physical proximity increases the frequency of both formal and informal "curbside consults," e.g., an EAP specialist consulting with a physician and a wellness/fitness specialist on an obesity management program. Staff from throughout FOH, from environmental health specialists and scientists, to physicians, nurses, psychologists, and social workers, are all available as resources on complex situations and on new program development and enhancement, both internally to each other as well as externally to our agency customers, providing enor-

mous depth and breadth to the program, unique to organizations both inside and outside the government.

Spectrum of Agencies Served

FOH provides services to an unusually wide spectrum of federal agencies and their respective employees. Each is unique and differs in culture, structure, mission, occupations, and locations, and include the Department of Defense, Homeland Security, Housing and Urban Development, the U.S. Postal Service, the Bureau of Prisons, Defense Commissary Agency, Internal Revenue Service and the Bureau of Engraving and Printing—to name but a few. Employees served by one or more of FOH's occupational health programs include scientific researchers, mail carriers, animal and plant inspectors, law enforcement and security officers, nuclear waste transporters, administrative and management personnel, commissary staff, internal revenue agents, military personnel, and many, many more job titles. This list shows that the agencies FOH serves and their employees have specialized needs with unique health risks, ranging from constant lifting of heavy objects, to the stresses of law enforcement and security work, to working in isolated locations, to employment in traditional office settings.

Integration for Customer Agencies: Barriers and Benefits

Like most other entities in the public and private sectors, the majority of FOH's federal agency customers do not have all OH-related services neatly bundled in one seamless department. Different people and/or different organizational entities often manage employee health, workers' compensation, safety, EAP, work/life, fitness, and environmental health, depending on the size of the company or agency. Such services are commonly divided among health and safety, human resources, employee benefits or medical departments, and usually have separate funding. The decentralized nature of oversight for these programs within many agencies may severely inhibit efforts to completely integrate many services. Maneuvering through bureaucratic entanglements of procurement and program authority within the public sector may be a bigger barrier than in the private sector, where there is significantly more flexibility and autonomy by companies to organize in ways that achieve maximum efficiency. However, administration and management of oc-

cupational health programs is often spread among different departments in the private sector as well.

Of the 377 federal agencies that contract with FOH for OH services, 46% purchase services from more than one product line, even though the same person may not manage them. The breakdown of percentage of customers by product area is as follows:

Clinical Only	160	(42%)
EAP Only	39	(10%)
EH Only	6	(2%)
Clinical and EAP	85	(23%)
Clinical and EH	35	(9%)
EH and EAP	3	(1%)
Clinical, EH and EAP	49	(13%)

With such a broad menu of services available to them, agencies have options to mix and match in an almost infinite variety of combinations. FOH has anecdotal confirmation from customers of the benefits to employers of having OH services provided by the same entity, including: centralized promotion, easier cross referrals between services, better handling of emergency situations, economies of scale resulting from reduced administrative efforts and improved contract efficiency, as well as increased employee health and productivity through coordinated, integrated health interventions.

Integration at the Point of Service— Clinical and EAP Services

With over 265 occupational health clinics, 35 wellness/fitness centers and 215 on-site counselors, there are many models and opportunities for integration. In some cases, nurses, employee assistance counselors, wellness/fitness coordinators, and other occupational health staff may be dedicated to and located at the same site within one agency. At some locations, FOH OH staff may serve employees from multiple agencies. However, because agencies may choose only one of FOH's offerings from our catalog of occupational health services, the EAP counselor may provide services to a different or overlapping set of clients than the occupational health nurse. Therefore, some models/sites are more conducive to integration of services than others.

We identified 16 sites where the occupational health nurse and the EAP counselor are co-located in the same office suite and took a closer

look at their interaction. Discussions with occupational health nurses, EAP counselors, and managers indicate that there are several perceived benefits to both employees and managers when the counselors and nurses share the same office suite. The most commonly cited was the added convenience and improved sense of confidentiality for employees seeking services, noting there may be less of a stigma associated with being seen going to a health unit where a counselor may be located vs. going to a designated EAP office. There also was a sense of better coordination of care and earlier detection of co-morbidities, such as stress and hypertension, smoking cessation and substance abuse, and chronic illness and depression, which theoretically would lead to better outcomes. However, there is no data yet to support these observations. Additionally, staff believed there were increased referrals and increased utilization of services, but again further collection and analysis of data would be necessary to confirm this.

Interestingly, feedback from staff was not uniformly positive from sites where counselors and health unit staff share space. Some noted specific negatives. For example, although an EAP client may feel less conspicuous going into a workplace health clinic, it could also be more likely that the client would be seen there by other employees who have come to an appointment with the nurse. Also, although a good relationship between the EAP counselor and the occupational health nurse can result in optimizing coordination of care, conversely, a poor working relationship due to space issues, misunderstandings about roles and responsibilities, or personality clashes could result in dissention that could be evident to clients, employees, and even agency management. Clearly, these can be significant challenges to achieving the full benefits of integration.

EVALUATION OF SERVICES

Customer Satisfaction

As a reimbursable agency that must compete for its business, FOH has become a customer-driven organization, measuring customer satisfaction for several years. Among several methods FOH employs to evaluate client satisfaction are surveys conducted at two levels: at the agency level from agency managers who purchase the services and at the end-user level from employees who actually receive counseling or health services. The agency manager satisfaction surveys are coordinated across divisions at the national level to eliminate redun-

dant questionnaires among common customers and improve data collection and comparison by utilizing the same questions. The end user level surveys, however, are conducted within the respective program area (e.g., EAP, clinical, environmental), tailoring questions unique to their services.

The clinical services end-user surveys measure satisfaction on a five-point scale on ten variables such as promptness, flexibility, professionalism, privacy and thoroughness and are offered to each client at the end of each encounter (e.g., walk-in care, examinations, immunizations, etc.). Data are collected in a central location and reported monthly to senior managers. Results have consistently indicated high levels of satisfaction on these variables for seven years, with average overall satisfaction rated 98% (4.9 out of 5) for the last three years. In a separate analysis of the most recent year's data, there were no significant differences on individual variables or on overall satisfaction of services with those sites where clinical and EAP staffs are co-located compared with the averages of all sites combined (Table 1).

EMPLOYEE ASSISTANCE PROGRAM CUSTOMER SATISFACTION SURVEY RESULTS

EAP end-user client satisfaction is obtained through several means, including a client satisfaction survey given to every user of EAP coun-

TABLE 1. Clinical Customer Satisfaction Survey Results: All Sites vs. Those Co-Located with EAP Services, 10/1/03-9/13/04

The following average scores are based on a 5-point scale, with 5 indicating the highest score.

Variable	All Sites n = 9628	Co-Located n = 895
Flexibility in scheduling	4.80	4.79
Prompt attention upon arrival	4.88	4.87
Courteousness of staff	4.93	4.94
Explanation of procedure	4.86	4.85
Thoroughness of service	4.90	4.88
Privacy/confidentiality of environment	4.81	4.81
Explanation of results/answer questions	4.88	4.84
Clarity on follow-up actions to take	4.86	4.88
Helpfulness of education/information	4.80	4.85
Overall helpfulness of our services	4.90	4.90

selling services. Questions cover many of the same criteria as the clinical survey: timeliness and accessibility of service, the provider's courtesy, knowledge and responsiveness, perceived benefits of the counseling, and overall satisfaction with the service received. Satisfaction ratings are historically in the 97% to 99% range. We have not yet had the opportunity to evaluate EAP client customer (end-user) satisfaction by co-location with health clinic. This would be useful data to compare against the health clinic end-user satisfaction data cited above.

SELECTED CLIENT OUTCOMES

Employee Assistance Program

Although we do not yet have client outcome data for all of our lines of service, over a period of three years, FOH staff collected and analyzed data from nearly 60,000 EAP clients who utilized their EAP services (Selvik, Stephenson, Plaza, Sugden, 2004).

FOH obtained information that measured six areas of functioning: (1) Productivity affected by mental health; (2) Productivity affected by physical health; (3) Work and social relationships; (4) General health status; (5) Absenteeism from work or tardiness; and (6) Global Assessment of Functioning (GAF). Both clients and their counselors contributed information about functioning and level of activity. EAP clients were asked to complete questionnaires before utilizing EAP services and upon completion of EAP counseling services, while counselors used the GAF scale, a diagnostic measure of psychosocial functioning. Based on the pre- and post-EAP questionnaires, FOH found that clients who used the EAP experienced significant improvements in all six areas of functioning.

The key findings of the study show that use of the EAP had the following effects, which strongly support the health and productivity benefits of the FOH EAP:

- Unplanned absences and tardiness from work decreased by an average of 1.5 days per EAP client.
- Counselors' clinical assessment of the clients' general psychosocial functioning (based on the GAF) rose an average of 10 percent.
- People reporting a great amount of difficulty accomplishing their daily work due to emotional problems (e.g., presenteeism) before

using the FOH EAP counseling services showed a 73% improvement in productivity after counseling.

- Persons reporting that their perception of their health status was fair or poor before using FOH EAP counseling services showed a 31% improvement in health perception after counseling.

Conducting a comparable end-user pre/post service survey is less meaningful in the health unit setting, since employees often use the health clinic for discrete services such as a blood pressure check. Such health and productivity data is better obtained through organization-wide health and productivity questionnaires.

Smoking Cessation

Although soon to be eclipsed by obesity, smoking is still the leading cause of preventable death and disability in the United States. It is estimated that annual U.S. deaths from tobacco-related causes exceeds 430,000 and costs to employers for medical treatment, early death and disability, lost work time, and decreased productivity are staggering.

In 2002, FOH inaugurated a smoking cessation (SC) program that provided participants an intake interview, a personalized, written quit plan, a four-week supply of nicotine replacement therapy (NRT) of patches, gum or lozenges and follow-up counseling, support, and problem-solving assistance. The programs are fully funded by the employing agency and the participant has no out-of-pocket expenses to enroll. Participants must simply agree to an intake interview and work with the interviewer to formulate a written quit plan. The intake interview covers smoking history and past quit attempts. Following the interview, the participant selects which NRT to use. Support from FOH after the interview varies by availability and interest on the part of the interviewer and the participant. There is no predetermined number of contacts the participant must make with FOH staff. Approximately 95% of participants enrolled in the SC program are served by face-to-face contact with an FOH nurse; the remainder are served by phone contact only.

Since its inception, FOH has enrolled approximately 6,000 employees and has helped over 1,000 federal employees stop smoking. Throughout this time, smoking cessation rates have remained steady between 17-18%, more than double the national average of 5-10% estimated by the Centers for Disease Control and Prevention (CDC) for unassisted individual cessation efforts. There is no significant difference found in

the cessation rates for the two contact methods (e.g., face-to-face or telephonic).

Stop smoking statistics are collected through phone calls and are self-reported. No biological testing to verify status is performed. To be qualified as a cessation, the participant must not be smoking cigarettes at all at 6 or more months from the initial start of the cessation effort. FOH attempts to contact all participants, but in excess of 20% of participants are lost to contact because they are seasonal or temporary employees. Failure to reach a participant is counted as an "unsuccessful" attempt. Although we gather statistics on those who reduce cigarette consumption, this group is also counted as "unsuccessful" for cessation statistics.

SPECIFIC EXAMPLES OF INTEGRATION EFFORTS

Smoking Cessation and EAP

In training interviewers for the SC program, FOH suggests that at least 50% of participants should be referred for voluntary EAP support to address co-morbidity factors such as alcohol abuse, poor stress coping skills, other substance abuse issues and various unaddressed mental health components identified during the interview process.

Because the majority of participants in the SC program work at locations where an EAP counselor is available onsite during the workweek, FOH has a good mechanism for feedback from these EAP counselors related to the numbers of voluntary referrals that actually contact EAP for follow-up. Unfortunately, over the past 3 years we have found that such self-referral simply does not happen. Of hundreds of suggested EAP referrals only a few have reported follow-up.

To better integrate EAP with smoking cessation, FOH is planning to pilot a proactive phone contact from an EAP counselor when the participant consents to such contact at the time of their intake interview. The rationale for this approach is that long-term success at smoking cessation is expected to be enhanced if co-morbid factors are appropriately addressed. Even if cessation rates are not affected, there are still potential significant benefits these individuals and their employers can reap from positive behavior changes related to these co-morbidities. Such EAP use also enhances EAP utilization, and increases the value-added benefit of the EAP to both the employee and employer.

Integration During Response to Crises

There have been many outstanding examples of coordination and integration of services in FOH across product lines in response to crises in recent years. The bombing of the Murrah Federal Building in Oklahoma City in 1995 and the attacks and collapse of the World Trade Center Towers on September 11, 2001, provided FOH an unfortunate opportunity to mobilize its substantial resources to meet the complex needs of the many federal agencies who were impacted by these disasters and/or involved in the subsequent clean-up efforts. In both cases, FOH provided health care, counseling and respiratory protection to employees of federal agencies that were responsible for emergency response and investigation, such as Federal Emergency Management Administration (FEMA), Federal Bureau of Investigation (FBI), and Alcohol, Tobacco and Firearms (ATF)—utilizing skills and expertise of each area of FOH. Medical monitoring and follow-up counseling are still being conducted today with many of these federal employees.

Similarly, during the anthrax exposures at the Capitol and U.S. Postal facilities later in 2001, FOH provided critical assistance in exposure assessment, testing, antibiotic prophylaxis, management consultation, and counseling to thousands of postal and other federal workers who risked severe illness and death. During the evolution of the crisis, FOH developed and distributed to federal agencies a series of timely fact sheets that integrated medical information on the disease, appropriate safety precautions to take within the mail handling systems, guidance to agency leaders on managing during a time of crisis, and ways to manage employees' stress and emotional reactions during and after the crisis.

NEXT STEPS—PROGRAM ENHANCEMENTS

FOH staff has special expertise and knowledge related to federal procedures, regulations and agency culture, as well as the OH disciplines. With its mission to provide occupational health services to federal agencies and federal employees, FOH has the unique opportunity to provide integrated OH services, thereby providing a more comprehensive approach to the occupational health care of the individual employee, as well as a more comprehensive approach to the health and productivity efforts of the federal agencies. Although we have made strides and engage in continuing efforts to promote integrated programs and care, a number of additional program enhancements are in discussion and/or in process, including:

- Creating broader cross-product knowledge within FOH staff
- Gathering additional data to assess care and program integration, such as:
 - cross-referrals between lines of service, e.g., clinical and EAP, clinical and EH, wellness/fitness and EAP;
 - outcomes and satisfaction related to co-location of direct service
- Increasing integrated programs: smoking cessation and EAP (facilitated referrals); Lighten Up (weight management)
- Offering integrated health and productivity management consultation and program services
- Developing consistent sets of client satisfaction and outcomes measures usable across lines of service
- Continue refinement of formal, integrated plans and methods of response to emergencies and disasters, such as hurricanes, floods and terrorist attacks.

CONCLUSIONS

FOH is a unique entity and the largest provider of comprehensive OH services within the federal government. It has achieved some notable success with the integration of its services across various levels of the organization with different federal organizations. Efforts have been particularly successful in bringing a coordinated response to various crises and emergency situations. With increasing knowledge and data on the benefits of integration, FOH is working to reduce both internal and external organizational barriers to bring integration of services to their maximum potential.

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APPENDIX A

Federal Occupational Health Lines of Service

Organizationally, FOH has three primary lines of service: the clinical services, the employee assistance program services (i.e., workplace behavioral health), and the environmental health services.

Clinical Services

Basic Occupational Health Center Services are provided through FOH's 265 Health Centers located in or near federal buildings throughout the United States. Services include but are not limited to:

- Emergency response/walk-in care and first aid
- Physician-prescribed services such as blood pressure and glucose monitoring, and allergy shots
- Immunizations
- Health and wellness seminars and programs on topics such as stress reduction; good nutrition and weight management; reducing cholesterol levels; breast, prostate, colorectal and skin cancer awareness, etc.
- On-line health risk appraisals
- Health screening for: High blood pressure, diabetes, vision, tuberculosis, hearing, glaucoma
- Individual health counseling
- Outreach programs

Wellness/Fitness Services including:

- Design and development of customized wellness and fitness programs
- Fitness assessments and pre-participation screenings
- Design and presentation of wellness/fitness seminars on such topics as weight management, nutrition, and stress management
- Promotion of wellness/fitness programs

Additional offerings include:

- smoking cessation
- automated external defibrillator (AED) programs
- workplace drug deterrence programs and MRO services
- injury prevention and disability management services
- a wide variety of exams including periodic health, medical surveillance, pre-placement, return-to-work and fitness for duty
- Development and review of medical standards for law enforcement agencies

Employee Assistance Program Services (Workplace Behavioral Health)

EAP services are generally provided on a per-capita basis. Face-to-face counseling services are provided by licensed, professional counselors located in more than 200 counseling offices in federal buildings across the country as well as through a vast network of affiliate counselors in approximately 14,000 locations across the country and overseas.

The employee assistance program offers a comprehensive work-life program for federal employees. The program provides services both online and telephonically by trained work-life counselors.

EAP services include:

- 24/7 service center
- EAP Website
- Employee and supervisor orientations
- Critical Incident Stress Management (CISM) Services
- Consultation to supervisor and managers
- Financial and legal services
- Educational/health and wellness seminars

The EAP has also developed a set of specialized programs including:

- Organizational Development (OD) Programs to help organizations and their employees develop business, organizational and behavioral strategies to adapt to the rapidly changing workplace.
- Law Enforcement Assistance Program to provide specialized services to members of the federal law enforcement community.
- Alternative Dispute Resolution (ADR) Services

Environmental Health Services

FOH's nationwide network of environmental health and industrial hygiene specialists provides environmental, health and safety consultations and services to help federal managers establish and maintain safe, healthy and productive work environments and to comply with OSHA and Environmental Protection Agency (EPA) regulatory compliance mandates. Services provided within this Division include but are not limited to:

- Indoor air and water quality assessments to investigate and evaluate situations where building occupants experience health problems that may be linked to air or water quality
- Hazard assessments to identify physical, chemical, radiological and biological stressors
- Asbestos detection, monitoring and abatement services
- Ergonomics—related to routine office settings (e.g., chairs, computer placement) as well as to a full scope of workplace activities (e.g., lifting, climbing)