Employee Wellness Programs: Guaranteeing Meaningful Results

Presented by:
Larry Chapman
June 13, 2017

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Employee Wellness Programs: Guaranteeing Meaningful Results

Presented by
Larry S. Chapman, MPH, CWWPC
President and CEO, Chapman Institute

Agenda

- Why Wellness is a business imperative for every employer
- How to define Wellness for your organization
- How to select the Wellness strategy that makes sense for your organization
- How to design your Wellness program so that it gets the results you want
- How to guarantee that your wellness program produces long term behavior change
- How to link your wellness program to other areas of your organization
- How to evaluate your wellness effort
- Some valuable and helpful wellness resources
FIRST UP

Why Wellness is a business imperative for every employer

Health Costs Remain a Challenge for U.S. Employers

* The actual cost increase for 2015 will be available later this year. **Projected
U.S. City Average of Annual Inflation (April to April) 1990-2015. Bureau of Labor Statistics. Seasonally Adjusted Data from the
EMPLOYERS MUST KNOW MORE ABOUT THE ECONOMICS OF WORKER HEALTH

Total = $37,106*

* = 2015 Dollars


AVERAGE PER EMPLOYEE COST IN THE U.S.: 2015

National Average
=$95,463 per year

Total Compensation 2015

59.3%

Salary & Wage Cost

22.1%

Non-Health Related Cost

18.7%

Health-Related Cost

THE “BOTTOM LINE” FOR ALL U.S. BUSINESS: 2015

U.S. Bureau of Labor Statistics and Collins, et.al., article on presenteeism costs applied to 2015 time period and dollars.

THE GLOBAL RELATIONSHIP OF HEALTH RISKS TO HEALTH COSTS

Source: World Economic Forum
NEXT UP

How to define Wellness for your organization

OUR DEFINITIONS

Wellness

“An intentional choice of a lifestyle characterized by personal responsibility, moderation, and maximum personal enhancement of physical, mental, and financial health.”

Worksite Wellness Program

“An organized program in the worksite that is intended to assist employees and their family members in making voluntary behavior changes that reduce their health and injury risks, improve their health consumer skills and enhance their individual wellness, productivity and well-being.”
THE “BIG 8” WELLNESS TARGETS

<table>
<thead>
<tr>
<th>Focus</th>
<th>Disease/Conditions</th>
<th>Possible Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Use</td>
<td>COPD, emphysema, bronchitis, lung cancer</td>
<td>Smoking cessation/policies</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Obesity, anxiety, sleep disorders, muscle pain</td>
<td>Walking program, fitness facility</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Obesity, deficiencies, eating disorders</td>
<td>Food choices, food demonstrations, education</td>
</tr>
<tr>
<td>Heart Health</td>
<td>Hypertension, hypercholesterolemia</td>
<td>Blood pressure testing, cholesterol testing</td>
</tr>
<tr>
<td>Weight Management</td>
<td>Overweight, obesity, diabetes type 2</td>
<td>Coaching, nutrition education, mentors</td>
</tr>
<tr>
<td>Stress</td>
<td>Anxiety, depression, sleep disorders, migranes</td>
<td>Stress management, Resilience education</td>
</tr>
<tr>
<td>Back Pain</td>
<td>Chronic pain syndrome, sciatic nerve pain</td>
<td>Conditioning, lifting techniques, ergonomics</td>
</tr>
<tr>
<td>Medical Self Care</td>
<td>URI’s, reflux, allergies, severe headaches</td>
<td>WebMD, e-Health portal, education, health advice line</td>
</tr>
</tbody>
</table>

MANY POSSIBLE ASPECTS TO WELLNESS

- Physical?
- Mental?
- Financial?
- Social justice?
- Environmental activism?
- Emotional?
- Social?
- Cultural?
- Intellectual?
- Professional?
- Spiritual?
- Worldview?

What you choose depends on your goals
NEXT UP

How to select the Wellness strategy that makes sense for your organization

MAJOR CONSIDERATIONS IN SELECTING YOUR WELLNESS STRATEGY

• Start with your Goals
  – Economic impact
  – Health improvement
  – Employee morale and satisfaction
  – Productivity enhancement
  – Retention and recruitment effects
• Work force needs
• Resource availability
• Program preferences
• Organizational will
Results-Driven Wellness

**Feel Good Wellness**
- Fun activity focus
- No risk reduction
- No high risk focus
- Not HCM oriented
- All voluntary
- Site-based only
- No personalization
- Minimal incentives
- No spouses served
- No evaluation

**Traditional Wellness**
- Mostly health focus
- Some risk reduction
- Little high risk focus
- Limited HCM oriented
- All voluntary
- Site-based only
- Weak personalization
- Modest incentives
- Few spouses served
- Weak evaluation

**Results-Driven Wellness**
- Add productivity
- Strong risk reduction
- Strong high risk focus
- Strong HCM oriented
- Some required activity
- Site and virtual both
- Strongly personal
- Major incentives
- Many spouses served
- Rigorous evaluation

**Main Features**

**Primary Focus**
- Morale-Oriented
- Activity-Oriented
- Results-Oriented

**CHOOSING YOUR WELLNESS STRATEGY**

**NEXT UP**

How to design your Wellness program so that it gets the results you want
DESIGN PROCESS FOR WELLNESS PROGRAMS

TYPICAL WELLNESS PROGRAM INTERVENTIONS

- Well-being assessments
- Wellness recommendations
- Preventive screening
- Lunch and learn sessions
- Wellness newsletter
- Walking programs
- Health fairs
- eHealth portals
- Health advice lines
- Online trackers
- Wearables
- Smoking cessation programs
- LMS module with quiz
- Weight management programs
- Flu shots
- Chair massage
- Wellness coaching
- Wellness incentives
- Food service improvements
- Aerobic exercise programs
- Stretching programs
- Fitness facility use
- Quiet space
- Recreation programs
- Cultural norm changes
- Wellness policies
SIX STEPS TO DESIGNING YOUR WELLNESS PROGRAM

Step #1: Scope the Program

Step #2: Plan Infrastructure
  • "Program" Infrastructure vs. "Administrative" Infrastructure

Step #3: Plan Communications

Step #4: Plan Health Management Process

Step #5: Plan Group Activities

Step #6: Plan Supportive Environment

NEXT UP

How to guarantee that your wellness program produces long term behavior change
MUST HAVE....

- Goal
- Objective
- Target behavior
- Intervention(s)
- Habit formation
- Metric
- Back to the beginning

FOUR KEYS TO AN EFFECTIVE WELLNESS PROGRAM

1. Ongoing methods for raising awareness
2. Ability to enhance motivation
3. Learn new skills associated with new behavior
4. Opportunity to practice those new behavioral skills

Source: Michael O’Donnell
NEXT UP

How to link your wellness program to other areas of your organization

LINKAGES

Policies

- Wellness as formal organizational value
- Wellness addressed in employee orientation
- Release/flex time for exercise
- Incentive rewards for wellness
- Wellness reimbursement
- Medical benefit coverage for prevention
- Use of CDHPs
- Performance appraisals
- Financial wellness orientation
- Other HR and benefit policies (25+)

Physical

- Onsite fitness facility
- Shower facilities
- Bike racks
- Walking trails
- Healthy food options
- Smoke-free
- Computer access to E-Health resources
- Health unit access
- Quiet space
- Training facilities
- Notices and messaging
- Cultural norms
- Recognition
- Managers participating
**NEXT UP**

How to evaluate your wellness effort

---

**FIRST, DETERMINE WHICH EVALUATION QUESTIONS YOU NEED TO ADDRESS**

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>FGW</th>
<th>TW</th>
<th>R-DW</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many people participated in the program?</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>How much did the program cost?</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Did the program meet its objectives?</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>How did the users like the program?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What improvements in individual health or risk factors occurred?</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>What positive effects did the program have on our organization?</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>What was the net economic effect (cost/benefit or ROI) of the program?</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>How should the program be changed for this next year?</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
THEN USE METRICS THAT MATCH THE EVALUATION QUESTIONS

Key Metrics
✓ Number of participants in each wellness activity
✓ Direct cost of the program
✓ Status of program objectives
✓ Percent of eligibles participating in each wellness activity
✓ Average participant satisfaction score
✓ Average percent health improvement in selected items from the HRA
✓ Average percent health improvement in selected items from screening
✓ Percent of eligibles meeting incentive requirements
✓ Total program cost savings
✓ Program’s C/B ratio or ROI

NEXT UP

Some valuable and helpful wellness resources
VALUABLE AND HELPFUL WELLNESS RESOURCES

- American Institute of Preventive Medicine, [https://healthylife.com/](https://healthylife.com/) (Materials & media)
- WellSteps, [https://www.wellsteps.com/](https://www.wellsteps.com/) (Challenge based programming)
- Shortlister, (Formerly Wellness Research Institute) [http://www.myshortlister.com/](http://www.myshortlister.com/) (Vendor selection)
- Community Prevention Services Task Force, [https://www.thecommunityguide.org/](https://www.thecommunityguide.org/) (Evidence-based policy-Organizational)
- Charles Duhigg, The Power of Habit, [https://www.youtube.com/watch?v=OMbsGB1pP30](https://www.youtube.com/watch?v=OMbsGB1pP30)
- Chapman Institute, [http://www.chapmaninstitute.com/](http://www.chapmaninstitute.com/), WellCert Program (Certification training – 4 levels)

WELLCERT SKILLS COVERED IN LEVEL 1 CWPC

<table>
<thead>
<tr>
<th>Skill #1</th>
<th>Skill #2</th>
<th>Skill #3</th>
<th>Skill #4</th>
<th>Skill #5</th>
<th>Skill #6</th>
</tr>
</thead>
<tbody>
<tr>
<td>How to build strong senior management support</td>
<td>How to assess your employees’ wellness needs</td>
<td>How to use a Health Risk Assessment (HRA)</td>
<td>How to set your wellness strategy</td>
<td>How to design your organizational infrastructure</td>
<td>How to design your technology infrastructure</td>
</tr>
<tr>
<td>Skill #7</td>
<td>Skill #8</td>
<td>Skill #9</td>
<td>Skill #10</td>
<td>Skill #11</td>
<td>Skill #12</td>
</tr>
<tr>
<td>How to design effective wellness communications</td>
<td>How to design your health management process</td>
<td>How to design group activities</td>
<td>How to create a supportive environment for wellness</td>
<td>How to design onsite programming</td>
<td>How to perform a simple evaluation of your program</td>
</tr>
</tbody>
</table>
RESOURCE MATERIALS


QUESTIONS?

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PLANNING WELLNESS:
Getting Off to a Good Start

By

Larry S. Chapman MPH

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PREFACE

In spite of the ongoing repeal and repair of the Patient Protection and Affordable Care Act (ACA) beginning in 2016, our problems with health care are likely to get worse. Even if the ACA had been fully implemented, increasing employer health care costs were likely continue to occur and pose a serious threat to the economic life of virtually all American employers. Behavioral and health risk issues of employees and their family members continue to loom large as a major reason for increasing health costs. For approximately 84% of the U.S. population, a strong link to an employer already exists. This and several other innate characteristics of the worksite itself, such as the amount of time people spend at work each week and the economic role of employers in the health of employees, make it an excellent place to conduct wellness programs. Wellness programs usually try to reduce the incidence and prevalence of illness and injury experienced by participants. In addition, employee wellness programs need to provide medical self-care skills and consumer health skills to employees if they want to bring about more efficient patterns of health care utilization. In these ways, wellness has a very significant potential contribution to make in helping stabilize national health care costs. The areas of risk factor reduction, medical self-care, and consumer health education generally falls under the rubric of health management and should be a central element in our efforts to improve population health.

Unfortunately, the vast majority of the very partisan rationale behind the ACA emphasized almost exclusively the supply side of the health care equation. Specifically, the “supply” side is the way in which doctors, hospitals, insurers, and payers interact, and how their relationships, economics and delivery of service roles are structured. Even with the prevention-oriented Title IV in the ACA, there is minimal emphasis on the “demand” side of the health care equation in the ACA. Wellness is one of the only platforms that can address the “demand” side. Business and government leaders are rapidly recognizing the need to improve the health and the productivity of employees to help stem the future rising tide of health benefit costs.

This publication is intended to offer the reader one comprehensive source that includes a very large number of practical insights to improve your planning and implementation of a cost-effective employee wellness program for your employees and their family members. This publication contains practical and time-tested advice on virtually every important aspect of wellness programming in the worksite. Most of the insights have come from work with more than 1,000 employee wellness programs in a wide variety of public and private employer settings as well as the results of well-designed research studies. These insights are organized around three different strategic program models for Worksite Wellness: a “Feel Good Wellness” (FGW) model of programming, the “Traditional Wellness” (TW) program model and a newer approach called the “Results-Driven Wellness” (R-DW) program model.

From our perspective at the Chapman Institute, it is our desire that the information, tools, and suggestions contained in this publication will help you plan and implement a successful Worksite Wellness program that is “right” for your organization. We hope you will use this publication to start an employee wellness program or to improve and upgrade a program you have already started.

Best wishes with your employee wellness endeavors!

Larry S. Chapman MPH  
President and CEO  
The Chapman Institute
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I. FUNDAMENTALS OF WORKSITE WELLNESS

A. What is “Wellness”?

To begin with, wellness has no standard or universally accepted definition of its overriding purpose or specific elements. Another term that is frequently used synonymously with “wellness” is “health promotion.” For our purposes, we will use these two terms interchangeably. Typically, the basic purpose of most employee worksite wellness programs is to improve the health and productivity of a particular working population or work group and reduce their health-related costs, primarily by helping change the pattern of lifestyle and behavioral choices of individuals in the group.

Almost universally, employee wellness programs are targeted on particular “health risk factors” that are modifiable and associated with particular kinds of illnesses and/or injuries. By changing the behaviors associated with “modifiable” risk factors, the chance of illness and/or injury (i.e., “morbidity”) is reduced for the individual, and as more individuals change their behavior, the morbidity for the entire group is reduced. This area of activity is also known as “Results-Driven Wellness,” or the intentional efforts that are used to help manage the need and demand for health care and the health-related productivity of working populations. For the major health concerns identified below, some typical modifiable “risk factors” targeted by most worksite wellness programs include:

| For Heart Disease       | • Cholesterol (total, LDH, and HDL amounts and ratios)  
|                        | • Cigarette smoking  
|                        | • High blood pressure  
|                        | • Uncontrolled high blood sugar or diabetic condition  
|                        | • Overweight and obesity  
|                        | • Lack of exercise or sedentary lifestyle patterns |
| For Automobile Accidents & Injuries | • Lack of use of seat belts or child restraints  
|                                      | • Speeding  
|                                      | • Drinking while driving  
|                                      | • Cigarette smoking  
|                                      | • Distance driven and defensive driving techniques used |
| For Pulmonary or Respiratory Diseases | • Cigarette smoking  
|                                       | • Occupational exposures  
|                                       | • Air pollution exposure  
|                                       | • Second-hand smoke exposure  
|                                       | • Recreational smoke or pollen exposure |
| For Selected Cancers | • Cigarette smoking  
|                        | • Obesity  
|                        | • Low fiber diet  
|                        | • High animal fat dietary intake  
|                        | • Lack of use of self-examination practices  
|                        | • Use of smokeless tobacco  
|                        | • Excessive alcohol consumption  
|                        | • Promiscuous sexual behavior |
Wellness programs typically begin by focusing on the reduction of health risks and then target issues that affect personal productivity, general well-being, Feel Good Wellness, personal growth, and other areas of interest.

| Wellness | “An intentional choice of a lifestyle characterized by personal responsibility, moderation, and maximum personal enhancement of physical, mental, emotional and spiritual health.” |

This definition of wellness is intended to highlight the concepts of appropriate levels of personal responsibility for one’s own health, pursuit of balance or moderation among various facets of life activity, the importance of a personal role in shaping one’s health, and the pursuit of individual efforts to be as healthy as possible as it applies to the areas of physical, mental, emotional, and spiritual health. This definition is intended to provide a broad framework for the integration of worksite-based health and wellness-related activities which are intended to enhance human functioning, performance, and the quality of life experienced by the individual. Next, let’s consider a practical definition for WHP or worksite wellness programs:

| Worksite Wellness Program | “An organized program in the worksite that is intended to assist employees and their family members (and/or retirees) in making voluntary behavior changes which reduce their health and injury risks, improve their health consumer skills and enhance their individual productivity and well-being.” |

This more streamlined definition of “worksite wellness” emphasizes the organized nature of the endeavor and its voluntary behavioral focus, and highlights the health risk and injury risk reduction or clinical focus of the program. In addition to targeting employees, it also targets the family members of employees (and/or retirees) while including health consumer issues and behaviors. Finally it identifies the enhancement of their functional productivity and their personal well being as an intended by-product of the program. Please consult the Glossary of Terms included in Appendix A for more information on these basic concepts.

On a practical level, the specific topics and issues addressed (such as weight management, back pain, resilience, cholesterol levels, etc.) by a worksite wellness program can vary greatly depending on the health and wellness issues which are relevant to a specific work group. Intentionally, the above definitions, in this more “global” form, can allow the choice of program components or elements that are unique to your population or sub-populations and that need to be address in your own worksite wellness program.

**B. What does a “typical” wellness program look like?**

When considering the specific topics or issues that should be addressed in your employee wellness program, it is often a good idea to first look at what other employers have done. Table 1 compares the results of four (4) national surveys of 730 to 1,600 employers with 50 or more employees from randomized stratified sampling regarding the types of topics addressed in worksite wellness programs. The percent figures in the table reflect the proportion of employers that addressed the various wellness topics.
In addition, the size of the employer will also have a lot to do with the breadth of topics and the complexity of the programs offered to employees. The smaller the employer, the more likely the program is more limited in its design and structure. The Office of Disease Prevention & Health Promotion (ODPHP) sponsored studies are very helpful in the sense that the employer respondents are broken out by the size of their employee work force and definite patterns emerge from the data. In general, smaller employers have more difficulty in offering menu-driven programs, which customarily provide several programming options for employees that wish to participate around a health issues such as tobacco cessation. Another clear pattern is that smaller employers tend to offer more programming that requires cost sharing with employee users. A third pattern is that smaller employers tend to offer programming that is provided by outside program vendors. For more specific information on the findings of the four studies and the conclusions from their analysis, readers are encouraged to contact the Government Printing Office or ODPHP directly for copies of the documents. There are several other surveys of regional businesses that have been published in the literature which may be helpful to you in your own locale. Some of these additional studies are as follows:


The choice of specific worksite wellness activities will include the consideration of what other area employers have done, what health risk factors or prevention targets are of concern for the groups involved, the interest patterns of the target group, and the objectives and resources of the program. First, let’s take a close look at the national employer survey data from the OHPDP surveys in Table 1:

<table>
<thead>
<tr>
<th>Type of Programs Offered</th>
<th>1985 Survey</th>
<th>1992 Survey</th>
<th>1999 Survey</th>
<th>2004 Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise/Physical Fitness</td>
<td>27%</td>
<td>41%</td>
<td>36%</td>
<td>20%</td>
</tr>
<tr>
<td>Smoking Control</td>
<td>36%</td>
<td>40%</td>
<td>34%</td>
<td>19%</td>
</tr>
<tr>
<td>Stress Management</td>
<td>27%</td>
<td>37%</td>
<td>35%</td>
<td>25%</td>
</tr>
<tr>
<td>Back Care</td>
<td>29%</td>
<td>32%</td>
<td>53%</td>
<td>45%</td>
</tr>
<tr>
<td>Nutrition</td>
<td>17%</td>
<td>31%</td>
<td>23%</td>
<td>23%</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>16%</td>
<td>29%</td>
<td>7%</td>
<td>36%</td>
</tr>
<tr>
<td>Weight Management</td>
<td>15%</td>
<td>24%</td>
<td>15%</td>
<td>21%</td>
</tr>
<tr>
<td>Off-the-job Accidents</td>
<td>20%</td>
<td>18%</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Job Hazards/Injury Prevention</td>
<td>na</td>
<td>64%</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>na</td>
<td>36%</td>
<td>28%</td>
<td>na</td>
</tr>
<tr>
<td>HIV/AIDS Education</td>
<td>na</td>
<td>28%</td>
<td>25%</td>
<td>15%</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>na</td>
<td>27%</td>
<td>23%</td>
<td>20%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>na</td>
<td>25%</td>
<td>12%</td>
<td>na</td>
</tr>
<tr>
<td>Cancer Detection/Prevention</td>
<td>na</td>
<td>23%</td>
<td>4%</td>
<td>22%</td>
</tr>
<tr>
<td>Medical Self-Care/CHE</td>
<td>na</td>
<td>18%</td>
<td>14%</td>
<td>22%</td>
</tr>
<tr>
<td>STDs (Sexually Transmitted Dis)</td>
<td>na</td>
<td>10%</td>
<td>25%</td>
<td>na</td>
</tr>
<tr>
<td>Prenatal Education</td>
<td>na</td>
<td>9%</td>
<td>12%</td>
<td>19%</td>
</tr>
<tr>
<td>Employer Participants</td>
<td>N=1358</td>
<td>N=1507</td>
<td>N=1544</td>
<td>N = 730</td>
</tr>
</tbody>
</table>

---

Table 1  Summary of Types of Wellness Programs Offered by U.S. Employers

From Table 1 you can see some of the trends over the past thirty (30) years regarding the types of worksite health promotion programs offered by employers. The size of the four sample populations are nearly identical, and with randomization, provide a good basis for assessing national trends in worksite health promotion or wellness programs. The data shows that the areas that have evidenced the most consistent emphasis by employers are: Exercise/Physical Fitness, Smoking Control, Stress Management, Back Care, Nutrition, High Blood Pressure, and Weight Management.

The “Top Ten” most prevalent programs in descending order in 2004 were back care (at 45%), high blood pressure screening (at 36%), stress management (at 25%), nutrition (at 23%), cancer detection/prevention (at 22%), medical self-care (at 22%), weight management (at 21%), Exercise/physical activity (at 20%), and cholesterol control (at 20%). However, based on these findings and comparable results from other more recent, but limited surveys done by other researchers, it is recommended that the following “core” topics should be addressed to some extent in virtually all employee health promotion or worksite wellness programs:

The “Top Ten”

- Back care
- High blood pressure screening
- Stress Management
- Nutrition
- Cancer detection/prevention
- Medical self care
- Weight management
- Exercise/physical activity
- Cholesterol control

Additional program areas that are recommended for inclusion in a worksite wellness program, reflecting more recent trends, that fit very well with the “top ten” include:

- Health Risk Assessment (HRA)
- Consumer Health Education
- Selected Biometrics Testing
- Injury Prevention
- Men’s and Women’s Health

These fifteen (15) areas of wellness programming should constitute the “core” of most employee wellness programs, and by implication, directly reflect the definition of wellness provided above. Not all fifteen areas must be addressed at the same time, but they should probably at minimum be considered and potentially be addressed over a two to three year program cycle. These topics or prevention “targets” also have a great deal of inherent synergy. For example, physical activity programming has been shown to have collateral beneficial effects on: weight management, tobacco use, nutritional practices, back pain, stress management and blood pressure. Any program that offers a mix of interventions in these areas will naturally benefit from their natural synergy. A comprehensive bibliography of articles on worksite wellness is provided in Appendix B.
C. What are “unhealthy lifestyle choices”?

When considering the primary behavioral or prevention “targets” or “unhealthy lifestyle choices” that are frequently the focus of WHP or worksite wellness programs, it is fairly easy to come up with a long list of specific items. All the behavioral choices involved are, by definition, under the voluntary control of the individual. Some of the major behavioral choices frequently targeted by employee wellness programs are presented in Figure 1.

From several recent sources, many of the unhealthy behavioral choices contained in Figure 1 are increasing in their prevalence in the U.S. population. The National Health Survey conducted by the National Center for Health Statistics, the CDC Behavioral Risk Factor Surveillance program and a variety of smaller population-based surveys are reflecting overall erosion in a variety of the health behaviors and consequently an increase in many of the unhealthy behaviors identified in Figure 1 below.

The increasing chronic disease burden of most populations is being reflected in population surveys and claims data from major health insurers. The higher prevalence of major health risk factors, such as obesity and inactivity, are of serious concern for the U.S. as well as many of its major trading partners.

<table>
<thead>
<tr>
<th>Behavioral Targets of Wellness Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>High saturated fat diets</td>
</tr>
<tr>
<td>Undetected high blood pressure</td>
</tr>
<tr>
<td>Binge alcohol consumption</td>
</tr>
<tr>
<td>Low dietary fiber intake</td>
</tr>
<tr>
<td>Obesity</td>
</tr>
<tr>
<td>Smokeless tobacco use</td>
</tr>
<tr>
<td>Excessive caffeine use</td>
</tr>
<tr>
<td>High-risk recreational activities</td>
</tr>
<tr>
<td>Lack of periodic screening</td>
</tr>
<tr>
<td>Lack of supportive relationships</td>
</tr>
<tr>
<td>Little physical exercise</td>
</tr>
<tr>
<td>Undetected high cholesterol level</td>
</tr>
<tr>
<td>Use of illegal drugs</td>
</tr>
<tr>
<td>Carelessness</td>
</tr>
<tr>
<td>Smoking</td>
</tr>
<tr>
<td>Excessive sun exposure</td>
</tr>
<tr>
<td>Lack of seat belt use</td>
</tr>
<tr>
<td>Lack of stress reduction activities</td>
</tr>
<tr>
<td>Inappropriate health care use</td>
</tr>
<tr>
<td>Inadequate sleep or rest</td>
</tr>
<tr>
<td>Risky sexual practices</td>
</tr>
<tr>
<td>Passive health consumer behavior</td>
</tr>
<tr>
<td>Unsafe home practices</td>
</tr>
<tr>
<td>OTC* medication abuse</td>
</tr>
<tr>
<td>Unaddressed depression</td>
</tr>
<tr>
<td>Irresponsible purchasing</td>
</tr>
<tr>
<td>Obsessive dieting</td>
</tr>
<tr>
<td>Undetected high blood sugar</td>
</tr>
</tbody>
</table>

*over the counter

Figure 1  Behavioral Targets of Worksite Wellness Programs

The long-term implications of some of these trends are not favorable, particularly with the aging of the “baby boom” generation and the growing evidence for the association between health risks and health costs. Behavioral targets of worksite wellness programs come in many shapes and sizes. In an effort to translate the general concept of health risk management into much more tangible considerations, Table 2 contains many of the potential behavioral “targets” that worksite wellness
programs frequently address and the increased cost associated with that particular health risk from a variety of studies.

It is important to remember that the unhealthy behavioral choices reflected here are usually the product of habit, cultural norms, marketing pressures, time, ignorance, or circumstance and therefore are appropriate targets for an employee wellness program. Program goals and objectives can be formulated around these risk factors and their related behaviors and can also be used to help evaluate the program’s effectiveness. It is also very appropriate to remember what a great American sage once said about the difficulty of changing these health habits:

“Habit is habit and not to be flung out of the window by any man, but coaxed downstairs a step at a time.”

- Mark Twain

Because of the critical importance of understanding the relationship between selected health risks and associated excess health costs, Table 2 contains summary information from six major studies that have attempted to determine the actuarial relationship between selected health risks and related health cost experience. The six studies are identified in the footnotes. The data contained in the table is the average percent difference between an individual with low risk level versus an individual with a high-risk level for the identified risk factors. The last column in the table provides a weighted average of the applicable studies and presumably represents the most valid composite reference point currently available on the quantitative relationship between health risks and health costs. All numbers associated with individual risk factors are the percent greater difference in per capita annual health costs between the low risk group and the high risk group. Negative numbers indicate an inverse relationship. (e.g. individuals with the high risk have lower health care costs)

This health risk versus health cost relationship also takes on increased significance because one of the most often cited major reasons that businesses conduct employee wellness programs is to help reduce employee health care costs. The literature also affirms that health risks and the aging process work synergistically in a direct way, as powerful predictors of increased health care use and cost. As a population ages and becomes less healthy, it is likely to use four to seven times the amount of health care a younger, and generally healthier, population will customarily utilize.

<table>
<thead>
<tr>
<th>Item</th>
<th>Study</th>
<th>Yen²</th>
<th>Brink⁶</th>
<th>Anderson⁷</th>
<th>Bertera⁸</th>
<th>Leigh⁹</th>
<th>Goetzel¹⁰</th>
<th>Weighted Average¹¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td></td>
<td>51.9</td>
<td>18.4</td>
<td>31.2</td>
<td>31.8</td>
<td>42.8</td>
<td>20.7</td>
<td>22.4</td>
</tr>
<tr>
<td>Alcohol use</td>
<td></td>
<td>83.1</td>
<td>-8.5</td>
<td>-11.8</td>
<td>12.0</td>
<td>113.1</td>
<td>-7.2</td>
<td>7.5</td>
</tr>
<tr>
<td>Obesity</td>
<td></td>
<td>38.0</td>
<td>11.0</td>
<td>37.3</td>
<td>12.7</td>
<td>53.0</td>
<td>21.4</td>
<td>11.0</td>
</tr>
<tr>
<td>Exercise</td>
<td></td>
<td>81.7</td>
<td>13.9</td>
<td>8.3</td>
<td>4.0</td>
<td>77.7</td>
<td>10.4</td>
<td>6.3</td>
</tr>
<tr>
<td>Seat belts</td>
<td></td>
<td>34.4</td>
<td>12.7</td>
<td>9.5</td>
<td>8.4</td>
<td>233.4</td>
<td>na</td>
<td>7.7</td>
</tr>
</tbody>
</table>

¹¹ The “weighted average” is based on the relative magnitude of life years in each of the six studies. In other words, the larger the study, the more weight given to it in proportion to the total life years in all the studies.
<table>
<thead>
<tr>
<th></th>
<th>29.2</th>
<th>2.2</th>
<th>0.0</th>
<th>11.5</th>
<th>na</th>
<th>-3.6</th>
<th>7.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholesterol</td>
<td>10.5</td>
<td>11.3</td>
<td>7.3</td>
<td>10.5</td>
<td>na</td>
<td>12.1</td>
<td>7.6</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>80.4</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>1.1</td>
</tr>
<tr>
<td>Drugs &amp; medications</td>
<td>52.8</td>
<td>na</td>
<td>24.4</td>
<td>na</td>
<td>na</td>
<td>46.3</td>
<td>38.9</td>
</tr>
<tr>
<td>Stress</td>
<td>52.8</td>
<td>na</td>
<td>24.4</td>
<td>na</td>
<td>na</td>
<td>46.3</td>
<td>38.9</td>
</tr>
<tr>
<td>Eating habits</td>
<td>na</td>
<td>na</td>
<td>40.5</td>
<td>na</td>
<td>na</td>
<td>-8.2</td>
<td>16.2</td>
</tr>
<tr>
<td>Life years in study</td>
<td>5,514</td>
<td>40,000+</td>
<td>6,000+</td>
<td>229,880</td>
<td>1,558</td>
<td>113,963</td>
<td>396,915</td>
</tr>
<tr>
<td>Proportion of total life years</td>
<td>0.014</td>
<td>0.103</td>
<td>0.015</td>
<td>0.579</td>
<td>0.004</td>
<td>0.287</td>
<td>1.00</td>
</tr>
<tr>
<td>Years of Study</td>
<td>3</td>
<td>3</td>
<td>1-3</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>18</td>
</tr>
</tbody>
</table>

**Table 2  Summary of Study Results on the Relationship of Health Risks to Health Costs**

Some of the key issues affecting the interpretation of the data in this table are as follows:

- Due to the high degree of “skewness” in health claims costs across populations, it is necessary to study large actuarial “credible” populations over long periods of time.
- The larger the study population and the longer the time period, the less the variability due to small population effects and consequently the more valid the findings.
- When studies use multiple regression techniques to examine interaction between multiple variables the results can be considered more valid.
- Some differences exist in the methodology used in the various studies to determine individual risk and time periods for measuring health costs.
- These findings all factor individual risk differences, but they do not address the issue of the synergistic impact of multiple risk factors in the same individual. (with the exception of the Goetzel study.)
- Health risk status is dynamic, and changes in an individual’s risk status during the study period are likely to provide some distortion in the results.
- Only one major study (Yen) has demonstrated that those with low risk who stay low risk over time have lower health costs while those with low risk who become high risk have high health costs; the opposite situation with high risk to low also has been documented.
- The significant differential in average per capita health costs attributable to health risks is likely to become more critical in the management of population health costs over time.

In order to put some additional perspective on these various behavioral choices, it would be useful to look at some general norms for the prevalence of many of these various factors for the average American workforce. Relatively good data exists for some of the items, while other items have weaker validity. An estimated range of prevalence for each behavior is identified below and reflects the potential range to be found in a defined work group independent of industry categorization. The data with an asterisk reflects an estimate for the 2010 time period:

<table>
<thead>
<tr>
<th>Unhealthy Lifestyle Choice</th>
<th>Percent-at-risk Range</th>
<th>Partial Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>High saturated fat diets</td>
<td>45% -69%</td>
<td>Prevention Index</td>
</tr>
<tr>
<td>Undetected high blood pressure</td>
<td>13% -29%</td>
<td>NHL&amp;BI, NIH</td>
</tr>
<tr>
<td>Excess consumption of alcohol</td>
<td>8% - 18%</td>
<td>Health: US 2009</td>
</tr>
<tr>
<td>Low dietary fiber intake</td>
<td>41% - 69%</td>
<td>Prevention Index</td>
</tr>
<tr>
<td>Obesity or excess % body fat</td>
<td>39% - 76%</td>
<td>Health: US 2009</td>
</tr>
<tr>
<td>Smokeless tobacco use</td>
<td>3% - 16%</td>
<td>Chapman Institute</td>
</tr>
<tr>
<td>Excessive caffeine use</td>
<td>17% - 29%</td>
<td>Chapman Institute</td>
</tr>
<tr>
<td>High risk recreational activities</td>
<td>14% - 21%</td>
<td>Chapman Institute</td>
</tr>
</tbody>
</table>
Lack of periodic screening 34% - 76%
Lack of supportive relationships 21% - 47%
Little physical exercise 57% - 92%
Undetected high cholesterol 28% - 58%
Use of illegal drugs 11% - 16%
Carelessness 27% - 52%
Smoking 18% - 39%
Excessive sun exposure 14% - 34%
Lack of seat belt use 9% - 46%
Lack of stress reduction 32% - 68%
Inadequate sleep or rest 12% - 44%
Risky sexual practices 9% - 37%
Passive health consumer behavior 68% - 83%
Unsafe home practices 36% - 74%
Over the counter medication abuse 8% - 34%
Unaddressed depression 7% - 18%
Irresponsible health care purchasing 21% - 36%
Obsessive dieting 7% - 13%
Undetected high blood sugar 13% - 23%

Note: The first number in the percentage column is the number from the source identified, except for the “lack of seat belt use” item. The second number in each range of percentages is the highest number the author has found with specific work groups.

References

✔ National Center for Health Statistics, USPHS, Health: United States 2009, DHHS publication (PHS)
✔ Chapman Institute, Lake Forest Park, WA

D. What is the total cost of unhealthy lifestyle choices?

The cost of potentially preventable illness and injury, which results from unhealthy lifestyle choices, is enormous. Based on the following adjusted national figures for 2010, the magnitude of the economic problem of potentially preventable conditions can be seen. Figure 2 contains an estimate of what the national annual total costs were in the base year and then these were adjusted for 2010 by using the national Consumer Price Index (CPI). Consequently, the estimated per employee annual costs for a number of major modifiable health problems are clearly a very significant societal economic cost.

No rigorous scientific approach or standard methodology has been developed to make these macro-level economic projections of cost, but we believe these adjusted and updated numbers are reasonable efforts to reflect the overall societal magnitude of these unhealthy behavioral choices, as well as how they affect our nation’s overall productivity. The original source of each condition estimates direct and indirect costs in a variety of ways. Because of the difficulties of accurately estimating the indirect costs (such as job productivity loss, waste rates due to errors, liability because of impaired judgment, worker replacement costs, administrative time requirements, and others), national estimates for specific conditions by different sources are likely to vary tremendously. Earlier estimates have been adjusted by using the Consumer Price Index percentages to develop estimates for 2015.
### Estimated Societal Cost of Selected Health Problems: 2015

<table>
<thead>
<tr>
<th>Health Problem / Condition</th>
<th>Annual Cost *</th>
<th>Per Employee Annual Cost **</th>
<th>Original Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>$412.0</td>
<td>$2,715</td>
<td>National Heart Lung &amp; Blood Institute, NIH, AHA</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>$351.1</td>
<td>$2,217</td>
<td>National Institute of Alcoholism &amp; Alcohol Abuse</td>
</tr>
<tr>
<td>Back Pain</td>
<td>$68.8</td>
<td>$522</td>
<td>National Safety Council</td>
</tr>
<tr>
<td>Lung Disease</td>
<td>$103.1</td>
<td>$752</td>
<td>National Heart Lung &amp; Blood Institute</td>
</tr>
<tr>
<td>Cancer</td>
<td>$143.8</td>
<td>$841</td>
<td>American Cancer Society</td>
</tr>
<tr>
<td>Work Injuries</td>
<td>$117.2</td>
<td>$789</td>
<td>National Safety Council</td>
</tr>
<tr>
<td><strong>Partial Totals</strong></td>
<td><strong>$1,022.5</strong></td>
<td><strong>$7,836</strong></td>
<td></td>
</tr>
</tbody>
</table>

* In billions of dollars per year.
** Based on annual cost in dollars per employee per year for a total U.S. labor force of 131,729,000.
The adjusted figures are based on an extrapolation of the estimates of the identified organizations increased by an estimated 7.6% annual non-compounded growth rate since the year of each of the original estimates. This is the average rate of growth in the medical care component of the Consumer Price Index during this period of time. The cost estimates include direct medical care costs, as well as other types of direct and indirect costs associated with each.

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**Figure 2  Cost of Selected Preventable Health Problems to Employers**

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### E. Who foots the bill for unhealthy lifestyle choices?

The direct medical care expenditure costs of unhealthy lifestyle choices on a national basis are born somewhat equally between the individual, business and insurance, and the government. Medicare and Medicaid are the final payer for a major portion of these costs associated with unhealthy lifestyle choices. However, the age and gender of the individual involved, their employment status, and the nature of health benefit coverage largely determines who pays for the direct medical expenditures associated with an unhealthy lifestyle for those of working age, such as those additional costs that were reflected in **Table 2** and **Figure 2**. For direct medical care expenditure costs, the major payers are as follows:

| Source: Health Care Financing Administration, Office of the Actuary, National Health Expenditures for 2015. |
The other non-medical care costs are frequently passed on to ultimate purchasers of goods and services in the form of higher prices or to taxpayers in the form of increased taxes. In virtually all cases, working Americans are absorbing the largest proportion of increased costs of unhealthy lifestyle choices because they either defer compensation in the form of health benefits or pay the taxes that subsidize public medical beneficiaries.

Even with this distribution of direct costs among categories of payers, there are a large number of other direct and indirect costs which are absorbed by individuals, insurance companies, employers, consumers of goods and services, and community/governmental entities. The estimates of a portion of these costs identified above are only a very limited estimate of the magnitude of costs related to these potentially preventable health problems. Some additional discussion about these costs follows.

1. Health-Related Costs of Unhealthy Lifestyles

There are a large number of health-related costs associated with an employee work force. Very few employers collect detailed cost information that reflects the true costs associated with worker health as a routine part of an employer’s financial picture. These costs are seldom viewed collectively or related to the health status of an employee work force, but they are one of the major labor-related cost elements associated with the operation of a business or public organization. Labor costs typically represent 60% to 70% of total annual operating costs for most organizations. Health related costs typically represent 11% to 17% of those costs. The ability to fully identify and enumerate the health-related costs associated with a particular work force is vital in gaining the support of senior managers to fund and mandate employee health enhancement efforts. This usually involves identifying the per employee per year costs for health benefit coverage, sick leave absenteeism, workers’ compensation costs, disability insurance costs and presenteeism costs (“presenteeism” is the economic value of lost productivity when an employee stays at work, but has an underlying health problem, such as a cold, migraine headaches, allergies, etc.). Usually there is little understanding by senior managers of the significance of the costs of doing business that are associated with the health status and health care use of employees, dependents, and retirees. One recent estimate placed the annual per employee cost as just under $35,000.

The importance of employee wellness interventions is usually driven home once the total of all health-related costs are compared to after-tax profits for profit-making companies or to net operating revenue for organizations in the public or non-profit sector.

With the increasingly competitive environment for funding human resource programs and activities, particularly in recessionary times, it is critical that employee health enhancement activities be linked to tangible contributions to the organization’s mission. If that mission is making a profit, then programs need to contribute to that goal in a meaningful way. If the organizational mission is not making a profit, but is instead providing service to customers, then a tangible improvement in service capability from on-going programs is required. Health-related costs are a clear starting point for linking employee health programs to the organizational mission and organizational purpose for private and public entities. The following are a series of health-related costs associated with most employer organizations. A series of descriptions of these costs follow and are important for employers to consider in order for employee health management efforts to be seen as a strategic business imperative and consequently allocated appropriate levels of resources and management attention. For each type of cost, some alternative sources of information are also identified.
List of Health-Related Employee Costs

<table>
<thead>
<tr>
<th>Primary Health Costs</th>
<th>Secondary Health Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Health Benefit Costs</td>
<td>● FASB 106</td>
</tr>
<tr>
<td>o Group health plan(s)</td>
<td>● Dread disease coverage</td>
</tr>
<tr>
<td>o Dental plan</td>
<td>● Eldercare support</td>
</tr>
<tr>
<td>o Vision plan</td>
<td>● Early medical retirement</td>
</tr>
<tr>
<td>o Prescription drug plan</td>
<td>● Medicare surcharge</td>
</tr>
<tr>
<td>o HSA contributions</td>
<td>● FASB 112</td>
</tr>
<tr>
<td>o COBRA payments</td>
<td>● FMLA costs</td>
</tr>
<tr>
<td>● Workers’ comp costs</td>
<td>● Retiree supplements</td>
</tr>
<tr>
<td>● Sick leave costs</td>
<td>● EE contributions</td>
</tr>
<tr>
<td>● Short term disability costs</td>
<td>● EE out-of-pocket costs</td>
</tr>
<tr>
<td>● Long term disability costs</td>
<td>● State premium taxes</td>
</tr>
<tr>
<td>● Life insurance and AD&amp;D costs</td>
<td>● Flexible spending accounts</td>
</tr>
<tr>
<td>● Presenteeism costs</td>
<td>● Consumer driven health plan costs</td>
</tr>
<tr>
<td></td>
<td>● Wellness reimbursement costs</td>
</tr>
<tr>
<td></td>
<td>● Employee health service costs</td>
</tr>
</tbody>
</table>

Each of these primary and secondary costs will be discussed in turn.

**Primary Health Costs:**

**Group health insurance benefits costs:** Depending on whether your organization is self-insured, insured, or providing multiple plan options with several premiums tiers, the cost information is usually available through employee benefits or through the organization’s financial management staff. These should be net costs, after all retrospective adjustments, COB recovery, re-insurance reimbursement, etc. adjustments have been made. Costs will generally be based on claims expense, premium costs, administrative fees, and investment income offsets. The bulk of these expenses are for hospital, physician, and ancillary health services. Approximately 90% of the health plan cost are from claims and approximately 10% are usually related to retention or administrative costs.

**Dental health plan costs:** Usually these costs are premium costs if the dental plan is insured. If it is a self-insured, direct reimbursement style dental plan, then costs will consist of claims cost plus administrative fees. This information is usually available from employee benefits staff, brokers, dental plan administrators, or financial staff.

**Vision care premiums:** Vision care costs are generally linked to eye exams, contact lenses coverage, frames, and regular lenses. Typically, these types of supplemental health plans are insured, and therefore costs would be derived from premiums paid during the benefit year. Information about costs are usually available from the same types of sources as medical and dental plan cost information.

**Prescription drug plan costs:** These costs would usually include pharmacy benefits management and network charges, claim costs, premium costs, and administrative fees. These programs are generally preferred network card-based programs and/or some
combination of maintenance drug mail order programs. Source of cost information would be the same as the previous categories of cost.

**COBRA payments:** COBRA coverage is mandated for employers with over 25 employees and is designed to allow individuals who are affected by a qualifying event (i.e., loss of job, death of working spouse, divorce, etc.) to continue their medical benefit coverage for up to 36 months. It is a federal law and generally costs employers the additional health claims generated by the COBRA covered individuals in excess of their premium payments. Employees usually pay the premium which is limited by law to 102% of the standard comparable employee premium. Since adverse selection is likely to be occurring with all COBRA enrollees the actual cost of the COBRA enrollee is likely to be high producing an excess COBRA coverage related cost. This cost information is typically available from employee benefits staff or financial staff.

**Workers’ compensation costs:** Workers’ compensation costs will usually be premium costs if the employer is part of a state-insured pool, or claims costs if they are self-insured for workers’ compensation. Claims costs will reflect two major categories, namely medical reimbursement charges and salary or wage continuation costs. The workers’ compensation staff, broker, or financial staff will usually have this information.

**Sick leave costs:** These costs are often not calculated, but can be approximated if sick leave is an earmarked benefit (rather than combine leave arrangements) the average number of hours or days of sick leave per year are known and the average hourly or daily salary or wage rate is known. Worker replacement costs are usually in addition to the loss of direct work time by the individuals who are absent. This information, if available, can usually be obtained from human resource staff who are responsible for compensation, payroll, or electronic time cards. The financial staff or benefits and compensation staff will usually have this kind of information.

**Short-term disability (STD) costs:** These costs are usually associated with injuries, illness, or pregnancy experienced by full-time employees. These costs are usually expended in the form of continuation of salary or wages during a period of convalescence. The federal Family Medical Leave Act passed in 1993 may produce replacement costs rather than direct STD costs, but they are related to this type of health cost. This information is usually available from benefits and compensation staff, human resource staff, or financial management staff. Short-term disability usually covers costs incurred for an absence up to 180 days (six months) and long term disability usually starts at 180 days and goes from 2 to 5 years.

**Long-term disability (LTD) costs:** These costs are similar to STD, but are usually for more prolonged absences that can last from 180 days to 2-5 years. Usually, the individual receives approximately 65% of their usual salary or wage, but it is not taxed at the federal level. The same sources of information as with STD apply to LTD. If this benefit is insured, then the plan sponsor or insurer provides the premium or cost information.

**Life insurance premium costs:** Life insurance premium costs can be both an employer and employee sponsored cost. Group life insurance is generally inexpensive, but does reflect another health-related or specifically mortality-related cost associated with the work force. The benefits compensation staff or financial staff or outside vendor will have this information.
Accidental Death & Dismemberment (AD&D) premium costs: This form of insurance coverage usually provides a defined benefit associated with a particular form of loss and is purchased as an insured product. For example, this type of policy may provide for a $5,000 lump sum payment in the event of an accidental death, $2,500 for the loss of an eye, $2,500 for the loss of a leg, etc. The cost of this form of health-related insurance can usually be derived from the insurance premium associated with this particular form of loss.

Presenteeism costs: This newer form of productivity-related cost is associated with performance at work that is impaired or adversely affected by underlying health condition. For example, somatic complaints due to high levels of personal stress, such as migraines, can have a significant effect on the productivity of an individual at work. Allergies have also been documented as significantly reducing personal performance at work. These losses have been recognized, but not quantified in financial terms, in the past. With recent developments in presenteeism and work productivity loss research and measurement methods, econometric analysis of worker presenteeism is now possible. Global presenteeism questions are now inserted in health risk assessments (HRAs) on a regular basis.

Secondary Health Costs:

FASB 106 (Future retiree medical cost) write-off: This Financial Accounting Standards Board (FASB) ruling is designed to provide accounting procedures for companies to place a financial value on the future year liabilities associated with the medical coverage provisions associated with the retiree population for that employer. This helps provide equity and accuracy in the financial picture associated with companies. GASB 110 (Government Accounting Standards Board ruling) is the public sector equivalent of FASB 106. This information is usually available from employee benefits staff or from financial staff.

"Dread-disease" supplemental insurance: Some employers provide heart disease or cancer supplemental insurance coverage under flex plans or under employee benefit programs. These will generally be premium costs because these types of supplemental plans are almost always insured products.

Eldercare support: This is a relatively new benefit, often found as a flex plan option, but it is directly related to the health and functional capability of the parents of employees and their spouses. This may take the form of agencies that offer respite care or who arrange for in-home services needed by an ailing parent. This type of cost information would typically be available from human resource, benefits, or financial staff.

Early medical retirement: Depending on the retirement and pension policies of an employer, this cost is associated with an individual that may be eligible for retirement and is allowed to take an early retirement for medical reasons. This may also be called a medical retirement and may then generate elevated retirement or pension costs. Compensation staff, pension administrators, human resource staff, or financial staff would typically have this kind of information if a pension plan covers this type of occurrence.
**Medicare surcharge:** This is a fixed amount of an employer's payroll (1.45% for both employer and employee) that is required to help offset the cost of Medicare Part A Hospital coverage. It is fixed by law and applies to all Social Security-eligible workers.

**FASB 112 (Future disability cost notation):** This is a similar category of cost as FASB 106, but it relates to future year disability cost (STD and LTD) liability for the company. It attempts to accurately portray the future financial obligations of the company for employees who are disabled. The employee benefits staff or the financial staff should have this information, if they are required to address it.

**Family Medical Leave Act (FMLA):** The Federal Family Medical Leave Act provides for up to six months of absence without pay in the event of a qualifying family medical problem. The costs associated with this law are likely to require a case-by-case analysis. The benefits and payroll staff should be able to estimate this health-related cost.

**Retiree supplemental health plan subsidy:** Increasingly rare, employers will separate out any retiree health plan cost subsidy while other times retirees may be included in the core health plan for active employees. These are usually “carve-out” health plan benefit offerings that continue supplemental coverage for retired employees until they become eligible for Medicare, and then the extent of coverage is reduced and frequently employers will provide a limited “carve-out” style of coverage which has an annual maximum dollar threshold. Source of cost information on this item would be the same as the other health plan supplemental coverage.

**Employee health plan contribution amounts:** These are the amounts of employee paid payroll contribution for health benefit coverage. These amounts will depend on the percent of employee and dependent premiums that are paid by employees as a payroll contribution. The typical pattern is that the employer pays 90% of the individual employee premium and 50% of the dependent coverage premium cost. However, the pattern varies tremendously by industry and with the steady movement toward higher premium contribution levels. This type of information can usually be obtained from employee benefits staff.

**Out-of-pocket health plan cost sharing amounts:** Many insurers and third party administrators (TPAs) provide information about the total and average amount of deductibles paid, co-pays, and co-insurance paid by employees. These amounts often reflect additional health costs that need to be added to the amount of claim cost and administrative cost associated with a self-insured health plan in order to get a clear perspective on total health costs for a given work force. This information will generally be included in financial reports from a TPA and the employee benefits staff will have this information if it is provided by an insurer or TPA. In 2009, according to the Census Bureau, the average family unit out-of-pocket costs not covered by a health plan was approximately $4,000.

**State premium tax:** These taxes are often rolled into premium costs, but they may be listed as a separate expense depending on the state laws and reporting conventions involved. These are typically 1½% - 5% of health insurance premiums for insured health plans. In many states these amounts are used to partially fund high risk insurance pools and may be used on Exchanges under the ACA law. The organization’s financial management staff usually has information about this type of health cost. Any future premium tax or dedicated payroll tax imposed by state or federal government requirements would fit under this category. This will also include any penalties for not providing health insurance coverage.
State earmarked health premium taxation: Many states have attempted to add additional taxes to employers in the form of premium and/or payroll taxes to provide additional funding for the medically indigent or for specific public health concerns. These state taxes are often linked to health issues and consequently vary significantly. The financial or payroll staff will generally have this kind of information as well.

Health care flexible spending account (FSA) amounts: These amounts are usually offered as part of a Section 125 Cafeteria Plan and are created by employees deferring a specific amount of their pre-tax dollars into their own FSA and then requesting reimbursement for eligible health-related expenses. Any amount not utilized during the year is retained by the employer, not the employee. Health care FSA contributions can also be made by employers. Cost information on FSAs is usually available from employee benefits staff or from the vendor that is administering the flex plan or FSA. The administrative cost of managing the FSA is also a part of the cost in addition to any matching amounts provided by employers. Financial management or benefits staff should also have this type of cost information.

Consumer-Driven Health Plan (CDHP) costs: These amounts include notational and actual funding of Section 105 Medical Reimbursement Plans (Health Reimbursement Arrangements) and the newer Health Savings Accounts (HSAs) under Section 1223. The cost can include amounts provided and/or used and the administrative cost of managing reimbursement claims. This cost can usually be provided by financial management, vendor or benefits staff.

Wellness reimbursement costs: This amount is usually limited to larger organizations but it frequently provides reimbursement of $240 to $400 per employee per year for fitness club dues, reimbursement for smoking cessation or weight management programs or the use of complementary or alternative medical services (i.e., naturopathic medicine, acupressure and acupuncture, homeopathic medicine, shiatsu, massage, etc.). Here again financial management staff can usually identify the size and magnitude of these costs.

Employee health service costs: These costs are usually characterized as function-related or individual recipient costs. Some of these costs are associated with legal compliance or state/federal mandates while others may reflect employer initiated activities designed to reduce the benefit-related costs identified above. These costs will generally have direct components, such as salary costs, space costs, equipment costs, supplies, materials, and outside vendor costs, as well as indirect cost components such as lost employee work time, productivity loss, etc. However, these still constitute health-related costs and should be examined to identify the full resource implications associated with employee/dependent/retiree health. If employee health professionals of all types are to be taken seriously in the worksite, the economic implications of employee health must be fully articulated for senior management. The following programmatic costs are also a part of the employee health picture:

- OSHA compliance costs
- Hazard communication compliance costs
- Occupational health services costs
- Exposure surveillance and hearing conservation programming
- Annual & periodic health screening costs
- Executive physicals
Industrial hygiene costs
Ergonomic consultation costs
Return-to-work costs
Safety program costs
Fitness facility or subsidy costs
Wellness program costs
Employee assistance program costs

These function-related, benefit-related and program-related employee health costs provide a clear indication of how important employee health issues are to all employers. Helping senior managers see the magnitude of these costs and the strategic potential of cost avoidance is critical to the future of employee health enhancement efforts.

2. Non-Medical “Costs” of Unhealthy Lifestyles

Many of the “excess” elements of cost that are associated with additional morbidity (illness and injury) and mortality associated with unhealthy behavior are as follows:

- Presenteeism related costs
- High absenteeism
- High workers’ compensation
- High disability claims
- Unnecessary health service use
- Excessive medical leave
- Early medical retirements
- High life insurance costs
- Significant productivity loss
- Excess worker conflict
- High production waste rates
- Family disruption
- Social disruption

F. What is the evidence for wellness programs at the worksite?

Employee wellness programs are usually not considered by an organization’s managers nor initiated without a very specific set of purposes and rationales. Typically, the usual range of reasons for initiating wellness are related to the concern of senior management about unacceptable increases in health care costs, personal biases of a senior manager, high employee absenteeism, injury rates, or general concerns for health and productivity. Regardless of the formal reasons given by senior management, it is important that a logical and defensible statement be developed as to why the proposed employee wellness program should be approved, funded, implemented, and continued over time. Therefore, the rationale for introducing a wellness program is usually based on two major premises: tangible benefits to be gained by implementing a program (e.g., health benefit cost savings, sick leave reductions, fewer workplace injuries, reduced presenteeism-related losses or improved productivity,) and intangible benefits to be gained (e.g., improvement in employee morale, need for improved physical conditioning, enhanced decision-making capabilities, or desire to do something
good for employees.). The extent to which one type of benefit is emphasized over the other will depend on your organizational context and the original concerns of senior management in initiating a preliminary organizational look at employee wellness. However, it is important to arrive at a balance between the economic and humanitarian rationales for wellness programming.

In understanding the benefits of employee wellness programs, it is important to recognize that both kinds of benefits are important to organizational performance. An over-emphasis on one type of benefit, such as tangible economic benefits, to the exclusion of the other, usually leads to a less than optimally effective program, increased confusion, and greater risk of future program reductions. Tangible and intangible benefits of workplace wellness documented in the literature include the following:

**Tangible Benefits**
- Reductions in sick leave
- Reduced use of health benefit
- Reduced workers’ compensation
- Reduced injury experience
- Reduced presenteeism losses

**Intangible Benefits**
- Improvements in employee morale
- Increased employee loyalty
- Less organizational conflict
- More productive work force
- Improved employee decision-making ability

There are more than 800 articles that now comprise the research and scientific evidence for the health and cost-effectiveness of employee wellness programs. These articles and reports provide the bulk of the circumstantial and direct evidence regarding the value of health promotion and wellness activities in the workplace. For a much more detailed analysis of the best of scientific evaluation literature, consult "Proof Positive: Analysis of the Cost-Effectiveness of Wellness." This book, part of the Chapman Institute eBooks and publications, provides a detailed analysis of 70+ of the most rigorous peer review articles in the evaluation literature for multi-component workplace wellness programs. A summary of the general results of these articles on the cost-effectiveness of worksite wellness from this publication is contained in Figure 3 below. These evaluation articles are included in Appendix I.

### Summary of Economic Return Studies of Worksite Wellness Programs

<table>
<thead>
<tr>
<th>Observed Measure</th>
<th>Range of Findings</th>
<th>Average Result (# of Studies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active participation levels</td>
<td>17% to 88% of eligibles</td>
<td>41% (39)</td>
</tr>
<tr>
<td>Adherence 1 year later</td>
<td>8% to 43%</td>
<td>NA</td>
</tr>
<tr>
<td>Reduction in sick leave</td>
<td>12.1% to 68.2%</td>
<td>-27.3% (23)</td>
</tr>
<tr>
<td>Reduction in health costs</td>
<td>7.1% to 61.8%</td>
<td>-28.1% (25)</td>
</tr>
<tr>
<td>Reductions in workers’ comp costs</td>
<td>20.0% to 52.0%</td>
<td>-31.9% (8)</td>
</tr>
<tr>
<td>Cost Benefit Ratio</td>
<td>1:2.05 to 1:19.4</td>
<td>1: 5.81 (22)</td>
</tr>
</tbody>
</table>


Figure 3  Summary of Economic Return Studies of Worksite Wellness Programs

G. Why does wellness make sense at the worksite?
In addition to the evidence in the evaluation and research literature about the tangible and intangible benefits of worksite-based wellness programs, from a theoretical perspective, the workplace is an ideal site for the establishment of a wellness program. Approximately 84% of Americans are associated with an employer; as an employee, family member or retiree. The many related reasons for this are highlighted below and can be used to help educate and convince senior management staff as to the value of a worksite wellness program.

The population is captive and they return regularly. Approximately 132 million adults over the age of 18 work in America. Approximately 84% work at sites that are solely devoted to work activity; in other words... a “workplace.” The vast majority of those individuals return five days a week to the same site. This large group is essentially captive due to the nature of the workday. Webster defines “captive” as “obliged or forced to listen, whether wanting to or not.” Worksite wellness communication programs frequently are hard to avoid and therefore have considerable long term potential to eventually influence behavior. The potential for effective long-term health behavior change is greater if your target population is captive.

There is an excellent potential for effective behavioral incentives. A large portion of the population in the worksite is under benefit programs and policies and is stable enough to utilize a wide variety of formal and informal incentives. Program participation and adherence to healthy behaviors can be the object of incentives at the worksite. The use of monetary incentives, material goods, time-off, lottery prizes, recognition, etc. are all very feasible and appropriate for use in the worksite. Incentives can add a significantly larger impact to a program’s effect on the participation and health behavior of employees and their family members.

The potential to influence behavior is high. Due to the repeated exposure associated with the worksite, along with the large number of people exposed to communication vehicles and messages, incentives and possible social and cultural reinforcement, the potential to influence the behavior of adults in the worksite is probably the greatest of any social setting in American society. The potential for beneficial health impact may be high, but it also requires the kind of programmatic effort that can fully realize the health enhancement potential associated with some of these innate characteristics of the American workplace.

There are clear organizational rewards for employers. As a long term source of motivation for employer management teams to conduct wellness activities in the worksite, the economic consequences of unhealthy lifestyle choices on the work enterprise are becoming more widely known and understood and therefore, stronger. As health care costs continue to increase, it is becoming more important for employers to implement successful wellness programs. The organizational rewards received by the work organization itself will likely reinforce the maintenance and enhancement of wellness programming in the workplace. The existence of clear tangible and intangible organizational rewards will also help assure long term commitment to wellness programming, particularly if the economic benefits are shared directly with employees.

Economies of scale are possible in programming. Due to the large numbers of individuals residing in many worksites, it is possible to gain benefit from economies of scale in programming activities. The use of mass communication techniques, serial feedback, staging theory applications, offering classes for larger groups, training trainers to provide multiple sessions at lower cost, use of online Learning Management Systems (LMS) and obtaining higher discounts from athletic clubs are all examples of the economies of scale which can result from programming efforts in the workplace.
Potentially all parties can benefit. If a wellness program is well designed and effectively implemented, employer, employees, labor groups, communities, and government can potentially benefit. A detailed look at these benefits is provided below:

**For Employees:**
- Increased knowledge about the relationship between lifestyle and health
- Increased opportunity to take control of their health and medical treatment
- Improved health and quality of life through reduction of risk factors
- Increased morale via management’s interest in their health and well-being
- Increased opportunity for support from co-workers and environment
- Reduced work absences
- Reduced presenteeism related productivity loss
- Reduced medical costs
- Opportunity to build Health Savings Account (HSA) balances
- Reduced pain and suffering from illness and accidents

**For Employers:**
- Increased worker morale
- Increased worker productivity
- Informed and health care cost-conscious workforce
- Positive public relations
- Recruitment tool
- Opportunity for cost savings via:
  - Reduced sick leave absenteeism
  - Reduced disability claims
  - Decreased health care utilization
  - Reduced premature retirement
  - Decreased overall health benefit costs
  - Fewer on-the-job accidents
  - Lower casualty insurance costs

**For the Community:**
- Contributes to establishing good health as a norm
- Complements and reinforces national and local public health initiatives
- Provides a model for other local organizations
- Improves quality of life of citizenry
- Helps control (and possibly reduce) the economic and social burden on all taxpayers from premature mortality and morbidity

These reasons are part of the rationale why wellness at the worksite makes good sense and can be used in justifying the development and initiation of an employee wellness program.

H. What can you realistically expect from an employee wellness program?

A wise thing to do right at the beginning of the planning process is to spend a little time thinking about what you can realistically expect from a wellness program in your work organization. The primary reason this makes good sense is that it will help you plan what specific components you will need to
include for a successful program, and it will help you develop a clearer perspective on what expectations senior management may have about the program once it’s implemented. A successful employee wellness program needs to be more than just a fragmented mixture of individual program components trotted out one after the other. Changing lifestyles and health behavior takes a lot more than a 3-hour seminar or a 12-week aerobic exercise class. Long-term health behaviors like smoking, physical activity, dietary habits, weight maintenance, stress responses and safety practices are very difficult to change and even more difficult to maintain over the long haul. The design of the wellness program, strength of incentives and the quality of the cultural change and program implementation activities will have a lot to do with the long-term success of your wellness efforts. This also translates into the program model you use to organize your worksite wellness efforts.

Another way to look at this issue of expectations is to think about the level of impact your wellness program is to have in terms of the major outcomes you want from the various components of your program. In a general sense, there are five major types of outcomes that can be expected from worksite wellness activities. These are identified in Figure 4.

![Figure 4](levels_of_wellness_programming_effects)

Levels of Wellness Programming Effects

<table>
<thead>
<tr>
<th>Information</th>
<th>✓Transfer of information effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivation</td>
<td>✓Enhancement of motivation to change behavior</td>
</tr>
<tr>
<td>Behavior Change</td>
<td>✓Behavior change skills and reinforcement</td>
</tr>
<tr>
<td>Economic Change</td>
<td>✓Changes in economic parameters</td>
</tr>
<tr>
<td>Cultural Change</td>
<td>✓Changes in cultural norms and perceptions</td>
</tr>
</tbody>
</table>

> Some mix of all five of these levels of programming effects is present in virtually all programs. However, careful attention needs to be given to selecting the right balance of wellness program model and interventions among the five levels of programming effects in order to produce the desired (or expected) program outcomes. For example, a program that relies only on wellness communication tools will not produce large amounts of behavior change, nor health cost savings, if these two concerns are the desired outcomes or expectations for the program. The program model and level of programming needs to match the goals, objectives and expectations for your program.

> Realistically, you should not expect a great deal of behavior change from a program that uses primarily “information transfer” or “Feel Good Wellness” types of program activities. If your program is appropriately designed and uses the appropriate program model, it should produce a balance of all five levels of program effects. In order to better understand this important concept Figure 5 below shows the relationship of program model to the expected effects of a worksite wellness program. The greater the number of pluses the greater the effects that can be expected.
<table>
<thead>
<tr>
<th>Type of Effects</th>
<th>Option #1 Feel Good Wellness (FGW) Program Model</th>
<th>Option #2 Traditional Wellness (TW) Program Model</th>
<th>Option #3 Results-Driven Wellness (R-DW) Program Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information</td>
<td>++</td>
<td>+ +</td>
<td>++</td>
</tr>
<tr>
<td>Motivation</td>
<td>+</td>
<td>+</td>
<td>+ ++</td>
</tr>
<tr>
<td>Behavior Change</td>
<td>+</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Economic Change</td>
<td>+</td>
<td>+</td>
<td>+ ++</td>
</tr>
<tr>
<td>Cultural Change</td>
<td>+ +</td>
<td>+</td>
<td>++</td>
</tr>
</tbody>
</table>

Figure 5  Levels of Wellness Programming Effects by Program Model
I. Your role as the “wellness catalyst”

In order to get a worksite wellness program going, someone has to function as the “Wellness Catalyst” (a.k.a. wellness coordinator or manager). Since you are reading this publication, it’s probably safe to assume that you are that individual. Congratulations! You should know that your role is critical in designing and implementing an effective employee wellness program within your organization.

Some of the things that are required of you in order to function as an effective “Wellness Coordinator” or “Wellness Catalyst” are as follows:

- Clarify the mandate from senior management for the program
- Identify major “agendas” of key senior managers toward the program
- Be able to be an advocate for “wellness”
- Research major vendors and resources to be used in the program
- Know how to get other people interested and involved
- Be able to communicate effectively in individual and group settings
- Be able to evaluate instructors, vendor staff, and programs
- Be able to call people up and hold them accountable in a nice way
- Select an appropriate program model for your program
- Select an appropriate set of interventions for the wellness program
- Be able to coordinate a wide variety of activities
- Be able to communicate and spread enthusiasm about the program
- Have an evaluation and continuous improvement orientation
- Make a personal effort to work on the major areas wellness for yourself

You don’t necessarily need a “health” professional background, but it is very helpful if you do. The larger the number of employees in your organization the more important a health background and specialized education. Your role also usually involves marketing, communications, management of volunteers, budgeting, record-keeping, supervision, vendor management, negotiation, and evaluation. In medium size employer settings (500+ employees) it probably makes a lot of sense to hire academically prepared wellness professionals at the Bachelors or Masters level. There are approximately 50-80 undergraduate and graduate level academic programs nationwide that prepare people for the role of wellness program manager. If you want to know more about these health education and wellness programs you can do a browser search. If you choose to hire an individual from one of these programs, make sure that the candidate(s) have had course work and experience in worksite settings. Individuals with clinical backgrounds in nursing, nutrition, physician extender training, exercise physiology, and clinical psychology can also be encouraged to acquire necessary expertise and skills for worksite wellness programs, particularly if your program is going to focus on health risks and health costs. Certification under the WellCert Program would also be advisable and would provide assurance that the individual could design and implement a program.

J. Keys to a successful wellness program.

There are a few very critical “keys” that will largely determine the success of your wellness program regardless of the program model you select. These keys are summarized in Figure 6 and are discussed below:
Keys to Successful Wellness Programs

- Strong senior and mid-level management support
- Behaviorally sophisticated programming
- Positive and upbeat program identity
- Well-designed and balanced programming
- Well-paced programming
- Effective use of incentives

Figure 6  Keys to Successful Wellness Programs

Strong Senior and Middle Level Management Support:

The extent to which senior management and mid-level managers support the program will probably be the single most important variable in determining whether the program will ultimately succeed. That support is expressed in the provision of time for the program on work time, by changing other policies and procedures and providing funds for staffing, purchasing equipment, vendor services, supplies, and incentive rewards. Other ways that management support gets expressed is through personal verbal support, actual involvement in various program activities, and the informal messages that are communicated to middle level managers and first line supervisors about the importance of wellness. These are all indications of the depth and permanence of the commitment to a wellness program by senior and mid-level managers.

Behaviorally Sophisticated Programming:

The extent to which the wellness program uses state-of-the-art behavior modification techniques and strategies is essential to the long term impact of the program. Simple wellness communications do not usually produce long term behavior change. Not until a well-designed program is combined with salient incentives and personal coaching and follow-up do you begin to see change in group norms and long term adherence to health and lifestyle behavior change. Each program intervention component, as well as the overall program, needs to be designed using sophisticated behavior change technology and methods. That sophistication also needs to embrace formal efforts to change the cultural norms that affect health in the worksite. Some of that newer prevention technology includes stage of change theory, serial feedback, high risk telephonic intervention, individualized feedback, self-directed change materials, use of computerization and telecommunications, strong incentives and on-line information access.

Positive and Upbeat Program Identity:

It is important for the wellness program to represent a positive and upbeat identity to the employees and family members that are affected by it. The program needs to be seen as flexible, user-friendly, and oriented in a compassionate, confidential and sensitive way to participants. The general perception which employees hold toward the wellness program is important in securing their participation and cooperation. This is often a real limitation for “shoestring” or minimally funded wellness programs. Also if employees see that management has not made a clear and tangible investment in wellness, they will tend to undervalue the program and not take its activities or purposes seriously.
Well-Designed and Balanced Programming:

The use of an appropriate program model and set of program interventions is essential to the effectiveness of the program. This includes the choices expressing the right balance of communications, health & fitness testing, group activities, “virtual” interventions, and the creation of a supportive environment tailored to the needs of the work force involved and the desired effects of the program. If tangible results are expected, then there definitely needs to be an adequate amount of testing and behavioral support interventions. Another important issue of balance is whether there are some short term “targets” to provide faster paybacks of tangible benefits from wellness programming or whether only long term chronic disease prevention are the primary targets. If a short term economic yield is desired, then seat belt campaigns, injury prevention efforts, medical self-care, consumer health education, medical screening, prenatal education, stress reduction aimed at somatic complaint reduction, and smoking cessation components need to be implemented. If your focus is long term, then emphasize fitness, weight management, general stress management, and tobacco use. It may not always be as clean cut a differentiation between short and long term benefits, but careful thought related to the program model to be used and the balance of program intervention always needs to be made.

Well Paced Programming:

In general, the best pace for a wellness program is one to four events a month with a highly promoted seasonal event during the spring and fall. Summers are usually relatively quiet while post-Christmas holidays can be slightly more active. Good programs avoid an unusually heavy amount of “clustering” where several activities are conducted at the same time period with long periods of limited activity in between. “Campaigns” offer a nice alternative to the heavy concentration of individual activities. “Campaigns” tend to focus on specific issues (i.e., high blood pressure, stress, physical activity, cholesterol composition, weight management, depression, etc.) and use a consistent pattern of heavy promotion, testing and measurement, referral to intervention activities, and retesting. The pacing of programs will also depend on which of the three program models that is used. For example, a “Feel Good Wellness” (FGW) style program will usually be paced according to the ebbs and flows of the work load, while a Traditional Wellness (TW) style program may follow the seasons of the year. The “Results-Driven Wellness” (R-DW) style program is likely to be more closely integrated with benefit open enrollment periods. A year-round component such as a eHealth website can usually be more actively promoted at times when few other activities are offered.

Effective Use of Incentives:

The use of well-designed incentives is an important part of any wellness program. Frequently, the presence of an incentive will help increase participation, increase adherence to specific behaviors, and increase follow-through by a factor of 2 to 8. Well-designed incentives can make significant contributions to a program’s success. A basic definition of “incentive” includes the concept of offering something that individual employees value in exchange for a prescribed behavior, action or achievement. The behavior or action may range from attendance at a wellness workshop to becoming a more consistent and regular exerciser. Almost without exception, any health behavior can be the focus of an incentive feature of a wellness program, but may include a pure participation option to avoid problems under the Health Insurance Accountability and Portability Act (HIPAA).

The type of reward that is exchanged for the behavior or action is called the “pay value.” There are many different kinds of “pay values.” Some of the most powerful pay values include cash, benefits,
time-off, material goods, recognition and personal challenge. Wellness incentives and their use are discussed in much more depth in a companion publication entitled, “Using Wellness Incentives: A Positive Tool for Healthy Lifestyles,” available from Chapman Institute in paper and eBook form.

In order to simplify incentive planning for your initial program design, you might want to consider the following types of incentives or incentive features:

### Incentives to Get People to Come to Your Program Activities:
- ✓ Door prizes for attending wellness events
- ✓ Discount fees for early registration
- ✓ “Bring a Buddy” discounts
- ✓ Handouts or gifts for attendees
- ✓ Holding a drawing later in the session for prizes for attendees
- ✓ Link attendance with a desirable incentive, such as a lower premium contribution level

### Incentives to Get People to Come to More Multiple Sessions:
- ✓ Rebate 20% -30% of their fee for near-perfect attendance
- ✓ Prize drawings at each session and at the end of the series based on participation
- ✓ Divide a dollar pot that they contribute with those near perfect attendees
- ✓ Provide an attractive prize to near-perfect attendees

### Incentives to Get People to Make Long-Term Behavior Changes:
- ✓ Conduct a prize drawing for people who continue the behavior at six months
- ✓ Write-up in an employee newsletter stories about an employee who makes a major sustained health habit change
- ✓ Provide a health insurance premium reduction for meeting several wellness criteria

These are only a few of the possible incentives you can use in your wellness program. Be creative and experiment!
II. KEY STEPS - PLANNING, DESIGN, AND IMPLEMENTATION

A. Planning and Needs Assessment

1. Why prepare to plan?

You might wonder, "Why should I prepare to plan? Why not just plan?" If you want the program to succeed, you should prepare to plan a worksite wellness program in a careful way. Before you start the process of formal planning, you need to take an informal inventory of several key issues. First, what exactly is your mandate from senior management for an employee wellness program? Webster defines “mandate” as “an authoritative order or command.” Is your mandate to design a program or simply to look at the feasibility of a program? Be sure and resolve this issue before you get too far down the road. If you don’t, you may be disappointed by their response once you come back with a proposal for something they didn’t really ask for or want.

The second issue that should be resolved is the nature of the product you are expected to come up with from your planning. Does senior management want a 3-page proposal with a rough budget or a 35-page proposal with detailed plans? Clarify with senior management what they really want as part of this step. Again, you don’t want to fail to meet their expectations about the wellness program and potentially cause a delay in the program’s possible development.

The third major issue to resolve is the length of time for your planning process. When is the “product” of your initial planning expected to be presented or reviewed? Does it relate to the annual budget cycle or to the desired start date for the program? How much time do you have to plan? Timing is almost always critical; if you come back with your plan and you’ve missed the budget planning “window,” it may delay the start of the program.

The fourth major issue to resolve is the budget level to be associated with the wellness activity. Organizations frequently spend between $50 per employee per year to $500 per employee per year. That’s a lot of difference in programming levels! It’s much better if you have at least a beginning benchmark to help with the planning. These four issues are critical to resolve before you formally start your planning process.

2. How do we get management support for our program?

It is extremely important to get and maintain strong senior management support for the wellness program and there are many strategies that can be used. Some of these strategies for getting and maintaining management support are contained in Figure 7. They include the following rationales for use with management staff in developing support and funding for an employee wellness program:
There are many other things that can be done to extend and deepen these rationales in the senior management group in an organization, and therefore deepen organizational support for an employee wellness program. Here are almost two dozen additional strategies for broadening your base of management support for wellness:

1. **Circulate program materials about other programs.** Acquire sample materials describing wellness programs offered by peer organizations or competitors, and circulate them to key decision-makers. Descriptive brochures or employee education materials that are well done and emphasize the full extent of programming conducted by other organizations are particularly effective in presenting tangible proof of what can be done in the employee wellness area. By doing this, you highlight the differences between your organization and others, and are more likely to help prepare decision-makers for approving employee wellness efforts.

2. **Utilize your own industry data on wellness programming.** Use trade or industry information that shows the number of peer organizations that are conducting employee wellness programs within your own industry, percent of members involved in various types of programming, its extent, and the identity of those organizations (frequently the leaders) that are involved. This will tend to convince senior managers that many organizations are doing it and it is generally recognized as appropriate for business enterprises such as yours. If no trade or industry data is currently available, lobby to have your industry or trade association conduct a study or survey its membership for wellness-related issues.

3. **Formally survey organizations which compete for labor.** Summarize the patterns and trends in those organizations that compete for the same labor pool that your organization uses. By asking questions about competitors’ wellness offerings, you also send a message to the other organizations, improving the chances of them addressing the wellness issue at the same time you are getting information. Where it is appropriate, make the data useful for other human resource issues as well (i.e., ask about childcare, flexible benefits, eldercare, stock option plans, etc.).
4. **Consolidate and present existing survey data.** Utilize existing survey data on the number and components of worksite wellness programs. Information from sources such as the Department of Health & Human Services, WELCOA, Mercer Employer Surveys, journal articles, benefit surveys, etc. can be very useful. By combining the sources and highlighting the information on the growing prevalence of employee wellness programs, it strengthens the rationale that these kinds of programs are becoming much more common (which we demonstrated in the early part of this workbook with the DHHS, ODPHP surveys) and that it makes sense to engage in worksite-based health promotion and wellness activities.

5. **Get key management people involved in local wellness groups.** Work to get key managers involved in wellness presentation activities of local business and health coalitions or in a local Wellness Council. Once they become visible in the community related to wellness issues, they have a much stronger incentive to make the program exemplary and successful. A speech that you arrange for a senior manager before a prestigious local or state group on the topic of worksite wellness can also act as a catalyst for their interest in wellness and in making the program successful.

6. **Use an employee survey to catalyze interest.** A one or two page interest survey can be used to cultivate employee interest and provide quantitative and qualitative information to senior management on the level of employee interest. These surveys can be structured to collect health risk prevalence (i.e., smoking, exercise activity, overweight status, etc.) and program preference information (i.e., programs and/or topics of interest, attendance potential, informational interests, etc.). Care should be taken in designing the survey instrument to make sure you ask questions in a way that will accomplish your goals in conducting the survey process. An example of a widely used employee wellness interest survey is contained in Appendix F.

7. **Use focus groups, information from an employee suggestion system, and employee letters.** These sources frequently yield employee opinions and expressions of interest in support of the need for wellness programming. You may even want to encourage more vocal employees to use these feedback methods if they feel strongly enough to advocate for a program. Focus group findings can also give credibility to employee desires for a worksite-based program. When data from any of these sources is combined and displayed, it can provide another source of influence for decision-makers.

8. **Emphasize the need for employee morale improvement.** Downsizing, staff reduction, and mergers/acquisitions are often opportunities to initiate or expand wellness activities designed to help employees cope with the changes and improve morale. By emphasizing the need for an organized effort to deal with declining employee morale from things such as stress due to merger or acquisition, uncertainties about their job future, or economic disruptions in the company’s market, you can strengthen the rationale for initiating a new program or expanding an existing one. Do not miss the chance to use these common perceptions of organizational “pain” to advocate for programming.

9. **Trade benefit changes for a wellness program.** Due to the periodic need for management to make benefit modifications and/or reductions for the purposes of helping slow the rate of increase in health benefit costs, there exists some real opportunities to trade such things as increased payroll contributions or patient cost sharing (i.e., increased payroll contribution, larger deductibles, higher coinsurance, new co-payments, higher out-of-pocket annual limits, etc.) for new or expanded employee wellness programs. The addition of an employee wellness program
Planning Wellness

10. Emphasize the organization’s social and community responsibility. By emphasizing the social responsibility of your organization as a leader, innovator, and major force in the community, it can enhance and rationalize an increased level of commitment to a corporate wellness program. Because more organizations are taking on mission statements that place a value on world-class performance, it should be easier to gain support for employee wellness efforts. Contrasting how many employer peers in your area have already initiated wellness programs also helps.

11. Cultivate management desire for leadership. Cultivate management’s natural desire to excel by focusing on the issue of being an innovator and leader in this area. This approach will have a greater effect if the organization has a corporate culture which values innovation and leadership or has provided community leadership in other areas.

12. Highlight the program’s relationship to company credo and/or culture. If the organization has a written credo or mission statement that emphasizes the importance of employees in the success of the organization, then make the link between a wellness program and the credo’s values and priorities. The culture of the organization may also reflect a clear informal norm that recognizes the value of employees to the company’s future, which can also be emphasized as part of the rationale for wellness.

13. Link programs to preventive maintenance strategy. If preventive maintenance is a strong part of the operational philosophy of the organization as it relates to plant machinery, fleet vehicles, equipment, buildings, etc., then use this example as an analogy to strengthen the rationale for wellness. Provide examples of major areas where the preventive maintenance strategy is used and then make the comparison to the organization’s most valuable resource — its people. This approach will usually help strengthen the argument for wellness programming. The relative financial relationship of the example to the total cost of compensation for the work force as a corollary approach is also often effective in enhancing support.

14. “Good health is good business.” Promote the general axiom that good employee health is good business. Fit and healthy employees are more productive, able to meet extraordinary demands better, deal with stress better, are absent less, reflect better on the company as exemplars, and so forth. Use this statement repeatedly to strengthen the general case for wellness programs. Summarize major health-related costs of the business and compare the total to the previous year’s after-tax profit or operating budget to demonstrate the economic argument more forcefully.

15. Do a “pilot program.” If there is a great deal of resistance to organization-wide wellness among top managers, then as a last resort, suggest a pilot program to test how wellness would effect the overall organization. Conduct the pilot in an area where data on productivity and/or health costs is available. Use an aggressive and consistent approach to overcome resistance among the doubtful, spiked liberally with the best data you can produce from formal program evaluation studies.

16. Challenge supporters or detractors to “test it out.” Challenge those who are strong supporters or detractors to test the feasibility and efficacy of a wellness program for their own employees on a test basis with a defined time period (i.e., 18 months to 36 months), and measure the results. You can also challenge them to personally participate in the program.
17. **Build wellness programming into your health cost management efforts.** A major portion of companies are adopting formal plans and strategies for managing their health benefit costs through wellness interventions. Work with benefit managers to incorporate wellness into formal plans for long term management of health costs and for organized health and productivity management (HPM) initiatives.

18. **Propose that wellness be funded from new employee premium contributions or benefit savings.** At the time of health plan redesign and benefit changes, get agreement from management that a $50 to $100 per month increase in the employee premium contribution for health plan coverage be used to create “funding” a significant wellness incentive reward. This amount can be eliminated for those who meet 8 out of 10 wellness criteria. Another strategy for funding wellness programming is to utilize a portion of the funds “saved” through plan design change or allocated to cover the cost of health benefits be retained to finance employee wellness activities. If 2% to 6% of health benefit costs were earmarked for wellness, it could provide a very substantial employee wellness program. The premium contribution amount employees pay can be adjusted to pay for wellness programming. In addition those who participate can be paid for by those who do not through a “play or pay” concept. This can be done in self-insured or fully insured health plan environments. The addition of higher deductibles, co-payments, etc., will frequently lower health plan costs, therefore potentially releasing funds that can be used for wellness programming if premiums are not fully “rolled-back” into reduced premium costs and “charge-backs.”

19. **Build short term cost savings strategies into your wellness program.** Instead of limiting your program focus to long term health impacts (i.e., cardiovascular risk reduction, exercise, nutrition, weight management, stress reduction, etc.), build short term cost savings activity into your wellness program by including activities such as: injury prevention, presenteeism interventions, medical self-care, smoking cessation, consumer education, instruction on how to appropriately use your health benefits, seat belt programs, low back pain prevention, etc. This will allow management to more comfortably justify the expenditures associated with a wellness program because the economic benefits to the company are not so far off in the future.

20. **Circulate studies and evaluation results.** Select some of the best studies on the evaluation of worksite wellness programs (such as the Baicker, Cutler, and Song, Meta-analysis), underlining key points in bright colors in the abstract of the article, and routing them to your mid-level and senior management staff. Space them out over time and continue to circulate newer studies. Look for studies that are from comparable industries or organizations. Use red or bright colored marking pens to underline the major “bottom-line” findings from the studies. Another publication available from Chapman Institute, entitled **“Proof Positive: An Analysis of the Cost-Effectiveness of Worksite Wellness,”** contains a detailed analysis of sixty of the most rigorous studies on the economic return of workplace wellness programs in the peer review scientific literature.

21. **Develop a sound evaluation plan.** Spend time designing and planning a periodic and ongoing evaluation plan for your proposed program. Evaluate something in each of the following categories: participant involvement, participant feedback and satisfaction, changes in information and attitudes, changes in population behavior, changes in health status measures, and specific organizational economic gains. Implement the evaluation plan after giving senior management an opportunity to comment and/or modify the basic approach. The last section of this publication discusses ideas for evaluation. Another publication that covers the specifics of program
evaluation, entitled “Program Evaluation: A Key to Wellness Program Survival,” is also available from Chapman Institute.

22. Suggest that management use a “total compensation” approach to human resources financial planning. When calculating the cost of labor for labor negotiations in unionized settings or for employee education in non-unionized settings, support the use of a “total compensation” approach which utilizes a total compensation “pie” with wages and salaries, retirement, taxes, life, health, disability, AD&D, workers’ compensation, sick leave absenteeism, dental insurance, etc., all as a part of the total “pie.” Then break out the health-related costs and focus management’s attention on the magnitude of current and projected future health costs in terms of the current and future profitability of the business. This will tend to highlight the importance of health concerns for your organization and for virtually any organization or work force. The collection of all health-related costs of doing business is usually much more effective than just the cost of the group medical plan.

23. Emphasize that health care utilization drives health care costs. The consistent message that utilization of health services drives the cost of health benefits will help bring attention to the fact that efforts have to be undertaken to better manage the work force’s morbidity (illness and injury), which leads to the demand for health care and the need to put a tangible downward pressure on health care utilization. This approach will help to secure a long-term position for employee wellness programs in the American worksite. Another publication from Chapman Institute, entitled “Results-Driven Wellness: Optimal Approaches for Managing the Health of Defined Populations,” focuses on health management strategies for employer and managed care organizations.

3. What data should be collected?

During the planning process, several different kinds of data should be collected to help formulate and shape the design of the program. The categories of information range from demographic data on the employee population, to the availability of physical space for programming, to the potential incentives that can be derived from benefit design changes. A word of explanation also needs to be offered to recognize that the information that should be collected has different value to the planning process. Not all information identified here has to be collected. Many decisions regarding program design can be made without organizational data after one has acquired some experience in programming. The types of information that are optimal to collect in planning an employee wellness program are contained in Figure 8.
This information is then combined to help identify what program model and programming interventions make the most sense. This area of activity should initially be based on rational conclusions until you have a considerable amount of experience designing and implementing worksite wellness programs.

4. How to assess your organizational culture.

An organization’s “culture,” meaning the composite reflection of values, expectations, and behavioral norms of the group involved, is an important variable in determining whether an employee wellness program will be as successful as it potentially can be. The culture of the organization has an impact on the level of employee participation, employee adherence, and whether management might be willing to use more innovative incentives and programming. These issues are not generally known in much detail and understanding them frequently requires a high degree of sophistication. A very rudimentary cultural assessment is contained in Figure 9 below. The greater the number of “true” responses, the greater the cultural potential for success of your employee wellness program.

These “cultural” issues can help predict the initial success of your wellness program, as well as help with the long-term success of your program. Again, the more “True” responses, the more...
compatible the work culture is to employee wellness programming, and the easier your program implementation efforts will probably seem. The work culture can be changed over time, but you may not have the luxury of enough time to focus directly on the other, broader, cultural issues highlighted in the self-test in order to create an organizational “climate” that is more conducive to employee wellness efforts.

**Cultural Wellness Assessment Self-Test**

**True or False?**

1. ___ Our organization is known as innovative.
2. ___ Senior management takes reasonable “risks” with new ideas.
3. ___ In terms of human resource issues, our company is seen as one of the most progressive in our local community.
4. ___ We have an organization “credo” that recognizes the importance of employees in the performance of our business.
5. ___ Employees generally recognize that management is concerned about health issues.
6. ___ There is not a high degree of distrust between employees and management.
7. ___ New programs are followed up reasonably well by management.
8. ___ Incentives have been successfully used with employees in our company.
9. ___ Employees usually react favorably to management initiatives.
10. ___ “New” programs are usually well received by employees.
11. ___ Health issues are identified periodically by individual employees in the form of suggestions or recommended actions.
12. ___ Management encourages employees to participate in some areas of decision-making within the organization.
13. ___ It is expected that employees will express caring and support for each other.
14. ___ Money, by itself, is not the only major factor used to make management decisions.
15. ___ Senior managers are good personal “role models” for wellness issues.
16. ___ Management frequently does things that demonstrate that they value employees.
17. ___ Management tends to do things that “empower” employees.
18. ___ A concern for health has been consistently expressed by senior management as an important consideration.
19. ___ Our safety program is more than just a “compliance-oriented” program.
20. ___ Other employees tend to support the healthy lifestyle practices of their co-workers.

*Figure 9 Cultural Wellness Assessment Self-Test*

5. **Conducting an employee interest survey.**

Employee interest surveys can be an important part of the planning process for an employee wellness program. They should not be overlooked, but they also need to be carefully constructed and interpreted. In a general sense, there is frequently a “halo” effect when employees are asked questions about what they want. This comes from a desire not to respond in an overly critical way and jeopardize any future program or survey process. Surveys themselves usually make a
positive statement about how much value is placed on the individual who is surveyed. A survey should say to the recipient, “I value you and your opinion highly enough to ask.” This is a very positive dynamic behind employee surveys. At the same time, survey results usually tend to be overly positive expressions because employees are reluctant to be critical for the reasons stated above. Another related issue is whether employees have been surveyed before, what the response of management was to the survey, and the length of time since the last survey occurred. If there is a large amount of animosity toward management from employees, then the survey results will usually be less positive, and fewer employees will generally respond to subsequent surveys. An implication of this phenomenon is that, when conducting an employee survey, you need to appreciate the dynamic of how previous surveys were handled and their perceived impact on the employee group in order to accurately interpret employees’ responses to a wellness survey. If previous surveys were done, but no feedback was provided to employees or no discernible change resulted from the survey results, then survey response rates will generally be low. (i.e., below 30%)

The following suggestions are intended to help you think through the process of planning and conducting a survey to determine employee interests in wellness program activities and to assess the need for various wellness program components for your organization.

Employee interest surveys are generally a good idea because:
- They can potentially help you design your program.
- They reduce the potential liability for bad program design choices.
- They have educational value for the respondents and can constitute an “intervention.”
- They enhance employee ownership of the program.
- They help diffuse resistance to the idea of a program.
- They can be used to help demonstrate employee support for your program.
- They can be used to solicit for people willing to help implement the program.
- They can help you eventually evaluate the impact of your program.

However, employee wellness or interest surveys that are poorly designed can do considerable damage and achieve much less than their full potential. Some of the possible pitfalls to avoid are:
- Having questions that are too general and not particularly useful for planning.
- Having a tone that is “uncaring” or “matter of fact.”
- Presupposing a higher level of knowledge than is appropriate.
- Ignoring timing issues that demonstrate insensitivity to other major issues affecting the workforce.
- Surveys that are poorly designed from a measurement and evaluation perspective.
- Failing to ask questions that are relevant to the design of programs.
- Surveys that are difficult to tally and aggregate because of poor design.

A well-designed employee wellness interest survey should:
- Give a clear statement as to who is doing the survey and why it’s being done.
- Give return address and person responsible.
- Give requested return date for survey.
- Be pilot-tested at least once, revised, then distributed to employees.
- Be graphically attractive and easy to complete.
- Be anonymous.
Provide structure through the questions, but should also give respondents enough room to write comments.

- Ask questions that provide data on major risk prevalence data for planning and evaluation purposes.
- Ask questions that help the respondent think about health issues in a personal way.
- Ask questions about key program options (i.e., time of sessions, days of week, etc.).
- Have a detailed listing of possible wellness programs with a clear message that a check mark next to the title indicates the respondent will personally attend at the identified time and place.
- Provide an opportunity to identify volunteers.
- Have an open-ended “other suggestions” opportunity.
- Contain a statement of appreciation for completing the survey.

Also remember to design the survey so you can easily tally the responses. Open-ended question responses are difficult to process, but can be tallied individually or sampled and categorized in order to derive useful information. If your organization is large, has the capability, and there is a possibility of annual surveys in the future, it would be best to develop a survey that can be optically read and tallied through a relational database management program. If your organization is very large, this becomes an even more important issue. By carefully designing your initial survey so that it can be modified slightly, used annually, and processed by machine, it can substantially reduce the processing time, shorten the feedback loop, and increase its usefulness as a planning and evaluation tool. Another option is to utilize questions in your survey that are from a health risk assessment (HRA) that you plan on using so that you can compare baselines to aggregate HRA results over time.

It is also important to provide feedback to your workforce, as a group, on the results of the survey as soon as possible, and then to continually link the survey results to program announcements, updates, and other communication. Also, plan to use your HRA each year and possibly expand the reported data. You can also use a consistent cohort of employees to help determine what is happening to the health of the work force and/or their spouses.

A sample Employee Wellness Survey that can meet many of these needs is included in Appendix F at the end of this document. You may want to start with it and then modify it according to your unique needs.

### 6. Surveying your worksite(s).

When planning an employee wellness program it is important to have a good understanding of the physical nature of the worksite and the actual work setting in which the program will be implemented. This collection of information about the worksite should also include the opinions of key decision-makers about the purpose and nature of the program. If you have been asked to design a program for other remote worksites, then you should go and visit the other sites. When you go to do a “walk-through” of these other worksites, Figure 10 below contains a number of things you should be looking for as you walk-through the particular worksites.
What to Look For During a Wellness "Walk-Through"

- Do they have bulletin boards that can be used as information channels?
- Does everybody use computers at work?
- Do they use email?
- Are showers available for noon-time or work-day exercisers?
- What beverages and food options are available to employees?
- What regular communication channels with employees exist and are used?
- Are there bike racks, basketball courts, walking trails, etc., on the physical grounds?
- Do the senior managers show evidence of personal interest in being “fit”?
- How are smoking policies enforced?
- Are training rooms available?
- What food establishments are nearby?
- Is there an active employee group that might be supportive?
- How many people work on-site versus off-site?
- Are there particular work hazards that have lifestyle implications?
- Do employees seem active and friendly?
- Are key managers supportive of a program at that particular site?
- What has been done in wellness at the site before?
- Are there any legacy issues or history that would affect a program?

Figure 10 What to Look for During a Wellness "Walk-Through"

The “walk-through” can be a time of making short notes about each of the above issues and can provide a much clearer sense of what potential wellness interventions may be considered to insure a successful program at each of the affected sites.

7. Planning “Do's” and “Don'ts"

It is a good idea to keep some basic guidelines or rules in mind when planning a wellness program. These guidelines are in the form of things to do and things not to do and have been developed through a considerable amount of positive (and negative) personal experiences.

"DO's"
- Do get a clear mandate from senior management to plan.
- Do get a clear idea of what senior management expects and when they expect it.
- Do get a clear idea of the reasons for initiating or re-designing the program.
- Do get clear on how the planning process is expected to be structured.
- Do talk to the key managers and get their ideas about what is important to them.
- Do involve the unions early, if any exist, but only with prior management approval.
- Do adopt five to eight measurable, realistic, and time-limited objectives for the program.
- Do consider the employee’s family, and particularly the spouse, in the planning.
- Do survey as much of your workforce as possible.
- Do visit the work sites involved.
- Do visit some other employers who have programs for comparison purposes.
✓ Do collect baseline data for planning and evaluation purposes.
✓ Do develop sensitivity to the culture of your workplace.
✓ Do be “inclusive” rather than “exclusive” in your approach to planning.
✓ Do consider as many “virtual” interventions as possible.

"DON'TS"
✓ Don’t go off “half-cocked” - get a clear idea of what is expected.
✓ Don’t select a program model that doesn’t fit management’s expectations.
✓ Don’t be side tracked by the employee “confidentiality” issue, it will resolve itself.
✓ Don’t let your efforts get side-tracked by union-management politics.
✓ Don’t narrow the range of program ideas too quickly.
✓ Don’t assume things without checking them out yourself.
✓ Don’t use a poorly designed employee interest survey.
✓ Don’t ignore the importance of what people perceive as the “real” reason for the program.
✓ Don’t impede the planning process with too much involvement.
✓ Don’t utilize an employee advisory group before some homework has been done.
✓ Don’t fail to have a proposal for your advisory group to react to.
✓ Don’t forget that everybody has their own personal interest in mind.
✓ Don’t forget that the initial image of the program is conveyed by the way you plan it.
✓ Don’t overlook the importance of program name, logo, tag line and graphic standards.
✓ Don’t forget to give yourself enough time to plan carefully.

8. A checklist for the planning phase.
This checklist can be used to help you complete the planning process for your employee wellness program. Check each item as appropriate.
1. ___ We have a written definition of wellness for our program.
2. ___ We have a clear set of reasons why senior management wants a program.
3. ___ There is a clear mandate from senior management to plan the program.
4. ___ It is clear what kind of planning document or proposal is expected by senior management.
5. ___ The “due” date for producing the plan document has been determined.
6. ___ We have identified a long-term strategy for increasing senior management support for wellness.
7. ___ We have adequate employee demographic data for planning.
8. ___ We have adequate data on employee sick leave patterns.
9. ___ We have adequate data on disability claims.
10. ___ We have adequate worker compensation claims experience.
11. ___ We have adequate data on health benefit claims experience.
12. ___ We have adequate data on current occupational health services needs.
13. ___ We have adequate on quantitative measures of productivity.
14. ___ We have information on previous wellness activity and/or surveys.
15. ___ We have adequate data on the characteristics of the physical space.
16. ___ We have identified an approximate budget range for the program.
17. ___ We have an awareness of what kinds of program components senior management expects to be included.
18. ___ We have an adequate understanding of the internal resources that can be utilized in the program.
19. ___ A maximum budget range for the wellness program that has been identified.
20. ___ We know what major risk factors we want to target with the program and what basic program model makes the most sense for us.
You are now ready to develop the specific design for the program!

### B. Design

The design of your wellness program is the focus of this section of Planning Wellness. The program model used to organize your program is a very critical issue to resolve early. Other important concerns include the objectives you select for your program, the program interventions you adopt, your draft proposal and budget, the intended identity of the program with employees, structuring an employee advisory committee, and establishing an administrative infrastructure for the program. These are the main components of the design of the program and will be addressed in order. Sample program names, themes, and logo ideas are provided in Appendix E.

#### 1. What are your program model options?

There are three major models for worksite wellness programs: Option #1, The Feel Good Wellness (FGW) Model, Option #2, the Traditional Wellness (TW) Model and Option #3, the Results-Driven Wellness (R-DW) Model. Each of these three program models will be addressed in depth in following sections.

<table>
<thead>
<tr>
<th>Feel Good Wellness</th>
<th>Traditional Wellness</th>
<th>Results-Driven Wellness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fun activity focus</td>
<td>Mostly health focus</td>
<td>Add productivity</td>
</tr>
<tr>
<td>No risk reduction</td>
<td>Some risk reduction</td>
<td>Strong risk reduction</td>
</tr>
<tr>
<td>No high risk focus</td>
<td>Little high risk focus</td>
<td>Strong high risk focus</td>
</tr>
<tr>
<td>Not HCM oriented</td>
<td>Limited HCM oriented</td>
<td>Strong HCM oriented</td>
</tr>
<tr>
<td>All voluntary</td>
<td>All voluntary</td>
<td>Some required activity</td>
</tr>
<tr>
<td>Site-based only</td>
<td>Site-based only</td>
<td>Site and virtual both</td>
</tr>
<tr>
<td>No personalization</td>
<td>Weak personalization</td>
<td>Strongly personal</td>
</tr>
<tr>
<td>Minimal Incentives</td>
<td>Modest Incentives</td>
<td>Major Incentives</td>
</tr>
<tr>
<td>No spouses served</td>
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<td>Many spouses served</td>
</tr>
<tr>
<td>No evaluation</td>
<td>Weak evaluation</td>
<td>Rigorous evaluation</td>
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</tbody>
</table>

You are now ready to develop the specific design for the program!
OPTION #1: FEEL GOOD WELLNESS (FGW) WELLNESS: “WELLNESS FOR FUN AND PLEASURE”

The first option in worksite wellness for you to consider is the Feel Good Wellness (FGW) style wellness program. This particular approach to wellness is where many programs have gotten their start. It’s a good place to begin if economic return or health status improvements are not strong drivers for your efforts. National resources for worksite wellness are provided in Appendix G while Appendix H contains suggestions for finding useful web resources.

A. Overview - The “What”

The Feel Good Wellness (FGW) model of worksite wellness focuses primarily on improving the morale of employees. It is intended to add quality to worklife and to improve camaraderie and relationships between employer and employees. This approach to worksite wellness involves entirely voluntary activities that are generally selected for the positive effect they are likely to have on employees. Activities under this approach are often passive and offer information and experiences that are generally desired by most employees. The key operative word here is “fun”.

B. Key Descriptors - “Adjectives and Adverbs”

The key descriptors that help capture the heart of this particular program model are presented below:

- Fun
- Empowering
- Event-driven
- Quality of Life
- Light
- Humorous
- Wholistic
- Intrinsic

- Experiential
- Fragmented
- Non-medical
- Pleasure-oriented
- Entertainment-oriented
- Interest-driven
- Morale building
- Enjoyable

C. Operating Philosophy - The “Why”

The operating philosophy behind this particular program model is reflected below in several defining criteria that help differentiate each of the three major program model options presented in this publication.

All voluntary programming: The FGW Model is characterized as including only voluntary programming or “use at will” program interventions. No mandatory or required program activities or components are generally used, and individual choice alone determines participation levels in the program.

Very low clinical health risk factor orientation: In the FGW Model, a very limited emphasis is usually made on clinical health risks, in such areas as hypertension, elevated cholesterol, lipid imbalances, cardiovascular function, percent body fat, etc. These areas are usually dealt with as secondary to other pursuits, which are usually linked more directly to
desired personal changes in activity levels, body weight, fitness levels, decreased anxiety, etc. These primary concerns are frequently related more to quality of life issues or mental well being than to Traditional Wellness clinical issues.

**Limited direct emphasis on secondary and tertiary prevention:** Virtually all FGW programs do not usually exhibit a heavy focus on the Traditional Wellness wellness and wellness areas of tobacco use, physical activity, nutrition, weight management, cardiovascular disease detection/prevention, and stress management. These areas of Traditional Wellness primary prevention and the associated areas of secondary prevention, specifically activities designed for the early detection of disease and the concomitant use of clinical preventive screening tests, are usually not significant components of the FGW Model. Mental well being, as an area of primary prevention, is emphasized and attitudes, self-knowledge, self-responsibility, and empowerment are all primary prevention components of the FGW Model. The Traditional Wellness clinical areas of tertiary prevention, including helping people manage existing diseases and medical conditions, are rarely addressed under this program model.

**Virtually no integration between various internal program components:** Integrated wellness programming rarely occurs under this program model, including individual activities which are often fragmented in their introduction and spaced out without much intention over time. Events are usually organized with a higher level of concern for the enjoyment and entertainment of employees. Also, due to the usual higher level of concern for psychosocial issues in this model, programming is likely to more closely address the perceived rather than clinical needs of the population involved.

**Limited systems orientation:** The FGW Model is not linked to other employee health service areas, such as occupational medicine, health benefits, industrial hygiene, safety, etc. Since the model has evolved from the psychosocial perspective, it has much greater potential linkages to employee health services and to mental health services such as Employee Assistance Programs. However, wellness or health promotion issues under this model are not linked to employer policies, employee benefits, or to any other employee health-related functions other than the EAP.

**Limited reach to spouses:** In this Model there is usually no programming for spouses of employees. Virtually all the wellness program interventions are targeted only to employees. The program interventions may be offered so that spouses are encouraged to participate but they rarely do so.

**Much less reliance on stable work environments and activity conducted during the work day:** Another feature of the FGW Program Model is less reliance on stable, Traditional Wellness work environments. The FGW Model is somewhat more amenable to dynamic and unstable work environments because it is highly flexible, event-driven and sporadic in nature. This is likely due to the inherent emphasis on enhancing personal performance and coping skills in fluid or volatile work environments, and the greater degree of adaptability to changing worksite characteristics associated with this model.

**More limited formal evaluation potential:** Finally, FGW worksite wellness programs, since they do not rely on as much Traditional Wellness clinical data collection, have virtually no formal evaluation activities. It is also much more difficult to perform precise and valid measurements of psychosocial changes in participants than in Traditional Wellness.
biometric and clinical areas. This does not mean that evaluation is not possible, but that it is likely to be much more of a challenge and rarely performed.

**Limited budget and staffing resources needed:** This program model is characterized by generally low budget requirements. This model usually does not require a dedicated staff person unless the work force size is over 1,000 employees. The typical program budget, not including any staffing or incentive cost is usually in the range of $10 to $45 per employee per year.

**Virtually no expectations for economic return or health cost savings:** In the FGW Model of wellness programs there is usually very little expectation for economic return. This type of wellness program is not expected to catalyze long term health behavior changes or produce savings in areas such as: health plan claims cost, reduction of sick leave, reduction of workers’ compensation costs, reduction of disability insurance costs or improvements in “presenteeism.” The typical level of return-on-investment (ROI), expressed in the form of a cost/benefit ratio, of the FGW program model is between zero to 1:1:0.

**D. Organizing Strategies - The “How”**

The organizing strategies of the Feel Good Wellness (FGW) Model reflect the types of interventions that are typically used and their respective role in the overall programming strategy.

**Very limited use of biometric screening:** Biometric screening, such as blood pressure, cholesterol, percent body fat, cardiopulmonary function, etc., are usually not routinely done or are performed in relation to meeting some personal desires of the participant. This appears to be a side effect of a low level of emphasis within the program on the clinical and medical model aspects of programming.

**Very limited use of an assessment process to lead to a personal plan for health improvement:** The FGW Model generally downplays formal assessment processes that are used to help develop a personalized plan for behavior change and health improvement. This appears to be due to the high reliance on the individual’s role in taking responsibility for their own health and to manage their behavior change without extensive involvement or follow-up from the program’s staff. This is consistent with a strong empowerment emphasis that is central to the program’s goals and objectives.

**Virtually no pro-activity:** In this program model there is usually no pro-activity. All interventions are structured in a reactive or passive mode where the individual participant must take some action to be involved. The activities and interventions are usually experiential in nature and all follow-up is at the discretion of the individuals.

**Moderate use of group educational techniques:** The use of Traditional Wellness group education techniques for workshops, support groups, and group provision of information are usually used in the FGW Model of worksite programming. Group activities tend to be more discussion and enjoyment oriented with greater reliance on self-directed and individual choices around behavior change. Groups are used to provide social and peer support with a strong emphasis on personal empowerment and experiential activities.
No high risk intervention: Since wholesale testing and biometric data collection usually does not occur under this model, it is usually not possible for individuals with severe single risk factors (i.e., a cholesterol of 390 ml/dl), or those with multiple major health risk factors, to be targeted by the program as a specific group. Interventions are usually not organized around reaching the "high risk" with specific designated activities, but rather are oriented to help empower all employees to seek and attain a higher level of health and well-being.

Incentives not used at all: In the FGW Model, formal incentives are seen as extrinsic motivators and as potentially undermining the development of intrinsic motivation. Therefore, they are usually not used as major program components or within any individual program component.

Use of generalized or non-segmented group communications: The FGW Model uses many communication channels, but virtually all of the communication is geared to unsegmented target populations, with very limited segment specific targeting of messages, vehicles, or program interventions.

Virtually no use of medical self-care/health-care consumerism focus: The FGW Model usually does not provide medical self-care programming or consumer health education interventions. These types of interventions are usually designed to help reinforce the self-responsibility and consumer empowerment issues, and to help modify health care utilization behavior by assisting people in dealing with symptoms or health care practitioner relationships. These values are not usually part of a FGW Model program. However, the overall empowerment emphasis of the FGW Model can be compatible with the empowerment emphasis inherent in medical self care and consumer health training.

Relatively low fitness facility-based emphasis: Another characteristic of the FGW Model is the much more modest reliance on fitness facility use in the worksite and greater use of "experiential" wellness style programming, such as non-competitive games, fun runs, walking programs, nutritional potlucks, personality analysis, inter-personal relations, team building, communication skills, humor at work, provision of chair-side massage, etc.. Facilities are typically seen as just another option or choice available for use by the participant/employee but their regular or consistent use is not emphasized.

Moderate level of intentional cultural change: The FGW Model, in its archetypal form, is usually characterized by a modest degree of intentional effort to change the culture of the worksite by making work more enjoyable. Widespread cultural change rarely occurs as a result of the use of this program model. However, this model of worksite wellness is usually very compatible with organizational re-design efforts and worker empowerment interventions.

E. Key Activities - The “Interventions”

There are a number of program interventions that characterize this particular program model. Figure 12 below contains some of the most typical interventions for this program model.
Each of these interventions will be described in turn.

**Health fair:** These are typically held in a central location and consist of a large number (i.e., typically 12 to 35) individual booths that offer information, products and testing for a specific health care issue. Health fairs are usually held in cafeterias, large foyers or in large conference rooms. Sometimes people can receive an incentive reward (i.e., lottery drawing, coupons for a mountain bike or dinner at a local restaurant, cash award, half day off in next 30 days, for getting their Wellness “Passport” stamped at all the testing booths. The booths typically include: cholesterol testing, blood pressure, strength and/or flexibility testing, lung function, blood pressure, percent body fat, American Heart Association, information on smoking cessation, depression testing, low back pain prevention, fitness club discount partners and Employee Assistance Program (EAP) information. Local alternative therapists such as: naturopaths, chiropractors, and shiatsu practitioners can also be included in a health fair under the FGW style wellness program model. Access to the health fair is usually free and spouses are encouraged to attend but seldom do so.

**Biometric testing option:** Biometric screening can be introduced in virtually any worksite setting. When first initiating a new wellness program, it is frequently possible to offer biometric testing, either at no cost or a nominal cost (i.e., $15 for all the tests. The most frequently used screening tests include: cholesterol, HDL, LDL, blood sugar, percent body fat or Body Mass Index (BMI), sub-maximal bicycle ergometer testing, height and weight and blood pressure. Other types of biometric screening include: screening for abdominal aneurysm, flexibility and strength, mammography, PSA, depression screening, bone density and vision and hearing testing. It is not a good idea to perform these kinds of tests on a voluntary basis every year on asymptomatic working
adults. Every 2 to 4 years makes the most sense. If testing is connected with health plan enrollment, so that everyone is tested, it makes much more clinical sense. Also if Health Risk Assessment (HRA) data can be used to do follow-up with those who really need to be screened it makes much better programmatic sense. Unfortunately many employers conduct voluntary biometric testing each year and then have no money to do follow-up with those who are high risk. This is an unwise program strategy.

**Lunch and learn sessions:** Educational sessions that are held at lunch time, usually of 45 minutes or an hour in length are called “Lunch and Learn sessions.” The topics can include: recent developments in weight management, women’s health issues, men’s health issues, personality profiling, developing your spiritual side, resiliency, financial wellness, scrap-booking, managing your time, avoiding temptations during the holidays, and beginning a walking program. These sessions often have door prize drawings for those who stay until the end of the session. They may include written materials or use of other audio-visual media. The lunch and learn sessions can also be used to create a more “holistic” approach to health and behavior change.

**Wellness “event”:** A wellness event can include the kick off of a new or newly revised wellness program and may include a wellness-oriented focus for the population involved. This can include a new games event, a fund raising event with a physical activity focus, a “volks-march” or orienteering event. This can also include a version of Olympic events or corporate competitions or special Olympics. It is something that has potential for all employees and usually has a lot of company and community visibility and promotion.

**Community sponsorship:** In addition to the “Wellness Event” option, the company or organization can also support the sponsorship of a community event, such as a fund raiser for breast cancer research or a program to raise funds for the building of a YMCA or YWCA. The organization can provide volunteers, merchandise or direct funding as part of their sponsorship. Recognition for volunteers is usually a high visibility at this kind of event. This often enhances the corporate citizenship status of the organization in the community.

**Chair massage option:** This programming option includes a regular offering of chair message for employees either subsidized fully, partially or not at all. This can include providing it as a “perk” for meeting production or work goals. This strategy can produce a lot of visibility and “buzz” that can be very positive. However, if you are a public agency and have a somewhat contentious relationship with the local press you need to be careful about the potential for adverse public feedback with this strategy. The chair message can be held in building foyers, fitness centers, conference rooms or cafeterias.

**Free fruit:** A low cost strategy which creates a good feeling is the provision of fresh fruit at organizational activities. Bananas, apples, oranges, pears, plums and peaches work well. These can be placed at reception points, conference rooms, fitness facilities or in break rooms. The basic message to employees and visitors is that….“we support healthy eating.”
Wellness materials in HR: Another program intervention option for the FGW program model is the placement of wellness oriented materials, such as those available from WELCOA (www.welcoa.org) or other wellness information vendors on various health and wellness topics. These materials can be provided to those employees who come to the Human Resources (HR) department looking for information. Brochures can be made available in racks or kept in files. The HR department can also provide longer materials and books on a library loan basis. These interventions are usually limited to a passive individual approach. This may include some web-based interventions.

Health cartoons circulated: This intervention involves posting or circulating wellness or health-oriented cartoons or humor. The context is keeping things in perspective and adding an element of humor to the program. These cartoons can be selected for their editorial message about wellness and health issues or can be circulated through social media connections. Cartoons can be used on an online wellness-exchange site and can be changed weekly or more often.

Nutritious pot lucks: This intervention involves the organization of a lunchtime potluck using only healthy food choices. Individual employees can put the recipes together and then co-workers can taste each dish and pick up the recipes that appeal to them. They can then prepare the healthy recipe for their own family. Variation can also include providing all recipes in a small publication or online where employees can mark their comments next to each recipe as they taste each. This event can also provide an opportunity to recognize individual employees for some wellness related achievement.

Celebrity event: This next intervention that is often associated with the FGW model involves a celebrity appearance connected with some wellness event. The celebrity can be a sports star, local news celebrity, entertainment personality or one that provides motivational or inspirational presentations and can also acknowledge individuals in the organization at a kick-off event for the wellness program.

These are just a few of the various interventions that can be used with a Feel Good Wellness (FGW) program model.

F. Resource Requirements - “Dollars and Sense”

The resources required for the FGW program model are nominal. The likely annual per employee per year cost for this form of worksite wellness programming is likely to be from $0 to $45 per year. This type of wellness program is typically created and delivered without a formal budget. It relies substantially on volunteer help and donations from vendors. Often there is no formal budget and programming just happens when some people come together to do wellness usually with permission from the senior/owner/manager. Typically this is a low cost entry into worksite wellness programming and can be a starting point for later movement to the Traditional Wellness (TW) program model.
G. Realistic Expectations - The “Likely Results”

This program model is not likely to produce any economic return. The haphazard nature of programming combined with the fragmented approach usually leads to very limited levels of economic return. Also associated with this form of wellness program are very low expectations for long term behavior change. Since very limited behavior change takes place there is typically very limited economic return. It is commonly held that this type of programming will seldom produce any economic return for an employer.

Rarely a single intervention in this form of program will show a very high cost benefit ratio. For example, a medical self-care workshop can be completed and then a follow-up survey used to determine how many emergency room visits or physician visits have been prevented. Then because the cost of the program may be very low when compared with the projected value of the health care avoided, potentially producing a cost/benefit ratio of 1:25.0. The strategic issue is that the small cost for the medical self-care intervention, even with a 25 to 1 benefit to cost ratio means that the program has experienced a small amount of economic return due to the small cost of the program intervention. As a result, in rare cases the overall cost to benefit ratio for this type of program model may be as high as 1:1.0.

H. Evaluation Activities - “Making Improvements for the Future”

A limited amount of evaluation potential is associated with this particular program model. The evaluation of participant satisfaction can be accomplished with a post program evaluation survey and some additional questions can be asked about improvements in the program and how important the program was to specific behavior changes.
OPTION #2  TRADITIONAL WELLNESS (TW) WELLNESS - “THE SAFE APPROACH”

A. Overview - The “What”

The Traditional Wellness (TW) model of worksite wellness focuses primarily on the passive offering of a more extensive set of interventions than the FGW program model. It is intended to offer a wide range of activities in a smorgasbord-style approach where about half the eligible employees will usually initiate the use of one or more program activities. The intention is to offer, on a completely voluntary basis, many different worksite-based wellness activities and to have something “…for everybody.” This approach to worksite wellness usually involves only site-based activities that are entirely voluntary without significant incentives. Activities under this approach can be characterized as generally passive and focused primarily on offering information and experiences that are intended to catalyze healthy behavior. The programming is usually not driven by a strong concern for health cost management (HCM) effects and the key operative word here is “safe”. This model is the one that is used in the majority of worksite wellness programs, particularly if economic return has not been a high priority over the history of the program. Incentives used are usually modest (e.g. $100 to $300) and program budgets are usually not very large. Evaluation can be done, but it is usually exceedingly difficult with some innate limitations and as a consequence often shows weak program effects.

B. Key Descriptors - “Adjectives and Adverbs”

The key descriptors that help capture the heart of this particular program model are presented below:

- Safe
- Comprehensive
- Conventional
- Typical
- Most prevalent form
- Health risk oriented
- Activity-oriented
- Medical model
- Standard approach
- Somewhat passive
- Proven
- Menu-driven
- “Smorgasbord” approach
- Use-at-will

C. Operating Philosophy - The “Why”

The operating philosophy behind this particular program model is reflected below in several defining criteria that help differentiate this model from the other two major program models presented here.

All voluntary programming: The Traditional Wellness (TW) Model is characterized as including only voluntary programming (rather than “mandatory”) or “use at will” program interventions. No mandatory or required program activities or components are generally used, and individual preference and choice alone determines participation levels in the program.

Very high clinical health risk factor orientation: In this model, a very strong emphasis is usually made on clinical health risks, in such areas as hypertension, elevated cholesterol, lipid imbalances, cardiovascular function, percent body fat, etc. These areas are usually emphasized strongly and are the primary focus of virtually all program interventions. These
primary concerns are frequently related to improved quality of life and reductions in morbidity (e.g. illness and injury).

**Heavy emphasis on primary and limited secondary prevention issues:** Virtually all Traditional Wellness wellness programs focus on tobacco use, physical activity, nutrition, weight management, cardiovascular disease detection/prevention, and stress management. These represent some of the major concerns of primary prevention. Secondary prevention, in the form of early detection of selected diseases and use of clinical preventive screening tests are also significant components of the Traditional Wellness (TW) Model. The typical screening areas are: hypertension, blood lipid composition, body mass index (BMI), and blood sugar.

**Limited integration between various internal program components:** Integrated programming is generally not the rule, but rather the exception in the T Model, with individual activities spaced over time without much integration or linkage. A calendar of events with little relationship among the various planned events is often a trademark of this particular program model. Most program interventions are introduced as “stand alone” activities and limited “campaign” strategies (i.e., campaigns typically include a series of activities including, education, testing, intervention, follow-up testing and reminders spaced out over 3 -4 months) which usually requires a higher level of programmatic and organizational integration.

**Limited systems orientation:** This model usually reflects a stand-alone approach to worksite wellness. Wellness or health promotion activities are not usually linked in the T Model to employer policies, employee benefits or to any other employee health-related functions. If there is a linkage to other activities and policies in the workplace it is usually at a fairly limited coordination of activity.

**Limited reach to spouses:** In this T Model, as with the FGW Model, there is usually no programming targeted on spouses of employees. Virtually all the wellness program interventions are usually targeted only on employees. The program interventions may be offered so that spouses are encouraged to participate, but they rarely do so.

**High reliance on stable work environments and activity conducted during the work day:** A key feature of the T Program Model is high reliance on stable, Traditional Wellness work environments. The T Model works better in reasonably stable work environments because it requires a slow, but consistent build up and development process. Unstable or highly dynamic work environments make it difficult to coordinate wellness activity and to integrate interventions. Along with this feature is the need to put almost all program activity on work time. This enhances participation levels, but can often create problems with mid-level and first line supervisors due to potential adverse impact on the work process.

**Limited formal evaluation activity:** Finally, Traditional Wellness worksite wellness programs usually have not conducted an organized approach to evaluation of such things as participation, participant response and satisfaction levels, risk factor prevalence, patterns of changes in individual health habits or clinical test results, changes in key organizational indicators, achievement of program objectives, or collection of anecdotal success stories. Evaluation has typically been much less comprehensive and much more fragmented in nature with this model.
Moderate budget and staffing resources needed: This program model is characterized by moderate budget requirements. This model usually requires a full time dedicated staff person for every 600 to 1,000 employees. The typical program budget, not including any staffing cost is usually in the range of $46 to $150 per employee per year.

Modest expectations for economic return or health cost savings: In the T Model of wellness programs there is usually a modest expectation for economic return. This type of wellness program has been proven to catalyze some level of long term health behavior changes and produce savings in areas such as: health plan claims cost, reduction of sick leave, reduction of workers’ compensation costs, reduction of disability management costs or improvements in “presenteeism.” The typical level of return-on-investment (ROI), expressed in the form of a cost/benefit ratio, of the T program model has been documented from 1:1.5 to 1:3.5.

D. Organizing Strategies - The “How”

The organizing strategies of the Traditional Wellness (TW) Model reflect the types of interventions that are typically used and their respective role in the overall programming strategy.

Regular use of biometric screening: Biometric screening, such as blood pressure, cholesterol, percent body fat, cardiopulmonary function, etc., are usually routinely done or are performed in relation to meeting some measurement or incentive feature. Unfortunately, there is a tendency to over utilize screening by using it on an annual voluntary basis. The scientific literature clearly demonstrates that the use of voluntary screening for asymptomatic healthy working adults is not clinically or financially warranted. However, biometric screening can be used to provide more objective evaluation of the health status changes of the participants over time so it can be of some value. Typically the biometric screening is connected in some manner to the completion of the HRA.

Periodic use of an assessment process leading to the development a personal plan for health improvement: The T Model generally offers a voluntary process with or without incentives to participate in a formal assessment process that are used to help develop a personalized plan for behavior change and health improvement. This often involves blood work, completion of an HRA, and a fitness assessment and possibly some follow-up from the program’s staff. This is usually consistent with enhanced empowerment and self-efficacy that is often central to the program's goals and objectives.

Very limited proactivity: In this program model there is usually very limited proactivity. Almost all interventions are usually structured in a reactive or passive mode where the individual participant must take some action to be involved or to utilize the program. The activities and interventions are usually group-based in nature and all follow-up is at the discretion of the individuals.

Heavy use of group educational techniques: The use of Traditional Wellness group education techniques for workshops, support groups, and group provision of information are usually used in the T Model of worksite programming. Group activities tend to be more educational in nature with greater reliance on behavior modification techniques around
selective changes in health behavior. Groups are used to provide social and peer support with a strong emphasis on long term behavior change.

**Limited high risk intervention:** Those individuals with severe single risk factors (i.e., cholesterol of 390 ml/dl) or those with several major health risk factors are generally not targeted or proactively reached by the program as a separate group. Interventions are usually not organized around reaching the "high risk" with specific designated outreach or pro-active activities.

**Nominal use of incentives:** In the T Model incentives are usually limited to T-shirts, water bottles and other low cost material goods. Few types of incentives are used and incentives are usually not seen as major program features or as part of an overall behavioral management strategic approach.

**Use of generalized or non-segmented group communications:** The T Model usually uses many communication channels, but virtually all communication is geared to the entire un-segmented or general target population, with very limited segment specific targeting or of messages and vehicles.

**Limited medical self-care/health care consumerism focus:** The T Model usually exhibits very limited use of medical self-care programming, or consumerism-oriented interventions, that are designed to modify health care utilization behavior or to assist people in dealing with symptoms or health care provider relationships.

**Heavy facility-based emphasis, usually at major worksites:** Another characteristic of the T Model is the primary reliance on a worksite based fitness center. Usually, T worksite wellness programs were initiated with the establishment of corporate fitness centers and these, by their nature, were usually in high density employee locations, such as corporate headquarters or major manufacturing locations.

**Minimal intentional cultural change:** The T Model is also characterized by limited intentional effort to change the overall health culture of the work place. Cultural change generally occurs in a limited manner but without an intentional and focused effort.

**Reliance on stable work environments and activity conducted during the work day:** Another feature of the T Program Model is the design of program activities based on assumptions that the work force is somewhat homogeneous, that work is stable, job security is high, and the culture of the worksite is not in significant transition.

### E. Key Activities - The “Interventions”

There are a number of program interventions that characterize this particular program model. **Figure 13** below contains some of the most typical interventions for this program model.
Each of these interventions will be described in turn and can be added to those identified under the Option #1 FGW Program Model.

**Health risk assessment (HRA):** In addition to many of the program activities identified under the FGW Program Model, the Traditional Wellness (TW) Program Model almost always includes the use of a voluntary Health Risk Assessment (HRA). These paper-based or web-based health surveys ask questions about the individual’s health habits, medical conditions, current symptoms, health risks, readiness to change, learning preferences and other issues. Each individual completing an HRA usually receives their own “personal health report” with an assessment of their likely future health and recommendations for how they can improve their health. HRAs are typically not used to shape proactive personalized interventions with those who can benefit from a specific behavior change in the T Model. The HRAs are usually voluntary and with minimal incentives for their completion. Suggested technical specifications for HRAs are provided in Appendix J.

**Biometric testing option:** Voluntary biometric screening for cholesterol, body fat or Body Mass Index (BMI, blood sugar, blood pressure, HDL or LDL are usually performed in a T Model program. These biometric tests are usually offered in some connection with the completion of an HRA. They are often repeated each year but unfortunately that has been proven to be a relatively poor use of program resources. Usually the biometric screening is not offered to spouses and the results are usually not shared with the individual’s primary care physician. Sometimes the biometric process is connected to an annual or periodic employee physical exam.
Fitness club Memberships/facility: Another typical intervention for this type of program model is the provision of a fitness facility at the workplace or the offering of a discount or subsidy for the use of a fitness facility. The subsidy from the company is usually in the area of $250 to $500 per year to offset the cost of fitness facility dues. Discounts are often given to corporations to entice their employees and/or spouses to join an athletic club as a member. Some of these arrangements have requirements for a minimum number of times per week that the facility is used or the individual has to pay back the subsidy. Sometimes in smaller worksite a fitness room is provided with fitness equipment that can be used on the employee’s time.

Weight management program: The next intervention that is usually seen in the T Program Model is a weight management program. These are always voluntary in nature and vary greatly in the core activities they include. Frequently employers who are doing a Traditional Wellness Program Model go out and get a vendor that can come into the worksite to conduct: weigh in procedures, small group discussion, perform dietary analysis, conduct cooking demonstrations, and provide counseling. Due to the increasing severity of the obesity problem, employers will likely begin to offer a broader range of weight management strategies to their employees in the future.12

Web-based health information: E-Health options provide health and wellness information to those who have computer and Internet access. This information source can often be accessed to both those at work and at home. Web-based health information can run the full range of primary, secondary and tertiary prevention topics. These information sources can also be offered through websites associated with the employers Intranet or can be provided by a health management information vendor. However, this particular intervention strategy remains very passive in nature.

Healthy cafeteria/vending options: This intervention usually involves making sure that cafeteria and vending machines provide healthy food options to workers. This includes vegetable and fruit options as well as high fiber, low fat and low salt content foods. These foods may be offered at low cost or partially subsidized in order to increase their consumption. Options such as salad bars, healthy soups, low fat yogurts and whole grain food choices are usually included in this intervention strategy.

Self-care book: A medical self-care book that usually addresses from 25 to 90 common medical conditions that are usually self-limiting. These reference books are usually given to employees along with some training on their use. The books are designed to help individual employees and their spouses to feel more confident making decisions about initial diagnoses, home treatment options and self-care practices. In addition the books are designed to help people recognize what symptoms do require appropriate medical attention and to improve the individual’s sense of confidence in making decisions about their health and/or the health of the family members.

Preventive medical benefit coverage: Typically in the Traditional Wellness program model employers include some form of preventive medical benefit coverage that provides some benefit coverage for preventive screening. These benefits provide secondary prevention services to an employee and dependent population which means early detection of an underlying disease process whose outcome can be modified in a positive way by early intervention. If biometric screening is not provided at the worksite then it becomes more important to have a preventive medical benefit coverage provision as part of a health plan.

Wellness newsletter: This intervention strategy involves the provision of wellness newsletter usually in paper form and mailed to individual employees home. These newsletters usually contain seasonally sensitive, health and wellness topics that provide practical advice and tips for health improvement. These newsletters also usually contain consumer health information as well as information on psychological and quality of life enhancement. These newsletters act as general sources for the marketing of wellness issues and the repetition and reinforcement of wellness concepts and suggestions.

Short term incentive program: This intervention usually involves incentive programs that run from 3 weeks to 12 weeks and focus on increasing physical activity, losing weight, improving nutrition practice or improving stress management practices. These short term incentive programs are designed to provide an opportunity for behavior change usually connected with rewards of some kind, such as merchandise items, cash prizes and special recognition. Health Enhancement Systems of Midland, MI is one vendor that has a number of good packaged short term incentive programs.

F. Resource Requirements - “Dollars and Sense”

The resources required for the T program model are moderate. The likely annual per employee per year cost for this form of worksite wellness programming is likely to be from $46 to $150. This type of wellness program is typically planned and delivered with a dedicated staff person and a formal budget. It usually relies substantially on vendors. One full time dedicated staff member with specialized training is usually needed for every 600 to 1,000 employees. This programming approach usually involves activities that are rolled out sequentially with some sensitivity to seasonal health issues like weight gain over the holidays, getting more fit for summer, or preventing injuries during winter. Typically this is a conventional foray into worksite wellness programming and can be a starting point for later movement to the Results-Driven Wellness (R-DW) program model.

G. Realistic Expectations - The “Likely Results”

This program model is likely to produce a modest economic return. The more comprehensive nature of programming combined with a “use at will” approach usually leads to approximately half of eligible employees taking some level of personal initiative to use at least one per year of the many types of program offerings that characterize this program model. Also associated with this more Traditional Wellness form of wellness program are moderate levels of expectations for long term behavior change. Moderate levels of behavior change lead to moderate levels of economic return. This program model is typically associated with a
cost/benefit ratio of 1:3.0 producing three dollars of savings to each dollar of cost invested in
the program, safely within 12 to 14 months of the start of the program.

H. Evaluation Activities - “Making Improvements for the Future”

Here again, as with the FGW model, a limited amount of evaluation potential is associated
with this particular program model. The evaluation of individual program components, such as
health fairs, lunch and learn sessions, voluntary completion of HRAs, and participant
satisfaction for various activities can be accomplished with a post program evaluation survey
and some additional questions can be asked about improvements in the program and how
important the program was to specific behavior changes. One of the innate limitations of this
particular program model is the absence of evaluation of the entire participant population
and/or the entire work force. It is then impossible to assess the impact of the program on health
risk prevalence, readiness to change, improved behavior patterns or health care utilization
experience. This innate weakness in evaluation capability combined with the relatively small
populations of participants makes Return-on-Investment (ROI) assessment extremely difficult.

Limited “formative” evaluation that is intended to improve the effectiveness of the program is
possible, but more substantive “comparative” evaluation, that assesses the performance of the
program against a normative standard is usually not possible without a large resource
commitment to evaluation.
OPTION #3  RESULTS-DRIVEN WELLNESS (R-DW) STYLE
WELLNESS - “SERIOUS WELLNESS”

A. Overview - The “What”

The Results-Driven Wellness (R-DW) model of worksite wellness focuses primarily on the proactive offering of a highly structured and substantial set of interventions than either the FGW program model or the T program model. It is intended to provide an infra-structure of health management activities offered to a large portion of the work force involved and their spouses. Usually more than 80% of eligible employees complete a Health risk assessment (HRA) each year and at least half the spouses. Strong incentives are used to achieve this high level of participation. Also the HRA is used to provide survey-guided programming that uses the information provided in the HRA to proactively offer support and coaching to participants. The core intention of the R-DW model is to offer an organized and intentional process of health improvement and health risk reduction for all participants.

This approach to worksite wellness usually involves both site-based activities and “virtual” activities (those involving use of mail, computer and telephone in home settings) that are connected to significant incentives. Activities under this approach can be characterized as highly personalized and proactive in nature and focused primarily on assisting the participant with reduction of selected health risks and improved management of health conditions. The programming is usually driven by a concern for health cost management (HCM) effects and the key operative words here are "serious wellness.”

This model is the one that is used in the most progressive companies, particularly if economic return is a high priority for their wellness program. Incentives used are usually significant and may range from $600 to $1,800 and program budgets are usually significant. Rigorous program evaluation is much more feasible and approximates much more of an epidemiologically sound approach.

B. Key Descriptors - “Adjectives and Adverbs”

The key descriptors that help capture the heart of this particular program model are presented below:

- Serious
- Comprehensive
- State-of-the-art
- Strategic
- Innovative
- Productivity-oriented
- Results-oriented
- Infrastructure approach
- Some required activities
- Coaching oriented
- Injury prevention
- Proven
- Medical and behavioral model
- Incentive-driven
- Futuristic approach
- Proactive
- High participation
- High ROI
C. Operating Philosophy - The “Why”

The operating philosophy behind this particular program model is reflected below in several defining criteria that help differentiate each of the three major program model options presented in this Publication.

Some mandatory programming: The Results-Driven Wellness (R-DW) Model is characterized by its inclusion of a few mandatory components of programming. These mandatory components usually include such things as annual program orientation sessions, involvement in core incentive programs, receipt of survey documents, involvement in benefit use or health care use workshops, mandatory open enrollment meetings with wellness briefing, etc.

Very high clinical health risk factor orientation: In the R-DW Model, a very strong emphasis is usually made on clinical health risks, in such areas as hypertension, elevated cholesterol, lipid imbalances, cardiovascular function, percent body fat, etc. These areas are usually emphasized in several ways and are the primary focus of many, if not all, program interventions. These primary concerns are frequently combined with special focus health risk issues such as migraines, allergies, and depression risk.

Balanced emphasis on primary, secondary and tertiary prevention issues: Virtually all R-DW style programs focus on a variety of primary, secondary and tertiary prevention. This includes dealing with precursors to illness and injury, early detection and improved management of disease conditions. The approach usually focuses on the prevalence and costly of conditions that are capable of being prevented or better management.

High level integration between internal program interventions: Integrated programming is generally the rule with individual activities spaced over time and connected to other linkages. A calendar of events with sequences of various planned events is often a trademark of this particular program model. Most program interventions are introduced with an eye to logical connections to other interventions and to referrals to complementary internal or external activities.

Strong systems orientation: The R-DW Model usually reflects a strong systems approach to worksite wellness. Wellness or health promotion activities are usually linked in their sequence, referral opportunities, selective use of information and compatibility of messages. The R-DW Model attempts to link health management interventions to employer policies, employee benefits and to other employee health-related functions. The linkage to other workplace activities and policies is usually designed to affect the direct health-related costs of employees, disability costs, absence from work and lost productivity due to health conditions.

Full reach to spouses: In this Model, unlike the previous two models, there is specific programming targeted at spouses of employees. Spouses are usually incented to complete HRAs and may also be provided with coaching intervention. “Virtual” types of wellness program interventions are offered to spouses. Some of the site-based program interventions may also be offered to spouses as appropriate.

Low reliance on stable work environments and activity conducted during the work day: A key feature of the R-DW Program Model is low reliance on stable, Traditional Wellness
work environments. The R-DW Model works somewhat better in reasonably stable work environments because it requires a slow, but consistent build up and development process. Unstable or highly dynamic work environments can be served well with the virtual components of the program even though they can make it difficult to coordinate wellness activity and to integrate interventions. Program activity can be on work time to achieve higher levels of participation but this may create problems with mid-level and first line supervisors due to the potential adverse impact on work process.

**Significant formal evaluation activity:** Finally, R-DW style worksite wellness programs conduct a very organized approach to evaluation of such things as participation, participant response and satisfaction levels, risk factor prevalence, patterns of changes in individual health habits or clinical test results, changes in key organizational indicators, achievement of program objectives, or collection of anecdotal success stories. Program evaluation is usually comprehensive and much more complete than in the other two program models.

**More budget and staffing resources needed:** This program model is characterized by generally larger budget requirements. This model usually requires full time dedicated staff or vendor staff in the range of one FTE for every 600 to 700 employees. The typical program budget, including staffing cost is usually in the range of $151 to $450 per employee per year.

**Solid expectations for economic return or health cost savings:** In the R-DW Model of wellness programs there is usually a significant expectation for economic return. This type of wellness program has been proven to produce long term health behavior changes and significant savings in areas such as: health plan claims cost, reduction of sick leave, reduction of workers’ compensation costs, reduction of disability management costs or improvements in “presenteeism.” The typical level of return-on-investment (ROI), expressed in the form of a cost/benefit ratio, of the R-DW program model has been documented from 1:3.6 to 1:7.0.

### D. Organizing Strategies - The “How”

The organizing strategies of the Results-Driven Wellness (R-DW) Model reflect the types of interventions that are typically used and their respective role in the overall programming strategy.

**Strong incentives or a requirement for completion of an annual Health Risk Assessment (HRA):** The R-DW Model utilizes either a strongly incented completion of an annual web-based HRA; providing more than $100 of pre-tax or after tax value to the participant for completion of the HRA as part of the annual application process for continuation of health benefit coverage. For example, in order to initiate or continue health benefit coverage, employees would complete the HRA once a year or possibly every six months. This obviously functions as a very powerful participation incentive for those who desire health insurance coverage.

**Balanced approach to long- and short-term clinical health risk factors:** Another characteristic of the R-DW Model is its balanced approach to short- and long-term clinical health risks. In this model, the long-term factors such as hypertension, elevated cholesterol, lipid imbalances, cardiovascular function, percent body fat, etc., are balanced against those factors that are short-term in their health impact, such as seat belt use, smoking and acute pulmonary disease, stress management, asthma management, low back pain prevention,
injury prevention, etc. Likewise, the reductions in the incidence and severity of major chronic diseases, such as cardiovascular disease, respiratory disease, and selected cancers, are balanced against the short-term morbidity impacts that produce short-term modifications in health service use and costs.

**Focused use of biometric screening:** Biometric screening is used in the R-DW Model to enable the individual to meet specific incentive criteria and to qualify for the incentive reward. Health risk assessments or health surveys can be used that collect information that can help the individual qualify for the incentive reward. The biometrics function to reinforce the clinical and medical objectives of the program and to help the individual manage their own health in the context of the criteria used by the incentive program. Biometrics are often linked in a way to selectively target those individuals who need follow-up biometric screening related to their clinically defined need for preventive care.

**Annual use of assessment to lead to a personal plan for health improvement:** The R-DW Model usually uses an annual assessment to help develop a personalized plan for behavior change and health improvement. This individualized plan usually becomes the responsibility of the individual to manage, with periodic follow-up from the staff of the program.

**Acute and chronic disease treatment focus:** Treating the major killers, such as heart disease, stroke, selected cancers, and chronic obstructive pulmonary disease, are a focus of the R-DW Model, along with the early diagnosis and treatment of acute health problems and prevention of injuries at work, at home, in vehicles and when engaging in recreational activities. Nurse advice lines and consumer training generally help provide advice and skills for health consumers when health care is needed.

**Light use of group educational techniques:** The use of group education activities, such as workshops, support groups, and group provision of information, are used rarely and are heavily augmented with other menu programming options in the R-DW Model of worksite programming, such as individual counseling, self-directed change materials, on-line phone support, etc. Wellness seminars and workshops are used periodically to help inform and assist with behavior change, but many other behavior change methods are typically made available to participants.

**Balanced approach to primary, secondary, and tertiary prevention:** In addition to the typical focus on primary prevention issues such as tobacco use, physical activity, nutrition, weight management, cardiovascular disease prevention, and stress management, the R-DW Program Model also addresses issues of secondary prevention such as preventive screening, and tertiary prevention issues such as effective disease and condition management. The tertiary prevention focus comes into play in such areas as prenatal care, low back pain management, diabetic care, asthma treatment, somatic disorder patterns, allergic reactions, etc. These areas tend to have an immediate impact on health care use.

**More extensive integration between various internal program components:** Integrated programming is generally emphasized in the R-DW Model through the linking of campaigns, extensive education and communications preceding testing opportunities, follow-up intervention opportunities, and providing opportunities for retest and re-focusing. Events with intentional linkages and integration among the program components are a general pattern of the R-DW Model.
**Strong systems orientation:** The R-DW Model usually reflects a strong systems approach to worksite wellness. Wellness or health promotion activities are usually linked to employer policies, employee benefits, or to other employee health-related areas. A systems view brings a higher degree of linkage to other aspects of the organizational culture. The types of interventions and linkages are typically more far-reaching and much broader in this program model.

**Organized high risk intervention:** Those individuals with severe single risk factors (i.e., a cholesterol of 390 ml/dl) or those with multiple major health risk factors are usually separately targeted under this program model. Follow-up interventions are usually organized around reaching the "high risk" with specifically designed and targeted intervention activities.

**Extensive use of incentives:** In the R-DW Model, core incentive programs with significant rewards, as well as nominal incentives, such as T-shirts, water bottles, and other low cost material goods, are often used. Incentives are seen as key program features or as a main part of a behavioral management strategic approach, so many types of incentives are used.

**Use of segmented group communications:** The R-DW Model typically uses multiple communication channels, with a modest portion of the communication activity geared to segmented target groups. This is accomplished with grouping based on location, age characteristics, gender characteristics, or stage of readiness to change.

**Major medical self-care/health-care consumerism emphasis:** The R-DW Model usually provides a clear, strong, and recurring focus on medical self-care programming or consumer-based interventions that are designed to modify health care utilization behavior. Another major emphasis is on assisting people in dealing with symptom-generated self care and attempts to impart skills related to improving relationships with health care providers.

**Moderate facility based emphasis:** Another characteristic of the R-DW Model is the relatively tangential role of a worksite-based fitness facility. Under this model, worksite wellness programs may utilize corporate fitness centers, but services are still brought out into the various worksites and usually affect employees in high density as well as remote locations. There is broader use of "virtual wellness" style programming or program infrastructure.

**Moderate intentional cultural change:** The R-DW Model is also characterized by a significant degree of intentional effort to change the culture of the work organization. Cultural change generally occurs in a consistent, intentional, and focused manner.

**Adapted to an unstable work environment and activity is seldom conducted during the work day:** Another feature of the R-DW Model is the design of programs based on assumptions that the work force is heterogeneous, that work is unstable and subject to change, job security is not assured, and the culture of the worksite is often in significant transition.

**Significant formal evaluation activity:** Finally, R-DW Model worksite wellness programs have often set in motion an organized approach to evaluation of such things as participation patterns, participant response and satisfaction levels, risk factor prevalence, patterns of
changes in individual health habits or clinical test results, changes in key organizational indicators, achievement of program objectives, or collection of anecdotal success stories. Evaluation, in the R-DW Model, is typically much more comprehensive and much more robust and cohesive.

E. Key Activities - The “Interventions”

There are a number of program interventions that characterize this particular program model. Figure 14 below contains some of the most typical interventions for this program model.

<table>
<thead>
<tr>
<th>R-DW Style Wellness Activities</th>
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<tbody>
<tr>
<td><strong>Everything previous plus...</strong></td>
</tr>
<tr>
<td>✓ HRA (incented and used for targeting)</td>
</tr>
<tr>
<td>✓ Risk stratification and interventions</td>
</tr>
<tr>
<td>✓ Telephonic coaching</td>
</tr>
<tr>
<td>✓ Medical self-care and consumer workshop</td>
</tr>
<tr>
<td>✓ Injury prevention</td>
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<tr>
<td>✓ Benefit linked incentive</td>
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<tr>
<td>✓ Wellness achievement incentives</td>
</tr>
<tr>
<td>✓ Resiliency initiative for productivity</td>
</tr>
<tr>
<td>✓ Spouses also served</td>
</tr>
<tr>
<td>✓ Integrated programming</td>
</tr>
<tr>
<td>✓ Uses R-DW framework</td>
</tr>
</tbody>
</table>

*Figure 14 Typical Wellness Activities for R-DW Program Model*

Each of these interventions will be described in turn and can be added to those identified under the Option #1 “FGW” Program Model and Option #2 “T” Program Model.

**HRA (heavily incented and used for targeting):** In addition to the more familiar uses of HRAs to catalyze change in the individual, under the R-DW program model, HRAs are also used for individual targeting of a variety of possible interventions. HRAs are designed to ask questions about the individual’s health habits, medical conditions, current symptoms, health risks, readiness to change, learning preferences and other issues that provide actionable insights so that something can be done about the health issue the individual identifies in the HRA. Each individual completing an HRA usually receives their own “personal health report” with an assessment of their likely future health and recommendations for how they can improve their health. HRAs are typically used to shape proactive personalized interventions with those who can benefit from a specific behavior.
change in the R-DW Model. The HRAs are often required for continued benefit eligibility or for a significant health plan premium discount.

**Risk stratification and interventions:** In the R-DW program model HRA data and selective health claims data from the work force is often used to stratified the population by major risk status. These stratifications usually include: disability risk, chronic disease risk, high health risk, moderate health risk, selective health care use at-risk and low risk. Each group then has a set of specially designed interventions and incentives for their completion. This risk stratification approach permeates the R-DW program model and helps to address the health needs of the entire population. If spouses are incented to complete the HRA they are also included in the risk stratification approach. The interventions that are offered to each risk strata are then designed for their effectiveness and efficiency.

**Telephonic coaching:** Telephonic coaching is then provided to each of the major risk strata groups in the population. The “disability” risk strata receive follow-up calls directed at their rehabilitation, wellness and health care use, the chronic disease strata receive disease management telephonic coaching for reduction of complications, increased compliance with medical and pharmaceutical regimens and control of lifestyle factors that complicate management of the disease or condition. Those with multiple elevated or abnormal health risks (i.e., the “high risk”) receive telephonic coaching over the year to reduce selected health risks while those with moderate health risks, such as obesity, depression and high levels of stress receive telephonic follow-up and coaching as well. Those with selected health care use at-risk issues such as: intention to become pregnant, recent low back pain, anticipated hospital admission or surgical procedure, high levels of somatic complaints, or high levels of emergency room use would also receive telephonic follow-up. Finally, those who are low risk would receive one telephone contact during the year to discuss their annual HRA results and would be encouraged to develop a personal wellness objective, utilize web-based information and lower cost interventions to remain at low risk.

**Medical self-care and consumer workshop:** Programs that adopt a R-DW approach usually have to dedicate specific time each year to training on medical self-care and consumer education. Typically a two hour time period a year at minimum is need to address the following topics: Why health care costs are going up so fast, how the consumer can affect those costs, what is the likely consequence of continued high rates of cost escalation, and what steps the consumer can take to: manage common medical conditions, deal with a major health problem, avoid injuries, purchase pharmaceuticals efficiently, interact with their practitioner appropriately, and how to avoid common health problems. Medical self-care reference texts or programs are usually used during the training session to help participants feel more comfortable using them at home. In addition the services that will be provided through the wellness program are also usually presented and the benefits to the individual are also highlighted.

**Injury prevention:** The R-DW program model also usually has a strong injury prevention focus that goes beyond the Traditional Wellness focus on worksite injury prevention and safety. Workplace safety is a top priority, but attention is also given to home injury prevention, vehicular injury prevention and recreational injury prevention. The emphasis on risk taking is placed in a full time emphasis with lifestyle safety practices that
flow from the worksite to these other areas and settings. The types of injury prevention interventions used include: safety checklists, review of major injuries by season, car emergency kits, emergency lighting strategies, disaster planning, reminder post cards, newsletter write-ups of common accidents and others.

**Benefit linked incentive:** Another key intervention of the R-DW model is the linkage of wellness to a major employee benefit. The most typical linkage is a premium contribution discount such as: if the individual employee completes an HRA and meets eight out of ten wellness criteria they can receive a $600 per year premium discount on their health plan coverage. The benefit linkage can also take the form of more benefit credits for purchasing benefit coverage under a Section 125 cafeteria plan, or increased vacation days or a larger contribution to their Health Savings Account or Flexible Spending Account. All of these benefit linked incentives have as their main purpose to encourage participation in the program and also adherence to healthy lifestyle behaviors such as: physical activity, blood pressure control, cholesterol levels, body mass index (BMI), seat belt use and many other wellness behaviors. The size of these incentives needs to be in the $600 to $1,800 in order to gain high levels of participation over the long term.

**Wellness achievement incentives:** The R-DW program model usually includes some method such as a criteria-based incentive program that is intended to catalyze participation in the program and the pursuit of specific health behaviors. Different levels of rewards can be provided for meeting various numbers of the criteria. An example of the types of wellness criteria that can be used in a wellness achievement program and linked to a major employee benefit are included in Figure 15 below:

<table>
<thead>
<tr>
<th>Possible Wellness Achievement Criteria</th>
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<tbody>
<tr>
<td><strong>Criterion #1</strong></td>
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<tr>
<td><strong>Criterion #2</strong></td>
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<td><strong>Criterion #3</strong></td>
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<td><strong>Criterion #5</strong></td>
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<tr>
<td><strong>Criterion #6</strong></td>
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<tr>
<td><strong>Criterion #7</strong></td>
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</table>

*Figure 15  Possible Wellness Achievement Criteria*
Resiliency initiative for productivity: Another typical component of a R-DW style wellness program is an initiative that is designed to enhance employee resiliency and productivity. These resiliency efforts are designed to help prevent common health conditions leading to productivity losses associated with “presenteeism” and to enhance the stamina and energy of employees. One model for the various components of a resiliency efforts are identified in Figure 16 below:

![Figure 16 Possible Components of a Resiliency Initiative](image)

Spouses also served: Another major program strategy of the R-DW program model is an intentional effort to reach the spouses of employees. This is typically done through the use of a health risk assessment (HRA) with the spouses, usually with some form of incentive, and the provision of a personal wellness report, followed by including the spouse in telephonic and/or computer email follow-up. It is also possible to include the employee’s spouse in a wellness achievement criteria program and provide a similar size financial reward for achievements at different levels. Spouses can also be served through on-site fitness facilities, family memberships at external fitness facilities, access to web-based eHealth portal information, preventive medical benefit coverage and through invitations to participate in selected wellness activities.

Integrated programming: Another strategy associated with the R-DW program model is the use of highly integrated programming. All interventions offered to the eligible population are examined for their ability to enhance each other’s effectiveness. This is designed to increase participation, add reminders for behavioral reinforcement, connect information to appropriate sources to improve the personalization of interventions and to achieve higher levels of behavioral adherence and change. This focus on providing more highly integrated programming is also designed to connect the wellness interventions to other worksite services such as employee assistance programs, worklife balance programs, financial planning and other benefit services.

Uses R-DW framework: Another element of the R-DW program model is the use of the R-DW Framework identified in Figure 17 below. This framework, originally developed by
Dee Edington of the University of Michigan, was first published and modified in an article in the American Journal of Health Promotion and later expanded in the Institute for Results-Driven Wellness’s Platinum Book: Practical Applications of the Health and Productivity Model. This framework is useful because it provides an overall framework for the planning, coordination and evaluation of the R-DW program model.

Figure 17 Results-Driven Wellness Framework

F. Resource Requirements - “Dollars and Sense”

The resources required for the R-DW program model are greater than the other two models combined. The estimated annual per employee per year cost for this form of worksite wellness programming is likely to be from $151 to $450 (Excludes staffing and incentive costs because of the multiple approaches that are possible in these two areas). This type of wellness program is typically planned and delivered with a dedicated staff and one or more health management vendors and a significant formal program vendor budget. One full time dedicated staff member (either company or vendor) with specialized training is usually needed for every 600 to 700 employees. This programming approach usually involves activities organized around the HRA process that are rolled out sequentially with some sensitivity to seasonal health issues like weight gain over the holidays, getting more fit for summer bathing suit season, or preventing injuries during winter. Typically the R-DW model is a much more sophisticated approach to worksite wellness programming and is usually reached by an organization that does the T program model for a number of years and then desires to have much greater health and economic return and migrates to this program model.

G. Realistic Expectations - The “Likely Results”

This program model is highly likely to produce a sizable economic return. The more comprehensive nature of programming combined with the use of proactive programming interventions usually leads to more than 80% of the eligible employees taking some level of

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personal initiative to use at least one program intervention in addition to completing the HRA each year. Also associated with this more aggressive form of wellness program are significant levels of long term behavior change. Significant levels of behavior change lead to significant levels of economic return. This program model is typically associated with a cost/benefit ratio of 1:4.5 to 1:6.0 producing four and a half to six dollars of savings for each dollar of cost invested in the program, safely within 12 to 24 months of the start of the program.

H. Evaluation Activities - “Making Improvements for the Future”

A significant amount of evaluation potential is associated with this particular program model. The evaluation of individual program components, such as health fairs, lunch and learn sessions, voluntary completion of HRAs, and participant satisfaction for various activities can be accomplished with a post program evaluation survey and some additional questions can be asked about improvements in the program and how important the program was to specific behavior changes. The high percent of the population completing an HRA each year allows a much more rigorous assessment of changes in the cohort population.

One of the basic strengths of this particular program model is the evaluation of the entire participant population and/or the entire work force through the HRA. It is then possible to assess the impact of the program on health risk prevalence, readiness to change, improved behavior patterns and health care utilization experience as well as sick leave experience, workers’ compensation cost experience, disability management experience and presenteeism effects. This increased potential in evaluation capability combined with the relatively large populations of participants reached with this model makes Return-on-Investment (ROI) assessment possible on an annual basis.

Also significant “formative” evaluation that is intended to improve the effectiveness and efficiency of the program is possible in this model, as well as the more substantive “comparative” evaluation, that assesses the performance of the program against a normative standard or expectation for performance.

I. References and Further Readings: - “Digging Deeper”

The following technical resources describe in more detail the Results-Driven Wellness (R-DW) Program Model and are available on www.Amazon.com:


## J. Your Program Model Options at a Glance

<table>
<thead>
<tr>
<th>Operating Principle</th>
<th>Option #1</th>
<th>Option #2</th>
<th>Option #3</th>
</tr>
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<tbody>
<tr>
<td>Voluntary versus mandatory activities</td>
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<td>Some mandatory</td>
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<td>1° + 2° + 3°</td>
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<td>Systems orientation</td>
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<td>Participation of spouses</td>
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<td>Worksite based program</td>
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<td>All</td>
<td>Work and home</td>
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<td>Budget requirements for programming</td>
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<td>Moderate</td>
<td>Major</td>
</tr>
<tr>
<td>Expectations for economic return</td>
<td>None</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Evaluation potential</td>
<td>Non-existent</td>
<td>Weak</td>
<td>Strong</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organizing Principle</th>
<th>Option #1</th>
<th>Option #2</th>
<th>Option #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of pro-activity of programming</td>
<td>None</td>
<td>Weak</td>
<td>Strong</td>
</tr>
<tr>
<td>Use of biometric screening</td>
<td>Very little</td>
<td>Heavy</td>
<td>Focused and linked</td>
</tr>
<tr>
<td>Use of personal plan for improvement</td>
<td>None</td>
<td>Moderate</td>
<td>Heavy</td>
</tr>
<tr>
<td>Use of group interventions</td>
<td>Mostly group</td>
<td>Mostly group</td>
<td>Mostly individual</td>
</tr>
<tr>
<td>Intervention with the high risk</td>
<td>None</td>
<td>Some</td>
<td>A lot</td>
</tr>
<tr>
<td>Use of incentives</td>
<td>None</td>
<td>Weak</td>
<td>Strong</td>
</tr>
<tr>
<td>Segmentation of programming</td>
<td>None</td>
<td>Light</td>
<td>Strong</td>
</tr>
<tr>
<td>Medical self-care and consumer emphasis</td>
<td>None</td>
<td>Light</td>
<td>Heavy</td>
</tr>
<tr>
<td>Onsite fitness facility emphasis</td>
<td>Weak</td>
<td>Strong</td>
<td>Weak</td>
</tr>
<tr>
<td>Intentional cultural change orientation</td>
<td>Weak</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
</tbody>
</table>
* = Type of prevention refers to primary prevention (1°) which involves affecting the precursors to disease and injury, such as physical activity, nutrition, seat belt use. Secondary prevention (2°) refers to early detection types of prevention including blood pressure screening, cholesterol screening, mammography and other tests. Tertiary prevention (3°) is the type of prevention that deals primarily with the management of confirmed diseases and conditions, such as diabetes, asthma, cardiovascular disease and others. Appendix C provides a wellness program planning worksheet that can be used with any of the three program models.

2. What organizing framework for your program makes the most sense?

The framework recommended here for use in organizing and designing your worksite wellness program has been field tested with more than a thousand employers with employee populations that range in size from 19 employees to 2.4 million. The suggested organizing framework comes out of a six step program planning process and is highlighted in Figure 18 below.

This six step process and the resulting organizing framework is used in the WellCert™ Worksite Wellness Certification Program and is useful for ordering the many activities that can go on in a worksite wellness program regardless of the program model that is selected. In addition, the more activities planned for each component, the larger the program’s effect. This suggested structure also has a logical rationale behind it. The “Scope” of the program helps to set the major parameters of the wellness program. While the “Infrastructure” (programmatic and administrative) is the basic infrastructure upon which the program is planned and conducted. The “Communications” component functions as a general marketing process for the entire population involved, as well as a major way to raise the knowledge levels of the group about wellness/health issues. The “Health Management Process” is the program component that provides each individual with quantitative test results and helps structure the personal behavior change process. This component is powerful because it uses the individual’s own test measurements as motivation in the behavior change process. The “Group Activities” component includes programs where social support and peer relationships are involved. These aspects are also critical to successful long term behavior change. Finally, the “Supportive Environment” component provides the general reinforcement for wellness behaviors by making changes in the environment which make it easier to initiate and maintain a health behavior.

There is also another facet to the internal logic of this approach. For each targeted risk factor (such as smoking) it is possible to organize activity in each one of the six major components and to think through the adequacy and completeness of the program effort by applying this framework. In addition, the collective results of individual testing (HRA and biometrics) in the Health Management Process component can be used to help structure group activities and individual interventions and to organize Supportive Environment component efforts. This internal logic and utility provides additional value to the model in addition to its operational practicality in structuring a worksite wellness program. Readers are encouraged to try the program model out to test its value. This WellCert™ Wellness Program Planning Process is highlighted in all five levels of certification training from Level 1 Certified Wellness Program Coordinator (CWPC) to Level 5 Certified Worksite Wellness Professional (CWWP).
<table>
<thead>
<tr>
<th>Step #1 - “Scope” the Program</th>
<th>This first step involves defining the major issues of the “scope of the program. That includes: target population, launch date, general focus, major goals, program model, and who should be involved in the planning process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step #2 - Establish the Infrastructure</td>
<td>This step involves the establishment of the program infrastructure and the administrative infrastructure for the program. The “program infrastructure” provides the “virtual” core components of the program while the administrative infrastructure includes 14 administrative components designed to help sustain the smooth operation and effectiveness of the program.</td>
</tr>
<tr>
<td>Step #3 - Plan the Communications and Promotion Activity</td>
<td>This step includes a variety of vehicles and methods for communicating information on various technical aspects of wellness and various promotion activities to help market the program.</td>
</tr>
<tr>
<td>Step #4 - Plan the Health Management Process</td>
<td>This step includes planning the health and biometric testing component where the program is providing individual quantitative information to motivate and help the individual participant to manage their health and wellness. Some common examples of components of the Health Management Process include wellness and laboratory or fitness performance tests, cholesterol tests, use of health risk assessments, development of wellness prescriptions, web-based health information sources and online self-tests.</td>
</tr>
<tr>
<td>Step #5 - Plan the Group Activities</td>
<td>This step includes a variety of group activities with a wellness focus. Group activities are important because they provide the reinforcement and social support that is frequently necessary for initiating a new health behavior, and as a support for long-term behavior change. For example, walking clubs, aerobic physical activity sessions, workshops, corporate competitions, fun runs, health fairs and nutritional potlucks are frequently used group activities.</td>
</tr>
<tr>
<td>Step #6 - Plan the Supportive Environment</td>
<td>This step in the planning process involves the creation of a supportive environment for wellness which usually includes supportive work and benefit policies and modification of the physical space of the worksite. For example, smoke-free policies, placement of wellness programs on work time, distribution of wellness materials, use of health plan incentives, addition of preventive medical benefit coverage, availability of “quiet” space, and many others could be used.</td>
</tr>
</tbody>
</table>

*Figure 18 Wellness Program Planning Process*
3. What are reasonable objectives for your program?

Program objectives are a key element of the design of your employee wellness program regardless of the program model selected. Your program objectives will have a significant impact on the actual program activities you choose to implement and can help organize and guide the development of your wellness efforts. It is usually advisable to develop five to ten measurable, time-limited, feasible, but slightly challenging objectives for your program each year. It is also important to remember that there are different kinds of objectives: including ultimate impact objectives, intermediate impact objectives, program activity and operational objectives. Each type of objective needs to meet the basic criteria as follows:

- Measurable
- Time limited
- Reasonably achievable
- Somewhat challenging
- Linked to your program goals

Usually, an organization’s senior manager is going to expect that you develop these kinds of objectives as part of a proposal for a wellness program. These objectives need to be developed fairly early in the process of program development and can help to guide your initial activity, as well as help give the proposed program credibility in the perception of senior and mid-level managers.

In the development process for the program, it is important that management staff perceive that the program has appropriate structure and a tangible direction and emphasis. These all make the proposed program feasible in the eyes of key managers. Program objectives can help to meet this need. They are also useful in providing a context for later evaluation and accountability. Objectives also provide a practical framework for justifying resources. If the objectives are clearly connected to the requested resources, then funding is usually more likely.

In summary, it is suggested that you develop, refine, and finally adopt five to eight program objectives each year. A sample set of first year wellness program objectives is contained in Figure 19 below.

Not all major proposed program activities should be converted into objectives unless there is a need to create a more stringent accountability structure for yourself or others who may be implementing parts of the program. If you are worried about the likelihood of follow-through, then place as many of the major activities into the form of program objectives as you can. Then the program objectives can be used to apply selective pressure to move the proposed activity forward.
Sample Set of Wellness Program Objectives

Overall Goal: To improve the health & well being of employees and their family members.

Program Objectives:

1. Reduce the average number of annual sick leave absenteeism hours for all employees by 10% from the previous year.

2. Establish a wellness advisory group, select and train a wellness coordinator, develop a program plan, budget, and evaluation plan by January 1.

3. Formally launch the employee wellness program with a letter from the CEO by February 1.

4. Provide cholesterol screening to 1,350 employees by March 1.

5. Conduct four Resiliency education classes for employees and their family members in the headquarters location by June 1.

6. Train 1,200 employees and family members in medical self-care and health care consumerism by September 30.

7. Conduct a blood pressure “sweep” for all employees by October 1.

8. Organize a financial incentive program linked to program participation and have it ready to implement as of January 1 of next year.

9. Conduct and write up a first year evaluation of the program by March 1 of next year.

10. Implement a Consumer-Driven Health Plan (CDHP) for all employees by September 1.

Figure 19 Sample Wellness Program Objectives

4. Suggestions for major activities in each program component.

For each of the six major program planning steps, there are several possible program ideas or options that can be implemented. General descriptions of major options and activities are presented in the accompanying figures.
### Step #1 Scope the Program

<table>
<thead>
<tr>
<th>Name</th>
<th>Brief Description of Major Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Population</strong></td>
<td>✓ All employees and their spouses.</td>
</tr>
<tr>
<td><strong>Launch Date</strong></td>
<td>✓ September 1.</td>
</tr>
<tr>
<td><strong>General Focus</strong></td>
<td>✓ Physical and mental health.</td>
</tr>
<tr>
<td><strong>Primary Goals</strong></td>
<td>✓ Slow the growth of health plan cost.</td>
</tr>
<tr>
<td><strong>Program Model</strong></td>
<td>✓ Traditional Wellness</td>
</tr>
<tr>
<td><strong>Planning Team</strong></td>
<td>✓ HR Manager, CFO and Safety Manager.</td>
</tr>
</tbody>
</table>

*Figure 20 - Step #1*

### Step #2 Establish the Infrastructure

<table>
<thead>
<tr>
<th>Program Infrastructure</th>
<th>“Virtual” program components including: Health Risk Assessment, Personal report, coaching, referral, welcome kit, self-guided change materials, email and mail reminders, wellness newsletter, PCP summary, eHealth portal and wellness incentives.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative Infrastructure</td>
<td>Site-based administrative components: such as</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Brief Description of Major Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Name</strong></td>
<td>✓ The name of the program.</td>
</tr>
<tr>
<td><strong>Program Logo</strong></td>
<td>✓ The logo to be associated with the program.</td>
</tr>
<tr>
<td><strong>Program Tag-Line</strong></td>
<td>✓ The short statement that captures the main thrust of the program.</td>
</tr>
<tr>
<td><strong>Program Art Style</strong></td>
<td>✓ The colors and graphic standards that help bring an identity to all the program activities.</td>
</tr>
<tr>
<td><strong>Wellness Coordinator</strong></td>
<td>✓ Guess who?</td>
</tr>
<tr>
<td><strong>Program Proposal</strong></td>
<td>✓ The written purpose, mission and proposed activities for the program including budget documents and timetables.</td>
</tr>
</tbody>
</table>
Wellness Design Team  ✓ The relatively small group used to help refine the design of the program. This usually includes several key decision-makers.

Wellness Advisory Group  ✓ A group of employees and interested managers that act as a sounding board and volunteer pool for selected wellness activities.

Wellness Program Work Plan  ✓ This annual plan of events and activities that will comprise the wellness program activities during the year. It usually identifies what will happen, when it will take place, and who will be doing it.

Wellness Program Budget  ✓ The estimated costs and revenues expected to be associated with the program during the year.

Employee Wellness Network  ✓ The network of individuals in all locations and major departments that have an interest in helping implement the wellness program. They also function as they eyes and ears for the program.

Wellness Program Objectives  ✓ The set of formal objectives that function to guide the program’s development and implementation.

Wellness Program Evaluation Plan  ✓ The formal evaluation plan for the program describing what will be evaluated and how it will be evaluated.

Figure 21 - Step #2

Step #3 Plan Communications and Promotion Activity

<table>
<thead>
<tr>
<th>Name</th>
<th>Brief Description of possible Major Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Launch Email/Letter</td>
<td>✓ A 1-2 page letter outlining the purposes, proposed activities, responsible people, and follow-up contacts for the new program.</td>
</tr>
<tr>
<td>Wellness Newsletter</td>
<td>✓ A monthly or quarterly professionally developed newsletter on a variety of wellness topics.</td>
</tr>
<tr>
<td>Email Request</td>
<td>✓ An email request that is sent out to employees that lets them select to receive printed material or self-directed change materials on specific wellness topics.</td>
</tr>
<tr>
<td>Posters</td>
<td>✓ Colorful posters on specific health or motivational messages that are placed in key locations.</td>
</tr>
<tr>
<td>Wallet Cards</td>
<td>✓ Plastic wallet cards with specific behavior tips on selected wellness topics such as reducing cholesterol levels, stress reduction techniques, etc.</td>
</tr>
<tr>
<td>PowerPoint Decks</td>
<td>✓ The sets of PowerPoints that are used for briefing and information dissemination</td>
</tr>
<tr>
<td>Web Information</td>
<td>✓ Information provided through websites.</td>
</tr>
<tr>
<td>Email</td>
<td>✓ Wellness email messages, ads and information which is distributed in work groups by means of electronic messaging.</td>
</tr>
<tr>
<td>Email List Serves</td>
<td>✓ The set of emails for advisory committee members, program contacts, vendors, and program supporters.</td>
</tr>
<tr>
<td>Mobile messaging</td>
<td>✓ Information sent through the individual’s smart phone or Personal Digital Assistant (PDA).</td>
</tr>
<tr>
<td>Reference Books</td>
<td>✓ Reference books on medical self-care, fitness, and nutrition.</td>
</tr>
<tr>
<td>Intake Instruments</td>
<td>✓ Initial survey instruments which collect health and wellness information on participants and establish a health management database on the individual.</td>
</tr>
</tbody>
</table>

*Figure 22 - Step #3*

<table>
<thead>
<tr>
<th>Name</th>
<th>Brief Description of Major Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Risk Appraisal</td>
<td>✓ A self-scored or computer scored inventory of the risks associated with an individual’s lifestyle choices and behaviors.</td>
</tr>
<tr>
<td>Personal Wellness Report</td>
<td>✓ A 2-10 page personalized report based on the information provided in an individual’s HRA.</td>
</tr>
<tr>
<td>Cholesterol Testing</td>
<td>✓ On-site testing for total cholesterol and HDL, usually carried out with a finger stick or micro method.</td>
</tr>
<tr>
<td>Blood Pressure “Sweep”</td>
<td>✓ A voluntary blood pressure reading taken as screeners walk “Sweep” through a work site and ask each employee if they want their blood pressure taken.</td>
</tr>
<tr>
<td>Worksite Screening Tests</td>
<td>✓ Screening tests conducted in the worksite for blood pressure, body weight or percent body fat, blood sugar, and others.</td>
</tr>
</tbody>
</table>
Wellness Assessment ✓ An organized process that performs individual fitness and health tests, uses a Health Risk Appraisal (HRA), reviews medical history, counsels the subject, develops personal health enhancement objectives, follows-up on the individual, and re-tests for changes.

Wellness Coach ✓ A trained “coach” to help the individual make long term health behavior change in either face-to-face or by telephone.

Web-Based Self-Tests ✓ Written or computer generated tests which help an individual determine if they are at low, medium, or high risk for specific health risks, such as alcohol use, sedentary lifestyle, stress, poor nutrition, spiritual health, and others.

Wellness Mentor ✓ Someone of the same gender who has made a successful behavior change and is now helping another individual to make a similar change.

Weight Scales ✓ Providing opportunities for individuals to weigh themselves on accurate scales at the worksite.

Software ✓ Software that provides tracking and record-keeping support for health behavior change.

Health Advice Lines ✓ Toll-free numbers where clinically trained personnel can help answer questions from individuals about their situation.

Figure 24 - Step #4

<table>
<thead>
<tr>
<th>Step #5 Plan the Group Activities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
<td><strong>Brief Description of Major Activities</strong></td>
</tr>
<tr>
<td>Smoking Cessation Program</td>
<td>✓ Use one of the many models of smoking cessation programs available from public and private groups.</td>
</tr>
<tr>
<td>Stress Management</td>
<td>✓ Usually a multi-hour or multi-day workshop designed to help participants adopt behaviors and habits that will help them manage excess stress more appropriately.</td>
</tr>
<tr>
<td>Walking Club</td>
<td>✓ A group which organizes and conducts walking events as a form of physical activity.</td>
</tr>
<tr>
<td>Support Groups</td>
<td>✓ Professionally or volunteer run groups which meet periodically to provide encouragement, problem-solving help, and support for coping with specific behavior or life problems.</td>
</tr>
<tr>
<td>Informal Sports Leagues</td>
<td>✓ An organized effort to encourage employees to be active and play sports activities together. Many different activities can be the focus of the league.</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Resiliency Education</td>
<td>✓ An educational session or sessions that help the participants to be more resilient to work demands and the need for productivity.</td>
</tr>
<tr>
<td>Women’s Health Issues</td>
<td>✓ Usually includes: breast cancer prevention and detection, menopause, osteoporosis, hormone replacement therapy (HRT), sexual performance, and urinary incontinence.</td>
</tr>
<tr>
<td>Weight Loss Group</td>
<td>✓ Usually a small group that meets weekly to monitor their weight, deal with their eating patterns and habits, and encourage each other.</td>
</tr>
<tr>
<td>Fitness Center Membership</td>
<td>✓ A specific location where physical activity classes and exercise and weight training equipment is made available to employees on a regular basis.</td>
</tr>
<tr>
<td>Medical Self-Care and Consumerism Training</td>
<td>✓ Training or education that is designed to help the individual handle minor self-limiting conditions more appropriately and to become a more active and confident health care consumer.</td>
</tr>
</tbody>
</table>

**Figure 25 - Step #5**

### Step #6  Plan the Supportive Environment

<table>
<thead>
<tr>
<th>Name</th>
<th>Brief Description of Major Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoke-Free Policy</td>
<td>✓ A policy that completely excludes smoking from any part of a facility or in any company owned vehicle.</td>
</tr>
<tr>
<td>Healthy Food Choices Program</td>
<td>✓ Organized activities to provide healthy food options and nutritionally sound information to employees.</td>
</tr>
<tr>
<td>Release Time for Wellness Program Activity</td>
<td>✓ A formal policy which encourages supervisors to release their employees to attend wellness program activities which are offered on work time.</td>
</tr>
<tr>
<td>Preventive Medical Benefit Coverage</td>
<td>✓ Coverage in health plans for well child physicals and for adult well physicals.</td>
</tr>
<tr>
<td>Flex Time for Physical activity</td>
<td>✓ A formal policy which encourages supervisors to allow employees to utilize flex time to help schedule physical activity into their work day.</td>
</tr>
</tbody>
</table>
Wellness Incentive Policies

- A set of policies or benefit linkages that provide for valuable rewards based on an individual’s choice of a wellness-oriented lifestyle. Other popular incentive forms include reductions in health plan premium contributions.

Preventive HR Policies

- The adoption of a variety of prevention-oriented human resource policies including such things as alcohol and drug policies, release time policies, smoking policies, food access policies, etc. There are more than twenty-five areas of employee policies that can become wellness-oriented and reinforce change in a worksite culture.

Figure 26 - Step #6

5. Examples of wellness programs.

In this section, we deal with examples of the three principal types of Wellness program models, the Quality of Work Life (FGW) program model, the Traditional Wellness (TW) program model and the Results-Driven Wellness (R-DW) program model. Each of these three different program models are archetypes and will be briefly discussed, including some of their practical considerations, cost implications, and likely effectiveness. Our focus here is on examples of the unique programmatic activities included in Steps #3 through #6 of the program planning process.

An example of a FGW style employee wellness program is as follows:
This level of programming primarily brings increased awareness and wellness information availability to your population. Although there may be some behavioral change benefits from the experiential wellness, this level of programming usually has a minor impact on long term individual health behavior and the actual prevalence of risk factors in the population. The direct cost of the FGW style program identified above is approximately $0 to $45 per employee (all employees in the company) per year, and does not generally require dedicated professional staffing. A part time health promotion coordinator would usually be necessary at the beginning to help initiate and guide the development of the program. This is the low cost program approach. Figure 28 contains an example of a Traditional Wellness style employee wellness program.

An example of a “TW” style employee wellness program is as follows:
### Example of “TW” Style Worksite Wellness Program

| Wellness | ✓ Distribute pamphlets in HR upon request.  
| Communication | ✓ Send a wellness newsletter to employees at their home each month.  
| | ✓ Post health promotion and motivational posters on bulletin boards and walls throughout the worksite.  
| | ✓ Distribute wellness smart phone app to employees.  
| | ✓ Mail a medical self-care book to every employee’s home. |
| Heath | ✓ Provide a voluntary HRA to employees.  
| Management | ✓ Provide an opportunity for basic fitness testing on a voluntary basis.  
| Process | ✓ Conduct an annual blood pressure “sweep.”  
| | ✓ Offer periodic cholesterol testing opportunity each year. |
| Group Activities | ✓ Run periodic weight loss contests, dividing the fee “pot” among those who have kept weight off at six months after the contest.  
| | ✓ Organize and promote a walking club.  
| | ✓ Open a small fitness facility funded with member dues and with dedicated space for stretching.  
| | ✓ Offer smoking cessation community classes.  
| | ✓ Conduct resilience education classes at periodic intervals.  
| | ✓ Provide monthly “Lunch and Learn” sessions on wellness topics. |
| Supportive | ✓ Adopt a smoke-free policy.  
| Environment | ✓ Put a microwave and healthier options into the lunch room.  
| | ✓ Install some bike racks and fitness equipment.  
| | ✓ Purchase and post motivational posters.  
| | ✓ Provide healthy food choices in the cafeteria.  
| | ✓ Install 12-14 areas of worksite policies that are supportive of wellness behavior. |

**Figure 28**  Example of a "TW" Style Wellness Program

This example of wellness programming provides a mix of information, motivation, and behavior change opportunities for employees. This level of programming usually requires professional level staff and a reasonable level of budgetary resources. The average cost of a T program would probably be in the range of $46-150 per employee per year. The larger the number of employees involved, the larger the budget must be for staffing. This level of programming usually includes some incentive features with primarily material good types of rewards.

An example of a R-DW style program is contained in **Figure 29**.
### Example of R-DW Style Worksite Wellness Program

| Communication & Promotion | ✓ Distribute brochures through a mail request vehicle periodically for each work group.  
| Require all employees to complete an HRA every year in order to maintain health benefit coverage.  
| ✓ Send wellness newsletter to employees in their homes each month.  
| ✓ Post wellness and motivational posters on bulletin boards.  
| ✓ Distribute annual wellness kit to employees home periodically.  
| ✓ Provide an online wellness library with educational videos and connect these to a core incentive program.  
| ✓ Conduct bi-annual blood pressure sweeps throughout the worksite.  
| ✓ Offer periodic lipid screens to help employees manage their nutrition patterns consistent with the new dietary guidelines.  
| ✓ Have wellness coaches follow up personally with each employee based on the results of their HRA. |

| Health Management Process | ✓ Run periodic weight loss, fitness activity and cholesterol lottery groups, dividing the matched fee “pot” among those who have maintained good results at six months after the last formal contest cycle.  
| ✓ Organize an active walking and recreational activities club.  
| ✓ Offer smoking cessation and weight management classes.  
| ✓ Conduct periodic resilience workshops.  
| ✓ Operate an on-site fitness facility with a strong linkage to the core incentive program. |

| Group Activities | ✓ Adopt a smoke-free policy.  
| ✓ Put healthy menu options into the cafeteria.  
| ✓ Require periodic completion of the health survey to maintain health plan coverage and provide a $1,000 health plan discount for meeting 8 of 10 wellness achievements linked to program participation, health status attainments, behavioral compliance and meeting organizational indicators.  
| ✓ Establish a fitness facility at each major worksite.  
| ✓ Mark out walking trails and install showers at all major locations.  
| ✓ Implement 20-24 worksite employment and benefits policies that are supportive of wellness behavior and employee health management |

| Supportive Environment | ✓ Require all employees to complete an HRA every year in order to maintain health benefit coverage.  
| ✓ Send wellness newsletter to employees in their homes each month.  
| ✓ Post wellness and motivational posters on bulletin boards.  
| ✓ Distribute annual wellness kit to employees home periodically.  
| ✓ Provide an online wellness library with educational videos and connect these to a core incentive program.  
| ✓ Conduct bi-annual blood pressure sweeps throughout the worksite.  
| ✓ Offer periodic lipid screens to help employees manage their nutrition patterns consistent with the new dietary guidelines.  
| ✓ Have wellness coaches follow up personally with each employee based on the results of their HRA. |

---

**Figure 29** Example of a R-DW Style Wellness Program

The R-DW style programming involves a serious and long term commitment to creating a healthy work force and a healthy work culture. The average annual cost per employee of this level of programming is probably in the range of $151-$450, not including the cost of professional staffing.
and the cost of financial incentives provided to employees because of all the possible alternative ways of providing both. For this level of direct and vendor provided programming, there should be a full time, professional health promotion staff person for every 600 to 700 employees either through internal staffing or outside vendor staffing.

6. **Preparing a draft program plan and budget.**

The development of a worksite wellness program requires the formulation of a draft plan for the program and an accompanying budget. Usually, an inside staff person is asked to develop the plan, with or without the help of an outside consultant. Sometimes outside consultants are engaged to develop the program proposal. In either case, the contents of the draft plan and budget should be very similar and based on a set of explicit goals and objectives for the program.

If you are the “inside person” asked to develop the health promotion or wellness program proposal you may have already decided what should be in your program. But if you are unsure, then the following steps will help you decide what your program should include:

- Visit other organizations your size and see what they are doing.
- Visit the companies that are recognized “leaders” in wellness and review what they have done.
- Read some of the materials identified in Appendix B of this Workbook (“Bibliography on the Design of Employee Wellness Programs”) to get more ideas.
- Find out what kinds of wellness activities have been carried out in the past in your organization and what reaction employees have had to them.
- Go to [www.welcoa.org](http://www.welcoa.org) and review their materials.
- Ask for some help from local employers and community resources such as local Wellness Councils.
- Move through the six step planning process identified in Figure 18 above.
- Start putting a draft wellness program proposal together.

An outline of how to structure a draft wellness program proposal is contained in Figure 30 below.
Outline of a Draft Wellness Program Proposal

Executive Summary (1-2 Pages)
A. Preface
B. Overview and Background of Current Wellness Activities
C. Proposed Program Mission and Vision
D. Introduction
Include a summary of major trends in worksite wellness, cost-benefit ratios, key characteristics of successful programs, local employer activities, labor pool competitor's activities, employer survey results, and basic risk factors.
E. Findings
Include a summary of key findings, such as health cost patterns, previous health promotion activity, expressions of interest, employee survey results, a summary of information to prove the need for the program, an outlined program model, and significant program design details.
F. Proposed Program Goals and Objectives
Include an overall goal statement, five to eight objectives, and a brief discussion of their feasibility. Also, state the expected impact on the organization, along with intangible benefits.
G. Proposed Program Activities
Include a proposed administrative structure, staffing, proposed wellness communication activities, health management process activities, group activities, and supportive policies and changes. Also, provide a rough timetable for implementing major activities. A useful format for structuring a proposed program plan for an employee health promotion program is to use a work plan type format. A sample health promotion program planning worksheet is provided in Appendix C.
H. Budget Projections and Justification
Include a staffing pattern, administrative resources needed, and vendor budget needed, or translate activities into a per employee cost and compare this graphically with how much is spent annually on health benefits.
J. Proposed Timetable
K. Proposed Evaluation Plan
Include data to be collected, timing of evaluation activity and reports, and issues to be evaluated. Also, include the identity of the audience and routing of reports.
L. Proposed Next Steps
M. Appendices
In this section, provide important documents that help complete your proposal. This can include such things as a copy of employee wellness interest survey results, a list of employee comments from the survey, a copy of a proposed job description for the wellness coordinator, a sample of the HRA or health survey to be used.

Figure 30 Outline of a Draft Wellness Program Proposal

The draft program proposal should be carefully written and then reviewed before submitting it to one of the key senior managers, such as a V.P. of Human Resources, to ensure that all major, outstanding issues of concern have been addressed in the proposal. Once reviewed by the appropriate senior manager, you are probably ready to submit it to the executive committee for approval and potential funding.

7. Selecting a program identity.
There are a number of adjectives and adverbs that can characterize the identity of an employee wellness program. As part of the design process, it is very useful to think about the type of identity you want to create as you develop and position the program. The following list of adjectives and adverbs represent some of the more positive facets of a wellness program's potential identity in the workplace and with a particular work force.

- Trendy
- High quality
- Top level support
- Important
- Concerned
- User-sensitive
- Sincere
- Incentive oriented
- Thoughtful
- Highly visible
- Fun & upbeat
- Witty & clever
- Employee oriented
- Positive
- Realistic
- Not too slick
- Consistent
- Guilt free
- Streamlined
- Behavior oriented
- Robust
- Caring
- Dynamic
- Recognition oriented

You may not achieve all of these characteristics of the program's identity right away, but they can be useful considerations in how you design and evolve your program. As the program unfolds, you will want to keep an eye on these characteristics to make sure you are moving your program in the right direction.

8. Setting Up a Wellness Program Advisory Committee

An advisory group or design team can be extremely helpful in planning the wellness program. You may also want to consider having an ad hoc design team or planning group that is composed of different people than the eventual employee advisory group will be. The reason this may be advisable is that key policy makers can be included on the planning committee or design team that is tasked with helping design the program, and then a new advisory committee can be formed after the program is approved to help steer and implement the program. The use of two separate groups works better in large, complex work organizations. When you are ready to organize an employee advisory committee, keep the following guidelines in mind:

**Use interest level as your main criteria.** The selection of individuals for the employee advisory group should include, as a requirement, that candidates be personally interested in the topic of wellness and in serving on the committee. One of the best ways to kill a wellness program is to put skeptics who are forceful into the group that is supposed to shape the design and/or implement the program. Interest level should be the most important criteria for membership on the committee.

**Pick people who are respected by their peers.** The second most important criteria for selection of advisory committee members is having the respect of co-workers. Inclusion of several questionable individuals has the effect of reducing the credibility of the committee and distancing the group and the program from the support of the bulk of employees.

**Have major department heads appoint candidates.** When the managers of major work units are in a position to nominate candidates for the employee wellness advisory committee, they are
likely to have a much greater sense of perceived ownership over the program. The individual nominees can then be interviewed to determine interest level and capabilities. You can have managers nominate more individuals than there are positions available if you want to be selective about who to include on the committee. The actual committee members should be nominated by major supervisors and then appointed by the senior manager involved, usually the Vice President of Human Resources, CEO or agency director. The committee members can also function as liaisons or contacts for the program once they are appointed. This allows them to become the principal conduits to their work unit for information to and from the program.

**Stagger the terms of office:** Set the advisory committee up so that each individual has a one to three year term and hold a drawing that allows 1/3 of the terms of committee members to change each year (or each two year period). This allows for fresh blood while maintaining some consistency and institutional memory within the committee membership. The larger the organization the more important this process is likely to be. For individuals that are responsible for key functions, like a benefits manager, have their positions be permanent. This set of policies also helps avert the potential hard feelings that can develop when people are not re-appointed without any discussion or knowledge about why. Particularly effective committee members can also be re-appointed or given a special role in the committee.

**Provide a clear mandate and task assignment to the committee.** The role of the committee should be spelled out in detail and in a clear manner at the beginning. This will avoid a great deal of confusion during the development process. The formal functions of the committee should include:

- Provide feedback on the needs of the work force
- Provide advice (rather than policy) on the planning, implementation, and evaluation of the employee wellness program
- Provide feedback on the program's annual plan and budget
- Provide assistance in securing improved coordination and integration with other services and workplace functions
- Provide advice on issues related to the health of the organization's workforce
- Assist in the selection of vendors for the program
- Provide evaluation feedback on the program
- Assist where appropriate with the implementation of the program

**Conduct an initial orientation and do annual training of members.** When the committee is first established, provide a formal orientation for the group. This can include an audiovisual presentation, a three ring binder with orientation materials, articles, books, and program announcements. It is also helpful to have committee members visit or tour other programs, fitness facilities, and worksites in order to broaden their own knowledge base. By providing a formal orientation, new members will likely contribute sooner to the decision making of the committee and become valuable members more quickly. This is also useful because it will help temper the effects of stronger members that may unwisely use their influence to try and move the program in inappropriate directions. There should also be an annual plan for committee training. One alternative for doing this would be scheduling on a quarterly basis for the committee meeting to include an educational module on a topic of choice. For example, using the Chapman Institute’s WellCert Master Class online learning module on how to estimate the ROI (return-on-investment) of your worksite wellness programs for educating your wellness advisory committee would be one easy way to help your advisory committee be more effective. (www.chapmaninstitute.net)
Use a three year project period for your wellness program. Adopt a three year period for your wellness program to help assure the program will mature and evolve appropriately. This allows you to focus on the first year but also gives some stability to your planning and implementation activity.

Use an annual time frame for planning the program. The use of an annual time period for laying out the wellness program activities will help the committee see the big picture. The fiscal year for the organization should be used to tie the budgeting process to the program planning process. Usually, annual budgets are prepared three to six months before the start of the new fiscal period. Therefore, this is a good time to draft an outline of activities for the coming year and to encourage the committee to revise and amend the proposed plan and budget.

Adopt a quarterly operational plan. The use of a quarterly calendar that gets translated into a monthly calendar of events is an effective way of breaking down the program activities. The use of a quarterly plan translates the proposed activities into manageable bites.

Focus committee meetings on key questions. Advisory committee deliberations should be focused on issues that help the program meet the needs of the workforce it strives to serve. These questions include the following:

- How should the program be presented to or positioned with employees?
- How can senior management show their support for the program?
- How are employees reacting to the program?
- What can be done to improve participation levels?
- How can we reach those who are not participating?
- What was your evaluation of this vendor/program?
- What program activities should be repeated?
- What programming option makes the most sense?
- Is there an identifiable group that feels left out?
- How can we improve the marketing of the program?
- How should our program be the connection with and the program be made?
- What should we be planning for the next cycle?
- What educational topics should we be covering for you as committee members?

Keep moving the committee toward clear-cut consensus. By drawing out less vocal committee members and asking them to share their opinions on the issues being discussed, you can help the group reach more clear consensus positions. Questions such as, “Do I hear you saying that a fitness contest would not work in April?” will help identify a clear consensus. By continuing to request group consensus, you will end up with clearer advice from the committee, a stronger sense of committee solidarity and more group decisions and ownership, versus the opinions of a particularly strong or vocal committee member or minority.

Listen to the advice provided by the committee. If you want to keep the committee active and enthusiastic about the program, you need to listen to their advice. Listening does not mean accepting their advice 100% of the time, but when you don't accept it, you should explain your rationale to them as soon as possible.
Wellness advisory committees can be very useful in the design and implementation of your program. However, I believe they should not have policy control over the program because their orientation and knowledge levels are not usually sufficient to assure that the program produces the long term behavior change and economic impact it is often expected to produce. Also at issue is the need to move the program into areas that may threaten your volunteers, such as medical self-care, wellness coaching or consumer health education. If the group is a policy setting group you may find them going in a “comfortable” direction rather than into some difficult areas of incentive design, high risk intervention, or “opt-out” programming. Larger worksites require much more sophisticated internal and external professional assistance to plan, design, and implement, particularly if there are multiple collective bargaining units involved.

9. Suggestions for the Program’s Administrative Structure

The administrative structure of the program is usually addresses in step #2 of the program planning process and will need to reflect the worksite's key organizational and cultural characteristics. These characteristics are the number of employees involved, their geographical or physical dispersion, the complexity of the organizational structure involved, the scope of proposed wellness activities, and the existing administrative mechanisms available for use with the program. Almost all worksite wellness programs require the minimum administrative structure and vehicles contained in Figure 31.

**Suggested Program Administrative Structure**

1. A part-time or full-time health promotion coordinator
2. An employee advisory committee
3. Ad hoc action teams for implementing specific program components
4. Program liaisons or contacts
5. Annual program plan
6. Program vendor budget
7. Program goals and objectives
8. Program evaluation plan

*Figure 31 Minimum Suggested Program Administrative Structure*

Almost all successful employee wellness programs have the following major administrative components:

1. **A part-time or full-time wellness coordinator:** The person supported by senior management, who helps plan and implement the program is the single most important factor in the program's success. In larger companies and agencies, one or more full-time staff is necessary to effectively conduct the program. A general rule for wellness program staffing is that a full-time trained wellness coordinator is necessary when there are more than 600 employees. Depending on how much outside vendor help is used, there should probably be a full-time wellness program staff member for every 600-700 employees.
In smaller organizations, a part time individual who has other duties is usually adequate, if that individual is committed to learning more about the field. There are a number of options for helping this individual fulfill their role as program coordinator. For example, there are a growing number of undergraduate and graduate programs that train people in how to manage worksite wellness programs. For newly appointed coordinators that have not had any formal training in this area, there are also several certification programs such as the WellCert Program (www.chapmaninstitute.net) that can help enhance their skills and capability. However, remember….the number one criteria for assignment of this role to an existing employee is the interest level of the individual!! If this person is interested and is given some time to work on wellness activities, he/she will usually have the initiative to learn the necessary skills. This individual should also be personable, a good communicator, and an effective delegator with a high level of people skills.

2. **An employee advisory committee:** As we learned from the last section, an effective employee advisory group is usually composed of interested and well-respected individuals, it is important to constitute it carefully. In larger organizations, as mentioned earlier, an initial policy-oriented group can take on more of a policy advisory role, while in smaller organizations the committee is more of an implementation and communication link with different organizational components and groups. The main thing to accomplish with the employee advisory group is to create an authentic sense of ownership by employees in the program. Most employee wellness programs perceived as solely a management initiated program forced on employees usually do poorly in participation levels and employee support. This is even more critical in highly blue collar and/or unionized workforce situations. Highly geographically dispersed and/or decentralized worksites will usually need their own employee advisory groups that operate with some latitude, but always supporting and complementing the corporate-wide wellness program.

3. **Ad hoc action teams for implementing specific program components:** Small groups of people who are interested in specific topics or campaigns, like implementing the American Cancer Society's Great American Smoke-Out or organizing a walking event or physical activity program, should be able to be mobilized into action teams. These small groups, with one clear leader for each small group, are usually initiated by the wellness program coordinator and function to plan the specifics of the assigned program component. They also may directly help implement the program or campaign. The small groups should report back to the employee wellness coordinator and the advisory committee. This pool of volunteers is especially critical if you do not have full time wellness program staff, have very low funding, or your organization is highly decentralized administratively or geographically. Representatives from each major group of employees to be targeted by the program need to be a part of the action team. Some action teams may extend beyond the event to take on another activity. Some action team members may actually conduct the program in the role of a smoking cessation program facilitator, aerobics or yoga instructor, or brown bag educational session presenter. It is only the smallest of work groups that do not usually have a number of talented people who can conduct some of the activities of the program.

4. **Program liaisons or contacts:** Another critical part of the administrative structure of the program is the program liaisons, or program contacts, for each separate work group. These individuals are the informational conduits for the program in relatively small work groups. They also function to provide feedback to the employee advisory group and the program coordinator. They are the distribution points for program informational materials...
and contact points for site-based program vendors. These individuals are key players in highly complex or large worksites.

5. Annual program plan: The wellness program should have an annual program plan that lays out the major activities, when they will occur, who has primary responsibility, and their estimated cost. This document helps to focus annual planning activity and can help all of those involved understand the full scope of the program. It becomes the blueprint for program implementation. This document can be developed by the wellness program coordinator or an outside consultant, or by an employee advisory group in a retreat-type setting.

6. A program vendor budget: The vendor budget is what you use to purchase wellness programs and services. The size of the program vendor budget will depend a lot on the internal resources available for use in the program. In larger companies, and in those with health professionals on staff, there are many things internal staff can do to augment the services of outside vendors. However, programs without vendor budgets are not usually going to accomplish much sustained meaningful behavior change or reduction of health risk factors.

7. Program goals and objectives: The program should have several overall goals and a series of five to eight measurable, time limited, attainable, but slightly challenging objectives. Examples of these objectives can be found in an earlier section. Initially, these objectives will help provide a useful planning framework. Later in the program’s development, they help provide efficient evaluation activity and an accountability framework for the program.

8. Program evaluation plan: This administrative component provides a blueprint for the future evaluation of the worksite wellness program, containing such items as a set of evaluation objectives, a proposed evaluation methodology, measurements to be used, samples of the evaluation instruments to be used, the anticipated form of the results and prospective uses of the evaluation findings. The evaluation plan should provide all the detail necessary to plan, organize, and conduct the evaluation activity for the program.

These administrative structures are required of virtually all employee wellness programs, regardless of the program model or level of resources used. However, their specific administrative configuration will, out of necessity, be strongly influenced by the unique circumstances and characteristics that define your organization.

10. Design “Do's” and “Don'ts”

The following list contains some suggestions for the design phase (“Do’s”), and some things you should try to avoid (“Don’ts”).

"DO's"

✔ Do clarify what your design “product” is expected to look like.
✔ Do select one of the three program model(s) that make the most sense for your population.
✔ Do make the program largely voluntary in nature, but make exposure to information about the program mandatory.
✔ Do consider the affect of the employee's family in planning the program.
✓ Do involve interested employees in the planning.
✓ Do involve union representatives as early as possible but always with management approval.
✓ Do get broad involvement in ratifying the draft program proposal.
✓ Do adopt five to eight good, measurable, time limited, slight stretch program objectives.
✓ Do a good job of laying out the planning process.
✓ Do recognize that the program will go through a definite set of stages.
✓ Do balance the concern for overall lifestyle change versus work-related health risks changes.
✓ Do be sensitive to the production of guilt. Try not to produce guilt in those who do not participate in your programming.
✓ Do be sensitive to age, body limitations, handicapping conditions, self-image, health norms, and work culture differences in your population.

"DON'Ts"
✓ Don't get sidetracked on second order issues — stay focused on the important issues.
✓ Don't worry about using aggregate employee data on risks or claims in the planning and evaluation process.
✓ Don't limit your design creativity at the beginning — think creatively!
✓ Don't forget to design some seasonal issues into your program — make it relevant to employee concerns.
✓ Don't expect to achieve much short-term healthcare utilization change unless you are addressing medical self-care, consumer health education, or health plan incentives.
✓ Don't let the program stagnate by simply making minor modifications each year — keep the design interesting to employees.
✓ Don't forget to look for opportunities to expand your support for the program among first line supervisors and mid-level managers.
✓ Don't forget to design your program with the "KISMIF" principle (Keep It Simple, Make It Fun!).
✓ Don't forget to give credit and thanks liberally to all who have helped.
✓ Don't forget to continue to encourage employee involvement and ownership in the program.
✓ Don't be dissuaded from tackling primary, secondary, and tertiary prevention issues.
✓ Don't forget to design in a valid evaluation program from the beginning.

11. A Checklist for the Design Phase

The following checklist is intended to help you successfully complete the design phase of your development of an employee wellness program for your organization. Check those items that have been completed.

1. ___ We have selected one of the three program models as an organizing structure for our program.
2. ___ We have selected five to eight measurable, feasible, time-limited, slight stretch program objectives.
3. ___ We have selected a few wellness communications activities and they are spread out over the year.
4. ___ We have designed a health management process that will help participants to change their behavior by providing personalized testing information to them.
5. ___ We have selected some additional testing or screening activities to take place during the year.
6. ___ We have selected a set of group activities for the year that are likely to be popular.
7. ___ We have identified the supportive workplace and benefit policies that need to be changed during the year.
8. ___ We have developed a draft program plan.
9. ___ We have developed a draft program budget.
10. ___ We have selected an appropriate level of overall programming to match our objectives and budget.
11. ___ We have selected a desired program identity that will guide the way we implement and evolve the program and how employees perceive the program.
12. ___ We have established a wellness advisory committee.
13. ___ We have requested and received management’s feedback on the draft program plan and budget.
14. ___ We have selected a wellness coordinator.
15. ___ We have a proposed timetable and work program for the program’s activities.
16. ___ We have followed through on the appropriate Do's.
17. ___ We have avoided the appropriate Don'ts.
18. ___ We have translated the program design into a one-page description in order to help explain it to employees and managers.
19. ___ We have addressed the issue of incentives for employees to participate and to change behavior.
20. ___ We have communicated the program design effectively to all our volunteers and committee members.

Once you have requested and received formal approval of the program plan and budget from senior management, you are ready to proceed with implementation of your program.
C. Implementation

Once you have approval of the proposed program plan and budget by your senior manager, the next step is to proceed into the concrete, step-by-step implementation stage. Implementation has many key elements that are addressed below.

1. How Do We Market and Promote the Program?

Effectively marketing the program to employees is critical to a successful program implementation. The marketing of the program usually begins during the planning and design phase, when employees are notified and surveyed about the activities being considered for inclusion in the program. This can happen formally through a written survey or informally through the "grapevine." The basic program purposes and values that drive the planning usually get disseminated informally to employees prior to the actual formal launch in small and medium size worksites. So realize that while you are planning and designing the program, you are also marketing!

Get on top of the program roll-out by making some formal notification to employees about the program, prior to the time you intend to formally launch it. This can frequently be done with a cover letter attached to the employee wellness survey you use during the planning process. However, be careful if you do not have approval from senior management to go forward at the time you do an interest survey. If the direction of the program looks to be fairly clear at the time of the employee survey, you can begin to communicate the basic purposes of the program to employees.

In addition to the cover letter for an employee survey, you can distribute a program launch letter or memo to all employees that describes the program's purpose and proposed activities. Appendix D contains an example of a draft program launch memo or email. This should be done at the beginning of the program and can be done each year as an introduction to any new or modified program activities. If your senior manager is the initiator of the memo or email it also gives the program a sense of importance and visibility that is valuable for the overall program’s success.

Once the program is introduced, it is important to have as many employees participate in the various wellness program activities as possible. A sense of high participation can add some energy and excitement to the effort. If you are using the R-DW program model, your incentive or disincentive is likely to be significant (for example, continued health benefit eligibility linked to completion of an HRA); you won’t have to work so hard to market and promote the program. If you have a $600 to $1,200 “carrot” attached to program participation and wellness achievements, you are likely to have a very high level of participation (for example 90%). If you do not have a compelling motivation for employees to participate, then it will require a careful and thorough approach to marketing, notifying and promoting the program to your target populations in order to get 40% to 60% to actively participate.

A general approach to the promotion of individual wellness events or activities is recommended in Figure 32, as follows:
Promotion Guidelines for Wellness Programs

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Schedule</td>
<td>2-12 months ahead</td>
</tr>
<tr>
<td>Advance Notice</td>
<td>4-6 weeks ahead</td>
</tr>
<tr>
<td>Program Memo</td>
<td>2 weeks ahead</td>
</tr>
<tr>
<td>Bulletin Board</td>
<td>1 week ahead</td>
</tr>
<tr>
<td>Email Registration</td>
<td>1 week ahead</td>
</tr>
<tr>
<td>Reminder Notice</td>
<td>2-3 days ahead</td>
</tr>
<tr>
<td>Email Reminder for Registrants</td>
<td>1 day ahead</td>
</tr>
<tr>
<td>Email Reminder for Registrants</td>
<td>1 hour ahead</td>
</tr>
</tbody>
</table>

Figure 32 Promotion Guidelines for Wellness Programs

Written communications play an important part in promoting an employee wellness program. In preparing written announcements, the “best practice” approach includes the following:

- Use appealing, simple lay-out designs.
- When possible, use attractive, eye-catching colors.
- Make it easy to recognize with logo, art style, tag line, and writing style.
- Emphasize the personal benefits of attending activities and events to employees.
- Use examples and illustrations that fit the population.
- Leave no major questions unanswered, such as who, what, why, when, etc.
- Use attention-getting pictures where possible.
- Circulate announcements early, but not too early and not too late.
- Write all documents from the audience's perspective.
- Don't be afraid to be redundant — it’s necessary for learning and retention.
- Test all documents first on the uninformed.
- Have a clear “call to action.”

Written or email communications alone are usually not enough to be the sole methods of program promotion and marketing. It is best to have several methods of promotion in addition to the Traditional Wellness written methods. The following material is highlighted from a chapter prepared by the author on awareness strategies for the book by O'Donnell, titled *Health Promotion in the Workplace*.

a. Traditional Wellness Awareness Communication Methods

The following awareness communications methods represent Traditional Wellness methods and vehicles used in the American worksite to educate and inform employees and their family members. It is not unusual to find several of these methods used in the communication of specific informational issues. Figure 33 contains a listing of the Traditional Wellness awareness communications methods for use in worksite settings.
### Traditional Wellness Awareness and Communication Methods

1. Announcements during meetings. One of the more effective methods is to make an informational announcement as part of a meeting with employees or with key staff. This awareness communication method, as is true of all methods, does not assure 100 percent retention or even general familiarity. However, individuals who are exposed to informational messages in this way are likely to have a fairly high degree of retention of the information.

2. Written individual notices. The individual email notice, memo, or letter is a typical approach used by the vast majority of work organizations. This approach can be embellished with distinctive art styles, colors, and desktop publishing criteria to enhance readership and retention. Unfortunately, a significant percentage of employees do not read written correspondence, usually because of illiteracy, apathy, or outright resistance. Penetration of awareness programming into spousal and dependent populations is also hindered by gate keeping that occurs for many different reasons.

3. Bulletin board notices. Another very Traditional Wellness awareness communication method involves the use of employee bulletin board notices. Prescribed as a required communication method in many state and federal laws, it is almost universal in all but the very smallest of worksites. In order to appreciate the prevalence and the role of bulletin boards in worksite awareness activities, it is appropriate to reflect on the make-up of the American work force by size of employer.

The distribution of employees by size of employee population illustrates the large proportion of the labor force that resides in relatively small worksites. This means that Traditional Wellness methods such as site-based bulletin boards are likely to be used by a large percentage of worksites and will likely be a major awareness vehicle.
in the near future. Of additional interest is the fact that even large employers have a disproportionately large number of their employees in small worksites and are likely to depend on communication methods that are more Traditional Wellness, such as bulletin boards. In relation to bulletin board use, the unfortunate reality is that announcements that are placed on bulletin boards, even if they are moved periodically and not crowded together usually do not get read. In addition, it is likely that many employees will not look at employee bulletin boards unless there is a compelling reason to do so. With the movement to email communications, bulletin boards are losing their general utility with most work groups.

4. **Printed pamphlets.** A very Traditional Wellness component of most awareness programs is the use of printed pamphlets that focus on specific health and wellness topics. Typically these vehicles are maintained in specified locations and can be picked up at will by employees. Other methods of distribution include email or mail request cards or memos that allow the individual employee to request a limited or unlimited number of pamphlets on specific health topics of interest. The best strategy with pamphlets is to provide them only when they are desired by the individual, primarily when he/she is interested in making a behavior change or is concerned about his/her own or a loved one's risks and needs.

5. **Payroll inserts.** Payroll inserts are written materials that are included in paycheck envelopes and are used to distribute selected information to employee populations. This method has been declining significantly in usefulness as the number of employees with direct electronic deposit of paychecks increases. In addition, much speculation has occurred about the quick discarding of everything but the paycheck by the employee, further undermining this method's usefulness. This limitation can be partially overcome by adopting a policy that prohibits electronic bank deposits and by using inserts with payroll stubs to communicate well-advertised and important items of information. This would hopefully further develop the employee’s sense of the importance of written materials received with employee paychecks.

6. **Marquees and electronic billboards.** This method involves the use of centrally located marquees or electronic billboards with a looped or repeating message. These are frequently used in building foyers, elevators, reception areas, lunch rooms, break rooms, waiting areas, and meeting areas. Its strengths are its repetitive nature, while its weakness includes the dependence on a highly traveled location.

7. **Face-to-face individual information sessions.** Undoubtedly one of the most effective methods for raising awareness involves the face-to-face encounter. This information exchange is usually two-way and capable of enhancing retention and understanding. From informal observation by the author, it appears as if the most effective form of this method is the question-and-answer approach involving challenge questions and specific knowledge goals.

8. **Group information sessions.** The use of group meetings for delivery of information is another Traditional Wellness communication method and is reasonably effective depending on the style and content of the information delivered. Brief meeting inserts on wellness topics can become a routine part of periodic meetings with employee work groups.
9. **Audio presentations.** Audiotape media are used increasingly in most working populations. The use of personal headsets and audio and CD recorders is widespread, although limited use is made of this awareness method in most worksite wellness programs. The span of content that audiotapes address is very wide, and more resources are becoming available. Professional education in many of the technical areas of concern in health promotion and wellness includes a large number of audiocassette resources.

10. **Audiovisual presentations.** The use of audiovisual technology is also a fairly typical approach used by employers. The options include 35 mm and overhead slide presentations, film media, and audiotape combinations. These methods are a mainstay for a culture as entertainment-oriented as ours. These approaches are typically integrated with other communication and awareness methods and are used in orientation, employee training, and waiting areas.

11. **Video opportunities.** Even more widespread in usage are video-based communication methods. The use of videotapes, LCD monitors, VCRs, and IPads has greatly extended this awareness and communication method with employee populations. Continuous loop presentations, user-initiated or controlled operation, and miniaturization of video recorders and monitors have greatly enhanced the potential of this method and its use by employers.

**b. Non-Traditional Wellness Awareness and Communication Methods:**

The following awareness and communication methods are generally considered more innovative and similar to the way that adult learners are prone to understand, assimilate, and retain information. These methods are considered non-Traditional Wellness, but may be combined with Traditional Wellness methods in the design of awareness, promotion or employee communication programs. **Figure 34** highlights the major non-Traditional Wellness awareness and communication methods that can be used in the worksite.

<table>
<thead>
<tr>
<th>Non-Traditional Wellness Awareness and Communication Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information-based puzzles or limericks</td>
</tr>
<tr>
<td>2. Self-quizzes</td>
</tr>
<tr>
<td>3. Mail and email request vehicles</td>
</tr>
<tr>
<td>4. Trigger cards</td>
</tr>
<tr>
<td>5. Continuous video loops</td>
</tr>
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<td>6. Web-based electronic bulletin boards</td>
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<td>7. Electronic message boards</td>
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<td>8. Electronic mail</td>
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<tr>
<td>9. Learning Management System (LMS) modules</td>
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<td>10. Telephone contact</td>
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<tr>
<td>11. Multimedia presentations</td>
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<tr>
<td>12. Computer-aided search station</td>
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</tbody>
</table>

*Figure 34 Non-Traditional Wellness Awareness and Communication Methods*
1. **Information-based puzzles or limericks.** Limericks and puzzles or brain teasers can be used effectively to increase knowledge and interest. This form of communication can add a dimension of interest and can contribute in a positive way to the organization’s culture.

2. **Self-quizzes.** The use of self-quiz vehicles on wellness topics is another example of a non-Traditional Wellness awareness tool that can be used successfully to engage the adult learner. The questions can be connected to incentives used as a qualifying requirement, or placed in a jeopardy-type game format. Self-quizzes can include answers or can require an additional step or action to provide a check on the right answers.

3. **Mail and email request vehicles.** This method involves providing employees and/or their family members a written form that can be used to request a limited number of pamphlets or materials on wellness topics. These materials are then sent to the address indicated by the requester. If a limited number of materials (no more than two or three written items per request) is used, it will tend to focus the individual on the information that is most relevant for decision-making needs. This method tailors information to individual needs. Periodic distribution of such a request vehicle is advisable.

4. **Trigger cards.** This awareness method involves the use of small wallet or pocket cards with health and wellness-related information specifically focused on behavior change. These materials can be made available at personnel or occupational health units or disseminated through routine distribution or contact methods. The types of topics they can address include questions for your doctor, consumer health skills, cholesterol reduction tips, stress management techniques, etc. Each card can contain 250-300 words if front and back surfaces are used.

5. **Continuous video loops.** This use of video messages is based on a relatively brief videotaped message that is designed to automatically recycle. This type of device can be used in waiting areas or in areas where viewers are stationary for three to four minutes. The messages should be changed frequently enough to offer variety to those who view it frequently.

6. **Web-based electronic banners or bulletin boards.** Another awareness technique or method involves the use of computer banner messaging or electronic bulletin boards. This method is used in heavily computerized organizational settings or where there is relatively high access to computer networks and equipment. A wellness or health promotion electronic bulletin board can contain listings of information about community-based programs and resources, as well as topic-specific information.

7. **Electronic message boards.** This particular awareness or communication method utilizes pre-programmed health or wellness messages that are displayed in light patterns on a screen or surface. The messages can trail in from one side, rotate up or down from below or above, or simply appear and then disappear. These devices can be placed where they will have maximum exposure to the group involved.

8. **Emails.** Another computer-based communication technique involves the use of electronic mail usually referred to as “email.” A sender can program and transfer
information via computer networks or through modem linkages. The types of information transferred in this way can include health information as well as program promotional information. With many remote worksites, wellness coordinators can utilize electronic mail to notify program contacts of upcoming activities, conduct informational polls, or provide program cues or reminders for follow-up.

9. **Learning Management System (LMS) modules.** Most larger work organizations utilize Learning Management Systems (LMS). These online learning platforms allow web access to asynchronous learning modules covering a broad array of topics ranging from sexual harassment to business continuity. The individual employee logs on to the LMD platform and completes the topical learning module then completes a quiz and the LMS tracks their response and completion. In the future, this service will likely be offered to all size organizations to assist them with staff training and skill development.

10. **Telephone contact.** The use of physician and nurse advice lines and the provision of toll-free access to wellness professionals for advice and coaching represents a non-Traditional Wellness approach to awareness programming. Providing an opportunity for asking questions of a health professional through a telephone advice and support system will likely increase all efforts to bring useful information to employees and dependents who are geographically dispersed among relatively small worksites.

11. **Multimedia presentations.** A newer technology option involves the expanded role of computers in multimedia presentations. These typically include text, sound, and picture capabilities linked to monitors or large-screen equipment. This technology is a somewhat recent development and it is likely that more wellness-related applications will become commercially available over time.

12. **Computer-aided search station.** Another awareness method that is now usually linked to cloud technology is the provision of computer search capabilities for consumers that allows them to enter diagnoses or health topics of interest. Abstracts and full articles then come up on the screen. These informational sources can then be printed or emailed, providing health information for the individual user.

The large number of Traditional Wellness and non-Traditional Wellness communication and awareness methods reinforces how many options wellness program staff have for communicating with an employee work force. In designing the communication and awareness strategies for a worksite wellness program, you should carefully mix the communication channels and vehicles that you want to use for maximum behavioral effect.

2. **Kicking Off Your Program with Style**

When initiating an employee wellness program, it is important to launch or kick it off with style. This is necessary to attract the attention of employees and to create momentum and enthusiasm for the program. In creating a memorable program launch, it is important to create a positive and upbeat climate. Some of the possible approaches that will help create a program launch "with style" are as follows:
Distribute a launch letter/email from the top senior manager. Prepare a very positive and supportive letter/email from the senior manager, stating why the program is being introduced, what activities will be offered, what employees were/are involved in the program's planning and implementation, and the level of management support for the effort. In order to make the launch even more noteworthy, work with a group of volunteers and before the workday starts, place the launch letter on each employee's desk or workstation with an apple on top of it. This will have the effect of producing a positive climate for the kick-off of the program and help make a strong initial statement.

Have a name appearance. Use a local sports or athletic figure to talk about motivation or personal excellence and relate it to wellness and lifestyle choices. This can have the effect of putting some positive energy into your program launch. The use of a recognizable sports figure can also help draw increased attention to the new wellness program at the time of the launch.

Schedule a special event. Kick off the program with a special event such as a cholesterol screening, free balloon animals, music recital, healthy food pot-luck, bag pipe serenade, fund raiser, and prize drawing. These special events heighten interest and enthusiasm and can also be useful in distributing materials about upcoming program activities. The special event may include a combined benefits fair and health fair for employees as well as dependents, with health screening opportunities.

Distribute an annual calendar of major events. In order to help employees see the big picture regarding the full range of activities to be offered through the program, it is helpful to provide quarterly or annual calendars. These calendars can convey the momentum and energy behind the program. Fun art style and creativity can add a useful boost to a program launch.

Use a wellness survey to get employee opinions. One of the best ways to raise awareness and enthusiasm as part of a program launch is to use an employee interest survey. A one to three page survey can be used with an incentive such as a free apple for returning the survey or a complimentary newspaper like hotels often do, or a coupon for use in the company cafeteria for new or healthy food choices. A number of small inexpensive incentives can be used to make the survey process more effective and momentum-building in nature. The survey results should be quickly tallied and reported back to employees so that the feedback provides a measure of visibility while responding to natural curiosity. Another approach is to have a few survey respondents selected from those who put their names on the surveys scheduled for a lunch or dinner with the senior manager. Appendix F contains a sample employee wellness interest survey that is useful for planning programs.

Use a wellness or fitness contest to promote interest. Another approach for energizing a program launch involves a promotional short term incentive contest that creates interest and group involvement. The use of points for individual wellness behaviors like pounds lost, days without smoking, aerobic point scores, or seat belt use can be used to stimulate activity at relatively low cost with high levels of involvement. Group incentives such as a reward for the departments with the highest level of involvement can help make the event more memorable and increase participation. Award ceremonies usually appeal in a positive sense to a specific group or segment in each work force.

These are just a few of the possible ways of launching your employee wellness program with a degree of “style.”
3. **Tips For Scheduling Your Wellness Program Activities**

The scheduling of wellness program activities is important in assuring high levels of employee and ideally, family member participation. Strong participation incentives will help assure high levels of program participation and are therefore the method of choice in designing worksite wellness programs. Some general rules of thumb concerning the scheduling of wellness activities with limited participation incentives are as follows:

1. Good times to launch wellness programs are in the fall (September), at the new year (January), and any time in the spring (March, April, and May). These are normal times for a break in routine, and are natural, seasonal markers for new program activities or the launching of incentive programs.

2. Multiple workshop series, such as “lunch-and-learn” wellness sessions, should be planned for the same day and time each month in order to make it easier for people to remember and schedule the session on their calendars. For example, consistently schedule lunch-and-learns for the third Thursday of each month, from 11:30 a.m. to 12:30 p.m.

3. Aerobics and physical activity sessions should be planned for lunch time if showers are available and at end of the day shifts if they are not. Eliminate summer scheduling of indoor aerobics because people usually like to be outside in the summer. In very large employee settings (3,000+), you can usually schedule regular physical activity programming in fitness center settings before shift, after shift, and lunch times all year long.

4. Schedule multiple offerings of the same type of activity so that spouses can attend and employees on all shifts have an opportunity to attend the activity. For example, schedule several sessions of a resilience workshop with an evening session offered for spouses and second shift workers. If you are going to plan a weekend session, use a sign-up sheet and connect it with a Saturday breakfast and opportunity for a social event.

5. Plan a health and fitness testing activity to take place right before you offer programs like smoking cessation, weight management, aerobics, or walking events so people have a logical follow-up to the initial testing process. This is also designed to help move people through the stages of readiness to change by linking opportunities created through education, testing, and into behavioral intervention in a “campaign” approach.

6. If general education and awareness makes sense for your group, start out with lunch-and-learn type sessions on employee's time, then later offer activities that are scheduled on work time if you have management support. However, fewer and fewer employers are using work time for programming because of increasing work demands and the general economic challenges faced by most employers.

7. Limit participation in some of the cyclic program offerings in order to add an element of value or exclusivity. This is recommended for programs that have a strong behavioral focus or are very expensive to provide, such as smoking cessation, weight management, or diabetic management.

8. Schedule workshops or program series that address selected health or wellness issues after you have communicated to the general employee group about the magnitude, severity,
or complications associated with that specific health issue. For example, publish an article in the employee newsletter on the benefits of physical activity or the personal negative side effects of a sedentary lifestyle before opening up an aerobics or physical activity opportunity for employees. This also supports movement through the stages of readiness to change.

9. Do not plan too much program activity at one time. Spread the program offerings out over time so that every couple of weeks, some event or wellness issue comes to the attention of employees; pace yourself!

10. Start your program slowly and build it with a quality feel over time. In this way, you can help assure that the quality will be good and employees will recognize that you (and the program) are going to be around for the long haul.

11. All scheduling needs to be communicated with a clear “call-to-action” and redundancy and remember, just as with any serious activity in the worksite, wellness requires enough focused effort to achieve maximum participation and success.

These are just a few of the guidelines that you can use to schedule events and get as many participants as possible.

4. **Use of Health Risk Assessments (HRAs)**

Health Risk Assessments (HRAs) are questionnaires that relate an individual's lifestyle choices, health behaviors, and current health conditions to probable future health. These instruments can be self-scored, but are usually computer processed and are used as a way of catalyzing an individual's interest in their own wellness-related behavioral choices. These types of surveys are sometimes used in a stand-alone approach to employee wellness, but this is generally not recommended. However, HRA’s will produce much more significant long-term behavior change if they are integrated into a carefully thought-out health management process such as that described earlier. Also, we are now into an era where second and third generation HRAs are available. The common characteristics of contemporary HRAs are identified in Figure 35 below.
Characteristics of Contemporary Health Risk Assessments (HRAs)

- Contain 35 to 75 questions with sub components.
- Request information on an individual's demographic characteristics, personal medical history, major chronic diseases and conditions, lifestyle choices, perceived health status, and selected health additional parameters.
- Usually computer processed and produces a “personal report” for the user.
- Compares the individual's responses against a large population database to examine likely longevity and/or probability of morbidity.
- Most provide an “Overall Wellness Score” that provides a view of the composite level of risk associated with individual's current health-related lifestyle choices.
- Provides the individual with information and recommendations on adopting healthier behaviors.
- Generally helps program staff to determine who are the individuals at highest health risk so intervention with them can take place.
- Usually examines “perceived health status” and readiness to change.
- Examines and recommends preventive clinical screening tests that make sense for the individual.
- Projects likelihood of morbidity and/or healthcare utilization.
- Determines the stage of change the individual is at in several key modifiable behavioral risk areas.

HRAs can be used to stimulate employees’ interest and to catalyze initiation of behavior change or movement in stage of readiness to change, but should not be used in ways that remove their long-term potential impact in motivating behavior change. An initial intake instrument or HRA can be more extensive than one that is used in a serial or follow-up manner. The HRA should be used to establish a permanent database that can be utilized for phone-based counseling and high-risk and at-risk individual intervention. This also implies that where HRAs are used, there should be a behavioral intervention to improve the individual's relative health risk status or help change their stage of readiness. If HRAs are used in a stand-alone manner without high-risk intervention, their behavioral motivation potential is often wasted without producing any significant long-term change.

If the HRA, or a streamlined version, is repeated at six-month intervals, the maximum improvement in personal health is likely to occur. Jim Fries MD from Stanford University documented this outcome along with the strategy of reminding individuals of their previous scores and challenging them to strive for personal improvement. It also appears clear in reviewing the scientific literature that it is preferable to use HRAs in an integrated multi-component approach rather than in a stand-alone, isolated manner. The next generation HRAs will likely be indispensable tools for behavior change and long-term health management, and will need to be part of a well-designed and multi-component approach. For a list of recommended technical specifications for HRAs, see Appendix J.
5. Selecting Good Program Vendors and Materials

When establishing an employee wellness program, internal staff can perform many program functions. For example, internal training and development staff can often conduct stress management or resiliency training, occupational health nursing staff can conduct health screenings; human resources staff can develop wellness communication pieces and perform internal policy reviews, benefits staff can examine the extent of support for wellness in current employee benefit programs. Regardless of the breadth and scope of internal resources in your organization, specific wellness activities need to be purchased from outside vendors. These outside vendors typically include fitness testing, biometric testing, wellness coaching, facilitating smoking cessation classes, leading weight management support groups, securing an eHealth portal or teaching medical self-care sessions. When selecting outside vendors, it is important to make sure that you secure a vendor that is the best fit for your organization. One of the ways that you can improve your chances of selecting a good vendor is to use a Request for Proposal (RFP) process and/or by utilizing a number of questions for selecting good vendors when you don’t use a more formalized RFP process.

The RFP process usually involves the following major steps:

1. Develop a definition of the specific services and products that you want to purchase. (Often called the “Scope of Work”)
2. Establish the desired timetable for the RFP process.
3. Translate the “scope of work” and the timing into a written RFP including specifications and instructions for vendors who are interested in responding. (This usually includes the organization’s “boiler plate” legal protections and terms for contracting.)
4. Determine which vendors will be asked to respond to the RFP.
5. Send out the RFP to the prospective vendors with time enough for them to prepare a thorough response.
6. Receive the proposals from the vendors.
7. Review and evaluate proposals submitted by interested vendors (or bidders) who want your business.
8. Select the top 2 or 3 bidders for interviews and a “best and final” submission.
9. Make your final selection.
10. Notify the successful vendor and negotiate a contract with them.

This more formalized process of procurement is designed to identify the best technical vendor of services for the best cost. In the event that a full-blown RFP approach is not feasible or appropriate, there are a number of questions that can be asked of wellness program vendors. These questions can be adapted to the specific type of service offered by the vendor. Figure 36 contains a series of general questions that should be used to help select wellness program vendors.
6. Delegating Responsibility

The development and implementation of an employee wellness program will always require some level of delegation of activities and tasks. In low cost wellness programs, this is even more critical because of the need to share the burden of responsibility and implementation of the various program activities. A wellness program coordinator absolutely has to have delegation skills. The more delegation skill the coordinator has the better the implementation of the program will proceed, particularly in medium and small employer worksites. Some of the delegation skills that are critical to a wellness program coordinator are identified in Figure 37.

<table>
<thead>
<tr>
<th>Key Delegation Skills for Wellness Program Coordinators</th>
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<tbody>
<tr>
<td>♦ The ability to identify people who can complete an assigned task.</td>
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<tr>
<td>♦ The ability to set up reminder systems to trigger follow-up at key points.</td>
</tr>
<tr>
<td>♦ The ability to determine the best approach to help the individual follow through on the assigned task.</td>
</tr>
<tr>
<td>♦ The ability to make contact with people and help make sure they are following through appropriately on the delegated activity.</td>
</tr>
<tr>
<td>♦ The ability to have a &quot;fail-safe&quot; checkpoint concerning the assigned task.</td>
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Figure 36 General Questions for Wellness Program Vendors

<table>
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<tr>
<th>General Questions for Worksite Wellness Program Vendors</th>
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<tr>
<td>General Concerns:</td>
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<tr>
<td>1. What are the educational and experiential qualifications of your key staff?</td>
</tr>
<tr>
<td>2. How many times has the program been given and to what kinds of employee populations?</td>
</tr>
<tr>
<td>3. What kinds of materials are used?</td>
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<table>
<thead>
<tr>
<th>Program Methods:</th>
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<tbody>
<tr>
<td>1. How do you know your materials and approach will meet the needs of my workforce?</td>
</tr>
<tr>
<td>2. How do you suggest the program be marketed to my employees?</td>
</tr>
<tr>
<td>3. What materials do you provide to market the program to employees?</td>
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<tr>
<td>4. What is the basic educational design that you use in the program?</td>
</tr>
<tr>
<td>5. What provisions do you have for follow-up?</td>
</tr>
<tr>
<td>6. How do you provide for referrals and linkages to other programs that are needed by participants?</td>
</tr>
<tr>
<td>7. What kinds of behavior modification techniques do you use in your program?</td>
</tr>
<tr>
<td>8. Does your program use the Transtheoretical™ or “Stages of Change” approach?</td>
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Program Effectiveness:

1. What skills do you have the participant practice?
2. How do you know your program works?
3. What percent of the participants will maintain a behavior change at six months? At twelve months?
4. How do you evaluate satisfaction levels of participants with the program itself?

Figure 37 Key Delegation Skills for Wellness Program Coordinators
The more skill a wellness program coordinator has with delegation the more likely the wellness program will be successful.

7. Implementation “Do's” and “Don'ts”

Implementing a wellness program is not necessarily easy, but it can be aided greatly by adhering to a few basic guidelines. Here are some Do's and Don'ts to help you in the program implementation stage.

“DO's”
✓ Do start off slowly with the program components that have the best chance of success.
✓ Do remember to continually market the program to employees.
✓ Do try some high visibility programs at the beginning and periodically from then on to help market the program.
✓ Do use various kinds of incentives to encourage participation, adherence, and completion of program series.
✓ Do let the program unfold with some flexibility — try not to over-structure it.
✓ Do support the integration of the program into various parts of the organizational culture.
✓ Do excellent quality programs. It is better to do fewer programs well than more programs with questionable quality.
✓ Do continue to work on your own personal wellness.
✓ Do monitor what rank-and-file employees think.
✓ Do evaluate your program in a consistent and thorough manner.

“DON'Ts”
✓ Don't be timid in promoting the program to employees and managers.
✓ Don't be afraid to have a mandatory briefing session on the value and details of the overall wellness program.
✓ Don't let the program get caught in union-management politics.
✓ Don't ignore the importance of the program's image among employees.
✓ Don't get so much employee involvement that you impede the development of the program.
✓ Don't forget about the pay value needs of the employee advisory committee volunteers.
✓ Don't forget to keep accurate and confidential records of all the quantitative data that is important for the evaluation of the program.
✓ Don't get out of balance between clinically significant programs and those that are just plain fun.
✓ Don't forget the need to individualize the program to different worksites and groups.
✓ Don't underestimate the importance of the personality of the program’s implementers and how it may affect employee reaction.
✓ Don't forget to capitalize on unplanned events that have health significance for the population.
✓ Don't hire any vendor sight unseen.
✓ Don't forget to implement the program using the "KISMIF" principle (Keep It Simple, Make It Fun!).

8. A Checklist for the Implementation Phase
The following checklist is intended to help you successfully implement your employee wellness program for your own workforce and organization.

1. ___ We have utilized an appropriate program model for implementing the program.
2. ___ We have identified an appropriate marketing approach for the specific program activities to be conducted during the coming year.
3. ___ Each of the identified activities has a lead individual who has accepted responsibility for its implementation.
4. ___ There is a systematic mechanism in place to follow-up on the timely completion of each major assigned task.
5. ___ We have identified a budget and a timetable for the program.
6. ___ We have scheduled the proposed group activities for the year.
7. ___ We have identified where and how HRAs will be used in the program.
8. ___ We are meeting monthly to go over our draft program work plan.
9. ___ We are reviewing our program budget on at least a quarterly basis.
10. ___ We are implementing an appropriate level of programming for our objectives and budget.
11. ___ We have taken steps to create a desired program identity that is guiding or influencing the way we implement the program.
12. ___ We have consistently utilized a wellness advisory committee.
13. ___ We have received user feedback on the program as it has been implemented.
14. ___ We are adequately staffed to implement the program.
15. ___ We are generally meeting the timetable for the program's activities.
16. ___ We are working to better integrate wellness values into other facets of our organization.
17. ___ We are communicating major program accomplishments to our senior managers.
18. ___ We have tried to reach all targeted sub-groups and sites with our program.
19. ___ We have followed through on the appropriate Do's.
20. ___ We have avoided the appropriate Don'ts.

As you work on implementation of your program, try to keep an eye on the things you have learned and how these things should shape your next year of programming.
III. EVALUATION

All employee wellness programs should have a formal evaluation on an annual basis. This is strongly advisable for two major reasons. First, worksite wellness programs are still relatively new endeavors for most organizations and their rationale and justification for existence are not always firmly established in the business community, particularly with today’s more volatile business climate and competitive markets. As a result, care and effort has to be taken to document the effectiveness and value of the program to the organization. This purpose is even more critical when one recognizes the nature of the organization’s business cycle. In good times, wellness may seem to be strongly supportable and perceived as a clear value to the organization. In harsher and more competitive economic times, wellness may be seen as a luxury that is not cost-justifiable given more streamlined or lean organizational priorities.

The second major reason evaluation is important is due to its importance in refining the wellness program over the long term. Without a formal and systematic evaluation effort, it is doubtful that the program will reach its maximum effectiveness and remain relevant to the changing needs of the workforce. This particular role for evaluation is frequently labeled the “formative” aspect of evaluation, contributing to the refining of the program's purposes and methods.

Both of these major reasons for including evaluation plans in the planning and design of your employee wellness program are essential in helping to secure a long-term future for the program. In this section, some practical suggestions for structuring the formal evaluation activities will be offered. Readers should be aware that a separate Chapman Institute publication that covers this topic in far greater depth is titled “Program Evaluation: A Key to Wellness Program Survival,” and is available in paper and eBook format from Chapman Institute.

A. Charting a Path for Evaluation

Evaluation is often intimidating to the novice. It does not need to be if a few basic guidelines are followed, as shown in Figure 37. They are intended to address the very pragmatic concerns of conducting a program evaluation that is as valid as possible under the very real constraints of limited time and resources available for evaluation in work organizations.

<table>
<thead>
<tr>
<th>Basic Program Evaluation Guidelines</th>
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<tbody>
<tr>
<td>1. Select only those issues to evaluate that are critical to key decision-makers and that you will need to have in order to refine the program.</td>
</tr>
<tr>
<td>2. Recognize that extremely valid evaluation research is very expensive.</td>
</tr>
<tr>
<td>3. Don't accept responsibility for extensive evaluation without the resources to accomplish it.</td>
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<tr>
<td>4. Don't collect information about the program that does not have a clearly defined use up front.</td>
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<tr>
<td>5. Recognize that even the best evaluation will not necessarily silence program critics.</td>
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<tr>
<td>6. Look for ways of using already existing information systems to collect information.</td>
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<tr>
<td>7. Don't do evaluation unless you plan to use the results.</td>
</tr>
<tr>
<td>8. Find out ahead of time what key decision-makers expect regarding evaluation methods and results.</td>
</tr>
<tr>
<td>9. Look for ways to maximize the validity of your evaluation efforts.</td>
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<tr>
<td>10. Keep asking others for suggestions on how to improve your evaluation efforts.</td>
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</tbody>
</table>

Figure 37 Basic Program Evaluation Guidelines
There are five major areas where formal evaluation should be planned for all employee wellness programs. With a little early planning, it is possible to structure some practical and easy-to-do evaluation activities that naturally flow out of routine record keeping and information sources. The five areas are evaluation of the program's objectives, monitoring participation and participant feedback, tracking changes in participant behavior and risk factors, compiling aggregate scores from test results, and monitoring selected changes in key organizational indicators. Each of these areas will be discussed in turn.

1. Evaluating Your Program's Objectives

In the development of your wellness program, it is recommended that you develop and adopt five to eight measurable and time-limited objectives for your program. A key element of your goal-based program evaluation efforts can be the formal evaluation of these objectives. This can be done by simply identifying the required pieces of information necessary to allow you to evaluate your objectives, and to follow through on your intentions to monitor and report on whether you accomplished your objectives and to what extent. The existence and use of yearly program objectives will help you focus your programming effort and help you evaluate your program at the end of each year.

In order to develop a perspective on the types of program objectives that employers have adopted for their wellness programs, it is useful to review some of the findings of a survey of 125 Fortune 500 companies that was done in the late eighties and is still relevant. Of the 113 responders, 49 (43%) indicated they had an employee wellness program with the following types of program objectives presented in Figure 38.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Objectives / Goals</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Promote better health</td>
<td>47</td>
<td>96%</td>
</tr>
<tr>
<td>2</td>
<td>Improve cardiovascular fitness</td>
<td>39</td>
<td>80%</td>
</tr>
<tr>
<td>3</td>
<td>Reduce coronary risk factors</td>
<td>33</td>
<td>67%</td>
</tr>
<tr>
<td>4</td>
<td>Decrease in health costs</td>
<td>32</td>
<td>49%</td>
</tr>
<tr>
<td>5</td>
<td>Improved relations</td>
<td>24</td>
<td>49%</td>
</tr>
<tr>
<td>6</td>
<td>Aid recruitment / retention</td>
<td>23</td>
<td>47%</td>
</tr>
<tr>
<td>7</td>
<td>Decrease in absenteeism</td>
<td>20</td>
<td>41%</td>
</tr>
<tr>
<td>8</td>
<td>Increased productivity</td>
<td>19</td>
<td>39%</td>
</tr>
<tr>
<td>9</td>
<td>Minimum level of fitness</td>
<td>19</td>
<td>39%</td>
</tr>
<tr>
<td>10</td>
<td>Increased muscular strength</td>
<td>12</td>
<td>24%</td>
</tr>
</tbody>
</table>

These reported programmatic objectives and their general nature illustrate the difficulty of selecting objectives that lend themselves to simple measurement methodology and practical assessment. The types of program objectives that make more sense are those with more

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measurable and useful forms for program evaluation, along with the specific data elements needed for measuring progress and relative accomplishment of each objective.

A sample set of recommended program objectives and how they would be measured are as follows:

1. *To reduce the average number of sick leave days taken by all employees during the year by 10%.*
   **Data Required:**
   ✓ Number of sick leave days used for the year for all employees  
   ✓ Average number of employees in the work force for the year

2. *To have 54% of the organization's full time workforce participate in one or more wellness program activities during the year.*
   **Data Required:**
   ✓ Names of all employees who participate in each wellness program activity  
   ✓ Unduplicated count of the number of employees who participated in one or more wellness program activities  
   ✓ Average number of employees in workforce for the year

3. *To implement seven different wellness activities for employees during the next year.*
   **Data Required:**
   ✓ Names of different wellness program activities implemented during the year

4. *To organize an informal sports league that involves at least 25% of employees during the year.*
   **Data Required:**
   ✓ Names of employees who actually participated in each of the informal sports league activities  
   ✓ Average number of employees in workforce

5. *To process 112 employees through a wellness assessment during the first and second quarter of the year.*
   **Data Required:**
   ✓ Number of employees completing the wellness assessments  
   ✓ The date they were processed through the wellness assessments

6. *To train 580 employees and 75 spouses in basic medical self-care and consumerism during the first quarter.*
   **Data Required:**
   ✓ Number of employees and spouses who were trained  
   ✓ The date they were trained
2. Using Participation and Participant Feedback to Improve Your Program

The second area of recommended wellness program evaluation includes the systematic collection of participation data and formal feedback from program participants using program sign-up sheets and post-session evaluation forms. This information is particularly useful in refining those programs that are periodically repeated. The adoption of a quantitative scale for participant satisfaction is recommended. An example would be the use of the following question:

*How would you rate the activity on a 1 to 10 scale, with 1 = poor and 10 = excellent? Please circle the number that reflects your assessment.*

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

If you use a standardized question such as this, average scores can be computed for each activity that allows a quick assessment of participant reaction to the activity. Different instructors giving the same workshop can be evaluated based on participant response.

Other kinds of standardized feedback from participants can include a broad range of issues. Some of the various types of feedback questions and their principal uses are contained in Figure 39.

<table>
<thead>
<tr>
<th>Some Suggested Standard Questions for Participant Evaluation Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How important was the activity in helping you make a desired health behavior change? Please circle the number which best reflects your assessment.</td>
</tr>
<tr>
<td>Not important 1 2 3 4 5 6 7 8 9 10 Extremely important</td>
</tr>
<tr>
<td>2. What one thing from the activity was the most useful to you?</td>
</tr>
<tr>
<td>3. What one thing would you improve about the activity?</td>
</tr>
<tr>
<td>4. What changes would make the activity more worthwhile?</td>
</tr>
<tr>
<td>5. What related topics would be interesting to you?</td>
</tr>
<tr>
<td>6. What could be done to attract more participants to the activity?</td>
</tr>
<tr>
<td>7. How did you learn about this wellness program activity?</td>
</tr>
</tbody>
</table>

*Figure 39  Standard Participant Evaluation Questions*

The consistent collection and summary of participant counts and information can be a very useful way of monitoring the program's acceptance by the employee population. By using the results to select programs, provide feedback to vendors, give feedback to instructors, and modify the way that programs are conducted and marketed, you can create a feedback loop that will help assure that the wellness program is behaviorally effective and well-received by your employees.
3. Tracking Changes in Participant Behavior

The third area of evaluation activity recommended for all employee wellness programs involves the use of some standardized survey tools that provide feedback on the health risk behaviors of the population served by the wellness program. An annual wellness survey can be used to record self-reported patterns of behaviors. Appendix F contains a Sample Employee Wellness Survey that can be used as an annual evaluation on an annual basis. The major categories of questions are demographic characteristics of respondents, health risk behaviors, and program preference information. Additional questions can be added to the survey instrument that asks respondents to indicate whether they filled out the survey the previous year. This allows what is called a longitudinal cohort to be developed that can be used to get more valid statistical information about changes in behavior and risk factors in the user population.

Ideally, this standard survey instrument can be placed in a web-based version integrated with a database program, allowing a number of different useful analyses to be carried out quickly and with much greater validity.

4. Compiling Changes in Average Test Score Results

The fourth area of evaluation recommended for all programs is the use of statistical data on test results such as blood pressure, body weight, total cholesterol levels, HDL ratio changes, percent body fat, fitness test scores, etc. to monitor changes in aggregate score patterns. These cohort scores can be aggregated and their distribution statistically analyzed. For example, if the same 55% of employees are tested on two different occasions that are six months apart for total cholesterol levels and HDL ratios, the cohort or group that had both pre and post tests performed could be used to monitor the change and effects of some of the wellness programming. A similar approach could be used to measure efforts to reduce related risk factors such as obesity, lack of exercise, and smoking. These sub-groups can be used to aggregate statistical information in a way that does not breach any confidentiality because the reported data does not contain any individual scores. Average scores, median scores, and measures of standard deviation can be used to show composite changes in the group. This is particularly important given the actuarial studies described earlier in this publication.

5. Monitoring Changes in Key Organizational Indicators

A number of key indicators are useful in evaluating some of the changes that are associated with employee wellness programs. This process usually involves the selection of a number of key indicators in a dashboard and the formation of a baseline, followed by periodic monitoring of the indicators, resulting in the subsequent creation of a trend analysis of changes occurring with the indicators over a multi-year period of time. This type of evaluation does not generally establish causality or attribution, but it does help demonstrate some potential degree of correlation between organizational activity, such as wellness programming, and the emerging health trend reflected in the indicators. If a significant change in trend is noted, then effort should be made to determine if there are any other plausible explanations or reasons for the trend. In this way, a general oversight of key health management issues can be made more visible through the choice of key indicators which are tracked in an annual evaluation effort.
Some of the types of key organizational indicators that should be tracked over time include:

- Number of employees participating in each wellness activity
- Per capita health benefit claims cost
- Per capita worker compensation cost
- Number of worker compensation claims filed
- Number of lost work days due to work-related injuries
- Number of days of sick leave absenteeism per period of time
- Per capita sick leave absenteeism cost
- Per capita disability claims cost
- Number of disability days per period of time
- Number of occupational injuries per 1,000 employee work days
- Number of early medical retirements per period of time
- Number of inpatient hospital days per 1,000 covered lives
- Number of employee health unit visits for acute illness per 100 workers per period of time
- Number of major International Classification of Disease (ICD) diagnoses that are linked to specific wellness related risk factors per year

These organizational indicators can also be part of the program's objectives or be used as non-goal based evaluation reference points.

For a much more thorough discussion of evaluation methodology for worksite wellness programs plus actual sample evaluation instruments please consult the publication entitled “Program Evaluation: A Key to Wellness Program Survival,” available from Chapman Institute in paper or eBook format.

B. Using Evaluation Results

Before finalizing any program evaluation plan, it is important to consider how evaluation results will be utilized. There are a number of possible things that can be done with the results of wellness program evaluation efforts to make optimal use of the findings.

Feedback to Employees: One important way to use evaluation results is to feed the information back to the employee work force as part of an employee newsletter article or a presentation describing the group highlights.

Periodic Reports to Senior Management: Another good use of program evaluation results is to summarize the key information and put it into a monthly or quarterly report format and route it to various senior managers. This periodic report should contain several graphics, illustrating such things as program participation levels, follow-up on program results, or participant satisfaction. This periodic report should have a more complete version that can be distributed upon request to important decision-makers.

Annual Summary Reports: For additional use of evaluation results, a summary of the year's program activity and various evaluation results can be developed and distributed. This annual report can also be used to catalog the variety of activities conducted under the auspices of the program and to contribute to the improved marketing of the program.
Publications: The evaluation results can also be used in the form of articles in the professional or business literature. The methodology used for evaluation and the results can be written up for publication in a variety of online and Traditional Wellness publication outlets.

Refine the Design of Program: The evaluation results can also be used to help refine the design of the wellness program for the next period of activity. Decisions concerning the choice of types of programming, strategies for enhancing participation, selection of the best information emphasis in newsletters, selecting the best hours for program scheduling, or choice of vendors can all benefit from information that is carefully collected through program evaluation.

C. Evaluation “Do's” and “Don'ts”

Several “DO’s” and “DON’Ts” are important to keep in mind when planning and conducting a wellness program evaluation. These include the following:

“DO's”

✓ Do plan the evaluation while you are designing the program.
✓ Do formulate how you are going to evaluate your objectives before you finally adopt them.
✓ Do commit your evaluation plan to paper.
✓ Do consult with those who know more about evaluation.
✓ Do read some articles or take some online modules on program evaluation.
✓ Do ask what use each piece of information will be put to before you start collecting it.
✓ Do develop a draft evaluation plan in order to help identify basic data requirements.
✓ Do get the draft evaluation plan signed off on by senior management.
✓ Do seek input into the plan from those who will have to ultimately provide the data.
✓ Do select a few key pieces of information for each of the five major evaluation areas.
✓ Do collect information in a consistent and sound manner.
✓ Do try to use valid and reliable methods and measurements.
✓ Do plan how the evaluation results will be used.
✓ Do provide feedback for volunteers and participants on the results of evaluation activities.
✓ Do set priorities in evaluation if time is scarce.
✓ Do get help for the more mechanical, time consuming chores.
✓ Do build evaluation data processing into your vendor contracts.
✓ Do seek help from graduate students if they are available.
✓ Do consider publishing your results.

“DON'Ts”

✓ Don't listen to those who tell you that a full-blown research approach is the only thing that makes sense.
✓ Don't collect any routine data unless you know how it will be used.
✓ Don't change your basic definitions along the way, make sure they are what you want up front.
✓ Don’t get too “research-oriented.”
✓ Don't get too detailed and lose sight of the main evaluation objectives.
✓ Don't do all “formative” or all “comparative” evaluation, but rather balance the two types of evaluation.
✓ Don't get intimidated by academic researchers.
✓ Don't fail to examine the availability of data before committing to do an evaluation.
Don't generate “orphan data” that does not have a home or a family or a purpose.
Don't let processing of raw data get too far behind.
Don't get sidetracked by other people’s interests in evaluation.
Don't fail to use clear, simple graphics in the presentation of the evaluation results.
Don't let evaluation activities become politicized.
Don’t forget your primary evaluation constituency -- those who control your budget.
Don't forget to get help from some graduate students if they are available.
Don’t fail to finish the analysis of program evaluation data.
Don’t forget to organize your program evaluation around the central evaluation questions you want to address.
Don’t delay asking for help if the evaluation gets too time consuming.
Don’t fail to write down all your assumptions as you make them so you will know where you got everything in your evaluation effort.

D. A Checklist for the Evaluation Phase

The following checklist is intended to be a practical way to help you structure and organize your program evaluation efforts.

1. ___ We have decided to address the evaluation issue as part of the planning process.
2. ___ A set of five to eight measurable and time-limited program objectives have been drafted.
3. ___ We have identified key data requirements for each objective.
4. ___ We have discussed evaluation objectives and expectations and clarified them with senior managers.
5. ___ We have identified and received approval for the preliminary evaluation timetable.
6. ___ We have identified primary and secondary data collection sources.
7. ___ We have received technical advice on the evaluation objectives and methods.
8. ___ We have established a set of standardized evaluation questions that will be used with all applicable wellness program activities.
9. ___ We have established a clear process for summarizing and aggregating participant feedback on the program.
10. ___ We have established a clear process for summarizing results from screening or testing activities.
11. ___ We have developed an annual wellness interest survey.
12. ___ The annual wellness survey will be used to generate longitudinal data on health risk factors in the work force.
13. ___ We have identified a series of key organizational indicators.
14. ___ The key organizational indicators will be monitored over time to detect changes in major trends.
15. ___ We have received reactions from major groups on proposed evaluation activities.
16. ___ We have identified the specific use of evaluation results.
17. ___ The form of evaluation results has been identified and agreed upon.
18. ___ We will use graphics in developing the package of evaluation findings.
19. ___ Acceptable levels of evaluation results have been articulated.
20. ___ We have identified all the uses of the evaluation results.

Evaluation is a critical endeavor, specially for a new corporate wellness programs. Do not overlook the importance of structuring programs from the beginning in a way that will expedite their evaluation.
With some careful planning, it will be possible to provide a sound rationale for the continuation and expansion of the employee wellness program.
# IV. OVERCOMING THE TOUGH PROBLEMS

This section deals with suggestions for solving some of the toughest problems facing those who are planning and implementing corporate wellness programs regardless of the type of program model that has been implemented. The suggestions here are designed to provide practical and sound advice on successfully meeting many of the key challenges all corporate wellness programs face.

## A. List of Problems to Be Addressed

Almost all employee wellness programs usually run into some very similar problems. This section is designed to deal with some of the more typical problems wellness programs are faced with solving. The following are the problems to be addressed in this section:

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<td>#2</td>
<td>How can our program address issues of downsizing and low employee morale?</td>
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<td>How do we reach families with our program?</td>
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<td>How do we affect health care costs with our program?</td>
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<td>How do we change health attitudes and health beliefs of people?</td>
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<td>#8</td>
<td>How do we change safety and risk-taking behavior?</td>
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<td>#9</td>
<td>How can we avoid any discrimination complaints about our program?</td>
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<td>#10</td>
<td>How can we integrate a more “intrinsic” approach to wellness into our program?</td>
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<td>#11</td>
<td>How do we program in small remote worksites?</td>
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<td>#12</td>
<td>How do we set up a “wellness center”?</td>
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<td>How can we reduce our sick leave absenteeism?</td>
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<td>How can we change our organizational culture to make it more wellness-oriented?</td>
</tr>
<tr>
<td>#15</td>
<td>How do we reach retirees with wellness?</td>
</tr>
<tr>
<td>#16</td>
<td>How should worksite wellness be integrated with managed care?</td>
</tr>
</tbody>
</table>

### #1 How do we keep strong middle level management support?

Middle managers are one of the keys to a successful employee wellness program. They will need to support individual employees participating in the program and agree to any infringement on work time that is required to conduct various components of the program. First, middle managers may be defined as all managers between first line supervisors and the top five to seven senior managers in a corporation. These managers generally supervise line supervisors and comprise the great bulk of managers in organizations with more than 1,000 employees. They, as a group, are not typically a prime focus of internal marketing for employee health programs. The problem is that if they are ignored (or taken for granted!) they can effectively limit the impact of the wellness program in very subtle and not so subtle ways. Some of these possible adverse effects include:
• **Personally ignoring the program**: The middle level manager is usually in significant competition with their peers and may choose, through the pressures of the job, to ignore their own “wellness” and not participate in the program activities.

• **By often alluding to the “bottom line”**: This message is usually communicated in ways that undercut any issues that are outside of the current range of crisis issues that usually have the attention of most middle managers. This essentially means that anything that does not contribute to immediate revenue and expense is relegated to a lower priority level.

• **Disregarding the program's needs**: This takes the form of pre-empting room assignments that conflict with the wellness program or in effectively reducing the program's internal marketing by limiting access to communication channels or other promotional approaches. This method usually demonstrates that the manager does not place a high priority on the program.

• **Covertly resisting employee participation**: This approach involves the recalcitrant manager letting it be known informally that he/she is not supportive of the idea of employees taking time away from work for “wellness” activities. They may sometimes do this by making jokes about people who are participating in the program or by making derogatory comments about the activities in small group settings. The way this comes across to supervisors is as an informal norm that applies to employees within that work unit. Managers have to be careful that their resistance is not too evident because they may risk being called on “the carpet” by their manager for obstructing the program. This covert kind of resistance is therefore the most pervasive and at the same time difficult to deal with because it can be denied.

• **Active resistance to employee participation**: This form is more overt and is usually expressed by the organizational “maverick” that may use his/her resistance to further signal how unique and “aggressive” they are as managers. Production goals take precedent over the needs of employees to improve their health and well being in this scenario. For example, this manager may circulate a memo that emphasizes that production goals must be met before anyone is released for wellness activities.

These various types of resistance range from the very passive to the very active. The reasons for the resistance need to be formally addressed in preparing a strategy to minimize its adverse effects on the program. The best ways of determining what the “real” reasons for resistance are is to go to the individual directly and talk about their position on the program. If that is not practical, then set up an opportunity to meet with a group of mid-level managers as a “piggy-back” opportunity to another meeting. You can then state your concern and then ask some specific questions that will help you deal with the lack of support problem.

One scenario of how that might go is as follows: After determining that there is no widespread problem of the program infringing on production goals, you request some time on the agenda of a division manager's meeting to briefly discuss the need of more closely fitting the employee wellness program into on-going work schedules. You might say something like:

"Thanks for the opportunity to speak with you briefly about the Living Well program. As you know, we have been trying to offer programs in such a way that they do not
impact adversely on employee productivity. We are concerned that employees who participate in events scheduled during work time, like the smoking cessation classes that ended last week, don't adversely affect your production goals. I would appreciate any feedback from you on the following points:

- First, is there a specific productivity problem related to attendance of some employees at Living Well workshops? If so what are the specifics of the situation?
- Second, is there a way to schedule the programs so they attract as many employees as possible, without impacting adversely on your production goals?
- Third, would you let me know when there is a problem with any individual or group that is causing you some difficulty in scheduling or production?

After hearing their comments you could say: “Thanks for the opportunity to get some feedback from you and please contact me if you have any questions.”

This scenario points out that the best strategy is to affiliate yourself with helping the middle managers meet his/her objectives (and broader needs!) as managers. If you can identify and address the needs that managers have, then they will usually soften their resistance toward the program.

Some possible strategies for dealing with individual managers after you have tried all the above, are as follows:

- **Talk with some first line supervisors.** Find out what kind of effect your programs are having on the flow of work. Ask about the inconveniences or hassles employee participation in your program creates. Find out if there are any ways of minimizing the adverse impact of the problem.

- **Meet with the uncooperative manager(s).** Find out specifically why the individual(s) is withholding support and cooperation. You should come prepared to share some specific evidence of resistance by that manager, but only share it if resistance is denied. Ask questions about how they perceive the effect that employee attendance at wellness program activities has on overall work performance.

- **Explore the development of a “release time” policy.** This kind of policy generally states that employees are encouraged to attend wellness program activities as long as routine work functions are not disrupted. This kind of policy will cause the “maverick” resistor to be made more visible. However, the policy can also be used by very assertive employees to gain an advantage with supervisors, which can improve the situation or cause it to deteriorate.

- **Offer to develop a memo to employees that highlights the problem and makes an appeal.** The straight-forward method would be to put the problem down in black and white so employees know that future scheduling for wellness programs will be contingent upon no disruption in work performance.

- **Offer to set-up a pilot test.** For the recalcitrant middle manager, offer to set up a pilot program in order to test the often firmly held conviction that “time equals
productivity.” In a few occupations and jobs this is true, but for the vast majority of jobs the individual has direct control over their own productivity. If they want to be more productive they can and will be. The test may include the identification of some performance criteria or indicators, and then the scheduling of a program or series on work time to test the gross effect of the program on the agreed upon productivity indicators.

- **Enlist the help of influential peers.** For managers who are supporters of the wellness program, enlist their help in convincing their peer that the program is worthy of support and that it does not represent a net drain on the productivity of staff.

- **Support the adoption of wellness oriented middle management goals.** Another strategy includes the adoption of goals for middle managers that deal with employee participation levels or involvement in wellness activities. An additional variation on this same theme is to integrate absenteeism, worker compensation costs, and health benefit costs into the cost structure of each major organizational unit as a part of incentive bonus plans for key managers. This effectively ties personal financial rewards for key middle managers with the illness and injury experience of a particular work group.

- **Conduct special programs for the middle managers.** This strategy utilizes the design and provision of programs that allow the key management staff to experience first hand, such as the fitness assessment, cholesterol test, blood pressure screen, and BMI. This helps them develop some enthusiasm and ownership over the program. These kinds of sessions can be “piggy-backed” onto retreats or other management meetings.

- **Publicize carefully selected personal health accomplishments.** This strategy involves keeping track of individuals from the uncooperative managers staff that have made very significant health accomplishments (i.e., lost 80 pounds, triathlon at age 50, 100-mile bike trip for a highly sedentary employee, etc.) and publicizing their accomplishments in company newsletters, or in special flyers. This will tend to informally highlight the uncooperative posture of the manager involved.

- **Develop a program option that will help increase the productivity of staff of that division.** This approach involves designing a special wellness program to help employees be more productive during key “crunch” times. For example, offering a resilience course during lunch hour for a highly stressed work group with the intent of providing helpful techniques on how to maintain production and preserve health under the current stressful work situation.

- **Provide a personal focus on the uncooperative manager.** For key individuals that are uncooperative, approach them with some special programming opportunities. Have them go through a pilot of the health and fitness testing you want to introduce or have them use a complimentary pass to a local fitness facility to help you evaluate that facility. This specialized attention is provided to help educate and open the possibility of developing support for the employee wellness program.

- **If all else fails, try the end run!** This option involves enlisting the support of senior management to place direct pressure on the offending manager(s). This kind of “top
management” support may be absolutely necessary when the resistance from the middle manager is not based on rational issues or concerns and they don’t respond to all the options identified above.

These are just a few of the possible strategies that you can use to improve the support your program receives from middle managers.

#2. How can our program address issues of tight budgets and low employee morale?

A famous lyric from a Bob Dylan song of the sixties was “... it doesn’t take a weatherman to tell which way the wind is blowing...” The same is true of our current recessionary times. Clearly, work organizations are changing rapidly and consequently adverse effects are becoming more visible. Rapid change is a necessary process for American business in a global economy, but the increased competition often strains our ability to cope with the change. In an era of greater market globalization and competition it is an increasing organizational necessity to remain competitive and to shake up our often mediocre approach to work performance. Mergers, acquisitions, and divestitures are all part of dynamic markets. Public sector organizations also have the added pressure of wholesale shifts in budgets, increasing tax payer resistance and hostile attitudes toward governmental entities to deal with. All of these things seem to be necessary characteristics of our changing times, changing values, and changing markets. However, when they all come together at the same time, it often produces a very significant set of adverse effects on the people in work organization.

The psychological and emotional responses associated with work pressure can take many forms. The responses I most often observe are as follows:

- Loss of a sense of commitment to the organization
- Less willingness to “go the extra mile,” in a pinch
- A sense of uncertainty and a loss of hope in the organization
- A much stronger form of “what’s in it for me?”
- A general sense of malaise and fatigue
- A loss of the ability to enjoy work related social events
- A greater reliance on non-work activities to meet personal needs
- A sense of increasing pressure and concern for burnout
- A higher sense of fear about losses, ill health, and organizational disruption
- A sadness about the loss of the “old ways of doing things” with some expressions of grief
- An awareness of the productivity losses associated with “presenteeism.”
- A sense of overload and saturation with choices and change

The organizational effects commonly associated with these responses also come in many sizes and shapes. Some of the more typical ones are:

- An unwillingness or resistance to fill out surveys, attend wellness and health-related activities, or other activities
- A similar unwillingness to attend any self-improvement oriented activity at the worksite
- Increased level of sick leave use
- Increased level of filing of health claims
- Increased occurrence of stress-related or somatic health complaints
- Increased rate of minor work-related injuries
Increased rate of employee complaints or grievances
Increased level of inter-personal conflict
Increased workplace violence
Increased vandalism of work property
Lower levels of employee volunteer activity
Fewer observances of special events such as birthdays, special acknowledgments, etc.
Possibly greater occurrence of workplace theft
Less long-term career planning concerns within the company or organization

The following are some suggestions on how to counter some of these adverse effects by providing leadership through your wellness program:

- **Build a human capital approach to human resources with your wellness program as a platform.** Take the lead at proposing a more global and far-reaching approach to the overall problem. This can also include adding “financial wellness” to your program’s definition of wellness.

- **Acknowledge the common sources of pain.** Ratify people’s unspoken concern by acknowledging the pain, the challenges and its source.

- **Identify the process of change that is going on and bring it into the open.** Recognize the situation for what it is – a necessary part of current day realities, the “new normal.”

- **Emphasize the connectedness and common community that exists for everyone within the company.** Use every opportunity to build a sense of community and highlight the inter-relatedness and inter-connectedness of each individual’s function and role.

- **Be an advocate for important organizational ceremonies that build a sense of community.** Campaign for maintaining the symbolic activities that give people a sense of hope for the future. These events often include such things as reward ceremonies, special recognition events, length of service rewards, CEO briefings, write-ups of significant individual achievements, and corporate or company celebrations.

- **Begin to integrate spiritual health issues into your programming.** Look for opportunities to include spiritual health interventions, such as values clarification, exploration of life purpose, worldview examinations, examination of what gives meaning to our lives, emphasis on the setting of priorities and personal objectives, communication themes of personal excellence, and pursuit of improved quality of life.

- **Emphasize quality of life issues in the context of the program.** Look for ways to bridge Traditional Wellness wellness issues with quality of life concerns. Address topics such as life management skills, simplification of lifestyles, creativity, social skills, green lifestyles, and seeking supportive relationships.

- **Start addressing the issues of “safe environments” and organizational “hope” more directly.** Give people permission to create “safe environments” and to talk about their hopes for the organization. Provide opportunities to discuss hopeful new changes or programs that are coming.
• **Look for ways to humanize technology.** When using highly technical systems and technology, look for ways of anthropomorphizing the technology, such as naming systems with humorous acronyms and names, or looking for human parallels to machine processes. Try to bring the technology back into a potentially controllable and understandable human perspectives.

• **Address social health as a part of personal health.** Expand your definition of wellness to bring in social interactions, social connectedness and social needs. This will give permission and make visible the importance of social relationships and the importance of a sense of community in meeting those social needs.

• **Emphasize healthy approaches to priority setting and simplification.** Address through communications, personal counseling, and education the need to periodically take stock and to determine what things are truly important to each of us. Help people see that priority setting is a requirement for a healthy life and sustainable lifestyle.

• **Incorporate work/Life-family and leisure themes.** Provide the visibility and credibility for work/Life-family balance and for the importance of leisure pursuits and vacationing for good mental health and long term productivity.

• **Look for opportunities to value creative problem solving and empowerment.** Fully integrate the message of empowerment and the need for creative problem-solving into the various communication channels for your program. Begin to reinforce the concept through repetition and emphasize its value to help minimize a sense of personal helplessness.

• **Look for opportunities to add a “resilience” emphasis to your wellness program:** Consider creating a new program focus on individual strategies for enhancing personal “resilience” to better cope with the complexity and demands of modern life.

• **Add a “financial wellness” emphasis to your program.** Many of the concerns of today’s workers stem from concerns for present and future financial security. Since almost all the employee benefits that are offered by employers usually deal with avoiding financial liability the addition of “financial wellness” can help employees cope and bring a more seamless approach to HR functions.

• **Look for ways to bring “lightness” and humor into the workplace.** Humor is an area of long-standing importance for wellness programming. The growing pressures associated with work life can be partially countered by bringing some “lightness” and humor into the workplace through a wellness program. Actually there may be no other place in the organization where humor can be openly addressed.

These are just a few of the strategies that employee wellness programs can utilize to counter some of the more negative effects of the widespread changes affecting today’s worksite.

**#3. How do we reach families with our program?**
There are several different types of strategies for increasing family member involvement in wellness programs. First of all, it is important to recognize some of the reasons why it makes good sense to get more family members, and particularly spouses involved in workplace wellness programs. Some of these reasons include:

- **We generally recognize that family members have a significant impact on each other's behavior.** Therefore, involvement of family members, particularly spouses, in programming will usually help them be more supportive of and actively reinforce selected behavior changes attempted by employees. This is particularly true in the areas of tobacco use, nutrition, physical activity, and seat belt use. Including family members in programming will usually help remove family member resistance to lifestyle changes and will hopefully lay the groundwork for active support of those changes.

- **Family members utilize a significant amount of the health services reimbursed under employee benefit medical plans.** Their level of health and well-being has a significant financial impact on employers, particularly when they are covered under family coverage provisions. This factor can frequently be leveraged to help support the inclusion of spouses in wellness programming. Family members often go in and out of spousal health benefit coverage over time. In other words, they may not be covered by your health plan this year, but a year from now they may have lost their own coverage and want to now be covered by your health plan.

- **The addition of spouses to specific program components can help improve the cost-effectiveness of the programming,** particularly if the demand for the program among employees is not great and excess capacity (i.e., empty seats!) exist. This is particularly useful in wellness assessment programs.

- **The effects of involving family members in wellness program activities, particularly in the areas of employee morale, employee loyalty, and employee retention, are generally very positive.** The creation of a family-oriented work culture has positive value for a large portion of most work group populations.

Strategies for increasing spousal involvement in wellness programs include:

- **Make it a formal policy.** In the development of a set of general wellness policies for the workplace, it is important to make a formal statement as to the desirability of family member involvement in specific aspects of the wellness program. This statement should be reinforced periodically to illustrate the commitment of senior management to the concept.

- **Offer programs at convenient times for family members.** Programs such as smoking cessation, weight management, and resiliency education can be set up to provide a time slot for use by family members. However, distinct differences exist in different work groups as to what times of the day are better for spousal involvement. The major options include early morning (7-9a.m.), lunch hours (11a.m. - 2p.m.), right after work (3 - 6p.m.), and evening (7 - 9p.m.) programming times. A survey of employee family members linked to specific program options will probably determine the most potentially successful scheduling pattern for your work group. Specific family characteristics usually are associated with each of the various time options. The presence and age range
of children and working status of the spouse are key variables in their choice of the various major program scheduling options.

- **Build times for spouses into major programs.** Provide a special opportunity designed specifically for spouses that will help employees who are attempting to make a major behavior change (i.e., weight loss, smoking cessation, physical activity) receive support from their spouse. The session can include such things as the importance of the change, the probable side effects and spill-over effects at home, fundamentals of behavior change, supportive behavior options for spouses, etc. By building this component into long-term behavior change programs, you can provide a formal message about the importance of family members in the process of behavior change.

- **Include spouses in biometric testing programs.** When biometric testing programs are conducted, provide an option for spouses to be included as participants. Spouses can be fully or partially subsidized or not subsidized at all (They pay the fee directly). By offering the testing and prescriptive part of the program to spouses, you gain crucial family support for recommended lifestyle changes, and also increase the volume of participants going through the program, possibly reducing unit cost for those participants subsidized by the employer (this does require the negotiation of volume discounts ahead of time from the wellness vendor you use). Providing a joint counseling session where both employee and spouse are counseled together has the potential to help them support each other more consistently.

- **Provide incentives for including spouses in programming.** Offer fee rebates or discounts if spouses participate in programming. Special lotteries or drawings can be held for those employees who bring their spouses to the program. Formal inducements like these communicate the seriousness of the organization’s intention to have spouses participate in the wellness programs.

- **Use social events to help incorporate family members.** Nutritious potlucks and wellness-oriented annual picnics are two types of social events that can be used to encourage family member involvement in wellness-oriented activities. There are other kinds of events like family hikes, fund raising events, etc., that can be used to incorporate family members.

- **Use financial gain-sharing based on family health care utilization.** Financial gain-sharing incentive programs, based on the amount of health care claims filed by an employee and their family members, can be designed and operated by an employer. Wellness “bonus” points can be added for a non-smoking employee, spouse, and dependents, weight within ideal range, fitness scores, etc. There are more than thirty different wellness-oriented measurements and related program participation that can be used in an incentive gain-sharing program. The primary issue here is the inclusion of the family members in an incentive program that includes healthy lifestyle behaviors.

- **Incorporate family support issues in behavior change programs.** It is important to build family member support issues into the design of program content in the areas of physical activity, smoking, weight management, nutrition, safety practices, substance control, injury prevention and stress management. The family support issue can be
addressed directly in the course content, added in the form of discussion questions, and/or evaluated in questionnaires or follow-up instruments.

- **Mail wellness newsletters to the employee's home.** Another method for involving family members in wellness issues is to mail monthly or quarterly wellness newsletters to employees at their homes. The potential for them to be read by family members is substantially better if they are mailed directly to the employee’s home. This is particularly true when the newsletter is eye-catching and has interesting information or activities in it.

- **Have the spouse of a senior manager communicate directly with employee spouses.** A communication from a senior manager’s spouse about the employee wellness program, with an invitation to specific events or activities, can create interest in the family members of employees. This needs to be a long-term strategy consistently applied in order to be successful. It has the potential to overcome some of the “gatekeeper” tendencies of employees who are not interested in wellness issues and do not usually inform their own family members about program opportunities.

Obviously, these are just a few of the possible ways of strengthening family, and particularly spousal involvement in employee wellness programs.

**#4. How do we reach the high-risk employees?**

Reaching “high-risk” employees should be a priority of all corporate wellness programs. However, drawing these individuals into your program takes a conscious effort. First, let’s try and define what a “high-risk” employee looks like. Unfortunately there is no standard or commonly accepted definition for what constitutes a “high-risk” employee. From an operational point of view, they can be defined as any employee with readily observable risk factors (i.e., grossly overweight, heavy smoker, decidedly low tolerance for excess stress, abusive personality, high levels of absenteeism, “type A” personality, poor social skills, weak social relationships, etc.). From a clinical point of view, it may be the employees with selected observable risks along with elevated cholesterol, low HDL, hypertension, family predisposition to specific diseases, a diabetic condition, elevated risk of cancerous condition, aversion to seeking medical attention, etc. You will need to decide what definition you want to use for “high-risk” at the beginning of your program and it should help in the selection of the programming approach you use in order to enhance your impact on this group in your workforce. “High risk” can also mean someone with a low “Overall Wellness Score” (OWS) from your Health Risk Assessment (HRA) indicating that they have several major health risks.

A few studies have examined the percentage of “high-risk” employees in a typical employee workforce. The customary range is approximately 31% - 53%, depending on the age, gender, education levels, type of industry, and cultural norms of the work group. An important consideration is that this group typically utilizes more health care and more sick leave time than their moderate-risk or low-risk peers. Therefore, this portion of your employee population is of significant concern, particularly if your wellness program is viewed as part of an overall “health cost management” strategy. Being able to make significant progress in reaching the high-risk portion of your workforce is frequently critical.
One stereotype of the high-risk employee includes someone who has probably tried to change their behavior, not succeeded, and is generally resistant and slightly resentful of any direct pressure to change a major lifestyle behavior. These individuals will generally choose to rationalize and avoid the opportunity afforded by your wellness program to test or screen for health risks. Nevertheless, remember that there is evidence in the literature that some high-risk individuals will voluntarily elect to go through coaching programs. However, in general, they tend not to participate in employee wellness programs.

One useful approach is to talk with some of your high-risk employees who typically do not participate and probe as to why they do not get involved in your program. The answers underneath the surface are important in getting to the real reasons that are behind their behavior. This is not easy, but it is extremely important in selecting the best formal approach to involving more of your high-risk employees. Once you have determined what some of the more typical (and subtle) issues are, then check the following list for strategies that might be the best choices for your specific situation.

- **Use a lottery approach.** One approach to getting more high-risk employees is to offer health and fitness testing/coaching opportunities on a lottery basis rather than on a strictly voluntary basis. By placing the names of all employees in a pool and randomly drawing out those who are to receive a “coupon” which entitles them to go through a wellness assessment process, you can end up with a much higher percentage of high-risk employees using your program. Since the drawing is random, it is possible to get a representative sample of individuals by their risk prevalence status. Since high-risk individuals tend to be underrepresented among voluntary participants, the lottery can significantly increase their involvement in the program. Based on experience with this approach, you can expect somewhere around a 6%-18% rate of refusal among those who are selected in the lottery. Additional benefits of this approach include a random cross-section of data from the entire work group, as well as the ability to have considerable control over the budget by knowing in advance how many testing “slots” would be offered to employees.

- **Survey employees for insights.** Another approach is to provide a targeted survey process that probes into ways that programming can better meet the needs of high-risk employees who are asked to respond to the survey. The survey can be constructed so that non-participants are the primary target of the survey. This approach can also communicate the interest and concern of the program for the high-risk employees. If an interview process is used with a series of questions designed to uncover some of the more subtle reasons why people are not participating, then it may be possible to design much more effective programs and marketing efforts for high-risk employees. Also, the expression of concern that can be made directly by program staff as part of the interview process can also have a very powerful effect on those interviewed. The selection process for the sample can focus on those with outwardly evident high-risk conditions.

- **Use a “buddy-type” incentive.** Another approach is to design a “buddy-type” feature into most of the programs that would appeal to a high-risk employee. The “buddy-type” incentive provides a fee discount or special prize for bringing a friend to the program. Another corollary feature would be a buddy support type feature to the program which would help with completion of program series and behavioral
adherence. This type of emphasis could be seen throughout the program’s design. Another logical extension of this idea involves the use of support groups focused on specific areas of behavior change.

- **Use strong incentive “carrots.”** One additional approach is to offer a strong “carrot” in order to entice the high-risk employee off the “fence.” For example, L.L.Bean, a Maine company provides a health plan premium reduction of $1,000 a year if the employee, completes and HRA, has at least one coaching call and completes a 10 week lifestyle improvement course of their choosing. The program after several years of operation gets 90%+ of employees participating each year.

- **Use a “sneak up on them” approach.** Another approach includes program designs that more aggressively bring the programming to employees. For example, using a “sweep” type approach to blood pressure testing, rather than the more conventional approach where interested employees go to the site where blood pressures are being taken. Under a “sweep,” the individuals who are doing the blood pressures actually come to each employee at their workstation and ask if the employee wants to have their blood pressure checked. This more aggressive or proactive form of testing usually has much higher rates of case finding within the workforce involved.

- **Conduct periodic mandatory orientations.** One method for reaching more of your high-risk non-participants is to conduct periodic mandatory orientations that provide an overview of the wellness program. These orientations may be structured to market the various program components with an opportunity to sign up for specific programs. This approach can be organized around individual work groups and used to encourage program involvement. It can also be “piggy-backed” onto open enrollment meetings. This content can also be translated into one or more Learning Management System (LMS) online modules.

- **Use progressively stronger policy positions.** Another method to involve more of the high-risk employees is to slowly introduce stronger policy statements on issues that directly affect specific risk factors. For example, progressively tightening of smoking policies or providing differential premiums for life, accident, and health insurance for those within the “ideal” weight range for their age and gender would be an example. It is also possible to link job promotions. Performance reviews or access to “outside” jobs to healthy lifestyle choices.

- **Conduct “we care about you” campaigns.** Another option is to openly address those with high health risks in a letter that goes to all employees and, in a sincere way, express concern for the effects of health risks on the personal well-being of individual employees. This approach can be particularly effective following an unexpected or tragic death of a younger employee from heart disease or suicide. This is essentially an emotional appeal to the high-risk employee with a specific planned programming opportunity.

- **“Straight talk” to employees.** This approach involves a letter from the CEO or chief administrative officer detailing the concern for increasing health care costs and other health related business costs, along with a concern for enhanced productivity, the effects of various major risk factors, and the need to do all that is possible to ensure
job security for everyone and overall organizational profitability/efficiency. If the employer is unionized, coordination of the statement with union officials is advisable. The use of specific numbers and data (e.g. rate of recent health benefit cost growth) about the company is often necessary to present a clear picture of the situation. This action, if repeated, will help to change workplace norms over time.

- **Use active personal intervention.** Perhaps the most aggressive strategy is to adapt the alcoholic intervention process to the confrontation of the high-risk individual. Under this approach, several coworkers, family members, and good friends meet to plan a formal confrontation with the individual using the facts of their own lifestyle choices and the probable effects on their health. The model is currently in use in the areas of substance abuse and can be fairly easily adapted to use with long-time smokers, the morbidly obese, and those with multiple cardiovascular risk factors. The individual still maintains responsibility for any decisions, but those who care about him/her have had an opportunity to directly share their concerns and caring with the individual.

- **Start a relational wellness process.** In this approach, wellness personnel over time, contact those that are clearly at high risk, and through the development of a relationship, begin to draw them into the program's activities. This relational wellness approach is designed to break down the fear and resistance of those that Traditional Wellness stay away from wellness program activities that all too often bring up memories of past failures or are areas of denial on the part of the individual.

- **Make the completion of HRAs a requirement for continued health benefit coverage.** Another method involves the implementation of a policy stating that in order for employees to continue to have health benefit coverage, they must complete an annual application that includes an HRA or health assessments at periodic intervals. This is a “shared responsibility” model rather than an entitlement model. This also allows the individual to be periodically exposed to their own issues of health risk and makes it almost impossible for them to ignore the issues that they may be in denial about. These forms of HRA incentives are some of the more promising approaches to creating effective R-DW style wellness programs.

- **Offer premium discounts for those who participate in programming.** Another approach involves the use of a lower health benefit premium contribution or discount for those who participate in the program. This has the ultimate effect of placing a higher premium on those who tend to ignore their own health and health risks and can be used to get the attention of many of those that will usually ignore their own health. This is more of a “tough love” approach to health management and wellness or what is referred to as a “play or pay” approach.

These are just a few of the strategies that can be used to increase the impact your program has on high-risk employees.

#5. How do we work with unions?
Many large employer organizations have one or more officially recognized collective bargaining units. Some types of industries are much more heavily organized than others. Regardless of the type of union (craft, industrial, general labor, independent, affiliated, international, local, or national) or the type of shop (closed, union, agency, or open), it is important to establish an early working relationship with key bargaining groups. Usually, the business representative for the bargaining unit is the key person to work with in developing an employee wellness program.

However, be sure you seek and obtain management approval to work closely with union officials before making contact. This is particularly important in work settings where there is a substantial amount of alienation, contention, bad feeling and distrust between labor and management groups. Needless to say, it is extremely hazardous to get yourself (and your program!) into the middle of a labor/management dispute. If at all possible, a wellness program should be implemented so that it builds trust between labor and management groups. Some suggestions for working effectively with unions are as follows:

- Get early approval to work with unions, when designing your program.
- Involve key union staff in the employee interest survey and program planning process.
- Be prepared for some “testing” and “posturing” by union representatives to test your sincerity and loyalties.
- Be careful about letting the program become an issue for bargaining. When possible, have it removed it from the table.
- Be sensitive to the issue that management may want to provide a wellness program to employees as a “quid pro quo” for health benefit cuts and concessions.
- Be aware that union “rank and file” may not reflect the same values expressed by union leadership. Therefore, the use of an employee interest survey may help bring recalcitrant union leadership closer to their membership's views regarding wellness (which may make your job easier or harder depending on the situation).
- Be aware that organized labor organizations usually see wellness programs as an effort by management to sidestep their responsibilities for maintaining a safe, hazard-free workplace. Organized labor sees its primary obligation as “control of the work environment” (AFL-CIO, Resolution on Health Care Costs and Worksite Health Programs, October 23, 1985, Industrial Union Department). Therefore, attention will most likely be focused on occupational health risk factors, as opposed to lifestyle health risk factors.
- Be prepared to link lifestyle risk factors to occupational risk factors and the relative contribution each makes to the frequency and severity of worker illness and injury.
- Be aware that union leadership will usually be most heavily concerned about:
  - Equal representation in planning and operation of the program
  - Confidentiality of program information
  - Participation in the program having no bearing on grievances
  - Disciplinary action consequences or impact on promotional opportunities
  - The effects of working and social conditions on health
  - Any form or hint of coercion (i.e., mandatory provisions)
  - Use of any penalties or “sticks” instead of “carrots”
  - Equity of access to all shifts, work locations and personnel
  - Respect for seniority provisions
  - Impact on possible lay-offs
• Be prepared to link the long-term effects of your wellness program to the costs of benefits, and consequently to potential future wage and salary gains for union membership.
• Be sensitive to the dynamics of how union requirements for wellness programming may affect employees who are not part of a collective bargaining agreement.
• Be sensitive to the use of union printers and unionized facilities for program activities (i.e., look for the union “bug” on business cards, printed material, union-made sportswear incentive prizes, etc.).
• Finally, try to maintain a reasonable level of neutrality and make the health and well being of all employees as your primary concern (and also remember who signs your check!).

Working with unions is an extremely important part of the long-term success of worksite wellness programs in work environments with significant amounts of collective bargaining. Do whatever you can to establish a strong partnership and high level of trust with union leaders.

#6. How do we affect health care costs with our program?

As the Patient Protection and Affordable Care Act (PPACA) works its way through the implementation stage, there will be more and more pressure to sharpen the role of worksite-based wellness programs in modifying people's patterns of use of health care services. From a global perspective on health care use, a small proportion of people do not use health care when they should, while a sizable proportion use it too much or unwisely. In addition, significant proportions of people use it for illnesses and injuries that arise from individual behavioral and personal risk taking choices.

If health care reform is to be effective over the long haul, it must set in motion both provider and consumer incentives to better manage the demand for health care, as well as realign the supply side of the “health care equation.”

The “health care equation”, in simplified form, can be stated as follows:

\[
\text{Total HC Cost} = (\text{Price} \times \text{Quantity} \times \text{Type of Service Used}) + \text{Administrative Cost}
\]

“Price” is the unit price of each service consumed, “quantity” is the number of various units of services used, and “type of service” is the actual identity or nature of the service(s) that were consumed. “administrative cost” is the cost involved in paying claims, monitoring quality, protecting consumers, etc. “Price” needs to be stabilized, “quantity” minimized, consistent with good health outcomes, and the “type of services used” needs to be the least costly alternatives that produce the best health outcomes. Approximately 92% of total health costs come from the interaction of “Price”, “Quantity” and “Type of Service Used” while about 8% on average is associated with the administrative cost of financing and delivering health care.

The components inside the parentheses constitute the “Utilization Cost” which then gets added to the “Administrative Cost” to make up Total Health Care Cost. “Utilization cost” is the area that wellness programs can affect. Wellness programs reduce “utilization cost” by reducing health risk factors, improving medical self-care practices and improving consumer health skills.
A direct corollary of improved management of health care and health care costs, is the need to know the major factors that drive the “utilization costs” in a population. The medical care literature is rich with studies that have attempted to dissect the influences of selected factors in the use of health services. The literature also demonstrates that the factors are multiple, extremely complex, highly interactive, and vary from population to population. There are endogenous (inside the individual) and exogenous (outside the individual) variables. There are age related and age independent factors. There are modifiable and non-modifiable factors. There are culturally dependent and culturally independent factors. And the list goes on......

In order to make this complex matter more simple (and hopefully more manageable), it is necessary to create some abstractions or generalizations. Here are some generalizations about what endogenous and exogenous factors affect health care use in a major way:

**The Major Endogenous Factors:**
- Family medical history
- Age
- Sex
- Sense of responsibility for personal health*
- Personal health behavior*
- Clinical risk factors*
- Safety and risk taking behavior*
- Attitudes about personal health and health care use*

**The Major Exogenous Factors:**
- Extent of insurance coverage
- Point-of-use cost sharing
- Geographic access to services
- Regional or local practice patterns
- Provider incentives for diagnosis and treatment decisions

The items with an asterisk (*) are those that Traditional Wellness worksite wellness programs can directly affect. However, the two most powerful variables in predicting health care use are age and gender, and the literature is not entirely clear on the degree to which age-related and gender-related use of health services is “fixed” or non-modifiable. Some more recent studies are showing significant reduction in health care use among older individuals with wellness-related interventions.\(^\text{15}\) This provides some promise for us that age and gender-based health care use patterns may not be as fixed or immutable as we have thought. This also may offer some real hope for long-term stabilization of health costs and improvements in the quality of life, particularly as the “baby boom” population ages.

As to the question concerning the proportion of health care use that is potentially modifiable by Traditional Wellness wellness programming, it is anybody’s guess. Some have projected that as high as 70% of health care costs are potential avoidable.\(^\text{16}\) My guess is that we have an opportunity to prevent up to 25% to 30% of current utilization by focusing our efforts on programming strategies.


that address those items that have asterisks above. If these efforts are combined with interventions in the exogenous factors identified above, we may be able to reduce as much as 35% to 45% of utilization. In a 3 trillion-dollar-plus health care economy, that is no small matter. Time will tell as to how all of this fits into the changing health care sector now struggling to implement the PPACA.

#7. How do we change health attitudes and health beliefs of people?

For this problem we will review the ways that wellness programs can directly affect the attitudes and beliefs employees hold about their health and about health care use. Attitudes are important because they act to shape behavior and influence expectations. Some of the attitudes that are key factors in influencing consumer decision-making about health and health care are as follows:

About Health....

♦ All illness and injury occurs on a random basis (i.e., “bad luck”).
♦ Illness and disease are in my genes – there is nothing I can do about it.
♦ I can do things I enjoy and that are unhealthy and nothing will happen to me.
♦ I’m going to get old anyway, so why not enjoy myself now?
♦ When I am sick I shouldn't be asked to do anything.

About Health Care....

♦ Medicine is 90% “science” and 10% “art,” or “the doctor knows best.”
♦ Those are my health benefits and I ought to use them.
♦ My health benefits should cover everything – or else they are no good.
♦ Doctors will fix me up like new if I have a problem.
♦ There is very little risk in receiving health care.
♦ If there is any chance it may help, go ahead and do it regardless of the cost.

These beliefs need to be challenged because they are fundamentally not true! Nor are these beliefs helpful in empowering consumers to function more effectively in terms of their own health and well being, such as by using Consumer Driven Health Plans (CDHPs). The counter-points to these beliefs should be presented with persuasive evidence, not overly detailed, but with as much credibility as possible. The counter-points will need to be repeatedly stressed because they fly in the face of conventional beliefs. These counter-points respond to each of the specific beliefs identified above:

- **Disease and injury are not random occurrences, but are highly related to genetic susceptibility and lifestyle behavior.** This point is made by presenting major causes of mortality, the risk factors associated with the mortality and the proportion of health care use for diagnoses that are linked to specific modifiable health risks. The lack of randomness in the frequency of disease and injury is fairly well documented.

- **Genetic susceptibility does not guarantee that you will develop the disease.** The existence of a family medical condition or disease does not mean that the individual will get the disease however fatalistic they are, it simply means that not taking preventive screening or engaging in healthy behavior only increases the probability that the condition or disease will actually occur. The existence of a hereditary pre-disposition should catalyze a more positive preventive response, rather than a fatalistic acceptance.
based on the perceived eventuality of the condition. Examples should be given for cardiovascular disease, reversal of arterial occlusions through lifestyle intervention, prevention of chronic obstructive pulmonary disease, peptic disorders, migraine headaches, etc.

- **Your lifestyle choices do have a direct effect on your health.** This counter-point is made through the presentation of the relationship between health risks and health care use. The major studies include Control Data Corporation, DuPont, Steelcase Corporation, and the Health Enhancement Research Organization. This point is also made by emphasizing the outcomes of major epidemiological studies such as the Framingham heart study, other major National Heart Lung & Blood Institute studies, the risk factor research published by the National Cancer Institute, and publications of the Federal Centers for Disease Control.

- **Aging does not have to lead to chronic disease if you are willing to moderate certain health behaviors.** This point gets made by showing risk factor changes in those over 55 and their impact on health care use. The published results of the HealthTrac program with Bank of America retirees would be a good study to use. Data from the National Health Survey for those over 65 with selected risk factors would be another useful source. Actuarial data on mortality from the Human Population Laboratory Studies in California would be another source to help demonstrate this point.

- **Sickness should not automatically mean “helplessness.”** This point is made through a discussion of the importance of an individual’s attitude in fighting a disease condition such as cancer. Another facet of this counter-point is the better documented aspects of the emerging fields of brain health and psychoneuroimmunology, or body-mind medicine. Also, another part of this message may include the role that attitude plays in terminal conditions, mortality rates, and the dangers of excessive passivity in health care use. An additional point of evidence might come from the studies that show that patient attitudes directly affect patient care outcomes. Another related point is that many studies show evidence that simply labeling a patient as having a certain condition, such as hypertension, produces very adverse behavioral effects as the person assumes the sick role. This takes place regardless of whether the person is diagnosed or labeled correctly or not. Another related issue is the strength of the “placebo effect.” This documented phenomenon demonstrates the importance of role of perception in personal health.

- **Medicine has less of a science base than most people think.** This point needs to be presented by giving aspects of the complexity of medicine, the numbers of potential diagnoses, large numbers of medical procedures, individual biologic variation, patient differences in pain tolerance, differences in medical knowledge and experience, regional variation in medical practice, limited number of randomized controlled clinical trials, and the considerable strength of the placebo effect. Another portion of this point involves the identification of examples of commonly accepted, but later discredited, medical procedures, such as gastric freezing, and the results of studies that show that significant portions of medical practices are judged as unnecessary or questionable, such as coronary artery by-pass grafts, C-sections, balloon angioplasty, etc.

- **Health benefits are to be conserved and used wisely if they are to be maintained over time.** The issue here is that employees need to know that irresponsible use leads to
increased cost, and that will lead to further efforts to constrain use and cost. Examples consist of such things as abuse of emergency rooms, excessive use of physicians for minor problems, cost differences between generic and brand-name drugs, hospital cost versus home care cost, inpatient cost versus outpatient cost for the same procedure, specialist care versus primary care, etc. The concept of “total compensation” is also important here. “Total compensation” looks at all salary/wage and employee benefits costs as coming out of the same “pot” and therefore health benefit costs increases will affect the other areas of compensation. The idea that benefit dollars are unlimited and that they have no relationship to salary and wages increases also needs to be countered through communication with employees.

- **Health costs are going up too much to simply have the company absorb the extra cost without affecting what the employee pays.** This point is presented by showing what the rate of increase in health benefit costs has been for the last five to ten years, particularly when contrasted to salary and wage gains and the CPI. Showing the difference in the composition of total compensation expense over a three- or five-year period will also drive home this point. Another strategy is to show the relationship of the total amount spent on health benefits in relation to the total after-tax profits of the business for each year. Another part of this point is the reality that we spend other people’s money differently than we spend our own. The Rand Health Insurance Study (RHIE) results are persuasive in this regard with twice the health care spending when we buy care with someone else’s money and no significant difference in health outcomes. Your own personal health consumer examples are also powerful. It is also possible to point out that providers and practitioners are often motivated by economic return. One way of illustrating this is to provide study results that show significant increases in the use of laboratory and x-ray services when the physicians have a financial stake in the ancillary services. “Excessive coverage generates excessive use” is another maxim that supports this point.

- **Medicine has some very real limits once you have a medical problem.** Medicine has many powerful diagnostic and treatment tools but it can not completely restore or cure the vast majority of diseases and conditions. Once the condition develops, such as hypertension, diabetes or chronic knee pain the treatment of choice frequently has side effects that often continue long-term. These side effects will produce significant limitations for the patient, such as loss of sexual drive as a side effect of anti-hypertension medication. Selected cancer treatment with radiation or chemotherapy and the side effects would be additional examples. The basic point is that medicine has real limitations that are best avoided by not getting the disease in the first place, if at all possible. Read to the group the contraindications from a package insert for a commonly used drug to demonstrate this point.

- **All health care has some level of risk.** This point is driven home by citing major studies that have examined the iatrogenic or patient safety risk involved in medicine. The estimates from the Centers for Disease Control of 90,000+ deaths per year in the U.S. each year due to medical mishaps should be quoted. The major types of iatrogenic risks, including adverse drug reactions, anesthesia reactions, surgical errors, cardiac arrests, hospital acquired infections, shocks, burns, and falls, should be identified along with an approximation of the probability associated with each risk.
• **More is not always better.** This point includes discussing the incentives that exist in the health care system to do more than is really necessary. The issue of iatrogenic risk comes into play as well as the fact that when capitation financing is used, generally 20% less care gets delivered with no adverse effect on the group involved. Clinical “need” is shaped by many things, not just the actual health condition or disease of the patient. The issue of incentives for more care should also be used to drive home this point. The role of advanced directives should also be introduced, particularly because of the eldercare responsibilities that large proportions of employees face at any given time. Quality of life examples from actual patients are also helpful, such as the respirator-dependent patient.

These counter-points to the commonly held beliefs about health and health care are important in helping empower people to take greater responsibility for their own health and health care. In conclusion, worksite wellness programs have a very significant potential role in managing the demand for health care and for improving the health and well being of a major portion of our population.

### #8. How do we change safety and risk-taking behavior?

First of all, safety and risk-taking behavior are directly associated with injuries and accidents, and usually account for between 3% and 12% of a typical employer’s health benefit claims expense, a major portion of their workers compensation cost, virtually 95% of their short term disability (STD) and long term disability (LTD) claims costs, and approximately 25% of their sick leave experience and presenteeism loss. The magnitude of these costs help provide a strong economic rationale for worksite wellness programming. Next, we will define the context of safety and risk-taking that makes sense for employee wellness programs to address. It makes sense to examine safety issues by considering the setting involved or the type of activity the individual is involved in performing. Therefore, the safety issue can be segmented into a variety of divisions and sub-components. One framework for examining safety, risk-taking and injury prevention issues is presented in Figure 40 below.
## Overview of Major Injury Prevention Issues

<table>
<thead>
<tr>
<th>Worksite Settings</th>
<th>Vehicular Settings</th>
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<td>♦ Work exposures and by-product issues</td>
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<tr>
<th>Home Settings</th>
<th>Recreational Settings</th>
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<td>♦ Garage-related issues</td>
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<td>♦ Falls and stairway safety issues</td>
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<td>♦ Fire safety and prevention issues</td>
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<td>♦ Gardening and yard work related issues</td>
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</tr>
<tr>
<td>♦ Ladder-related issues</td>
<td>♦ Earthquake and severe weather safety issues</td>
</tr>
</tbody>
</table>

### Figure 40 Overview of Major Injury Prevention Issues

The choice of which injury prevention area(s) to target in a worksite wellness program should be based on five concerns. First, the multi-year claims experience for accident claims that are under a health benefit plan, STD plan, LTD plan, or sick leave experience may provide some clue as to reoccurring problems and significant patterns and trends. Second, the age and gender demographics of the population involved can provide clues as to what safety risks are likely to be encountered. Third, a review of the season of the year, and any regularly scheduled events coming up, may provide direction as to the potential safety and injury prevention targets. For example, winter weather, spring yard and ladder work, summer vacation travel, etc. Fourth, special areas of focus for safety interventions may come out of unusual external events and media visibility, such as a cross-country skiing party that becomes snowbound in the mountains. Fifth, acquiring targeted direct employee feedback on areas of interest may help refine safety and healthy risk-taking issues of interest to the group involved.

The issue of an individual's personal attitude toward risk-taking is a somewhat distinct and yet complementary issue to all the safety issues identified above. It is also a somewhat murky, complex, yet an extremely important concern. The relative irrationality of personal risk-taking is well documented in the literature, and unfortunately our knowledge of intervention and educational strategies is currently at a very primitive stage. Issues of denial, self-destructive tendencies, adrenaline addiction, intensive pursuit of life, live-hard and play-hard, machismo, etc., all seem to be at work.

Turning our attention now to how worksite wellness programs can potentially help reduce the injury prevention and risk-taking “risks” of employees, family members, and retirees, it is useful to review five Traditional Wellness intervention strategies and five interventions that are more innovative in nature.
The five Traditional Wellness intervention safety strategies include:

- **Provision of information on the risk of exposure and on some simple ways to reduce the risk.** This can be done through articles and tips presented in employee newsletters, take-home safety checklists, computer bulletin board information, request online information, emails and pamphlets and written materials.

- **Inclusion of specific safety risk information into employee screening exams and physicals.** When the age, gender, family living circumstances, and recreational preferences are collected during a wellness assessment or physical exam, it is possible to construct an injury prevention risk profile with a set tailored recommendations. This could occur at a time when physical health risks are assessed.

- **Use of group safety incentive rewards.** The use of material good and special privilege safety achievement rewards can be used for non-work related injury experience as well as work related injuries. These can include group recognition awards as well. The use of incentives in worksite safety is well accepted, but incentive use for home, recreational, and vehicular safety and injury prevention achievements is also possible.

- **Teaching “present moment thinking” applied to work and non-work injury risk.** “Present moment thinking” is a technique that is used to help individuals focus on the moment and to resist the temptation to daydream at times where that is particularly risky. It can also be focused on those individuals that have filed an injury claim in the previous 24 months.

- **Use descriptions of actual accidents.** If a brief write-up is provided to employees that describes the conditions of the accident, and what could have been done to prevent its occurrence, it can help raise safety awareness and reinforce good group safety practices. This can be done with all types of accidents and can be written so that the individual is not specifically identified.

Those safety and risk taking activities that are more innovative in nature include the following:

- **Use of age-specific, gender-specific, family living, and recreational activity-specific safety risk assessments.** The collection of a limited amount of personal information during a Health Risk Appraisal (HRA) process can be used to create an individual injury-specific risk profile and a personal safety enhancement plan. This information is similar to what is produced as a by-product of an HRA process, but with a much more detailed and specific safety and injury prevention focus.

- **Use of incentive rewards for documented accident prevention activities.** This approach can use material goods, special privilege, and/or financial awards for those that have completed checklists or surveys for home safety, vehicular safety, recreational safety, and for other designated safety or injury prevention activities.

- **Provision of formal employee education on healthy risk-taking.** This approach directly addresses the psychological phenomenon of personal risk-taking including such topics as severity of personal risks, dynamics of healthy risk-taking, uncovering denial, assessing injury probabilities, excitement and its role in risk-taking, maximizing
concentration at key moments, etc. Those individuals that are self-admittedly accident-prone would be particularly good targets for this type of educational intervention. This educational content could also be placed on a LMS platform and linked to completion incentives.

- **Identification and categorization of individuals as to their composite risk of accidents.** By using self-reported data and/or incidence data, develop a categorization related to injury risk and use it to target safety intervention activities, such as those described above.

- **Use of financial gain-sharing based on injury or accident experience.** Develop formal incentive programs to share specified financial savings with employees or retirees for lower-than-expected safety or injury experience.

These are just a few of the possible activities that worksite wellness programs can use to help reduce the accident and injury experience of individuals and groups. A greater emphasis on injury prevention can have a very beneficial effect in terms of managing the demand for health care, as well as significantly reducing the other human and financial costs associated with injuries and accidents.

**#9. How can we avoid any ADA or HIPAA discrimination complaints about our programs?**

In the past a great deal of attention has been focused on the law and regulations of the Americans with Disabilities Act (ADA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as their various Titles and Sections have become effective. Any examination of the breadth of the two laws immediately reveals that very significant enforcement and legal issues are likely to cloud the waters for some time to come. In the mean time, I believe that employers need to move ahead with employee wellness programs and examine ways of linking wellness issues to other employee benefits. However, this needs to be done thoughtfully and with as large a measure of common sense as can be mustered.

On a strictly ethical and humanitarian level, all employers need to comply with the spirit and intent of both laws. Mean-spirited acts by employers should not be tolerated, whether there are laws about discrimination or not. However, with a law such as the ADA, administered by the Equal Employment Opportunity Commission (EEOC), we have the rights of legal remedy and the concurrent responsibilities to act and behave in a reasonable and ethical fashion. One of the most difficult challenges faced in the enforcement of the ADA is how to prevent the law and implementing regulations from being used by unscrupulous individuals who qualify as having a “disability” (i.e., an evolving series of characteristics) and who want to accomplish a purely selfish aim, such as preventing others from receiving a reward for voluntary healthful behavior. Or the legal and appeals recourse can be used to get back at an employer that does not want to act to further enable dysfunctional behavior. In other words, the noble intent of the ADA has the continuing potential to become mired in a straight-jacket of constraint and legal restrictions on innovations designed to help everyone, often times perpetrated by a very small minority.

In order not to succumb to the fear of possible liability or delay too long in using more innovative linkages between wellness and employee benefits, it is probably prudent to use a few preventive strategies in moving forward. After a fairly thorough review of the law, current legal opinions,
governmental technical assistance documents, and a myriad number of periodical articles on both laws, here is what I would suggest.

- **Keep everything voluntary!** The HIPAA law and EEOC staff opinions are very clear that voluntary wellness programs, that are not linked to other employee benefits, are completely acceptable under the ADA and HIPAA as long as the privacy provisions of HIPAA are met. Stay away from mandatory requirements with the exception of annual HRA’s and possibly requiring all-employee meeting(s) to receive information about what is available through the wellness program and why it is of benefit to them.

- **Think ahead about “reasonable accommodations” for the disabled!** Before a disabled person requests a “reasonable accommodation” to attend a seminar or check out a book from your wellness library, think about how you can accommodate someone with a sight, hearing, or movement disability. Take an initial look at the narrow view of disability until the full scope of the definition of disabled gets translated through case law. Also provide waiver options for wellness achievement criteria to lessen the discrimination risk under HIPAA. Develop a set of “alternative standards” for each wellness criteria for the various major classes of disabilities. Always provide options for meeting the criteria.

- **Keep monitoring for equal (and easy)access for all!** The program and activities involved in a wellness program should be accessible to all. If you can work to make provisions to assure this to the maximum extent possible, the better off you will be.

- **Make sure that all health and wellness related information is handled in full compliance with HIPAA privacy provisions!** One of the major aspects of the HIPAA law is to protect everyone from unauthorized disclosure of Individually Identified Health Information that is collected by your program. If you make all information collection a choice and you do not penalize those that do not provide the information with removal of any employment benefit you should be well within the scope of compliance with ADA and HIPAA laws.

- **Stick to what is fair treatment!** If you use some level of common sense (not all too common perhaps), you should be able to avoid liability by giving the benefit-of-the-doubt to anyone that has a remote case for preferential treatment or “accommodation” under ADA and HIPAA. If you choose to use a wellness premium contribution reduction for those that do not smoke, have cholesterol below 200 mg/dl, or have percent body fat in normal ranges for their gender, then provide a waiver or adjusted criteria for the woman who is pregnant, or the man with a metabolic disorder. Require a medical opinion if you want external verification. But, do not fail to adopt an incentive program simply because you may have to be lenient and give a few individuals the incentive reward.

- **Stay away from the use of “sticks!”** I don’t recommend the use of penalties or curtailment of benefits related to wellness because it usually creates alienation and loss of “good will” that you have to work harder to recover. I also believe that penalties should not be used for liability or risk aversion purposes as well. With that said, it is still possible to require that individuals complete an annual application for continued health benefit coverage. That “application” can include (and definitely should include) an HRA.
However, you are far less likely to experience complaints or possible legal challenges if you work with voluntary “carrots” rather than mandatory “sticks.” HIPAA and its December 13, 2006 implementing regulations are very clear about the rules for use of wellness incentives linked to health plan coverage.

- **Use only wellness criteria or achievements that are attainable by all, and waive with reasonable cause those that cannot meet them!** There are a large number of wellness criteria or achievements that can be linked to incentive rewards or employee benefits. For a much more comprehensive discussion of your wellness incentive options and possible strategies consult another Chapman Institute eBook entitled: “Using Wellness Incentives: Tools for Encouraging Healthy Lifestyles”.

In addition to these seven general strategies for avoiding potential liability from legal action connected with the ADA and HIPAA, we want to now look at what specific wellness criteria can be used in the development of wellness incentive features and linkages to employee benefits.

There are a large number of possible criteria or achievements that can be used to translate “wellness” into tangible and measurable metrics for use in the worksite. While these wellness criteria can be used to provide incentives it is always a good strategy to have substitution or waiver opportunities when an individual is in a clear and objective sense, precluded from attaining the criteria or meeting the requirement. Waiver consideration processes can be made available for all individuals with disabilities for use with all wellness criteria, which will help to reduce the risk of legal or financial liability. This also functions to keep the incentive and the benefit linkages fair and equitable for all employees.

On a general note, the comments regarding specific wellness criteria are all based on the following caveats:

- A process for consideration of a request for waiver of a specific wellness criteria by someone with a qualifying disability or special circumstances is in place.
- Someone with a qualifying disability has duly submitted a request for a “reasonable accommodation” or an “alternative standard.”
- The employer has appropriately considered the request and responded back to the individual.
- The use of any “five out of eight criteria” or any “eight out of ten criteria” is a sound approach because it doesn’t cause any one wellness criteria to have to be met in order to receive the reward. This creates some dynamic tension for the individual who can then decide which criteria to try and meet. It also will function to reduce the submission of requests for waivers.
- The use of at least two tiers of rewards, such as the full reward (i.e., a $1,200 premium discount per year) and a “nice-try” reward (i.e., a $600 premium reduction) is also advisable to prevent the unintended artifacts associated with “all or nothing” pressure.

There are two major types of incentive criteria according to the HIPAA December 13, 2006 Federal Regulations. The first group is comprised of primarily “participation” criteria, while the second are “standard” (read “outcome”) based criteria and often are associated with clinical and biometric measurements. Let’s examine some examples of each.
a. **Participation Wellness Criteria:**

Some examples include:

1. Participate in HRA and/or fitness/wellness assessment.
2. Participate in selected wellness programs or activities.
3. Minimum levels of use of the fitness facility per month.
4. Completion of an online lifestyle improvement LMS module.
5. Agreement to wear a seat belt 100% of the time when in a motor vehicle.
6. Agreement not to engage in “binge drinking” or to drive after having more than one drink.

**Comments:**

Participation oriented wellness criteria are usually easier to implement than standard-based criteria. Because of their largely behavioral and action-oriented nature, they, as a class, are usually easier to administer and are less risky to use with litigation-prone employees. The ADA related aspects that are key include the need to have a completely voluntary choice around participation, the need for and provision of a “reasonable accommodation” for those with a disability if requested, and the appropriateness of the potential to accomplish the individually required activities by those with a specific type of disability. Participation criteria generally have a lower liability potential and are often a good beginning point for employers just starting wellness incentive programs. They also tend to be somewhat more benign, but also more prone to “gaming” than the standard-based criteria.

Some degree of verification is usually appropriate to help create a “sentinel” effect among participants and to lend more credibility to the wellness incentive program. Participation and completion type wellness criteria are also usually easier and less costly to perform than clinical or biometric measurements. The general rule is about half your criteria should be objectively verifiable.

In the case of smokers that have tried every cessation method and have documented their efforts in a credible manner, it is possible to provide for some waiver provisions where they can participate in a program that would help them to be as healthy a smoker as possible, if they choose not to quit.

b. **Standard-Based Wellness Criteria**

Some examples include:

1. Total cholesterol under 200 mg/dl or a reduction of 10% from the previous level or participation in a cholesterol reduction program.
2. HDL ratio less than 4.0 or participation in a cholesterol reduction program.
3. No more than 10 pounds over your ideal weight or participation in a weight management program.
4. Percent body fat within desirable range for your age and sex or participation in a weight management program.
5. Blood pressure under 140/90 mm/hg or participation in a blood pressure control program.
6. VO2 uptake in top 25% for your age and gender or participation in a formal physical activity program.
7. Overall Wellness Score from your HRA above 85 (out of 100) or attendance at a wellness workshop.
8. Non-tobacco user for the past 3 months or participation in a smoking cessation program.
9. No more than 2 sick leave days or unscheduled leave days in the previous twelve months.
10. Current on all preventive screening according to your Primary Care Practitioner (PCP).

Comments:

The clinically and biometric based wellness criteria represent a more aggressive approach and may include a participation option for meeting the criteria. This is not required by HIPAA’s non-discrimination regulations of December 13, 2006 but it is a good way to retain employees year after year in the program.

The use of a sick leave criteria is also a more controversial wellness criteria and should be used with care. The requirement should never require 100% of the applicable time (i.e., no sick leave) because it provides too strong an incentive for unintended artifacts, such as coming to work when the individual is clinically ill or contagious. The reward also should not be so large or desirable that is creates too much of an incentive. This is another reason why any “eight out of ten criteria” is a better approach.

However, standard-based criteria also reflect a more direct and stronger epidemiological link to reduced health risks and reduced health costs. From the perspective of the ADA, the issues that are of concern include the ability of someone with a movement-oriented disability to participate in regular, active physical activity and the ability to obtain a waiver of selected criteria that are impossible for someone with a qualified disability to accomplish. A related concern is the ability to reduce blood pressure and lipoprotein levels without using pharmacological means. However, it can probably be argued that if we agree that the risk associated with selected high clinical measurements, such as cholesterol level is significant, then their reduction may be important enough to use pharmacological methods to reduce higher levels. Another solution for this concern is to allow individuals to receive credit for meeting a standard-based wellness criteria if they improve their score by 10% between measurement periods. This would tend to reduce the disadvantage to those with disabilities and also enhance the motive force effects or participation in the incentive program.

If waiver provisions are reasonable, it is unlikely that anyone would complain or take action against their employer. Waivers for individual behavioral and clinical wellness criteria can be granted by providing a process whereby employees who feel that there are extenuating circumstances that make meeting the specific wellness criteria …“unreasonably burdensome” or “medically inadvisable” can request a waiver of the criteria or an alternative standard. Use a one page form that includes date, name of individual making the waiver request, email address, department or work unit, day and/or evening phone number, description of their efforts at meeting the requirement, extenuating circumstances, a request statement for consideration for the waiver of the requirement or an alternative standard, and a disposition box for record-keeping and processing. The criteria for reviewing the waiver requests should include the following:

- The individual made a sincere, clearly demonstrated, and sustained effort to meet the wellness criteria.
• Events, actions, or circumstances outside of their reasonable direct control thwarted the individual.
• The individual would have sustained injury or adverse health outcomes by complying with the required behavior. (“Medically inadvisable”)
• The individual is willing to substitute an agreed-upon healthful activity or behavior in the place of the wellness criteria for which the waiver is being requested. (“Alternative standard”)
• The required activity or criteria is excessively difficult due to the characteristics of the individual or their circumstances. (“Unreasonably burdensome”)
• The individual has demonstrated evidence of improvement that is acceptable and agrees to continue to make efforts for improvement.

The individual requesting the waiver should be able to demonstrate that they can meet one or more of these criteria in order to receive the waiver. It is also a good idea to avoid requiring a perfect score in attaining all wellness criteria, but instead provide incremental rewards so that the motive force of the incentive is strong and the individual can experience the benefits of goal attainment while not placing an undue pressure on the achievement of every wellness criteria.

First, a short discussion of context. Employers that are considering some linkage of wellness with employee benefits first need to determine what general characteristics define their employee and employment environment. If the work environment is characterized by significant labor-management conflict, then it is generally not a good idea to move very far into linking wellness to benefits. If labor groups recognize the importance of helping reduce the demand for health services and their costs by reducing risk factor prevalence in the work force (and perhaps dependent/retiree population), then a strongly supported joint labor-management approach to wellness and benefits integration should be attempted. Without widespread acceptance and support, it is likely that contentiousness may bog down the effort with challenges and litigation. In a similar vein, if your organization is highly visible and often challenged by outside groups, then the linkage of wellness to employee benefits may not be advisable.

Fortunately, the vast majority of employers are not faced with the situation described above and can potentially benefit from linking wellness to employee benefits. It is probably a good idea to highlight the main caveats that should influence the approach employers take regarding wellness and employee benefits. If employers adhere to the following guidelines, it is likely, but not guaranteed, that they will not incur employee complaints or liability under the ADA or HIPAA.

• **Avoid “penalties”: Always use “carrots” instead of sticks** Stay away from connecting any specific wellness criteria to any penalty provision for anyone that does not met any of the possible wellness criteria that could be used, such as being a smoker or someone who is more than 40 pounds over their ideal weight. Give the advantage to the employee (and spouse or retiree) that is actively taking good care of their own health. The individual who does not try to meet the wellness criteria or tries and does not get the full reward may feel like it’s a penalty, but technically its not.

• **Provide wellness criteria that allow for measures of improvement.** The motivational nature of the wellness criteria will have a much stronger effect on the entire population if individuals can meet the particular criteria by making some measure of improvement. For instance, if someone who has a physical disability and is wheel chair bound, has not achieved a total cholesterol of 200 mg/d but has reduced their cholesterol by at least 10%
(i.e., they went from 286 mg/d to 242 mg/d), then they would meet that wellness criteria. This applies to all employees regardless of whether they have a disability or not.

- **Use individually designed wellness criteria for the individual’s achievement, to substitute for the group standard of a particular wellness criteria.** This accommodation is designed to encourage the disabled to be involved in their own individually designed approach to wellness. It is possible then that a physically or sight impaired person will have a set of personal wellness achievements that are tailored to that individual’s physical or visual capability and that can become individually tailored alternative standard for that individual. These individually tailored wellness criteria can then be used to help the individual qualify for the reward as well as move closer to their maximum potential for improvement in the wellness area.

- **Simply provide the wellness incentive reward to all recognized or qualified disabled persons under a blanket inclusion approach.** With this approach, you eliminate any requirement or differential in the criteria that may exist between those that are disabled and the non-disabled. This will function to simplify your efforts at providing “reasonable accommodation” for any of the wellness criteria that are used in the incentive structure. It also administratively removes any potential for an ADA based challenge.

- **Provide rewards that are in the “gray area” of employee benefits.** Under this approach, you could opt to provide a positive reward that may not technically meet the legal definition of employee benefits. Examples of this might include the provision of “well bucks” that can be used to offset employee cost sharing under the company’s health plan, provision of points for use with a merchandise redemption catalog, provision of a fitness club subsidy, provision of airline travel coupons or travel miles, special parking privileges, modified work hours, or other incentive arrangements. According to some legal experts… “While equal access is required, an employer is not expected to ensure that the disabled receive the same results of benefits or ‘precisely the same benefits and privileges’. This appears to provide an opportunity to offer some differentiation in benefits.

- **Make sure that you meet the ADA and HIPAA privacy and confidentiality rules in the wellness incentive program.** The ADA and HIPAA requires that all medical information relating to employees be written on separate documents or forms, maintained in separate medical files and treated as confidential medical information. This rule applies to all medical information, not with standing how it is collected. Wellness screening information on cholesterol, blood pressure, percent body fat, and VO₂ uptake all qualify as medical information. Therefore, this information needs to be collected only in a voluntary manner, deriving directly from a wellness program based activity, and should be maintained in a separate management information system. There are several more detailed provisions in the two law concerning privacy and confidentiality, but the basic application of the comments made above still apply.

- **When in doubt, check with those who are disabled.** A reasonable approach, when a situation with a wellness program arises that has unclear impact on the disabled, is to ask those who are disabled how they would suggest handling the situation. This is likely to lead to a reasonable outcome and further reduce the potential for any discrimination compliant.
In summary, if an employer wants to minimize complaints and potential liability under the ADA and HIPAA, I would suggest the following:

- Explain the purposes and rationale for the wellness/benefits linkage
- Keep everything voluntary
- Stay away from penalties
- Focus on positive rewards or “carrots”
- Provide waiver opportunities to the disabled
- Provide individualized wellness criteria for the disabled
- Plan out reasonable accommodations for the disabled
- Apply fairness and equal access tests to everything you do
- Be prepared to sincerely listen to the needs of the disabled
- Ask those with a disability if you are unclear as to how to proceed

The ADA and HIPAA are hopefully having a positive long-term effect on the quality of life and livelihood of a large number of citizens in the years ahead. Hopefully we can reach a reasonable position on its implementation in the worksite so that it does not impede the efforts to improve the health and well being of all employees.

#10. How can we integrate a more “intrinsic” approach to wellness into our program?

The predominantly “holistic”, “intrinsic-oriented” or “bio-psychosocial” approach to wellness is another option for worksite wellness professionals. It purposely avoids the use of formal incentives and seeks to only reach those who are already intrinsically motivated to pursue wellness. Its value is partially related to the creation of a more positive emphasis in employee wellness programming. The down side is that in the increasingly competitive resource environment of American business, the full-scale adoption of the “intrinsic” approach has significant inherent risks associated with it.

The most serious of these risks is that only about 25% of most work groups are intrinsically motivated to participate in worksite wellness programs and part of that is often due to a “novelty” effect. This means that the wellness program is not likely to attract and retain a very large population resulting in reaching far fewer employees and spouses than most employers want to reach. This can then produce what senior managers may see as a problem of under-performance and lead to termination of the program. Also the absence of desired/expected magnitude change in measurement parameters, low clinical relevance, limited documentation of health risk prevalence and reduction, and shortfall in economic return, is a major problem for the long-term survival of wellness programs. In order to minimize this risk of programs being terminated due to a lack of engagement, health improvement and/or economic return and to maximize the value of the intrinsically oriented approach it makes sense to use extrinsic sources of motivation such as wellness incentives and also to utilize formal strategies to enhance the level of intrinsic motivation of participants.

This set of suggestions provide fifteen (15) ways to enhance the level of intrinsic motivation related to health behavior change into worksite or corporate wellness programs. Many of these suggestions have been used in a large number of worksite-based wellness programs for many years.

The ways that intrinsic motivation can be enhanced are as follows:
• **Use the term “well-being” rather than “health.”** The general purpose of the wellness program can be focused on well-being and away from narrowly defined medical or clinical health purposes. This is even more appropriate when the prevailing concern of the program has been heavily body-centered with little attention to psychological and/or emotional health. Well-being can then be used to place emphasis on the inner or personal perception of good health, rather than health as defined by health professionals. The concept of resiliency also fits well within this strategy.

• **Emphasize a holistic approach to well being.** Another way to emphasize intrinsic motivation is to utilize a holistic approach to the definition of health, one that addresses the physical, emotional, psychological, social, and spiritual dimensions of well-being. This approach brings into balance the physical dimension with the other dimensions of health and wellness.

• **Reduce the clinical emphasis.** Another approach is to downplay the clinical aspects associated with wellness and substitute more of an emphasis on enjoyment, pleasure, personal experience, quality of life, future health, personal growth, or other dimensions. Also, emphasize why the individual would want to continue an activity or behavior, particularly in terms of personal satisfaction and personal rewards.

• **Be options oriented.** Virtually all programming within a wellness program should be options oriented, meaning the focus of the program should emphasize that we all have a wide variety of alternatives or choices to consider. Options help empower human behavior by recognizing that control and responsibility do in fact reside in the individual for a large number of areas of life. If the program emphasizes that more alternatives exist than what we usually recognize as individuals, it helps empower the individual and helps us realize that we need each other to help counter the narrow thinking that often thwarts personal growth and personal change. Programs can enhance intrinsic motivation by advocating the value of having options and alternatives.

• **Be menu-driven.** Giving choices for program options such as self-help materials, web-based programming, or phone-based coaching support for smoking cessation in addition to a more structured Traditional Wellness program is an example of menu-driven programming. The provision of choices within a “menu” helps empower the individual by letting them actively select the program intervention that more closely fits their personal desire and/or need.

• **Emphasize the internal dialogue.** The intrinsic approach can place a strong emphasis on becoming aware of and influencing the internal dialogue that goes on somewhat consistently in our consciousness. These messages, statements, beliefs, and reasoning help shape our behavior and our attitudes. Programs can include a formal recognition of the importance of thought life and self-talk in well-being and in the process of changing health-related behaviors.

• **Give permission to care for self.** For many reasons, we frequently do not take very good care of ourselves. The program can formally address the issue of self-care in ways that give people permission to rest, be renewed, to step back periodically, to balance work and life commitments, and to strive to enjoy life. Not enough to encourage narcissism
or self-centeredness, but rather to reach a more healthy balance for those who are uncomfortable taking time for physical activity or for personal enjoyment.

- **Be authentic.** Another method for enhancing the holistic or intrinsic balance in the program is to emphasize the need for people to be authentic and real about their difficulties and struggles in making behavior and habit changes. When people share more openly the struggles of life and well being, it underscores a stronger intrinsic message within the program.

- **Emphasize self-discovery.** By emphasizing the value and rewards of self-discovery and self-understanding, it is possible to give permission and approval for efforts to become more sensitive to internal-cues rather than just external-cues. If self-discovery is valued, it gives a clear message that is of intrinsic value to participants.

- **Focus on the pleasure and personal rewards.** Keep focused on the pleasurable effects of being healthy and the need to balance personal rewards in the pursuit of life. Pleasure can be emphasized over the risk related issues related to specific health behaviors and health conditions. This helps to reduce the guilt-driven second order consequences sometimes associated with more Traditional Wellness wellness programming.

- **Do not over-structure activities.** Leaving room for spontaneity and for personal control is another way to emphasize the intrinsic approach. If programming is over-structured and leaves very little opportunity for personalization, it discounts the value of the individual and reveals a more mechanistic and less “adult” approach to behavioral intervention.

- **Minimize competitive aspects.** Competition, if it is designed to pit individuals or groups against each other in a way that becomes unfriendly, is likely to undercut the intrinsic basis of motivation for change. Competition that is focused on voluntary or self-selected efforts to improve on your own scores or achievements for the personal rewards is probably most compatible with the intrinsic approach. This means that competition can be used, but it should be significantly modified so that extrinsic comparisons or external rewards and negative messages are not encountered.

- **Ask what level of extrinsic motivation is needed.** In programming for individual behavior change, such as smoking cessation, weight management, physical activity, or stress management, structure the program so that individuals have an opportunity to reflect on what level of extrinsics (i.e. motivation that comes from outside the individual) would be helpful for them based on their past experience with change and their present perception of their own support needs for behavior change. This also values the individual by treating them in an adult manner and by including them in the decision-making regarding the balance of intrinsic versus extrinsic motivation. Some people will likely know that they need more extrinsic motivation than others.

- **Use adult messages.** The messages to participants should always be adult-to-adult rather than adult-to-child. The nature of the message should communicate a caring, honest, straight-forward, valuing, and empowering message. The tone of messages needs to be strongly peer-to-peer in the intrinsic approach and also needs to value and expect adult
responses and behavior. The “honor system” and mutual trust should be the norm until evidence dictates otherwise.

- **Emphasize the positive.** The perspective of recognizing the good, emphasizing personal strengths, the progress made, or the value of the achievement or effort is another method for capitalizing on intrinsic motivation. This attitude or underlying philosophy of “Positive Psychology” is inclined to empower participants and to help overcome the inertia of habit or fear of failure. A realistic assessment of the positive aspects of the situation is usually always very helpful.  

**#11. How do we program in small remote worksites?**

The problem of moving wellness programming from corporate headquarters out into the field usually presents a clear challenge to corporate wellness staff. The predominant pattern of limited fitness facilities and wellness programming in remote worksites (all locations other than corporate headquarters) is fairly typical for most medium and large employers. It is understandable that headquarters-only programs are a logical beginning point for most corporate wellness efforts. However, the organization that has a majority of its workforce at the headquarters facility is increasingly rare. Divisional headquarters, manufacturing facilities, service centers, technical support operations, sales offices, retail store sites, dealerships, and production facilities are the usual worksites a large portion of the U.S. civilian labor force.

This challenge also underscores the similarities that exist between remote worksites of larger corporations and the preponderance of small employer worksites. Based on data provided by the U.S. Census Bureau and the Department of Commerce, the composition of the American civilian employer community by the size of their employee work force is depicted in Table 3.

**U.S. Employers by Selected Characteristics**

<table>
<thead>
<tr>
<th>Employment by Class Size</th>
<th>Number of Business Units</th>
<th>Percent of Employers</th>
<th>Percent of Employees</th>
<th>Percent of Total Payroll</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20 Employees</td>
<td>6,528,000</td>
<td>85.8%</td>
<td>24.6%</td>
<td>21.0%</td>
</tr>
<tr>
<td>20 to 99 Employees</td>
<td>890,000</td>
<td>11.7%</td>
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<td>100 to 499 Employees</td>
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<td>0.009%</td>
<td>13.6%</td>
<td>18.3%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>7,601,000</strong></td>
<td><strong>99.7%</strong></td>
<td><strong>99.8%</strong></td>
<td><strong>99.8%</strong></td>
</tr>
</tbody>
</table>

* Excludes the self-employed.

**Table 3  U.S. Employers by Selected Characteristics**

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The primary challenge to wellness professionals in programming for remote employee worksites is usually the limitation of resources that are allocated to non-headquarter sites, regardless of whether the organization is in the public or private sector.

Other specific challenges that arise from remote worksites include the following:

- Frequent lack of sufficient numbers of interested employees to justify bringing education, screening, fitness facilities, or capital improvements to the remote site.
- Lack of money to retain vendors who are capable of traveling to the various locations with program activities.
- Scarcity of knowledgeable on-site staff who can function as wellness program coordinators at these remote sites.
- The difficulty of creating effective communication linkages to remote sites.
- Very different levels of support from site-based senior management staff in different locations.
- The common tradition of decentralized operational responsibility that prevents a cohesive organization-wide wellness effort.
- Variability of local and community wellness and fitness resources, such as local parks and fitness facilities.
- Demographic, locational and seasonal variations affecting employee interest and willingness to participate in attempts at corporate-wide wellness planning.
- Difficulty in assuring program quality control and assuring corporate-wide parity in wellness programming efforts.
- Difficulty in conducting a valid and reliable corporate-wide program evaluation with highly variable patterns of programming.

Given these considerable challenges, a number of strategies can help you conduct cost-effective wellness programming in remote worksites. They include the following:

- **Adopt a “core plus” strategy for corporate-wide wellness.** Such a strategy encourages all worksites to use the same basic core components of a corporate-wide wellness program in a consistent manner. It also allows for the implementation of site-developed activities that reflect the unique interests and needs of the local employee group involved. This allowance for individual site variation is central to the development of a sense of program “ownership” on the part of the remote site personnel. The core program components allow a consistency in programming that will make program evaluation more feasible and will add overall effectiveness and efficiency to the effort. An appropriate programming ratio between core and homegrown activity might be 80/20 or 70/30.

- **Use a site-based wellness coordinator.** For each remote worksite, it is essential to have someone who functions as the coordinator/liaison for any program activities that are conducted at that site. The site coordinator/liaison can hold other related duties, such as safety coordinator, employee services representative, or human resources representative. The primary requirement for this individual should be an interest in seeing a successful program implemented for the employees of that particular site. These individuals play a critical role in assuring that the wellness activities designed for the remote sites are implemented as intended, and that some unique site-determined programming is
developed. The presence of an on-site coordinator is usually required to give the program adequate visibility, a sense of “presence” and to establish its credibility.

- **Establish a remote site-based wellness committee.** An important part of the administrative structure for remote sites is the establishment of a small working group that can assist with planning and implementing employee wellness program activities. These small committees can consistently help bring the corporate program to life by adding some local color, variety, and variability.

- **Send customized wellness newsletters through the mail.** For employees who work in remote or small worksites, a monthly, bimonthly, or quarterly email wellness newsletter with a customized masthead and organizational message is a good method for unifying the corporate-wide program. The use of the corporate program logo and identifiers can help enhance the visibility of the employee wellness program. Introduce special focus campaigns with the help of the newsletter. Program awareness and health information awareness are also significantly enhanced in a cost-effective manner. The cost for a nice set of newsletter templates is minimal. If employer-specific program information is included, it can also greatly enhance general employee knowledge and use of specific program activities. Direct mailing of a paper version of the newsletter to the employee’s home is particularly helpful in reaching employees who travel a great deal, and improves the chances of family members benefiting from the newsletter.

- **Use a remote site communication and distribution network.** Establish a communication network for information dissemination. The network should look something like a tree, with the roots being the headquarters wellness program staff, the trunk representing the flow out to the remote worksite coordinators or contacts, and the branches being the flow of information to each of the major work units, and finally to each individual employee and their family members. This networking structure can be used to quickly disseminate information through electronic mail, PDA, and voice mail chains. This system can be used for reminders and for eliciting feedback as well.

- **Distribute mail and email request devices.** Another useful strategy for remote worksites, and particularly for field staff who spend minimal time in an office or who work at home and “telecommute,” is to periodically provide a mail and/or email request vehicle that gives the individual an opportunity to indicate wellness topics that interest them. Typically, a mail/email request device is sent to the employee, notifying them that they have the option of receiving email or written information on three or four topics selected from a long list of potential topics. The limited areas selected are usually of interest to the individual because they are under consideration as an area of behavioral change. The content can also be identified through web search history. The mail/email request device can be distributed through internal email systems or to the individual's home through the postal service. The individual employee dependents can also be solicited as to their interests if volunteer resources are sufficient to meet the work demand.

- **Use an individualized health management process.** Another approach for remote sites is to provide a health management process that includes the following components:
  - Incentive for completion of initial and periodic HRA
  - Intake instrument with medical self-care text and training
Personalized wellness report with health management priorities
Request mail/email vehicle for self-directed change materials
High-risk and at-risk intervention outbound calls
Health advice line with in-bound call capability (limited to use with CDHPs)
Monthly in-home wellness newsletter
Incentive worth $500 to $1,500 for selected health and wellness achievements

This type of health management process can be delivered over the telephone, by computer and through the mail and is designed to provide “virtual” integrated and highly personalized health management interventions. These are just a few of the methods that can be used to serve small and remote employee sites. The R-DW program model is particularly effective due to its “virtual” core program interventions.

#12. How do we set up a “wellness center”?

Often an employer's small size and/or lack of resources rules out the installation of a fully equipped employee fitness center. However, it is still important to provide a physical space that can be a resource for employees in the pursuit of wellness objectives. If an employer wants to provide a physical area where wellness issues can be addressed and where employees can come to get help with specific problems, they should consider the possibility of establishing a wellness center.

Wellness centers can take many different forms, depending on the size of the employee population, the needs of employees and the resources available at the worksite. Here is a good working definition of a wellness center: “A physical space at the worksite, dedicated to personal wellness issues, that functions as a resource area, a place for informational and educational activity, and a place for biometric and psychological testing, counseling, access to the Internet for health issues, and follow-up designed to help employees change lifestyle and health habits.”

This definition can be used to help structure the services and activities that will be offered within your wellness center. A wellness center is a useful strategy for employers to consider for several reasons:

◊ It helps enhance the visibility of wellness issues and provides a physical “concreteness” to an employer's largely “virtual” wellness program.
◊ It increases employees’ accessibility to information, testing, and counseling on lifestyle issues.
◊ It can appeal to a much broader cross-section of employees than a conventional employee fitness center.
◊ When emphasizing a self-help perspective, it can reinforce empowerment, self-efficacy holistic health principles, and intrinsic motivation.
◊ It can provide the focus and location for low-cost programming options.

In order to be successful and encourage high levels of usage, wellness centers must have several key characteristics or criteria. These include:

◊ a dedicated space that is adequate for the work force and consistent wellness promotion;
◊ useful materials, computer resources, exhibits, self-tests, and reference sources;
◊ menu styles of programming options for helping employees make health behavior changes;
◊ strong, positive, “take charge” and affirming ambiance.
In order for a wellness center to be effectively used by an employee population, it must be consistently acknowledged and used in ways that draw attention and interest. The following is a series of suggestions on how to ensure the success of a worksite-based wellness center:

- **Locate your wellness center in a highly accessible location.** The location of a wellness center will be an important factor in the degree of use by employees. It should be along routes of major egress in the flow of people through the worksite. Locations off a main foyer, on the ground floor, close to elevators and escalators, and accessible from cafeteria facilities and employee lunchrooms are all desirable. Relatively difficult access can significantly detract from usage.

- **Place clear signs and directions to the wellness center in key locations.** The clarity of signage and directions to a wellness center will also have an impact on its use. Holding new employee orientations in a classroom or training facility within the wellness center is a good way of exposing employees to the available resources there. Each sign to and for the wellness center is a reminder or a message about the value the organization puts on wellness.

- **Make the space comfortable to use.** The space for a wellness center needs to be comfortable and large enough to welcome people. The presence of comfortable chairs, a reading area, and enough open space to move around are all important. Adequate numbers of computer stations and reference materials can help ensure that the center is inviting to users.

- **Use an LCD video or poster-size announcement at the entrance to guide those using the resources in the room on their own.** The wellness center should have a large written marketing piece at the entrance, or a user initiated continuous loop video presentation on how to use the center. This mini-orientation is extremely important in maintaining a user-friendly perception on the part of the employees. The orientation should cover the entire center’s main services, its staffing, and policies concerning use of the materials, equipment, and activities at the center.

- **Use bright and attractive colors and décor.** The wellness center should be attractively decorated with bright, carefully chosen colors to create an upbeat, warm and positive feeling. The space should reflect the qualities and character of wellness, and should convey the cultural messages that are consistent with wellness.

- **Have a sign-in procedure.** Near the entrance to your wellness center, place a sign-in log or badge swipe reader terminal with a notice requesting that all visitors sign in. This accomplishes several things, including the establishment of an entry exchange or act from the user, while helping you to evaluate the use level of the facility, particularly if it is unmanned during all or a portion of the day. The sign-in also helps in a limited way with a sense of security for the equipment and materials in the wellness center. Access to the general public needs to be prevented or controlled in order to safeguard against loss.

- **Organize the resources in the wellness center to fit the target population.** Make sure that the issues addressed in the wellness center are consistent with the needs and common problems of the work groups being served. Be sure to balance the general health
problems, medical self-care needs and lifestyle issues in the materials and emphasis of the center as well. If your wellness program is heavily oriented to holistic programming, well-being and intrinsic motivational factors, then you may not want to address Traditional Wellness health problems in the visible displays and materials in the wellness center. The important issue is that the materials and activities provided in the wellness center should reflect the areas of interest to the population involved. Presenteeism issues and interventions can also be addressed in a wellness center.

- **Consider having professional staff coverage or knowledgeable volunteers.** The wellness center will be much more effective if it is staffed with knowledgeable professional staff or volunteers. Even a time corridor of availability, such as 10 a.m. to noon, is better than nothing. The individuals involved should have good people skills and should understand how to provide reinforcement, empowerment and encouragement to users. For simple testing, staff should be trained to provide valid and reliable measurements such as blood pressure and weighing. Wellness mentors could also use the facility as a meeting place.

- **Encourage spouses and dependents to use the center.** Direct mailing of program announcements to employees' homes with a clear invitation to spouses and dependents can be an effective strategy for encouraging their involvement. Special promotional campaigns for health issues that are important to female and male spouses, such as mammography, women's health issues, and men's issues, can generate additional participation.

- **Provide a broad range of resource options and opportunities.** The wellness center should offer a wide range of informational, educational, and experiential learning opportunities. Some of the possible options include:
  - a wellness resource library for use on-site and for short-term loan;
  - multiple computer stations with health management website links;
  - video loop presentations on key health and wellness topics;
  - handouts on single focus high-interest issues including minor health problems;
  - weight scales;
  - automated blood pressure machines;
  - self-quiz instruments on key topics;
  - bibliographies on key wellness topics;
  - consumer cards covering topics like, “Questions for Your Doctor.”

- **Keep a simple, clear focus and add a new slant on it periodically.** Cultivate a simple focus for the wellness center based on the major program theme, and use it consistently in every phase of the center’s activities. For example, if the program theme is “Be the best you can be,” then keep that theme throughout. Periodically change the emphasis to include different facets of life, such as intellectual, recreational, creative, physical, etc. This will tend to develop a sense of identity for the wellness center, and bring some continuity and reinforcement to your efforts.

- **Actively promote and heighten the visibility of your wellness center.** This activity is key to the degree of use your wellness center achieves. Constant promotion and increased visibility are critical to the effectiveness of the facility. Nutritional potlucks, special events, and campaign kick-offs are some of the activities you might consider for
promoting use of your center. Fresh fruit, lottery opportunities for using the center, and free specialty advertising gifts are some additional approaches you can try. Linking the wellness center to your benefit programs, wellness incentive criteria or employee assistance plan, immunizations, screenings, and other personnel functions, can also enhance the use of the facility.

These are just a few ideas on how to organize and run a wellness center for employee populations.

#13. How can we reduce our sick leave absenteeism?

The use of sick leave by employees is influenced by many clinical and non-clinical factors. Understanding these factors is the key to minimizing absenteeism at your facility. According to the National Center for Health Statistics and the National Institute for Occupational Safety and Health, the typical employee uses 5.4 days of sick leave for personal health reasons and 2.7 days for non-health reasons per year. Each industry and employer will show a somewhat different pattern of absenteeism associated with these causes, as will each employee. Some employees are prone toward absence rather than attendance. Some employees will use sick leave in a manner more independent of their actual health needs. Comparison data on sick leave occurrence can be acquired through browser searches for the National Chamber of Commerce annual surveys, Bureau of Labor Statistics or the Commerce Clearinghouse.

Health problems are not evenly distributed in any workforce, so there will be variations in sick leave use due to differences in morbidity as well. According to the National Center for Health Statistics, National Health Interview Survey, the average American adult experiences an average of two (2) medical symptom events per month (24 per year). Clearly only a few times a year we decide to be absent from work. The use of sick leave is generally influenced by the following variables:

- **The generosity of sick leave benefits:** If sick leave allowances are generous, it is likely that they will be used more extensively by employees, particularly based on their age. The typical employer allowance for sick leave is 8-12 days per year, usually accrued at a rate of one day per month. Another important feature of the generosity of sick leave practices is the maximum amount of sick leave that can be accrued and carried forward.

- **The age and sex characteristics of the work force:** Some general caveats can be made concerning age and sex characteristics of work groups. First, younger employees who are less skilled generally use sick leave at higher rates. Second, women tend to use more sick leave than men. Some of this sick leave use is for the care of children. Third, older employees will generally use more sick leave than middle-aged employees. Obviously, there are situations and individuals that are exceptions to these generalizations, but they should still hold true more often than not.

- **The season of the year:** The seasonal spread of viral infections in the fall and winter and the preponderance of post-holiday stress resulting in depressed immune functions frequently produce seasonal trends in sick leave use. Most sick days will be taken during the winter.

- **The perception of job security:** If job security is threatened, the work force is likely to become attendance prone to enhance job security. Another segment may experience
more somatic complaints due to the excess stress associated with the uncertainty of the employment situation. The net effect on sick leave usage will be influenced by the intensity of the job insecurity, the length of time the uncertainty is present, and other factors of the work force.

- **The lifestyle patterns of the employee population:** The predominant lifestyle patterns among employees will influence how much sick leave a work force uses. Activities such as heavy or erratic alcohol use, lack of physical activity, smoking, and poor stress management have an influence on the amount of sick leave an employee will need during a given period of time. For example, significant alcohol or drug use tends to be exhibited among employees who are frequently absent on Mondays or Fridays – their weekends begin earlier and often lasts longer.

- **The family and dependent pattern in the work force:** Single parents with young children may feel compelled to take sick leave to care for a sick child because they have no alternative. Likewise, dual income families may find it necessary for one of the parents to stay home with a sick child. For these reasons, many employers have arranged for worksite based childcare, and some offer care for the child with minor self-limiting acute illness.

- **Patterns of weather and recreational opportunities:** Rainy or extremely cold weather can discourage work attendance among those with minor health problems. Extremely high temperatures can have the same effect. Ski season, boating season, or clear, sunny weather can also affect sick leave use, particularly in areas that do not have a lot of good weather during certain seasons of the year.

- **The work group norms concerning absenteeism:** Group norms concerning sick leave use can also influence the degree of absenteeism. For example, if “mental health days” are openly acknowledged, it is likely that absenteeism will be higher. Conversely, if employees function in a highly interdependent manner or in a strongly team-oriented fashion, expect lower levels of sick leave use unless other major variables are at work.

- **Personal values concerning use of sick leave policies:** Sick leave use is also directly affected by the inherent nature of the policies themselves. For example, under a “use or lose” sick leave policy, the employees are faced with the loss of sick leave days when they have not used their allowed or accrued days. If the policy provides for up to twelve days of sick leave per year with no carry-over accrual provision, they likely will be used in the last month or two of the year. Likewise, maximum accrual provisions, carry forward policies, disability coverage provisions, and cash-out practices will all influence sick leave behavior.

- **The state of employee-employer relations:** The general nature of employee-employer relations will also influence absenteeism patterns. If a significant amount of distrust and rancor exists, absenteeism will likely be high. If a good relationship exists, absenteeism will usually be minimal. Bitter labor disputes, lay-offs, hostile takeovers, and merger or divestiture can also increase absenteeism.

- **The use of combined leave structures:** The presence or absence of combined leave or “paid time off” (PTO) systems will also have a significant effect on sick leave use. Under
these increasingly popular approaches, all forms of leave: vacation, sick, administrative, reserve duty, jury duty, and others is combined into a general pool of days and these days are used for all types of leave. Under these approaches the incentive to the employee is to take better care of their health because if they are sick for five days a year then they have five days less “vacation.”

These factors all work to create complex and highly unique sick leave problems. The relative presence or absence of these factors will determine what potential remedies make the best sense. The first step in solving a sick leave problem is finding out which factors are contributing to the problem.

Here are some potential remedies for high levels of sick leave absenteeism. Each remedy should be selected based on the specific underlying causes of the absenteeism in that particular population and/or organization.

- **Elimination of sick leave.** If the economic status of the organization is severely compromised, it may be necessary to eliminate sick leave entirely. Granted, this is a draconian remedy, but it may have to be considered. Communicating the seriousness of the situation to the employees, and indicating this option is actually being considered, may have the effect of minimizing abuse by employees.

- **Move to combined leave systems.** Another option is to monitor the average amount of sick leave, administrative leave, vacation usage, and any other type of leave, and determine a desirable reduced level of combined leave days. Typically, this may involve setting a combined or total leave amount that is one-half to three-quarters of what the average amount of leave for all causes has actually been. These combined leaves, or paid time off (PTO) systems, eliminate sick leave, remove the categorization of leave, and can provide an incentive for individuals to take better care of their health and wellness. The use of the category of “unscheduled leave” as a request for leave made less than 48 hours from its use can provide a rough proxy measure of sick leave. Another benefit of combined leave is that it minimizes dishonesty. On the negative side it makes it harder to measure the effects of a wellness program on sick leave utilization.

- **Make a direct appeal to employees.** If you suspect that sick leave is being abused, make a direct appeal to the employees. The tone of the appeal should be adult and straightforward. The recognition that a problem exists and dissemination of information on average sick leave usage can be effective.

- **Use a corridor exclusion feature.** Another approach involves the use of a corridor exclusion; such as the first three days of any sick leave are not paid by the employer. This kind of provision, which resembles an insurance deductible, is primarily applicable for hourly wage earners, although it can be used with salaried employees using a pro-rated deduction from regular salary levels. With this approach, a set number of annual sick leave days can be established for employees. If the average length of absences begins to increase after the introduction of this approach, a doctor’s note can be required in order for the employee to receive credit for applicable days of sick leave, however this is likely to increase primary care physician visits, adding some increased cost to compliance. Reduced annual accrual rates can also be used to moderate the adverse affects.
- **Use of a doctor’s note for all sick leave.** With this approach, a doctor’s note can be required for all sick leave absences longer than two or three days. This tends to reduce the average length of sick leave absences. Unfortunately, this approach may also result in increased physician use and prescription drug use under the company’s health plan. Approximately two thirds of physician office visits result in a prescription for medication. Patients fill prescriptions about 80% of the time. If occupational health staff are available, they may be used to provide clinical approval for the absence and thus minimize such health plan related problems.

- **Reduce the annual amount of covered sick leave.** Another option is to reduce the number of annual days of sick leave. If a significant portion of the employee work force uses sick leave as soon as it is accrued, then it may be advisable to reduce the number of sick leave days allowed. As a protection for employees, a specified amount of emergency sick leave can be made available in the event of a major debilitating condition or injury. A sick leave bank can also be used for short term disability absences from work.

- **Exclude patterned sick leave situations.** If the problem of excessive sick leave use is associated with selected patterns, then exclude sick leave coverage when it occurs within those patterns. For example, if sick leave use is associated with Mondays and Fridays, then designate any sick leave occurring on a Monday or Friday as uncovered. Or, exclude sick leave coverage if the absence occurs within the three days prior to or immediately following a holiday or a vacation.

- **Provide an incentive for accrual of sick leave days.** Many different types of incentives can be established for the accrual of unused sick leave days. Possible pay values include conversion of unused days into credits for selecting gifts from a merchandise redemption catalog, conversion into one-hour reductions in daily work hours, conversion into tickets for use in a prize drawing, conversion into credit for redemption of airline flight coupons earned through company travel, redemption of one of several prizes or gifts, or conversion into cash. In all of these accrual incentives the redemption value should not exceed one-half the financial value of the actual wage or salary cost associated with the sick leave involved. In other words, the motivating force or attractiveness of the pay value should be maximized for the employee, while minimizing the direct cost of the incentive reward to the employer.

- **Use of special privileges for low sick leave users.** In this remedy, those employees who have used three days of sick leave or fewer during the previous year can be given a special privilege. This may take the form of a waiver of all or a portion of their monthly payroll contribution for health plan coverage for a month or two, two extra vacation days, higher life insurance or disability benefits, a waiver of some of the health plan deductible requirements, or some other special privilege. The provision of the special privilege should not be based on a complete absence of sick leave use, but rather on low levels of usage. More so than virtually any other sick leave policy change, a standard of no sick leave use can lead to the unintended result of having employees come to work when they should really stay home.

- **Use of a cash-out provision.** Cash-out of accumulated sick leave should only be used as a last resort, after using a variety of other remedies or incentives identified here. The problem with cash-out programs is that they can produce a significant financial liability,
regardless of whether they are funded or unfunded. If cash-out provisions are used, they should provide no more than one-half the amount of the daily wage or salary amount at the time they are accrued. Once a cash-out provision is adopted it is usually extremely difficult to modify or eliminate it.

- **Use of hardship donations of sick leave.** This approach allows individual employees to voluntarily donate excess accrued sick leave to other employees who experience a serious or debilitating illness or injury. A minimum amount of annually accrued sick leave, such as 30 days, should be established. The individual can donate any amount of sick leave accrued beyond the 30 days, up to the maximum allowable accrual carry over amount, typically 90 to 150 days.

- **Purchase additional leave days through flex plan options.** For those employees who consistently use sick leave and/or annual leave for health reasons, another option is to provide additional vacations days that can be purchased by employees through the use of Section 125 cafeteria or flex plan credits. If the employees use their own individual benefit dollars to cover the additional use of leave days, then the costs associated with the absence are at least covered by the employee instead of the employer.

- **Use of medical self-care and preventive measures to reduce sick leave and presenteeism losses.** Another remedy for clinically related sick leave is to provide focused efforts to help educate employees on how to monitor and assess the need for medical intervention with colds, flu, allergies, migraines, depression and other selected self-limiting conditions. This can be accomplished with algorithms for treatment of minor conditions and the use of medical self-care texts or software. The diagnosis and home treatment of many self-limiting common conditions can help employees deal more effectively with these conditions and help reduce their absenteeism and presenteeism related productivity losses. Flu shots have also proven to be useful in reducing the amount of lost work time associated with this seasonal occurrence. Stress reduction training at key times, like the holidays, focused on somatic complaints due to stress can also help prevent some of the common illnesses and conditions that exacerbate sick leave use. These preventive strategies need to be addressed directly in the planning of your wellness program activities regardless of which program model you select.

**Evaluation Recommendations**

When examining sick leave usage, it is important to have a valid and reliable method for measuring its occurrence and the effects of your efforts to intervene. In monitoring sick leave usage, these key statistics are useful:

- **Average number of sick leave hours (or days) per full-time equivalent (FTE) employee.** This statistic is created by adding the number of sick leave hours (or days) per period of time, divided into the average number of FTEs in the work force during that time period. Usually, 2,000 hours of paid work time per year is equal to one FTE however different organizations may use other standards. This statistic can be maintained on a monthly, quarterly, and annual basis. It can be placed onto a trend chart to show variations and patterns over time. The average salary/wage for the work force
involved per hour or day can be used to project the economic cost associated with the observed sick leave.

- **Percentage of sick leave days on Monday and Friday.** This statistic provides the proportion of sick leave days that occur on either Monday or Friday, and on the two days combined. The proportion expressed in percentages can be examined for hourly workers vs. salaried workers, by major organizational unit, or by site. This statistic may also be used as a rough proxy measure of drug or alcohol use within a work force, particularly if it is extremely high. A trend line for comparison purposes can be developed over time.

- **Total number of sick leave days per year.** This number can portray the total amount of sick leave days used by period of time, such as month, quarter, or year for the work group involved. The value of lost time or sick leave can then be imputed by multiplying the average hourly or daily wage or salary rates for the entire work force, for major work groups, or for specific organizational units, multiplied by the amount of sick leave used by the group.

- **Distribution of leave by type.** This involves the determination of the total number of leave days used by all employees by major category for a specified time period, and can also include the estimated cost of that leave. It can then be presented in a pie chart form, showing the breakdown by major category – sick leave, family leave, medical leave, vacation leave, and any other type of leave provided to employees. This is a critical step in moving to a combined leave approach.

Some additional evaluation activities that can be utilized to help determine the effectiveness of your efforts at reducing sick leave include the following:

- **Tracing key sick leave usage statistics over time.** By using the statistics suggested above and by graphically presenting that information, trends and patterns can be analyzed. Any intervention designed to reduce the use of sick leave by employees can be tracked over time if the basic data collection methodology is consistently maintained.

- **Use of anonymous surveys of those using selective types of leave.** Questions in the survey instruments can include issues such as reasons for use of leave, involvement of health practitioners, underlying causes, frequency of occurrence, effectiveness of changes in policies or incentives, suggestions for reducing need, perception of work place norms regarding use of leave, and other issues.

#14. How can we change our organizational culture to make it more wellness-oriented?

As wellness becomes a more widespread and accepted human resources and human capital enhancement strategy, it is important to create as many forms of potential linkages or means of integration with other aspects of employee policies as possible. In assessing the ways in which wellness can be more strongly integrated into these areas, the large number of possibilities provides a clear challenge for program managers. This large number of potential options means it is likely that some of them can be applicable for every worksite, regardless of the conservatism of management.
First, it is important that we know why integration and linkages to other HR policies and programs are desirable. Here are main reasons:

- **Increased credibility.** Each time the employee wellness program is formally linked or integrated into another facet of employee benefits or personnel policies, the program’s credibility and visibility with employees and management is enhanced.

- **Increased program marketing impact.** Each individual mention of each wellness linkage will augment the visibility of the program, particularly if employees perceive the integration as positive.

- **Increased program use.** As linkages are made and as positive incentives are used to promote wellness behaviors and program involvement, it will likely result in increased use of the program.

- **Improved program outcomes.** Depending on the desired type of outcomes expected from the wellness program, it is likely that increased integration will increase the magnitude of outcomes produced by the program. For example, if the integration is focused on reducing health care utilization and the linkage to health benefits is an incentive utilizing lifestyle bonus points, then increased program effects will include greater risk reduction among employee groups involved while lowering health benefit costs.

- **Improved program longevity.** If the wellness program, wellness behaviors, and wellness issues are formally integrated with other employee benefits provisions and HR policies, then elimination of the program is much less likely, particularly if these linkages are formalized in collective bargaining agreements. It should be stressed, however, that this only makes elimination more difficult – not impossible.

The possible linkages and methods of integrating wellness into employee benefits and other dimensions of the workplace include:

- **Employee health benefits.** Some of the options for linking wellness with benefits includes premium discounts for those who meet a minimum number of wellness criteria, (such as non-smoker status, fitness screening participation, low total cholesterol, and others); waiver of portions of payroll contributions; waivers of deductibles; additional flex benefit credits; lower co-insurance percentages; elimination of co-pay requirements; lower plan out-of-pocket maximums; access to additional benefit coverage; reimbursement for community wellness programs; expanded preventive medical benefit coverage; and incentive gain-sharing features that reward healthy lifestyle choices and prudent use of health services.

- **New employee orientation sessions.** Wellness program activities and issues can be more effectively integrated with other dimensions of work life by including a program briefing and some wellness program activities as part of new employee orientation. This helps to establish a personal link to the program early in the employees’ work life with the organization. If completion of an HRA and some biometric screening
activities such as cholesterol testing are offered, they can also be linked with follow-up testing opportunities.

- **Collective bargaining agreements.** Another potential opportunity for integration is building wellness programs into labor contracts. They then can become a negotiable item if the employer is considering eliminating them. This issue needs to be approached carefully, and it helps if it is labor’s idea to incorporate the program into its collective bargaining agreement. Participation goals can also be agreed upon to help mobilize labor support for the program and its activities. Labor groups are usually more willing to address the issue of wellness if they perceive the utility of such action in relation to the preservation of benefit levels, and the potential expansion of benefits and/or salary and wage levels in the future. Sometimes it is easier to give wellness to non-covered employees first and then have labor groups request that it be included in their contract(s). If wellness becomes part of a collective bargaining agreement there is a potential that employees will consider wellness as an entitlement.

- **Release time policies.** Management can develop and adopt a release time policy that encourages employees to be physically active, use fitness facilities, participate in screening programs, and attend wellness education activities. This policy is intended to make a formal statement about the desire of management to have its supervisors and middle level managers support the program. Usually a statement is made that the release of employees to attend program activities is encouraged or expected in situations where the normal work requirements are not adversely affected.

- **Facility modification and construction.** There are a number of options for integrating wellness when making facility modifications. Some of the more typical modifications include addition of bicycle racks, showers and lockers, walking trails, quiet space, fitness rooms and centers, visual displays, wellness self-test stations, indoor and outdoor walking courses, and access to on-line computer network information at kiosks. These modifications can help make a visual and physical link to wellness.

- **Communication activities.** Create a wellness presence in the major forms of communication with employees. A wellness column in the employee newsletter, messages on electronic sign boards, and the use of marquee space are frequently used options. If corporate or company communication is more sophisticated, and includes video and teleconferencing, these can provide additional opportunities. If employee bulletin boards are the primary means of communication, then these methods can be used to supply information about wellness topics and wellness program activities.

- **Corporate picnics and gatherings.** Corporate events can have a wellness emphasis or dimension. Organizing active games in which all employees can participate is an activity that can bring some increased enjoyment to a company picnic. Low calorie, low fat, and low sodium foods can be served, and physical and screening tests can be integrated into the activities. Health fair types of components can also be offered. Management retreats can be structured to include health-oriented activities, and these can become an integral part of major corporate events and gatherings, further integrating wellness concerns into the organization’s culture.
- **Sponsorship of community events.** Another approach is to have the wellness program facilitate sponsorship of community events, such as Special Olympics and other charitable events that involve physical activity or purposes that are compatible with wellness.

- **Occupational health exams.** Wellness and lifestyle issues can also be integrated into occupational health exams. This can include the use of health risk assessments, discussion of lifestyle risks, development of health enhancement objectives, use of laboratory tests that help provide health status measures that are affected by lifestyle, review of lifestyle risk factors for the age and gender of the individual, and discussion of issues of self-esteem and self-mastery skills in behavioral change. These preventive components can be modified according to the type of occupational health exam involved. The different types of exams include executive physicals, periodic employee health exams, occupational risk exposure exams such as hearing conservation, and pre-employment exams.

- **Alcohol and drug policies.** The enforcement provisions and consequences of drug or alcohol use at the worksite can be followed by mention of the lifestyle and stress related concerns of alcohol and drug use. Corporate policy should explicitly recommend abstinence from drug use and moderation in alcohol consumption, as well as recommending recognition and avoidance of binge drinking.

- **Safety integration.** Wellness issues can be integrated into safety education and analyses of underlying causes of workplace injuries. Wellness education can also address safety or injury prevention issues in terms of work plus home, vehicular and recreational settings. A strong and broad injury prevention program can offer greater credibility to a fledgling wellness effort. Lifestyle precursors to selected workplace injuries, such as low back pain events, can help further integrate wellness efforts into the organization.

- **Workers’ compensation linkage.** The recognition of the relationship of lifestyle risks in many work injuries can be highlighted in referrals to wellness program staff and in injury prevention education. Post-injury physical reconditioning can frequently be handled through the wellness program and its staff. Work-related injuries and illnesses often require modification of lifestyle to minimize risk.

- **Ergonomics and work hardening.** The exercise physiology and exercise science background of many wellness professionals can be a useful adjunct to some of the assessments and behavioral adaptations that are necessary. As an adjunctive strategy, wellness programs can also be linked to work hardening efforts. In these situations, if significant injury risk cannot be engineered out of the work tasks, then helping the affected individuals become “hardened” to reduce their personal risk is another strategy option.

- **Disability management linkage.** In those cases where a non-work disability has occurred, it is also possible to integrate wellness activities into the intervention activity with the employee. This is best structured on a case-by-case basis with a standard assessment process, which can help determine the appropriateness of wellness program staff intervention.
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- **Tobacco use and purchase limitations.** Another potential wellness linkage is the curtailment of tobacco sales at the worksite and the control of smoking. It is now much more common to have a smoke-free policy for all facilities and vehicles used in the course of the workday.

- **Job qualifications and promotion considerations.** General qualifications related to an applicant’s fitness to perform specific tasks can be required for particular employment positions. A related issue is the fitness level needed for the exercise of specific jobs that are involved in a promotion. The implementation of the Americans with Disabilities Act has influenced the degree to which employers can use fitness and health issues in determining employment or promotion potential. Even the inclusion of a requirement for a general level of fitness commensurate with the needs of a position would provide some visibility to the wellness issues, without creating an excessive obstacle to promotion.

- **Open enrollment meetings.** Provide opportunities for wellness as part of open enrollment meetings for employees. Use of medical self-care training and distribution of materials, consumer health information, tips on wise benefit use, introduction to an introduction of wellness program activities can all be included in these sessions.

- **Wellness activities in meetings.** Have meetings incorporate health issues, such as non-caffeinated and diet drinks, resiliency education, fruit juices, fresh fruit, stretch breaks at intervals, use of mental and social ice-breakers, emphasis on partnership processes rather than hierarchical control, physical activity or movement breaks, nutritious meal options, non-alcoholic options at social events, group walking events, and access to sports and athletic facilities at meeting sites.

These are just a few of the ways in which wellness can be more fully integrated into an employer’s organizational culture.

### #15. How do we reach retirees with wellness?

Retirees constitute an important group for targeting by worksite wellness programs. The number of Americans over age 65 will grow to 17.7% by the year 2015; they made up 12.7% of our population in 1985. The vast majority of this group are retirees. This group constitutes a major economic and political constituency in our population, and they represent particular types of programming needs.

There are also some important dynamics which bring retirees into the focus of employers. Beginning in 1993, the Financial Accounting Standards Board (FASB) required that independent audits of corporations would need to estimate the potential post-employment medical benefit liability that a company has to its retirees and their spouses.

This additional liability on the books is substantial, and the change in accounting conventions can have serious consequences for the affected business organizations. The original exposure draft for this particular policy position created a great deal of concern among business leaders. For those companies that have made a commitment to retirees through post-retirement medical benefit coverage, this proposed change in accounting practices has had a significant impact. Because of this,
organizations with retiree medical benefit coverage need to engage in much more aggressive wellness program activities and increased efforts to manage the health and health costs of retirees and their dependents. Governmental agencies now have similar requirements on their accounting and financial reporting procedures. These two requirements are included in statements FASB 106 (Post-retirement medical benefit coverage), FASB 112 (Post-employment but not retirement non-pension liability) and GASB 45 which parallels the FASB statements. If private and public employers can keep retirees more healthy they can reduce the liability associated with post-retirement medical benefit coverage. The same issue applies for disability insurance costs (Short Term Disability and Long Term Disability).

Retirees represent a unique set of challenges for wellness programs. One challenge is created when company retirees move to distant locations, such as the sun belt areas of the country. However, those who have moved away can be kept informed and encouraged about wellness through virtual interventions using mail, phone and computer email. Retirees who remain where employers are located can be reached directly by virtual methods and site-based wellness program staff.

Another challenge associated with retiree programming is incorporating sensitivity to the usual physical effects of aging and the unique health and medical self-care need of seniors. Also important is the distinction between the physically active retirees and the relatively inactive retiree. Research shows that once significant health problems are encountered, retirees begin to be less physically active. As chronic conditions worsen, it is likely that physical and social activity will diminish further creating a downward spiral in health status.

An additional challenge with serving retirees is that their medical costs are usually limited for the employer once Medicare coverage comes into effect. This acts to remove some of the potential economic incentive that employers have to invest in wellness for their retiree population. The availability of CDHPs are likely to modify this situation in the years ahead.

However, while retiree programming presents unique challenges, there are also some real advantages in reaching retirees with wellness programming. For one thing, most retirees are highly motivated to maintain their health, and as such are usually interested in practical information which can lead to a healthier lifestyle. Retirees frequently face the early appearance of chronic conditions and disability, which brings increased medical attention and advice to improve their diet, lose weight, become more physically active, monitor blood pressure, and advice concerning other health practices. Often, retirees experience a fear of some possible underlying malady, such as cancer, heart disease, or memory loss potentially associated with Alzheimer’s disease. These fears tend to make retirees much more health conscious and particularly receptive candidates for health and wellness programs.

In programming for retirees, it is also important to recognize that as a group they tend to be high users of medical care, sometimes for social as well as for strictly clinical reasons. Therefore, there is considerable potential to introduce medical self-care programs and consumer education programs for the retiree population, and then to produce a significant impact on health care costs of retirees.

There are a number of strategies that can help employee wellness programs more effectively meet the needs of your retiree group. These strategies include:

- **Communicate through a newsletter.** There are several good commercial wellness newsletters which are geared specifically to retiree groups and seniors in general. These sources can be used to provide periodic wellness, medical self-care, and consumer health.
messages. If the group has more than 10,000 members it may be cost effective to develop your own messages which can be added to the commercial material. If your retiree group is large, say, greater than 30,000, it may make more sense to develop your own specialized wellness newsletter for retirees. The newsletter should contain topical content and practical suggestions, all geared to a retiree’s lifestyle. These newsletters should be sent to the retiree’s home. Make sure that any seasonal move away from winter climates has an alternative address in the email list database.

- **Expand employee programming.** Another strategy is to look for opportunities to expand employee programming so that retirees and their spouses can participate. This has some additional beneficial effects in reinforcing social relationships and providing social support for behavior change. By including retirees and their spouses, it also sends a message that the company cares about employees beyond the time of their employment. Realistically the first priority for participation has to be with full-time, permanent employees, but retirees can frequently be added without adversely affecting the availability of programming and participation of employees. Medical self-care and consumerism workshops are a particularly beneficial activity for retirees.

- **Welcome the involvement of spouses of retirees.** Also important is a consistent policy supporting inclusion of spouses of retirees. By encouraging their involvement, you are likely to increase the number of retired employees who participate. If program notices can be sent with wellness newsletters so that the chances of spouses seeing them in advance of the session are increased, it is likely that more retirees and their spouses will attend. Screening programs are usually attractive to retirees and spouses. State that spouses are welcome. This needs to be done consistently in order to develop a general perception of the appropriateness of spousal involvement among retiree couples. Be certain to include surviving spouses and single or widowed retirees. The broader approach to inclusion of spouses is a positive development and should strengthen the program and its impact.

- **Make it a social event.** In designing wellness activities for retirees, it is important to create a social event along with the specific program activity. Usually the provision of refreshments and some relaxed time before, during, or after the programs, will provide this social opportunity. It is likely that retirees will know each other to some degree, and by providing opportunities to renew friendships, it is possible to add an attractive aspect to your wellness program. Nutritional potlucks or food demonstrations can also be used to structure a social event. If retirees are not active socially on their own, this type of event will help meet some of their social needs.

- **Address age-related matters.** When selecting the content of programs, be sure to address issues which are relevant to retirees. Concerns include chronic digestive disease, low-budget food preparation, cooking tips for one-or two-person families, consumer tips to save on health care expenses, prevention of osteoporosis, sleep disorders, stress reduction tips for more sedentary individuals, walking activities, vitamin supplements for the aged, cancer prevention diets, adapting to weather changes, control of incontinence and others. The perspective should include a sensitivity to the unique physical, emotional, and psychological characteristics of retirees. Do not encourage the perpetuation of Traditional Wellness assumptions about retirees. For example, regular
physical activity should become a part of the expected norms for retiree behavior, rather than reinforcing an expectation that retirees are expected to be less active.

- **Emphasize medical self-care.** One of the primary concerns of the retiree is contending with some of the routine chronic conditions that are an all-too-familiar adjunct of aging. According to findings from the National Health Survey, conducted annually by the National Center for Health Statistics in Hyattsville, MD, the average 65-year-old has more than ten self-limiting chronic conditions that periodically flare up and become symptomatic. Because of the significant concern for health and the need for symptomatic relief, medical self-care programs are usually of great interest, particularly when a medical self-care text and case vignettes designed for the retiree are used. These programs can also include consumer health topics such as tips for shopping for prescription drugs, vision appliances, durable medical goods, dental care, and podiatric care. Instruction in the understanding of Medicare rules and regulations can also be included. These programs are designed to help retirees become wiser health consumers and can therefore be an important adjunct to your post retirement health plan coverage.

- **Use surveys to communicate with retirees.** One way of conveying a sense of inclusion and value is to use survey instruments on health care and wellness-related issues. Develop an annual retiree wellness survey that asks questions about selected health risk behavior and interest in program options and wellness-related informational topics. Another approach for large retiree populations is to use an instrument with retirees that elicits opinions about various hospitals, clinics, and doctors in order to provide a ranking of health care providers by satisfaction levels. This type of information is likely to be highly valued by retirees, and by asking their opinions you are acknowledging their value. The results of these surveys should be distributed within four to six weeks from the return date of the survey. By using the same basic HRA type survey each year, and by receiving a statistically significant sample size, you can draw conclusions about changes in health risk behavior and risk factors among the respondents.

- **Encourage support groups for specific areas.** You can help meet the support needs of retirees by providing general guidelines on how support groups should function, and by organizing such groups around areas of mutual concern. The types of groups could include spousal care, weight management, hypertension control, coping with the loss of a spouse, and others. These support groups, if they function effectively, can meet a particular area of need in retirees and contribute to some long-term behavioral changes. These groups can be launched periodically and left to go on their own course.

- **Conduct screening that is age- and risk-specific for retirees.** When designing biometric testing, use tests and procedures that are relevant for retirees. The recommendations contained in the publication “Guide to Clinical Preventive Services Fourth Edition,” should be used to help structure the testing or screening protocols. This publication, which is the formal report of the U.S. Preventive Health Services Task Force, and is under a continuous process of revision can be found at http://www.uspreventiveservicestaskforce.org/recommendations.htm. The report is a valuable resource for designing screening programs for all age groups. Norms for rating performance will need to reflect age and physical condition. Some of the tests check cholesterol level, high-density and low-density lipoprotein amounts, percent body fat,
blood sugar and screenings for colon-rectal cancer, prostate cancer, hearing loss, and vision impairment, to name a few.

- **Communicate the value of making changes to retirees.** There is often a general sense that it is “too late” to get personal benefit from wellness-oriented activities by the time individuals are in retirement. This is clearly not correct. By communicating research findings, recommendations, and examples of successful change by retirees, it is possible to counter these general beliefs, which are obstacles for retiree behavior changes. Show the value of change and reinforce the issues periodically to encourage retirees making behavior changes. Challenge those self-defeating clichés, such as “old dogs can’t learn new tricks,” before they drain potential motivation and enthusiasm for change. The area of “Compression of Morbidity” in the clinical research literature provides great hope for the senior who wants to engage in wellness and get the health benefits for themselves.

- **Enlist retirees as volunteers in implementing the program.** By encouraging retirees to participate as volunteers in helping implement activities, it is possible to get them involved and help them become participants. For example, if you plan to hold a walking event and need some route monitors, enlist some retirees.

- **Support advocacy efforts for retirees and seniors.** By actively supporting advocacy and service programs that are targeted to the needs of seniors and retirees, you can strengthen the relationship between retirees and the company – particularly if the advocacy groups are concerned about health-related issues. Informational meetings can be piggybacked onto wellness program activities.

- **Provide a problem-solving perspective for retiree programs.** Try to identify prevalent, common problems experienced by retirees, and address the problems with helpful hints. Adopt a problem-solving perspective in your communication and programming to enhance the value and acceptability of your overall wellness efforts. For example, if retirees are confused about how your retiree medical plan works with Medicare, provide an informational meeting or online Learning Management System (LMS) module to cover the issues. If retirees are concerned about addressing long-term care needs, provide an informational series on long-term care plans, use of health savings accounts, selection of a nursing home, or common problems in nursing homes.

- **Provide personalized feedback and communication to retirees.** Where possible, personalize the feedback and contact with retirees. Using first names in periodic contact will help program acceptance and effectiveness over time, as relationships are established and nurtured.

- **Use materials and programs from senior citizen organizations.** The American Association of Retired Persons (AARP) has a variety of consumer health and wellness-oriented resources that can be distributed to retirees. Area agencies on aging are also resources for materials and for programming alternatives. Contact AARP at www.aarp.org/ and visit their health and wellness portal.

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• **Adopt incentives for healthy lifestyle choices for retirees.** Possibilities for incentives might include a premium discount for their health plan for participation in completing HRAs, health assessments or screening programs. Another option would be to include retirees in an incentive gainsharing program where they share in lower-than-expected health plan costs and have an opportunity to quality for additional wellness bonus points. The use of incentives is a method of choice, particularly for retirees who have moved to other areas of the country. Use of incentives such as these are important in addressing the needs of retirees.

These are just a few of the ways you can more effectively reach your retiree population.

**#16. How should worksite wellness be integrated with managed care?**

Managed care has lost most of its national momentum, but it still represents a positive force for adding some discipline to the health care market place. As such, it is appropriate for employer wellness activities to be integrated with the health management activity of managed care vendors. The following are some of the ways this can be accomplished:

• **First, establish an on-going dialogue with your providers.** This may be in the form of a periodic letter, distribution of your program materials and calendar, creation of a special joint newsletter, piggy-backing your message onto medical education events, providing education materials to physicians for use with your enrollees, and/or providing a clear message about the intentions and objectives of the program.

• **Address confidentiality issue.** This issue is important to all parties and a release or consent form signed by the patient for health information on an individual from a provider is probably a prudent measure. Sensitive information should probably be identified by category and excluded from any sharing of information through a Business Associate agreement under HIPAA.

• **Determine what information should be shared.** Discussion will be needed to help clarify what information will be shared between employer's wellness staff and the managed care vendor’s staff. Some of the possible types of aggregate and/or individual information that could be shared under a Business Associate agreement includes the following:

  From the worksite wellness effort to the health care providers:
  ◆ share HRA data.
  ◆ share results of other feedback instruments completed by employees.
  ◆ share results of intervention and telephonic counseling advice.
  ◆ share attendance at program activity.
  ◆ share information about achievement of any wellness incentives.
  ◆ share profile of primary prevention risks.
  ◆ share clinical standards regarding risk definitions and levels.
  ◆ share secondary prevention screening results.
  ◆ share selected information about occupational health risks.
  ◆ share about availability of programming.
  ◆ share process and results of any proactive high risk intervention.
From the primary care practitioner or managed care organization to the worksite wellness staff:
- share major prevention advice given to individual.
- share information on special modification of risk intervention attached to unique characteristics of the individual.
- share information on prevention protocols used by the managed care provider.
- share information on prevention resources and intervention capability.

- **Gain selected agreements from the managed care primary care physician.** There are a variety of areas of potential agreement from managed care vendors that would be of substantial value in helping individual employees and/or spouses attain improved health. These areas of agreement are as follows:
  - Agree to utilize common clinical standards regarding risk definitions and levels.
  - Agree to address key health risks through lifestyle modification.
  - Agree to utilize pharmaceutical intervention after appropriate lifestyle intervention.
  - Agree to provide incentive information affecting the individual.
  - Agree to counsel the individual patient in a supportive manner to the prevention approach used within your worksite-based program.
  - Agree to refer to worksite program activities when possible.
  - Agree to emphasize the importance of prevention with the patient.
  - Agree to recommend use of worksite-based screening opportunities when available.
  - Agree to use similar screening methods where appropriate.
  - Agree to support a behavioral management perspective in the provision of information about primary risk factors. (Primary prevention)
  - Agree to utilize national guidelines in developing a clinical preventive screening plan for each individual. (Secondary prevention)
  - Agree to support the provision of tertiary prevention materials to those with selected diseases or conditions. (Tertiary prevention)
  - Agree to provide documentation that the patient/employee is “current” on all preventive screening.

- **The employer can provide encouragement and or incentives for participation and successful completion of prevention activities conducted by managed care vendors.** This function should serve to increase use and efficiencies of provider-sponsored or provider delivered primary, secondary and tertiary prevention activities.

- **A core set of prevention activities can be developed by the employers as part of the bid specifications provided to managed care vendors.** Vendors would be able to exceed the specifications, but would be required to meet a minimum set of primary, secondary, and tertiary prevention specifications.

- **Finally, both the employer and the managed care vendor can cooperate in the integration of primary, secondary, and tertiary prevention.** If the managed care vendor does not take the lead in integrating primary, secondary, and tertiary prevention for the individual patient/employee and for their family members, then the
vendor should support the intervention conducted by an additional outside vendor or by the employer’s staff.

These are just a few of the possible ways in which worksite-based prevention programs can work more closely with managed care vendors to enhance the effectiveness of worksite-based health improvement efforts.
V. SUMMARY AND CONCLUSION

This publication is intended to be a reasonably thorough guide for the planning and development of an employee or corporate wellness program. Many issues are of general concern to all program development efforts. Conversely, unique considerations also derive from the characteristics associated with a specific employer and work group. This publication is intended to be a useful tool in the identification of those generic issues, as well as a catalyst for asking valuable planning questions that may uncover the more unique considerations that should help influence your planning and development choices.

Readers are encouraged to consult the Appendices that follow for more useful ideas, examples, and information. Again, best wishes for a successful process of planning a wellness program for your organization.
VI. APPENDICES

The Appendices include:

A Glossary of Terms
B Bibliography on the Design of Employee Wellness Programs
C Draft Health Wellness Planning Worksheet
D Draft Program Launch Memo or Email
E Sample Wellness Program Names, Themes, and Logo Ideas
F Sample Employee Wellness Interest Survey
G National Resources for Worksite Wellness
H Finding Valuable Web Resources for Wellness
I Bibliography of Evaluation Articles on Worksite Wellness
J Technical Specifications for Health Risk Assessments (HRAs)
Appendix A - Glossary Of Worksite Wellness Terms

The following terms, and their respective definitions, are important in the development, implementation and evaluation of employee wellness programs.

**Action**
The stage of readiness to change from the Transtheoretical Model of behavior developed primarily by James Prochaska PhD, that involves directly engaging in a particular behavior change, but is usually limited to having performed the behavior under six months of continuous activity. One of five major stages of change in the Transtheoretical Model. Please see Stage Theory or Transtheoretical Model.

**Adherence**
To continue to maintain a consistent position toward a specific behavioral activity. Usually the term is used to define a consistent engagement in a specific behavioral activity, such as continuing the use of stress management practices, or maintaining a nonsmoking status with the passage of time.

**Antecedents**
Anything that comes before or precedes something else. Usually used to connote the lifestyle behaviors that predispose the individual to specific diseases or injuries.

**Asymptomatic**
Showing or causing no symptoms. Usually the term is applied to clinical disease conditions that do not evidence any symptoms that are observable by the individual, but may sometimes be identified by a health care professional. Asymptomatic disease found in screening activities that can be treated, resulting in an improved patient care outcome, is generally desirable as an objective of secondary prevention.

**At-Risk Intervention**
The series of activities that are undertaken to help an individual address a specific health risk factor and to reduce the associated risk connected with their risk status. The typical interventions used with those who are “at-risk” are special mailings, outbound telephone contacts, relational programming, incentives and special program offerings.

**Behavior Modification**
A school of thought in psychology that emphasizes patterns of human behavior and attempts to use a variety of techniques and approaches to influence specific behavioral activities of individuals.

**Blood Pressure**
The pressure exerted on the walls of arteries and veins through the on-going function of the cardiovascular system. Blood pressure is usually measured in terms of the diastolic and systolic pressures in millimeters of mercury (mm of Hg) at sea level.
**Body Mass Index**

The most common measurement used to reflect obesity is Body Mass Index (BMI). BMI has been adopted primarily because of its ease of use when compared with the range of methods used for determining percent body fat, but one of its key weaknesses is that it fails to differentiate between lean body mass and body mass consisting of fat. The metric formula is weight in kilograms divided by height in meters squared. The non-metric version of the formula is 703 times weight in pounds divided by height in inches squared.

**Cardiovascular**

Pertaining to the heart and blood vessels. Often this term also commonly relates to the interaction of the blood within the lungs and is then more accurately described as cardiopulmonary.

**Cholesterol**

A crystalline fatty alcohol found in animal fats, blood, nerve tissue, and bile that is a major factor in the development of atherosclerosis. The fractionalization of cholesterol provides various blood lipid components such as High Density Lipoproteins (HDL), Low Density Lipoproteins (LDL), and triglycerides. These lipid fractions have various roles in the development and reversal of atherosclerotic heart and vessel disease.

**Chronological Age**

The actual age of an individual in years and months. The term is usually used in older mortality-based Health Risk Assessment (HRA) instruments and is compared with the individual’s Health Age based on the risks associated with a specific set of lifestyle choices.

**Clinical Disease**

A disease condition that can be detected by actual observation of a clinician. This term is usually used as a counter to an asymptomatic disease, usually not detectable by a clinician in a normal clinical contact with a patient, without the application of a specific biometric screening test. These types of conditions are often detectable by a clinician in his/her office setting and are one of the prime reasons for preventive clinical visits.

**Condition**

A health characteristic that is a departure from a state of physical or mental well being. Conditions are usually divided into two categories: acute, having a duration of less than three months; or chronic, having a duration of longer than three months, and typically requiring medical attention and restricted activity.

**Consumer Health**

The activity and actions surrounding the receipt of health care services by the patient. The term usually relates to the role of the consumer in the purchasing of health-related goods and services. The development of consumer health skills is the focus of consumer health education. Consumer health training is the activity that is used to help develop consumer health skills of participants.
**Consumer Driven Health Plan (CDHP)**
A type of health plan that has a high deductible, a personal health care account that is managed by the consumer and the remainder is carried over if not used during the benefit year combined with 100% coverage for preventive care. The personal health care accounts can either be a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA).

**Compression of Morbidity**
The compression of morbidity in public health is a hypothesis put forth by James Fries, professor of medicine at Stanford University School of Medicine. The hypothesis was confirmed by a 1998 study of 1700 University of Pennsylvania alumni over a period of 20 years. Fries’ hypothesis is that the burden of lifetime illness may be compressed into a shorter period before the time of death, if the age of onset of the first chronic infirmity can be postponed. This hypothesis contrasts to the view that as the age of countries’ populations tends to increase over time, they will become increasingly infirm and consume an ever-larger proportion of the national budget in healthcare costs.

**Contemplator**
The stage of readiness to change from the Transtheoretical Model of behavior that involves thinking about or considering a proposed behavior change but without a conscious choice being made to change. One of five major stages of change. Please see Stage Theory or Transtheoretical Model.

**Cost-Benefit Analysis**
The formal evaluation of the derivable economic costs of an activity when compared with the derivable economic benefits of the activity. The analysis uses an evaluation methodology that attempts to determine the net economic benefit to be derived from an activity or activities. A cost benefit ratio is the numerical integer consisting of the ratio of the direct and/or indirect costs divided by the direct and/or indirect benefits. A cost benefit ratio that is greater than 1.0 means that more benefit is derived than the economic costs of conducting the activity. A typical cost benefit ratio is reported as 1:3.0 meaning one dollar of cost to three dollars of benefit. This is the equivalent of a 300% Return-on-investment (ROI).

**Culture**
The collection of ideas, customs, beliefs, norms and values that guide behavior and thought in a particular group at a particular point in time.

**Demand Management**
The collection of activities, strategies, and actions that are designed to improve the way people utilize health care services.

**Diastolic Pressure**
That element of blood pressure that represents the pressure on the walls of arteries when the heart is dilated or at rest, rather than in a contracted state. This means that the diastolic pressure will always be lower than the systolic pressure.
**Disability**
Any temporary or long-term limitation of a person's activity to function as a result of an acute or chronic condition. Frequently measured in terms of the number of days that a person's activity has been reduced or impaired.

**Disincentive**
An anticipated negative reward designed to influence the behavior and/or performance of an individual or group. Commonly referred to as a “stick.”

**EAP**
Employee Assistance Program (EAP) is an organized program or service offered to an employee and/or their family member in order to help them resolve a difficulty. Typical types of problems that are addressed are alcohol and drug abuse, divorce recovery, child discipline problems, vocational conflict, legal problems and/or financial difficulties. EAPs are usually information referral or brief intervention oriented programs run by individuals with counseling backgrounds who either interact with people on a face to face basis or by phone. They may be internal staff or external vendor staff.

**Epidemiology**
The scientific discipline that deals with the incidence, prevalence, and etiologic factors associated with disease and injury.

**Etiology**
The science of the causes and origins of diseases and injuries. One of the principle concerns of epidemiology.

**FASB**
Financial Account Standards Board is the organization that is responsible for the development of the standards and conventions to be used in the financial management and accounting functions of the American economy. Several statements or standards issued by this group affect the estimation and treatment of medical cost among retirees and others.

**Fitness**
The condition of being fit and able to function. The term is usually used in relation to physical fitness, but its general use has expanded to define other dimensions of human functionality.

**GASB**
Government Accounting Standards Board is the organization that is responsible for the development of the standards and conventions to be used in the financial management and accounting functions of governmental organizations in the U.S. Several statements or standards issued by this group affect the estimation and treatment of medical cost among retirees and others.
### HDL
High Density Lipoprotein is the portion of cholesterol that has a relatively high molecular weight. Its role in the body is not fully understood, but it is associated with the removal and transport of other fractions of blood lipids. The ratio of HDL to total cholesterol is referred to as the HDL ratio. An HDL ratio of 4.4 or lower is generally perceived as beneficial in the prevention of atherosclerosis.

### Health Age
The estimated age of the individual in years and months, based on an analysis of the individual's specific lifestyle related risks when compared to mortality and morbidity information from large numbers of people. The term is usually used in contrast with chronological age in the processing of older mortality-based Health Risk Assessment (HRA) instruments.

### Health Cost Management
The process of analyzing and modifying characteristics of the work place and health plan design to manage the broad range of health-related costs associated with an employee work force. These costs include such things as employee health benefit costs, disability costs, worker's compensation costs, occupational health costs, supplemental insurance costs, early medical retirement costs, life insurance costs, sick leave absenteeism, presenteeism and costs associated with health risks and health-related actions of employees.

### Health Management
The field of endeavor that deals with the strategies, technology and methods of primary, secondary, and tertiary prevention including the nature and structure of incentives that affect health care use.

### Health Plan Design
The characteristics of health insurance coverage that include eligibility, scope of services, cost sharing features, administrative features, provider limitations, and exclusions and limitations. Generally, health plan design has significant effects on the utilization and cost of health insurance coverage.

### Health Promotion
Health promotion is the science and art of helping people change their lifestyle to move toward a state of optimal health. Optimal health is defined as a balance of physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be facilitated through a combination of efforts to enhance awareness, change behavior and create environments that support good health practices.

### Health and Productivity Management
The integrated management of health risks, chronic illness, and disability to reduce employees' total health-related costs including direct medical expenditures, unnecessary absence from work, and lost performance at work (i.e., presenteeism).
**Health Promotion Program**
An organized program intended to assist employees and their family members in making voluntary behavior changes that reduce health risks and enhance their individual productivity while contributing to the maximum enhancement of their physical, mental, and spiritual health.

**Health Risk Assessment**
Health Risk Assessments (HRAs) are a class of paper and pencil instruments, or web-based surveys that are computer processed, that can provide a quantitative reflection of the relative risk of disease, injury, or death associated with a specific set of lifestyle behaviors when combined with other specific information about the individual involved. Most of the early HRAs provide a mortality-based comparison between the individual's chronological age, health age, and achievable health age. The newer HRAs generally provide an Overall Wellness Score (OWS) that reflects the morbidity risks associated with the behavior and health conditions of the individual.

**Health Reimbursement Arrangements**
The use of a Section 105 medical reimbursement plan under the Internal Revenue Code that can be used as the personal health care account for Consumer Driven Health Plans (CDHP). These accounts have different characteristics than Health Savings Accounts (HSA) but both can be used in CDHPs.

**Health Risk Factors**
Those specific behaviors, activities, or conditions that place the individual at increased risk of specific disease conditions or injury when compared to the average individual in the same age and gender cohort in the population.

**High Risk Intervention**
The series of activities that are undertaken to help an individual address one or more high-risk factors and to reduce the associated risk connected with their risk status. The typical interventions used with high risk are special mailings, outbound telephone contacts, relational programming, incentives and special program offerings.

**Health Savings Accounts**
The newest form of tax advantaged benefit savings vehicle that allows those individuals and families covered by a qualified High Deductible Health Plan (HDHP) to put aside contributions that can be used for qualified medical expenses under federal plan minimum provisions. These accounts are used in CDHPs and are funded and transferrable to heirs.
**High Risk**

An individual whose combination of lifestyle and health risks exceeds the average health risks for an individual who is the same gender and age. A single high risk factor or a combination of several high risk factors can create a higher risk of probability of disease, injury, or death. An individual can also be considered as high risk if he or she has a health risk that is extremely high. For example, someone with a total serum cholesterol of 475 mg dl could be considered high risk. In addition someone with an Overall Wellness Score under 80 (on a scale of 1 to 100) may be considered “high risk.” There are no standard definitions of ‘high risk.’

**Holistic**

The tendency to deal with the “whole” rather than with their parts or sub-components. Also considered as a non-medical approach to wellness with a much stronger emphasis on psychosocial factors of health.

**Hypertension**

The abnormal elevation of blood pressure, particularly with electrocardiographic evidence of cardio arterial derangement. The National Heart Lung & Blood Institute (NHLBI) indicates that a “high risk blood” pressure level is above 140 mm Hg systolic blood pressure and/or 95 mm Hg diastolic blood pressure observed on three separate occasions. Hypertension is a primary risk factor for atherosclerotic heart and vessel disease and stroke.

**Incentive**

An anticipated positive reward designed to influence the behavior and/or performance of an individual or group. Commonly referred to as a “carrot.”

**Incidence**

The number of new cases of disease or injury having their onset during a prescribed period of time (usually a year period). Incidence is a measure of frequency of morbidity or other health related events that occurred within a specified period of time.

**Integrated Health Management**

The way in which an employer brings the wide variety of worksite activities such as safety, disability management, workers compensation, ergonomics, health benefits, fitness, wellness, occupational health services, training, etc., into congruence so that the health of the population is significantly enhanced. It is also sometimes referred to as “Health and Productivity Management.”

**Lifestyle**

The consistent, integrated way of life of an individual as typified by his/her manner, attitudes, and behavior. This term is usually applied to a wide range of health related behaviors, often associated with specific health risk factors in the field of wellness.

**Life Expectancy**

The average number of years of life remaining for a person at a particular age, based on a given set of age-specific death rates for the mortality conditions existing in the period mentioned and the in the population cohort to which the individual belongs.
**Lipids**

A group of biologic substances, including the fats and esters, having analogous properties. Blood lipids are involved in a large number of critical biochemical functions and are important in the etiology and prevention of atherosclerotic heart disease. The body’s inflammatory process has been implicated as the other major factor in atherosclerotic heart disease.

**Low Risk**

An individual whose combination of lifestyle and health risks are below the average for a individual who is of the same gender and age. The absence of a combination of health risk factors can create a low risk for selected disease, injury, or death.

**Maintenance**

The stage of readiness to change from the Transtheoretical Model of behavior that involves having engaged in a particular behavior continuously for more than six months. One of five major stages of change. Please see Stage Theory or Transtheoretical Model for more information.

**Medical Self-Care**

The process of using selected clinical and medical information to make appropriate decisions concerning the identification of common medical conditions and their preferred home treatment regimens. Also included is the use of medically and technically sound information to determine when to seek medical attention for selected symptoms and conditions.

**Moderate Risk Level**

An individual whose combination of lifestyle and health risks are about average for a individual who is the same gender and age.

**Norm**

A standard, model, or pattern of behavior or expectation for a group. In the cultural use of the term, it relates to the expected pattern of behavior condoned or positively supported by a group. In the clinical sense of the word, it represents a standard against which other things are compared.

**Overall Wellness Score (OWS)**

The index score that reflects the level of wellness of the individual completing an HRA. This score is usually between 1 and 100.

**Percent Body Fat**

The percent, by weight, of fat in the human body. It is a general test of obesity and physical fitness. The measurement of percent body fat is frequently used in fitness assessments and can be determined by one of several different methods.

**Results-Driven Wellness**

Results-Driven Wellness (R-DW) is a field of endeavor which intentionally and proactively utilizes a variety of individual, organizational and cultural interventions to help improve the morbidity patterns (i.e., the illness and injury burden), health status and the health care use behavior of defined populations.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation</td>
<td>The stage of readiness to change from the Transtheoretical Model of behavior where the individual is neither engaging in the particular behavior or even considering engaging in it. One of five major stages of change. Please see Stage Theory or Transtheoretical Model.</td>
</tr>
<tr>
<td>Precursors</td>
<td>An event or condition that goes before or in advance of another. The term is used in examining the clinical or lifestyle behaviors and habits that go before clinical disease or other medical conditions.</td>
</tr>
<tr>
<td>Preparation</td>
<td>The stage of readiness to change from the Transtheoretical Model of behavior that involves actively planning to engage in a new behavior within 30 days. One of five major stages of change. Please see Stage Theory or Transtheoretical Model.</td>
</tr>
<tr>
<td>Primary Prevention</td>
<td>That category of preventive health activity that is designed to reduce the occurrence of precursors or risk factors that are associated with disease conditions or injuries. Examples of primary prevention activities are smoking cessation classes, weight management programs, physical activity programs, and incentives for seat belt use.</td>
</tr>
<tr>
<td>Presenteeism</td>
<td>The measurable extent to which health symptoms, conditions and diseases adversely affect the work productivity of individuals who choose to remain at work.</td>
</tr>
<tr>
<td>Prevalence</td>
<td>The number of new and existing cases of disease or injury having their onset during a prescribed period of time (usually a year period). Prevalence is a measure of frequency of morbidity or other health related events that occur within a specified period of time.</td>
</tr>
<tr>
<td>Preventive</td>
<td>To stop or keep something from happening. The term is used in the context of wellness, primarily to signify the nature of some action or actions that prevent an adverse health effect from occurring, or assures the attainment of a higher or more beneficial state of health for the individual.</td>
</tr>
<tr>
<td>Recidivism</td>
<td>The return to a former condition or behavior after the passage of time. A tendency to relapse, particularly used in the behavioral science literature concerning habitual criminal behavior. The term is most often associated with habitual drug and alcohol use, but is also used with selected wellness behaviors. Also known as relapse.</td>
</tr>
<tr>
<td>Relative Risk</td>
<td>The state of having a chance of injury or disease that is different than the standard of comparison. The term is usually used in the analysis of health risk conditions among individuals with similar age and gender characteristics. The term is also used frequently in the health risk assessment and medical literature.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td><strong>Resiliency</strong></td>
<td>The ability to maintain one’s physical, psychological and emotional balance in the midst of change and stressful life events; the ability to readily recover from adversity and/or life stress.</td>
</tr>
<tr>
<td><strong>Secondary Prevention</strong></td>
<td>That category of preventive health activity that is designed to detect disease conditions to insure that their early treatment will minimize adverse sequellae, or lead to clear improvements in health status. Examples of secondary prevention are blood pressure screening, cholesterol screening, blood sugar screening, and mammography.</td>
</tr>
<tr>
<td><strong>Screening</strong></td>
<td>Examination of individuals to disclose certain characteristics, or the presence of a certain condition, such as elevated cholesterol, elevated blood pressure, or abnormal levels of glucose in the blood. Screening is a major dimension of secondary prevention.</td>
</tr>
<tr>
<td><strong>Sentinel Feature</strong></td>
<td>The occurrence of a feature or a process characteristic that acts as an influence on the accuracy of an individual’s responses or claims. Individuals usually act differently if they know that someone is watching or knows what they are doing. Often used in structuring the completion process for HRAs and for wellness incentive programs to reduce self-report error or gaming.</td>
</tr>
<tr>
<td><strong>Serial Feedback</strong></td>
<td>The aspect of survey methodology that notifies participants in advance that the information they provide now will be reported back to them for the next 1-5 years. For example including instructions in the HRA that the individual’s OWS for this year will be provided to them in their future HRA reports for the next three years. This approach is considered a form of sentinel feature and has the effect of reducing self-report error.</td>
</tr>
<tr>
<td><strong>Sick Leave Absenteeism</strong></td>
<td>Time away from work due to a health related conditions of the individual involved or of their family member(s). Each organization or employer defines this type of occurrence in somewhat unique ways with unique policies.</td>
</tr>
<tr>
<td><strong>Smoking Cessation</strong></td>
<td>The ceasing or stopping, either forever or for some period of time, of the smoking of tobacco products. Most often applied to the termination of cigarette smoking. Smoking cessation can also be viewed as tobacco cessation, meaning the ending of use of all tobacco products such as smokable forms, &quot;chew,&quot; tobacco patches, and snuff.</td>
</tr>
</tbody>
</table>
Social Learning Theory  
A theoretical area of psychology that proposes a multi-factorial approach to the explanation of human behavior. Behavioral influences are grouped into constraining influences and promoting influences, and change in behavior is related back to shifts in these two groups of factors. Two of the major proponents of this concept are Kurt Lewin and Albert Bandura. This approach is sometimes utilized in the technology of behavior change within the wellness movement, but is being largely replaced by the “stages of change” or Transtheoretical Model of Behavior Change theory.

Somatization Disorder  
The clinical syndrome where selected individuals react with physical symptoms and conditions when they experience high levels of excess chronic stress. The National Institute of Mental Health found that about one quarter of all primary care visits in the U.S. are due to somatization or somatization disorder.

Stage Theory  
The popular term applied to a set of behavioral change principles technically referred to as the “Transtheoretical Model of Behavior Change”, developed primarily through the work of James Prochaska and Louis DiClemente. This promising viewpoint on behavior change involves the “staging” of individuals toward a specific health-related behavior. The assignment of one’s status of change to one of five defined “stages of readiness” or activity include pre-contemplation, contemplation, preparation, action, and maintenance. See the individual terms for additional information.

Stress Management  
The field of endeavor arising from the disciplines of psychology and physiology that seeks to provide methods for individuals to reduce or minimize their levels of excess personal stress. These techniques or strategies can be focused on the individual through skill transfer at specific training opportunities, or through an organizational focus that requires organizational interventions. Some of the types of individual stress reduction or stress management techniques commonly addressed include progressive relaxation techniques, change-of-pace strategies, use of quieting response, present moment thinking, biofeedback, and physical activity.

Stress  
Mental or physical strain or tension. The term is usually applied to the long-term adverse consequences of high levels of chronic excess stress. A prolonged elevated level of stress usually has a number of debilitating effects and is associated with a variety of clinical diseases and conditions.

Systolic Pressure  
That element of blood pressure that represents the pressure on the walls of arteries when the heart is maximally contracted, rather than in a relaxed or dilated state. This means that the diastolic pressure is always lower than the systolic pressure.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trantheoretical Model</strong></td>
<td>The formal model of behavior change that is also known as the “Stage Theory” model of behavior change. It involves a process of identifying the stage of readiness to change related to a specific health-related behavior. The intention is then to help the individual move from stage to stage until they have assimilated the desirable health behavior as a part of their everyday life, and have fully assimilated the behavior into their own concept of self. Please see Stage Theory for the five defined stages of readiness.</td>
</tr>
<tr>
<td><strong>Tertiary Prevention</strong></td>
<td>That category of preventive health activity that is designed to help those with a clinically confirmed disease, condition or diagnosis to more effectively and efficiently manage their condition or problem. This type of prevention is designed to reduce the adverse sequellae and to assure optimal health for those with a confirmed disease or condition. Examples of tertiary prevention are diabetes management, asthma management, high-risk pregnancy interventions, etc.</td>
</tr>
<tr>
<td><strong>Triglycerides</strong></td>
<td>A class of blood lipids and esters that are used in the diagnosis of a number of clinical conditions, particularly cardiovascular disease conditions. Triglycerides have to be fractionated separately to be able to derive HDL and LDL components of cholesterol.</td>
</tr>
<tr>
<td><strong>V0₂ Uptake</strong></td>
<td>The amount of oxygen that can be utilized by the body under controlled amounts and duration of physical work. The higher the amount of oxygen that can be used, the more efficient the cardiopulmonary system of the individual. V0₂ uptake is used as a general measure of an individual's aerobic fitness level.</td>
</tr>
<tr>
<td><strong>Virtual Wellness</strong></td>
<td>A form of wellness that feels complete and comprehensive to the individual, but does not require the extensive site-based Traditional Wellness infra-structure of programming. It generally relies on periodic computerized information collection, individualization of responses, mailings, phone-based coaching, selected pro-active interventions, and incentive technology.</td>
</tr>
<tr>
<td><strong>Weight Loss</strong></td>
<td>The temporary or sustained loss of body mass, usually identified as loss of pounds or kilograms of body weight. Weight loss or gain is often one of the personal health enhancement objectives of individuals involved in wellness programs.</td>
</tr>
<tr>
<td><strong>Wellness</strong></td>
<td>An intentional choice of a lifestyle characterized by personal responsibility, balance, and maximum enhancement of physical, mental, and spiritual health.</td>
</tr>
<tr>
<td><strong>Work Plan</strong></td>
<td>A formal plan for accomplishing a complex set of activities or actions. Work plans usually identify what actions are to be taken, when they will be taken, who will be responsible for completing them, and may include how much they will cost in terms of staff time and/or budget resources. The use of the term here is associated with the formal plan for implementing an employee health promotion or wellness program.</td>
</tr>
<tr>
<td><strong>Worksite</strong></td>
<td>A setting, influenced by organizational, cultural, and environmental factors where work is performed and employee services are provided.</td>
</tr>
<tr>
<td><strong>Worksite Wellness Program</strong></td>
<td>An organized program in the worksite that is intended to assist employees and their family members (and/or retirees) in making voluntary behavior changes which reduce their health and injury risks, improve their health consumer skills and enhance their individual productivity and well-being.</td>
</tr>
</tbody>
</table>
Appendix B - Bibliography on Employee Wellness Programs

The following articles and publications provide helpful information about the design of employee wellness programs.


Appendix C - Draft Wellness Program Planning Worksheet

This worksheet is to be used to help you plan and organize the various activities you are considering for your worksite wellness program. Place your proposed activities, their cost, and primary assignment of who will be responsible to complete the activity in the appropriate space below.

<table>
<thead>
<tr>
<th>Program Component</th>
<th>Proposed Activity</th>
<th>Estimated Cost</th>
<th>Assigned To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications &amp; Awareness</td>
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<tr>
<td>Health Management Process</td>
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<tr>
<td>Group Activities</td>
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<tr>
<td>Supportive Environment</td>
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</tbody>
</table>
Appendix D - Draft Program Launch Memo or Email

The following draft memo can be adapted to your own company circumstances.

To: All Employees
From: President and CEO

Like many companies, have been considering the possibility of starting a wellness program for all employees. Our reason for doing so includes our concern for the health and well-being of employees, as well as our concern about the escalating cost of our health benefit program. Based on the feedback received from the Employee Wellness Survey completed a short time ago, we are pleased to announce the formal start of our new wellness program on [Starting Date]. Our new wellness program is designed to help provide a healthful work environment and to support the adoption of healthy habits by employees who want to improve their own health and fitness levels.

The Program will be called [Program’s Name] and will become more fully developed with your input over the months and years ahead. For this coming year, the following major activities will be offered:

- A two hour mandatory wellness workshop for all employees and spouses.
- A wellness newsletter will be sent to each employee’s home.
- A confidential wellness survey will be offered next month.
- A more complete wellness assessment will be offered in the spring.
- A series of wellness classes will be offered to help employees stop smoking, lose weight, and handle their stress better.
- Some changes in policies, work facilities, food access, etc., will be made in order to make it easier to adopt healthy behaviors.
- A new wellness financial incentive program will be introduced in the fall.

The staff person who has been given responsibility for developing and managing this new program is [Name of Wellness Coordinator]. She/he will be working with an employee advisory committee to make sure the program addresses your needs. You will be hearing more about the specifics of the program in the weeks ahead. The details are available on our website.

Along with the rest of the executive team, I am personally excited about this new program, and I am very pleased that our organization is embarking on this new course. Please join with me in supporting this new program effort. Good health is an extremely valuable asset to all of us.
Appendix E - Sample Wellness Program Names, Themes, and Logo Ideas

There are a large number of possible names for employee wellness programs. If at all possible, a name that brings a health promotion or wellness focus and at the same time builds on, or plays off, of your organization's mission or nature is a good strategy. Possible program themes and logo options are identified below, along with possible program names. All employee wellness programs should adopt their own program name, program theme, and logo as part of the program development process. Many of the names in the following list have been used by various employers for their programs. Usually, local employers do not seek to trademark or register their program name or logo, but some employers who decide to market their programs nationally sometimes do just that. In those situations where you may be marketing products or services under the program’s name, you will need to be very careful in selecting names, themes, and logos.

POSSIBLE PROGRAM NAMES:

<table>
<thead>
<tr>
<th>A Healthier You</th>
<th>Health Awareness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advantage</td>
<td>Health Awareness: Full Life</td>
</tr>
<tr>
<td>Balance</td>
<td>Health Beat</td>
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<td>Be Well</td>
<td>Health Break</td>
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<tr>
<td>Be Well</td>
<td>Health Break</td>
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<tr>
<td>Better Health</td>
<td>Health Builders</td>
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<tr>
<td>CARE</td>
<td>Health Challenge</td>
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<tr>
<td>Choose Health</td>
<td>Health Cycle</td>
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<td>Come Alive</td>
<td>Health Designs</td>
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<tr>
<td>Discover Yourself</td>
<td>Health Equation</td>
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<tr>
<td>Energize</td>
<td>Health Habits</td>
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<tr>
<td>Energize</td>
<td>Health Hints</td>
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<tr>
<td>Esprit</td>
<td>Health Knack</td>
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<td>Excel</td>
<td>Health Line</td>
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<tr>
<td>Feel Fit</td>
<td>Health Line</td>
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<tr>
<td>Feeling Better</td>
<td>Health Matters</td>
</tr>
<tr>
<td>Feeling Fit</td>
<td>Health Notes</td>
</tr>
<tr>
<td>Feeling Good</td>
<td>Health Outlook</td>
</tr>
<tr>
<td>Feeling Good</td>
<td>Health Potentials</td>
</tr>
<tr>
<td>Feeling Well</td>
<td>Health Prospects</td>
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<tr>
<td>Fine Tune</td>
<td>Health Reach</td>
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<tr>
<td>Finishing Fit</td>
<td>Health Run</td>
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<tr>
<td>Fit-aware</td>
<td>Health Savers</td>
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<td>Fitness Factors</td>
<td>Health Sense</td>
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<td>Fitness Forefront</td>
<td>Health Spring</td>
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<tr>
<td>Fitness Fundamentals</td>
<td>Health Watch</td>
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<tr>
<td>For Your Health</td>
<td>Healthful Hints</td>
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<tr>
<td>Force of Living</td>
<td>Healthstyle</td>
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<tr>
<td>Full of Life</td>
<td>Healthwiser</td>
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<tr>
<td>Getting Fit</td>
<td>Healthy Choices</td>
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<tr>
<td>Good Health</td>
<td>Healthy Dynamics</td>
</tr>
<tr>
<td>Good Sense</td>
<td>Healthy Prospects</td>
</tr>
<tr>
<td>Health Access</td>
<td>HealthyTimes</td>
</tr>
<tr>
<td>Health Aspects</td>
<td>Here's to Health</td>
</tr>
</tbody>
</table>
How Well Are You? The Well Being
It's For You To Your Health
It's Your Life! Total Health
Life Balance Vital Signs
Life Styles Wealthy & Wise
Life Time Well Ahead
Life Well Well Ahead
Lifeline Well Aware
Lifelines Well Aware
Lifestyle Excellence Well Balance
Lifetime Well Being
Lifetime Health Well Challenge
Living Well Well Control
Living Well Well Cycle
Maxima Well Do It
Positive Dynamics Well Motion
Positive Health Well Spring
Positive Pulse Well Together
Positively Healthy Well Watch
Promote Health Well Winners
Revitalize WellCare
Share Health Well-Off
Sound Health Wellsome
Stay Well Aware Well-Time
Staying Well WellWays
Strive Whole Health
Taking Shape Whole Life Alive & Aware
Target Health Wise & Well
The Health Advantage Work N’ Well
The Time of Your Life

Remember, before you select a program name for a large corporate wellness program, make sure that the name you are considering is not federally trademarked or is held by proprietary interests. Usually, if you check with the Secretary of State, in your state, or the state official who is responsible for legally registering the names of corporations, you can find what names may have been registered by commercial firms. You can also do a trademark search to be sure.
POSSIBLE PROGRAM THEMES:

The following are some possible program tag lines or program themes that help communicate the program’s purpose and what employees will come to associate with the program. Again, pick your tag line carefully

- Be All That You Can
- Do It Well!
- Feel Well!
- Feels Good!
- Fit To Be Tied!
- For the Health of It
- For Your Health!
- Heads Up For Health
- Health Can Do It!
- Health Does Matter
- Healthy, Wealthy, and Wise
- Hooked on Health
- How Well Can You Be
- It’s for You!
- Prospects for Health!
- Stay Healthy
- Staying Well is Wise
- Take Charge of Your Health
- Take Time To Be Well
- The Time of Your Life
- To Your Health
- Well For Life!
- Well forever
- You Bet Your Life!
- Your Health Is Up To You
- You're In Charge

PROGRAM LOGO IDEAS:

Program logos are also an important decision because they become the symbol that represents the program to your employees. Some possible program logo ideas include:

- A rainbow with your organizational logo under it.
- Apple or apples with the organization initials
- People running
- Cartoon character in running shorts, etc.
- Heart shape with electrocardiogram wave
- Sun coming up
- Person standing with arms outstretched
- Lightening bolt
- Medical caduceus (Snake wrapped around a staff)
- Geometric symbol of major program components
Appendix F - Sample Employee Wellness Interest Survey

We are examining the possibility of developing an employee wellness program, and would like to learn about your interests in wellness and health related activities. Please take a few minutes to complete this survey. Please check those items that apply.

Tell Us About Yourself!

I. Male □ Female □

II. Age Group: (Please check the age group in that you belong.)

- Under 21 □
- 21-30 □
- 31-40 □
- 41-50 □
- 51-60 □
- 60+ □

III. Your worksite: ____________________________

IV. Your Department: ____________________________

Your Current Health Habits

The following questions are about your current health habits and interest in pursuing a healthier lifestyle.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Complete if appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>I would if:</td>
</tr>
</tbody>
</table>

1. I exercise vigorously for at least 20 minutes three or more days a week or moderately for 5 or more days a week for a minimum of 30 minutes

2. I regularly smoke cigarettes.

3. I am more than 20 lbs. over my ideal weight.

4. I avoid eating too much fat.

5. I practice some type of stress management on a regular basis.

6. I have had my blood pressure checked within the past year.

7. I wear a seat belt all the time when I am in a motor vehicle.

8. I have had a bout of low back pain in the last six months.

9. I have at least three drinks containing alcohol every day.
10. I usually consult a medical self-care book when I'm sick. □ Yes □ No I would if:

11. I make an effort to eat enough fiber from whole grains, cereals, fruits, and vegetables. □ Yes □ No I would if:

12. I eat breakfast every day. □ Yes □ No I would if:

13. If you could receive written information for three of the health topics listed below, which three would you select? (Check only four!)

- Tips for reducing cholesterol
- Information on AIDS
- Weight management techniques
- Starting a walking program
- Spiritual wellness
- Health effects of cocaine use
- Alcohol tips
- Asthma management
- Starting to exercise
- Avoiding sports injuries
- Stress reduction tips
- Nutritious cooking tips
- Medical self-care
- Dealing with your doctor
- Pre-menstrual tension tips
- Questions for your doctor
- Second-hand smoke
- Prevention of sexually transmitted disease
- Preventing carpal tunnel disorders
- Sleep disorders
- Recreational safety
- Eldercare issues
- Testicular exam for cancer
- Personal violence protection
- Dealing with depression
- Parenting tips
- Controlling high blood pressure
- Headache prevention
- Preventive dentistry
- Auto safety
- Back care
- Foot care
- VDT safety
- Home safety
- Vitamin facts
- Prescription drug tips
- Low salt tips
- Heart disease prevention
- Cancer detection/prevention
- Diabetes
- Hospitalization kit
- Smoking reduction tips
- Breast self-exam
- Men’s health
- Women’s health
- Use of Antioxidants
- PMS
- Health issues for shift workers
- Resiliency

14. Would you personally participate in a wellness program if we offered one? Yes □ No □

15. Would you participate in any of the following wellness activities on a regular basis if they were offered at work? (Check all those that apply.)

- Aerobic exercise classes
- Medical self-care training
- Weight management program
- Monthly Wellness seminar
- Confidential health screening
- Smoking cessation program
- Sports league activity
- Blood pressure screening
- Health fair
- Nutritional pot-luck
- Fitness or Wellness contest
- Blood test for cholesterol
- Walking event or club
- Workshop on self-esteem
- Parenting skills and support
- Join a support group
- Consumer health training session
- Complete a personal fitness contract
- Watch enjoyable movies during lunch
- Annual health management session
16. If you would like to volunteer to help with the program please write your name, phone number and any special interest you might have, in the space provided.

Name: __________________________________________

Work Unit: ________________________________________

Phone: ___________________________________________

Mail Stop or E-Mail Address: _______________________

Your wellness interests: ____________________________

__________________________________________________________________

17. Would you like a financial incentive to help motivate you to take better care of your own wellness? Yes ☐ No ☐ Comments:

18. Which of the following categories would you place yourself? (Please check only one!)

☐ I’m not interested in pursuing a healthy lifestyle.

☐ I have been thinking about changing some of my health behaviors.

☐ I am planning on making a health behavior change within the next 30 days.

☐ I have made some health behavior changes but I still have trouble following through.

☐ I have had a healthy lifestyle for years.

19. In the last six months, how many days have you been absent from work due to illnesses or injuries? _____

20. In the last six months, how many times have you visited the doctor? _____

21. In the last six months, how many days were you in the hospital as a patient? _____

22. Any additional comments or suggestions for a wellness program for employees?

Thanks for completing this survey!
Appendix G - National Resources for Worksite Wellness

The following are excellent resources for employers who are planning to provide a worksite wellness or health promotion program.

LOW COST INFORMATIONAL SOURCES

American Heart Association. Provides low cost or free resources on a wide variety of wellness topics. Call their local chapter or visit their website at http://www.heart.org/GettingHealthy/

National Business Group on Health. Call and ask for a catalog of their printed materials at 202-558-3000 or visit their website at www.businessgrouphealth.org/

National Health Information Center. Call and ask for their list of publications at (800) 336-4797 or visit their website at www.health.gov/nhic/ or http://www.healthfinder.gov/.

National Heart Lung & Blood Institute. Call and ask for their publications catalog at (301) 592-8573 or contact their website at www.nhlbi.nih.gov.

National Wellness Institute. Call for materials on membership and annual conference and to request their resource directory at (715) 342-2969 or (800) 243-8694 or visit their website at http://www.nationalwellness.org.

Wellness Councils of America. WELCOA. Call and ask for information on a local Wellness council in your area at (402) 827-3590 or visit their website at www.welcoa.org.

NEWSLETTERS & PERIODICALS:


Health Promotion Practitioner. A very practical monthly newsletter for health promotion professionals published by Health Enhancement Systems that also provide excellent short term incentive programs, visit their website at www.hesonline.com.


Medical Benefits, an excellent bi-weekly digest of health cost management, health benefits and selected wellness article abstracts published by , $439 yearly, visit their website at www.aspenpublishers.com.

EMPLOYEE EDUCATION RESOURCES
American Institute of Preventive Medicine. Specializes in medical self-care materials. Reach them at 30445 Northwestern Highway Suite 350, Farmington Hills, MI 48334 or call for information at (800) 345-2476 or (248) 539-1800 or visit their website at www.healthylife.com.

Krames Staywell. Publishes a large number of excellent paper, DVD and video resources on patient education, health promotion, safety, disease management, safety and wellness education resources. Request some samples and a catalog by calling (866)-249-7953 or visit their website at http://www.kramesstaywell.com.

Parlay International. Another excellent resource for reproducible materials covering a wide range of health promotion and wellness topics. Reach them at 712 Bancroft Road #505 Walnut Creek, CA 94598 or call for their catalog at (800)457-2752 or visit their website at http://www.parlay.com/.

Whole Person Associates, Inc. A rich set of materials and resources on stress and wellness. Reach them at 210 West Michigan St., Duluth, MN 55802 or call for their catalog at 1-800-247-6789 or 218-727-0500 or visit their website at www.wholeperson.com.

TRAINING OPPORTUNITIES

American Journal of Health Promotion Annual Conference (AJHP). Annual Conference and intensive workshops. A four-day annual conference usually held in the spring each year, and two-day intensive workshops held periodically. For information reach them at 1120 Chester Avenue, Suite 470,Cleveland, OH 44114-3514 or call (248) 682-0707 or visit their website at www.healthpromotionjournal.com.

Chapman Institute. Provides five levels of onsite and online certification for individuals that want to work in the worksite wellness field through the WellCert™ Program. Call (206) 364-3448 or visit their website at http://www.chapmaninstitute.net.

National Wellness Conference. Call National Wellness Institute for information at (715) 342-2969 or (800) 243-8694 or visit their website at http://www.nationalwellness.org, five day meeting is usually held in the third week of July each year. Offers a large number of presentations and topics.

Institute for Health and Productivity Management (IHPM) Provides a wide range of training opportunities, publications each year. Reach them at 17470 N. Pacesetter Way, Scottsdale, AZ 85255 Phone: (480)305-2100 or visit their website at www.ihpm.org.


VENDORS OF NATIONAL WELLNESS PROGRAMS

American Institute of Preventive Medicine (Southfield, MI). Specializes in train-the-trainer programs. Call for information at (800) 345-2476 or (248) 539-1800 or visit their website at http://www.healthylife.com

Health Fitness Corporation Provides a broad range of programming anywhere in the country. For information reach them at (800) 639-7913 or visit their website at http://healthfitness.com/.
Staywell Inc. Provides a variety of health management services to employers. Call and request information at (800) 373-3577 or visit their website at www.staywell.com.


Appendix H - Finding Valuable Web Resources for Wellness

This appendix identifies high value web resources for the planning, design and implementation of worksite health promotion and wellness programs. Each web resource listed here will be described with a special emphasis on the value and utility associated with each site.

ACA Update is a federal website that provides updates on the status of implementation of the Affordable Care Act (Obamacare) and information on prevention and wellness under the ACA. Available at Website Address = http://www.healthcare.gov/index.html (Find out the status of ACA implementation.)

AHRQ’s Electronic Preventive Services Selector (ePSS) for smart phones. Bringing the prevention information clinicians need—recommendations, clinical considerations, and selected practice tools—to the point of care. The ePSS helps you identify and select screening, counseling, and preventive medication services based on specific patient characteristics. Available at http://epss.ahrq.gov/ (Get the smart phone version of USPSTF recommendations on preventive screening and other services to help design your wellness program.)

AHRQ Prevention and Care Management Program aims to improve delivery of appropriate clinical preventive services to the U.S. population. The program of the federal Agency for Healthcare Research and Quality (AHRQ) disseminates the USPSTF recommendations in multiple formats and facilitates health care delivery systems’ implementation of evidence-based preventive services through partnerships, communication, user-driven tools, and outreach. Among the many tools and resources, you will find the following: • Brochures on staying healthy and on cardiovascular diseases, • Fact sheets on cardiovascular diseases, • Videos on using “I” statements in clinical practice, • Checklists for staying healthy at age 50+, • And more, for clinicians, health care systems, and consumers. For more information, and to view the materials online, go to Website Address = http://www.ahrq.gov/clinic/ppipix.htm. (Get low cost tools for improving health you can use in your wellness program.)

AJHP is one of the most important journals for the worksite health promotion field. Published every two months each edition contains a large number of peer reviewed articles on health promotion. Website Address = www.healthpromotionjournal.com (Review new research on health promotion to help you design your wellness program.)

BLS is the Bureau of Labor Statistics which provides a wide range of data on employers and the U.S. labor force. Website Address = http://www.bls.gov/ (Get benefit and cost data on working populations to help you plan your wellness program.)

BRFSS is the CDC sponsored phone interview system that operates in each state and provides self-reported comparison data for a wide variety of health promotion behaviors and metrics. The behavioral Risk Factor Surveillance System (BRFSS) provides state-specific and national data on a wide range of behaviors and risks. Website Address = http://www.cdc.gov/Brfss/ (Get population data on health
promotion behaviors and risk factors for comparison with your HRA data to plan and evaluate your wellness program.

**HealthFinder** is a series of government publications that provide low cost yet scientifically sound health promotion information for use by consumers and employers. Website Address = [http://www.healthfinder.gov/prevention/ACA-crosswalk.aspx](http://www.healthfinder.gov/prevention/ACA-crosswalk.aspx) (Get low cost health promotion materials for your wellness program.)

**Health Project** is a website that hosts the C.Everett Koop Awards. These awards are given to employers for wellness programs that show evidence of reducing the need and demand for health care. There are more than 70 winners and each has a descriptive write-up. Available at Website Address = [www.sph.emory.edu/healthproject/](http://www.sph.emory.edu/healthproject/) (Access brief descriptions of winning wellness programs that reduced health care need and demand.)

**HERO** is a website for the Health Enhancement Research Organization (HERO), a multi-organization consortium that has completed some of the most important research on the relationship between health risks and health costs. Go to their website and click on “Research” and “Studies” and you will find 14 articles that can be purchased. Website Address = [www.the-hero.org](http://www.the-hero.org) (Find studies on the relationship of health risks to health costs to make a stronger case for your wellness program.)

**HMRC** is a website for the Health Management Research Center at University of Michigan. HMRC and its Director (Dee Edington) has been a pioneer in research on the relations of health risks and health costs. Go to their website and click on the “Publications and Research” tab and review their published studies abstracts are free. Website Address = [www.umich.edu/hmrc/](http://www.umich.edu/hmrc/) (Find more studies on the relationship of health risks to health costs to further help justify your program.)

**JOEM** is the Journal of Occupational and Environmental Medicine, the major journal for articles that affect the health of working adults. You can also sign up to receive a monthly electronic version of their Table of Contents which allows you to stay current without much effort. If you see an article that looks interesting you can get the abstract on Medline and decide if you want to order it through Loansome Doc. Website Address = [http://journals.lww.com/joem/pages/default.aspx](http://journals.lww.com/joem/pages/default.aspx) (Monitor primary journal for articles on occupational health and worksite wellness.)

**Loansome Doc** is a U.S. National Library of Medicine operated website where you can order scientific articles. If you go to their website and open an account you can order virtually any scientific article in the medical literature. Website = [www.nlm.nih.gov/loansomedoc/loansome_home.html](http://www.nlm.nih.gov/loansomedoc/loansome_home.html) (Order needed research articles to use with your program.)

**Medline** is a free search engine that provides access to more than 22 million medical and scientific articles. This site allows you to quickly search for specific articles and study findings. Website Address = [www.pubmed.gov](http://www.pubmed.gov) (Search the scientific literature and retrieve articles that help you design, implement and evaluate your wellness program.)

**National Guideline Clearinghouse™ (NGC)** is a database of evidence-based clinical practice guidelines and related documents. To access, go to [http://www.guideline.gov](http://www.guideline.gov). (Consult this database to gain access to best practice guidelines.)

**Statistical Abstract** is the annual federal compilation of a wide range of data and information from all federal agencies. Website Address = [http://www.census.gov/compendia/statab/2012edition.html](http://www.census.gov/compendia/statab/2012edition.html)
(Use this data source to get national health care information, employer information and benefits information for your wellness program.)

**USPSTF** is the United States Preventive Services Task Force, a federal advisory group that makes recommendations on prevention services for various age and gender groups based on the scientific evidence. Website Address = [http://www.uspreventiveservicestaskforce.org/recommendations.htm](http://www.uspreventiveservicestaskforce.org/recommendations.htm) (Get science-based recommendations on all types of preventive services.)

**WebMD** is a free eHealth portal that provides an enormous amount of health information to more than 70 million unique users each month. Website Address = [www.webmd.com](http://www.webmd.com) (Free health, medical, pharmaceutical and medical self-care information.)

**Appendix I - Bibliography of Evaluation Studies of Worksite Wellness**

From *Proof Positive: An Analysis of the Cost-Effectiveness of Wellness*, 2013, by Larry S. Chapman MPH of Chapman Institute.PO Box 55056, Seattle, WA 98155. Publication can be ordered in paper copy by calling (206) 364-3448 or visiting Amazon.com. It can also be purchased in eBook form directly from the Chapman Institute website.


## Appendix J - Suggested Technical Specifications for HRAs

<table>
<thead>
<tr>
<th>Technical Specification</th>
<th>Why its Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you provide a toll-free line for respondent questions?</td>
<td>It is particularly important to have a toll-free hotline for questions for individuals who are completing HRAs at home. If spouses receive an HRA, it is important that they have a number to call for questions. This is also important to reduce the number of surveys that require follow-up with respondents prior to processing because of incomplete responses or misunderstandings.</td>
</tr>
<tr>
<td>Can you process the HRA with or without biometrics or laboratory data?</td>
<td>As the advisability of mass screening for symptom-free or healthy adults continues to come under question, it is important that HRA sponsors have the option of not including biometric data on their population. This is even more critical with small, remote worksites where biometric screening is not possible. It is also important to have the ability to triage for screening or identify which respondents need to have biometric testing performed, and then to use their personal report to urge them to have testing done on their own or through your program.</td>
</tr>
<tr>
<td>Does your HRA use stage of change assessment? If so, for what behaviors?</td>
<td>The Transtheoretical Model (TTM), developed by Prochaska et.al., often called the “stages of readiness to change model”, is an extremely useful model for behavior change as part of a health management program. It allows a much more effective tailored intervention process and produces much more successful programs. (Prochaska, 1994)</td>
</tr>
<tr>
<td>Does your HRA utilize character recognition technology?</td>
<td>OCR, or optical character recognition, is important because it prevents the errors and low survey response associated with “bubbling” approaches and other write-in methods and it enables a much faster processing cycle.</td>
</tr>
<tr>
<td>Does your HRA connect processing and responses to earlier completed surveys?</td>
<td>Serial feedback is important because it gives the individual comparison points from previous surveys and it provides a sentinel effect leading to higher response accuracy.</td>
</tr>
<tr>
<td>Does your HRA utilize digital and document imaging?</td>
<td>Digital and document imaging involves a process where the entire HRA is digitally entered into a computer database for permanent storage and the ability to be processed for comparison at any point in the future. This technology allows the confidential destruction of the originals, eliminating expensive archival costs, while assuring the permanent maintenance of the original data. This technology also allows the ability to provide originals to the interventionists talking with the at-risk individual or the individual that may have called the health advice line. This integrated data technology allows: greater accuracy, reproducibility, accessibility, speed of processing, capture of personal signatures on release forms, and form design flexibility.</td>
</tr>
<tr>
<td>Archival storage of survey results?</td>
<td>It is important to retain and have easy access to survey results from all previously completed survey instruments. This is important for reasons of program evaluation and individual counseling.</td>
</tr>
<tr>
<td>Verification of survey data before processing?</td>
<td>This is important in assuring accurate individual report processing and accurate aggregate reporting. Approximately 7% to 12% of submitted surveys on an industry-wide basis usually require human edit due to errors in completion, interpretation or survey damage.</td>
</tr>
<tr>
<td>Health behaviors?</td>
<td>These items are critical to the measurement of health risks and the identification of at-risk individuals as a prelude to proactive intervention.</td>
</tr>
<tr>
<td>Chronic conditions?</td>
<td>Ditto (Chronic disease risks)</td>
</tr>
<tr>
<td>Medications?</td>
<td>Ditto (Chronic disease risks)</td>
</tr>
<tr>
<td>Health status perceptions?</td>
<td>Ditto (Utilization prediction)</td>
</tr>
<tr>
<td>Social support?</td>
<td>Ditto (Special condition risks)</td>
</tr>
<tr>
<td>Safety?</td>
<td>Ditto (Special condition risks)</td>
</tr>
<tr>
<td>Preventive screening?</td>
<td>Ditto (Special condition risks)</td>
</tr>
<tr>
<td>Likelihood of health care use?</td>
<td>Ditto (Utilization prediction)</td>
</tr>
<tr>
<td>Days of sick leave?</td>
<td>Ditto (Economic savings projection)</td>
</tr>
<tr>
<td>Physician visits?</td>
<td>Ditto (Economic savings projection)</td>
</tr>
<tr>
<td>Hospital days?</td>
<td>Ditto (Economic savings projection)</td>
</tr>
<tr>
<td>Desired informational method?</td>
<td>Ditto (Intervention method)</td>
</tr>
<tr>
<td>Primary care physician’s name?</td>
<td>Ditto (Transfer of survey results)</td>
</tr>
<tr>
<td>Family medical history?</td>
<td>Ditto (Chronic disease and screening risks)</td>
</tr>
<tr>
<td>Height and weight?</td>
<td>Ditto (Health risk identification)</td>
</tr>
<tr>
<td>Interest in additional information?</td>
<td>Ditto (Intervention method)</td>
</tr>
<tr>
<td>Interest in self-directed change materials?</td>
<td>Ditto (Intervention method)</td>
</tr>
<tr>
<td>Can you report on departmental sub-groups?</td>
<td>Ditto (Sub-group reporting)</td>
</tr>
<tr>
<td>Do you have the ability to use previous HRA data from other vendors?</td>
<td>Ditto (Continuity of data)</td>
</tr>
<tr>
<td>Does your HRA contain “sentinel “ features to ensure honest and accurate self-report answers?</td>
<td>Sentinel features are essential for the reduction of self-report errors or bias. There are many possible sentient features that can be utilized.</td>
</tr>
<tr>
<td>Do you provide large print reports for seniors?</td>
<td>Large print is very helpful to seniors and is important in increasing compliance with recommendations.</td>
</tr>
<tr>
<td>Is a version of the information sent to the individual’s primary care physician? Case manager?</td>
<td>It is also critical to establish a follow-up information link to the individual’s primary care physician so that there can be a greater opportunity for support and cooperation with the physician involved in the individual’s care.</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Is written information sent automatically where appropriate?</td>
<td>When individuals indicate an interest in information about a particular behavior, written materials appropriate to the stage of readiness should be sent to the individual involved. With the inclusion of a release statement and the agreement of the individual, lists of individuals interested in smoking cessation, weight management, stress reduction, and additional selected areas should be available to internal health promotion staff for program marketing and recruitment purposes.</td>
</tr>
<tr>
<td>Are other language versions available?</td>
<td>It is important that a variety of language versions be available including appropriate cultural sensitivities to selected health issues for various major language sub-groups.</td>
</tr>
<tr>
<td>A useful group report?</td>
<td>It is crucial to have an aggregate or group report from HRA data that serves a useful set of functions. These should include: average values for all questions, graphic display of information for planning purposes, prospective recommendations on program priorities, changes from previous survey cycles for cohort groups, likely prevention issues, and comparisons with national or normative data.</td>
</tr>
<tr>
<td>Does your HRA have an error report capability?</td>
<td>It is important to monitor the kind of data errors or incomplete items over time. This is a critical process to assure accuracy and refine the design of survey instruments.</td>
</tr>
<tr>
<td>A high degree of personalization?</td>
<td>It is extremely important that personal reports be as individualized as possible. The degree of individualization and custom text blocks will determine much of the persuasiveness of the instrument in motivating or reinforcing desired health behaviors. The way in which customization potential can be measured is to examine the percent of responses contained in an HRA that produce changes in the personal report generated by the HRA.</td>
</tr>
<tr>
<td>A large number of potential at-risk categories?</td>
<td>It is critical that the HRA used can provide both a present and future basis for identification of individuals whose responses indicate that they are “at-risk” for some health issue and would potentially benefit from intervention.</td>
</tr>
<tr>
<td>Can your HRA be administered in a variety of ways?</td>
<td>The ability to administer the HRA in other methods than the Traditional Wellness paper and pencil form is important given the variety of literacy levels in most populations. The HRA should be available via telephone, intranet and internet.</td>
</tr>
<tr>
<td>Is the HRA data able to be accessed or used by interventionists?</td>
<td>If the HRA data is to have full usefulness, it needs to be part of a system that provides on-line access by interventionists that may be working with the individual. HRA data has limited usefulness unless it is used in follow-up interventions.</td>
</tr>
<tr>
<td>Are mailroom fulfillment services available? Any minimum quantity requirements?</td>
<td>The ability to prepare and fulfill joint mailings, combination mailings, and special inserts is important in bringing integrated programming to your population. Also, some vendors may have minimum quantity requirements before they provide any mailroom fulfillment services.</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Can the HRA be customized into an enrollment form?</td>
<td>It is important to link the collection of information about health management from each individual to an organized Results-Driven Wellness approach. The use of HRAs as part of annual enrollment or re-enrollment processes for health plans is an important strategy for reaching as high a percentage of the population involved as possible.</td>
</tr>
<tr>
<td>Does your HRA integrate data from serial surveys?</td>
<td>It is also important that each HRA processed be linked to “short form” surveys that can be used to capture more selected data from the individual. This allows integration with disease and case management programs.</td>
</tr>
<tr>
<td>Does your HRA integrate with incentive programs?</td>
<td>Due to the importance of incentives in assuring high levels of participation, it is important that HRAs link with incentive programs.</td>
</tr>
<tr>
<td>What are the various costs of your HRA?</td>
<td>The cost components usually include: survey document charge, processing charge, special report charges, charges for lack of eligibility file, color variations on reports, postage, special charges, etc.</td>
</tr>
</tbody>
</table>

**Notes:**
Setting the Stage

Two earlier editions of *The Art of Health Promotion* reported formal meta-evaluations of economic return studies of worksite health promotion programs.¹ ² These meta-evaluations were among the most popular articles in our publishing history because practitioners, scientists, and employers continue to seek evidence on the economic effectiveness of workplace health promotion. The 2003 report examined 42 peer-reviewed journal articles that met the inclusion criteria, and the 2005 report examined 56 peer-reviewed journal articles. This 2012 update examines 10 additional studies that met the same set of inclusion criteria; four of the weaker studies were dropped, resulting in a total of 62 studies in this report.

The meta-evaluation method used here is the same as used in the earlier reports and has been adapted from use with other preventive health programs, providing an overall summary and individual look at the quality of the peer reviewed articles that comprise the current scientific evidence of economic return for worksite health promotion and wellness programs.

The term “meta-evaluation” as used in this article is defined as the application of a systematic review process to a set of evaluation studies with a similar purpose in order to determine their respective quality and to summarize their primary findings. It applies the formal meta-evaluation review process and methodology developed and refined by Windsor and Orefice³ and further modified by Boyd and Windsor⁴ to studies of multi-component worksite health promotion programs as defined by Heaney.⁵ This report include excerpts from the book *Proof Positive: An Analysis of the Cost-Effectiveness of Worksite Wellness*, seventh edition, revised and expanded in December of 2011,⁶ which applies the same methodology.

This edition of *The Art of Health Promotion* addresses the following topics:

- Study inclusion criteria
- Literature search process
- Description of meta-evaluation approach

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Study Inclusion Criteria

The study selection or inclusion criteria used remained the same for this update as for the two earlier reports. In addition, for the purposes of this updated meta-evaluation, articles classified as “program evaluations” by Medline were included if they met all of the following criteria:

1. **Multicomponent Programming.** Qualifying articles must report on programs that include any combination of a minimum of three of the following types of program interventions: smoking prevention and cessation, physical fitness, nutrition, stress management, medical self-care, high blood pressure control, cholesterol reduction, cardiovascular disease prevention, prenatal care, seat belt use, back injury prevention, back pain prevention, weight management, and nutrition education.
2. **Workplace Setting Only.** Qualifying articles must report on evaluation of organized program efforts conducted only in workplace settings for working populations with or without spouses.

3. **Reasonably Rigorous Study Design.** Qualifying articles must include the use of a comparison or control group; however, participants can be used as their own controls in order to meet this criterion.

4. **Original Research.** Qualifying articles must represent the initial or original publication of research findings and results.

5. **Examine Economic Variable.** Qualifying articles must evaluate one or more economic variables associated with working populations or characteristics of organizational life as part of the evaluation design and measurement strategy. This typically includes any one or combination of health benefit plan costs (including health care utilization indicators), sick leave absenteeism, workers’ compensation costs, disability insurance and management costs, pension effects, and/or presenteeism effects.

6. **Publication in a Peer-Reviewed Journal.** Qualifying articles must be published in a peer-reviewed journal and follow traditional methods of peer review and scientific inquiry.

7. **Use of Statistical Analysis.** Qualifying articles must include some appropriate form of statistical analysis of observed changes.

8. **Sufficient Sample Size.** Qualifying articles must have large enough samples to allow meaningful analysis and statistical power.

9. **Replicable Interventions.** Qualifying articles must use replicable interventions that can be conducted in typical worksite settings.

10. **Minimum Length of Intervention Period.** Qualifying articles must include an experimental or observational period that is a minimum of 12 months in duration.

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**Literature Search Process**

As documented in previous reports, the research and evaluation literature on health promotion and wellness programs in workplace settings is both complex and voluminous. The literature is characterized by more than 650 formal program evaluation studies of varying quality and methodology, a large number of secondary descriptions of program results, a variety of summary articles reviewing the evaluation literature with varying degrees of rigor, reports of multiple studies, and a growing number of well-designed scientific studies of evaluation findings for programs implemented in workplace settings.\(^1\)\(^2\)\(^3\)\(^4\) For the purposes of this updated review and analysis, the literature was again divided into original and secondary reports of worksite health promotion program evaluation efforts and the secondary literature then discarded after review for article leads.

In addition, a distinction continues to be made in this analysis between evaluation studies of single program components or interventions (e.g., a smoking cessation or weight management program evaluation) versus multiple or more comprehensive program interventions (e.g., including a program with smoking cessation, physical activity, cardiovascular health, weight management, and stress management interventions). Another component of the original meta-evaluation approach that was maintained here included an organized search process using both “health promotion” and “wellness.” Additionally, one potential article considered for review was rejected because of its inclusion and emphasis on a disease management program in the evaluation design.\(^5\)

The search process used to identify the relevant literature that is analyzed in this update remained the same as the earlier meta-evaluations and was as follows:

**Step 1. Online Search of the Business Literature Database.** A computerized search of the business literature was conducted using the University of Washington’s computer database entitled “Business Index–1989 to the present.” This search was conducted in November, 2011, and utilized four primary search terms, “health promotion,” “return-on-investment,” “worksite,” and “evaluation,” in an expanded string search format. This search was primarily conducted to uncover citations from the peer-reviewed literature that were relevant to the search topics.

**Step 2. Online Search of Health and Social Sciences Databases.** Health and social sciences literature was searched through databases that included Medline, 1966 to present; Nursing & Allied Health, 1982 to present; PsycINFO; Psychology, 1967 to present; Expanded Academic Index, 1989 to present; ERIC, 1982 to present; and Health Plan, 1986 to present. Title word and abstract limitations were applied to all Medline searches. All potential review articles were acquired through Loansome Doc. The key words used in various combinations in the search process included cost/benefit, cost-effectiveness, cost savings, disability experience, economic analysis evaluation, health care cost, health promotion, health and productivity management, presenteeism, prevention, program, sick leave absenteeism, wellness, workers’ compensation, and worksite or workplace.

**Step 3. Review of Selected Publications for Program Evaluation Findings.** The electronic databases of the following journals were reviewed to identify articles on the economic evaluation of worksite health promotion programs: *American Journal of Health Promotion; American Journal of Preventive Medicine; American Journal of Public Health; Annals of Public Health; Health Values; Inquiry; JAMA, the Journal of the American Medical Association; Journal of Occupational and Environmental Medicine; Health Services Research; Medical Care; Population Health Management; and Public Health Reports.*

**Step 4. Back Search of References From Primary Articles.** The references of articles already included in the meta-evaluation were reviewed to identify additional studies.

**Step 5. Colleague Inquiry.** Several professional colleagues were approached in late 2011 to determine if any applicable articles might be in publication that were likely to meet the study inclusion criteria.

The literature search process described above identified 62 qualifying evaluation studies of the economic return associated with worksite health promotion and wellness programs and are formally analyzed in this meta-evaluation. The studies included in this meta-evaluation are identified in Table 1. The 10 new studies...
Table 1, Continued


Table 1, Continued


55. Shi L. Worksite health promotion and changes in medical care use and sick days. Health Values. 1993;17:9–17.


* Indicates one of the 10 new studies added to the list of studies from the 2005 meta-evaluation.
Methodology scores range from 12 to 30. The median year of publication for the studies was 1996. Comment: Slightly more than half the 62 studies have been published since 1996, or within the past 16 years. The more recent studies report larger average effects and higher cost-benefit yields than the earlier literature.

Recent Studies Have Better Study Methodology. Of the 10 highest scoring studies in the meta-evaluation, only one was published before 1990, and six were published after 2000; the combined subjects for the 10 best studies included 381,738 subjects, or 69.7% of all the subjects involved in all 62 studies. Comment: The more recent and larger studies receive the most weight in the meta-evaluation methodology and continue to reflect the most important research findings.

Recent Studies Use New Approaches. The more recent studies also tend to use the newer prevention technologies including the following: use of the Transtheoretical Model™, Internet-provided health information, tailoring, benefits-linked financial incentives, telephonic high risk intervention coaching, self-directed change, and annual required morbidity-based health risk appraisals used for individual targeting of interventions. Comment: These newer prevention technologies are also associated with higher levels of economic impact and return. Their use in the studies that have been published in the past 10 years has resulted in slightly more than double the average cost-benefit ratio reported in studies of

Table 2
Meta-Evaluation Criteria and Scoring Rules

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<td>5</td>
<td>Randomized pretest and posttest, plus matched control group with multiple replications</td>
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<td>4</td>
<td>Equivalent control group design, with pretest and posttest with multiple replications</td>
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<td>Nonequivalent control group design, with pretest and posttest with multiple replications</td>
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<td>Last year of intervention conducted prior to 1989</td>
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<td>* Sample size was not used to independently weight the observed effect in each study. This varies from traditional meta-evaluation methods, but follows the approach advocated by Windsor and Orleans* and Boyd and Windsor.*</td>
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Methodology Quality. Methodology scores range from 12 to 30. Comment: Given the wide variation in the quality of research methodology, we need to be cautious about the way we summarize the literature to estimate the impact of programs. It may be prudent to report the range of outcomes reported in the literature rather than predict a single likely outcome.

Numbers of Subjects. The number of the subjects in all studies combined was 546,971. Comment: This is a large number of study subjects and represents a very diverse range of industries and types of organizations, including public sector agencies. Given an average duration of 3.83 years for the 62 studies, the number of person-years of observation was close to 2.1 million. This represents a significant amount of experimentation and observation by any standard.

Organization Size. Studies were conducted in a wide range of sizes of organizations. Comment: The distribution of studies by organizational size is shown in Table 5.

Publication Year. The median year of publication for the studies was 1996. Comment: Slightly more than half the 62 studies have been published since 1996, or within the past 16 years. The more recent studies report larger average effects and higher cost-benefit yields than the earlier literature.
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traditional program models; in other words, instead of the typical 1:3.0 cost-benefit ratio they report 1:6.1.

Health Care Utilization or Cost as a Study Outcome. Thirty-two studies, or 51.6%, used health care utilization or cost as an outcome measure. Comment: Persistent health care cost escalation in spite of health care reform will likely continue to make this economic variable the most significant concern for employers. As a consequence, it is likely to continue to be the most frequently examined economic variable in future program studies.

Absenteeism as Outcome Measure. Sick leave absenteeism was measured in 26 studies (41.9%). Comment: Sick leave effects are the second most common economic variable used to examine the economic return associated with worksite health promotion programs. Interest in absenteeism is likely to increase given the growing interest in productivity as an overall outcome, but may be more difficult to measure given the growing tendency of employers to include sick days and vacation time into combined leave approaches. Several of the more recent studies reported here attempt to monetize the savings associated with reduction of presenteeism-related losses. However, most studies included here only used one of five possible economic variables to examine economic return, resulting in a significantly lower level of reported economic benefit.

Workers’ Compensation and/or Disability as an Outcome Measure. Only seven studies examined workers’ compensation and/or disability management costs. Comment: The limited number of studies that examine these two economic variables continue to indicate that few health promotion programs have included injury prevention or a concern for costs associated with injuries.

Plan cost, sick leave cost, workers’ compensation cost, disability management, and presenteeism cost effects. This approach to economic return would likely provide a more realistic assessment of the economic return associated with worksite health promotion and wellness programs and would tend to make health promotion and wellness more of a strategic business issue.

Meta-Analysis: A Significant New Research Finding

As a significant new development since the previous meta-evaluation, a formal meta-analysis has been published in the peer review literature. The article, authored by Katherine Baicker, David Cutler, and Zirui Song, is a meta-analysis of the literature on the financial impact of workplace health promotion limited to health plan cost savings and sick leave absenteeism savings. This analytic process involves combining the raw data or the reported outcomes from multiple studies to perform new statistical analysis. The authors limited their analysis to data from studies with experimental or quasi-experimental study designs for health care cost savings. This included data from 22 studies that examine health plan cost savings associated with worksite health promotion programs and 22 studies that examine sick leave absenteeism savings. This analytic process involves combining the raw data or the reported outcomes from multiple studies to perform new statistical analysis. The authors limited their analysis to data from studies with experimental or quasi-experimental study designs for health care cost savings. This included data from 22 studies that examine health plan cost savings associated with worksite health promotion programs and 22 studies that examine sick leave absenteeism savings. Some of the studies addressed both economic variables. Baicker and colleagues calculated ROIs of $3.27 for medical cost savings and $2.73 for absenteeism reduction. Because of the importance of this independent study, using much more sophisticated statistical techniques, it should be cited much more frequently by health promotion and wellness professionals. Studies included in this analysis are indicated in Tables 3 and 4.

Conclusion

This 2012 meta-evaluation update provides a systematic look at the quality and summary results of the literature on the financial impact of workplace health promotion programs. The summary evidence continues to be strong with average reductions in sick leave, health

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* New study in this update of the meta-evaluation.
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plan costs, and workers’ compensation and disability insurance costs of around 25%. These outcomes continue to have profound implications for American employers, as well as all our global trading partners in developed nations, and should eventually lead to the institutionalization of appropriately designed and executed worksite health promotion programming for all working populations.

Based on these published results, it is reasonable to conclude that worksite health promotion represents one of the most effective strategies for reducing medical costs and absenteeism. Future research will help us understand the impact of health promotion on enhancing the broader productivity of American workers. This will become increasingly important because the average age of American workers is increasing faster than that of many of our newer global trading partners and competitors. This becomes even more strategically important if our worksite wellness efforts reflect more of a health and productivity management approach in which health plan cost, sick leave cost, workers’ compensation costs, disability management costs, and presenteeism costs are a primary objective. Abstracts of the newly included 10 articles can be found in the Selected Abstracts section that follows.


tables and figures

**Table 4, Continued**

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<sup>a</sup> WC/DM refers to workers’ compensation costs and disability management claims cost.
<sup>b</sup> New study in this update of the meta-evaluation.
<sup>c</sup> This study was included because of its large population (i.e., >100,000 subjects) and its primarily “virtual” style of interventions.
<sup>d</sup> Included in the Baicker et al.<sup>15</sup> meta-analysis.
<sup>e</sup> Imputed from data provided in the study.
<sup>1</sup> Analysis of claims data provided a range of $101 to $648 a year of savings for program participants. A midrange estimate of $374 of annual savings then compared to the Harvard meta-analysis program cost finding of $144/participant/yr provides an imputed cost/benefit ratio of 1:2.59.
<sup>2</sup> For consistency, whole integers reported in the literature have been written as a decimal (x.0) and for cost-benefit ratios an additional significant digit has been added (x.y0).
<sup>3</sup> An estimate of 56% for hospital costs as a portion of overall costs was made, and then applied to the overall observed change to derive the measure of 7.4%.
<sup>4</sup> This study also examined offsetting pension costs, decreased life insurance costs, increased productivity, and program revenue generation.
<sup>5</sup> This study found that health promotion program participants experienced higher behavioral health service costs than nonparticipants, indicating that they were more likely to seek help for mental health issues after the program. No meaningful percentages were possible to extract from the article, but the results were considered significant because of the behavioral health implications.
<sup>6</sup> This study provides an initial look at the relationship between an index of health risk (HQ) and per capita medical plan costs, sick leave, and short term disability (STD) days, but does not lend itself to percentage calculation.
<sup>1</sup> The 8.0% reported reduction was in doctor visit rate. There was also a reported reduction of 1.0% in hospitalizations, but this was not significant.
<sup>2</sup> Reductions were found in hourly employees only.
<sup>3</sup> This cost-benefit ratio was the highest of three different program intervention models.
<sup>4</sup> This article is included because it is one of the first to show a “dose-related” response with increasing intervention intensity and offers one of the few cost-effectiveness analyses in the economic cost/return literature.
<sup>5</sup> Includes 10.4% reduction in presenteeism losses and translates to a 1:4.29 cost-benefit contribution.
<sup>6</sup> Applying more rigorous statistical methods revealed that participants did not have a statistically significant lower per capita cost, but the rate of cost growth for participants was 12% lower than for nonparticipants.
<sup>7</sup> This number is the average found with two of the three studies. The third study found no significant change.
<sup>8</sup> This study showed that wellness program participants had higher health costs during the study period but had several major limitations.
<sup>9</sup> Program also examined cardiac rehabilitation savings and savings from treadmill testing.
<sup>10</sup> Averages values reported are simple mathematical means of the average reported effect size of each study. They do not reflect the use of a weighted average related to the sample size of each study.
The Impact of a Prospective Survey-Based Workplace Intervention Program on Employee Health, Biologic Stress Markers, and Organizational Productivity.

Anderzen I, Arnetz BB.

OBJECTIVE: To study whether knowledge about psychosocial work indicators and a structured method to implement changes based on such knowledge comprise an effective management tool for enhancing organizational as well as employee health and well-being. METHODS: White-collar employees representing 22 different work units were assessed before and after a 1-year intervention program. Subjective ratings on health and work environment, biologic markers, absenteeism, and productivity were measured. RESULTS: Significant improvements in performance feedback, participatory management, employeeship, skills development, efficiency, leadership, employee well-being, and work-related exhaustion were identified. The restorative hormone testosterone increased during the intervention and changes correlated with increased overall organizational well-being. Absenteeism decreased and productivity improved. CONCLUSIONS: Fact-based psychosocial workplace interventions are suggested to be an important process for enhancing employee well-being as well as organizational performance. J Occup Environ Med. 2005;47:671–682.

Recent Experience in Health Promotion at Johnson & Johnson: Lower Health Spending, Strong Return on Investment.

Henke RM, Goetzel RZ, McHugh J, Isaac F.

Johnson & Johnson Family of Companies introduced its worksite health promotion program in 1979. The program evolved and is still in place after more than thirty years. We evaluated the program’s effect on employees’ health risks and health care costs for the period 2002–08. Measured against similar large companies, Johnson & Johnson experienced average annual growth in total medical spending that was 3.7 percentage points lower. Company employees benefited from meaningful reductions in rates of obesity, high blood pressure, high cholesterol, tobacco use, physical inactivity, and poor nutrition. Average annual per employee savings were $565 in 2009 dollars, producing a return on investment equal to a range of $1.88–$3.92 saved for every dollar spent on the program. Because the vast majority of US adults participate in the workforce, positive effects from similar programs could lead to better health and to savings for the nation as a whole. Health Aff (Millwood). 2011;30:490–499.

Impact of a Comprehensive Worksite Wellness Program on Health Risk, Utilization, and Health Care Costs.

Hochart C, Lang M.

In 2005, Blue Cross Blue Shield of Kansas City initiated a comprehensive worksite wellness program designed to impact employer culture and to assist healthy employees to stay at low risk and to reduce risk levels for those at moderate or high risk. Fifteen employer groups (9637 employees) participated in the A Healthier You (AHY) program for 3 consecutive years, 2006–2008. The results of health risk appraisals and biometric screening were used to evaluate program impact. Among the 4230 employees (44.0% of eligible employees) who completed health risk appraisals in all 3 years, 85.38% of individuals in the low-risk category in 2006 remained at low risk in 2008. There were also improvements in other risk categories, with 39.9% of those in the medium-risk category and 48.9% of those in the high-risk category in 2006 moving to a lower risk category in 2008. There were improvements in blood pressure control and total cholesterol, but no improvement in weight control. To assess financial and utilization outcomes, claims for the participating employer groups were compared to those for 7 employers (3800 employees) who did not participate in AHY in 2006–2008. Although none of the utilization measures was statistically different, the AHY groups had significantly smaller increases in both overall and emergency room costs per member per month. The AHY program now has over 180 employer groups, which will allow future evaluations to examine the impact of the program on a much larger population and to focus on the comparative effectiveness of different intervention strategies across implementations. Popul Health Manag. 2011;14:111–116. doi: 10.1089/pop.2010.0009, [published online ahead of print 2011 Jan 17]

Table 5

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References


This study evaluated the impact of an integrated population health enhancement program on employee health risks, health conditions, and productivity. Specifically, we analyzed changes in these measures among a cohort of 543 employees who completed a health risk assessment in both 2003 and 2005. We compared these findings with 2 different sets of employees who were not offered health enhancement programming. We found that the DIRECTV cohort showed a significant reduction in health risks after exposure to the program. Relative to a matched comparison group, the proportion of low-risk employees at DIRECTV in 2005 was 8.2 percentage points higher; the proportion of medium-risk employees was 7.1 percentage points lower; and the proportion of high-risk employees was 1.1 percentage points lower (p < 0.001). The most noticeable changes in health risk were a reduction in the proportion of employees with high cholesterol; an improvement in diet; a reduction of heavy drinking; management of high blood pressure; increased stress management; increased exercise; fewer smokers; and a drop in obesity rates. We also found that a majority of employees who improved their risk levels from 2003 to 2005 maintained their gains in 2006. Employees who improved their risks levels also demonstrated relative improvement in absenteeism. Overall, this study provides additional evidence that integrated population health enhancement positively impacts employees’ health risk and productivity; it also reinforces the view that “good health is good business.”


A Case Study of Population Health Improvement at a Midwest Regional Hospital Employer.
Long DA, Sheehan P.

This article reviews the population health improvement initiative of a Midwest regional hospital employer. Services included health risk assessments, health education, and motivational health coaching conducted telephonically. Outcomes for this program evaluation comprised participation rates, participant satisfaction, health status and behavior change, productivity change, health care claims savings, and return on investment. Participation rates varied widely with incentive structure, although retention of participants in coaching programs averaged 89%. The participant satisfaction rate for the last 14 months of interventions was 96%. Four years of population health status and behavior trending showed significant improvements in smoking status, dietary fat and fiber intake, exercise, mental health (ie, stress, effects depressive symptoms in the past year, life satisfaction), readiness to change (ie, diet, exercise, stress, smoking, body weight), perceptions of overall health, index of good health habits, sum of lifestyle health risks, and sum of risks and chronic conditions. Body mass index showed nonsignificant improvements during the years of greatest participation (years 2 to 4). Indicators of productivity demonstrated improvements as well. These gains were noted for employees across all health risk statuses, which suggests population health improvement strategies can influence productivity even for healthy employees.

Program year 3 was evaluated for health care claims savings using a 2-stage multivariate regression approach. Stage 1 was a computation of propensity-to-participate scores, Stage 2 was an estimation of per member per month (PMPM) claims savings for participant cohorts using a propensity score-weighted linear regression analysis. Participants averaged $40.65 PMPM savings over the control population. Program return on investment, including incentive costs and vendor fees, was $3,568,837. For every dollar spent on the HLIP the county saved $3.85.

CONCLUSION: Financial incentives and then a desire for better health were the primary reasons for participation. The HLIP resulted in substantial health care cost savings for Salt Lake County Government.


Impact of Worksite Wellness Intervention on Cardiac Risk Factors and One-Year Health Care Costs.
Milani RV, Lavie CJ.

Cardiac rehabilitation and exercise training (CRET) provides health risk intervention in cardiac patients over a relatively short time frame. Worksite health programs offer a unique opportunity for health intervention, but these programs remain underused because of concerns over recouping the costs. We evaluated the clinical efficacy and cost-effectiveness of a 6-month worksite health intervention using staff from CRET. Employees (n = 308) and spouses (n = 31) of a single employer were randomized to active intervention (n = 185) consisting of worksite health education, nutritional counseling, smoking cessation counseling, physical activity promotion, selected physician referral, and other health counseling versus usual care (n = 154). Health risk status was assessed at baseline and after the 6-month intervention program, and total medical claim costs were obtained in all participants during the year before and the year after intervention. Significant improvements were demonstrated in quality-of-life scores (+10%, p = 0.001), behavioral symptoms (depression +33%, anxiety +32%, somatization +33%, and hostility +47%, all p values <0.001), body fat (+9%, p = 0.001), high-density lipoprotein cholesterol (+13%, p = 0.001), diastolic blood pressure (~2%, p = 0.01), health habits (~60%, p = 0.0001), and total health risk (~25%, p = 0.0001). Of employees categorized as high risk at baseline, 57% were converted to low-risk status. Average employee annual claim costs decreased 48% (p = 0.002) for the 12 months after the intervention, whereas control employees’ costs remained unchanged (~16%, p = NS), thus creating a sixfold return on investment. In conclusion, worksite health intervention using CRET staff decreased total health risk and markedly decreased medical claim costs within 12 months.


Lowering Employee Health Care Costs Through the Healthy Lifestyle Incentive Program.
Merrill RM, Hyatt B, Aldana SG, Kinnersley D.

OBJECTIVE: To evaluate the impact of the Healthy Lifestyle Incentive Program (HLIP), a worksite health program, on lowering prescription drug and medical costs. DESIGN: Health care cost data for Salt Lake County employees during 2004 through 2008 were linked with HLIP enrollment status. Additional program information was obtained from a cross-sectional survey administered in 2008. INTERVENTION: The program includes free annual screenings, tailored feedback on screening results, financial incentives for maintaining and modifying certain behaviors, and periodic educational programs and promotions to raise awareness of health topics. MAIN OUTCOME MEASURES: Frequency and cost of prescription drug and medical claims. RESULTS: Participation increased from 16% to 23% in men and 34% to 45% in women over the 5-year study period and was associated with a significantly greater level of physical activity and improved general health. Participants were generally satisfied with the HLIP (43% were very satisfied, 51% satisfied, 5% dissatisfied, and 1% very dissatisfied). The primary factors contributing to participation were financial incentives (more so among younger employees), followed by a desire to improve health (more so among older employees). Over the study period, the cost savings in lower prescription drug and medical costs was $3,568,837. For every dollar spent on the HLIP the county saved $3.85.

CONCLUSION: Financial incentives and then a desire for better health were the primary reasons for participation. The HLIP resulted in substantial health care cost savings for Salt Lake County Government.

When we launched the American Journal of Health Promotion in 1986, five studies had been published on the financial impact of workplace health promotion, and three more were published that same year. We had a solid conceptual framework to justify our hypothesis that health promotion programs were likely to reduce medical costs and enhance productivity, but we had very little empirical evidence to prove it. We now have at least 62 studies, and that is after dropping four that have weak methodology.

I am reminded of a dinner conversation I had with Gerald Greenwald in 2003. He had been vice chairman of Chrysler Corporation when I managed the employee wellness programs at their corporate headquarters in the early 1980s. He was later chairman and CEO of United Airlines Corporation, has served on the boards of at least five Fortune 500 companies, and has led several large investment groups. He asked me if workplace health promotion programs really saved any money. As I was prone to do all the time, and as I thought was appropriate given Mr. Greenwald’s business and investment acumen, I went into a detailed analysis of the results and methodological limitations of the studies that had been published by that date. He cut me off after a few minutes, saying “Wait a minute, did you say you have more than a dozen well-designed studies that show an ROI of 3:1? I have a lot less evidence than that when I have to make billion-dollar investment decisions on new products!”

We still have many questions to answer before we fully understand the financial impact of workplace health promotion. For example, we need to identify the specific characteristics of health promotion programs that produce the strongest financial outcomes and also improve health and quality of life. We need to expand the financial outcomes we study, with special attention to enhancing productivity. We need to learn how to apply these analyses to small employers, especially those who are not self-insured. If we want to continue to impact national policy, we need to expand our unit of analysis beyond employers, and in doing so, measure the impact of health promotion programs on Medicare, Medicaid, and Social Security spending, as well as state and federal corporate and individual income tax revenues. ¹ (Whoops, am I getting a little off topic?) We also need to strive to improve our research methodology, working to improve each aspect of the way we design and execute studies. Scientists and accountants will quibble over specific elements of our methodology, but business decision makers will not.

The existing research is more than adequate to provide business decision makers the evidence they need that investments in workplace health promotion save money. In fact, I suspect that the methodological quality of the studies we conduct on this topic is superior to the methodology used to study the financial impact of any other treatment in health care or any other investment in business that costs only $200–$300 person per year to deliver.

Michael P. O’Donnell, MBA, MPH, PhD, is Editor of the American Journal of Health Promotion.

References

On a Personal Note…

By Larry S. Chapman, MPH

This edition of The Art of Health Promotion is my last. My 15 years as editor has been a real privilege! Thank you, Michael O’Donnell and all the staff of the American Journal of Health Promotion, for your support and confidence! During its 25+ years of existence the Journal has provided the field of health promotion and wellness with valuable tools, has improved knowledge and science, and has demonstrably deepened and improved the quality and effectiveness of our efforts and contributions.

You will now be in the very capable hands of Paul Terry, PhD, who will be taking over as the new editor of The Art of Health Promotion. Welcome, Paul!

Comment From Michael O’Donnell…

I want to recognize and thank Larry Chapman for his excellent work on this article on the economic return from workplace health promotion and for the outstanding contributions he has made in serving as editor of The Art of Health Promotion for the past 15 years. Larry helped me conceive the idea of The Art and has written or edited the contents of nearly all the issues during its lifetime. I also want to thank Larry for his astounding contributions to the field of health promotion. He is indeed one of our true pioneers. In his 35+year career, Larry has helped to develop and/or improve more than 1000 workplace health promotion programs, written 13 books, and shared his knowledge with thousands of health promotion professionals in hundreds of training sessions. Larry is one of a small handful of people who literally shaped the field of workplace health promotion.