IN THIS ISSUE: This issue of Absolute Advantage is intended to offer the reader a comprehensive resource that includes a very large number of practical insights related to wellness planning. By reading this issue, you will greatly improve your planning and implementation of a cost-effective employee wellness program for your employees and their family members.

Each month you can learn more about the articles in Absolute Advantage. Simply log on to WELCOA’s members only website to get more in-depth coverage of the topics that matter most to you. Find full-length interviews, expert insight, and links to additional information that will help you do your job better!
From The Executive Editors

In this issue of *Absolute Advantage*, we’ve partnered with nationally recognized wellness expert, Larry Chapman. As you may know, Larry is the Chairman and Founder of the Summex Corporation, an Indianapolis-based population health management company. In this issue, Larry will provide important information regarding the planning, design, and implementation of effective wellness programs. And, because this is such an important topic, we’ll actually dedicate a future issue of *Absolute Advantage* to addressing it as well.

With Larry’s 20+ years of experience in designing effective wellness programs, this issue of *Absolute Advantage* will first explore the fundamentals of worksite wellness. In addition, Larry will walk through the key steps for planning, designing, and implementing successful wellness programs as well as provide useful checklists to help guide you through the process of designing your own employee wellness program.

I’d like to extend special thanks to Larry for his dedication to the field and his willingness to selflessly share information that can help to advance worksite health promotion.

I hope you enjoy this first of the two-part series dedicated to wellness planning.

Yours in good health,

Dr. David Hunnicutt
President, Wellness Councils of America

“If you want a program to succeed, you should prepare to plan a worksite wellness program in a serious way.”
WELCOME

Absolute Advantage is the interactive workplace wellness magazine that helps large and small employers link health and well-being to business outcomes. Absolute Advantage arms business leaders and wellness practitioners with leading-edge workplace wellness information straight from the field’s most respected business and health experts.

With its online component, Absolute Advantage provides the industry’s most current and accurate information. By logging on to the magazine’s interactive website, you can access a whole new world of health promotion—including in-depth interviews with national health promotion experts and insider’s information about industry products.

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Ab•sol•ute Ad•van•tage:

When a company can produce more than its competitors—even though they have the same amount of resources—it has an absolute advantage.

We believe wellness is that advantage.

EXECUTIVE EDITOR | David Hunnicutt, PhD

Dr. Hunnicutt is President of the Wellness Councils of America. As a leader in the field of health promotion, his vision has led to the creation of numerous publications designed to link health promotion objectives to business outcomes.

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As WELCOA’s Director of Membership, David is responsible for recruiting and servicing member organizations throughout the United States. David’s background has been grounded in worksite wellness for the past 25 years.

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As the Director for Council Affairs, Kelly is responsible for leading WELCOA’s cadre of locally-affiliated wellness Councils. In this capacity, Kelly coordinates the Well Workplace awards initiative as well as the Well City USA community health project.

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Adam joined WELCOA in early 2005. With corporate experience in design and videography, he brings a wealth of talent to WELCOA’s publication. In the capacity of a multimedia designer, Adam contributes to the publications of The Well Workplace newsletter and Absolute Advantage magazine.

Information in this publication is carefully reviewed for accuracy. Questions, comments, or ideas are welcome. Please direct to Dr. David Hunnicutt, Executive Editor, at the address below.

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The worksite wellness planning process is systematic and requires meticulous attention to details—at the same time, keeping the big picture in mind. In this section you’ll learn how to plan, design, and implement worksite wellness programs.

The 1990’s and 2000’s, the emergence of wellness programs in the workplace has assumed a new significance, particularly with the intense pressure to prevent large increases in annual health care costs. In this article, learn the basics of worksite wellness from one of the best.
Fundamentals of Worksite Wellness
Increasing employer related health care costs continue to provide a serious threat to the economic life of virtually all American employers. Behavioral issues of employees and their family members continue to loom large as a major reason for increasing health costs. In addition, more than 131 million individuals are in the U.S. work force and another 55-65 million are linked through family relationships or retirement relationships, putting employers in a key role related to health and wellness issues for approximately 80% of the U.S. population. This and several other 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 intend 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 health care utilization. In these areas, wellness has a very significant potential contribution to make in helping stabilize health care costs. The areas of risk factor reduction, medical self-care, and consumer health education generally fall under the rubric of health management and should be a central element in our efforts to reform the health care system.

Unfortunately, a vast majority of past and present discussion on health care reform emphasizes 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 and economic and delivery of service roles are structured. As a consequence, Worksite Health Promotion (WHP) or wellness, as it successfully addresses health and health care use patterns, will likely be given much greater priority in the years ahead.

During the 1990s and the early 2000’s, the emergence of wellness programs in the workplace has assumed a new significance, particularly with the intense pressure to prevent large increases in annual health care costs. Business and government leaders are slowly recognizing the need to improve the health and the productivity of their employee work force, as well as help stem the future rising tide of health benefit costs.

This publication is intended to offer the reader one comprehensive resource that includes a very large number of practical insights which will greatly improve your planning and implementation of a cost-effective employee wellness program for your employees and their family members. This Guide contains practical and time-tested advice on virtually every important aspect of wellness programming in the worksite. Many of the insights have come from more than 600 employee wellness programs in a wide variety of public and private employer settings. These insights are organized around three different strategic options for WHP: a “Quality of WorkLife” (QLW) model of programming, the traditional or conventional (ToC) model and a newer approach called the “Health and Productivity Management” (HPM) model.

From our perspective at Summex Health Management, it is our desire that the information, tools, and suggestions contained in this Guide will help you plan and implement a successful worksite wellness program that is “right” for your organization. The field of WHP and Wellness is still at a relatively early stage of development, yet many pragmatic insights have been acquired to date. We hope you will use this Guide to start an employee wellness program or to upgrade a program you have already started. We would also appreciate any feedback on how useful this workbook has been to you and what improvements in the Guide would be helpful.

Best wishes with your employee wellness endeavors!

Larry S. Chapman, MPH
Chairman and Co-Founder
Summex Health Management
1.1 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 or worksite health promotion (WHP) or 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 becoming known as “health and productivity management,” 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, LDL, 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 products ➤ 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, quality of worklife, 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 nature, 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. For the reader’s benefit a Glossary of Terms is included in Appendix A (which will be included in an upcoming edition of this publication.)

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

When considering what kinds of specific topics or issues 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 a 1985 national survey conducted by the Office of Disease Prevention and Health Promotion (ODPHP) of the U.S. Public Health Service of employers with over 50 employees (sample population of N = 1,358 employees) with a 1992 (N=1,507 employers) and 1999 (N=1,544 employers) repeat of that same survey regarding the types of topics addressed in worksite wellness programs. The percent change in various categories of health promotion activity demonstrates which programs have increased/decreased or have been found to be needed or wanted by employees. The items on the bottom of the table were included in the 1992 version of the survey but not included in the earlier 1985 version.

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 simple in its design and structure. The 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 three studies and the conclusions from their analysis, readers are encouraged to contact the Government Printing Office or ODPHP directly for copies of the two 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 are of concern for the groups involved, the interest patterns of the target group, and the objectives and resources of the program. First, take a close look at the national employer survey data from the OHPDP surveys in Table 1:

Table 1

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

From Table 1 you can see some of the trends over the past twenty years regarding the types of worksite health promotion programs offered by employers. The size of the three 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 greatest growth from 1992 to 1999 are back care, STD education, and prenatal education.

The five most prevalent programs in descending order in 1999 were back care (53%), exercise/physical fitness (at 36%), stress management (at 35%), smoking control (at 34%), and substance abuse (at 28%). Obviously we are ready for another national survey that should be conducted in 2005 or 2006. However, based on these findings and comparable results from the more recent but limited surveys done by other researchers, the following “core” topics should be addressed to some extent in virtually all employee health promotion or wellness programs:

**The Big “Five”**
1. Back care and Injury Prevention
2. Physical Exercise
3. Stress Management
4. Tobacco use
5. Substance abuse prevention

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

- Weight management
- Medical Self-Care
- Consumer Health Education
- Cholesterol Reduction
- Nutritional Interventions
- Selected Biometrics Testing
- Hypertension management

These twelve areas of wellness programming should constitute the “core” of most employee wellness programs, and by implication, directly reflect the definition of the wellness program provided above. Not all twelve 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 (which will be included in an upcoming edition of this publication.)

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### 1.3 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.

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

---

**Figure 1**

<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>
</tbody>
</table>

Smoking

Excessive sun exposure

Lack of seat belt use

Lack of stress reduction activities

Inappropriate health care use

Inadequate sleep or rest

Risky sexual practices

Passive health consumer behavior

Unsafe home practices

OTC* medication abuse

Unaddressed depression

Irresponsible purchasing

Obsessive dieting

Undetected high blood sugar

*over the counter
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, 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 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 importance of understanding the relationship between health risks and health costs, Table 2 contains summary information from six major studies that have attempted to determine the actuarial relationship between selected health risks and 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 positive (negative) difference in per capita annual health costs between the low risk group and the high risk group.

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 health care costs. The literature also confirms that health risks and the aging process work synergistically in a negative way as powerful predictors of increased health care use. 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 consume.

## Table 2

<table>
<thead>
<tr>
<th>Item \ Study</th>
<th>Yen%</th>
<th>Brink%</th>
<th>Anderson%</th>
<th>Bertera%</th>
<th>Leigh%</th>
<th>Goetzel%</th>
<th>Weighted Average%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</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>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>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>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>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>
<tr>
<td>Cholesterol</td>
<td>29.2</td>
<td>2.2</td>
<td>0.0</td>
<td>11.5</td>
<td>na</td>
<td>-3.6</td>
<td>7.3</td>
</tr>
<tr>
<td>Blood pressure</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>Drugs &amp; medications</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>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>
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 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 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.
- 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.
- 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 counter situation with high risk 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 very little valid data available. 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 2004 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 2003</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>29% - 56%</td>
<td>Health: US 2003</td>
</tr>
<tr>
<td>Smokeless tobacco use</td>
<td>3% - 16%</td>
<td>Summex Health Management</td>
</tr>
<tr>
<td>Excessive caffeine use</td>
<td>17% - 29%</td>
<td>Summex Health Management</td>
</tr>
<tr>
<td>High risk recreational activities</td>
<td>14% - 21%</td>
<td>Summex Health Management</td>
</tr>
<tr>
<td>Lack of periodic screening</td>
<td>34% - 76%</td>
<td>Summex Health Management</td>
</tr>
<tr>
<td>Lack of supportive relationships</td>
<td>21% - 47%</td>
<td>Summex Health Management</td>
</tr>
<tr>
<td>Little physical exercise</td>
<td>57% - 92%</td>
<td>NCHS Series 10</td>
</tr>
<tr>
<td>Undetected high cholesterol</td>
<td>28% - 58%</td>
<td>NHL&amp;BI, NIH</td>
</tr>
<tr>
<td>Use of illegal drugs</td>
<td>11% - 16%</td>
<td>NIDA</td>
</tr>
<tr>
<td>Carelessness</td>
<td>27% - 52%</td>
<td>Summex Health Management</td>
</tr>
<tr>
<td>Smoking</td>
<td>22% - 49%</td>
<td>Health: US 2003</td>
</tr>
<tr>
<td>Excessive sun exposure</td>
<td>14% - 34%</td>
<td>Summex Health Management</td>
</tr>
<tr>
<td>Lack of seat belt use</td>
<td>11% - 46%</td>
<td>Prevention Index</td>
</tr>
<tr>
<td>Lack of stress reduction</td>
<td>32% - 68%</td>
<td>Prevention Index</td>
</tr>
<tr>
<td>Inadequate sleep or rest</td>
<td>22% - 44%</td>
<td>NCHS Series 10</td>
</tr>
<tr>
<td>Risky sexual practices</td>
<td>13% - 37%</td>
<td>Summex Health Management</td>
</tr>
<tr>
<td>Passive health consumer behavior</td>
<td>68% - 83%</td>
<td>Summex Health Management</td>
</tr>
<tr>
<td>Unsafe home practices</td>
<td>46% - 74%</td>
<td>Summex Health Management</td>
</tr>
<tr>
<td>Over the counter medication abuse</td>
<td>18% - 34%</td>
<td>Summex Health Management</td>
</tr>
<tr>
<td>Unaddressed depression</td>
<td>7% - 13%</td>
<td>Summex Health Management</td>
</tr>
<tr>
<td>Irresponsible health care purchasing</td>
<td>21% - 46%</td>
<td>Summex Health Management</td>
</tr>
<tr>
<td>Obsessive dieting</td>
<td>7% - 13%</td>
<td>Summex Health Management</td>
</tr>
<tr>
<td>Undetected high blood sugar</td>
<td>13% - 23%</td>
<td>Summex Health Management</td>
</tr>
</tbody>
</table>

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.
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 2004, 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 2004. Consequently, the estimated per employee annual costs for a number of major modifiable health problems are clearly a very significant societal economic cost.

No exacting scientific approach or standard methodology has been developed to make these macro-level economic projections of cost, but 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 or 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 2004.

**Figure 2**

<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>$357.7.0</td>
<td>$2,715</td>
<td>National Heart Lung &amp; Blood Institute, NIH, AHA</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>$292.1</td>
<td>$2,217</td>
<td>National Institute of Alcoholism &amp; Alcohol Abuse</td>
</tr>
<tr>
<td>Back Pain</td>
<td>$58.8</td>
<td>$522</td>
<td>National Safety Council</td>
</tr>
<tr>
<td>Lung Disease</td>
<td>$99.1</td>
<td>$752</td>
<td>National Heart Lung &amp; Blood Institute</td>
</tr>
<tr>
<td>Cancer</td>
<td>$110.8</td>
<td>$841</td>
<td>American Cancer Society</td>
</tr>
<tr>
<td>Work Injuries</td>
<td>$104.0</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.
1.5 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. The age and sex of the individual involved, their employment status, and nature of health benefit coverage largely determines who pays for the direct medical expenditures associated with an unhealthy lifestyle, 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:

<table>
<thead>
<tr>
<th>Payer</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Government</td>
<td>36%</td>
</tr>
<tr>
<td>State &amp; Local Government</td>
<td>7%</td>
</tr>
<tr>
<td>Business &amp; Insurance</td>
<td>34%</td>
</tr>
<tr>
<td>Philanthropy</td>
<td>5%</td>
</tr>
<tr>
<td>Individual Health Care Consumers</td>
<td>18%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100%</td>
</tr>
</tbody>
</table>


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 or 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.

Health-Related Costs Of Unhealthy Lifestyles

There are a large number of health-related costs associated with an employee labor force. Very few employers collect detailed cost information that reflects the true costs associated with worker health that are 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 9% to 14% 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. 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.

The importance of employee health interventions is usually driven home once the total of all health-related costs are compared to after-tax profits 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, 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 warranted. Health-related costs are a clear starting point for linking employee health programs to the organizational mission and 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 strategic 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>- Group health plan</td>
<td>• Dread disease coverage</td>
</tr>
<tr>
<td>- Dental plan</td>
<td>• Eldercare support</td>
</tr>
<tr>
<td>- Vision plan</td>
<td>• Early medical retirement</td>
</tr>
<tr>
<td>- Prescription drug plan</td>
<td>• Medicare surcharge</td>
</tr>
<tr>
<td>- Preventive care credits</td>
<td>• FASB 112</td>
</tr>
<tr>
<td>• 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 premiums, 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. Costs will generally be based on claims expense, premium costs, administrative fees, and investment income offsets. The bulk of these expenses are hospital, physician, and ancillary health services. Approximately 90% of the health plan cost are from claims and approximately 10% are 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 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 employee premium. Since adverse selection is occurring the actual cost of the COBRA enrollee is likely to be high producing a 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 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 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 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 to 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 often not taxed. The same sources of information as with STD apply to LTD. If this benefit is insured, then the plan sponsor or insurer provides the 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 workforce. 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 a 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 financial staff and is usually 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 limited by health-related issues. 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 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
Secondary Health Costs:

- **FASB 106 (Future retiree medical cost) write-off**: This Financial Accounting Standards Board 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 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 (1.75%) 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 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 12 weeks 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**: Some of the time employers will separate out any retiree health plan cost subsidy while other times retirees will be included in the core health plan for active employees. These are usually health plan benefit offerings that continue the coverage for retired employees until they become eligible for Medicare, and then the extent of coverage is reduced and frequently employers will provide a “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 100% of the individual employee premium and 50% of the dependent coverage premium cost. However, the pattern varies tremendously with the movement toward higher premium contribution levels with the several recent years of double digit annual increases in per capita health plan cost. 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, 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 2004, according to the Census Bureau, the average family unit out-of-pocket costs not covered by a health plan was approximately $2,000.

- **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 1% - 5% of health insurance premiums for insured health plans. In many states these amounts are used to partially fund high risk insurance pools. The organization’s financial 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.

- **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 that are linked to health issues 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). 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 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, acupuncture 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 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.

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

1.6 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 specific set of purposes and rationales. Typically, the usual range of reasons for initiating wellness are related to the concern of senior management about rapid 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 two major 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 absenteeism
- 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 600 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 Summex Health Management Guide series, provides a detailed analysis of 50+ of the most rigorous peer review articles in the evaluation literature for general 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 (which will be included in an upcoming edition of this publication.)

1.7 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. The many 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 characterized as captive and they return. Approximately 121 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 possibilities 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

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**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: 5.50 (20)</td>
</tr>
</tbody>
</table>

impact may be high, but it also requires the kind of programmatic effort that can fully realize the health enhancement potential that comes with some of these innate characteristics of the 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, and obtaining greater 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 very thorough look at these benefits is provided below:

For Employees:

- 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
- 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 should be used in justifying the initiation of an employee wellness program.
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, exercise, 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.

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 “Quality of WorkLife” 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 effect that can be expected.

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**Figure 4**

<table>
<thead>
<tr>
<th>Levels Of Wellness Programming Effects</th>
<th>Type Of Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information</td>
<td>Option #1 Quality of WorkLife (QWL)</td>
</tr>
<tr>
<td>Motivation</td>
<td>Option #2 Traditional or Conventional (ToC)</td>
</tr>
<tr>
<td>Behavior Change</td>
<td>Option #3 Health and Productivity Mgmt (HPM)</td>
</tr>
</tbody>
</table>

- Information: **+**
- Motivation: **+ +**
- Behavior Change: **+ + +**
- Economic Change: **+ + + +**
- Cultural Change: **+ + + + +**
1.9 Your role as the “wellness catalyst.”

In order to get a 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 larger 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 request a directory of academic programs from the Fisher Institute for Wellness at Ball State University in Muncie, Indiana. 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.

1.10 Keys to a successful wellness program.

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

**Figure 6**

<table>
<thead>
<tr>
<th>Keys To Successful Wellness Programs</th>
</tr>
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<tbody>
<tr>
<td>♦ Strong senior and mid-level management support</td>
</tr>
<tr>
<td>♦ Behaviorally sophisticated programming</td>
</tr>
<tr>
<td>♦ Positive and upbeat image</td>
</tr>
<tr>
<td>♦ Well-designed and balanced programming</td>
</tr>
<tr>
<td>♦ Well paced programming</td>
</tr>
<tr>
<td>♦ Effective use of incentives</td>
</tr>
</tbody>
</table>

**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 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 Image:**

It is important for the wellness program to represent a positive and upbeat image 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 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 or two 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 “Quality of WorkLife” (QWL) style program will usually be paced according to the ebbs and flows of the work load, while a Traditional or Conventional (ToC) style program may follow the seasons of the year. The “Health and Productivity Management” (HPM) style program is likely to be more closely paced to benefit open enrollment periods. A year-round component such as a E-Health 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 or action. 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 must always 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,” a Health Management Guide available from Summex Health Management.

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 health insurance premium

**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 about an employee who makes a major sustained health habit change
- Provide a health insurance premium discount 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!
Steps:
Implementing, Design, Implementation
### 2.1 Planning & Needs Assessment

#### 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 serious 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 to plan 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 budget or a 35-page proposal with detailed plans? Clarify with 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 $10 per employee per year to $1,000 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.

#### 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 below. They include the following rationales for use with management staff in developing support and funding for an employee wellness program:

**Figure 7**

#### General Rationales for Management Support of a Wellness Program

- It will help reduce our health costs.
- Our competitors are doing it.
- Our organizational peers are doing it.
- Our employees want it.
- It will improve morale.
- It is socially responsible.
- It will help make us a leader.
- It is consistent with our credo/culture.
- It is good business.
- It will reduce our labor costs over time.

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:

**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 for 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. 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.

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.).

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.

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.

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
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.

- **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 can help balance the unspoken axiom of “quid pro quo” for making potentially negative benefit design changes.

- **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 corporate wellness programs. 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.

- **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.

- **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.

**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 is also often effective in gaining support.

**“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 profit or operating budget to demonstrate the economic argument more forcefully.
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 affect the overall organization. Conduct the pilot in an area where data on productivity and/or health costs is potentially measurable. 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.

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.

Build wellness programming into your health cost management efforts. More and more 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.

Propose that wellness be funded from benefit savings or employee premium contributions. At the time of health plan redesign and benefit changes, get agreement from management that a portion of the funds “saved” through the 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 would 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.”

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, 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.

Circulate studies and evaluation results. Select some of the best studies on the evaluation of worksite wellness programs, underlining key points in bright colors in the abstract of the article, and route 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 Health Management Guide available from Summex Health Management, entitled “Proof Positive: An Analysis of the Cost-Effectiveness of Worksite Wellness,” contains a detailed analysis of fifty-three of the most rigorous peer review studies on the cost-effectiveness of workplace wellness programs in the scientific literature.

Develop a sound evaluation plan. Spend time designing and planning a periodic and on-going evaluation plan for your 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 Guide discusses ideas for evaluation. Another Guide that covers the specifics of program evaluation, entitled “Program Evaluation: A Key to Wellness Program Survival,” is available from Summex Health Management.
Suggest that management use a “total compensation” approach to human resources. 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.

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 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.


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 marginal 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 below.

This information is then combined to help define 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.

Figure 8

General Rationales for Management Support of a Wellness Program

- It will help reduce our health costs.
- Demographic data on the workforce (i.e., age, gender, and location)
- Sick leave experience (causes are helpful, if available)
- Health plan claims data by Major Diagnostic Category (MDC)
- Quantitative productivity indicator experience (any standard measures that can be used to evaluate program effects)
- Reasons for implementing a wellness program (particularly senior management opinions)
- Previous survey results on wellness and/or health
- Dedicated physical space for program (staff and training space, particularly)
- Approximate budget range for key components (in dollars per employee per year, plus staffing)
- Health benefit experience (the composite increases in per capita health benefit costs for the last five years)
- Disability claims experience (the causes and per capita cost experience)
- Workers’ compensation claims experience (the cause, frequency, and average cost per case by years)
- Programs under consideration
- Employee wellness policies (what human resource or personnel policies are supportive of wellness)
- Employee interest survey results
How To Assess Your Organizational Culture

An organization’s “culture,” meaning the composite reflection of values, expectations, and behavioral norms reflected by 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 to the right. The greater the number of “true” responses, the greater the cultural-based potential for the 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.

Conducting An Employee Interest Survey

Employee interest surveys are 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.

**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 an insensitivity to other major issues effecting 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 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.
- Have an open-ended “other suggestions” opportunity.
- Contain a statement of appreciation for completing the survey.
- Provide an opportunity to identify volunteers.
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
calculate 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 (which will be
included in an upcoming edition of this publication.) You
may want to start with it and then modify it according to
your unique needs.

**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 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” through
of these other worksites, Figure 10 on this page contains a
number of things you should be looking for as you walk-
through the particular worksites.

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 activities will be
necessary to insure a successful program at each of the
affected sites.

---

**What to Look for During a Wellness “Walk-Through”**

- Do they have bulletin boards that can be used as
  information channels?
- Does everyone 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 evidence 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?
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** be sensitive to the culture of your workplace.
- **Do** be “inclusive” rather than “exclusive” in your approach to planning.

“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 and graphic standards.
- **Don’t** forget to give yourself enough time to plan carefully.
# A Checklist For The Planning Phase

The checklist to the left can be used to help you complete the planning process for your employee wellness program. Check each item as appropriate.

You are now ready to develop the specific design for the program!

## 2.2 Design

The design of your wellness program is the focus of this section of the wellness guide. The program model used to organize your program is a very critical issue to decide. Other important concerns include the objectives you select for your program, the program elements you adopt, your draft proposal and budget, the intended identity of the program with employees, structuring an employee advisory committee, and establishing an administrative structure for the program. These are the main components of the design of the program and will be addressed in order. See Figure 11 below. Sample program names, themes, and logo ideas are provided in Appendix E (which will be included in an upcoming edition of this publication.)

### Program Model Options

<table>
<thead>
<tr>
<th>OPTION #1</th>
<th>OPTION #2</th>
<th>OPTION #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of WorkLife</td>
<td>Traditional or Conventional</td>
<td>Health and Productivity Management</td>
</tr>
</tbody>
</table>

- **OPTION #1**
  - Mostly health focus
  - Some risk reduction
  - Limited HCM oriented
  - All voluntary
  - Site-based only
  - Weak personalization
  - Minimal incentives
  - Few spouses served
  - Weak evaluation

- **OPTION #2**
  - Mostly health focus
  - Some risk reduction
  - Limited HCM oriented
  - Voluntary
  - Site-based only
  - Weak personalization
  - Modest incentives
  - Few spouses served
  - Weak evaluation

- **OPTION #3**
  - Mostly health focus
  - Strong risk reduction
  - Strong HCM oriented
  - Some required activity
  - Site and virtual both
  - Strong personalization
  - Major incentives
  - Many spouses served
  - Rigorous evaluation

These three program options will be examined in depth in the following sections. Let’s first examine Option #1, the ‘Quality of WorkLife” style wellness program.
Option #1

Quality of WorkLife (QWL) Wellness: “Wellness For Fun and Pleasure”

The first option in worksite wellness for you to consider is the Quality of WorkLife (QWL) style wellness. 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 local wellness resources (both of which will be included in an upcoming edition of this publication.)

A. Overview – The “What”

The Quality of WorkLife (QWL) 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 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: Experiential
- Empowering: Fragmented
- Event-driven: Non-medical
- Quality of Life: Pleasure-oriented
- Light: Entertainment-oriented
- Humorous: Interest-driven
- Wholistic: Morale building
- Intrinsic: 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 Guide.

- All voluntary programming: The QWL 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 QWL 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 clinical issues.

- Limited direct emphasis on secondary and tertiary prevention: Virtually all QWL programs do not exhibit a heavy focus on the traditional wellness and wellness areas of tobacco use, exercise, nutrition, weight management, cardiovascular disease detection/prevention, and stress management. These areas of traditional 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 QWL 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 QWL Model. The traditional 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 QWL 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 QWL Program Model is less reliance on stable, traditional work environments. The QWL 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, QWL worksite wellness programs, since they do not rely on as much traditional 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 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 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 QWL 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 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 QWL program model is between zero to 1:1:5.

D. Organizing Strategies – The “How”
The organizing strategies of the Quality of WorkLife (QWL) 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 QWL 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 to take 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 proactivity: In this program model there is usually no proactivity. 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 group education techniques for
workshops, support groups, and group provision of information are usually used in the QWL 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 QWL 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 QWL Model uses many communication channels, but virtually all of the communication is geared to un-segmented target population, with very limited segment specific targeting of messages, vehicles, or program interventions.

- **Virtually no use of medical self-care/health-care consumerism focus:** The QWL 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 QWL Model program. However, the overall empowerment emphasis of the QWL 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 QWL 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, 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 QWL 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.

**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.

*Figure 12*

**QWL Wellness Activities**

- Health fair
- Biometric testing option
- Lunch-and-Learn sessions
- Wellness “event”
- Community sponsorship
- Chair massage option
- Free fruit
- Wellness materials in HR
- Health cartoons circulated
- Nutritious pot lucks
- Celebrity event

Each of these interventions will be described in turn.
\textbf{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 QWL style wellness program model. Access to the health fair is usually free and spouses are encouraged to attend.

\textbf{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 unfortunate program strategy.

\textbf{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.

\textbf{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.

\textbf{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.

\textbf{Chair massage option:} This programming option includes a regular offering of chair massage 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 massage 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 QWL 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 limited to a passive individual approach.

**Health cartoons circulated:** This intervention involves posting or circulating wellness or health-oriented cartoons. 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. Cartoons can be used on a wellness-bulletin board and can be changed weekly.

**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 fix the recipe for their own family. Variation can also include providing all recipes in a small publication where employees can mark their comments next to each recipe as they taste each. This also can provide an opportunity to recognize individual employees that are being recognized for some wellness related achievement.

**Celebrity event:** This next intervention 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 Quality of WorkLife (QWL) program model.
F. Resource Requirements – “Dollars and Sense”

The resources required for the QWL 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 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 or Conventional (ToC) 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 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. This type of programming will seldom produce any economic return for an employer.

Rarely a single intervention in this form of program will be available and will show a very high cost benefit ratio. For example a medical self-care workshop can be completed and then a 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 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. In rare cases the cost to benefit ratio for this type of program model may be as high as 1:1.5.

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.

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

The following technical resources describe in more detail the types of philosophy and activities associated with the Quality of WorkLife (QWL) Program Model and are available at www.Amazon.com:


Option #2

Traditional or Conventional (ToC) Wellness – “The Safe Approach”

A. Overview – The “What”
The Traditional or Conventional (ToC) model of worksite wellness focuses primarily on the passive offering of a more extensive set of interventions than the QWL 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 passive and focused primarily on offering information and experiences that are generally valued by most employees. The programming is usually not driven by a 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 in the history of the program. Incentives used are usually nominal and program budgets are usually not very large. Evaluation can be done, but it is usually exceedingly difficult and as a consequence often shows weak effects.

B. Key Descriptors – “Adjectives and Adverbs”
The key descriptors that help capture the heart of this particular program model are presented below:

- **Safe Medical model**
- **Comprehensive Standard approach**
- **Conventional Passive**
- **Typical Proven**
- **Most prevalent form Menu-driven**
- **Health risk oriented “Smorgasbord” approach**
- **Activity-oriented 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 each of the three major program model options presented in this Guide.

- **All voluntary programming**: The Traditional or Conventional (ToC) 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 high clinical health risk factor orientation**: In the ToC 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 improved quality of life and reductions in morbidity.

- **Heavy emphasis on primary and limited secondary prevention issues**: Virtually all programs focus on tobacco use, exercise, 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 or Conventional (ToC) Model. The typical screening areas are: hypertension, blood lipid levels, 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 ToC 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) which usually requires a higher level of integration.
Limited systems orientation: The ToC Model usually reflects a stand-alone approach to worksite wellness. Wellness or health promotion activities are not usually linked in the ToC 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 ToC Model, as with the QWL Model, there is usually no programming targeted on spouses of employees. Virtually all the wellness program interventions are usually targeted only to 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 ToC Program Model is high reliance on stable, traditional work environments. The ToC 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 work process.

Limited formal evaluation activity: Finally, traditional 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.

Moderate budget and staffing resources needed: This program model is characterized by generally 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 ToC 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 ToC program model has been documented from 1:1.5 to 1:3.5.

D. Organizing Strategies – The “How”
The organizing strategies of the Traditional or Conventional (ToC) 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 ToC 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 group education techniques for workshops, support groups, and group provision of information are usually used in the ToC 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 ToC 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 ToC 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 of or messages and vehicles.

**Limited medical self-care/health care consumerism focus:** The ToC 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 ToC Model is the primary reliance on a worksite based fitness center. Usually, ToC 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 ToC 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 ToC 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.

*Figure 13*

**Figure 13**

**Traditional or Conventional (ToC) Wellness Activities**

- Health Risk assessment (HRA)
- Biometric testing option
- Fitness club memberships/facility
- Weight management program
- Web-based health information
- Health cafeteria/vending options
- Self-care book
- Preventive medical benefit coverage
- Wellness newsletter
- Short term incentive program

Each of these interventions will be described in turn and can be added to those identified under the Option #1 QWL Program Model.
Health risk assessment (HRA): In addition to many of the program activities identified under the QWL Program Model, the Traditional or Conventional (ToC) 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 ToC Model. The HRAs are usually voluntary and with minimal incentives for their completion. Suggested technical specifications for HRAs are provided in Appendix J (which will be included in an upcoming edition of this publication.)

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 ToC 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 ToC 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 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.

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 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 packaged short term incentive programs.

F. Resource Requirements – “Dollars And Sense”
The resources required for the ToC 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 Health and Productivity Management (HPM) 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 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 QWL 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.

I. References And Further Readings: - “For Digging Deeper”

The following technical resources describe in more detail the types of philosophy and activities associated with the Traditional or Conventional (ToC) Program Model and are available at www.Amazon.com:


E-Health options provide health and wellness information to those who have computer and Internet access.
Option #3

Health And Productivity Management (HPM) Style Wellness – “Serious Wellness”

A. Overview – The “What”

The Health and Productivity Management (HPM) model of worksite wellness focuses primarily on the proactive offering of a highly structured and substantial set of interventions than either the QWL program model or the ToC 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 HPM 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 $300 to $1,000 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:

<table>
<thead>
<tr>
<th>Serious</th>
<th>Coaching oriented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive</td>
<td>Injury prevention</td>
</tr>
<tr>
<td>State-of-the-art</td>
<td>Proven</td>
</tr>
<tr>
<td>Strategic</td>
<td>Medical and behavioral model</td>
</tr>
<tr>
<td>Innovative</td>
<td>Incentive-driven</td>
</tr>
<tr>
<td>Productivity oriented</td>
<td>Futuristic approach</td>
</tr>
<tr>
<td>Results-oriented</td>
<td>Proactive</td>
</tr>
<tr>
<td>Infrastructure approach</td>
<td>High participation</td>
</tr>
<tr>
<td>Some required activities</td>
<td>High ROI</td>
</tr>
</tbody>
</table>

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 Guide.

> **Some mandatory programming:** The Health and Productivity Management (HPM) 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 HPM 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.
Balanced emphasis on primary, secondary and tertiary prevention: Virtually all HPM 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 HPM 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 HPM 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 HPM Program Model is low reliance on stable, traditional work environments. The HPM 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, HPM 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 300 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 HPM 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 HPM program model has been documented from 1:3.6 to 1:7.0.
D. Organizing Strategies – The “How”

The organizing strategies of the Health and Productivity Management (HPM) Model reflect the types of interventions that are typically used and their respective role in the overall programming strategy.

- **Strong incentives for completion of an annual Health Risk Assessment (HRA):** The HPM Model utilizes either a strongly incentivized completion of an annual paper-based or web-based HRA (Providing more than $100 of pre-tax or after tax value to the participant for its completion or completion of the HRA) is part of the annual application process for continuation of health benefit coverage. For example, in order to initiate or maintain health benefit coverage, employees would complete the HRA once every 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 HPM 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 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 HPM 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 to 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 HPM 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 HPM 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. Health 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 HPM Model of worksite programming, such as individual counseling, self-directed change materials, on-line phone support, etc. WellBeing 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, exercise, nutrition, weight management, cardiovascular disease detection/prevention, and stress management, the HPM 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 HPM Model through the linking campaigns, extensive education and communications preceding testing
opportunities, follow-up intervention opportunities, and providing opportunities for retest. Events with intentional linkages and integration among the program components are the general pattern for the HPM Model.

**Strong systems orientation:** The HPM 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 HPM Model, core incentive programs, as well as incentive features, 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. However, not all program activities are structured around the incentive program, which distinguishes this model from the Incentive-Based Model.

**Use of segmented group communications:** The HPM 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 HPM Model usually provides a clear, strong, and recurring focus on medical self-care programming or 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 HPM 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 worksite and usually affect employees in high density as well as remote locations. There is broader use of “virtual wellness” style programming.

**Moderate intentional cultural change:** The HPM 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 HPM 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 usually in significant transition.

**Significant formal evaluation activity:** Finally, HPM 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 HPM Model, is typically much more comprehensive and much more 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.

**Figure 14**

**HPM Style Wellness Activities**

Everything previous plus...

+ HRA (incented and used for targeting)
+ Risk stratification and interventions
+ Telephonic coaching
+ Medical self-care and consumer workshop
+ Injury prevention
+ Benefit linked incentive
+ Wellness achievement incentives
+ Resiliency initiative for productivity
+ Spouses also served
+ Integrated programming
+ Uses HPM framework

Each of these interventions will be described in turn and can be added to those identified under the Option #1 QWL 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 HPM program model, HRAs are also used for individual targeting of interventions. These paper-based or web-based 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. 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 HPM Model. The HRAs are usually required for continued benefit eligibility or for a significantly health plan premium discount.

**Risk stratification and interventions:** Using the HRA data and selective health claims data the workforce is stratified by major risk status. These stratifications usually include: disability risk, chronic disease risk, high health risk, moderate health risk, selective at-risk and low risk. Each group then has a set of interventions and incentives for their completion. This risk stratification approach permeates the 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 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 at-risk issues such as: intention to become pregnant, recent low back pain, anticipated hospital admission or surgical procedure, high levels of somatic complaints, would also receive telephonic follow-up. Finally those who are low risk would receive one telephone contact during the year and would be encouraged to utilize web-based information and lower cost interventions to remain at low risk.

**Medical self-care and consumer workshop:** Programs that adopt an HPM approach usually have to dedicate specific time each year to training on medical self-care and consumer education. Typically a two hour time period 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 avoid common health problems. Medical self-care reference texts 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 HPM program model also has a strong injury prevention focus that goes beyond the traditional 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 100% time emphasis with 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 accidents and others.

**Benefit linked incentive:** Another key intervention of the HPM 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 premium discount on their health plan coverage. The benefit linkage can also take the form of more benefit credits for purchasing 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 $300 to $1,000 in order to gain high levels of participation.

**Wellness achievement incentives:** The HPM program model usually includes some method such as a criteria-based incentive program that is intended to catalyze participation in the program and 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:

**Figure 15**

<table>
<thead>
<tr>
<th>Possible Wellness Achievement Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Criterion #1</strong></td>
</tr>
<tr>
<td>&quot;No tobacco product use of any kind since January 1 or participation in an approved tobacco cessation program within this time period.&quot;</td>
</tr>
<tr>
<td><strong>Criterion #2</strong></td>
</tr>
</tbody>
</table>
| "A minimum average of two times a week use of an on-site fitness facility or an outside fitness facility or completion of an on-going activity log with minimum qualifying levels of activity since January 1."
| **Criterion #3**                      |
| "Participation in at least 2 qualifying wellness program activities or web-based programs since January 1."
| **Criterion #4**                      |
| "An Overall Wellness Score (OWS) of 85 or higher on the HRA or a minimum improvement of 10 points from the previous HRA."
| **Criterion #5**                      |
| "Active participation in the wellness program as: a Wellness Mentor, Wellness Menteer, Wellness Rep, or having originated a wellness activity at your own site since January 1."
| **Criterion #6**                      |
| "A Body Mass Index (BMI) in a healthy range for age and gender or participation in a weight management program or health coaching process since January 1."
| **Criterion #7**                      |
| "Attendance at a 2 hour Consumer Training Workshop and successful completion of the Wellness Quiz on the company website since January 1. or completion of a Personal Safety Checklist."
Resiliency initiative for productivity: Another typical component of an HPM style wellness program is an initiative that is designed to enhance employee resiliency and productivity. These resiliency efforts are designed to help prevent common reasons, such as health conditions, for 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.

Spouses also served: Another major intervention of the HPM 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 with the spouse. 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 facilities, access to web-based health management information, preventive medical benefit coverage and through invitations to participate in selected wellness activities.

Integrated programming: Another intervention associated with the HPM program model is the use of highly integrated programming. All interventions offered to the eligible population are examined for their ability to enhance each others 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 programs, financial planning and other benefit services.

Uses HPM framework: As part of the HPM program model there is also the use of the HPM Framework identified in Figure 17 below. This framework was first published in an article in the
American Journal of Health Promotion and later expanded in the Institute for Health and Productivity Management’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 HPM program model.

F. Resource Requirements – “Dollars and Sense”

The resources required for the HPM program model are greater than the other two models combined. The likely annual per employee per year cost for this form of worksite wellness programming is likely to be from $151 to $450. 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 budget. One full time dedicated staff member (either company or vendor) with specialized training is usually needed for every 300 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, or preventing injuries during winter. Typically this is a much more sophisticated approach to worksite wellness programming and is usually reached by an organization that does the ToC program model for a number of years and then desires to have much greater health and economic return and moves to this 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 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 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 1:6.00 producing six 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”

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 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.

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

The following technical resources describe in more detail the types of philosophy and activities associated with the Health and Productivity Management (HPM) Program Model and are available at www.Amazon.com:


### J. Your Program Model Options At A Glance

<table>
<thead>
<tr>
<th>Program Feature</th>
<th>Option #1 Quality of WorkLife Program Model (QWL)</th>
<th>Option #2 Traditional or Conventional Program Model (ToC)</th>
<th>Option #3 Health and Productivity Management Program Model (HPM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary versus mandatory activities</td>
<td>All voluntary</td>
<td>All voluntary</td>
<td>Some mandatory</td>
</tr>
<tr>
<td>Clinical risk factor orientation</td>
<td>Weak</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>Type of prevention*</td>
<td>1°</td>
<td>1° + 2°</td>
<td>1° + 2° + 3°</td>
</tr>
<tr>
<td>Degree of program integration</td>
<td>None</td>
<td>Weak</td>
<td>Strong</td>
</tr>
<tr>
<td>Systems orientation</td>
<td>None</td>
<td>Weak</td>
<td>Strong</td>
</tr>
<tr>
<td>Participation of spouses</td>
<td>None</td>
<td>Weak</td>
<td>Strong</td>
</tr>
<tr>
<td>Worksite based program</td>
<td>All</td>
<td>All</td>
<td>Work and home</td>
</tr>
<tr>
<td>Budget requirements for programming</td>
<td>Limited</td>
<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>
<tr>
<td>Operating Principle</td>
<td></td>
<td></td>
<td></td>
</tr>
<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>Heavy</td>
</tr>
<tr>
<td>Medical self-care and consumer emphasis</td>
<td>None</td>
<td>Light</td>
<td>Weak</td>
</tr>
<tr>
<td>Onsite fitness facility emphasis</td>
<td>Weak</td>
<td>Strong</td>
<td>Strong</td>
</tr>
<tr>
<td>Intentional cultural change orientation</td>
<td>Weak</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>Organizing Principle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>None</td>
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<td>None</td>
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<td>Weak</td>
</tr>
<tr>
<td>Onsite fitness facility emphasis</td>
<td>Weak</td>
<td>Strong</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, cholesterol levels, 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 (which will be included in an upcoming edition of this publication.)

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

The framework recommended here for use in organizing your worksite wellness program has been field tested with more than 600 employers with employee populations that range in size from 19 employees to 1.4 million. The model and its five major components are highlighted in Figure 18.

This organizing framework 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 of the five major programmatic components, the larger the program budget. This suggested structure also has a logical rationale behind it. The Administrative Structure is the infrastructure upon which the program is planned and conducted. The Wellness 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 and should be done continuously. The Health Management Process is the component that provides the individual’s test results and helps structure the personal behavior change process. This component is potentially more powerful because it uses the subject’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 Policies component provides general reinforcement for wellness behaviors by making changes in the environment which make it easier to initiate and maintain a specific health behavior change.

There is also another expression or level to this internal logic in the program design. For each targeted risk factor (such as smoking) it is possible to organize activity in each one of the five components and to think through the completeness of the program effort by using 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 Policies component efforts. This internal logic provides value to the model in addition to its operational usefulness in structuring a wellness program. Readers are encouraged to try the program model out to test its relevance and utility.

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 will help organize your wellness efforts. It is usually advisable to develop five to eight 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, and operational objectives. Each type of objective needs to meet the basic criteria as follows:

Objectives should be...
- 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 of 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. 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 requesting 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. A sample set of first year wellness program objectives is contained in Figure 19.

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.

4. Suggestions for major activities in each program component.

For each of the five major program components, there are several possible program ideas or options that can be implemented and general descriptions of major options and activities are presented in the accompanying figures.

![Administrative Structure](image)

Sample Set of Wellness Program Objectives

<table>
<thead>
<tr>
<th>Overall Goal</th>
<th>To improve the health &amp; well being of employees and their family members.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Objectives:</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Reduce the average number of annual sick leave absenteeism hours for all employees by 10% from the previous year.</td>
</tr>
<tr>
<td>2.</td>
<td>Establish a wellness advisory group, select and train a wellness coordinator, develop a program plan, budget, and evaluation plan by January 1.</td>
</tr>
<tr>
<td>3.</td>
<td>Formally launch the employee wellness program with a letter from the CEO and President by February 1.</td>
</tr>
<tr>
<td>4.</td>
<td>Provide cholesterol screening to 1,350 employees by March 1.</td>
</tr>
<tr>
<td>5.</td>
<td>Conduct four Resiliency education classes for employees and their family members in the headquarters location by June 1.</td>
</tr>
<tr>
<td>6.</td>
<td>Train 1,200 employees and family members in medical self-care and health care consumerism by September 30.</td>
</tr>
<tr>
<td>7.</td>
<td>Conduct a blood pressure “sweep” for all employees by October 1.</td>
</tr>
<tr>
<td>8.</td>
<td>Organize a financial incentive program linked to program participation and have it ready to implement as of January 1 of next year.</td>
</tr>
<tr>
<td>9.</td>
<td>Conduct and write up a first year evaluation of the program by March 1 of next year.</td>
</tr>
<tr>
<td>10.</td>
<td>Implement a Consumer-Driven Health Plan (CDHP) for all employees by September 1.</td>
</tr>
</tbody>
</table>
### Communications and Awareness

<table>
<thead>
<tr>
<th>Name</th>
<th>Brief Description of Major Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Launch 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>Mail Request Card</td>
<td>A mail request card 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>Payroll Inserts</td>
<td>Wellness messages prepared for use as payroll inserts.</td>
</tr>
<tr>
<td>Web Information</td>
<td>Information provided through Intranet and Internet websites.</td>
</tr>
<tr>
<td>Email</td>
<td>Wellness email messages, ads and information which is distributed in highly computerized 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>Fax Trees</td>
<td>Fax reproductions distributed to remote sites or departments through fax tree networks.</td>
</tr>
<tr>
<td>PDA messaging</td>
<td>Information sent through the individual’s Personal Digital Assistant.</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>

### Health Management Process

<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 12-20 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 mammography, PSA, ultra-sound diagnostic purposes, bone density scans, and others.</td>
</tr>
<tr>
<td>Wellness Assessment</td>
<td>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 differences.</td>
</tr>
<tr>
<td>Wellness Coach</td>
<td>An individual trained to help the individual make long term health behavior change in either face-to-face or by telephone.</td>
</tr>
<tr>
<td>Web-Based Self-Tests</td>
<td>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.</td>
</tr>
<tr>
<td>Wellness Mentor</td>
<td>An individual who has made a successful behavior change and is now supporting another individual to make a similar change.</td>
</tr>
<tr>
<td>Weight Scales</td>
<td>Providing opportunities for individuals to weigh themselves on accurate scales.</td>
</tr>
<tr>
<td>Software</td>
<td>Software that provides tracking and record-keeping support for health behavior change.</td>
</tr>
<tr>
<td>Health Advice Lines</td>
<td>Toll-free numbers where clinically trained personnel can help answer questions from individuals about their situation.</td>
</tr>
</tbody>
</table>
**Group Activities**

<table>
<thead>
<tr>
<th>Name</th>
<th>Brief Description of Major Activities</th>
</tr>
</thead>
<tbody>
<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 exercise.</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>Resiliency</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 exercise 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>

**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>Showers for Exercisers</td>
<td>The physical installation of showers on work premises for those employees who want to exercise as part of the workday.</td>
</tr>
<tr>
<td>Release Time for Exercise</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 Exercise</td>
<td>A formal policy which encourages supervisors to allow employees to utilize flex time to help schedule exercise into their work day.</td>
</tr>
<tr>
<td>Wellness Incentive Policies</td>
<td>A set of policies or benefit linkages that provide for cash or other valuable rewards based on an individual’s health habits and/or use of health benefits. Other incentive forms include risk rated premiums, flex plan wellness credits, merchandise systems, wellness-oriented Health Savings Accounts (HSAs) and others.</td>
</tr>
<tr>
<td>Wellness Lending Library</td>
<td>An organized lending program for wellness books, materials, audio tapes, and videos which employees and their family members can borrow and use.</td>
</tr>
<tr>
<td>Consumer-Driven Health Plan (CDHP)</td>
<td>A High Deductive Health Plan combined with a personal health care account.</td>
</tr>
<tr>
<td>Preventive HR Policies</td>
<td>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.</td>
</tr>
</tbody>
</table>
5. Examples of wellness programs.
In this section, we deal with examples of the three Models of programs, the Quality of WorkLife program (QWL) model, the Traditional or Conventional (ToC) program model and the Health and Productivity Management (HPM) style program model. Each of these three different options for worksite wellness programs is briefly discussed, including some of the practical considerations, cost implications, and program impact implications of each level.

Figure 25 contains a brief summary of a QWL style employee wellness program.

This level of programming brings increased awareness and information availability to your population. Although there may be some benefit from the experiential wellness, this level of programming will usually have a fairly minor impact on individual health behavior and the prevalence of risk factors among the population. The cost of the QWL program described above is approximately $0 to $45 per employee per year, and does not generally require dedicated professional staffing. A part time health promotion coordinator would be necessary at the beginning to help initiate and guide the program. This is the low cost program approach. Figure 26 contains an example of a ToC style employee wellness program.

**Example of ToC Style Wellness Program**

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

*Example of a QWL Wellness Program*

<table>
<thead>
<tr>
<th>Wellness Communication</th>
<th>✓ Distribute free pamphlets in the Human Resources.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✓ Post the wellness newsletter on bulletin boards.</td>
</tr>
<tr>
<td></td>
<td>✓ Distribute a health tip memo periodically.</td>
</tr>
<tr>
<td></td>
<td>✓ Put wellness information in the employee newsletter.</td>
</tr>
<tr>
<td>Health Management Process</td>
<td>✓ Provide a weight scale in the lunchroom.</td>
</tr>
<tr>
<td></td>
<td>✓ Offer to take blood pressures periodically in the cafeteria.</td>
</tr>
<tr>
<td></td>
<td>✓ Provide an annual personal Wellness Inventory option.</td>
</tr>
<tr>
<td></td>
<td>✓ Provide a chair massage time each week.</td>
</tr>
<tr>
<td>Group Activities</td>
<td>✓ Run a periodic weight loss contest, dividing the fee “pot” among those who have kept weight off at six months after the contest.</td>
</tr>
<tr>
<td></td>
<td>✓ Organize an active walking club and lunch outings.</td>
</tr>
<tr>
<td></td>
<td>✓ Provide a “Colors” program to help understand working and communication styles.</td>
</tr>
<tr>
<td></td>
<td>✓ Provide a membership discount to a local fitness club.</td>
</tr>
<tr>
<td></td>
<td>✓ Provide a naturopathic physician for brief consultation sessions at work.</td>
</tr>
<tr>
<td>Supportive Policies</td>
<td>✓ Adopt a smoke-free policy.</td>
</tr>
<tr>
<td></td>
<td>✓ Put a microwave into the lunch room.</td>
</tr>
<tr>
<td></td>
<td>✓ Provide healthier choices in vending machines.</td>
</tr>
<tr>
<td></td>
<td>✓ Remove cigarette vending machines.</td>
</tr>
<tr>
<td></td>
<td>✓ Purchase posters and cartoons and place them on bulletin boards.</td>
</tr>
</tbody>
</table>
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 ToC 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 HPM style program is contained in Figure 27. This level of programming requires a major commitment of resources and organizational energy.

The HPM 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. For this level of direct and vendor provided programming, there should be a full time, professional health promotion staff person for every 300 to 700 employees.

### 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 the level of sophistication of the program developer(s).

If you are that 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” 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 (which will be included in an upcoming edition of this publication.)
- 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.

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### Example of HPM Style Wellness Program

<table>
<thead>
<tr>
<th>Wellness Communication</th>
<th>Supportive Policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Distribute brochures through a mail request vehicle periodically for each work group.</td>
<td>✓ Adopt a smoke-free policy.</td>
</tr>
<tr>
<td>✓ Send wellness newsletter to employees in their homes each month.</td>
<td>✓ Put a microwave and healthy menu options into the cafeteria.</td>
</tr>
<tr>
<td>✓ Post wellness and motivational posters on bulletin boards.</td>
<td>✓ Require periodic completion of the health survey to maintain health plan coverage and provide a $600 health plan discount for meeting 8 of 10 wellness achievements linked to program participation, health status attainments, behavioral compliance and meeting organizational indicators.</td>
</tr>
<tr>
<td>✓ Distribute wellness materials periodically.</td>
<td>✓ Establish a fitness facility at each worksite.</td>
</tr>
<tr>
<td>✓ Provide a wellness library with books and videos to check out, and connect these to a core incentive program.</td>
<td>✓ Install walking trails and showers at all major locations.</td>
</tr>
</tbody>
</table>

### Health Management Process

<table>
<thead>
<tr>
<th>Group Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ 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 formal contest cycle.</td>
</tr>
<tr>
<td>✓ Organize an active walking and recreational activities club.</td>
</tr>
<tr>
<td>✓ Offer smoking cessation and weight management classes.</td>
</tr>
<tr>
<td>✓ Conduct periodic resilience workshops.</td>
</tr>
<tr>
<td>✓ Operate an on-site fitness facility with a strong linkage to the core incentive program.</td>
</tr>
</tbody>
</table>

---

**Figure 27**

An example of a HPM style program is contained in this publication.)
An outline of a draft wellness program proposal is contained in Figure 28.

This draft proposal should be carefully reviewed before submitting it to senior management to ensure that all major, outstanding issues of concern have been addressed in the proposal. Once reviewed, you are probably ready to submit it for approval and potential funding.

**Outline of a Wellness Program Proposal**

Executive Summary (1-2 Pages)

A. Preface
B. Overview and Background of Current Wellness Activities
C. Proposed Program Mission and Vision
   Introduction
   Include a summary of major trends in workplace wellness, cost-benefit ratios, key characteristics of successful programs, local employer activities, labor pool competitor’s activities, employer survey results, and basic risk factors.
   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.
D. 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.
E. 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 (which will be included in an upcoming edition of this publication.)
F. 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.
G. Proposed Timetable
H. 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.
I. Proposed Next Steps
J. 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.

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 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
- Guilt free
- Consistent
- Not too slick
- 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 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/design committee that is tasked with helping design the program, and then a new advisory committee can be formed 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 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 on the program.

**Stagger the terms of office:** Set the committee up so that each individual has a one to three year term and hold a drawing that allows ¼ 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. This 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 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
- 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 a formal orientation.** 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 move the program in inappropriate directions.
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 two 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. Committee deliberations should be focused on issues that help the program meet the needs of the workforce it serves. These questions include the following:
- How should the program be presented to 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 the connection with a CDHP and the program be made?
- What should we be planning for the next cycle?

Keep moving the committee toward a 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 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 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, 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 has the potential 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 an inappropriate direction when you need to go 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 programs, particularly if there are multiple collective bargaining units involved.

9. Suggestions for the Program’s Administrative Structure

The administrative structure of the program 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. Most worksite wellness programs require the administrative structure and vehicles contained in Figure 29 below.

**Figure 29**

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

1. **A part-time or full-time wellness coordinator:** The person 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 600-800 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 maximize 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 annual workshops and conferences that can help prepare them. 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 capability with people skills.

2. **An employee advisory committee:** Because 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 it 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 a management initiated program forced on employees 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 need their own employee advisory groups that operate with some latitude, but maintain the core, corporate-wide program as the base.
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 an action team. These small groups, with one clear leader for each small group, are initiated by the wellness program coordinator and function to plan the specifics of the program component. They also help implement the program or campaign. The small groups should report back to the employee wellness coordinator and 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 stop smoking facilitator, aerobics instructor, or brown bag educational session presenter. It is only the smallest of work groups that do not 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 are 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 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 going to accomplish much sustained meaningful behavior change or reduction of health risk factors.

7. **Program goals**: The program should have several overall goals and a series of five to eight measurable, time limited, attainable, but challenging objectives. Examples of these objectives can be found in an earlier section. Initially, these objectives will help provide a planning framework. Later in the program, they have the ability to efficiently conduct evaluation and provide 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.
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.
- **Do** get broad involvement in ratifying the draft program proposal.
- **Do** adopt five to eight good, measurable, time limited 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 lifestyle change versus work-related health risks.
- **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.

“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 identify employee involvement and ownership in the program.
- **Don’t** be dissuaded from tackling primary, secondary, and tertiary prevention.
- **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.

**Design Phase Checklist**

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

2.3 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.

**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 a draft program launch memo or letter (which will be included in an upcoming edition of this publication.) This should be done at the beginning of the program and can be done each year as an introduction to any new program activities. If your senior manager is the initiator of the memo or letter 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 HPM 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 $300 to $1,000 “carrot” attached to program participation and wellness achievements, you are likely to have a very high level of participation. 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 30, as follows:

Figure 30

<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>E-mail Registration</td>
<td>1 week ahead</td>
</tr>
<tr>
<td>Reminder Notice</td>
<td>2-3 days ahead</td>
</tr>
<tr>
<td>E-mail Reminder for Registrants</td>
<td>1 day ahead</td>
</tr>
<tr>
<td>E-mail Reminder for Registrants</td>
<td>1 hour ahead</td>
</tr>
</tbody>
</table>

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 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.

Written 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 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 Awareness Communication Methods

The following awareness communications methods represent traditional 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 31 contains a listing of the traditional awareness communications methods for use in worksite settings.
Each of the Traditional Awareness and Communication methods will be discussed in turn.

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 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 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 gatekeeping that occurs for many different reasons.

3. **Bulletin board notices.** Another very traditional 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 methods such as 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, 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. However, bulletin boards are losing their general utility with most work groups.

4. **Printed pamphlets.** A very traditional 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 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 somewhat in

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<table>
<thead>
<tr>
<th>Traditional Awareness and Communication Methods</th>
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<tbody>
<tr>
<td>1. Announcements during meetings</td>
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<tr>
<td>2. Written individual notices</td>
</tr>
<tr>
<td>3. Bulletin board notices</td>
</tr>
<tr>
<td>4. Printed pamphlets</td>
</tr>
<tr>
<td>5. Payroll inserts</td>
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<tr>
<td>6. Marquees and electronic billboards</td>
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<tr>
<td>7. Face-to-face individual information sessions</td>
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<tr>
<td>8. Group information sessions</td>
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<tr>
<td>9. Audio presentations</td>
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<tr>
<td>10. Audiovisual presentations</td>
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<tr>
<td>11. Video opportunities</td>
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</table>
usefulness as the number of employees with electronic deposit of paychecks increases. In addition, speculation has sometimes been made 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 a 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 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, television monitors, and VCRs 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 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, but may be combined with traditional methods in the design of awareness or employee communication programs. Figure 32 highlights the major non-traditional awareness and communication methods that can be used in the worksite.

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 be 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 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 bulletin boards.** Another awareness technique or method involves the use of computer 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. **Electronic mail.** Another computer-based communication technique involves the use of electronic mail. 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. **Fax networks.** Facsimile transmission equipment offers another more innovative methodology for the transfer of information.
The widespread distribution of fax technology makes this a particularly useful tool for remote worksites and locations. Many fax machines provide simultaneous, pre-programmed, multi-site transmission.

10. Telephone contact. The use of health advice lines and the provision of toll-free access to health and wellness professionals for advice represents a newer non-traditional 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 recent development and it is likely that more wellness-related applications will become commercially available.

12. Computer-aided search station. Another awareness-aided method that is usually linked to CD-ROM 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, providing health information for the individual.

The large number of traditional and non-traditional communication and awareness methods provide a clear picture of 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 that you use for maximum effect.

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 from the senior manager. Prepare a very positive and supportive letter from the senior manager, stating why the program is being introduced, what activities will be offered, what employees were and 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 effective, 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 make a nice 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 help draw increased attention to the new 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 give-away, 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 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 use, 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 (which will be included in an upcoming edition of this publication.)

**Use a wellness or fitness contest to promote interest.**

Another approach for energizing a program launch involves a promotional 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. 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.”

**Tips For Scheduling Your Wellness Program Activities**

The scheduling of wellness program activities is important in assuring high levels of employee and 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 building self-esteem 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 social event opportunity.

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 testing process. This is also designed to help move people through the stages of readiness by linking opportunities created through education, testing, and into behavioral intervention.

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 the luxury. However, fewer and fewer employers are using work time for programming because of the adverse effects of downsizing, re-engineering, and the general instability of 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 exercise or the personal side effects of non-exercise before opening up an aerobics or physical activity opportunity for employees. This also supports stage of readiness to change behavioral technology.

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. Instead of overwhelming the target population(s), pace yourself!

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

11. All scheduling needs to be communicated with redundancy and clarity just as with all activities where you want maximum participation.

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

### Use Of Health Risk Assessments (HRAS)

Health Risk Assessments (HRAs) are written questionnaires that relate an individual’s lifestyle choices, behaviors, and current health conditions to probable longevity or morbidity. These instruments can be self-scored or computer-scored and are used as a way of catalyzing an individual’s interest in wellness-related behavioral choices. These types of instruments are sometimes used in a stand-alone approach to employee wellness. However, they 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 central characteristics of these new HRAs are identified in Figure 33 below.

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 manner. The HRA should be used to establish a permanent database that can be utilized for phone-based counseling and high-risk intervention. This also implies that where HRAs are used, there should be a behavioral intervention to improve

![Figure 33](image-url)

#### Characteristics of Contemporary Health Risk Assessments

- Request information on an individual’s demographic characteristics, family medical history, personal medical history, major chronic diseases and conditions, lifestyle choices, perceived health status, and selected health parameters.
- Usually computer processed.
- Compares the individual’s response against a large population database to examine likely longevity and/or probability of morbidity.
- May impute a relative “health age” that is the composite level of risk associated with individual’s current lifestyle choices.
- Provides the individual with a print-out or prescription that attaches a health outcomes probability or value to selected behavior changes.
- Generally helps you determine who are the individuals at high risk so intervention can take place.
- Looks at perceived health status.
- Examines 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 behavioral risk areas.
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, will be repeated at six- to twelve-month intervals, and the individuals are reminded of their previous responses and challenged to produce improvement in their personal scores, it is preferable to use HRAs in a stand-alone, isolated manner. The next generation HRAs will be indispensable tools for behavior change and long-term health management, and will need to be part of a well-designed and implemented program. For a list of suggested technical specifications for HRAs, see Appendix J (which will be included in an upcoming edition of this publication.)

**Selecting Good Program Vendors And Materials**

When establishing an employee wellness program, your internal staff can perform many functions. For example, training staff can frequently conduct stress management or resiliency education training, occupational nursing staff can conduct health screenings; personnel staff can develop wellness communication vehicles and other activities. Regardless of the scope of internal resources an organization has, usually specific activities need to be purchased from outside vendors. These outside services typically include health and fitness testing, cholesterol screening, wellness coaching, facilitating smoking cessation classes, leading weight management support groups, or teaching medical self-care sessions. When selecting outside vendors, it is important to make sure that you get the best that you can. One of the ways that you can select good vendors is to use a Request for Proposal (RFP) process for programs for large populations of over 1,000 employees, and a series of questions for selecting vendors outside of the more formalized RFP process.

The RFP process usually involves the following steps:

1. Development of a definition of the features of the services that you want to purchase.
2. Translation of those desires into an RFP in the form of specifications that a potential vendor who submits a proposal is required to address.
3. Selection of potential bidders who will receive the RFP.
4. Distribution of the RFP to the potential bidders.
5. Delineation of a review timetable and development of criteria for evaluation of proposals submitted in response to the RFP.
6. Receipt of the proposals submitted in response to the RFP.
7. Conducting a process that evaluates the proposals using the identified evaluation criteria, and resulting in the definition of the proposal and price that best meets the requirements of the RFP.
8. Notification of potential bidders at the outcome of the review, and negotiating and developing a contract with the bidder whose proposal was selected.

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 in an informal manner of wellness program vendors. These questions can be adapted to the specific type of service offered by the vendor. Figure 34 contains a series of general questions that should be used to help select wellness program vendors. These questions can be used informally to help select vendors of any kind.

**General Questions for Health Promotion Program Vendors**

**General Concerns:**
1. What are the educational and experiential qualifications of the key staff?
2. How many times has the program been given and to what kinds of employee populations?
3. What kinds of materials are used?

**Program Methods:**
1. How do you know your materials approach will meet the needs of my workforce?
2. How do you suggest the program be marketed to my employees?
3. What materials do you provide to market the program to employees?
4. What is the basic educational design that you use in the program?
5. What provisions do you have for follow-up?
6. How do you provide for referrals and linkages to other programs that are needed by participants?
7. What kinds of behavior modification techniques do you use in your program?
8. Does your program use the Transtheoretical or Stages of Change approach?

**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?
Delegating Responsibility
The development of an employee wellness program will 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 35.

The more a wellness program coordinator who is responsible for program implementation can develop these skills, the more successful the program will likely be.

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 in a shoddy manner.
- 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 overall 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 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 affects employee reactions.
- 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!).
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.

<table>
<thead>
<tr>
<th>Implementation Phase Checklist</th>
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<tbody>
<tr>
<td>☐ We have utilized an appropriate program model or models for implementing the program.</td>
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<tr>
<td>☐ We have identified a marketing approach for the series of specific program activities to be conducted during the coming year.</td>
</tr>
<tr>
<td>☐ Each of the identified activities has an individual who has accepted responsibility for its implementation.</td>
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<tr>
<td>☐ There is a systematic mechanism in place to follow-up on the timely completion of each assigned task.</td>
</tr>
<tr>
<td>☐ We have an identified a budget and a timetable for the program.</td>
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<tr>
<td>☐ We have scheduled the proposed group activities for the year.</td>
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<tr>
<td>☐ We have identified where and how HRAs will be used in the program.</td>
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<tr>
<td>☐ We are meeting monthly to go over our draft program work plan.</td>
</tr>
<tr>
<td>☐ We are reviewing our program budget on at least a quarterly basis.</td>
</tr>
<tr>
<td>☐ We are implementing an appropriate level of programming for our objectives.</td>
</tr>
<tr>
<td>☐ We have taken steps to create a desired program identity that is guiding or influencing the way we implement the program.</td>
</tr>
<tr>
<td>☐ We have consistently utilized a wellness advisory committee.</td>
</tr>
<tr>
<td>☐ We have received user feedback on the program as it has been implemented.</td>
</tr>
<tr>
<td>☐ We are adequately staffed to implement the program.</td>
</tr>
<tr>
<td>☐ We are generally meeting the timetable for the program’s activities.</td>
</tr>
<tr>
<td>☐ We are working to better integrate wellness values into other facets of our organization.</td>
</tr>
<tr>
<td>☐ We are communicating program accomplishments to our senior managers.</td>
</tr>
<tr>
<td>☐ We have tried to reach all sub-groups and sites with our program.</td>
</tr>
<tr>
<td>☐ We have followed through on the appropriate Do’s.</td>
</tr>
<tr>
<td>☐ We have avoided the appropriate Don’ts.</td>
</tr>
</tbody>
</table>

As you work on implementation of your program, try to keep an eye on the things you have learned and how these things will be shaping your next year of programming.
Don't accept rising health costs due to poor employee health.
You already know that your high-risk employees consume most of your health care budget.

Those employees want a healthier lifestyle.
The right kind of help will get them there.

Our interventions move 35% of your high-risk employees to low-risk status in one year.

We'll show you how.
Planning Wellness

In this issue of *Absolute Advantage*, we’ve partnered with nationally recognized wellness expert, Larry Chapman. As you may know, Larry is the Chairman and Founder of the Summex Corporation, an Indianapolis-based population health management company. In this issue, Larry will provide important information regarding the planning, design, and implementation of effective wellness programs. And, because this is such an important topic, we’ll actually dedicate a future issue of *Absolute Advantage* to addressing it as well.

With Larry’s 20+ years of experience in designing effective wellness programs, this issue of *Absolute Advantage* will first explore the fundamentals of worksite wellness. In addition, Larry will walk through the key steps for planning, designing, and implementing successful wellness programs as well as provide useful checklists to help guide you through the process of designing your own employee wellness program.

I’d like to extend special thanks to Larry for his dedication to the field and his willingness to selflessly share information that can help to advance worksite health promotion.

I hope you enjoy this first of the two-part series dedicated to wellness planning.

Yours in good health,

Dr. David Hunnicutt
President, Wellness Councils of America