THE EVOLUTION OF THE HEALTH OPPORTUNITY PROGRAM MODEL: LESSONS LEARNED IN THE PROCESS OF CREATING AN EVIDENCE-BASED, RESULTS-ORIENTED WORK SITE WELLNESS PROGRAM AT THE SIERRA NEVADA BREWING COMPANY

A Project
Presented
to the Faculty of
California State University, Chico

In Partial Fulfillment of the Requirements for the Degree Master of Arts in Interdisciplinary Studies Wellness and Health Education

by
Ana Varona
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AN EVIDENCE-BASED, RESULTS-ORIENTED WORK SITE
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ABSTRACT

THE EVOLUTION OF THE HEALTH OPPORTUNITY PROGRAM MODEL: LESSONS LEARNED IN THE PROCESS OF CREATING AN EVIDENCE-BASED, RESULTS-ORIENTED WORK SITE WELLNESS PROGRAM AT THE SIERRA NEVADA BREWING COMPANY

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This project has two related parts. The first is a review of the field of health promotion and its applications to worksite wellness facilitation. It examines the rationale for wellness programs, the various models and components that have been developed, and the theoretical bases for effective applications. It includes a detailed description of Sierra Nevada Brewing Company’s Health Opportunity Program as an illustration of worksite wellness program implementation. The second part is a supplementary PowerPoint
presentation that may be delivered to prospective wellness facilitators or business leaders interested in the theory and practice of worksite wellness.
CHAPTER I

INTRODUCTION

In February of 2008, I responded to a job posting by the Sierra Nevada Brewing Co. in Chico, CA. The company was looking for a fulltime massage therapist to add his or her services to their employee benefits offerings. In the process of being interviewed, I proposed the added role of wellness facilitator, giving proof of previous experience and qualifications to direct a worksite wellness program. Although the company had implemented a number of wellness initiatives, a systematic program had not yet been established. The idea was accepted and I was hired to fulfill the dual role of massage therapist and wellness program facilitator.

After establishing the therapeutic practice, the remainder of that year was dedicated to the preliminary work of designing the wellness program and introducing it first to management, and then to the workforce. I read everything I could find, and located resources and training programs to bring my wellness skills up to date. The company was generous enough to send me to the Health Management Training Seminar offered by Wellsource, a respected worksite wellness provider and training organization in Portland, Oregon. I then presented management with a proposal for a comprehensive in-house program. It included evidence-based data on the relationship of health risks to health costs and productivity, a job description for the position of Wellness Coordinator, a detailed description of program components, a budget, and a strategic plan. By the end
of the year the Health Opportunity Program (HOP) was launched with a presentation at an all-employee meeting, followed by the first large-scale health screening for employees and spouses in early 2009.

What follows is an overview of the theoretical and scientific basis of the program and a documentation of its design, development, implementation, and modifications over the course of three years. This qualitative review and program description, and the supplementary PowerPoint presentation, will explore the art and science of health promotion and worksite wellness and its applications to an actual program. It will document the models, strategies, and elements that have been adopted; the various program components and their applications, the lessons learned, and the vision for the next stage of development.

Given the massive body of scientific literature that supports the need for improving specific areas of personal health and the extensive evidence-based recommendations available to the public for making these improvements, this report will not explore this literature in detail; reference will be made to the literature only as it applies directly to wellness programming. The science of behavior change, however, will be given special attention. This is an area that offers perhaps the greatest challenge to health promotion practitioners and program designers. Fortunately, the more recent literature is framing its findings in ways that relate directly to health promotion. As a profession, as individuals, we know what needs to change—the evidence is unequivocal—but we’re still lagging on how to get there. The research and writings of leaders in the various fields contributing to health promotion and worksite wellness have been critical to the development of the HOP and will continue to inform its evolution.
A Health Crisis in Need of a Solution

The function of protecting and developing health must rank even above that of restoring it when it is impaired.

—Hippocrates

The reality of the health and health-care crisis in America and the world and the need for a solution are regularly featured in the news and in public health messages delivered by governmental and non-governmental organizations. There is widespread awareness that the situation is serious, not only in terms of costs but in terms of human suffering and the burden it places on individuals, families, businesses, communities, and nations. In spite of technological improvements in diagnosis and treatments, and in spite of increased life expectancy, adult and childhood obesity, diabetes, heart disease, hypertension, and cancer rates continue to rise (Centers for Disease Control, 2010). Centers for Disease Control (CDC) data indicate that almost two-thirds of adults are either overweight or obese, two out of five engage in virtually no physical activity, and one in four young adults still use tobacco (CDC as cited by Smeltzer, Ozminkowski, & Musich, 2011). Additionally, the current shortage of physicians and nurses and the predicted disparity between health care demand and supply (Okrent, 2011) presents a picture that is anything but hopeful. This presentation makes a case for finding solutions to this crisis in one place that is particularly well suited to play a role in reversing the troubling trends of the past few decades: the workplace.

Before considering solutions to the health crisis, however, one must look at one of its chief drivers: the whole complex of chronic diseases, sometimes called lifestyle or behavioral diseases, and the risk factors that have created a situation of epidemic
proportions. Chronic diseases include heart disease, stroke, cancer, chronic respiratory diseases and diabetes (World Health Organization, 2005). Their causes have been widely investigated and it is now known that every one of these diseases can be traced to risk factors that can be modified. In other words, these risk factors are behavioral rather than genetic in nature and if eliminated or minimized, could prevent, control, or reverse some of these diseases.

The most common modifiable risk factors are unhealthy diet and excessive weight, physical inactivity, and tobacco use (World Health Organization, 2005). The incidence and prevalence of chronic diseases have increased alongside record obesity rates. Close to 34% of the American population is now obese (National Center for Health Statistics, 2010) and it is estimated that 45% of the population has at least one chronic disease (Thorpe & Ogden, 2008). According to the WHO, if the above-mentioned risk factors were eliminated, at least 80% of all heart disease, stroke, and type 2 diabetes, and over 40% of cancer would be prevented. Recent studies also point to stress as a risk factor for chronic diseases (Potts, 2007) and CareerBuilder Inc. found that 32% of workers report that work-related stress contributed to their weight gain (as cited in American Psychological Association, 2010).

There is growing awareness of end-of-life issues in healthcare, especially as the baby boomers begin to swell the senior population in unprecedented numbers. While we know that we all must die some day, it is fair to say that how we live largely determines how we die. A healthy lifestyle could make the difference between a long period of morbidity in the later years and a long life with relatively high quality followed by a short illness at the very end. This is known as “compression of morbidity,” a
paradigm that predicts that a person with few health risks will have one-fourth the
disability of those with more risks and the onset of disability is postponed by up to 12
year (Fries, 2003). And that is a much more appealing scenario than what many
individuals and families face today: a medical system that keeps people alive at any cost
regardless of the suffering caused by the treatments themselves. While there is a strong
argument for preventing premature death, there is an equally strong argument for
ensuring quality of life for those who are living into their 70s and 80s.

There is no single or simple solution to the chronic disease epidemic. The
CDC report *Health, United States, 2010* (Centers for Disease Control and Prevention,
National Center for Health Statistics, 2010) suggests that different states of health require
different approaches, from health promotion, to early detection efforts, to disease
management. But the same document affirms what many patients, consumers, and health
promotion practitioners have learned through experience: That the health care system is
not designed to prevent chronic diseases, but is focused instead on finding treatments and
cures. This explains why health care is often called “sickness care.” While the need to
prevent chronic disease may seem obvious to most people, the Centers for Medicare and
Medicaid Services reports that 95% of health care dollars go to treatment and only five
percent to prevention (as cited by Edington, 2009).

Dr. Steven Aldana, a leading health promotion scholar and practitioner, gives
two reasons for the disparity between prevention and treatment efforts: first, physicians
receive very little, if any, training in nutrition or physical activity in medical school and
second, insurance companies pay physicians for procedures, medications, and treatments,
not for talking to patients about physical activity and nutrition (Aldana, 2005). Yet, there
is a growing movement in the medical professions to integrate preventive and behavioral medicine into medical practice (American College of Preventive Medicine, 2011). This, however, will take time. At least for now, individuals, workplaces, and communities with the help of health promotion and prevention specialists (which of course, in many instances include nurses, doctors, and public health educators) are going to have to step in where the medical establishment has fallen short.

The World Health Organization (WHO) report cited earlier states: “Taking up the challenge of chronic disease prevention and control requires a certain amount of courage and ambition. The agenda is broad and bold, but the way forward is clear” (WHO, 2005, p. 31). One cannot argue that the vision of what needs to be done on an individual and collective level is clear: reducing those risk factors that lead to disease and establishing the lifestyle behaviors that improve and maintain health. What remains illusive is exactly how this is to be accomplished. Worksite health promotion is paving the way.

The Cost and Burden of Poor Health on Individuals and Businesses

Community-based health promotion has been successfully adapted to the workplace, which after all, provides the context within which many people spend most of their waking hours. The existence of worksite health promotion programs over more than 35 years reflects a “shift in responsibility for health care from government to employer and from the health care industry to its consumers” (Reardon, 1998). In fact, Dr. Aldana notes: “In one of the most bizarre twists of our capitalist society, worksites, not medical professionals, have played the largest role in helping people have healthy lifestyles”
And it’s no surprise, when you consider that employers carry the lion’s share of costs for the health care of their employees and these costs continue to rise year by year.

Several economic measures suggest a trend that has been spiraling out of control. This year alone, health-care costs increased by nine percent over 2010 (Abelson, 2011). According to the Kaiser Family Foundation (KFF) (Kaiser Family Foundation, 2011a), health care costs in the U.S. account for 16% of the country’s gross domestic product—higher than any other industrialized country and double that of Japan’s. During the past decade, health care spending has grown faster than inflation and national income, and average annual health insurance premiums for families went from $7,061 in 2001 to $15,073 in 2011—more than a 50% increase (KFF, 2011b)! The economic downturn of recent years has increased the impact of this situation and added a new urgency to finding sustainable solutions to address our health care needs.

Businesses bear a good deal of the brunt of the chronic disease and health care crises. A study published this year concluded that modifiable health risks (obesity, high blood pressure, high blood glucose, high triglycerides, and inadequate exercise) are associated with higher employer health and productivity costs (Kowlessar, Goetzel, Carls, Tabrizi, & Guindon, 2011). A recent study of the impact of weight gain at a large company published in the Journal of Occupational and Environmental Medicine (Kowlessar et al., 2011), found that people who reached a body mass index (BMI) of 30 or higher, added an additional $1,000 to medical costs.

Beyond the risk factors named above, stress also impacts health care costs. A 1998 study funded by the Health Enhancement Research Organization (HERO) found
that employees reporting high levels of stress had 46% higher costs (as cited by Lindsay (2000). And according to Rosch (2001), “job stress is estimated to cost U.S. industry more than $300 billion a year in absenteeism, turnover, diminished productivity and medical, legal and insurance costs” (as cited in American Psychological Association, 2010, p. 1).

But businesses with health promotion programs do see savings. A 1996 review of 75 studies of comprehensive health promotion programs by Pelletier (as cited by Lindsay, 2000), demonstrated that these programs were effective in improving health and reducing costs. The University of Michigan has conducted and published case studies on the impact of worksite wellness on costs in companies of all sizes and types (Health Management Research Center, 2011) and a literature review by three respected Harvard University economists published in 2010 concluded that for every dollar invested, worksite programs can save about three dollars within three years (as cited by Goetzel, 2011).

Beyond health cost containment and risk reductions, productivity, work satisfaction, and improved morale are also documented benefits of worksite wellness programs (Chapman, 2007; HERO, 2010). Healthier employees are more productive, take fewer sick days, and make positive contributions to companies (Aldana, 2005). In addition, according to Guardian Life Insurance Company of America, 85% of employees taking part in wellness programs agreed that the programs had been effective in promoting good health (as cited by American Psychological Association, 2010).
A Brief History of Worksite Wellness

The present-day trends in health promotion and worksite wellness hearken to the 1970s. Johnson and Breckon (2006) give a chronology of key developments. In the early 1970s, the newly created National Center for Health Education pushed for expanded worksite programs. In 1979, the Surgeon General’s report entitled *Health People* was published. A Department of Education was established as part of the Department of Health and Human Services (DHHS) and was charged with the responsibility of supporting health education, health promotion, and wellness programming. In 1981, the DHHS published *Objectives for the Nation in Disease Prevention and Health Promotion*, followed in 1991 by *Healthy People 2000*, and *Healthy People 2010* in 2001, each with specific goals for national health improvement. The latest version of these programs, *Healthy People 2020*, outlines goals that are much more far reaching than previous versions.

A visit to the Healthy People 2020 website makes it clear that the agenda has expanded with updated health promotion strategies intended to assist community and worksite wellness programs (U.S. Department of Health and Human Services, 2010a). In its press release, Department of Human Health Secretary Kathleen Sebelius stated, “Our challenge and opportunity is to avoid preventable diseases from occurring in the first place” (U.S. Department of Health and Human Services, 2010b). It is clear that health promotion on a national level has come of age and is addressing all the relevant issues, yet with obesity rates at an all-time high in America (CDC, 2011), one has to wonder how effective three decades of government-sponsored initiatives have been. All the more reason for worksite health promotion programs to heed Secretary Sebelius’ call.
Soon after the beginning of the health promotion movement, scholars and practitioners formed non-profit as well for-profit organizations to advance the art and science of health promotion in the workplace. Prominent among these are the University of Michigan Health Management Research Center (UM-HMRC), Wellness Councils of America (WELCOA), and Wellsource. Research published by the American Journal of Health Promotion (AJHP), the Health Enhancement Research Organization (HERO), among others, have helped to further inform and guide the practitioner in his or her efforts to implement a successful worksite programs. The UM-HMRC, for instance is the authority on health risks and behaviors and their effects on individuals and businesses; WELCOA and Wellsource provide resources and training for wellness facilitators; and the AJHP publishes peer-reviewed studies. These organizations continue to be an invaluable resource for me and anyone involved in health promotion.

In a legislative breakthrough, in June of 2011, the Surgeon General released the nation’s first “National Prevention and Health Promotion Strategy: America’s Plan for Better Health and Wellness” (O’Donnell, 2011b). The plan’s vision is “Working together to improve health and quality of life for individuals, families, and communities by moving the nation from a focus on sickness and disease to one based on prevention and wellness” (as cited by O’Donnell, 2011b, p. iv). The plan will take time and poses great administrative and implementation challenges, but it is a long overdue victory for the health promotion community, which has spent years advocating for this type of legislation. The document calls for the formation of an advisory group that is to include worksite health promotion experts. It will be interesting to follow its development and see
if this government plan is effective in facilitating wellness in the population in general and in the workplace in particular.

In another recent development, the health care reform signed into law in 2010 grants loans to small businesses to create comprehensive wellness programs; provides that the CDC offer technical assistance to employers to train staff on how to evaluate existing wellness programs; and increases the amount by which employers may reward employees who participate in wellness programs and/or meet certain health standards. (Hunnicutt & O’Donnell, 2010). Additionally, group health plan and health insurance providers will be required to provide wellness and health promotion programs for enrollees under their plans covering the areas of smoking cessation, weight management, stress management, physical fitness, nutrition, heart disease prevention, healthy lifestyle support, and diabetes prevention (Wellsource, 2010). Perhaps an effective collaboration between government agencies and the private sector is finally in the making.

A discussion on health promotion would not be complete without a working definition. This particular definition is included at the end of the discussion because it is a result of all the years of development and reflects what practitioners and researchers have discovered and applied over those years. It was written by the American Journal of Health Promotion editor, Michael P. O’Donnell in 2009 and is cited on the home page of the publication (O’Donnell, 2011a):

Health Promotion is the art and science of helping people discover the synergies between their core passions and optimal health, enhancing their motivation to strive for optimal health, and supporting them in changing their lifestyle to move toward a state of optimal health. Optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be facilitated through a combination of learning experiences that enhance awareness, increase motivation,
and build skills and, most important, through the creation of opportunities that open access to environments that make positive health practices the easiest choice.

The description of optimal health in the above also serves as a definition for the concept of wellness. Health promotion, then, is the means to achieve wellness (Reardon, 1998).
CHAPTER II

HEALTH PROMOTION IN ACTION:
PROGRAM ELEMENTS AND DESIGN

The world we have made as a result of the level of thinking we have done thus far, creates problems we cannot solve at the same level of thinking at which we created them.

—Albert Einstein

Program Design Overview

In order to craft a comprehensive wellness program at SNBC, the HOP turned to two leading organizations in worksite wellness providing evidence-based recommendations: Wellness Councils of America (WELCOA) and Wellsource. Both organizations emphasize the importance of planning, assessing the population, promoting healthy environments, and evaluating programs. WELCOA’s Seven Benchmarks (2008) were strong guiding principles for HOP and continue to be part of operations. They are:

- Capturing CEO support
- Creating cohesive wellness teams
- Collecting data to drive health efforts
- Carefully crafting an operating plan
- Choosing appropriate interventions
- Creating a supportive environment
- Carefully evaluating outcomes (WELCOA, 2008)

Wellsource (2008) offered tools for program and outcome evaluations and has provided HOP’s chief population assessment tool for three consecutive years.
Once senior support was secured and a plan was laid out, the next order of business was to establish a baseline and benchmarks by which to measure needs and plan interventions. There is no better way to do this than with a Health Risk Assessment (a fancy name for a lifestyle survey) and biometrics such as heart rate, blood pressure, BMI, body composition, and ideally a full lipid and chemical blood panel. The personal reports from such a health screening serve to educate participants about risk factors in general, and in particular, about where they fall on the risk scale—whether in the low, medium, or high-risk category. They also give recommendations based on those results. HOP provides an HRA, complete blood analysis, and biometrics yearly. By January of 2012, the program will have gathered three years of data on the population’s health risk trends. This is an indispensable tool for evaluating the program’s outcomes.

Given the overwhelming evidence linking most chronic diseases with lack of physical activity and inappropriate diet (Roberts & Barnard, 2005) these—and the related problem of overweight and obesity—are the most obvious targets for programming that addresses lifestyle change. Stress, as an underlying cause of many unhealthy behaviors, and tobacco use, with its well-known harmful effects, are equally important risks that must be addressed in a comprehensive health promotion program. In some programs (such as HOP), injury prevention and musculoskeletal health are included as well.

In addition to lifestyle change interventions and just as important, worksite wellness experts insist on the necessity of encouraging health-enhancing changes in the culture and environment of the workplace (Edington, 2009; Goetzel, 2011; HERO 2010; Lindsay, 2000; Reardon, 1998). The implementation and evolution of programs to
facilitate lifestyle, cultural, and environmental change in the HOP program will be examined in a later section.

Creating a Flexible, Adaptive Model for Program Implementation

What are the overarching, evidence-based principles that can guide wellness practitioners in the processes of planning, implementation, and evaluation of programs? How does one integrate all the many wellness elements and variables into a cohesive, effective program? How does one keep a program fresh so that the interventions remain relevant, evolve, and continue to invite participation? These are some of the questions that have led me to explore the deeper sociological and psychological aspects of wellness and the various models of implementation in the literature.

Wellness is by definition multidisciplinary and multidimensional; the physical, emotional, social, spiritual, and intellectual dimensions have already been stated. It is informed by a variety of disciplines from nutrition, fitness, and stress management, to behavioral economics, motivational psychology, and mindfulness studies. Then there is the cultural factor: different people and different groups of people have different backgrounds, different needs, and respond differently to programs that promote change. Additionally, health behavior is influenced by multiple factors, in particular the environmental and social context in which it occurs. It’s a complex situation; there is no one formula that works everywhere or for everyone, but there are some sound theories to help address these challenges.

On the most practical and immediate level, O’Donnell and Harris (as cited by Lindsay, 2000) suggest that health promotion programming address three levels of
intervention: activities and information that increase awareness, lifestyle change through education and behavioral modification techniques, and environments that support and promote changes in health behavior. Eddy, Donahue, Webster, and Bjornstad (2002) have proposed an ecological approach to program planning and implementation. They suggest that program designers look at health behaviors not as isolated phenomena, but as something that takes place in, and can be affected by, a multi-layered framework that includes the following realms: intrapersonal (personal knowledge, awareness attitude), interpersonal (social interactions), institutional (company culture, policies, resources), community (community programs and resources) and public policy (national or state programs and policies).

More recently, Best (2011) and others have proposed a systems-thinking approach to health promotion as a way to provide the multilevel interventions it requires. Systems thinking is also known as complex adaptive systems because “complex problems require interventions at many different system levels” (Best, 2011, p. eix). Systems approach “emphasizes a health work culture and representation across all units in the planning process to optimize individual, organizational, and environmental factors that influence health” (Miller, Zhu, & Barlett, 2007, p. 2). In a paper advocating systems thinking in public health, Lieschow et al. (2008) describe a study that investigated the application of systems thinking to improve tobacco control programs. As part of the initial process of exploring what this meant, two conclusions were reached:

(1) Understanding and implementing complex systems is all about the relationships among people, collections of information, and even concepts; and (2) these relationships work or do not work as a function of information and how it is communicated. (Lieschow et al., 2008, p. 198)
While systems-thinking recognizes the multidimensionality and multi-level influences of health behavior and health promotion spelled out in the ecological model, it adds the element of unpredictability, requiring flexibility and adaptation (Best, 2011). Best contends that a systems-thinking approach is the required mind-shift for health promotion to move from a focus on individual health to “a more comprehensive, integrated, and dynamic framework for population approaches to health for all” (2011, p. eix).

For a health promotion program facilitator the lessons to take away from the above models are many: To gain an understanding of the complex and dynamic nature of health promotion and behavior change and be willing to explore, experiment, adapt, and constantly evaluate the various elements of the program; to address individual needs, but always in the greater context of the physical and social environment in which they occur; to access and incorporate resources for communication and intervention at the individual, family, workplace, and community levels; to integrate all of the above in every stage of planning, implementation, and assessment; and finally, to closely follow developments in the field at a time when it is experiencing a surge in innovation and a fundamental paradigm shift.
CHAPTER III

PROMOTING BEHAVIOR CHANGE

There is a simple way to package information that under the right circumstances can make it irresistible. All you have to do is find it.

—Malcolm Gladwell

Of the systems outlined in the previous section, the most complex of all is human behavior itself, and it is precisely this that wellness programs target. That being the case, a behavioral change program that is not informed by science, is unlikely to achieve success. While wellness and health promotion practitioners do well to be fully informed about the causes and consequences of poor health and should become knowledgeable in the areas of fitness, nutrition, obesity, stress management and mental health, musculoskeletal health, self-care, preventive health, tobacco use, and other precursors of chronic disease, an understanding of how people change and how to facilitate change seems essential. Without it, it’s fair to assume, all the knowledge in the world would fail to translate to actual change and health improvement. Everyone knows from experience that changing behavior is not easy—even when one has all the facts and a clear roadmap as to how to proceed. We seem to be resistant to change. Therefore, an in-depth exploration of the subject seems relevant—at least in areas that are particularly relevant to health behaviors and specifically, to workplace driven interventions.
The Science Behind Communication, Nudges, and Choice

A significant part of what a wellness facilitator does is to communicate. The message must not only be accurate and well informed, it must also be effective in enhancing motivation, clarifying choices, influencing health-enhancing action in terms that are simple yet universal, appealing as it often must, to broad populations. At the same time communication is sometimes geared very specifically to an individual or sub-group of the population. In either case, facilitators play a significant role in helping their audience navigate the overwhelming 21st Century world of choices and decisions they face on a daily basis.

Nobel laureate Daniel Kahneman and his associate Amos Tversky (1984) have done extensive work on how humans make decisions and choices. Their research has had wide-ranging implications in behavioral economics. But their discoveries have applications to a wide range of behaviors and, in particular, to the effect of message framing on outcomes. Framing can be conceived simply as “the language of descriptions” (Schwartz, 2004). Kahneman and Tversky (1984) have shown that decision problems can be framed in ways that will have a significant effect on choice preference. For instance, they discovered that because humans are “loss averse,” framing a message in terms of what you might lose by not participating results in higher participation than a message that communicates what you might gain. A possible application for health promotion relates to financial incentives for participation. A message that reminds people that not participating means losing or giving up a discount might be more effective than one that tells them they are benefiting from a savings by joining or staying in the program. They
also discovered that an aspect of loss aversion is that we favor stability over change. This can be leveraged in the design of a program by making it easy for people to stay in the program (don’t lose it) and maintain the status quo; they would have to take an action to opt out (making it a little harder to change the status quo).

In the combined results of two studies that looked at message framing addressing health behaviors, Stuart and Blanton (2003) made a curious discovery. Their work suggests that when communication attributing positive outcomes to a healthy choice is used, the behavior is perceived as being less common than when negative attributes are associated with unhealthy choices. In other words, communication using a positive frame that praises people who make healthy choices tends to convey the message that healthy behavior is uncommon. This may work against the desired outcome. Obviously, it would be a mistake to frame every health message in negative terms (or in terms of losses versus gains), yet the authors caution against using positively-framed image appeal in behavior interventions. This is something worth exploring and assessing for anyone responsible for health behavior communications, with the caveat that it’s still advisable to deliver positive feedback about changes made and to celebrate accomplishments. Malcolm Gladwell (2000) suggests that to make health advice stick in spite of the information overload we face today, the message must have two qualities—it must be personal and it must be practical. If these conditions are met, according to Gladwell (2000), the message becomes memorable.

In their bestselling book *Nudge*, Thaler and Sunstein (2008) have a term for describing someone who organizes the context in which people make decisions: a choice architect. According to their theory of “libertarian paternalism,” it is “legitimate for a
choice architect to try to influence people’s behavior in order to make their lives longer, healthier, and better” (p. 5). They propose a number of ways in which choice architects can “nudge” people towards desirable choices. But a nudge must be held to a very high standard: it must allow freedom of choice. To count as a nudge, “the intervention must be easy and cheap to avoid . . .. Nudges are not mandates” (p. 6) they add.

One nudge that was already mentioned is that of making it easy for people to maintain the status quo—it seems that people tend to stick to default choices when they are made available. Not surprising, good information and feedback also count as nudges. Because humans like to conform, the authors suggest that another way to nudge people is simply to inform them about what others are doing. They warn, in line with Stuart and Blanton’s studies, that if you want help people move toward a desirable behavior, “do not, by any means, let them know that their current actions are better than the social norm” (p. 69)—this may become a disincentive to stay on track. Another nudge worth mentioning is the “mere-measurement effect,” which shows that when people are simply asked what they intend to do, they tend to act according with their answer. Furthermore, asking people when and how they intend to meet their goal can increase this effect. The authors suggest that nudges may be most useful for choices that have delayed effects (and many health behaviors do), or are difficult, infrequent, or offer poor feedback, or those for which we cannot rely on experience.

Making choices is complicated by the overabundance of choice in our modern world. While this has expanded personal freedom, the effect of having so many options vying for our attention, can lead to uncertainty of purpose, which in turn can “sap people’s resolve” and diminishes the value of choice (Csikszentmihalyi, 1990). In The
Paradox of Choice, Barry Schwartz (2004) postulates that we may be “biologically unprepared for the number of choices we face in the modern world” (p. 142). One obvious area where people could use guidance in negotiating their choices is nutrition and eating well. When one considers the overwhelming abundance of food products on the market, many of which make false and deceptive claims regarding their health value, a wellness facilitator can be instrumental in narrowing the field of choices and offering guidelines for truly healthy options.

Addressing people’s tendency to conform to the behavior of others, Schwartz (2004) observes, “Overwhelming choice is going to push you in the direction of looking over your shoulder at what others are doing” (p. 200). And the more difficult the decision, he suggests, the more we will rely on the decisions of others. But he has a slightly different approach to those outlined earlier. He adds that when people compare themselves with others who are better in some way, they may feel envy or resentment, but they may also feel inspired or motivated. In a wellness program this can translate to celebrating the successes of those who have made positive changes.

The suggestions by these authors on leveraging communication and facilitating healthy choices can be applied not only to lifestyle and behavior change, but also used to increase participation in a program in general. They can be useful in communications to promote acceptance of environmental and cultural changes (such as a vending machine program with healthy options) and in establishing vibrant health as a new norm in the workplace.
Motivation, Incentives, and Sustainable Change

Behavior change must be preceded by a wish to change, by some kind of motivation to make the necessary efforts or adjustments required to achieve an outcome. Enter the science of motivation. Motivation can be of two types: intrinsic (driven from inside the individual) or extrinsic (driven from outside the individual). Daniel Pink (2009) has written a popular book on the subject, appropriately titled *Drive: The Surprising Truth About What Motivates Us*. Extrinsic motivators, or “if-then” reward—the proverbial carrots—Pink tells us, are effective so long as the behavior they are encouraging is mechanical and mindless. Then they work, although the effect seems to wear off with time. On the other hand, when applied to behaviors that are by nature creative, interesting, and challenging, extrinsic motivators don’t work at all. And anyone who has tried it will attest to the challenge and creative energy that behavior change demands—one is in fact, attempting to recreate a part of oneself. Furthermore, extrinsically motivated behavior, according to Brown and Ryan (2004), leads to behavior that is “reward dependent” and this in turn undermines any intrinsic motivation that may have been present before. Pink (2009) suggests that one way to help people access their inner drive is to help them “reawaken their deep-seated sense of autonomy and self-determination” (p. 87). Self-determination and autonomy and their role in behavior change facilitation will be explored in a later section.

In spite of the warnings against using extrinsic motivators, these types of incentives are common in worksite wellness and there is no question that there is a place for them. Yet they should be used judiciously while taking into account their limitations.
The recent provision in the Patient Protection and Affordable Care Act allowing employers, beginning in 2014, to give employees discounts of up to 30% of the employee’s total premium as outcome-based wellness incentives, has sparked a heated debate in health promotion circles. There is a strong argument for tying health premiums to health goals or outcomes in the name of equity, by reducing the amount paid by workers with good health practices, and not requiring that they subsidize the costs of workers unwilling to take steps to improve their health (O’Donnell, 2011a). However, writing in the New England Journal of Medicine, Volpp, Asch, Galvin, and Loewenstein (2011) state that although it may make sense to charge higher premiums for such things as smoking, a high body-mass index, cholesterol or high blood pressure, evidence that differential premiums help change health behaviors just isn’t there. Furthermore, they argue that such a scheme would probably put the burden of higher premiums on low-income families. They also suggest that since premium reductions would start at the beginning of the next enrollment period, the delayed reward would be less effective. “Ideally,” they tell us, “incentives should provide small but tangible and frequent positive feedback and rewards” (Volpp et al., 2011, p. 389).

Terry and Anderson (2011) argue for a “progress-based approach to incentives”–one that coaches individuals to make health improvements and rewards them for participation in wellness activities. While this debate will no doubt continue, there is agreement on a few incentives that do work. For instance, providing financial incentives for employees to complete a Health Risk Assessment can increase participation rates from the 20-40% range to the 70-90% range (O’Donnell, 2011a). Of course, as was expressed by Terry and Anderson (2011), “incentives are not enough unless the employer
helps to create the true culture of health that is needed for workplace wellness programs to take hold and thrive” (p. evi).
CHAPTER IV

THE INTERNAL WORKINGS OF
BEHAVIOR CHANGE

All change comes from within
—Buddhist saying

How exactly does one facilitate intrinsic motivation? How is behavior change sustained? What attitudes should one encourage in those one is helping? What attitudes should one cultivate in oneself as a facilitator? These questions must be uppermost in the mind of anyone engaged in health promotion. Science provides some answers.

Autonomy, Self-Regulation, and Mastery

Edington (2009) calls for helping employees in workplace programs play a larger role in their health, take more responsibility for their outcomes, and become “self-leaders.” The role of the facilitator in his model is to provide the tools of engagement and create a very supportive environment. But how are we to empower people to be self-leaders?

In the 1980s Deci and Ryan (as cited by Brown & Ryan, 2004) proposed a self-determination theory (SDT) of behavior. Self-determined behavior is autonomously motivated and “self-endorsed, volitional, and done willingly” (Brown & Ryan, 2004, p. 105). SDT is applied specifically to “the process through which a person acquires
motivation for initiating new health-related behaviors and maintaining them over time” (Ryan, Parick, Deci, & Williams, 2008, p. 2). This goes to the heart of the challenge facing all health facilitators: The need to help people take charge of their health and make the information and knowledge acquired their own.

Behavior that is not autonomous, on the other hand, is somehow motivated by “controls, restrictions, and pressures, arising either from social, contextual, or internal forces” (Brown & Ryan, 2004, p. 105). But intrinsic motivation is not always autonomous, as when a person has internalized a conditioned behavior learned through external pressures. By the same token, extrinsic motivation can actually take an autonomous form, as when a behavior is valued and embraced as personally important (Brown and Ryan, 2004). This speaks to the necessity of delivering health communication and interventions that are relevant, practical, meaningful, and always in people’s best interest.

Health behavior change involves not only initiating a change, but also the often more difficult task of maintaining change. Anyone who has witnessed the success of a weight-reduction program, only to be followed by a failure to keep the weight off, knows the difficulty of making change last. The ingredients for maintaining behavior change are often missing, but there is growing evidence that SDT provides an effective approach to facilitating both behavior change and adherence (Ryan et al., 2008). In this respect, self-determination presumes not only autonomy, but also confidence, leading to mastery, and competence, leading to self-regulation, all of which give individuals a sense of agency and choice in their own lives (Ryan et al., 2008). This kind of autonomy, according to Ryan et al. (2008), leads to the “internalization” and “integration” through
which a person self-regulates and sustains healthy behaviors. A person must not only fully endorse a behavior; they must also integrate it into other aspects of their lifestyle.

Another factor explored by Ryan et al. (2008) in their model of health behavior facilitation through SDT, is that of relatedness. This applies specifically to the relationship of practitioners to clients or program participants and their role in facilitating autonomous self-regulation. They suggest that the experience of connection and trust in this relationship allows people to internalize the skills and behaviors learned.

Goal setting is an obvious part of the process of making change. But goals are difficult to sustain, as we have seen. When a commitment is made, however, goals give meaning to a person’s life (Csikszentmihalyi, 1990). There are suggestions in the literature that people with a sense of purpose, of involvement with something larger than themselves, experience increased wellbeing (Pink, 2009). As well, those who experience gratitude tend to be healthier, and gratitude for improvements in one’s life helps maintain those improvements (Schwartz, 2004). Commitment, purpose, gratitude—these are all qualities that support self-determined behavior, and which a facilitator has opportunities to promote.

Clearly, SDT offers a framework that helps practitioners design programs that adhere to the highest principles of human freedom and dignity and promote a high level of intention and attentiveness in every step of the way. During the past year, the HOP has been evaluating the types of interventions, incentives, and communications it adopts in light of the humanistic values presented here.
Mindfulness and Self-Compassion

Mindfulness has become a household word in recent years. It was popularized by the Mindfulness-based Stress Reduction programs, based on Buddhist meditation, developed by Jon Kabat-Zinn in the late 1970s, a program that continues to gain momentum in the medical and mental health professions. The center he established defines mindfulness as “a way of learning to relate directly to whatever is happening in your life, a way of taking charge of your life, a way of doing something for yourself that no one else can do for you” (University of Massachusetts Medical School, 2011).

Nyanaponika (as cited by Brown & Ryan, 2004) defines mindfulness as “the clear and single-minded awareness of what actually happens to us and in us at the successive moments of perception” (p. 140).

Brown and Ryan (2004) suggest that the enhanced self-awareness of mindfulness provides an opportunity “to choose the form, direction, and other specifics of action; that is, to act in an autonomous manner” (p. 140). They further suggest that autonomy can be facilitated externally through social support, and internally “through the receptive attention and awareness to present experience that defines mindfulness” (p. 143). If self-determination, with all its dimensions, is a requirement for true and sustainable behavior change, then mindfulness and awareness serve to facilitate autonomous decision-making and self-regulation.

Kristin Neff (2002) has brought attention to a related subject: Self-compassion—an attitude toward oneself that requires the “equilibrated mental perspective known as mindfulness” (p. 88). When one is touched by one’s own suffering, and does not avoid it, she tells us, one can generate the desire to alleviate that suffering and be
motivated to heal oneself. Self-compassion implies an attitude of kindness and forgiveness for one’s own limitations or failings. She warns however, that this does not mean that our failing go unnoticed, but rather, “that the actions needed for optimal functioning and health are encouraged with gentleness and patience” (p. 87). While this attitude clearly would encourage an individual to bring attention to his or her own state of health and promote an aspiration to make improvements, it would seem particularly useful in helping to sustain behavior change given the difficulties inherent in maintaining new behaviors.

As elucidated by the research, mindfulness and self-compassion have the potential of supporting the practitioner’s efforts to inspire, motivate, and support others. Just as importantly, they can inform, support, and sustain the practitioners themselves in the challenging and often frustrating situations that seem to be part and parcel of behavior change facilitation.
CHAPTER V

SHAPING THE ENVIRONMENT AND
CULTURE TO SUPPORT HEALTH

We shape our environment, and then our environment shapes us.

—Winston Churchill

The Power of Context

As has been mentioned, no amount of behavioral change facilitation will have lasting effect if the context in which the behaviors take place does not support the healthy behaviors. In his best seller, *The Tipping Point: How Little Things Can Make a Big Difference*, Malcolm Gladwell (2000) observes, “In ways we don’t necessarily appreciate, our inner states, are the result of our outer circumstances” (p. 152) and addresses what he calls the power of context. It’s one of the factors that can tip an epidemic—something that can cause a specific behavior to spread to a large segment of the population. He suggests that changing the smallest details of the immediate environment or of a situation can bring about behavior change. This can be as simple as making staircases more accessible or providing easier access to parks and walkways. Thaler and Sunstein (2008) add that simply removing obstacles can often facilitate good behaviors. On the social front, the power of context also refers to group behavior, and Gladwell (2000) reminds us that being part of a group makes people susceptible to peer pressure
and social norms. This concept is so universal that it permeates the strategies proposed by most of the authors examined here.

A report from the Institute for Government (2010), a British organization, titled *Mindspace*, makes a case for a shift in the facilitation of behavioral change from “changing minds” through incentives and accurate information, to “changing contexts” by affecting the environment within which people make decisions and respond to cues. The latter taps into our “automatic mind” which is largely emotionally driven and much faster; while the former, the “rational mind,” the one we have traditionally relied on, is much slower and often rendered ineffective in contexts that don’t support what the person knows. The document makes extensive use of the behavioral science literature already cited here. One can only hope that these concepts will begin to permeate public policy in our country and slowly reverse some of the conditions that have created unhealthy environment in our communities.

Creating Healthy Cultures at Work

These ideas outlined above have specific applications to healthy behavior facilitation in the workplace. Whereas in the past, workplace wellness programs focused on the individual and specifically on high-risk employees, the major shift at the moment is toward creating cultures of health and environments that support healthy behaviors. In May of 2011, at the Prevention & Wellness 2.0 Congress (World Congress, 2011), Dr. Dee Edington spoke on the next era of wellness in the workplace. He emphasized the need to move “from the cost of disease to the value of health,” from “individual participation to total population engagement” and from “behavior change to
transformation of the culture.” He had a very simple definition of healthy culture: “Ask: How do people think and feel around here? And then make health a part of it.” He concluded his talk by asking his audience, “What’s the point of all this?” and then gave the answer: “People helping people, families, and communities.”

In his book Edington (2009) states, “The objective is to create an enhanced environment in which the workplace and workforce become part of a health-promoting culture that helps the healthy people stay healthy” (p. 68). His current philosophy is one of “just don’t get worse.” This is based on the finding that when people improve or stabilize their health, their health costs remain stable year to year. Tom Golaszewski (as cited by Edington, 2009) concludes that focusing on employees alone does not work since all too often the changes produced by such programs are short-lived, minimal, and frequently affect only a nominal group of employees. Melmed (2011) suggests that to counteract this “lack of traction” wellness programs need to establish cultures of health, tailoring communications and programs to employees’ needs and priorities.

Edington (2009) suggests that creating a culture of health requires making changes to three aspects of the environment: the physical environment, the psychosocial environment, and the Human Resources practices. Changes to the physical environment include smoking policies, access to fitness facilities either on-site or in the community, and on-site health clinics. The psychosocial environment addresses the social relationships within the organization and looks at such things as shared values, norms, peer support, and climate (Judd as cited by Edington, 2009). It considers the influence of organizational and social traditions and whether there is a “sense of community, shared vision, and positive outlook” within the organization. Edington’s third cultural aspect,
Human Resources, includes such things as career opportunities, job design, ergonomics and flow of work between employees, flexible working hours, and benefits design. The latter should give priority to preventive medicine, give employees choice of providers, and include financial incentives to encourage healthy behaviors. Inclusion of family members in the wellness program also advances the culture of health.

From its inception, the Health Opportunity Program has sought to make wellness a part of the company’s core values, culture, and day-to-day operations. It has facilitated many health-enhancing changes in the physical environment, and has become part of the fabric of the social and organizational life of the company.
CHAPTER VI

THE HEALTH OPPORTUNITY PROGRAM

Beginnings

The objective of the HOP from the beginning has been to facilitate behavior change and instill a health-enhancing culture in the workplace. SNBC had initiated some wellness programming prior to my joining the company. Chief among them is the Oasis Clinic, a health clinic staffed part-time by a team of physician assistants and nurse practitioners established in 2006. In addition to general immediate care for employees and dependents, the clinic also offers women’s health services. The HOP has sought to integrate the operations of the clinic with the mission and operations of the wellness program so that it may include a focus on prevention and wellness in addition to traditional health care services. A joint mission statement was drafted that provides an integrated approach to health care and wellness. To this effect the HOP has involved the clinic providers in some of its initiatives, engaging them to help participating employee interpret their yearly health reports, including them in specific campaigns that involved taking blood pressure or other measurements, and contracting wellness providers, such as a health coach and nutritional counselor who delivered services at the clinic. The HOP has also provided the practitioners with information on the therapeutic services through its musculoskeletal injury prevention program and encouraged them to refer patients when appropriate, as in the case of minor muscular strains, muscle spasms, or tendonitis.
The HOP is currently assisting HR management in the process of redesigning the model and services used at the Oasis Clinic. The upgrade will provide an expanded scope of medical service, including a medical director, as well as greater collaboration and cross referrals between the clinic and the wellness program. The vision for the clinic’s future places it up front and center as the place where health care and management meets wellness resources and facilitation.

Additional to the Oasis Clinic, the company was already offering health club membership discounts, tobacco cessation assistance through reimbursements for aids and gift incentives for quitting, and a yearly health fair which included optional health screenings for employees. The screenings however, were not widely used, with only 30 employees having participated the year before the HOP was implemented. Wellness as an integral part of company life had not yet been firmly established. This reflects a common problem encountered in the industry—one that comes up wherever worksite wellness facilitators gather: wellness is often delegated to a busy employee already engaged in other fulltime endeavors, allowing little time for the kind of planning and promotion that wellness programs require. This is one of the chief lessons that can be drawn from the HOP experience: In order to be successful and sustainable, wellness programs require a fulltime person on staff dedicating all their time and resources to developing, implementing, and evaluating every aspect of the program and integrating it into the operating plan and culture of the organization.
Foundations

The theoretical foundations of the HOP have been described in detail. They can be summarized as being evidence-based and adaptive to emerging scientific literature. They include documented best practices in communications, behavior change facilitation, environment enhancement, relationship building, and culture integration. The vision and mission statements provide a philosophical compass for the program’s goals and ideals and align the program with the company’s core values. A statement from the founder/owner conveys senior support and engagement. A brand name and logo give the program a visible identity and allows people to feel connected to something unique and fun.

Program Design

The HOP is a membership program. This model was adopted as a way to incentivize participation. Not only do members receive a no co-pay insurance card for themselves and their dependents if the later are enrolled in the company’s health plan, they also receive points and rewards for participation. But membership requires a significant commitment: taking part in the annual health screening. Beyond that, participation in the remaining program offerings is voluntary. The premise behind this design is that once a member participates, receives their personal health report, and attends a meeting to review the results and hear about the HOP services and resources, they will be motivated to take action on behalf of their own health. The screenings are available to all employees—full as well as part-time and per diem, local as well as out of
state, and spouses and domestic partners are invited to participate. This has helped increase its popularity and most participants return year after year.

Based on the literature on message framing and the science of choice, this year the program is enrolling past participants in the program by automatically providing them with their screening appointment and information packet – making the healthy choice the easy choice—by default. If they do not wish to re-enroll, they will need to opt out. Only new members are being asked to attend enrollment events or contact the wellness office to sign up. Additionally, current members who refer a new member are being entered into a special prize drawing. Also in line with the literature, the promotion emphasizes the fact that most employees already participate.

Beyond participation in the annual health screening, with its various incentives, employees are incentivized to participation in many of the HOP’s events and activities through a multi-level point system. Although the idea that the greatest incentive for participation is the potential to make informed decisions and improve health, the point system is a way to encourage tracking of behaviors, reinforce commitment, and give participants a means to compete with themselves. At the end of the year, points are added and gifts for each of the various levels, Bronze, Silver, and Gold, delivered to qualifying participants. Gifts are cumulative and participants who reach a new level receive the gift for that level plus the gift(s) for the level(s) below. A fourth level, the Platinum, offers a special prize, which in the past two years has consisted of an end of year party where participants who achieved this level were honored with a certificate of recognition awarded by the company owner. The party, coined the Hoppy Awards, has featured a gourmet buffet dinner, live music or DJ, and included a guest on the part of each
participant. The plan for next year is to offer something new: A chartered, catered, and guided day expedition to a local hiking destination of geographical and geological interest. The idea behind this reward is to celebrate physical activity through enjoyment of the outdoors – one of the chief values of wellness.

**Program Facilitation**

*Internal Resources.* While the program facilitator carries the chief responsibility for every aspect of the program, he or she must invite and encourage the endorsement, leadership, and support of other members of the workplace community. Chief among them is the CEO or owner, and other senior leaders who must be perceived by employees as fully supportive and engaged. The role of the wellness facilitator must be integrated into the fabric of the organization’s operations with access to all levels of the organizations so that he or she is not working as a separate entity, or something occurring in the sidelines. In this regard, the support of department managers and supervisors is critical to facilitating communication and not impeding participation by their team members (after all, participation often does take a little time away from routine duties). A Wellness Advisory Group, comprised of members of each department ensures employee input in the program design and feedback on its effectiveness. They often bring back the “word on the street,” and contribute some of the most creative ideas or adaptations to the program. This engages the population and provides ambassadors for wellness throughout the organization.

The HOP has engaged some of SNBC’s own human resources into its programming. It partners with the clinic, as has been mentioned, and is likely to see increased collaboration in the future. The Human Resources team is intimately involved;
not only is the HR manager the overseer and chief senior advocate of the program, there are also many opportunities to interface with the benefits plan, training and orientations, payroll deductions, and so on. A number of programs have involved the food service staff from the Restaurant and Big Room departments in providing healthy foods for events, in facilitating food preparation classes, and in providing regular lunch options for the HOP vending machine program. The Safety department is a partner in the ergonomics, injury prevention, and first aid programs and a number of assessments and recommendations are carried out jointly. In a project with the Agriculture department, a walking path was created to give employees access to active breaks during the day. One of the traditions the program has established is a Wellness and Sustainability Fair on Earth Day which it organizes in partnership with the company’s Sustainability program. And employees who participate in the Sustainability program’s Bike to Work initiative also earn fitness points in the HOP. All of these collaborations help embed the program in the day to day work.

External Resources. The HOP has also made every effort to partner with local professionals in diverse areas of health promotion by engaging providers associated with the local university, hospital, agencies, and health care provider groups. These partners have provided components such as comprehensive health coaching, tobacco cessation, healthy eating and weight management, stress reduction, fitness, pre- and post-natal care, and goal setting. The occupational health department staff of our local hospital facilitates and provides reporting for our annual health screenings.

The immediate community is included in other ways. An account was opened with a local food purveyor for our monthly fresh fruit snack program and, when possible, vending machine items are purchased from local producers. Efforts are made to provide
gifts and rewards that engage participants in the local community and the products and opportunities for health it offers. Employees are encouraged to participate in community events that promote health, such as races, walkathons, and volunteer activities, and a HOP-sponsored family hike in the local park takes place in the spring. Employees are regularly reminded of the advantages of shopping at local farmers’ markets through communications about eating well (local and seasonal produce in particular) and through the program’s healthy eating challenges. Engagement in the health-enhancing opportunities offered in the community can only reinforce the behaviors the program promotes while employees are at work.

Lastly, there is also a great deal of interfacing with organizations outside of the immediate community and utilization of professional services and resources at the state and national levels. As a member of a coalition of wellness professionals encompassing a large region of Northern California, there are many opportunities to share information and resources with others in the field on a regular basis. A strong link has also been forged with the company’s health insurance administrators who strongly support and promote the program and have become partners in incentive planning.

Membership in WELCOA and a subscription to the American Journal of Health Promotion (AJHP) help keep the program abreast of the latest science, as does attending national conferences such as those sponsored by these two entities and others. A number of online publications and newsletters provide excellent sources of information and health news that can be shared with members. Among these are the Harvard Medical School’s Healthbeat, WebMD, Dr. Ann Kulze’s Wellness Newsletter, and the health sections of the New York Times and Huffington Post. Lastly, the program plans some
events to coincide with national health observances and special campaigns such as the American Cancer Society’s Breast Cancer Awareness Month and Great American Smokeout, and the International Diabetes Federation’s World Diabetes Day, among others.

**Behavior Change Opportunities**

Although HOP encourages all employees to become members, its programs and services are available to all employees, members and non-members alike. As already mentioned, members have the advantage of the no co-pay benefit and the opportunity to earn points for rewards. Besides the annual health screening with its various awareness-promoting and educational components, HOP offers numerous program options in a variety of formats throughout the year. During the first two years, the program offered a number of educational presentations at lunchtime meetings (lunch included). Although they seemed like a good idea, addressed key wellness issues, and were much appreciated, it became evident that such events tend to attract a good number of the office staff and very few of the production and food service staff whom, due to schedule constraints, found it difficult to attend. Too many employees were unintentionally excluded from these events. As a consequence, the focus during the current year has shifted to the types of programs that allow employees to participate on their own time. These include quarterly challenges with tracking components, one-on-one services such as health coaching, nutritional counseling and fitness training. A restructured format for the “lunch ‘n learn” presentations, allowing for several smaller sessions to be delivered at different times to different segments of the population may be an alternative way to return to those
educational options in the future. An array of ongoing programs throughout the year, along with the environment interventions put in place, round out the HOP’s offerings.

**Physical Activity Components.** The HOP’s physical activity and fitness recommendations and initiatives are based on the American College of Sports Medicine (ACSM) guidelines (2011). Aside from the discounted health club memberships, the chief fitness component has been the HOP “FitCard,” which spells out the (ACSM) recommendations and encourages participants to engage in physical activity most days of the week. It helps participants stay on track with their chosen physical activity programs by tracking their weekly engagement every month. The cards are turned in monthly and a drawing for a gift card takes place at the beginning of each month and the winner announced. While this small incentive by itself is not expected to motivate use of the card, it adds to the fun of participating. This simple activity seems to genuinely help people be consistent with their physical activity. About 40-60 employees participate each month.

Other fitness interventions have included “Lunch ‘n Learn” presentations and handouts on the elements of fitness and instruction on customizing them to suit an individual’s personal health profile, needs, and preferences. A company-wide walking challenge using pedometers had excellent participation rates, as did a challenge to add a new component to one’s physical activity. A walking group was active for about six months, and for a period of several weeks, a fitness trainer was available onsite. Each of these events and activities will be evaluated in the context of the next year’s program and some of them may be repeated.
Plans for the future include an in-house gym and a collaborative project between the Oasis Clinic and the occupational health group we partner with already. Employees receiving a prescription for increased physical activity by the clinic staff (or their primary care provider), will have access to exercise physiologists at the nearby hospital. The exercise physiologist would then provide exercise counseling and training. This is a direct application of the Exercise is Medicine model which encourages health care providers “to assess and review every patient’s physical activity program at every visit” (Exercise is Medicine). In the meantime employees are encouraged to use their health club memberships and to walk during break and lunch period.

**Eating Well and Weight Control Components.** The area of eating well has also been a major component of the HOP programming. The philosophy is a simple one: Avoid special or restrictive diets, avoid overeating, practice moderation in the consumption of alcoholic beverages, and adhere to a diet that is based on real food, minimally processed, and which includes whole grains, fruits, and vegetables. The new Harvard School of Health’s “Healthy Eating Plate” (Harvard Health Publications, 2011) has been adopted as the program’s eating guide, and along with it, Michael Pollan’s recommendation, “Eat food, not too much, mostly plants” (2009, p. xv).

A number of group presentations have addressed good nutrition and weight management strategies. There have been multi-week classes on the same subject, and a number of food preparation workshops. Additionally, a nutritional counselor was available twice a month at the health clinic for over a year. Several food-related challenges have taken place: A water challenge which included reducing sugary and diet
drinks and increasing water intake, a popular fruit and veggies challenge, and a “going locavore” challenge, which encouraged participants to eat local, seasonal foods.

Books to guide employees in their eating choices have been given away at the annual health screenings and other HOP events. They have included Michael Pollan’s *Food Rules: An Eater’s Manual* (2009), Ann Kulze’s *Eating Right for Life: Your Common Sense Guide to Eating Right and Living Well* (2010) (distribution of the companion cookbook is planned for 2012), and Steven Aldana’s *Stop & Go: Fast Food Nutrition Guide* (2010). Healthy recipes are frequently shared in the regular HOP emails or through the company’s newsletter. Most of the programs or messages regarding eating well include tips and strategies for weight reduction and/or maintenance. Needless to say, any message regarding weight management is accompanied with the inarguable need for engaging in physical activity on a regular basis.

One of the more influential projects has been the elimination of all candy, sodas and other unhealthy snacks for purchase onsite, and the establishment of the company’s own vending machines, with all the ordering and operations managed by the HOP. The options available in the machines are a vast improvement over the regular vending fair, with most products being minimally processed, many of them organic, and most passing the test of lower sugar content than their more commercial counterparts. Additionally, fresh lunch wraps and salads, prepared by SNBC staff are loaded onto the machines three times a week. While there was some initial resistance to the new vending program, it has been received with general enthusiasm and use of the machines continues to increase month by month. Furthermore, this program offers an excellent opportunity to bring awareness to quality of ingredients (and how they enhance not only health, but
flavor), label reading, product comparison, and the benefits of healthy snacking. This program is an example of peer support in action; many employees who initially resisted the change have been won over by their peers’ positive reactions and comments. Besides the healthy snacks offered, the “Fruit Friday” program delivers fresh fruit to all the break rooms on the last Friday of each month.

In 2012, the program will contract the services of a registered dietitian at the Oasis Clinic and will make every effort to integrate their services with those already offered there. Another program planned for next year is a series of short food preparation classes for small groups in the kitchen facilities of various break rooms throughout the plant. The objective will be to demonstrate how to prepare a quick meal featuring a large proportion of vegetables and whole grains which will be enjoyed by participants as their midday meal. These sessions will be carried out in collaboration with the Agriculture department, which will provide fresh produce from the organic gardens that supply the company’s restaurant. Finally, for those who prefer to work in a group, partial reimbursement will be offered to Weight Watchers participants who adhere to the program for at least six months.

Stress Reduction Components. Stress reduction is perhaps the most elusive aspect of wellness, being so intimately connected as it is to behaviors such as sleep, exercise, nutrition, substance use, to name a few. An effort is made to address these connections and their relevance to stress management. Still, opportunities are provided that address stress directly and offer strategies for personal use. The program has sponsored practical talks on the mindfulness approach, bringing attention to the idea of responding rather than reacting to stimuli, and to being present to what is happening in
the moment rather than dwelling on past events or projecting one’s fears into the future. A stress reduction challenge, suggesting a number of daily stress-reducing strategies, takes place annually. Tips for reducing stress and improving sleep are regularly featured in communications. A plan for the coming year, in conjunction with the creation of an onsite gym or work-out space, is the creation of a quiet space, which would facilitate, silent breaks, relaxation, meditation, stretching, reading, etc., with tools such as guided meditation and relaxation CDs, yoga mats, and sitting cushions provided.

**Tobacco Cessation Component.** It is well known that for tobacco users, the most significant behavior change they can make is to quit and that this action has dramatic immediate, as well as long-term, health improvement effects. Therefore, tobacco cessation is a constant feature of the program and promoted in a variety of ways. For the HOP, the first step was to establish a policy of non-use inside the company walls. Two inconvenient locations at the periphery of parking areas were allocated as the only locations where smoking or tobacco chewing are permitted. This has significantly reduced the number of times per day that tobacco users can dedicate to these activities. It has also isolated the practice and reinforced the perception that it is undesirable and not endorsed by the rest of the organization.

In addition to the tobacco use policy, the HOP offers ongoing support for anyone wishing to quit. Group classes with a trained facilitator have been offered free of charge, and more recently, the possibility of one-on-one motivational interviewing sessions with the facilitator to assist participants in the difficult process of overcoming their addiction. As a way to support commitment and offer an incentive, the cost of services, which the participant pays up front, is reimbursed after six months if they
remain tobacco-free. Any expenses incurred in quitting aids or services are also reimbursed at a generous maximum after six months. The Great American Smokeout, celebrated every November provides an occasion to bring attention to the issue of tobacco use, disseminate information, and promote the cessation program.

**Musculoskeletal Health Component.** Given my background and training in kinesiology and various modalities of manual therapies, musculoskeletal health has been a HOP component from the beginning. Therapeutic services include deep-tissue, trigger point, relaxation, and chair massage (all of which focus primary on back, neck, and shoulder care) and in the last couple of years, following company-sponsored certification training, Active Release Techniques® (ART). The latter modality has proven an effective approach for evaluating and treating soft tissue strains and discomforts covering an extensive number of conditions pertaining to muscles, tendons, ligaments, fascia, and nerves of the spine and trunk as well as the lower extremities. The treatments are relatively short and often go to the specific source of the problem quickly, without involving a more comprehensive treatment on the massage table. Treatment is often delivered in a seated or standing position and rarely is any kind of clothing removal required.

The effectiveness and convenience of ART®, makes it an ideal workplace intervention. Along with deep tissue and trigger point massage, it has been incorporated into the Injury Prevention Program being developed in collaboration with the Safety department. In that context, these interventions are part of first-aid treatments for employees who report soft tissue pain, whether or not the condition resulted from a work-related event. In these instances, the first aid treatment may prevent the complaint from
developing into a more serious condition requiring medical treatment. Most treatments, whether they are treated as first-aid, or routine maintenance and prevention, are supplemented with recommendations for exercises, movements, or postures to facilitate postural correction and address muscular imbalances. In some instances instruction for cold and /or heat applications are also given.

Another aspect of the musculoskeletal health program is ergonomics. This program is also implemented in collaboration with the Safety department. While the office ergonomics program is fully operational, the industrial part of the program is still in the preliminary phase. As part of the program, many office workers have had sit-to-stand workstations installed in their work areas. This allows workers who spend long hours at their desk, to alternate between sitting and standing during their day. Besides addressing specific areas where ergonomic controls are necessary and training employees in sound ergonomic practices, the program also plans to facilitate a workplace conditioning and stretching program that incorporates simple exercises into short, daily group sessions led by a department team leader or “coach.”

Social Wellness Component. HOP provides opportunities for employees and their families to interact in non-work related activities. The annual family spring hike in the park is an example. Employees are invited to bring family members, friends, and dogs. It is an opportunity to meet people from other departments and make new connections. Another place where the HOP plays a role is in promoting and rewarding volunteer activities in the community. Employees who participate in such events earn points toward their HOP rewards. Again, it is not implied that this is enough to motivate participation; rather, it is a way to keep the HOP in the picture and integrate it into the
various aspects of life that affect health. As already mentioned, the program interfaces with the local community in a number of ways that promotes social involvement and meaningful interaction with others.

**Self-care Component.** The concept of self-care is implicit in a healthy lifestyle and in many of the program components already mentioned. Additionally, members are provided with an extensive self-care guide at the beginning of the year: the *Healthwise Handbook, A Self-Care Guide for You and Your Family* (Kemper & Henley, 2008). This comprehensive book covers first aid and emergencies, common health problems, management of chronic diseases, and sections on staying healthy. It is organized by conditions and symptoms and gives detailed instruction for self-evaluation, home care, use of over the counter remedies, and situations that require medical attention. This book is a great way to extend the program’s reach to include spouses and other family members. Besides this guide, the wellness office offers a Wellness Library, with a collection of books and DVD’s on food awareness and cooking, weight reduction, stress management, fitness and disease prevention. HOP encourages prevention and preventive care through its various messages channels and highlights community services and national prevention campaigns.

A new program recently launched is “Great Beginnings.” This program for expectant mothers, employees and spouses alike, has the main objective of providing expert education, services, and resources to facilitate successful breastfeeding during their baby’s first year (or a portion of it). It also provides referrals to HOP and or community services that support proper nutrition and fitness during the pre- and post-natal months.
Behavior Change at a Distance. The “HOP to Go” program adapts some of the activities and events described above for the sales department employees, whom are spread throughout the country, through email and electronic means. While there is robust participation from this department in the annual screenings, and while they receive all the communications delivered to the rest of the workforce and benefit from the cultural influence of the program, participation in the behavior change components available to them has been minimal. Going forward, the plan is to engage this segment of the population through social media and online applications designed to facilitate behavior change to a mobile population.

Environmental and Cultural Context

To maximize effectiveness, a wellness program must become a part of daily life in the workplace and be considered an integral part of the company’s identity, values, and operating plan. If seen as separate from the whole—an optional perk for a few—the program will have little chance of gaining the popular support it needs to endure and fulfill its mission. The HOP program has striven to establish itself in this way through a variety of means. It is a challenging proposition and requires time, experimentation, and frequent self-examination, the program being as it is, a relatively “new kid on the block.”

Physical Enhancements. Mention has been made of the chief environmental changes the program has promoted: A tobacco use policy, healthy vending and lunch options, and a walking path on the company’s property. The current tobacco policy was adopted as a transitional measure by moving the smoking area from a location within the plant to a peripheral location outside the walls. The next obvious step will be an updated policy that bans tobacco-use completely anywhere on company property. A date has not
yet been set for this, but the subject will be an important part of the wellness conversation in 2012. Plans for the coming year also include an onsite gym and a quiet room.

The program has established a visible presence through wellness bulletin boards throughout the premises that provide health tips and literature, and notices of upcoming activities, and events. A wellness page with information on the program, contact information, and upcoming events, is available at digital touch-screens found at three key locations in the plant. Future plans include the creation of a wellness intranet site accessible to all employees. This will not only provide an enhanced communications channel, but also allow participants a personal page where they will be able to track their wellness goals.

**Cultural Integration.** Part of the HOP’s goal is to integrate wellness values into the fabric of company life. Communications have stressed the fact that as members of a community, employees have the opportunity to help and influence one another to make health improvements. Another message that has permeated promotion of the program is a reiteration of the value of human freedom within a context of accountability, responsibility, and cooperation. This is particularly relevant in the context of group health insurance plans, to which, as Edington (2009) points out, the 80-20 rule applies. In the case of health care it implies that in any given population 20% of the people incur 80% of the cost. Yet everyone shares in the cost.

As mentioned already, communication channels with supervisors and managers have been established to ensure their engagement and support, and the Wellness Advisory Committee provides a program advocate and spokesperson in each department. The HOP is included on the agenda of all-employee meetings at least once a
year. Monthly company-wide emails and newsletter articles establish wellness as a regular aspect of the conversation around company issues.

Another way to include awareness of wellness values in company life has been the promotion of healthy food options at company meetings and celebrations. The underlying premise promoted is that healthy options can be as delicious and fun, if not more so, than their unhealthy counterparts. This campaign has had limited success, but it is expected to gain momentum as management and employees come to value healthier foods and moderate portions (without sacrificing taste or variety).

As previously mentioned, a large annual company event places wellness center stage alongside sustainability. This event, formerly known as the “Sustainability & Wellness Fair,” has recently been renamed “Earth Day Expo.” This event highlights the common ground between behaviors that promote personal health and behaviors that promote environmental stewardship and promotes the idea that healthy people and a healthy planet go hand in hand. The fair provides an opportunity for all employees to explore what the HOP and the sustainability programs offer as well as meet representatives of community organizations and programs that promote wellness and environmental values. It is a festive event with opportunities for socialization, enjoying healthy foods, learning about community resources and services, and entering a prized drawing for a large array of health-enhancing gifts donated by exhibitors. This year was the second year of this event and saw participation increase considerably and it is hoped that it will continue to be a well-attended company tradition in coming years.

Relationship-building. Reference has been made to the many advocates, both within and outside of the organization, which help build a true popular movement in the
workplace. Of these relationships, the most important one for the facilitator is the personal relationship with the employees themselves, the end-users, or “customers” of the program. Cultivation of a non-judgmental, respectful, receptive, and empathic attitude on the part of the facilitator in his or her communications and contacts will result in a more fruitful relationship with all members of the population—one that promotes trust and invites interaction. This aligns with the self-determination theory of behavioral change outlined earlier and positions the facilitator as an advocate rather than an authority figure. While managers, supervisors, and certain members of the workforce are partners in helping disseminate information and facilitate participation, they are also users of the program, and that side of the relationship must be maintained. Obviously, this must extend to family members as well.

Besides cultivating a friendly, supportive communication and facilitation style, it is also helpful to be visible, to mix and mingle with employees whenever possible. This offers the opportunity to establish the above-mentioned attitude and also makes the facilitator available for questions, requests, suggestions, and feedback that may come up in the moment. Informal and unexpected encounters sometimes afford the greatest opportunities for education, referral, or supportive encouragement – the proverbial “teaching moment.”

Program Planning, Evaluation, and Adaptation

Planning. Program planning has as its chief objective the reduction of health risks and improvement in health outcomes in the population and the reduction of health care costs for employer and employees alike. As such, it should include specific goals for
improving those metrics. Preliminary planning of the program is carried out in conjunction with management and presented to the Wellness Advisory Group for input and feedback. The plan is informed by the needs and interests of the population as assessed through surveys, by the aggregate report received as part of the annual screenings, and by participants’ feedback. The annual aggregate report conveys information such as percent of the population at various levels of risk, predominant risk factors in the population, and participants’ readiness to change. These are all useful in prioritizing the focus of the program. During the second year of operations the HOP performed a needs-and-interests survey that suggested employee support for lifestyle facilitation programs such as simple strategies for eating well, exercise for weight loss and cardiovascular health, back care, and massage therapy, among others.

Planning of new programs and continuation of current ones is done on a yearly as well as quarterly basis. It is informed by ongoing evaluation of existing programs and providers, often through participant surveys, and by the readiness of the organization to incorporate new components. Aside from considerations of relevance to the needs of the employees and their families, planning also takes into consideration, specific conditions of the workplace and workforce. For instance, it considers accessibility to computers and email, shift schedules, production schedules, and environmental factors such as the availability of spaces conducive to proposed programs.

**Evaluation and Adaptation.** Periodic reviews and continual development of program components are necessary in order to provide quality assurance and ensure effectiveness (Edington, 2009; HERO, 2010; Wellsource, 2008). Analyzing results and outcomes helps to identify what was successful and what needs to be improved.
Evaluation of wellness programs can be of several types. The most obvious is participation. Do a substantial number of employees take part in the events or activities? Do participants represent the various departments or segments of the population? Some events are expected to attract a majority of employees, as is the case with the annual health screenings. At SNBC participation in the screening during the last two years has reached approximately 60%. The goal for 2012 is to reach between 75-80% of employees. Other events are restricted to a small segment of the population as in the case of tobacco cessation or the Great Beginnings program. In either case, participation should reflect the proportion of the population the specific program addresses.

One of the most significant evaluation tools is the annual health report. This comprehensive report provides such data as percent of the population with each major health risk. It also itemizes the percent of participants that fall under the low, medium, and high risk categories, thus providing a current health scorecard for the population as a whole. Most importantly, the report provides a comparison of health outcomes and risks from year to year. This trend report according to Hall (2011) and others, is a valid way to evaluate the effectiveness of a program. It also brings attention to areas of increased risk or little progress, which can inform future programming. The HOP has seen modest, yet significant improvements in such metrics as blood pressure, triglycerides, and blood glucose over the past two years. The most significant were an 11% improvement in triglyceride levels in 2010 and a 5.3% improvement in fasting glucose levels in 2011 for the participating population.

Other places to look for benchmarks include yearly health costs, health claims and absenteeism indicators such as workers’ compensation, sick days, and family medical
leaves (Edington, 2009; HERO, 2010; Smeltzer et al., 2011). Productivity, which involves much less tangible variables such as work performance, decision-making ability, and potential to increase revenues, are also valid ways to evaluate a wellness program (Chapman, 2007). But these types of evaluations are challenging and difficult and involve multiple complex variables (Chapman, 2007; Smeltzer et al., 2011).

Experts agree that a program must be in place at least three years before health and financial outcomes can be measured (Thorpe & Ogden, 2008). Eventually, a valid assessment of the program must be made, one which provides a cost-benefits analysis and return on investment ratio. This usually implies a non-randomizes study. To be valid, such analyses involve sophisticated statistical methods that account for variability in the distribution of health care utilization in the population and other factors such as demographics, health status and sample size. Such evaluations usually require the expertise of an outside agency or research group (Smeltzer et al., 2011). Going forward, every effort will be made to make this kind of analysis a reality for the HOP. In the meantime the program will continue to implement the best practices that have shown a return on investment in other programs (Chapman, 2007; Edington, 2009; HERO, 2010; Thorpe & Ogden, 2008). HOP will continue to address the obvious health needs of the population and continue to improve and develop programs based on past experience, participation rates, annual health report results, survey results, participant feedback, and evidence-based research.
Closing Thoughts

Many lessons have been learned during the past three years. Chief among them is the need to develop warm, caring, empathic, and respectful relationships with those whom the program serves. The importance of being open, receptive, compassionate, and willing to accept responsibility for shortcomings cannot be stressed enough (while applying a good dose of self-compassion when necessary). Listening to participants’ opinions, suggestions, and feedback and acting on them is not optional. The key to all of the above is finding a balance between offering the best possible interventions and respecting self-determination and personal choice.

The need to evaluate programs and be flexible enough to change course and explore new options has also become evident. The value of including family members and designing programs that are accessible to large portions of the populations has proven essential. At the same time it is important to consider the needs and constraints of specific portions of the population and offer special programs to address them. It has also proven effective to offer programs that are short, portable, and repeatable.

The process of developing and implementing the HOP has not been easy, nor has it yielded immediate results. As anyone in the field of worksite wellness knows, the road is difficult and challenging. However, the prospect of making a difference in peoples’ health and quality of life provides motivation and encouragement for practitioners to persevere in continuing to develop best practices. It is hoped that the experience described here will be of use to others involved in similar undertakings. The journey continues.
REFERENCES


Aldana, S. (2005). The culprit and the cure: Why lifestyle is the culprit behind America’s poor health and how transforming that lifestyle can be the cure. Mapleton, UT: Maple Mountain Press.


APPENDIX A
Workplace Wellness at the Sierra Nevada Brewing Co.
Ana Varona

HEALTH OPPORTUNITY PROGRAM

A Critical Situation

HEALTH CARE DEMAND, HEALTH CARE COSTS, AND HEALTH RISKS
**THE HEALTH AND HEALTH CARE CRISES**

- The health care crisis is due to continued increases in rates of chronic diseases and predisposing factors such as obesity.
  - Shortage of physicians and nurses aggravate the situation.
- Chronic, or lifestyle diseases include:
  - heart disease
  - stroke
  - cancer
  - chronic respiratory diseases
  - diabetes.
- The most modifiable risk factors are:
  - unhealthy diet and excess weight
  - physical inactivity
  - tobacco use.
- Elimination of risks would:
  - Prevent at least 80% of all heart disease, stroke, and type-2 diabetes
  - Prevent over 40% of cancer
  - Lead to better quality of life and shorter period of morbidity at the end of life.

Sources: CDC; WHO; Fries

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**A SHIFT FROM SICKNESS CARE TO WELLNESS CARE AS A SOLUTION**

- Health care has focused primarily on treating diseases rather than promoting health.
- There is a need to bridge the gap between prevention and treatment efforts through health promotion, prevention and early detection, and disease management.
- Key players in risk reduction and lifestyle change:
  - Community health promotion programs
  - Worksite wellness programs

Sources: Aldana; Edington; CDC
THE COST AND BURDEN OF POOR HEALTH

- Health care costs are increasing at rates higher than inflation and national income.
- Modifiable health risks are associated with higher employer health and productivity costs.
  - In particular obesity, high blood pressure, high blood glucose, high triglycerides, inadequate exercise, and stress
- Worksite wellness reflects a shift in responsibility for health care from government to employer and from the health care industry to its consumers.

Sources: Kaiser Family Foundation; Reardon; Kowlessar et al.

PROVIDING SOLUTIONS

HEALTH PROMOTION AND WORKSITE WELLNESS
HEALTH PROMOTION AND WELLNESS DEFINED

- **Health Promotion:**
  + The art and science of helping people discover the synergies between their core passions and optimal health, enhancing their motivation to strive for optimal health, and supporting them in changing their lifestyle to move toward a state of optimal health. Optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be facilitated through a combination of learning experiences that enhance awareness, increase motivation, and build skills and, most important, through the creation of opportunities that open access to environments that make positive health practices the easiest choice. – Michael P. O’Donnell

- **Wellness:**
  + The description of optimal health in the above definition also defines the concept of wellness. Health promotion, then, is the means to achieve wellness.

**Source:** American Journal of Health Promotion

PROGRAM DESIGN MODELS

- **Ecological design:**
  + Healthy behaviors take place in, and are affected by, a multi-layered number of factors including:
    - Intrapersonal (personal knowledge awareness attitude)
    - Interpersonal (social interactions)
    - Institutional (company culture, policies, resources)
    - Community (community programs and resources)
    - Public policy (national or state programs and policies).

**Sources:** Eddy et al.
PROGRAM DESIGN MODELS, CONT.

- Systems thinking:
  + Adds the element of unpredictability to the ecological model
  + Understanding and implementing complex systems considers
    - The relationships among people
    - Collections of information and concepts
  + Relationships in complex systems are dependent on information and how it is communicated


TAKE-AWAY ON PROGRAM DESIGN MODELS

- Understand the complex and dynamic nature of health promotion and behavior change.
  + Be willing to explore, experiment, adapt, and constantly evaluate all elements of the program.
- Address individual needs.
  + But always in the greater context of the physical and social environment in which they occur
- Incorporate communication, resources, and interventions at various levels:
  + The individual
  + The family
  + The workplace
  + The community
- Integrate all of the above in every stage of planning, implementation, and assessment.
- Follow developments in the field at a time of innovation and paradigm shift.
WORKSITE WELLNESS PROGRAM DESIGN APPLICATION

- WELCOA’s Seven Benchmarks:
  - Capturing CEO support
  - Creating cohesive wellness teams
  - Collecting data to drive health efforts
  - Carefully crafting an operating plan
  - Choosing appropriate interventions
  - Creating a supportive environment
  - Carefully evaluating outcomes

Source: Wellness Council of America

PROGRAM COMPONENTS

- A Health Risk Assessment (HRA) Survey
  - Provides awareness, information and education to participants
  - Provides information on the populations health status and health risks
  - Sets a baseline and benchmarks to assess needs and plan interventions
  - Provides data for program evaluation
    - Biometrics such as BMI, blood pressure, and a complete blood panel complete
      the risk assessment process
- Activities and information that increase awareness
- Lifestyle change program to address modifiable health risks
  - Healthy eating and weight control, physical activity, stress, tobacco cessation, injury prevention
- Promotion of a health-enhancing culture and health-supporting environment in the workplace

Source: Edington, L.; Goetzel, R.; HERO; Reardon, J.; Lindsay, G.
Communication, Decisions, Choices

- Message framing:
  - How decision problems are described have an effect on choice preference
  - Humans are “loss averse”
    - Framing a message in terms of what you might lose by not participating results in higher participation than a message that communicates what you might gain
    - People favor stability over change. Default options make it easy for people to stay in a program
  - Health communication using a positive frame that praises people who make healthy choices tends to convey the message that healthy behavior is uncommon

Sources: Kahneman, D., & Tversky, A.; Schwartz, B.; Stuart, A. & Blanton, H.
COMMUNICATION, DECISIONS, CHOICES

× Choice architect: someone who influences peoples’ behavior, or “nudges” them in order to help them improve their lives.
  + Nudges must be easy, cheap, and easy to avoid – they are not mandates. Examples:
    × Make it easy for people to maintain the status quo
    × Provide good information and feedback
    × Do not inform people that their actions are better than the social norm
    × Encourage people to express what they intend to do, and when and how they intend to meet their goals ("mere-measurement effect")

Source: Thaler, R. & Sunstein, C.

COMMUNICATION, DECISIONS, CHOICES

× Making choices is complicated by the overabundance of choice in the modern world
  + Having so many options vying for peoples’ attention can lead to uncertainty, can “sap resolve”, and can diminish the value of choice
  + Advise that is personal and practical becomes memorable.
  + People rely on the decision of others (peer pressure)
    × While they may feel envy or resentment when comparing themselves to others, they may also fell inspired or motivated

Sources: Csikszentmihalyi, M.; Schwartz, B.
MOTIVATION, INCENTIVES, AND ADHERENCE

- Behavior change is preceded by motivation to change.
  - Extrinsic motivation consists of “If-then” rewards.
    - They work so long as the behavior they are encouraging is mechanical and mindless
    - Their effect wears off
    - Lead to behavior that is reward-dependent
    - They don’t work when applied long as the behavior they are encouraging is mechanical and mindless

Source: Pink, D.

MOTIVATION, INCENTIVES, AND ADHERENCE

- Extrinsic incentives in health promotions:
  - Their use to motivate behavior change and produce healthy outcomes is the subject of debate.
  - They are a valid strategy for motivating participation
    - A progress-based approach coaches individuals to make health improvements and rewards them for participation in wellness activities.
    - Providing financial incentives for employees to complete a Health Risk Assessment can increase participation rates dramatically.
  - Incentives only work in the context of a true culture of health.

Sources: O’Donnell, M.; Velpp et al.; Terry, P., & Anderson, D.
MOTIVATION, INCENTIVES, AND ADHERENCE

- Intrinsic motivation is internally driven.
  + Self-determination Theory (SDT):
    ✗ The process through which a person acquires motivation for initiating new health-related behaviors and maintains them over time
    ✗ Self-determined behavior is autonomously motivated, self-endorsed, volitional, and done willingly.
    ✗ Behavior that is not autonomous is motivated by “controls, restrictions, and pressures, arising either from social, contextual, or internal forces”.

Source: Brown, K. & Ryan, R.

MOTIVATION, INCENTIVES, AND ADHERENCE

- SDT and adherence:
  + Self-determination is not only characterized by autonomy, but also by:
    ✗ Confidence, leading to mastery and
    ✗ Competence, leading to self-regulation.
  + Self-regulation promotes integration and internalization.
    ✗ Allows a person to integrate new behaviors into other aspects of their lifestyle and maintains them over time
  + The concept of relatedness describes a connection of trust between the participant and the facilitator.
    ✗ This relationship facilitates the internalization of new skills and behaviors.

Source: Ryan, R., et al.
**MOTIVATION, INCENTIVES, AND ADHERENCE**

- **Goals, commitment, purpose**
  + When a commitment to a goal is made, it gives meaning to a person’s life.
  + People with a sense of purpose, of involvement with something larger than themselves, experience increased wellbeing.
  + People who experience gratitude tend to be healthier, and gratitude for improvements in one’s life helps maintain those improvements.

**MINDFULNESS AND SELF-COMPASSION**

- **What is Mindfulness?**
  + A way of learning to relate directly to whatever is happening in your life, a way of taking charge of your life, a way of doing something for yourself that no one else can do for you.
  + The clear and single-minded awareness of what actually happens to us and in us at the successive moments of perception.

  Mindfulness provides an opportunity to choose the form, direction, and other specifics of action; that is, to act in an autonomous manner.
MINDFULNESS AND SELF-COMPASSION

Self-compassion is an attitude toward oneself that requires mindfulness.

- It implies an attitude of kindness and forgiveness for one’s own limitations or failings, without ignoring them.
- The actions needed for optimal functioning and health are encouraged with gentleness and patience.
- Self-compassion is particularly useful in helping to sustain behavior change given the difficulties inherent in maintaining new behaviors.

Source: Neff, K.

Healthy Environments and Cultures of Health
THE POWER OF CONTEXT TO SUPPORT HEALTH
CULTURE AND THE ENVIRONMENT

- New focus in worksite wellness:
  - A shift from attention on the individual to creating cultures of health and supportive environments – from changing minds to changing contexts.

- Creating a culture of health requires changes in three areas:
  - The Physical environment
  - The psychosocial environment
  - Company benefits and policies

Sources: The Institute for Government; Edington, D.

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CULTURE AND THE ENVIRONMENT

- Physical environment change:
  - Changing the details of the environment in which people make decisions and respond to cues can bring about behavior change. This can often be done simply by removing obstacles.
  - Examples:
    - On-site medical clinic and other health services
    - Encouraging physical activity through access to stairwells or walking paths
    - Providing healthy food choices
    - Providing space for quiet breaks

Sources: Thaler, R., & Sunstein, C.; Gladwell, M.; & The Institute for Government
CULTURE AND THE ENVIRONMENT

- Psychosocial change:
  + Addresses social relationships within the organization
  + Examples of psychosocial considerations:
    × Shared values, vision, norms, peer support, and climate
    × Influence of organizational and social traditions
    × Sense of community

Source: Edington, D.

CULTURE AND THE ENVIRONMENT

- Company policies and benefits:
  + Provide opportunities for career and personal improvement and development
  + Give priority to prevention and wellness
    × Provides financial incentives for healthy behaviors, and include family members
  + Examples:
    × Career opportunities, job design, ergonomics and flow of work between employees, flexible working hours, and benefits design which includes wellness programming

Source: Edington, D.
THE HEALTH OPPORTUNITY PROGRAM (HOP)

- **Vision:** We believe that health is an optimal state of physical, mental, emotional, and spiritual well-being and not merely the absence of disease. We believe that fostering optimal health among our employees and their families is integral to our company’s culture and success.
- **Mission:** To empower employees to make informed decisions about their own health; to promote, support, and celebrate healthy lifestyles; to create a healthy culture at work; and, to support practices that reduce health-related costs for the company and its employees.
- **CEO’s statement:** “We realize that there are many ways to travel through this world and that we are all free to choose our own paths. Our goal is to help provide opportunities and options to help you enjoy life to its fullest.”
- **Program motto:** “Take care of your health so you don’t have to worry about it.”
HOP PROGRAM DESIGN

- Membership program:
  + Membership is contingent on participation in annual health screening and health risk assessment. Spouses can participate.
  + Incentive includes no co-pay health insurance card for member and dependents.
    - Other premium-based incentives being considered for future
  + A point system offers rewards based on participation.
  + A version of the program is available for the sales force via online and long-distance facilitation which includes access to the annual health screenings.

HOP PROGRAM FACILITATION

- Internal Resources:
  + Program is facilitated by a full-time wellness coordinator with support from, and collaborations with, various internal entities
  + The CEO and senior leadership
  + The Human Resources Department, the Safety and Sustainability programs, and the various food-related departments (Agriculture, Restaurant, Big Room)
  + Oasis Clinic staff and services
  + All department managers and supervisors
  + A Wellness Advisory Group comprised of employees from every department
HOP PROGRAM FACILITATION

✖ External Resources:
  + Community-based health providers as contracted partners:
    ✖ From local university, hospital, agencies, health care provider groups
    ✖ They provide components such as health screenings, health coaching, tobacco cessation, healthy eating and weight management, stress reduction, fitness, and pre- and post-natal care
  + Local businesses, services, and facilities integrated into incentives and programming:
    ✖ Local food and fitness stores, farmers’ markets, area parks, community events, etc.
  + Regional, state and national organizations, resources, and programs integrated into programming:
    ✖ Through resources and membership in regional and national wellness organizations, attending conferences, and subscribing to health promotion and wellness publications
    ✖ Through promotion and distribution of published materials from the above

BEHAVIOR CHANGE OPPORTUNITIES

✖ Physical Activity Component:
  + Health club membership discounts
  + Monthly fitness tracking card
  + Onsite walking path and walking club
  + Lectures, publications, challenges
  + Personalized physical activity program through onsite fitness trainer or external service
  + Plans for onsite gym
BEHAVIOR CHANGE OPPORTUNITIES

Eating Well and Weight Control Components:
+ Healthy eating lectures and multi-media presentations
+ Food preparation classes
+ Nutritional counselor onsite
+ Distribution of eating guides, cookbooks, and other written materials
+ Regular food-related challenges
+ Healthy vending machine and lunch program

BEHAVIOR CHANGE OPPORTUNITIES

Stress Reduction Components:
+ Stress reduction messages embedded in programs promoting fitness and eating well
+ Lectures and multi-media presentations on mindfulness-based stress reduction
+ Stress reduction challenges
+ Future quiet room with resources for relaxation, meditation, yoga, etc.
BEHAVIOR CHANGE OPPORTUNITIES

- Tobacco Cessation Components:
  + Tobacco use policy limiting access to use during the workday
  + Tobacco-cessation facilitator onsite
  + Resources and referrals for product and services to aid tobacco cessation
  + Financial subsidy for expenses incurred in cessation products or services if long-term adherence is achieved

BEHAVIOR CHANGE OPPORTUNITIES

- Musculoskeletal Health Components:
  + Onsite therapeutic massage, Active Release Techniques® (ART), and postural re-education
    - These techniques with the option of cold applications are used as part of a first aid program for soft tissue strains
  + Ergonomics and Injury Prevention Program
    - Assessments, recommendations, and training
    - Sit-to-stand stations for office workers
    - Plans for pre-shift or break-time group conditioning and stretching sessions
BEHAVIOR CHANGE OPPORTUNITIES

- Social Wellness Components:
  - Company-wide events that promote socialization
    - Annual hike in the park
    - Hoppy Awards event for high users of the program
  - Promotion and incentives for participation in community volunteer programs
  - Involvement of employees in promotion of the program (Wellness Advisory Group)
- Self-care Components:
  - Distribution of a self-care handbook to all program participants
  - Regular self-care tips and messages
  - Great Beginnings Program
    - Facilitates self-care for expectant mothers, particularly in the area of breastfeeding
  - Wellness library and resource center

ENVIRONMENTAL AND CULTURAL CONTEXT

- Physical Enhancements:
  - Tobacco use access at distant, de-centralized locations
  - Company-owned vending machines carrying nothing but healthy options
  - Onsite walking path and future plans for onsite gym and quiet room
  - Visible presence through wellness bulletin boards and information page in company touch-screens
  - Future plans for company intranet site with wellness page accessible to all employees
ENVIRONMENTAL AND CULTURAL CONTEXT

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**Cultural Integration:**

- Program promotion and communication
  - Provide opportunities for employees to influence one another to make health improvements and to celebrate accomplishments
  - Stress the value of human freedom within a context of accountability, responsibility, and cooperation
  - Includes workforce in planning and promotion
  - Regular wellness emails and regular column in the company newsletter
- Company events and celebrations
  - Events that highlight wellness, such as the Sustainability & Wellness Expo
  - Promote healthy food and beverage options and moderate portions

**Relationship Building:**

- As facilitator, cultivate friendly, non-judgmental, respectful, receptive, and empathic relationships with employees (the program’s “customers”)
  - Develop trust and invite interaction
  - Mix and mingle with the workforce as much as possible and be available for requests, inquiries, suggestions, feedback, and “teaching moments”
PROGRAM PLANNING, EVALUATION, AND ADAPTATION

✗ Planning is done on a quarterly and yearly basis:
  ➕ Should include specific goals for improving participation and health outcomes
  ➕ Should be informed by the needs and interests of the workforce
  ➕ Takes into account, success of previous programs and participant feedback
  ➕ Depends on the readiness or capability of the organization to accommodate programs
    ➕ Availability of adequate space
    ➕ Scheduling constraints
    ➕ Computer and internet access

PROGRAM PLANNING, EVALUATION, AND ADAPTATION

✗ Evaluation and Adaptation
  ➕ Periodic reviews and continual development provide quality assurance and ensure effectiveness
  ➕ Evaluation is of various types:
    ➕ Participation: What percentage of the population participated? Are all departments represented? Are specific programs being utilized by the target population?
    ➕ Health risk, health status, and yearly trends are assessed through the Summary Health Report based on results of the annual health screening
    ➕ Absenteeism can be assessed through indicators such as sick days, family medical leave, and workers’ compensation.
    ➕ Productivity assessments involve such variables as work performance, decision-making ability, and potential to increase revenues
  ➕ A comprehensive program evaluation is difficult and requires expertise and sophisticated statistical methods
    ➕ Outside organizations or experts can be contracted to perform the analyses
    ➕ Evidence-based best practices increase the likelihood of effective programming

Sources: Smeltzer et al.; HERO; Edlington; Chapman
CLOSING THOUGHTS

- Health promotion is difficult and challenging. It requires patience, persistence, creativity, and the flexibility to engage in an ongoing process of learning and adaptation.
- The prospect of making a difference in peoples’ health and quality of life is motivation and encouragement enough for practitioners to persevere in continuing to develop best practices.

Thank you
REFERENCES

Aldana, S. (2005). *The culprit and the cure: Why lifestyle is the culprit behind America’s poor health and how transforming that lifestyle can be the cure*. Mapleton, UT: Maple Mountain Press.


http://journals.lww.com/joem/Abstract/2011/05000/The_Relationship_Between_11_Health_Risks_and.3.aspx


Lindsay, G. M. (2000). Auditing health promotion. *Occupational Medicine, 50*(2), 137-140. Retrieved from 
http://occmed.oxfordjournals.org/content/50/2/137.full.pdf


