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Inside this Issue
Interview: Lauve Metcalfe
Practitioner’s Corner: The 4E’s of Engagement
Research Briefs, Return on Investment

Lauve Metcalfe looks back on her career in worksite health promotion
An Interview with Lauve Metcalfe

Education Chairperson, IAWHP

Board and Al Haig, COO of United Technologies. They not only supported me, but also promoted me and our program throughout the subsidiaries.

Here is an example of a challenging situation I experienced. A group of predominantly male marathon runners were highly skeptical that a woman could perform well in my position, and they told me so early in my tenure. In response, I joined them for their training runs, and started a training club for runners. Shortly afterward, we competed in four marathons (including Boston), the Corporate Invitational run, and many other events as a Pratt team, and the skeptics became my strongest advocates.

The program was a bottom up and top down approach. The employees were looking for a way to have a sense of community and team pride, and the leadership wanted to create an innovative worksite that emphasized corporate commitment to employees. Our program was a win/win for everyone.

WH: You were one of the founders of the former Campbell’s Institute that, in the mid 80s, was an influential voice for regular physical activity for all Americans. What was its mission and did you feel it made any impact?

Campbell’s was a wonderful opportunity to impact so many dimensions of health and fitness. The CEO of Campbell’s Soup had a strong commitment to creating a company of “well-being,” for employees and retirees. Campbell’s developed one of the first in-house day care facilities, and provided funding for national, state, and local opportunities so that individuals and organizations could move the fitness and nutrition agenda forward. We impacted our employees with in-house wellness facilities and programs that continue to be active today. We funded White House Conferences focused on Youth Fitness, Women’s Health, Sports Medicine, Nutrition, and Employee Health. We sponsored the initial research and rollout of the Fitnessgram, physical activity reporting system that is used throughout the nation and internationally. We worked with grass roots organizations to develop and build community programming and join forces with state and national associations to share expertise and success stories. It was an incredible experience working with such a great, talented team, and I can also say: BEST JOB EVER!

WH: In the earlier years, employer programs were primarily fitness-focused, specifically through the corporate fitness center. It’s my observation that the pendulum had swung from fitness to risk reduction in the late 70s, integrating a
number of interventions besides physical activity, including nutrition, tobacco control, and stress management. Today, a broader population health strategy includes disease management. It appears from my perspective that the pendulum may be swinging back towards physical activity first because of the broader benefits that regular physical activity provides, based on current research. What’s your opinion?

I have always believed that physical activity is a core value/habit that generates positive momentum for a healthier outlook, greater physical stamina, and an overall more positive attitude towards life. My personal experience with participating in daily outdoor activity reinforces this. My professional experience with employee populations, and youth and adults continues to support fitness as the most undervalued “secret” to dealing with destructive lifestyle behaviors and negative mindsets. Early in my career, I learned that one of the keys to having fitness work was to make it fun and enjoyable. I have never had a participant drop out of a program because they were having too much fun! Building on the social enjoyment and positive psychological benefits of physical activity is a fundamental first step I emphasize for any lifestyle challenge.

WH: You have done much work on studying body image especially among women. What have been some of your key observations and how can worksite health practitioners apply your findings when designing programs?

I find a large percentage of the individuals I work with are uncomfortable with their bodies due to the enormous pressure our society puts on looking a certain way: thinner, fitter, more attractive, sexier, younger, lighter, darker, taller, shorter, etc. We spend an inordinate amount of time worrying about our bodies because of this social stigma, and as we age, we have even more rigid societal standards for how we “should” look. Focusing on the whole person, shifts the attention away from the body and creates a richer dialogue with what we mean by wellness. My coaching work at the University of Arizona Center for Integrative Medicine exposes individuals to seven core areas of health that include: sleep, movement, nutrition, relationships, resiliency, spirituality, and environment. We discuss one’s current satisfaction with each of these areas and work together on how to improve daily choices using self-care practices. This broader perspective takes the weight off how your body looks and deepens the conversation and meaning of personal health and well-being.

WH: You are past president of an earlier iteration of IAWHP—Association for Fitness in Business (AFB). Today you serve as IAWHP’s Education Co-Chairperson. How has educational preparation and continuing education changed over the past four decades and what advice would you give to young professionals?

I believe that education is a life-long process, and that investing in your professional associations is a great way to keep sharp and feel connected. We are bombarded with information 24/7. It’s overwhelming and creates unneeded professional stress. Networking with your peers in IAWHP can clear the clutter of information overload and provide key resources and contacts to keep you current. The value of creating a “reach out and touch” relationship with leaders in the field is essential to maintaining and sustaining a career in today’s work environment.

WH: You have been actively involved in health coaching and in developing standards for credentialing. What progress has been made in this area?

Health and wellness coaching has been a popular part of worksite health promotion programs for many years now, but without any standard description of what coaching includes or what credentials are needed for delivery. Several years ago, a National Consortium for Credentialing of Health and Wellness Coaches was created to develop a national standard and certification examination that is projected to launch in the Fall of 2017. This certification should provide guidance to worksites for selecting coaches that have the education and experience to provide health coaching at the worksite.

As a practitioner, who is a certified wellness coach and serves on the advisory board for the Institute of Coaching (a Harvard School affiliate), I feel coaching is an excellent skill for a practitioner’s tool box, but it’s not the “total package” in WHP programming. Coaching can offer a deeper understanding of thoughts, behaviors, and habits that can get in the way of practicing a healthier lifestyle/work style. The “dose” of coaching sessions depends on the issues/behaviors that need to be addressed. The National Consortium and Institute of Coaching are compiling research on best practices to assist coaches and organizations determine their best practices.

WH: I have known you for almost 40 years and as long as I have known you, “you have walked the talk” not only in how you take care of yourself, but also—more importantly—your positive attitude toward living. Do you have any parting words of advice for our readers?

Thanks George! I am so appreciative of the high quality professionals I have met throughout my career, whom I respect and care about deeply. Their individual strengths make each of them so effective in the health promotion field. You!, Charlie Estey, Bob Karch, Richard Keeler, Reed Engel, Steve Cherniak, and Nico Pronk have given me unconditional support, helped me keep my attitude positive and to have fun and a unique perspective on the profession. Interestingly, these are also our leaders in IAWHP. It has been a great ride, and I have enjoyed every aspect it!
No doubt, the need to establish systems for measuring program effectiveness and financial impact are critical success factors for any reputable worksite health promotion program. But, as futurist Alvin Toffler stated almost 40 years ago in his landmark book The Third Wave, there are multiple bottom lines—not just return-on-investment (ROI). Recently, there’s been a greater discussion and emphasis on incorporating other outcome measures such as value-on-investment (VOI) and what Dee Edington, PhD and Jennifer Pitts, PhD call Value-of-Caring (VOC), in their book Shared Vision, Shared Results.

Beyond measuring cost-effectiveness, both VOI and VOC are qualitative means to define and defend the business rationale for investing in worksite health promotion/management programs. In both cases, the organization defines value and how to quantify it.

As such, do we, as a profession, lose sight of these other bottom lines that worksite health promotion programs can impact? After all, a positive ROI is not a guarantee that a program will survive, let alone flourish. This has become evident by the fact that over the years, some highly recognized worksite programs have been either significantly downsized or eliminated in spite of becoming C. Everett Koop Award recipients—the “Oscar” of our profession, in my opinion.

By no means am I suggesting that we place less attention and resources on traditional program evaluation that measures economic impact and program outcomes. As this issue demonstrates, there is an expanding body of evidence that worksite health promotion works, and we as a profession need to promote these findings to both management and employees, whenever we have the opportunity. However, let’s not ignore the fact that we are in the people business, and there are other ways we need to measure and report organizational and personal benefit.

I suggest that we develop an additional index for outcome research—the personal-return-on-investment (PROI).

The PROI is the bottom line of behavioral change and parallels the research findings of James Prochaska with his stages of change model. In a nutshell, PROI is the qualitative measure of a person’s commitment to change, based on his or her self-assessment that change is worth the effort (investment). “Is investing my time, money, sweat, and sacrifice worth the effort, compared to what I am doing now? Will I truly benefit?”

Another way to phrase this is in the words of Mahatma Gandhi: “Don’t give up anything, until you don’t need it anymore.” Unless there’s a valuable replacement (greater benefit), there’s no momentum or personal inclination to change—the perceived personal return needs to be significant!

For health promotion practitioners, a low PROI is equivalent to low employee engagement and therefore lower program impact. Unless we can help employees (and their loved ones) raise their PROI—change in any meaningful form will not happen nor persist. Not an easy task! But, that is what we need to consider when designing our curriculums, coaching protocols, incentives, communications, and assessment tools.

The fact is, as professionals, we are collecting PROI data almost every day. They come in the form of testimonials and unsolicited memos from appreciative participants. They come in the form of spontaneous thank-yous to the CEO or other senior officers during company events. They come in the form of participant surveys. Yet, why haven’t these been more effective in quantifying these soft measures to create this other bottom line? The time has come.

“PROI is the qualitative measure of a person’s commitment to change, based on his or her self-assessment that change is worth the effort (investment). “Is investing my time, money, sweat, and sacrifice worth the effort, compared to what I am doing now? Will I truly benefit?”
The Willis-Towers-Watson annual 2015/2016 Staying@Work survey reported that 43% of employers said the most worrisome barrier to having a successful worksite health program, was the lack of employee engagement. 

Related to this issue were the relatively small average participation rates in common program offerings, such as tobacco cessation (8%), weight management (10%), physical activity (22%), stress management (11%), health coaching (12%-17%), and disease management (14%). These rates were low in spite of various incentive program offerings within relatively comprehensive program models. The most widely used programs were one-event offerings: health risk assessments (48%) and biometric screening (48%).

This survey and other outcome studies reinforce the challenges that worksite health promotion practitioners have in driving participation rates especially within targeted health initiatives that are primarily designed to support employees in reducing health risks and/or manage specific chronic health conditions.

In this case, “participation” is the “entry point” of the intervention process, since more complex interventions are required (e.g., time, doses, modalities) to realize meaningful outcome(s).

Within this context, we are discussing engagement rather than participation (i.e., the act of “showing up”) that can be defined as:

“The personal commitment to the sustained execution of specific skills and behaviors that are aligned with predetermined health goals and desired outcomes.”

As such, engagement calls for:

- A two-way, bi-lateral communication with documented activity or outcomes
- Commitment to change through the practice of specific practices/behaviors. This calls for a clear understanding and acceptance of expectations and responsibilities during the change process including the use of available resources and supports (e.g., health coaching)
- Short (e.g., behavioral change) and long-term efforts (e.g., maintenance) related to prescribed practices
- Having well-defined goals and objectives before the intervention begins and means to measure and track changes based on established baselines. For example, using S.M.A.R.T. methodology (Specific, Measureable, Attainable, Realistic, and Time-bound) helps create a formalized process to help individuals clearly define what they intend to do, intend to accomplish, and how soon

The 4Es Model

One means of illustrating the engagement process and the realities and challenges that health promotion practitioners face, can be depicted as a target with four distinct concentric rings illustrated in Chart 1 below. 

Chart 1: 4Es Model
Eligible: The percentage of a population that is eligible to participate within a specific program or intervention. The eligible population can be 100% of full-time employees for health risk assessments and biometric screening or a sub-set of the total employee population for specific, targeted health interventions. Subset populations are usually defined through screening, assessment tools, health claims, and needs/interest surveys. For example, tobacco-users within an adult population average 19% of all employees and, as such, would be defined as the eligible population (refer to Chart 2).

Enrolled: The percentage of the eligible population who actually sign-up for a specific intervention. For example, the most recent Willis-Towers-Watson survey showed that on average, participation rates for tobacco cessation programs was 8%. In this case, the enrolled population is significantly lower than the eligible population as demonstrated in Chart 2, using a 1,000-employee organization.

Engaged: The percentage of employees enrolled in the intervention (e.g., tobacco cessation) that completes a defined “course.” For example, a tobacco cessation program may be comprised of a six-week behavioral coaching course with nicotine replacement therapy. Though reported completion rates vary, a general consensus among tobacco cessation counselors is that 30% to 40% of the enrolled population will finish the prescribed intervention.

End-Result: Based on a defined criterion for “success,” the bull’s eye represents the total percentage of individuals who have successfully complied in meeting program goals. For example, in the case of tobacco cessation, a commonly accepted success criterion is being “tobacco free” six months post intervention.

Running the Numbers

As Chart 2 illustrates, a 1,000-employee organization with an eligible population of 190 tobacco users (19% of 1,000), would have only one (1) successful graduate of the intervention program, if we use a 20% success rate criteria within this cohort.
These types of engagement statistics are not exclusive to tobacco cessation though we know that this is perhaps the most challenging intervention in spite of incentives and program supports. We understand that exercise, weight/obesity, alcohol, and medication adherence have the same engagement issues that can question the value and efficacy of targeted health intervention programs.

Yet, one flaw of this model is concluding that the organization has not impacted health behaviors, unless measured, it can ignore the positive role that a “culture of health” can have on a certain segment of employees (and family members) in becoming self-motivators—those who have made positive health changes independent of formal interventions.

As health promotion practitioners, our challenge is not only to improve our success rates (e.g., end-result), but also enroll and engage a greater mass of a targeted population to the bull’s eye (directly and indirectly). Without engaging a critical mass of individuals, organizations cannot realize the value on their investments.

Table 1 provides some troubleshooting strategies within the 4Es Model for improving employee engagement and outcomes.

Table 1: Engagement Troubleshooting

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<th>Stage</th>
<th>Problem</th>
<th>Strategies</th>
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<tr>
<td>Eligible</td>
<td>Identifying the total number of “at risk” employees. Identifying employees who are interested in a specific program offering.</td>
<td>Needs/interest survey: Paper or online—employees have the option in being contacted (e.g., permission marketing) for when a specific program is being offered. Non-Participant Focus Group: Invite employees who typically do not participate in health promotion programs. Offer coffee and/or a healthy snack, and ask them about barriers to participation—what it would take for them to participate. Promote program privacy and confidentiality. Health risk assessments. Paper or online—employees have the option in being contacted (e.g., permission marketing) for when a specific program is being offered by the company. Health/biometric screenings: Offered as part of an annual benefits fair or enrollment. It’s a great way to transition employees when introducing a new benefit plan design. It can be offered onsite, or through a lab test or physician form verification. Pharmaceutical claims for NRTs</td>
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**Table 1: Engagement Troubleshooting, continued**

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<th>Stage</th>
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| Enroll | Poor sign-ups for targeted program offerings. | - Organizations should consider two kinds of motivators: Extrinsic and intrinsic. Intrinsic motivators come from within. Extrinsic motivators are external incentives such as recognition or monetary incentives for participation or meeting a health goal.  
- Offer and promote group programs more than once per year. Establish, distribute (e.g., desk drops), post in high traffic areas (e.g., break areas, rest rooms, dedicated wellness bulletin boards), and on the website.  
- “Opt-Out”: Employees who have been identified as “at risk” are “automatically” eligible to receive a targeted intervention (e.g., health coaching/disease management). They are contacted by the health coach to establish a coaching schedule.  
- “Opt-In.”  
- Providing program free-of-charge.  
- Promoting an engagement incentive for completion of intervention.  
- Incentives can be financial, health plan premium reduction, gift raffle, or a couple of extra days of paid time off.  
- Educate managers and supervisory personnel on available programs and how to provide “gentle prods” through group meetings (e.g., team huddles with bullet point briefings) and appropriate ways to promote programs on an individual basis.  
- Train and use “wellness champions” to promote programs within their specific work groups.  
- Awareness: Through employee communications (e.g., newsletter, poster campaign, videos on health website), feature testimonials of employees who have successfully achieved their health targets through company sponsored programs. This approach helps make prospective participants aware of available programs, and that they work!  
- Organizational activities: Promote your wellness offering as part of new employee orientations, departmental meetings, monthly safety meetings, and regular benefit enrollment communications. |
### Table 1: Engagement Troubleshooting, continued

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<th>Stage</th>
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| Engage | High dropout rate. | - Provide a number of intervention options (e.g., text messaging, face-to-face, group, online, telephonic). Use S.M.A.R.T. goals (i.e., Specific, Measureable, Attainable, Realistic, and Time-bound) across all interventions.  
- Have a formal process for collecting and evaluating S.M.A.R.T. goals.  
- Provide onsite supports (e.g., seminars, benefits and safety fairs, health coaching), if practical.  
- Provide digital supports (e.g. webinars, Podcasts, YouTube testimonials, email links, motivational text messaging)  
- Audit, expand, and improve environmental supports for physical activity, clean and safe staircases, healthier eating and vending choices, stress management, and tobacco-free worksites.  
- Provide an engagement incentive (e.g., for completion of an intervention).  
- Motivate: Through employee communications (e.g., newsletter, poster campaign, videos on health website), feature testimonials of employees who have successfully achieved their health targets through company sponsored programs.  
- Create and distribute a survey targeted to program dropouts—reasons for dropping out, barriers to engagement, and suggested program improvements. Revise/improve program models based on pertinent feedback.  
- Participatory programs: Conditions for obtaining a reward or incentive are NOT based on an individual satisfying a standard that is related to a health factor.  
- Health-contingent programs: May be activity based (requires an individual to perform or complete an activity related to a health factor to obtain a reward or avoid a penalty) or outcomes based (requires an individual to attain or maintain specific health outcome in order to receive a reward or avoid a penalty). |
2. Size of reward is 30% to 50% of the cost of coverage  
3. Must be designed to promote health or prevent disease  
4. Offer a Reasonable Alternative Standard “RAS” to earn incentive if individual cannot reach their goal;  
5. All plans that describe the terms of the program but also disclose the availability of an RAS.  
6. Must meet five standards to comply. Refer to EEOC website. |

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### In Summary

Health promotion practitioners are realizing that “employee engagement” is a critical success factor in increasing the odds of positively impacting program goals and outcomes. Participation, though important, should be viewed as the front end of the engagement process when the intervention requires a sustained commitment and active involvement in making change happen and continuing the desired behavior. As such, engagement doesn’t stop once the formal intervention ends—there needs to be organizational, environmental, informational, and support systems in place that help make health the easier choice. The key is to foster a program that leads to high participation and engagement with a commitment to supportive steps:

- Set your organizational wellness goals and align incentive design with overall benefit and health plan strategy
- Understand your health risk, claims trend, worker’s comp, and injury history
- Consult in-house legal counsel while developing a health promotion and incentive plan
- Have a clear end goal for your wellness program initiatives and anticipate the data needed to be able to track and measure impact effectively
- Demonstrate executive and mid-level management support through resources, communications, and participation

### Table 1: Engagement Troubleshooting, continued

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<td>End-Result</td>
<td>Small percentages of employees have successfully achieved their health targets.</td>
<td>- Provide formal and informal recognition for employees who have successfully achieved desired health goals (e.g., 60% improvement from prior health status score, migrate from at risk to healthy status, tobacco-free, target weight).</td>
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<td>- Provide recognition or an incentive for successfully achieving health goal.</td>
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<td>- Reinforce: Through employee communications, feature testimonials of employees who have successfully achieved their health targets through company sponsored programs. By being featured, employees are more inclined to maintain their health practices.</td>
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<td>- Follow-up: Have a formal process/communication plan for following-up with formal participants to reinforce available information and support to help prevent recidivism.</td>
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<td>- Create standard dashboards and metrics.</td>
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<td>- Hold vendors accountable: Based on your organization’s dashboards, require third-party vendors to comply with data requirements. Depending on company size, consider quarterly activity reports including an objective analysis of concerns and suggested action items.</td>
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<td>- Be transparent: Share results (dashboards) with key stakeholders (e.g., management, employees, vendors) through an annual “Report Card.”</td>
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### References

| Reference                                                                 | Overview                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Description                                                                                                                                                                                                                                                                                                                                                       | Reported ROI                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Musich S, McCalister T, Wang, et al. Evaluation of the Well at Dell Health Management Program: Health Risk Change and Financial Return on Investment. *Am J Health Promot.* 2015; 29:347–363 | A quasi-experimental design was used to measure financial impact and a nonexperimental pre-post design to evaluate change in health risks. Subjects were 24,651 employees with continuous medical enrollment in 2010–2011 who were eligible for 2011 health management programming. Well@Dell is an incentive-driven, outcomes-based multi-component corporate health management program with two primary components: health risk assessment/wellness, lifestyle management and disease management coaching programs. | The overall ROI was $2.48 in 2011. Years 2 and 3 showed a sustained ROI.                                                                                                                                                                                                                                                                                                                                                        |
| Henke R, Goetzel R, McHugh J, et al. Recent Experience in Health Promotion At Johnson & Johnson: Lower Health Care Spending, Strong Return-on-Investment. *Health Aff* (Millwood), 2011; 30:490-499 | Compared 2002–08 medical and drug cost trends of J&J to companies similar in industry and size. Propensity-score matching was applied to minimize the effects. *Live for Life* has been in place since 1979 focusing on employee health risks and medical care utilization. The program provides a $500 incentive for participation in health screenings and targeted interventions.                                                                                                                                                                                                                 | ROI between $1.88—$3.92 for every dollar spent.                                                                                                                                                                                                                                                                                                                                                                                  |
| Baxter S, Sanderson K, Venn AJ, et al. The Relationship Between Return on Investment and Quality of Study Methodology in Workplace Health Promotion Programs. *Am J Health Promot.* 2014; 28:347–363 | Review of 51 peer-reviewed studies (61 intervention arms) published between 1984 and 2012. Methodological quality was graded using British Medical Journal Economic Evaluation Working Party checklist. Economic outcomes were presented as ROI.                                                                                       | When factoring methodological quality, an inverse relationship to ROI was found where higher quality studies demonstrated a smaller mean ROI when compared to moderate and low-quality studies. A surprising finding was that randomized control trials (RCT) showed a negative ROI.                                                                                                                                                                                                                           |
| Berry L, Mirabito A, Baun W. What’s the Hard Return on Employee Wellness Programs? *Harvard Business Review.* December 2010 | The authors conducted field visits with 10 organizations that had financially sound worksite wellness programs. Based on interviews with key stakeholders including senior leaders, the authors identified six key attributes (pillars) of successful programs.                                                                                                                                                                                                                     | The ROI on a comprehensive, well-managed employee wellness program can be as high as $6.00 for every dollar spent.                                                                                                                                                                                                                                                                                                                                                     |
William M. Baun Passes

William (Bill) Baun, former member of the Board of Directors of IAWHP and past president of the National Wellness Institute, died peacefully on November 5, 2016. Bill was Wellness Officer for the University of Texas, MD Anderson Cancer Center. In honor of Baun’s service to worksite health promotion, IAWHP has established an award in his name to recognize outstanding practitioners who have demonstrated outstanding service to the field.

IAWHP Announces Presenters for 2017 Webinar Series

Lauve Metcalfe, Education Chairperson, has announced the following presenters for IAWHP’s webinar series:

- Joseph Leutzinger, PhD, March 9 at 12:00 p.m. EST—Evaluation and Measurement
- Alberto Ogata, MD, Q2, TBA—ABQV (Portuguese)
- Wolf Kirsten, MS, Q3, TBA—Global Health Awards winners
- Charles Estey, MS, Q4, TBA—Presidential Insights

For dates and times, please visit www.iawhp.org

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Worksite Health International is looking for case studies, research papers, and practitioner tips from our members. If you have an article that you wish to submit or have an idea you would like to share, please contact:

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IAWHP’s Mission

To advance the global community of worksite health promotion practitioners through high-quality information services, educational activities, personal and professional development and networking opportunities.