



An Interview with Wolf Kirsten



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WHI: What made you get involved in worksite health promotion?

WK: As an athlete, I was always interested in sports and physical education. My undergraduate studies at the University of Alabama in Birmingham led me to focus more and more on health education and promotion. My first internship was in a workplace setting, and ever since I have been gripped by the opportunities at the worksite to improve the health and quality of life of people.

WHI: As President of IAWHP, what would you like to accomplish during your term?

WK: Overall, I will do my best to lift the IAWHP to the next level and make it more significant globally. I think we have a great foundation, and with the talented team on board, I truly believe we can get there. Specifically:

- Grow the IAWHP membership database, especially outside of the U.S. The opportunities are immense.

- Strengthen the link to the academic community and make students aware of the benefits of getting involved in the IAWHP.
- Reach out to key international organizations and form partnerships with them.
- Add to and enhance the many existing resources the IAWHP provides, such as the online certification course, webinars, newsletter, etc.

WHI: In countries that have socialized medicine, is worksite health promotion less prevalent or do these programs have a different focus?

WK: There is less of a direct incentive to invest in worksite health promotion in countries where the state provides many health benefits and also carries the brunt of the costs. However, this is changing rapidly with the increasing research and proof of how programs can have a significant impact on productivity, employee morale, and corporate image. In addition, in many countries, healthcare benefits provided by the state are increasing in cost and dwindling in scope.

WHI: From an international perspective, where is the greatest growth and/or interest for worksite health?

WK: Promoting health at the workplace is a global trend which is very exciting. Some countries, such as Finland, Singapore, or Brazil, have recognized the many benefits of worksite health promotion earlier than others and are more active. There is

tremendous growth in Asia where the wellness concept has been received enthusiastically by many employees. In other regions, such as the Middle East or Africa, awareness of healthy lifestyles and individual responsibility needs to be further increased. Given the alarming chronic disease trends I am convinced we will see more growth.

WHI: IAWHP recently endorsed the “Total Worker Health” model developed by NIOSH. What is the model and why is it different from typical occupational health programs?

WK: To some employers, the integration of occupational health and safety and worksite health promotion is an old hat. However, from a global perspective, there is a huge need for better integration as many occupational health programs focus only on protecting employee health. I am glad that NIOSH is pushing the “Total Worker Health” model, especially as it matches with the World Health Organization (WHO) “Healthy Workplace” model, which is more comprehensive and also incorporates the areas of corporate social responsibility and the psychosocial work environment.

WHI: Total return on investment continues to be the litmus test for most U.S. organizations when evaluating worksite health promotion programs. How important is ROI in other westernized countries?

WK: In the U.S., programs tend to be under greater pressure to provide financial justification for their required investment.

Outside the U.S., this concept may be viewed as excessive, since an investment in health promotion is typically justified by positive outcomes, such as productivity, engagement, and retention, rather than focusing on a purely financial return. The following quote from a corporate medical director in Europe drives home the point I think: “There is a huge difference between ROI in the U.S. vs. outside the U.S. ROI receives a lot of attention in the U.S. but elsewhere, we would only expect to break even.” This is reflected in the scarcity of ROI research outside of the U.S. While very much recognizing the realities of the business world, I personally believe it is good for our field to move away a little from the heavy focus on ROI.

WHI: Health engagement, defined as completing and sustaining desired health practices, continues to be a major programming challenge especially in targeting high-risk populations. This doesn’t include achieving desired outcomes. How can companies address low-employee engagement rates?

WK: There are many different strategies and methods globally to address the engagement challenge. Companies often look for a single best practice technique, which doesn’t exist. It seems in the U.S., many employers put all their eggs in one basket, such as providing financial incentives. This happens to a much lesser degree outside of the U.S. My experience has been that without active senior leadership support—beyond approving budgets—and employee involvement from the outset, including such things as needs surveys, committees with employee representation, cooperation with work councils, and so forth, there is no chance for sustainable engagement. Too often, unfortunately, I have worked with employers that have none in place, or merely one or the other.

President’s Message

The IAWHP Board of Directors conducted its first strategic planning meeting, hosted by HealthPartners, in Minneapolis, Minnesota on August 21st and 22nd. On day 1, we focused on an environmental overview of the worksite health promotion space and revisited IAWHP’s mission, goals, and objectives. On day 2, our focus narrowed to specific initiatives that:

- Improve and expand the member experience—providing value to worksite health practitioners.
- Leverage opportunities that expand IAWHP’s international visibility and influence in such areas as worksite health policy, research, and advocacy.
- Explore market and service models that broaden IAWHP’s membership and facilitate collaboration among key stakeholders and thought leaders in the field of worksite health promotion.

Based on the above, project teams developed and presented specific recommendations, preliminary action items, and accountabilities. Under consideration are the following general initiatives that will require further study, letters of understanding/agreements, and Board approvals:

- Refining our membership categories and fee schedules.
- Expanding our membership structure that would encompass individuals, organizations, and academic/research institutions.
- Exploring potential opportunities for the rapid expansion of IAWHP’s membership internationally, including the appointment of regional chairs.
- Providing an entry-level certification program in worksite wellness.
- Providing members with greater international networking opportunities.
- Exploring collaborative arrangements that would provide IAWHP with access to a central database of best practices in worksite health.

On behalf of IAWHP’s Board, we are enthusiastic about the potential opportunities that exist for improving the member experience, expanding our international presence, and improving collaboration, rather than competition, among organizations within the worksite health arena.



Using D.A.T. Analysis for Program Design

George J. Pfeiffer, MSE, FAWHP

Program design should be based on objective data, collected appropriately and benchmarked through pre-assessment, interpretation, and prioritization of identified program elements (e.g., leadership, policies, benefits, environmental supports, communications, interventions) using standard problem-solving/planning techniques. Based on these criteria, the program design process is more effective and provides the following benefits:

- Aligns program elements with goals and objectives
- Provides greater program integration
- Focuses investments/resources that have greater value
- Drives greater participation and engagement
- Achieves better outcomes

A simple litmus test for evaluating the total value of a planned initiative before actual design is implemented, is conducting what I call a D.A.T. Analysis.

D.A.T. Analysis

DATA-DRIVEN

- Design decisions are based on reliable data (e.g., pre-assessment)
- Design is predicated on appropriate planning (e.g., prioritization, resources)
- Design elements can be measured objectively for effectiveness

ALIGNED

- Design decisions are aligned with the organization's culture and business
- Design decisions are aligned with specific goals and objectives (e.g., foster engagement)
- Design decisions are integrated across the total program model (e.g., population health)

TESTED

- Design decisions are (preferably) evidence-based
- Design elements are pre-tested (e.g., focus groups, piloted)
- Based on pre-testing, design elements can be refined, re-engineered, or abandoned

By using a D.A.T. Analysis, practitioners have a standard means to quickly assess whether a proposed initiative is based on credible intelligence and planning processes. In doing so, the actual program design process is more closely aligned with the organization's overall goals and objectives.



Coaching as an Integral Part of Onsite Health Promotion

Helping people change through coaching, using motivational interviewing and personalized planning

Terry Karjalainen PhD, RN

Case Study

Introduction

Most professionals in the fields of wellness and health promotion, and/or healthcare, understand and appreciate the difficulties in changing health behaviors. The process for effecting behavior change begins with the Health Risk Appraisal (HRA), which has been the industry’s instrument of choice for measuring levels of risk and the likelihood of future illness. Commonly, the HRA is used to compile a risk analysis using biometric measures such as blood pressure, weight/BMI, blood glucose, and cholesterol; self-reported behavioral practices such as level of physical activity and use of tobacco and alcohol; and perceptual measures such as life and health satisfaction.

Health promotion program participants receive the results of the HRA, which show their risks. Then what? Are participants left to their own devices? Studies have shown that implementing the HRA alone has no significant influence on changing health engagement and risk status. Yet commonly, programs rely on the HRA alone, or perhaps an HRA with a biometric screening, but without an integrated interpretation/coaching component. As a result, the value of the relative investment for risk screening is reduced and teachable moments for health engagement are lost. Conversely, through the implementation of an integrated interpretation/coaching component, the teachable moments can be captured and put into action, thus increasing the value of the organization’s investment.

The following case study shows a relatively simple approach to integrating onsite health coaching into an existing health risk appraisal system, which is part of a comprehensive worksite health promotion program. Thus, leveraging onsite health coaching to facilitate better outcomes.

Creating a Health Risk Screening System

An existing client company added health coaching to its onsite health screening process. This location provides annual onsite health screenings, which include the HRA with biometrics, immediate feedback, and now, an appointment with a health coach.

While the prior program provided the common elements of most wellness/health promotion programs, the addition of a more robust focus on the “person,” improved results.

Table 1 below compares the previous program to the current comprehensive and personalized approach.

Table 1	
EARLY PROGRAM	PROGRAM WITH ONSITE HEALTH COACHING, INCENTIVES, AND TRACKING
HRA/biometric screening with follow-up, onsite only at the time of screening	HRA/biometric screening with formal coaching onsite
HRA offered online	HRA offered online. Incentives offered to increase onsite participation and coaching
No formal coaching	Coaching with advanced platform tracking
No formal incentives	Incentives for HRA/biometric screening and coaching, and for participation in wellness programs
Wellness programs	Incentives for participation in wellness programs
Tracking of onsite HRA/ biometric screening and participation in online HRA	Tracking of HRA/biometric screening, online HRA and physician biometrics, participation in coaching, participation in wellness program, and incentives

At the initial meeting, the health coach reviews the results of the HRA and begins a conversation that focuses on the participant’s “perception” of his or her health status and level of risk. Often, understanding this perception will facilitate opening a dialogue about the participant’s actual risk status, and important information about his or her health behavior.

Once the coach has ascertained the level of knowledge about those health risks, the participant will choose the risk he or she intends to mitigate, and how it will be done. Together, they will develop a strategy—or action plan—for health improvement based on the participant’s interests and preferences.

Tracking

Another important addition to the program was the tracking of coaching interactions. A tracking “platform” was created that linked the HRA to coaching interactions, which gave them access to health risk information. The coaches were able to track each participant’s coaching interactions, his or her level of risk, and notes documenting conversations and/or issues. Incentives, another major addition to the program, also were tracked on this platform.

The Role of Behavior Change in Coaching

Behavior change is key to improving health, and there is a need for the coach to help the participant make necessary changes in behavior and take a more personal approach to issues of life satisfaction. The coach also can help the participant develop a clearer understanding of his or her health status and ability to improve it; thereby, also improving his or her perception of health—or self-efficacy.

An important part of the coaching interaction is developing the participant’s personalized action plan. The “action” phase is the most important step in changing behavior; it’s also the most difficult. The results of this program indicated that health coaching was effective in motivating the participant to take action, which is demonstrated by the improvement in risk from T1–T2 HRA results.

Impact of Health Coaching on Risk

A comparison of HRA results year to year showed more favorable changes in the numbers of risk factors when coaching was added to program participation.

In this population, participants in the HRA alone (N=753) were compared to participants in the HRA with coaching (N=1194), and the changes in risk levels were noted. For those who participated in the HRA only, the number of risk factors increased 29.6% compared to 20.8% for those who participated

in the HRA plus coaching. In these same groups, the percentage of risk factors that decreased were 36.4% compared to 38.9% respectively.

Also measured was the level of risk status. In this same population, there was a greater migration to the low risk category by those who were coached (7.9%) than those who were not coached (3.8%), from medium risk, (-4.4%) for those coached, (-2.2%) non-coached; and from high risk, (-3.4%) for those coached, (-1.5%) non-coached. These observations are aligned with Dee Edington’s viewpoint, “don’t get worse,” in which keeping the low risk from migrating to medium or high risk is the “currency” of any program.

It seems clear that an increased participation in coaching resulted in a higher percentage of participants migrating to the low risk group, and away from the medium- and high-risk groups.

This, then, supports the idea that one-on-one coaching provides the necessary support for the behavior change process that helps the participant commit to making that difficult change.

Adding Coaching to your Program

The importance of personalized coaching seems clear; it can be added to any wellness program, and measured for effectiveness by comparing HRA results as demonstrated. While it has been common practice to measure results of T1–T2 HRAs for risks, and for changes in risks, it is less common to measure other program components. Therefore, it is important to understand the need to include the coaching process in those measurements.

To achieve the full effect of coaching:

- Reduce access barriers to health coaching by providing an onsite option, rather than other modalities—telephonic and/or online only.
- Provide onsite HRAs with biometric screening with immediate evaluation of results, thus supporting and capitalizing on the “teachable moment.”
- Provide personalized coaching throughout the year; 2–4 weeks from the initial screening for a detailed review (establish intent, set goals, answer questions), a follow-up in 3–6 months (progress check), and later in the year (for maintenance) That’s 3–4 coaching sessions/12 months—regardless of risk. (Remember: the goal is to keep the low risk at low risk!) ➔

- Add and integrate coaching data into your measurement system.
- Measure and compare the influence coaching has on risk migration and risk status.
- Add year over year cost trends, which include coaching participation, measurement, and evaluation.

Coaching should include:

- Reviewing HRA results and, through open-ended questions, evaluating the participant's knowledge about their health risks.
- Allowing for feedback and questions, and providing written educational information as "take-aways."
- Documenting the coaching session's overall conversation; including level of knowledge, misconceptions, need for further education, and overall risk level from HRA results.
- Asking the participant to choose the risk to improve, and helping him or her develop a plan of action.
- Documenting the participant's plan of action and level of readiness to change.
- Scheduling and documenting a follow-up appointment.

Conclusion and Recommendations

There are many strategies used in coaching, and many involve motivational interviewing techniques and the understanding of the transtheoretical model of the stages of behavior change. Coaches should be well versed in these theories and techniques through formal education and/or certification; however, the most important component of coaching is the personalized approach. It's the one-on-one empathy and partnership with his or her "client" that really makes the difference. For these reasons, we conclude it is effective and important to provide this health coaching support onsite.

While it's a good first step to understand one's health status and level of risk, taking action to improve one's health is a much bigger, much more important step; it's a step that very few people can take on their own. Providing a personalized approach and support throughout the year, appears to make a substantial difference in the participant's ability to change health behavior.

This study is preliminary and further research on these data is ongoing; however, the early conclusions seem clear.

If the goal of your program is to make a substantial improvement in your population's level of risk, we recommend providing a personal approach to behavior change through onsite support programs and continual measurement of program outcomes. Change is difficult. Changing long-practiced health behaviors requires changing one's thinking about health, and this requires strong support.





What Are the Healthiest Companies in South Africa?

Wolf Kirsten, M.S., International Health Consulting

South Africa is a growing economic power with significant health challenges. The HIV/AIDS crisis is well documented, and has a significant impact on the workplace. Lesser known internationally, however, is the emergence of non-communicable diseases caused by changes in lifestyle and behavior, most notably hypertension, high cholesterol, obesity, and diabetes. While a number of employers—mostly large and multinational companies—run successful programs focused on HIV/AIDS prevention and education, South African workplace health promotion is still in the early stages.

In order to highlight the need for more comprehensive approaches as well as benchmarking and tracking, over time, key health issues in South Africa, the Healthy Company Index was developed in 2010 by Discovery Health, the University of Cape Town, the University of the Witwatersrand, and Dr. Ron Goetzel (Director of the Emory University Institute for Health and Productivity Studies). Specifically, survey results document:

- the burden of chronic diseases linked to lifestyle, in South African companies.
- the prevalence of wellness facilities in the South African workplace.
- to what extent South African employees engage in healthy behaviors and activities.
- an estimate of how many South African employees are at risk for chronic diseases linked to lifestyle.

The Survey Process

The employees of participating companies complete a questionnaire about their health, lifestyle habits, and stress levels. Next, each employee receives a report outlining his or her biggest health risks and “vitality age.” Vitality age is a risk-based age relative to a healthy person of the same chronological age based on body mass index, exercise levels, nutrition habits, smoking status, alcohol consumption, and stress levels.

Each employer receives a report outlining overall employee risk for chronic disease due to lifestyle choices, chronic disease levels, motivation levels to change behaviors, stress levels and ability to manage stress compared to the average vitality age.

With the generated data, employers have the opportunity to benchmark their scores against those of other employers across industries.

The survey findings have led to an annual list of winners featuring the following categories:

- Healthiest company
- Healthiest workplace
- Healthiest eating habits
- Best shape (BMI)
- Healthiest motivation to improve health
- Greatest health knowledge
- Most smoke free
- Most conducive working environment
- Most physically active

South Africa: Key Health Facts

- Life expectancy at birth is only 53.5 years for males and 57.2 years for females.
- Prevalence of AIDS in adults (from age 15 to 49) is estimated to be 10.6% (5.21 million).
- 29.8% of the male population and 54.9% of the female population are obese or overweight.
- 26.5% of children younger than 7 years went hungry at some stage during the year because of poverty.
- 27.5% of males and 9.1% of females consume tobacco.
- South Africans consume more than 5 billion liters of alcoholic beverages per year, which amounts to 120 liters per person per year.
- South Africa’s cape region has the highest recorded levels of fetal alcohol syndrome (FAS) in the world: 122 per 1,000 live births.

Source: Global Perspectives in Workplace Health Promotion, 2011

To find out who the healthiest companies are, go to: <http://www.healthycompanyindex.co.za>.

Worksite Health Promotion for the 21st Century: Part 2

Dee Edington, PhD and Thomas Golaszewski EdD

In our previous discussion, the topic of assessment in the 21st century for worksite health promotion was introduced. Borrowing from futurist Alvin Toffler's advice to search for solutions in the future rather than the past, we focused on the health risk appraisal (HRA), perhaps the field's most established tool, and examined its limitations. Part 2 continues this discussion, offering selected suggestions about how the HRA might be enhanced as a measurement tool and repositioned in a 21st century assessment strategy.

Current HRAs are clearly better than their predecessors, with such new features as stage of change assessment, multiple language capability, customized individual reports, and online data collection. These new additions are welcomed, but what might the next generation of HRA include? Importantly, how might their results be used most effectively? Here is a sampling of thought that might apply.

The future of HRA may start with a decreasing emphasis on health risk and a lesser focus on risk-based interventions. Individual health is the measure of concern. Subsequently, borrowing terminology from the quality of life assessment (Renwick, Brown & Nagler, 1996), a new name is in order; perhaps Health Status Appraisal (HSA). Two factors define health status: function, a combination of physical and cognitive abilities; and feelings or perceptions. Therefore, health status is represented by a confluence of performance indicators that describe human function along multiple dimensions, such as aerobic capacity, strength and balance, and cognitive dimensions, such as memory, problem solving, and creativity. How one feels is equally important and is measured along multiple continua; for example, from anxious to contented; depressed to excited; pained to comfortable; or exhausted to energetic. Much of the latter are obtained from new, metrically-tested, mini-scales rather than the current use of single item HRA questions measuring cognitive domains.

With advances in electronic data collection and storage, the HSA process is continuous throughout the work life. Results are maintained on a secure database and constantly updated. For example, the company fitness center provides physical performance measures. The EAP taps psychosocial information, while human resources might focus on job or life satisfaction. Corporate training might include cognitive ability measures, and so on.

At some point, data are shared with health providers who add their own standard laboratory and examination results. Thus the HSA is multidimensional and provides a link between worksite health promotion and traditional medical care. Importantly, function and feeling are its key indicators and become parallel and interactive trend lines. Ideally, they improve during early work life and are maintained into advanced middle age.

Two factors define health status: function, a combination of physical and cognitive abilities; and feelings or perceptions.

Risk identification remains an assessment objective because risk can undermine function and feeling. Individual risk diminishes as the focal point of both assessment and intervention. However, as function and feeling improve, risk is likely stabilized if not decreased. Further, intervention is not solely individually based. Considerable, if not greater, attention is paid to changes in the social environment, the organizational structure, the community, and public policy because they all influence how we perform and how we feel.

*Reference: Renwick, R., Brown, I. & Nagler, M. (Eds.). (1996). *Quality of life in health promotion and rehabilitation: Conceptual approaches, issues, and applications*. Thousand Oaks, CA: Sage Publications.



“World Cafe” Exercise at the IAWHP Summit in Las Vegas, on March 27.



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