

Wellness With Impact: It Takes a Culture Shift to Affect Overall Health of Populations

By JAYNE SCHMITZ

The design and function of worksite wellness programs have evolved since they began to emerge in the 1950s and '60s. What started out as a focus on occupational health and safety transitioned to a focus on health and recreation, then a focus on measuring and changing health risks, and most recently to a focus on organizational well-being.

Occupational health and safety, as well as employee morale, were priorities for many companies in the 1970s. At the time, wellness primarily focused on recreation and fitness, and how opportunities for exercise at the worksite could boost morale. Company softball, bowling or basketball leagues became quite common. Many companies offered onsite fitness centers. Attention to measuring how wellness programs might affect worker productivity, absenteeism, or health care costs didn't really surface until the 1980s.

In the late '80s, StayWell, along with actuarial firm Milliman & Robertson, released a study showing for the first time that common health-risk factors such as smoking, obesity and sedentary lifestyles were strongly linked to higher health care costs. In response, the '90s brought widespread use of health risk assessments and



biometric screenings in worksite wellness programs (cholesterol, blood pressure, BMI, body fat, etc.), focusing on the measures of health of individuals.

Today, annual health-risk assessments and biometric screenings are routine at many companies, with 70 percent of large employers and 34 percent of small employers offering them in 2011, according to Mercer, the international human resources consulting firm. The assessments ask many questions about each employee's health status and behaviors in a wide variety of areas such as weight, tobacco use, alcohol and other substance use, nutrition, exercise, depression, stress management, sleep, seat belt usage, and more. Individuals shown to be "at risk" are flagged and offered wellness interventions.

The downside of this trend is that many employers started using health-risk assessments to identify and focus interventions almost exclusively on those with the highest health risks. Research has since shown that if you only focus on the 20 percent of your organization that is costing the most, and let the other 80 percent fend for themselves, some employees in the 80 percent group will eventually become high-risk. In other words, it is also important to keep the healthiest people healthy.

There are other downsides to measuring the health of a workforce via health risk assessments. These assessments can and do result in invalid data. People will answer any way they wish if they are concerned about privacy, especially

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when the assessment offers incentives for certain responses, something that's now commonplace.

The other key areas of focus for worksite health have been diet, weight loss and exercise. For years, wellness and health professionals have designed, implemented and promoted healthy eating, weight loss and movement programs. Since 1980, nutrition information from the U.S. Department of Agriculture has helped to guide our food choices. The first set of dietary guidelines was based on the prevalence of heart disease, the number one cause of premature death and disability in the country. The messages on an individual level were loud and clear: Eat foods with less fat and cholesterol to reduce your risk of heart disease. Dietitians, nutritionists and health care providers alike would counsel their clients and patients to eat fewer high-fat and high-cholesterol foods, and media messages around the country followed suit.

But Is It Working?

Almost forty years later, however, Americans are sicker than ever. The prevalence of type 2 diabetes (due to obesity) increased by 166 percent from 1980 to 2012. Nearly one in ten adults currently lives with the disease, which is one of the most costly chronic diseases in the U.S. More than a third of the country is obese, making the U.S. one of the fattest countries in the world.

In Massachusetts, 59 percent of adults are above a healthy weight (slightly below the national average of 63 percent). One in five adults is obese, with the obesity prevalence rising at an alarming rate. More than 300,000 Massachusetts residents have been diagnosed with diabetes, while the U.S. Centers for Disease Control and Prevention estimates that there may be an additional 100,000 undiagnosed individuals in Massachusetts. Given the strong association between weight and type 2 diabetes, the major increase in type 2 diabetes may be attributed to an increase in obesity during the same period.

Today, individuals actually sit more, eat out much more frequently, and choose high-calorie, fast food and processed food options more often than they did thirty

years ago. The low-fat and heart-health movement promoted by the food industry, which introduced low-fat yogurts, "light" microwave dinners, and fat-free cheese-flavored snacks and cookies, has led to more consumption of less-healthy food. Our country's consumption of refined-grain breads, cereals, and pastas—so-called "healthy carbohydrates"—soared, as we consume up to eleven servings a day of these foods.

Clearly, something isn't working. A focus on individual lifestyle changes is not enough to move the needle on the overall health of a population. It takes a combination of efforts—personal, political and social—to yield the greatest impact on reducing illness and improving health status.

Policies Matter

Think about the powerful impact that no-smoking legislation and cigarette taxes have had on smoking rates. For years, the wellness and health care communities offered smokers education and smoking cessation programs, but it wasn't until policies, regulations and laws were put in place that we saw a real reduction in smoking rates in Massachusetts and across the country. It seems unbelievable now that smoking used to be allowed on commercial flights. We've come a long way.

Lessons learned from our tobacco successes and our dietary failures tell us that it's complicated to change the behaviors of a nation, or even smaller populations. It requires a multi-pronged approach that includes campaigns directed at individual choices and responsibility, along with an emphasis on social, environmental, community and employer responsibility and involvement. Policies matter, and they can have an impact on health behavior. Organizational culture plays a key role in influencing the health of the workforce, and that change must occur at many levels in order to have a significant impact on the health of larger population groups.

During this decade, we have seen a trend away from "medicalizing" wellness and trying to get people to change behaviors and habits, toward creating healthy cultures at work. Healthy behaviors are contagious, just like unhealthy ones are.

It is common to see companies make environmental changes with the goal of "making the healthy choice the easy choice."

Elements of Effective Programs

What would you see at a municipality with a thriving worksite culture? Here are some examples:

- Healthier foods offered at municipal meetings and events and in vending machines. Choosing healthier food options is contagious. With time, new norms can be established.
- Water dispensers in break rooms. Drinking water, as opposed to less-healthy options, is also contagious and can become the norm over time.
- Groups of staff members walking outside together during their breaks because policy changes allow for time off for exercise during the workday. Doing the exercises as a group helps to build morale. Offering exercise programs at the worksite removes barriers to physical activity. Creating and marking walking paths, and providing signs and maps, can encourage this activity.
- DPW workers doing stretching exercises every morning, as supervisors set the expectation that this is part of the workday.



- Immediate supervisors praising their staff for jobs well done. Employees need to know they are appreciated and valued, which is associated with job satisfaction, well-being and productivity. A "Wall of Gratitude" on the bulletin board in

continued on page 30

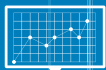
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WELLNESS WITH IMPACT
continued from page 17

the library or staff break room is one example.

- Leadership engagement and modeling healthy behaviors, which are keys to a successful wellness program. One example would be the mayor or town manager/administrator walking with employees in a Fitbit challenge.

- Fire and police personnel attending a “building resilience” training. Training opportunities build employee skills.

- Teachers sharing healthy recipes with each other. Engagement around mutual interests boosts morale, and opportunities for sharing increase well-being.

In their 2014 book *How to Build a Thriving Culture at Work*, Rosie Ward

and Jon Robison write: “The right culture makes all the difference for every stakeholder—the employer, employees and customers/clients. Employers get more productive workers who think critically and creatively to ensure they are contributing everything they can. Employees feel valued and appreciated, so they enjoy and are engaged in their work, and this promotes their physical and emotional health as well. Customers/clients receive top-quality products and/or service from workers who take pride in what they do.”

Wellness today means bringing about a cultural shift in the workplace. When this is done, everybody wins. 🌟

LAW

continued from page 29

upon that third member. Within three business days following the end of the negotiation period, the APA is required to provide the panel with its original proposal. Within that same three-day period, the PEC may submit an alternate mitigation proposal.

The regulations anticipate that the panel will meet and render its decision within ten days after receiving the APA’s proposal. Provided that (1) the dollar amounts of the APA’s proposed changes to the cost-sharing features of its plans do not exceed the corresponding features of the GIC benchmark plan, or (2) the anticipated savings from a transfer of subscribers to the GIC would be at least 5 percent greater than the maximum possible savings that could be realized by the plan design changes authorized by Section 22, the panel *must approve* the APA’s proposed changes. The panel may, however, in consultation with the GIC’s actuary, review the APA’s calculation

of its monetary savings. The panel may also conclude that the APA should share additional savings with subscribers (but no more than 25 percent of savings).

As PECs have recognized that the panel is *required* to confirm the APA’s proposed plan design changes (as long as the changes are within the allowable limits) or proposed transfer of subscribers to the GIC if the required savings can be established, and as municipal representatives have assumed that the panel would decide that the maximum percentage (25 percent) of savings should be shared with subscribers, the overwhelming majority of cases have settled with the execution of a written agreement.

Simply stated, Sections 21 through 23 have provided substantial relief to cities and towns throughout Massachusetts. Cities and towns that have not yet used the opportunities to change health insurance benefits embodied in those sections are urged to consider them. 🌟

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