CPH News and Views

A semi-monthly column on emerging topics related to healthy workplaces

Issue # 6: The Healthy Workforce Act of 2007 and Quality Standards for Workplace Health Promotion Programs

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The Healthy Workforce Act of 2007[1] seeks to encourage businesses to invest in workplace health promotion programs by providing tax incentives covering up to half of program costs. Sponsored by Senator Thomas Harkin (D-IA, S-1753) and Representative Tom Udall (D-NM, H.R. 3717) with bipartisan co-sponsorship, this legislation represents a significant step in moving our nation towards true preventive health care. In contrast, the cost of our current heavy reliance on reactive treatment of disease is revealed in the following analogy: It is like waiting for a house to burn down almost to the ground, and then rushing in with five fire engines to save it.[2] This approach cannot protect us from ill health, and it is enormously expensive.

In an independent but parallel positive development, the National Committee for Quality Assurance (NCQA)[3] has embarked on the development of quality standards for workplace health promotion programs. With a growing number of organizations investing in these programs, a set of quality standards will provide welcome guidance to many organizations and might also serve as criteria for tax credit eligibility under the Healthy Workforce Act of 2007.

These parallel developments warrant specific comment. CPH-NEW is currently testing a new evidence-based, best-practices methodology to facilitate the move from reactive to preventive workplace programs, by integrating two aspects of prevention: reducing workplace risk factors and facilitating individual adoption of healthy behaviors.[4] It addresses two known shortcomings of conventional workplace health promotion programs: the difficulty of engaging workers who most need help, and a lack of program sustainability.

In this approach, small teams of workers participate in designing a program that is tailored to their own identified needs and that also addresses the work environment's influence on health behaviors. These "design teams" receive training and are provided with professional expertise in ergonomics, stress prevention, and health promotion to assist in identifying and prioritizing health risks and in developing, testing and modifying interventions. A steering committee with members from all relevant levels of the organization oversees design team efforts and provides the necessary resources. This participatory approach is modeled after "health circles" found in Europe,[5] and also after participatory ergonomics programs in the U.S. and abroad[6]. The 'bottom-up' program promotes long-term employee commitment and program sustainability as workers become stakeholders in grassroots interventions, providing an important advantage over conventional, top-down health promotion programs. In addition, the integrated approach offers new opportunities for synergies with existing ergonomics and other health and safety programs.[7] The Healthy Workforce Act of 2007 has in fact proposed to incorporate some aspects of this employee engagement approach.

While we see opportunities for extraordinary advancement from the Healthy Workforce Act of 2007 and NCQA's efforts to set quality standards for workplace health promotion programs, we believe that these two important initiatives would benefit from the following additions, based in CPH-NEW research results and current evidence in the health promotion literature:

1. *Development and incorporation of criteria for the evaluation and certification of health promotion programs that acknowledge and measure the amount and quality of worker participation*.[7] The same criteria proposed in the Healthy Workforce Act of 2007 could be incorporated into the NCQA definitions of worker participation. More specifically, the NCQA

could develop standards for the "*employee engagement component*" of the Act, which provides for (a) the establishment of a committee to actively engage employees in worksite wellness programs through worksite assessments and program planning, delivery, evaluation, and improvement efforts, and (b) the tracking of employee participation in these activities. Workers could play a pivotal role on these committees, and worker design teams would provide needed "shop floor" support to these programs and sensitivity to local workplace health issues.

2. *Support of integrated approaches, in which changes in work organization are undertaken to benefit worker health as a complement to safety and health programs and other health promotion activities.* Avoid defining workplace health promotion as a stand-alone program.

3. *Development and dissemination of best practices for implementation of participatory workplace health promotion programs.* CPH-NEW field research has identified a number of significant start-up fundamentals necessary for a participatory workplace health promotion program. These include providing specialized training and orientation at all levels of the organization, and the use of key personnel interviews, focus groups and confidential baseline surveys to initially assess worker health status and concerns. Management must be prepared to engage in a continuous improvement process[8] and to implement an integrated health promotion program in which workers actively participate in identifying and controlling impediments to good health behaviors, as well as workplace hazards to health and safety.

4. *Increased federal research support for the NIOSH WorkLife Initiative,[4] to develop the knowledge base and support system for such programs.* Conventional workplace health promotion programs often lack organizational policy and resources to support long-term sustainability. Cross-disciplinary research efforts must continue to identify new integrated approaches for economically sound changes in work organization that will address these limitations. An expanded Center of Excellence system can provide support for such new initiatives that are tailored to regional workplace health needs.

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