Results of the Kentucky Worksite Assessment: Utilization of the CDC’s Health ScoreCard

Cecilia M. Watkins  
*Western Kentucky University, cecilia.watkins@wku.edu*

Grace Lartey

Gretchen Macy

Vijay Golla  
vijay.golla@wku.edu

Teresa Lovely

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Results of the Kentucky Worksite Assessment:
Utilization of the CDC’s Health ScoreCard

Final Report

Cecilia Watkins, PhD, MS, CHES,¹ Grace Lartey, PhD, MA,¹ Gretchen Macy, EdD, MPH,¹ Vijay Golla, PhD, MBBS, MPH,¹ Teresa Lovely, MS, CHES²

1. Western Kentucky University
2. Kentucky Department for Public Health
PREFACE

This project was a collaboration between the Kentucky Department for Public Health and the Western Kentucky University (WKU) Department of Public Health.

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The contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

Results of the Kentucky Worksite Assessment: Utilization of the CDC’s Health ScoreCard. View the full report and executive summary at http://kentucky.stateofwellness.org/ and http://chfs.ky.gov/dph/info/dpqi/cd/
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SUMMARY

Study Objectives and Research Approach

A Health Impact Assessment (HIA) conducted in 2011-2012 of a proposed Kentucky Worksite Wellness Tax Credit highlighted gaps in the data available on worksite wellness programs in the Commonwealth of Kentucky.

Conducting a state-wide assessment of worksite wellness programs was a recommendation that resulted from this HIA.

The purpose of the assessment is to:
1) Identify the number of comprehensive worksite health promotion programs in Kentucky.
2) Determine the health needs of worksites in Kentucky.

By Identifying current wellness practices in Kentucky, better tools and support can be provided at a state level to assist organizations to implement results-oriented wellness programs. As worksite wellness science continues to advance and the expectations of successful outcomes continue to increase, more will be required of those in charge of these programs.

Upon receiving approval from WKU’s Institutional Review Board (IRB), 1,200 randomly drawn businesses received a questionnaire via email. Two-week increments were allowed for workplaces that needed reminders or more time to complete the survey. The survey began in May 2013 and closed in October 2013.

Data was analyzed for outstanding themes, which will form the bases for decisions made on the needs of worksite-wellness programs in Kentucky. Data was analyzed further — descriptively and inferentially — to determine worksite factors that contribute to the increasing trends of chronic diseases in the workplace.
ACKNOWLEDGEMENTS

The group would like to acknowledge the following individuals for their contributions to the project:

- Sue Thomas-Cox, Kentucky Department for Public Health
- Dennis Chaney, Barren River District Health Department
- Sireesha Kodali, Graduate Assistant, WKU Department of Public Health
- Melissa Sacrey, WKU Student Intern, Kentucky Department for Public Health
ABBREVIATIONS

AED: Automated External Defibrillators

CDC: Centers for Disease Control and Prevention

COPD: Chronic Obstructive Pulmonary Disease

CPR: Cardiopulmonary Resuscitation

EAP: Employee Assistance Program

FDA: Food and Drug Administration

FTE: Full-Time Employee

GED: General Education Development

HIA: Health Impact Assessment

HP: Health Promotion

HRA: Health Risk Assessment

HSC: Worksite Health Scorecard

KDPH: Kentucky Department for Public Health

NIOSH: National Institute for Occupational Safety and Health

OTC: Over-the-counter

PEHP: Public Employee Health Plan

PTO: Paid time off

WHP: Worksite Health Promotion
**LITERATURE REVIEW**

**United States health issues and chronic diseases:**

The Centers for Disease Control and Prevention (CDC) reported that chronic diseases are the leading cause of death and disability in the United States. Four modifiable lifestyle behaviors are responsible for a considerable amount of these chronic diseases: sedentary lifestyles, poor nutrition, tobacco use and excessive alcohol consumption (Centers for Disease Control and Prevention, 2012). Stress is also a contributor to chronic diseases. In a study conducted by Wolever et al., (2012), stress essentially has been linked to all chronic conditions and depression, anxiety, fatigue, obesity, musculoskeletal pain, productivity loss and elevated healthcare costs.

It is estimated that 164 million Americans or nearly half of the U.S. population will have at least one chronic disease by 2025 (The Growing Crisis of Chronic Disease in the United States, n.d.). Due to the increase in chronic diseases and subsequently the increased need for health care services, the costs of health care premiums will continue to catapult for U.S. businesses and their employees. Health care premiums have increased by 87% since the year 2000 (The Growing Crisis of Chronic Disease in the United States, n.d.).

**Kentucky Health Issues and Chronic Diseases**

The five most common causes of death in the United States are: heart disease, cancer, stroke, chronic lower-respiratory diseases and unintentional injuries. When comparing Kentucky’s rates to the U.S. in these leading causes of death, Kentucky’s rates are higher in all categories (CDC, 2008). In 2011, Kentucky reported 29% of adults and 26% of high school students as being current smokers, costing $1.46 billion in personal healthcare expenditures and $2.3
billion in lost productivity annually (CDC, 2013a). In 2007, 69% of Kentucky high school students did not attend physical education classes and 56% of Kentucky adults were not moderately or vigorously physically active, resulting in 16% of high school students and 69% of adults reported as overweight or obese (CDC, 2008).

In “America's Health Rankings” (2013), Kentucky’s overall ranking was 45 out of 50. Kentucky’s challenges noted in this report included a high rate of smoking, a high rate of preventable hospitalization, and a high rate of cancer deaths. Some of the core measures of “America's Health Rankings” reveal the continued challenges Kentuckians experience in improving lifestyle behaviors. In these core measures, Kentucky ranks 50 in smoking, 50 in cancer deaths, 49 in preventable hospitalizations, 46 in physical inactivity and 42 in obesity (United Health Foundation, 2013).

**What is Worksite Health Promotion (WHP)**

Worksite Health Promotion (WHP) is “the business-/industry-sponsored employee health promotion/education/safety programs with a goal of realizing a person’s fullest physical, psychological, social, spiritual and economic potential” (Michaels, & Greene, 2013).

According to the National Prevention Strategy (2011), employers have the ability to implement policies and programs that can improve the health, well-being and safety of their employees. Prevention is the National Prevention Strategy’s core value and is the most cost-effective way for Americans to live longer and with a better quality of life.

One of the actions recommended by the National Prevention Strategy is for businesses and employers to provide preventive services and comprehensive wellness programs to their employees (National Prevention Council, 2011). Key elements of a comprehensive WHP
are: health education; links to related employee services; supportive physical and social environments for health improvement; integration of health promotion into an organization’s culture; and employee screenings with adequate treatment and follow up (Goetzel & Ozminkowski, 2008).

**Benefits of WHP Programs**

A study by Baicker, Cutler and Song (2010) on the available literature on wellness programs revealed interesting findings about wellness-generated savings. Implementation of worksite wellness programs resulted in a three-fold reduction in costs associated with medical care and two-fold decrease in costs due to absenteeism (Baicker et al., 2010). Studies have concluded that an effective worksite wellness program can save $3.27 in medical cost savings and $2.73 in absenteeism reductions for every dollar employers invest in health promotion activities (Parkinson, 2013). WHP programs reduce absenteeism, increase productivity and eliminate financial loss incurred due to decreased morale and employee illness (McPeck, Ryan & Chapman, 2009). Additionally, Fabius et al., (2013) revealed that companies building a culture of health by focusing on the well-being and safety of their workforce yielded greater value for their investors.

The Task Force on Community Preventive Services notes that the worksite environment provides advantages over other types of environments for the creation of health promotion. The large and rather stable population of the worksite, the potential for recruitment and participation in programs and the social support and peer influences of coworkers are all advantages that the worksite environment offers the health promotion effort (Task Force on Community Preventive Services, 2010).
Challenges of WHP Programs

Results from the 2004 National Worksite Health Promotion Survey revealed that two of the five most common challenges to effective worksite health-promotion programs are employee related — lack of employee interest and participation of high-risk employees. Lack of funding, management support and staff resources are considered administrative challenges to successful worksite health promotion programs (Linnan et al., 2008). Regardless of the evidence that WHP programs are popular due to both financial and non-financial outcomes, these programs are often not effective. Fewer than 1 in 10 companies offer wellness programs of sufficient quality and scope to be considered comprehensive (Felter, Nolan, Colombi, Albert & Pringle, 2013).

Ethical concerns can also be a challenge in implementing wellness programs in the workplace. A study conducted in 2010 on obesity in the workplace, revealed some general ethical concerns of employees involving the promotion of healthy eating and exercise, even though workplace safety and security not being met. Specific methods and strategies such as food changes, point-of-decision prompts, use of incentives and confidentiality in conjunction with privacy issues also caused ethical concern (Gates & Brehm, 2010).

A 2008 study found that employees perceive environmental factors at the workplace can influence their eating and exercise behaviors. This study revealed that the majority of employees perceived the quality of food and stress influenced their eating choices, while the lack of access to a gym prevented them from getting enough exercise. Cost and time affected both eating and exercise habits at the workplace (Watkins, Lartey, Golla & Khubchandani, 2008).
A statewide survey conducted on worksites in New York examined the worksite policy and environmental support for physical activity, healthy eating, stress management and preventive screenings. Results of this study revealed that small and medium worksites reported significantly less support for environmental policies in all four categories. These results address the need for assistance in worksites with fewer than 200 employees when starting a wellness program. Findings also indicated that programs supported by a wellness committee or a designated manager are more likely to be successful than those without one (Brissette, Fisher, Spicer & King, 2008). While small employers (fewer than 500 employees) make up 99.7% of the workforce in the U.S., less than 7% of small businesses have comprehensive wellness programs (McPeck et al., 2009). According to a 2011 statewide health-impact assessment (HIA), approximately 99% of Kentucky’s businesses have fewer than 249 employees, which would contribute to the notion that WHP programs if implemented effectively could benefit Kentucky (Lovely & Watkins, 2012).

Trends in WHP

Sparling (2010), notes that there are 10 key principles when determining the success of a WHP program. Successful WHP programs:

• are comprehensive and integrated.
• have top leadership commitment.
• are available to all employees.
• provide systematic health assessments with feedback and goal setting.
• have programs designed to an individual’s needs.

These programs also:
• provide effective incentives.
• are supported by healthy environments and policies.
• are linked to safety and job performance at all employee levels.
• deliver extended services to employee families.
• have systematic evaluation of needs and programs.

Even though a comprehensive program is needed for long-term success in WHP, not all worksites are at the same capacity to establish a comprehensive WHP program. The Worksite Health Promotion Capacity Instrument (WHPCI) is a tool developed to assess the collective willingness and systemic implementation of health-promotion activities in companies (Jung et al., 2010). This study suggests that this tool will have the ability to diagnose, describe, explain and evaluate the present level of health promotion readiness in businesses and the degree to which businesses currently are implementing WHP systematically (Jung et al., 2010).

The integration of health promotion and health protection is a trend that is gaining substantial support in the field of worksite health promotion. A recent article, Hymel et al. (2011) discussed the case for changing the way health promotion and health protection are separately managed and how integration of these two can create a healthier and safer workforce through synergy. As Goetzel (2005) notes in a final report to NIOSH, although much research is needed to learn more about what works best and why, employers can maximize safety and employee health by integrating health, safety and worker-productivity management programs. Goetzel discusses the common practice of departments within organizations to operate in silos with little interaction, which can impede the integration process mentioned above (Goetzel, 2005).
The Worksite Health Promotion Readiness Checklist (WRCL) is a tool developed to measure the readiness of a company to implement a worksite health promotion and health protection program. This tool may also be capable of identifying the availability of existing resources that can be utilized, especially by small worksites that often have a preconceived notion that wellness programs are too expensive (Faghri, Kotejoshyer, Cherniack, Reeves & Punnett, 2010).

In a brief issued by Trust for America’s Health (2013), recommendations to provide workplace wellness programs to all American workers included the following:

“comprehensive wellness programs should be offered by the federal government that can serve as a model for other governmental and private workplaces; state and local governments should offer effective wellness programs to their employees; and wellness programs should be offered to educators to pass on to their students”. In addition, states should offer wellness programs as a key component of their Health Insurance Exchanges. And private businesses should partner with government, hospitals and community-based organizations to offer wellness programs, while federal, state and local governments should offer tax incentives and other assistance to encourage the usage of wellness programs.

The 2013 RAND Workplace Wellness Programs Study evaluated current wellness-program participation, program impact, and the role of incentives in workplace wellness programs. Results from this study revealed that about half of U.S. employers with 50 or more employees provide a wellness program and are committed to long-term support of the program. The evidence reveals that lifestyle management interventions can reduce risk factors and increase healthy behaviors. Although employers believe that wellness programs are a viable strategy to contain healthcare costs, the outcomes are rarely formally evaluated.
Incentives of more than $50 appeared effective in getting employees to complete an HRA. Five factors are considered as key facilitators to make WHP successful: effective communication strategies; providing opportunities to employees to engage; engaged leadership at all organizational levels; efficient utilization of existing resources; and relationships and continuous evaluation (Mattke et al., 2013).

The 2013 Staying@Work Survey results revealed that establishing a culture of health as a company’s top priority is vital to a healthy company. A major component to sustaining healthy behaviors is connecting the health, well-being and worker-effectiveness strategy to employee values. Stress, obesity and lack of physical activity are the biggest challenges that the respondents faced and most often are targeted in program development. The top priorities of the respondents’ health and productivity programs included developing a culture where employees are responsible for their health while they understand its importance, improving employee engagement in health programs, educating employees to be better healthcare consumers, improving employee awareness of health and risks, and improving employee physical and emotional/mental health (Towers Watson, 2013).

The Stay@Work survey showed several factors that contributed to the major challenge of a participant’s lack of engagement in programs and ways to alleviate them.

• First, was the lack of a clear articulated health and productivity strategy. Employees must understand the program and how their values tie into the goals of the program.

• Second, was a lack of employee accountability can also inhibit employee engagement (Towers Watson, 2013).
Extrinsic incentives such as penalties, gateway incentives and outcome-based incentives are becoming more and more common, but the ability to tie intrinsic values of health is proving to be a more sustainable way to make employees responsible for their health.

• Third was that efficient but not effective programs have shown that while some successes can be experienced through innovative methods, such as flex time and financial incentives, low usage rates keep the programs from being as effective as they could be (Towers Watson, 2013).

• Fourth, was that the needs and desires of the employees must be acknowledged and programs tailored to individuals and specific demographic groups with proper dissemination of information and evaluation of progress.

• Fifth was that limited engagement of vendors and providers need to be alleviated by making these groups part of the workplace environment whenever possible (Towers Watson, 2013).

WHP in Local Governments and States

According to Benavides and David (2010), local governments are becoming more invested in wellness. With rising healthcare costs and the need to maintain a healthy workforce, many local governments are determining that prevention is more effective than treatment. The latest results from the Principal Financial Well-being Index revealed that 57% of employees surveyed believed wellness benefits are very or somewhat successful in reducing healthcare costs and 74% agreed that wellness benefits encouraged them to work harder. The Centers for Disease Control and Prevention (CDC) funded a comprehensive worksite wellness program to improve employee efficiency at the Metropolitan Transportation Authority in Austin, Texas. The return on investment was $2.43 for every dollar spent on the worksite.
wellness program during a four-year period (Davis et al., 2009). Kansas City’s Healthiest Employer is available to help employers considering implementing a wellness program. Healthiest Employer is a wellness company that provides unbiased data and advice to aid in analyzing a company’s wellness status, and it builds a strategy for implementation of a worksite wellness program (Kansas City: Healthiest Employer, 2011).

More states are implementing wellness programs designed for improving the health of their workforce. The Kansas Department of Health and Environment has begun a campaign that promotes implementing comprehensive worksite health-promotion programs throughout the state (Kansas Department of Health and Environment, 2014). States such as Alabama and Arkansas offer discounts ranging from $10 to $30 on the state employee’s wellness premium upon submission of their Health Risk Assessments (HRA). Other states such as Delaware, Missouri, Ohio, South Dakota and West Virginia are offering financial incentives to encourage participation in state wellness programs. Utah’s Public Employee Health Plan (PEHP) — unique from other states — offers rebates starting from $50 up to $300 depending on the health improvements made by the PEHP member. Montana’s wellness program has been offering state employees free health screenings along with health coaching, as well as lunch and learn programs for no cost since 2007 (National Conference of State Legislatures, 2012).

In 2012, the Kentucky Coordinated Chronic Disease Prevention and Health Promotion Program released its Unbridled Health Report, A Plan for Coordinated Chronic Disease Prevention and Health Promotion (2012-2016). This plan is a call to action for a healthier Kentucky. This effort includes the shared vision and united effort of all community entities, including employers, and aims to improve health through the implementation of tobacco-free
policies at facilities, the use of incentives to reduce barriers and encourage regular screenings, providing healthy foods in vending machines and cafeterias, and adopting comprehensive worksite wellness policies and programs (Kentucky Department for Public Health, 2013).

**The CDC Worksite Health ScoreCard**

The CDC recently released its Worksite Health ScoreCard (HSC), an instrument designed by the Emory University Prevention Research Center in partnership with the CDC, state health departments and worksite health experts. The HSC is a tool designed to aid employers in assessing to what degree their health promotion interventions are comprehensive and evidenced-based. With the HSC, the employers can identify gaps in their programs and prioritize strategies for improvements. The HSC covers the following health topics: organizational support, tobacco control, nutrition, physical activity, weight management, stress management, depression, high blood pressure, high cholesterol, diabetes, signs and symptoms of heart attack and stroke, and emergency response to heart attack and stroke (Matson-Koffman & Dyann, 2012).

At the end of 2012, New Hampshire’s Cheshire County began using the CDC Worksite Health ScoreCard to help attain its Vision 2020 initiative of “the healthiest community in the nation”. More than 1,900 individuals and 80 organizations are currently registered in Cheshire County’s “Champion Program”. Champions are committed to either implementing or improving their employer-based, health-promotion programs with assistance from the CDC’s ScoreCard. With results from the ScoreCard, businesses are encouraged to select
three issues as first-year priorities and receive help designing an action plan. An inventory of practical assistance and local resources based on each question on the ScoreCard is being compiled for county employers. Eventually, all Champion organizations will use the ScoreCard for health program improvement. The ScoreCard also will be used yearly to track improvements in programs and overall employee health status. These worksite health-promotion programs have a high capacity for reaching most adults in Cheshire County with its approximately 45,000 working-age adults and its low unemployment, approximately 5% (CDC, 2013b).
METHODS

Research Design
The CDC Health ScoreCard was used to collect information on health promotion practices at workplaces in Kentucky. Workplace health promotion practices were examined under the following health topics: organizational supports, tobacco control, nutrition, physical activity, weight management, stress management, depression, high blood pressure, high cholesterol, diabetes, signs and symptoms of heart attack and stroke, emergency response to heart attack and stroke, lactation support, occupational health and safety, vaccine-preventable diseases, community resources, cancer, and asthma and chronic pulmonary disease (COPD).

Sample Selection
A random sample of 1,200 workplaces in Kentucky was selected from a database to participate in the study. Of this sample, 206 emails were undeliverable resulting in 994 potential participating worksites. The database consisted of a directory of all workplaces (excluding federal agencies, healthcare, and retail worksites) in Kentucky obtained from the Kentucky Cabinet for Economic Development’s Select Kentucky searchable database and a directory of all workplaces in Kentucky purchased from a commercial mailing list company. The two directories were combined into one database. The database was cleaned to prevent duplication of workplaces before sample selection.

Instrument Development
The CDC Health ScoreCard was used to collect information from workplaces. The CDC ScoreCard is a 22-page instrument designed to capture information on a variety of health-
promotion activities. The instrument consisted of a combination of close-ended and open-ended questions. The ScoreCard is arranged in modules and asks for information on the following health topics: organizational supports, tobacco control, nutrition, physical activity, weight management, stress management, depression, high blood pressure, high cholesterol, diabetes, signs and symptoms of heart attack and stroke, and emergency response to heart attack and stroke. Additional questions provided by the CDC related to lactation support, occupational health and safety, vaccine-preventable disease, and community resources also were included. The CDC permitted inclusion of these questions as they intend to use them as part of the ScoreCard in the future. The instrument also included background questions to determine the characteristics of workplaces and employees. In addition to the questions from the ScoreCard, the researchers added four questions related to cancer and five questions covering asthma and COPD, per request of the Kentucky Department for Public Health (KDPH).

**Procedure**

The instrument was entered in the Qualtrics research software for electronic distribution. The ScoreCard and additional questions were entered in modules for ease of scoring. Upon IRB approval from Western Kentucky University, a participation letter was sent out to all potential worksites one week prior to the commencement of the assessment period asking for their participation and providing information regarding the purpose of the study, potential benefits of participation, and an introduction of the researchers.

The following week, a survey link was distributed to the Worksite Health Promotion Directors/Managers identified through the database directory as contacts at their respective
worksites or to Human Resource Managers through email. The email explained to participants that their responses would be saved after completion of each module and that they could return to continue the survey at any time. Informed consent also was included in the email and participants were informed they could leave the study at any time without penalty. Two weeks after the email containing the survey link was first distributed, a second email was sent out to any potential participants that had not completed the survey urging their participation.

Following the initial reminder, weekly reminders were sent to all participants that had not completed the survey. The response rate was very low after the initial reminder. Therefore, weekly reminders were distributed for the duration of the study period to encourage participation. During the last weeks of the study, participants who had not responded to the survey were contacted via telephone to urge their participation. Following completion of the individual assessment, each participant was emailed a scoring sheet and a link to the CDC Health ScoreCard document. Directions for comparison of individual worksites to the sample of worksites participating in the ScoreCard Validation Benchmarking Report also were included.

Data Analysis

SPSS 21 and the Qualtrics research software were used to analyze the data. Descriptive summary statistics were used to describe the central tendency and variance of each variable measured, including the demographic characteristics. Graphs also were included to provide a pictorial display of the information.
RESULTS

Company Demographics

Among 944 invited companies, 365 participated in the assessment for a 37% response rate. Sixty-seven of the participants (39%) had less than 50 full-time employees (FTE) with 11% reporting between 1-19 FTE and 28% reporting between 20-49 FTE. Among all participants, 44% had between 50-250 FTE, 20% had between 50-99 FTE, and 24% had between 100-249 FTE. Nineteen participating companies (11%) had between 250-499 FTE and 11 companies (6%) had more than 500 FTE. (See Table 1).

Table 1. Participating workplaces by number of full time employees (FTE)

<table>
<thead>
<tr>
<th>Workplace Size</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-19 FTE</td>
<td>19</td>
<td>11%</td>
</tr>
<tr>
<td>20-49 FTE</td>
<td>48</td>
<td>28%</td>
</tr>
<tr>
<td>50-99 FTE</td>
<td>34</td>
<td>20%</td>
</tr>
<tr>
<td>100-249 FTE</td>
<td>41</td>
<td>24%</td>
</tr>
<tr>
<td>250-499 FTE</td>
<td>19</td>
<td>11%</td>
</tr>
<tr>
<td>&gt; 500 FTE</td>
<td>11</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>172</td>
<td>100%</td>
</tr>
</tbody>
</table>

Of the participating companies, 144 (73.8%) indicated that they were located at their company’s headquarters. The majority of the companies (72%) reported being for-profit businesses. Seventeen businesses (9%) were categorized as nonprofit/other. An additional 12
participants (7%) indicated that their business was best described as construction. Another 11 participants (6%) indicated they were governmental/nonprofit. (See Table 2).

Table 2. Description of Organization by Business Type

<table>
<thead>
<tr>
<th>Business Type</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>For-profit</td>
<td>132</td>
<td>72%</td>
</tr>
<tr>
<td>Nonprofit/other</td>
<td>17</td>
<td>9%</td>
</tr>
<tr>
<td>Nonprofit/governmental</td>
<td>11</td>
<td>6%</td>
</tr>
<tr>
<td>Construction</td>
<td>12</td>
<td>7%</td>
</tr>
<tr>
<td>Finance and Insurance</td>
<td>8</td>
<td>4%</td>
</tr>
<tr>
<td>Real Estate &amp; Rental &amp; Leasing</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Information</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Total</td>
<td>184</td>
<td>100</td>
</tr>
</tbody>
</table>
When asked which category best described the business industry type, 87 (48%) workplaces listed manufacturing. An additional 18% of the respondents reported “other services” as the organization’s industry, 15 participants (8%) reported Healthcare and Social Assistance, and 8% of organizations reported that retail/wholesale best described the company’s industry type. (See Table 3).
Table 3. Description of Organization by Industry Type

<table>
<thead>
<tr>
<th>Industry Type</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manufacturing</td>
<td>87</td>
<td>48%</td>
</tr>
<tr>
<td>Other Services (except Public Administration):</td>
<td>32</td>
<td>17%</td>
</tr>
<tr>
<td>Healthcare &amp; Social Assistance</td>
<td>15</td>
<td>8%</td>
</tr>
<tr>
<td>Retail/Wholesale Trade</td>
<td>14</td>
<td>8%</td>
</tr>
<tr>
<td>Transportation, Warehousing &amp; Utilities</td>
<td>10</td>
<td>5%</td>
</tr>
<tr>
<td>Educational Services</td>
<td>7</td>
<td>4%</td>
</tr>
<tr>
<td>Professional, Scientific &amp; Technical Services</td>
<td>6</td>
<td>3%</td>
</tr>
<tr>
<td>Agriculture, Forestry, Fishing &amp; Hunting</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>Accommodation &amp; Food Service</td>
<td>4</td>
<td>2%</td>
</tr>
<tr>
<td>Mining, Quarrying, Oil &amp; Gas Extraction</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Arts, Entertainment &amp; Recreation</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Administrative &amp; Support &amp; Waste Management &amp; Remediation Services</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Total</td>
<td>183</td>
<td>100%</td>
</tr>
</tbody>
</table>
The majority of respondents (98%) indicated that his/her company provided health insurance coverage to employees. Only 51% of participants responded as to whether his or her organization had a wellness program. Of this group, 49% indicated that a wellness program was in place (See Table 4). Among those reporting an established wellness program, the majority (95%) indicated that his/her organization had offered the wellness program for less than five years. Among businesses with 1-19 FTE, 37% reported having a wellness program, while among businesses with 20-49 FTE, 25% reported having a wellness program. On average, larger businesses were more likely to report having a wellness program. Among businesses with 250-499 FTE, 63% reported having a wellness program and of those businesses with >500 FTE, 91% reported having a wellness program (See Table 5). Among those that indicated that their organization did not currently have a wellness program, 69% reported no intention of starting a program. None of the 12 organizations with 1-19 FTE without a wellness program reported an intention to start a wellness program in the future and only 23% of those organizations with 20-49 FTE without a wellness program reported an intention to start a wellness program in the future. Of the seven organizations with 250-499 FTE without a wellness program, 71% reported an intention to start a wellness program in the future and the organization with >500 FTE without a wellness program reported an intention to start a program. The majority of companies (57%) that expressed an intention to start a program in the future reported plans to do so during the next two years.
Table 4. Businesses Reporting Established Worksite Health Promotion (WHP) Programs

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>90</td>
<td>49%</td>
</tr>
<tr>
<td>No</td>
<td>95</td>
<td>51%</td>
</tr>
<tr>
<td>Total</td>
<td>185</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 5. Established worksite health promotion program by workplace size

<table>
<thead>
<tr>
<th>Worksite Size</th>
<th>Established WHP Program</th>
<th>Total Worksites by size</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes n (%)</td>
<td>No n (%)</td>
</tr>
<tr>
<td>1-19 FTE</td>
<td>7 (37)</td>
<td>12 (63)</td>
</tr>
<tr>
<td>20-49 FTE</td>
<td>12 (25)</td>
<td>36 (75)</td>
</tr>
<tr>
<td>50-99 FTE</td>
<td>13 (38)</td>
<td>21 (62)</td>
</tr>
<tr>
<td>100-249 FTE</td>
<td>25 (61)</td>
<td>16 (39)</td>
</tr>
<tr>
<td>250-499 FTE</td>
<td>12 (63)</td>
<td>7 (37)</td>
</tr>
<tr>
<td>&gt; 500 FTE</td>
<td>10 (91)</td>
<td>1 (9)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The most frequently reported elements offered as part of a worksite health promotion program were links to employee related services and supportive physical and social environments for health improvement. Of the options provided, the element offered least was integration of health promotion into the organization’s culture. Responses for all element offerings are shown below (See Table 6).

**Table 6. Offering of specific elements of WHP program (n=185)**

<table>
<thead>
<tr>
<th>Element</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health education (e.g., skills development and behavior change classes; awareness building brochures, posters)</td>
<td>92</td>
<td>50%</td>
</tr>
<tr>
<td>Links to related employee services (e.g., referral to employee-assistance programs (EAPs))</td>
<td>105</td>
<td>57%</td>
</tr>
<tr>
<td>Supportive physical and social environments for health improvement (e.g., tobacco-free policies, subsidized gym memberships)</td>
<td>103</td>
<td>56%</td>
</tr>
<tr>
<td>Integration of health promotion into your organization's culture (e.g., health promotion being part of business mission statement)</td>
<td>33</td>
<td>18%</td>
</tr>
<tr>
<td>Employee screenings with adequate treatment and follow-up (e.g., Health Risk Assessments (HRAs) and biometric screenings)</td>
<td>90</td>
<td>49%</td>
</tr>
</tbody>
</table>
Workforce Demographics

Among the participating companies, the majority of the workforce was female (54%). Most employees were between 45-64 years of age (42%). Non-Hispanic whites (88%) were the majority of the workforce, with Non-Hispanic blacks (8%), Hispanic/Latino (2%), Asian (1%), and American Indian/Pacific Islander/Other (1%) comprising the remaining 12%. Most employees (76%) were paid hourly. The highest degree earned for the majority of employees (53%) was a high school degree/GED, with 7% earning an advanced degree, 23% earning a college diploma, 14% reporting some college hours or a technical degree, and approximately 3% reportedly not having at least a high school diploma or GED (See Table 7).
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>%</th>
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<tbody>
<tr>
<td>Total Employees</td>
<td>57,511</td>
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<tr>
<td><strong>Gender</strong></td>
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</tr>
<tr>
<td>Male</td>
<td>26,341</td>
<td>46</td>
</tr>
<tr>
<td>Female</td>
<td>31,170</td>
<td>54</td>
</tr>
<tr>
<td><strong>Age in years</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 18</td>
<td>114</td>
<td>.2</td>
</tr>
<tr>
<td>18-34</td>
<td>15,419</td>
<td>29</td>
</tr>
<tr>
<td>34-44</td>
<td>13,247</td>
<td>25</td>
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<tr>
<td>45-64</td>
<td>22,426</td>
<td>42</td>
</tr>
<tr>
<td>&gt;65</td>
<td>1,654</td>
<td>3</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
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</tr>
<tr>
<td>Non-Hispanic Whites</td>
<td>34,607</td>
<td>88</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>3,154</td>
<td>8</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>721</td>
<td>2</td>
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<tr>
<td>Asian</td>
<td>579</td>
<td>1</td>
</tr>
<tr>
<td>American Indian/Pacific Islander/Other</td>
<td>395</td>
<td>1</td>
</tr>
<tr>
<td><strong>Job Type</strong></td>
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<tr>
<td>Salaried</td>
<td>9,940</td>
<td>24</td>
</tr>
<tr>
<td>Hourly</td>
<td>31,434</td>
<td>76</td>
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<tr>
<td><strong>Education Level</strong></td>
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<tr>
<td>&lt; High school diploma</td>
<td>401</td>
<td>3</td>
</tr>
<tr>
<td>High school Diploma/GED</td>
<td>7,238</td>
<td>53</td>
</tr>
<tr>
<td>Some college or technical school</td>
<td>1,883</td>
<td>14</td>
</tr>
<tr>
<td>College graduate Advanced degree</td>
<td>3,184</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>931</td>
<td>7</td>
</tr>
</tbody>
</table>
Organizational Support

Participating workplaces were asked if they conducted needs and interests assessment for planning their health promotion activities during the past 12 months. Out of the 172 workplaces that responded, only 32 (19%) conducted needs and interests assessment (See Figure 1). Similarly, about 37% of workplaces conducted health-risk appraisals/assessments, health plans or provided individual feedback or health education (See Figure 2). Sixty workplaces (35%) reported that their organizational support and commitment of worksite health promotion was demonstrated at all levels of management (See Figure 3).
Figure 1. Workplace conducted employee needs and interests assessment for planning health promotion activities (n=172)

Figure 2. Workplace conducted employee health-risk appraisals/assessments through vendors, on-site staff, or health plans and provide individual feedback plus health education (n=171)
To assess how employees are motivated to participate in worksite health promotion programs, workplaces were asked whether they used incentives with other strategies to promote participation. Sixty (44%) out of 170 workplaces reported they did use incentives with other strategies (See Figure 4). Only 58 (34%) of workplaces reported using competitions combined with interventions to support employees making behavior changes (See Figure 5).

On marketing health promotion programs to employees, 40% (69) workplaces reported promoting and marketing health programs to their employees (See Figure 6). About 33 (20%) workplaces reported using examples of employees role-modeling appropriate health behaviors or health-related stories as marketing materials (See Figure 7).
Figure 4. Workplace used and combined incentives with other strategies to increase participation in health promotion programs (n=171)

Figure 5. Workplace used competitions when combined with additional interventions to support employees making behavior changes (n=171)
Regarding adaptation of health-education materials to suit language, literacy level, culture, or readiness to change, only 42 workplaces (25%) reported doing this (See Figure 8). Less than one-fifth of workplaces (32 or 19%) reported having an active health-promotion committee (See Figure 9). The same number of workplaces reported having a paid health-promotion
coordinator responsible for implementing worksite health-promotion programs either part time or full time (See Figure 10). Furthermore, 29% of workplaces (50) reported having a champion(s) who strongly advocated for health promotion programs (See Figure 11).

**Figure 8. Workplace tailored some health promotion programs and education materials to the language, literacy levels, culture, or readiness to change of various segments of the workforce (n=171)**
Figure 9. Workplace enacted an active health-promotion committee (n=171)

![Bar chart showing the percentage of workplaces with an active health-promotion committee.](chart1)

Figure 10. Workplace paid health promotion coordinator whose job (either part time or full time) is to implement a worksite health promotion program (n=169)

![Bar chart showing the percentage of workplaces with a health promotion coordinator.](chart2)
Workplaces also were asked about dedicated funds for health-promotion programs. Forty-seven (28%) workplaces reported having an annual budget for their programs during the past 12 months (See Figure 12). Only 31 workplaces (19%) set annual organizational health promotion objectives (See Figure 13). In addition, approximately 31 workplaces (13%) had business objectives or an organizational mission statement which made references to improving or maintaining employee health (See Figure 14).
Figure 12. Workplace possessed an annual budget or receipt of dedicated funding for health promotion programs (n=167)

![Bar Chart]

- Yes: 28%
- No: 72%

Figure 13. Workplace established annual organizational objectives for health promotion (n=167)

![Bar Chart]

- Yes: 19%
- No: 81%
Figure 14. Workplace included references to improve or maintain employee health in the business objectives or organizational mission statement (n=167)

Thirty-seven workplaces (22%) reported they conducted evaluations of their health promotion programs using multiple data sources (See Figure 15). Availability of health promotion programs to employee family members was slightly better. Fifty-five workplaces (33%) reported making health promotion programs available to family members (See Figure 16). Provision of flexible work-schedule policies was also assessed. Fifty-eight workplaces (34%) reported having flexible work-schedule policies to promote employee health during the past 12 months (See Figure 17). When going beyond the workplace into the community, 71 workplaces (42%) reported engaging in community health initiatives and supporting employee participation and volunteer efforts during the past month (See Figure 18).
Figure 15. Workplace conducted ongoing evaluations of health-promotion programming that used multiple data sources (n=170)

Figure 16. Workplace offered health promotion programs available to family members (n=169)
Figure 17. Workplace provided flexible work-scheduling policies (n=169)

Figure 18. Workplace engaged in other health initiatives throughout the community and supported employee participation and volunteer efforts (n=170)
Tobacco Control

Of the 170 respondents, 86 (51%) indicated that there was a written policy banning tobacco at his/her worksite. The majority of participants (51%) also indicated that his/her worksite actively enforced a written policy banning tobacco use (See Figure 19). Additionally, 97 (58%) workplaces said that his/her worksite displayed signs with information about the tobacco-use policy (See Figure 20). However, less than half of all respondents (31%) indicated that his/her worksite referred tobacco-users to a state or other tobacco-cessation telephone quit line (See Figure 21).

Figure 19. Workplace established and actively enforced a written policy banning tobacco (n=170)
Sixty-eight (41%) of the participants reported that his/her worksite provided health insurance coverage for prescription tobacco-cessation medication, 55 (33%) of workplaces indicated provision of health insurance coverage for FDA-approved over-the-counter, nicotine-replacement products (See Figure 22). Of the participating
workplaces, 64 (38%) provided or promoted free or subsidized tobacco-cessation counseling (See Figure 23), while 74 (44%) workplaces informed employees about health insurance coverage or programs that include tobacco cessation and counseling (See Figure 24).

**Figure 22. Workplace provided health insurance coverage for prescription and over-the-counter (OTC) medications for smoking cessation (n=170)**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health insurance coverage for prescription medications</td>
<td>59%</td>
<td>41%</td>
</tr>
<tr>
<td>Health insurance coverage for OTC medications</td>
<td>67%</td>
<td>33%</td>
</tr>
</tbody>
</table>
Figure 23. Workplace provided and/or promoted free or subsidized tobacco-cessation counseling (n=170)

![Bar chart showing 38% Yes and 62% No]

Figure 24. Workplace informed employees about health insurance coverage or programs that include tobacco-cessation medication and counseling (n=168)

![Bar chart showing 44% Yes and 56% No]

Of 168 respondents, 28 (17%) provided incentives for being a current nonuser of tobacco or for users taking part in cessation activities (See Figure 25). Lastly, 80%
indicated that the sale of tobacco products on company property was prohibited (See Figure 26).

**Figure 25.** Workplace provided incentives for being a current nonuser of tobacco and for current tobacco users that are currently involved in a cessation class or actively quitting (n=167)

**Figure 26.** Workplace permitted the sale of tobacco products on company property (n=170)
**Nutrition**

Among 170 workplaces, 141 provided places for employees to purchase food and beverage (See Figure 27). Although most workplaces provided places to purchase food and beverages, only 21% of participating workplaces had written policies or formal communication making healthier food and beverage choices available in vending machines (See Figure 28). Twenty-one workplaces (14%) reported more than 50% of food and beverage choices available in vending machines, cafeterias, snack bars or other purchase points were healthier choices during the past 12 months (See Figure 29).

**Figure 27. Workplace provided places to purchase food and beverages (n= 170)**
Figure 28. Workplace established a written policy or formal communication that made healthier food and beverage choices available in vending machines (n=146)

Figure 29. Workplace made healthier most (more than 50%) of the food and beverage choices available in vending machines, cafeterias, snack bars, or other purchase points (n=147)
Twenty eight workplaces (19%) provided nutritional information (beyond food labels): sodium, calories, trans and saturated fats for foods and beverages sold in workplace cafeterias, snack bars or other purchase points (See Figure 30). In addition, 34 participating workplaces (23%) reported using signs or symbols in identifying food and beverage choices (See Figure 31).

Figure 30. Workplace provided nutritional information (beyond standard nutrition information on labels) on sodium, calories, trans fats, or saturated fats for foods and beverages sold in worksite cafeterias, snack bars, or other purchase points (n=147)
Figure 31. Workplace identified healthier food and beverage choices with signs or symbols (n=147)

Only 10 workplaces (7%) reported subsidizing or providing discounts on healthier food and beverages sold on their premises (See Figure 32). When asked about a written policy or formal communication making healthier foods and beverages available during meetings when food is served, 16 (10%) of workplaces responded “yes” (See Figure 33). An overwhelming majority of workplaces (148 or 88%) reported providing employees with food preparation and storage facilities (See Figure 34).

Figure 32. Workplace subsidized or provided discounts on healthier foods and beverages offered in vending machines, cafeterias, snack bars, or other purchase points (n=146)
Figure 33. Workplace established written policy or formal communication, which makes healthier food and beverage choices available during meetings when food is served (n=169)

[Bar chart showing 10% Yes and 90% No]

Figure 34. Workplace provide food preparation and storage facilities to employees (n=169)

[Bar chart showing 88% Yes and 12% No]

Less than one-fifth of workplaces (27 or 16%) offer or promote during the past 12 months an on-site or nearby farmers’ market where fruits and vegetables are sold (See Figure 35). Close to half of participating workplaces 78 (46%) reported providing healthy eating information through brochures, videos, pamphlets, newsletters or other written or online avenues to their
employees (See Figure 36). On educational seminars, workshops or classes on nutrition, approximately 45 workplaces (27%) reported offering such programs to their employees (See Figure 37). Twenty-two percent of workplaces (36) reported providing free or subsidized self-management programs for healthy eating (See Figure 38).

**Figure 35. Workplace offered or promoted an on-site or nearby farmers’ market where fresh fruits and vegetables are sold (n=169)**
Figure 36. Workplace provided brochures, videos, posters, pamphlets, newsletters, or other written or online information that address the benefits of healthy eating (n=168)

![Bar chart showing the percentage of workplaces providing healthy eating information](image)

Yes: 46%  
No: 54%

Figure 37. Workplace provided a series of educational seminars, workshops, or classes on nutrition (n=170)

![Bar chart showing the percentage of workplaces providing nutrition education](image)

Yes: 27%  
No: 73%
Figure 38. Workplace provided free or subsidized self-management programs for healthy eating (n=167)

Physical Activity

Participating workplaces were asked about the provision of on-site or subsidized off-site exercise facilities during the past 12 months. Out of the 169 workplaces responding, 34 (20%) provided an on-site exercise facility, while, 55 (33%) of workplaces offered subsidized or discounted cost of on-site or offsite exercise facilities (See Figure 39). Forty-seven (28%) workplaces reported a provision of environmental supports (e.g. trails or walking tracks, maps of suitable walking tracks, bicycle racks, a basketball court, open space designated for recreation, a shower or changing facility) during the past 12 months (See Figure 40). Only 9 (5%) of workplaces posted signs at elevators, stairwells, and other locations that encourage employees to use the stairs, while approximately 39 (24%) of workplaces offered organized individual or group physical activity programs for employees during the past 12 months (See Figure 40).
In order to examine other elements related to physical activity, workplaces were asked whether educational classes and materials were present at the workplace in the past 12 months. Sixty-six workplaces (40%) provided brochures, videos, posters, pamphlets,
newsletters, or other written or online information addressing the benefits of physical activity. While, only 33 (20%) provided educational seminars, workshops, or classes on physical activity (See Figure 41). According to the results, there was also a lack of assessments and counseling regarding physical activity at the workplace. Only 23 (14%) of the 165 participating workplaces offered or subsidized physical fitness assessments, follow-up counseling and physical activity recommendations either on-site or through a community exercise facility. The same number of workplaces (14%) provided free or subsidized self-management programs for physical activity (See Figure 41).

**Figure 41. Workplace provided written or online information and education seminars, workshops, or classes about physical activity**
Weight Management

Participating workplaces were asked about the provision of assessments and educational information regarding weight management during the past 12 months. Out of the 167 workplaces responding, 58 (35%) provided free or subsidized body composition measurement, Body Mass Index (BMI) scores, or other body fat assessments (beyond HRAs) followed by direct feedback and clinical referral when appropriate (See Figure 42).

**Figure 42. Workplace provided free or subsidized body composition measurement, Body Mass Index (BMI) scores, or other body fat assessments (n=167)**

Only 65 (39%) workplaces provided brochures, videos, posters, pamphlets, newsletters, or other written or online information that addressed the risks of overweight or obesity during the past 12 months. Forty-one workplaces (25%) reported offering educational seminars, workshops, or classes on weight management during the past 12 months (See Figure 43).
Figure 43. Workplace provided educational materials and classes related to weight management (n=167)

Approximately 39 (24%) workplaces offered free or subsidized one-on-one or group lifestyle counseling for employees who were overweight or obese during the past 12 months.

Additionally, 23% of workplaces offered free or subsidized self-management programs for weight management (See Figure 44).
Stress Management

Participating workplaces were asked about elements related to stress management provided to employees. Out of the 165 workplaces responding, only 17 (10%) provided a dedicated space where employees could engage in relaxation activities like meditation, yoga or biofeedback (See Figure 45). However, 105 (63%) workplaces sponsored or organized social events during the past 12 months (See Figure 46).
Forty-five (32%) participating workplaces reported that stress management programs were provided during the past 12 months. Similarly, 53 (32%) workplaces offered work-life balance/life-skills programs for their employees (See Figure 47).
Of the 165 participating workplaces, only 37 (22%) provided training for managers on identifying and reducing workplace stress-related issues (See Figure 48). Just 43 (26%) workplaces provided employees with opportunities to participate in organizational decisions regarding workplace issues that affect job stress (See Figure 49).

Figure 48. Workplace provided training for managers to identify and reduce workplace stress (n=165)
Figure 49. Workplace utilized employee participation in decisions regarding workplace stress (n=165)

**Depression**

Participating workplaces were asked about providing screenings and assessments for depression during the past 12 months. Of the 167 workplaces responding, 31 (19%) provided free or subsidized clinical screening for depression (beyond HRAs) followed by direct feedback and clinical referral when appropriate, while only 35 (21%) workplaces offered access to online or paper self-assessment depression-screening tools (See Figure 50).
Only 24 workplaces (15%) provided brochures, videos, posters, pamphlets, newsletters, or other written or online information addressing depression during the past 12 months.

Similarly, less than 24 (15%) provided educational seminars, workshops, or classes on preventing and treating depression. Only 39 (23%) of the 167 participating workplaces offered one-on-one or group counseling for employees with depression (See Figure 51).
Figure 51. Workplace provided written or online information, educational workshops or classes, and one-on-one or group counseling for depression

There was also a lack of training in the workplaces regarding depression. Out of all participating workplaces, 9 (6%) provided training for managers on depression in the workplace (See Figure 52). However, 95 workplaces (58%) provided health insurance coverage with no or low out-of-pocket costs for depression medications and mental health counseling (See Figure 53).

Figure 52. Workplace provided training for managers related to depression (n=165)
Figure 53. Workplace offered health insurance coverage for depression medication and mental health counseling (n=164)

![Bar chart showing health insurance coverage for depression medication and mental health counseling](chart.png)

**High Blood Pressure**

Participating workplaces were asked about screening and educational materials and classes addressing high blood pressure during the past 12 months. Out of the 164 workplaces that responded, 58 (35%) provided free or subsidized blood pressure screening (beyond HRAs) followed by direct feedback and clinical referral when appropriate (See Figure 54).

Figure 54. Workplace provided screening for high blood pressure (n=164)

![Bar chart showing blood pressure screening](chart2.png)
Sixty-nine workplaces (43%) provided brochures, videos, posters, pamphlets, newsletters, or other written or online information that addressed the risks of high blood pressure.

Approximately 30 (18%) workplaces provided educational seminars, workshops, or classes on preventing and controlling high blood pressure (See Figure 55).

**Figure 55. Workplace provided written or online information and educational workshops or classes related to high blood pressure**

As for providing counseling and self-management programs for high blood pressure in the workplace, 40 (25%) participating workplaces offered one-on-one or group lifestyle counseling and follow-up monitoring for employees with high blood pressure or pre-hypertension. Only 36 (22%) provided free or subsidized self-management programs for blood pressure control (See Figure 56).
Figure 56. Workplace provided counseling and self-management for employees with high blood pressure (n=162)

Approximately 34 (21%) workplaces made available blood pressure-monitoring devices with instruction to employees to conduct their own self-assessments (Figure 57). More than half (67%) of the workplaces provided health insurance coverage with no or low out-of-pocket costs for blood pressure control medications (See Figure 58).

Figure 57. Workplace made available blood pressure monitoring devices for self-assessment (n=162)
High Cholesterol

Participating workplaces were asked if they provided screening, and educational materials and classes that addressed high cholesterol during the past 12 months. Out of the 165 workplaces that responded, 56 (34%) provided free or subsidized cholesterol screening (beyond HRAs) followed by direct feedback and clinical referral when appropriate (See Figure 59).
Figure 59. Workplace provided screening for high cholesterol (n=165)

Approximately 64 participating workplaces (39%) provided brochures, videos, posters, pamphlets, newsletters, or other written or online information that addressed the risks of high cholesterol. Nearly 25 (16%) workplaces provided educational seminars, workshops, or classes on preventing and controlling high cholesterol (See Figure 60).

Figure 60. Workplace provided written or online information and educational workshops or classes related to high cholesterol
As for providing counseling and self-management programs for high cholesterol in the workplace, 36 (22%) participating workplaces offered one-on-one or group lifestyle counseling and follow-up monitoring for employees with high cholesterol. Only 34 (21%) workplaces provided free or subsidized self-management programs for cholesterol control (See Figure 61).

**Figure 61. Workplace provided one-on-one or group counseling and free or subsidized self-management for employees with high cholesterol**
More than half (66%) of the workplaces provided health insurance coverage with no or low out-of-pocket costs for cholesterol control medications (See Figure 62).

**Figure 62. Workplace provided health insurance coverage with no or low out-of-pocket costs for cholesterol control medications**
Diabetes

Participating workplaces were asked about screenings and assessments for diabetes during the past 12 months. Out of the 162 workplaces responding, 51 (32%) provided free or subsidized pre-diabetes and diabetes risk factor self-assessments and feedback, followed by blood glucose screening and clinical referral when appropriate (See Figure 63).

Figure 63. Workplace provided self-assessments for pre-diabetes and diabetes

Sixty (37%) workplaces provided brochures, videos, posters, pamphlets, newsletters, or other written or online information addressing diabetes. Approximately 30 (18%) provided educational seminars, workshops, or classes on preventing and treating diabetes (See Figure 64).
Forty (25%) of the participating workplaces offered one-on-one or group lifestyle counseling and follow-up monitoring for employees with abnormal blood glucose levels (pre-diabetes or diabetes). Similarly, 40 (24%) workplaces offered free or subsidized self-management programs for diabetes control (See Figure 65). Among the workplaces, 101 (64%) provided health insurance coverage with no or low out-of-pocket costs for diabetes control medications and supplies (See Figure 66).
Figure 65. Workplace provided one-on-one or group counseling and free or subsidized self-management programs for diabetes control

Figure 66. Workplace provided health insurance coverage for diabetes control medication and supplies (n=158)
Signs and Symptoms of Heart Attack and Stroke

Participating workplaces were asked about utilizing signs, posters, and additional information regarding the signals and symptoms of heart attack and stroke during the past 12 months. Out of the 164 workplaces that responded, 48 (29%) indicated that posters or fliers identifying the signs and symptoms of heart attack and informing that heart attacks are to be treated as emergencies were placed in common areas. Of the participating workplaces, 45 (27%) indicated that posters or fliers that identified the signs and symptoms of stroke and informing that strokes are to be treated as emergencies were placed in common areas (See Figure 67).

Figure 67. Workplace utilized signs or posters in common areas identifying the signals and symptoms of heart attack and stroke
Fifty-eight (36%) of participating workplaces provided other information on the signs and symptoms of heart attack and 48 (29%) provided other information on stroke through emails, newsletters, management communication, websites, seminars or classes (See Figure 68).

**Figure 68. Workplace provided other information on the signs and symptoms of heart attack and stroke**

![Graph showing the percentage of workplaces providing information on heart attack and stroke.](chart)

**Emergency Response to Heart Attack and Stroke**

Workplaces were asked about the presence of an emergency response plan, offerings of Cardiopulmonary Resuscitation (CPR) training, and placement of Automated External Defibrillators (AED). Among the 165 participating workplaces, 84 (51%) had an emergency response plan that addressed acute heart attack and stroke events. Additionally, 93 (56%) had an emergency response team for medical emergencies (See Figure 69).
Figure 69. Workplace established emergency response plans for heart attack/stroke and established an emergency response team (n=165)

Access to a nationally-recognized training course on CPR that includes training on AED usage was offered by 96 (59%) participating workplaces (See Figure 70). Ninety-seven workplaces (59%) had a policy that requires an adequate number of employees per floor, work unit, or shift, in accordance with pertinent state and federal laws to be certified in CPR/AED (See Figure 71).
Figure 70. Workplace offered access to a nationally recognized CPR/AED training course (n=163)

Figure 71. Workplace established a policy requiring an adequate number of employees trained in CPR/AED

Additionally, 82 (50%) workplaces had one or more functioning AEDs in place (See Figure 72). And 73 (89%) workplaces indicated the presence of one or more functioning AEDs in the workplaces and had an adequate number of AED units in order to reach a person within 3-5 minutes of collapse (See Figure 73). Among this same group, 67 (82%) indicated that the location of AEDs were identified with posters, signs, markers, or other forms of communication other than the AED (See Figure 74) and 82 (99%) indicated that routine
maintenance or testing was performed on all AEDs (See Figure 75). In addition, 47 (59%) workplaces with at least one AED in place provided information to the local community Emergency Medical Service providers regarding the presence of an AED in case of an emergency response (See Figure 76).

**Figure 72. Workplaces with functioning AEDs (n=164)**

![Bar chart showing 50% and 50% for Yes and No respectively.]

**Figure 73. Workplace provided adequate number of AEDs among workplaces with one or more AEDs (n=82)**

![Bar chart showing 89% and 11% for Yes and No respectively.]

Figure 74. Workplace identified location of AEDs with posters, signs, markers or other forms of communication other than the AED itself among workplaces with one or more AED (n=82)

![Bar chart showing 82% Yes and 18% No](image)

Figure 75. Workplace performed routine maintenance or testing on AEDs among workplaces with one or more AEDs (n=82)

![Bar chart showing 99% Yes and 1% No](image)
Additional CDC Health Scorecard Modules

Lactation Support

Participating workplaces were asked about elements of lactation support provided to employees. Out of the 165 workplaces responding, only 18 (11%) had a written policy on breastfeeding. Less than half (43%) provided a private space (other than a restroom) that could be used by employees to express breast milk (See Figure 77).
Figure 77. Workplace established a written policy on breastfeeding and private space for employees to express milk (n=165)

Fourteen (9%) workplaces provided breast pumps at the worksite, while almost half (49%) of workplaces provided flexible break times to allow mothers to pump breast milk (See Figure 78).

Figure 78. Workplace provided breast pumps and flexible break times for pumping breast milk
Twelve (7%) of the participating workplaces offered free or subsidized breastfeeding support groups or educational classes, while 49 (30%) offered paid maternity leave separate from any other accrued leave (See Figure 79).

**Figure 79. Workplace provided breastfeeding support groups or educational classes and paid maternity leave separate from other accrued leave**

![Bar chart showing the percentage of workplaces offering support groups and educational classes, and paid maternity leave separate from other accrued leave.]

**Occupational Health and Safety**

Workplaces were asked about the presence of occupational health and safety measures. Of the 161 participating workplaces, 63 (39%) included references to improving/maintaining job health and safety in the business objectives or organizational mission statements (See Figure 80). Additionally, 111 (68%) had a written injury and illness prevention program (See Figure 81), while 70 (43%) workplaces employed an occupational health and safety professional (See Figure 82).
Figure 80. Workplace included references to improving/maintaining job health and safety in mission statement (n=161)

![Bar chart showing percentages of workplaces with and without references to job health and safety in mission statements.]

Figure 81. Workplace referenced a written illness and injury program (n=164)

![Bar chart showing percentages of workplaces with and without a written illness and injury program.]
Of the participating workplaces, 150 (93%) encouraged reporting injuries and near misses, while 125 workplaces (79%) provided opportunities for employee input on hazards and solutions (See Figure 83).
Additionally, 130 (81%) workplaces had a program to investigate the causes of injuries or illnesses. In addition, 115 (72%) workplaces provided written materials about health and safety at work to educate employees (See Figure 84). One-hundred and twenty-nine workplaces (81%) also provided training to all new workers on how to be safe on the job. However, only 56 (35%) coordinated with health and safety administrators and health-promotion and wellness professionals to plan activities for employees (See Figure 85).
Figure 84. Workplace offered a program to investigate causes of injury/illness and provision of written materials about health and safety at the workplace.
When asked about the establishment of policies or employee benefits related to occupational health and safety, 102 (63%) workplaces offered paid time off (PTO) for days of hours especially for sickness/illness of employees or dependents, while 155 (95%) offered paid vacation time or personal days or hours for non-exempt employees (See Figure 86).
Vaccine Preventable Disease

Participating workplaces were asked about vaccinations and education in the past 12 months. Among the 163 workplaces responding, 126 (77%) provided health insurance coverage with no or low out-of-pocket costs for influenza vaccination. Ninety-six of the 162 responding workplaces (59%) conducted influenza vaccinations at the worksite (See Figure 87). Among the workplaces offering on-site influenza vaccinations, 94 (99%) offered vaccinations with no or low out-of-pocket costs to employees. Within the same group, 28 (29%) offered vaccinations other than seasonal influenza at the worksite with no or low out-of-pocket costs to employees (See Figure 88).
Figure 87. Workplace provided health insurance coverage for influenza vaccines and on-site influenza vaccinations

![Bar chart showing health insurance coverage for flu vaccines and conducted on-site flu vaccines.]

- Health insurance coverage for flu vaccines (n=163): 77% Yes, 23% No
- Conducted on-site flu vaccines (n=162): 59% Yes, 41% No

Figure 88. Workplace provided on-site vaccinations at no or low-cost to employees

![Bar chart showing on-site vaccinations at no or low-cost.]

- Flu vaccines (n=95): 99% Yes, 1% No
- Vaccines other than flu (n=96): 29% Yes, 71% No
The majority of workplaces (55%) promoted influenza vaccinations through brochures, videos, posters, pamphlets, newsletters or other written or online information that addressed the benefits of influenza vaccinations (See Figure 89).

**Figure 89. Workplace promoted influenza vaccines through written and online information (n=161)**

Community Resources

Participating workplaces were asked about providing information, programs or resources from various organizations. Response rates for each are listed below. (See Figure 90).
Participating workplaces were asked if they received technical support from various organizations related to the development of a workplace wellness program. Response rates for each are listed below (See Figure 91).
Participating workplaces were asked if they participated in any Community Coalitions focused on health or business and community partnerships. Response rates are listed below (See Figure 92).

Figure 92. Workplace participated in community coalitions focused on health or business and community partnerships (n=160)
Kentucky Department for Public Health Questions on Chronic Disease

Cancer

Participating workplaces were asked about benefits, paid time off, and communication regarding cancer screening. Among the 165 participating workplaces, 151 (92%) provided health benefit coverage at no or reduced cost for screening of breast, cervical and colorectal cancers. Seventy-seven of the 163 participating workplaces (47%) provided paid time off (PTO) to get preventive cancer screenings. Sixty-nine workplaces (42%) communicated the importance of breast, cervical, and colorectal cancer screenings (See Figure 93). Among workplaces that communicated the importance of these screenings, the most frequently cited methods of communication were through open enrollment fairs and written or electronic communication (e.g. reminders, newsletters, brochures).

Figure 93. Workplace provided health coverage and PTO for breast, cervical and colorectal cancer screenings
Asthma and Chronic Obstructive Pulmonary Disease (COPD)

Participating workplaces were asked about screening benefits and policies related to asthma and chronic obstructive pulmonary disease (COPD). Among the 158 participating workplaces, 25 (16%) provided free or subsidized clinical screenings for asthma and COPD (See Figure 93).

Figure 93. Workplace provided screenings for asthma and COPD (n=158)

Eighty (50%) workplaces had a written policy regarding the reduction of risk for airborne particulate matter related to chemicals, dust and other possible respiratory exposures in the workplace. Among the 156 participating workplaces that participated, 39 (25%) had written policies for factors that affect asthma and COPD including integrated pest management (i.e. reduction of cockroaches, droppings from mice), limiting indoor spraying of pesticides, and immediate attention to water damage to reduce mold (See Figure 94).
Among participating workplaces, 112 (69%) provided health insurance coverage with no or low out-of-pocket costs for asthma and COPD inhalers and medications. And 34 (21%) workplaces provided brochures, posters, pamphlets, newsletter articles, or other written or on-line information that address asthma and/or COPD (See Figure 95).
Figure 95. Workplace provided health insurance coverage for asthma and/or COPD inhalers and medication and written or online information addressing asthma and/or COPD
DISCUSSION

Workplace health-promotion programs are identified as an effective strategy to improve the health, well-being and safety of employees (National Prevention Strategy, 2011). Yet only 51% of survey participants responded as to whether their organization had a wellness program and of this group, only 49% indicated that a wellness program was in place. Additionally, among those that indicated that their organization did not currently have a wellness program, 69% reported no intention of starting a program. These results support the notion that although the workplace environment offers the best opportunities over other types of environments for health promotion awareness and education, Kentucky’s workplaces are not utilizing (whether by choice or through lack of resources) this advantage (Task Force on Community Preventive Services, 2010).

Kentucky’s Unbridled Health Report, A Plan for Coordinated Chronic Disease Prevention and Health and Health Promotion (2012-2016), calls for employers to adopt comprehensive workplace wellness policies and programs. A comprehensive workplace health promotion program includes: the components of health education; links to related employee services; supportive physical and social environments; integration of health promotion into the organization’s culture; and employee screenings with adequate treatment and follow-up. Comprehensive workplace health promotion programs are more effective in improving employee health than programs without these components (Goetzel & Ozminkowski, 2008).

Only 18% of responding workplaces stated that their organization integrated health promotion into their culture, even though the 2013 Staying@Work Survey results indicated that establishing a culture of health is vital to a healthy company. Approximately half of the
responding workplaces offered the remaining components of a comprehensive health-promotion program.

The majority of responding workplaces (83%) have fewer than 249 employees, (often categorized as small companies) which represent approximately 99% of Kentucky Businesses (Lovely & Watkins, 2012). Small companies were less likely than large companies to report having a wellness program and small companies without a wellness program were less likely to report an intention to start a wellness program than larger companies. These results are synonymous with the 2004 National Worksite Health Promotion Survey results, which state the number, quality and types of workplace health promotion programs, especially in small companies, must be increased (Linnan et al., 2008).

Among respondents, 98% indicated that health insurance coverage was provided to employees. While health insurance is an important benefit, prevention is the most cost effective way for Americans to live a longer and better quality of life (National Prevention Council, 2011). Kentucky is ranked 49 in preventable hospitalization (United Health Foundation, 2013). The lack of preventive services and health promotion programs coupled with the substantial number of preventable hospitalizations possibly contributed considerably to the high healthcare costs experienced in Kentucky.

**Organizational Support:**

Few workplaces (19%) had an active health promotion committee, or had a full-time or part-time wellness coordinator. A New York state study revealed that workplace health promotion programs supported by a wellness committee or designated manager are more likely to succeed than those without (Brissette, Fisher, Spicer & King, 2008).
Similarly, only 19% of responding workplaces conducted employee needs and interest assessments or established annual organizational objectives for health promotion, while only 13% included references to improve or maintain employee health in the business objectives or organizational mission statement. Establishing a “culture of health” in the workplace is vital for a successful company (Fabius et al., 2013). Workers need to understand the health promotion program and how their values tie into the goals of the program. The needs and interests of workers should be acknowledged and programs should be tailored to individuals and specific demographic groups with effective communication and evaluation of progress (Towers Watson, 2013).

While Sparling (2010) notes that successful health promotion programs should have a systematic evaluation of needs and programs and should extend health promotion and preventive services to family members, only 22% of responding companies conducted ongoing evaluations of health promotion programming and just 33% made their workplace health promotion programs available to employee families.

**Tobacco Control:**

In 2011, tobacco use cost Kentucky $1.46 billion in personal healthcare expenditures and $2.3 billion in lost productivity annually (CDC, 2013a). Although in “America's Health Rankings” (2013), Kentucky ranks 50 among states in smoking and 50 in cancer deaths (United Health Foundation, 2013), 79% of responding workplaces permitted the sale of tobacco products on company property.

Half of the participants had an actively enforced written policy banning tobacco. Only 31% of responding workplaces referred tobacco users to a state or other tobacco-cessation
telephone quit line, while just 33% provided health insurance coverage for OTC smoking-cessation medications and 41% for prescription smoking-cessation medications. Tobacco-cessation counseling was offered by 38% of responding workplaces and 44% informed employees about health insurance coverage or programs that include cessation medication and counseling. Just 17% of workplaces offered incentives for current nonusers of tobacco and for current tobacco users that are currently quitting. This pattern promotes the use of tobacco products, while offering little incentive to quit.

**Nutrition:**

While the majority of responding workplaces (88%) provided sites to purchase food and beverages, only 21% had a written policy that made vending machine food or beverage offerings healthier and a mere 10% had written policies for healthier food and beverage services at meetings. Just 14% of participating workplaces made more than half of the food and beverages choices available in vending machines, cafeterias, snack bars or other purchase points healthier. Only 23% identified healthier food and beverages with signs and symbols, and just 19% provided nutritional information (beyond standard information on labels) for food and beverages sold. Although 46% provided information on the benefits of healthy eating, only 26% offered or promoted on-site or nearby farmers’ markets and just 7% subsidized or provided discounts on healthier foods and beverages sold. Environmental factors at the workplace, such as time and costs constraints along with the quality of food can negatively influence a worker’s eating choices (Watkins et al., 2008). As noted by the National Prevention Council (2011), employers can assist workers in eating healthier through making available affordable and healthy foods at the workplace (e.g., through policies, farm
to work programs and farmers’ markets) along with easy-to-understand nutritional information at the point of purchase.

**Physical Activity:**

Only 20% of responding workplaces provided an on-site exercise facility, while 33% offered subsidized or discounted cost of on-site or off-site exercise facilities. Approximately 28% reported providing environmental supports (e.g. trails or walking tracks, maps of suitable walking tracks, bicycle racks, a basketball court, open space designated for recreation, a shower or changing facility), while 24% offered organized individual or group physical-activity programs for employees. A mere 5% posted signs at elevators, stairwells, and other locations that encourage employees to use the stairs. The written or online information about the benefits of physical activity was offered more often (40%) than educational seminars, subsidized assessments with follow-up counseling or free or subsidized self-management on physical activity (20%-14%). Studies found that employees who received consultation and were provided educational materials reported greater readiness to change their exercise behavior than employees who did not (Mattke, Schyer & Van Busum, 2012). The National Prevention Council (2011) has recommended that employers should adopt policies and programs that promote physical activity such as access to fitness facilities, flex time and changing facilities which can increase the number of employees who are physically active during the day.
Weight Management:
A study conducted by Archer et al., (2011) identified six promising worksite practices that were viable for employee weight loss. These are enhanced access to opportunities for physical activity combined with: health education; exercise prescriptions; multicomponent educational practices; weight loss competitions and incentives; and behavioral practices with and without incentives. Approximately 35% of participants offered body fat assessments, while 39% provided educational materials and 25% offered classes related to weight management. Only 24% workplaces offered free or subsidized one-on-one or group lifestyle counseling for employees who were overweight or obese. Additionally, 23% of workplaces offered free or subsidized self-management programs for weight management. Implementation of effective weight management programs has the potential to lower medical costs and absenteeism associated with obesity, and to increase productivity (Archer et al., 2011). These results show more opportunity for physical activity along with education and that other weight-loss strategies need to be made available at Kentucky workplaces.

Stress Management:
According to the 2013 Staying@Work Survey, stress is the biggest lifestyle-risk issue in the U.S. workplace. As noted by Wolever et al., (2012), stress-management programs should have company leadership’s support and should be made easily accessible and convenient through on-site locations and flexible time requirements. While a majority of responding workplaces (63%) sponsored or organized a social event, only 32% of workplaces offered work-life balance/life skills programs, and just 22% provided stress-management programs. Twenty-two percent provided training to managers on stress identification and management
and 26% offered opportunities to employees to participate in organizational decisions related
to workplace issues affecting job stress. A small percentage of responding workplaces (10%)
reported having dedicated spaces where employees could engage in relaxation activities.
Efforts to provide stress-management programs and to train management on stress
identification must be accessible to improve the employee well-being and quality of life
(Towers Watson, 2013). Studies found that individuals using telephone-based counseling and
educational materials were twice as likely to practice stress management and showed a 6.1%-risk reduction compared with nonparticipants (Mattke, 2012).

**Depression:**

U.S. businesses spend $2,184 or 48% more in medical costs on workers with depression than
on workers without (Goetzel, et al., 2012). While 58% of participants provided health
insurance coverage at no or low out-of-pocket cost to employees, only 6% of workplaces
offered trainings on depression to managers. And 19% percent of workplaces provided free
or subsidized clinical screening for depression (beyond HRAs).

**High Blood Pressure:**

Workers with high blood pressure pay 31.6% more in medical costs than employees without
high blood pressure (Goetzel, et al., 2012). Thirty-five percent of workplaces provided free
or subsidized blood pressure screenings (beyond HRAs) followed by direct feedback and
clinical referrals when appropriate. A slightly higher percentage of workplaces, 43%,
provided written and electronic information on the risk of high blood pressure to their
employees. About 25% of workplaces provided one-on-one or group counseling and follow-
up monitoring for employees with high blood pressure or pre-hypertension. Only 22% of workplaces provided free or subsidized self-management programs for blood pressure control. Twenty-one percent of workplaces had blood pressure monitoring devices available with instructions for employees to monitor their blood pressure. A majority of workplaces offered health insurance that covered blood pressure-control medications at no or low out-of-pocket costs. Prevention of high blood pressure is more cost effective than treatment of high blood pressure, yet only 18% of responding workplaces offered educational classes, workshops or seminars on preventing and controlling high blood pressure.

**High Cholesterol:**

On the issue of cholesterol, 34% of workplaces provided free or subsidized cholesterol screening (beyond HRAs) followed by direct feedback and clinical referral when needed. Thirty-nine percent of workplaces provided information on the risk of high cholesterol through a wide range of written and electronic communication. Just 22% of participating workplaces offered one-on-one or group counseling and follow-up monitoring for cholesterol. Only 21% of workplaces provided free or subsidized self-management programs for cholesterol control to their employees. The good news is that 66% provided health insurance coverage with no or low out-of-pocket costs for cholesterol control medications. Prevention of high cholesterol is more cost effective than treatment of high cholesterol, yet only 16% of responding workplaces provided educational workshops, seminars and classes on preventing and controlling high cholesterol.
**Diabetes:**

Kentucky has the eighth-highest rate of diabetes in the U.S. (Kentucky Department for Public Health, 2013). Workplaces were asked about their activities regarding diabetes. Thirty-seven percent of workplaces provided diabetes information through a variety of written and electronic communications to their employees. Thirty-two percent of workplaces provided free or subsidized pre-diabetes and diabetes risk factor assessments and feedback to their employees. These workplaces followed the assessment with blood glucose screening and clinical referral when appropriate. Twenty-four percent of workplaces offered free or subsidized self-management programs to help employees control their diabetes. The majority of workplace health insurance, 64%, covered diabetes medication and supplies at no or low out-of-pocket cost. A study conducted by Aldana, et al. (2005), determined that diabetes prevention programs are effective in the workplace. Only 18% of workplaces provided diabetes prevention seminars, classes and workshops.

**Emergency Response to Heart Attack and Stroke:**

To assess employee familiarity with signs and symptoms of a heart attack and stroke, workplaces were asked if they had any information on their premises to which employees could refer. Surprisingly, only 29% of workplaces had posters or fliers identifying the signs and symptoms of a heart attack and stroke, and 27% went further to inform employees to treat such cases as emergencies.

Quick response time decreases a patient’s hospitalization and recovery time (McGruder et al., 2008, O’Brien et al., 2012). Workplaces were asked about the presence of an emergency response plan, CPR training and placement of AED, and 51% of the workplaces had an
emergency plan for acute heart attack and stroke incidents. Fifty-six percent of workplaces also had a response team in place for medical emergencies. Fifty-nine percent of workplaces participated in CPR trainings that included AED provided by nationally recognized bodies. One half of responding workplaces reported having one or more functioning AEDs. Almost all of these workplaces provided information to their local Emergency Medical Service about the presence of an AED in case of emergency response. And 89% of workplaces with functioning AEDs reported having their units in places so that a victim could be reached within 3-5 minutes of collapse. Most workplaces with functioning AEDs had posters, signs, markers and other forms of communication indicating the location of AEDs. Almost all workplaces routinely maintain their AEDs.

**Lactation:**

Lactation policies appear deficient in Kentucky workplaces. This is evident is the small percentage of responding workplaces — only 11% — that had written breastfeeding policies. About 43% of workplaces reported having a private space other than a restroom for breast milk expression by their employees. About half of responding workplaces provided flexible break times to nursing mothers to pump breast milk. However, only 9% of workplaces provided breast pumps at their sites. Only 7% of workplaces provided free or subsidized breastfeeding education classes or support groups. It came as no surprise that only 30% of responding workplaces offered paid maternity leave separate from any accrued leave. Employers can increase employee satisfaction and morale, lower absenteeism, decrease turnover, and reduce insurance costs by supporting breastfeeding mothers in the workplace (Mills, 2009).
Occupational Health and Safety:
Workplaces reported that to reduce injury and illness at the workplace 68% had written injury and illness prevention programs. Furthermore, 43% of this group had employed an occupational health and safety officer to promote these policies. And 93% of workplaces encouraged employees to report injuries or near misses, while 79% provided opportunities for employees to offer input on hazards and solutions. Similarly, 81% provided safety training to all new employees. Among respondents, 63% provided paid time off to sick employees or their dependents. Non-exempt employees received paid vacation or personal days from 95% of workplaces. Regardless, a little more than one-third of responding workplaces or 39% included safety and maintenance of job health in their business objectives and or organizational mission. Health promotion and occupational health and safety when integrated can create a “culture of health,” which would create synergy and enhance the overall health and well-being of the workforce and prevent occupational injuries and illnesses (Hymel, et al., 2011).

Vaccine Preventable Disease:
Providing vaccination opportunities and getting employees vaccinated ensures protection or community immunity to employees. Community immunity prevents the spread of certain infectious diseases among employees (Department of Health and Human Services, 2013; Eash, 2009). Individuals are protected from illness and the consequences of illnesses when they get vaccinated. Vaccinated employees have fewer loss-work days and are able to work and provide for themselves and their families (Eash, 2009). Employer-offered health
insurance covered vaccinations at no or low-out-of-pocket cost was offered, according to 77% of responding workplaces. Similarly, more than half of workplaces offered on-site influenza vaccinations, while approximately 29% also offered other on-site vaccinations beside the seasonal influenza vaccinations at no or low-out-of-pocket cost to employees. Fifty-five percent of workplaces promoted their influenza vaccinations through written or electronic media to their employees.

Community Resources:

Among workplaces responding: 81% reported receiving health plan information, resources and programs from health insurance companies; 45% reported receiving those from health and wellness organizations; and 30% reported receiving those from other health-related organizations. But only 7% of workplaces reported receiving health information and resources from the State Department for Public Health. Insurance companies still lead in providing technical support to workplaces. Fifty percent of workplaces reported receiving technical assistance from insurance companies. Twenty-nine percent of workplaces reported receiving technical support from health and wellness agencies with only 1% of workplaces reporting receiving technical support from State Department for Public Health. The State Department for Public Health may not have enough resources to meet the needs of most workplaces, however, the department can partner with health and wellness agencies to provide information, resources and technical support to workplaces. A pilot study, The Small Worksite Wellness Project (SWWP), was conducted to match small businesses with existing community wellness resources. The study found that employees found it helpful to know
about the community resources and reported less stress, sick time and fewer injuries during the study period (Weed & Bras, 2013).

**KDPH Chronic Disease:**

**Cancer:**

Most workplaces offering health insurance policies to their employees cover cancer-prevention programs with 92% reporting their polices covered breast, cervical and colorectal cancer screenings at no or reduced costs and 53% reporting their policies offered paid time off for preventive cancer screenings. Kentucky leads the nation in lung cancer deaths (Kentucky Coordinated Chronic Disease Prevention and Health Promotion Program, 2012). Screening may provide opportunity for early detection and treatment of lung cancer (Diagnosing Lung Cancer - American Lung Association, n.d.). Surprisingly, only 42% of workplaces reported communicating the importance of cancer screening to their employees. Workplaces that provided the importance of cancer screenings to their employees did so during open enrollment fairs, and with written and electronic communication.

**Asthma and COPD:**

Written policies regarding airborne particulate matter related to chemicals, dust, and other possible workplace respiratory exposures were even. About half of responding workplaces did have written policies. On the other hand, only 25% of workplaces had written policies on asthma and COPD, including pest management, and 69%) health insurance policies that cover asthma and COPD medications or inhalers with no or very low-out-pocket costs. Workplaces in Kentucky thus place more emphasis on particulate matter than asthma and
COPD. Asthma is one of the top 10 most costly and prevalent health conditions associated with presenteeism — the measurable extent to which health symptoms, conditions and diseases adversely affect the work productivity of individuals who choose to remain at work (Chapman, 2005). Health-promotion programs can also include disease management elements that can aid individuals with asthma or other existing ailments through adherence to treatment and patient self-management (Goetzel & Ozminowski, 2008).
LIMITATIONS

This study potentially had the following limitations:

• The response rate of 37% was a potential threat to external validity. The finding of the study would have been different if all workplaces had responded.

• Some data may have been under- or over-reported due to the self-reporting nature of the instrument.

• External validity may also have been affected by the respondents of the survey.

• The majority of respondents were Human Resources Personnel who may not be familiar with health-promotion programs in their workplaces, thus resulting in response bias. Another internal validity threat may have been recall bias. Respondents had to recall activities conducted during the past 12 months on most questions.

• Several modules of the Health ScoreCard (Lactation Support, Occupational Health and Safety, Vaccine Preventable Disease, and Community Resources) had not yet been validated. This study was a pilot for these questions and revision of the questions may be deemed necessary in the future.
CONCLUSION

Few workplaces in Kentucky have health promotion programs and even fewer have comprehensive programs. More businesses rely on health insurance to treat chronic diseases than health promotion programs or preventive services to reduce chronic diseases. Poor lifestyle habits that contribute to chronic diseases are not being addressed at the majority of Kentucky’s workplaces. Tobacco control, nutrition, physical activity, weight management and stress management could all be improved through employee screenings with adequate treatment and follow up, health education, links to related employee services, supportive physical and social environments for health improvement, and the integration of health promotion into the worksite culture.

Small companies were less likely to have a wellness program and less likely to have intentions of starting a wellness program. A clearinghouse for resources needs to be established for small companies along with training for employers so they can realize the importance of prevention, both for human capital and financial capital.
RECOMMENDATIONS

Kyhealthnow 2019 Goals

*Kyhealthnow is Gov. Steve Beshear’s 2019 health goals for Kentucky. You can visit kyhealthnow.com to view all seven of the health goals. These goals align with the recommended strategies from this assessment (2013 Kentucky Worksite Health Assessment Survey results).

*Goal: Reduce Kentucky’s smoking rate by 10%
- Expand and actively enforce tobacco-free policies in all workplaces
- Increase availability of smoking-cessation resources (telephone quit line, subsidized cessation medication, cessation counseling) in all workplaces
- Establish or increase incentives for current nonusers of tobacco and for current tobacco users that currently are quitting in all workplaces

*Goal: Reduce the obesity rate among Kentuckians by 10%
- Make affordable and healthy foods available at the workplace (e.g., through policies, farm to work programs and farmers’ markets) along with easy-to-understand nutritional information at the point of purchase
- Work with public and private workplaces to adopt healthy concessions and vending policies reflecting federal guidelines in all workplaces
- Provide ready access to employees to stairwells at all workplaces
- Develop initiatives to honor and recognize businesses and schools that provide greater opportunities for physical activity
- Employers should adopt policies and programs that promote physical activity such as access to fitness facilities, flex time and restructuring the physical environment at facilities to increase the number of employees who are physically active
- All employers should offer enhanced access to opportunities for physical activity combined with health education, exercise prescriptions, multicomponent educational practices, weight loss competitions and incentives, and skill building opportunities
- Increase the availability of body fat or other body-composition assessments
- Increase access to opportunities for physical activity
- Increase multicomponent educational practices, including weight-management classes
- Offer free or subsidized one-on-one or group counseling for weight management
• Offer weight loss competitions and incentives

*Goal: Reduce Kentucky Cancer Deaths by 10%
• Increase screening rates for colon, lung and breast cancer by 25% in accordance with evidence-based guidelines in all workplaces

*Goal: Reduce Cardiovascular Deaths by 10%
• Increase employee accessibility to blood pressure, cholesterol and diabetes screening at the workplace
• Offer educational classes, workshops or seminars on preventing and controlling high blood pressure in all workplaces
• Offer educational workshops, seminars and classes on preventing and controlling high cholesterol in all workplaces
• Offer educational workshops, seminars and classes on preventing and controlling diabetes in all workplaces
• Workplaces should partner and support the ongoing efforts of the Kentucky CARE Collaborative, a statewide effort designed to provide blood pressure-awareness education within communities

*Goal: Reduce by 25% the average number of poor mental health days of Kentuckians
• Increase efforts to provide stress-management programs and to train management on stress and depression identification in all workplaces
• Stress management programs should have management support and should be made easily accessible and convenient with on-site locations (when feasible) and flexible time requirements in all workplaces

Organizational Support
• Build employee health into your mission
• Know the needs and interests of your employees
• Establish an active health promotion committee; get expert advice when possible
• Management should support wellness initiatives and serve as role models
• Establish a “culture of health”
• Small companies should seek community resources when available
• Include families in wellness initiatives

Emergency Response to Heart Attack and Stroke
• Provide more posters or fliers identifying the signs and symptoms of a heart attack and stroke
• Train employees to identify and treat individuals with signs and symptoms of a heart attack and stroke as emergencies

Lactation
• Provide written policies on breastfeeding
• Provide a private area (other than a restroom) for breast milk expression
• Provide flex time for breast milk expression
• Increase employee accessibility to breastfeeding support groups through the workplace

Occupational Health and Safety
• Include safety and maintenance of job health in the company’s mission
• Integrate health promotion and health protection (safety) to create a “culture of health”

Vaccine Preventable Disease
• Offer flu and other vaccinations on-site
• Promote vaccination adherence through written or electronic media

Community Resources
• Wellness resources and technical support from local, state and national agencies need to be established to provide assistance in wellness efforts, especially for small businesses

Cancer
• Increase screening rates for colon, lung and breast cancer by 25% in accordance with evidence-based guidelines in all workplaces

Asthma and COPD
• Written policies need to be established for asthma and COPD in all workplaces
• Offer educational classes, workshops or seminars on preventing and controlling asthma and COPD in all workplaces
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