Saving Lives and Dollars Through Comprehensive Preventive Health Care

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The United States does not currently have a *health* care system. It has an extensive disease management system, with some fragmented attempts at health care found here and there in a handful of worksite and community programs. Although there is widespread agreement that we should prevent the development of diseases such as heart attacks, strokes, kidney failure, cancer, alcoholism, and drug abuse in order to reduce the morbidity, mortality, and spiraling treatment costs that they produce, very little is offered in the way of a practical strategy for achieving this goal. Until this situation is altered and a system is created that delivers health care, including an array of procedures that prevent and control health risks and unhealthy behaviors, the country will continue to have an excess of premature morbidity and mortality, and an escalating price tag for disease management.

Public discussion of preventive health measures usually envisions a limited set of activities—for example, well-baby clinics, inoculation programs, and occasional education programs and media campaigns to raise public awareness of health risks. Planners sometimes assume that making people aware of their health risks (such as smoking, drinking alcohol to excess, obesity, and high blood pressure) is sufficient to produce behavior to reduce risks. However, research has shown that 70 to 80 percent of the adult population has correctable health risks and that most of this group are aware of these risks, but only 10 to 15 percent of the population works actively to remove or reduce the risks.

Moreover, most of the people who do try to change risky life-style behaviors later relapse into previous unhealthy behaviors. Many such behaviors are pleasurable, and some of these behaviors help to reduce stress and anxiety. Others, such as working under prolonged stress, are responses to situations over which many people are convinced they have little control.

Effective preventive health care approaches must reach people while they are still healthy, help them identify their health risks and alternative

behaviors that they might try, assist them in actually making changes in their health behaviors, and then support them in maintaining changes so that they do not relapse into earlier disease-prone behaviors.

Overview of the University of Michigan Model

Three sets of service are needed in order to achieve long-term health risk reduction: (1) engagement services that attract and involve people with health risks in risk reduction interventions, (2) treatment or assistance services provided to the people who participate, and (3) support services that help people maintain health improvements and reduce the number of relapses. The University of Michigan Model for preventive health care includes all three sets of activities (Heirich, Erfurt, and Foote, 1992; Erfurt, Foote, and Heirich, 1992).

The model utilizes a variety of mechanisms for attracting and engaging participation, but the crucial aspect of all engagement activities is systematic outreach by the service provider. Merely opening the door and announcing the availability of preventive health care services will attract some people, but not the majority.

Programs for relatively nonstigmatic health risks (for example, high blood pressure or cholesterol, inadequate exercise, smoking, obesity, and high stress levels) provide health risk screening in settings where people regularly congregate, such as at worksites, churches, neighborhoods, or schools. Simply offering screening, however, is not sufficient to attract a majority of the target group. The University of Michigan Model includes specific strategies for achieving a high rate of participation. Screening allows not only the identification of people with specific health risks but also initial counseling about those risks and what they mean, and referral to sources of assistance.

In order to find people with health problems of a more stigmatic nature that are not easily identified through health screening (such as drug and alcohol abuse or mental health problems), worksite supervisors are trained to identify people whose work performance has significantly changed and to refer them to an assessment center where a professional can help identify the causes of the problems.

By themselves, these methods of identifying and referring people with health risks do not produce long-term health improvement. Some people do not seek the assistance to which they were referred; many others drop out of their programs. In order to encourage participants to begin and maintain programs to reduce their risks, they are contacted periodically for follow-up counseling and monitoring of their health, using confidential computerized records. Follow-up contacts are made routinely, just as many dentists now remind their patients when they are due for a preventive checkup rather than wait for patients to come in when problems arise. Counseling and recommendations are tailored to each individual's situation.

Routine follow-up contacts thus serve to continue the process of engaging people in activities to improve their health, as well as to support behavioral changes over time. As noted earlier, 70 to 80 percent of adults have health risks that put them at long-term risk for developing serious health problems. With regular, persistent outreach and follow-up counseling, over half of these people will adopt behaviors that improve their health and lessen or eliminate their health risks. Follow-up counseling also provides a mechanism for informing people about the behavioral and environmental causes of illness and the actions that can be taken to alter those causes, such as the facilitation of organizational changes and modifications in the corporate culture designed to create healthier work environments, reduce stress, and increase employee well-being.

These are primary prevention strategies to reduce the incidence of health risks by preventing their development. Regular wellness counseling coupled with organizational efforts to improve the overall environment can prevent the development of many health risks by encouraging healthier eating and exercise habits and more effective management of personal stress, and discouraging unhealthy behaviors such as excess use of alcohol. The model thus addresses all three modes of prevention—primary, secondary, and tertiary—for the chronic health problems that are endemic in our society (Erfurt, 1990).

The University of Michigan Model takes advantage of the fact that many businesses across the country already have employee assistance programs (EAPs) to deal with problems of alcohol, drug abuse, and mental health, and many offer some kind of wellness program. However, many existing worksite wellness programs (WWPs) lack the engagement and follow-up components needed to make them fully effective.

Employee Assistance Programs

From the time EAPs first began to proliferate around 1971, they have been adopted by a great majority of major corporations and are rapidly spreading into intermediate- and small-size worksites (Hayghe, 1990). EAPs have four basic client service components: case finding, problem assessment, referral for treatment or other service, and follow-up.

The case-finding component includes (1) training of supervisors and union representatives to identify employees with impaired work performance, to utilize constructive confrontation with employees who deny that they have problems, and to refer employees with identified problems to an EAP (Kurtz, 1980; Reichman, Young, and Gracin, 1988), (2) program promotion to encourage employees with problems to come to the EAP on their own (self-referrals), (3) consultation with supervisors and union representatives regarding troubled employees and how to deal with specific cases, and (4) periodic review of employees' work performance records to

identify indications of deteriorating performance. EAP policies usually specify that use of the EAP is confidential and will not affect the employee's job security. Use of the EAP should not, however, protect workers from the consequences of their poor job performance.

The second component of the program involves troubled employees who seek assistance or are identified as having work performance problems. The EAP provides an assessment of whether a substance abuse or other behavioral or medical problem exists, or whether the performance problem stems from work conditions.

The third component is the process of referring clients to appropriate services to address their problems. These services can include inpatient treatment, outpatient treatment, counseling, legal advice, or other services in the community that are potentially rehabilitative for the clients' situations, and in many cases they can also include short-term counseling by the EAP staff.

The fourth and perhaps most important component of the EAP process is follow-up, which occurs in three stages. The first stage entails follow-up by the EAP counselor with the client and the treatment agency during the treatment process. The second stage, also carried out by the EAP counselor, occurs when the client returns to work, during the early part of the posttreatment period. This service is designed to help the client begin a successful recovery period (Foote and Erfurt, 1988, 1991b). The third and final stage of follow-up involves monitoring of the client's recovery over a longer period of time and includes periodic counseling and assistance in helping the client prevent relapse. This can be done by the EAP counselor or by a counselor working in the wellness program.

Worksite Wellness Programs

WWPs are even more common than EAPs. Almost two-thirds of all companies with fifty or more employees offer such activities (Fielding and Piserchia, 1989). However, most of these activities are fragmented, episodic, and uncoordinated, in contrast to EAPs, for which a consistent set of program ingredients can be observed (Roman and Blum, 1988).

Research examining the effectiveness of various worksite wellness models has identified a set of integrated components that make up a comprehensive WWP (Erfurt, Foote, Heirich, and Gregg, 1990; Gregg, Foote, Erfurt, and Heirich, 1990; Erfurt, Foote, and Heirich, 1991; Heirich, Konopka, Erfurt, and Foote, 1989). WWPs have four basic components: wellness screening, treatment and health improvement programs, follow-up counseling, and worksite organization.

The first component involves screening of the entire target work force for various health risks, including high blood pressure, elevated cholesterol, smoking, obesity, lack of physical exercise, and high levels of stress

(Erfurt, Powell, Foote, and Heirich, 1992; Erfurt, Foote, Heirich, and Brock, 1993). This process is carried out at the worksite on a one-to-one basis so that the professional screener can summarize for the client all of his or her health risks and provide appropriate counseling and recommendations.

The screening process sets the stage for the second component, specific health improvement interventions. Employees found to have elevated blood pressure or cholesterol levels are referred by the screener to their physicians in the community for further evaluation, diagnosis, and possible treatment and are also encouraged to sign up for nutritional counseling or exercise programs, as appropriate, to assist in reducing the elevated blood pressure or cholesterol. Employees with other health risks such as obesity and smoking are invited to sign up for health improvement programs for their respective risks, and exercise and stress management programs are offered to all employees. Health improvement programs are provided at the worksite whenever possible, usually on the employees' own time.

Screening also sets the stage for the third component of the wellness program, regular follow-up counseling with employees who are found to have health risks. Employees with health risks are enrolled in the follow-up caseload and contacted about every six months for wellness counseling and monitoring. Very well staffed WWPs may routinely contact and monitor *all* employees, including those with no identified health risks (Erfurt and Holtyn, 1991). One program found that employees with no identified health risks became even healthier as a result of this follow-up counseling. Holtyn (1990) refers to this process as "health proofing" the work force.

Follow-up counseling activities commence after screening has been completed, beginning with those at highest risk. In order to ensure a 90 percent or higher rate of participation in follow-up, the process should include multiple strategies for implementation (see Gregg, Foote, Erfurt, and Heirich, 1990).

There are four major purposes of follow-up counseling: to ensure that employees reach appropriate treatment and health improvement programs, to help employees reduce or control their health risks, to reduce relapse and ensure that the employees' health risks stay reduced or controlled, and to prevent treatment and program dropout. The follow-up system powers the WWP. It moves people into health improvement interventions, and it supports them in making and sustaining health-related behavioral changes. This is what makes the WWP both effective and cost-effective. Follow-up is ongoing; employees in the follow-up caseload should be encouraged to continue seeing the wellness counselor throughout their careers with the company. When follow-up is discontinued, relapse to previous risk levels is common (Erfurt and Foote, 1990).

The fourth component of the WWP is worksite organization, which begins before screening is implemented and is developed gradually as

screening, health improvement programs, and follow-up counseling are launched, building on each of these activities (Heirich and others, 1989). Worksite organization begins with the formation of a worksite wellness committee, which facilitates the promotion and marketing of the WWP to all employee groups. The committee and wellness staff develop support for health improvements, organize worksitewide events around specific health issues, and attend to organizational policies, procedures, and services that can be altered to further encourage and promote good health.

Costs of Preventive Health Care

The cost of a typical EAP or WWP is quite low in relation to the things it can accomplish. The overall cost for all of the activities described above is $150 to $180 per employee per year (about $100 to $120 for WWP activities and $50 to $60 for EAP activities). This cost is extremely low when compared to the cost of treating illnesses that the program is designed to prevent.

For every dollar invested in an effective EAP, the employer may receive up to three-and-one-half times that amount in return after one or two years as a result of reduced health care claims, with the payback continuing as long as the program remains effective (Foote and Erfurt, 1990). And for every dollar invested in an effective WWP, the employer receives up to three times that amount in return after four to five years of sustained programming, which again should continue to accrue in subsequent years if the program remains effective (Gibbs, Mulvaney, Henes, and Reed, 1985; Bertera, 1990; Foote and Erfurt, 1991a).

Implementation of Preventive Health Care Programs in Family Businesses

Some types of worksites are more likely to adopt and implement preventive health care programs than are others. Companies with high turnover or a young work force may decide that their employees will not benefit from such programs. Worksites that offer minimal or no health benefits are unlikely to offer effective prevention programs. On the other hand, worksites in which management has had direct experience with heart attacks, strokes, or other preventable diseases are more likely to offer effective prevention services, regardless of whether the firms are family-owned. The owners and managers can create corporate cultures that strongly support healthy lifestyles. When the family that owns a business is sensitive to the personal as well as the fiscal costs of preventable illness, it is more likely to translate this awareness into company policies that support good health.

Readiness to implement a prevention program is also affected by the availability of resources. Although an effective program should ultimately pay for itself by reducing health care costs, this reduction is not immediate,

and funds must be found to support the program until the reduction in costs is evident. Even then, it is often difficult to directly trace the cost reduction (or reduction in the rate of cost increases) to a prevention program.

Firms vary in their willingness to realign budgets to support prevention. Again, however, this variation exists across family-owned as well as non-family-owned firms. In considering how family ownership may affect implementation of preventive health care programs, we identified two possibilities. First, family businesses may have simpler decision-making structures, although this may be true primarily of smaller businesses, reflecting size rather than ownership per se. Second, to the extent that family businesses tend to be smaller than other companies, there are implementation factors that are directly affected by size.

Smaller businesses tend to have more of a family orientation and a team spirit and can be more swift and flexible in dealing with innovation (Toffler, 1990). They also tend to value human capital as a resource and to respect the individual employee (Bezold, Carlson, and Peck, 1986). These generalizations do not necessarily apply to every small business, and they also characterize some large businesses. Nevertheless, taken together, they describe the kind of work setting that may be more open to preventive health care programs for employees.

Implementation of health care programs in small businesses is easier than in large worksites because access to workers is typically easier. Services center on one-to-one counseling, which can be conducted over the telephone when necessary, and guided self-help with regular follow-up contacts every few months. Small businesses realize that formal behavior modification classes are not realistic when there are only small numbers of employees, so they rely more on guided self-help programs, one-to-one counseling, and user-friendly videos, audiotapes, newsletters, computer software, and take-home kits.

Because of the smaller numbers of people, it is easier to communicate and implement programs in small businesses, and significant results can be seen in as little as three months. In addition, in small worksites a supportive culture can develop more rapidly than is possible in large companies.

More small businesses are self-insuring. Businesses that use community-rated insurance policies do not receive the benefits of reduced utilization when their employees get healthier, but they receive these benefits if they are self-insured or experience-rated.

Most small businesses are not in a position to hire professional staff to run health programs, and they need to contract for these services. However, some small businesses are forming coalitions that allow them to hire staff or purchase services for larger numbers of employees. Some are also incorporating spouses and dependents into programs.

Whether staff are hired through a coalition of businesses, or whether businesses contract with local service providers, they need to be sophisti-

cated buyers of preventive health care services. The businesses must either specify the nature and quality of services to be provided, following models that have been shown to produce long-term health improvement, or else demand to see evidence that the services suggested by potential providers reduce health risks.

Many services are available at much less than the $150 per person per year for the EAP and WWP described earlier here. Before buying such services, a business should demand to see evidence that these cheaper programs work to reduce (1) risk factors related to premature morbidity and mortality, (2) relapse and recurrence over time in these health risks, and (3) subsequent morbidity, mortality, and consequent excess health care claims that result from uncontrolled health risks. If these cheaper programs cannot present such evidence, then they are probably not preventive health care systems and will in the long run be more expensive.

A better alternative to reviewing the array of disparate services offered in the marketplace and trying to choose among them is for the family business to outline its program requirements, including, where possible, all of the components described above, and ask providers to provide bids for those services. In this way, the company retains control over what services will be provided.

A successful voluntary preventive health care program in a small business will achieve participation of 75 to 100 percent of the employees, including the majority of the people with health risks, for one or more years. It will show 50 to 100 percent reduction in identified health risks within six months to one year, with those reductions maintained over time.

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