Worker Well-being and High Performance Workplaces
Two Sides of the Same Coin

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This conference is all about worker wellbeing because it is important for healthier, happier and longer working lives. We've already heard from a variety of presenters around their efforts to define, study and improve worker wellbeing. Today I'll be focusing on a set of work-related outcomes that tie worker wellbeing to workplace performance. Worker wellbeing should be of interest to a variety of stakeholders and key decision-makers including workers, employers and policymakers. While their perspectives may vary, they all could benefit from sound evidence around the relationships between work and health.

First, I'll start by reviewing definitions of worker wellbeing since there are a variety of ways to define and measure the concept.

I'll then connect the concept to what it means to be a high performance workplace and how that concept can be measured.

I'll reflect on the importance of a systems perspective for understanding how the parts are related to each other and the key value of acknowledging the multidirectional relationships. Health affects work just as work affects health and these relationships exist in a context that must be measured, not ignored, if we are to make progress on improving worker wellbeing.

Finally, I discuss implications for both research and practice.

1.

Worker Well-being

What do we mean when we say worker wellbeing? We've already seen several definitions but I think we might all agree that at a conceptual level we mean healthier and happier workers that are able to be productive members of the workforce as long as desired. I realize even that statement can be contested, so let's break it down starting with what we know about the work-health relationship.

In February 2017, IBI and some of its members sponsored a special issue of Health Affairs on the work/health relationship with policy briefings in Wash DC and San Francisco. I highly recommend this special issue as an excellent reference on the evidence base as it covers about a dozen papers and a range of topics on how work and health are interconnected.

We are continuing to follow-up with the authors of these papers to highlight their work in ways that resonate with a variety of audiences, not just researchers. This translational work includes a series of briefs; the first one spotlights organizational culture and climate. On the topic of organizational culture we also sponsored a Twitter Chat on David Rehkopf's (Stanford physician researcher) paper appearing in this special issue that highlights the connections between the work environment and hypertension. The five topical areas summarized for the series based on the special issue include:

1. Prevention and wellness
2. Supportive health intervention
3. Supportive work intervention
4. Organizational culture and climate
5. Public policy

Our paper in the Health Affairs special issue focused on the importance of physical and cognitive job demands on productivity as measured by the outcomes -- absence and presenteeism. Presenteeism occurs when an individual attends work while ill or injured. In this paper we examined the influence of workplace safety and employee health in relation to job demands across approximately 17,000 employees working for 314 large, midsize and small businesses in Colorado. These data come from the Pinnacol Assurance study, launched by the workers' compensation carrier to focus on how they might influence injury events by better understanding the connection between WC claims and non-occupational injuries and illnesses. As part of these efforts a health risk appraisal including health and work outcomes information was administered to the employees who participated in the worksite wellness program offered by the WC carrier.

We found that both workplace safety and employees' chronic health conditions contributed to absenteeism and job performance, but their impact was influenced by the physical and cognitive difficulty of the job. If employers want to reduce health-related productivity losses, they should take an integrated approach to mitigate job-related injuries, promote employee health and improve the fit between a worker's duties and abilities.

Further analyses with these data around work stress and variation in outcomes across setting suggest the importance of workplace factors and the potential for context redesign to influence work-related outcomes.

Source: Jinnett, K, *Employee Wellbeing for Better Business Results - Connecting Wellbeing to Business Performance: An Integrated Approach.* November 2016. IBI Report.

How might these employee workplace outcomes such as absence and presenteeism be related to both workplace culture of health and operational & business outcomes?
In a recent IBI publication we outlined those connections in "Employee Wellbeing for Better Business Results – Connecting Wellbeing to Business Performance: An Integrated Approach."

In this report we draw upon a current review of wellbeing measurement instruments and reflect on the various ways in which wellbeing is conceptualized and metrics developed around it. Wellbeing can be measured subjectively or objectively and different academic disciplines (economist, sociologist, psychologist) often spar with each other on whether feeling happy with your living environment, for example, is *better, the same as, or worse* than living in a neighborhood with a lot of broken windows. Of course, the correlation between a subjective measure like feeling happy and an objective measure like the number of broken windows in a neighborhood is high and there are other such examples of questions and observational items that show correspondence with each other and with outcomes of individual and societal importance such as worker health and productivity.

In addition to how an item might be measured, there are various dimensions of wellbeing that can be rolled-up into a global wellbeing measure. In this report we outline examples of how five dimensions of wellbeing -- financial, mental, physical, social, spiritual – might be reflected in subjective & objective questions. While global measures of wellbeing are important for comparing groups, cities, countries in aggregate, the item level detail is required over time by researchers to understand what factors account for the greatest differences in outcomes between groups over time. In this way new policies, practices and work designs can be developed and measures refined to support wellbeing improvement across groups in ways that are equitable and impactful.

2.

High Performance Workplace

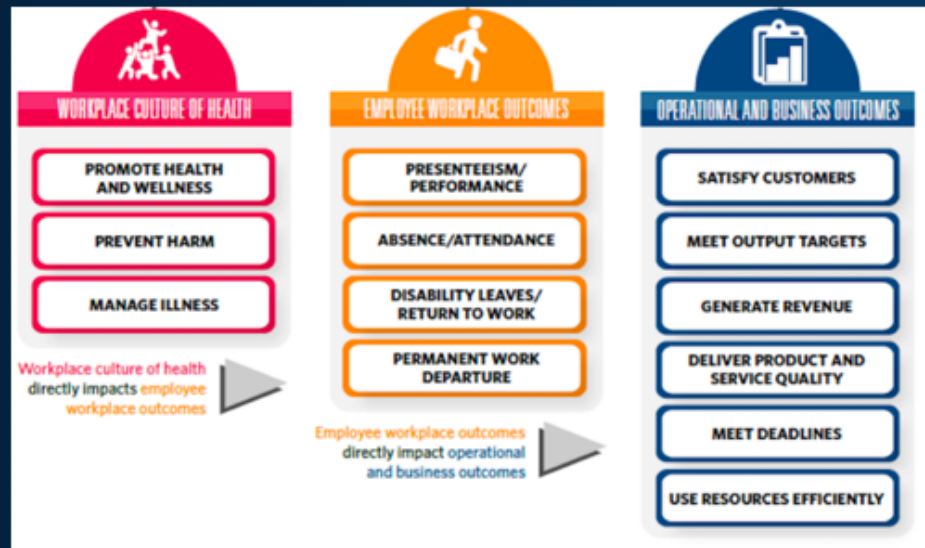How can we better connect the work in wellbeing measurement and practice to the measurement and evidence base on high performance workplaces? To do so, we'll need to deeply understand what matters to both employees and employers when it comes to performance. What is required for employees to do their best work and how do employers measure high performance and productivity?

Source: Jinnett, K, *Employee Wellbeing for Better Business Results - Connecting Wellbeing to Business Performance: An Integrated Approach.* November 2016. IBI Report.

So, let's take a look at what leads to high performance. This is a deep dive on the diagram I showed earlier from the *Wellbeing for Better Business Results* publication. Here we outline the dimensions of workplace culture that directly impact employee outcomes, followed by how those employee outcomes affect operational and business outcomes of interest to employers.

Often times, particularly as organizations get larger, those tasked with improving and managing employee health work in relative isolation from each other; in siloed departments that might not communicate well with each other, share resources or know about potential duplication of efforts or important gaps needing attention. Here we identify three such functional areas in an organization that might be siloed, but there can be more and they can go by different names in any individual organization.

Typically there are at least three departments engaged in the following activities: 1) promote health and wellness, 2) prevent harm and 3) manage illness. Health promotion and wellness activities typically involves a health risk appraisal, biometric screening, perhaps even an onsite clinic and might include involvement of a chief medical officer based on the company's size and industry. Preventing harm often involves safety and workers' comp professionals' efforts to reduce hazards in the workplace that can cause or exacerbate injury or illness. While most attention has been paid to physical harms there is increasing attention to psychosocial harms in the workplace. Finally, activities directed at managing illness include disease management efforts, development of high quality provider networks and access to effective treatments. These efforts are aimed at worker health and current evidence closely ties employee health to the employee workplace outcomes of presenteeism/performance, absence/attendance, disability leaves/return to work and permanent work departure. Research further demonstrates that operational managers know the effect on key business metrics when workers are absent or performing poorly. Let's take a deeper look at these inter-related influences.

Improving Workforce Performance in a Changing Work Climate
The Impact of Health on Job Performance and Productivity
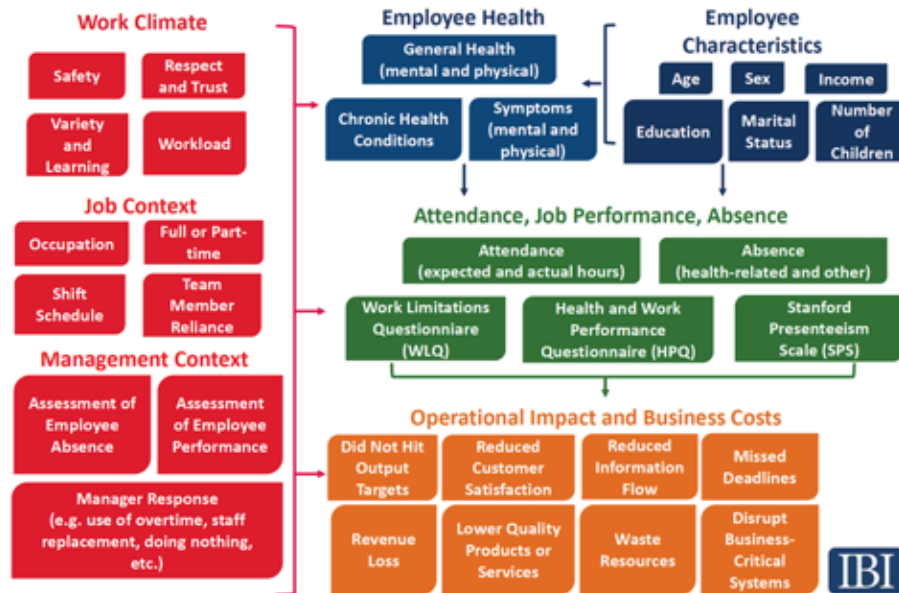
Source: Jinnett, K, *Human Capital Investment for Better Business Results: Connecting Work Climate, Employee Health and Job-Related Outcomes.* July 2015. IBI Report.

We have a current study with open recruitment that is exploring the inter-relationships between these dimensions. For each employer involved in the study we work closely with the human resources department or relevant unit around the structure and function of their organization. We identify the main departmental units by function and select a diverse sample of functional units. For those units, we sample managers and their direct reports and field a secure online survey to both the managers and the employees. This is an IRB-approved study. Information around the sites involved and managers & employees participating is confidential and only known to the research team. Thus far we have two sites completed, a health system and a county. We have produced two IBI reports using these data and continue to recruit employers interested in participating.

The employee survey obtains information on the employee's health status including chronic conditions and symptoms. We have often found that an individual might have a diagnosis of a condition but if their symptoms are under control the ill effects of that condition on work outcomes is non-significant. Socio-demographic variables associated with health and work such as age, education, marital status are also collected. The employee is asked to report on their attendance, job performance and absence over a short recall period. Employees are also asked about their assessment of work climate using the General Social Survey quality of work life questions. These items collapse into four areas: safety, respect and trust, variety and learning and workload. Research demonstrates that strong safety environments with high respect and trust, opportunities for variety and learning and reasonable workloads are associated with better worker attendance, higher job performance and less turnover.

Managers are asked to reflect on the employee's attendance and performance record and how it affects operations and business costs. We also ask about how the manager responds to these work disruptions.

Work climate exacerbates the effect of health symptoms on absence and performance
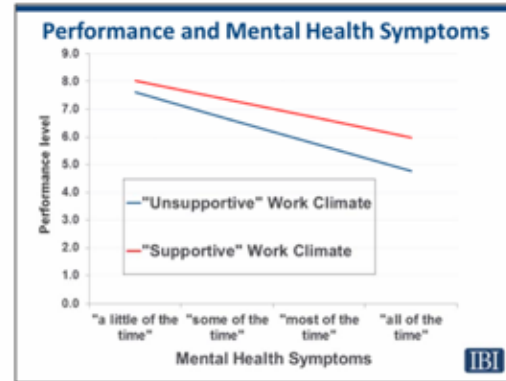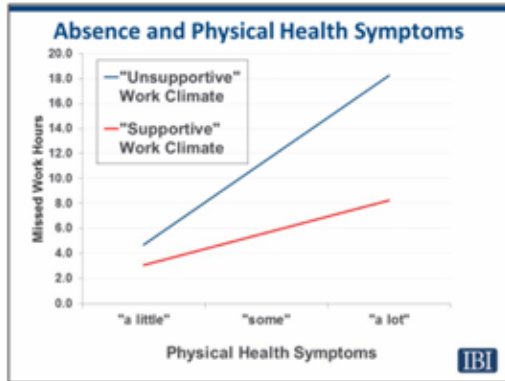
Source: Jinnett, K, *Human Capital Investment for Better Business Results: Connecting Work Climate, Employee Health and Job-Related Outcomes*. July 2015. IBI Report.

For one of the two IBI reports we have completed to date with these data we find that work climate exacerbates the effect of health symptoms on absence and performance. Based on employees responses to the work climate questions around safety, trust, learning and workload, we classified the work environment of a department as having a supportive or unsupportive work climate. We assessed the extent to which individual's experiencing different levels of physical and mental health symptoms fare better or worse in terms of absence and job performance outcomes in these different work climates. As expected, when symptoms get worse, absence increases and performance declines, but these effects are exacerbated when individuals are in unsupportive work climates. That's why we see the separation of the lines or different slopes for those lines in these graphs. The relationship between symptoms and work outcomes is more pronounced in unsupportive work climates than supportive ones. Using methods that allow us to see these differential effects will help us address equity issues around differences in health and wellbeing by group in addition to overall levels of wellbeing.

Practically, these findings imply that returning an individual to an unsupportive work climate undercuts investments made in employee health improvement and treatment access. Context design efforts must be considered as the work environment has real and measurable effects on employee's health and work outcomes.

3.
Systems Perspective
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We must take a systems perspective and move away from relying too heavily on measures that are easily available because this perpetuates the over reliance on outcomes we are currently observing to the exclusion of outcomes we should be observing. What this means, practically, is that we must move beyond measuring only claims or utilization data because these data represent current benefitted users of the system. We must explore whole populations of workers and do so over time.

Unfortunately, those charged with making employee health investment decisions for a workplace are most often asked to reduce health care costs. The easiest way to do so is to not measure anything beyond costs to the employer. By shifting costs to the worker and not measuring anything beyond cost to the employer, a rapid cost reduction can be demonstrated in the near-term. But, if health outcomes are measured across the population of workers, such a strategy would reveal treatment access problems among the workers and a logically related health decline over time.

Since research and evidence strongly connects health to work-related outcomes like absence, job performance and work disability, employers ought to pay more attention to worker health, not simply health claims costs. Connecting the disparate departmental siloes and bringing together the health promotion, safety and disease management functions either in conversation or structurally are fruitful ways for an organization to develop a systemic population-based perspective to employee health and wellbeing improvement for better business results.
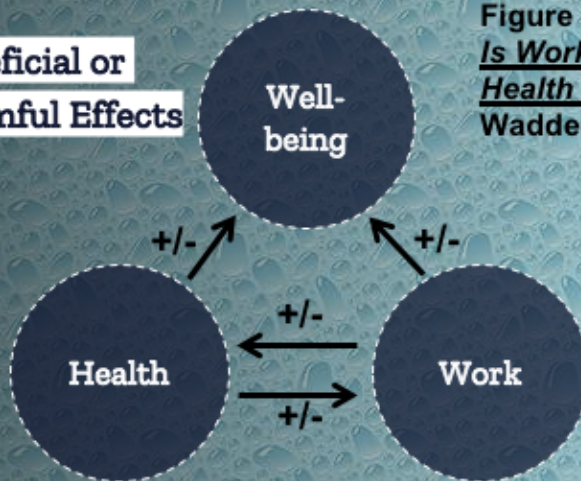
Over ten years ago, in 2006, the UK Department for Work and Pensions commissioned an independent review of the scientific evidence on whether work is good for health and well-being. It has been well-known and documented that long-term worklessness is harmful to physical and mental health. This review sought to better understand when, how and under what circumstances work might be beneficial to health.

The review focused on adults of working age and the three health conditions that account for two-thirds of work disruption (sickness absence, work disability or long-term departure from the workforce): mild/moderate mental health, musculoskeletal and cardio-respiratory conditions.

They found that there was a lot of evidence on both the effects of health on work and work on health. On the whole, work is generally good for employee health and wellbeing, but the nature and quality of work and the context of work can negatively affect overall health and wellbeing. Importantly, the work must be "good" work.

Whether an employee is healthy, contemplating employer accommodations so they may stay at work or return to work after a work disability, attention to context design and the nature of the work itself may play a big role in whether that employee's health and wellbeing improves or declines over time.
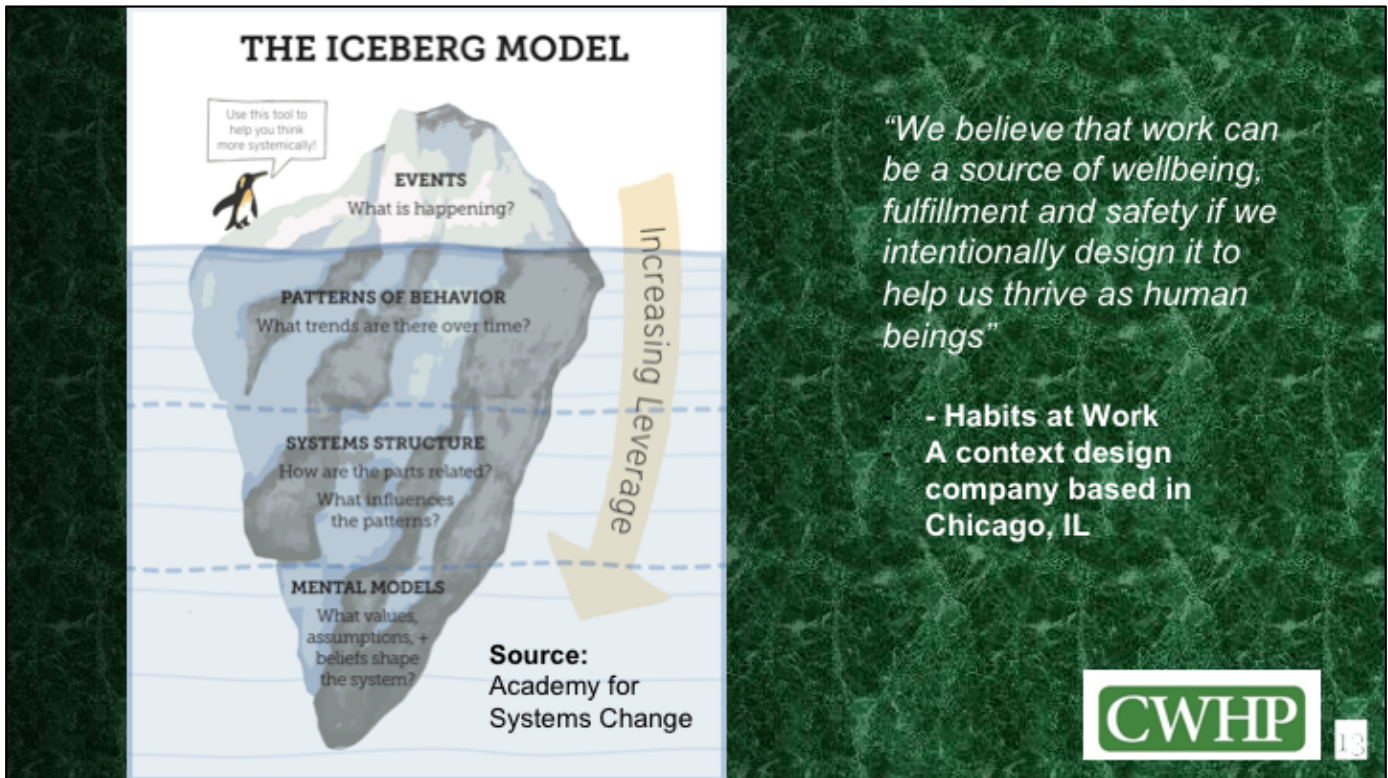
At the conference we will hear from many speakers about the value of context design. We are currently involved in a qualitative study with a context design company based in Chicago, IL, Habits at Work. We are following three employers that participated in a *context design for wellbeing* workshop to assess the challenges and opportunities they face in taking what they learned at the workshop and trying to implement these lessons in their respective companies.

Context design demands a systems perspective. Often times these types of trainings start with the easily visible behavior that is a target of change efforts, the tip of the iceberg. Given enough time, this was a 2-day workshop, the participants begin to discuss behavioral patterns across their organization, they compare notes with each other and present their ideas, they challenge each other and dig deeper. They begin to share thoughts around why these behaviors exist and what might explain these patterns that could be influenced by the employer. They begin to understand that an overweight problem in the office might be influenced by the sedentary nature of the work and the example set by senior leaders to eat lunch at their desk and be heads-down in work all day. They begin to see that the deepest part of the iceberg reveals these assumptions and beliefs around what it means to be a hard worker and move-up in the organization and that if those ideals aren't changed, very little of the attention paid to changing the surface behaviors will result in any lasting improvement.

4.

**Implications for Research & Practice**

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Tackling these assumptions and beliefs may feel beyond the scope of both researchers and practitioners but we must challenge ourselves to dig deeper else the improvements we seek to achieve will never be realized. By working together, research can inform practice and practice can inform research.

Of course, a fallback option is to allow the system to play-out as currently set up. So we wait until someone develops a chronic disease or until an injury occurs and we try to apply the best strategies available to allow that person to either stay at work or return to work in a healthy and productive fashion. This is pretty much the way we operate now. It means we spend a good deal of time on disease management efforts and less on prevention. The exception might be in the safety realm where policies and practices demand compliance with incident prevention efforts. There remain physically hazardous jobs and work places and such efforts must continue and be ramped-up in some cases, but on the whole, there have been great improvements achieved on reducing workplace accidents and injuries. Psycho-socially hazardous workplaces are receiving more attention as researchers investigate the effects of work stress on safety incidents and the development or exacerbation of chronic conditions. Drawing-upon strategies used to curb physically hazardous work environments, we can apply lessons to address reduction in psycho-social hazards that may exist in the workplace. We need to focus our attention on prevention and treatment, not one at the exclusion of the other. And, as this presentation has sought to demonstrate, we need to understand how the various disparate perspectives we have as *employers, employees, clinicians, policymakers and researchers* can be brought into connection with each other and reflect on the overall context in which we work and live.

"High-deductible health plans are often just risk/cost shifting to employees with the likelihood that employees will become less compliant with evidence-based care"

- Richard Feifer, MD

Source: Parry, T. and Jinnett, K. *The Employer's Role in Using Research-Based Healthcare Evidence.* **May 2018. CWHP Report.**

THE EMPLOYER'S ROLE IN USING RESEARCH-BASED HEALTHCARE EVIDENCE
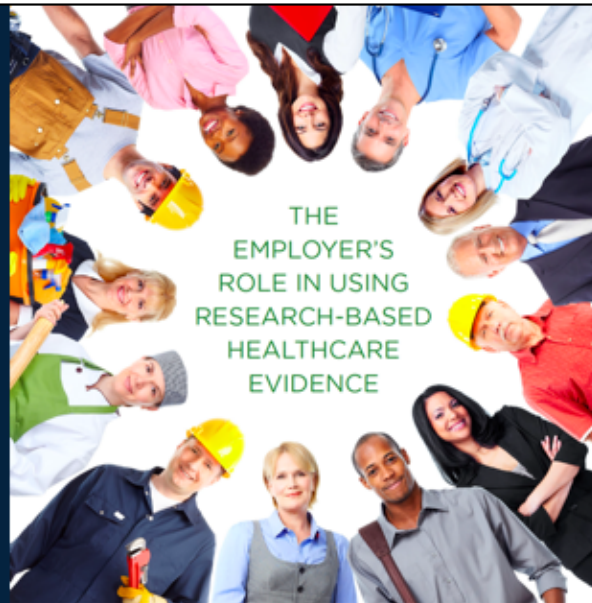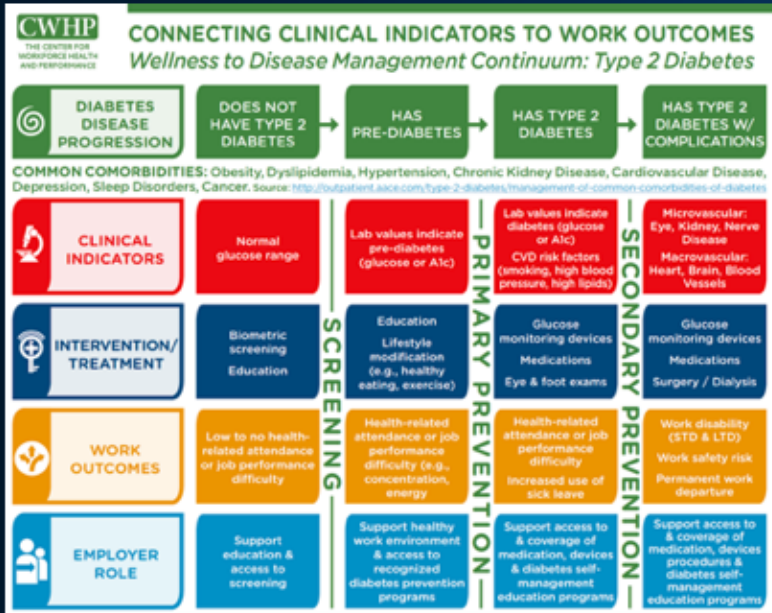
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Part of the series Patient-Centered Outcomes Research (PCOR) Dissemination at Work: How Employers Use Evidence to Make Employee Health Investment Decisions

Part of the Series: *Patient-Centered Outcomes Research (PCOR) Dissemination at Work: How Employers Use Evidence to Make Employee Health Investment Decisions,* partially funded through a Patient-Centered Outcomes Research Institute (PCORI) Eugene Washington PCORI Engagement Award (#2970-CWHP).

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One of our current research efforts funded by PCORI relies on qualitative interviews, expert panels and literature reviews to connect clinicians' perspectives to outcomes of relevance to employees and employers. A series of a dozen interviews with senior corporate leaders across a variety of industry types reveals a difficult challenge for those charged with improving employee health in their respective companies. Often, there is a heightened focus on health care cost reduction without due attention to work-related outcomes such as absence, performance deficits and periods of work disability. The leaders interviewed understand that preventive and contextual factors may be critical for the long-term health and wellbeing improvement of workers but sometimes meet with resistance in their organizations. Successful efforts at these employer organizations include breaking-down siloes to help human resource officers, safety managers and health promotions staff better connect with each other and operational managers and hold themselves accountable for outcomes beyond health care cost reduction.

Also part of the PCORI project are a series of frameworks built upon expert panel feedback involving clinicians and disability management practitioners and literature reviews of the existing evidence that associates chronic conditions to work–related outcomes. We connect the perspectives of clinicians and clinician researchers with employers and employees and those working in the stay-at-work and return-to-work field. Reports related to this project will be released over the coming months along with opportunities to engage in webinars and meetings.

We surveyed our assembled clinical and disability management experts around the most prevalent chronic conditions in the U.S. workforce for which there was a known effective treatment and for which, if treated, we would expect work-related outcomes -- *such as absence, performance and work disability* -- to improve. The panel chose the following five groups to study: diabetes, depression, cancer, pain and multimorbidity. These last two – pain and multimorbidity – represent features that cross conditions. Here we show the diabetes framework that connects clinical indicators to work outcomes for Diabetes. We will further develop the employer role to incorporate work context changes in addition to the treatment and behavioral changes already noted. We also welcome feedback as we see these frameworks as living documents that should change as the evidence does.
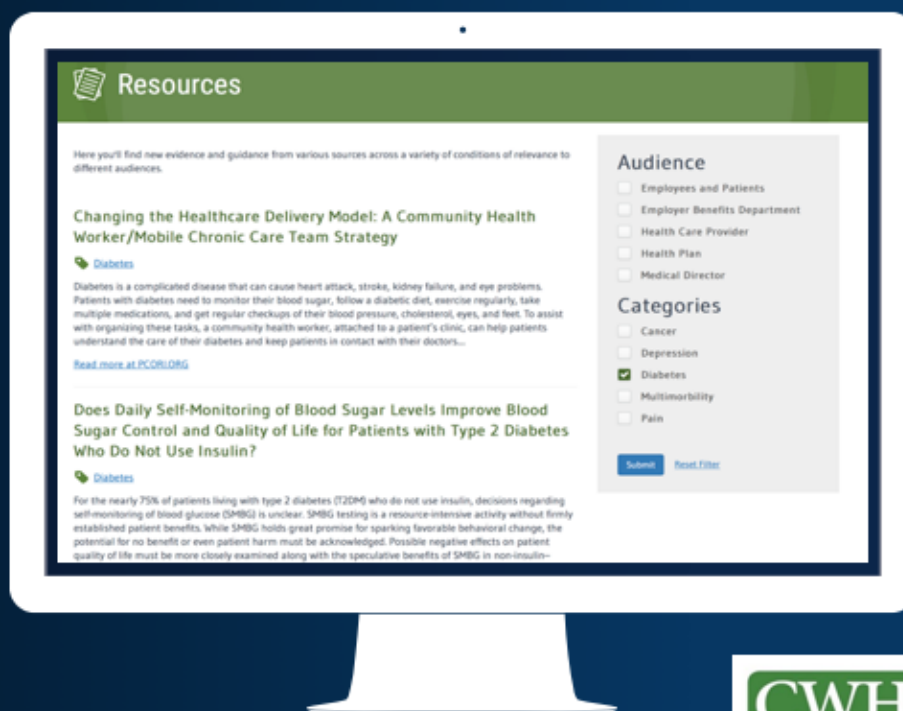
Across these five conditions we are tailoring searchable evidence to different audience interests. We will launch a portion of our website that connects employees/patients, medical directors, and other groups to evidence of relevance to them. We will be launching and further refining this tool over the next several months and welcome review and suggestions of relevant materials for posting.

Any Questions?
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