INTEGRATION OF HEALTH PROTECTION AND HEALTH PROMOTION

Jeanne P. Sherwood RN, CWWS
Kerre E. Aufsesser CWWM, CWWS

GOALS AND OBJECTIVES

- Integration of safety and health with evidence-based health promotion: A Best Practice Approach
- Assessing Population Health
- Making the Business Case and Evaluation
- Implementation: Steps to Rolling Out an Integrated Program

INTEGRATING HEALTH PROTECTION AND HEALTH PROMOTION

A Best Practice Approach
THE INTEGRATED PROGRAM

- Strategy integrating occupational safety and health protection with health promotion to
  - Prevent worker injury and illness; and
  - Advance health and well-being
- A holistic framework for enhancing the safety and health of the workforce population.

HEALTH, SAFETY AND PRODUCTIVITY MANAGEMENT APPROACH

- Individual Programs
- One Holistic Program

IN PRACTICE EXAMPLE

- Wellness: Health promotion professionals who want to reduce musculoskeletal disease can be more effective if they address the role that organization of work plays.
- Safety: Programs directed at maintaining or achieving zero injury rate can be more effective if they can improve the health of the workforce.
INTEGRATED STRATEGY

- A strategic and coordinated approach;
  - Enhances the safety & health of the population
  - Reduces costs
  - Achieves common goals
  - Improves engagement

“An integrated strategy leverages the best of both, targeting organizations to bring about collective behavior change, ensuring that the work organization and environment facilitates health. It applies the hierarchy of controls to health conditions, starting with prevention at the organizational level.” – NIOSH Total Worker Health™

INTEGRATION OF HEALTH PROTECTION AND HEALTH PROMOTION

Importance and Benefits of Integration

BENEFITS TO WELLNESS & SAFETY

- Removing the “silos” of accountability
  - Wellness and safety – parallel pathways
  - Impact of adverse health effects

- Proven benefits to Employers & Employees
  - Retention rates
  - Reduced costs
  - Reduced turnover
  - Fewer disability claims
  - Increased output

**BENEFITS TO ORGANIZATION**

- Broader work organization and issues have been proven to benefit from an integrated strategy.
- Increased trust and observed commitment to safety and health lead to reciprocal benefits such as improved morale and employee retention.
- Additionally, research shows increased participation and effectiveness for high-risk workers.

**VALUE OF THE INVESTMENT (VOI)**

- The reasons for integration provide a balance between:
  - The “business case” for integrated programs—focusing on potential cost savings and productivity gains for an organization, market place benefits; and
  - The “worker case” for integrated programs—focusing on clear benefits as well as the intangible benefits for workers as a result of a holistic approach to worker health.

- Paving the way for the approach to Total Worker Health™
  - Innovative NIOSH project addressing all aspects of workplace health.

**ASSESSING POPULATION HEALTH**

- [Image of infographic]

- [Image of infographic]
RATIONALE

- Individuals with health risks have a higher risk for on and off-the-job injury

<table>
<thead>
<tr>
<th>Health Risk Prevalence</th>
<th>Safety &amp; Environmental Risk</th>
</tr>
</thead>
</table>

RISK RELATIONSHIP

- Workers' Risk of Disease is increased by exposures to both occupational hazards and risk-related behaviors

- The workers at highest risk for exposure to hazardous working conditions are also those most likely to engage in risk-related health behaviors

TARGETING HEALTH RISKS

<table>
<thead>
<tr>
<th>Health Risk Measure</th>
<th>High Risk Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>Systolic ≥140 mmHg or Diastolic ≥90 mmHg</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index ≥30.0 (35.0 or greater = obese)</td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td>≥240 mg/dl</td>
</tr>
<tr>
<td>HDL</td>
<td>Less than 40 mg/dl</td>
</tr>
<tr>
<td>Glucose</td>
<td>≥200mg/dl non-fasting, &gt;126mg/dl fasting</td>
</tr>
<tr>
<td>Waist Circumference</td>
<td>Men &gt;40” Women &gt;35”</td>
</tr>
<tr>
<td>Alcohol</td>
<td>More than 14 drinks per week</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Less than optimum nutritional value/habits</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Less than one time per week</td>
</tr>
<tr>
<td>Safety</td>
<td>i.e. using a safety belt less than 100% of the time</td>
</tr>
<tr>
<td>Smoking</td>
<td>Current Smoker</td>
</tr>
<tr>
<td>Stress</td>
<td>High</td>
</tr>
</tbody>
</table>

HEALTH RISKS BY ASSESSMENT

Percentages based on number with risk compared to the actual number of participants who completed the specific screening.

2013 to 2014 Matched Group
Biometric + HRA Risks – 1418 Participants

<table>
<thead>
<tr>
<th>Number of Risks</th>
<th>2013 Participants</th>
<th>2014 Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>392</td>
<td>411</td>
</tr>
<tr>
<td>1</td>
<td>297</td>
<td>308</td>
</tr>
<tr>
<td>2</td>
<td>301</td>
<td>295</td>
</tr>
<tr>
<td>Low Risk</td>
<td>960 with 880 risks 70%</td>
<td>1014 with 858 risks 72%</td>
</tr>
<tr>
<td>3</td>
<td>219</td>
<td>219</td>
</tr>
<tr>
<td>4</td>
<td>118</td>
<td>118</td>
</tr>
<tr>
<td>Medium Risk</td>
<td>342 with 1158 risks 24%</td>
<td>327 with 1129 risks 23%</td>
</tr>
<tr>
<td>5</td>
<td>45</td>
<td>47</td>
</tr>
<tr>
<td>High Risk</td>
<td>81 with 650 risks 6%</td>
<td>57 with 364 risks 5%</td>
</tr>
<tr>
<td>Total Risks</td>
<td>1418 with 2525 risks</td>
<td>1418 with 2391 risks</td>
</tr>
</tbody>
</table>

Decrease of 134 risks, or 5%
### 2012 to 2014 Matched Group
**Biometric + HRA Risks - 1195 Participants**

<table>
<thead>
<tr>
<th>Number of Risks</th>
<th>2012 No. of Quants</th>
<th>2013 No. of Quants</th>
<th>2014 No. of Quants</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>332</td>
<td>337</td>
<td>362</td>
</tr>
<tr>
<td>1</td>
<td>252</td>
<td>266</td>
<td>261</td>
</tr>
<tr>
<td>2</td>
<td>250</td>
<td>251</td>
<td>252</td>
</tr>
<tr>
<td>Low Risk</td>
<td>852 with 752 risks</td>
<td>854 with 766 risks</td>
<td>873 with 765 risks</td>
</tr>
<tr>
<td>3</td>
<td>227</td>
<td>227</td>
<td>242</td>
</tr>
<tr>
<td>4</td>
<td>113</td>
<td>101</td>
<td>99</td>
</tr>
<tr>
<td>Medium Risk</td>
<td>320 with 1053 risks</td>
<td>316 with 1035 risks</td>
<td>260 with 857 risks</td>
</tr>
<tr>
<td>5+</td>
<td>52</td>
<td>49</td>
<td>51</td>
</tr>
<tr>
<td>High Risk</td>
<td>53 with 283 risks</td>
<td>52 with 243 risks</td>
<td>51 with 277 risks</td>
</tr>
<tr>
<td>Total Risks</td>
<td>1195 with 2079 risks</td>
<td>1195 with 2046 risks</td>
<td>1195 with 1939 risks</td>
</tr>
</tbody>
</table>

Decrease of 32 risks from 2012 to 2013 and 107 risks from 2013 to 2014.
Decrease of 139 risks from 2012 to 2014, or 7%.

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### Risk Profile
- Essential to the success of integrated program
  - Characteristics of the Target Population
  - Environmental Risks/Exposures
  - Proportion of the population that participates and is engaged

Environmental Variations
2013 to 2014 Matched Group
Biometric + HRA Risks Shift by Location

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of Risks</th>
<th>2013 Participants</th>
<th>2014 Participants</th>
<th>Number of Risks (Reduction)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlanta Packaging Plant</td>
<td>69</td>
<td>168</td>
<td>134</td>
<td>-34</td>
<td>20.2% reduction</td>
</tr>
<tr>
<td>California Production</td>
<td>40</td>
<td>89</td>
<td>79</td>
<td>-10</td>
<td>11.2% reduction</td>
</tr>
<tr>
<td>South Bend Fabrication</td>
<td>56</td>
<td>151</td>
<td>136</td>
<td>-15</td>
<td>9.2% reduction</td>
</tr>
<tr>
<td>New Orleans Distribution</td>
<td>127</td>
<td>311</td>
<td>300</td>
<td>-11</td>
<td>3.8% reduction</td>
</tr>
<tr>
<td>Dallas Tech Plant</td>
<td>75</td>
<td>142</td>
<td>148</td>
<td>-6</td>
<td>4.2% reduction</td>
</tr>
<tr>
<td>South City Manufacturing Center</td>
<td>65</td>
<td>130</td>
<td>125</td>
<td>-5</td>
<td>3.8% reduction</td>
</tr>
<tr>
<td>South County Mill</td>
<td>58</td>
<td>118</td>
<td>116</td>
<td>-2</td>
<td>1.7% reduction</td>
</tr>
<tr>
<td>Georgia Plant</td>
<td>241</td>
<td>477</td>
<td>478</td>
<td>+1</td>
<td>0.2% increase</td>
</tr>
</tbody>
</table>

Atlanta Packaging Plant Matched Group
2013 to 2014 Biometrics + HRA – 69 Participants

<table>
<thead>
<tr>
<th>Risk</th>
<th>2013 %</th>
<th>2014 %</th>
<th>Count</th>
<th>Count</th>
<th>Shift</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waist (Circumference)</td>
<td>49</td>
<td>33</td>
<td>33</td>
<td>22</td>
<td>-12</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>38</td>
<td>28</td>
<td>28</td>
<td>19</td>
<td>-9</td>
</tr>
<tr>
<td>Exercise</td>
<td>25</td>
<td>29</td>
<td>29</td>
<td>20</td>
<td>-5</td>
</tr>
<tr>
<td>Drugs/Alcohol</td>
<td>17</td>
<td>12</td>
<td>12</td>
<td>8</td>
<td>-4</td>
</tr>
<tr>
<td>Stress</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-2</td>
</tr>
<tr>
<td>Safety</td>
<td>7</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>-2</td>
</tr>
<tr>
<td>A1C</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>-1</td>
</tr>
<tr>
<td>Nutrition</td>
<td>25</td>
<td>28</td>
<td>28</td>
<td>19</td>
<td>-1</td>
</tr>
<tr>
<td>Tobacco</td>
<td>17</td>
<td>16</td>
<td>16</td>
<td>11</td>
<td>-5</td>
</tr>
<tr>
<td>BMI</td>
<td>42</td>
<td>43</td>
<td>43</td>
<td>30</td>
<td>1</td>
</tr>
</tbody>
</table>

Reduction of 34 risks, or 20.2%
TRENDS IN POPULATION HEALTH

- Preventable disease accounts for the highest proportion of illness
- Modifiable health risk factors = disease, excess cost, poor output
- Health promotion = reduced health risk factors
- Health risk trends correlate with costs
- Best practice design and implementation leads to highest benefit

HEALTH RISKS LEAD TO DISEASE STATES

<table>
<thead>
<tr>
<th>Condition</th>
<th>Diseases/Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity (BMI ≥30)</td>
<td>Type 2 Diabetes, Stroke, Coronary Heart Disease, Arthritis, Sleep Apnea and Respiratory Problems, Some Cancers (Endometrial, Breast and Colon)</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>Coronary Heart Disease, Heart Attack, Stroke, Atherosclerosis (fatty buildups in arteries)</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Heart Attack, Stroke, Kidney Failure, Atherosclerosis (fatty buildups in arteries), Blindness</td>
</tr>
</tbody>
</table>

THE BUSINESS CASE

Why invest in occupational health wellness and safety?
BUSINESS CASE

- Integrated approaches have been shown to
  - Improve health behaviors
  - Improve employee participation in programs
  - Reduce occupational injury rates
  - Reduce absenteeism and improve presenteeism and productivity
  - Improve working conditions and morale
  - Improve health and safety programs

VALUE OF THE INVESTMENT (VOI)

- The reasons for integration provide a balance between
  - The “business case” for integrated programs—focusing on potential cost savings and productivity gains for an organization, market place benefits; and
  - The “worker case” for integrated programs—focusing on clear benefits as well as the intangible benefits for workers as a result of a holistic approach to worker health.

- Paving the way for the approach to Total Worker Health™
  - Innovative NIOSH project addressing all aspects of workplace health

TOTAL WORKER COST

- Average annual cost per employee

  Total = $34,918

- Breakdown of costs:
  - Health Plan: $10,122
  - Sick Leave: $1,757
  - Workers Comp: $773
  - Disability: $1,111
  - Presenteeism: $11,206

Note: NIOSH, 2012; National Business Group; White Paper; NIOSH (2012) data adjusted to 2010 by Mercer Employer Survey Results and by Collins’ Presenteeism study (2005) of Dow Chemical that was used for determining the presenteeism cost.
OBESITY IN THE US

Prevalence* of Self-Reported Obesity Among U.S. Adults

*Prevalence refers to self-reported obesity in 2013, and hence, estimates could not be computed in households of 2009.

ABC COMPANY
Matched Group HRA & Biometrics: 547 Screened

19% Reduction of Total Risks

<table>
<thead>
<tr>
<th>BIOMETRICS</th>
<th>2011 PARTICIPANT RISK</th>
<th>2012 PARTICIPANT RISK</th>
<th>SHIFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
<td>131</td>
<td>39</td>
<td>-92</td>
</tr>
<tr>
<td>BMI</td>
<td>376</td>
<td>338</td>
<td>-38</td>
</tr>
<tr>
<td>Waist Circumference</td>
<td>184</td>
<td>182</td>
<td>-2</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>169</td>
<td>169</td>
<td>0</td>
</tr>
<tr>
<td>HDL (good cholesterol)</td>
<td>29</td>
<td>29</td>
<td>0</td>
</tr>
<tr>
<td>Smoking</td>
<td>31</td>
<td>26</td>
<td>5</td>
</tr>
<tr>
<td>Alcohol</td>
<td>17</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>Exercise</td>
<td>42</td>
<td>127</td>
<td>+85</td>
</tr>
<tr>
<td>Total Risks</td>
<td>1101</td>
<td>888</td>
<td>-213</td>
</tr>
</tbody>
</table>

MEDICAL COSTS ASSOCIATED WITH EXCESS RISK

Medical costs per person per year:

Actual 2010 - $8,350
Projected by 2018 - $13,100

$1,500 - $3,500 in excess claims for each additional health risk factor

0=$2,400
1=$4,000
2=$5,000
3=$6,500
4=$7,800
5=$9,000
6=$10,500
7+=$11,000

SHORT TERM DISABILITY ABSENCES ARE ASSOCIATED WITH BMI

Source: Burton et al., JOEM, 1998

HEALTH CONDITIONS ARE ALSO ASSOCIATED WITH PRODUCTIVITY LOSS

*Objective measurement of productivity of telephone customer service representatives. Burton, Conti, Chen, Schultz, Edington, 1999. JOEM.

OBJECTIVE MEASURE OF PRESENTEEISM IS ASSOCIATED WITH HEALTH RISKS

*Objective measurement of productivity of telephone customer service representatives. Burton, Conti, Chen, Schultz, Edington, 1999. JOEM.
ROLLING OUT AN INTEGRATED PROGRAM
Getting in the Mindset

PROGRAM DESIGN

There is no one-size fits all, only a tailored and targeted program to all levels and groups within an organization will ultimately be effective and successful.

- Leadership
- Relevance
- Partnership
- Comprehensiveness
- Implementation
- Engagement
- Communication
- Data-Driven
- Compliance

CREATING A CULTURE OF HEALTH

INTEGRATING ALL PROGRAMS AND INITIATIVES THAT SUPPORT WORKER HEALTH

INTEGRATED HOLISTIC OPTIMIZED PROGRAM

INDIVIDUAL ENTITIES

INTEGRATED PROGRAM
CREATING A CULTURE OF HEALTH

INDICATORS FOR INTEGRATION

- Leadership Commitment
- Coordination of departmental health initiatives
- Supportive organizational policies & practices
  - Accountability and training
  - Management and employee engagement
  - Benefits & incentives to support safety and/or wellness initiatives
  - Integrated evaluation and surveillance

Sorensen et al, AJPH 2010; IOM, Integrating Employee Health 2005

CREATING A CULTURE: FOUNDATION

A synergistic relationship where the total is greater than the sum of the parts

- Disciplines are both behavioral
- Address risks to existing and potential employees
- Interventions at work can just as easily cover personal habits as they do work habits

ROLLING OUT AN INTEGRATED PROGRAM

Ensuring a Data Driven Program on the front end

"From the beginning it is important to have design elements that ensure the use of data in measuring, integrating, evaluating, and reporting program evolution and continuous improvement efforts" - Nicolaas Pronk
ANALYZE HEALTH CLAIM DATA

Report Criteria
Table of Contents
Key Statistics Medical
Demographic Medical
Provider Net. Med.
Medical Cost Sharing
Trend Analysis
Hosp. Profile Med.
Medical Catastroph.
Health Prof. Top 20 DM

- Major Cost Drivers
- Spending on Preventable injury, incidents and disease
- Emergency Care Costs

LIMITATIONS
- Not always available
- Lagging indicators what has already happened not what could happen
- Not all incidents/reportables are recorded
- High claimant data impairs ability to see what is going on on the individual claim level.

HEALTH SCREENINGS

“ Provision of onsite, comprehensive workplace screenings for work and non-work related health risks” – NIOSH’s Total Worker Health™

- Detailed look at health risk profile
  - Individual level, job types, departments and regions.
- Crucial teachable moment
  - Important to avoid risk migration & unwanted shifts.
- Data is generated in an aggregate format
  - Snap shot of the health risks of individual populations
  - Relevant foundation for targeting integrating programming
- Conduct screenings before or after meeting with leadership
  - Following initial; every year or two years to track risk shifts and project population health outcomes

DEVELOP A RISK PROFILE

- Taking claims data, health screenings and national data (if necessary)
  - % Low Risk
  - % Moderate Risk
  - % High Risk
- Focus on health risks with indirect or direct impact on occupational health risks
  - Logical areas for integration
GETTING SUPPORT & INVESTMENT

- Who needs to be convinced to adopt the integrated approach?
  - Who within the organization influences these stakeholders?
  - Stakeholders are not limited to C-Suite
    - Middle level management is the true key to success
- Get into the mindset of the stakeholders and the people that influence them
- Identify optimal project management tools

ROLLING OUT AN INTEGRATED PROGRAM

- Form A Committee
COLLABORATIVE EFFORT

Goal: align all initiatives focused on worker health to reduce duplicated efforts,
- Optimize budgets
- Utilize Limited Resources
- Amplify the impact of all programs involved
- Bringing all of these groups together is the best way to systematically;
  - Gain insight from all interested factions and
  - Assure that the program is relevant

THE COMMITTEE

THE COMMITTEE

Rolling Out an Integrated Program
Observation & Job Shadowing
GOAL OF SHADOWING

A successful integrated program is one that is tailored and targeted to the individual worker.

- Understand work life and daily activities of specific job types
  - Allow for a more targeted, relevant and effective program
- Gain insight into individuals work and home environments
- See what the reality of the program that will eventually be in place might look like
  - At the same time formulate the short term

METHODS FOR SHADOWING

- Keep it Casual
  - Observe and investigate
- Allow time for Open Dialogue
  - Gain insight into the “day to day”
  - Understand what could really work/help the individual
- Ask Open Ended Questions
  - What is preventing employees from engaging in healthy and safe behaviors

ROLLING OUT: WHERE ARE WE?

✓ Gaps in non-integrated programs are now more evident
✓ It is clear where programs have room to grow, be tweaked and be amplified through integration

A PLAN CAN NOW BE CREATED!
Developing a Comprehensive Program

ROLLING OUT AN INTEGRATED PROGRAM

Overarching Comprehensive Program
- Encompasses assessment and improvement of overall health in addition to occupational injury & prevention
- Tailored and specific stems that move across regions, locations, areas and levels
  - Get more specific & tailored as it moves
- Aligns with the World Health’s Organizations definition of health
  - "a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity"

Comprehensive: One Unified Goal
- Comprehensive program may include:
  - Job safety initiatives and efforts to create a culture of health
  - Early recognition and treatment of injury or illness;
  - Disability prevention and return to work programs;
  - Assessment of worker health status
  - Proactive response to personal health risks;
  - Emergency preparedness planning; and
  - Behavioral health and environment safety issues.

Promoting Overall Member Health and Preventing Work Place Injuries and Illnesses

NISH (2012)
UTILIZING RISK PROFILE

- Address both high and low risk
- It is critical to prevent risk migration
- Effectiveness of a comprehensive integrated program is dependent
  - Health Risk Profile
  - Relevance: a % of organization participates programming directed at these in order for a change to be made

NIOSH RISK INTEGRATION AREAS

- Respiratory protection program that simultaneously and comprehensively addresses tobacco cessation
- Integrated ergonomic consultations joint, knee, back health and arthritis
- Implementation of training and prevention programs that counter hazards and risks faced by workers both on and off the job.
- Collaboration of all departments that have health protection and health promotion goals and objectives

NIOSH (2012)

SPECIFIC AREAS FOR INTEGRATION

Protect and Promote Employee Health

- Safety Programs
  - Ergonomics
  - Musculoskeletal Anti-Fatigue
  - Industrial Hygiene
  - Respiratory and Hearing Protection
  - Personal Protective Equipment
  - Injury Prevention
  - Emergency Response & Preparedness
  - Acute Care
  - Illness Prevention and Treatment
ENGAGEMENT & COMMUNICATION

- Integration of programs themselves will to a certain level increase engagement
  - Communication regarding the program content is equally important to communicating the benefit of the content
  - Seeing the value in itself
- Incentives
  - Campaigns vary across organizations
  - Imperative to find out what resonates with individuals & what is going to motivate them

MONITORING & EVALUATION

- Tools to accurately monitor and evaluate the program.
  - Changes in health claims and risk shifts
  - Changes in productivity
- Multiple tools, adaptable to various environments and programs have been created to monitor and evaluate integrated program,
  - Public Resources (not limited to):
    - Blue Print for Health; A Frame Work for Total Cost Impact
    - Health Work and Performance Questionnaire
    - Stanford Presenteeism Scale
    - Work Productivity and Activity Impairment Questionnaire

ROLLING OUT AN INTEGRATED PROGRAM

Drivers and Steps for Success
DRIVERS FOR SUCCESS

- Workplace must be increasingly used as a setting for promotion of preventative health protection and health promotion activities
- Must be every growing and changing to adapt to its successes and failures
- Continual buy-in, support and input from all levels of stakeholders (C-Suite to Individuals)

CRUCIAL STEPS FOR SUCCESS

1. Culture of Health & Indicators For Integration
2. Understand and Address Stakeholders
3. Assess Data
4. Form a Committee
5. Job Observation “Shadowing”
6. Develop a Comprehensive Program
7. Engagement and Communication
8. Monitoring and Evaluation

CONCLUSION

- There are many “visions” of what an optimal integrated program looks like
  - Overall what is being created is a holistic and comprehensive program targeting preventative health and safety measures
  - Long lasting tangible and intangible benefits to both employers and employees
  - A Culture of Health is the new marker of a great business

“A good organization will have workers come to work every day and keep them safe at work. The best organizations also invest in making that worker a healthier overall employee” –
Dr. Casey Choosewood Senior Medical Officer for Total Worker Health™
REFERENCES

REFERENCES


12. World Health Organization, Regional guidelines for the development of healthy workplaces, World Health Organization, Western Pacific Regional Office.


REFERENCES


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