The movement from wellness to well-being has been as rapid in national adoption as it has been elusive per a consensus definition. Still, what I love about the movement is that it reflects an era of expansiveness, maturation, and innovative thinking in health promotion. Reflecting on the grand amalgam of art and science that the term well-being represents, I thought of Dr. David Homans, a brilliant scientist and exemplary educator whom I’ve known most of my career. He is deliberate, astute, and inexhaustible in the use of data. When I worked with him as fellow researcher and teacher, I knew the Homans who poured over large data sets for clinical studies and pondered individual patient data in preparation for speeches at medical conferences. It has been in more recent years, since I chose Dr. Homans as my doctor, that I have experienced how seamlessly his penchant for data plays servant to his primary role as a caregiver.

There is a moment in my office visits with Homans that I’ve come to appreciate as solemn, in spite of the fact that the first time it happened, I resisted rolling my eyes. It’s that moment when he lays his hand on my shoulder just so, leans in slowly with his stethoscope, and listens carefully to my heart. The moment used to feel ironic because it followed on our discussion of results from more modern-day assessment tools such as electrocardiograms or ergometer tests. Organ monitoring, such as heart performance, is precisely displayed and the volume of a patient’s blood flow is now monitored perennially in minute fractions. Today’s methods offer a plethora of data compared to a patient’s blood flow is now monitored perennially in minute fractions. Today’s methods offer a plethora of data compared to fractions. Today’s methods offer a plethora of data compared to fractions. Today’s methods offer a plethora of data compared to fractions. Today’s methods.

But what I’ve come to understand is how simply and powerfully the moment conveys both the art and science of his craft as a healer.

In this moment, I take a run at nothing less than the genesis of well-being. As the Editor in Chief described in the TAHP section, there is little about well-being that wasn’t illustrated in my interview with Dr. Don Ardell in the last issue. I feature a report on ideas for improving health outcomes by Paul E. Terry, PhD. I feature a report on ideas for improving health outcomes by Paul E. Terry, PhD. I feature a report on ideas for improving health outcomes by Paul E. Terry, PhD. I feature a report on ideas for improving health outcomes by Paul E. Terry, PhD. I feature a report on ideas for improving health outcomes by Paul E. Terry, PhD. I feature a report on ideas for improving health outcomes by Paul E. Terry, PhD. I feature a report on ideas for improving health outcomes by Paul E. Terry, PhD. I feature a report on ideas for improving health outcomes by Paul E. Terry, PhD. I feature a report on ideas for improving health outcomes by Paul E. Terry, PhD.

In this issue of The Art of Health Promotion (TAHP) we examine the movement from wellness to well-being. I feature a report from Oklahoma State University (OSU), who trademarked the moniker “America’s Healthiest Campus®.” Though Dr. Suzy Harrington, the author of the OSU story, refers to theirs as a wellness movement, I invited her to share their strategic approach because it impresses me as a fulsome example of what most are now characterizing as well-being. Perhaps wellness and well-being will mingle as overlapping terms for years to come. Nevertheless, OSU’s strategy not only revitalizes all the dimensions of the wellness wheels from the 1970s but also is wrapped within an incisive organizational development framework. How did Harrington create such an homage to individual wellness while orchestrating a model for organizational well-being? She leaned in just so at countless OSU meetings and listened carefully to what was in the hearts of those she serves.

Listening is the art part of health promotion, but as with any other discipline, we can’t manage what we don’t measure. To this end, I asked Dr. Siyan Baxter, another inexhaustibly data-driven expert, to describe how the disciplines of health economics and survey research could inform strategy at OSU. Attentive American Journal of Health Promotion readers will recall a return on investment (ROI) review article Baxter coauthored that was described by our Editor in Chief as the best in the history of this journal.

Unencumbered by the confines of an ROI stethoscope, you will see that, like Homans, Baxter embraces a plethora of sophisticated data domains along with a concomitant fidelity to the art of the well-being strategy at OSU. In my closing commentary, I take a run at nothing less than the genesis of well-being. As illustrated in my interview with Dr. Don Ardell in the last issue of the TAHP section, there is little about well-being that wasn’t promoted in the original conception of wellness. What is largely different 40 years later is our discipline’s Hegelian spiral toward putting such concepts into action.

If we deliberately combine the art forms the Harrington’s of our field create with the measures that minds like Baxter’s can conjure, it won’t matter if we call it wellness or well-being. Better health, by any other name, will still smell as sweet.

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Blog your ideas and reactions at: http://www.healthpromotionjournal.com/blog/
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University health is nothing new. Yet, like all health promotion communities and populations, great variability exists, both in concept and in implementation. Oklahoma State University (OSU) has been ahead of the wellness curve for years as it has been striving to be a national leader in creating a healthy environment. In 2013, OSU became “America’s Healthiest Campus” by trademarking the term. While no benchmarking exists to validate this claim, OSU is definitely one of the leaders in university health and well-being and is currently collaborating with national organizations to identify consistent benchmarks so all campuses can strive to be healthy campuses.

OSU has a history of wellness that helps substantiate the title “America’s Healthiest Campus,” with extensive “pockets of excellence” in its vast variety of wellness programs, services, and resources and declares many “firsts”:

- First stand-alone university wellness center
- First tobacco-free university system, which was student led and guided, resulting in Oklahoma being one of three states with 100% smoke-free higher education institutions
- First university with certified healthy departments
- First dedicated university Chief Wellness Officer
- First comprehensive integrated pet therapy program
- One of few to offer free employee fitness membership
- One of the largest intramural programs and recreation programs with the most personal trainers

To support a culture of wellness, OSU has developed a model and an organizational structure to mobilize and engage individuals and a culture that can be transferable to others, even those with limited resources.

**Chief Wellness Officer and Leadership Support**

Leadership support is a requisite for a true culture of wellness. OSU has strong leadership support as President Burns Hargiss and his wife, Ann, walk the talk, living the life of wellness. They saw the need for a Chief Wellness Officer to advance OSU wellness system-wide and collaborate within the state to improve the health of all Oklahomans.

The role of the Chief Wellness Officer is to provide expert executive health advice and coordination for the OSU system. In other words, the CWO’s responsibility is to strategically coordinate all things wellness for students, faculty, and staff employees and the communities where they live, learn, work, and play. OSU is the only university aligning and streamlining these groups to support overarching health and well-being for entire communities throughout the state.

OSU is formalizing its culture of wellness across all of its campuses and 77 county extension service offices, as well as with cities, counties, and even state and national entities, through partnerships and collaborations. In addition to the continuation and development of programs and services, it is developing a unified structure and communication network to focus and cross-pollinate resources, providing a true synergy of wellness support. It is important to ensure healthy options are available and that social engagement is encouraged. It is important to have a true culture of wellness. What does that mean?

As OSU’s first Chief Wellness Office, I arrived on the Stillwater campus in October 2013 during the exciting time of Homecoming and also Halloween. With its effort to be America’s Healthiest Campus, OSU had a plethora of programs and services in place. However, many of the programs were siloed and the university was losing the opportunity to share resources and cross-market. I quickly realized we needed a consistent and expanded definition of wellness, an evidence-based theoretical model to guide us, and a culture of wellness organizational structure.

**Wellness Definition**

The first thing we needed to do was ensure we had a consistent definition of wellness. When we first think of health and wellness, we often think of someone who is physically healthy or disease-free, and typically the thoughts of “diet and exercise” follow. The World Health Organization (WHO) defined “health” in 1947 as “a state of complete mental, physical, and social well-being, not merely the absence of disease or infirmity” (WHO, 1947). This definition remains one of the standards of today.

In the past, communicable diseases such as plague and smallpox or environmental and occupational issues such as unsafe working conditions, poor sanitation, or lack of clean drinking water were our primary causes of death. Now, according to the Centers for Disease Control and Prevention (CDC), our nation’s leading causes of death are noncommunicable, or not contagious, primarily caused by behaviors, especially as our national population is becoming increasingly sedentary and consuming less than optimal choices.

As a result, our nation is experiencing a national paradigm shift. The focus has been on medical care, spending about 80% of our health care dollars on 20% of the population, and it isn’t working. However, we are moving in a positive direction as we shift to a proactive, value-based health care system from a volume-based, reactive medical system. We have a variety of national and state quality and wellness drivers with a plethora of acronyms: CDC, NIOSH, HHS, NPS, HP2020, PPACA and OPDPH. OSU believes universities have the opportunity to be wellness drivers too, and they are stepping up!

Michael O’Donnell, creator and editor of the American Journal of Health Promotion, defined optimal health in 1989 as “a balance of physical, emotional, social, spiritual and intellectual health…Lifestyle change can be facilitated through a combination of efforts to enhance awareness, change behavior and create environments that support good health practices. Of the three, supportive environments will probably have the greatest impact in producing lasting change.”

When many individuals hear the word wellness, they think “diet” and “exercise” and they feel immediate resistance. This resistance is arguably one of the strongest barriers to a health and well-being professional. These words are things we “do” rather than things we “are.” They are chores, which we start and stop. While an active lifestyle and healthy nutrition are important, a true definition of wellness is much broader. It includes adequate rest and hydration, tobacco cessation, social engagement, a sense of peace and resilience, energy and purpose in life, and the management of stress to include financial pre-
paredness and the pursuit of lifesline learning. It also includes preventive and clinical care and safety efforts such as wearing seatbelts and avoiding distracted driving, without texting, or driving after drinking alcohol.

Wellness is who we are. It is a lifestyle full of choices and moderation. It is the symmetry of our personal and professional lives and most importantly, it is about fun and joy. Wellness is the harmony of our physical, emotional, spiritual, social, and profession dimensions of wellness. OSU declares wellness is a “harmony” rather than the struggling and juggling of “balance.” It is who we are and how we live that allows us to be the most vibrant, resilient, successful, and happy we can be. We want to ensure OSU has the culture that sustains successful graduates, successful employees, and successful family and community members.

So the next question is how do we do it and then, how do we prove it? First things first, we developed a theoretical model to guide assessment, planning, structure, and implementation and outcomes.

OSU Wellness Strategy Model
The OSU/A&M Wellness Strategy Model is a rotational model. The three outer levels reflect the vision, which interdependently rotate around the central mission to LIVE America’s Healthiest Campus®. As the vision levels rotate around the axis, they tangentially provide a comprehensive, multifocal strategic approach to assessment, planning, implementation, and evaluation for an exemplary and sustainable culture of wellness across the OSU/A&M system.

Let’s explore the different levels of the model:

(why) LIVE America’s Healthiest Campus®
Central to the model, the bull’s eye, is the mission. We ARE America’s Healthiest Campus®. Our goal is to be it and to live it, living at our best to be the most productive, most engaged, most successful, happiest we can be.

(who) Enrich the Lives of Our Students, Employees, and Communities
Our vision is to enrich the lives of our students, our employees, and the communities in which we live, learn, work, and play to be the best they can be. In universities, student health and employee health are typically siloed.

While funding streams may be different, the overarching goal is similar. Both groups are more similar than different. They can share ages, as both students and employees can be 18 years to “senior,” and both groups share some of the same social issues: relationships, professional/academic success, financial concerns, and even alcohol use.

Our students are change agents of the world. If we can keep them healthy and engaged, we are providing an exceptional student experience and exceptional graduates. Our students are community members of their homes, their campuses, and more importantly, their future communities as individuals, families, and employees. Our intent is to support the development of life skills so they can truly be successful graduates and OSU ambassadors.

Happy, engaged, content employees support our mission of successful graduates while increasing creativity, production, and job satisfaction. Worksite wellness outcomes typically focus on return on investment (ROI), or dollars saved in injuries. Insurance and pharmacy claims are a hot topic. The more important OSU question is the value on investment, or the softer measures of more active engagement, strong work-life balance, more pleasure, more joy—essentially a higher quality of life. Retention
is a measure of wellness for happy employees, and students will remain loyal and stay. OSU is committed to achieving healthy work environments.

Our employees are part of the communities in which they live, learn, work, and play. If the communities do not have healthy options, the employees and students may struggle. We have a great opportunity to support community wellness through our academic research, the outreach of our county extension service offices, and through each OSU employee, family, and alumnus who resides in the community.

A recent slogan said, “When ‘I’ is replaced by ‘We,’ even ‘illness’ becomes wellness.” As we spread wellness, we begin to thrive in its true culture, where the right choice is not just the easy choice, but the fun choice, the first choice—as it is so prevalent. Working together—at home, at school, in the work place, in the community—we support each other and continue the “epidemic of wellness.”

(what) Harmonize the Physical, Emotional, Spiritual, Social, and Professional Dimensions of Wellness

As previously mentioned, OSU wellness is the harmony of our physical, emotional, spiritual, and professional dimensions of wellness. Each of the five dimensions is composed of several elements within. I will briefly describe each dimension and address one of the elements within.

(how) Synergize the Personal, Interpersonal, Organizational, and Environmental Levels of Change

As we move to the outer ring, the model demonstrates the multifocal ways we change behavior. It is about the synergy of personal, interpersonal, organizational, and built environment, sharing resources and cross-pollinating. You may notice it is the socioecological model without policy. Policy is found in the Organization section. This requires a top-down, bottom-up approach, addressing health at all levels.

Culture of Wellness Organizational Structure

The Wellness Strategy Model sets the wellness constructs, but to systemize it, several organizational components needed to be in place. In partnership with the OSU Chief Wellness Office, wellness services, and human resources, each of the OSU institutions are asked to adopt, support, and sustain the OSU/A&M components for student and employee culture of wellness, in addition to the programs, policies, and process in place. Institutional initiatives are asked to address the dimensions of wellness as defined by the OSU/A&M Wellness Strategy Model and include the following culture of wellness components:

1. Wellness Councils
2. Wellness Innovator System
3. Communication Strategy
4. Recognition Process
5. Outcomes and Impact Tracking

To learn more about these OSU structures, visit this Journal’s blog.

Conclusion and Next Steps: Outcomes and Impact Tracking

Next steps include identifying, measuring, and tracking measurable health and well-being outcomes and impact objectives. At minimum, ROI, value on investment, and quality-of-life indicators that support increased engagement and retention must be examined. Empirical evidence and best practices are needed to drive the assessment, planning, and evaluation of student and employee wellness. Wellness indicators need to be aligned with available national, state, and best practice outcomes and benchmarks. It is vital to demonstrate harmony of quantifiable wellness success for individuals and organizations, both personally and professionally.

References

Establishing a Health Economic Evaluation for Collective Well-Being in Workplace Health Promotion

Siyen Baxter, PhD

Striving to conduct rigorous evaluations with the goal to strengthen the evidence is an imperative for the field of workplace health promotion (WHP). Like many businesses, organizations, and decision makers around the globe, Oklahoma State University (OSU) has a need to provide comprehensive evidence to support implementation of their workplace health initiative that will assist in future planning, and (3) maintain fiscal accountability. Additionally, stronger evidence is needed to guide workplace health program strategists, for incentives are now offered to employers who can demonstrate a methodologically sound and effective program under the current Patient Protection and Affordable Care Act of 2010.1

Establishing sound evidence to determine the impact of an initiative on employee health is a reasonable expectation of any conscientious employer. It requires commitment to improve on current methodologies and measures.

Economic Evaluations of the Socioecological WHP Model

The groundswell of interest in a more socioecological approach to delivery of WHP has intensified the need to broaden evaluations in workplace health in recent years, arguably returning to earlier renditions of scope. The most traditional economic outcome measure has been return on investment (ROI), yet terms that represent evaluative frameworks, such as value on investment (VOI)2 and the most recent return on investment (ROI), despite the labeling of indicators as “value,” represents evaluative frameworks, such as value on investment (VOI)2 and the most recent return on allocated resources (ROAR).3,4 are now being considered. This broadening of the WHP model requires that evaluators concerned with the economics of WHP to consider comprehensive measures for health and nonhealth costs and consequences on which economic value can be placed. This leads to a need to better identify, measure, and value what is given up (costs) and what is gained (consequences, benefits) as well as a consideration of the opportunity cost, that is, the benefits foregone from the next best alternative use of funds.

The application of health economic theory to WHP offers two advantages. First, it provides a (measureable) link between healthy workers and sustainable development. This is the macroeconomic concept that elevated the “workplace” to a public health “setting.”5,6

Healthy workers → Productive workers → Successful businesses → Healthy economy → Sustainable development
(Source: World Health Organization-WPRO7)

Second, it encourages strengthening of stakeholder partnerships and corporate sector investment. This is the microeconomic approach that acknowledges the value in optimizing human resources through health promotion. Recognition of economic advantage and business success promoted WHP as mutually beneficial for both employees and the organizations adopting it. Although the economic motivation for implementing WHP is primarily the benefits to the organization arising from outcomes of healthy and happier employees, the economics of employee health originated from a social responsibility ideology intent on improving employee welfare, conditions8 and equity,9 not an organization’s bottom line. However, in the mid 1980s, companies recognized preventive health care at the workplace as a fiscally responsible approach to cost containment for overutilization of clinical services. This helped prioritize the development of criteria to justify a workplace health program,10 now known as the business case for WHP.

Measures Within Complex WHP Interventions

On first reading the OSU Web page to learn about their Wellness Strategy, their goal to have a “thriving culture” was considered and contemplated. How could one provide a true quantification of “thriving”? Though Gallup has a commonly recognized well-being index that assesses individual thriving, the OSU use of the term is considerably broader. Their model represents a population-level strategy aimed at influencing the collective OSU community by shifting the total distribution toward optimal states of health and wellness. This resembles the basic tenets of the socioeconomic perspective, which encompasses individual physiological health and emotional well-being along with organizational and community levels of social cohesion and health status.11 According to the definition of the Medical Research Council,12 the OSU Wellness Strategy would be considered a complex intervention in that it consists of a number of interacting components, targets a number of groups or organizational levels, has large numbers and variability of outcomes and a high degree of flexibility and tailoring. Thus, a number of criteria for assessing the merits of the strategy are warranted.

What the OSU decision makers choose to assess “thriving culture” against will depend on what shift in culture they most value. It may be from the aspect of the individual subjective well-being perspective (spatially, temporally, socioculturally), or include epidemiologic indices of illness: its prevalence, incidence rates, and severity. Still, other aspects may also hold importance such as tracking measures of work-life balance, healthy behaviors, psychological distress, or efforts to provide a healthier built environment. Performance indices will most likely be viewed as very important, such as graduation success, community involvement, cyclical events, as well as monitoring any improvement in seasonality of education calendar stressors (such as examinations, grant writing, unplanned sick leave), or even safety concerns such as frat party incidents, campus security call-outs, and violations of personal safety. At a minimum, they seek to measure quality of life, engagement, and retention. Retention can be measured by calculating the number of resignations by the replacement cost of staff turnover (for Australia, evidence suggests a range from 75% to 150% of the workers’ wages13). Engagement at this time does not have an inherent economic value, although one could be attached by undertaking a discrete choice experiment. However, an explanation of this is beyond the scope of the article, so let’s consider quality of life.

Quality of Life (QoL)—A Focus on the Individual

“Quality of life” is a very broad measure of your perception of your place in life. When assessing a WHP initiative, it is more
specific to refer to “health-related quality of life” (HRQOL), which is “the integrative measure of physical and emotional well-being, level of independence, social relationships and their relationship to salient features of their environment.”14 HRQOL captures life’s aspects that can be impacted by health, for which numerous self-reported survey instruments are available and can be administered to measure it. Within an employee population, a generic instrument is best.

Going beyond HRQOL to health utility, employee health status can be included in a health economic evaluation when “value” is placed on it. Such values are known as “health utility.” Health utility maps a person’s HRQOL on the continuum 0 to 1, either from a simple, linear, “rate your health,” where 0 is a health state similar to death and 1 is perfect health, or more commonly, through administration of a multiattribute utility instrument (MAUI). Health utility represents the equivalence of being alive for a certain proportion of a year in perfect health.15 Although historically utility values were used alongside survival time for evaluating cancer treatments, evidence suggests they are now being looked at to assess the value of an investment in public health interventions, irrespective of mortality threat. The short form 6D (SF-6D) MAUI has been validated in employee populations.16

Though there are critics of the use of health utility measures in workplace populations, it is my belief that a preference-based measure that aggregates different aspects of health into a single index, allowing value to be placed on the multidimensional concept of health, requires our attention. Employee health status is, however, a long-term outcome and requires lengthy follow-up periods to assess impact. Evaluating health status requires sustained commitment to the intervention in order to assess future changes that may be realized. Intermediate outcomes of health must also be considered for interim evaluations. Consideration should be given to the modeling of health status in order to evaluate intervention effects and translate final outcomes when intervention durations are short.

Capacity—A Focus on the Organization

The OSU wellness strategy acts to build the capacity of individuals within the university, its community, organization and possibly, government. Incorporating an organizational approach to WHP epitomizes the growing interest in a broader, multilayered focus.17 Indeed, in 2006, “capacity building” was added to the WHO health promotion glossary,18 emphasizing that effective health promotion involves advancing knowledge and skills, expanding support and infrastructure, and developing cohesiveness and partnerships. Building capacity means improving organizational capabilities: commitment, structures, systems, and leadership.19 Currently, WHP best practice encourages building organizational capacity for health promotion in workforces.20–23 However, no single set of characteristics or scientific evidence validating measurement of organizational supports exists. Despite this, interventions implementing an organizational approach such as the one at OSU are emergent and the proposed broader “value” of WHP may emanate from participatory, multidisciplinary, or integrative initiatives. Consequently, economic evaluations should consider incorporating organizational capacity as a measure of efficiencies in resource use to better reflect WHP comprehensiveness. This requires novel methods to be considered. One possible direction will be to integrate both quantitative and qualitative data (possibly from an implementation audit repeated over time) and a mixed methods analysis approach.

Analysis Options

The overarching goal for economic evaluators in WHP is to offer a more complete picture of economic value: one that is transparent and one that captures unbiased evidence that stakeholders agree is important for informing decisions. Accordingly, providing a solid base of relevant data using established guidelines, reporting standards, and analytical techniques will serve us well, and ensure resilience under scrutiny along with greater evidence acceptance.

Can the Real ROI Stand Up?

In WHP reporting, an ROI has been the predominant analytical form.24 However, the ROI metric has come under recent scrutiny as the sole measure of value.10 Inadequacies include its implied certainty and the presumption that a program has failed if it doesn’t produce a positive ROI. ROI methodology is not to blame here. Prudent evaluators should report the confidence intervals (uncertainty) around these estimate measures. They should also expand on which measures go into the ROI calculation (beyond health care costs and absenteeism) to broaden its relevance. As a result of these documented inadequacies, new labels such as VOI are gaining traction, and this journal’s introduction of ROAR may soon follow. Yet, ROIs (like benefit-cost ratios and net benefit calculations) are an outcome measure derived from a cost-benefit analysis (CBA). A CBA is an economic, analytical technique aligned within the discipline of health economics and one that has great applicability to WHP. It is a strident hope that, as we evolve economic evaluation methodologies in this field that we ensure evidence generation is supported by known analytical techniques.

Analytical Techniques Used for Health in Economic Evaluations

Deciding what type of economic analysis to adopt will depend on how the benefits of greatest interest to the program strategists are to be expressed. There are several types. Cost-effectiveness analysis (CEA) expresses benefits in terms of a single unit of effect such as function, risk severity, or other units (i.e., mm Hg for blood pressure or number of days absent from work). If the effect is measured by healthy years (i.e., using a preference-based health measure such as health utility), the analysis is referred to as a cost-utility analysis (CUA), although some continue to refer to it as a CEA equivalent. When all consequences are translated into a monetary value (i.e., benefits due to improved health, increased productive output, enhanced health status, or decreased adverse consequences or health care costs avoided), the analysis is referred to as a cost-benefit analysis (CBA). All three analytical types can offer a value-for-money answer as they value effectiveness measure(s) relative to costs.34,35

Fundamentally, “value” must be defined by the decision maker whose resources are given up and the value for money conditional on a threshold that may reflect budget constraints, best alternative use of funding, or other considerations such as their specific goals and guidelines. Value on investment can be assessed by undertaking any number of economic evaluative techniques. A logical course for the development of WHP “frameworks” is to align with those already established in scientific disciplines. Thus, the VOI framework for employee health management that “uses a cost-effectiveness analysis (CEA) convention”10 would be best expressed as a health economic CEA and follow CEA analytical techniques. Let’s call a spade a spade!
An Example of Analysis for the OSU

It is an inherent task for economic evaluations to deliver a comparative analysis to provide information on actions that may or may not be beneficial enough in respect to the best alternative use of funds. Ultimately, the OSU decision makers may require an economic evaluation to assess whether their wellness strategy is worthwhile, i.e., does the strategy provide value for money in comparison to alternative uses of the resource. If so, the evaluation will relate to allocative efficiencies that require undertaking a CBA, and not just technical or production efficiencies, which is the role of a CEA.

To assess allocative efficiency to inform whether the OSU strategy influences the masses and acts on the population as a whole, an economic question could be: “What is the value for money to the employer of implementing the WHP strategy at OSU on the health of the OSU population and population subgroups (compared to status quo, regional, or national comparisons)?” In contrast, production efficiency could be assessed by answering the question, “How effective was X at producing health change for a reasonable cost? Did intervention X prove to be cost-effective between participants compared to nonparticipants from the OSU employer perspective?”

Undertaking such a study requires analysis of the characteristics of the population, not solely characteristics of individuals. One example for measuring a health change target to assess value would be to monitor the prevalence of obesity on campus. Weight change is a function of a change in caloric intake as well as a change in physical activity (energy expenditure). Poor diet and low activity have been linked to a number of noncommunicable diseases, such as coronary heart disease and type II diabetes. The OSU strategy can affect a “nutritional transition” upon its population through decreasing fats, sugars, and salt content in their food options. This would represent an intervention that from a macroeconomic level is measurable by aggregate obesity rates and associated disease costs. Comparisons can be sourced from community obesity rates and public health expenditures, from either direct medical costs and/or indirect, nonmedical costs relating to productivity loss costs.

Adopting the ideals from seminal works, such as those by Geoffrey Rose, offers a possible future direction in evaluating the socioecological paradigm. Based on Rose’s concepts, evaluators would shift from the risk approach that targets susceptible individuals to a population approach that looks at the systems that act upon the individuals in order to control the causes of the incidence of disease.

What About the Complexities of This Population-Wide Intervention?

Overcoming the difficulties in evaluating an initiative implemented across the whole of a large, diverse working population is central to good research. The ultimate aim is to evaluate under a condition of randomization (to show causality), however it is rarely the case that randomization is feasible for workplace-based research. Alternatively, there is an approach endorsed by the Medical Research Council guidance for use in complex interventions known as a stepped wedge trial design approach. This approach would help to address some complexities inherent in WHP. By implementing a (randomized) sequencing approach to WHP intervention roll out, a stepped wedge design trial can (1) provide comparisons in organization-wide delivery when no natural comparator exists (or when obtaining regional or national comparisons is difficult), and (2) allow the observational design suited to WHP to gain improved experimental evidence. As each center acts as its own control, the stepped wedge approach ensures that we compare “apples to apples.” Furthermore, as expected effectiveness occurs over a considerable length of time in WHP, the effects of time on outcomes of interest can be modeled. This approach could also assist in detecting points of success or failure by distinguishing between the integrity of the evaluation process and the intervention itself. Such evidence is currently lacking in the field. For OSU, which has nine OSU and A&M affiliate campuses, staggered implementation across the organization may be a real possibility.

In Conclusion

When considering social ecology in health promotion, the evaluative criteria OSU adopts should be influenced by the measurement of short-term and cumulative health outcomes, as they are influenced by improved OSU cultural qualities within their setting. These should be tracked over time to assess the role their wellness strategy has on improving social cohesion and physiological and psychosocial well-being among its community members. Furthermore, when considering the economics of this strategy, measures deemed important to them and for which value can be placed, are necessary. It would then be diligent to incorporate age-based, sex-based, and ethnicity-based subgroups for these measures to assess equity among their community.

Conducting economic evaluations in WHP is a complex undertaking. The discipline of economics as a whole and branches such as health economics, offer accepted methods, guidelines, and standards that can be applied to provide robust and transparent analysis. By far the most challenging component of an economic evaluation and the one least well performed in WHP is the measurement of benefits. This commentary describes a bold vision that can be validated with smart measurement approaches that account for individual, cultural, well-being, and health-related quality of life indices. Hopefully it offers inspiration toward a future that holds exceptional possibilities and plenty of room for innovation. Ultimately, the path should be paved toward the measurement of benefits that align with the multideterminants of workers’ health, the decision maker’s definition of health, and with a view to place value on health, incorporate the interaction of organizational mechanisms, and provide a whole-level assessment. It is not a question of whether change will come in the evaluative process, rather which direction that change will take.

For a complete glossary of terms used in this article, please visit the journal’s blog.

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References

COMMENTARY: THE GENESIS—AND GRAND POSSIBILITIES—OF WELL-BEING

Paul E. Terry, PhD

During this year’s Art and Science of Health Promotion conference, I regularly asked participants how they defined well-being. I would then reframe the question and ask how well-being was different than wellness. For both questions, their answer was essentially the same. Compared to wellness, well-being signifies a “broader… more holistic…more inclusive” concept. Nevertheless, their examples of well-being as inclusive of “social, cultural, and spiritual” dimensions have an unambiguous resemblance to the origins of the wellness term. As I recommend in a prior issue of The Art of Health Promotion (TAHP), Google “wellness wheel” under the “Images” tab to see how commonly wellness has been cast as a multidimensional construct in the past 4 decades. In spite of this, the conference participants I queried felt this “new” interest in well-being emanates from a perception that wellness has focused too much on the physical, individual, and clinical domains and that these broader dimensions will bolster the wellness value proposition.

Whether the well-being term proves to be trendy or truly trending in the field of worksite-based health promotion, it remains that efforts to define, intervene on, and lead in “well-being” are not new. What’s more, the term has been a staple of political economics and social policy long before its current run at replacing wellness. To wit, you will get double the results from a Web search on the terms “well-being and social policy” compared to “well-being and health promotion.” In this commentary, I will feature those health experts and organizations that I consider the prime movers of the well-being movement in health promotion. But, at the outset, I would invite readers to consider a truly broader proposition: that we will not do the well-being term justice if it is simply wellness warmed over. If we borrow from the rich well-being traditions of community development and social theory and fortify these with ingredients from positive psychology, brain science, and wellness, only then might the well-being term become transformative in the field of health promotion.

Well-Being for Employees, Families, and Communities

What might such an expansive approach look like? It starts with the simple observation that health is just one constellation in the well-being universe. Moreover, well-being cannot be harnessed via one locus of influence such as the workplace. At the Health Enhancement Research Organization (HERO), the organization I serve, we recently revised our vision. During the past 20 years HERO has become well known as a national leader in advancing best practices in employee health management (EHM). We have left the EHM acronym behind with our new vision that “all workplaces positively influence the health and well-being of employees, families, and communities.” Where HERO will continue to focus, however, is on the vital leadership role employers can play in advancing well-being for all.

From a political science and community development vantage point, there is nothing new about the employer’s powerful role in building and sustaining well-being. The legacy of the well-being term carries with it the importance of jobs and economic development, as they are precursors to community welfare, citizen engagement, and a vibrant community that is attractive to families. Employers understand that a healthy community, in turn, is the foundation for a competitive and sustainable workforce. Where should health promotion professionals turn to learn what a truly broader well-being value proposition will require of us? As with our migration to “culture of health” or “employee engagement” concepts, we should tap into the impressive scholarship from outside the health promotion field.

Connecting workplace health promotion to the community is a two-way street. Employers have much to bring to their communities, but we should also come prepared to learn. In the Community Development Journal, Adam Dinham wrote an article titled “Raising Expectations or Dashing Hopes? Well-Being and Participation in Disadvantaged Areas.” Wellness program planners have time-honored assumptions that high participation rates in health assessment activities are a great way to build inertia for engagement in health improvement offerings. It may be disconcerting for many health promotion enthusiasts to read about Dinham’s findings that in disadvantaged areas, many find such assessments to be a negative experience and indices of well-being decrease.

And, lest you think the above well-being finding is simply a proxy for the health disparities wrought by economic disadvantages, think again. The well-being term as used in social policy circles has much longer arms. Diener and Seligman, writing in Psychological Science in the Public Interest, describe how limited economic measurements are for assessing overall well-being. Their article, “Beyond Money Toward an Economy of Well-being,” describes their findings from some of the most underdeveloped countries to support their call for a national well-being index that would feature many key variables besides economic indicators.

Who Should Define Well-Being?

In this issue of TAHP, the former Chief Wellness Officer of Oklahoma State University (OSU), Dr. Suzy Harrington, describes the tremendous amount of listening she did across...
many stakeholder groups to arrive at OSU’s strategy to become “America’s Healthiest Campus®.” The effectiveness of a participatory inquiry approach is well documented, but again, largely outside of typical health promotion scholarship. In an article in the European Journal of Social Theory, for example, Séverine and McGregor explain the troubling disconnects between how individuals gauge their life satisfaction and how public policy is too often created. Their article, entitled “The Capability Approach and the Politics of a Social Conception of Wellbeing,” argues that full participation, especially the kind that draws dissenting views, is the best route to public policies that influence positive well-being.

What is grand about such a broad, community and individually derived formulation of well-being is that the measures that matter are, by design, of equal interest to employers, employees, and their families. Grander still is the notion that the best definition of well-being resides within the unique cultural contexts of each workplace, family, and community. Many readers of this TAHP section of the Journal take advantage of the Journal’s Webinars that follow. There, we get the opportunity to interact with the experts featured on these pages and recently, I hosted health promotion experts La Vaughn Palma-Davis, Laura Linnan, and Laurie Whitisel who had contributed to “The Game Changers” issue of TAHP. We each agreed that those who have led transformations in the field of health promotion in the past have been cross-sectoral thinkers. To test the receptivity of our Webinar audience to a broader role for employers in health and well-being, we polled our audience and found interesting variation related to the following question:

Game changers worked across sectors to change national policies, but employers now play a greater role in health promotion than in the past. Which best represents your view on the potential of employers in advancing health?

A. Employers have a natural stake in the health of employees and that is where they should remain focused. (11%)
B. Family health is inextricably linked to employee health and I am a strong advocate for enlarging the employer’s role to include family health promotion. (36%)
C. Employee and family health is a great start, but the higher calling for employers is to be a change agent on behalf of community health. (20%)
D. I think employers/companies should give equal weight to their role in advancing the health of employees, families, and communities. (34%)

With just 11% holding the view that employers need only focus on employees, it is easy to say goodbye to employee health management as the moniker that represents the work of workplace-based health promotion professionals. That 54% of our Webinar participants resonated with the items connecting employers with their communities also ratifies HERO’s new vision that all workplaces will positively influence the health and well-being of employees, families, and communities.

Well-Being as Currently Used in Health Promotion

I argue above that health promotion professionals should draw from the work of scholars outside of our field if the well-being term is to transform our approach to health promotion. I also suggest that the term likely has its greatest utility when it is defined at the constituent level. Still, both within and outside the health promotion field, there have been calls for a clearer consensus in the use of the term. One recent study reviewed literature from 10 journals in the occupational science literature and found “inconsistent definitions and uses of ‘well-being’ throughout the literature.” Similarly, the Centers for Disease Control and Prevention’s (CDC’s) Web description of well-being indicates that “there is no consensus around a single definition of well-being, but there is general agreement that at minimum, well-being includes the presence of positive emotions and moods (e.g., contentment, happiness), the absence of negative emotions (e.g., depression, anxiety), satisfaction with life, fulfillment and positive functioning. In simple terms, well-being can be described as judging life positively and feeling good.”

Drawing from the CDC’s definition, these broader dimensions of well-being include the following:

- Physical well-being
- Economic well-being
- Social well-being
- Development and activity
- Emotional well-being
- Psychological well-being
- Life satisfaction
- Domain specific satisfaction
- Engaging activities and work

Where the CDC represents the largest public health agency with a point of view on well-being, Gallup, often via its partnership with Healthways, has also developed a well-being framework and definitions, and has led in supporting businesses interested in investing in employee well-being. As you can see, each of the CDC well-being dimensions noted above overlap with the Gallup/Healthways well-being index. Both organizations have collected data to analyze each of their dimensions in relation to health, productivity, and chronic conditions. The Gallup/Healthways well-being assessment produces an index derived from five elements:

- Purpose: Liking what you do each day and being motivated to achieve your goals
- Social: Having supportive relationships and love in your life
- Financial: Managing your economic life to reduce stress and increase security
- Community: Liking where you live, feeling safe, and having pride in your community
- Physical: Having good health and enough energy to get things done daily

While the CDC and Gallup have led in defining well-being and testing their indices relative to health and productivity, other health organizations are imbedding well-being into their teaching and advocacy agendas. Well-being was featured prominently in this Journal’s Art and Science of Health Promotion conference. In my closing session, “What Have We Learned,” I drew a word cloud to illustrate how well-being was the dominant term at the sessions and had replaced the culture of health term that had been trending similarly just a few years ago. I’ve seen the same shift at the national conferences held by HERO, The World Health Care Congress (WHCC), The National Business Group on Health, and the Integrated Benefits Institute. The learning objectives this year at WHCC, for example, were, “develop holistic well-being programs and address employee physical, financial, mental, emotional, and behavioral needs” and “integrate...
well-being within the overall organizational mission and ensure it is included in the C-suite conversation.”

The Research Base and Business Case for Well-Being

For decades, the wellness movement was fueled with research showing how improving health and/or lowering health risks reduces preventable health care costs, improves productivity, improves morale, and increases employee retention, employee satisfaction, and perceived organizational support.10 As current research has shown, “well-being” also correlates positively with each of these outcomes. Sara Johnson from Prochange has been reporting similar data at conferences, as well as Hamar and colleagues from Healthways, who have reported similar findings from companies investing in both wellness and well-being. The study of Hamar and colleagues1 shows that “well-being and job performance increased and presenteeism and health risk decreased significantly over the 2 years [after a well-being intervention].” They conclude that “there is accumulating evidence that programs can address and impact individual and population well-being, as opposed to the more limited traditional goal of improving physical health.”11 In a similar article, Gandy and colleagues12 noted that “The gap in previous literature and the importance of a more holistic approach...showed that well-being is a more important determinant of employee productivity than is the presence of a chronic disease.”13

More research is needed to demonstrate whether and how well-being will compare with the more extensive literature related to investing in wellness. However, the well-being movement is being driven by far more than the interests of, or outcomes from, employers. A growing acceptance of the merits of positive psychology has already occurred in health care, particularly the mental health sectors. This assets-based approach derives from strong and growing evidence that a psychological approach emphasizing human potential and capacity is effective in improving health. Positive psychology proponents deride the limits of a “deficit model” that was based on finding and treating pathology. The “father” of positive psychology, Martin Seligman, wrote that “well-being should be the ultimate goal around which economic, health, and social policies are developed, not simply because well-being is an important indicator in itself but also because well-being is many times a cause of other valued outcomes, such as worker productivity and rewarding relationships.”14

Building on the advantages of an assets-based approach, Gandy and colleagues15 summarized their review of well-being–related studies by arguing that well-being can have greater impact when compared to disease targeting and risk reduction. They wrote that health risk assessments only identify “existing health risk factors,” but that “well-being improvement initiatives can benefit all employees and have the opportunity to improve productivity of an entire workforce, not just those with existing health problems, to allow employers the opportunity to shift the focus from productivity loss to productivity gain.”16 It is more than a coincidence that well-being is ascending at a time when the need to produce a return on investment from wellness has descended in importance. As Gandy and colleagues noted, well-being “is aligned with the paradigm shift in which employees are considered ‘human capital’ and are thus of strategic importance to success in the marketplace rather than an expense to be managed.”17 Johnson Controls wrote a white paper in 2014 with a similar view that the business case for wellness needs to be broadened18 and IBM’s approach to well-being is similarly positioned.19

Like most concepts in formative stages, our understanding hinges on finding best examples of what a concept is and what it is not. For a very accessible and instructive 20-minute presentation on positive psychology and innovations in mental health and well-being, watch Martin Seligman’s TED Talk on the state of psychology.20 For a thoughtful exposition on what well-being is not, revisit an article written for TAHBP by Nichburg and Grossmeier who argue that “well-being is not code for ‘stress management’ nor for the absence of anxiety and depression. It connotes a broader, deeper sense of personal ease and positive experience in the realms of emotion, mindset, relationships and spirit. From our perspective and as our working definition, people who enjoy a high level of well-being experience a preponderance of positive emotion, optimism and hope, mutually supportive relationships, purpose and meaning. Ample research findings suggest well-being is a powerful driver of both health outcomes and performance, acting as risk factor when in deficit and as a protective factor when in abundance.”21

Is It Time, Yet, to Seek a Consensus on Well-Being?

The wellness provisions of the Affordable Care Act continue to spawn important consensus work on questions such as what constitutes a reasonably designed wellness program.10 Perhaps there will soon be an interest in what constitutes a reasonably designed well-being approach. From my examination of the few published studies of well-being initiatives in the workplace, I’d suggest consensus discussions need to await more research. Though several studies feature well-being in their titles and the introductory sections of their papers, the study methods and results reported are essentially the same as wellness program studies. That is, employees complete assessments, receive individualized feedback and a personalized plan, and are offered telephonic coaching, goal setting, tracking tools, and health education. Some researchers describe these above interventions and note that they also initiated culture of well-being methods such as employee competitions, fitness classes, and communications aimed at enhancing well-being.

We will need many more workplace-based studies that are considerably more specific to the science generated by positive psychologists that isolate variables relating to improvements in health, happiness, and life satisfaction. The “how” of well-being, drawing from the Seligman talk,22 will relate to how health is a product of daily pleasures, life engagement, work flow, and meaning. Seligman has studied specific intervention examples such as how to “design a beautiful day” and use savoring and mindfulness techniques to achieve it. Similarly, he recommends a “gratitude visit” or a “strengths date” as a path to well-being. He also describes research showing the well-being impact of couples doing something fun together versus doing something philanthropic.23 Guess which produces happiness that lasts longer? Dr. Barbara Frederickson, a brain scientist/positive psychologist, was the keynote speaker at this journal’s Art and Science conference and, like Seligman, she described research that coupled the emotional and social with the physical.24 She taught how smiling, feelings such as gratitude, or reflections on social connections relate to what we eat and how we become more active, and vice versa. Her research shows how individuals create community one “micro-moment” after another.

Workplaces remain a researcher’s green field for developing robust, scientifically valid well-being approaches. Proving the well-being case will not come from studies on programs as much as from requiring tailoring approaches according to the unique well-being needs and goals of each organization. The article in
the above issue from Dr. Harrington, formerly of OSU, explains
the strategy model she developed in collaboration with OSU
stakeholders campus-wide that accounted for the dynamic inter-
actions between individual and organizational well-being. But it
will not be until we implement the sophisticated measurement
approaches recommended by Dr. Baxter, also featured above in
this issue, that we could aspire to achieve consensus on what con-
stitutes an effective approach to positively influencing well-being.

Correlation Versus Causation in Well-Being
Like our acceptance of the face validity of the value of a culture
of health, it is likely that our enthusiasm for investing more of
our capital in well-being will be based on correlational research.
Writing about the challenge of defining well-being, Dodge and
colleagues18 suggest that a better approach would be defining
how individuals achieve it, rather than simply describe what it is.
It seems to be the case so far that the emergence of well-being
has been a heavy retreat of the holistic dimensions that influ-
ence health with few examples of how employers can cogently
address most of these influences. Dodge and colleagues18 posit
that well-being is more than an association between variables.
Instead they maintain that “in essence, stable wellbeing is when
individuals have the psychological, social and physical resources
they need to meet a particular psychological, social and/or
physical challenge.”18 This sounds like what health promotion
professionals are trained to address, but with respect to the
dimensions we tend to focus on, it seems to call for a more mea-
sured and intentional emphasis on the kinds of positive psychol-
ogy methods used by leaders such as Seligman and Frederickson.

Given the immature state of the art for advancing well-being
in the workplace, there are innumerable opportunities for lead-
ership and innovation. Indeed, the problem is not what needs
improving, because everything from assessment to interventions
to evaluation is green space. Health promotion professionals are
devising definitions of well-being, but given the scarcity of popula-
tion-based evidence that can influence well-being, we could be risking our credibility. It’s hubris to infer that health
promotion has a corner on a concept that economists and social
reformers have studied long before us. We can march boldly
ahead, however, with an assumption that each organization we
work with is capable of framing and pursuing those dimensions
of well-being that are most congruent with its culture, values,
and organizational objectives.

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