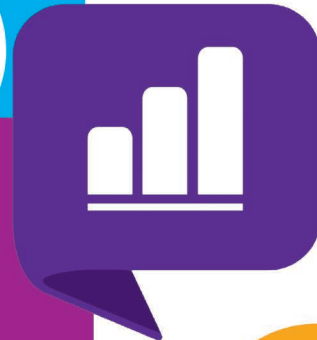


TRENDS REPORT 2016

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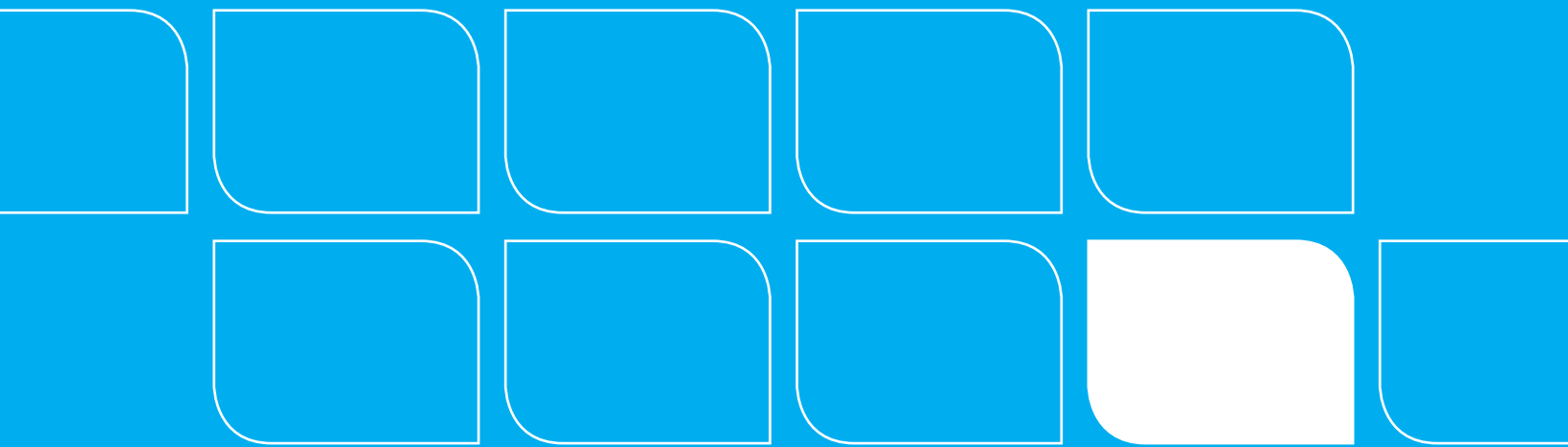


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“The only thing that is constant is change.”

~ Heraclitus, Ancient Greek Philosopher

INTRODUCTION



Once again I'm pleased to share with you the Chestnut Global Partners (CGP) Trends Report. Change remained a constant in 2015 as globalization helped to make our world get just a little bit smaller. The impact of terrorism in France and elsewhere, the Syrian refugee crisis, and the drop in oil prices was felt globally in our living rooms and debated by our politicians. At the same time, the growing 24/7 culture continued to put pressure on the business community to innovate, perhaps nowhere more noticeably than in the health care industry. In this report, CGP examined trends within our own book of business, surveyed EAP colleagues, and analyzed recently published research and survey data in the areas of employee assistance services, behavioral health, and workplace well-being. We have highlighted five trends that caught our eye, offering an analysis and recommendations for best practice implementation.

I hope you find this report to be a useful tool in supporting your employee wellness and performance management initiatives. As always, feel free to contact us with any questions or to find out how CGP can partner with your organization to develop customized solutions tailored to your unique business needs.

Sincerely,

Todd Donalson

Todd R. Donalson
Director of Training & Consultation

INCREASING DEMAND FOR EAP SERVICES DUE TO OCCUPATIONAL STRESS

By Todd Donalson
CGP Director of Training and Consultation



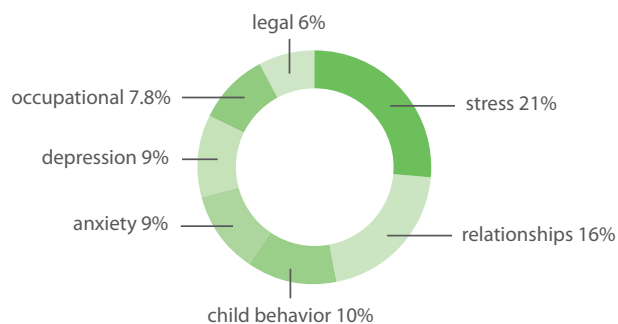
Users of CGP's EAP services in North America demonstrated higher levels of occupational distress in 2015. The number of EAP cases for occupational stress (job satisfaction, workload, co-worker conflict) was sixth on the list of top presenting concerns, breaking into the top seven for the first time since CGP began publishing information on EAP utilization data. The continuation of this two year trend represents a 15% increase in the number of EAP cases due to occupational stress compared to 2013. Overall EAP utilization was 6.9%, similar to the 2014 rate of 7.0%, but higher than recently published industry benchmarks.^{1,2}

Similarly, three out of six regional EAP vendors who participated in a convenience survey conducted by CGP reported an increase in the number of crisis counseling sessions provided in 2015. Crisis counseling sessions were primarily defined as sessions provided for high risk conditions including mandatory referrals for work performance or conflict, risk of harm to self/others, and serious mental health concerns. While the underlying causal factors are difficult to pinpoint, they appear partially related to ongoing organizational changes evident in many industries, continued economic stress, and a general trend by employers to move toward high deductible medical plans which can have an unintended cost of driving more employees with high-risk conditions to the EAP.

Overall, the top five reasons for accessing EAP services remained the same as the previous two years with stress and relationships

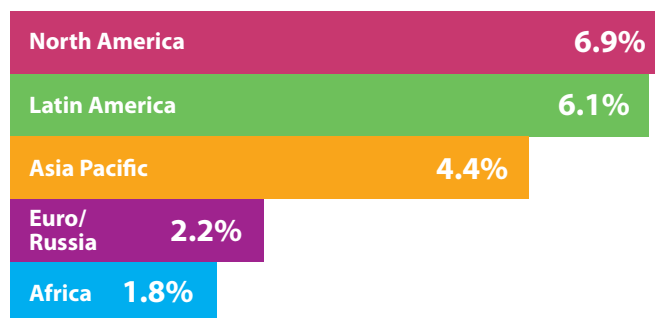
as the most common presenting concerns. Requests for assistance with child behavioral concerns increased for the second year in a row, moving into the top three for the first time.

North American Primary EAP Concerns



For EAP services provided outside North America, the cumulative utilization rate was 4.3%, with use the highest in Latin American countries at 6.1%. Compared to North America, the range of utilization rates varied much more dramatically, largely in response to greater variety in program promotional practices and involvement by local stakeholders. For the third straight year, marital/relationship, child behavior, and stress remained the top three presenting concerns respectively. Legal concerns returned to the top five at number four after dropping out in 2014, followed by depression. While regional differences existed in overall program utilization and in the primary reasons for accessing services, CGP's experience has shown that the keys to an effective global EAP includes ongoing program awareness and the engagement of local/regional stakeholders whose expertise helps to make services culturally relevant. For example, CGP has seen well-promoted EAP programs in China achieve a 10% annual utilization.

2015 CGP EAP Utilization



Ongoing organizational change, continued economic stress, and the movement toward high deductible medical plans appear to be factors contributing to the greater emotional distress seen from many users of EAP services.

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MORE COMPANIES ARE SEEKING GLOBAL EAP SERVICES: THE NEED TO MODIFY RFPs

By Dave Sharar
Chief Clinical Officer



As more and more companies become multi-national, many are looking to extend EAP services outside their “Western” based home country.

IN 2015, THE NUMBER OF INQUIRIES CGP RECEIVED FOR A REQUEST FOR PROPOSAL (RFP) FOR GLOBAL EAP SERVICES INCREASED BY NEARLY 25%.

The reasons for the increase were varied but seemed largely driven by 1) a desire by procurement departments to streamline administrative processes and consolidate EAP vendors, 2) ongoing mergers and acquisitions that have in part resulted in a desire to provide consistency in benefit offerings across countries, and 3) increased awareness of service capabilities in emerging markets that previously did not provide EAP services. Yet as the number of RFPs seem to be on the increase, the information often requested by procurement, benefits, or HR departments suggests that many do not always have a clear understanding of how a Western style EAP “transfers” when set up offshore. Below are some key issues for consideration.

Network Delivery Structure and Credentials: Global vendors will assert that they have a competent and well-trained network of counseling professionals in hundreds of countries, but EA providers as subcontractors are not uniformly or sufficiently equipped in terms of EA knowledge, clinical skills, or operational infrastructure. The huge variety of provider types, credentials (or lack thereof), office settings, data systems, available supervision, and theoretical orientations that exist outside the “west” have significant implications for purchasers of an international EAP. There are numerous countries outside the “west” that have no recognized licensure or regulatory bodies that govern the practice of psychology, social work, or counseling. For example, a 2015 survey of international providers conducted by CGP revealed that in many developing countries there were no requirements other than having a Bachelor’s degree to deliver counseling services. In addition, the certification or accreditation process was frequently unregulated by the government and often rested with an independent professional association when it existed. The ultimate quality of the primary global vendor is dependent on the vendor’s ability to prepare, influence, train, and monitor a remote and far-flung network. Unless the RFP process is designed

to assess this, a standard yes/no grid sheet asking if providers meet the minimum qualification standards may prove inadequate for many purchasers.

Cultural Relevance: A “Western” style EAP cannot be promoted and transferred “lock, stock, and barrel” to an Asian or Latin American country. For example, the approach used in announcing an EAP service in a collectivist culture (such as China) will differ from the approach used in an individualist culture (such as the U.S. or Australia). The former is oriented towards group rules and compliance with norms, so the emphasis is put on using the EAP to promote harmony in the workplace or to become a better person or family member. This is in contrast to the latter where the program emphasizes “fixing personal problems”.

Another cultural relevance issue has to do with initial access. Indigenous employees show a strong preference for contacting professionals who speak their first language and know their cultures and communities. Employers are advised to engage in some due diligence and testing for those EAPs that have “regional” call centers claiming to cover multiple countries to handle numerous languages in one central location. Language translation services commonly used in these regional call centers are not usually perceived by EAP clients as “culturally relevant”, inviting, or supportive – especially when calling about a sensitive personal issue. Most global EAP vendor call centers cannot truly staff 24/7 access to professionals fluent and competent in multiple languages - perhaps making “in-country” access a best practice model.

Finally, “work-life” services as defined and understood in the U.S. or U.K. - and commonly included or embedded with an EAP offering – are frequently not culturally relevant and may not even make sense. For example, child and elder care services in numerous Asian countries are mainly a family obligation and few, if any, child and elder services are even available as a resource. In many European countries child care is a public resource covered by social taxation, so custom referrals to child care providers are not needed. Employers should not assume that a standard U.S. style work-life service will even be applicable in numerous overseas locations.



relevance

continued...

MORE COMPANIES ARE SEEKING GLOBAL EAP SERVICES: THE NEED TO MODIFY RFPs

By Dave Sharar
Chief Clinical Officer



Short-term counseling and referrals. In many parts of the world an EAP is the “de facto” outpatient mental health benefit as private commercial health insurance is not a covered employee benefit. Numerous countries that have national health plans (e.g. “socialized medical care”) do not cover outpatient mental health counseling and instead only cover pharmacological mental health care delivered by a psychiatrist (e.g. medical doctor). The substance abuse treatment infrastructure is also sparse and even non-existent in large parts of the world. In many cases the treatment delivery system, when it exists, lacks efficacy, evidence of outcomes, and is plagued with long wait lists. There are still thousands of practitioners in Europe, Asia, and Latin America who were trained in the psychoanalytic or psychodynamic tradition and view short-term counseling as 75 or more visits – certainly not a Western “EAP” model where brief counseling interventions such as cognitive-behavioral or solution-focused are the preferred approaches. One of the core components of an EAP is facilitating a referral to resources beyond the EAP when ongoing treatment is indicated. However, these resources are frequently non-existent outside of the Western world – so the EAP has to “do what it can” within the allotted six visits, for example.

Confidentiality is foundational to building trust in an EAP type service. But in some countries, such as China, there are no laws to protect confidentiality, requiring an EAP vendor to work with country-based providers to set up strong privacy protections in countries where there is no enforcement. While a conscientious approach to privacy protection by a global EAP can be effective in gaining employee trust in the absence of legal enforcement, it does require additional effort.

Supervisory consultations and referrals as they exist in the west do not transfer well to many countries with different and complex labor laws, particularly around issues with employee conduct and discipline. In some countries, the HR department is also viewed differently, frequently as pseudo EAP counselors. In other situations, the need to refer difficult and complex EAP cases to specialized or longer term care is not well understood, often due to high expectations that the EAP will resolve all employee concerns.

Program Implementation. While CGP’s experience has shown that there are many administrative advantages to having a global or regional EAP, the most successful programs also allow for local employer stakeholders to have direct relationships with local providers/clinicians, allowing for the many cultural nuances to be resolved in a consultative yet direct manner rather than being filtered through Western approaches.



1. Examine the initial telephone access functions, including who answers calls, in what language, and in what location.
2. Have local, “in-country” personnel review promotional materials for proper translation and cultural sensitivity.
3. Ask to see the actual names, locations, and credentials of affiliate providers serving your global workforce.
4. Evaluate how your primary vendor trains, supports, and pays its global affiliates.
5. Determine if your company has health benefits coverage for mental health or substance use disorders that are supportive of making referrals outside the EAP.

COUNSELING Referrals CREDENTIALS
Cultural Confidentiality Implementation
STRUCTURE RELEVANCE Consultations

UTILIZATION OF MOBILE HEALTH APPS INCREASE, **BUT DO THEY DRIVE OUTCOMES?**

By Pam Kouri
Director of Health and Wellness



The Centers for Disease Control and Prevention (CDC) refer to chronic diseases such as heart attack, stroke, diabetes, high blood pressure and obesity as the public health challenge of the 21st century.¹ The implications to both the individual and the employer are significant. For individuals, heart disease and stroke remain a leading cause for death and disability, while diabetes is the leading cause of adult blindness, kidney disease, and amputations.^{2,3} For employers, 75% of health care costs are associated with chronic diseases, and when the employee's lost productivity is also factored in, the estimated cost more than doubles the medical and pharmacy costs.⁴

While this portrays a grim and bleak outlook...as well it should... this does not necessarily need to be the case. According to the CDC, behavior is the leading determinant of an individual's health. Both employers and health professionals are looking for new and innovative approaches to help individuals change behaviors and develop a healthier lifestyle, and the use of technology and mobile apps is one approach being increasingly used. In the past two years, the volume of commercialized mobile health applications (mHealth apps) has more than doubled to over 100,000 according to a 2015 publication by IMS Institute For Healthcare Informatics.⁵

TODAY, 32% OF CONSUMERS HAVE AT LEAST ONE MOBILE HEALTH APPLICATION (MHEALTH APP) ON THEIR MOBILE DEVICE, AND THIS NUMBER IS EXPECTED TO KEEP GROWING.⁶



The functionality of mHealth apps is varied and ranges from controlling the inflation or deflation of a blood-pressure cuff to the measurement of blood glucose levels; providing smoking cessation reminders to storing personal health data; connecting medical providers with diagnostic or dosing tools; and motivating

patients to do their physical therapy exercises through video games. But while the capability to connect so many individuals to so much information has never been greater, published research is limited as to whether these apps actually improve health outcomes in a meaningful or sustainable way.

One data point researchers identify as useful for assessing an individual's potential for behavior change is whether they remain interested and involved in using the app over time, otherwise referred to as the retention rate. Typically the longer or more frequently an individual participates in an intervention, the greater likelihood there is for habit formation to occur. mHealth developers will commonly cite the total number of downloads an app has achieved, and while this provides a point of reference for whether an app is popular, it does not help purchases assess an individual's retention rate. Think of the number of downloads an app receives as similar to the number of gym memberships sold. Because only a portion of individuals purchasing a gym membership actually participate in regular workouts, membership data by itself is not a useful metric for measuring behavior change. According to the IMS report, the average 30-day retention rate for a health and fitness app is 47%. Interestingly enough, when mHealth apps were prescribed by a health care provider, the 30-day "retention rate" increased an additional 10-30%, suggesting that outcomes for health apps may improve when used in conjunction with the supportive guidance of a health professional.

Another important part of the equation in evaluating the effectiveness of mHealth apps is efficacy. In other words, does use of the mHealth app actually lead to behavior change or improved health? To this point, the American Heart Association (AHA) conducted a recent literature review on mobile technologies and the impact on cardiovascular risk behaviors (i.e. smoking, physical activity, healthy eating and maintaining a healthy weight).

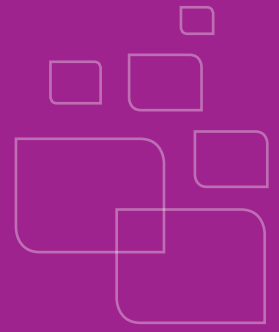
The AHA found that "although the number of apps continues to grow at an exponential rate, none have been critically evaluated, and their development was not evidence based, often not building on the theoretical frameworks that address behavior change."⁷

Similarly, the 2015 IMS report states that while there are hundreds of mHealth apps currently in clinical trials, "the majority of studies published discuss app usage, not app effectiveness in terms of improving health outcomes or lowering healthcare costs." The authors of the IMS publication go on to indicate that while there is preliminary evidence that mHealth apps can produce positive clinical outcomes and cost effectiveness, greater research is needed before this can be stated conclusively.

continued..

UTILIZATION OF MOBILE HEALTH APPS INCREASE, **BUT DO THEY DRIVE OUTCOMES?**

By Pam Kouri
Director of Health and Wellness



When it comes to informed decision making for purchasing mobile health apps for your organization, please consider the following actions:

1. **Verify the basis for claims made.** When a health app is touted as a “top” app, is the distinction based on customer reviews/ratings, the number of downloads, or the ability to create behavior change that improves health metrics?
2. **Verify data collection methods.** Is there enough data across enough time to draw meaningful conclusions? If not, are there plans for ongoing data collection; and what is the intent of the developer to use data for future app updates?
3. **Verify the engagement or retention rates.** Are the retention rates sustained long enough for habit formation to occur? Habit formation varies from 18 days for easy tasks to 254 days for more complex tasks.⁸
4. **Verify if behavior change techniques were incorporated into the app development.** Beyond the common behavior change techniques such as tracking/self-monitoring or education, what other techniques were used? For example, in addition to tracking the number of steps taken or the number of fruit servings consumed a day, does the app incorporate any strategies that help the user overcome new barriers to help fulfill the current goal or to increase the goal.
5. **Verify whether the app can address motivation for those who may not be interested or ready to change unhealthy behaviors.** According to James Prochaska, a leading authority in behavior change science and the developer of the Transtheoretical Model of Behavior Change, less than 20% of a population at risk is prepared to take an action at any given time. How will the other 80% become motivated enough to willingly download an app?
6. **Consider a blended approach that allows for a mobile health app to be used in combination with a health professional.** A health professional, coach, or counselor who is highly skilled in the art of behavior change and utilizes evidence-based practices can nicely fill in the app gap.

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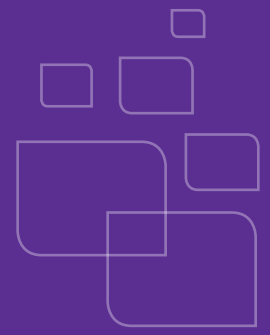
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RECOGNITION OF THE RELATIONSHIP BETWEEN FATIGUE AND WORKPLACE SAFETY INCREASES: **BEST PRACTICES IN IMPLEMENTING A FRMS**

By Todd Donalson
CGP Director of Training and Consultation



During the 1980's and early 1990's, the United States recognized the dangers of employee drug and alcohol misuse on workplace safety and personal health with the passage of the Drug Free Workplace Act of 1988¹ and the Omnibus Transportation Employee Testing Act of 1991². Passage of these legislative acts spurred employers to implement programs designed to reduce employee substance misuse, ranging from drug testing and awareness programs to procedures outlining how to identify and refer an impaired employee to appropriate treatment resources. Today these programs remain a critical component of workplace health and safety initiatives, a trend that is supported by evidence showing substance misuse is associated with occupational injury and a cause of nearly 20% of all workplace fatalities.^{3,4} Interestingly enough, evidence is now showing that insufficient sleep also causes impairment in a similar manner as does substance misuse. For example, researchers at the University of South Australia determined that an individual who is awake for longer than 17 hours is impaired at a similar level as an individual with a blood alcohol content of 0.05.⁵ In the past few years, some industries have begun to develop policies and procedures to reduce the potential health and safety consequences associated with fatigue, replicating a trend that was observed in the 1980's following implementation of the Drug Free Workplace Act.



While initial efforts to manage worker fatigue over a decade ago focused primarily on limiting the maximum number of hours worked per day/week or rotating shifts in a manner that allowed for sufficient rest opportunities, these efforts have been shown inadequate in part because they fail to address the behavioral,

lifestyle, and medical conditions that commonly contribute to fatigue. In the last 3-4 years, the concept of an integrated Fatigue Risk Management Systems (FRMS) has begun to establish itself as the gold standard for reducing organizational risk caused by worker fatigue, and a number of industries have implemented one or more of its components.

FRMS

What Is A Fatigue Risk Management System?

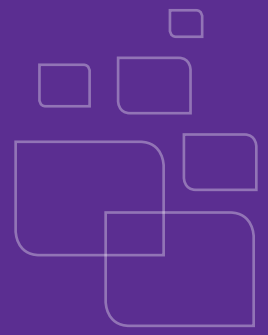
A FRMS is a data driven, science based system that focuses on outcomes rather than prescriptive rules. A number of authors have outlined the key characteristics of a FRMS, which typically consists of six components:⁶

1. Employee and supervisor education on sleep disorders, sleep health, and strategies that help workers stay alert during periods where sleepiness is high due to circadian rhythms.
2. Screening and referral for treatment of undiagnosed medical or behavioral conditions such as sleep apnea which can place employees at up to four times greater risk of accident.
3. Analysis of workplace hazards contributing to fatigue such as performing tasks in harsh environments, or which are highly strenuous or monotonous.
4. Implementation of a reporting system that provides early intervention for employees demonstrating warning signs of fatigue impairment.
5. Creation of an incident investigation process that includes assessments for fatigue impairment.
6. Internal and external auditing of the FMRS to evaluate outcomes and insure a continuous improvement process.

continued..

RECOGNITION OF THE RELATIONSHIP BETWEEN FATIGUE AND WORKPLACE SAFETY INCREASES: **BEST PRACTICES IN IMPLEMENTING A FRMS**

By Todd Donalson
CGP Director of Training and Consultation



How Are Some Industries Responding?

The **Australia Mining and Transportation** industries have had one of the longest histories of utilizing a FMRS. All Australian States and Territories have established formal “codes of practice” designed to control fatigue related risks in the workplace. The first of these was the West Australian Code of Practice: Working Hours established in 2006.⁷ This has since been followed by codes in most states and territory jurisdictions including South Australia⁸, New South Wales,⁹ and most recently on a national level.¹⁰

The **United States Department of Transportation** has been a leader in addressing fatigue risks in the U.S., listing it on the NTSB’s “Most Wanted List” every year since its creation in 1989. While the Federal Aviation Administration and the Federal Rail Administration have issued regulations requiring the implementation of a FRMS in recent years, the Federal Motor Carrier Safety Administration has stopped short of requiring implementation of a FRMS, and instead considers it voluntary.^{11,12,13}

In 2014, the **European Aviation Safety Authority** announced that EU regulation no. 83/2014 required the implementation of a FRMS effective Feb 18, 2016.¹⁴ Required in the plan are (1) policy, (2) limits on duty and flight times, (3) employee training, and (4) hazard identification and risk assessment. This regulation follows years of discussion and research on the implications of fatigue on airline safety, including a 2013 British Airline Pilots Association survey of 500 pilots showing that 56% of member pilots admitted to falling asleep in the cockpit, and more than 80% indicated their ability to fly was “compromised” by fatigue in the past six months.

The **American Petroleum Institute** issued recommended practice guideline PR755 in 2010 for U.S. facilities¹⁵ following the death of 15 employees in the 2005 explosion at BP’s Texas City refinery where fatigue was cited as a contributing factor. These voluntary guidelines recommended establishing limits on hours of service, employee training, screening for sleep disorders, and an incident investigation process. Similarly the **U.S. Pipeline and Hazardous Materials Safety Administration** published recommendations effective in 2011¹⁶ addressing many of the same components.

While **OSHA** does not have any specific standards on fatigue, they have issued guidelines on extended and unusual work shifts encouraging employers to address fatigue impairment as part of its injury and illness prevention program.¹⁷ Similarly, a 2011 alert published by **The Joint Commission (JCAHO)**

called for sweeping actions to reduce medical errors due to fatigue.¹⁸ While these recommendations were non-binding, they included developing strategies to evaluate shift work policies including 30 hour “on duty” limits for medical residents, and 16 hours if residents were in their first year.¹⁹



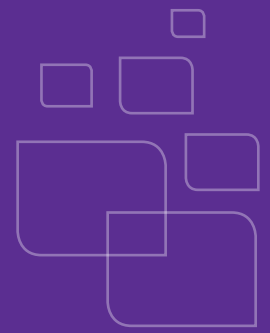
A number of factors can contribute to employee fatigue ranging from roster and work schedules, environmental and medical conditions, and behavioral/lifestyle habits including stress and work life balance. While a FRMS outlines the key components of a best practice approach to reducing fatigue risks, organizations not yet prepared to implement all of the components may want to consider the following guidelines as a starting point.

1. Review your incident reporting process and collect at least 2-3 fatigue related data points such as time of incident, total hours slept in the previous 48 hours, or total hours continuously awake at time of accident.
2. Consult with your EAP vendor to determine if they can provide resources to assist in reducing fatigue risks such as sleep health education, screening for sleep disorders or behavioral health intervention for conditions contributing to fatigue. In addition, find out if your EAP offers specialized training or health coaching programs for sleep difficulties.
3. Consult with your occupational health provider to determine if pre-employment or post-accident evaluations assess for sleep disorders or other conditions impacting sleep quality and quantity.

continued..

RECOGNITION OF THE RELATIONSHIP BETWEEN FATIGUE AND WORKPLACE SAFETY INCREASES: **BEST PRACTICES IN IMPLEMENTING A FRMS**

By Todd Donalson
CGP Director of Training and Consultation



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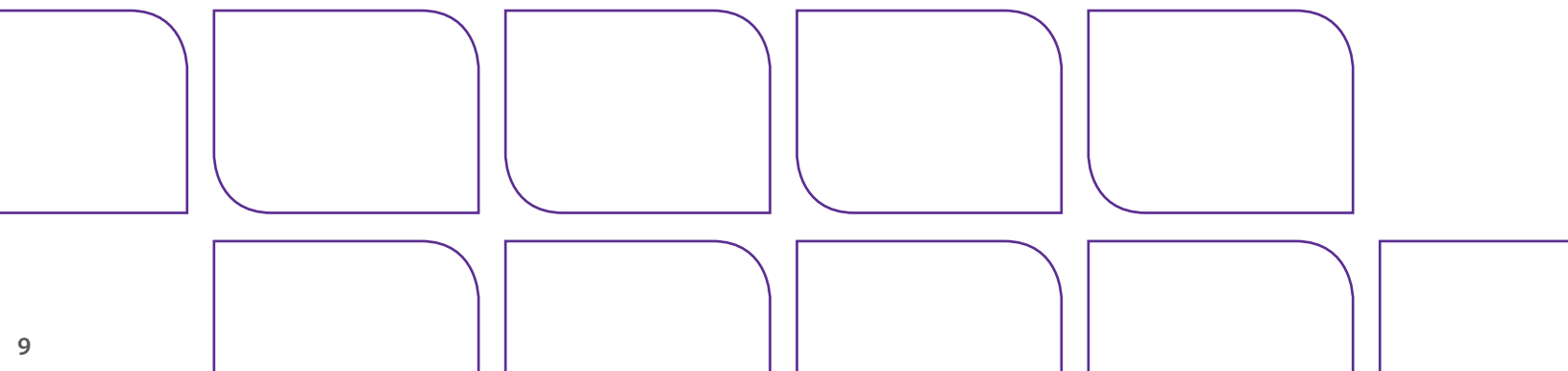
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¹⁷US Department of Labor press release number 10-1238; issued September 2, 2010; https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=NEWS_RELEASES&p_id=18285

¹⁸The Joint Commission Sentinel Event Alert, issue 48, December 14, 2011; http://www.jointcommission.org/assets/1/18/SEA_48.pdf

¹⁹Accreditation Council for Graduate Medical Education; 2011 duty hour standards; <http://www.acgme.org/acgmeweb/tabid/271/GraduateMedicalEducation/DutyHours.aspx>



EMPLOYEE ENGAGEMENT INITIATIVES ARE HAVING LIMITED IMPACT: WHY TOOLS PROMOTING PERSONAL GROWTH ARE NEEDED

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Employee engagement in the past decade has shown little improvement despite the deployment of significant resources by many organizations. According to a 2015 Gallop poll, only 32% of US employees are engaged, a statistic that has remained relatively unchanged over the past 15 years. One reason for the unchanging level of employee engagement is that there has been very little change in approaches to measuring and improving engagement since the initial work began nearly two decades ago.

THERE HAS BEEN LITTLE CHANGE IN THE APPROACHES TO MEASURING AND IMPROVING ENGAGEMENT DURING THE PAST TWO DECADES.

Unfortunately most of the discussion is in the form of consultation that is atheoretical rather than a research oriented approach meant to communicate between scholars and encourage peer review. This practical approach creates a fairly fragmented coverage of the topic as typified by the lack of an agreed upon single definition. For example, Gallup's (2013) definition of engagement refers to individuals who work with passion and feel a profound connection to their employer. This definition has two distinct elements: 1) a passionate basis to their everyday activity, and 2) an emotional connection to their employer. On the other hand, Maylett and Warner (2014) define work engagement as the emotional connection that the employee has to organization. This definition, however, focuses on the global emotional connection, ignoring the performance of everyday activity altogether. Kruse (2013) defines engagement in affective terms and as one's emotional commitment to their organization's organizational goals, again sidestepping the performance and cognitive issues. Finally, MacPherson (2014) defines work engagement as the degree to which an employee is psychologically invested in the organization and motivated to contribute to its success. Though somewhat vague, it is essentially about one's emotional connection to the organization.

Secondly, most measures of engagement are questionnaires administered to employees on a population basis. The most influential of these is the Gallup survey that consists of a series of self-report items directed at engagement-like behaviors thought to indicate a strong emotional connection to the organization. There is typically not an attempt to conduct a research study, but rather a simple assessment designed to get an indication of the engagement culture in the organization. Consultants then use these tallied results as a basis for recommending an organizational strategy that can change the culture and improve the number of engaged employees. Throughout the literature, however, there is strong acknowledgement that engagement is a two-way street, and that employees need to be receptive to engagement improvement programs. Blessing and White (2013) assert that engagement is fundamentally the responsibility of the employee. Yet there is very little discussion in the literature of the potential for change in the

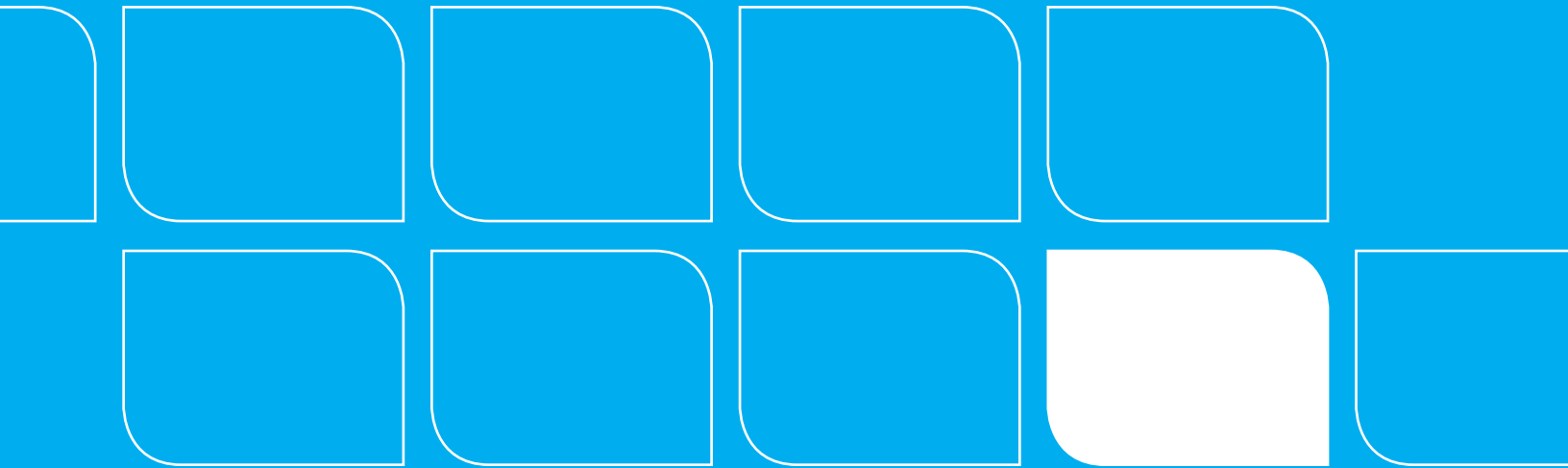
individual employees, and none of the published research present any analysis of individual change based upon a specific intervention. For example, the recent psychological research (Schaufeli, Bakker, & Salanova, 2006; Macey & Schneider, 2008; Gibbons, 2014) is focused on the organization's effect on the individual, not personal work engagement. While Maylett and Warner (2014) coin the phrase "personal work engagement" to emphasize this point, they stop short of offering any curriculum for training engagement. In short, the general approach continues to be one of using self-reported questionnaires to assess whether organizational strategies are impacting engagement levels, not on evaluating which strategies are most effective in enhancing engagement at an individual employee level.

The existing organizational paradigm is focused on moving engagement levels by changing the corporate culture. This top-down approach assumes that the cultural changes will trickle down to the individual employee which of course makes up the overall corporate environment. There is little published evidence that this works very well. From a strictly behavioral change perspective, this top-down approach is incapable of tracking how much work engagement changes within an individual employee. While interest in the personal side of engagement is not necessarily new, the focus on employee intervention is new, and Maylett and Warner's (2014) use of questionnaires to direct change is ground breaking.

Unfortunately what is still needed is to provide employees with the tools for change such as a curriculum that specifies the reason why employees should be concerned about their personal work engagement, and a method by which they can direct their own improvement in that area.

There are many important lessons to be learned from the first two decades of work engagement discussion. What is common among most of these top-down approaches is the importance of having the active participation of the employee in order to change the culture. Blessing and White (2013) go as far as to say that although the culture is important, engagement is fundamentally the responsibility of the employee. In the most comprehensive statement to date of the role of the employee in work engagement, Maylett and Warner (2014) coined the term "personal work engagement" to mean the extent to which the employee actively assimilates one's working role into one's total self-concept. As a result, a missing piece of an employee engagement intervention and a likely trend for the future is one that helps the employee understand the importance of their role, and how improved work engagement benefits not just the company, but the employee as well.

Perhaps the next 20 years will provide the opportunities for researchers and employers to develop the necessary learning and training that can result in improved engagement via both employer and employee change strategies.



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