



# The CDC Worksite Health ScoreCard Scoring Methodology

Evidence and Impact Ratings and Supporting Citations



National Center for Chronic Disease Prevention and Health Promotion  
Division for Heart Disease and Stroke Prevention





## STEP 1: RATING SYSTEM OF EVIDENCE FOR EACH SURVEY ITEM

**Evidence-Base Rating:** To establish the evidence base for each of the strategies, the CDC National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) Workplace Workgroup subject matter experts (SMEs) and the Emory University Institute for Health and Productivity Studies (IHPS) staff conducted extensive literature searches to find the most up-to-date evidence, in the form of studies, review articles, Cochrane reports, Community Guide summaries, and U.S. Preventive Services Task Force recommendations, supporting each item on the CDC Worksite Health ScoreCard (HSC).<sup>a</sup>

The CDC Workplace Workgroup then met several times throughout 2010 to review the scientific evidence and rate the evidence for each item using a 4-point scale (from 1=Weak to 4=Strong). During this rating process, SMEs were allowed to consult with other SMEs in their topic area of expertise; however, only the rating of one SME was required for establishing the evidence and impact rating for a given survey item. For more information about the evidence rating system, please see the following table:

Evidence Rating	Definition of the Rating Categories
Weak (1)	Research evidence supporting relationship is fragmentary, nonexperimental or poorly operationalized. There is debate among experts in the field as to whether or not causal impact is plausible or exists.
Suggestive (2)	Two or more studies support relationship, such as pre- and post-evaluations, but no studies reported using control groups (e.g., randomized control groups, quasiexperimental studies.) Most experts believe causal impact is plausible and consistent with knowledge in related areas but some experts see support as limited or acknowledge plausible alternative explanations.
Sufficient (3)	Relationship is supported by at least two well-designed quasiexperimental studies containing comparison groups, but no randomized control groups. Experts believe that relationship is likely causal, and studies have eliminated most alternative confounding variables or alternative explanations.
Strong (4)	Cause effect relationship is supported by at least one well-designed study with randomized control groups or three or more well-designed quasiexperimental studies with little or no debate among experts of causal relationship.

<sup>a</sup> Please see the CDC Worksite Health ScoreCard Manual's acknowledgement page for names and affiliations of all CDC and Emory University IHPS personnel that contributed to the development of the rating system.

## STEP 2: RATING SYSTEM OF IMPACT FOR EACH SURVEY ITEM

Based on the evidence-base gathered during step 1, the SMEs rated each item (for the section(s) in which they had expertise) in terms of its estimated impact on health outcomes or behaviors (i.e., effect size) using a 3-point scale, as defined in the following table:

Impact Rating	Definition of the Rating Categories
Small (1)	0 to 1 percentage point improvement in 1 year
Sufficient (2)	>1 to 2 percentage point improvement in 1 year
Large (3)	>2 or more percentage point improvement in 1 year

For example, promotion of stair use may get a “Strong-4” rating on strength of evidence and a “Large-3” impact rating for its potential impact on physical activity (it is expected to increase physical activity of the employees by more than 3 percentage points).

## STEP 3: ASSIGNING A WEIGHTED-SCORE TO EACH SURVEY ITEM

Once evidence and impact ratings were determined, the CDC Workgroup and Emory University IHPS team met to assign a weighted score to each item. The weighted score for each item was calculated by adding the item’s “Evidence-Base Score” to the item’s “Impact Score” and adjusting the value based on the criteria below.

### *Weighted Scoring Key*

<u>Evidence Base:</u>	+	<u>Item Impact:</u>	=	<u>Adjusted Value</u>	=	<u>Final Health Impact Point Value</u>
1 = Weak		1 = Small		Total Pts = 2,3    Value = 1		1 = Good
2 = Suggestive		2 = Sufficient		Total Pts = 4,5    Value = 2		2 = Better
3 = Sufficient		3 = Large		Total Pts = 6,7    Value = 3		3 = Best
4 = Strong						

Each item on the HSC has an associated health impact point value between 1 and 3, where 1 = good, 2 = better, and 3 = best. This point value reflects the level of impact (i.e., observable change elicited in a 1-year period) that the strategy has on health outcomes or behaviors and the strength of scientific evidence supporting this impact, as determined by SMEs.

The following pages contain the evidence and impact ratings, adjusted value, and final assigned point values for each item on the HSC. Citations supporting these ratings are found in the Reference section.

## Organizational Supports

Evidence Base 1-4	Item Impact 1-3	Total	Adjusted Value	<b>Organizational Supports</b> <i>During the past 12 months, did your worksite:</i>
2	1	3	1	1. Conduct an employee needs and interests assessment for planning health promotion activities? <sup>1-3</sup> <i>Answer “yes” if, for example, your organization administers focus groups or employee satisfaction surveys to assess your employee health promotion program(s). Answer “no” if your organization administers general surveys that do not assess your employee health promotion program(s).</i>
4	2	6	3	2. Conduct employee health risk appraisals or assessments through vendors, on-site staff, or health plans and provide individual feedback plus health education? <sup>4-7</sup> <i>Answer “yes” if, for example, your organization provides individual feedback through written reports, letters, or one-on-one counseling.</i>
2	3	5	2	3. Demonstrate organizational commitment and support of worksite health promotion at all levels of management? <sup>2,4,6,8-17</sup> <i>Answer “yes” if, for example, all levels of management participate in activities, communications are sent to employees from senior leaders, the worksite supports performance objectives related to healthy workforce, or program ownership is shared with all staff levels.</i>
3	2	5	2	4. Use and combine incentives with other strategies to increase participation in health promotion programs? <sup>2-6,8,10,11,16,18-22</sup> <i>Answer “yes” if, for example, your organization offers incentives such as gift certificates, cash, paid time off, product or service discounts, reduced health insurance premiums, employee recognition, or prizes.</i>
2	3	5	2	5. Use competitions when combined with additional interventions to support employees making behavior changes? <sup>22-30</sup> <i>Answer “yes” if, for example, your organization offers walking or weight loss competitions.</i>
2	1	3	1	6. Promote and market health promotion programs to employees? <sup>2,6,9,10,14,15,31</sup> <i>Answer “yes” if, for example, your worksite’s health promotion program has a brand name or logo, uses multiple channels of communication, or sends frequent messages.</i>
1	1	2	1	7. Use examples of employees role modeling appropriate health behaviors or employee health-related “success stories” in the marketing materials? <sup>4,5,12,32-36</sup>



Evidence Base 1-4	Item Impact 1-3	Total	Adjusted Value	<b>Organizational Supports</b> <i>During the past 12 months, did your worksite:</i>
4	3	7	3	8. Tailor some health promotion programs and education materials to the language, literacy levels, culture, or readiness to change of various segments of the workforce? <sup>2,6,8,10,16,36-45</sup> <i>Answer “no” if you do not perceive a need for your organization to tailor its health promotion programs and education materials to any specific group(s).</i>
2	2	4	2	9. Have an active health promotion committee? <sup>3,8,11,12,32,46,47</sup> <i>Answer “yes” if your health promotion committee exists and has been involved in planning and implementing programs.</i>
2	2	4	2	10. Have a paid health promotion coordinator whose job (either part-time or full-time) is to implement a worksite health promotion program? <sup>3,4,6,8,32</sup> <i>Answer “yes” if implementing the employee health promotion program(s) at your worksite is included in a paid staff member’s job description or performance expectations.</i>
2	2	4	2	11. Have a champion(s) who is a strong advocate for the health promotion program? <sup>8,11,12,32,46</sup> <i>Answer “yes” if there is someone at your worksite who actively promotes programs to improve worksite health promotion.</i>
2	2	4	2	12. Have an annual budget or receive dedicated funding for health promotion programs? <sup>3,11,32</sup>
2	2	4	2	13. Set annual organizational objectives for health promotion? <sup>3,4,8,10,32</sup>
2	1	3	1	14. Include references to improving/maintaining employee health in the business objectives or organizational mission statement? <sup>2,8,10,48</sup> <i>Answer “no” if your organization’s business objectives or mission statement only reference occupational health and safety, without reference to improving the workforce’s health.</i>

Evidence Base 1-4	Item Impact 1-3	Total	Adjusted Value	<b>Organizational Supports</b> <i>During the past 12 months, did your worksite:</i>
3	2	5	2	15. Conduct ongoing evaluations of health promotion programming that use multiple data sources? <small>2,8,10,16,32,49-52</small> <i>Answer “yes” if, for example, your organization collects data on employee health risks, medical claims, employee satisfaction or organizational climate surveys.</i>
1	1	2	1	16. Make health promotion programs available to family members? <small>2,53,54</small>
2	2	4	2	17. Provide flexible work scheduling policies? <small>55-60</small> <i>Answer “yes” if, for example, policies allow for flextime schedules and work at home.</i>
2	2	4	2	18. Engage in other health initiatives throughout the community and support employee participation and volunteer efforts? <small>4,8,37,61,62</small> <i>Answer “yes” if, for example, your organization supports participation in community events and school-based efforts, such as corporate walks, collaborate with state and local advocacy groups, health and regulatory organizations, and coalitions.</i>
<b>Total Possible Points</b>			33	

## Tobacco Control

Evidence Base 1-4	Item Impact 1-3	Total	Adjusted Value	<i>Tobacco Control</i> <i>During the past 12 months, did your worksite:</i>
3	3	6	3	19. Have a written policy banning tobacco use at your worksite? <sup>63-68</sup> <i>Answer “yes” if your worksite adheres to a statewide, countywide, or citywide policy banning tobacco use in the workplace.</i>
1	2	3	1	20. Actively enforce a written policy banning tobacco use? <sup>69</sup> <i>Answer “yes” if, for example, your worksite posts signs, does not have ashtrays, or communicates this written policy banning tobacco use through various channels at your worksite.</i>
1	2	3	1	21. Display signs (including “no smoking” signs) with information about your tobacco-use policy? <sup>70</sup>
4	2	6	3	22. Refer tobacco users to a state or other tobacco cessation telephone quit line? <sup>72-74</sup> <i>Answer “yes” if, for example, your worksite refers tobacco users to 1-800-QUIT NOW or smokefree.gov.</i>
4	3	7	3	23. Provide health insurance coverage with no or low out-of-pocket costs for <b>prescription</b> tobacco cessation medications including nicotine replacement? <sup>74-76</sup> <i>Answer “yes” if, for example, your organization provides coverage for inhalers, nasal sprays, bupropion (e.g., Zyban) and varenicline (e.g., Chantix).</i>
3	2	5	2	24. Provide health insurance coverage with no or low out-of-pocket costs for FDA-approved <b>over-the-counter</b> nicotine replacement products? <sup>74,77</sup> <i>Answer “yes” if, for example, your organization provides coverage for nicotine replacement gum, patches, or lozenges.</i>
3	2	5	2	25. Provide or promote free or subsidized tobacco cessation counseling? <sup>74,77</sup> <i>Answer “yes” if these programs are provided on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/programs, community groups, or other practitioners.</i>



Evidence Base 1-4	Item Impact 1-3	Total	Adjusted Value	<i><b>Tobacco Control</b></i> <i><b>During the past 12 months, did your worksite:</b></i>
3	2	5	2	26. Inform employees about health insurance coverage and programs that include tobacco cessation medication and counseling? <sup>78,79</sup>
2	1	3	1	27. Provide incentives for being a current nonuser of tobacco and for current tobacco users that are currently involved in a cessation class or actively quitting? <i>Answer “yes” if, for example, your organization provides discounts on health insurance, increases in disability payments or additional life insurance for nonsmokers and tobacco users who are actively trying to quit.</i>
1	2	3	1	28. Do not allow sale of tobacco products on company property? <i>Answer “yes” if, for example, your worksite does not sell tobacco products on company property in vending machines or through on-site vendors.</i>
<b>Total Possible Points</b>			<b>19</b>	

## Nutrition

Evidence Base 1-4	Item Impact 1-3	Total	Adjusted Value	<i>Nutrition</i> <i>During the past 12 months, did your worksite:</i>
NA	NA	NA	0	29. Provide places to purchase food and beverages? <sup>81-84</sup> <i>Answer “yes” if, for example, your worksite provides vending machines, cafeterias, snack bars, or other purchase points.</i> <b>IF NO, PLEASE SKIP TO QUESTION 36.</b>
1	1	2	1	30. Have a written policy or formal communication that makes healthier food and beverage choices available in <b>cafeterias or snack bars</b> ? <sup>85-88</sup> <i>Answer “yes” if, for example, the policy or formal communication makes vegetables, fruits, 100% fruit juices, whole grain items and trans fat-free/low-sodium snacks available in cafeterias or snack bars.</i>
1	1	2	1	31. Have a written policy or formal communication that makes healthier food and beverage choices available in <b>vending machines</b> ? <sup>85-88</sup> <i>Answer “yes” if, for example, the policy or formal communication makes vegetables, fruits, 100% fruit juices, whole grain items, and trans fat-free/low-sodium snacks available in vending machines.</i>
3	3	6	3	32. Make most (more than 50%) of the food and beverage choices available in vending machines, cafeterias, snack bars, or other purchase points be healthy food items? <sup>84,89,90</sup> <i>Answer “yes” if the healthy foods are items such as skim milk, 1% milk, water, unsweetened flavored water, diet drinks, 100% fruit juice, low-fat and low-sodium snacks, or fresh fruit. (See Dietary Guidelines for Americans, 2010, or GSA/HHS Health and Sustainability Guidelines for Federal Concessions and Vending Operations.)</i>
2	2	4	2	33. Provide nutritional information (beyond standard nutrition information on labels) on sodium, calories, trans fats, or saturated fats for foods and beverages sold in worksite cafeterias, snack bars, or other purchase points? <sup>91-93</sup>
3	3	6	3	34. Identify healthier food and beverage choices with signs or symbols? <sup>84</sup> <i>Answer “yes” if, for example, your worksite puts a heart next to a healthy item near vending machines, cafeterias, snack bars, or other purchase points.</i>

Evidence Base 1-4	Item Impact 1-3	Total	Adjusted Value	<i>Nutrition</i> <i>During the past 12 months, did your worksite:</i>
3	3	6	3	35. Subsidize or provide discounts on healthy foods and beverages offered in vending machines, cafeterias, snack bars, or other purchase points? <sup>90,94-97</sup>
1	1	2	1	36. Have a written policy or formal communication making healthy food and beverage choices available during meetings when food is served? <sup>87,88,98,99</sup> <i>Answer “yes” if, for example, the policy or formal communication makes vegetables, fruits, 100% fruit juices, whole grain items, or trans fat-free/low-sodium snacks available during meetings.</i>
1	1	2	1	37. Provide employees with food preparation and storage facilities? <sup>b</sup> <i>Answer “yes” if your worksite provides a microwave oven, sink, refrigerator, or kitchen.</i>
1	1	2	1	38. Offer or promote an on-site or nearby farmers’ market where fresh fruits and vegetables are sold? <sup>100,101</sup>
1	1	2	1	39. Provide brochures, videos, posters, pamphlets, newsletters, or other written or online information that address the benefits of healthy eating? <sup>55,102,103</sup> <i>Answer “yes” if these health promotion materials address the benefits of healthy eating as a single health topic or if the benefits of healthy eating are included with other health topics.</i>
3	2	5	2	40. Provide a series of educational seminars, workshops, or classes on nutrition? <sup>55,102-104</sup> <i>Answer “yes” if these sessions address nutrition as a single health topic or if nutrition is included with other health topics. These sessions can be provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/ programs, community groups, or other practitioners.</i>
3	2	5	2	41. Provide free or subsidized self-management programs for healthy eating? <sup>7,55,103</sup> <i>Answer “yes” if these programs are provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/ programs, community groups, or other practitioners.</i>
<b>Total Possible Points</b>			<b>21</b>	

<sup>b</sup> SME comment: “In spite of the weak evidence that exists, this is an important item because it can encourage employees to bring or prepare healthy food from home.”

## Physical Activity

Evidence Base 1-4	Item Impact 1-3	Total	Adjusted Value	<i>Physical Activity</i> <i>During the past 12 months, did your worksite:</i>
4	3	7	3	42. Provide an exercise facility on-site? <sup>59,89,104-108</sup>
4	3	7	3	43. Subsidize or discount the cost of on-site or off-site exercise facilities? <sup>59,104-106</sup>
4	3	7	3	44. Provide other environmental supports for recreation or physical activity? <sup>4,59,89,105-109</sup> <i>Answer “yes” if, for example, your worksite provides trails or a track for walking/jogging, maps of suitable walking routes, bicycle racks, a basketball court, open space designated for recreation or exercise, a shower, and changing facility.</i>
4	3	7	3	45. Post signs at elevators, stairwell entrances/exits and other key locations that encourage employees to use the stairs? <sup>59,107,108</sup> <i>Answer “no” if your worksite is located in a one-story building.</i>
4	3	7	3	46. Provide organized individual or group physical activity programs for employees (other than the use of an exercise facility)? <sup>59,104</sup> <i>Answer “yes” if, for example, your worksite provides walking or stretching programs, group exercise, or weight training.</i>
1	1	2	1	47. Provide brochures, videos, posters, pamphlets, newsletters, or other written or online information that address the benefits of physical activity? <sup>55,102,104,106</sup> <i>Answer “yes” if these health promotion materials address the benefits of physical activity as a single health topic or if the benefits of physical activity are included with other health topics.</i>
3	2	5	2	48. Provide a series of educational seminars, workshops, or classes on physical activity? <sup>55,104,106</sup> <i>Answer “yes” if these sessions address physical activity as a single health topic or if physical activity is included with other health topics. These sessions can be provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/programs, community groups, or other practitioners.</i>
5	3	7	3	49. Provide or subsidize physical fitness assessments, follow-up counseling, and physical activity recommendations either on-site or through a community exercise facility? <sup>59,104,106</sup>
3	3	6	3	50. Provide free or subsidized self-management programs for physical activity? <sup>59,104,106</sup> <i>Answer “yes” if these programs are provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/programs, community groups, or other practitioners.</i>
<b>Total Possible Points</b>			<b>24</b>	

## Weight Management

Evidence Base 1-4	Item Impact 1-3	Total	Adjusted Value	<i>Weight Management</i> <i>During the past 12 months, did your worksite:</i>
3	2	5	2	51. Provide free or subsidized body composition measurement, such as height and weight, Body Mass Index (BMI) scores, or other body fat assessments (beyond HRAs) followed by directed feedback and clinical referral when appropriate? <sup>7</sup>
1	1	2	1	52. Provide brochures, videos, posters, pamphlets, newsletters, or other written or online information that address the risks of overweight or obesity? <sup>102,110,111</sup> <i>Answer “yes” if these health promotion materials address the risks of overweight or obesity as a single health topic or if the risks of overweight or obesity are included with other health topics.</i>
4	2	6	3	53. Provide a series of educational seminars, workshops, or classes on weight management? <sup>54,102,111,112</sup> <i>Answer “yes” if these sessions address weight management as a single health topic or if weight management is included with other health topics. These sessions can be provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/programs, community groups, or other practitioners.</i>
4	3	7	3	54. Provide free or subsidized one-on-one or group lifestyle counseling for employees who are overweight or obese? <sup>102,112</sup> <i>Answer “yes” if these programs are provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/programs, community groups, or other practitioners.</i>
3	2	6	3	55. Provide free or subsidized self-management programs for weight management? <sup>112</sup> <i>Answer “yes” if these programs are provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/programs, community groups, or other practitioners.</i>
<b>Total Possible Points</b>			<b>12</b>	

## Stress Management

Evidence Base 1-4	Item Impact 1-3	Total	Adjusted Value	<i>Stress Management</i> <i>During the past 12 months, did your worksite:</i>
1	1	2	1	56. Provide space where employees can go to practice relaxation techniques such as meditation, yoga, and biofeedback? <sup>c</sup>
1	1	2	1	57. Sponsor or organize social events throughout the year? <sup>d</sup> <i>Answer “yes” if, for example, your worksite sponsors or organizes team building events, company picnics, holiday parties, or employee sports teams.</i>
4	3	7	3	58. Provide stress management programs? <sup>114-122</sup> <i>Answer “yes” if these programs address stress management as a single health topic or if stress management is included with other health topics. Answer “yes” if these programs are provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/programs, community groups, or other practitioners.</i>
4	2	6	3	59. Provide work-life balance/ life-skills programs? <sup>114-122</sup> <i>Answer “yes” if, for example, your worksite provides elder care, child care, referrals, tuition reimbursement, or other programs that are offered through vendors, on-site staff, or employee assistance programs.</i>
3	3	6	3	60. Provide training for managers on identifying and reducing workplace stress-related issues? <sup>116,123,124</sup> <i>Answer “yes” if, for example, your worksite provides training on performance reviews, communication, personnel management, assertiveness, time management, or conflict resolution.</i>
4	3	7	3	61. Provide opportunities for employee participation in organizational decisions regarding workplace issues that affect job stress? <sup>1,56,123-130</sup> <i>Answer “yes” if, for example, your worksite provides opportunities for employees to participate in decisions about work processes and environment, work schedules, participative problem-solving, and management of work demands.</i>
<b>Total Possible Points</b>			<b>14</b>	

<sup>c</sup> SME Comment: “Although we did not find any studies on designated space, stress management (SM) subject matters experts (SMEs) evaluated six widely used occupational SM interventions and found that relaxation was the most practical intervention and space would be needed for this. The SMEs considered history of success and duration of effect, as the most important factors when selecting SM interventions.”

<sup>d</sup> SME Comment: “Although we did not find any studies on the impact of social events, we felt that this item was important for showing a caring atmosphere and building morale, productivity, and a culture of wellness as part of a comprehensive approach.”



## Depression

Evidence Base 1-4	Item Impact 1-3	Total	Adjusted Value	<i>Depression</i> <i>During the past 12 months, did your worksite:</i>
3	3	6	3	62. Provide free or subsidized clinical screening for depression (beyond HRAs) followed by directed feedback and clinical referral when appropriate? <sup>56,79,131,132</sup> <i>Answer “yes” if these services are provided directly through your organization or indirectly through a health insurance plan.</i>
3	2	5	2	63. Provide access to online or paper self-assessment depression screening tools? <sup>131,133,134</sup>
2	2	4	2	64. Provide brochures, videos, posters, pamphlets, newsletters, or other written or online information that address depression? <sup>135</sup> <i>Answer “yes” if these health promotion materials address depression as a single health topic or if depression is included with other health topics.</i>
4	3	7	3	65. Provide a series of educational seminars, workshops, or classes on preventing and treating depression? <sup>116,117,136-140</sup> <i>Answer “yes” if these sessions address depression as a single health topic or if depression is included with other health topics. These sessions can be provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/programs, community groups, or other practitioners.</i>
4	3	7	3	66. Provide one-on-one or group lifestyle counseling for employees with depression? <sup>122,141-145</sup> <i>Answer “yes” if these programs are provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/programs, community groups, or other practitioners.</i>
2	3	5	2	67. Provide training for managers on depression in the workplace? <sup>123,124,146</sup> <i>Answer “yes” if for example, your worksite provides managers with training on how to recognize depression, productivity/safety issues, and company/community resources for managing depression.</i>
4	3	7	3	68. Provide health insurance coverage with no or low out-of-pocket costs for depression medications and mental health counseling? <sup>75,76,79,143,144,147</sup>
<b>Total Possible Points</b>			<b>18</b>	

## High Blood Pressure

Evidence Base 1-4	Item Impact 1-3	Total	Adjusted Value	<i>High Blood Pressure</i> <i>During the past 12 months, did your worksite:</i>
4	2	6	3	69. Provide free or subsidized blood pressure screening (beyond HRAs) followed by directed feedback and clinical referral when appropriate? <sup>7,79,148-154</sup>
2	1	3	1	70. Provide brochures, videos, posters, pamphlets, newsletters, or other information that address the risks of high blood pressure? <sup>22,46,149,151,153,155-157</sup> <i>Answer “yes” if these health promotion materials address the risks of high blood pressure as a single health topic or if the risks of high blood pressure are included with other health topics.</i>
4	2	6	3	71. Provide a series of educational seminars, workshops, or classes on preventing and controlling high blood pressure? <sup>50,71,80,122,149,151,152,158-163</sup> <i>Answer “yes” if these sessions address preventing or controlling high blood pressure as a single health topic or if preventing and controlling high blood pressure are included with other health topics. These sessions can be provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/programs, community groups, or other practitioners.</i>
4	3	7	3	72. Provide one-on-one or group lifestyle counseling and follow-up monitoring for employees with high blood pressure or pre-hypertension? <sup>7,22,79,80,148-150,154,156,158,159,161,164-170</sup> <i>Answer “yes” if these programs are provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/programs, community groups, or other practitioners.</i>
4	2	6	3	73. Provide free or subsidized self-management programs for blood pressure control? <sup>7,46,50,71,156,157,159,163,164,166,169-172</sup> <i>Answer “yes” if these programs are provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/programs, community groups, or other practitioners.</i>
3	1	4	2	74. Make blood pressure monitoring devices available with instructions for employees to conduct their own self assessments? <sup>46,156,171</sup>
3	2	5	2	75. Provide health insurance coverage with no or low out-of-pocket costs for blood pressure control medications <sup>75,76,154,170</sup>
<b>Total Possible Points</b>			<b>17</b>	

## High Cholesterol

Evidence Base 1-4	Item Impact 1-3	Total	Adjusted Value	<i>High Cholesterol</i> <i>During the past 12 months, did your worksite:</i>
4	2	6	3	76. Provide free or subsidized cholesterol screening (beyond HRAs) followed by directed feedback and clinical referral when appropriate? <sup>7,80,151,152,173-178</sup>
2	1	3	1	77. Provide brochures, videos, posters, pamphlets, newsletters, or other information that address the risks of high cholesterol? <sup>46,151,153,176</sup> <i>Answer “yes” if these health promotion materials address the risks of high cholesterol as a single health topic or if the risks of high cholesterol are included with other health topics.</i>
4	2	6	3	78. Provide a series of educational seminars, workshops, or classes on preventing and controlling high cholesterol? <sup>7,50,71,80,122,151,152,158,159,162,163,166,169,175-177,179-184</sup> <i>Answer “yes” if these sessions address preventing and controlling high cholesterol as a single health topic or if preventing and controlling high cholesterol are included with other health topics. These sessions can be provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/ programs, community groups, or other practitioners.</i>
4	3	7	3	79. Provide one-on-one or group lifestyle counseling and follow-up monitoring for employees who have high cholesterol? <sup>7,80,151,159,162,164,166,169,173,175,176,180,185-187</sup> <i>Answer “yes” if these programs are provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/ programs, community groups, or other practitioners.</i>
4	3	7	3	80. Provide free or subsidized lifestyle self-management programs for cholesterol/lipid control? <sup>7,46,50,151,157,159,164,166,169,173,175,179,185,188-190</sup> <i>Answer “yes” if these programs are provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/ programs, community groups, or other practitioners.</i>
3	2	5	2	81. Provide health insurance coverage with no or low out-of-pocket cost for cholesterol/lipid control medications? <sup>75,76,178</sup>
<b>Total Possible Points</b>			<b>15</b>	

## Diabetes

Evidence Base 1-4	Item Impact 1-3	Total	Adjusted Value	<i>Diabetes</i> <i>During the past 12 months, did your worksite:</i>
4	2	6	3	82. Provide free or subsidized pre-diabetes and diabetes risk factor self- assessments (paper/pencil or online) and feedback, followed by blood glucose screening and clinical referral when appropriate? <sup>191-197</sup>
1	1	2	1	83. Provide brochures, videos, posters, pamphlets, newsletters, or other information that address the risks of diabetes? <sup>198-201</sup> <i>Answer “yes” if these health promotion materials address the risks of diabetes as a single health topic or if the risks of diabetes are included with other health topics.</i>
3	3	6	3	84. Provide a series of educational seminars, workshops, or classes on preventing and controlling diabetes? <sup>198-201</sup> <i>Answer “yes” if these sessions address preventing and controlling diabetes as a single health topic or if preventing and controlling diabetes are included with other health topics. These sessions can be provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/programs, community groups, or other practitioners.</i>
4	3	7	3	85. Provide one-on-one or group lifestyle counseling and follow-up monitoring for employees who have abnormal blood glucose levels (pre-diabetes or diabetes)? <sup>191-197</sup> <i>Answer “yes” if these programs are provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/programs, community groups, or other practitioners.</i>
3	3	6	3	86. Provide free or subsidized lifestyle self-management programs for diabetes control? <sup>193,202</sup> <i>Answer “yes” if these programs are provided in-person or online; on-site or off-site; in group or individual settings; through vendors, on-site staff, health insurance plans/programs, community groups, or other practitioners.</i>
3	2	5	2	87. Provide health coverage with low or no out-of-pocket costs for diabetes medications as well as supplies for diabetes management (glucose test strips, needles, monitoring kits)? <sup>75,76,201,203-205</sup>
<b>Total Possible Points</b>			<b>15</b>	

## Signs and Symptoms of Heart Attack and Stroke

Evidence Base 1-4	Item Impact 1-3	Total	Adjusted Value	<i>Signs and Symptoms of Heart Attack and Stroke<sup>e</sup></i> <i>During the past 12 months, did your worksite:</i>
2	1	3	1	88. Have posters or flyers in the common areas of your worksite (such as bulletin boards, kiosks, break rooms) that identify the signs and symptoms of a heart attack and also convey that strokes are to be treated as emergencies?
2	1	3	1	89. Have posters or flyers in the common areas of your worksite (such as bulletin boards, kiosks, break rooms) that identify the signs and symptoms of a stroke and also convey that heart attacks are to be treated as emergencies?
2	1	3	1	90. Provide any other information on the signs and symptoms of heart attack through e-mails, newsletters, management communications, Web sites, seminars or classes?
2	1	3	1	91. Provide any other information on the signs and symptoms of stroke through e-mails, newsletters, management communications, Web sites, seminars or classes?
<b>Total Possible Points</b>			<b>4</b>	

<sup>e</sup> From an evidence standpoint, this section is difficult; the evidence is still evolving. Much of the literature about signs and symptoms of heart attack and stroke does not specify what messages were tested. If posters, etc., in worksites contain evidence-based messages, they are more likely to make an impact than some of the less-tested messages. A good, comprehensive worksite health improvement program should include education.

## Emergency Response to Heart Attack and Stroke

Evidence Base 1-4	Item Impact 1-3	Total	Adjusted Value	<i>Emergency Response to Heart Attack and Stroke<sup>f</sup></i> <i>During the past 12 months, did your worksite:</i>
2	2	4	2	92. Have an emergency response plan that addresses acute heart attack and stroke events?
2	2	4	2	93. Have an emergency response team for medical emergencies?
4	2	6	3	94. Offer access to a nationally-recognized training course on Cardiopulmonary Resuscitation (CPR) that includes training on Automated External Defibrillator (AED) usage?
2	2	4	2	95. Have a policy that requires an adequate number of employees per floor, work unit, or shift, in accordance with pertinent state and federal laws, to be certified in CPR/AED?
4	2	6	3	96. Have one or more functioning AEDs in place? <b><i>IF NO, PLEASE PROCEED TO THE END OF THE SURVEY.</i></b>
3	2	5	2	97. Have an adequate number of AED units such that a person can be reached within 3-5 minutes of collapse?
1	1	2	1	98. Identify the location of AEDs with posters, signs, markers, or other forms of communication?
2	1	3	1	99. Perform maintenance or testing on all AEDs?
2	1	3	1	100. Provide information to your local community Emergency Medical Service providers so they are aware that your worksite has an AED in place to facilitate emergency response?
<b>Total Possible Points</b>			<b>17</b>	

<sup>f</sup> The Cardiac Arrest Survival Act was signed in 2000 by President Clinton to expand the availability of AEDs in public settings. It requires guidelines for placement of AEDs in buildings owned or leased by the federal government—"Guidelines for Public Access Defibrillation in Federal Facilities."

The American College of Occupational and Environmental Medicine (ACOEM) has created guidelines for the use of AEDs in the workplace. Many of these recommendations are not based on RCTs and therefore do not have systematic reviews, etc. to support them. Rather, they are logical components of a comprehensive AED worksite initiative (e.g., AED maintenance, testing, signage). (206. Starr LM. Automated external defibrillation in the occupational setting. *Journal of occupational and environmental medicine*. 2002;44(1):2.) For many of the questions in this section, it seems somewhat inappropriate to give each separate component a rating for impact because they are part of a comprehensive AED worksite initiative.

There are not many experimental trials on AEDs in worksite settings but there is a fair amount of evidence for AED use in general as well as bystander CPR. This evidence, paired with expert recommendations like those from ACOEM, is the base for many of the questions in this section. (207. Sasson C, Rogers MAM, Dahl J, Kellermann AL. Predictors of Survival From Out-of-Hospital Cardiac Arrest. *Circulation: Cardiovascular Quality and Outcomes*. 2010;3(1):63-81, 208. Hallstrom AP, Ornato JP, Weisfeldt M, et al. Public-access defibrillation and survival after out-of-hospital cardiac arrest. *The New England journal of medicine*. 2004;351(7):637.)



## References

1. Pelletier KR. A review and analysis of the clinical-and cost-effectiveness studies of comprehensive health promotion and disease management programs at the worksite: 1998-2000 update. *American Journal of Health Promotion*. 2001;16(2):107-116.
2. O'Donnell M, Bishop C, Kaplan K. Benchmarking best practices in workplace health promotion. *Art Health Promot*. 1997;1(1):1-8.
3. Naydeck BL, Pearson JA, Ozminkowski RJ, Day BT, Goetzel RZ. The impact of the highmark employee wellness programs on 4-year healthcare costs. *Journal of occupational and environmental medicine*. 2008;50(2):146.
4. Goetzel RZ, Baker KM, Short ME, et al. First-year results of an obesity prevention program at The Dow Chemical Company. *Journal of occupational and environmental medicine/American College of Occupational and Environmental Medicine*. 2009;51(2):125.
5. Chapman LS. Meta-evaluation of worksite health promotion economic return studies: 2005 update. *Am J Health Promot*. 2005;19(6):1-11.
6. Terry PE, Seaverson ELD, Grossmeier J, Anderson DR. Association between nine quality components and superior worksite health management program results. *Journal of occupational and environmental medicine*. 2008;50(6):633.
7. Soler RE, Leeks KD, Razi S, et al. A Systematic Review of Selected Interventions for Worksite Health Promotion:: The Assessment of Health Risks with Feedback. *American Journal of Preventive Medicine*. 2010;38(2):S237-S262.
8. Goetzel RZ, Shechter D, Ozminkowski RJ, Marmet PF, Tabrizi MJ, Roemer EC. Promising practices in employer health and productivity management efforts: findings from a benchmarking study. *Journal of occupational and environmental medicine*. 2007;49(2):111.
9. Ozminkowski RJ, Ling D, Goetzel RZ, et al. Long-term impact of Johnson & Johnson's Health & Wellness Program on health care utilization and expenditures. *Journal of occupational and environmental medicine*. 2002;44(1):21.
10. Pelletier KR. A review and analysis of the clinical and cost-effectiveness studies of comprehensive health promotion and disease management programs at the worksite: Update VII 2004-2008. *Journal of occupational and environmental medicine*. 2009;51(7):822.
11. Goetzel R. Wellness-essential building blocks for successful worksite health promotion programs. *Managing Employee Health Benefits*. 1997;6:89-94.
12. Pronk N, Allen C. A culture of health: creating and sustaining supportive organizational environments for health. *ACSM's Worksite Health Handbook*. 2nd ed. Champaign (IL): Human Kinetics, Inc. 2009:224.

13. Musich S, Schubiner H, McDonald TJ. ACSM's worksite health handbook. In: Pronk N, ed. *ACSM's Worksite Health Handbook. 2nd ed. Champaign (IL): Human Kinetics, Inc.* Champaign, IL: Human Kinetics; 2009:196-205.
14. Goetzel R, Kahr T, Aldana S, Kenny G. An evaluation of Duke University's Live for Life health promotion program and its impact on employee health. *American journal of health promotion: AJHP.* 1996;10(5):340.
15. Nyberg A, Alfredsson L, Theorell T, Westerlund H, Vahtera J, Kivimäki M. Managerial leadership and ischaemic heart disease among employees: the Swedish WOLF study. *Occupational and environmental medicine.* 2009;66(1):51.
16. National Institute of Occupational Safety and Health (NIOSH). Essential Elements of Effective Workplace Programs and Policies for Improving Worker Health and Wellbeing. 2008; <http://www.cdc.gov/niosh/docs/2010-140/pdfs/2010-140.pdf>. Accessed November 22, 2011.
17. Westerlund H, Nyberg A, Bernin P, et al. Managerial leadership is associated with employee stress, health, and sickness absence independently of the demand-control-support model. . *Work.* 2010;37(1):71-79.
18. Volpp KG, John LK, Troxel AB, Norton L, Fassbender J, Loewenstein G. Financial incentive–based approaches for weight loss. *JAMA: The Journal of the American Medical Association.* 2008;300(22):2631.
19. Matson-Koffman D, Lee JW, Hopp JW. The impact of incentives and competitions on participation and quit rates in worksite smoking cessation programs. *American Journal of Health Promotion.* 1993.
20. VanWormer J, Pronk N. Rewarding change: principles for implementing worksite incentive programs. In: NP P, ed. *ACSM's worksite health handbook.* Vol 2nd edition. Champaign, IL: Human Kinetics; 2009:239-247.
21. Tsai AG, Wadden TA. Systematic review: an evaluation of major commercial weight loss programs in the United States. *Annals of Internal Medicine.* 2005;142(1):56-66.
22. Poole K, Kumpfer K, Pett M. The impact of an incentive-based worksite health promotion program on modifiable health risk factors. *American Journal of Health Promotion.* 2001;16(1):21-26.
23. Blake S, Caspersen C, Finnegan J, Crow R, Mittlemark M, Ringhofer K. The shape up challenge: a community-based worksite exercise competition. *American journal of health promotion: AJHP.* 1996;11(1):23.
24. Cahill K, Perera R. Competitions and incentives for smoking cessation. *Cochrane Database of Systematic Reviews.* 2008;3.
25. Leeks KD, Hopkins DP, Soler RE, Aten A, Chattopadhyay SK. Worksite-Based Incentives and Competitions to Reduce Tobacco Use:: A Systematic Review. *American Journal of Preventive Medicine.* 2010;38(2):S263-S274.

26. Stunkard AJ, Cohen RY, Felix MRJ. Weight loss competitions at the worksite: how they work and how well. *Preventive medicine*. 1989;18(4):460-474.
27. Worick A, Petersons M. Weight loss contests at the worksite: results of repeat participation. *Journal of the American Dietetic Association*. 1993;93(6):680-681.
28. Collins J, Wagner S, Weissberger L. 125 Teams lose 2,233 pounds in a work-site weight-loss competition. *Journal of the American Dietetic Association*. 1986;86.
29. Cohen RY, Stunkard AJ, Felix MRJ. Comparison of three worksite weight-loss competitions. *Journal of behavioral medicine*. 1987;10(5):467-479.
30. Brownell KD, Cohen RY, Stunkard AJ, Felix M, Cooley NB. Weight loss competitions at the work site: impact on weight, morale and cost-effectiveness. *American journal of public health*. 1984;74(11):1283.
31. Knight KK, Goetzel RZ, Fielding JE, et al. An evaluation of Duke University's LIVE FOR LIFE health promotion program on changes in worker absenteeism. *Journal of occupational medicine.: official publication of the Industrial Medical Association*. 1994;36(5):533.
32. Kruse M. From the basics to comprehensive programming. In: Pronk N, ed. *ACSM's worksite health handbook*. Vol 2nd edition. Champaign, IL: Human Kinetics; 2009:296-307.
33. Lorig K, Ritter PL, Villa FJ, Armas J. Community-Based Peer-Led Diabetes Self-management. *The Diabetes Educator*. 2009;35(4):641-651.
34. Lewis SD, Johnson VR, Farris RP, Will JC. Using success stories to share knowledge and lessons learned in health promotion. *Journal of women's health*. 2004;13(5):616-624.
35. Lavinghouze R, Price AW, Smith KA. The program success story: A valuable tool for program evaluation. *Health Promotion Practice*. 2007;8(4):323-331.
36. Campbell MK, Tessaro I, DeVellis B, et al. Effects of a tailored health promotion program for female blue-collar workers: health works for women. *Preventive medicine*. 2002;34(3):313-323.
37. Norris SL, Nichols PJ, Caspersen CJ, et al. Increasing diabetes self-management education in community settings:: A systematic review. *American Journal of Preventive Medicine*. 2002;22(4):39-66.
38. Lorig KR, Ritter PL, Laurent DD, Fries JF. Long-term randomized controlled trials of tailored-print and small-group arthritis self-management interventions. *Medical Care*. 2004;42(4):346.
39. Yancey A, Tomiyama AJ, Keith N. Addressing diversity and health literacy at the worksite. *ACSM'S worksite health handbook: A guide to building healthy and productive companies (2nd ed.)*. Champaign, IL: Human Kinetics. 2009;1.
40. Marcus AC, Mason M, Wolfe P, et al. The efficacy of tailored print materials in promoting colorectal cancer screening: results from a randomized trial involving callers to the National Cancer Institute's Cancer Information Service. *Journal of health communication*. 2005;10(S1):83-104.

41. Prochaska JO, DiClemente CC, Norcross JC. In search of how people change: Applications to addictive behaviors. *American psychologist*. 1992;47(9):1102.
42. Strecher VJ, McClure J, Alexander G, et al. The role of engagement in a tailored web-based smoking cessation program: randomized controlled trial. *Journal of medical Internet research*. 2008;10(5).
43. Resnicow K, Davis RE, Zhang G, et al. Tailoring a fruit and vegetable intervention on novel motivational constructs: results of a randomized study. *Annals of Behavioral Medicine*. 2008;35(2):159-169.
44. Strecher V, McPheeters M. The potential role of tailored messaging. *Behavioral healthcare*. 2006;26(10):24.
45. Strecher V, Wang C, Derry H, Wildenhaus K, Johnson C. Tailored interventions for multiple risk behaviors. *Health education research*. 2002;17(5):619-626.
46. Matson-Koffman D, Goetzel RZ, Anwuri VV, Shore KK, Orenstein D, LaPier T. Heart Healthy and Stroke Free:: Successful Business Strategies to Prevent Cardiovascular Disease. *American Journal of Preventive Medicine*. 2005;29(5):113-121.
47. Heaney CA, Goetzel RZ. A review of health-related outcomes of multi-component worksite health promotion programs. *American journal of health promotion: AJHP*. 1997;11(4):290.
48. Noeldner S. Connecting the program to core business objectives. *ACSM's Worksite Health Handbook. 2nd ed. Champaign (IL): Human Kinetics*. 2009.
49. Short ME, Goetzel RZ, Pei X, et al. How Accurate are Self-Reports? An Analysis of Self-Reported Healthcare Utilization and Absence When Compared to Administrative Data. *Journal of occupational and environmental medicine/American College of Occupational and Environmental Medicine*. 2009;51(7):786.
50. Aldana SG, Greenlaw RL, Diehl HA, Salberg A, Merrill RM, Ohmine S. The effects of a worksite chronic disease prevention program. *Journal of occupational and environmental medicine*. 2005;47(6):558.
51. Braeckman L, De Bacquer D, Maes L, De Backer G. Effects of a Low-Intensity Worksite-Based Nutrition Intervention. *Occupational Medicine*. 1999;49(8):549-555.
52. Pohjonen T, Ranta R. Effects of a worksite physical exercise intervention on physical fitness, perceived health status, and work ability among home care workers: five-year follow-up. *Preventive Medicine*. 2001;32(6):465-475.
53. Zimmerman RS, Gerace TA, Smith JC, Benezra J. The effects of a worksite health promotion program on the wives of fire fighters. *Social Science & Medicine*. 1988;26(5):537-543.
54. Fries JF, Bloch DA, Harrington H, Richardson N, Beck R. Two-year results of a randomized controlled trial of a health promotion program in a retiree population: the Bank of America study. *The American journal of medicine*. 1993;94(5):455-462.

55. Task Force on Community Preventive Services. A recommendation to improve employee weight status through worksite health promotion programs targeting nutrition, physical activity, or both. *Am J Prev Med*. 2009;37(4):358-359.
56. Joyce K, Pabayo R, Critchley JA, Bambra C. Flexible working conditions and their effects on employee health and wellbeing. *Cochrane Database of Systematic Reviews*. 2010;2.
57. Linenger JM. *Physical fitness gains following simple environmental change*: DTIC Document;1990.
58. Kruger J, Yore MM, Bauer DR, Kohl HW. Selected barriers and incentives for worksite health promotion services and policies. *American journal of health promotion: AJHP*. 2007;21(5):439.
59. Kahn EB, Ramsey LT, Brownson RC, et al. The effectiveness of interventions to increase physical activity: A systematic review. *American Journal of Preventive Medicine*. 2002;22(4):73-107.
60. von Thiele Schwarz U, Hasson H. Employee Self-rated Productivity and Objective Organizational Production Levels: Effects of Worksite Health Interventions Involving Reduced Work Hours and Physical Exercise. *Journal of occupational and environmental medicine*. 2011;53(8):838.
61. Heath GW, Brownson RC, Kruger J, Miles R, Powell KE, Ramsey LT. The effectiveness of urban design and land use and transport policies and practices to increase physical activity: a systematic review. *Journal of Physical Activity and Health*. 2006;3(1).
62. Hopkins DP, Briss PA, Ricard CJ, et al. Reviews of evidence regarding interventions to reduce tobacco use and exposure to environmental tobacco smoke. *American Journal of Preventive Medicine*. 2001;20(2):16-66.
63. Gadoński AM, Stayton M, Krupa N, Jenkins P. Implementing a smoke-free medical campus: Impact on inpatient and employee outcomes. *Journal of Hospital Medicine*. 2010;5(1):51-54.
64. Lin D, Stahl DC, Iklé D, Grannis Jr FW. Employee attitudes and smoking behavior at the City of Hope National Medical Center smoke-free campus. *Journal of the National Comprehensive Cancer Network*. 2006;4(6):535-542.
65. Sheffer C, Stitzer M, Wheeler JG. Smoke-free medical facility campus legislation: Support, resistance, difficulties and cost. *International Journal of Environmental Research and Public Health*. 2009;6(1):246-258.
66. Pierce J. Evaluating the Effectiveness of Smoke-free Policies, vol. 13. Lyon, France: IARC (International Agency for Research on Cancer Prevention). *Tobacco Control*. 2009.
67. Osinubi OYO, Sinha S, Rovner E, et al. Efficacy of tobacco dependence treatment in the context of a “smoke-free grounds” worksite policy: A case study. *American journal of industrial medicine*. 2004;46(2):180-187.
68. Wheeler JG, Pulley LV, Felix HC, et al. Impact of a smoke-free hospital campus policy on employee and consumer behavior. *Public Health Reports*. 2007;122(6):744.



69. Eddy JM. Making Your Workplace Smoke Free: A Decision Maker's Guide. 1996.
70. CDC Healthier Worksite Initiative. Implementing a Tobacco-Free Campus Initiative in Your Workplace. 2010; <http://www.cdc.gov/nccdphp/dnpao/hwi/toolkits/tobacco/index.htm>. Accessed December 2, 2011.
71. Bertera RL. Behavioral risk factor and illness day changes with workplace health promotion: two-year results. *American Journal of Health Promotion*. 1993.
72. Schiebel N, Ebbert J. Quitline referral vs. self-help manual for tobacco use cessation in the Emergency Department: a feasibility study. *BMC Emergency Medicine*. 2007;7(15).
73. Centers for Disease Control and Prevention. Best practices for comprehensive tobacco control programs. 2007; [http://www.cdc.gov/tobacco/stateandcommunity/best\\_practices/index.htm](http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm). Accessed December 7, 2011.
74. Fiore M, Jaén C, TB B, al. e. Treating Tobacco Use and Dependence: 2008 Update. *Clinical Practice Guideline*. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.
75. Austvoll-Dahlgren A, Aaserud M, Vist G, et al. Pharmaceutical policies: effects of cap and co-payment on rational drug use. *Cochrane Database Syst Rev*. 2008;1.
76. Choudhry NK, Fischer MA, Avorn J, et al. At Pitney Bowes, value-based insurance design cut copayments and increased drug adherence. *Health Affairs*. 2010;29(11):1995-2001.
77. University of Wisconsin Center for Tobacco Research and Intervention. Summary of Selected Tobacco, Prevention, and Public Health Provisions from H.R. 3590 and H.R. 4872. <http://www.ctri.wisc.edu/Insurers/HeathReformTobaccoSummary.pdf>.
78. Centers for Disease Control and Prevention's Task Force on Community Preventive Services. The Community Guide. 2007; <http://thecommunityguide.org>.
79. Matson-Koffman D, Lanza A, Campbell KP. A purchaser's guide to clinical preventive services: a tool to improve health care coverage for prevention. *Preventing chronic disease*. 2008;5(2).
80. Nilsson PM, Klasson EB, Nyberg P. Life-style intervention at the worksite-reduction of cardiovascular risk factors in a randomized study. *Scandinavian Journal of Work Environment and Health*. 2001;27(1):57-62.
81. Blanck HM, Yaroch AL, Atienza AA, Sarah LY, Zhang J, Mâsse LC. Factors influencing lunchtime food choices among working Americans. *Health Education & Behavior*. 2009;36(2):289-301.
82. Harnack LJ, French SA. Effect of point-of-purchase calorie labeling on restaurant and cafeteria food choices: A review of the literature. *International Journal of Behavioral Nutrition and Physical Activity*. 2008;5(51).
83. French SA, Story M, Fulkerson JA, Hannan P. An environmental intervention to promote lower-fat food choices in secondary schools: outcomes of the TACOS Study. *American journal of public health*. 2004;94(9):1507.



84. Engbers LH, Van Poppel MNM, Chin A Paw MJM, van Mechelen W. Worksite health promotion programs with environmental changes: a systematic review. *American Journal of Preventive Medicine*. 2005;29(1):61-70.
85. Story M, Kaphingst KM, Robinson-O'Brien R, Glanz K. Creating healthy food and eating environments: policy and environmental approaches. *Annu. Rev. Public Health*. 2008;29:253-272.
86. Backman D, Carman J, Aldana S. Fruits and vegetables and physical activity at the worksite: Business leaders and working women speak out on access and environment. *California 5-a-day Worksite Program*. 2004.
87. Office of Personnel Management. Health and Sustainability Guidelines for Federal Concessions and Vending Operation. [http://www.gsa.gov/graphics/pbs/Guidelines\\_for\\_Federal\\_Concessions\\_and\\_Vending\\_Operations.pdf](http://www.gsa.gov/graphics/pbs/Guidelines_for_Federal_Concessions_and_Vending_Operations.pdf).
88. Centers for Disease Control and Prevention. Improving the Food Environment Through Nutrition Standards: A Guide for Government Procurement. *U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division for Heart Disease and Stroke Prevention*. February 2011. [http://www.cdc.gov/salt/pdfs/DHDSP\\_Procurement\\_Guide.pdf](http://www.cdc.gov/salt/pdfs/DHDSP_Procurement_Guide.pdf).
89. Matson-Koffman D, Brownstein JN, Neiner JA, Greaney ML. A site-specific literature review of policy and environmental interventions that promote physical activity and nutrition for cardiovascular health: What works? *American Journal of Health Promotion*. 2005.
90. Jeffery RW, French SA, Raether C, Baxter JE. An environmental intervention to increase fruit and salad purchases in a cafeteria. *Preventive Medicine: An International Journal Devoted to Practice and Theory*. 1994.
91. Balfour D, Moody R, Wise A, Brown K. Food choice in response to computer-generated nutrition information provided about meal selections in workplace restaurants. *Journal of Human Nutrition and Dietetics*. 1996;9(3):231-237.
92. Burton S, Creyer EH, Kees J, Huggins K. Attacking the obesity epidemic: the potential health benefits of providing nutrition information in restaurants. *American journal of public health*. 2006;96(9):1669.
93. Roberto CA, Larsen PD, Agnew H, Baik J, Brownell KD. Evaluating the impact of menu labeling on food choices and intake. *American journal of public health*. 2010;100(2):312.
94. Kimathi AN, Gregoire MB, Dowling RA, Stone MK. A healthful options food station can improve satisfaction and generate gross profit in a worksite cafeteria. *Journal of the American Dietetic Association*. 2009;109(5):914-917.
95. Michels KB, Bloom BR, Riccardi P, Rosner BA, Willett WC. A study of the importance of education and cost incentives on individual food choices at the Harvard School of Public Health cafeteria. *Journal of the American College of Nutrition*. 2008;27(1):6-11.

96. French SA. Pricing effects on food choices. *The Journal of nutrition*. 2003;133(3):841S.
97. French SA, Story M, Jeffery RW, et al. Pricing strategy to promote fruit and vegetable purchase in high school cafeterias. *Journal of the American Dietetic Association*. 1997;97(9):1008.
98. Centers for Disease Control and Prevention. 2006 Healthy Food at Meetings Guide. [http://www.cdc.gov/nccdphp/dnpa/pdf/Healthy\\_Worksite\\_food.pdf](http://www.cdc.gov/nccdphp/dnpa/pdf/Healthy_Worksite_food.pdf).
99. CDC Guide to Fruit and Vegetable Strategies to Increase Access, Availability, Consumption. March 2010; <http://www.cdph.ca.gov/SiteCollectionDocuments/StratstoIncreaseFruitVegConsumption.pdf>.
100. Wong E, Portello D, Izumo A. Kaiser Permanente's Farmers' Markets Help Members, Staff, and Community Members Eat Better and Live Healthier: Results from a Patron Survey. *Journal of the American Dietetic Association*. 2006;106(8):A78-A78.
101. Brown C, Miller S. The impacts of local markets: a review of research on farmers markets and community supported agriculture (CSA). *American Journal of Agricultural Economics*. 2008;90(5):1296-1302.
102. Benedict MA, Arterburn D. Worksite-based weight loss programs: a systematic review of recent literature. *American Journal of Health Promotion*. 2008;22(6):408-416.
103. Glanz K, Sorensen G, Farmer A. The health impact of worksite nutrition and cholesterol intervention programs. *American journal of health promotion: AJHP*. 1996;10(6):453.
104. Canadian Cancer Society Knowledge Exchange Network. Information Package for Evidence-Informed Interventions: Effective workplace physical activity interventions. February 2011; <http://guidance.nice.org.uk/PH13>.
105. Sallis JF, Bauman A, Pratt M. Environmental and policy interventions to promote physical activitya. *American Journal of Preventive Medicine*. 1998;15(4):379-397.
106. National Institute for Health and Clinical Excellence. *Workplace health promotion: how to encourage employees to be physically active*. NICE PH Guidance 13 May 2008.
107. World Health Organization. Preventing Noncommunicable Diseases in the Workplace through Diet and Physical Activity WHO/World Economic Forum Report of a Joint Event. 2008; [http://whqlibdoc.who.int/publications/2008/9789241596329\\_eng.pdf](http://whqlibdoc.who.int/publications/2008/9789241596329_eng.pdf)
108. Emmons KM, Linnan LA, Shadel WG, Marcus B, Abrams DB. The Working Healthy Project: a worksite health-promotion trial targeting physical activity, diet, and smoking. *Journal of occupational and environmental medicine*. 1999;41(7):545.
109. Vuori IM, Oja P, Paronen O. Physically active commuting to work--testing its potential for exercise promotion. *Medicine and Science in Sports and Exercise*. 1994;26(7):844.
110. National Heart Lung and Blood Institute. *The Practical Guide: Identification, Evaluation, and Treatment of Overweight and Obesity in Adults*: National Institutes of Health, National Heart, Lung, and Blood Institute, NHLBI Obesity Education Initiative, North American Association for the Study of Obesity; 2000.

111. Archer WR, Batan MC, Buchanan LR, et al. Promising Practices for the Prevention and Control of Obesity in the Worksite. *American Journal of Health Promotion*. 2011;25(3):12-26.
112. Anderson LM, Quinn TA, Glanz K, et al. The Effectiveness of Worksite Nutrition and Physical Activity Interventions for Controlling Employee Overweight and Obesity:: A Systematic Review. *American Journal of Preventive Medicine*. 2009;37(4):340-357.
113. Bellarosa C, Chen PY. The effectiveness and practicality of occupational stress management interventions: A survey of subject matter expert opinions. *Journal of Occupational Health Psychology*. 1997;2(3):247.
114. Maes S, Verhoeven C, Kittel F, Scholten H. Effects of a Dutch work-site wellness-health program: the Brabantia Project. *American journal of public health*. 1998;88(7):1037.
115. McCraty R, Atkinson M, Tomasino D. Impact of a workplace stress reduction program on blood pressure and emotional health in hypertensive employees. *The Journal of Alternative & Complementary Medicine*. 2003;9(3):355-369.
116. Corbière M, Shen J, Rouleau M, Dewa CS. A systematic review of preventive interventions regarding mental health issues in organizations. *Work (Reading, Mass.)*. 2009;33(1):81.
117. Evers KE, Prochaska JO, Johnson JL, Mauriello LM, Padula JA, Prochaska JM. A randomized clinical trial of a population-and transtheoretical model-based stress-management intervention. *Health Psychology*. 2006;25(4):521.
118. Lucini D, Riva S, Pizzinelli P, Pagani M. Stress Management at the Worksite. *Hypertension*. 2007;49(2):291-297.
119. Sherman B. Work-life balance: Key component of an integrated HPM strategy. *Health & Productivity Management*. 2004;3(3):19-20.
120. Murphy LR. Stress management in work settings: A critical review of the health effects. *American Journal of Health Promotion*. 1996.
121. Billings DW, Cook RF, Hendrickson A, Dove DC. A web-based approach to managing stress and mood disorders in the workforce. *Journal of occupational and environmental medicine*. 2008;50(8):960.
122. Milani RV, Lavie CJ. Impact of worksite wellness intervention on cardiac risk factors and one-year health care costs. *The American journal of cardiology*. 2009;104(10):1389-1392.
123. Parker CP, Baltes BB, Young SA, et al. Relationships between psychological climate perceptions and work outcomes: a meta-analytic review. *Journal of Organizational Behavior*. 2003;24(4):389-416.
124. Macdonald S, Csiernik R, Durand P, Rylett M, Wild TC. Prevalence and factors related to Canadian workplace health programs. *Canadian journal of public health*. 2006;97(2):121-125.
125. Tsutsumi A, Nagami M, Yoshikawa T, Kogi K, Kawakami N. Participatory intervention for workplace improvements on mental health and job performance among blue-collar workers: a cluster randomized controlled trial. *Journal of occupational and environmental medicine*. 2009;51(5):554.

126. Bourbonnais R, Brisson C, Vinet A, Vézina M, Lower A. Development and implementation of a participative intervention to improve the psychosocial work environment and mental health in an acute care hospital. *Occupational and environmental medicine*. 2006;63(5):326.
127. Kobayashi Y, Kaneyoshi A, Yokota A, Kawakami N. Effects of a worker participatory program for improving work environments on job stressors and mental health among workers: a controlled trial. *Journal of occupational health*. 2008(0):810200031.
128. MacKay CJ, Cousins R, Kelly PJ, Lee S, McCAIG RONH. 'Management Standards' and work-related stress in the UK: Policy background and science. *Work & Stress*. 2004;18(2):91-112.
129. Riedel JE, Lynch W, Baase C, Hymel P, Peterson KW. The effect of disease prevention and health promotion on workplace productivity: a literature review. *American journal of health promotion: AJHP*. 2001;15(3):167.
130. Vézina M, Bourbonnais R, Brisson C, Trudel L. Workplace prevention and promotion strategies. *Healthcare Papers*. 2004;5(2):32-44.
131. Berg A. Screening for depression: recommendations and rationale. *The American journal of nursing*. 2002;102(7):77.
132. Valenstein M, Vijan S, Zeber JE, Boehm K, Buttar A. The cost-utility of screening for depression in primary care. *Annals of Internal Medicine*. 2001;134(5):345-360.
133. Campbell K, Lanza A, Dixon R, Chattopadhyay S, Molinari N, Finch R. A purchaser's guide to clinical preventive services: moving science into coverage. *Washington (DC): National Business Group on Health*. 2006.
134. Charbonneau A, Bruning W, Titus-Howard T, et al. The community initiative on depression: report from a multiphase work site depression intervention. *Journal of occupational and environmental medicine*. 2005;47(1):60.
135. Hammer JH, Vogel DL. Men's help seeking for depression: The efficacy of a male-sensitive brochure about counseling. *The Counseling Psychologist*. 2010;38(2):296-313.
136. Kawakami N, Araki S, Kawashima M, Masumoto T, Hayashi T. Effects of work-related stress reduction on depressive symptoms among Japanese blue-collar workers. *Scandinavian journal of work, environment & health*. 1997;23(1):54-59.
137. Kuoppala J, Lamminpää A, Husman P. Work health promotion, job well-being, and sickness absences-a systematic review and meta-analysis. *Journal of occupational and environmental medicine*. 2008;50(11):1216.
138. Martin A, Sanderson K, Cocker F. Meta-analysis of the effects of health promotion intervention in the workplace on depression and anxiety symptoms. *Scandinavian journal of work, environment & health*. 2008.
139. Mino Y, Babazono A, Tsuda T, Yasuda N. Can stress management at the workplace prevent depression? A randomized controlled trial. *Psychotherapy and psychosomatics*. 2006;75(3):177-182.

140. Koertge J, Janszky I, Sundin Ö, et al. Effects of a stress management program on vital exhaustion and depression in women with coronary heart disease: a randomized controlled intervention study. *Journal of internal medicine*. 2008;263(3):281-293.
141. McLeod J. How effective is workplace counselling? A review of the research literature. *Counselling and Psychotherapy Research*. 2001;1(3):184-190.
142. Roman P, Blum T. Employee assistance programs and other workplace preventive strategies. *The textbook of substance abuse treatment*. 2004:423-435.
143. Lo Sasso AT, Rost K, Beck A. Modeling the impact of enhanced depression treatment on workplace functioning and costs: a cost-benefit approach. *Medical Care*. 2006;44(4):352.
144. Wang PS, Simon G, Kessler RC. The economic burden of depression and the cost-effectiveness of treatment. *International Journal of Methods in Psychiatric Research*. 2003;12(1):22-33.
145. Hargrave GE, Hiatt D. The EAP Treatment of Depressed Employees. *Employee Assistance Quarterly*. 2005;19(4):39-49.
146. Myette TL. Integrated management of depression: improving system quality and creating effective interfaces. *Journal of occupational and environmental medicine*. 2008;50(4):482.
147. Nieuwenhuijsen K, Bultmann U, Neumeyer-Gromen A, Verhoeven A, Verbeek J, van der Feltz-Cornelis C. Interventions to improve occupational health in depressed people. *Cochrane Database Syst Rev*. 2008;2.
148. Foote A, Erfurt JC. The benefit to cost ratio of work-site blood pressure control programs. *JAMA: The Journal of the American Medical Association*. 1991;265(10):1283.
149. Erfurt JC, Foote A, Heirich MA. Worksite wellness programs: Incremental comparison of screening and referral alone, health education, follow-up counseling, and plant organization. *American Journal of Health Promotion*. 1991;5(6):438-448.
150. Chobanian AV, Bakris GL, Black HR, et al. Seventh report of the joint national committee on prevention, detection, evaluation, and treatment of high blood pressure. *Hypertension*. 2003;42(6):1206-1252.
151. Shi L. The impact of increasing intensity of health promotion intervention on risk reduction. *Evaluation & the Health Professions*. 1992;15(1):3.
152. Racette SB, Deusinger SS, Inman CL, et al. Worksite Opportunities for Wellness (WOW): effects on cardiovascular disease risk factors after 1 year. *Preventive medicine*. 2009;49(2-3):108-114.
153. Engbers LH, van Poppel MNM, van Mechelen W. Modest effects of a controlled worksite environmental intervention on cardiovascular risk in office workers. *Preventive medicine*. 2007;44(4):356-362.
154. Matson-Koffman D, Ayala C. *Hypertension evidence-statement: screening, counseling, and treatment*. Washington, DC2011.



155. Gemson DH, Commisso R, Fuente J, Newman J, Benson S. Promoting weight loss and blood pressure control at work: impact of an education and intervention program. *Journal of occupational and environmental medicine*. 2008;50(3):272.
156. Glynn LG, Murphy AW, Smith SM, Schroeder K, Fahey T. Interventions used to improve control of blood pressure in patients with hypertension. *Cochrane Database Syst Rev*. 2010;3(3).
157. Aldana SG, Greenlaw RL, Diehl HA, Merrill RM, Salberg A, Englert H. A video-based lifestyle intervention and changes in coronary risk. *Health education research*. 2008;23(1):115-124.
158. Henke RM, Goetzel RZ, McHugh J, Isaac F. Recent Experience In Health Promotion At Johnson & Johnson: Lower Health Spending, Strong Return On Investment. *Health Affairs*. 2011;30(3):490-499.
159. Larsen P, Simons N. Evaluating a federal health and fitness program: indicators of improving health. *AAOHN journal: official journal of the American Association of Occupational Health Nurses*. 1993;41(3):143.
160. Masur-Levy P, Tavris D, Elsey-Pica L. Cardiovascular risk changes in a work-site health promotion program. *Journal of the American Dietetic Association*. 1990;90.
161. Jackson J, Kohn–Parrott KA, Parker C, et al. Blood Pressure Success Zone: You Auto Know A Worksite-Based Program to Improve Blood Pressure Control Among Auto Workers. *Population Health Management*. 2011;14(5):257-263.
162. Henritze J, Brammell H, McGloin J. LIFECHECK: a successful, low touch, low tech, in-plant, cardiovascular disease risk identification and modification program. *American journal of health promotion: AJHP*. 1992;7(2):129.
163. Goetzel RZ, Ozminkowski RJ, Bruno JA, Rutter KR, Isaac F, Wang S. The long-term impact of Johnson & Johnson's Health & Wellness Program on employee health risks. *Journal of occupational and environmental medicine*. 2002;44(5):417.
164. Chung M, Melnyk P, Blue D, Renaud D, Breton MC. Worksite health promotion: the value of the Tune Up Your Heart program. *Population Health Management*. 2009;12(6):297-304.
165. Morikawa N, Yamasue K, Tochikubo O, Mizushima S. Effect of Salt Reduction Intervention Program Using an Electronic Salt Sensor and Cellular Phone on Blood Pressure Among Hypertensive Workers. *Clinical and Experimental Hypertension*. 2011;33(4):216-222.
166. Muto T, Yamauchi K. Evaluation of a multicomponent workplace health promotion program conducted in Japan for improving employees' cardiovascular disease risk factors. *Preventive medicine*. 2001;33(6):571-577.
167. Gomel M, Oldenburg B, Simpson JM, Owen N. Work-site cardiovascular risk reduction: a randomized trial of health risk assessment, education, counseling, and incentives. *American journal of public health*. 1993;83(9):1231.



168. John EJ, Vavra T, Farris K, et al. Workplace-based cardiovascular risk management by community pharmacists: impact on blood pressure, lipid levels, and weight. *Pharmacotherapy*. 2006;26(10):1511-1517.
169. Hochart C, Lang M. Impact of a comprehensive worksite wellness program on health risk, utilization, and health care costs. *Population Health Management*. 2011;14(3):111-116.
170. Rein DB, Orenstein D, Constantine RT, et al. Peer Reviewed: A Cost Evaluation of the Georgia Stroke and Heart Attack Prevention Program. *Preventing chronic disease*. 2006;3(1).
171. Kelly JT. Evaluating employee health risks due to hypertension and obesity: self-testing workplace health stations. *Postgraduate medicine*. 2009;121(1):152.
172. Ozminkowski RJ, Goetzel RZ, Smith MW, Cantor RI, Shaughnessy A, Harrison M. The impact of the Citibank, NA, Health Management Program on changes in employee health risks over time. *Journal of occupational and environmental medicine*. 2000;42(5):502.
173. Antonopoulos S. Third report of the National Cholesterol Education Program (NCEP) expert panel on detection, evaluation, and treatment of high blood cholesterol in adults (Adult Treatment Panel III) final report. *Circulation*. 2002;106(3143):3421.
174. Wang J, Carson E, Lapane K, Eaton C, Gans K, Lasater T. The effect of physician office visits on CHD risk factor modification as part of a worksite cholesterol screening program. *Preventive medicine*. 1999;28(3):221.
175. Clark M, Ghandour G, Miller NH, Taylor C, Bandura A, DeBusk RF. Development and evaluation of a computer-based system for dietary management of hyperlipidemia. *Journal of the American Dietetic Association*. 1997;97(2):146-150.
176. Bloch MJ, Armstrong DS, Dettling L, Hardy A, Caterino K, Barrie S. Partners in lowering cholesterol: comparison of a multidisciplinary educational program, monetary incentives, or usual care in the treatment of dyslipidemia identified among employees. *Journal of occupational and environmental medicine*. 2006;48(7):675.
177. Byers T, Mullis R, Anderson J, et al. The costs and effects of a nutritional education program following work-site cholesterol screening. *American journal of public health*. 1995;85(5):650.
178. Matson-Koffman D, Dai S. *Lipid disorders evidence-statement: screening, counseling, and treatment. A Purchaser's Guide to Clinical Preventive Services: Moving Science into Coverage*. National Business Group on Health, Washington, DC.
179. Anderson J, Dusenbury L. Worksite cholesterol and nutrition: an intervention project in Colorado. *AAOHN journal: official journal of the American Association of Occupational Health Nurses*. 1999;47(3):99.
180. Baer JT. Improved plasma cholesterol levels in men after a nutrition education program at the worksite. *Journal of the American Dietetic Association*. 1993;93(6):658-663.

181. Hartman TJ, Himes JH, McCarthy PR, Kushi LH. Effects of a low-fat, worksite intervention on blood lipids and lipoproteins. *Journal of occupational and environmental medicine/American College of Occupational and Environmental Medicine*. 1995;37(6):690.
182. Naito M, Nakayama T, Okamura T, et al. Effect of a 4-year workplace-based physical activity intervention program on the blood lipid profiles of participating employees: the high-risk and population strategy for occupational health promotion (HIPOP-OHP) study. *Atherosclerosis*. 2008;197(2):784-790.
183. Perovich SJ, Sandoval WM. Outcomes of a worksite cholesterol education program over a 5-year period. *Journal of the American Dietetic Association*. 1995;95(5):589.
184. Pescatello LS, Murphy D, Vollono J, Lynch E, Bernene J, Costanzo D. The cardiovascular health impact of an incentive worksite health promotion program. *American journal of health promotion: AJHP*. 2001;16(1):16.
185. Calderon KS, Smallwood C, Tipton DA. Kennedy space center cardiovascular disease risk reduction program evaluation. *Vascular health and risk management*. 2008;4(2):421.
186. Prior JO, van Melle G, Crisinel A, Burnand B, Cornuz J, Darioli R. Evaluation of a multicomponent worksite health promotion program for cardiovascular risk factors--correcting for the regression towards the mean effect. *Preventive medicine*. 2005;40(3):259-267.
187. Fielding JE, Mason T, Knight K, Klesges R, Pelletier K. A randomized trial of the IMPACT worksite cholesterol reduction program. *Am J Prev Med*. 1995;11(2):120-123.
188. Angotti CM, Levine MS. Review of 5 years of a combined dietary and physical fitness intervention for control of serum cholesterol. *Journal of the American Dietetic Association*. 1994;94(6):634-638.
189. Reynolds KD, Gillum JL, Hyman DJ, et al. Comparing two strategies to modify dietary behavior and serum cholesterol. *Journal of Cardiovascular Risk*. 1997;4(1):1.
190. Aldana SG, Greenlaw R, Diehl HA, Englert H, Jackson R. Impact of the Coronary Health Improvement Project (CHIP) on several employee populations. *Journal of occupational and environmental medicine*. 2002;44(9):831.
191. Orchard TJ, Temprosa M, Goldberg R, et al. The effect of metformin and intensive lifestyle intervention on the metabolic syndrome: the Diabetes Prevention Program randomized trial. *Annals of Internal Medicine*. 2005;142(8):611-619.
192. Herman WH, Hoerger TJ, Brandle M, et al. The cost-effectiveness of lifestyle modification or metformin in preventing type 2 diabetes in adults with impaired glucose tolerance. *Annals of Internal Medicine*. 2005;142(5):323-332.
193. Ackermann RT, Marrero DG, Hicks KA, et al. An evaluation of cost sharing to finance a diet and physical activity intervention to prevent diabetes. *Diabetes Care*. 2006;29(6):1237-1241.
194. Loveman E, Cave C, Green C, Royle P, Dunn N, Waugh N. The clinical and cost-effectiveness of patient education models for diabetes: a systematic review and economic evaluation. *Health Technology Assessment*. 2003;7(22):1-190.

195. Oberlinner C, Neumann SM, Ott MG, Zober A. Screening for pre-diabetes and diabetes in the workplace. *Occupational medicine*. 2008;58(1):41.
196. Aldana SG, Barlow M, Smith R, et al. The diabetes prevention program: a worksite experience. *AAOHN journal: official journal of the American Association of Occupational Health Nurses*. 2005;53(11):499.
197. The CDC Diabetes Cost-effectiveness Group. Cost-effectiveness of intensive glycemic control, intensified hypertension control, and serum cholesterol reduction for type 2 diabetes. *JAMA*. 2002;287.
198. Deakin TA, McShane CE, Cade JE, Williams R. Group based training for self-management strategies in people with type 2 diabetes mellitus. *The Cochrane Library*. 2006.
199. Fitzner K, Fox K, Schmidt J, Roberts M, Rindress D, Hay J. Implementation and outcomes of commercial disease management programs in the United States: the disease management outcomes consolidation survey. *Disease Management*. 2005;8(4):253-264.
200. Mangione CM, Gerzoff RB, Williamson DE, et al. The association between quality of care and the intensity of diabetes disease management programs. *Annals of Internal Medicine*. 2006;145(2):107-116.
201. Schmittiel J, Uratsu C, Fireman B, Selby J. The effectiveness of diabetes care management in managed care. *The American journal of managed care*. 2009;15(5):295.
202. Finch EA, Kelly MS, Marrero DG, Ackermann RT. Training YMCA wellness instructors to deliver an adapted version of the Diabetes Prevention Program lifestyle intervention. *The Diabetes Educator*. 2009;35(2):224-232.
203. Mahoney JJ. Reducing patient drug acquisition costs can lower diabetes health claims. *Am J Manag Care*. 2005;11(5 suppl):S170-S176.
204. Karter AJ, Stevens MR, Herman WH, et al. Out-of-pocket costs and diabetes preventive services. *Diabetes Care*. 2003;26(8):2294.
205. Tseng CW, Tierney EF, Gerzoff RB, et al. Race/ethnicity and economic differences in cost-related medication underuse among insured adults with diabetes. *Diabetes Care*. 2008;31(2):261.
206. Starr LM. Automated external defibrillation in the occupational setting. *Journal of occupational and environmental medicine*. 2002;44(1):2.
207. Sasson C, Rogers MAM, Dahl J, Kellermann AL. Predictors of Survival From Out-of-Hospital Cardiac Arrest. *Circulation: Cardiovascular Quality and Outcomes*. 2010;3(1):63-81.
208. Hallstrom AP, Ornato JP, Weisfeldt M, et al. Public-access defibrillation and survival after out-of-hospital cardiac arrest. *The New England journal of medicine*. 2004;351(7):637.



