Evaluation of the WorkHealth Coach Program

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Accompanying documents to this report

Title:	***Report number:***
Executive Summary - Evaluation of the WorkHealth Coach Program	***1113-008.1-R1B***

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Executive Summary

Key messages

The WorkHealth Coach evaluation findings suggest an improvement in the self reported lifestyle factors associated with chronic disease for Victorian workers who participated in the program. The program was preferred by white collar workers aged between 45 and 65. Withdrawal trends indicate 26.2% of participants withdrew before the first coach call and 30.0% withdrew at the half way point, compared with a "non-referral" recruitment program design (New South Wales Get Healthy Coaching) where 14.0% withdrew before the initial coaching call and 33.0% at the halfway point. Top goals selected in the program were to increase exercise, make better food choices and reduce weight. Weight loss was the goal least likely to be achieved at the midway and completion points and exercise goals which were achieved at midway point were less likely to be maintained to program completion. Between 75-100% of participants who reported achieving their goal by halfway through the program and remained in the program, maintained their goal at program completion.

Participants who completed the program were more likely to report higher levels of health improvement in the workplace than those who withdrew from the program before the halfway point. The greatest improvements were seen in physical and emotional wellbeing, improved energy and productivity at work. Despite the program being designed for the workplace, only half of survey respondents reported taking their call during work hours.

Purpose

WorkHealth Coach is a telephone coaching support program available for Victorian workers who have had a WorkHealth check and learnt that they are at medium risk of type 2 diabetes or medium or high risk of cardiovascular disease. The aim of this evaluation is to measure the impacts of a telephone coaching program in the workplace setting. The objective of this evaluation is to identify if the WorkHealth Coach program (Coach program) enabled positive behaviour change for worker health and lifestyles and to understand the barriers and enablers of a telephone coaching program delivered through the workplace.

Rationale

Previously published evidence suggests that telephone coaching programs can be effective at improving the lifestyle behaviours and health of participants. The WorkHealth Coach program is a telephone coaching program designed for workers who attended the WorkHealth Program and were found to be at risk of type 2 diabetes and cardiovascular

disease. Evaluating this program will contribute to identifying the impact of delivering a telephone coaching program in the workplace setting.

Methods

The evaluation utilises a mixed methods design in three components. Participant data collected throughout the program (n=6325) was analysed and triangulated with participant survey data (n=415), semi-structured interviews with participants (n=21) and in depth interviews with WorkHealth coaches (n=5).

Research findings

Participation trends

Participants were more likely to be from white-collar occupations and aged between 45 and 65 years of age. Participants were most likely to passively withdraw from the program citing time barriers, achievement of goals and no further assistance required as the main reasons. Participants who withdrew from the program before the halfway point also cited quality of coaching as a significant reason for discontinuing. The referral pathway from WorkHealth checks into the program was beneficial for many participants.

Goal choice, achievement and maintenance

Participants chose to focus on improving exercise and food choices over other goals such as stress, smoking and alcohol intake. At the program halfway point goal achievement was reported by 50% or more of participants who selected healthy food choices, smoking, alcohol, and exercise and stress management as their goal. At program completion, goal achievement was observed for 50% or more participants who selected goals of waist reduction, healthy food choices, smoking, alcohol, exercise and stress management, but not in weight reduction. 75-100% participants who achieved their goals at week 12 maintained this goal at week 26 of the program. Participants reported improved physical and emotional wellbeing and more energy at work as a result of participating in the program.

Workplace setting for telephone coaching

Only half of survey participants reported taking their WorkHealth Coach calls during work hours. Participants identified open plan office space and lack of support by management as barriers to taking calls during work hours however many participants were willing to take calls outside work times to manage this. Two thirds to three quarters of survey respondents

reported improved physical and emotional wellbeing and energy at work after participating in the WorkHealth Coach program.

Use of the research

This evaluation can be used by WorkSafe Victoria to understand the efficacy of a telephone coaching program to improve the health and wellbeing of Victorian workers. The demographics of WorkHealth program participants indicate that the uptake of this program was most likely to be by older white-collar workers born in Australia which must be considered in policy and planning if telephone coaching is to be used as an intervention to improve the health of Victorian workers in the future.

Potential impact of the research

This evaluation provides understanding into the potential benefits of a telephone coaching program in the workplace. Whilst self reported health improvements were observed in participants, the workplace setting impacted the implementation quality of the program and therefore must be considered in future decision making if telephone coaching is used in the future to improve the health and wellbeing of Victorian workers.

1 Introduction

This report presents the findings of the evaluation of the WorkHealth Coach Program conducted by Monash University's Global Health and Society Unit. The evaluation investigated the impact of the program on participant self reported health and the barriers and enablers of the program as an intervention to improve the health and wellbeing of Victorian workers.

Chronic disease accounts for almost 80 percent of the burden of disease in Australia (NHPAC 2006). In 2010, cardiovascular disease (CVD) accounted for approximately 16% of the overall disease burden in Australia and is estimated as the most expensive disease group for direct health-care expenditure in Australia (AIHW 2010a). Type 2 diabetes affects approximately 720,000 Australians and accounts for approximately 88% of all people with diabetes (AIHW 2010a). The lifestyle risk factors contributing to the prevalence of CVD and type 2 diabetes include poor nutrition, physical inactivity, tobacco use and harmful alcohol use. Biomedical risk factors include obesity, hypertension and high blood cholesterol (AIHW 2009, 2010b). Data from 2004-5 National Health Survey indicates that 96% of working-aged Australians have experienced at least one of these risk factors (AIHW 2009). Research from the Monash Centre of Occupational and Environmental Health found that 43% of WorkHealth check participants were identified to be at medium risk of type 2 diabetes, while 16% were at medium or high risk of CVD (Gwini, Botlero, Roberts and Sim 2012). Evidence indicates that chronic disease prevalence significantly affects the productivity of the Australian workforce (AIHW 2009, 2010b). Australians with a chronic disease are less likely to participate in the workforce or be employed full-time than Australians without a chronic disease (AIHW 2009).

1.1 Telephone coaching

Telephone health coaching is an effective intervention to improve the lifestyle behaviours and health outcomes of people with chronic diseases. The efficacy of telephone coaching has been demonstrated through an increasing number of randomised controlled trials and studies over the last decade and is now considered as a useful model of intervention (Nuebeck, Redfern, Fernandez, Briffa, Bauman and Freedman, 2009; Goode, Reeves, and Eakin, 2012).

Telephone-based interventions are a cost-effective way to successfully promote both initiation and maintenance of health behaviour change (Eakin, Reeves, Winkler and Owen, 2010) and reach people from socially and geographically disadvantaged regions including hard-to-reach population groups like men (Aoun, Osseiran-Moisson, Shahid, Howat and O'Connor 2011; Francis, Feyer and Smith 2007; O'Hara, Phongsavan, Venugopal and Bauman 2011). Studies have reported significant improvements in weight, waist circumference, physical activity, and nutrition-related practices of participants (O'Hara, Phongsavan, Venugopal, Eakin, Effins, Caterson, King, Allman-Farinelli, Hass and Bauman 2012).

The literature has highlighted several key factors associated with the implementation of telephone coaching to ensure its effectiveness. The success of telephone coaching is very much rooted in the relationship between participants and their coaches, where effective communication skills are essential (MacLean, White, Broughton, Robinson, Armstrong Schultz, Weekes and Wilson, 2012), for example in problem solving, goal setting and cognitive behavioural techniques (Francis et al, 2007). In addition to this, health coaches must often deal with complex patient situations involving medical consideration but also specific social contexts, requiring adaptability and flexibility of the coaching to support patients (Walker, Furler, Blackberry, Dunbar, Young and Best, 2011) and to match their stage of readiness (Francis et al, 2007). Tailored training is therefore required to be undertaken by health professionals to better support the self-management of health behaviours by patients (Lindner, Menzies and Kelly 2003). Well-developed organisational structures and infrastructure support are also important factors in facilitating participant's recruitment and maximising coaching impact (Francis et al, 2007). To enhance the penetration and sustainability of telephone coaching interventions, this should be more integrated into existing health system networks with GPs and other health service providers by developing multidisciplinary cooperation.

While there is strong evidence that telephone coaching promotes healthy behaviour change in participants, further evaluation is needed to understand the sustainability of reported behaviour change (Goode et al, 2012) and if on-going contact after the intervention is required to produce long-term maintenance of positive behaviour change (Eakin et al, 2010). Current evidence is also based on intensive small-scale controlled trials whose effects' replication remains uncertain at a larger scale (O'Hara et al 2012).There is still a paucity of evidence regarding the dissemination, dose-response, maintenance and cost-effectiveness of telephone coaching (Goode et al, 2012).

Interventions are still being studied to measure the effectiveness of SMS and email to support telephone calls (Goode et al, 2012).

1.2 WorkHealth Coach Program

WorkSafe Victoria's WorkHealth Coach (Coach) Program is a free, confidential support program available for Victorian workers who have had a WorkHealth check and learnt that they are at medium risk of type 2 diabetes (AUSDRISK score ≥6) or medium or high risk of heart disease (CVD Risk Score ≥10%)*. WorkHealth Coach aims to support workers to reduce the risk factors identified through their WorkHealth check in order to prevent or delay the onset of type 2 diabetes or cardiovascular disease. The program focuses on the following health goals for participants:

- Be more active
- Healthy eating
- Manage waist measurement
- Manage weight
- Manage stress
- Manage alcohol intake
- Reduce or quit smoking

The program is delivered by Medibank Health Solutions Telehealth Pty Ltd (MHS). Participants are eligible for 10 telephone support calls (1 initial call and 9 coaching calls) over six months conducted by a health professional with coaching qualifications (Health Coaching Australia). The service is available 8am to 8pm Monday to Fridays and 9am to 5pm on Saturdays.

*Note, workers identified at AUSDRISK ≥ 12, or previously diagnosed CVD or Gestational Diabetes Mellitus, were referred to the Life-Diabetes Telephone Coaching Program or Group Program delivered by Diabetes Australia Victoria.

1.3 Evaluation objectives

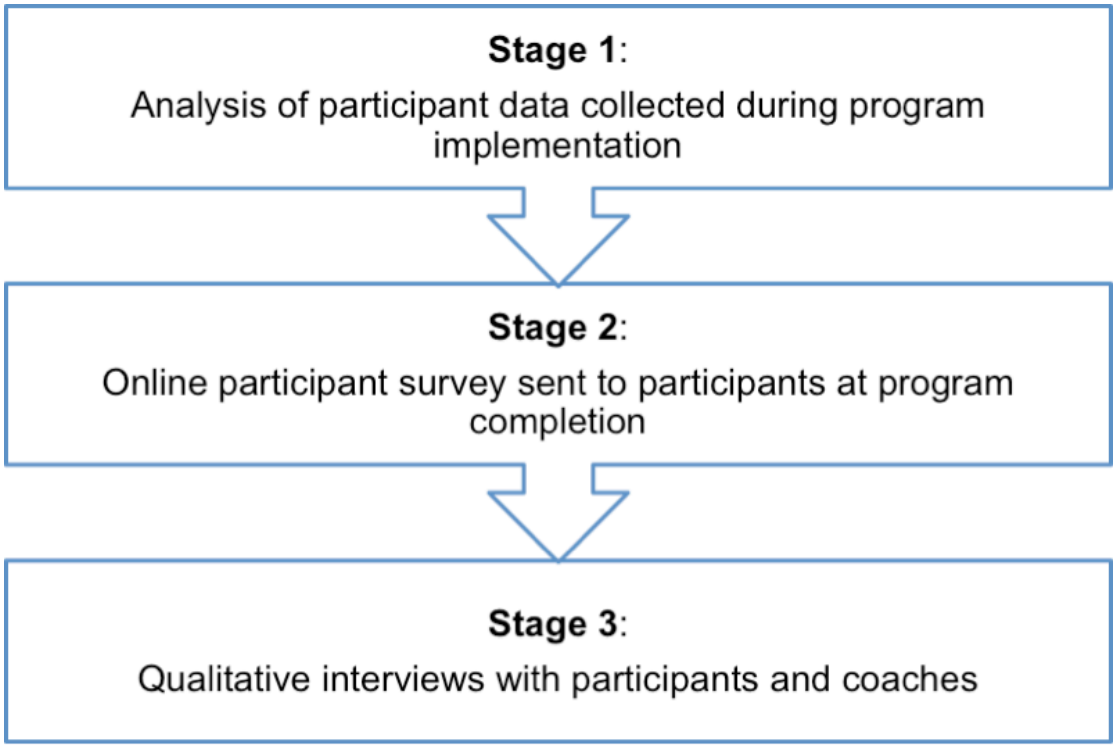
The aim of this evaluation was to understand the impacts of the WorkHealth Coach program as an intervention for Victorian workers at risk of type 2 diabetes and CVD. The objectives of this evaluation were

- To identify if the WorkHealth Coach program enabled positive behaviour change for worker health and lifestyles;
- To understand the barriers and enablers of a telephone coaching program delivered through the workplace setting.

2 Methodology

This study used a mixed methods research design to achieve the objectives of the evaluation. Data was collected sequentially from four data sources across three phases (Figure 1). The different types and measures of data collection techniques allowed for the triangulation of the data to increase the validity and reliability of the findings (Neuman, 1997).

Figure 1: Mixed methods evaluation design



2.1 Stage 1: Participant data

Data collected by Medibank Health Solutions Telehealth Pty Ltd (MHS) throughout the program was analysed in relation to: participant characteristics; withdrawal trends and personal goal improvement trends. The data set included participant information from 7 March 2011 to 21 October 2013.

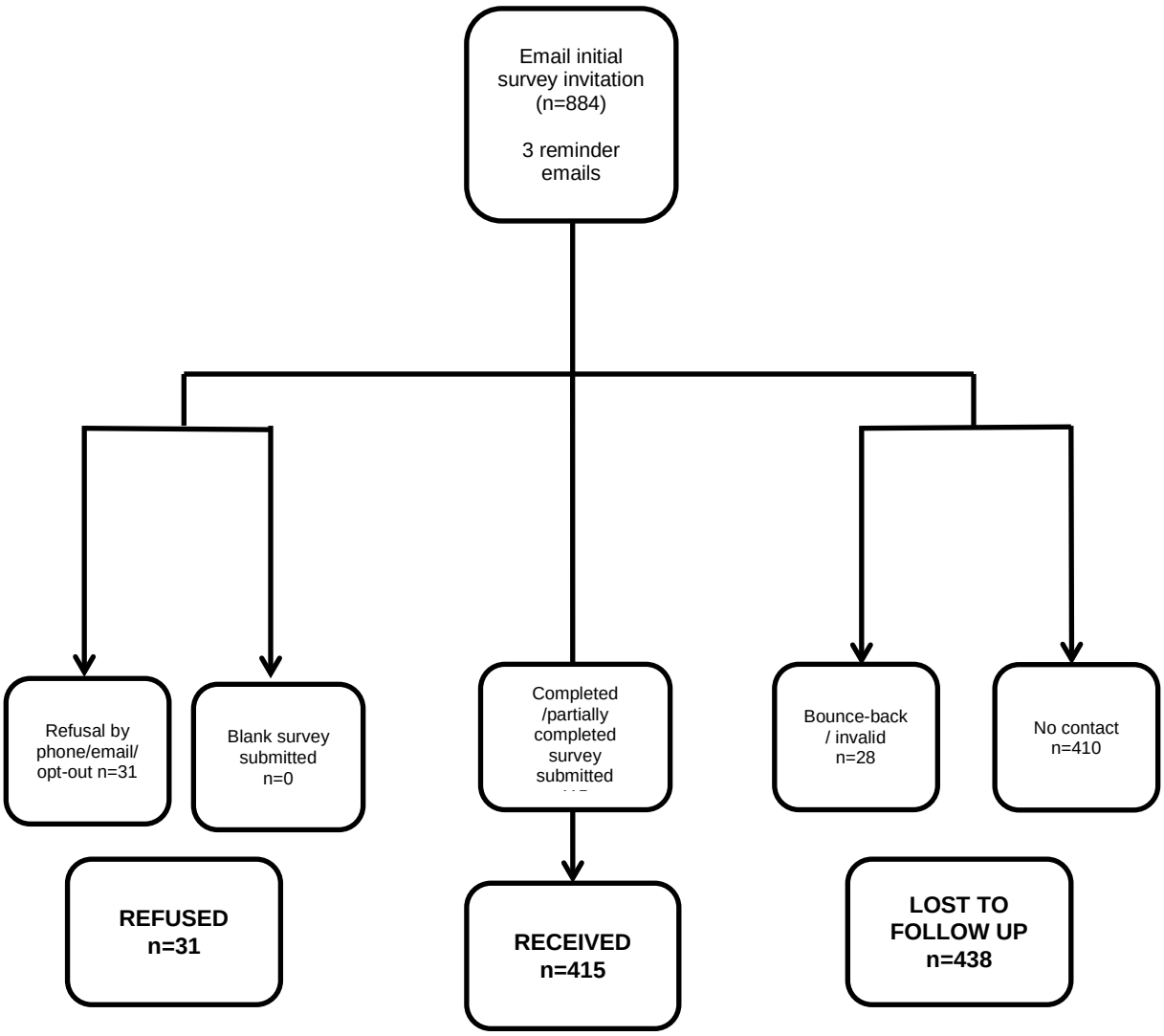
2.2 Stage 2: Online participant survey

An online survey was sent to a subset of WorkHealth Coach participants who had completed the program in a six month time period prior to data collection (Appendix A). The survey collected data about participant experience of the program, the organisational supports in place for a telephone-coaching program conducted through a workplace setting, impact of the coaching service to motivate change in behaviour and improve health status, reasons for opting out of the program; and barriers and enablers around sustainability of positive behaviour changes. The survey comprised of 20 closed questions and two of these questions asked additional open questions to illicit further information.

All participants of the WorkHealth Coach program who had participated between February 1 2013 and July 31 2013 and had received at least one coaching session after the initial call were included in the mailing list. The mailing list was cleaned and participants were deleted if the primary email or name of contact person were missing or incomplete. 884 eligible participants were sent an email invitation to participate in the evaluation via SurveyMonkey [1]. The survey was live from August 13th 2013 to September 17th 2013. Reminder emails were sent out on August 20th 2013 (start of second week), August 27th 2013 (start of third week) and a final reminder was sent on September 3rd 2013. Figure 2 illustrates the data collection process using the online survey.

[1] www.surveymonkey.com

Figure 2: Participant survey data collection flow chart



2.3 Stage 3: Qualitative interviews

2.3.1 Semi-structured interviews with participants

Semi-structured interviews were held with participants who agreed to participate in a telephone interview at the end of the online survey. Key interview themes included behaviour change, quality of coaching, behaviour change maintenance and the workplace as setting for telephone coaching (Appendix B). The contact details of all participants who opted into further evaluation were entered into an Excel spreadsheet and categorised by the number of coaching sessions that they completed[2]. Seven participants from the three categories were then randomly selected for a telephone interview.

- Group 1: Non-completers who withdrew at or before the halfway point (n=7)
- Group 2: Non-completers who withdrew after the halfway point (n=7)
- Group3: Completers (n=7)

If participants were not available at the best available time specified at the end of the survey, a new respondent was selected from the list to contact until a successful call was made. In the case of Group 1, there were insufficient respondents in the list of participants so an incentive of a $30 gift voucher was provided to participate in an interview.

2.3.2 In depth interviews with coaches

In depth interviews were conducted with coaches to determine the impact of the program from the program deliverer's perspective (Appendix C). Questions covered their experience as a WorkHealth coach, training for their role, participant motivation and support required for behaviour change and the workplace as an appropriate setting for a telephone coaching program.

All registered WorkHealth telephone coaches (n=9) were sent a letter of invitation to participate in the research. This letter was sent to coaches via the Relationships Manager at Medibank Health Solutions. Coaches then contacted the researchers via

[2] Group 1: 1-4 sessions completed, Group 2: 5-8 sessions completed, Group 3: 9 sessions completed

email if they were interested in participating in an interview.

2.5 Data management and ethical approval

A Low Risk Project Involving Human Ethics application was approved on 24th July 2013 (CF13/1991-2013001045). This application was submitted after the WorkHealth Coach Evaluation plan was accepted through the OH&S Program at the Institute of Safety and Recovery Research (ISCRR).

Databases, spreadsheets and transcripts were stored in an electronic password protected folder only accessible to the researchers. The researchers de-identified audio files before they were sent to the transcription company.

2.6 Data analysis

The data set provided by Medibank Health Solutions (stage 1) and responses from SurveyMonkey (stage 2) were downloaded into STATA 12 for statistical analysis. Descriptive statistics were conducted on both complete data sets after they were cleaned. Frequencies, cross-tabulations, proportions and means, were calculated.

Telephone interviews held with program participants and WorkHealth Coaches were audio-taped and then transcribed by a Melbourne-based company. Transcripts were then coded using open and focused coding to sort and organise the data before being coded using selective coding to construct emerging concepts and themes to answer the evaluation questions (Liamputtong 2010).

3. Results

The results of the evaluation are presented in the three stages of data collection.

- Stage 1: Data collected from program participants during the WorkHealth Coach program (program participants between 7 March 2011 and 21 October 2013);
- Stage 2: Data from the online participant survey (program participants between February 1 2013 and July 31 2013); and
- Stage 3: Data from qualitative interviews with program participants and WorkHealth Coaches.

3.1 Stage 1: Participant data

3.1.1 Recruitment and withdrawal trends

Referral trends indicate that three quarters of referrals for lifestyle programs were made into the Coach program (Table 1). Of those contacted for the Coach program, 33.3% agreed to enroll in the program and 73.8% progressed to setting goals with a coach at Week 1. Withdrawal from week 0 (initial call) to week 1 (first coaching call) was 26.2%.

Table 1: Program recruitment into WorkHealth Coach program

	N	%
Referrals from WorkHealth check	37,039	100
Total referred to Diabetes Program	12,069	32.6
Total contacted for Coach Program	24,970	67.4
Total enrolled in Coach Program after initial call	8,312	33.3
Total set goals in Coach Program at Week 1	6,138	73.8

Workers who were referred into the program and took the initial call were more likely to be male (52.3%), from a white collar occupation (77.8%) and born in Australia (61.7%). After the initial call and enrolment, workers who withdrew from the program were more likely to passively withdraw (Table 2). Most of these workers either did not answer the call (73.4%) or coaches were given an incorrect contact number (25.7%). Participants who withdrew at any point after commencing the program were more likely to passively withdraw, with average passive withdrawal rate of 77.5% compared with active withdrawals at 22.5%. Participants who actively withdrew from the program reported

being not interested in the program (39.3%), not ready to change behaviour (26.9%), did not require assistance (17.3%) and unavailable for program duration (12.3%).

Table 2: Withdrawals from the program

Total enrolled in program: n= 8312	n	%
active withdrawal	1563	18.8%
passive withdrawal	5162	62.1%
graduated	1587	19.1%

3.1.2 Demographics of participants

Participant demographics are provided at the commencement of the program (week 1), midway point (week 12) and end of the program (week 26) (Table 3). In total, 6325 participants (individual client IDs) were included in the dataset. Participants were most likely to be from a white-collar occupation, aged between 45 and 64 years of age and born in Australia. There was only a slight gender difference in participants however slightly more women participated in the program at week 1 (54.4%) which changed from the initial call (week 0) where slightly more men were eligible to start the program (52.3%).

Table 3: WorkHealth Coach participant demographics

	Week 1 (n=6137) %	**Week 12** (n=2929) %	**Week 26** (n=1555) %
Gender			
Male	45.6	47.0	45.5
Female	54.4	53.0	54.5
Age			
18-24	0.5	0.7	0.9
25-34	6.1	4.4	3.4
35-44	21.8	18.0	16.0
45-54	30.0	30.1	28.2
55-64	30.8	33.7	36.4
65+	10.8	13.1	15.1
Country of Birth			
Australia	67.4	64.1	62.2
Greater Asia	19.0	21.7	22.2
Other	13.6	14.2	15.6
Occupation			
White collar worker	86.4	85.7	86.1
Blue collar worker	13.4	14.2	13.7
Unpaid worker	0.2	0.1	0.2

3.1.3 Selected goals at the start of WorkHealth Coach program

In week 1, participants were required to select health goal(s) for their coaching sessions. Table 4 displays the goals chosen by participants. Increase my exercise level was the most popular goal (32.1%) followed by make better food choices (28.6%) and reduce my weight (15.8%). These top three goals represent 76.5% of goals chosen. Slight gender differences were seen in the choice of goals. Females were more likely to want to lose weight, decrease waist circumference and increase exercise, males were more likely to want to make better food choices, quit smoking and reduce their alcohol intake. Older age groups (45-64 years of age) were more likely to want to reduce waist circumference and manage their stress and less likely to want to increase their exercise levels or make better food choices. It is interesting to note that only 3.1% chose reduce alcohol as a goal and 3% chose to reduce/quit smoking.

Table 4: Goals chosen in Week 1 by demographics of participants (n=6,325)

Goals chosen at Week 1	Total %	Female %	Male %	25-34 %	35-44 %	45-54 %	55-64 %
Increase my exercise level	32.1	32.5	31.6	34.3	34.3	31.7	32.0
To make better food choices	28.6	26.5	31.0	29.3	29.3	26.8	23.6
Reduce my weight	15.8	17.8	13.4	15.3	15.3	17.5	13.7
Reduce my waist circumference	7.5	8.3	6.4	7.1	7.1	7.9	9.1
Better manage my stress	6.1	6.8	5.6	5.5	5.5	6.2	8.9
To reduce or quit smoking	3.4	2.2	4.7	3.3	3.3	3.1	3.1
Reduce my alcohol intake	1.7	1.4	2.1	1.7	1.7	1.6	3.0
Other Goals*	4.8	4.5	5.2	3.5	3.5	5.2	6.7

*maintain exercise levels, review by GP, take medication, manage pain, manage fatigue, quality of life, test blood glucose, visit dietician.

Table 5 illustrates the choices of goals in week 1 by occupation. When goals are analysed by occupation, unpaid workers (including those on sick leave), managers and professional service workers were more likely to want to increase exercise levels and labourers scored highest in selecting a goals of improving food choices (33.9%) and reducing weight (19.5%). Managers and professional service workers were more likely to choose the goal to reduce stress levels and machine operators, technicians, sales workers and labourers were more likely to choose a goal to reduce/quit smoking. Note the small number of participants for the unpaid workers category (n=10).

Table 5: Goals chosen at Week 1 by occupation (ANZIC classification) of participants (n=6,261)

	Clerical or Admin worker	Community or Personnel	Labourer	Machinery operator or driver	Manager	Professional services	Sales worker	Service worker	Technician or trades worker	Unpaid work
	n=1325 %	n=374 %	n=221 %	n=180 %	n=1281 %	n=1856 %	n=255 %	n=314 %	n=445 %	n=10 %
Increase my exercise level	31.3	29.9	22.6	31.7	34.6	33.8	30.2	28.3	31.9	60.0
To make better food choices	27.7	28.6	33.9	30.6	25.7	29.5	26.7	33.1	29.4	30.0
Reduce my weight	18.1	18.2	19.5	12.8	14.5	14.7	18.0	15.0	14.2	0.0
Reduce my wai circumference	8.2	8.8	7.7	5.6	6.3	7.6	7.8	8.3	4.9	10.0
Better manage my stress	6.1	6.4	5.0	3.9	7.5	7.0	2.7	5.4	4.0	0.0
To quit smoking	2.4	2.1	5.9	10.0	3.0	2.0	6.7	4.5	7.9	0.0
Reduce my alcohol intake	1.3	1.9	0.9	0.6	3.0	1.3	2.4	1.0	2.2	0.0
Other Goals*	4.8	4.0	4.5	5.0	5.5	4.1	5.5	4.5	5.4	0.0

Table 6: Average (mean) self-reported confidence scores in achieving goals at start, midway and end points of program.

	week 1	week 12	week 26	Difference
Alcohol				
Male	6.5	7.3	7.7	+1.2
Female	6.7	7.4	7.3	+0.6
Blue	6.5	7.3	7.4	+0.8
White	6.8	7.7	8.2	+1.4
Diet				
Male	7.4	7.7	8.1	+0.7
Female	7.2	7.6	7.9	+0.7
Blue	7.2	7.4	7.6	+0.4
White	7.3	7.5	7.9	+0.6
Exercise				
Male	7.2	7.5	7.9	+0.7
Female	6.9	7.3	7.8	+0.9
Blue	7.1	7.4	7.8	+0.7
White	7.3	7.6	8.2	+0.9

Table 6 measures self- reported confidence to achieve goals reported at weeks 1, 12 and 26 for goals set (except smoking which was not recorded). A likert scale was used to measure confidence, with 1= not confident and 10 = confident. Participants reported above average confidence levels at the start of the program and these increased slightly throughout the duration of the program on average by 0.8. Confidence increased most significantly for those participants who set goals around alcohol intake, in particular for males and white collar workers.

3.2.2 Program goals achieved

Participants reported on goal achievement throughout the program. Goal achievement was calculated by comparing initial self-reported measures at week 1 with self- reported measures at the halfway point (week 12) and program completion (week 26). Figure 3, represents goal measures at week 12 and week 26 for all participants in the program who were contacted at those time points. The graph indicates that participants who remained in the program for the full 26 weeks were more likely to achieve their goal. Increase/maintain exercise was the only goal which recorded a decrease in goal maintenance from week 12 to week 26. Figure 4

indicates both males and females reported increased goal achievement from Week 12 to week 26, apart from goal achievement to reduce alcohol consumption where males reported less achievement at week 26 compared to week 12 and goal achievement of maintaining / increasing exercise where both males and females reported less achievement at week 26 compared to week 12.

Table 7 analyses goals achieved by age. This indicates the percentage of participants reporting achievement of weight reduction goals from week 12 to 26 increased for all age groups, except for workers aged <25 years or >=65 years, and the percentage of participants reporting achievement of alcohol reduction goals from week 12 to 26 increased for all age groups except for workers aged between 35-44 years and 55-64 years. Goal achievement in stress management/reduction increased from week 12 to 26 in all age groups, with the exception of the 55-64 years groups. Trends indicate reported goal achievement for maintaining/increasing exercise did not increase from week 12 to week 26 in any age groups apart from the >=65 years group where levels were maintained.

Table 8 analyses goal achievement by occupation. This indicates reported achievement of weight reduction goals increased from week 12 to week 26 in all occupations apart from labourers and sales workers and achievements in maintaining / increasing exercise goals increased from week 12 to 26 for all occupations apart from machinery and unpaid workers. Reported achievement of stress management /reduction goals increased from week 12 to 26 in all occupations except for machinery workers and reported achievement of improving food choices goals increased from week 12 to week 26 in all occupations.

Figure 3: Goals achieved at week 12 and week 26

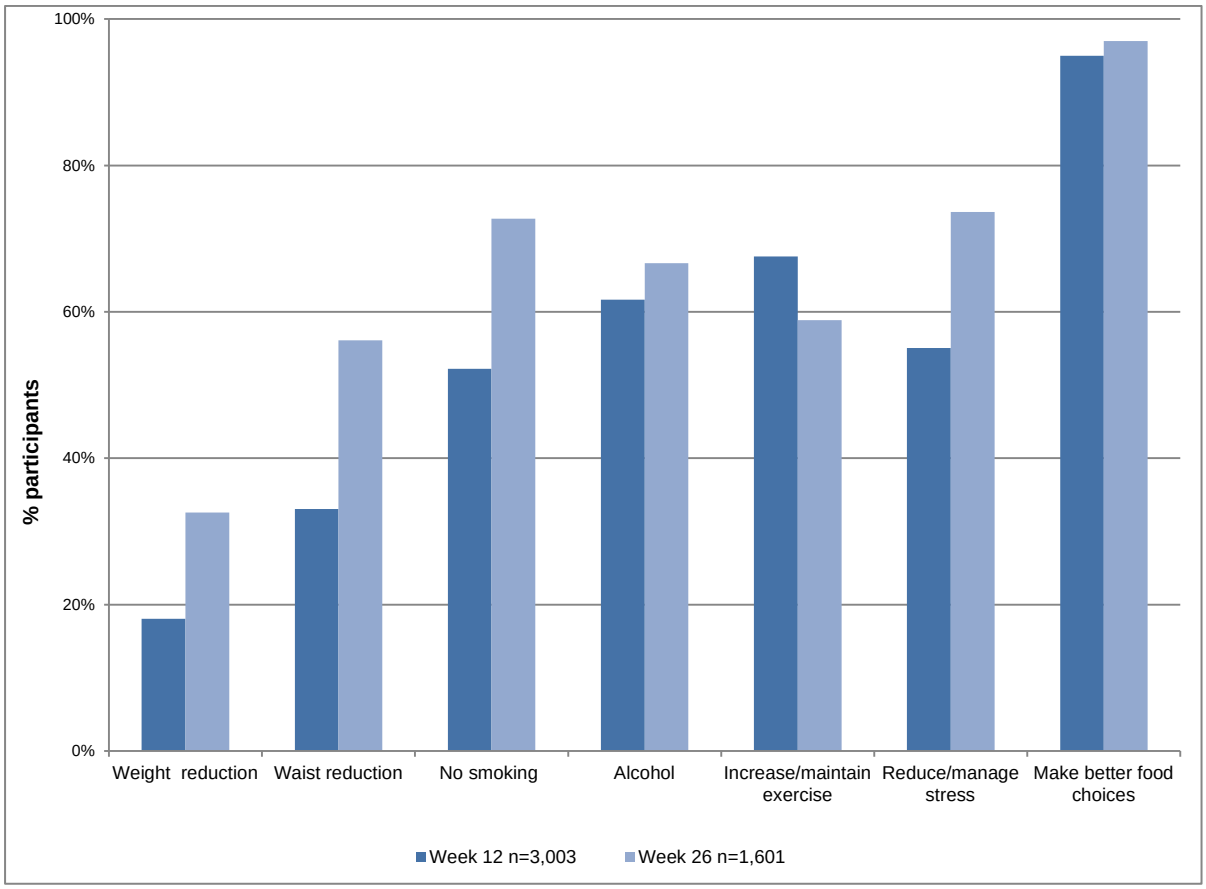


Figure 4: Goals achieved at week 12 and week 26 by gender

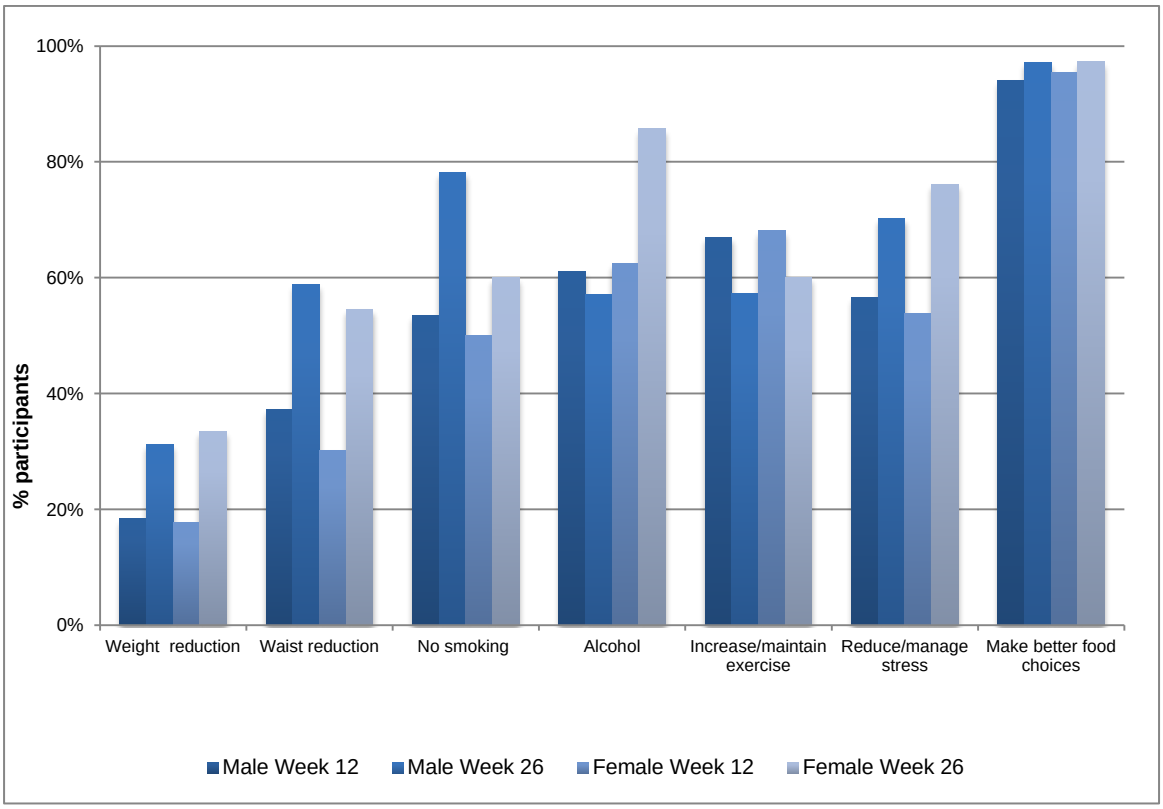


Table 7: Goals achieved at week 12 and week 26 by age

	<25 years		25-34 years		35-44 years		45-54 years		55-64 years		>=65 years	
Wk 12		Wk 26	Wk 12	Wk 26	Wk 12	Wk 26	Wk 12	Wk 26	Wk 12	Wk 26	Wk 12	Wk 26
Weight reduction	22.0%	0.0%	17.8%	27.8%	18.4%	37.5%	20.3%	32.5%	12.8%	30.4%	20.0%	3.0%
Waist reduction	0.0%	0.0%	31.8%	50.0%	25.0%	47.4%	34.4%	59.2%	37.7%	65.0%	50.0%	40.0%
No smoking	50.0%	.	35.7%	57.1%	42.9%	66.7%	63.6%	75.0%	57.1%	87.5%	100%	.
Alcohol	.	.	50.0%	100%	64.3%	50.0%	66.7%	77.8%	60.0%	50.0%	33.0%	100%
Increase/maintain exercise	89.0%	50.0%	61.9%	51.0%	69.4%	61.4%	67.1%	57.3%	68.1%	59.7%	69.0%	69.0%
Reduce/manage stress	0.0%	100%	52.0%	75.0%	55.9%	75.0%	50.8%	89.5%	68.1%	59.0%	60.0%	63.0%
Food choices	100%	100%	93.1%	96.4%	96.4%	96.2%	92.2%	98.0%	96.7%	97.6%	100%	100%

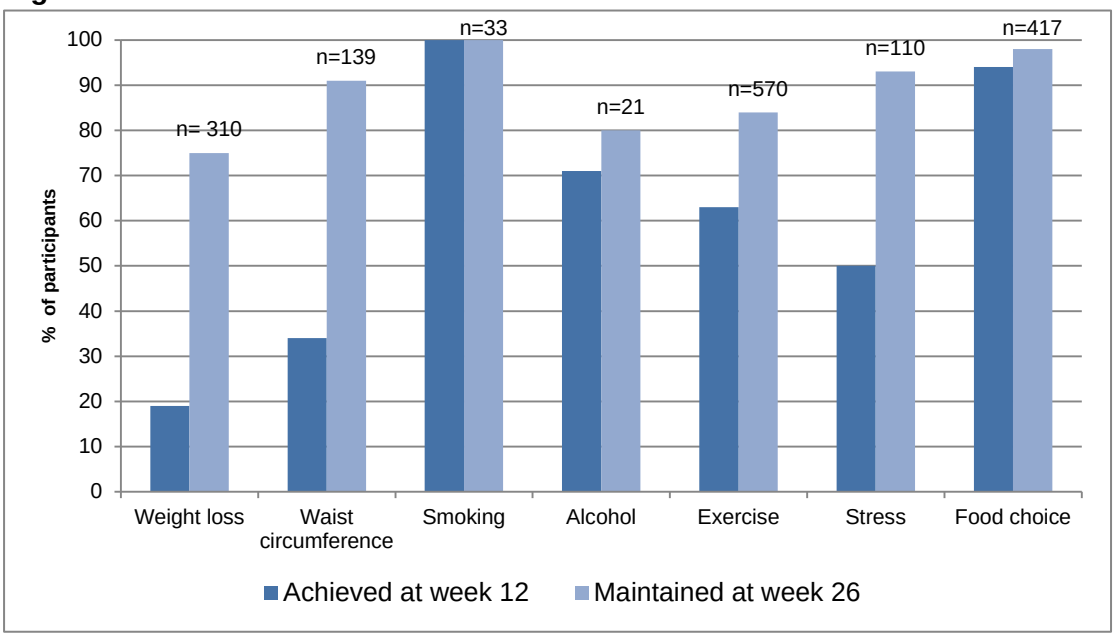
Table 8: Goals achieved at week 12 and week 26 week by occupation

	Clerical		Community worker		Labourer		Machinery		Manager		Professional services		Sales worker		Service worker		Technician/trade		Unpaid	
	Wk 12	Wk 26	Wk 12	Wk 26	Wk 12	Wk 26	Wk 12	Wk 26	Wk 12	Wk 26	Wk 12	Wk 26	Wk 12	Wk 26	Wk 12	Wk 26	Wk 12	Wk 26	Wk 12	Wk 26
Weight reduction	16%	44%	17%	35%	36%	27%	13%	72%	18%	28%	18%	26%	32%	23%	15%	42%	12%	39%	.	.
Waist reduction	40%	68%	36%	63%	.	57%	25%	33%	29%	52%	31%	45%	11%	0%	33 %	50%	62%	100%	.	.
No smoking	43%	50%	100%	100%	60%	50%	75%	.	53%	73%	36%	80%	67%	100%	67%	50%	46 %	67%	.	.
Alcohol	100%	100%	50%	.	100%	100%	.	.	54%	67%	43%	25%	80%	67%			100%	100%	.	.
Increase/maintain exercise	64%	70%	60%	79%	62%	67%	64%	39%	65%	69%	62%	74%	62%	69%	66%	73%	54%	67%	75%	50%
Reduce/ manage stress	55 %	76%	40%	57%	33%	60%	100%	0.%	58%	90%	60%	76%	80%	100%	38%	58%	50%	56%	.	.
Food choices	96%	99%	98%	93%	97%	100%	100%	100%	95%	99%	93%	96%	92%	100%	98%	100%	93%	94%		100%

3.3.2 Maintenance of goals achieved

An analysis of 1600 participants, followed by client code, indicated that if a goal was achieved by a participant at week 12, this was maintained at week 26 by 75-100% of the participants. For example, although only 19% achieved a goal of weight loss at week 12, of those achievers 75 % maintained the weight loss to week 26. Smokers goal achievement at week 12 (100%) was matched by 100% at week 26 and better food choices, 94% at week 12 was maintained by 98% of participants at week 26.

Figure 5: Goals achieved and maintained from week 12 to week 26



3.2 Stage 2: Online participant survey

415 online surveys were completed. This is a response rate of 46.9%. Table 9 shows the demographics of survey respondents. This subset of participants is fairly representative of the WorkHealth Coach participants presented in section 3.1.

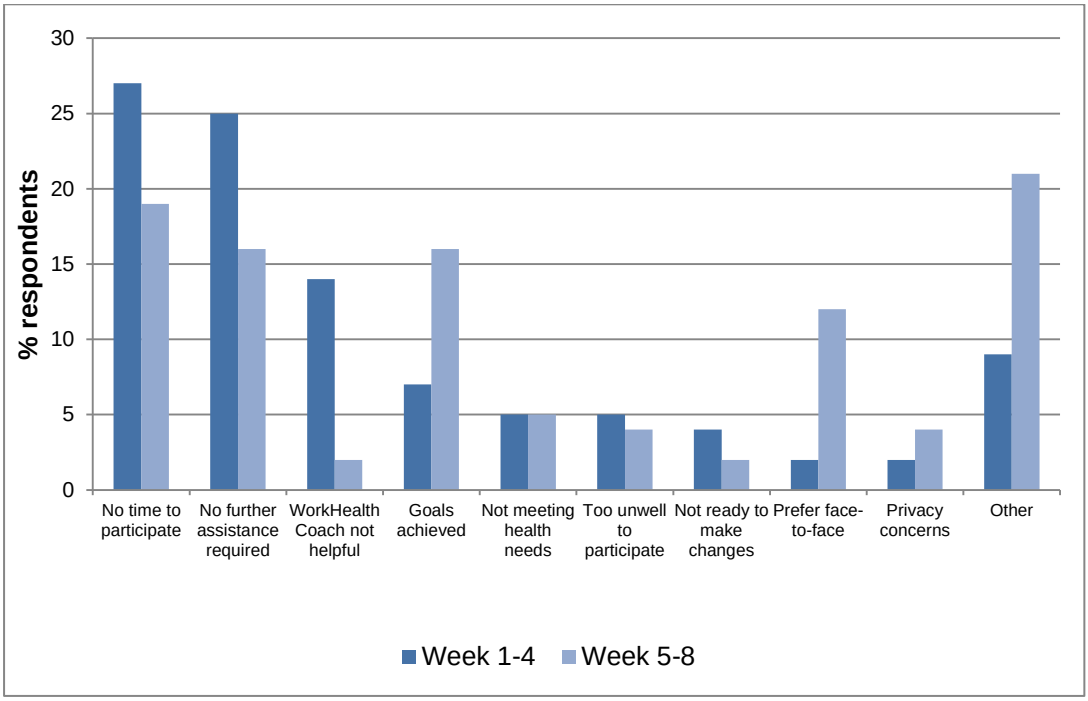
Table 9: Demographics of online survey respondents

Demographic characteristic	Frequency	Percentage
Gender		
Male	168	40.5%
Female	247	59.5%
Age		
18-24	5	1.2%
25-34	43	10.4%
35-44	103	24.8%
45-54	163	39.3%
55-64	94	22.7%
65+	7	1.7%
Location		
Metropolitan Melbourne	284	68.4%
Rural Victoria	131	31.6%
Occupation		
White collar worker	364	87.7%
Blue collar worker	38	9.2%
Unpaid worker	13	3.1%
Industry		
White collar	349	90.5%
Blue collar	38	9.5%
WorkHealth Coach sessions completed		
1-4 sessions	43	10.8%
5-8 sessions	55	13.8%
Complete program	301	75.4%

3.2.1 Participant withdrawal

Survey respondents who withdrew from the program before completion indicated that the top three reasons for discontinuing were time barriers (29.1%), not requiring further assistance to improve their health (27.2%) and achieving their goals set at the start of the program (22.3%) (Figure 6). Further analysis of the two withdrawal groups shows that participants who withdrew before the halfway point were much more likely to find their coach unhelpful (14%) whereas those who withdrew after the halfway point were more likely to state that they withdrew because they had achieved their goals (16%) and they preferred face-to-face support (12%). Those who responded 'other' listed travel, missing the phone call, family commitments and Coach unavailability.

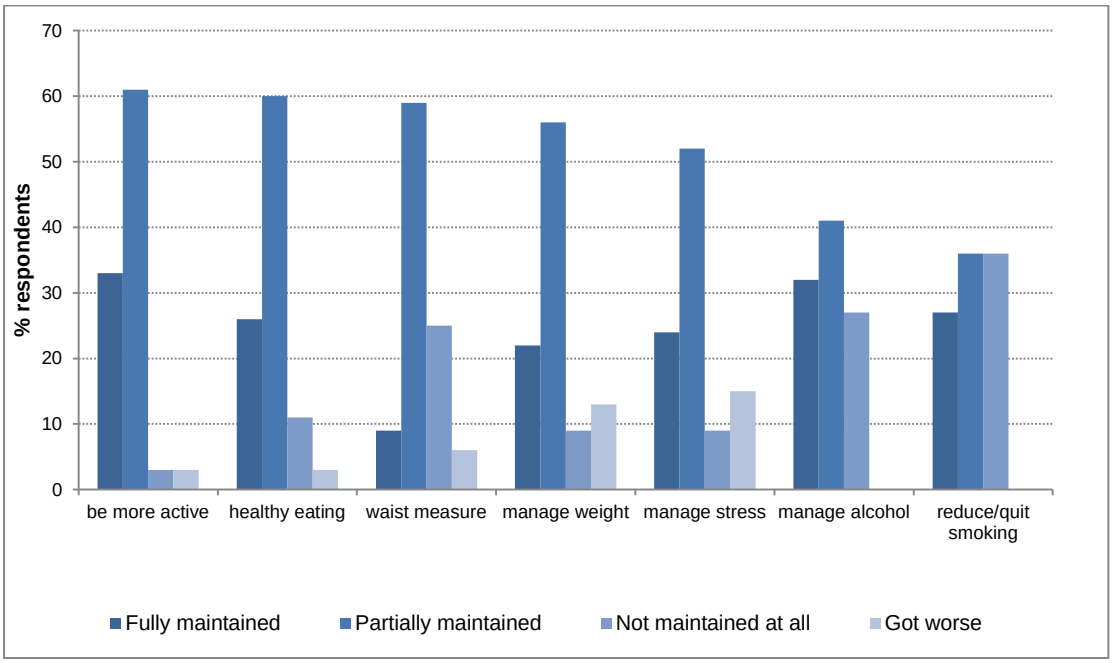
Figure 6: Reasons for discontinuing the WorkHealth Coach program (n=103)



3.2.2 Goal attainment and maintenance

Survey respondents were asked to what extent they had maintained the goals they had set at the start of the program (Figure 7). Participants were most likely to have reported that they partially maintained their health goals set at the start of the program. Higher proportions of participants report not maintaining their alcohol intake or reducing/quitting smoking.

Figure 7: Maintenance of goals since the WorkHealth Coach Program (n=393)



Survey participants were asked what reasons prevented them from maintaining their goals. Participants identified too busy at work (45.6%), too busy at home (39.7%) and not motivated (22.5%) as the top reasons for not maintaining goals. Analysis did not show any distinct trends within participant demographics in relation to the reasons participants were not maintaining goals.

Table 10: Changes observed from participating in the WorkHealth Coach program (n=393)

	Agree/ Strongly agree %	Neither agree or disagree %	Disagree/ Strongly disagree %
More productive at work	49.9	47.5	2.6
Improved energy at work	63.3	33.2	3.4
Sick less often	43.9	48.0	8.1
Reduced stress at work	39.9	48.4	11.7
Greater ability to complete job tasks	44.8	48.8	6.5
Improved physical wellbeing	78.8	19.0	2.2
Improved emotional wellbeing	69.3	27.0	3.7
No changes	19.8	33.2	47.1

Survey respondents were most likely to report improved physical wellbeing (78.8%), emotional wellbeing (69.3%) and improved energy (63.3%) in their work environment after completing the WorkHealth Coach program. Further analysis of these results indicated that respondents who completed all sessions in the program were more likely to report that they agreed or strongly agreed that they observed positive health changes at work after completing the program, in particular, physical wellbeing, emotional wellbeing and improved energy at work (Table 11).

Table 11: Observed health changes at work by session completion

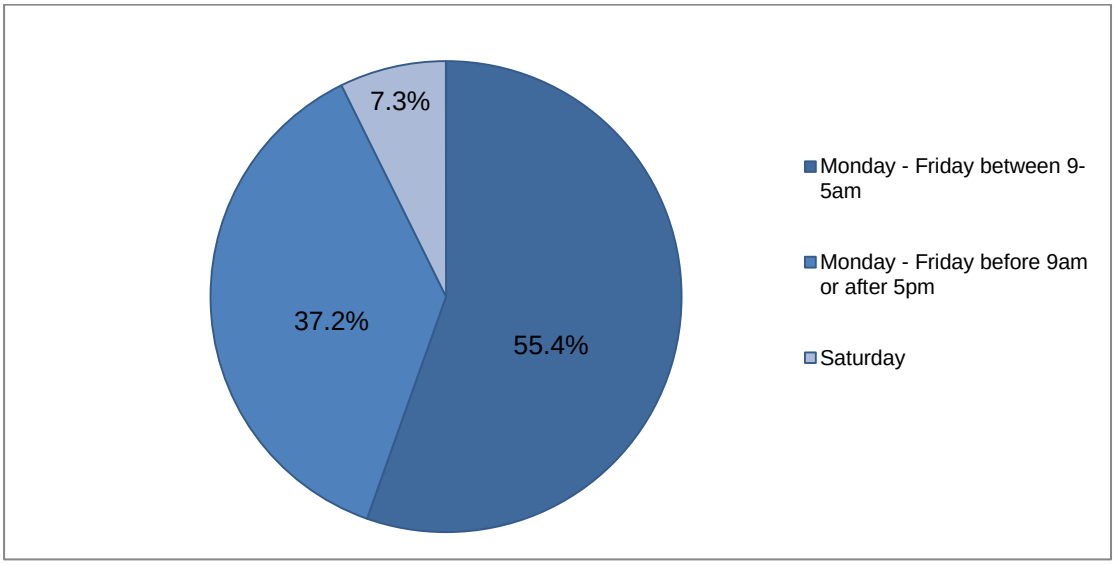
Health improvement	1-4 sessions	5-8 sessions	9 sessions
More productive at work	28%	38%	55%
Improved energy at work	44%	49%	68%
Sick less often	35%	49%	45%
Reduced stress at work	35%	36%	41%
Greater ability to complete job tasks	33%	44%	46%
Improved physical wellbeing	53%	67%	84%
Improved emotional wellbeing	50%	62%	73%

3.2.3 Program structure and quality

Survey responses showed that just over half (54.4%) of survey respondents took their coaching calls during work hours. For those respondents who reported taking their calls outside of work hours, only 7.3% took their calls on a Saturday, choosing instead to take their sessions before or after work hours on a weekday (37.2%).

Of the respondents who identified taking their calls outside of work hours, 76.4% identified workload issues as the reason for doing so, and 24.6% identified privacy concerns. Privacy concerns were often linked to open plan office space in interviews where participants did not have an area to take the call confidentially. Those who took their calls during work hours commented that this was often during their lunch break.

Figure 8: Time of coaching session calls (n=395)



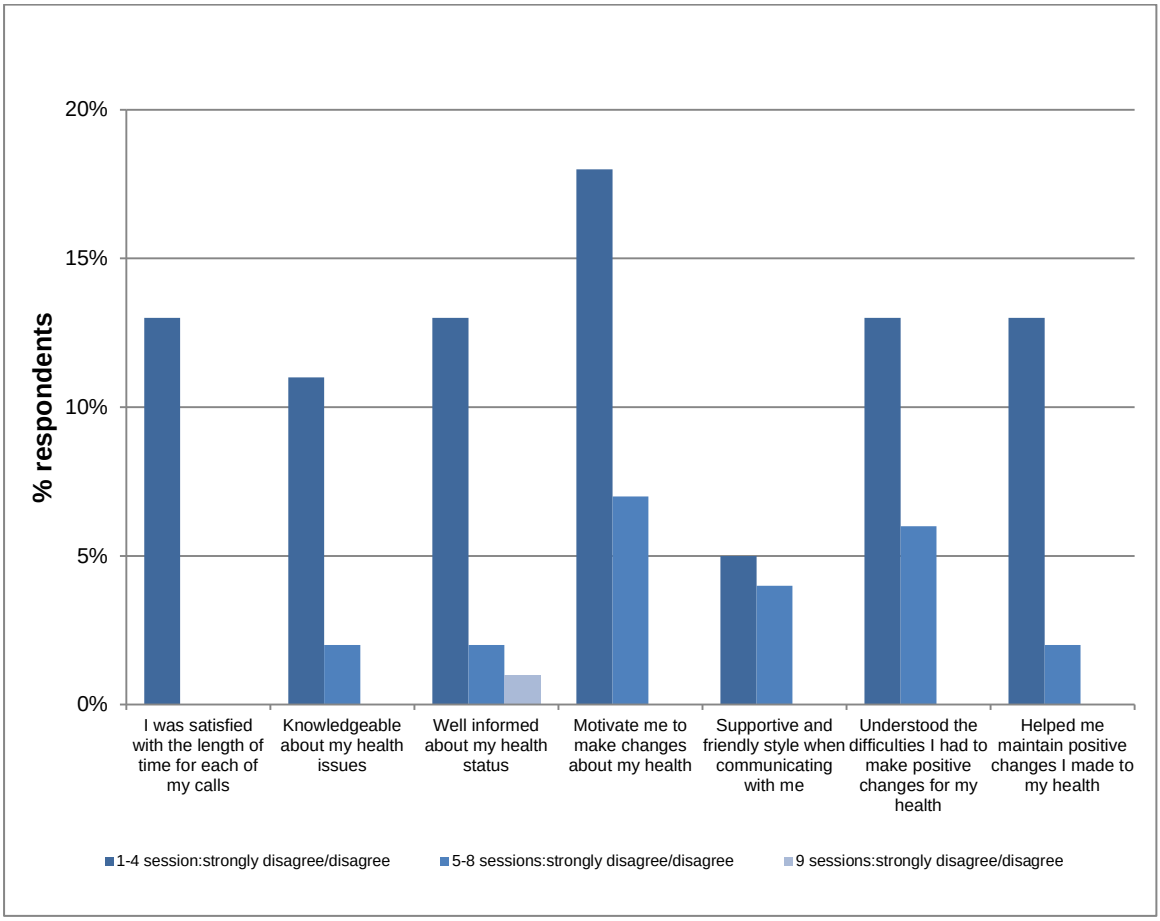
Overall, survey participants were very satisfied with the quality of the coaching provided in the program as illustrated in Table 12. Participants were most happy with the supportive nature of their Coach and the length of time for each of their calls. Interviewees who completed the program were very positive about the support they received from their Coach.

Table 12: Quality of coaching during the WorkHealth Coach program (n=395)

Component of Coaching	Strongly agree/Agree
I was satisfied with the length of time for each of my calls	95%
My Coach was very knowledgably about my health issues	90%
My Coach was well informed about my health status	90%
My Coach was able to motivate me to make changes about my health	88%
My Coach had a supportive and friend style when communicating with me	96%
My Coach understood difficulties I had to make positive changes for my health	87%
My Coach helped me maintain positive changes I made to my health	88%

Further analysis revealed that survey respondents who were unsatisfied with the quality of telephone coaching were most likely to have withdrawn from the program before the halfway point (Figure 9). However, caution must be taken with the small number of respondents in this question.

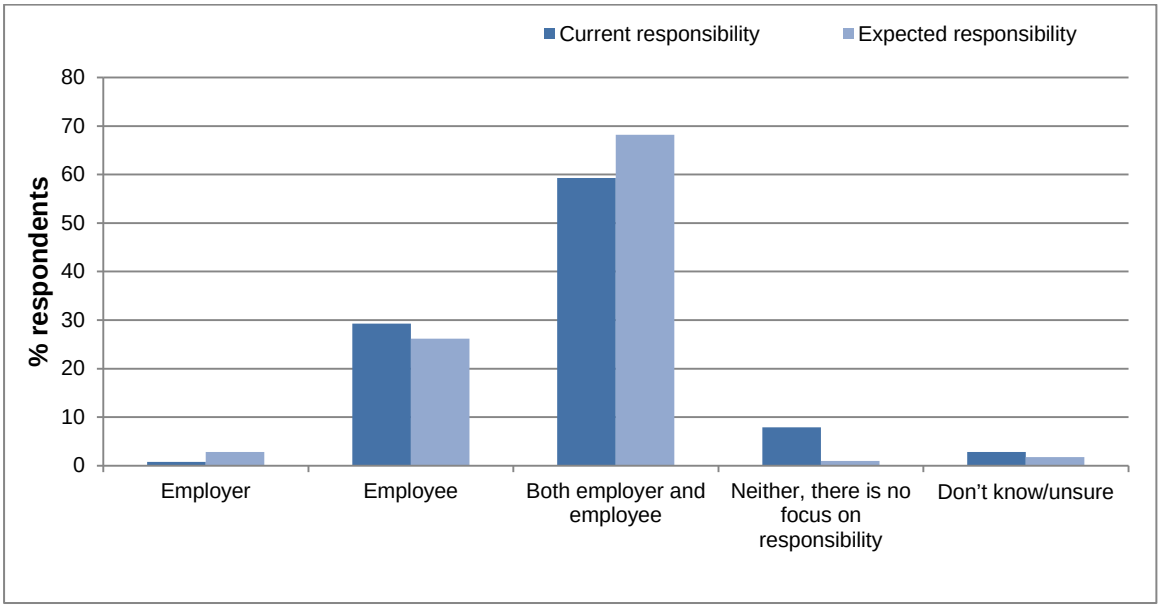
Figure 9: Dissatisfaction with quality of coaching (n= 12)



3.2.4 Workplace environment for WorkHealth Coach

More than half of survey respondents reported that responsibility for health and wellbeing in the workplace fell on both the employer and employee (59.3%), or the employee (29.3%). When asked who should have responsibility, shared responsibility increased slightly (68.2%) and decreased for employees (26.2%).

Figure 10: Primary responsibility for health and wellbeing in the workplace (n=393)



Around half (55.2%) of survey respondents reported that their workplace was proactive in providing health and wellbeing programs and a similar number (58.4%) reported that their workplace encouraged participation in health and wellbeing programs. Around two thirds (63.1%) of survey respondents reported discussing their participation in the WorkHealth Coach program with someone else. This was most likely to be a family member (78.9%), friend (56.9%) or work colleague (54.1%) rather than a manager (20.7%). A positive correlation was calculated between participants who reported that their workplace encourages participation in health and wellbeing programs with those who reported their manager was supportive of their participation in the WorkHealth Coach program (Spearman's rho, ρ=0.45).

3.3 Stage 3: Qualitative interviews

At the close of the survey, 185 respondents agreed to participate in a semi structured telephone interview. 21 respondents were randomly selected into the three categories representing stages of program completion. Five in depth interviews were conducted with WorkHealth Coaches (response rate =55.5%).

Key themes emerged from both semi-structured and key informant interviews:

- Referral into the program
- Structure of the program
- Quality of telephone coaching
- Telephone coaching in the workplace

3.3.1 Referral into the program

For workers at risk of type 2 diabetes and cardiovascular disease, the option to refer into the WorkHealth Coach program at the end of their WorkHealth check was considered a beneficial pathway by participants. Most participants cited their WorkHealth check results as the driver for program participation, stating that they would not have signed up for the program if they had not been told they were at risk of type 2 diabetes or cardiovascular disease at their WorkHealth check.

> *I think from the WorkHealth check, and I think me knowing that I had to make a change – Participant (1-4 sessions)*

> *I guess the fact that I was at risk or at a level of risk of getting diabetes was certainly something that never crossed my mind – Participant (completed program)*

Coaches all agreed that the referral pathway from a WorkHealth check into the program meant that most participants had already moved from the pre-contemplation to the contemplation stage of change through the advice they received from the WorkHealth check professional. They agreed that this meant participants were more likely to actively engage in the program.

> *It's often people who weren't considering it before their health check so now they've been given advice from a health professional and I guess their readiness to change depends on how much they value that advice and how much it plays into their self image of what they believe their health is like – WH Coach*

In most interviews, participants mentioned that they were hoping that the program would help them to improve their health behaviours but did not have any expectations around program delivery or structure before the program commenced.

> *I was hoping that the program would give me probably a little bit more motivation on how to make some changes in my life that I already knew I had to make and so when we had the health check at work, and because my family's risk of diabetes was picked up and I was entitled to a health coach, I decided, 'Oh well, I'll give that a try and see if that's for me or not -Participant (1-4 sessions)*

3.3.2 Structure of the program

Interviews with participants elicited several suggestions about the delivery of the program. Many participants commented that they would have liked a reminder SMS message the day before their session. Several participants also suggested that reminder texts could also include motivational messages from their Coach.

> *Remind people that there is a catch up scheduled because a few times I hadn't put in my diary and I was caught off guard basically, and I was either driving or I was doing something else and I couldn't take the call at the time. – Participant (1-4 sessions)*

Many of the participants interviewed also suggested additional support to the telephone calls. Face to face support at the halfway point and 3 months after program completion was a popular supplementary component suggested. Other participants recommended an online forum or website which could provide further information about behaviour change and health information. A few participants suggested an interactive forum where participants could communicate with each other.

> *I'm better interacting in a group, so I don't know if there is something that the organisation could do that, say once a month or twice a year, there is a group that meets – Participant (1-4 sessions)*

Coaches agreed that it would be beneficial to have a component of the program run face to face to support the telephone calls and they highlighted the potential of online interactive programs like Skype, which could improve their ability to Coach and build a relationship with the client.

> *I think you really need that communication with people I think it's more valuable than texting and messaging, I just – people often ask for that, thinking that that's easier for them but I try and explain it's not – it's not a successful way to do education and build a rapport and, see I think the phone coaching works quite well and if technology improves in the future then we could probably do other things as well. – WH Coach*

Interview data also revealed that for some participants, the length of call was not long enough for them or that they would have preferred more frequent calls to keep their motivation in the program.

> *They were certainly long enough for the WorkHealth coach to get through what they needed to get through but from my point of view I don't think they got anywhere near the issues about me that prevents me from taking daily exercise for instance – Participant (1-4 sessions)*

Several WorkHealth coaches concurred with this opinion stating that it takes time to build a relationship with a client in order to understand their lifestyle and support them through positive behaviour change. They agreed that keeping calls to within the shorter time slots in the program was often difficult.

> *The seven minute calls I would think they could be longer, they're fine, you know, you can do it even shorter if someone's going along great with their goal and there's no problems then, sure, you're in and out in less than that sometimes. But a lot of the times you're going on further than that because you can't just leave someone hanging without a solution with whatever they're struggling with. – WH Coach*

3.3.3 Quality of telephone coaching

Participants overall were very happy with the quality of the coaching which is illustrated in Table 11, however, interviews revealed the barriers and enablers to good coaching quality. The relationship between the coach and the participant was highlighted as a critical factor for participant engagement in the program.

> *He made me feel quite comfortable, he sort of was quite empathetic and open to hearing what I had to say and also quite encouraging, there were a couple of months where I'd gone backwards a little bit but he was always open and maintained my focus and he was always motivated and bright and happy and said thanks for taking my call, so very courteous - Participant, 9 sessions*

Interview data supported the slight drop in satisfaction illustrated in Table 12 for three key components: My Coach was able to motivate me to make changes about my health, My Coach understood the difficulties I had to make positive changes to my health and My Coach helped me to maintain positive changes I made to my health. These three elements were most often cited in interviews as problems with program quality. In particular, the ability for the Coach to understand the participant's lifestyle was mentioned.

> *I found that the person who I was talking with wasn't particularly engaged. I think that's a hazard of the job…With something as sensitive as someone's health you do need to have someone who is engaged* – Participant (1-4 sessions)

Whilst survey data showed that overall respondents were satisfied with the quality of coaching, further survey analysis revealed that respondents who withdrew from the program before the half-way point were most likely to rank the quality of their coaching poorly.

> *For my situation, I have two kids with a disability and a wife with diabetes as well. So my lifestyle is not the standard one and things can change all the time so this is why I need more process rather than outcomes – Participant (1-4 weeks)*

> *She didn't sort of make any suggestions, it was more so, 'How do you think you should cope with it?' or 'How do you think you could make it better?', there was no 'Well what about trying this?' kind of a thing. I guess in a way that disappointed me – Participant (9 sessions)*

WorkHealth Coaches stated that they believed the process for withdrawing from the program was complicated and time-intensive.

> *There should be an easier way for people to opt out, we do waste a lot of time trying to contact people that might've fallen off the wagon instead of having an easy opt out – WH Coach*

> *I just sort of thought, you know, I can do it by myself…And with my role, to take sort of half an hour of my day once a month, it still does have a bit of impact, you know, on time management and what not' - Participant (1-4 sessions)*

3.3.4 Workplace environment for telephone coaching

Participant data collected throughout the program indicated that the majority of Coach participants were from white collar occupations. Several program participants during interviews mentioned that their workplace environment was not conducive to taking calls and therefore they opted for an out of hours session.

> *I work in an open planned office area and it's not easy to take calls like that when you are at your desk. It disturbs your colleagues and there is the element of privacy. I'd rather my colleagues not overhear a conversation around my health* – Participant (1-4 sessions)

Coaches spoke about whether participants' workplaces were supportive of the Coach program. All coaches interviewed felt that most workplaces still did not support employee participation in health and wellbeing programs and that the WorkHealth Coach program was a good example of this.

> *'I think sometimes workplaces, as soon as the financial pressures kick in, then any sort of good thoughts about what they were going to do , or you know, what people can do to look after themselves kind of go out the window' – WH Coach*

They felt that whilst the WorkHealth check was beneficial in starting the conversation about wellbeing in the workplace, most participants did not have other health and wellbeing activities running within their workplace or particular support from management or colleagues.

Often the barriers for people is their workplace, the thing that gets in the way of them going out on a lunch walk or doing whatever it is, it's often work-related and also the challenges of taking calls on the program can be work-related as well, and yeah that's one of the main barriers I hear is well work's been busy – our work's too busy – I can't stop for a break or I can't – so, yeah, it is, I think workplaces – how to fix it I'm not sure. – WH Coach

Many participants in interviews reported that they had not discussed their participation in the program with anyone in their workplace and therefore were unsure of whether management supported their participation.

Probably they would have I guess, I didn't broadcast it that I was doing the program – Participant, 9 sessions

They took the opportunity to offer staff the opportunity to engage in this, so the follow on is just a natural part I would feel – Participant, 5-8 sessions

In a few interviews, participants spoke about sharing their participation with other colleagues who were also involved in the program. This was more common than participants sharing program experiences with their manager.

We were sort of, I don't know, urging each other on I suppose…The other lass and I sort of compared notes occasionally and if we had a query, you know, our Coach would send us an email with the info on it and that sort of thing, so that was good – Participant (completed program)

Respondents who agreed or strongly agreed that their workplace encouraged participation in 'It's a more positive outlook. I was finding when I actually enrolled in the program, I was finding I had a high degree of stress, just trying to manage work and life balance. I found through doing the program, through just slowing down and looking at my diet and exercise, it has sort of allowed me to put that balance back in my life' – Participant (9 sessions)

With a busy lifestyle, its establishing a routine, and also I think six months was long enough to make sure – one of the things that I did was swim every week – it's become part of my routine, so on a Friday morning now I wake up and think 'Right, I'm going swimming'. And that was probably the biggest benefit for me – Participant (9 sessions)

4. Discussion

The aim of this evaluation was to measure the impact of the WorkHealth Coach program, a telephone coaching program offered to workers who were found to be at medium risk of type 2 diabetes and medium or high risk of cardiovascular disease at their WorkHealth check.

Data was collected at the three stages of the evaluation design. Stage 1 analysed existing data collected throughout the WorkHealth Coach program by the WorkHealth coaches; stage 2 collected data from a subset of participants who had recently completed the program and stage 3 gathered interview data from both participants and coaches. The data were analysed and presented independently in the previous chapter. This enabled clarity around what information and insights each data technique provided about the program's effectiveness.

The evaluation indicates the WH Coach program was most effective in reaching white collar workers aged between 45 and 65 years of age living in metropolitan Melbourne and least effective in reaching blue collar younger workers.

Additional key findings from the WorkHealth Coach program evaluation are listed below and all findings are then discussed in two key themes of positive behaviour change and enablers and barriers to change:

- Withdrawal from the program was most likely to be due to time barriers, achievement of goals and no further assistance required. Participants who withdrew from the program before the halfway point also cited quality of coaching as a factor influencing withdrawal;
- The top goals chosen by participants in the program were improving exercise and better food choices and reducing weight;
- Top goals achieved at the half way point were better food choices, reducing alcohol and increasing exercise and at program completion better food choices, improving exercise, reducing alcohol, although improving exercise was achieved at a reduced rate at program completion compared with the half-way point;
- Participants who remained in the program for a full 26 weeks were more likely to achieve their goal;
- Between 75-100% of participants who achieved their goals at week 12 maintained this goal at week 26;

- After completing the program, the highest reported improvements in health at work were improved physical wellbeing, improved emotional wellbeing and improved energy in their work environment.

4.1 Positive behaviour change for worker health and lifestyles

The WorkHealth Coach program was specifically designed to target the wellbeing of workers. Participants referred into the program were identified at risk of type 2 diabetes or cardiovascular disease through a WorkHealth check. The demographics of WorkHealth Coach participants indicate that this program is most likely to be taken up by white collar workers aged between 45 and 65 years of age who are born in Australia. Online survey data also indicated that participants were more likely to live in metropolitan Melbourne.
Withdrawal trends throughout the program indicate that 26.2% participants withdrew before the first coaching call and 30.0% participants withdrew by the halfway point of the program. After setting goals at week 1, retention to program completion measured from data analysed in stage 1 of the evaluation, was 25.9%. The New South Wales Get Healthy Coaching service reported a 14% withdrawal between the initial call and the first coaching call and a 33.0% withdrawal from week 1 to the halfway point of their program. (O'Hara et al., 2012). This program used a self-referral model and so it is expected that participant retention rate at the start of the program would be higher. Reasons for withdrawing from the WorkHealth Coach program were reported as time barriers, not requiring any further assistance and already achieving goals.

The majority of participants chose to focus their coaching sessions on exercise and nutrition related goals (increasing exercise levels, making better food choices and reducing their weight) above other goal options including managing stress and reducing alcohol intake and smoking. Gender and occupation trends were observed within the goal choices of the cohort. More females chose goals to increase their exercise levels and reduce their weight and more males chose to make better food choices. Of the least chosen goals, managing stress was most likely to be chosen by females, participants aged between 55 and 64, managers and professional services. Males, machine operators, sales workers and technician and trades workers were most likely to choose smoking as a goal. Older workers (55-64) and managers were more likely to choose reduce my alcohol intake. Goal choice results indicate that health issues may be considered of varying priority by age and occupation. Data related to motivation for goal choice was not available for this evaluation.

Data on goal achievement, collected at stage 1 and 2 of the evaluation, indicates that at halfway point, more than 50% of participants achieved goals set for improving food choices, increasing exercise, managing stress, reducing alcohol, reducing/quitting smoking, while goals of weight and waist reduction were achieved by only 18% and 33% respectively. At program completion more than 50% of participants achieved all goals other than weight reduction. Goal attainment for increasing exercise decreased from 68% in week 12 to 59% in week 26.

Of the participants who completed the program recorded in stage 1 data, trends indicate that between 75% and 100% were able to maintain goals achieved at weeks 12 to program completion. Highest maintenance rates were recorded for reducing/quitting smoking (100%), improving food choices (98%), and managing stress (93%) and lowest maintenance rates were recorded for reducing weight (75%). Survey data indicates that of those who completed the program, more than 85% participants reported maintaining or partially maintaining their goals. In interviews, participants at all stages of program completion reported making changes to their health and wellbeing. Interviewees who completed the program were more likely to report sustained behaviour changes. This would indicate that participants who completed the program had a high level of improved and sustained positive behaviour change. Reasons for not maintaining goals included being too busy at work and home and not being motivated to make changes to their health.

Survey data indicates that participants reported positive changes to their health at work. In particular, improved physical and emotional wellbeing and improved energy levels. They were least likely to report reduced stress and being sick less often. Participants who completed the program were more likely to report higher levels of health improvement in the workplace than those who withdrew from the program before the halfway point. The greatest improvements were seen in physical and emotional wellbeing, improved energy and productivity at work.

4.2 Enablers and barriers to telephone coaching in the workplace

The WorkHealth Coach program participants were predominantly white collar workers aged between 45 and 65, most likely to be born in Australia. However, at the initial call (week 0), eligible participants were more likely to be male and a greater proportion were blue collar workers. Further investigation is required to understand the reduced proportion of program uptake by males and blue collar workers. Withdrawal from the program was predominantly

passive including reaching the maximum number of allocated calls for contact, incorrect details for contact details. WorkHealth coaches reported that there was no clear mechanism for participants to actively withdraw from the program resulting in unproductive time spent by coaches following up with these participants.

Data from stage 2 and 3 has indicated that the workplace environment influenced participant engagement in the program. Program delivery, support from management and colleagues and workplace culture are factors influencing participant engagement. Although the WorkHealth Coach program was designed to be delivered in the workplace, only 55.4% survey respondents reported taking their call during work hours. Interviews with participants indicated that a lack of private space to take calls prevented them from receiving coaching calls during work hours. This was supported by survey data which reported that calls were taken out of work hours because participants were either too busy at work or had privacy concerns. Given the majority of participants were from white collar occupations, many participants in interviews cited open planned office space as a barrier to taking calls at work.

Only half of survey respondents reported that their workplace was proactive in providing health and wellbeing programs and a similar proportion reported that their workplace encouraged participation in health and wellbeing programs. This suggests that the workplace culture for many participants did not support their involvement in the WorkHealth Coach program. Only one in five respondents identified discussing their participation in the program with their manager. Yet, respondents did not cite lack of management support as a reason for not taking their calls during work hours. Participants interviewed did not recognise the Coach program as employers' responsibility. They did not consider that their workplace needed to provide additional support for their participation in the program. However, coaches reported that because most clients did not discuss their participation in the context of their workplace, more could be done to improve the organisational culture for worker health and wellbeing.

Participants are most likely to remain in program if they were able to build a good relationship with their coach who was able to motivate them and provide useful feedback on how they could improve their health. Survey respondents who withdrew from the program before the halfway point indicated that the quality of coaching was poor. Interview data supported this, and participants revealed that their coach did not understand their barriers to behaviour change.

4.3 Limitations of evaluation findings

Several limitations to the evaluation findings must be considered. Data analysed in stage 1 of the evaluation is self reported therefore these results should be considered with some caution. In addition, missing data reduced the sample size. The high number of non-completers in the program may also bias the results in stage 1. The sample of participants included in the data set in stage 2, although representative of program participants, was skewed towards participants who had completed the program (75.4%).

4.4 Suggestions for program improvement

The WorkHealth Coach program has shown to have positive impacts on self reported participant health and wellbeing. However, suggestions to improve program delivery, participant engagement and retention include:

- Understanding reasons for low program uptake by blue collar and younger workers;
- Improved mechanism for active withdrawal from the program;
- Reminder texts for upcoming coaching sessions to minimise missed calls;
- Face to face sessions at halfway and 3 month follow up time periods to improve participant motivation;
- Online interactive website to support participation and participant tracking of goals.

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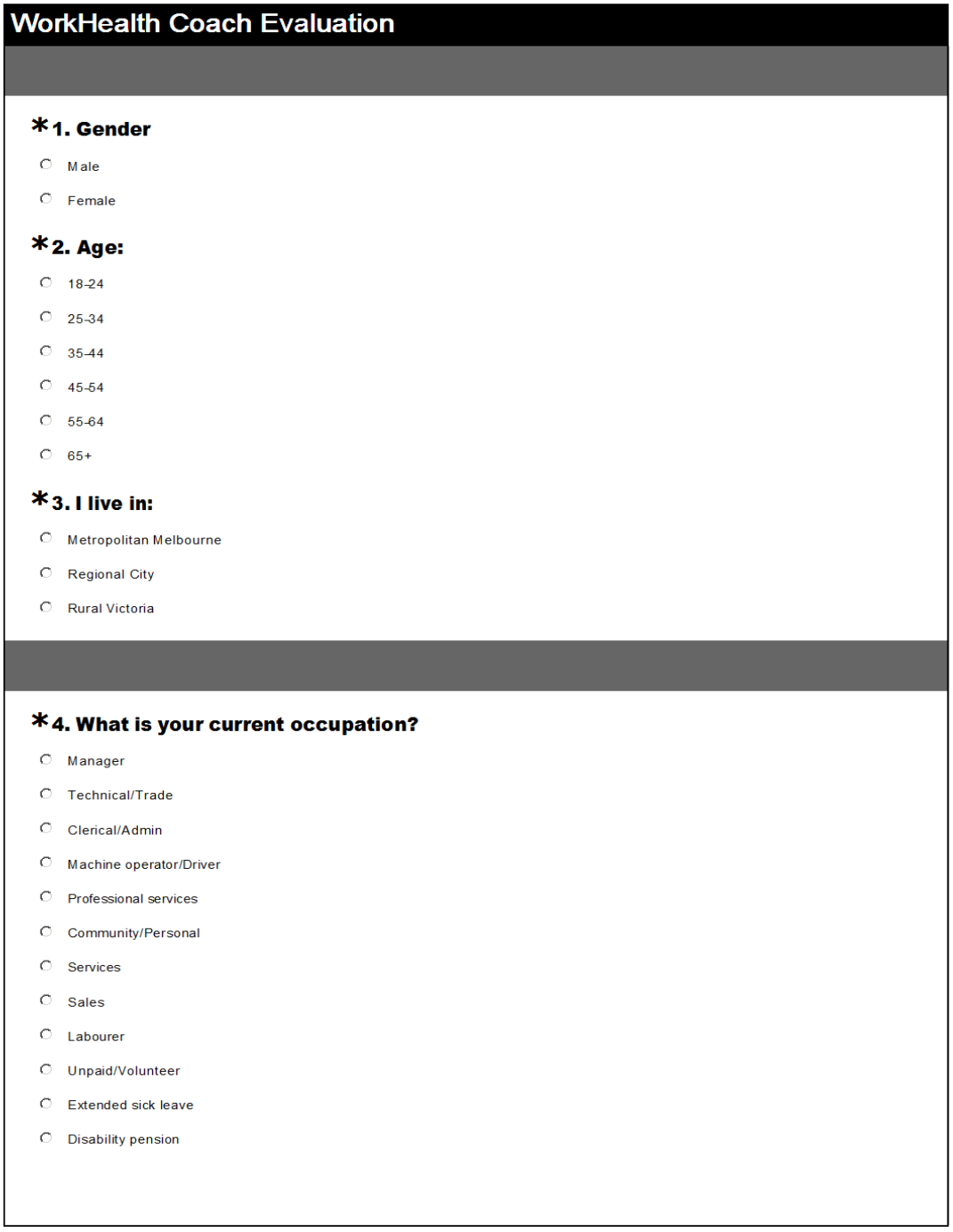
Appendices

A: Participant survey



WorkHealth Coach Evaluation

*1. Gender

- Male
- Female

*2. Age:

- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65+

*3. I live in:

- Metropolitan Melbourne
- Regional City
- Rural Victoria

*4. What is your current occupation?

- Manager
- Technical/Trade
- Clerical/Admin
- Machine operator/Driver
- Professional services
- Community/Personal
- Services
- Sales
- Labourer
- Unpaid/Volunteer
- Extended sick leave
- Disability pension

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WorkHealth Coach Evaluation

***5. Which industry do you currently work in?**

- Accommodation and food services
- Administrative and support services
- Agriculture, forestry and fishing
- Arts and recreation services
- Construction
- Education and training
- Electricity, gas, water and waste services
- Financial and insurance services
- Health care and social assistance
- Manufacturing
- Media and telecommunications
- Mining
- Professional, scientific and technical services
- Public administration and safety
- Rental estate and services
- Retail trade
- Transport, postal and warehousing
- Wholesale trade
- Other services

Your participation in the WorkHealth Coach Program

6. When did you enrol in the WorkHealth Coach Program?

Month

Year

7. How many WorkHealth Coach sessions did you complete out of the nine available sessions?

- One to three sessions
- Four sessions (mid point)
- Five to eight sessions
- I completed the full program (9 sessions)

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WorkHealth Coach Evaluation

8. If you did not complete all session of the WorkHealth Coach Program, what were the reason(s) for discontinuing with the Program? (Tick as many as relevant)

- ☐ Did not require any further assistance to improve my health
- ☐ I had achieved my goals set at the start of the Program
- ☐ Not ready to make changes and/or to change my behaviour
- ☐ Prefer face-to-face support
- ☐ Privacy concerns
- ☐ Program was not meeting my health needs
- ☐ Too unwell to participate
- ☐ Did not find my WorkHealth Coach helpful
- ☐ Found it hard to find the time to participate
- ☐ Other

Other (please specify)

***9. When did you request your WorkHealth Coach to call you for your telephone coaching session?**

- ○ Monday –Friday between 9-5am
- ○ Monday –Friday before 9am or after 5pm
- ○ Saturday

10. If you preferred an out of work hours call or weekend call, what was the main reason for requesting this time?

- ☐ Too busy at work
- ☐ Participation not supported by management
- ☐ Concern over privacy (ie not suitable location to conduct call)
- ☐ Other

If other, please specify

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WorkHealth Coach Evaluation

***11. The following questions are related to your WorkHealth Coach and the quality of coaching you received during your WorkHealth Coach sessions:**

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
I was satisfied with the length of time for each of my calls	○	○	○	○	○
My Coach was very knowledgeable about my health issues	○	○	○	○	○
My Coach was well informed about my health status	○	○	○	○	○
My Coach was able to motivate me to make changes about my health	○	○	○	○	○
My Coach had a supportive and friendly style when communicating with me	○	○	○	○	○
My Coach understood the difficulties I had to make h positive ganges for m health	○	○	○	○	○
My Coach helped me maintain positive changes I made to my health	○	○	○	○	○

12. To what extent do you think you have been able to maintain your agreed goals since the WorkHealth Coach Program?

	Not a goal	Fully maintained	Partially maintained	Not maintained at all	Got worse
Be more active	○	○	○	○	○
Healthy eating	○	○	○	○	○
Manage waist measurement	○	○	○	○	○
Manage weight	○	○	○	○	○
Manage stress	○	○	○	○	○
Manage alcohol intake	○	○	○	○	○
Reduce or quit smoking	○	○	○	○	○
Other	○	○	○	○	○

If other please specify

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WorkHealth Coach Evaluation

***13. What reasons prevented you from maintaining your goals? (Tick as many as relevant)**

- ☐ Too busy at work
- ☐ Too busy at home
- ☐ Not a priority
- ☐ Not motivated
- ☐ Too unwell
- ☐ Not supported at work by management and staff
- ☐ Financial cost of sustaining a healthy lifestyle
- ☐ Other

If other, please specify

***14. What changes about your health at work did you observe after completing the Program?**

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
More productive at work	○	○	○	○	○
Improved energy at work	○	○	○	○	○
Sick less often	○	○	○	○	○
Reduced stress at work	○	○	○	○	○
Greater ability to complete job tasks	○	○	○	○	○
Improved physical wellbeing	○	○	○	○	○
Improved emotional wellbeing	○	○	○	○	○
No changes	○	○	○	○	○

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WorkHealth Coach Evaluation

***15. As a result of participating in the WorkHealth Coach Program:**

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
I feel better able to manage my health	○	○	○	○	○
The improvements I have made are now part of my lifestyle	○	○	○	○	○
I now have the skills and knowledge needed to maintain a healthier lifestyle	○	○	○	○	○
My overall attitude towards maintaining a healthier lifestyle has improved	○	○	○	○	○
I have made no significant changes since completing the WorkHealth Coach Program	○	○	○	○	○

Organisational support for your participation in the WorkHealth Coach Progr...

***16. In your workplace, who do you consider is primarily responsible for the health and wellbeing of employees (beyond OHS responsibilities)?**

- ○ Employer
- ○ Employee
- ○ Both employer and employee
- ○ Neither, there is no focus on responsibility
- ○ Don't know/unsure

***17. In your workplace, who do you consider should be primarily responsible for the health and wellbeing of employees (beyond OHS responsibilities)?**

- ○ Employer
- ○ Employee
- ○ Both employer and employee
- ○ Neither, there is no focus on responsibility
- ○ Don't know/unsure

***18. Did you discuss your participation in the WorkHealth Coach Program with anyone?**

- ☐ No
- ☐ Yes

WorkHealth Coach Evaluation

19. I discussed my participation in the WorkHealth Coach Program with:

- ☐ Other
- ☐ My manager
- ☐ My work colleagues
- ☐ Family member/s
- ☐ Friends

If other, please specify

***20. To what extent do you agree or disagree with the following statements?**

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
My workplace is proactive in providing health programs in the workplace	○	○	○	○	○
My workplace encourages participation in health and wellbeing programs at work	○	○	○	○	○
My manager was supportive of my participation in the WorkHealth Coach Program	○	○	○	○	○

Participation in a telephone interview

Thank you for completing the survey. Your time is very much appreciated.

We would like to invite you to participate in the second phase of this evaluation. This involves a short telephone interview taking about 20 minutes of your time. We will be asking you questions about your participation in the WorkHealth Coach Program. If you would like to participate, please provide your contact details below:

21. Contact Details

Name	
Contact number	
Most appropriate contact time	

B: Participant interview schedule

Theme	Questions
Reasons for participating	(a) What appealed to you about this program? (b) What were your expectations of the program?
Workplace as a setting and organisational support	(a) Did you participate during work hours or outside work hours? Why did you choose this option? (b) Can you share your thoughts with regards to your workplace offering this particular type of program e.g. was the format suitable to your workplace? Why/why not? (c) Is there anything that your workplace could have done to make it easier for you to participate in the program during work hours? If yes, what things?
Factors influencing completion of the program	(a) What were some of the key factors that kept you motivated to continue through to the end of the program? (b) What are some of the reasons you left the program?
Quality of Coaching	(a) Do you feel the sessions allowed enough time to build a relationship with your coach? (b) On average how long do you think your sessions lasted? (c) Are there any other tools that you think could have further supported you during the course of the program? (d) Was there anything that didn't go so well for you with your coach?
Sustainability of behaviour change	(a) Approximately when did you drop out or finish? (b) As a result of the program, have you gained any helpful knowledge or skills about your health you didn't have before starting the program? (c) As a result of the program, have you gained motivation to make healthy changes in your life? (d) Can you tell me about the types of things you have been doing to help you maintain a healthy lifestyle since finishing the program?

C: Coach interview schedule

Themes	Questions
Experience as a WH Coach	Can you tell me about your role as a telephone coach in the WorkHealth Coach Program? How long have you been conducting telephone coaching?
Training	What training did you receive to qualify you as a WorkHealth Coach? Was this adequate for the role as a Coach?
Motivation and behaviour change	Tell me about the experiences you have had in the Program – what are the critical success factors for a program like this in your opinion? Do you think the structure of the course lends itself to produce sustainable behaviour change with participants?
Workplace as a setting	How well do you think a program like this fits within the workplace environment? What needs to happen in the workplace to ensure that participants are supported in their involvement in the program?