



Getting buy-in for wellness

This leading consultant outlines 6 principles for obtaining buy-in for older-adult wellness initiatives

by John Rude, MS

I often find myself seated in a boardroom, wondering what these dedicated trustees are thinking as I load them up with information about the intrinsic values of wellness. Are they personally committed to better health? Do they manage or work in an organizational setting that supports

health and well-being? Like most North Americans, are they dependent on the *disease model*? How flexible are their thinking patterns as they contemplate a wellness initiative for the organization they serve? Are they willing to make a wellness investment, knowing it's much more difficult to finance *prevention* programs as opposed to disease programs? These and many other questions arise, spoken or unspoken, as organizational leaders attempt to make intelligent decisions about embracing a new business venture of any kind—including wellness.

Further, the questioning process doesn't begin and end at the board level. It occurs at all levels in an organization (i.e., the executive management team, department heads, frontline personnel, consumers, committees, volunteers and family members). So how can you effectively reach a critical mass of governance groups, providers and consumers to assure the success of a new initiative? Answer: by getting *buy-in*.

The 6 principles put forth in this article are relevant, I believe, to most organizational settings, both proprietary and nonprofit. Yes, there may be differences in titles, how products and services are described, or even the mission of the business. However, for the most part, the process of getting buy-in is the same, and the principles described below can help you realize this support.

Principle 1: Success is in direct proportion to getting buy-in at all levels in an organization

What is *buy-in* and why is achieving it critical? Buy-in means to take part in, or have a share in, something. For any new product or service, long-term success in an organization requires awareness during the introduction, plus an understanding and acceptance at all levels (whether directly or indirectly involved). When leadership fails to take the time for this critical step, breakdowns occur and mixed messages result.

Some personnel may feel left out, exhibit no sense of ownership, and become passive. Others may perceive the new initiative as a threat to their specific jobs or departments and may sabotage these efforts. Working hard on getting buy-in will greatly reduce such negative outcomes and enroll constituents in a healthy and supportive process. For example, take the time to

understand the roles of colleagues, respect that their positions are critical to achieve success and, finally, invite them to be *team* players.

Principle 2: Critical mass germinates success exponentially

Critical mass, a key concept in obtaining buy-in, refers to the minimum amount necessary for something to occur, or a point at which change occurs. For example, I have discovered that critical mass for a wellness program occurs when enrolling 35% of a resident population in a retirement community. When critical mass is achieved, a product or service will grow exponentially (or rapidly become greater in size). On the other hand, if buy-in happens at 10%, the initiative will grow at a much slower pace than expected. Critical mass works because the users of a product or service become part of the *marketing machine*, which reinforces other formal and informal communications also promoting the product/service.

What can you do to ensure your wellness initiative achieves critical mass? First, by applying the principles described in this article, you will build awareness and support for the initiative among constituents. Second, you might want to consider introducing people to your program in stages—I use a 3-step process of education, assessment, and enrollment. You can keep your initiative on track to succeed if you recognize that a drop-off in participation occurs naturally with each stage, and you set goals that allow you to reach 35% by enrollment.

Principle 3: Success is more productive when it's top-down

In a wellness initiative, substantial resources such as qualified and trained personnel, age-appropriate equipment,

sufficient and dedicated space, and an adequate budget are necessary to assure success. Mediocre results usually occur when a shortsighted manager hands off this huge responsibility to a mid-to-low-level employee with few resources. This *on-the-cheap* approach is doomed to fail, because it doesn't have the holding power to sustain some unexpected pitfalls that often arise in the developmental process.

So where do you begin on the road to better buy-in for a wellness initiative? In a nonprofit setting, this effort begins with the board of trustees. In a proprietary setting, it begins with the owner(s), who could be one or more investors. This may involve demonstrating the financial feasibility of the initiative by demonstrating that increased traffic and sales will cover new expenses. When buy-in is achieved from the top-down (board members or owners), you get a deeper commitment: a commitment carefully evaluated by those who carry the financial responsibility of the business or organization. Essentially, leadership is *invested* in the initiative, supports sustainability and wants a successful outcome.

Principle 4: Timing is everything

- Organizations have their own agendas.
- Organizations have their own readiness for change or innovation.
- Organizations may need a *respite* from a recent initiative.
- Organizations have financial *windows* for growth and development.
- Organizations have their own timelines.

So when is the opportune time for you to make an intervention to achieve wellness buy-in? Understanding the

Continued on page 30

current nature of the business will provide clues. However, you still have to do your homework to get a clear picture. For example, discover what the workload is for each department. Your research may reveal that one department is ready and anxious to move forward, but another department is not. This may require you to delay the start date, get consensus on a more probable date, then move forward with an operational plan based on the agreed upon date.

Principle 5: Each employee level has its own value system

In a retirement housing setting, the value systems look like this:

- *Trustees.* They are interested in the big picture (i.e., competition, financial solvency, feasibility of a new project, and return on investment [ROI]).
- *Executive staff.* They are interested in the effectiveness of operations such as marketing communications, personnel, food service, cash flow, etc.
- *Midlevel personnel* (department heads). They are interested in qualitative services and programs, plus compliance (if they work in healthcare related industries).
- *Frontline personnel.* They are interested in operational initiatives that will make their work experience more efficient. (If a wellness initiative can lighten the load of frontline personnel, they will respond positively.)
- *Consumers.* They are interested in compressing morbidity, enhancing quality of life and preserving their autonomy.

Note: If you are employed in a different business environment, list the various levels of ownership, leadership and personnel in your organization, and assign values

relative to your specific industry. This will help you in producing targeted communication that is relevant to the different audiences in your business environment.

When starting a wellness initiative, it behooves you to focus on the specific wants, needs and desires of the specific group you are targeting for buy-in. You cannot rely on a tactic that relates to each of the above groups with the same information. For example, let's say a new competitor is establishing a business within one mile of your business. The communication to the trustees/owners and the executive staff may focus on repositioning your business with a new marketing message related to your wellness initiative. For midlevel and frontline personnel, the communication may concentrate on a new employee benefit: a worksite wellness program.

Principle 6: You must unlearn your conditioning before you can discover a new paradigm

A common denominator among all organizational groups in a retirement housing and/or healthcare setting is that most adults in Western society are highly conditioned around the disease model—one that is reactive in nature, focuses on *care*, and often produces dependence or codependence.

Most personnel who work in a healthcare setting (continuing care retirement community, assisted living, acute care, or skilled nursing facility) are not only educated in the disease model, but they also experience it every day. In addition, they are driven by state and federal rules and regulations to conform. The nature of this work experience reinforces the view that aging is essentially about disease, decline, disengagement and death (all “D” words).

If you assume the above as the starting point, you will need to dismantle old belief systems before a new paradigm can emerge. This will take some work. Keep in mind that social constructs of reality are difficult to break (similar to behavior patterns), and it will take several initiatives to *wake up* board members, staff or consumers to a new consciousness.

Education is the starting point to get buy-in from all publics you are trying to reach. You may choose to do this by drawing from case studies, referencing research or doing process work among pairs or small groups. This will raise the awareness of individuals and break them loose from unconscious thinking patterns. Beyond that, there are other tactics such as putting board members in contact with their peers in comparable facilities, sending staff on a field trip to visit successful wellness programs/operations, and giving residents or members an opportunity to observe or try out a new program prior to committing to participation.

Once you have exposed the various groups to new possibilities, it's time to reconvene and hear what people have to say. Have their awareness levels increased? Is their language changing? Do they understand the distinctions between prevention versus disease care? Are they beginning to see how conventional medical practices and prevention can coexist? Are they becoming enthusiastic and motivated to be engaged in whatever capacity to create change?

Even if constituents are still contemplating the prospects, it's a positive sign that buy-in is beginning to take hold. Curiosity indicates that their positions have shifted and they are open to possibility. If individuals haven't

Continued on page 32



come to this level, it's time for you to do more homework and reactivate the educational process.

There are additional tactics to get buy-in—for example, establishing a wellness task force or wellness committee to do research, articulate policy and procedures, be ambassadors for the program, etc. These groups may consist of staff and consumers individually, or staff and consumers combined. (I've worked with all 3 scenarios, and all can be effective.) Your decision about which scenario to pursue may be driven by the strength of the people involved. Or you may choose to engage a smaller group to begin with, and then later become more inclusive by expanding the membership.

Still another model is a wellness council, which represents a much broader scope in a multi-site organization and has a similar purpose to a task force or committee. Membership may come from trustees, regional directors, executive directors, wellness directors, corporate personnel (representing marketing, resource development, operations, etc.) and consumers. Larger groups take more time to get organized; however, they often have a broader skill set and can be very powerful.

A needed shift

There is still much work to do to get buy-in for prevention and wellness. A majority of Americans are inactive, shows the US Department of Health and Human Services' *Health, United States 2005* report. And "chronic diseases and conditions account for at least 7 of every 10 deaths in the United States and for more than 60 percent of medical care expenditures," according to the department's *Prevention* blueprint, published in 2004.

Signaling the scope of the public health problem, the prevalence of type 2 diabetes has skyrocketed in the last 20 years among children and young adults. "Type 2 diabetes has changed from a disease of our grandparents and parents to a disease of our children," writes Francine Ratner Kaufman, MD, then-president of the American Diabetes Association, in a 2002 article.

Shifting consciousness is a tall order. However, when those of us who focus on prevention can achieve a critical mass in any group, organization or population, the paradigm will shift. The buy-in principles above will put you on the pathway to this success. ☺

With advanced degrees in both business and gerontology, John Rude has an unusual blend of expertise, which spans

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References

National Center for Health Statistics. (2005.) *Health, United States 2005 with Chartbook on Trends in the Health of Americans, with Special Feature on Adults 55–64 years*. Trend Table 72, pg. 273. Hyattsville MD: US Department of Health and Human Services, Centers for Disease Control and Prevention. Retrieved on May 15, 2006, from <http://www.cdc.gov/nchs/data/hs/hs05.pdf#summary>.

Office of the Assistant Secretary for Planning and Evaluation. (2004, April). *Prevention: A Blueprint for Action*. Washington DC: US Department of Health and Human Services. Retrieved on May 15, 2006, from <http://aspe.hhs.gov/health/blueprint/blueprint.pdf>.

Kaufman, F. R. (2002). Type 2 Diabetes in Children and Young Adults: A "New Epidemic." *Clinical Diabetes*, 20(4), 217–218.

Rosenbloom, A. L., Joe, J. R., Young, R. S., & Winter, W. E. (1999). Emerging epidemic of type 2 diabetes in youth. *Diabetes Care*, 22(2), 345–354; February.