

Technical Report:
FINDING *FIT*: Increasing Participation Rates in Wellness Programs for Small and Medium Organizations

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Increasing Participation Rates in Wellness Programs for Small and Medium Organizations

TABLE OF CONTENTS

I. Executive Summary	7
A. Literature reviews	8
B. Focus Groups with Sample Organizations	9
C. Analysis of 2017 Harris Poll Survey Responses	10
D. Employers	10
E. Employees	11
F. Aggregation of Publicly Available Resources	12
G. Development of the Employer Guide	12
II. Project Details	14
H. Project Description	14
I. Project Goals	14
J. Project Outcomes	14
III. Understanding Employee Participation	16
K. Motivation Theories and Frameworks	17
1. Reinforcement Theory	17
2. Expectancy Theory	18
3. Early Behavioral Theory	18
4. Goal Setting Theory	19
L. Methods of Influence	19
5. Rewarding Desired Behavior	19
6. Coercing Desired Behavior	20
7. Framing the Desired Behavior in Values	20
8. Controlling the Environment	20
9. Making Exchanges	20
M. Conclusions about Participation	21

IV. Literature Reviews.....	22
N. Initial Literature Review	22
10. Goals	22
11. Search Methods and Results.....	22
12. Initial Literature Review Findings.....	23
i. Representation of Small and Medium Organizations in the Literature.....	23
ii. Participation Rates for All Organizations	23
iii. Employee Participation: Facilitators and Barriers.....	24
13. Conclusions.....	25
O. Secondary Literature Review	25
14. Goals	25
15. Search Methods and Results.....	25
16. Secondary Review Findings	27
iv. Representation of Small and Medium Organizations in the Literature.....	27
v. Participation Rates Reported for All Organizations	27
vi. Participation Rates Reported for Small and Medium Organizations.....	27
vii. Employee Participation: Barriers and Facilitators.....	28
17. Conclusions.....	29
V. Focus Group Investigation	31
P. Focus Group Goals	31
Q. Description of Approach and Questions Pursued	31
R. Strategies for Soliciting Participation in Focus Groups	32
S. Focus Group Methods	32
18. Protocol	33
19. Coding of Focus Group Data	33
T. Focus Group Findings	38
20. Individual-Level Decision Factors	38
viii. Facilitators - Fit.....	38
ix. Facilitators - Readiness.....	38

x.	Facilitators - Ability	39
xi.	Barriers - Fit.....	40
xii.	Barriers - Readiness	41
xiii.	Barriers - Ability.....	42
21.	Organization-Level Decision Factors	43
xiv.	Facilitators - Fit.....	44
xv.	Facilitators - Knowledge	45
xvi.	Facilitators - Readiness.....	46
xvii.	Facilitators - Ability	47
xviii.	Facilitators - Other.....	49
xix.	Barriers - Fit	49
xx.	Barriers - Knowledge.....	50
xxi.	Barriers - Readiness	53
xxii.	Barriers - Ability	55
xxiii.	Barriers - Other.....	56
22.	Insights and Conclusions	57
VI.	Harris Survey Sponsored by TCHS.....	59
U.	Description of the Harris Survey.....	59
V.	ICHW Analysis Goals.....	59
W.	Employer Survey Results by Organization Size	59
23.	Demographics	59
24.	Wellness Programs Offered	60
25.	Types of Employees Participating in Wellness Programs	62
26.	Levels of Participation	63
27.	Presence of Key Features Supporting Wellness Programs	64
28.	Estimated Impact of Wellness Programs on Organizational Outcomes	65
29.	Strategies for Countering Concerns about Employees' Ability to Participate in Wellness Programs	67
30.	Reasons for Not Offering Wellness Programs	68
X.	Employee Survey Results by Organization Size	69
31.	Demographics	69

32. Wellness Programs Offered	70
33. Participation in Wellness Programs.....	74
VII. Strategies for Enhancing Facilitators and Overcoming Barriers to Wellness Program Implementation and Employee Participation.....	75
Y. Overall Conclusions about Wellness Program Participation	75
Z. Strategy for Making Wellness Programs Easier to Implement in Small and Medium Organizations	76
AA. Enhancing Organizational Facilitators.....	79
34. Employee Motivation	79
35. Employee Social Interest	79
36. Employee Work Hours	80
37. Employee Cost.....	80
38. Leadership Support.....	80
39. Leadership Communications	81
40. Organization’s Financial Status	81
BB. Overcoming Organizational Barriers	82
41. Hours of Work.....	82
42. Motivation to Participate	83
43. Lack of Knowledge	83
44. Cost Concerns	84
45. Roles & Responsibilities.....	84
46. Physical/Structural Impediments.....	85
47. Privacy/Liability Concerns.....	85
48. Leadership Support.....	86
49. Leadership Attitudes.....	86
CC. Enhancing Personal Motivation to Participate in Wellness Programs....	87
DD. Enhancing Leadership Support for Employee Participation in Wellness Programs.....	87
VIII. Employer Guide	89
IX. Appendix.....	90

Executive Summary

The Interdisciplinary Center for Healthy Workplaces (ICHW) at the University of California (UC), Berkeley, was asked by the Transamerica Center for Health Studies (TCHS) to create an Employer Guide to engage fully employees in health-promoting behaviors in small and medium organizations. This project builds upon work that had previously been completed by the Institute for Health and Productivity Studies (IHPS) at the Johns Hopkins Bloomberg School of Public Health, where investigators provided preliminary information on how to design, implement, and evaluate workplace health promotion programs. Two issues remained unresolved in the IHPS study: (1) the extent to which the findings are applicable to all sizes of organizations, and (2) how to engage employees more effectively such that their participation in wellness programs significantly increases and is sustained over a long period. This project specifically addressed these two issues by examining the potential fit between wellness program requirements and the opportunities and constraints of all organizations, and in particular, with small and medium organizations.¹ We also developed an Employer Guide, which offers employers a way to match their organizational opportunities and constraints to best-fitting wellness programs and multiple ways to improve employee participation in wellness programs.

As we started this project, we made decisions about the scope of organizations to include in our study and what would be considered to be a “wellness program.” We defined small organizations as having 1-49 employees and medium organizations as having 50-499 employees, based on mandatory small business insurance requirements and size distinctions generally used by the Bureau of Labor Statistics. We recognized that small organizations come in many different forms: early stage start-ups, “Mom and Pops,” non-profits, fully-remote, and small online businesses, among others. Consequently, we did not treat small organizations as if they were a single type. Instead, we focused our analysis on the degree to which leaders were willing and able to invest in a wellness program regardless of organization type and size. This is because leaders’ appetite for wellness investments is likely to vary across types of organizations. We also expanded the definition of “wellness program” to include a continuum of wellness initiatives from health awareness to reactive treatment of chronic disease. Many organizations do not consider themselves to have a “wellness program” even though they do when they provide or support indirectly the provision of educational information to increase awareness of factors that affect employee wellness. By expanding the definition, we were able to provide more options for organizations to find a wellness program that “fit” with their unique circumstances. A summary of our project activities and study findings are described below.

¹Our study was not intended to be a direct comparison with the Johns Hopkins study. Rather, our study was designed to extend the information provided in the earlier study specifically to small and medium organizations and to address the issue of employee participation.

Literature reviews

Our first step was to conduct a comprehensive literature review of participation rates in organizations of all sizes and factors underlying successful engagement in the nine wellness programs examined in the IHPS study. Of the 699 studies reviewed, we found very few studies that described wellness programs in small and medium organizations and in general, very little information was included in study descriptions regarding employee participation rates. Methods used to engage employees in wellness programs were not studied directly and thus, useful information on this topic was largely missing or authors speculated on what may have affected participation rates.

Where participation rates were reported, we found that three different participation rates could be calculated. For all organizations that reported participation rates, the average was 51.4% counting employees who *intended to participate*, 74.9% counting employees who *completed the program out of those who intended to participate*, and 36.4% counting employees who *completed out of all employees*. When small organizations were examined only, all three participation rates were higher: 71.7% *intended*; 77.2% *completed out of total intended*; and 53.8% *completed out of all employees*. This means that employees in small organizations participated more in their organizations compared to all organizations when a wellness program was available. It also means that about half of all employees in small organizations participate in wellness programs. All participation rates, however, should be interpreted cautiously because of publication bias: generally only positive findings are published, and the averages does not reflect unpublished failures.

Of those studies that discussed factors that facilitated participation, the following were considered as contributors: having a health-oriented culture, organizational commitment to employee health, employee involvement in program design, a supportive workplace environment, friendly competitions among co-workers, individually tailored interventions, fitting interventions to the resources and characteristics of the worksite, and conducting the program during work hours. The use of monetary incentives were not consistently effective.

Factors that presented barriers to participation included lack of time to participate, lack of knowledge of the program, fear and self-consciousness in the workplace about health, lack of managerial commitment to wellness programs and employee participation, lack of employee motivation, a workplace environment that made it difficult for participation, concerns about confidentiality, programs perceived as not useful, and no accountability for participation.

Focus Groups with Sample Organizations

Our second step was to conduct intensive, one- to six-hour-long focus groups with 29 small and medium organizations to supplement our knowledge gained from the literature review and to gather detailed, on-the-ground information about the facilitators of and barriers to successful wellness programs.² Sample organizations were recruited through HR professional organizations, a survey recruiting firm, and through other venues, such as the Chamber of Commerce, Forbes “Best Places to Work,” and more.

Both individual and organizational perceptions of wellness program adoption and employee participation were explored. Many of the factors mentioned in the scientific articles were corroborated by focus group members. Employees of small and medium organizations talked extensively about what would promote their participation in wellness programs. Having peers at work who share health values and interests provides important support and encouragement that helps employees to increase and maintain engagement in healthy behaviors. Similarly, peer support for lifestyle changes was an important resource that enabled individuals to engage in behavior change. Employees’ intrinsic interest in healthy behavior at work also contributed to participation, as did their perceived need for taking time for wellness. The affordability of activities that promote healthy behavior was also important for employees to take the first step towards forming healthy habits (e.g., working out at a gym).

Employees also mentioned significant barriers that discouraged participation. They were competing demands for their time such as family responsibilities, difficulty in making wellness a priority given few hours left outside of work, lack of energy to participate due to job burnout, and wellness being a “luxury” when not even basic needs like eating or sleeping are being met. Other reasons given were a perceived lack of need for a wellness program, a distrust in the motive behind management-initiated programs, privacy concerns related to personal health conditions, and the absence of a program of activity that they would be interested in or enjoy.

Facilitators of employee participation from the perspective of organizational leaders (e.g., HR, C-Suite officers, managers) included several aspects of leadership support: leadership understanding the link between health and important work outcomes, leaders’ active support for their workers participating in wellness-related activities, leaders cultivating a culture of health, and leaders understanding how to design wellness activities that take into account the needs and preferences of employees. Organizational leaders also reported the importance of scheduling wellness events at a time and place convenient to employees and establishing

²Some of the participating organizations had recently surpassed our definition of a medium organization due to recent growth, however we still included them in our study.

expectations of reasonable work hours so that employees are more inclined to engage in healthy behaviors. Organizational leaders also reported a recognition that the workspace itself could be designed for health and wellness such as accessible stairwells, bike racks, height-adjustable work surfaces, and outdoor physical activity and healthy eating options. They also indicated that a major facilitator was establishing a variety of high-quality methods to communicate about wellness and with the right messages.

Many barriers to participation were expressed by organizational leaders. A number of factors were associated with the leaders themselves: a lack of clarity regarding the link between wellness programs and business outcomes, concerns about the funds necessary to effectively implement a wellness program, a leadership attitude that employees may take advantage of wellness events to take time away from work, the belief that taking action toward addressing employee health and well-being won't work if the employees lack the motivation to change, the perceived lack of need for wellness programs because employees already take care of their own health, and concerns about liability. One of the most prevalent issues mentioned by organizational leaders was the lack of personnel to "own" wellness initiatives and take the lead. Organizational leaders also cited other problems such as wellness-related events being scheduled at inconvenient times during work (e.g., client meetings) or after work (e.g., personal plans), and the type of work employees perform does not allow them to participate during work hours (e.g., client-facing work). The lack of leaders' active and consistent leadership support for employee participation and the absence of a culture of health were also mentioned as barriers. Many structural and operational barriers were mentioned: the lack of financial resources to support wellness initiatives, the expectation of long work hours, bureaucratic and logistical issues that prevent or discourage wellness activities from being scheduled or communicated in a timely manner, and employees occupying multiple roles in the organization which limits their ability to participate. Finally, confusion about benefits that can be provided by the health insurance company to assist employees' wellness and the failure to take full advantage of health insurance company benefits add to the barriers to employee participation.

Analysis of 2017 Harris Poll Survey Responses

TCHS provided response data from the 2017 Harris Poll Survey administered online between July 19 and August 10, 2017 to employers and employees from thousands of organizations for the purpose of learning about healthcare trends and experience with wellness programs. We analyzed responses to two separate surveys, one directed to employers and the other to employees.

Employers

The Harris Poll of employers surveyed 1,520 HR Directors, Benefits Managers, company Presidents, Owners, and CEOs. Survey respondents were

randomly selected to participate in the survey. The employer survey included 685 (45.1%) small organization employers, 342 (22.5%) medium employers, and 493 (32.4%) large employers. Consistent with expectations, large companies were most likely to offer a formal wellness program (82.6%), followed by medium (76.9%) and small companies (24.7%). When a wellness program was implemented in small organizations, a higher percentage of small organizations had participation rates exceeding 50% compared to the percentages reported by medium and large organizations.

When we compared the wellness program elements present in small, medium, and large organizations, health education and a supportive physical and social environment were the two most common wellness elements across all three groups of organizations. Healthy food/drink offerings were more common in small organizations than in medium and large organizations, and links to related employee services such as EAP more common in large organizations than small and medium organizations.

A comparison of key features of wellness programs across organization size showed that all organizations highly valued leadership commitment and support for wellness programs, a culture that supports employee wellness, and organizational support for a healthy lifestyle. Employers in small organizations placed a much lower value on financial and non-financial incentives for program participation than other employers. Clearly, leadership's support of wellness programs is a key aspect of program effectiveness.

When asked about strategies for countering concerns about employees' ability to participate in wellness programs, small organization employers exerted much less effort than their counterparts in medium and large organizations did. In fact, the most common strategy reported by these employers was "not doing anything different." Similarly, the least common strategy was talking to managers about allowing employees to participate without negative repercussions. This combination of results may explain why adoption of wellness programs in small organizations is considerably lower than adoption rates in medium and large organizations.

When asked about reasons businesses do not offer a wellness program, "the company is not big enough" was named most often by small organization employers. In contrast, concerns about program costs were most often reported by medium and large organizations and considerably less so by small organizations. Small and medium organizations reported the lack of employee interest as another reason for not offering a wellness program.

Employees

A total of 2,892 individuals completed the Harris Poll of employees. The employee survey included 882 (30.51%) employees from small organizations, 698

(24.1%) employees from medium organizations, and 1,307 (45.2%) employees from large organizations. When employees were asked about the wellness programs offered at their organizations, the most common wellness programs reported by employees in small organizations were exercise programs, monitoring of biometrics, preventative screenings and vaccinations, health risk appraisals, weight management, ergonomic workstations, and managed programs for substance abuse or mental health. The majority of these are managed by their health insurance providers. Also, medium organizations generally offered more wellness programs than small and even large organizations. Large organizations had considerably lower adoption rates than medium organizations in two areas: medication adherence, social engagement, individual mental or physical health tracking through wearables, and mindfulness/meditation training.

Employees also reported their participation in 17 different wellness programs potentially offered by their employer. Comparisons between wellness programs “offered and enrolled” versus “offered and not enrolled” revealed important differences in the perceived value of different programs. For all three sizes of organizations, preventative screenings and vaccinations, monitoring of health goals/biometric, and completing a health risk appraisal showed the highest participation rates. Percentages of employees reporting enrollment in wellness programs were higher for all wellness programs than non-enrollment, indicating a greater value to employees for those programs. However, there were three exceptions: managed programs for substance abuse or mental health, smoking cessation, and weight management programs. These programs had lower enrollments, perhaps because they were targeted to high-risk individuals. Clearly, wellness programs provided by third parties (healthcare vendors) added value for employees.

Aggregation of Publicly Available Resources

The next step was to conduct a comprehensive search and aggregation of low- or no-cost, publicly-available resources to supplement wellness program offering for small and medium organizations. We wanted to provide an extensive repository of external resources as a “one stop shop” for small and medium organizations to supplement their internal resources in providing wellness opportunities to their employees. A total of 167 resources were included in this Report (and in the Employer Guide, described below).

Development of the Employer Guide

The last step was to create an Employer Guide based on our research and analysis to help employers identify wellness program options that “fit” with their unique constraints and opportunities. We developed a hierarchical model of wellness programs, arranged in order of the degree of leadership involvement. Wellness programs that require little or no involvement of leadership are at the

lowest level, and those that require direct and high involvement of leadership are at the highest levels. This model, combined with information we gleaned from the literature review, focus groups, and analysis of Harris Poll survey responses regarding Facilitators and Barriers associated with wellness programs, assisted in the creation of the Assessment Tool for finding the right “fit” with a wellness program. The Employer Guide educates employers on the types of wellness programs that have been shown to be effective if implemented appropriately and provides a step-by-step process for identifying one or more wellness programs that “fit” each employer’s unique set of opportunities (called Facilitators) and constraints (called Barriers). The Employer Guide also includes information designed to help employers increase participation in selected programs based on psychological principles of motivation.

Project Details

Project Description

This project involved gathering information from several sources regarding wellness programs in small and medium organizations in order to learn what wellness programs were implemented in such organizations and how participation in programs offered was obtained. A major focus of this research was to learn what factors promoted employee participation in wellness programs in these organizations, and what barriers existed which served to decrease implementation of wellness programs and decrease employee participation. Given the Facilitators and Barriers identified in this research, we sought to develop strategies for enhancing Facilitators and overcoming Barriers in order to make wellness programs more successful in small and medium organizations.

Project Goals

Project goals were the following:

1. To identify wellness programs that “fit” with the opportunities and constraints associated with small and medium organizations.
2. To determine the Facilitators of employee participation in wellness programs for small and medium organizations.
3. To determine the Barriers to employee participation in wellness programs for small and medium organizations.
4. To identify ways that employers could enhance Facilitators and overcome Barriers in order to increase the effectiveness of wellness programs in small and medium organizations.

Project Outcomes

We created an Employer Guide for small and medium employers to understand the factors that increase wellness program effectiveness and employee participation and to identify the best “fit” between their organization’s opportunities and constraints and a wellness program. This Guide includes:

1. A step-by-step guide that provides employers an easy process to complete the tool.
2. A list of Facilitators and Barriers most relevant to small and medium organizations.

3. An assessment tool for evaluating an organization's current Facilitators and Barriers.
4. A scoring process for the assessment tool by which organizations can determine the degree of "fit" between the organization's Facilitators and Barriers, and wellness program requirements and characteristics for each of eight groups of wellness programs.
5. Recommendations for enhancing Facilitators and overcoming Barriers to employee participation and wellness program effectiveness.
6. An extensive repository of external resources that employers can use to supplement internal wellness offerings.

Understanding Employee Participation

Participation in wellness programs is a key issue in promoting wellness program effectiveness. If participation is low, even effective programs are rendered ineffective because there is little opportunity for significant change in employee health and well-being to occur. At the extreme, very low participation is essentially the same as no wellness program at all—regardless of what is advertised. Because one of the major problems of wellness program success is relatively low participation rates, then it is important to figure out how participation rates can be increased so that the key components of the program can help employees become healthier.

The determinants of employee participation in health promotion programs have been examined from a variety of theoretical perspectives. One commonly utilized approach involves examining how broad, contextual factors influence employee participation. For example, researchers have investigated the role of social or interpersonal factors such as coworker and management/leadership support³⁴ in promoting participation. At the organizational level, factors that have been associated with differing levels of participation in wellness initiatives include workplace culture, organizational policies, and the availability of resources that serve to support wellness programs.⁵⁶ Finally, community/society- and policy-level factors have also been pointed to as possible contextual influences on participation in workplace health promotion programs.⁷

Although these contextual features can and do impact participation levels, such approaches neglect to examine how individual-level factors can also affect participation. Such intra-individual factors are vast and include employee motivations, beliefs, attitudes, needs, and knowledge. For example, an employee may be more likely to participate in a program to the extent that he or she believes that engaging in the activity will be in some way beneficial. Similarly, employees may not take full advantage of on-site clinical screenings because they have not

³ Sloan, R.P. & Gruman, J.C. (1988). Participation in workplace health promotion programs: The contribution of health and organizational factors. *Health Education Quarterly*, 15(3), 269-288.

⁴ Tamers, S. L., Beresford, S. A., Cheadle, A. D., Zheng, Y., Bishop, S. K., & Thompson, B. (2011). The association between worksite social support, diet, physical activity and body mass index. *Preventive medicine*, 53(1), 53-56.

⁵ Crump, C. E., Earp, J. A. L., Kozma, C. M., & Hertz-Picciotto, I. (1996). Effect of organization-level variables on differential employee participation in 10 federal worksite health promotion programs. *Health Education Quarterly*, 23(2), 204-223.

⁶ Edmunds, S., Hurst, L., & Harvey, K. (2013). Physical activity Barriers in the workplace: An exploration of factors contributing to non-participation in a UK workplace physical activity intervention. *International Journal of Workplace Health Management*, 6(3), 227-240.

⁷ Linnan, L. A., Sorensen, G., Colditz, G., Klar, N., & Emmons, K. M. (2001). Using theory to understand the multiple determinants of low participation in worksite health promotion programs. *Health education & behavior*, 28(5), 591-607.

been informed of the value of such screenings for long-term health maintenance. Beyond psychological variables, participation may also be a function of an individual's relative health status. For example, those individuals with identified risk factors (e.g., being overweight) may be more likely to participate in certain programs (e.g., physical activity). To summarize, whether an individual voluntarily participates in workplace health promotion programs depends on multiple levels of influence, including both contextual and individual factors.

Motivation Theories and Frameworks

Theories of human motivation provide a useful starting point for developing strategies for increasing participation in wellness programs. Each of the motivation theories discussed below have a common element which is essential for obtaining employee cooperation in and sustained participation: they provide an opportunity to engage in a target behavior when a person perceives that the activity *results in a good deal*. This perception has been labeled several different things, but perhaps most succinct as “what’s in it for me” or the “WIFM” commonly used in sales and customer service. Deciding to act in a desired manner can be seen as a comparison between two alternatives. One is deciding to act in a desired manner, and the other is deciding to continue one’s usual behavior or to do nothing. These motivation theories share the core assertion that a person would decide to act in a desired manner if doing so would provide more of what he or she wants compared to the alternative. Assuming people are rational decision-makers and would want to maximize their gains, then a successful wellness program would need to offer employees more desirable outcomes than what they would obtain from competing alternatives. The following is a review of selected motivation theories that can be applied to the case of employee participation in wellness programs.

It should be noted that being motivated to participate in a wellness program is not the sole determinant of whether a person does so or not. As is obvious from the findings from the scientific literature reviewed, the focus groups and the Harris Poll, contextual factors also play an important part in the determination. This project, however, brings forward employee motivation to participate more directly because we believe progress can be made toward greater participation by understanding how to structure employees’ choices such that participation is perceived as a good deal.

Reinforcement Theory

Reinforcement theory or behavior modification⁸ asserts that behavior that is rewarded is repeated, and behavior that is not rewarded is not repeated. It also asserts that undesirable behavior that is punished will not be repeated. The application of this theory to employee participation is simple and is, in fact, quite common. This is the basis for financial and non-financial incentives tied to

⁸Skinner, B.F. (1969). *Contingencies of reinforcement*. East Norwalk, CT: Appleton-Century-Crofts.

participation or specific behaviors of interest (e.g., attending weight management classes, losing weight). It is much less often applied in the form of punishments to stop unhealthy behavior. An example might be the forfeiture of a financial incentive if weight is gained rather than lost, or getting physically ill after drinking alcohol when a person is taking the drug Antabuse to discourage drinking alcohol. Rewarding people for desirable behavior is highly effective when tied to specific behaviors that can be objectively verified. Punishing people for undesirable behavior stops that behavior but does not increase the likelihood of desirable behavior. Also, failure to reward desirable behavior will extinguish desirable behavior. In sum, this theory works well when applied to employee participation if specific targets can be identified and rewards continue as long as the behavior is desired.

Expectancy Theory

Expectancy theory in its basic form⁹ asserts that people will make a choice among alternatives based on which choice will maximize their gain. Every choice involves a level of effort ranging from low to high, and each level of effort will produce an outcome, which in turn will result in a reward (financial or non-financial) of some value. The theory says that people estimate the probability that effort will lead to a specific outcome and the probability the outcome will result in a valued reward. Depending on the probabilities estimated, people will choose a level of effort that has the greatest payoff given the amount of effort required. This theory recognizes that the highest levels of effort may not result in the greatest payoff because the probabilities may be too low; in that case a person would choose a lower level of effort that nets less payoff but at a lower person cost (in effort).

This theory can be applied to employee participation by understanding how employees think about the choices they can make regarding a wellness program. If the choice to participate or not participate result in the same outcomes, then there is no additional value to participate. If a person perceives that a desirable outcome has a low probability of occurring, the person will choose not to participate. If a person thinks that by participating in a wellness program it will result in negative outcomes and not participating will result in positive outcomes, then the person will choose not to participate. In sum, according to the theory a person thinks about how much effort will be required, estimates whether the effort will result in a change, and estimates whether that change will result in positive rewards that make the effort worth it. Wellness programs set up properly to make participation the most desirable choice can positively affect participation rates.

Early Behavioral Theory

This theory is based on a series of studies of human productivity conducted within the Western Electric factory in Hawthorne, Illinois. The theory asserts that

⁹Vroom, V.H. (1964). *Work and Motivation*. New York: Wiley.

people modify an aspect of their behavior in response to their awareness of being observed.¹⁰ The insight derived from the Hawthorne studies was that people who believe they are important or “special” because they are members of a selected group would work harder or behave in a desired manner. Applied to employee participation this may mean that setting up a wellness program such that participants feel important or special for participating may motivate participants to engage fully in the program and achieve the programs goals. While this approach does not seem immediately to correspond to what we observe in organizations, one aspect does. That is, peer support and public recognition for lifestyle changes or efforts to adopt healthier behaviors does have a “Hawthorne effect.” If employees felt they were doing something important by participating in a wellness program and their participation was observed by others, this may increase participation rates.

Goal Setting Theory

This theory states that people will achieve more if they set specific goals than if they just say that they are going to “try their best.”¹¹ Goal setting is effective to the extent the goals are challenging, but also realistic and achievable. Accountability for progress toward goals and celebration of goal achievement are also important aspects of this theory. Goal setting can be applied to employee participation by thinking about whether the wellness program is amenable to setting challenging goals that people find important and achievable. To the extent employees imagine themselves achieving goals and being celebrated for their achievements, they may choose to participate in the wellness program in order to achieve those goals. The key part, however, is employees’ perception that the goals are achievable and not too challenging. In sum, goal setting could be an important aspect of recruiting participants into wellness programs if progress toward goals and goal attainment was clearly articulated and appeared achievable.

Methods of Influence

In addition to motivation theories, it is also useful to understand frameworks used to influence human behavior. These frameworks are closely tied to motivation theories, but they put these theories in practical, easy-to-use terms. Five methods of influence are described below.

Rewarding Desired Behavior

This method follows reinforcement theory described above, and sets up circumstances where when desired behavior is observed, the person is rewarded for that behavior. Rewarding does not need to happen each time desired behavior

¹⁰ Mayo, E. (1933). *The human problems of an industrial civilization*. New York: Macmillan.

¹¹ Locke, E. A., & Latham, G. P. (1984). *Goal setting: A motivational technique that works!* Englewood Cliffs, NJ: Prentice Hall.

occurs, but rewarding does have to occur frequently enough that a person makes the connection between behavior and reward. This method of influence is effective to the extent that the receiver values the reward and wants the reward. This method has no effect if either the reward is not perceived as valuable or the person is not in need of the reward.

Coercing Desired Behavior

This method uses fear of punishment or of negative consequences to encourage desired behavior. Avoidance of undesired outcomes is the primary motivator of desired behavior. Examples are telling people that they have a high probability of contracting terminal cancer if they do not stop smoking or their peers will be angry with them if they do not participate on a company-sponsored sports team. Coercion works to the extent a person is fearful of the negative outcome or wants to avoid the negative outcome, and to the extent the person believes his behavior will result in negative outcomes. This method has no effect if the person is insensitive to the negative consequences or does not believe they will occur.

Framing the Desired Behavior in Values

This method works by increasing a person's desire to be influenced when by engaging in a desired behavior, a person reinforces an important value that she lives by. There is no external reinforcement nor is there coercion to act in a certain manner. This method relies on people have values which guide their day-to-day behavior. People desire to behave in a manner consistent with their values, and by tying desired behavior to a person's values, the person will be naturally and willingly motivated to act in that manner. This method does not work if the framing builds upon values that are not important to the receiver.

Controlling the Environment

This method works by manipulating the physical environment in ways that makes desirable behavior more likely and undesirable behavior less likely (so-called "nudging" by "choice architecture") (so-called "nudging" by "choice architecture"). Examples of this method are moving unhealthy snacks to shelves that are difficult to reach or to locations that take a long walk to retrieve, and providing attractive walking paths and rest areas outside to encourage physical activity. This method influences behavior to the extent people can easily adapt to physical environmental changes, and it will not work to the extent people find ways to get around these changes.

Making Exchanges

This method builds upon the concept of "horse-trading" where two parties (e.g., leadership and employees) strike a deal where each party gets something they

want. This is distinguished from a compromise as compromise results in both parties losing what they want. An example of a compromise would be employees agree to complete a Health Risk Assessment in exchange for one hour of paid release time to talk to a personal health coach. In contrast, exchanges explicitly give each party what they want by creating an opportunity to give the other party something they desire. An example of an exchange would be employees having a social event during lunch time and the leadership arranges catering and a facilitator for social networking. This method appears to be underutilized in general, although politicians know this strategy very well.

Conclusions about Participation

In summary, there are a number of ways employee participation can be increased theoretically by applying the motivation theories and methods of influence in an appropriate manner. We now turn to descriptions of our project activities to provide important information about wellness programs in small and medium organizations and employee participation. We will return to the topic of how to increase the adoption of wellness programs and employee participation in a later section, capitalizing on everything that we learned through our project activities.

Literature Reviews

Initial Literature Review

Goals

Small and medium organizations face challenges that make it difficult to develop and implement wellness programs with their employees and to reach high participation rates. This is unfortunate given evidence showing that integration of lifestyle management interventions at the workplace can reduce various risk factors in employees, such as smoking, unhealthy eating habits, and being overweight.¹² However, not enough is known about program/intervention design and how to implement these programs for sustainable behavior change and employee participation. Accordingly, the purpose of this literature review was to identify workplace wellness program participation rates and the associated factors that contribute to behavior change. In this phase, we reviewed the literature on successful engagement in wellness programs where participation rates reached 20% or greater. Specifically, participation rates in nine different types of wellness programs (originally identified in the 2015 Johns Hopkins report, [*From Evidence to Practice: Workplace Wellness that Works*](#)) were reviewed: Nutrition and Weight Management, Physical Activity, Diabetes (High Blood Glucose) Management, Tobacco Cessation, Stress Management, Clinical Preventive Screenings/Biometric Assessments, Sleep Hygiene, Social Connectedness, and Alcohol Management.

Search Methods and Results

UC Berkeley graduate student researchers conducted a literature search in databases PubMed, Scopus, and PsycINFO. Searches for words, “workplace wellness programs” AND “participation” AND “diabetes” were used to identify studies on diabetes management, for example. To be eligible for inclusion, studies needed to be published within the past 10 years (2007 - 2017). The articles were not limited to studies conducted in the U.S., however Scopus allows specification of country, thus the focus was limited to U.S. studies for articles identified through Scopus. In addition, employee wellness programs were one of the “types” of programs listed above (or has multiple components of programs) and reports participation levels as initial enrollment, completion of program, or completion of follow-up survey.

Applying these search criteria, 699 studies¹³ were identified from these relevant databases. Of the articles returned from the searches, 33 unique articles¹⁴

¹² Mattke, S., Liu, H., Caloyeras, J., Huang, C. Y., Van Busum, K. R., Khodyakov, D., & Shier, V. (2013). Workplace wellness programs study. *Rand health quarterly*, 3(2).

¹³ Search results returned duplicates, therefore these 699 articles were not unique.

¹⁴ See Appendix B for a full list of studies reviewed.

met the inclusion criteria and covered the following content areas (not mutually exclusive): Nutrition and Weight Management (13 studies), Physical Activity (13 studies), Tobacco Cessation (four studies), Stress Management (nine studies), Clinical Preventive Screenings/Biometric Assessments (for Blood Pressure, Cholesterol and Blood Sugar) (11 studies), Diabetes (High Blood Glucose) Management (four studies), Sleep Hygiene (two studies), Alcohol Management (one study), and a category labeled “other” (three studies). No studies met the inclusion criteria for Social Connectedness. Both quantitative and qualitative studies were included provided they were replicable and applicable to various populations.¹⁵ When not opinion-based, relevant articles were included from business databases and magazines (e.g., articles that described workplace wellness programs with higher participation rates and/or those that described why a given program was successful).

Following identification of the eligible primary studies, each of these was then reviewed by one researcher for information on participation rates. In addition to participation rates, the following information relevant to participation rates was recorded: program type (e.g., tobacco cessation), company size (often the total eligible population), organization size (small, medium, or large), employee description (e.g., “Amtrak workers”), and facilitators or barriers to participation (if identified). A record of the information collected from studies by researchers can be found in Appendix A.

Initial Literature Review Findings

Representation of Small and Medium Organizations in the Literature

Of the 33 studies, only eight reported company size, all of which were large (greater than or equal to 500 employees). There is no clear representation of small or medium organizations in the literature from this search.

Participation Rates for All Organizations

Participation was not well defined across studies and was generally dependent on how each study interpreted participation. Study participation was defined as completing a program or completing follow-up surveys. The participation rates reported for all size organizations appear in Table 1 below. Average participation rates were determined by averaging the rates of follow-up respondents or retention rates.

¹⁵ McKibbin, K. A. (1998). Evidence-based practice. *Bulletin of the Medical Library Association*, 86(3), 396.

Table 1

Average Participation Rates and Ranges for All Studies

	Average Participation Rate	Range of Participation Rates
Organizations Across All Sizes	61.6% (N = 33)	21-100% (N = 33)

A major limitation was small sample sizes within the studies and the small number of studies. All articles had very limited information on participation rates and all participation rates were inferred. The majority of these studies determined participation based on survey completion rather than their actual behavior. Many of these studies had controlled trials where everyone was “enrolled” and participation was high by default or some studies were cross-sectional survey of employees enrolled in a worksite wellness program, thus inflating participation rates. When we omit these studies from the analyses, the average participation rate drops to 58% from 61.6%.

Employee Participation: Facilitators and Barriers

A number of facilitators and barriers were mentioned across the literature, and these factors affected the degree of sustained behavior change and implementation success of these programs. Some of the facilitators and barriers were common across workplace sectors, occupations, and industries; however, some were specific to particular occupations and/or industries. Common barriers included lack of time (work schedules, competing priorities), lack of knowledge of program, fear and self-consciousness in the workplace, lack of managerial commitment to programs and employees, lack of motivation, and a workplace environment which made it difficult for employees to participate.

Common facilitators included a health-oriented workplace culture, organizational commitment, employees empowered by being able to create their own programs, monetary incentives, and a supportive workplace environment such as access to healthy food and resources near the worksite. Based on our review, it would also seem that applying technology and web-based tools is a realistic method to increase participation as many employees now have access to web-based tools in forms of computers, cellular devices, etc. Technology-based programs are relatively inexpensive and can be utilized outside of the workplace. Changing the physical and social workplace environment may change the “default behaviors” expected in that environment and may sustain long-term behavior change. While companies may have existing wellness programs, they may not be doing enough to capture the attention of employees. One way to ensure that pre-existing programs are successfully engaging employees is by increasing the awareness and reminding employees of the benefits. Similarly, companies with successful programs foster a healthy workplace culture and include an encouraging and supportive senior management.

Conclusions

Although findings varied as a function of study design, occupation, and other demographics, they have given us a general understanding of the calculation of participation in wellness programs in organizations and have provided preliminary insights into some of the factors associated with effective engagement of participants. This review also gives some insight to the barriers and facilitators to employee participation, however not much information is shared from studies on the reasons for particularly high or low participation -- many of the barriers or facilitators, if offered, were no more than speculative. This review indicates a need to define participation and systematically investigate participation rates specifically among wellness studies, as well as a need to investigate the barriers and facilitators to successful implementation and engagement in wellness programs.

Secondary Literature Review

Goals

After the initial literature review, a follow-up review was conducted. This review sought to more fully understand workplace wellness program participation rates based on pre-specified criteria as described below. Secondly, the review analyzed studies reporting all levels of participation rates rather than limiting the review to those that reported participation rates of 20% or greater. Lastly, this review aimed to provide additional support for the individual- and organization-level factors that promote participation as identified in the first review.

Search Methods and Results

This second review differed from the first in that it entailed a secondary synthesis of reviews (i.e., a “review of reviews”) rather than a direct search of primary articles. Specifically, we searched PsycINFO and Google Scholar for review articles on each of the wellness program content areas researched in the first review (i.e., Nutrition and Weight Management, Physical Activity, Diabetes (High Blood Glucose) Management, Tobacco Cessation, Stress Management, Clinical Preventive Screenings/Biometric Assessments, Sleep Hygiene, Social Connectedness, and Alcohol Management). Searches of the word “review” along with multiple terms covering each of the content areas (e.g., “stress management,” “tobacco cessation,” “healthy nutrition”) were conducted. In addition to keyword searches, an ancestry approach to literature searching, where articles were identified using citations from relevant articles, chapters, and book chapters, was also used.

To be eligible for inclusion, reviews needed to be a systematic review of wellness interventions conducted in organizational settings and published in the last 10 years (2007 - 2017) (where “systematic” refers to a review with a defined review protocol and search strategy that aims to detect as much of the relevant

literature as is possible). In addition, the review needed to contain at least some studies that evaluated the effectiveness of interventions for creating changes in at least one *health*-related outcome (as opposed to, for example, solely evaluating business outcomes). Finally, the review must not have been limited to a certain worker population (e.g., healthcare professionals). Reviews of both U.S. and non-U.S. studies were included.

Applying these search criteria, 57 reviews were identified. Of these, 31 did not meet the inclusion criteria. The remaining 24 reviews covered the following content areas: physical activity (six), nutrition and weight management (eight), tobacco cessation (three), stress management (five), and alcohol management (two). Primary studies from the most recent review within each topic area were then identified and reviewed. To be included, primary studies must have a) described an intervention/program for which assessment of participation was appropriate (this excluded informational interventions) and b) reported sufficient information for determining wellness program participation rates (see below). Notably, the vast majority of studies did not provide enough information to allow for an assessment of participation even though the intervention type would have allowed for such an assessment. Given this, 65 of the 195 primary studies contained in the reviews met these inclusion criteria.

Following identification of the eligible primary studies, each of these was then independently reviewed by two different researchers for information on participation rates. Specifically, we recorded participation rates based on three separate indices: 1) the number of individuals who intended to participate relative to the total number of eligible workers; 2) the number of individuals who completed the intervention relative to the number of individuals who intended to participate [i.e., the retention rate] and 3) the number of individuals who completed the intervention relative to the total eligible worker population. This methodology allowed for assessment of participation rates, not only in terms of initial enrollment in a program, but also in terms of participation through the duration of the program. Any discrepancies between the coding completed by the two independent reviewers were discussed and consensus reached.

In addition to participation rates, the following information relevant to participation rates was recorded: program content (e.g., tobacco cessation), program focus (e.g., primary vs. secondary vs. tertiary), study location (US vs. non-US), program duration, organization size (small, medium, or large), and employee description (e.g., “firefighters”). A record of the information collected from studies by researchers can be found in Appendix C. Finally, because none of the studies directly studied the factors that either promote or detract from participation, researchers reviewed the Method and Discussion sections of studies for any information that might help explain participation rates for a given study (e.g., the use of incentives, monetary or otherwise).

Secondary Review Findings

Representation of Small and Medium Organizations in the Literature

Of the 65 primary studies reviewed¹⁶, 25 reported organizational size. Based on mandatory small business insurance requirements and size distinctions generally used by the Bureau of Labor Statistics, we defined small organizations as those consisting of 0-49 employees, medium organizations as consisting of 50-499, and large organizations as consisting of 500 or more employees. Of these 25 studies, 18 were conducted using samples from large organizations, three from medium organizations, and three from small organizations. Two studies were conducted using samples from both medium and large organizations.

Participation Rates Reported for All Organizations

As noted above, participation rates were assessed using three different indices. A summary of this information can be seen in Table 2. The first of these calculations (hereafter referred to as Index 1), the number of individuals who intended to participate relative to the total number of eligible workers, was 51.4% across all organizations, regardless of size. Second, the number of individuals who completed the intervention relative to the number of individuals who intended to participate (i.e., the retention rate; hereafter referred to as Index 2), was the highest of three assessments at 74.9%. Lastly, the number of individuals who completed the intervention relative to the total eligible worker population (hereafter referred to as index 3), was 36.4%. Notably, not all three participation rates were reported by every study: 27/65 studies reported participation rate by Index 1, 40/65 reported participation rate by Index 2, and 31/65 reported participation rate by Index 3. Thus, those who completed the intervention/those who intended to participate was most commonly reported and showed the highest levels of participation. Index 3 was the lowest, suggesting that, and perhaps not surprisingly, only a small percentage of the population being served by an intervention actually chose to participate.

Participation Rates Reported for Small and Medium Organizations

For small organizations, participation rates for Indices 1, 2, and 3 were 71.7%, 77.2%, and 53.8%, respectively. For medium organizations, participation rates for Indices 1, 2, and 3 were 18.5%, 70.3%, and 13.3%, respectively. For large organizations, participation rates for Indices 1, 2, and 3, were 44.8%, 67.4%, and 32.7%, respectively. The specific number of studies reported each of these participation rates by organization size can be seen below in Table 2.

¹⁶ See Appendix D for a full list of studies reviewed.

Across the three types of participation indices, small organizations showed the highest participation rates, followed by medium and large organizations with one exception. Index 2 for medium organizations showed slightly higher rates of participation compared to large organizations. In general, participation rates for small and medium organizations were based on a (study) sample size of three; thus, these participation estimates may not be representative of participation levels in small organizations more generally.

Table 2
Summary of Participation Rates

	Index 1	Index 2	Index 3
Small Organizations	71.7% (<i>N</i> =3)	77.2% (<i>N</i> = 3)	53.8% (<i>N</i> = 3)
Medium Organizations	18.6% (<i>N</i> = 3)	70.3% (<i>N</i> = 2)	13.3% (<i>N</i> = 2)
Large Organizations	44.8% (<i>N</i> = 11)	67.4% (<i>N</i> = 13)	32.7% (<i>N</i> = 14)
Across all Sizes	51.4% (<i>N</i> = 27)	79.9% (<i>N</i> = 40)	36.4% (<i>N</i> = 31)

Note. Index 1 = those who intended to participate/ total (eligible) worker population, Index 2 = those who completed intervention/those who intended to participate, Index 3 = those who completed intervention/total (eligible) worker population. *N* = number of studies (out of 65) reporting participation in this manner.

Employee Participation: Barriers and Facilitators

As noted above, researchers also reviewed the articles for any information about factors that may have promoted or served as a Barrier to participation in employee wellness programs/interventions. Factors that may promote participation include the use of friendly competition among participating coworkers (e.g., MacKinnon et al., 2010). Second, individually tailored interventions (either to the individual or to the organization) in general were touted as more successful. For example, DeJoy, Padilla, Wilson, Vandenberg, and Davis (2013) suggested that the use of peer coaches who regularly met with and provided feedback to participants helped to establish participant motivation, commitment, and participation. Likewise, at the organizational level, interventions whose organizers fit the intervention to the resources and characteristics of the work site were seen as more successful (Willemsen, de Vries, van Breukelen, Genders, 1998). Perhaps not surprisingly, some authors (e.g., Sutton & Hallett, 1988) also suggested that conducting the program during work hours probably served as an incentive to participate. A handful of studies on the topic had mixed results on the effectiveness

of monetary incentives for increasing participation rates. Whereas Windsor, Lowe, & Bartlett (1988) found that monetary incentives had no effect on quit rates in a tobacco cessation study, Hennrikus et al. (2002) found that offering incentives had a strong effect on registration in smoking programs, nearly doubling enrollment rates. Moreover, more sensitive programs (e.g., tobacco cessation, alcohol management) may be more successful to the degree that they were embedded within a larger “health promotion” program (e.g., Richmond, Kehoe, Heather, & Wodak, 2000). Finally yet importantly, leadership and/or management support for the program was mentioned by several different authors (e.g., Dallam & Foust, 2013; Taradash, 2015) as a critical organizational factor that likely contributed to higher participation rates.

Factors associated with lower participation levels included: lack of time to complete the intervention, concerns about confidentiality (especially for tobacco cessation, alcohol management, and weight management), employees’ perceptions that the program/program activities were not useful, and no pre-existing mechanism (e.g., meetings with a counselor or a tracking system) for ensuring accountability among participants.

Of note, the studies reviewed here did not involve empirical tests of the abovementioned factors, and as such, results are primarily based on inference on part of both the authors and our researchers. With this in mind, we took a conservative approach to drawing conclusions about these factors. Readers are encouraged to review the focus group summary for an empirically-based review of Barriers and Facilitators.

Conclusions

Most studies did not report the size of the organization from which the sample came. Of these, the vast majority of studies were conducted using samples from relatively large companies (those with 500 or more employees). When considering organizations of all sizes, those who completed the intervention relative to those who intended to participate was most commonly reported and was the highest of the three rates reported in this review. This suggests that most of the people who enter into the intervention do end up completing it. Small companies report the highest participation rates, but, as noted above, this finding may not be reliable due to the small number of studies reporting participation rates for small organizations. Lastly, the participation barriers and facilitators identified in this review largely corroborate the findings from the initial review and the focus group interviews.

It is important to recognize that the studies compiled in this review are published studies. In general, we would expect that, in order for a study to be published, it must have achieved relatively high participation rates. Thus, the

participation rates as reported here may be overly optimistic. In addition, the barriers and facilitators identified here were not explicitly addressed in the studies. Thus, empirical research that directly tests the role of these identified factors is needed in order to validate our initial findings.

Focus Group Investigation

Focus Group Goals

The focus group investigation was intended to provide a better understanding of the dynamics surrounding the adoption (or non-adoption) of wellness programs, and the factors affecting participation in wellness programs that are implemented. Because of the shortcomings in published studies in which key information is not available or not collected, we used focus groups as a method for obtaining ground-level, highly detailed information about employers' decision-making regarding adoption of wellness programs and employees' experience with wellness programs in general and specifically those implemented in their organizations. Thus, focus groups were designed to extract the most valuable information about views on wellness programs, facilitators and incentives to participating in wellness, barriers or disincentives to participation, and overall challenges small and medium organizations face and must overcome in order to implement a wellness program. Strategies for wellness program implementation mentioned in studies reviewed were collected and turned into discussion questions presented to focus group participants. In addition, we collected ideas for ways wellness program adoption and implementation including employee participation might be improved.

Description of Approach and Questions Pursued

We gathered representatives from 29 organizations spanning a variety of industries and geographies (see Table 3 below). Scripts were developed for Human Resources (HR) and Management as well as for Direct Reports, both for organizations with and without programs.

There were four general areas of inquiry:

- 1) **Background Regarding Existing Wellness Programs.** We asked questions about what wellness programs are in place, whether employees are aware of the programs, who is eligible for the programs, to what extent people participate in the wellness programs and any other descriptions of what currently exists and how they are being received. Organizations who do not have a wellness program or employees are not aware of any wellness program move on to a script for no program.
- 2) **Reasons for Participating in Wellness Programs.** Second, we asked questions about the factors that encourage employee participation in the wellness programs implemented in their organization. The purpose of these questions was to understand in what ways wellness programs can be introduced into small and medium organizations so that high levels of participation are achieved and sustained in the long-term. For employees

whose organization who did not have a wellness program, we asked broader, hypothetical questions about what might entice them to participate in a given program were it offered.

3) **Barriers and Disincentives to Participating in Wellness Programs.**

Third, we asked questions about what kinds of factors (e.g., company culture, leadership, manager attitudes, work demands, lack of time, and lack of value to employee) discourage employees from participating in the wellness programs offered by their employer. As with the second set of questions (see section 2 above), the purpose of these questions was to understand the role organizations play in maintaining high wellness program participation rates. Again, employees whose organization did not offer wellness programs were asked to answer hypothetically.

4) **The Unique Features of Small and Medium Organizations.** Lastly, we asked questions about the unique circumstances small and medium organizations face when attempting to improve the health and well-being of their employees through wellness programs. Small and medium organizations tend to have much less experience with wellness programs and more formidable barriers to successful implementation, as compared to large organizations where there is sufficient resources, staff, cash flow, and time to support implementation and employee participation. Therefore, the purpose of these questions was to determine how constraints could be minimized so that wellness programs can be effectively introduced into small and medium organizations.

Strategies for Soliciting Participation in Focus Groups

Professional societies, such as the Northern California Human Resources Association (NCHRA) and the Society for Human Resource Management (SHRM) were asked to distribute a call for participation in the focus groups. Researchers also identified organizations through other venues, such as the Chamber of Commerce, Forbes “Best Places to Work,” and more. For the final nine focus groups, we also enlisted the assistance of a third-party agency that used similar recruitment methods to enlist participating organizations from their network of HR and C-suite officers. Organizations were then contacted and asked to complete a survey which revealed basic demographic information about the organization such as size, number of employees in the Human Resources (HR) Department, and presence of a wellness program; see Appendix E. Participating organizations were asked to recruit employees from each category (HR, Management/Leadership, and Direct Reports).

Focus Group Methods

The focus group protocol (goals, methods, materials, and personnel) was submitted to the Committee for Protection of Human Subjects and approved by the Institutional Review Board (IRB). We presented the risks and benefits to focus group participants and obtained their written consent as directed by the IRB. The Informed Consent Form they signed is provided in Appendix F.

Protocol

One focus group facilitator and (typically) one note-taker attended each focus group. In addition to notes typed in vivo, all sessions were voice recorded. After obtaining informed consent, a Demographic Questionnaire (see Appendix G) was distributed and collected at the end of the session. Some focus groups were conducted virtually using video conferencing technology; in such cases, informed consent forms and the demographic questionnaires were distributed and collected via email prior to the scheduled focus group. The facilitator followed a script when conducting the focus group. This script included an introduction and outlined general and guidelines participating in the focus group. Six different scripts were used depending on the type of employee being interviewed (Management/HR vs. directly reporting employees vs. a heterogeneous (i.e., “mixed”) group), and depending on whether the organization currently offered a wellness program. Thus, one of six different scripts (see Appendix H) were used for each focus group:

- 1) HR/Management employees, organization offers a program;
- 2) HR/Management employees, organization does not offer a program;
- 3) Direct reporting employees, organization offers a program;
- 4) Direct reporting employees, organization does not offer a program;
- 5) “Mixed” group of employees, organization offers a program; and
- 6) “Mixed” group of employees, organization does not offer a program.

The information collected from the organizational demographics survey was used to determine which of the six scripts to use. Facilitators were encouraged to follow closely the script, but could ask additional questions that deemed relevant to the discussion, such as the type of insurance used, maturity of the company, or historical context.

Coding of Focus Group Data.

The notes and voice recordings taken during each focus group were reviewed and entered into a spreadsheet capturing information about the organization’s health and wellness practices, along with organizational demographics (i.e., size, industry, geographic region, and number of focus group participants in each employee category). One of the two focus group attendees entered the information into a master spreadsheet and the other attendee reviewed the information for accuracy. Any discrepancies between the two were recorded and discussed.

Table 3

Organization Size, Industry, Region, and Focus Group Participants

Org.	Org. Size	Org. Size (2) (Approx. No. Employees)	Industry (US Bureau of Labor Statistics)	US (Census) Region	HR Employee Attendance	DR Employee Attendance	Mgmt/Lead -ership Attendance
1	Large	500	Other Professional, Scientific, and Technical Services (NAICS 5419)	West-Pacific	4	5	7
2	Medium	120	Management, Scientific, and Technical Consulting Services (NAICS 5416)	West-North Central	0	7	4
3	Medium	120	Footwear Manufacturing (NAICS 3162)	West-Pacific	5	1	5
4	Small	10-15	Architectural, Engineering, and Related Services (NAICS 5413)	Middle Atlantic	0	4	5
5	Medium	65	Advertising and Related Services (NAICS 5418)	West-Pacific	1	3	9
6	Large	540	Educational Services (NAICS 61)	West-Pacific	2	1	2
7	Medium	60	Other Professional, Scientific, and Technical Services (NAICS 5419)	West-Pacific	2	0	1
8	Small	6	Advertising and Related Services (NAICS 5414)	West-Pacific	0	2	2
9	Medium	51-499	Educational Services (NAICS 61)	West-Pacific	2	5	6
10	Small	28	Museums, Historical Sites, and Similar Institutions: NAICS 712	West-Pacific	1	6	2
11	Medium	75	Warehousing and Storage: NAICS 493	West-Pacific	1	3	3
12	Medium	50	Administrative and Support Services (NAICS 561)	West-Pacific	0	0	4
13	Medium	50-70	Printing and Related Support Activities (NAICS 323)	West-Pacific	2	3	3

14	Medium	53	Religious, Grantmaking, Civic, Professional, and Similar Organizations (NAICS 813)	West-Pacific	1	4	3
15	Medium	51-200	Finance and Insurance (NAICS 52)	West-Pacific	1	5	4
16	Medium	51-200	Health and Personal Care Stores: NAICS 446	West-Pacific	1	3	7
17	Medium	120	Educational Services (NAICS 61)	West-Mountain	0	5	3
18	Small	18	Health Care and Social Assistance (NAICS 62)	West-Pacific	1	6	4
19	Medium	350	Manufacturing (NAICS 31-33)	West-Pacific	1	5	1
20	Medium	51-200	Other Professional, Scientific, and Technical Services (NAICS 5419)	West-Pacific	3	2	3
21	Small	14	Advertising and Related Services: (NAICS 5418)	Midwest-West North Central	1	2	0
22	Medium	150-200	Construction (NAICS 23)	Northeast-Middle Atlantic	2	1	2
23	Small	12	Computer Systems Design and Related Services (NAICS 5415)	South-Atlantic	0	1	4
24	Medium	280	Accommodation and Food Service (NAICS 72)	West-Pacific	1	2	2
25	Small	23	Arts, Entertainment, and Recreation (NAICS 71)	Northeast	0	0	2
26	Medium	52	Construction (NAICS 23)	Midwest-East North Central	0	0	1

27	Medium	70	Architectural, Engineering, and Related Services: NAICS 5413	Midwest-East North Central	1	1	0
28	Medium	103	Finance and Insurance (NAICS 52)	Northeast-Middle Atlantic	1	2	0
29	Small	14-16	Advertising and Related Services: (NAICS 5418)	South-West South Central	0	1	2

Note. Small organizations are those with 1-49 employees, medium organizations are those with 50-499 employees, and large organizations are those with 500 or more employees. DR = directly reporting employees.

As seen in Table 3, we conducted focus groups with eight small organizations, 19 medium organizations, and two large organizations. Organizations represented a variety of industries, from advertising to education. The majority of organizations (17 of 29) were located in the West-Pacific region of the U.S. A total of 205 individuals were interviewed: 34 human resources employees, 80 directly reporting employees, and 91 employees occupying (non-human resources) management or leadership positions.

In addition, demographic information was collected from each individual focus group participants. Focus group participants were, on average, 38.74 years of age. Gender composition of the sample was 35.2% male, 63.2% female, and 1.6% other. Participants reported the following racial/ethnic identities: 63.2% White, 12.4% Hispanic/Latino, 7.8% African American/African/Black, 7.8% mixed, 6.2% Asian/Asian American, and 2.6% other. Average job and organizational tenure were 4.0 and 5.6 years, respectively.

Table 4 summarizes the wellness program practices at the organizations included in this study. The types of programs offered most often were social connectedness programs (25 out of the 29 organizations interviewed), healthy food/drink offerings in house (16 out of the 29) and ergonomic furniture/equipment (15 out of 29). Targeted behavior change programs for high-risk employees were least likely to be offered (four out of the 29 organizations interviewed), followed by individual mental or physical health tracking through a wearable device or online program (five out of 29 organizations).

Table 4
Wellness Practices at Participating Organizations

Wellness Practice	No. Organizations Promoting
Health education via pamphlets, meetings, etc.	10/29
Health advice from a qualified vendor (e.g., coach) for promoting healthy behavior (e.g., nutrition)	14/29
Individual mental or physical health tracking	5/29
Targeted behavior change programs for high risk employees (smoking/weight/disease/alcohol management, medication compliance)	4/29
Healthy on-site food/drink offerings	16/29
Clinical screenings and biometric assessments	8/29
Social Connectedness (e.g., sports teams, interest groups)	25/29
Mindfulness, meditation, relaxation, yoga	12/29
Links to employee services (e.g., EAP) for support for personal issues	12/29
Ergonomic furniture/equipment	15/29

Subsidized gym membership	9/29
Fitness gym facilities or outside exercise areas	10/29

Focus Group Findings

Individual-Level Decision Factors

At the individual level, we have loosely categorized each of the identified Facilitators and Barriers into one of three categories: Fit, Readiness, and Ability. Fit refers to the degree of equivalence between the individual employees' needs and preferences, and the wellness programs offered by their organizations. Readiness refers to individual employee's willingness and motivation to participate in workplace wellness initiatives. Finally, Ability refers to the individual employee's capacity to participate, financially, emotionally, or otherwise.

Facilitators - Fit

Shared values and interest among peers. Having peers at work who share health values and interests provide an important aspect of support and encouragement that helps increase and maintain engagement in healthy behaviors. For example, in the words of a focus group participant, having an "accountabilibuddy" gave her motivation to participate and stay engaged. Employees often looked for ways to connect with others over shared interests, such as in group chats or forums surrounding themes of interest (e.g., healthy food group) or in clubs (e.g., running club, exercise club, meditation club). Those employees who were able to find others to engage in preferred activities also felt a sense of accountability to themselves and others. They also made stronger connections and bonds with their peers, acting sometimes as an "icebreaker," to help feel more connected with the organization or with employees that may otherwise interact infrequently, even if the organization is geographically or functionally fragmented. For example, a new employee at a technology company, which has regional offices and half of its employees working remotely, attended an in-person training with other new employees. As part of the introduction, employees participated in a workout together. This employee noted that for their group, it was a good activity because they did not mind working out in front of each other, *"It was a really great icebreaker for us, and a great way to be connected to each other while going through this grueling workout."*

Facilitators - Readiness

Individuals are motivated to engage in healthy behaviors at work. Many of the wellness-related activities, whether a part of a formal program or not, were born from an individual's intrinsic motivation to engage in a particular activity. Grassroots initiatives are some of the most successful programs in engaging employees because they attract participation without extrinsic incentives.

When employee initiative is not discouraged by leadership—and is even actively encouraged and supported—participation in these activities tends to be maintained over time. For example, an employee at one organization was already motivated to go walking around the paths outside the office space and would leave work for 30 minutes at a time to do so. Some employees also expressed pride in providing healthy products and healthy role models to patients. This pride sustained employee motivation to engage in wellness and promote it at the organization.

Perceived need for taking time for wellness. Wellness programs were well attended when employees perceived that they needed a program or activities to maintain their health and well-being. Employees realized their need in different ways. Some employees recognized a particular need for taking time for wellness, often after a personal event. For example, one employee who had a health scare realized he needed to get fit and healthy and so was ready to put time into wellness. Similarly, an employee from a company that often has demanding deadlines said, “*Stress relief is a big motivator*” for seeking out help or performing exercises that would address stress before it became a problem. Other employees reported that they needed to take time for wellness so that they could be a role model to their family (often their children), be active enough to keep up with their young children, be strong enough to take care of aging parents, and be well enough to keep up with demands of work.

Facilitators - Ability

Peer (emotional) support for lifestyle changes. Employees often rely on support from their peers as much as from leadership for lifestyle changes. Peer support acts as a resource that enables individuals to engage in behavior change, and supporters can be anyone who acts like a “cheerleader” when trying to lose weight, or achieve a weight goal, etc. This support often results in an increased ability to achieve goals. As one employee noted, “*Having some people doing the same thing [means] that you don’t stray off [and] keep going in [the] direction to achieve [your] goal. I did a six week challenge with coworkers [and it was] so much easier to stay focused with two other people.*” Additionally, when peers recognize each other’s efforts and applaud employees for that, it acts as a meaningful incentive to continue to engage in healthy behaviors.

Affordability. The affordability of activities that promote healthy behavior is a very important factor in getting employees to take the first step towards healthy habits. Affordability refers to both the cost of an activity (e.g., gym membership, class fee, registration fee, equipment costs) and lost cost (e.g., leave without pay). If individuals cannot afford to do it, they will not try. For example, one employee said, “*If it [subsidized gym membership] was offered, I’d be more likely to do it.*” Many employees cited a subsidized or fully-covered gym membership as a motivator. One company that offers subsidized gym membership to all its employees has a high number of employees who take advantage of the offer. Another example

of affordability is receiving a “bonus” to spend on health-related activities. One employee interviewed said, *“Money at the end of the year helps me buy exercise equipment, which was low on the list if we’re tight on money.”* Similarly, employees identified having exercise or stretch equipment provided at the office as an affordable alternative to needing a gym membership.

Barriers - Fit

Personal preferences. When asked what would prevent or disincentivize employees from participating in wellness activities, the most frequent Barrier identified was that the program or activity offered would not be something the employee enjoys or is interested in doing. For example, some employees who self-identified as introverts did not look forward to the social events intended to be opportunities to build connection. For these employees, large social events were in fact stressful and did not facilitate connection. For others, a gym membership discount was either insufficient to make it affordable, or was not their membership of choice (e.g., dance classes, yoga studio membership, massage services, or purchase of personal fitness equipment vs. gym membership). In these cases, the program offered did not align with employee preferences. Similarly, organizations that implemented activities based on the preferences of leadership, or the preferences of many but not all, often assumed that employees share their enjoyment in the activity when they may not have. Some employees had no desire to engage in healthy behavior and even defended their right to engage in unhealthy behaviors. For example, some employees at one organization smoke tobacco and had no desire to quit. For these employees, expressed a desire to protect a person’s “right” to smoke. In other groups, employees wanted to engage in healthy behaviors, but the wellness activities at their organization are too challenging for them. Other employees reported the opposite—their personal fitness goals were higher than those set in their wellness program.

Privacy concerns. Employees and employers both cite privacy concerns as a Barrier to participating in wellness programs, particularly ones directly related to health conditions. Employees across organizations voiced their concern that information about their health status would become known to their employers. For example, employees in one organization found the concept of an in-house clinical screening off-putting because of the perceived exposed nature—other employees would be able to hear the clinician talking or see results of blood pressure or cholesterol readings. Employers also felt apprehensive about the legality that might be involved around getting close to personal issues like health. As one employer noted, *“There are rules about what you can even say to people. I’m not allowed to ask if someone is married. Some of these things strike me as teetering on the edge of social boundaries.”* In a similar vein, employees cited discomfort as a Barrier. Some employees explained discomfort as being unprofessional in front of their colleagues (e.g., at a yoga class) and getting sweaty and disheveled in front of their colleagues (e.g., riding a bike to work when there is no shower at the office, forced laughing as

a stress-reduction exercise in front of colleagues). Others felt that “all eyes were on them” if they tried to use a treadmill desk or stationary bike in their all-glass-walls fitness room, even when the room is approved for use and modeled by leadership. Similarly, another employee noted that while some people might enjoy a weight-loss competition among their colleagues, others would feel self-conscious if their weight were to be broadcast to their peers. Another aspect of privacy concerns is that employees feared targeted programs would single people out, especially in such a small company. Additionally, some employees thought that programs addressing their health were invasive, especially tobacco cessation, alcohol management, and weight management programs.

Barriers - Readiness

Perceived lack of need. Many employees cited a lack of need as the reason why they would not participate in wellness programs. For many, there is a perception of current, high-level engagement in healthy behaviors. For example, one organization noted that their employees, having mostly military backgrounds, were already conscious of their health and maintained healthy habits to keep themselves fit. Other organizations believed that because people in their geographic region are healthier on average, there wasn't a need for the workplace to install specific programs; health and wellness was already embedded in the culture, environment, and life more generally. Some organizations thought smoking cessation and alcohol management programs were unnecessary because they perceived that very few people had these issues. This latter belief was prevalent among employees in many of the organizations interviewed. Additionally, some individuals thought that programs centered on educational material or expert guest speakers would not go over well with their peers because they were well-informed people who were already in possession of the information. Other employees simply said they were content with the status quo. Some were even resistant to changes including introduction of wellness programs and prefer instead a traditional work setup.

Low expectations. Another factor that could influence participation is the expectations people have of their organization and its ability to offer wellness programs. Indeed, several employees remarked that they do not expect their organization to offer much because they are a small company and have contract workers. In the words of one participant, “*This isn't Google.*” Even employers recognize the low expectations that come from employees—some organizations recognize that they are a secondary job for many of their employees and believe that their employees do not expect much from them, as was the case with one security organization who employed mostly contract and night shift workers. In this example, the leadership knew that employees did not look to the organization as their first line for wellness. Some employees professed that they decided to work at their organization because of the work itself and rewards of the mission, not because of the “perks” of wellness they would receive. Similarly, other employees felt uncomfortable asking their organization for additional programming if they felt

that the organization had already done enough given their limited financial resources. One employee stated, *“You already are given so much and it feels weird. I do feel guilty for asking when I’m given so much.”*

Distrust of Management. Many employees (at all levels) view work and wellness as two separate and incompatible domains. As such, some developed a distrust in the motive behind management-initiated wellness. As an example, one organization’s employees described a wellness program which was advertised to employees as being a social event where they could relax, however the event turned out to be an “exposure” opportunity for the company and employees were expected to be there in a professional manner and represent the company. Other employees expressed a similar concern that wellness activities will not actually provide a break from work in reality (by demanding emotional labor or additional requirements that feel like work). One employee said she didn’t want to attend an employee barbecue because, after a long day of work, she would need to continue to work through the event by supervising, cleaning, cooking, and being forced to socialize. Other employees distrusted management because despite having reporting their needs to management when asked for feedback, no changes had occurred. Employees also developed a cynicism around wellness because *“leadership throws the word ‘wellness’ around but doesn’t do anything about it.”*

Barriers - Ability

Family responsibilities. Employees often cited family responsibilities as competing with the time they would devote to wellness activities. Some employees complained that wellness activities that are planned just after work hours are in fact impossible to attend because they must pick up their children after school. Some employees with families were also not willing to attend group events that took place on weekends because these employees felt that time with their family was as important or more important than activities that promote their health. As one HR representative said, *“Families with small children have a rich life back there and it helps them perform better. To the extent we don’t throw wrenches into it—that is a good thing.”*

Difficulty of prioritizing how time is spent. Employees cited that they had difficulty prioritizing their time, especially when there were so few hours left outside of work. Some employees were not sure they could schedule time to go to a gym even if their organization offered subsidized or free membership. Other employees simply prioritized work over non-work activities, especially for employees in industries and organizations that are demanding and performance-oriented (e.g., sales). It was also difficult for employees to prioritize time for wellness when their schedules either were irregular or so tight that they barely had time for basic necessities. One example of this was an organization where employees are sometimes scheduled to close a store and also open it early the next day, leaving

little time for anything else and affecting their time even on the days before and after the “clopener” shift.

Employee burnout. Some employees experienced burnout, “an overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment.”¹⁷ Consequently, they do not have the vigor or emotional energy to participate in wellness-related activities. For example, one teacher group confessed that they would not have enough physical energy or motivation to go to the gym after the school day because their energy was spent on engaging students. Employees that have cynicism towards their work or towards leadership also were not motivated to participate in wellness activities hosted by the organization. For example, one group of employees we interviewed had strong feelings of resentment toward management for a number of reasons (e.g., because they felt that they limited the amount of time they could take for lunch, off from work for a doctor appointment, etc.). Speaking of the management, one employee said, *“I think they like it when we have so much to do. They seem to like it when we’re stressed. You are expected to do more and if you don’t you feel like you are looked down upon.”* This resentment spilled over into a general distrust of and disdain for anything the management did, including wellness events. Indeed, one employee identified management as modeling burnout-causing behavior claiming, *“Burnout is so common and a bigger part of the culture we have and is modeled here by the people who are leading us too.”*

Employee basic needs are not met. Many employees revealed that even their most basic needs of safety, food, or sleep were not being met and so a wellness program seems like a “luxury” or is not high on the priority list. Most often, employees described the choices they would have to make between conflicting needs (e.g., “Do I choose healthy food which is more expensive or less healthy food that is more affordable?” “Do I choose waking up an hour early to go to get exercise in or do they spend the extra hour of sleep?”). Some employees interviewed live and/or work in a location that is generally unsafe, and so not only does the stress of feeling unsafe affect their health and well-being, it can also lead employees to prioritize safety over engaging in wellness that can put them in danger. For example, individuals from one organization whose headquarters is in a dangerous part of the city said that use of active transportation (e.g., biking to work), walking groups, and outdoor activities—even during the day—were not wise endeavors. Employees also did not feel safe venturing too far from work to find a food vendor that serves healthy foods and instead ate often unhealthy foods closer to work.

Organization-Level Decision Factors

¹⁷ Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: recent research and its implications for psychiatry. *World Psychiatry, 15*(2), 103-111.

As with the individual level decision factors, Barriers and Facilitators were labeled as pertaining to either Fit, Readiness, or Ability. At the organizational level, Fit refers to the degree of equivalence between the wellness initiatives and organizational capacities. Here, Readiness refers to willingness on behalf of the organization to effectively implement and sponsor wellness initiatives. Third, organizational Ability refers to the organization's capacity (financially or otherwise) to implement and sustain a wellness program or wellness-related initiative. In addition, we introduced a fourth category at the organizational level - Knowledge. The Knowledge category reflects any gaps in understanding that would prevent successful implementation of a wellness program in an organization. Finally, any factors that did not neatly fit into either of the four categories were labeled as Other.

Facilitators - Fit

Wellness initiatives align with organizational needs. The degree of overlap between the organization's broader needs and the content of wellness programs and activities matters. With this in mind, several organizations that we interviewed capitalized on employees' need for achievement and incorporated healthy peer-competition into their wellness programs, and in doing so, motivated employees to participate. For example, to appeal to employees' need for competition, some organizations set up a system where employees earned points based on the number of healthy activities (e.g., physical exercise) they engaged in during a specified time period (e.g., a month). Another organization hosted physical activity challenges (e.g., a wall sit) and healthy cooking competitions on-site during the workday. Beyond leveraging their competitive culture, other organizations focused on introducing wellness-related activities that could thrive based on their current point of social and organizational development. For example, the vast majority of organizations we interviewed (especially the relatively younger organizations) saw a need for establishing and maintaining quality connections between employees. These organizations therefore focused on implementing events that aimed to increase social connectedness among employees. Organized social events included a variety of formal and informal activities, ranging from attending a happy hour after work to a three-day employer-organized camping trip.

Some organizations simply provided benefits that would make a better work-life balance possible for employees. For example, one non-profit company with many young workers adjusted their benefits to include more generous parental (mother and father) leaves with a better reintegration process for when the parent was able to return to work. In addition, employees could have flexible schedules to account for things that come up at home or with an unreliable public transportation system. One employee said these benefits alone are the reason he has stayed with the company for 12 years, despite knowing he could be earning twice as much working somewhere else where it may not be as flexible.

Convenience. Wellness events were well attended when events were held at a time and place that fits employees' schedules. We collected many more instances of *inconvenient* scheduling as described below, but there were some exceptions. For example, one organization hosted healthy cooking competition on-site during work hours. This event was, in general, well attended. Other organizations offered access to gyms that were located within the building, and employees from other organizations who did not offer such on-site access lamented the fact. A couple of organizations offered on-site flu shots, an offering that was very well-received by employees who appreciated not needing to go to their doctor or pharmacy for a flu shot.

Reasonable work hours. Organizations that impose and monitor reasonable expectations for work hours have employees tend to have employees who are more inclined to engage in healthy behaviors because they have time to do so. For example, one organization interviewed had an unspoken policy on limiting overtime: *"We are also good at limiting overtime. Architects are famous for making people work overnight. We have grown beyond that."* This organization also understood that certain elements like a nap room would not actually be helpful to their employees—not because they do not need to rest and recharge, but because they believed that providing employees a place to sleep would be counterproductive to their goal of limiting work hours. In other words, leadership did not want to enable employees to work long days (and long nights) and would rather they have reasonable work hours. Employees at a start-up organization described how the work hours are almost forcibly long due to being in that early stage of company development. Some employees practice self-imposed work hour limitations by turning the notifications off on their phones in the evening, overnight, and on weekends. This helped to keep their stress levels low by resulting in a more manageable workload, as well as helped maintain good sleep habits. Although this was not a formal company policy, this strategy was pioneered by people in management who would presumably have an influence the introduction of such a policy in the future. Indeed, the company seemed to be heading in that direction.

Facilitators - Knowledge

Leadership understands the link between health and work outcomes. As mentioned above, many organizational leaders were skeptical of the utility of wellness programs for improving employee health outcomes, and in turn, organizationally valued outcomes such as performance. Indeed, for many organizational leaders, this negative perception was a critical first Barrier to entry. However, among those we interviewed, some leaders did seem to have an understanding of how employee health is related to valued outcomes such as productivity, engagement, and motivation. These individuals were quick to prioritize wellness initiatives, whereas the more skeptical leaders were slow to respond. In particular, leaders who understood the connection between health and work outcomes were generally more permissive in allowing employees to take

breaks for their health *because* they knew that these employees would still get their work done. This attitude was particularly true among organizations in industries where the risk for burnout is high (e.g., creative services, HR support, and customer service). An example is one leader who recognized that frequent travel can negatively impact health, so he advocated for eating well, exercising right, and having good sleep habits. Other organizations implemented wellness programs because the programs brought their organization together like a family, building trust and increasing job satisfaction. One organization realized the value in holding social events was in the way it knocked down “silos” in the organization, enabling the organization to run more efficiently overall.

Leadership understands employee needs and preferences. Once leaders understand the value of wellness initiatives in their organizations, a critical next step is understanding how to select wellness activities taking into account the needs and preferences of employees. Beyond understanding what types of programs employees consider helpful, leaders also need to determine which participation incentives employees consider most relevant and how they want to be recognized for their efforts. There are several ways to gain this knowledge. One approach is to survey employees directly; indeed, very few of the organizations interviewed administered employee feedback surveys. One organization did so in order to “personalize” wellness based on the nuances of their employee population. Another organization deployed a survey app to learn how to provide for employee needs and surveyed employees regularly to solicit feedback. They learned from their surveys that beyond providing equipment (such as an elliptical, ergonomic desk, or Fitbit), they also needed to provide employees with training on how to use that equipment most effectively.

A more common approach among the organizations we interviewed was to organize a dedicated wellness committee consisting of volunteer employees who met regularly to plan events, publish wellness newsletters, and represent employees’ interests generally to leadership. For many organizations, this committee was still early in development or in need of revival, but the desire was there.

Facilitators - Readiness

Leadership support. Within organizations, employee health and wellness—and participation in wellness-related initiatives—is enhanced to the degree that leaders at all levels provide active support for their workers. This support includes more active “cheerleading,” as well as demonstrating concern. For example, one employee said the following about his supervisor: *“I had my wisdom teeth pulled last week and our chairman texted me saying she wanted me to take the day off today, and was insistent about it.”* This employee—and others with similar experiences—suggested that this type of demonstrated concern made them feel more comfortable approaching their supervisors to make their health needs known. Leadership support is also made evident when leadership works to enact certain

policies and decisions—even if not part of a formal wellness program—that can affect employee health and well-being. For example, in several organizations, we heard about supervisors who approved flexible work arrangements for employees with a long commute, or who provided employees with an ergonomic chair or workstation upon request. Modeling healthy behavior is also an important demonstration of leadership support. Employees can be hesitant to take advantage of equipment, classes, or lessons even if it was sanctioned by leadership. One employee described how seeing leadership engaged in wellness changed her motivation to participate as well: *“I was initially afraid to take advantage of these initiatives because in my previous workplace we were talked about for using these facilities. For me, it took leadership modelling the behavior (going on a treadmill) to help me understand that it’s acceptable.”* Seeing leadership engage in wellness will often be that “permission” that employees are looking for to finally engage in wellness activities at work or take time for wellness during work.

Culture of health at work. As described above, an organization with a strong culture of health is one that promotes patterns of healthy behaviors among its employees. A culture of health mostly manifests through positive health values and attitudes toward health improvement and related programming. The majority of the companies we interviewed could not be described as having a culture of health; fortunately, there were exceptions. For example, one manager said: *“Our employees care about wellness and living an active lifestyle. It is integral to our company motto. Wellness is one of our strongest cultural competencies as a company.”* Other ways organizations could exhibit a culture of health are when employees value maintaining a healthy lifestyle and are actively engaged in a plan to improve their general health. For example, at one company, motivational programming to support healthy habits is encouraged, and personal success stories (e.g., losing 40 lbs. in a year) are put into the company newsletter and applauded. Consistent with the research literature, it became clear across focus groups that leadership plays an important role in promoting and maintaining a health-oriented culture: *“Our president and chairman is passionate about wellness, we do a lot for that cause.”* In particular, leaders who promote a culture of health are those who model healthy behavior (such as taking breaks from work, eating healthy, staying active) and who demonstrate a concern for the health of their employees by accommodating their needs.

Facilitators - Ability

Appeals to personal preferences. Programs are more likely to be successful when they are designed to match employee preferences. For example, one organization had a particularly physically active group of employees. Noting this, they created initiatives such as a company sports team and a physical activity tracking program that were compatible with employees’ interests rather than focusing on other types of initiatives (e.g., stress management). What appeals to employees can vary greatly. One individual may be most interested in stress

management whereas another is more concerned with healthy eating. The key appears to be appealing to employee interests in as many different ways as is possible, given the organization's resources. The critical point is, before an appeal can be made, preferences must be assessed. When it comes to assessment, some leaders at the relatively smaller organizations believed they had a distinct advantage compared to larger organizations because, due to their small size, they can sample preferences and needs more quickly and easily.

Built environment. The workspace itself can be designed for health and wellness. For instance, several of the organizations we interviewed had centralized, accessible stairwells, bike racks, height adjustable surfaces, outdoor physical activity options (e.g., walking paths) and nearby community fitness facilities, access to windows, healthy food vendors near the work location, and partial kitchen access during the work day. Some organizations even turn an empty office or conference room into a fitness room or resting room. As one employee said, *"Having it here is one less barrier for me. Even when I had a gym membership, I still used the cardio room because it's there and easy. Same with the healthy snacks. Just access to it is easy."* Many organizations had the opportunities for being healthy right outside their doors, but just lacked the facilities or the culture to make it usable. For example, one organization was surrounded by several sports fields, but one employee noted, *"We have something right across the street that would be perfect for exercise, but there's no facilities (changing room, lockers)."* Those organizations who were successful in their wellness efforts made sure that they supported using the built environment with necessary facilities, flexibility in scheduling, and a culture to support the behavior. For other organizations with an employee base that was partly or mostly remote, the strategic use of technology to connect employees expanded beyond facilitating work -- it facilitated relationship-building and a sense of community despite the physical divide. One organization demonstrated this well by promoting the use of video-conferencing software over phone calls to interact with remote workers, giving employees a chance to put names to faces and creating an opening for employees working from home to share parts of their family or home life with other co-workers if desired, such as introducing family members or commenting on personal touches in their home office.

Acknowledging low-cost options. Many of the small organizations we interviewed identified cost as the biggest Barrier to a thriving wellness program. While costs is a natural concern, it need not prevent an organization from implementing a program. Indeed, of the organizations we interviewed, the most successful ones were those that recognized that cost was an issue and came up with ways around it. For instance, one organization decided that, due to financial limitations, their wellness program would be a wellness "awareness" program, one that was primarily educational in nature. As such, they focused on distributing health resources to employees. Other organizations could not afford to have regular on-site exercise classes (i.e., held weekly) so instead they hired someone on a semi-

regular basis (e.g., monthly), which maintained employee motivation and was generally helpful, but less costly than a regularly-held class. In sum, organizations that recognized that wellness initiatives need not be costly, thrived.

Facilitators - Other

Strong communication system. One major Facilitator is the strength of the communication surrounding wellness. Specifically, organizations fared better when they used a variety of high quality methods to communicate about wellness (e.g., electronic calendar, email, centralized screen display, intranet). Beyond the communication medium, the general style of communication matters greatly. For instance, positive—as opposed to negative—messaging (e.g., “Participate to stay fit!” as opposed to “Participate to lose weight!”), was better received by employees. Also important is the communication process. If employees are involved in the decision-making when it comes to wellness, the program itself will be more successful and sustainable. One leader noted that *“You can’t plop down a structure that you just came up with. You need to build it together. The authenticity is the key.”* Employees were more likely to take advantage of any offerings when they perceived that leadership sponsored the initiative. Such sponsorship lets employees know that their participation is valued. Lastly, organizations that had strong communication systems took advantage of the onboarding process for new employees to inform employees about their ongoing wellness initiatives.

Barriers - Fit

Inconvenience. Many focus group participants identified inconvenient scheduling of wellness-related events and activities as a Barrier to entry. Scheduling was considered to be inconvenient for two primary reasons: either events were scheduled during work hours when employees were busy (e.g., in a meeting, interfacing with clients) or events were scheduled after work hours when individuals had personal plans (e.g., for leisure activities, family responsibilities). Such scheduling difficulties were exacerbated to the extent that events were planned at the last minute and employees were unable to plan in advance. In fact, several focus group participants indicated that they would have liked to attend events, but did not receive enough advance warning. For example, a teacher group described how information on wellness activities were known among office staff well in advance (for weeks) but the information was never shared with the teaching staff until the last minute. *“Sometimes we get the information the day before, and then I’m like ‘but I have an appointment, I can’t make it.’ If they let us know a week before at least, that would be great.”*

For some, the extra effort of having to leave the office was inconvenient. One participant said that even though her preferred well-equipped gym is nearby the office, she would use the smaller fitness room with a stationary bike and weights to work out, simply because it was closer. For those organizations that do not have on-

site fitness spaces like an on-site gym or on-site clinician, leaving the office can be perceived as inconvenient. An HR manager in a focus group noted that, “*Many times, employees don’t participate because it’s an inconvenience—making an appointment, going to a doctor, paying a co-pay even if it’s reasonable.*” Sometimes financial incentives are needed. At this organization, the leadership resorted to motivating employees to get a flu shot with a \$20 bonus.

Nature of Work. The type of work employees are engaged in can prevent them from participating, or from participating fully, in an organization’s wellness initiatives. For example, several organizations are primarily involved with client-facing work, putting their employees (or a subset of employees, such as the sales team) at the mercy of the client’s schedule. Client-facing work can also be demanding of employees in other ways, leaving them physically and emotionally drained and needing to recharge. For example, several organizations engaged with people in communities of need such as low-income populations, foster youth, or medical patients. In these cases, employees often did not have the energy to participate in the physical fitness or social activities offered in their organization. Similarly, employees in certain industries can be under the pressure of tight deadlines, making wellness a luxury. A focus group participant working at an advertising agency said: “*During busy times, even taking away 20 minutes from my desk would not be possible.*” Moreover, interdependent work can also pose problems. According to some focus group participants, the absence of one person from a small team of 4-6 people—even if simply to go to a doctor appointment during work hours—would impact the team and not go unnoticed, sometimes severely interrupting the workflow. To quote one focus group participant on this topic, “*Everybody wears many hats and it’s very hard to fill the gaps if people are gone.*” Moreover, participation in wellness programs can be impeded when an organization has a portion of its employees working remotely or who travel extensively. Choosing a wellness program or program elements can be challenging when there are very distinct employee groups within the organization, such as those in manufacturing or construction. As one employee observed: “*Sometimes it’s like we have two different companies: floor [(the manufacturing bench)] and carpet [(office admin)]. I think that’s how manufacturing is in general.*”

Barriers - Knowledge

Lack of clarity regarding the link between wellness programs and business outcomes. Several leaders interviewed suggested that they were hesitant to formally support and/or sponsor any wellness initiatives because they did not understand how it would be of value to the company. For those who espoused this view, wellness programs seem to be a good idea “in theory” but not in reality. Said differently, some employers were not convinced of the “business case” for employee wellness. This was categorized as a gap in knowledge because there is considerable support for the utility of promoting employee health. Other leaders were not convinced that wellness programs would solve employees’ health problems or

provide improved organizational outcomes beyond providing a competitive advantage with regards to recruitment and retention.

Concerns about funding. Perhaps not surprisingly, nearly all of the organizations we interviewed expressed concerns about not having the funds needed to implement a wellness program effectively. While having substantial financial resources can certainly help, all of these employers failed to realize that there are many cost-effective alternatives to relatively expensive wellness initiatives. For example, organizations expressed concerns that they could not afford to build an on-site gym, but did not consider checking if local gyms provide discounted membership rates for groups or organizations. Likewise, some organizations expressed an interest in stress management programs but did not believe they had the financial resources to hire a trainer or instructor for stress management programs. They did not consider how they might provide employees with access to free resources (e.g. YouTube videos, online instruction, podcasts) to address the same need. Indeed, as highlighted in the resources section of the employer guide that was produced as a part of this project, there are many ways that employers can effectively address employee health and well-being at little to no cost. An unusual concern about funding came up during a focus group concerning the impact of wellness program expense on profit-sharing, a bonus compensation system where employees receive a direct share of the company's profits. Participants from an organization that has a profit-sharing plan expressed concern that many employees would reject the idea of using any extra funds for a wellness program, which might not involve activities they are interested in and expend the funds they might have seen in a bonus.

Leadership issues. A number of knowledge-related leadership issues plagued organizations. First, one prevailing leadership attitude was that employees would take advantage of any wellness-related events, using them as an excuse to take time away from work. One leader clearly stated that wellness programs are in conflict with work responsibilities. Second, managers and leaders indicated that, although they could take action toward addressing employee health and wellness, such efforts would not be of any benefit to employees who lack the motivation to change. To quote one manager, "*We don't have any influence over those who don't particularly care.*" Some participants suggested they did not do more to promote employee health because of the high turnover rate of the employees at the organization, or the belief that a wellness program offered by one organization for a short time would be ineffective for both the employee and the organization. Leadership also believed that employees who worked two or even three jobs would not want to (or be able to) participate in wellness activities. Third, one small business owner seemed to take an "all or nothing" approach to wellness whereby she believed she needed to offer perks on a regular basis or not at all.

Lack of experience. In some cases, employers were interested in getting a program started, but progress was delayed because they did not know where to start, and had no prior experience in this area. For example, employees from one organization reported that leadership did not know how to handle employees when they were experiencing high levels of stress and took a reactive—rather than preventative—approach to stress management. On at least several occasions, the most senior leadership expressed a strong interest in a “how-to” guide or exemplar that they could use or look to create their own program. In fact, for these organizational leaders, so limited was their knowledge in this area, that simply providing them with the list of types of wellness programs (used as a handout during the focus groups) was seen as helpful. Other organizations had HR personnel who could theoretically implement a program, but these individuals did not have the background or practical knowledge to do so because they were promoted from within their organization without HR background or training.

Perceived lack of need. When asked why they did not do more to promote employee health, some focus group participants suggested that they did not do so because employees already managed their own health (by exercising, eating healthy, regularly visiting the doctor, etc.) and/or because they had already achieved high baseline health levels. This perception was especially pronounced within organizations with a relatively young employee population, and when interviewees were asked whether a tobacco cessation or alcohol management program would work well in their organization. Regarding the latter, there seemed to be a strong view that if alcohol and tobacco use was not visibly interfering with work, then it was not a problem that needed to be addressed.

Inaccurate perceptions of wellness program “failure.” We noted that some small organizations perceived their wellness-related events to be unsuccessful based on “low” participation rates. For example, one organization attempted to initiate a yoga class during the day but the activity organizers noticed it was not well attended and did not try it again. The reason for lower than usual attendance was not determined, however, some employees noted that the office is “a little dead” over the summer. Thus, while on the surface attendance may seem low, many organizations failed to realize that other factors, beyond lack of employee interest, contributed to low attendance. This perception of failure was, in several cases, unfortunate because it caused a vicious cycle whereby activity planners noted lack of participation and decided that this meant lack of interest among employees, which prevented any future event planning.

Confusion about insurance. One of the most basic forms of knowledge gaps was in regards to health insurance. Specifically, within some organizations, employees at all levels (including human resources and management) were simply unaware of the ways in which they could use their insurance provider to assist with wellness endeavors (e.g., on-site biometric screenings, discounted gym

memberships, information for new mothers, resources for stress management, etc.). In many cases, our conversation prompted them to consider that it could be worth looking into. At a company that uses an HR broker to help ease the workload for their HR staff, an employee confessed, *“I don’t think we’ve ever gone over what’s offered [by insurance], to be honest we’re confused about what’s offered.”* Part of the reason for this confusion is that, by using an HR broker to deal directly with employees and insurance, the organization is no longer “in the loop” about insurance and wellness offerings. Another reason for confusion about insurance can stem from there being “too many insurance options” that are offered to employees. For example, an organization interviewed has been using Tri-Net because of the greater number of options afforded for a small-sized company, but this has resulted in the *“HR group not having much control... and there has been much miscommunication.”* This organization is growing to the point where it can afford to leave the Tri-Net group, which will result in HR having more control over plans offered.

A related confusion came from a lack of knowledge regarding their employment status and rights to breaks. For example, one employee did not know if she was exempt or non-exempt, and if taking time for wellness during the day was “on the organization’s dime” and she would have to make up the time she spent participating in wellness, or if it was built in to her day.

Barriers - Readiness

Lack of clear ownership. One of the most prevalent issues within the organizations we interviewed was a clear lack of ownership, meaning there was no clear designation employee or group of employees responsible for planning and organizing wellness activities. For example, in one organization, human resources thought leadership was responsible for planning wellness, and vice versa, leadership thought human resources was in charge. This resulted in general confusion among employees about who to approach with wellness-related concerns. When asked who they would approach about with questions about wellness initiatives, one employee said *“We would go to HR or Finance. HR asks to ask finance. Like mom and dad—does mom approve? If mom approves, dad approves.”* As described below, this lack of ownership often resulted in an employee-owned grassroots effort.

Lack of active and consistent leadership support. Put simply, leaders can say they support employee health, but where the “rubber meets the road” is the degree of explicit encouragement expressed by leaders. For example, employees in one organization indicated that their supervisors were relatively mute in terms of their support of employee health. Noting this, some employees reported feeling uncomfortable asking their direct supervisors for relatively simple accommodations (such as leaving work for a doctor appointment) and/or felt reluctant to participate in scheduled on-site wellness activities for fear that their supervisor did not approve of them taking a break. Some organizations had the attitude that wellness

programs (i.e., preventative health) was not the purview of employers, and as such employees revealed that *“The conversation [on wellness] only starts when someone is burned out.”* Related, some employees indicated that they received the greatest amount of instrumental support from human resources rather than their direct supervisors. Moreover, supervisor support was often inconsistent within organizations, with some employees reporting supportive supervisors and others indicating that their supervisors were challenging in this respect. One reason for this lack of active support was poor leadership attitudes. Specifically, some managers were quick to state that they did not believe that they are responsible for addressing the wellness of employees. Likewise, some leaders saw a role for the organization, but believed that they could only do so much to promote employee health in part because the organization was small and lacked financial resources.

Lack of culture of health. An organization with a strong culture of health is one in which the employer places a high value on employee health and well-being as a part of the company’s core values. Several organizations did not embody such a culture, instead emphasizing performance to the neglect of employee wellness needs. This cultural atmosphere often resulted in a disconnect between work and wellness, with employees at all levels (i.e., from direct reports to CEOs) viewing work and wellness as two incompatible goals. For some organizations, the concept of wellness was new or was not yet accepted, as was the case with one East Coast company where leadership acknowledged that their company had not caught up yet to the culture of “West Coast wellness and meditation.” Still, in some organizations, employees felt they could take wellness breaks, but did not because their culture made it evident that there were inequitable wellness opportunities. Specifically, employees with tenure or with a stronger performance record felt comfortable taking a break whereas others still needed to “prove themselves” prior to doing so. Similarly, employees in such organizations expressed guilt about taking time for wellness because they felt pressured to prioritize work above all else. In some cases, the organization perpetuated a culture of unhealthy behaviors in order to be competitive or respond to workload demands, such as a culture of pulling all-nighters in one organization. Leadership played a critical role to this culture. Beyond emphasizing a performance culture, leaders did not model healthy behavior (e.g., smoking) and/or enabled unhealthy behaviors (ordering pizza for lunch). Indeed, in one organization, employees joked that the only way to get a meeting with the CEO was to “start smoking.”

Low morale. Finally, some organizations were not ready to take charge of programs fully due to the current atmosphere within the company. One company, in particular, had recently undergone two major reductions in force that left many employees feeling uncertain about their future at the company and about the company’s potential for growth. An upcoming “refresh” was planned, the goal of which was, in part, to reset the company culture and to reinvigorate spirits; however, to quote employees, this seemed “like a façade.” Another source of low

morale was tension with management resulting from their lack of understanding of the job demands of employees everyday work tasks. For example, school teachers from one focus group felt like the administrative staff did not understand that they needed to provide constant oversight of their students. This lack of understanding resulted in a disconnect when it came to allowing employees to balance personal health with their work tasks. Specifically, administrative staff expected them to be able to engage in activities when in fact their job structure and responsibilities would not allow them to. Presumably, garnering the motivation needed to get employees interested in wellness would be difficult in this type of negative work environment. Indeed, some employees at an organization without a wellness program were so demoralized by their work and treatment from leadership that they likened their work environment to a prison: “*We have multiple sites, one looks like a prison.*”

Barriers - Ability

Lack of financial resources. Several small organizations were indeed limited in their ability to support financially wellness initiatives (however, as mentioned above, there are ways that employers can effectively address employee health and well-being at little to no cost). To quote one manager, “*We can’t afford to do any more than what we are already doing.*” For many, this meant that organizations were either unable to directly support wellness initiatives (e.g., healthy food and beverage options) and/or unable to support indirect costs (e.g., hiring an employee to organize and plan wellness initiatives). In many cases, these limitations were linked to the organization’s maturity as a company. For example, employees at the younger, start-up companies we interviewed mentioned that, at this point in their development as a company, they are “*just trying to stay afloat.*” Some organizations had financial resources to devote to wellness program activities, but had difficulty justifying the adoption of certain programs if they thought that so few people were going to use it. This stems from the Leadership being aware that even one fewer participant in a small organization is a “big” drop in participation.

Long work hours. Long work hours result in difficulty making time to spend doing wellness-related activities. People need time to engage in wellness throughout the day, whether it is taking part in a screening, taking a social break, or going to the gym. The vast majority of employees we interviewed indicated they work long hours, whether as part of the job description (such as a store clerk or lab technician working 10-12 hour shifts) or due to their workload (such as a salesperson or fundraiser constantly needing to finish paperwork before deadlines), or they travel for work and have limited time to schedule breaks from work.

Employees occupy multiple roles. Within some small companies, employees are limited in their ability to participate because they occupy multiple roles. One organization, for instance, was not yet able to afford hiring staff to take care of ancillary — yet necessary — tasks such as janitorial work or fixing computer

problems. In this sense, employees are sometimes spread quite thin across roles, and, as a result, have difficulty making the time for their health when there are so many other tasks needing their attention.

Failure to take full advantage of insurance. We noted that, within small organizations, human resources employees often have multiple responsibilities and their time is extremely divided. A critical wellness-related responsibility lies in creating and maintaining relationships with insurance brokers. Brokers are the third-party individuals or entities who can serve to inform organizations on the best insurance options and packages. Without having developed this relationship, organizations miss personalized programming, as well as up-to-date information such as perk and subsidy options. For example, if an organization sees an increase in size, a broker is the one who would analyze how well the current plan fits the organization and suggest options for insurance moving forward.

Bureaucratic and logistical issues. Several bureaucratic and logistical issues prevent full participation in wellness initiatives. Some organizations communication channels served to prevent or discourage activities from being scheduled or communicated in a timely manner. As one focus group participant said, “*Anything with administrative implications (e.g., payroll, permission to leave, coordination across groups)—seems to be what stops the introduction of wellness programs.*” In one education organization, any communication between the regional support office and the regional schools must go through the organization’s CEO. This set up often resulted in delays in the organization of events. Since it was much easier to suggest and implement wellness activities for the regional support office than it was for the schools, the organization resulted in a well-built program for the regional support office and a meager and inconsistent program for the schools. For other organizations, a third party (such as a broker) either slowed action or diffused information. Logistical issues emerged as because an organization had multiple locations with each having different cultures and types of workers. These organizations found it challenging to execute one cohesive wellness program across the organization. Lastly, we saw instances in which organizations used a tedious manual—rather than electronic—behavior tracking system, which employees reported interfered with participation.

Barriers - Other

Poor communication. Problems with communication were common among the organizations we interviewed. These issues manifested in a number of different ways. At the most basic level, the method and/or quality of the chosen communication method was less than ideal (e.g., irregular, informal, word-of-mouth, ad-hoc, untimely, diffused, and communicated as mandatory (vs. optional). One organization communicated their wellness activities through a company calendar; however, one employee lamented that, “*Some people don’t even know that there is a company calendar.*” Other organizations lacked an official mechanism that

leadership could use to communicate about wellness and/or did not offer a centralized, repository of information (for event scheduling, to communicate what services are covered by insurance, etc.) for employees to access. One employee observed about their piecemeal program that, *“These programs seem to be pieces that are separated and random. It would be great if leadership could be on board with it and if these can all be put in one package and communicated as a whole.”* A couple of organizations with more established programs did not take advantage of the employee onboarding process as a way of communicating what the organization offers. Instead, they focused only on communicating information about insurance and benefits. Other organizations that did try to communicate wellness offerings often overwhelmed employees with too much information at once and in a way that is not user-friendly, rendering the information lost from the start. For example, an employee at an organization that provides health insurance, EAP, and gym subsidy said, *“When employees come in, they’re given a benefits folder. I’m sure [EAP] is in there, but not everyone reads through 55 pages of paper.”* Lastly, some organizations did not clearly communicate the motivations for a given activity (e.g., meditation for stress reduction, a volunteer event to help with team building). In these cases, participation was hampered, in part because employees were not clear on the purpose.

Concerns about liability. At least one organization was reluctant to sponsor certain wellness-related activities (i.e., an outdoor sporting event) because they feared that they would be liable for any adverse events (e.g., an injury) that might occur.

Insights and Conclusions

The focus groups revealed that small and medium organizations face many of the same Barriers to implementing wellness programs and engaging employees. However, the industry (e.g., architecture vs. sales and marketing), organization size (e.g., 5 employees vs. 200 employees), and type of work (e.g., product development vs. education) often resulted in a specific set of Barriers. Some of the organizations we interviewed were struggling to find a program that would fit with their employees, be worth the effort, and improve — not only employee health — but also organizational outcomes (e.g., productivity, job satisfaction, and turnover). Other organizations were resourceful and opportunistic, sometimes bringing ideas of wellness programs and program elements from their past experiences at other organizations. Despite the specific needs of these very different organizations, some themes emerged across both Facilitators and Barriers: Leadership Support, Culture of Health, Communication, Stress Management, and Social Connectedness.

Leadership Support and Culture of Health were closely intertwined. Specifically, as evidenced above, the actions of leaders who are invested in and support wellness endeavors helps to create a culture of health that, in turn, serves as a strong Facilitator of employee participation. On the contrary, lack of leadership

support is a powerful Barrier against successful implementation and participation in wellness activities.

Another main theme was Communication. We saw many examples of breakdowns in communication between insurance, HR, management, and employees. First, information from insurance companies was sometimes not being communicated to HR (either because the organization did not have a dedicated HR person to investigate what was being offered, or because the organization worked with an HR broker). This meant that organizations did not know what was being offered. Second, HR/leadership did not have a system of communication for wellness-related information, did not communicate consistently to employees, or did not have a repository of wellness information. This resulted in an imbalance of information—HR/leadership would have information on insurance-resources and benefits, health education, and wellness program activities, but employees would not be aware of these resources. When communication was clear, many organizations did not have a mechanism for tracking participation or soliciting feedback from employees in order to evaluate the program's fit with an often diverse and dynamic workforce. Organizations that did have a tracking mechanism were able to provide evidence for maintaining an activity or suggesting a new one. Organizations with strong communication between HR/leadership and their employees were also more confident about launching a new activity or initiative because such strong communication took the “guesswork” and “risk” out of wellness.

Stress Management was identified as a much-needed area of focus for employees across industries and job types. Causes of stress were mostly related to workload and (lack of) time. Many organizations who successfully addressed stress management in their wellness activities have leaders who recognize the connection between addressing health and well-being and employee productivity. Some organizations enforced reasonable work hours, some leaders encouraged taking vacation time as needed, and some organizations created a culture around taking lunch with others to get away from work. Other organizations, if unable to change the job-related stressors because of the nature of the work, promoted social connections among employees or resources for stress management at home, such as meditation.

Finally, Social Connectedness was a major theme. Many of these smaller organizations do much to enhance social connections because they are small enough that employees can easily get to know others within the organization. In addition, many leaders of smaller organizations touted that it was easy for employees to approach them—as one leader mentioned, “*There’s no ivory tower here.*” This is possibly due to the fact that smaller organizations can have looser hierarchy and perhaps need their employees to fulfill multiple roles—a Barrier that was mentioned above.

Harris Survey Sponsored by TCHS

Description of the Harris Survey

Results from two surveys collected within the United States by Harris Poll on behalf of the Transamerica Center for Health Studies were analyzed. The two surveys were an employer survey and an employee survey. Both surveys were approximately 20 minutes in length and were administered online. The employer survey was taken by employer decision makers from for-profit organizations occupying the following roles: Owner, CEO/Chairman, President, Director of HR, Benefits Manager, other HR professional responsible for employee benefits, or other professional responsible for employee benefits. The employee survey was taken by individuals employed by for-profit organizations, non-profit organizations, or government entities. The employer survey was conducted July 25 to August 10, 2017 and the employee survey was conducted July 19 to August 2, 2017.

ICHW Analysis Goals

We analyzed the results of both surveys based on organization size because we were interested in whether responses would differ as a function of whether the organization was small vs. medium vs. large. Specifically, questions relevant to participation in wellness programs were pulled for analysis.

Employer Survey Results by Organization Size

Demographics

Individuals representing 1,520 companies¹⁸ filled out the employer survey. These respondents were, on average, 41.8 years of age ($SD = 12.2$). Gender composition of the sample was 43.4% male, 56.9% female, and 0.1% transgender and .2% other. Additional demographic information is detailed below:

Job Titles:

- Owner: 754 (49.6%)
- CEO/Chairman: 141 (9.3%)
- President: 67 (4.4%)
- Director of HR: 379 (24.9%)
- Benefits Manager: 107 (7.0%)
- Other HR professional responsible for employee benefits: 30 (2.0%)
- Other professional responsible for employee benefits: 42 (2.8%)

¹⁸ 100% of respondents represented for-profit organizations as opposed to non-profit or government enterprises.

Total number and sizes¹⁹ of organizations represented:

Small: 685 (45.1%)

Medium: 342 (22.5%)

Large: 493 (32.4%)

Industries represented:

Manufacturing: 201 (13.2%)

Agriculture, mining, or construction: (116) 7.6%

Transportation, communications, or utilities: 76 (5.0%)

Professional services (finance, legal, engineering, healthcare): 504 (33.2%)

Service (e.g., retail, hospitality, administrative): 190 (12.5%)

Other: 433 (28.5%)

Q4000_1 - Q4000_5: Are you...? [response options:] Male; Female; Transgender; Other.

Q280: Respondent Age [keyed entry].

Q640: What best describes the company or organization you work for?

Q605: What is your title with your company?

Q645: Which industry category best describes your company's primary business?

Q612: Including yourself, what is your company's total number of active employees based in the United States, including all branches and locations, as well as full-time and part-time employees?²⁰

Wellness Programs Offered

A total of 839 (55.2%) businesses offer a wellness/health promotion program. Specifically, 169 of 685 small companies (24.7%), 263 of 342 medium companies (76.9%), and 407 of 493 large companies (82.6%). These results suggest that, consistent with expectations, large companies are most likely to offer a formal wellness program, followed by medium and small companies. Further, similarly high percentages of medium and large companies offer wellness programs, whereas the percentage of small organizations offering wellness programs is comparatively much lower.

Data regarding the utilization of 15 identified wellness program elements was also analyzed by company size. Table 5 below summarizes the total number of small, medium, and large businesses offering 15 identified wellness program elements.

¹⁹ Throughout this section, small organizations are considered those with 1-49 employees, medium organizations are those with 49-499 employees, and large organizations are those with 500 or more employees.

²⁰ Prior to conducting analyses, this question was recoded into small, medium, and large organizations.

Table 5
Total Number of Small, Medium, and Large Businesses Offering 15 Identified Wellness Program Elements

Wellness Program Element	Small		Medium		Large	
	Total	%	Total	%	Total	%
Healthy food/drink offerings (in cafeteria, vending machine, etc.)	93	55.0	114	43.3	196	48.2
Integration of health promotion into culture	75	44.4	116	44.1	190	46.7
Clinical screenings and biometric assessment	47	27.8	109	41.4	162	39.8
Health education - general pamphlets, informational meetings, online tips and messages	74	43.8	123	46.8	204	50.1
Health education - skills development and behavior change classes	96	56.8	158	60.1	247	60.7
Health advice from a qualified vendor (e.g., coach, health professional, etc.)	63	37.3	106	40.3	185	42.2
Individual mental or physical health tracking through device or online program	38	22.5	63	24.0	133	32.7
Targeted behavior change program (e.g., smoking cessation, weight management)	54	32.0	85	32.3	162	39.8
Social engagement (e.g., social clubs, interest groups, sports teams, etc.)	56	33.1	80	30.4	145	35.6
Mindfulness, meditation, yoga, relaxation training	48	28.4	64	24.3	132	32.4
Links to related employee services for support with personal issues (i.e., EAP)	65	38.5	99	37.6	207	50.9
Ergonomic furniture/equipment	41	24.3	77	29.3	127	31.2
Subsidized gym memberships	59	34.9	75	28.5	146	35.9
Fitness gym facilities or outdoor exercise areas	55	32.5	91	34.6	160	39.3
Supportive physical and social environment (e.g., tobacco-free policies)	100	59.2	152	57.8	233	57.2

Note. 169, 263, and 407 individuals from small, medium, and large organizations endorsed having a wellness program.

This table also indicates the most and least popular program elements in small, medium, and large businesses, where popularity refers to the percentage of organizations offering the program element. The “top three” most and least popular elements by organization size can be summarized as follows:

Most popular elements:

Small businesses:

- 1) Supportive physical and social environment (e.g., tobacco-free policies) (59.2%)
- 2) Health education - skills development and behavior change classes (56.8%)
- 3) Healthy food/drink offerings (55%)

Medium businesses:

- 1) Health education - skills development and behavior change classes (60.1%)
- 2) Supportive physical and social environment (57.8%)
- 3) Health education - general pamphlets, informational meetings, online tips and messages (46.8%)

Large businesses:

- 1) Health education - skills development and behavior change classes (60.7%)
- 2) Supportive physical and social environment (57.2%)
- 3) Links to related employee services for support with personal issues (i.e., EAP) (50.9%)

Least popular elements

Small businesses

- 1) Individual mental or physical health tracking through device or online program (22.5%)
- 2) Ergonomic furniture/equipment (24.3%)
- 3) Clinical screenings/biometric assessments (27.8%)

Medium businesses:

- 1) Individual mental or physical health tracking through device or online program (24.0%)
- 2) Mindfulness, meditation, yoga, relaxation training (24.3%)
- 3) Subsidized gym memberships (28.5%)

Large businesses:

- 1) Ergonomic furniture/equipment (31.2%)
- 2) Mindfulness, meditation, yoga, relaxation training (32.4%)
- 3) Individual mental or physical health tracking through device or online program (32.7%)

Q821: Does your company offer a wellness (health promotion) program?

Q822_1 - Q822_12: What type of wellness program do you offer?

Types of Employees Participating in Wellness Programs

Table 6 below shows the types of employees organizational representatives reported as participating in wellness programs. The greatest percentage of small, medium, and large organizational representatives reported that managers participated in wellness programs, followed by professionals and hourly workers. Comparatively smaller percentages of organizational representatives (from organizations of all sizes) reported participation among the C-suite and contractors.

With the exception of workers falling into the “other” category, a greater percentage of large company representatives reported participation among all types of workers.

Table 6

Types of Employees Reported as Participating in Wellness Programs

Employee Status	Small		Medium		Large	
	Total	%	Total	%	Total	%
Hourly workers	109	64.5	171	65	265	65.1
Professionals	94	55.6	190	72.7	325	79.9
Managers	117	69.2	194	73.8	332	81.6
C-suite	67	39.6	113	43	199	48.9
Contractors	37	21.9	72	27.4	130	31.9
Others	14	8.3	17	6.5	19	4.7

Note. 169, 263, and 407 individuals from small, medium, and large organizations endorsed having a wellness program.

Q823A_1 - Q823A_6: Who participates in your wellness programs?

Levels of Participation

Tables 7 and 8 below describe the lowest and highest reported levels of participation in any given wellness program element offered (those listed in Table 5) by company size. The greatest percentage of small organizational representatives reported highest participation rates of 50% or higher, whereas representatives from medium and large organizations reported highest participation rates of 21-40% and 41-50%, respectively. This might suggest that, although wellness programs are difficult to implement in small organizations, once initiated, they see higher levels of participation.

In terms of lowest participation rates, the greatest percentage of organizational representatives (from organizations of all sizes) reported lowest participation rates between 11-40%.

Table 7

Lowest Reported Levels of Participation in any Given Wellness Program Element Offered

Lowest Reported Participation Levels	Small		Medium		Large	
	Total	%	Total	%	Total	%
< 10%	37	21.9	29	11	44	10.8
11-20%	38	22.5	52	19.8	120	29.5
21-40%	40	23.7	89	33.8	89	21.9
41-50%	24	14.2	61	23.2	74	18.2
> 50%	18	10.7	31	11.8	73	17.9

Note. 169, 263, and 407 individuals from small, medium, and large organizations endorsed having a wellness program. Unaccounted for percentages reflect respondents who indicated that question was "not applicable."

Table 8
Highest Reported Levels of Participation in any Given Wellness Program Element Offered

Highest Reported Participation Levels	Small		Medium		Large	
	Total	%	Total	%	Total	%
< 10%	3	1.8	3	1.1	5	1.2
11-20%	9	5.3	13	4.9	26	6.4
21-40%	52	30.8	91	34.6	104	29.4
41-50%	43	25.4	86	32.7	139	34.2
> 50%	61	36.1	70	26.6	132	32.4

Note. 169, 263, and 407 individuals from small, medium, and large organizations endorsed having a wellness program. Unaccounted for percentages reflect respondents who indicated that question was "not applicable."

Q822A: What percentage best describes the highest level of employee participation in any wellness program you offer?

Q822B: What percentage best describes the lowest level of employee participation in any wellness program you offer?

Presence of Key Features Supporting Wellness Programs

Table 9 shows the average reported presence of key features of wellness programs, ranging from leadership support to measurement and evaluation of effectiveness. In particular, all organizations highly value leadership commitment and support for wellness programs, a culture that supports employee wellness, and organizational support for a healthy lifestyle.

Table 9
Average Reported Presence of Key Features of Wellness Programs

Wellness Program Feature	Small	Medium	Large
Leadership commitment and support for the program	3.28 (.85)	3.39 (.70)	3.43 (.71)
A culture that supports employee wellness	3.38 (.76)	3.35 (.71)	3.44 (.67)
Financial incentives for program participation	3.02 (1.02)	3.12 (.83)	3.26 (.82)
Non-financial incentives for program participation	3.04 (.98)	3.21 (.80)	3.24 (.76)
Peer support for program participation	3.14 (.85)	3.21 (.76)	3.32 (.75)
Employee involvement in program design	3.11 (.85)	3.22 (.78)	3.28 (.72)

Manager support for participation in program during work time	3.16 (.86)	3.29 (.75)	3.38 (.77)
Programs tailored to employees' needs and interests	3.22 (.82)	3.28 (.71)	3.34 (.73)
Organizational support for a healthy lifestyle	3.40 (.74)	3.34 (.73)	3.41 (.70)
Benefit plan design that encourages preventive screenings	3.12 (.89)	3.30 (.77)	3.38 (.70)
Measurement and evaluation of program effectiveness	3.08 (.87)	3.30 (.72)	3.33 (.75)
Measurement of the degree of participation in the program	3.12 (.91)	3.26 (.72)	3.35 (.70)
Process for obtaining feedback from employees on program desirability	3.18 (.87)	3.28 (.71)	3.37 (.74)

Note. Standard deviation appears in parentheses. Responses were reported on a 4 point scale where 1=not at all present, 2=not very present, 3=somewhat present, 4=completely present.

Q823C_1 - Q822_13: Please rate the extent to which each of the following is present in your wellness program.

Estimated Impact of Wellness Programs on Organizational Outcomes

Respondents estimated the impact (either negative, neutral, or positive) that they believed their workplace health promotion had on a variety of organizational outcomes. Table 10 shows the results of this analysis as a function of organizational size. For organizations of all sizes, most respondents believed that programs had a positive—rather than negative or neutral—impact. Moreover, respondents from organizations of all sizes were most likely to view a positive connection between wellness programs and the following outcomes: worker health, job performance and productivity, organizational commitment, and job satisfaction. Of note, a substantial percentage of respondents viewed programs as having a neutral effect and some (albeit a small percentage) viewed programs as having a negative effect. In general, these findings mirror the perceptions we observed in our focus groups.

Independent samples t tests were performed to compare small and medium companies to large companies on a number of employer concerns about wellness programs. Results indicated that, compared to small and medium companies, large companies reported significantly higher levels of concern about the following: 1) the amount of the amount of time needed for employees to take advantage of the

Table 10

Estimated Impact of Workplace Health Promotion on Organizationally-Valued Outcomes

Outcome	Small			Medium			Large		
	Negative Effect	Neutral Effect	Positive Effect	Negative Effect	Neutral Effect	Positive Effect	Negative Effect	Neutral Effect	Positive Effect
Worker health	1.2% (2)	16% (27)	80.5% (136)	2.7% (7)	24.7% (65)	71.5% (188)	1.0% (4)	16.7% (68)	79.6% (324)
Healthcare costs	4.1% (7)	29.6% (50)	59.8% (101)	3.0% (8)	24.7% (65)	70.3% (185)	2.2% (9)	23.8% (97)	71.3% (290)
Performance and productivity	1.2% (2)	18.3% (31)	76.9% (130)	1.1% (3)	21.3% (56)	76.0% (200)	1.7% (7)	19.7% (80)	74.4% (303)
Job satisfaction	0.6% (1)	20.1% (34)	74.6% (126)	2.7% (7)	25.1% (66)	70.0% (184)	0.5% (2)	19.7% (80)	75.4% (307)
Organizational commitment	0% (0)	20.7% (35)	75.7% (128)	1.9% (5)	23.2% (61)	73.4% (193)	1.2% (5)	21.6% (88)	72.7% (296)
Turnover	3.6% (6)	29.6% (50)	60.4% (102)	1.5% (4)	32.4% (90)	61.6% (162)	2.0% (8)	32.2% (131)	62.9% (256)
Absenteeism	6.5% (11)	30.8% (52)	57.4% (97)	4.6% (12)	32.3% (85)	59.7% (157)	2.2% (9)	35.1% (143)	59.5% (242)

Note. 169, 263, and 407 individuals from small, medium, and large organizations endorsed having a wellness program. Number in parentheses refers to the total number of company representatives endorsing the response.

wellness program(s) ($t(1518) = -9.97, p < .01$); 2) the degree of manager support for employees who want to participate in wellness programs during work time ($t(1518) = -9.30, p < .01$); and 3) improving the health and well-being of employees in tangible ways at work ($t(1518) = -6.46, p < .01$).

This finding, although counterintuitive may suggest that large organizations have a unique set of issues related to the number of employees they have to serve in this manner. That is, the logistical/management requirements needed to implement wellness programs properly in large organizations is much greater compared to small and medium organizations.

Q824_1 - Q824_7: What impact has your workplace health promotion program had on...?

Q923_3 - Q923_5: How concerned is your company about the following?

Strategies for Countering Concerns about Employees' Ability to Participate in Wellness Programs

Survey respondents reported the strategies that were being used in reaction to concerns about employees' ability to participate in such programs. As shown in Table 11 below, a larger percentage of small organization representatives report "not doing anything" in responses to concerns. In addition, all four strategies are utilized at much lower rates compared to medium and large organizations. Among small organizations, the least utilized strategy is talking to managers about allowing employees to participate.

Table 11

Strategies for Countering Concerns about Employees' Ability to Participate in Wellness Programs

Strategy	Small		Medium		Large	
	Total	%	Total	%	Total	%
Talking to managers about allowing employees to participate without negative repercussions	101	17.8	154	52.8	218	45.2
Creating a company culture that supports employees' efforts to improve their health and well being	171	30.2	157	48.2	244	50.6
Communicating to employees the importance of participating	157	27.7	159	48.8	254	52.7
Offering incentives to make participation more likely	121	21.4	146	44.8	250	51.9
Not doing anything different	257	45.4	33	10.1	35	7.3

Note. $N = 566, 326, \text{ and } 482$ for small, medium, and large businesses, respectively.

Q925A_1 - Q925A_5: What are you currently doing in reaction to your concern about employees' ability to participate in wellness programs?

Reasons for Not Offering Wellness Programs

Table 12 shows the reasons that small, medium, and large organizations are not likely to offer a wellness program. Greater percentages of employees from medium and large organizations were unlikely to do so because the company was concerned about the cost of the program, whereas small companies simply said that the “organization was not big enough”. Large percentages of representatives from small and medium organizations also said that programs were not implemented because employees were not interested.

Table 12

Reasons Businesses Do Not Offer a Wellness Program

Wellness Program Element	Small		Medium		Large	
	Total	%	Total	%	Total	%
Company encountering business difficulties	31	5.6	38	17.4	35	7.1
Company not big enough	276	49.8	32	14.7	36	13.9
Company or management is not interested	62	11.2	39	17.9	41	15.8
Company is concerned about the cost of a program	77	13.9	58	26.6	56	21.6
Concerned about the resources needed to administer and monitor a wellness program	39	7	39	17.9	49	9.9
Concerned about fiduciary liability	29	5.2	44	20.2	38	7.7
Employees are not interested	128	23.1	47	21.6	59	12
Employees don't have time to participate	55	9.9	36	16.5	42	8.5
Employees can't afford the cost of participation in the program	54	9.7	36	16.5	42	8.5
The employee coverage mandate does not apply to my company	78	14.1	30	13.8	39	15.1
Other	51	7.4	9	4.1	8	1.6
Don't know	49	7.2	9	4.1	29	11.2

Note. N = 554, 218, and 259 for small, medium, and large businesses, respectively.

Q1032_1 - Q1032_12: What are the reasons that your company is not likely to offer a wellness program?

Employee Survey Results by Organization Size

Demographics

A total of 2,892 individuals²¹ filled out the employee survey. These respondents were, on average, 41.9 years of age ($SD = 12.4$). Gender composition of the sample was 57.7% male, 42.7% female, and 0.1% transgender and .2% other. Additional demographic information collected at both the individual and organizational levels is detailed below:

Race/Ethnicity:

African American or Black: 238 (8.2%)
Asian: 252 (8.7%)
Caucasian: 2064 (71.4%)
Hispanic: 263 (9.1%)
Mixed Race: 3 (.1%)
Native American or Alaskan Native: 15 (.5%)
Pacific Islander: 5 (.2%)
Other: 26 (.9%)
Declined to Answer: 26 (.9%)

Employment Status:

Full time: 2131 (73.7%)
Part-time: 497 (17.2%)
Self-employed: 252 (8.7%)
Independent contractor: 12 (.4%)

Total numbers and sizes of organizations represented: 2,887²²

Small: 882 (30.5%)
Medium: 698 (24.1%)
Large: 1307 (45.2%)

Industries represented:

Manufacturing: 241 (8.3%)
Agriculture, mining, or construction: 85 (2.9%)
Transportation, communications, or utilities: 111 (3.8%)
Professional services (finance, legal, engineering, healthcare): 468 (16.2%)
Service (e.g., retail, hospitality, administrative): 371 (12.8%)
Education: 63 (2.2%)
Other: 572 (19.8%)

²¹ Individuals who were unemployed, students, or retired were excluded from the analysis.

Throughout this section, any discrepancies between the total number of survey respondents (2,892) and totals within a given section (e.g., industry) reflects a missing response.

²² Five individuals did not report organization size.

Types of Organization:

For-profit: 1911 (66.1%)

Non-profit: 566 (19.6%)

Government: 410 (14.2%)

Q268NEW_1 - Q4000_4: Are you...? [response options:] Male; Female; Transgender; Other.

Q280: Respondent Age [keyed entry].

Q485: Racial Background [keyed entry].

Q1410: Which one of the following best describes your employment status?

Q1950: What best describes the company or organization you work for?

Q1955: Which industry category best describes your company's primary business?

QS600: How many people work full-time at your organization or company in the US²³

Wellness Programs Offered

A total of 1,133 (39.4%) businesses offer a wellness/health promotion program. Specifically, 151 of 882 small companies (17.1%), 290 of 698 medium companies (41.5%), and 692 of 1,307 large companies (52.9%). These results suggest that, consistent with expectations, large companies are most likely to offer a formal wellness program, followed by medium and small companies. Further, similarly high percentages of medium and large companies offer wellness programs, whereas the percentage of small organizations offering wellness programs is comparatively much lower.

Table 13 shows the total number of employees indicating that their organization offers any of the following 17 wellness program elements.

The “top three” most and least popular elements by organization size can be summarized as follows:

Most popular elements:

Small organizations:

- 1) Exercise programs (61.6%)
- 2) Monitoring of health goals/biometrics (60.9%)
- 3) Preventative screenings and vaccinations (57.6%)

Medium organizations:

- 1) Monitoring of health goals/biometrics (66.2%)
- 2) Exercise programs (63.4%)
- 3) Preventative screenings and vaccinations (62.4%)

²³ As with the employer survey, prior to conducting analyses, this question was recoded into small, medium, and large organizations.

Table 13

Total Number of Employees Indicating That Their Organization Offers Any of 17 Identified Wellness Program Elements

Wellness Program Element	Small		Medium		Large	
	Total	%	Total	%	Total	%
Preventative screenings and vaccinations	87	57.6	181	62.4	474	68.5
Exercise programs - either on-site or discounts for local gyms	93	61.6	184	63.4	432	62.4
On-site health clinic - for routine visits at my office	66	43.7	136	46.9	266	38.4
Monitoring of health goals/biometrics (e.g., BMI, cholesterol)	92	60.9	192	66.2	416	60.1
Healthy food/drink offerings (in cafeteria, vending machine, etc.)	75	49.7	157	54.1	336	48.6
Lunchtime lectures/education on healthy behaviors	71	47.0	162	55.9	298	43.1
Completing a health risk appraisal	86	57.0	176	60.7	416	60.1
Managed programs for substance abuse or mental health	86	57.0	159	54.8	342	49.4
Medication adherence programs	70	46.4	131	45.2	195	28.2
Case managers to track disease management	62	41.1	139	47.9	227	32.8
Smoking cessation programs	81	53.6	164	56.6	420	60.7
Weight management programs	86	57.0	164	56.6	399	57.7
Corporate sponsored challenges	70	46.4	165	56.9	361	52.2
Mindfulness, meditation, yoga, relaxation training	68	45.0	140	48.3	276	39.9
Social engagement (social clubs, interest groups, sports teams)	73	48.3	147	50.7	273	39.5
Individual mental or physical health tracking through a wearable device or online program	74	49.0	147	50.7	252	36.4
Ergonomic workstations	80	53.0	154	53.1	327	47.3

Note. 151, 290, and 692 individuals from small, medium, and large organizations indicated that their organization offered a wellness program.

Large organizations:

- 1) Preventative screenings and vaccinations (68.5%)
- 2) Exercise programs (62.4%)
- 3) Smoking cessation programs (60.7%)

Least popular elements

Small organizations:

- 1) Case managers to track disease management (41.1%)
- 2) On-site health clinic (43.7%)
- 3) Mindfulness, meditation, yoga, relaxation training (45.0%)

Medium organizations:

- 1) Medication adherence programs (45.2%)
- 2) On-site health clinic (46.9%)
- 3) Case managers to track disease management (47.9%)

Large organizations:

- 1) Medication adherence programs (28.2%)
- 2) Case managers to track disease management (32.8%)
- 3) Individual mental or physical tracking through a wearable device (36.4%)

As seen in Table 13, medium organizations generally show higher rates of employees reporting that their organization offers one of the wellness program elements. These findings generally corroborate our speculations about the reasons for the differences between small, medium, and large organizations in their levels of concern about the following: 1) the amount of time needed for employees to take advantage of the wellness programs, 2) the degree of manager support, and 3) their concern for improving the health and well-being of employees. In all three areas, large companies reported higher levels of concern. As suggested earlier in this report, large organizations showed the greatest levels of concern, perhaps because they face unique logistical/management challenges that are not faced by smaller organizations. Small organizations may face similar challenges because they may have limited financial resources. Thus, medium organizations may have higher reported adoption rates because they do not face the same challenges faced by small and large organizations.

There are, however, a few exceptions. Specifically, compared to small and medium organizations, large organizations report higher adoption rates for preventative screenings and vaccinations, smoking cessation programs, and weight management programs. Compared to large and medium organizations, small organizations report the highest adoption rates for managed programs for substance abuse or mental health and medication adherence programs.

Q1130A: Does your employer offer a workplace wellness (health promotion) program?

Q1131_1 - Q1131_18: Which of the following does your employer offer?

Table 14

Participation in Wellness Programs as Reported by Employees

Wellness Program Element	Offered - Not Enrolled			Offered - Enrolled		
	Small	Medium	Large	Small	Medium	Large
Preventative screenings and vaccinations	23.8%	22.8%	20.8%	33.8%	39.7%	47.7%
Exercise programs - either on-site or discounts for local gyms	28.5%	34.5%	35.4%	33.1%	29.0%	27.0%
On-site health clinic - for routine visits at my office	20.5%	21.0%	15.6%	23.2%	25.9%	22.8%
Monitoring of health goals/biometrics (e.g., BMI, cholesterol)	27.2%	24.8%	21.5%	33.8%	41.4%	38.6%
Healthy food/drink offerings (in cafeteria, vending machine, etc.)	19.2%	22.4%	18.8%	30.5%	31.7%	29.8%
Lunchtime lectures/education on healthy behaviors	24.5%	27.6%	21.7%	22.5%	28.3%	21.4%
Completing a health risk appraisal	24.5%	21.7%	17.8%	32.5%	39.0%	42.3%
Managed programs for substance abuse or mental health	34.4%	26.9%	35.8%	22.5%	27.9%	13.6%
Medication adherence programs	21.2%	21.4%	13.7%	25.2%	23.8%	14.5%
Case managers to track disease management	19.2%	22.8%	17.5%	21.9%	25.2%	15.3%
Smoking cessation programs	29.8%	34.5%	45.5%	23.8%	22.1%	15.2%
Weight management programs	28.5%	28.6%	37.4%	28.5%	27.9%	20.2%
Corporate sponsored challenges	20.5%	27.2%	27.0%	25.8%	29.7%	25.1%
Mindfulness, meditation, yoga, relaxation training	21.9%	27.2%	23.6%	23.8%	21.0%	16.3%
Social engagement (social clubs, interest groups, sports teams)	20.5%	19.7%	23.3%	27.8%	31.0%	16.2%
Individual mental or physical health tracking through a wearable device or online program	23.2%	28.3%	18.2%	25.8%	22.4%	18.2%
Ergonomic workstations	20.5%	28.6%	24.0%	32.5%	24.5%	23.3%

Note. 151, 290, and 692 individuals from small, medium, and large organizations indicated that their organization offered a wellness program. Unaccounted for percentages reflect respondents who either indicated that the organization did not offer the program or they did not know if the organization offered the program.

Participation in Wellness Programs

Information about participation in wellness program is provided in Table 14. With the exception of the following programs, a greater proportion of employees tend to report enrolling in — versus not enrolling in — all types of wellness programs: managed programs for substance abuse or mental health, smoking cessation and weight management programs. These programs may have seen lower enrollment rates because they target high-risk individuals.

Q1131_1 - Q1131_18: Which of the following does your employer offer?

Strategies for Enhancing Facilitators and Overcoming Barriers to Wellness Program Implementation and Employee Participation

Overall Conclusions about Wellness Program Participation

Based on all of the information collected across sources described in this report, it is clear that participation is highest when employees want to improve their health, the wellness program meets employees' needs, engagement in the program is convenient and does not result in negative consequences, there is peer and manager support for participation, leadership is supportive of a healthy culture, and results of the wellness program are personally rewarding. Although the elements for building strong participation seem straightforward and easy to comprehend, they appear to be difficult to execute. That is our challenge.

The Barriers to employee participation are many. Leadership attitudes toward wellness programs are probably the most difficult to overcome because without significant intervention, they are resistant to change. Leadership support for employee wellness appears to be one of the most critical factors in wellness program effectiveness and in the encouragement of employee participation in those programs. Without leadership's support, many aspects of the work and work environment are likely to work against employees having the time and opportunity to improve their health.

Other significant Barriers for small and medium organizations are a lack of knowledge about wellness programs, employee fear and self-consciousness about their health status, concerns about confidentiality, insufficient personnel available to "own" a wellness initiative, competing demands for employees' time outside of work, lack of energy to participate in wellness programs due to burnout, a lack of financial resources to pay for wellness initiatives, and a lack of organizational infrastructure to adequately launch and manage wellness initiatives, especially with respect to a reliable system for intra-organizational communications.

Another significant Barrier is employee motivation to engage in a wellness program. Depending on the age of employees, participation may be low because employees may believe they are healthy already and do not need a wellness program. Employees may also believe that whatever is offered is not interesting or enjoyable, and therefore not worth their time. Confidentiality and trust also enter into the picture and have the effect of discouraging participation. Being targeted as a high-risk employee also has negative connotations and discourages participation. Lastly, employees fear repercussions from managers if they participate instead of doing their work.

The question is, how can we move forward with such daunting Barriers? The answer seems to be to enhance the Facilitators of and remove the Barriers to employee participation by matching organizational constraints to wellness programs that are compatible with those constraints. We developed this strategy in the Employer Guide accompanying this report. The strategy is explained below.

Strategy for Making Wellness Programs Easier to Implement in Small and Medium Organizations

The basic premise of our strategy is to make it easier for small and medium organizations to implement a wellness program successfully by developing a method for matching an organization's opportunities and constraints with the requirements and characteristics of wellness programs. We can achieve matches by giving organizations a way to evaluate their current Facilitators and Barriers to adoption of a wellness programs and to employee engagement. We developed an Assessment Tool that allows this assessment of Facilitators and Barriers. The Assessment Tool was developed from what we learned from the literature reviews, the focus groups and the Harris Poll.

We also categorized wellness programs into eight types, each type describing a class of wellness programs that have the same unique implementation characteristics. The eight types differ overall in their degree of leadership involvement in the success of the wellness program.

The eight program types are organized into a hierarchical order, starting with wellness programs that do not involve leadership at all and instead engage employees through their own initiative outside of work. The next type consists of wellness programs that also do not involve leadership at all and instead engage employees through their own initiative outside or on site at work in social activities. For each successive type of wellness programs, leadership is involved in gradually increasing roles. The first of these involves social activities organized by personnel in the organization. Social connections are enhanced through meetings, events, and socially organized groups and coordinated by organizational representatives (e.g., HR). Following this type is a set of wellness programs that are coordinated by a third party—the health insurance vendor—who conducts screenings and tracks biometrics. The leadership is involved because they have health insurance for their employees and have actively engaged their vendor to perform these services. The next two sets of wellness programs involve the leadership more directly by having an organizational member implement activities that encourage healthy behaviors at work in the “lite” version, and in the enhanced version, leaders structurally influence healthy behaviors at work by making investments in the employees' physical environment. The financial investment required for this latter type could be substantial depending on the extent of physical modifications to the workplace (e.g., in-house gym, Biophilia, walking paths, restorative rooms and the like). The final two sets of wellness programs involve health professionals in the monitoring

and care of employees who have health-related issues. The first involves coaching and counseling employees by health professionals in an attempt to prevent illness and disease such as hypertension, diabetes, cancer, and cardiovascular disease. High-risk employees are identified here and specifically encouraged to participate in order to reduce the occurrence of debilitating disease. The second set involves health professionals in disease management where employees who have active disease are monitored, coached, and treated in order to improve their health status and to maintain treatment. The eight types of wellness programs described above are listed below in hierarchical order:

1. Education Programs pursued by employees on their own outside of work. Examples are classes, lectures, podcasts, videos, and clubs/groups where employee learn about healthy behaviors and pursue them on their own.
2. Social Community Building by the Employee where employees initiate in a grassroots manner a variety of social activities for the purpose of enhancing social relationships at work and experiencing more enjoyment in life with their peers.
3. Social Community Building by the Organization where a member of the organization takes ownership of improving social community within the workforce. The organizational leader arranges social events at work and encourages development of clubs, interest groups, sports teams and all other manners of developing social connections with peers at work.
4. Preventative Care Program (Lite) involves the health insurance vendor in performing health assessments and preventative screenings. Employee-specific recommendations are delivered to the employee at the organization in order to encourage illness and disease prevention.
5. Healthy Habit Development (Lite) consists of a set of organization-led interventions in the workplace that encourage healthier eating, greater physical activity, tracking personal mental and physical health, and enjoying restoration. Examples of interventions are providing healthier food at work, organization-sponsored classes on-site, gym memberships, health tracking through wearable devices, and local health-related events such as “fun runs.”
6. Healthy Habit Development (Enhanced) involves a much greater investment on the part of the leadership in making physical enhancements to the worksite to introduce healthier habits as a part of employees’ workday. Examples include building in-house gym facilities, in-house cafeterias with chef-made healthy meals, sports facilities with showers, attractive stairways, gardens and outdoor running paths, and

workspace enhancements with natural light, temperature controls, good ventilation, non-toxic materials, and noise pollution controls. May also include HR policies that reduce stressors related to child/elder care, commuting and travel, and long work hours.

7. Preventative Care Program (Enhanced) is a partnership between healthcare providers and organizational leadership in an effort to reduce the incidence of serious illness and disease. Wellness programs involve the integration of health promotion into the culture and organizational decision-making, and actively engages health professionals in coaching employees on disease prevention and health promotion. Also includes targeted programs (e.g., smoking cessation) for high-risk employees.
8. Disease Management where the leadership makes significant investments in the establishment of in-house medical clinics and occupational health programs in order to service employees' health needs and to treat employees who are sick, injured, or have active disease that needs consistent treatment and medication. The role of leadership is to ensure effective operation of the clinic and its programming to meet employees' health needs.

We identified Facilitators and Barriers associated with each wellness program type in order to construct a set of requirements associated with each type. We determined the degree of “fit” between an organization and a wellness program type by comparing the Facilitators and Barriers identified in the organizational assessment with those in the wellness program requirements. A good fit is achieved when the organization has all the Facilitators needed and does not have Barriers that prevent a wellness program from operating effectively. Depending on the Facilitators and Barriers identified in an organization's assessment, more than one type of wellness program may prove to be a good fit.

To assist with the development of the Assessment Tool as part of the Employer Guide, we created a “roadmap,” included in Appendix I, which connected Facilitators and Barriers to each type of wellness programs to serve as a “scoring key” for the Tool. Based on the description of the program type, we could identify Facilitators and Barriers that directly affected the wellness programs included in each type. The Assessment Tool utilized this scoring key to guide employers to types of programs that matched Facilitators they identified in the Tool and disqualified types of programs where employers also indicated that critical Barriers also existed. A description of all Facilitators and Barriers collected across sources are listed and described below.

Enhancing Organizational Facilitators

We compiled Facilitators of wellness programs and employee participation stated in the literature, focus groups and in the Harris Poll Survey into a comprehensive list provided below. The Facilitators are divided into seven different groups. Recommendations for enhancing Facilitators follow each set.

Employee Motivation

- Individuals are motivated to engage in healthy behaviors at work.
- Employee efforts to engage in healthy behaviors at work are not discouraged by leadership.
- There are employees who want to stop their smoking habit.
- There are employees who want to lose weight to be healthier.
- There are employees who perceive a need to lower their alcohol intake.
- Employees perceive the need for taking time for wellness.
- Employees like the concept of financial incentives tied to healthy behaviors.
- Employees like the concept of non-financial incentives such as public recognition and acknowledgement of healthy goal achievement.
- There is an employee group that is involved in designing wellness programs.

Motivation can be enhanced by understanding the “WIFM” for employees in each of these statements and then tying the wellness program specifically to the “WIFM” as directly and clearly as possible. If the “WIFM” is mainly a value such as wanting to improve one’s health, efforts could be made to elaborate on how the wellness program will result in feeling good about doing something positive for oneself. If the “WIFM” is mainly extrinsic such as a financial reward for achieving specific behavioral targets, then the wellness program needs to be designed so that target achievement is clear, verified, and publicly transparent, and rewards are significant and delivered as close to the time of the target achievement as possible. If the “WIFM” is feeling important because of being involved in the design of the wellness program, then the employee involvement process needs to have high integrity, fair in the selection of employees involved, meaningful to the participants in the design process, and generate results that are perceived by others as appropriate.

Employee Social Interest

- There are shared values and interests among peers.
- Employees want to engage in social activities at work.
- Employees have an effective communication system at work so that they can publicize and organize social activities.

Employee interest in social activities can be enhanced by ensuring that engagement in such activities are voluntary and are sufficiently enjoyable for employees to anticipate feeling good about participating. Social activities should be created that appeal to a wide variety of cultures and personal tastes to avoid

appearing as it is serving one constituency. Making social encounters safe and confidential if needed may encourage more employees to attend. A communication system within the organization which is used by all employees and which functions as a conduit through which employees of similar interests can be found would facilitate efforts to make social connections.

Employee Work Hours

- Employees can take time out from work to engage in healthy behaviors such as taking a walk, exercising, eating healthy food, and participating in social activities.
- The nature of employees' work does not prevent them from leaving their work to participate in a wellness program for a short period.
- Managers support employees who want to leave their work to participate in a wellness program.
- Employees have reasonable work hours.
- Wellness programs are scheduled at a convenient time and location.

Permission to leave work to engage in wellness programs is key to this Facilitator. Messaging from leadership and especially managers supervising employees is necessary to make clear that employees have this permission. If the nature of the work makes it difficult for an employee to disengage from his workstation, then efforts should be made to create a system of either pausing operations for the duration of the wellness program, replacing employees by others temporarily to enable participation in the wellness program, or scheduling the wellness program when the wellness program will not interfere with such duties.

Employee Cost

- Wellness programs are affordable for employees.
- The cost of employee participation in a wellness program is subsidized by the organization.

The cost for employee participation should be low enough not to be a Barrier to engagement. Ideally, the organization would bear the complete cost of participation in the wellness program. Attaching a penalty to employees who do not participate as well as imposing some cost however small on the employee to make sure the employee has "skin in the game" would be a mistake. This is because it creates a perceived Barrier to participation, which could be used by the employee as an excuse for not participating. Non-participation in programs completely subsidized can be dealt with in other, positive ways.

Leadership Support

- Leadership understands the link between health and work outcomes.
- Leadership supports employee involvement in wellness program design.
- Leadership models healthy behavior.

- Leadership demonstrates concern for employees' health and well-being.
- Leadership is interested in addressing employee health issues such as diabetes, hypertension, cardiovascular disease, and obesity.
- Leadership offers financial rewards for employees who achieve their wellness goals.
- Leadership trusts that employees will take time for their health and get their work done.

Leadership support is critical for encouraging employee engagement in all healthy behaviors. Trust is established through consistency in messaging, modeling and decision-making by the leadership. Employees need to know that leadership understands the link between health and work outcomes, and the best way to know is to observe demonstrations of it and to hear it from the leadership themselves.

Leadership Communications

- Leadership asks employees what wellness activities they want and need.
- Leadership communicates that work and health have equal priority in the organization.
- Leadership publicly recognizes employees who achieve their wellness goals.
- Leadership encourages employees to take time for their health.
- Leadership uses an organization-wide communication platform to communicate their support of healthy behavior.
- Leadership communicates positive messages about wellness.

Leadership communications are critical for reinforcing employee health improvement. Their public recognition of employee health achievements and invitations to employees to take advantage of the opportunities provided to them to promote their health are especially important for employees to understand leadership's commitment. The communication platform needs to be easy to use and universally available to all employees, especially those who work in the field away from the workplace. Communications are the glue that bind leadership and employees together in their unified effort to promote health at work.

Organization's Financial Status

- Organization can afford to make financial investments to improve employees' health and wellness (e.g., ergonomic furniture, sports areas, gym, walking paths).
- Organization can afford to dedicate a person or department to managing employee wellness.
- Leadership has established reasonable work hours.
- Employees have organization-sponsored health insurance.
- Organization has a healthcare provider that offers wellness programs that employees use.

Having the financial resources to implement robust wellness programs is helpful in engaging employees in these programs. Being able to extend to employees

healthcare insurance at a reasonable price opens up multiple opportunities for employees to receive preventative care as well as to protect them from catastrophic medical expenses. Being able to afford to hire or designate an organizational leader (e.g., HR) to take on employee wellness initiatives will greatly increase opportunities for employees to engage in these activities. Not only are financial resources needed, but operating profit at a level where the leadership can establish norms for work hours will give employees time outside of work to engage in wellness activities. These Facilitators can be enhanced when leadership carefully evaluates what they can afford in resources in order to achieve better work outcomes, and then makes the necessary investments.

Overcoming Organizational Barriers

We also compiled Barriers to wellness programs and employee participation stated in the literature, focus groups and in the Harris Poll Survey into a comprehensive list provided below. The Barriers are divided into nine different groups. Recommendations for overcoming Barriers follow each set.

Hours of Work

- Wellness programs are inconvenient and interfere with work.
- Nature of the work prevents time out to participate in wellness programs.
- Long work hours are expected in this organization—no time for it.
- Employees have difficulty prioritizing how time is spent especially when there are so few hours left outside of work.

How many hours employees work and the nature of their work prove to be significant Barriers to employee participation in wellness programs. Sometimes the need to work long hours and for employees to be immediately responsive to customer demand is a *perception* rather than reality. Perceptions are formed often out of a fear of being perceived as a low performer and being potentially at risk of termination. Perceptions are also based on social norms that form within a competitive work culture where working more is valued more than working smarter. If it is a perception, then leadership has a role in communicating to employees the importance of dedicating time to their personal health and well-being and attempt to limit the amount of time employees spend at work or how much time they spend at their workstation. If the long work hours and tethering employees to their workstations is a reality, then leadership can take actions that lower the number of hours any single employee has to spend at work or at the workstation. This would require “relief” employees who can cover for employees for short periods so they can participate in wellness activities, or hiring more staff to lower the overall workload. The benefit of hiring more employees is that each employee would be more productive and thus, generate more positive organizational outcomes (e.g.,

higher revenue, lower absenteeism, lower turnover) when they are more able to be productive and have fewer work-related health problems.²⁴

Motivation to Participate

- Competing demands for one's time, especially family responsibilities outside of work.
- Employees' basic needs are not met (safety, eating, sleeping) so wellness programs seem like a luxury or not high enough on the priority list.
- Employee burnout—no physical or emotional energy to participate).
- Employees do not expect much from their employer because they are a small company.

This Barrier typically is the result of employees not having reserves in their lives to allow for the “luxury” of attending to their health. This could occur as a function of a number of factors including work overload, unrealistic performance expectations, extreme anxiety due to poor leadership and poor working conditions, significant commitments outside of work, and so forth. If these factors are present, it is difficult for employees to believe they have time to spend on themselves. Overcoming this problem will not be easy. Leaders who recognize this Barrier in their employees (when the leaders are not the cause) can talk to employees about their workstyles and work expectations. Re-setting expectations of reasonable work performance and giving employees permission to take time for themselves to take care of their personal needs may help to remove this Barrier. Referring employees who are truly suffering in the workplace because of overwork, burnout and excessive responsibilities to organization-provided counseling or healthcare professionals would help to remove this Barrier. If the leadership can identify structural aspects of the work such as job design, staffing, or poor management, then this may relieve the conditions that create this sense of helplessness, employees may be helped to the point of having more “breathing room” for their own care.

Lack of Knowledge

- Lack of understanding about the connection between wellness and organizational outcomes (productivity, absenteeism, presenteeism, turnover).
- Perception that some wellness programs are unsuccessful because participation is low.
- Lack of knowledge of the wellness resources available through health insurance vendors as part of health insurance benefits.
- Lack of experience implementing a wellness program so they do not know where to start.

²⁴ Kaplan, S.A., Deshon, R.P., & Tetrick, L.E. (2017). *The bigger picture of employee well-being* [White paper]. October 4, 2017, from: http://www.siop.org/SIOP-SHRM/2017_02_SHRM-SIOP_Employee_Well-being.pdf.

- Lack of knowledge of what employees want and need.

This Barrier can be remedied by the transmission of knowledge that is lacking in leadership. As simple as that may seem, this remedy may be the simplest of all of the remedies mentioned in this report. However, getting the appropriate information to leadership in a manner that is persuasive and compelling is another endeavor. This report combined with the Employer Guide may go part of the way towards informing leaders about the organizational benefits associated with well design and expertly executed wellness initiatives. The rest has to be focused on what information the leaders collect for themselves. For example, understanding that employees need to have healthy working conditions and opportunities for them to protect and promote their health is foundational. What to offer employees has to come from the employees themselves in order for the response to be focused in exactly the places where needed and no more. This can be done through employee interviews, surveys, or focus groups. The results of this data gathering can inform the design of future wellness programs. Fundamentally, leaders need an avenue through which they can get the information they need and act on it in a manner consistent with their organizational philosophy and within their constraints.

Cost Concerns

- Organization has concerns about the costs associated with wellness programs.
- The organization lacks the financial resources to support wellness programs.

This Barrier is problematic whenever wellness programs require a substantial financial investment. The perception is that almost all wellness programs cost a lot. However, several types of wellness programs do not cost anything. Employee-initiated social activities that take place during breaks and before/after work help to build social connections which benefit employee health either through physical activity or through positive emotions that emerge during the activity. In addition, educational programs designed to instruct people on how to promote one's health can be delivered on site or located off site and made available to employees at their leisure. Company-sponsored social activities at work may also be an option that is low cost. All three types of wellness programs require very little if any investment. An organization that does not have financial resources can take advantage of free programs available to the public.

Roles & Responsibilities

- Lack of ownership of wellness within the organization.
- People within the organization “wear multiple hats” and are spread too thin (no ability to own wellness).
- Leadership doesn't model healthy behaviors and actively encourages unhealthy behaviors (unhealthy food)

This Barrier reflects the need for one or more organizational members to take on wellness as an organizational priority. When responsibility for employee wellness is not assigned to an organizational leader, then it is very difficult to improve the health of employees in a consistent manner. If this is not on anyone's "plate," then it falls to the bottom of everyone's plate. The best remedy is to put this responsibility on someone's plate and protect that responsibility from being corrupted by other priorities so that there is consistency in the organization's approach and employees perceive that progress is being made.

Physical/Structural Impediments

- Poor method or quality of communicating information to employees.
- Insurance offerings to support wellness not communicated or not known.
- Bureaucracy or logistical issues prevent or discourage activities from being scheduled or communicated in a timely manner.
- No formal system for requesting wellness programs or activities.
- Lack of physical facilities to incorporate wellness programs.
- Lack of employee health insurance.

Several structural elements of the organization can impede dissemination of important information to employees regarding wellness programs and for obtaining feedback from employees on their needs and participation. Other structural elements involve the physical plant. A lack of space for walking, exercising, holding wellness activities, and eating can make healthy behavior considerably less likely. A lack of health insurance also removes an opportunity for employees to take advantage of health benefits offered by the insurer. Remedies for these Barriers may be to identify public spaces nearby where organized wellness activities can take place or moving items within the workspace to make space for these activities. Retaining a healthcare provider if affordable would be preferred.

Privacy/Liability Concerns

- Employee discomfort dealing with health issues.
- Lack of privacy of health status, especially in small company.
- Perceived invasiveness of attempts to change personal habits (e.g., smoking, drinking, eating).

Privacy regarding one's health is a reasonable concern. Consulting healthcare professionals who are used to dealing with such issues may provide avenues that are easy to implement in the organization for the protection of employee health status and personal health information. This concern has been dealt with in many contexts, and finding the appropriate expert to guide the organization's treatment of employee health concerns is a reasonable course of action. The net result of such action is a communication to employees regarding how their confidential information will be protected and kept confidential so that they do not need to worry about the organization having that information or acting on it. The more challenging issue to remedy is employees' resistance to changing their personal

habits such as smoking and drinking. This issue can be dealt with by healthcare professionals as part of the benefits offered through the health insurer.

Leadership Support

- Lack of consistent support across organizational leaders.
- Failure to actively encourage employees to engage in wellness programs.
- Leadership bases program on their own personal needs.
- No feedback or input asked for from employees on wellness programs or activities.
- Concept of wellness is new to organizational leaders and not yet accepted.

This Barrier occurs when there is little agreement among the organizational leaders regarding their role in promoting employee health and well-being. The leadership needs to reach consensus on what their role will be going forward, and once this is decided, then responsibilities associated with this role should be integrated into each leader's performance expectations and performance evaluation criteria in order to bring this role to a level of equal importance as other performance criteria. If this is not done, then it is unlikely that leaders will take the time to fulfill this responsibility given other priorities. Building employee health and well-being into leadership's responsibilities and holding them accountable in a tangible manner will be a solution to inconsistent messaging, lack of support demonstrated, and contradictory actions.

Leadership Attitudes

- Concerns about employee abusing time off to participate in wellness programs.
- Cynicism about the value of wellness programs.
- Perception that wellness is the employee's responsibility.
- Employ younger, more fit workers so no need to deal with wellness issues.
- Organization can do only so much for employees.
- Work and wellness are two separate things--they are not connected.
- Employees have to prove themselves first before they can participate in wellness.
- Employees are satisfied with the status quo—no need for a wellness intervention.
- Wellness programs are not interesting or enjoyable.
- Belief that a program would need to be on a regular basis or not at all, fear of long-term commitment (do not want to retract).
- Distrust in the motive behind management-initiated wellness programs.

Leadership attitudes can be “deal-breakers.” Because they are opinions and attitudes, they are personal and often resistant to facts, observation, and rationality. Cynicism and beliefs that wellness programs have no place in the workplace are very difficult to counter because they are just that—beliefs. If these

attitudes and beliefs cannot be addressed through knowledge, then the science of attitude change directs us to create situations where leaders can experience it first-hand. That is, acting in a manner consistent with a new attitude (e.g., healthy behaviors do promote better health and greater productivity at work) will lead people to changing their attitude. For example, challenging the leaders to engage in a wellness program such as physical exercise for a required period and then measuring the results may demonstrate the value of such programs and thus, change their understanding of wellness programs. Once they are more vulnerable to health-related information, there can be a concerted effort to bring forth the most compelling evidence that employee wellness translates into better business performance. However, if leadership is not even open to experiencing a wellness program, then it is a deal-breaker. The alternative is encouraging employees to pursue wellness activities on their own, without leadership support.

Enhancing Personal Motivation to Participate in Wellness Programs

Employee motivation to participate in wellness programs can be enhanced by spending the time to identify the “WIFMs” that might exist within the employee population. It may be financial rewards, or employee recognition, or simply the enjoyment of establishing new social relationships at work. Whatever the “WIFM” is, the wellness program needs to be structured in a way to deliver it--consistently. A critical component of employee motivation is their understanding of what they will get by participating in the wellness program and being convinced that they would actually receive it. Therefore, the structuring of the program, the messaging that goes along with its implementation, the rollout of the program, and the feedback that is collected from employees during the course of the program must be carefully orchestrated and executed well. To the extent any of those pieces fails, the motivation to participate may be compromised.

Enhancing Leadership Support for Employee Participation in Wellness Programs

Leadership plays a critical role in the successful implementation of all wellness programs whether they are employee-initiated or sponsored by the organization. The leadership communicates to employees what they consider important, and if employee health and well-being is not at the top of the list, employees will be reluctant to spend their time on anything that the leadership does not regard as important. What leadership considers important will filter down to managers, and managers will behave in a manner consistent with leadership. Managers are often the gatekeepers for how and when employees participate in wellness programs. A manager who is not on board with wellness initiatives can undo what the organization has committed to doing. Therefore, managers must be held accountable for executing the initiatives set by leadership regardless of their personal preferences or beliefs. When the leadership and managers are in alignment, employees will find it easier to take the time to engage in wellness

programs and benefit from the intended purpose of the program. This is the desired outcome of a well-informed, progressive organization that believes that work and health are not separate issues and that they are, in fact, connected.

Employer Guide

This Technical Report accompanies an Employer Guide we developed to help employers understand all of the Facilitators and Barriers to employee participation. A key component of this Guide is an assessment tool that employers can use to evaluate which Facilitators and Barriers exist in their organization. This information is then used to determine which type of wellness programs best “fit” their organization, given current opportunities and constraints.

Using this tool, we offered participating organizations recommendations for which programs best fit their organization and also made specific suggestions for how they can enhance Facilitators and overcome Barriers. Examples of the suggestions we made based on the assessment tool can be found in Appendix J, “The Employer Guide in Action.”

Lastly, this project revealed a need to provide employers and employees with limited resources options for no- or low-cost wellness solutions. We therefore compiled information from credible health and wellness resources, and included assessments, toolkits, planning guides, educational articles, wellness technology options, and webinars. The list of resources identified can be found in the Employer Guide and in Appendix K.

Appendix

See Appendix supplement for the following:

- A) Summary of Studies Collected for Initial Literature Review
- B) Citations of studies reviewed for Initial Literature Review
- C) Summary of Studies Collected for Secondary Literature Review
- D) Citations of studies reviewed for Secondary Literature Review
- E) Initial Wellness Program Assessment
- F) Focus Group Informed Consent Form
- G) Focus Group Demographic Questionnaire
- H) Focus Group Questions
- I) Roadmap Used to Guide Solutions for Employer Assessment Tool
- J) The Employer Guide in Action
- K) External Resources