University of North Carolina Asheville
Journal of Undergraduate Research
Asheville, North Carolina
December 2019

Challenges and Solutions in Implementing Workplace Wellness Initiatives

Leah Fagan
[1]Health and Wellness Promotion Department
[2]Department of Management and Accountancy
The University of North Carolina Asheville
One University Heights
Asheville, North Carolina 28804 USA

Faculty Advisor: [2]Dr. Mary Lynn Manns, [1]Dr. Amy Lanou

Abstract

In seeking understanding around the implementation and sustainability of a Workplace Wellness Initiative, management and employee perspectives must be considered. Challenges arise when attempting to bring these interests together, and overcoming the constraints of both parties. Management seeks reduced healthcare costs and healthy members of their staff, whereas employee motivation can be more elusive and ultimately requires a degree of intrinsic drive. Workplaces are well-suited for bringing about health behavior change given the ubiquitous role they have in modern adult life. Solutions for relieving the tension between these interests require participation and investment from both parties. Initiatives that only address implementation and neglect maintenance fail to achieve the health outcomes sought by management and employees. Further research is needed on how to best create programs that meet the needs of employers and employees and how to bring the fields of health promotion and organizational behavior together.

1. Introduction

While there is no prevailing definition for a workplace health or wellness initiative, these programs are increasingly common in workplaces around the world seeking to improve the health of their employees. For our purposes, a workplace wellness initiative (WWI) is an initiative sponsored by an employer with a stated goal to improve the health and wellness of employees. Minimally, these initiatives seek to improve health for employees and to lower healthcare costs for management.

The most frequently targeted behaviors include physical inactivity, smoking and weight loss, as these behaviors are associated with much higher disease risk and higher healthcare costs.[10] Three common goals for adopting a WWI include lowering healthcare costs, addressing human relations objectives and improving productivity.[14] This can be achieved through programming that includes primary prevention, secondary prevention and/or health promotion.[8]

The indirect costs of employees with chronic disease are four times higher than for those without.[10] WWIs both promote the reduction of these costs and intend to enhance the lives of participants. “Health and fitness programs can benefit the organization in numerous financial and nonfinancial ways, including reduced illness and absenteeism, lower health insurance premiums, increased productivity, improved morale, reduced turnover, increased recruitment potential and more. Personal benefits include increased energy, increased coping skills, greater ability to manage personal lives and improved employee interactions.”[7]

WWIs are growing in prevalence and are often tied to workplace health insurance. Almost ⅔ of adult Americans receive their health insurance from their workplace, so there is a relationship between the health of the employees and the expenses of the organizations.[14] It is in the best interest of employers to offer resources for health promotion that transcend (and potentially circumvent) disease management and foster a culture of health and wellness. Successful programs recognize the role of social support and offer resources that support the lifestyles of different demographics.[12] Government-supported interventions (ie Healthy People 2010 and 2020) promote internal marketing, evaluation and leadership, to reach these demographics and create a health-positive culture.[8]

Challenges arise when these programs fail to address both management and employee goals. Fortunately, organizations and researchers are addressing these challenges head-on, and there are several solutions that improve efficacy and longevity of WWIs.

2. Methodology

This research was conducted through a meta-search of Google Scholar including the terms "health, wellness, initiative(s), program(s), challenge(s), value, ROI and cost(s)." Fifteen peer-reviewed articles were selected for the purposes of this investigation. They included systematic reviews, workplace studies, national surveys and assessment guides. Relevant content was critically analyzed and gaps in understanding were identified.

3. Data

3.1 Challenges

Many variables play into successful WWIs, and challenges arise around implementation and maintenance of these programs. According to Lovato and Green (1990), "When the number of employees participating in a program begins to decline, the program itself may be threatened with extinction because the program loses administrative support."[6] There is equal responsibility between management and employees to foster an influential WWI and differences in motivation between management and employees can manifest in many ways. This disconnect can undermine a well-planned program. According to one study, the most commonly reported barriers or challenges to the success of health promotion programs are lack of employee interest (65.5%), staff resources (50.1%), funding (48.2%), participation on the part of high risk employees (48.0%) and management support (37.0%).[5] We explore more management-specific and employee-specific challenges below.

Both management and employees look to insurance providers for direction in establishing a WWI and many experience confusion with implementation and understanding what is actually offered. Notably, business size plays into whether a company has insurance and if it offers a wellness program. Only 62% of small businesses (those with fewer than 50 employees) purchased health insurance for their employees, compared with 96% large businesses.[14]

The five components of an effective WWI, as proposed by HealthyPeople 2020, include health education, supportive social and physical environments, integration of programs into organization structure, linkages with existing programs and screening programs.[9] Of those that offer WWI, approximately 24% of large businesses offer all elements of HealthyPeople 2020, whereas only 4.6% of small businesses do.[9] This indicates room for improvement for all organizations, but a disproportionate degree of efficacy depending on business size.

Further complications arise in implementation according to the industry in which a company works. For example, jobs that require a lot of physical labor need programs that handle injury prevention, whereas office workplaces often need to address sedentary behavior. Different industries have differing perceptions around the feasibility of a WWI. Of those measured on a scale of 1-5, readiness in the education sector was 3.11, healthcare and social assistance was 3.35, food service and retail was 2.73 and manufacturing was 3.22.[1]

Both individual behaviors and work environment influence improvements in employee health.[5] WWIs are not one-size-fits-all, as different industries, organization sizes, regions, and distinct workplace cultures all influence the best practices for a given organization.

3.1.1 management-specific

When management considers implementing a WWI, they are interested in the well-being of their staff and the financial return on investment. Managers often consider structural (policies, benefits plan, promotion), cultural (cultural norms and values) and work (size and involvement) factors in how they approach a WWI.[3]

Decision makers are typically upper management and human resources, but the responsibility of implementing a WWI often falls on human resources.[3] Unfortunately, HR personnel are typically time-constrained by other facets of their work, so WWIs are not always prioritized by or feasible for those designated to implement. They also typically lack training in health promotion or public health. Lack of personnel and time constraints are commonly cited barriers, as well as employee interest, management support, staff resources, funding and low participation of high risk employees.[9,14] Again, there is a strain between managerial intentions and employee willingness.

High risk employees, which include men, smokers, those who are overweight or have chronic conditions, are the ones companies most hope will participate.[6,9] Some managers have concerns around statutory, regulatory and common laws and how to utilize a "carrot versus stick" approach for incentivization. According to the Health Insurance Portability and Accountability Act, Americans with Disabilities Act, Civil Rights Act, Employee Retirement Income Security Act and Genetic Information Nondiscrimination Act, some stick approaches are considered discriminatory.[10] Another issue is that organizations need to manage liability for employees injured while participating in WWIs. Many programs require participants to sign waivers of liability or explicitly state that injuries incurred while participating in WWIs are not eligible for workers' compensation claims.

Cost is considered one of the most prohibitive factors, and many managers are interested in ROI in terms of direct costs (lowered healthcare and insurance costs).[14] This perspective fails to recognize the benefits for indirect costs, including increased productivity, improved morale, reduced turnover, increased recruitment potential, and reduced absenteeism.[7] Small businesses lack the resources and expertise necessary for implementing a WWI. They adopt programs that are free of charge and provide company-specific advice for program design and execution. Although insurance providers offer programs that are often included in their existing insurance packages and can provide some program direction, many small businesses are unaware of the opportunities.[11] Furthermore, small businesses may adopt low cost programs that are not evidence-based, and therefore unable to achieve a return on investment.

3.1.2 employee-specific

Employees are arguably the most important stakeholders in WWIs, because their participation is both the purpose and function of an initiative. Most organizations recognize that programs that are not "employee driven" are much harder to maintain.[14] Employee participation requires both individual readiness and structural/cultural adaptation within the organization.

Readiness is a key feature of whether an intervention will be adopted and implemented.[1] Employee readiness can be inhibited by four key factors: 1) uncertainty from lack of information, fear of the unknown and lack of control, 2) fear around job security, threatened status, inconvenience, peer group norms, pressure to learn new skills, fear of failure and reluctance to let go and try new ideas, 3) organizational culture blames those who make mistakes, pays too much attention to custom, or is weighed down by historical factors, and/or 4) bad relationships, a need to make new relations or a situation where there is low trust in the organization."[7]

According to an employee survey about "barriers to participation in a worksite wellness program," the most common barriers include inconvenient locations, insufficient incentives, time limitations, disinterest in topics offered, schedule, marketing, health beliefs, undefined reasons and disinterest in program.[12] These are complicated barriers, as these are the responsibility of the organization to attempt to mitigate, but there is not a one-size-fits-all approach for eliciting employee interest. According to another study, employees are most likely to drop out of a program when the exercise facility is not convenient to the workplace, the program was offered during an inconvenient time, or the facilities are overcrowded during usual program times.[6] Location, scheduling and adequate interest are overlapping concerns highlighted by these two studies.

3.2 Solutions

In light of these barriers, many solutions strive to address both management and employee needs and motivation. The most successful programs are employee driven with management support and enthusiasm.[2] The combination of health promotion theory and organizational theory can achieve further balance.

Health promotion theory recognizes that relapse occurs naturally in behavior change efforts. Programming must address the discomfort associated with many health behavior changes and shape expectations accordingly. For some individuals, self-control is intrinsically satisfying and long-term health-promoting behaviors are rewarding and comforting. These individuals have a heightened capacity to endure the discomfort of health-promoting behavior change. However, over 50% of WWI participants relapse within the first six weeks. Although relapse is predictable, the programs can manage the degree to which relapse occurs before it levels off. Programs designed for maintenance can reduce the number of cases of relapse and sustain health behavior change. According to Lovato and Green,"The inclination to define participation and maintenance rates of 20-40% as failure has more to do with unwarranted expectations, overpromising, and unrealistic goals than with any objectively determined standard."[6]

Three strong themes for WWIs are 1) internal marketing, 2) program evaluation and improvement and 3) leadership and accountability.[10] Internal marketing can be one-on-one interactions, group meetings, mass disseminations, or information during onboarding, and serves to both inform and create a health-promoting culture. Program evaluation

and improvement is best conducted through needs assessments and check-ins. Programs that seek to understand employees through needs assessments can better address reluctance, improve employee perspectives, provide targeted solutions, and empower employees to resolve true non-readiness issues.[7] Leadership and accountability is ideally composed of upper and middle management, as well as employees. Multiple stakeholder perspectives make for the most successful programming.

3.2.1 management-specific

Fortunately for management, many insurance providers offer "turnkey programs," which are easily implementable initiatives supported by health promotion concepts.[2] According to Hannon et al (2012)., "The key to increasing these employers' [workplace health promotion] implementation may not be "making the case" for [workplace health promotion] to them so much as improving their implementation capacity."[1]

Some researchers suggest weaving health promotion principles into organizational development.[7] Designated personnel are one of the best ways of achieving this. In a study that controlled for variables of workplace size, experience and industry type, sites that provided a designated staff person were 10.3 times more likely to have a comprehensive program. Comprehensive worksite health promotion programs are defined as having the five Healthy People 2010 key elements of health education, supportive social and physical work environment, integration, linkage and worksite screening and education.[5] Implementation of WWIs requires not only monetary resources, but also time spent on developing programming, outreach, participant intakes, and program maintenance. Designated staff can foster applicable and effective programming that aligns with their organization's broader mission and goals.[7]

Some crucial factors for successful WWI include long-term commitment, top-level management support, employee involvement, and leadership.[12] Management has the capacity to support a work environment defined by values of health and wellness by working it into administrative philosophy.[6] They must also form specified objectives and detailed plans, and focus on employee needs, to address employees with a lower health baseline. These include blue-collar, lower education and minority status employees, and have the greatest opportunity for improvement.[9] Earnest consideration of how to best support employees can go a long way.

3.2.2 employee-specific

Employees rely on personal motivation and institutional culture and environment when engaging in WWIs. A certain harmony needs to occur between employee participation and enthusiasm and management buy-in.[2] The most successful programs seek and apply employee input throughout the development process. According to Lovato and Green (1990), "Satisfaction and program success increase when employees have the opportunity to participate actively in planning the program."[6] Low participation rates are not unique to workplace settings. Although WWIs will not appeal to all employees, getting at least 75% involved increases the likelihood for behavior change maintenance and reduced impact of relapse.[14]

The four correlates for predicting participation are demographic and socioeconomic characteristics, motivational characteristics, physical, manual, or economic facilitators or barriers and rewards and penalties associated with behavior in the social environment.[6] In terms of demographic characteristics, research shows that participation is lower among men, those with poor health and those who are overweight.[9,6] When these demographics adopt healthier behavior, healthcare costs decrease, creating a positive feedback loop for managerial buy-in. Motivational characteristics vary between individuals, so targeted initiatives can prime employees with tools for readiness and self-efficacy. The work environment, in terms of company culture and physical environment, play a large role in employee engagement. Coworker support and the role of encouragement in organizational norms can have a strong impact on behavior maintenance. Bandura's Social Learning approach suggests that behavior change is heavily influenced by role models and can be furthered by encouragement from social connections.[7] In the workplace, participation and involvement of upper management and fellow employees can significantly improve participation of all staff. Several articles also suggest physical facilities onsite to remove the barriers of transportation, parking, bad weather and family obligations.[6] Lastly, incentives can provide extrinsic motivation and increase adherence during the initiation of new behaviors. This can be cash, cash equivalents or adjusted healthcare costs. The role of incentives is poorly understood although they are increasingly popular in WWIs. Incentives seem to assist motivation in the short term, but do not produce sustained behavior change. Evidence supports the inclusion of benefits for spouses to support employees in the upkeep of their behavior change. Up to 52% of employers have expanded wellness benefits to include spouses due to the relatively low cost and significant impact.[1]

As mentioned, strong WWIs cultivate readiness and self-efficacy in each individual. It is impossible to know and address all of the variables which influence a person's readiness for change, but addressing the overall readiness of all employees can substantially improve participation and maintenance. The Transtheoretical Model (often used in health behavior change) depicts five stages of change: precontemplation, contemplation, preparation, action and maintenance. Interventions that account for and provide assistance with each of these stages are much more likely to be successful. Furthermore, six conditions identified in reducing resistance are, "1) the individual knows what change is desirable and why, and has the substantive knowledge required for the change, 2) the individual has the skill to use this knowledge to operate effectively in implementing the change, 3) the change is in his/her self-interest, 4) the change is in the self-interest of groups (families, peers, etc) with which he/she identifies, 5) internal and external environmental forces require change and 6) internal and external change agents give their support and provide feedback throughout the process."[6] SMART goals (those which are Specific, Measurable, Attainable, Relevant and Timebound) can help individuals achieve their desired results and build self-efficacy around behavior changes.[6] Programs should be flexible in nature and shift emphasis from recruitment to maintenance over time.[6]

3.3 Other Considerations

Existing data fails to cohesively bring together health promotion and organizational behavior and theory. Much of the evidence has been collected from large business settings, but these models do not appear to apply to small companies.[9] In one study, "...only 49.5% of sites used data to guide program direction, and only 30.2% had a 3- to 5-year strategic plan in place for worksite health promotion." Worksites with more than 750 employees offered more health promotion programs, services and screening programs than smaller sites. According to Linnan et al. (2008) in a national worksite health promotion survey, "Given that small businesses (those with fewer than 500 employees) represent 99.7% of all US employers… it is apparent that important opportunities to improve the public's health are being missed."[5]

Because interventions must be flexible and adaptive to employee needs, action research may be beneficial. Action research uses data for strategic programming, with applied research-based workplace interventions. Action research can not only help individual organizations identify approaches that fit their needs, but also provide information for broader investigations on efficacy in workplace health promotion. Action research is best achieved through a wellness committee composed of a variety of workplace stakeholders. Data collection methods include individual interviews, focus group interviews (for exploring why past employee involvement failed), field notes of committee meetings (as a useful means of orienting new staff members to the projects history and development) and/or survey questionnaires.[4] Instead of boilerplate recommendations, the value of this model is to replicate self-design and encourage learning, so that other organizations can arrive at their own understandings. The limitations of this approach are that some organizations do not have the capacity for data analysis and synthesis and that it creates an overabundance of data.[4]

The CDC has established a Swift Worksite Assessment and Translation (SWAT) guide for assessing health-related programs and services, health-related policies, health benefits, environmental support, community linkages and workplace governance. "The SWAT approach was developed as a middle-ground evaluation method that aims to be business-friendly while being solidly based in good evaluation practice." The SWAT framework helps to identify the attributes of successful initiatives to include in CDC recommendations for workplace wellness. This has the potential to direct future initiatives from an evidence-based understanding.

4. Conclusion

Main decision makers in a workplace wellness initiative often include management and human resource department, however the most successful programming is often employee driven. Employee participation and enthusiasm is a vital element for the longevity and efficacy of WWIs.[2] Some of the most cited barriers include lack of employee interest, participation on the part of high risk employees and management support. This shows the overlap between management and employee barriers and the issues that must be addressed from both the top down and the bottom up.

Some advocate for "turn-key programs" to ease the complications in bringing health promotion into the workplace. Others recognize the need for more customized programming that utilizes employee feedback every step of the way. The field of organization behavior may hold some insights, but there presently appears to be a disconnect between best practices in organizational behavior and health promotion. In addition, even though management seeks lowered healthcare costs and improved employee health, the trend of implementing WWIs has progressed without the guidance of health promotion models and tools. A 2010 survey showed that usually less than 20% of eligible employees participate in wellness programs. "Thus, a dynamic and innovative wellness industry has outpaced its underlying

evidence base. The available evidence provides "proof of concept," but more research is needed to determine the impact of workplace wellness in real-world settings in order to inform policy decisions."[8]

A health promotion lens anticipates relapse and stages of change. Those in charge of implementing initiatives do not often know how to collect information about their employees health, what to offer employees for the most impact, or how far into the program a return on investment is attainable. Furthermore, Healthy People 2010 recommendations are aspirational and beyond the reach of most employers.

McCoy et al. (2014) indicate that "the five components of an effective WWI, as proposed by HealthyPeople 2020, include health education, supportive social and physical environments, integration of programs into organization structure, linkages with existing programs and screening programs."[9] Person to person involvement is essential for eliciting the kind of motivation that creates lasting behavior change. Health promotion models, such as Bandura's Social Learning Approach recognize that role models play a large role in behavior change. Designated personnel are best positioned for creating the dynamics that can make a WWI successful. They work as intermediaries between employee needs and desires and management choices.

Ideally, organizations can create positions specifically for the creation and maintenance of a WWI. Strong WWIs include internal marketing, program evaluation and improvement and leadership and accountability.[10] They also cultivate readiness in employees and management, and seek the input of both throughout. This work also takes dedication, humility, curiosity and compassion and requires time and other resources. For the organizations that truly hope to see a return on investment, they will likely get much farther with a designated member of their team to handle the intricate dimensions of a WWI. Designated staff can also serve as the directors of programs that are otherwise created by organizational stakeholders. Some research recommends that upper and middle management and employees all work in a committee to identify shared goals and brainstorm approaches for moving forward.

Ultimately, more research is necessary. An issue with drawing themes from existing literature is that the definition of "participation" varies; research often investigates attendance but does not collect data on behavior maintenance.[6] Action research and SWAT analyses may provide a lens for recognizing the intricate workings of successful and sustainable programs and may establish best practices for WWIs in the future.

5. Acknowledgements

I would like to thank; Dr. Mary Lynn Manns, Brandy Bourne, Jordan Perry, UNCA Writing Center, and HWP Department for their contributions, guidance and wisdom for my process with this research.

6. References

1. Hannon, P. A., Garson, G., Harris, J. R., Hammerback, K., Sopher, C. J., & Clegg-Thorp, C. (2012). Workplace health promotion implementation, readiness, and capacity among mid-sized employers in low-wage industries: a national survey. *Journal of occupational and environmental medicine/American College of Occupational and Environmental Medicine*, *54*(11), 1337.

2. Hannon, P. A., Hammerback, K., Garson, G., Harris, J. R., & Sopher, C. J. (2012). Stakeholder perspectives on workplace health promotion: a qualitative study of midsized employers in low-wage industries. *American Journal of Health Promotion*, *27*(2), 103-110.

3.Hughes, M. C., Patrick, D. L., Hannon, P. A., Harris, J. R., & Ghosh, D. L. (2011). Understanding the decision-making process for health promotion programming at small to midsized businesses. Health promotion practice, 12(4), 512-521.

4. Hugentobler, M. K., Israel, B. A., & Schurman, S. J. (1992). An action research approach to workplace health: integrating methods. *Health education quarterly*, *19*(1), 55-76.

5. Linnan, L., Bowling, M., Childress, J., Lindsay, G., Blakey, C., Pronk, S., ... & Royall, P. (2008). Results of the 2004 national worksite health promotion survey. *American Journal of Public Health*, *98*(8), 1503-1509.

6. Lovato, C. Y., & Green, L. W. (1990). Maintaining employee participation in workplace health promotion programs. *Health Education Quarterly*, *17*(1), 73-88.

7. Madsen, S. R. (2003). Wellness in the workplace: Preparing employees for change. *Organization Development Journal*, *21*(1), 46.

8. Mattke, S., Schnyer, C., & Van Busum, K. R. (2013). A review of the US workplace wellness market. *Rand health quarterly*, *2*(4).

9. McCoy, M. K., Stinson, M. K., Scott, M. K., Tenney, M. L., & Newman, L. S. (2014). Health promotion in small business: a systematic review of factors influencing adoption and effectiveness of worksite wellness programs. *Journal of occupational and environmental medicine/American College of Occupational and Environmental Medicine*, *56*(6), 579.

10. Mujtaba, B. G., & Cavico, F. J. (2013). Corporate wellness programs: implementation challenges in the modern American workplace. *International journal of health policy and management*, *1*(3), 193.

11. Newman, L. S., Stinson, K. E., Metcalf, D., & Fang, H. (2015). Implementation of a worksite wellness program targeting small businesses: the Pinnacol assurance health risk management study. *Journal of occupational and environmental medicine*, *57*(1), 14.

12. Person AL, Colby SE, Bulova JA, Eubanks JW. Barriers to participation in a worksite wellness program. Nutr Res Pract. 2010 Apr;4(2):149-154.

13. Sparling, P. B. (2010). Worksite health promotion: principles, resources, and challenges. *Preventing chronic disease*, *7*(1).

14. Witt, L. B., Olsen, D., & Ablah, E. (2013). Motivating factors for small and midsized businesses to implement worksite health promotion. *Health promotion practice*, *14*(6), 876-884.

15. CDC. Worksite, S. Assessment and Translation (SWAT) Implementation Guide. Retrieved from https://stacks.cdc.gov/view/cdc/31332