FACTORS INFLUENCING THE DEVELOPMENT AND IMPLEMENTATION OF WORKPLACE WELLNESS PROGRAMS IN NEW BRUNSWICK WORKPLACES

by

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ABSTRACT

This study addresses the lack of published information from New Brunswick, Canada on the range of workplace wellness programs and the factors that impact program development and implementation. The qualitative examination used a multiple case study design involving a purposive sample of 10 diverse organizations (six with programs and four without programs). The organizations varied by location, size, sector, and type of work. Data were collected through interviews, focus groups, documentation from the organizations, and field visits.

The six programs varied in their mandate, organization, funding support, and work environments. All six identified management commitment as a key factor influencing program implementation; most collected little formal data on their programs. In three organizations without programs, participants were enthusiastic about establishing a program. However, barriers included lack of budgets, staffing, and other factors; the fourth organization was not considering a program.

The results from this research were synthesized into a Framework for Comprehensive (or Best Practice) Workplace Wellness Programs to guide future decision-making. The three key recommendations resulting from this research are to: 1. increase management’s understanding of comprehensive programming and the important role organizational leaders play in program sustainability; 2. identify and implement strategies to motivate workplaces to implement comprehensive programs; and, 3. strengthen knowledge exchange on workplace wellness.
DEDICATION

This dissertation is dedicated to the current and future leaders in workplace wellness in
the Province of New Brunswick, Canada
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Just as it takes a community to raise a child, it takes a community to create a dissertation.
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Chapter One: Introduction to the Study

An Introduction to Workplace Wellness Programs

The workplace is recognized as a useful setting for wellness and as a factor in employee health (Eakin, Cava, & Smith, 2001; Goetzel & Ozminkowski, 2006; Hannon, Hammerback, Garson, Harris, & Sopher, 2012; Lowe, 2004; Menkens, 2009; Public Health Agency of Canada, 2001; World Economic Forum, 2008a; World Health Organization; 2010). Wellness programs, defined as “efforts that enhance awareness, change behaviour, and create environments that support good health practices” (Aldana, 2001, p. 297), optimize health by helping to prevent both disease and premature death and enhance quality of life, regardless of current employee health status (DeGroot & Kiker, 2003; Edington, 2001; Hughes, Patrick, Hannon, Harris, & Gosh, 2011; The Conference Board of Canada, 2002).

A new paradigm for productivity in the workplace involves preservation and enhancement of human capital (Chapman & Sullivan, 2003) with a focus on prevention of health risks, diseases, and injuries that result in lost productivity. Well-designed and well-implemented workplace wellness programs (WWPs) can improve employee health, productivity, and job satisfaction when integrated into a business strategy and healthy corporate culture (Chapman, 2012; Edington, 2009; Goetzel & Ozminkowski, 2006; Lowe, 2010; Markides et al., 2011; Partnership for Prevention, 2001; Riedel, 2007; Seward, 2010; The Conference Board of Canada, 2002, 2010b; World Economic Forum,
Healthy work environments assist in reducing absenteeism, disability claims, and the costs of health benefits for employees, retirees, and their families thereby improving the bottom line in organizations of all sizes (Birken & Linnan, 2006; Chapman, 2012; Downey & Sharp, 2008; Hughes et al., 2011; University College London, 2004; World Economic Forum, 2008a, 2008b).

The broad vision of a healthy organization offered by Lowe (2010) links health promotion with organizational performance and social responsibility. There is no one recipe for the creation of a healthy organization; each workplace needs to find the most suitable way to connect wellness with healthy working conditions, performance, and the unique needs of the organization. Lowe recommends a process of organizational change to create a healthier and more productive culture and working conditions.

Corporate culture is defined as an organization's personality and philosophy (Lowe, 2010); health culture relates to how people stay healthy while employed by the organization (Hunnicutt, 2007). Integration of multicomponent wellness programs into corporate culture involves connecting to how work is done in the organization, collectively and individually (Eakin et al., 2001; Partnership for Prevention, 2001). Aligning a healthy corporate culture with corporate structure is an important consideration (Lowe, 2010).

When introducing WWPs within organizations, linking health issues to other organizational metrics, such as absenteeism, helps position programs as a performance-enhancing strategy (Baase, 2001; DeJoy & Wilson, 2003; Eakin et al., 2001; Kelly et al., 2010; Lowe, 2010; Seward, 2010; The Conference Board of Canada, 2010b). Programs
can be explained as an investment in corporate success rather than an expense (University of Toronto, n.d.).

Organizational readiness for a program provides another perspective and is described as a shared commitment among managers, a collective perception of the need for a program, and a shared belief in the collective ability and capacity of the organization to implement a program (Hannon, Garson et al., 2012; Weiner, 2009). Management commitment to developing a program should be followed by careful planning to avoid challenges with implementation (Birken & Linnan, 2006). Sustained and visible management support is required throughout program implementation (Birken & Linnan, 2006; Linnan & Birken, 2006).

Many Canadian organizations, including those in the Atlantic region, have not maximized the full potential of workplace wellness programming. A study from 2000 found that only 6% of Canadian firms had incorporated wellness fully as a corporate value and only 3% had an integrated approach (Downey & Sharp, 2007). In Atlantic Canada, programs are “yet to be widely implemented in an integrated manner” (Makrides, Heath, Farquharson, & Veinot, 2007, p. 179). Other Canadian research suggests that employee health is gradually moving onto the radar screens of upper management and increasing in priority for corporate leaders (Eakin et al., 2001; Lochhead, 2002; Pridham & Mardsen, 2000). Research with employers is required to provide information to maximize the potential of WWPs in this province.
Workplace Wellness in New Brunswick

Workplace wellness is an important consideration for the Province of New Brunswick (NB), which currently faces challenges associated with an aging population, escalating health care costs, and rising rates of chronic disease. Although health care budgets have continued to increase, the NB population has gotten sicker (New Brunswick Health Council, 2010). Approximately 77% of New Brunswickers report a diagnosis of one or more chronic conditions (Department of Health, New Brunswick, 2010; Statistics Canada, 2005). The provincial wellness strategy (Department of Wellness, Culture and Sport, New Brunswick, 2009) envisions “healthy New Brunswickers who live, learn, work, and play in a culture of well-being” (p. 4). The document defines wellness as “an ongoing process to enhance the many dimensions of well-being that enable people to reach and maintain their personal potential, and contribute to their communities” (p. 5).

Current Government of NB (GNB) policy recognizes the need for workplaces to offer wellness programs to help reduce chronic disease (New Brunswick Select Committee on Wellness, 2008; Department of Wellness, Culture and Sport, New Brunswick, 2009). This mandate presents the opportunity to affect the health of the present labour force of over 400,000, roughly 53% of the total NB population of over 755,000 (Department of Finance, New Brunswick, 2012). GNB, for its part, initiated a workplace wellness program for departmental employees in 2010.

The Heart and Stroke Foundation of NB (HSFNB) provides leadership by encouraging workplaces to offer wellness programs, developing resources and organizing
an annual conference on workplace wellness. While some organizations have been recognized publicly for their efforts (Heart and Stroke Foundation of New Brunswick, n.d.), detailed descriptions of these programs have not been published. There is no ongoing follow-up with award winners and program sustainability is unknown.

The Study Overview

**Study purpose and significance.** Numerous factors influence whether organizations establish WWPs and how they implement and sustain them (Edington, 2009). These factors have been identified and examined in numerous organizations with WWPs in North America. In organizations without WWPs, information on barriers to program development is rare (only one Canadian study was found, see the Conference Board of Canada, 2002).

In NB, little has been published on the range of WWPs that exist in the province, and there has been no research that focused on the influencing factors, either in organizations with WWPs or without WWPs. This qualitative study will help fill these gaps. The research questions for this multiple case study of organizations with and without programs are:

- What is the current range of WWPs in a sample of NB organizations?
- Which factors in NB organizations either with or without programs facilitate or create barriers to the development and implementation of WWPs?
This research will enhance understanding of the types of WWPs occurring in NB, the sources of program support, and the challenges they face. The research is enhanced by using factors already identified by the literature to inform data collection and analysis. This study can inform future policy development regarding workplace wellness in NB, inform decision-making by government and non-government agencies that assist organizations with WWPs, and help individual organizations to develop or enhance their programs. It builds on the work of Canadian authors by providing detailed information on program range and factors in diverse NB organizations, especially for organizations without programs; establishes a specific NB evidence base for organizations with and without programs; informs population health and wellness policy and practice regarding workplace settings in NB and other Atlantic provinces; and, can help to maximize the full potential of workplace wellness programming.

The remainder of the dissertation. The literature review in Chapter Two provides both background information on WWPs as context for the research and the conceptual foundation for the study. Chapter Three describes the methodology, including the theory and rationale for the use of a multiple case study design, the selected data gathering methods, and a description of the study protocol. Cases are described in Chapter Four in relation to the first research question on the range of programs. Chapter Five addresses factors influencing organizations with programs while Chapter Six addresses factors influencing organizations without programs. The conclusions and recommendations are provided in the final chapter.
Chapter Two: The Literature Review

Introduction

In this research it is important to understand the context behind WWPs, to describe the potential range of programs in other jurisdictions, and to examine the existing literature on factors that influence program development and implementation. This chapter begins with an explanation of the search parameters for the literature review followed by an overview of workplace wellness context and the conceptual foundation for the study.

The review includes both peer-reviewed and gray literature, the latter providing policy context for Canada and information on the business case for WWPs. Searches were conducted using databases available through the University of New Brunswick World Catalogue, including ERIC EBSCO, PubMed, Emerald, SAGE, Scopus, and ProQuest Nursing and Allied Health.

Different authors use a variety of health promotion and/or health management terminology to refer to workplace programs. Articles were selected from relevant electronic journals using key-words such as: workplace or worksite “health promotion”, “health management programs”, “case studies”, “wellness”, and “business cases”, and health promotion “implementation” and “marketing”. A search of the American Journal of Health Promotion between 2000 and December 2012 was conducted manually. Health promotion and methodology textbooks were reviewed as were relevant international, government, university, research organization, and not-for-profit web sites.
Workplace Wellness Context

Aspects of workplace wellness that help provide context for this research are: the importance of the workplace as a program setting and the interactions between employee health and their work; the possible benefits associated with workplace wellness; information on the business case for WWPs, including the return on investment (ROI) in jurisdictions outside of NB; and, a description of wellness policy and relevant initiatives in NB.

The workplace as a program setting. A setting is the context in which people live, work, study, or play and is a potential environment for wellness program implementation (Poland, Krupa, & McCall, 2009, University College London, 2004). Workplaces consist of both physical and social environments that provide opportunities to improve employee and organizational health (Edington, 2009; Health Canada, 2009, University College London, 2004) and to implement comprehensive programs (Hughes et al., 2011; World Health Organization, 2010).

Employee health can be improved through WWPs since employees spend a significant portion of their waking hours at work (Baicker, Cutler, & Song, 2010; Chapman, 2004a; Chu et al., 2000; Edington, 2009; Hannon, Garson et al., 2012; Harden, Peersman, Oliver, Mauthner, & Oakley, 1999; Health Canada, n.d.; Health Council of Canada, 2008; Makrides, 2010; Makrides et al., 2007; Micucci & Thomas, 2007; World Economic Forum, 2008a, 2008b). The existing systems, structures, networks, and resources within workplaces can facilitate implementation of program activities (Bureau
The relationship between the workplace and employee health. The workplace itself is a factor that impacts employee health through physical, psychosocial, and organizational aspects of work (Eakin et al., 2001). Employment and working conditions are among the social determinants of health identified by the Public Health Agency of Canada (2001). The World Health Organization (2010) addresses the need to organize work in a way that will support a healthy society. Shain and Kramer (2004) point to the interaction between what the employee brings to work and what the workplace does to the employee and reference the "under-recognized burden of the organization of work on the health of workers" (p. 645). The Whitehall studies (University College London, 2004) have shown a gradient of increasing mortality and morbidity for employees in the lower ranks of the British Civil Service.

Work-related stress, work-life imbalance, organizational change and job security, effort-reward imbalance, and social support are important considerations (Eakin et al., 2001; Health Canada, 2009; University College London, 2004). Stress can be related to how work is organized; shift-work, contract work, low pay and benefits, and strained relationships with supervisors and co-workers are examples (Eakin et al., 2001). Employees may struggle at times throughout their careers with stress associated with the demands of home and work (Cooper & Patterson, 2008; Edington, 2006; Health Canada, n.d.; Lowe, 2010; Makrides et al., 2007; Shilton, 2009; The Conference Board of Canada,
2002; University College London, 2004; World Economic Forum, 2008a). Work-life balance is negatively impacted by the blurring of boundaries between the workplace and employees’ personal lives (Zoller, 2003).

A survey of over 30,000 Canadian employees in a total of 100 medium and large organizations in the private, not-for-profit, and public sectors found that Canadians face challenges trying to balance work-life and life at home (Duxbury & Higgins, 2003). Employees with dependents, those working in the not-for-profit sector, and women in management positions have the greatest difficulty balancing work and home. Issues for employees in larger organizations include stress, lack of both job satisfaction and commitment to the employer, and absenteeism due to physical and mental health issues resulting from role-overload.

This struggle is intensified in organizations that experience constant organizational change (downsizing, reorganizing), increasing workloads, growing job pressures, and excessive over-time. Lowe (2010) considers some of these to have become “standard features of working life and therefore health risks in their own right” (p. 61). Rapid organizational change and daily stressors result in a negative impact on productivity (Duxbury & Higgins, 2003; Eakin et al., 2001; Hanson, 2007; Lochhead, 2002; Lowe, 2003; Lowe, Schellenberg, & Shannon, 2003; Makrides et al., 2007; Pridham & Mardsen, 2000; University College London, 2004).

Factors that influence how an employee views an employer include the work environment and treatment at work. If negative, employee recruitment and retention are impeded and affect the employer’s bottom-line. Over the past decade, productivity has decreased due to the deterioration of the physical and mental health of employees and
their families resulting from role-overload. While providing WWPs can help employees cope with these factors several authors recommend that organizations assess their workplace practices, policies, and environments to ensure they support the health of employees (Baase, 2001; Duxbury & Higgins, 2003; Lowe et al., 2003; Makrides et al., 2007; University College London, 2004).

**Program benefits.** Potential program benefits can motivate senior management in organizations to consider WWPs (Witt, Olsen, & Ablah, 2013). Program benefits can be direct and measurable, such as reductions in drug costs (Makrides et al., 2011), while others are indirect and are associated with less tangible human resource (HR) considerations. Lowe (2010) refers to collateral benefits and to the hard and soft sides of workplaces. He believes the intangibles drive the tangible results, including productivity, growth, and profits. Organizational benefits can be achieved by reducing costs, enhancing team effectiveness, increasing productivity, and improving morale (Lowe, 2010; Makrides et al., 2011). At the individual level, benefits include improved employee satisfaction, engagement, effectiveness, health, and work-life balance.

Ten frequently cited categories of program benefits include:

1. reduced health risks and associated costs (disability claims and the costs of health benefits for employees, retirees, and their families, and injuries and associated compensation claims);

2. reduced presenteeism (present at work physically but not fully productive) yielding increased productivity while at work;

3. reduced incidental or casual absenteeism (one or two days in duration) linked to chronic conditions (yielding reduced costs for replacement employees
and/or increased productivity);

4. reduced work disruption caused by absenteeism (yielding increased productivity for other employees);

5. enhanced job satisfaction (commitment, motivation, and improved morale);

6. reduced turn-over of employees (reduces time spent on staffing vacancies by HR including orientation and training of new staff);

7. enhanced recruitment and retention of employees (employer of choice);

8. enhanced corporate image and customer loyalty;

9. enhanced work-life balance and stress reduction; and,

10. increased profits and ability to compete in a global market


There is growing recognition of the need for WWPs to help reduce the risk factors associated with the rising rates of noncommunicable, chronic diseases in society.
Makrides et al. (2007) write that “Atlantic Canadians share numerous health issues including high rates of smoking, physical inactivity and obesity, which puts them at higher risk for chronic conditions” (pp. 178-179). Employee participation in a wellness program may yield changes in behaviour that result in improvements in health status. Employee families and friends may adopt similar behaviour change thereby slowing or reducing rates of chronic illness in society (Bureau de Normalisation du Québec, 2008; Hannon, Garson et al., 2012; Health Canada, n.d.; Hughes et al., 2011; Makrides et al., 2007; World Economic Forum, 2008a; Young, 2006).

Employers benefit by maintaining corporate history in the workplace when older, more experienced employees avoid or delay retirement (Cooper & Patterson, 2008; Edington, 2006; Edington, 2009; Lowe, 2004; World Economic Forum, 2008a). Individual employees may progress from low to high risk of poor health as they age, further supporting the need for workplace programs that are sustainable over the career of an employee (Edington, 2009; Golaszewski et al., 2008; Hunnicutt & Sabbag, 2008).

The business case. The benefits derived from programs are part of the business case rationale for offering WWPs (Lowe et al., 2003). Workplace wellness is recommended as a business strategy and investment (American Heart Association, n.d.;
Edington, 2009; Makrides et al., 2011). Canadian examples of ROI vary by organization. Canada Life Assurance Co. cites a return of nearly seven dollars for each dollar spent after ten years of programming (University of Toronto, n.d.). They found that over a one year period, per capita medical expenses did not increase for program participants but increased 25 per cent for non-participants (The Conference Board of Canada, 2002). Telus BC and BC Hydro report returns of three dollars for every dollar spent on wellness (National Quality Institute, 2008; University of Toronto, n.d.).

The Public Health Agency of Canada (2007) cites that: participants in the first six months of the Toronto municipal 'Metro Fit' fitness program missed 3.35 fewer days than non-participants; BC Hydro employees enrolled in a work-sponsored fitness program had a turnover rate (employees leaving the organization) of 3.5% compared with the company average of 10.3%; Canada Life Assurance Company turnover rate for fitness program participants was 32.4% lower than the company average over a seven-year period; and, Toronto Life Assurance employee turnover rate for those enrolled in the company’s fitness program was 1.5% versus 15% for non-participants.

In 2000, Statistics Canada reported an average annual absenteeism rate of eight days per full-time employee (The Conference Board of Canada, 2002). This can be compared to: MDS Nordion’s program, which contributed to annual sick day usage of four days and a reduced turnover rate among employees of six per cent (National Quality Institute, 2008; The Conference Board of Canada, 2002); the Canadian Wheat Board’s reported annual rate of sick leave of 3.8 days with their program (University of Toronto, n.d.); and BC Hydro’s program, which was credited with contributing to an absenteeism rate of 5.8 days per employee and increased employee engagement and morale.
Organizational renewal, increased productivity, and employee retention were the objectives in a Quebec organization’s program that contributed to reducing absenteeism by 28% and employee turnover by 54% in a three year study (Renaud et al., 2008).

A BC Hydro cost/benefit study of their program from 1996 showed: $1.2 million in reduced sick leave costs annually; $97,000 in reduced accident costs per year; a $35,000 Workers’ Compensation Board (WCB) rate reduction; productivity gains of $919,000; and employee retention and corporate image gains (Public Health Agency of Canada, 2007).

Results from the Vancouver Airport Authority's employee health and safety program described: total absenteeism reduced from 4.07% in 1999 to 2.56% in 2002; injuries decreased from 22 in 1999 to six in 2002; ‘days lost' to injury decreased from 223 in 1999 to 24 in 2002; and enhanced employee satisfaction with a high level of commitment to the Airport Authority as evidenced in an employee survey (Public Health Agency of Canada, 2007).

Lighthouse Publishing in Nova Scotia, an organization with fewer than 50 employees, reported significant returns from an initial program investment of $2,000 (The Conference Board of Canada, 2010b). Employees lost over 260 pounds and four employees quit smoking resulting in savings of six thousand dollars in health benefit 2premiums. The company reported improved morale and improved corporate image related to community involvement in activities. Secunda Marine Services, also headquartered in Halifax, had 350 employees located on 14 ships. After an initial investment of $35,000 in a program called Ship Shape, the organization reported savings
of $200,000 annually, decreased absenteeism due to injury by 80%, and increased employee retention to 97% (The Conference Board of Canada, 2009). The University of Toronto (n.d.) asks how organizations can afford not to invest.

More recently, the Department of Justice in the Government of Nova Scotia participated in an economic analysis of their comprehensive Healthy LifeWorks wellness program in 12 sites across the province (Makrides et al., 2011). The study examined the relationship between modifiable health risks and employee absenteeism in a sample of 402 employees and, modifiable health risks and drug costs in 298 of the 402 participants. Participating employees were divided into four risk categories depending on their results from baseline (2004) and post intervention (2008) Health Risk Assessments (HRAs) and biometric screening. The categories included low-low, low-high, high-low, and high-high. Those who moved from low risk to high risk showed the highest relative percentage increases in the usage, supply, and cost of drugs while those whose risk status changed from high to low had the smallest relative increases. Participants who moved from low risk to high risk had the highest increase in absenteeism hours and cost. During the study, the total number of risks for participants decreased yielding a conservative projected savings in 2007-2008 of $6979 in absenteeism associated with risk reduction. Makrides et al. (2011) stress the importance of offering opportunities for high risk reduction while maintaining other employees at low risk to control drug costs. The study supports the value of WWPs in decreasing absenteeism.

Wellness in NB. A number of salient NB examples of workplace wellness initiatives exist in the public, not-for-profit, and private sectors. GNB has provided policy documents for the development and implementation of programs in the province. The
2004-2008 Provincial Health Plan contained four main priorities to improve the health of New Brunswickers, one of which was improving population health with an emphasis on healthy living and wellbeing. The New Brunswick Wellness Strategy (Department of Health and Wellness, New Brunswick, 2006) was developed as a result of this plan and was based on four pillars of healthy lifestyle: physical activity, healthy eating, tobacco-free living, and mental fitness and resiliency. These pillars were supported by five strategic directions: partnership and collaboration; community development; the promotion of healthy lifestyles; surveillance, evaluation, and research; and healthy public policy.

A subsequent report from the New Brunswick Select Committee on Wellness (2008) offers a provincial vision for wellness as holistic, based on the determinants of health, and a shared responsibility. The workplace is named as one of several settings with the potential to positively influence population health and wellbeing. Employers are viewed as stakeholders with the ability to: support community capacity through partnerships, research, monitoring and evaluation; provide messaging consistent with school and community settings; and disseminate information on their activities. More specifically, the suggested role of employers includes: supporting employee wellness by creating opportunities for education and skill building; creating a supportive workplace environment; implementing healthy workplace policies; and, implementing initiatives that support physical activity, healthy eating, tobacco-free living, and psychological wellness. (New Brunswick Select Committee on Wellness, 2008)

Elements to create a wellness culture are described as: commitment, leadership, and champions; supportive environments and healthy public policy; an integrated,
comprehensive approach; and, a diversity of sectors, partnerships, and a mindset or paradigm that makes use of assets which are readily available (New Brunswick Select Committee on Wellness, 2008).

A second wellness strategy for 2009 to 2013 followed (Department of Wellness, Culture and Sport, New Brunswick, 2009). The strategy emphasizes the need to create a provincial wellness culture through various settings while utilizing a comprehensive, multidimensional, and collaborative approach. The original four pillars and five strategic directions remain in place. The strategic vision is described as “healthy New Brunswickers who live, learn, work, and play in a culture of well-being” (p. 4). The need for evaluation is stressed.

A four year wellness program for GNB departmental employees (schools, hospitals, and crown corporations are excluded) was initiated in 2010 (Department of Wellness, Culture and Sport, New Brunswick, 2010). Employees are encouraged to complete HRAs to identify personal health risks. Aggregate HRA data inform the specifics of departmental wellness programs and indicate trends over the life of the initiative. The five program goals are to: improve the wellness of public employees, reduce modifiable health risks and decrease the high prevalence of chronic disease, identify initiatives and activities to promote a healthy workplace, encourage success in achieving personal and corporate wellness goals and milestones, and, improve morale and job satisfaction.

The HSFNB has taken a leadership role to enhance workplace wellness programming, especially in small and medium sized organizations (Health Canada, n.d.). A program tool kit (Heart and Stroke Foundation of New Brunswick, 2008) was prepared
to assist organizations with developing programs. The HSFNB began organizing annual workplace wellness conferences in 2007 to disseminate information on best practices and to provide networking opportunities. Awards are announced during the conferences to recognize achievements in workplace wellness with four levels of programming: gold, silver, bronze, and distinction. The criteria are based on a matrix related to the four pillars from the provincial wellness strategy and to four intervention strategies (awareness and education, skill building and learning, environment, and policy). However, details about these award-winning programs have not been published. During the 2013 conference, a community of practice was officially launched for participants interested in workplace wellness in NB.

Regarding the private sector, thirty Chief Executive Officers (CEOs) from Atlantic businesses assembled at a forum held in Saint John in 2008 to exchange knowledge on programs and to determine how Atlantic Canadian CEOs could provide leadership. Those present discussed lessons learned within their respective organizations. They decided that there was a need to develop a model for use by Atlantic companies that "would facilitate the development, implementation and evaluation of a 'value-based' health management strategy" for the region (Makrides, 2008, pp.7-8).

Conceptual Foundation

**Overview.** The literature in the conceptual foundation was selected to inform the data gathering and analysis in response to the two research questions:

- What is the current range of WWPs in a sample of NB organizations?
• Which factors in NB organizations either with or without programs facilitate or create barriers to the development and implementation of WWPs?

In relation to the first research question, the first section describes a continuum of levels of organizational commitment to wellness developed by Edington (2009). This is followed by examples of programs to further demonstrate the potential range of programs. To help answer the second research question, the next section identifies and describes factors that facilitate or create barriers to the development and implementation of WWPs found in a variety of studies; it ends with a list of recurring factors.

**Program range as a continuum of employer commitment.** Edington (2009) uses a continuum to describe four major levels of employer commitment to wellness programs: Level 0 is doing nothing for employee health, Level 1 is traditional programming, Level 2 is comprehensive programming, and Level 3 is for champion employers who offer best-practice programs to their employees. A description of these levels provides insight into the potential range of programs.

**Doing nothing for employee health.** This level applies to organizations with leaders who are not ready to commit to WWPs. Edington (2009) calls this level zero and describes the organizational leadership as accepting no responsibility for employee health. Weiner (2009) explains organizational readiness for change as requiring shared management resolve to implement a program coupled with shared confidence in their collective ability to do so. More recently Hannon, Garson et al. (2012) describe organizational readiness as attitudinal readiness or perceived need for a program and perceived fit of the program within the organization coupled with structural capacity,
including financial and human resources. These studies provide possible explanations for
the lack of commitment to initiate programs in some organizations. The remaining three
positions on Edington’s continuum relate to varying levels of commitment to program
implementation and reflect the evolution of recommendations regarding programs over
the years.

**Traditional programs.** Level one of the continuum of organizational commitment
(Edington, 2009) describes traditional or common-practice programs. These programs
focus primarily on changing the behaviour of individual high-risk employees to reduce
personal health risk factors associated with specific chronic diseases and are often
delegated to HR departments for implementation. Program activities are piece-meal and
restricted mostly to educational offerings. Traditional programs lack senior management
commitment, are not linked to other initiatives or integrated into the business strategy,
and normally are not sustained or evaluated (Canadian Diabetes Association, 2003;
Edington, 2006, 2009; Makrides, 2010; Terry, Seaverson, Grossmeier, & Anderson,
2008).

**Comprehensive programs.** Level two of the continuum (Edington, 2009) involves
programs for all employees not just those with high health risk factors. Other authors
refer to comprehensive programs that include both individual and organizational or
environmental change (Harden et al., 1999). The approach is described by some authors
as a determinants or social ecological model with the focus on the link between the
individual and the environment in which the individual lives, learns, works, and plays
(Eakin et al., 2001; Golaszewski et al., 2008; Kok, Gottlieb, Commers, & Smerecnik,
2008; Linnan & Birken, 2006). Senior management is engaged and a program committee
is responsible for implementation. Regular measurement connects participation in program activities to outcomes (Edington, 2009).

Program integration into the organizational culture and structure and multiple implementation strategies help to build a supportive physical and social work environment (Golaszewski et al., 2008; Linnan & Birken, 2006; Springett & Dugdill, 1995). Focusing on both employees and their corporate environment helps maintain and improve employee health (Eriksson et al., 2008; Hanson, 2007; Health Canada, n.d.; Lowe, 2004; O’Donnell, 2002; Serxner et al., 2009; World Economic Forum, 2008a). Other authors (Makrides, 2010; World Economic Forum, 2008a) broaden this perspective by stating that the growing health and opportunity costs associated with employee chronic conditions make comprehensive workplace wellness a necessity for organizations to remain sustainable and competitive.

Comprehensive workplace wellness is further described by Makrides (2004; 2010) as an investment in remaining competitive, integrated within the organization’s strategic plan, and a philosophy reflected in organizational values and culture. Program activities are sustainable and communicated effectively to employees. A comprehensive program includes ongoing monitoring of progress against measurable goals and formal evaluation of results against criteria and indicators (Harden et al., 1999; Lowe, 2004; Makrides, 2004, 2010; National Quality Institute, 2008; Serxner et al., 2009; World Economic Forum, 2008a).

Other authors state that sustainable and comprehensive WWPs begin with the assessment of individual employee health risks, provide interventions based on aggregate employee needs, are linked to other initiatives such as employee benefits, and are
integrated into the daily work life of the organization through senior management commitment and a supportive corporate culture and physical work environment. Similar to employee safety, wellness involves everyone in the organization and requires ongoing communication (Bureau de Normalisation du Québec, 2008; Chapman, 2004a; Chu et al., 2000; Edington, 2009; Linnan & Birken, 2006; Lowe et al., 2003; Makrides, 2010; Makrides et al., 2007; O’Donnell, 2002; Serxner, Anderson, & Gold, 2004; Shilton, 2009; Tones & Green, 2006; University of Toronto, Centre for Health Promotion, n.d.; World Economic Forum, 2008a, 2008b; Young, 2006).

A comprehensive program uses a variety of implementation strategies including: enhancing awareness, health education, capacity building, creating supportive physical and psychosocial environments, coaching, counselling, healthy public policy, incentives, benefit plan restructuring, HRAs, screening activities, marketing, tailored communications, and knowledge translation (Chapman, 2006; Chu et al., 2000; Edington, 2009; Gilkey, Earp, & French, 2008; Gingerich, Anderson, & Koland, 2012; Hughes et al., 2011; Johnson, Cummins, Evers, Prochaska, & Prochaska, 2009; Linnan & Birken, 2006; Lowe et al., 2003; Maiiese & Fox, 1998; Makrides, 2004; Makrides et al., 2011; McPeck et al., 2009; Merrill et al., 2011; O’Donnell, 2009; Plotnikoff et al., 2005; Tones & Green, 2006; Wills & Douglas, 2008; World Economic Forum, 2008a).

A description of comprehensive programs provided by the American Heart Association (n.d.) lists specific activities regarding tobacco cessation, physical fitness, stress management and/or reduction, early detection and/or screening, nutrition education, weight management, cardiovascular disease prevention, back pain prevention and management, adult vaccination, alcohol and substance abuse assessment, and
maternal and infant health education and guidance. The Association recommends that comprehensive programs include or address: motivational interviewing and assessment of readiness to change; the needs of all employees regardless of gender, age, ethnicity, culture or physical or intellectual capacity; modifications of the physical work environment to facilitate healthy behaviours; decision-making that promotes wellness; and active learning where outcome evaluation is an integral component. Further, the Association suggests that organizations can achieve comprehensive programs through incremental efforts.

According to Grossmeier, Terry, Cipriotti, and Burtaine (2010), there is consensus that comprehensive programs include:

- population-level assessment, targeted follow-up programs for those at highest risk, and population-level health awareness and education activities for all employees,
- an on-site program management team,
- HRAs, preventive health screenings, incentive models, focused behaviour change programs, lifestyle management and disease management programs,
- wellness campaigns, personal online health web sites, and on-site fitness centres,
- consistent offerings to all employees,
- local-level customization of program offerings. (p. 5)

**Best-practice or champion programs.** The final level of organizational commitment along the continuum is referred to as best-practice or champion programs (Edington, 2009). Senior management creates a vision for a sustainable and integrated program, is visibly committed, and leads by example. The program is part of an organization's culture of wellness, organizational values, and decision making. Unions and community partners are involved where applicable. Others describe a new era in
programs requiring a strategic approach with greater attention to accountability and effectiveness (Golaszewski et al., 2008; Ryan, Chapman, & Rink, 2008; World Economic Forum, 2008a, 2008b). Edington (2009) and others recommend that traditional offerings evolve towards best-practice programs (Goetzel et al., 2007; Terry et al., 2008).

**Examples of the range of programs.** The following examples of WWPs relate to the comprehensive and best-practice end of Edington’s (2009) continuum and help to demonstrate the potential breadth, depth, and focus of such programs. The examples are frequently cited and/or are found in well known organizations. One description was found for a WWP in NB. The section ends with a discussion of program sustainability and unintended consequences of programs.

**Programs in the US.** The US currently leads the world with WWPs some of which have been in place since the 1970s (Bertera, 1990; Blair, Piserchia, Wilbur, & Crowder, 1986; Frankish, Johnson, Ratner, & Lovato, 1997; Makrides, 2004; O’Donnell, 2002). Corporations such as DuPont and Johnson & Johnson enhanced employee health and productivity while reducing both absenteeism and presenteeism (Bertera, 1990; Bly, Jones, & Richardson, 1986; Breslow, Fielding, Herrman, & Wilbur, 1990; Isaac & Flynn, 2001; Springett & Dugdill, 1995). More specifically, in 1981, DuPont had approximately 110,000 employees in over 100 sites around the world conducting a wide variety of tasks (Bertera, 1990). The company’s wellness program was pilot tested at two sites and was developed using a public health education framework for employees, their families, and retirees. The epidemiological analysis of company morbidity and mortality data provided the program planners with an aggregate picture, comparable to that of the adult US population, for major causes of death including heart disease, stroke, cancer, and injury.
Similar to the Whitehall studies (University College London, 2004), highest levels of morbidity aligned with lowest levels of income.

The planners then conducted an assessment in 1982 of the company’s wellness resources, activities, and expectations using a survey instrument distributed to 75 worksites (Bertera, 1990). The company had many activities underway in various locations related to smoking cessation, blood pressure control, healthy eating, physical activity, cancer prevention, stress management, and addiction prevention that incorporated counselling, and the use of educational, communication, and promotional materials. An administrative audit was conducted to determine factors associated with introducing a program and focused on organizational strengths and limitations. The audit included a review of existing policies and involved medical staff, supervisors, employees, and union representatives. A careful link was made to existing health and safety activities and approaches. Educational sessions were offered during regular health and safety meetings to promote safety both on and off the job.

The resulting pilot program involved employees, volunteers, medical personnel, and health and fitness specialists. Activities included: HRAs, group and self-directed activities, use of on-site and community-based resources, recognition and awards, and changes to smoking policies and cafeteria and vending machine choices (Bertera, 1990). Specific objectives were developed for a five year period related to decreases in smoking, blood pressure, cholesterol levels, and weight, along with increases in exercise, disease-specific screening, and seatbelt use. Participating job sites had coordinators and committees and were supplied with marketing and orientation materials in different formats. Recognition and incentives were used to reinforce behaviour change, including
newsletters, plaques, certificates, and attendance at conferences. The company also focused on sustaining the program.

The pilot results were positive (Bertera, 1990). The Memphis plant, one of the test sites, was typical of a manufacturing site with over half of the employees considered to be in blue-collar jobs. The population was aging and turn-over was low. Over the test period, there was a decline in the number of work days lost for hourly employees and disability days declined by 47.5%. The second pilot site began a year later and the results were equally positive.

In 2004, Volvo initiated Health for Life, a wellness program for North American employees, with the intention to build a culture of health (Grossmeier et al., 2010). The program, described as comprehensive, has senior management support that begins with the CEO. The medical director in each country has responsibility for the program and the program budget rests with the health benefits department. There are fitness facilities on site at major locations. To facilitate program participation, employees have access to online or paper versions of HRAs, self-paced program offerings, coaching and counselling to assist in behaviour change, comprehensive marketing and communication materials, incentives, biometric and preventive screenings, and on-site staff. An internal award recognizes best practices in workplace wellness and a Participant-of-the-Year is selected. The Health for Life program has been recognized by external award programs. Activities are evaluated; outcomes and employee satisfaction with program activities are measured.

**International programs.** In several other international programs, the activities were based on a needs assessment, an employee survey, or a focus group session (World Economic Forum, 2008a). Chronic disease risk-factors were modified through healthy
eating, physical activity, smoking cessation, and stress reduction interventions. Organizations either used in-house expertise or developed partnerships with outside experts or health-related organizations. Confidentiality of employee personal health information was guaranteed. The range of interventions included (World Economic Forum, 2008a): on-site fitness facilities, stretching exercises, massage, day-cares, and healthy foods in cafeterias and vending machines; gym memberships off site; smoking cessation programs and policies addressing smoking on-site or in vehicles; access to in-house medical professionals and employee assistance programs; screening clinics (glucose, blood pressure, cholesterol, and weight status); peer education, educational campaigns for specific conditions, on-line learning; e-mail, and posters; wellness days; leisure activities for employees, families, and communities; and, volunteering in the community.

An example from NB. A Canadian series of case studies conducted in 2001-2002 determined that organizations promoting health and wellness would have a recruitment and retention advantage during the predicted period of skill shortages (Lochhead, 2002). A purposive sample of 12 organizations was selected from across the country to provide a variety of sector, size, and union status. One case study was conducted in NB with Irving Paper, a mill operating 24/7, located in Saint John. At the time of Lochhead’s study, the on-site Health Services Department had developed a wellness policy and program activities including company-funded smoking cessation, fitness, and weight activities in collaboration with the unions and mill employees. The on-site occupational health nurse also offered screening for blood pressure, cholesterol, and blood glucose levels. An employee assistance program provided counselling services. A library of health-related
information was available and monthly information sessions were held. Other initiatives included annual wellness fairs, sports teams, recreational events, and poster contests for children and grandchildren of employees.

Irving management described program benefits as “increased safety, reduced short-term disability claim costs, increased job satisfaction, and vastly improved labour-management relations” (Lochhead, 2002, p. 2). Management also saw a connection between wellness and the facilitation of organizational change. The proactive process of developing and implementing a program after a strike positively influenced communications and trust between unions and management. Management viewed employee wellness as a means of achieving the organization’s goals and business strategy. A governance structure was established for planning and decision making. Employees attended conferences and research was conducted to develop new initiatives. Statistics were maintained, results were evaluated regularly, and the wellness program budget was protected during fiscally difficult times. Wellness was included in the criteria to determine employee performance and bonuses. Program communication was ongoing and time was devoted at meetings to wellness discussions.

Program sustainability. Programs become unsustainable due to a variety of factors. Award winning programs with positive ROIs such as DuPont (see description above) and Pacific Bell have been discontinued. Reasons for the elimination of the program at Southern California Edison, after six years of implementation, include the lack of a management champion, the lack of resources, reorganizing, changing business priorities, and turn-over in employees (Schmitz, 2001). AT&T launched one of the first health promotion programs in 1983 only to see the program cut in 1998 and “the culture
of health replaced by a culture of survival” (McCauley, 2001, p. 376). The demise of the program resulted from the loss of the management champion, spending cuts to avoid layoffs, and technological challenges that had captured the attention of management.

**Unintended consequences of program activities.** Involving employees as end-users throughout the development and implementation of a wellness program is consistently recommended by various authors (Chu et al., 2000; Eakin et al., 2001; Edington, 2009; Hanson, 2007; Kuoppala, Lamminpää, & Husman, 2008; The Conference Board of Canada, 2010a; Weiner, 2009; World Economic Forum, 2008a).

The importance of employee involvement from the beginning of the development process was demonstrated in a two-year study at the Nihon Kuruma Automotive manufacturing facility, in the US (Zoller, 2004). The organization had constructed an on-site recreation facility for employees that resulted in morale problems, divisiveness, and alienation among some workers. The employees were not consulted about their needs nor did they participate in the decision to construct the recreation facility. Women did not feel welcome at the facility and the program messages around self-discipline were not well received by some staff. The results reflected cynicism and mistrust of management rather than appreciation. Zoller’s (2004) recommendations to avoid suspicion associated with organizational motives include facilitating factors: integration of programs within organizational decision-making; and participation by a broad representation of employees and union representatives in the planning stage to augment program flexibility, promote understanding among the intended audience, and encourage employee participation. Edington (2009) agrees with including union representation and recommends integration in organizational values and decision making to help ensure sustainability.
Factors that facilitate or create barriers to program development and implementation. The literature yields a list of a dozen recurring factors that facilitate or create barriers during program development and implementation. Comprehensive WWPs, such as those already described, are affected by a variety of factors evident through decades of programming (Edington, 2009; Goetzel et al., 2007; Terry et al., 2008; Weiner, Lewis, & Linnan, 2009). However, Weiner et al. (2009) mention the corresponding lack of studies to explain which factors are more important and why they are more important, either individually or in combination with others. A number of factors that facilitate program development and implementation are as follows.

**Management commitment.** The importance of senior management commitment is stressed by the World Economic Forum (2008a). Edington (2009) describes a process of moving from commitment to action. Management decides on a level of commitment to a program. Once the decision is made by senior management to authorize a program, the next steps involve developing a vision for a culture of wellness, communicating this vision to employees and the community, and leading by example. It is his view that other factors cannot overcome the lack of a serious commitment from senior management (Edington, 2009).

**Strategic plan.** Including wellness in the organization’s strategic plan helps to demonstrate senior management commitment to wellness as an organizational priority (World Economic Forum, 2008a).

**Program resources and program committee.** Management supports the decision to develop a program by allocating adequate program staff and funding. Authority and
responsibility are delegated to program staff and an implementation committee (Edington, 2009; Hannon, Hammerback et al., 2012; World Economic Forum, 2008a).

**Supportive physical work environment.** Employee benefits, organizational policies and procedures, and incentives (point collection, money, merchandise, gift certificates) are aligned to support the program (Edington, 2009; Gingerich et al., 2012; Makrides et al., 2011; Merrill et al., 2011; University College London, 2004; World Economic Forum, 2008a).

**Data for needs assessment, monitoring, and evaluation.** Data related to the employee needs assessment can be obtained from various sources, including HRAs, screening clinics, and benefits providers. Ongoing data collection is required to support program monitoring and evaluation (Edington, 2009; Makrides et al., 2011; University College London, 2004; World Economic Forum, 2008a).

**Additional facilitating factors.** Other factors (Hannon, Hammerback et al., 2012; World Economic Forum, 2008a) are as follows: ongoing intranet communications; program marketing; cultural sensitivity; and, involvement of employees and their families, retirees, corporate clients and suppliers, and the surrounding communities. Employee participation and program ownership or buy-in are important.

**Barriers.** The facilitating factors described above may also become barriers. Lowe describes this as “flip sides of the same coin” (2003, p. 36). For example, instead of management commitment to a program, management resistance may act as a barrier. Likewise, policies and practices to promote health can be neutralized by policies and practices in other areas of an organization.
A report by The Conference Board of Canada (2002) outlined the reasons given by Canadian organizations (in the 2000 National Wellness Survey by Buffett Taylor and Associates) for not having a program. The barriers were: no budget, no staff, concerns over program costs, lack of wellness knowledge, unconvinced of savings associated with wellness, concerns over making wellness available to all employees, and, inability to quantify results.

Another significant barrier occurs when employees most in need of program interventions do not participate (Baicker et al., 2010; Harden et al., 1999; Zoller, 2004). Achieving high early participation rates and maintaining behaviour change over time are described by the American Heart Association (n.d.) as universal challenges along with maintaining confidentiality and privacy, data management, and providing policies for employees who telecommute or work from remote locations.

Other authors (Birken & Linnan, 2006; Hannon, Garson et al., 2012; Hannon, Hammerback et al., 2012; Lowe, 2003; The Conference Board of Canada, 2010a; Zoller, 2004) identify additional barriers as: lack of information or organizational data; not addressing the most important health issues; lack of promotion and organizational logistics, including communication channels; organizational inconsistencies from a lack of internal communication; disagreements on program priorities; inconvenient program offerings; and, focusing solely on individual behaviour change (as in traditional programs).

According to Birken and Linnan (2006), these general barriers to implementation are consistent regardless of the size of organizations and should be addressed in the
program planning stages. Their recommendations to avoid barriers include strategic planning, a needs assessment, a marketing plan, and involving unions.

**Size of the organization.** Canadian data show that the size of the workplace influences the program activities provided (Craig, Beaulieu, & Cameron, 1994). For example, small companies are more likely to provide information or approve policies rather than offer program activities. Reasons given in the US (Bertera, 1990; Hughes et al., 2011; Linnan & Birken, 2006; McPeck et al., 2009; Witt, Olsen, & Ablah, 2013) for the gap in the availability of programs among large and small organizations include: lack of a champion to ensure resources and commitment; lack of time, space, organizational structure, and staff resources; lack of organizational awareness of programs; lack of employee buy-in; lack of employee health benefits; program costs; competing demands; the struggle to survive; culture; beliefs; and, privacy issues.

To close the gap in program availability between large and small employers, Bertera (1990) recommends: integration of the program within existing structures; use of existing resources; and an implementation plan. Other recommendations include: changes in public policies; partnerships among small organizations through business networks such as Chambers of Commerce; establishing cooperatives and partnerships with community organizations; and involvement with community resources such as the YMCA, YWCA, Cancer Society, Lung Association, Heart and Stroke Foundation, and the Red Cross (Bertera, 1990; Linnan & Birken, 2006; McPeck et al., 2009).

**Integration of health and safety and wellness programs.** Yet another barrier relates to lack of integration across health and safety (legislated requirements) and wellness programs (Alexander et al., 2006; Hughes et al., 2011). The competition among
disciplines for dominance includes “constraints on what can and cannot be thought, said or done” as part of programming and company norms (Alexander et al., 2006, p. 76).

Two dominant program approaches are described as either 'health as safety' or 'health as lifestyle' with “tension between the two discourses as practitioners stake their territory by marginalizing alternative views” (p. 81). Once again emphasis was placed on management leadership and employee involvement in program planning, implementation, and evaluation.

**Recurring factors.** Based on the literature above, a dozen recurring factors surface that may impact comprehensive WWPs either positively or negatively (Birken & Linnan, 2006; Chapman, 2004a, 2004b; Chu et al., 2000; Eakin et al., 2001; Edington, 2009; Goetzel et al., 2007; Golaszewski et al., 2008; Grossmeier et al., 2010; Hannon, Garson et al., 2012; Hannon, Hammerback et al., 2012; Hughes et al., 2011; Lowe, 2003, 2004; Makrides, 2010; Makrides et al., 2007; Partnership for Prevention, 2001; Terry et al., 2008; The Conference Board of Canada, 2002; 2010a; Weiner, 2009; Wellness Councils of America, 2008; Witt, Olsen, & Ablah, 2013; World Economic Forum (2008a). The factors are as follows:

1. management commitment, support, and participation;
2. a strategic plan that includes wellness;
3. integration within the organization including linkages to business objectives and other programs offered by the organization;
4. program resources, including staff and funding;
5. a program committee or, in a small organization, a champion for coordination;
6. program activities that relate to the needs assessment, target several health issues, and are tailored to specific employee and organizational needs;

7. participation of employees, retirees, unions, and the community; engaging all employee groups in the process;

8. a physical workplace environment that is supportive of the program, through organizational procedures and policies, benefit design, and effective incentives;

9. program marketing and communication with employees;

10. a needs assessment, such as HRAs;

11. management of other necessary HR and financial data; and,

12. monitoring and evaluation to measure progress against established goals, criteria and indicators.

In summary, the conceptual foundation informs the two research questions by providing: a description of Edington’s (2009) continuum of employer commitment coupled with the descriptions of programs in different organizations; and, a list of recurring factors that facilitate or act as barriers to program development and implementation. All subsequent aspects of this dissertation were informed by this foundation. These include the screening tool for recruitment of organizations for this study, the data gathering instruments, the themes for data analysis, and the conclusions and recommendations. Details of how these concepts were utilized in the methodology are provided in the next chapter.
Chapter Three: Methodology

This study was designed to obtain detailed information about the range of workplace wellness programming in NB and the factors that facilitate or act as barriers to program development and implementation in organizations with and without programs. The first section in this chapter provides the theory and the rationale behind the selection of an exploratory, multiple case study design; the second section explains the rationale behind the research protocol used to conduct this study. The last section describes the study protocol including case recruitment, data collection, and analysis.

Case Study: Theory and Rationale

The case study method was selected for this research as the best fit for the research questions. A case study is defined by Yin (2003) as:

an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident.... and ... relies on multiple sources of evidence, with data needing to converge in a triangulating fashion. (pp. 13-14)

Case studies are defined by Merriam and Simpson (2000) as “an intensive description and analysis of a particular social unit that seeks to uncover the interplay of significant factors that is characteristic of that unit” (p. 225). The research questions in this study are consistent with both definitions. The contemporary phenomenon of workplace wellness was studied in the real-life context of the organizations in which the programs occurred.
or in organizations without programs that were willing to discuss the topic. Multiple sources of evidence were gathered with the intention of describing programs in detail and analysing influencing factors in organizations with and without programs.

The investigator is described by Yin (2003) as having no control over the contemporary phenomenon being studied, which is applicable to this research. Case studies enhance understanding of context, including organizational decision making, policy development, or program planning, implementation, and evaluation, which corresponds to the program nature of this study (Creswell, 1998; Lincoln & Guba, 1985; Marshall & Rossman, 2006; Merriam & Simpson, 2000; Stake, 2006; Thomas, Nelson, & Silverman, 2005; Yin, 1993, 2003).

A multiple case study may have more than one research question as is applicable here. Questions may be exploratory, descriptive or explanatory in design (Yin, 1993, 2003). Case studies are generalizable to theoretical propositions, not populations. Where propositions do not exist, a case study is considered exploratory and is expected to yield propositions for further study. Given the lack of published information to describe WWPs in NB, this study is exploratory in nature and concludes with recommendations for future research.

Research Protocol: Rationale

**Recruitment of multiple cases.** According to Stake (2006), studying multiple locations or entities is useful for complex initiatives. Descriptions from the perspective of different organizations with or without programs provide a deeper understanding of the factors involved in program development and implementation (Stake, 2006). Usually
some cases are known in advance with the others being selected as a purposive sample in accordance with how readers will generalize to their own situations. Stake (2006) recommends that the case selection relate to relevance, diversity, and learning potential. Yin (1993) suggests a total of five or six cases to enhance certainty of results. The purposive samples of NB organizations recruited for this study involve different sizes, sectors, types of work conducted, and locations, accordingly. The recruitment instruments are found in Appendix A.

**Data collection.** In qualitative studies, the researcher is the main instrument and collects "words rather than numbers; .... the researcher's goal is to organize a large quantity of specific details into a coherent picture, model or set of interlocked concepts.... to verify a sequence of events or the steps of a process" (Neuman, 1997, p. 420). The researcher's ability to interact effectively with the participants, to inform participants of what is expected of them, to ask meaningful questions, to clarify and probe for adequate responses, and to provide feedback and reinforcement are all essential to the quality of the data (de Leeuw, Hox, & Dillman, 2008; Merriam, 1998). Creswell (1998) emphasises the need for listening skills.

Permission is obtained from the organizational gatekeeper regarding the range of data collection techniques available to enhance description (Creswell, 1998; Merriam, 1998; Merriam & Simpson, 2000; Stake, 2006; Yin, 1993, 2003). In this case, a letter requesting consent was sent to the organizational contact. The letter described the proposed approach to data collection (see Appendix B: Informed Consent). All data collected for this study were aimed at obtaining a better understanding of the range of programs in NB and the factors in organizations with and without programs that facilitate
or act as barriers to program development and implementation. The rationale for selecting the techniques for this study, namely semistructured face-to-face interviewing, focus groups, document and aggregate data review, and direct observation follows below.

Interviewing is “a series of steps in a procedure” beginning with selecting the type of interview and the purposeful selection of interviewees (Creswell, 1998, p. 123). Semistructured interviews are useful for complex topics (Merriam, 1998; Merriam & Simpson, 2000). A well designed interview guide provides more consistency across interviews than an unstructured approach (Creswell, 1998). Leading questions or questions that result in socially appropriate answers should be avoided. While open ended questions and prompting allow for a broader response from participants, more time is spent on coding and content analysis since unanticipated information is obtained. Questions should be pretested, culturally appropriate, and mindful of the literacy levels of participants. Introductory letters and/or emails are recommended to help prepare the respondents for the interview experience (Merriam, 1998). Interviews should be recorded to enhance validity. In this case, a semistructured interview guide was developed and the questions were pretested with the University of New Brunswick (UNB) Campus Wellness Committee (Appendix C). The questions addressed both program range and influencing factors. After providing answers to a number of open ended questions, participants were given the list of recurring factors (see Chapter Two) to obtain their view on whether these factors were relevant within their organizations. Participants were informed of the interview process in advance and all interviews were digitally recorded.

Semistructured, facilitated focus groups, using ground rules and a pretested interview guide, are a valuable tool for exploratory research (Hyde, Howlett, Brady, &
Drennan, 2005; Makrides et al., 2007). Focus groups can be used to obtain rich data on group meanings (Bloor, Frankland, Thomas, & Robson, 2001). Knap and Propst (2001) preferred using focus groups rather than questionnaires to obtain richer data and greater understanding of social context. Data can be obtained from group dynamics and group interaction relative to vulnerabilities, social meaning, and cultural norms that may not surface through one-on-one interviews and can substantiate or raise doubts relative to interview data. Selecting purposive samples of participants is based on interest or expertise (Merriam & Simpson, 2000). A safe environment must be provided for these sessions with postsession debriefing available to any participant who may want to discuss the process. The researcher’s skill and sensitivity to group dynamics impact the reliability and validity of data (Merriam & Simpson, 2000). In this study, a semistructured guide was developed and was also pretested with the UNB Campus Wellness Committee (Appendix C). The open-ended questions were similar to the interview questions to allow for additional perspectives from focus group participants. However, the list of factors was not included. Suggested wording to recruit participants for the focus group sessions was made available to organizational contacts to facilitate organizing the sessions (Appendix B). The focus groups were conducted within workplaces and digitally recorded.

Reviewing documents and aggregate data provides access to existing sources of organizational information (Merriam & Simpson, 2000). The types of documents requested for review in this study, based on examples in the literature and the pilot with the UNB Campus Wellness Committee, included strategic plans, program descriptions, minutes from meetings, and communication materials. This information was used to elaborate on the status of workplace wellness within organizations, program processes,
activities, and outcomes. Requests for aggregate data related to absenteeism and HRAs were made to determine the extent to which organizations were using data to inform their programs. In accordance with Creswell's (1998) recommendation, field notes were kept on what was gathered, from whom, and when.

Observation is viewed by Creswell (1998) as a series of steps. Prior to beginning data gathering, a decision is required on the observation role of the researcher, ranging from a complete participant to a complete observer. The researcher must avoid deceiving participants. Attention to detail is supported by a protocol or instrument describing what will be observed, when, how, and for how long. Careful note-taking is required regarding the environment, events, activities, and researcher reactions. Merriam and Simpson (2000) describe observation as ranging from structured use of rating scales to unstructured observation of an activity and warn researchers of unpredictability. In this study, the researcher functioned as a complete observer; a semistructured instrument, adapted from checklists prepared by Tri Fit (2005) and the Government of Wisconsin (n.d.), helped to determine the extent to which the physical work environments provided support for the programs and to describe the range of programs (e.g., exercise facilities and healthy food choices in vending machines or cafeterias). The instrument was pretested during the pilot with the UNB Campus Wellness Committee and is included with the data gathering instruments in Appendix C.

Analysis. The researcher, having gathered information on many themes or patterns, analyses data inductively, focuses on the meaning for participants, and describes the process (Lincoln & Guba, 1985; Yin, 1993, 2003). When possible, Stake (2006) recommends including information on the present, the past, and the future plans for a
program to learn from various stages of development or evolution. Neuman (1997) writes that qualitative researchers “rarely know the specifics of data analysis when they begin a project ... and begin analysis early ... while they are still collecting the data” (pp. 419-420). Jackson (2003) agrees that data analysis happens simultaneously with the data collection. The results of early data analysis guide subsequent data collection.

Establishment of a detailed data base to serve as an audit trail and chain of evidence contributes to being transparent and systematic (Yin, 2003). Creswell (1998) describes strategies for analysis in a spiral that begins with establishing a data management process. In this study, NVivo 9 provided storage for electronic data sources and facilitated data management. As suggested by Creswell, the researcher recorded field notes after each visit to aid in establishing initial ideas for analysis and reviewed all data to obtain an overview of results before beginning detailed coding.

Describing, classifying, and interpreting to yield context, categories, and comparisons are also components of Creswell’s (1998) spiral. Detailed descriptions of each case provide context for the reader and facilitate a comparison across cases. Wolcott (2009) concurs with Creswell and considers description to be the foundation for qualitative inquiry. During the analysis phase of this study, the researcher was immersed in the data by reading and rereading, identifying themes, patterns, categories, similarities, and differences. Creswell describes this process as reducing data to a manageable volume. All data were analyzed relative to program range and the recurring factors from Chapter Two to help identify corresponding themes and any new themes arising from the data. The final components of the spiral provide visual representation of results in tables, matrices, coding trees, and/or propositions. Quotes are essential in providing a voice to
participants. Yin (2003) stresses that results must be reported fairly and clearly, while revealing any biases of the researcher.

**Data triangulation and trustworthiness of results.** Multiple data collection techniques build upon one another (Patton, 2002) and facilitate triangulation. Data triangulation improves the trustworthiness of the research and requires two or more instances of a theme from different data sources to validate the interpretation (Tones & Green, 2006). Creswell (1998) describes this as corroborating evidence and considers the process of member checking with case study representatives and seeking input from other researchers as useful approaches to confirm interpreted meaning. Stake (2006) describes triangulation of data both within and across cases as an assurance that the researcher is interpreting the data correctly.

Criteria suggested by Lincoln and Guba (1985) to establish trustworthiness relate to credibility, transferability, dependability, and confirmability. The inquiry must be conducted “in such a way that the probability that the findings will be found to be credible is enhanced and ... by having them approved by the constructors of the multiple realities being studied” (p. 296). Knap and Propst (2001) define three of the criteria for trustworthiness as follows:

- dependability, the qualitative parallel to reliability, may be increased by using an ‘auditor’ or a second opinion in data analysis.... and constructing an audit trail;
- credibility or internal validity refers to how truthful particular findings are. Credibility can be enhanced through use of descriptions and quotes to support interpretations and triangulation of data sources;
• confirmability or objectivity relates to neutrality of findings and avoiding the researcher’s bias which can be reduced through involvement of other researchers during the sample selection, data collection, coding and analysis, and report writing. (p. 75)

Transferability relates to external validity and is defined by Merriam and Simpson (2000) as “the degree to which the results of a study are generalizable to other situations under similar circumstances” (p. 227).

In this study, the researcher visited each of the participating organizations and conducted all data collection thereby enhancing consistency of collection, analysis, and interpretation. Interviews and focus groups were digitally recorded by the researcher and transcribed verbatim by a third party. The transcripts were verified by the researcher for accuracy against original audio files. All transcripts were reviewed several times by the researcher. These results were subsequently combined with the results from observation of the work environment, documents, and data gathered for triangulation and coding purposes. Summary reports were returned to organizational contacts for member checking. These reports contained recommendations specific to each organization as a gesture of gratitude for their participation. The results have been discussed with experienced researchers and are supported by the voices of participants. An audit trail was created for all data.

Study Protocol

This section describes in more detail the protocol used to conduct this study.
**Case study recruitment criteria.** Given that the research questions focused on obtaining information on a range of programs and factors in organizations with and without programs, variety in organizations was an important recruitment criterion. Organizations were sought that varied by location, number of employees, sector, type of work, and program range. Cases were a mixture of private, not-for-profit, and public sector as well as small/medium (up to 200 employees), and large (201+ employees) organizations. These size categories were those used by Plotnikoff et al. (2005). No organizations with fewer than ten employees were included. The mixture of cases is in keeping with Stake’s (2006) contention that descriptions from the perspective of different organizations provide a deeper understanding of programs and that case selection relates to relevance, diversity, and learning potential for the reader. Although the original intention was to meet Yin’s (1993) recommendation of five or six cases with and without programs for a total of 10 to 12 cases, this was unattainable.

Ten cases were obtained in total, six with WWPs and four without programs. The process for selecting cases was as follows: first the researcher contacted senior management in two large organizations considered to be leaders within the provincial workplace wellness community; the remaining cases with programs were selected from the list of winners from the HSFNB “Wellness at Heart” program awards; and, cases without programs were selected from NB organizations known to the researcher through management contacts from private sector, public sector, and not-for-profit organizations.

Three organizations from the list of “Wellness at Heart” award winners with discontinued programs were asked to participate but declined. Ten other organizations
were contacted as potential case studies and either declined or did not respond to voice mail messages. The final case selection was as follows:

- cases with programs
  - two large public
  - three large and one small private
- cases without programs
  - one large public
  - two small private
  - one small not-for-profit.

**Initial contact in organizations both with and without programs.** Senior management representatives (Vice Presidents, HR Directors, Office Managers) were contacted by telephone and/or email to determine their interest in participating as a case study. A screening tool (Appendix A) guided telephone conversations and selection decisions. Contacts were asked questions about organizational demographics, number of employees, type of work and, in the case of the six organizations with programs, the range of the program activities. The list of program activities was informed by the literature review. The six organizations with WWPs self-identified as having programs and the four organizations without programs self-identified as not having WWPs in accordance with Aldana’s (2001) program definition (see p. 1).

When verbal agreement to participate was obtained, the researcher explained methodology, and answered questions with the appropriate contact by phone or e-mail. This initial verbal confirmation was followed by a letter sent by email that included the informed consent form outlining the Research Ethics Board approval and details of data
collection. Consent to this letter formalized participation at the organizational level (Appendix B). This letter also confirmed permission to organize interviews and focus groups, conduct an observation of facilities, and to obtain copies of pertinent aggregate data and program related documentation.

**Field visits.** Field visits were organized with the designated case study contact. These individuals then identified others within the organization, including program staff, program volunteers, or program committee members to participate in interviews and/or focus group sessions. Depending on the organization’s size and program range, there were from one to three face-to-face interviews per organization and a focus group session was conducted with the program committee if there was interest. Informed consent forms were signed by each participant at the beginning of the interviews and focus groups (Appendix B). The importance of maintaining confidentiality of focus group discussions was stressed. While it was not possible to protect the identity of participants within the workplace, no individual was identified by name or position in the results. Anonymity of responses and confidentiality of personal and corporate specific information was guaranteed by the researcher and verified by the original contacts when they were sent their organization’s case study report.

**Data collection.** Primarily, four types of data were collected in the six organizations with programs: semistructured interviews with senior management and/or program related personnel and/or program committee members in all cases, focus group sessions with program committee members in two of the six cases, researcher observation of the work environment in all cases (e.g., opportunities to exercise, food availability), and, program documents in all cases. The aggregate absenteeism and/or HRA related data
collected were minimal due to the lack of availability of the data or due to participant time constraints to compile the data in a format that would protect employee confidentiality.

Data collection for organizations without programs involved: semistructured interviews with the head of the organization or a senior management designate in all four cases; researcher observation of the work environment in two of the four cases (e.g., opportunities to exercise and food availability); and, a strategic plan from one organization.

Summary of data collection. The results are based on interviews and focus groups with a total of 28 individual participants, document analyses, and observations of the physical work environments. More specifically, data gathered during the summer and fall of 2011 include:

- a total of 15 face-to-face interviews, each approximately one hour in length; one interview had two participants for a total of 16 interviewees;
- two hour-long focus group sessions with program committees from two different cases, including six participants in one focus group and nine in the other; three of these 15 participants were also interviewed;
- program-related documents gathered for all six cases with programs and for one case without; and
- observation of the physical work environments in eight of the 10 cases, focusing primarily on the food and fitness facilities available on-site or near-by. The two cases without observations are without programs.
Study Limitations. This study has limitations that must be considered when interpreting the results. The first relates to the difficulty in recruiting cases. Three organizations from the list of award winning programs had discontinued their programs, and so were ineligible to participate as organizations with WWPs. In the organizations without programs, there were two refusals and eight unreturned calls. Access was gained to three of the four cases without programs because the contacts had a preexisting interest in wellness and/or had prior positive experience with a program elsewhere. While these organizations did not have WWPs, they had some ad hoc activities occurring. After several weeks of leaving voice mail messages and waiting to hear from the eight organizations, the researcher identified the fourth case without a program through a colleague. It was the only case that had no workplace wellness activities. Finding a more efficient way to recruit organizations without WPPs and without any workplace wellness activities is required to facilitate future research on barriers to program development.

Having a more even split between large and small as well as urban versus rural cases across organizations with and without programs would have facilitated comparisons of factors among large and small cases and urban and rural cases. Although multiple data sources were used for triangulation purposes, only two of the six cases with programs were willing to conduct focus groups. The program leaders were present at both sessions, which may have influenced participant responses. Obtaining program related data and documentation was challenging as some participating organizations felt it took too much time to prepare.

The researcher. In accordance with Lincoln and Guba’s (1985) recommendation that the researcher state any personal bias that may influence the study, I declare my
optimistic view of WWPs. I consider wellness programming to be useful from four perspectives: the first, as a person-centered counsellor interested in enhancing human potential and encouraging individual and group behaviour change; the second, as a former HR Director with an interest in how wellness programs can impact an organization and its employees; the third, as a past Program Manager in the federal government with a general appreciation for various types of programs; and the fourth, as a part-time senior program advisor in the Office of the Chief Medical Officer of Health, NB Department of Health, with an interest in how wellness programs can contribute to improving population health through the workplace setting.

Summary. The chapter described: the theory and the rationale behind the selection of an exploratory, multiple case study design and the research protocol used to conduct the study; and, the actual study protocol including, case recruitment, data collection, and analysis.
Chapter Four: The Range of Workplace Wellness Programs in a Sample of NB Organizations

Introduction

The results contained in this chapter relate to the first research question - What is the current range of WWPs in a sample of NB organizations? The chapter begins with an overview of the 10 cases. The next section consists of case-by-case descriptions of the six organizations with programs. The overview and case descriptions together provide a descriptive response to program range. This is followed by the case-by-case descriptions of the four organizations without programs. The chapter ends with a cross-case analysis of the six cases with programs. During data collection, concepts surfaced related to the background of WWPs and the conceptual foundation provided in Chapter 2. This information is included here to enhance the context regarding programs in NB.

Overview of the cases. In eight of the 10 cases, the field visit took place at the organization’s head office. Nine of the 10 organizations are decentralized, with employees in multiple locations within NB and/or elsewhere (see Table 4.1). Six cases are located in urban areas and four in rural communities. Three cases are from the public sector and involve two large organizations with programs and one large organization without a program. The six cases in the private sector include three large organizations and three small; four have a program and two do not. The tenth case is a not-for-profit organization without a program. The organizations range in size from 12 to 1000 employees.
Five of the six cases with programs were in large organizations (three in the private sector and two in the public sector). The only small case was in the private sector. All six programs are located in different areas of the province; three are in urban centres and three in rural areas. The nature of the work varies in the six organizations, both within and across the organizations, from desk jobs to light/medium production in two large manufacturing facilities. All six cases involve shift work. At the time of data gathering, the six programs had been in place from three to 15 years, with the most recent in a rural manufacturing organization and the longest duration in a public organization.

The four cases without programs included one large public sector organization, two small private companies, and one small not-for-profit. Three of the organizations are located in urban areas and one is in a rural location. Three of the four are decentralized in nature. The cases range in size from 12 to 1000 employees and include both the smallest and the largest cases.
## Table 4.1: Overview of the 10 Cases

<table>
<thead>
<tr>
<th>Case # &amp; Sector</th>
<th>Participants by sex for both interviews &amp; focus groups:</th>
<th>Participants’ Role in Program/Organization</th>
<th>General Description</th>
</tr>
</thead>
<tbody>
<tr>
<td># 1. Large Public, rural</td>
<td>2 females 1 male</td>
<td>Program leader &amp; 2 program volunteers</td>
<td>750 employees</td>
</tr>
<tr>
<td>With programs: cases 1-6</td>
<td></td>
<td></td>
<td>Shift work</td>
</tr>
<tr>
<td>Without programs: cases 7-10</td>
<td></td>
<td></td>
<td>Decentralized</td>
</tr>
<tr>
<td># 2. Large Private (non-manufacturing), urban</td>
<td>1 female</td>
<td>A manager in HR</td>
<td>350 employees</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Shift work</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Decentralized</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>HQ elsewhere</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Joint Health &amp; Safety Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Program duration of 15 years</td>
</tr>
<tr>
<td># 3. Large Private (manufacturing), urban</td>
<td>2 females</td>
<td>A manager &amp; a supervisor in HR</td>
<td>230 employees</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Shift work</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Decentralized</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>HQ</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Workplace Wellness Committee</td>
</tr>
<tr>
<td># 4. Small Private, rural</td>
<td>1 male</td>
<td>Program leader</td>
<td>100 employees</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Decentralized</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>HQ</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Workplace Wellness Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Program duration of 5 years</td>
</tr>
<tr>
<td># 5. Large Public, urban</td>
<td>2 females 5 additional females in focus group; 1 male 2 additional males in focus group</td>
<td>Program leader &amp; Workplace Wellness Committee; (focus group contained 9 participants; a cross-section of the organization; (2 were also interviewed individually)</td>
<td>700 employees</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Shift work</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Decentralized</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>HQ</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Workplace Wellness Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Program duration of 6 years</td>
</tr>
<tr>
<td># 6. Large Private (manufacturing), rural</td>
<td>1 female 2 additional females in focus group; 3 males in focus group</td>
<td>Program leader &amp; Health &amp; Safety Committee; (focus group contained 6 participants; a cross-section of the organization; (1 was also interviewed individually)</td>
<td>300 employees</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Shift work</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Decentralized</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>HQ</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Health &amp; Safety Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Program duration of 3 years</td>
</tr>
</tbody>
</table>
### Case # & Sector

<table>
<thead>
<tr>
<th>Case # &amp; Sector</th>
<th>Participants by gender for both interviews &amp; focus groups</th>
<th>Participants’ Role in Program/Organization</th>
<th>General Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>With programs: cases 1-6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Without programs: cases 7-10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># 7. Small Private (non-manufacturing), urban</td>
<td>1 female</td>
<td>Manager</td>
<td>67 employees Decentralized HQ No WWP but with ad hoc activities</td>
</tr>
<tr>
<td># 8. Small Private (manufacturing), rural</td>
<td>1 female</td>
<td>Vice President</td>
<td>100 employees Decentralized HQ No WWP but with ad hoc activities</td>
</tr>
<tr>
<td># 9. Large Public, urban</td>
<td>2 males</td>
<td>Both in HR branch: one manager &amp; one employee responsible for Employee &amp; Family Assistance Program</td>
<td>1000 employees Shift work Decentralized HQ No WWP but with ad hoc activities Largest case</td>
</tr>
<tr>
<td># 10. Small, not-for-profit, urban</td>
<td>1 female</td>
<td>Head of the organization</td>
<td>12 employees; individual employment contracts; HQ No WWP and no ad hoc activities Smallest case</td>
</tr>
<tr>
<td>Total 10 cases: 3 Public 6 Private 1 Not-for-profit 4 Rural 6 Urban</td>
<td>Total of 28 Participants 18 females 10 males</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Descriptions of the cases

The case descriptions begin with the six organizations with programs followed by the four without programs and are presented in the same order as in Table 4.1.
Case #1: with program; large; public; rural. The field visit to this public sector organization involved three interviews, one with the program leader and two with employees who were program volunteers (1 female and 1 male) followed by an observation of on-site facilities. Relevant program related documents were also provided and included aggregate sick-leave data used to inform program activities.

The organization and the nature of the work. The facility is located in rural NB and has approximately 750 employees. The aging workforce is roughly 80% male with an average age of 47. Younger employees are replacing retiring workers. Employees perform a range of professional, scientific, technical, and administrative duties with shift work involved in some positions. Wellness has not achieved the same priority as safety due to the increased risk of injury involved in some elements of the work. One of the participants commented that “workplace wellness should be just as important as safety”.

Program overview. The corporate strategic plan references wellness and is considered by the program leader to be integrated within corporate culture. The program is the longest duration of the six programs and receives support from senior management and the unions. However, an interviewee commented that “they support us but they don’t participate.” A budget and several employees are assigned to the program; the leader has been involved for over 15 years. Different staff members provide varying percentages of their time to the program. One is an occupational health nurse with access to a consulting physician, when required. There is a second nurse and a fitness specialist on staff. Families are welcome to participate in program activities. The leader thinks the program is “more successful actually, if the families are involved”.

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The workplace wellness committee was discontinued since it was not found to be an effective approach to program development and implementation. The program leader explained that:

We had a committee and it failed. We ran it for about a year until we finally went ‘ok that’s dead’. I know other companies have ... a really high functioning committee, here ... that didn’t happen; there was a lot of dissension in the committee and it couldn’t come up with a reason why they existed.

Several employees volunteer regularly to assist program staff with activities. One of the participant volunteers describes herself as “a major advocate of workplace wellness”.

**Program activities.** The various activities include healthy eating, physical activity, and stress management initiatives. Assistance with smoking cessation is available to any employee who decides to quit. While following a population health model, the program leader described the program as having evolved into a holistic blend of initiatives to balance the wants and needs of staff. Provincial health trends combined with employee population data from HRAs, health screening clinics, mandatory annual medicals, and sick-leave analysis inform development of activities.

Various activities have been offered over the years, including: flu shots, wellness fairs, Employee and Family Assistance Program (EFAP) benefits, Weight Watchers, walking clubs, biking groups, invited speakers, presentations at staff meetings by program staff, and activities for the shift work population. Self-sustaining activities are continued while those of little interest to employees are discontinued.
The marketing and communication channels include mass e-mails, unit staff meetings, newsletters, posters, and electronic screen messages. However, these efforts are not yielding the desired level of participation. Interested employees have commented about missing events and program staff and volunteers are working to improve dissemination of program information. Incentives to participate are not normally used.

**Observation of the physical work environment.** The observation of the work environment confirmed that a small but well equipped exercise facility is available to all employees. On-site trails of varying lengths facilitate walking during breaks. There are two cafeterias, run by the same vendor, and both offer the same menu. Healthy food choices are limited (examples: salads, some fruit, yogurt) and are harder to find. Vending machines contain a small number of healthy choices (milk, fruit juices, and V8 juice). Adequate lunch room facilities (refrigerators, microwaves) are provided for employees who bring their lunches to work. There is a sick bay on-site and smoking is permitted in only three designated areas outside. Information is posted on bulletin boards and electronic messaging boards.

**Perceived benefits.** The participants mentioned that the same people participate regularly in program activities and the percentage of participation is too low. Anecdotally they reported health improvements for some participating employees. However this was not confirmed by program documentation or data. According to the program leader:

the overall health of the employees has … improved significantly and what I’m basing that on is … annual medicals…. That includes blood work, chest x-rays … physical assessments…. Their abilities to pass those medicals and … physicals
have been increasing every year and the amount of people that smoke here is much lower than it was 16 years ago ... and the diet and nutrition is much better. ... Shift workers used to eat terrible, high fat ... and now a lot of shift workers eat very, very healthy.... They’ve actually listened to some of the training.

Employee family members also benefit from program initiatives and/or interaction with program staff. One of the volunteers interviewed mentioned that her husband (not an employee) lost 20 pounds from participating in a body-mass activity offered during wellness month and elaborated that he is now “off blood pressure pills”.

**Case summary.** In summary, this program has been in place for approximately 15 years, which is the longest duration of the six programs. It is supported by management and unions, offers a broad range of activities, and is considered by the program leader to be integrated within the corporate culture. Volunteers assist program staff with activities. Participation by both management and employees is lower than desired and reaching employees with program information remains a challenge. The participants recognize that the on-site cafeterias and vending machines do not support the wellness program.

**Case # 2: with program; large; private; non-manufacturing; urban.** The field visit to this private sector organization involved an interview with a manager in HR followed by a demonstration of the program intranet site and an observation of the facilities, the results of which were combined with relevant program related documents.

*The organization and the nature of the work.* The organization is located in an urban area and has approximately 350 employees. Although the workforce includes all
ages, from 17 to 65, the average age is 34, and the workforce is roughly 70-75% female, including many young mothers.

The nature of the work performed is a range of professional, general labour, and administrative duties to service international customers. The participating manager pointed out that bilingual employees are harder to recruit. She elaborated that:

French is hard to find here and ... Spanish, and so I’ve been able to obtain ... permits to hire temporary foreign workers.... I’ve got ... five or six in the building at this point in time.

Hence, there is an ongoing effort on the part of the employer to minimize employee turnover by making the physical workspace attractive, and to add fun to the work experience. The manager explained that “the employment market in {name of city removed} is quite tight and if we’re not responsive to people’s needs, then we’re not going to find the people that we need”.

According to the participant, the work is highly scheduled, sedentary, and controlled and requires shift work on a 24/7 basis. Organizational concerns reported include work design, lack of control over work, costs associated with absenteeism, a high number of smokers, obesity, and a high incidence of mental health related short-term disability claims. Absenteeism is tracked as a key corporate measure and ergonomic considerations are important given the constant use of computers. In an effort to reduce the sedentary nature of the work, a few flexible workstations have been added so that employees can adjust desk height and stand while working, if interested; “you flip the
lever and the whole thing rises up rather than just the keyboard ... there’s a couple of people that use those to the fullest extent but most people are sitting”.

**Program Overview.** Wellness is part of the organization’s health and safety strategy and is considered by the participant to be integrated into corporate culture. Program documentation states that “health, safety, and wellness have been one of our company’s key cultural pillars for a number of years”. The program receives support from senior management and the unions. Financial and staff resources have been assigned to the program for over seven years. According to the manager “wellness is ... the next level after health and safety” and is mandated to the Joint Health and Safety Committee which is co-chaired by management and “an employee co-chair”.

**Program activities.** The various activities include healthy eating and physical activity initiatives. An EFAP is available for nutrition counselling, stress management, and smoking cessation. The manager explained that the committee:

- organizes incentives and ... different activities throughout the year. We have a wellness week in the fall, where we bring in ... various vendors.... Traditionally we get the flu shot; ... we have the {nurses} come in to do blood sugar, cholesterol, blood pressure checks.... We’ve had different speakers come in, a chiropractor, ergonomics.... subsidized gym memberships for people.... through payroll deduction. So it’s convenient and ... spread out over the year.... We try to have a monthly message ... through a Power Point presentation at monthly communication meetings for departments or information in a newsletter.

Committee members have been trained to conduct ergonomic assessments and have developed a checklist to guide this activity. Other program activities include fitness
and weight loss competitions, chair massages, and a monthly theme day, that’s “just meant to fun it up a little bit”. The manager further mentioned having “lots of recognition and celebrations to ... create a sense of camaraderie and community within the building.”

Employee families are involved in corporate activities such as sleigh rides, movie days, an annual children’s party, skating, swimming, a Christmas party, and a summer lobster party. The company is active in the community, especially in fund raising through events such as “bowling for cancer, curling for cancer ... run for the cure.... and beach volleyball ... for United Way”.

The share point site stores wellness information; a program logo brands all promotional materials; email is the main communication tool. New employees are introduced to wellness through the employee hand book and orientation process. This case is the strongest example of the use of quarterly incentives to encourage participation including cash, small prizes, or travel points.

Due to the nature of the various work schedules, lunch and learn activities are not an option. The manager explained that:

We haven’t nailed it.... I’ve had people come in to the building to do that kind of thing ... then I have to set up a series of meetings from 11 till 7 at night, so that we can get the majority and there’s a lot of people that aren’t interested in doing that.... It’s challenging for us, we haven’t mastered it yet {laughter}.

A popular off-site fitness activity for staff during lunch breaks was lost due to significant changes in the arrangement requested by the service provider. Providing physical fitness opportunities and healthy food options during working hours are an ongoing concern.
**Observation of the physical work environment.** Although there are gym facilities within the city, half hour lunch breaks and finding transportation to the gym are obstacles to exercising during the workday. From a healthy eating perspective, the attractive lunch room is equipped with refrigerators and microwaves. The vending machines have some healthy choices (fruit, yogurt, milk, fruit juices, and frozen meals). Bulletin boards display information and the office walls feature photos taken by employees.

**Case summary.** In summary, the program is supported by management through allocation of resources and their participation in activities, offers a range of activities, and is considered by the participant to be integrated into corporate culture as an extension of the Health and Safety Program.

**Case # 3: with program; large; private; manufacturing; urban.** The field visit to this private sector manufacturer involved two interviews, one with a manager in HR and the other with a supervisor who represents HR on the Wellness Committee. The interviews were followed by a demonstration of the program intranet site, an observation of on-site facilities, and receipt of program related documentation.

**The organization and the nature of the work.** This organization is proud of having been in business in NB for over 70 years. Although the head office is located in an urban area, over 100 of the approximately 230 full-time employees work across the province in product distribution. The aging workforce conducts a range of professional, technical, administrative, and labour related duties with some involving 24/7 shift work.

**Program Overview.** Wellness is a strategic planning priority and is supported by the senior management team. The program is integrated into organizational culture and
corporate planning and policy. Open communication and caring about employees are informal organizational values. Initially, the wellness program was mandated to HR as separate from the health and safety program and was introduced specifically to help reduce absenteeism and presenteeism. The manager confirmed that “there can be a problem with presenteeism too {laughter}....That’s my bigger problem”.

The program has evolved from an earlier decision to have an EFAP. The manager and the General Manager looked at the EFAP from the perspective that “if we help one person, the program was worth it.” Eventually a small but committed wellness committee, with representation from several divisions in the organization, was given responsibility for program implementation. According to the manager; “before HR just used to run with it, okay, but I find if you involve more people, you get more opinions....and we did involve our union with it and I think that’s a plus”.

The wellness committee decides how the allotted budget is spent. The supervisor commented that not having to fund-raise to cover the costs of program activities facilitates the effort. She attends local wellness network meetings and gains new ideas and information. Similarly, employees are encouraged to suggest wellness related ideas and to volunteer to organize activities. The union is supportive of the program and some activities involve employees’ families, including their grandchildren.

**Program activities.** The program activities are purposely group activities and include healthy eating, physical activity, and mental resiliency initiatives. Assistance with smoking cessation is available to any employee who wants to quit. Activities included are annual screening clinics, flu shots, wellness fairs, invited speakers, presentations at staff meetings, celebrations, competitions, support for local charities, and family events,
(BBQs, picnics, and corn boils). Periodically, fruit is provided as a healthy snack in all locations across the province. Education sessions include a healthy meal. Walks are occasionally organized on Fridays followed by a healthy lunch. A drug and alcohol policy prevents product liability issues and helps employees deal with addictions. Marketing and communications tools include an intranet site to distribute program information across the province. Incentives such as gift certificates are sometimes provided by the organization to enhance participation.

**Observation of the physical work environment.** The observation of the work environment focused on two well equipped lunch rooms. Refrigerators are stocked with free healthy choices, including milk, juice, and yogurt. Bulletin boards display wellness materials. The on-site basketball net provides an opportunity to exercise during breaks.

**Perceived benefits.** Participants reported changes in organizational culture and mindset regarding wellness since the program began. Further, they reported a sense of belonging associated with the program and employees supporting one another in times of need. They consider there to be fewer smokers now that financial assistance is available to quit; the no-smoking policy includes company vehicles and results in disciplinary action for non-compliance. Occasionally during annual screening clinics employees are advised to consult their physicians.

**Case summary.** In summary, the program is supported by management and unions, offers a range of activities, and is described as being integrated into corporate culture. Participants reported a good rate of employee participation at the main office; technology is used to reach employees in other locations. Program marketing and
communication tools are available. Employee volunteers support the committee in implementation of program activities.

**Case # 4: with program; small; private; rural.** The field visit to this private sector organization involved: one interview with the program leader; an observation of on-site facilities; and detailed program documents that included some aggregate health related data used to inform program activities.

*The organization and the nature of the work.* The main office of this decentralized organization is located in a rural community (that is near an urban center) in a new building which employees helped to design. The workforce of approximately 100 full-time employees is mostly male but more females have been hired recently. Employees range in age from 30 to 50. Teamwork and respect are organizational values. The nature of the work performed is a range of professional, technical, administrative, and labour related duties. The work can be stressful due to tight deadlines, especially bidding on contracts.

*Program overview.* According to the program leader, wellness is formally established as an organizational priority, is reflected in corporate policy, and is integrated into organizational culture. Funding is always available for activities. When asked about the budget, the program leader commented that:

> if it's something that's worth doing, they're going to pay for it. And it's usually at the end of the year, after the fact, that people go, oh, well this was the budget for Health and Wellness, rather than this is your budget, stay within it.
Senior managers are proud of the program and are visibly involved. Management recognizes the business case connection between employee participation in the program and reduced absenteeism and fewer early retirements. The program leader remembered a senior manager's wife commenting that “the cost of administering a program, you’re going to save that money in the end, when your employees aren’t sick everyday and ... when they’re not retiring early”.

The HR Director chairs the small workplace wellness committee and the program leader is a member. The program is employee driven and they suggest wellness related ideas. Employee volunteers organize activities while outside consultants provide specific expertise when required. The program leader commented about the informal approach:

we do our committee meeting every month ... but the best thing about our Health and Wellness Program, I think, is any employee ... feels empowered ... to ... say, I want to do this, so let's do it for our employees. A good example, last month ... somebody said, we should have some picnic tables out there, to enjoy the sun and it wasn't even a committee decision.... I talked to our ... chair of the committee and I said, can we ... take it out of the Health and Wellness budget and he said yeah, go ahead.... We try to be a little structured but things work a lot better when the employees just come up with an idea and we find a way to make it happen.

Program activities. The various activities include healthy eating, physical activity, and mental resiliency initiatives. Assistance with smoking cessation is available to any employee who wants to quit. The program offers a wide variety of initiatives, involving employees, their families, the community, casual workers, and suppliers.
Aggregate data are available on the health of some employees from HRAs and health screenings. Interest in activities is determined by employee surveys.

Other initiatives offered include flu shots, wellness fairs, an EFAP, invited speakers, presentations at staff meetings, celebrations, competitions, support for local charities and family events. The program leader noted the availability of fresh fruit and vegetables for snacks. He “can’t imagine not working here now that {they} have it ... we get fruit and vegetables brought in every week ... and the superintendents on site ... they have the ability to bring that in as well”.

Video-conferencing technology supports program activities and connects the various offices. Program marketing and communication includes e-mails, flyers, phone calls, word-of-mouth, staff meetings, newsletters, bulletin boards, and posters. Non-monetary incentives are sometimes provided by the organization to enhance participation but bragging rights are usually enough.

**Observation of the physical work environment.** The work environment has individual offices rather than cubicles and new, ergonomic office furniture. The boardroom contains video-conferencing equipment and can be used for training purposes. A small but well equipped on-site exercise facility (Wii, television, free weights, two tread mills, elliptical machine, exercise ball, instructions on how to use machines) and a shower are available. Employees have access to a local pool and other fitness equipment within a short walking distance. The lunch room is equipped with a coffee maker, refrigerator, dish washer, microwave, dishes, and toaster-oven. Picnic tables and a BBQ
are located in the large parking lot; there are no vending machines on-site. Bulletin boards display safety and wellness materials.

**Perceived benefits.** According to the participant, the percentage of employee participation in the main office is high and there is a sense of belonging associated with the program. The perceived culture change is demonstrated through peer pressure and gentle reminders to change behavior and by supporting one another to do so. The program leader commented that:

if I come in to the lunch room with three hamburgers, somebody’s going to say, wow, {name removed} you’re going to have a heart attack! Or ... that’s not good for you! So, it’s been a real culture shift since this program started.... Everyone’s looking out for each other.

He further elaborated that:

it seemed like the typical {occupation removed} company, when I started.... A lot people smoked, everybody ate fast food every day and then ... management initiated this ... Health and Wellness Committee and ... ever since then, we have ... presenters come in to discuss various topics.... We’ve got less than a handful of people here in the office that actually smoke now.... We try to promote smoking cessation.... and ... when we do conferences and things like that ... we hire someone that ... has healthy eating menus and it’s been a big, big change and I think ... we’re a lot healthier than we were five years ago, for sure.

However, finding ways to enhance participation for employees working away from the main office remains a challenge.
Case summary. In summary, the current program is supported by management, offers a broad range of activities, and is considered to be integrated into corporate culture. There is a good level of employee and management participation and marketing and communication methods are available. Electronic technology, including video conferencing, is used to reach employees located in various locations. Volunteers play a role in program implementation.

Case # 5: with program; large; public; urban. The two field visits to this public sector organization were conducted a week apart and consisted of three interviews, one with the program leader and two with wellness committee members (one female and one male). A focus group session with nine members of the wellness committee was conducted along with an observation of on-site food and fitness facilities in four different buildings. Two of the one-on-one interviewees also participated in the focus group yielding a total of 10 individual participants. Detailed program related documents were provided along with a demonstration of the workplace wellness intranet site.

The organization and the nature of the work. The decentralized organization is located within an urban area and has approximately 700 full-time employees. The workforce is aging, retirements are pending, and younger employees are replacing retirees. The ratio of male to female employees is approximately 55/45 to 60/40. The nature of the work involves a broad range of professional, technical, administrative, and labour related duties. The program leader described the organization as:

different from a typical ... work place because each department has its own culture and some people have shift work, some employees are in unions, some
aren’t. There are different unions representing the different groups ... we’re scattered around ... all these different facilities.

Focus group members and the two other interviewees confirmed the different cultures and types of work as they talked about their respective units. A wellness committee interviewee explained that in his unit, shift work is further complicated by split shifts six days per week. It was noted that it is more difficult to implement activities during the summer and winter seasons due to the seasonal nature of some of the outside work.

**Program Overview.** The program receives management support through allocation of annual budgets and the salary of the program leader who described herself as the program cheerleader. However, the budget was reduced when the initial round of HRAs was completed and the fear of further budget cuts is always present given current fiscal restraint in the public sector. Other participants also mentioned having small budgets which were established before the program was formalized. Although senior managers are supportive of the program overall, some participate more than others. Management commitment to the program was described by an interviewee as “sort of three camps”, beginning with providing “strong support - to they could go either way depending on how the mood is of their employees ... - to indifference. If we have it great, if we don’t have it, okay.... we survived without it.” Focus group members and the other interviewees described some managers as supportive and made reference to other units where support was lacking.

The wellness committee members assist the leader in program development and implementation and represent a cross-section of organizational units. An interviewee and a couple of focus group participants who represent larger departments within the
organization mentioned that they have established small wellness sub-committees within their respective work units to involve other employees. The leader describes the committee as innovative in finding new ideas for activities and adapting them to the variety of workplace cultures. Most, but not all of the unions are supportive of the program; however, it can become a “bargaining chip”. Families participate in some activities.

An interviewee explained that the concept of a wellness program began from activities originally implemented in her unit. The leader confirmed this and described the program evolution, as beginning with:

a pilot program ... and ... a committee of about six individuals ... to develop the program to see if there was interest among employees.... I’ve been involved since the beginning ... it actually became a full program in 2005 with a budget.

The originating unit still leads the organization by serving as a pilot unit to test new activities prior to implementation across the organization.

A program plan was developed with information collected during an employee survey that was conducted by an external organization with the required expertise. The leader explained that the program further evolved to ensure that activities reach employees in other locations within the decentralized workplace, as follows:

one of the things that we’ve really made an effort to do is to make the {name removed} program not just a {head office} program. Because I think that probably in the first two or three years it was a {head office} thing. So one of the outreach things that we’ve done is our Health Fairs actually travel to the individual work places now which they didn’t at first. Our flu shot program
travels to the different facilities and different times in the last two or three years when we’ve had like a speaker or something, we’ve tried to put them into the individual work places as much as we can.... as shifts and things allow.

Partnerships with external experts have resulted in the sharing of wellness information and ideas for program activities while lending credibility to the program. A source of pride for the committee relates to other organizations seeking information from their organization on how to initiate or improve their programs. One of the participants commented that she and the leader had attended a conference and realized that they had already implemented many of the ideas being discussed; it felt “good to know that we were ahead of the curve in a sense but also to have people coming to us to give them advice ... it’s a real feather in the cap”.

The wellness committee focus group members consider the program to have evolved to a new phase and are contemplating how best to move forward. Rather than the committee initiating activities in future years, members anticipate that activities may result from employee suggestions. They also ponder whether a blending of the current activities available to all employees and their families with future offerings that focus on small pockets of high risk employees may yield higher participation and feel more personalized to employees. Committee members were quick to add that new members with new ideas would be welcome. A female participant elaborated that her “wellness is well established, I don’t need to come; I’ll continue to be an ambassador over there... it will bring new commitment from new employees”.

**Program activities.** The rotation of a wide variety of activities involves healthy eating, physical activity, and mental resiliency. Assistance with smoking cessation is
available to employees who want to quit. The program leader explained that “ever since the Heart and Stroke Foundation started their Wellness at Heart Awards, that’s been really good for us because … we’ve always sort of kept the {NB wellness strategy} pillars top of mind”.

Coaching is available through partnerships with external organizations for smoking cessation and nutrition. Flu shots, wellness fairs, an EFAP, invited speakers, family events, Weight Watchers, BBQs, bowling, ball teams, cooking demonstrations, employee appreciation activities, pre-shift stretching, and massage therapy are part of the list. Challenges have been held over the years frequently enough that some employees are tired of them. The wellness committee members and interviewees consider the variety in activities as a specific strength of the program.

An intranet, which is accessible from employees’ homes, provides distribution of program information across the organization. This is accompanied by printed program materials in all lunch rooms. Program marketing and communication materials carry a logo and tag line to brand the program across the organization. E-mails, flyers, staff meetings, newsletters, bulletin boards, educational materials, and small promotional items are used. A variety of posters with wellness messages are rotated regularly.

*Observation of the physical work environment.* The observation of the work environment involved four different facilities. In one facility, a small but well equipped gym was cost-shared with a union and is available to that work unit. During the focus group session, a participant commented that any new buildings constructed by the employer should include shower facilities and space for a gym. If at least showers are available then employees are able to exercise on their way to work or during lunch hour.
She elaborated that “we bike to work, get showered in our locker room facilities which is
great and I know we have an advantage”. Another wellness committee member
mentioned that he received requests from staff for a gym. Although the space is currently
not available for a gym, employees can walk the perimeter inside the large building
where the participant is located and record their laps on the bulletin board.

Several lunch rooms in different buildings are well equipped with water
dispensers, refrigerators, microwaves, kettles, dishes, and toaster ovens. Not all kitchens
have vending machines. Where available, machines feature water, juice, and diet pop as
healthier options. Baked chips did not sell and have been removed. Wellness newsletters
are left on tables and educational materials are left in lunch rooms for reading during
breaks. Bulletin boards display wellness materials and back issues of newsletters; some
employees do not have access to a computer or are not comfortable with computers and
rely on the bulletin boards for information. In one facility, a computer room was created
for those who do not have a computer but who want to access information on-line.

The program leader explained her approach to newsletters and posters as follows:
we introduced an employee newsletter.... Once a month I’ll go around to the
different facilities and drop copies of that off and they can be circulated internally
as well, in mailboxes.... We have 24 locations ... and we have four posters in
each frame....We’ve sort of tried to tailor the posters to the workplace as much as
we can and then after a four month rotation ... switch them out with another set,
so ... over a two or three year period there will always be a new message every
month.... We would have one or two posters that would deal with shift work
...where I know that smoking is a concern we might have a poster on smoking, the benefits of quitting.... It just sort of keeps the program top of mind.

**Perceived benefits.** The program leader provided examples of success stories: 
we did a Weight Watchers at work program and there is one girl in particular ... I think she’s lost over 100 pounds and... it all started with the ‘at work’ program and then ... she continued on her own.... We’ve had some folks ... three of them, they all quit smoking kind of at the same time and supported one another.

Smoking policy has evolved over the years and is now prohibited in the organization’s vehicles. It was the leader’s opinion that:

the number of employees smoking has really, really reduced in the last five to ten years.... It’s becoming more and more difficult to smoke anywhere and ... the cost and ... you can’t smoke in your vehicle, you can’t smoke on property, and you can’t smoke in the building or even outside the building... and then of course for the health reasons.... But just listening to a couple of these individuals, their stories and talking about the impact it’s had already on their life and how they feel and their relationships even with family members and the support they’ve had, like really.... it was fantastic....What a difference it’s made in their lives.

Another interviewee described a group of employees who stopped smoking together and others whose spouses became involved. Focus group participants confirmed that “hard core” smokers had been successful in quitting. Biometric screening clinics have recommended that employees consult their physicians for elevated readings.

**Case summary.** In summary, the program is supported, for the most part, by management and unions. The level of employee participation in the wide range of
activities is considered to be high and there is a concerted effort to reach all employees across the decentralized organization. Marketing and communication methods range from electronic technology to paper copies of newsletters and posters in lunch rooms in various facilities. Other organizations seek information on the program.

**Case # 6: with program; large; private; manufacturer; rural.** The field visit to this private manufacturer consisted of: a one-on-one interview with the program leader; a focus group session with six Joint Health and Safety Committee members, including the program leader; receipt of program documents; and an observation of on-site facilities.

**The organization and the nature of the work.** This decentralized organization, with the head office located in a rural area, employs approximately 300 full-time employees. The ratio of male to female employees is approximately 60/40 with an average age of 45. The workforce is aging and retirements are pending. While core employees have been with the organization for 30 years, there is employee turnover with younger employees returning to school. Since the organization has started hiring immigrants, English as a second language and cultural differences have become considerations. Literacy may be an issue for some employees.

The work is either professional, administrative, or production related and involves shift work for manufacturing employees. Contact with sharp materials and repetitive motion are part of the continuous light/medium production process making safety a primary concern.

**Program overview.** Wellness is an organizational priority which is visible through senior management attendance at family related program activities. Although the
program leader has been responsible for health and safety for roughly ten years, her involvement with development of the wellness program began about three years prior to the interview. The program does not have separate funding; annual activities are funded by the HR budget; new activities are considered for funding as they arise. The leader is supported by a Joint Health and Safety Committee; members represent a cross-section of organizational units. The committee makes recommendations to senior management.

**Program activities.** The activities involve healthy eating, physical activity, and mental resiliency. Assistance with smoking cessation is available to employees who want to quit. A nurse provides health, safety, and wellness orientations for new employees, screening and immunization clinics, and coaching for smoking cessation and nutrition. A medical doctor is available for consultations and provision of standing orders.

A variety of other program offerings include wellness fairs, an EFAP, information sessions with a dietitian, Weight Watchers, lunch and learns on different topics, fitness challenges, family BBQs and picnics, curling, soft ball, golf, and pre-shift stretching exercises for manufacturing related jobs.

Program marketing and communication channels include safety meetings, newsletters, bulletin boards, and a video screen in the lunch room. Posters promote upcoming events. Important information is attached to pay checks and the possibility of winning gift certificates helps to ensure that employees read and return the attached information, including employee surveys. A raffle is held for an employee parking spot next to the building (although this might be viewed as promoting sedentary behaviour).

**Observation of the physical work environment.** The observation of the work environment focused on the lunch room which is equipped with refrigerators,
microwaves, and a toaster. A slushy machine is available for use on hot days. The healthier choices in the vending machines include water, juice, seeds, and nutri-grain bars. The electronic screen in the lunch room features power point presentations on a variety of topics while bulletin boards display safety, wellness, and production materials. Classroom space is available for training.

Perceived benefits. The leader reported that screening clinics have resulted in employee visits to the nearest emergency room, recommendations that employees consult their physicians for elevated readings, and information being copied to family physicians. Anecdotally, progress has been reported in reducing the number of smokers. Partnerships with local organizations, including local health sector staff, enhance the program and have resulted in the sharing of wellness information and ideas for program activities.

Employees and family members involved in Weight Watchers have lost weight. One female focus group participant proudly reported having personally “lost over 85 pounds and if it wouldn’t have been for the Weight Watchers Program coming in here, I wouldn’t have joined”; she went on to say that “it helped a lot of people”.

Program participation is lower than desired. Due to the rural location, employees live in various communities across the region and drive significant distances to work. Driving to wellness activities on the weekend can be unattractive to some and can reduce family and leisure time. A focus group participant described a female employee as saying: “I don’t want to drive all the way from {name of community removed} on a Saturday when I drive five days a week”.

Case summary. In summary, although the program is relatively recent, it is supported by management and offers a range of activities. Employee participation is
growing and there is a concerted effort to reach all employees through marketing and communication.

**Case # 1: without program; small; private; non-manufacturing; urban.** The field visit to this private sector organization was organized through a manager. She agreed to an interview and a tour of the office space due to her interest in including wellness in the organization’s recently developed health and safety program.

**The organization and the nature of the work.** This organization is located in an urban area and there are other offices across the Atlantic region. The nature of the work is described as professional with tight deadlines and long hours. The manager explained:

having to perform … meeting deadlines. I haven’t really worked outside the professional industry in probably 30 years so I don’t remember what it is like but, you know, I have talked to people in other industries, and going home at 4:30 every day is just what they do {laughter}.

**Interest in a wellness program.** When asked about whether the possibility of a program had ever been discussed in the organization, the manager responded:

We actually started discussing it probably about three or four months ago in this particular location … because we’ve had … people out on leave…. One of the members of our Health and Safety Committee has been out on sick leave…. So we have had difficulty trying to go forward with the incentives or the goals that we’ve placed for ourselves; so we started discussing this about four or five months ago…. It is kind of our next step in our Health and Safety program; first
we wanted to make sure that the safety was under control and now we are looking
at the health side.

**Perceived health concerns.** Stress, working through lunch hours, and eating junk
food were mentioned as employee reactions to tight deadlines, although smoking is less
of a problem than might have been expected. The manager explained that they:

have had a few people go out on stress leave recently ... at the staff level; the
{occupation of employees removed} tend to be, I think they are as stressed but
they tend not to .... admit it maybe, can’t say show it, but admit it ... so that’s
always an ongoing concern..... We are fairly fortunate that our smoking
population is not as high as some other {organizations}; we have maybe out of 67
I’d say under 10 smokers which ... is very encouraging.

**Business case for a program.** Recent employee health issues had enhanced senior
management’s awareness of the business case for wellness. The connection had been
made on the part of the participant between the concept of workplace wellness and the
costs and productivity losses associated with staff out on long-term sick leave, especially
with the subsequent need to train temporary replacements. Reducing absenteeism was
considered a potential program related benefit and was described as follows:

I think it would reduce absenteeism for one thing.... People tend to get stuck in
ruts.... Probably the most common one I see is when they’re not taking breaks,
they’re not taking their lunch hour.... You can only work overtime for a period of
time before it starts to affect your sleep patterns, your ability to deal with the
stress ... your eating habits. I mean I have one staff member who consistently ...
had worked ... overtime each year, and one of the things I started to notice was
she was eating junk food all the time because ... she was not stopping to take her
meals.... She started smoking again; she was having more difficulty dealing with
the pressures at home and so we, we cut out the overtime; we refused to pay her
any more overtime. We brought in another staff member to take on some of the
tasks that she had been doing.

**Perception of the role of the employer in a program.** The participant described
the role of the employer regarding the health and wellness of employees, in terms of
awareness, accommodation, and ergonomics.

I think it is important for the employer to be aware of Health and Safety because I
am also on the Health and Safety Committee and there are Health and Safety
issues that can affect anyone’s (participant emphasis) ability to perform their
duties.... We try to be conscientious about factors from outside the office that
might affect them, such as family issues ... so we try to be as accommodating as
we can be but still ... keep the office going.... We recently did a renovation ... to
ensure that the work stations are ergonomic, the chairs are ergonomic.

**Perspective regarding wellness programming.** The participant’s perspective
regarding content and approach to a wellness program further reflects her involvement
with the health and safety program. She commented that a:

program would be ... almost like ... an agenda where you have different things
you want to accomplish ... information that you want to get out to the people,
perhaps even sessions like training sessions.... The Health and Safety Committee
has talked about ... bringing someone in to actually go by the different work
stations and ensure that people are set up correctly.... If they are not set up correctly, it causes you know health issues.... That is what I see, is kind of developing programs to encourage awareness and ... compliance.

**Networking with other organizations.** Although the manager was interested in adding workplace wellness as a component to the health and safety program, she had not discussed programs with similar organizations; “there has not been a lot of discussion, I think {occupation removed} are probably one of the groups that are behind”.

**Existing wellness related activities.** The manager mentioned several wellness related activities already in place within the organization, primarily fitness activities:

We do Run for the Cure.... Recently ... we had a walk challenge. Everybody got a walk pedometer and for a month ... you had to track your steps. There were prizes for people with the most steps and prizes for the teams.... We ... encourage everyone to use the stairwells between floors as opposed to the elevator.... We have tried to encourage people to get up from their desks.... We went to a shared printer situation so it forces you to get up.... Staff have two 15 minute breaks a day plus their lunch hour and we encourage them not {participant emphasis} to work through their lunch hour. We just feel that’s not healthy ... they do not all take breaks but you know, it all depends on their workload.... The other thing I meant to mention is that we do have a fitness allowance ... so any employee who signs up ... gets the discounted rate ... and they can do it as a payroll deduction which I think is very helpful.
*Observation of the physical work environment.* The observation of the workspace found that boardrooms and a lunch room are available on-site while trails, restaurants with healthy offerings, and a gym are near-by, all of which could support future program activities. The lunch room has an attractive view of the city and is well equipped for employees who bring a lunch to work. A few healthy selections could be found in the vending machine which was on-site specifically to accommodate employees with deadlines. The manager elaborated that the lunch room seats 10 or 12 and “firm members are provided with free coffee and tea … filtered water…. We keep a vending machine for staff … and also we have two fridges in that location and a fridge … at our coffee station.”

*Case summary.* The manager sees wellness as a logical next step in the development of the organization’s Health and Safety Program and recognizes the business case and potential benefits regarding reduced absenteeism and increased productivity. The observation of the physical work environment found that infrastructure is in place both on-site and in the immediate vicinity to potentially support a program. The manager mentioned that for a wellness program to be initiated the approval process would need to consider the decentralized nature of this firm since all the offices would have to be “in agreement with the approach” to any new program.

*Case # 2: without program; small; private; manufacturing; rural.* The field visit to this private manufacturing facility involved an interview with a Vice President (VP) and a tour of two buildings on the site. The VP agreed to participate because she wanted to learn more about wellness. Recent results from an employee survey had indicated interest in establishing an on-site gym. She explained as follows:
Well every year we do a survey with our employees just to sort of take the pulse of things ... and one of the things that came back in the Other Comments section was it would be great to have a gym here or a place where we could, you know, work out. And that came up in three different just sort of comments at the end and we hadn’t seen that before.

**The organization and the nature of the work.** The small, decentralized organization has an aging but stable workforce of approximately 100 employees and is located in a scenic rural area. The worksite is fairly isolated and no gym or restaurant facilities are near-by. The bulk of the workforce is involved in the manufacturing process but there are managerial and administrative employees as well. The VP described the organization as a “pretty fast paced environment.... and I think unless you’re pulled out ... you just sort of eat your lunch at your desk”.

**Interest in a wellness program and perceived benefits.** The participant emphasized her personal belief in wellness and the importance of exercise from both a physical and mental health perspective. Given her past and present expressions of interest in wellness, she was given the responsibility to explore the establishment of an on-site gym. Although she had attempted to initiate fitness activities previously, she received no support from her management colleagues. However, the survey results coupled with other management considerations meant the timing was right. She explained that:

exercise is very important to me, mental health and physical health, and so I presented {a previous proposal} to the management team. At that time the team wasn’t open or receptive of it. I think it’s sort of different now ... we’re seeing rising health care costs here; we have an aging demographic.... So there’s just
some different things that we have been talking about so when you called I thought well oh it’s a hot topic right now.... I just believe in it, I believe in it (participant emphasis).... like I know people personally who have ... started exercising and were able to get off whatever blood pressure medications.... It works so I believe in it and I think that would apply here. We have some smokers, ... some people with high blood pressure.... I also think it’s a big factor in mental wellness as well.... Today’s environment is hard for people to work and make ends meet and I think a good 45 minute exercise session is ... good for your mind.

The management team within the organization places importance on providing feedback to employees after a survey is conducted. The VP elaborated that:

it’s important to us that we always demonstrate that we’re listening. And I think the ... gym thing where ... it’s good for everybody; and then the feedback, we can go back and say ... thanks for your feedback.... And so that’s sort of where it’s at right now. And it’s in my court, like the whole thing to move it forward.

Approval process for a gym. Although there was no deadline associated with reporting back to other managers on the task, she did ask one of her employees to determine the costs associated with turning an existing room into a gym. A decision was required regarding leasing versus purchasing equipment and any necessary changes to insurance. She explained that:

there is a room right now that is just basically used for storage and extra office space but it was designed with a gym in mind. Like it’s got a rubber floor ... the back wall goes into the other side which has showers so we’re pretty much ready to go with it.... it’s just committing to it.
Networking with other organizations. When asked if she or other managers had talked to any other companies about workplace wellness she responded: “No, I think it’s been born from within, I really think I am probably the primary one”.

Wellness related activities. Although there is no program, wellness related activities mentioned include: the EFAP with access to a broad range of counseling services; baskets of apples made available throughout the facility in the fall; and employees receiving flu shots at work.

Observation of the physical work environment. The physical work environment and the surrounding area have features to support a future program. The observation of the proposed gym facility confirmed the availability of bathrooms and showers adjacent to the vacant room. There is a walking trail near-by, there are large, well-equipped kitchens and a boardroom area to host corporate guests that could be used for cooking classes and lunch and learns, for example. A company newsletter presently offers wellness tips and could be expanded to include program marketing and communications.

Case summary. The VP’s interest in workplace wellness was driven by the need to respond to an employee survey suggestion to establish an on-site gym coupled with her own belief in wellness. The physical work environment has infrastructure available to support the gym and additional wellness activities. The VP thought it was important to develop a program that ensures “something for everyone” with different activities for different needs and interests.

Case # 3: without program; large; public; urban. The third case involved a field visit to a large, public organization. The two male interviewees worked in the HR department and both were interested in wellness. One is a manager and the other is
involved with the EFAP committee. Both saw a connection between wellness and the Joint Health and Safety Committee; one commented that “there is definitely a pairing with Health and Safety and health and wellness, a logical connection there”.

The organization and the nature of the work. This is the largest case with roughly 1000 employees working in several different corporate cultures across various work units. Employees are located in several buildings but all in the same urban area. There are a number of unions and shift work is involved for some of the employees. The manager described the work force demographics as “aging and ... aged ... I think we’re going over the demographic cliff edge ... as the baby boomers retire.... you’re going to see a huge amount of turnover in the organization”. The other participant described health concerns based on his EFAP involvement, as follows:

mental health is becoming more and more of an issue for us.... We’re seeing that on a daily basis.... in disability claims, even in the WorkSafe stuff, we are seeing more and more claims there.... It’s all purely anecdotal evidence. We’ve never really done ... studies or I guess surveys to even look into this.

Interest in a wellness program. The Strategic Plan states the intention under the human resource component to “create a corporate wellness program that builds on existing initiatives and meets the evolving needs of ... employees”. However, no one has been assigned the responsibility for wellness nor is there a budget allocated for this purpose. Although wellness is referenced in the strategic plan and several collective agreements, the only current, corporate-wide wellness related activity is the EFAP. There is a scent free policy, a return to work program, and a no smoking policy for vehicles. The manager remembered:
a wellness task force or wellness committee was set up a few years ago. I think it was the first formal recognition that I can remember that the issue was of corporate significance.... there was ... I think, an attempt to develop and implement a corporate wellness program but ... I'm not sure about the sustainability of that or whether it really has been sustained. And I'm pretty sure that one of the problems initially at least ... is that it wasn't budgeted, it wasn’t really funded.

When asked if the employer has a responsibility for wellness, the EFAP participant added that:

from a sort of philosophical point of view.... I think ... we have a responsibility with regards to pushing forward wellness, mentally and physically for our employees.... I think one of the problems is when you’re talking about wellness people often think and they don’t understand that to really implement a wellness program it takes a budget.... And we just haven’t had that level of support.... The other part of it too without ... the baseline ... it’s hard to say give me $100,000 and create a ... wellness program with nothing really other than anecdotal evidence that it’s actually making a difference.

*The business case for a program.* The two participants were aware of the business case for wellness programs. The manager remarked that “it’s probably fairly easy to build a business case but it’s very difficult to sell the business case.” Although no serious wellness discussions have been held with the various unions, the topic surfaces occasionally at both Joint Health and Safety Committee and EFAP Committee meetings.
Wellness activities. Individual work units have attempted a variety of wellness activities over the years, including walking challenges, lunch & learns, and an unfunded, yet well attended, wellness fair. These activities were not sustained. Managers can currently claim 50% of the cost of an annual gym membership.

Social responsibility. When asked about management involvement in wellness, the manager responded that they are generally “very very supportive and proactive with ... community events, runs and walks to raise money for various ... causes, and ... really champion and support the idea of corporate social responsibility”. He elaborated that since “employees have always been involved in things for ... the wellness of the community ... they are realizing that that has benefits for the employees as well”. He described the potential benefits for employees as “networking with people ... maybe picking up some ... lifestyle behavioral changes themselves that they can integrate into their own lifestyles”. He considers that the organization has “not just an opportunity but a responsibility to ... do these kinds of things .... it really impacts the whole organization”. When asked to describe social responsibility, the manager described it as:

the responsibility at a personal level of each member of staff, each member of the organization to participate in ... wellness related activities and other activities that strengthen the moral, physical, and social fiber of the community.... generally speaking. So it’s not just a matter of {organization’s name removed} giving “x” dollars to ... this good cause, it’s a matter of staff getting out on Saturday and helping to make the cause and also assuming leadership roles in various community groups, and volunteering.
The physical work environment. An observation of facilities was not conducted; however, both interviewees reported that lunch rooms were poorly equipped in all buildings. They commented that one building has a gym for use by a work unit and another building has individual pieces of equipment, with the funding provided by the respective unions. In the case of the building where the interview was held, there are restaurants, a gym, and a pool near-by. When asked if there are vending machines in the lunchrooms, the manager responded affirmatively but described the contents as unhealthy choices, “it’s usually coke, chocolate bars, and chips instead of healthy alternatives”.

Case summary. Although the strategic plan calls for a wellness program, resources have not been made available and activities organized by individual units in the past have not been sustained. Improvements to the physical work environment would be required to support a program. However, a Health and Safety and an EFAP committee currently exist to potentially help to develop and/or implement a wellness program.

Case # 4: without program; small; not-for-profit; urban. The initial contact for this fourth case was made through a colleague to the head of a not-for-profit organization who agreed to participate in an on-site interview.

The organization and the nature of the work. This urban organization is the smallest of the 10 cases. Of the 12 employees on staff at the time of the interview, 10 worked on annual contracts funded by a variety of federal and provincial initiatives to support a vulnerable population. The participant commented that the organization:
has an incredible \textit{participant emphasis} responsibility ... when it helps people....

We are a service agency.... The people that work here ... are paid for by specific
... funding dollars.... \textit{However participant emphasis}... because we are a not-
for-profit there’s a number of things that we see requiring service that nobody
wants to pay for so people here are wearing multiple hats all of the time....

Everything is contract based.... every April ... usually we lose people and then,
you know, you just hang on and hang on and hang-on and ... you get more.

Salary levels are low, two thirds of the employees are female, and turn-over is
high, especially with males. The head of the organization also mentioned that they have
experienced the biggest turn-over ... since ‘95.... because ... unfortunately we
had a staff member who passed away this summer.... Then we had ... two staff
who kind of up and left ... so right now we are operating with four brand new
people.... It’s been difficult.

However, finding new employees has not been an obstacle; for every job advertised they
receive from “30 to 50 resumes”.

\textbf{Network of not-for-profits.} The organization is part of a network of not-for-
profits and typically there are more females than males in these organizations; that
“speaks to the money in a lot of cases; women traditionally will work for less; it’s tough
to keep men because of that”.

\textbf{Job related stress.} Employees are given notice every February that their contracts
are up for renewal which adds to the stress of the daily work associated with vulnerable
clients. The participant elaborated that “if you’ve been with me for two years ...
consecutively you’re fulltime, so I have to give you three month notification that your job
is ending so everybody gets a lay-off notice in January”. She described other stressors as:

the level of need that we see.... children having babies, and ... they’ve got
addictive boyfriends, abusive boyfriends. We see people living on the
streets ... people spending all their money at the gambling machines ... people
that can’t get off dilaudids.... It’s just making really ineffective choices ... no
matter what we’ve said {participant emphasis}... and it can be taxing if you do
not ... package that in ... the right way.

She added that “if you really know the children that are not eating tonight, or that are
dealing with violence” it is tiring. Other stressors relate to “when governments change,
because social development can’t be done on a four year mandate and it’s the first to go
... then you’ve got ... suicides and attempted suicides”.

Coping with stress. There is no EFAP to turn to. The participant has observed that
half the staff smoke and eating junk food becomes a means of coping when stress runs
high. Walking trails are nearby and half the staff make use of the trails at noon when time
permits. Laughter, prayer, and a bit of flexibility to shut down the office for an occasional
staff day or to give an employee time off to deal with personal issues without reducing
their paycheck are the current options. The participant explained that:

most of us smoked before we got here.... You can tell when there’s stressors
going on because people start eating crap....You can smell the {restaurant’s name
removed} coming through ... from folks who have ... religiously brought their
lunches ... made sure that it ... wasn’t processed stuff.... Then they all get into an
urge that at a staff meeting we have to have cake.... I’ll also get ... ‘is it time for a
staff day’ … We try to get at least three or four a year where we just don’t do anything … we just send people home when they’re tired.

**Role of the employer in wellness.** When asked what role, if any, an employer has regarding the health and wellness of employees, she responded:

I need to know that my folks are as happy and healthy … as they can be…. I do believe it’s my responsibility to draw attention to … healthy behaviours and not so healthy behaviours…. {Organization’s name removed} does not have a lot of money to spend on … retreats and … team building stuff … but we do have the flexibility to say … go home and … it is not going to affect your pay…. if you are taking care of yourself and this is a part of it…. I can’t pay people to go to the gym … but if they need … services … if they’re okay with telling me … pay isn’t going to get docked…. So while we can’t really bring in a lot ... of healthy services … we can support people’s needs.... If there are family members that are sick or children are sick…. You go and take whatever time you need and I will support that as best we can.

**Perception of wellness programs.** When asked about her perception of wellness programs, she responded:

Well you know I really don’t know; … I don’t know that I was ever … really conscious of … that as a kind of a planned thing. It’s just it happens or it doesn’t happen…. I hear … about … doing like breakfasts together, and … having a guest speaker in or, or whatever but really no … my brain is not real open to that.

**The physical work environment.** There is no staff room on-site. However, the office is located close to several fast food outlets, grocery stores, and a walking trail.
Case summary. This is the smallest of the 10 cases. Most staff members work on annual contracts and there are no employee benefits. Apart from flexibility demonstrated by the head of the organization, there are no existing wellness related activities. The employees put the wellness of clients ahead of their own. However, there is a network of local not-for-profits for information exchange.

Cross-case Analysis of the Six Cases with Programs: Additional Context

A cross-case analysis of the data from the six cases with programs raised the following common themes to add to the description of wellness programs in NB.

Perceived program benefits. Benefits participants mentioned included weight loss, smoking cessation, seeking medical help as a result of screening clinics, injury prevention, and eliminating medication to control blood pressure. Most of the benefits were reported anecdotally; data were seldom collected to provide evidence of benefits. Documentation from the private non-manufacturing organization refers to: “several colleagues hav[ing] experienced great personal victories in terms of weight loss, reduced inches, toning, ceased use of prescription medication, overcoming ailments, which in turn, has bettered their overall health and wellbeing at work.”

The researcher also observed the success with Weight Watchers of the program leader in the rural manufacturing case through the pictures proudly displayed in her office:
they still marvel at us when we walk through the plant and it’s like ... you’ve
encouraged me to go or I’m going to go next year.... We must have had nine
people hit lifetime membership ... it’s sort of by example, that you can do it.

A female focus group participant in this organization who was not following the Weight
Watcher’s program appreciated the encouragement from colleagues; “watching what they
eat encourages me to eat better too and ... there’s a couple of them that go for walks, at
11:30 at night, when they are done their night shift.... it’s just that they have a partner ... it means you have someone encouraging you”.

A program volunteer in the rural public organization offered another example of
employees encouraging one another to walk during noon hour. One of her colleagues
mentioned to her that her blood pressure was down and she was “pretty sure that it’s the
walking”. The colleague was grateful for the motivation. The volunteer personally
benefits from having “more energy in the afternoon” following their noon hour walks.

The other volunteer with this program sees his participation as helping him to
potentially avoid health issues currently facing his friends: He explained as follows:

I’m looking at my friends who are ten years older than me, the same weight as me
... in for bypass surgery.... So I’m saying ok ... I’ve got to do something now
before I’m ... getting stents put in or having ... cardiac bypass.... It’s pretty easy to
look back and say well ... if you had promoted this sort of thing ... years ago.

A participant in the urban public case described how, as a result of a clinic at a
health fair, “a couple of people {were taken} right to the hospital because their blood
pressure was so high”. Further, she considers the pre-shift exercises introduced a number
of years ago to have “really helped prevent injuries”. The program leader in the rural
manufacturing case has had a similar experience; pre-shift exercises resulted in “very good success with reductions of soft tissue injuries when ... enforcing it vigorously.”

Participants also identified benefits related to the work environment and recruitment and retention of employees. The participating manager from the private non-manufacturing organization described the program as contributing to the creation of a fun atmosphere at work that in turn contributes to the retention of bilingual employees in a tight labor market. Their program documentation further mentions those involved in a physical fitness group as having a “remarkable sense of belonging” while having “developed a unique sense of camaraderie and a renewed sense of loyalty to the organization”, as reflected in annual employee surveys and the organization’s “enviable turnover rate” among similar organizations.

A focus group participant in the rural manufacturing case commented that their program brings a fun atmosphere to the workplace; “the golfing and the ballgames and curling.... it’s a place to see people outside the workplace and ... you meet people you don’t talk to everyday”.

A participant in the urban public case described the improved morale and cited the data confirming the low level of absenteeism in her unit compared to other units. Her unit was the first to initiate wellness activities within the organization.

An additional benefit of program participation related to building rapport among employees across divisions which seemed to increase productivity. A focus group participant in the rural manufacturing case described this as follows:

when I first started here ... there was a lot of people I didn’t know but then I started going to these activities and I got to know them and then ... if you
happen to be in the shift in the department with them or whatever, you have a rapport with them. And it's a lot easier to work with someone you know a little bit than work with strangers.... You could approach one familiar face in that department and say do you know who I could see about this. It just makes it a lot easier. A lot of days it makes it a lot easier.

Focus group participants in the urban public organization mentioned that the program contributed to morale and employee resiliency. One explained that "usually you're a little happier too. Employees can put up with the difficulties at work that it brings these days because everything is so fast at work now; it's just the way it is".

The participant in the small private case also described how he has personally benefited from being involved in the program: "It's been a big, big change for me since ... coming right out school, not caring about my health at all, to ... knowing what's right and wrong and what's good for me and what's not". He provided an overall summary regarding program benefits when he commented that "it's challenging sometimes when there's lots to do but the benefits, you know, outweigh the pain of doing it".

**Unintended consequences of program activities.** As described in Chapter Two, program activities can result in negative unintended consequences. One example was reported in the urban public organization. The organization conducted ergonomic assessments with the best of intentions and raised the expectations of staff that ergonomic issues might be addressed; however the funding to follow-up on the recommendations was unavailable in some departments.
A second example, in this same case, related to the relationship employees build with nurses who conduct screening clinics under contract arrangements. When the nurse changes, for whatever reason, employees need to re-establish trust.

A third example involved an external partner in the private non-manufacturing organization. The partnership did not end well; the sudden loss of the physical fitness consultant was a disappointment to the employees who relied on the service for noon hour exercise. The service was utilized by “an awful lot of young mothers”. This left the organization searching unsuccessfully for a comparable arrangement.

**Evolution of programs.** Participants mentioned that their programs were evolving with time and experience. The program leader for the most recent program, in the rural manufacturing case, commented that:

"I’m always learning and ... I discovered it doesn’t have to be earth shattering and, ... I can’t be everything for everybody.... What I’m passionate about is probably the best thing that I can put in.... and so, ... it doesn’t have to be huge but it’s a constant thing."

Similarly, the urban manufacturing case mentioned how they “started small” and employees are starting to take them seriously now.

An interviewee in the urban public case considers their program (in place since 2005) to be a “gold star” but mentions that “it took time for that to grow”. During the focus group session in that organization, another participant mentioned that although their program is excellent, in her opinion, after roughly seven years, they had reached a “plateau” and changes were required. She was struggling with how to move forward. She wanted to enhance participation while keeping the program interesting for those who
already participate; “you’ve got the low hanging fruit, now you have to start trying to climb the tree”. The program leader agreed. The parting comment on the topic from the group was that “it needs to be employees saying this is important to us and we want to do this, then we facilitate it. I think that’s kind of the next generation of programs”.

**Program sustainability.** In Chapter Two, examples were provided of comprehensive programs from other jurisdictions that were unsustainable for a number of reasons. The concept of program sustainability surfaced in this study. A participant in the urban public organization mentioned the need to:

> keep the momentum going.... It’s so important that people don’t view it as a one off; like it’s part of who we are. It’s something that we offer, it’s not here and then it’s gone. It’s just something that is part of the corporation that we care about our employees; that we, you know, want to help our employees be healthier, happier, more productive. And the sustainability, monitoring the program and data... this is definitely an area {where} I’ve focused more attention. Because I didn’t think about it, to be honest, as much ... in the early years, so we’ve put a lot more effort into that because we want to make sure the program is still here in ten years.

A second participant in the same case raised the same concern regarding how important it is to have ongoing management support and funding for activities. Some of the employees in her unit initially were skeptical that the program would not last:

> oh yah it’s good for this week but next week it’s going to get yanked out from under us and we’re on to our third year now where they trust the process ... and
the guys are starting to … have some faith in what we are doing and I have seen some dramatic results in some of our employees.

**Networking with other organizations.** Participants valued their attendance at local wellness networks organized by GNB and/or the annual workplace wellness conference organized by the HSFNB. A participant in the urban manufacturer described meeting “every three months” with her local network and sharing information and new ideas. She wants:

- another award from the Heart and Stroke Foundation.... our general manager ... is a part of the Rotary Club. And, I’m sure he’s hearing a lot about the wellness program there.... I think he’s proud of that too. Because we know people are looking and want to hear about what we do.

In the small case, the participant expressed his appreciation for the annual workplace wellness conference. He described the conferences as a “meeting of like minds.... it’s great sometimes to expand on what you’re already doing”.

In summary, the descriptive information provided in this chapter sets the stage for the cross-case analyses of the factors that facilitate or create barriers to the development and implementation of workplace wellness programs in organizations with and without programs, as presented in the next two chapters.
Chapter Five: Factors Influencing NB Organizations with Programs

This chapter contains a cross-case analysis for the cases with programs to help answer the second research question - which factors in NB organizations either with or without programs facilitate or create barriers to the development and implementation of workplace wellness programs? The chapter provides an overview of the most important factors as perceived by the six program leaders and closes with a summary of the factors.

Cross Case Analysis of Factors in Organizations with Programs

This section presents information from participants in the six cases with programs. The data and analysis provide NB specific information to help clarify and build on the 12 recurring factors introduced in Chapter Two:

1. management commitment, support, and participation;
2. a strategic plan that includes wellness;
3. integration within the organization including linkages to business objectives and other programs offered by the organization;
4. program resources, including staff and funding;
5. a program committee or, in a small organization, a champion for coordination;
6. program activities that relate to the needs assessment, target several health issues, and are tailored to specific employee and organizational needs;
7. participation of employees, retirees, unions, and the community; engaging all employee groups in the process;
8. a physical workplace environment that is supportive of the program, through
organizational procedures and policies, benefit design, and effective
incentives;
9. program marketing and communication with employees;
10. a needs assessment, such as HRAs;
11. management of other necessary HR and financial data; and,
12. monitoring and evaluation to measure progress against established goals,
criteria and indicators.

**Management commitment, support, and participation.** Management
commitment or support in the six programs ranges from passive involvement to active
participation in activities. Tangible, yet passive, support is demonstrated in all six cases
through ongoing allocation of funding for program staff and activities. The level of
management participation in program activities varies across the organizations and a
desire for more participation from management was voiced by several participants.

A participant in one of the public organizations commented that “they support us
but they don’t participate”. The same concern was voiced by a participant in the other
public organization.

I can only do so much…. it really has to come from the senior managers. Because
the employees … it’s great that I care about them but … if they have the sense
that their manager would be annoyed if they take the time to do this…. So that
has to come from the senior folks…. it really sends a strong message when the
{head} of an organization participates and, for example, goes to the health fairs or
… is actively involved and supportive, that sends a really strong message.
In one of the manufacturing organizations, preference for active participation was confirmed when a participant mentioned that one of the company VPs “was at the baseball tournament, he played ... that speaks volumes for me.” A participant in the other manufacturing facility commented that they are “so lucky because {they} haven’t been denied anything.” However, she too went on to express her preference for more visible management participation. Another participant in this case described a precipitating event experienced by the head of the organization as a possible reason for his program support; “his father died very young of a heart attack and he’s not going to ... he really looks after himself”.

A participant in a public organization provided his perspective as follows: “to me the management participation is just there to set a good example so the other employees are going to want to do it. To me ... the most important thing is employee participation, everything else is just a way to get that to happen.”

In the private non-manufacturing organization, the importance of senior management support to the program was confirmed:

if I had to fight a battle every time I wanted to try something ... it would be not so nice but that support is always there.... and ... the whole leadership team, everybody in the building gets it.... if we provide activities that help with people’s wellness, that it will ... be a better work environment.

When asked about the future of the program in the small private organization, the participant did not have any concerns going forward “because ... the same management team that implemented this ... five years ago, is still at the helm”. Further, he sees their
corporate culture as supporting the program: “probably the biggest thing here for our program, we just have the culture ... to be helping each other out and be healthy. “

Management commitment, support, and participation related to belief in wellness. Management support for a program can be rooted in less tangible concepts such as belief. The participating manager in the non-manufacturing organization expressed her belief in the connection between exercise and mental resiliency: “I’m always a believer that ... a little exercise can help work some of that stuff through”.

Union support. In addition to support from management and program leaders, unions can potentially provide support. In the case of the urban public organization, a participant credited one of their unions for providing the funding for an on-site gym. This was confirmed by others during the focus group session. Similarly, a participant in the rural public case mentioned that a union contributed to program activities. A second participant in this case confirmed that the union “really backs workplace health.”

A strategic plan that includes wellness. Only the rural public organization, which is the organization with the program of the longest duration, provided a strategic plan document that included employee wellness as a corporate priority. A participant from this organization considered wellness to be integrated into the corporate culture. A participant from a second organization mentioned that wellness was part of senior management’s annual strategic planning process: “we go away every October.... We get to vote on what we’re going to do ... but always health and safety and wellness ... this is all discussed in our strategic plan”.

Integration within the organization. The six programs were developed either as an extension of the health and safety program or as a stand-alone program. In the private
non-manufacturing organization, where the program is mandated to the Health and Safety Committee, program documentation states that “health, safety, and wellness have been one of our company’s key cultural pillars for a number of years”. The participant in this case says that she continues “to align safety and wellness in the same sentence”.

The program leader in the rural public organization mentioned that for her “it’s always linked to safety too, either at the workplace or at home”. One of the volunteers interviewed in this case expressed a desire for wellness to be equivalent to safety. The other volunteer interviewed has a concern regarding a potential misperception of participating in a wellness program “because you’re not well ... not ... because you want to stay well”.

In the view of the program leader the Health and Safety Program takes precedence over the recently developed wellness component in the rural manufacturing case. She commented that “once we get a little bit more on top of the safety feature we can concentrate on wellness, mental health, morale, because morale is also wellness.” Regarding safety, she reported that the culture is slowly changing which is demonstrated by decreased accident rates. Her expectations for wellness are different. During the focus group session with the Health and Safety Committee, she commented that:

some of the safety stuff was mandatory and we could enforce it because … we have laws that we have to abide by.... The wellness thing is more of an education, encouraging … that kind of stuff ... more fluffy but … we are on our way, I see a difference.

The other focus group participants did not express contrary views.
While the participant in the small private case has a separate wellness program, he sees safety and wellness as complementary due to the physical nature of the organization’s work. He elaborated that:

safety is the first thing; we need to make sure our people go home at the end of the day. After that, we need to make sure that they show up again tomorrow ... and they’re not sick and they’re not stressed out.

**Internal partnerships.** Integration of the program within the organization relates to developing partnerships with other units in the organization. A participant with the urban public program explained how collaboration with the information technology staff during a planned tour of facilities to introduce on-line pay gave her the opportunity to promote the use of the wellness program information at home through the intranet. Since she is a member of both the Wellness and the Joint Health and Safety Committee, the two committees collaborate on activities of mutual interest.

**Program resources.** All six programs are funded and assigned dedicated staff; however, not all programs have a separate budget. Specific budget amounts were not provided to the researcher, and none of the organizations have a program leader/coordinator allocated 100 percent to the wellness program. Program leaders/coordinators range from nurses to interested employees. Human resource and/or health and safety staff play a role in program development and implementation.

**Program committees.** Program committees existed in five of the six cases and were either an existing health and safety committee or a separate wellness committee. The one case without a formal committee, in the large, rural, public case, has several staff members available who contribute varying percentages of their time to the program along
with interested volunteers. Interestingly, the program of longest duration functions without a committee. In the large, urban, public case, the wellness committee is supported by smaller sub-committees established in larger divisions to help determine program needs and implement activities.

An HR manager in a private case indicated the importance of having a committee that extends beyond HR staff:

if I was running with this, it wouldn’t be as successful as it is because this committee’s involved.... Our goal is one company but we do have different departments and ... different types of people.... that need different things too.

She described the committee as dedicated to the program. In this same organization, the decision making authority delegated to the committee by senior management is viewed positively.

the senior management team doesn’t tell us ... they let us decide and we haven’t been given guidelines.... I hear a lot of people at these {wellness} networks, and they don’t have any money, they have to fundraise.... We haven’t been fundraising ... we were given an amount of money and we can run with it.

However, concerns about the necessary time commitments of committee members were expressed by several participants. In the urban manufacturer, a participant commented that “I don’t have a whole lot of time and every one of us is so busy.” In this case, the committee asks for volunteers to help out with large activities. Overall the participant is happy with the committee. She explained as follows: “I do believe that for the first time we have members that are happy to be part of the committee and have great ideas and that want [participant emphasis] to do things.... and I really believe that.”
In the rural manufacturing case one participant commented that her husband, a non-employee, "is sort of overloaded with my weekend {program} activities." She added that "we don't have enough people wanting to volunteer". A similar concern was voiced in the small private case regarding the time required to organize activities; "that would be the thing I like the least ... I get tasked with a lot of things that I don't have time for".

The only wellness committee that participated in a focus group in this study was in the urban public organization. The program leader is happy with the committee and the committee seemed pleased with both the leader and the program. A female participant remarked that having a dedicated employee available to "keep it going" strengthens the program and others agreed. Although having the program leader present at the focus group session may have resulted in less criticism of the program, it was evident that the committee members were comfortable speaking frankly with one another and with the leader. Interestingly, members were open to being replaced with "new blood" if that meant having new ideas for the program.

**Program activities.** Similar to the descriptions in the literature, there are many common program activities across the six NB cases. The activities relate to the four pillars in the NB wellness strategy and the HSFNB award criteria. However, no two programs are the same. Each has unique elements or characteristics that relate to the nature or location of the organization and the nature of the work. Examples include: daily stretching exercises for employees involved in labour and manufacturing; delivering healthy snacks to employees on job sites; focusing on ergonomic computer desks and chairs for computer related tasks, including stand-up computer desks, and opus back forms for operators of heavy equipment; walking the perimeter of large buildings when
gyms are not available; establishing unique partnerships with unions or external organizations; and becoming involved in local wellness networks.

Although the same activities are not consistently available in all six cases, examples include:

- **healthy eating** - healthy snacks and meals at meetings, occasionally having fruit available in a central location as a healthy snack, nutrition coaching, cooking classes, and Weight Watchers sessions at work;
- **physical activity** - fitness assessments, on-site fitness facilities or corporate rates on gym memberships, walking or biking groups, fitness challenges, stretching exercises as a part of pre-shift warm-ups, sports teams, yoga, golf, and curling;
- **tobacco cessation** - coaching and medication through employee benefits, and policies to prohibit smoking in company vehicles; and,
- **mental health/mental resiliency** - EFAPs, chair massages, and information sessions on how to balance home responsibilities with those at work.

Other common activities include HRAs, screening clinics (blood pressure, cholesterol, glucose), immunization clinics, annual wellness fairs, a variety of educational sessions, employee and family leisure activities (picnics, BBQs, Christmas parties), recognition and awards, community involvement and fund raising, ergonomic assessments, and a focus on fun and humour in the workplace.

*Activities supported by external partnerships and resources.* When specific expertise was not available within an organization for required program activities, organizations established external partnerships. Examples include nurses, Weight
Watchers, dietitians in grocery stores, fitness instructors, and local physicians. Examples of external wellness resources include: WELCOA, Personal Best, and the HSFNB website as well as knowledge exchange through local wellness networks and the annual HSFNB workplace wellness conference.

Programs benefited from external partnerships. A participant with the urban public program expressed her appreciation for the external partners who provided specific expertise in program development and implementation:

we have had a great opportunity to work with [name of organization] and … other outside professionals; we have been able to develop … an action plan; we’ve had … surveying done of the employees. So that’s really kind of mapped out the areas that we wanted the program to develop.

**Participation.** All six program leaders and other participants expressed a desire for higher rates of employee participation and see lack of participation as a program challenge. Since all six organizations are decentralized, reaching employees in multiple locations with program activities is a common concern. One organization uses videoconferencing to enable participation from various offices during training and information sessions.

A participant from the rural manufacturing facility elaborated that “it’s always the same group of people that are going to participate ... people don’t want to give up any leisure time ... they don’t want to participate in lunch and learns ... because that takes away from their smoking”. This program is the most recent and the participant sees “motivating people to give us ideas and to then participate” as the biggest challenges. She further described the barrier to participation as “resistance to change…. nobody wants to
divert from what they are doing". A participant in the urban manufacturing facility commented on the people who could really benefit from program activities “but they’re not there yet.”

Regarding decentralization, the participant in the small private organization expressed his concern about reaching the staff located away from the head office: “it’s a challenge sometimes and I should say though, the people that do participate, that are normally out on the job site, they are 100% involved in the program. Usually, those are the top ranking people in the challenges that we do”. A manager in the urban manufacturing facility expressed a similar concern about their decentralized operations: She wants to “improve it somewhat in the branches... because we don’t want any division ... to feel like they’re not part of it”.

The lack of employee participation may relate to frequent repetition of program offerings. In the non-manufacturing organization, they had too many challenges and participation eventually declined: “you can’t run those things continuously, because they die.” The urban manufacturing facility had a similar experience. They ran a challenge for the entire summer and lost participants: “it was too long.... people had given up, people dropped out.”

However, this same organization involved families in a staff picnic with a positive outcome: “our workforce is aging, so a lot of us don’t have young children, but some of us have grandchildren ... so it was very nice”. The urban public organization also includes families in activities to enhance participation. The assumption is that employees feel less guilty about participating if they are not taking time away from their families. The other reason relates to support for employees in making healthy choices if family members
receive the same information. Smoking cessation was an example of when it was easier
to quit if those smoking at home had stopped as well.

In two of the rural cases, the greater travel distance to attend activities was raised
as a barrier to participation. A participant from the rural manufacturer commented that
“we cannot use community resources ... cause it’s too far of a drive.... it’s too hard to do
outside activities.”

Winter weather may further contribute to lower participation. In the rural public
organization, a participant admitted that he was walking at home but that lapsed “over the
winter months”. Focus group participants from the urban public organization mentioned
their challenge in keeping employees active during the winter. However, they did offer a
successful cooking demonstration at noon hour during the previous winter season. The
leader commented that they:

- actually provided lunch and ... information and materials. So I think we had 33
  employees participate ... and that was really well received. So we will probably
do that again this winter. It’s kind of a nice winter thing ... a good reason to
leave the office when it’s just as easy to stay.... We had really good feedback.
A focus group participant in the urban public case described how difficult it is to
involve employees with physically demanding jobs in fitness activities: “they’re
shovelling all day or on the construction site and it’s tough to get them to try to walk to
work or bike”. Focus group participants wondered if employees were more likely to
participate in wellness at home due to role modelling at work.

**Participation linked to convenience.** In the non-manufacturing case, convenience
was identified as a motivating factor linked to participation. Young mothers preferred to
participate in a fitness activity during their lunch hour since they did not “have time to find a babysitter and go to the gym after work.”

A participant in the rural public organization commented on his participation in activities as follows: “that’s the only reason why I got involved, it’s just because it’s there and it’s easy ... if it’s not easy, I’m probably not going to do it”. He went on to say that “you don’t have to ... schedule time out of your day to go do something after you get home. And that’s probably one of the strongest things, is the fact that it’s right there, right in the workplace.” A participant in the urban public case explained that activities are conducted in different organizational facilities to remove excuses about having to drive to other locations.

Convenience also relates to having access to a health care professional. In the urban public case it was explained that:

because of the doctor shortage and ... maybe they have moved here as a result of working for the {organization}... and then they try to get a doctor and they are on a list.... I know of two or three individuals that have said, you know, if it wasn’t for the health fairs I wouldn’t see a {health care provider} at all.... What I have learned over the years is that the more convenient and ... the easier it is ... to participate ... the more they will.

The concept of easy access to health care providers was confirmed in the focus group session from this organization.

Employees can obtain a flu shot at work in all six cases. In the urban manufacturer, the uptake on flu shots has increased and other health issues have been discovered as a result. The manager explained that:
every year ... it costs us more money which tells me that we have more interest....

And it’s been very beneficial for us because we have found employees that do not
go to a doctor on a regular basis and we did detect that they had a problem; like
for instance, high blood pressure that they didn’t have under control and this nurse
would refer them immediately to a doctor.

**Participation linked to the nature of the work.** The six cases do not have regular
nine-to-five work schedules for the entire workforce since varying types of work require
different hours of operation. The work varies within and across organizations from office
jobs with regular schedules to 24/7 shift work. Such variability presents challenges in
organizing program activities and in facilitating participation. Focus group participants
and interviewees from the urban public organization see half hour lunch breaks, shift
work, and the physical nature of some of the work as barriers.

In the private non-manufacturing organization, employees come to work at
different hours of the day to accommodate customer volume. The work is “highly
scheduled” which is viewed as an issue with job design. There is a “lack of autonomy”
and the work is sedentary. It is a struggle to organize lunch and learns for these
employees since they start their shifts at staggered hours.

In the urban manufacturing facility, a participant confirmed that shift work makes
it “very difficult” to organize activities. Similarly, in the rural manufacturer, a participant
noted that “when I’m working a program, I’m always working it to make sure that I hit
all the three shifts.” The same difficulty arises in the public sector. A participant in the
urban public case talked about the difficulty in scheduling for split shifts six days a week.
In the manufacturing cases, disrupting production is a related concern; “it’s hard to pull the supervisors off the floor... and .... even harder pulling the employees off.” Focus group participants discussed poor nutrition as another issue with shift work; “there is nobody that eats worse than the graveyard shift. They don’t eat at all.... lots of coffee and cigarettes.... occasionally a bag of chips.”

**Physical work environment.** The observation of the physical work environment found three organizations had well-equipped gyms available on-site for staff. They were located in the small private case and in both the rural and urban public organizations. However, in the latter, the gym was available only to employees in one work unit because it had been cost-shared by the respective union. In the rural public case, multiple walking trails are available on site, in addition to the gym.

In the other three cases, both of the private manufacturing facilities have a concern about potential liability associated with an on-site gym. However, there was no concern regarding liability in the small private case. The non-manufacturing organization opted for a corporate discount at a local gym that employees can purchase through monthly pay-roll deductions. Regarding subsidizing gym memberships, the participants in the urban manufacturing facility think that “it will only hit the people that are already going to a gym.” In two cases, employees had asked for exercise facilities to be made available within their workplace; however, space was not available. Participating in fitness activities is further complicated by a lack of transportation to near-by facilities.

Well equipped lunch rooms are available in all six cases for employees who choose to bring food from home. Several kitchens were large enough to enable food preparation or to accommodate cooking classes. Only the rural public organization had
cafeterias on-site. They operate through an external vendor and are profit driven. The availability of healthy choices relates to what sells. Two participants in this case commented spontaneously regarding the cafeteria. The female mentioned the portion sizes: “I’ll get something to go and it’s two meals sometimes it’s more than two meals. It’s ... humongous, it is absolutely hu-mongous (participant emphasis)”. The male remarked about the location and lack of healthier choices:

you go down there and it’s the vending machines full of chocolate bars and the vending machines full of chips, the pop ... there’s muffins all over the place, there’s Danishes. If they have a salad, it’s hidden way, way in the back and, by God, you’ve got to walk by all this other really good stuff to get there.

Vending machines are also available on-site in the large organizations. The machines offer a limited number of healthy offerings; they too are owned by external vendors and are profit driven. In the non-manufacturing organization the following comment on the vending machines was provided:

healthy choices from a vending machine are almost like an oxymoron but it can be done. The ... employees dictate by what they buy.... If they want to buy junk and they continue to buy junk, then that’s what’s going to end up in the vending machine.

A participant in the rural manufacturing case agreed. She commented that: “we are never going to get to fruit in there, vegetables ... because the employees are not willing enough to change enough to make it worth his while ...we don’t own the vending machines”.

In all six cases, bulletin boards post program related materials. In terms of more unique features, participants from the rural manufacturing facility commented during
their focus group session that wellness messages on the screen in the lunch room “generate conversation”. The small private case uses video conferencing to offer wellness sessions to employees located in other offices.

Supportive policies. The urban manufacturing case provided examples of how both their smoking and drug and alcohol policies support a healthy workplace environment. The manager remarked about smoking that “eventually, we’re going to say none on the property, I think we’re probably a year from there.” When asked about their vehicles she confirmed that “it’s just not acceptable.... No, if {the organization} owns the vehicle, you don’t smoke in it.... and we’ve caught an employee and ... the next time, he wouldn’t have a job here.” Regarding the drug and alcohol policy, she explained:

one day an employee ... said to me ‘if you people think ... that you don’t have a drug problem, you’re crazy’ and he said ‘I’m telling you, if I get hurt because somebody is using drugs, you don’t have enough money to pay me off.’ So, I sat down and I wrote a policy; very positive... to help the person, not to get rid of the person....We’ve had a few ... that we’ve really helped and some that ... decided to resign ... but to me it’s very positive. It’s been very good for our employees.

The participant confirmed that the union supports this policy.

Employee benefits package. In the rural public organization a participant raised the importance of having an employee benefits package (medical, dental, and complementary and alternative services) to supplement program activities. She explained that “it’s very difficult to separate wellness from our benefits package.... It can give you the resources to be better.... If you need massage therapy to get de-stressed then you have the benefits package that will support that”.

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**Incentives.** Although the use of incentives is recommended in the literature, in these six cases providing incentives was a minor program component. Some organizations provided no incentives while others provide small promotional items, gift certificates, small cash incentives, and/or accumulation of travel points. The perspectives differ across the six cases.

The participant in the small private organization commented that “we don’t need incentives around here, just knowing that you beat the other person is incentive enough usually”. In the rural public program, it was explained that “the company won’t do incentives”. The concern was expressed in the urban public program that “if you offer an incentive … it’s almost like you have to up the ante…. you gave me this for participating, but what am I going to get next time.”

On the other hand, the urban manufacturing case uses gift certificates to raise awareness. In the rural manufacturing program the participant explained that “about the only thing they get to win is bragging rights.... I don’t do incentives for everything, just things that we want returned”, such as employee surveys.

**Program marketing and communication.** Although all six cases have program related marketing and communication, they are not all at the same level. A participant from the rural public organization mentioned that the “biggest challenge is ... communication; we find it difficult to get the message out”. This was confirmed by another participant in this organization; “I think the programs are there … I don’t know how many people know that the programs are there.”

However, in the other public program their approach was described as beginning
with the selection of a “catchy” program name along with a logo and slogan to brand the program. The tag line is embedded in all program e-mails. One participant thinks that “pretty much everyone has at least heard of {the program} by now” because of the ongoing program presence. In the small case, they use emails, phone calls, posters, “everything we can to get the word out”.

**Use of information technology versus paper.** Information technology is used to support the programs in several ways. Intranet sites store program materials, serve as marketing and communication channels, and link various offices. In addition to intranet sites for program materials, participants discussed use of email, webinars, video conferencing, and screens in lunch rooms, as examples. Technology facilitates participation from employees in multiple locations and enables employees and their families to access program information from home.

However, in the rural manufacturing facility, a participant commented that she still primarily communicates via paper since “they don’t like emails....They have to look once a month for an email from me; that’s a chore ... That’s why most of the communication has to go out with posters.... paychecks, and things like that.” A focus group participant in the urban public organization expressed her displeasure with technology in their program. However, an interviewee in this case stressed the need to balance technology with paper so that both are available to satisfy preferences.

**Data.** In general, data are lacking to guide program development and implementation across the six programs. One of the participants from a manufacturer expressed a desire “to be able to do more data collection”. The few examples of available data relate primarily to employee surveys, HRAs, and/or absenteeism data. A participant
from a public organization commented on the importance of “knowing your employees and what interests them and what their needs are”. She describes how the results of the initial round of HRAs helped to guide program activities.

we did health risk appraisals … when we first introduced the program and I know our four key areas for health risks were … nutrition, physical activity, weight, and stress. And … physical activity and weight I think we’ve really seen a lot of improvements there over the years. And even with stress … we’ve focused a lot of our programming attention on stress, stress reduction, work-life balance and that sort of thing. So anecdotally I do feel that … the program has made a difference.

However, she mentioned that the budget for HRAs was lost after the initial offering which makes it difficult to include data on new staff and to measure change over time.

In all six cases, HRAs provide information to individual employees and aggregate information for program needs. A participant from a public organization commented on her own experience with HRAs:

I still remember those now … because it was very personal, and it was somebody that’s kind of removed from the situation and it’s not your spouse or your mother…. She told me that I needed to wear sunscreen … because I was kind of into tanning then and, I listened to her, and she told me that I need to do this self breast exam…. I never did but … I really should be doing it right? And the other thing she told me is that I should be eating more fruits and vegetables like I … listened to that advice as well.
Data on absenteeism are not readily available in all six cases. Comments ranged from the small private case where they “don’t really keep a tight track on statistics like that” to the non-manufacturing organization where they “track everything.” While absenteeism data may not be recorded in the small private organization, they do conduct employee surveys to determine program interests and they receive aggregate HRA data. In the non-manufacturing case, it is not clear that absenteeism data are tied to the wellness program. It may be related to the nature of the work and the need to schedule sufficient staff to meet customer demand.

In the case of the rural public organization, absenteeism data are used as a way to evaluate the program. The program leader explained:

that sick time analysis that I sent you, that showed a big change year over year, we’re now going out to all the leaders with their individual packages and saying, ‘here’s the change we’ve seen, we don’t know why but you should know why and what you can do to change it’.

Interviewer: So the employer has made the connection then to the business case?
Participant - I have anyway. See that’s why I run that sick time analysis every year…. because, until we can start to impact that number ... that’s the only evaluation we do.... At the end of the year we look back and say what was driving our sick time and what was keeping people away from work and … that would be the only evaluation we’d do.

**Monitoring and evaluation.** Monitoring employee participation at specific activities happens in all six cases, and the results are used primarily to determine if there is sufficient interest to continue with an activity. Formal monitoring or evaluation of
progress or outcomes is rare. Only one case, a public organization, had brought in an external evaluator a number of years ago, which resulted in process changes.

The non-manufacturing organization conducts an annual internal audit as part of their Health and Safety Program. However, wellness had not been integrated into the audit process. The urban manufacturing facility views evaluation differently. A participant explained that she is asked “how many people participated ... so that’s an important factor.... There’s no formal evaluation but ... if it wasn’t doing us a good turn, I wouldn’t get the money for it again”.

In the small private case, completing the application process and being selected as an award winning program by the HSFNB is considered to be sufficient evaluation. The participant commented that: “we evaluate ours through the Heart and Stroke Foundation, that’s our main ... critic.... And from what they tell us, we’ve been doing better every year”. From a monitoring perspective, this organization asks employees for feedback either face-to-face or through surveys. The perspective on evaluation “has always been, does management think it’s okay”?

**Participants’ views of the most important factors.** The program leaders were asked for their opinions on which two or three factors were most important to their respective programs. The following table summarizes the responses according to the six program leaders.
Table 5.1: Program leaders’ opinions: the most important factors impacting programs

<table>
<thead>
<tr>
<th>Factor</th>
<th>Case #1</th>
<th>Case #2</th>
<th>Case #3</th>
<th>Case #4</th>
<th>Case #5</th>
<th>Case #6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management commitment and/or support</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Marketing</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Corporate culture</td>
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<td>X</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Program committee</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision making process</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data</td>
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<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Team-building</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Work environment</td>
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<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Program coordinator</td>
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<td></td>
<td>X</td>
</tr>
<tr>
<td>Needs assessment</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

In the rural public case, the program of longest duration, “management commitment and the ability to market it” were selected as the two most important factors. In the non-manufacturing organization, the response was: “the support of leadership and their corporate culture.... And ... the health and safety committee is, again, a key ... for us keeping what we have going, for sure.” The participant in the urban manufacturing organization responded that:

it has to come from the top down or it’s not going to work.... And I think it’s very important that both management and employees are playing a role here in the decision making..... It’s about all of us ... it’s not we and they.... And of course if we didn’t evaluate or have the data, I wouldn’t get the commitment from the top. In the case of the small organization, the participant was of the opinion that:

it is the corporate culture and secondly it is management commitment. I mean, I say management commitment as second because management can give us all the money they want and tell us to do all these things but unless everybody in the
organization actually, you know, subscribes to the program and wants to do it themselves, there’s ... not much point in throwing money at something.... It’s a great organization... it feels like a family and everybody tries to support each other.

He went on to add a third: “team building.... we’re like a family, so we go out together ... and have a good time .... that’s a big team building thing, it really helps you ... relate to the person”.

The response for the newest program was management support and the nature of the work environment. The latter was selected since she has literacy issues with some of the staff in the manufacturing facility and she spends time on health education. The urban public organization selected the: “key person in your organization that’s your go to person” along with “senior management support” and a “needs assessment ... to make sure what you are offering is what they need”.

**Summary of Factors**

Management commitment and management support are used interchangeably from the perspective of the participants. This factor is mentioned in all six cases; its importance is consistent with Edington’s (2009) findings.

None of the six programs had all of the dozen recurring factors. However, each case had a sufficient combination of factors to have sustained a program from three to 15 years. It would seem that program sustainability relates to maintaining a sufficient combination of factors to facilitate program implementation. Important recurring factors
in the six programs were management commitment or support, dedicated program staff and funding, a program committee, and a wide variety of activities to garner employee participation. All six cases expressed a desire for higher levels of participation.

The programs in this study have a tendency to be less formal than those described in the literature. Internal and external partnerships, including those with unions, external experts, and local wellness networks provide additional program support. All programs used marketing and communication strategies to promote their programs. Incentives to promote participation are not used consistently.

All six programs might benefit from improved data gathering, program documentation, goal setting, and evaluation procedures. While data are available regarding employee needs through surveys and HRAs, absenteeism data are not gathered consistently. Data may be gathered that do not get linked to the wellness program. Participation in program activities is monitored in all programs but formal strategic plans that mention wellness, program plans, and evaluations are missing in most cases. Change is not measured over time.
Chapter Six: Factors Influencing NB Organizations without Programs

Cross Case Analysis of Factors in Organizations Without Programs

This chapter provides a cross-case analysis of both the factors that facilitate and those that create barriers to program development from the perspective of organizations without programs. The overview of the facilitating factors and barriers is followed by a case by case discussion of the barriers and participant suggestions on information sources that would be useful in future program development. The chapter ends with a brief summary of the factors with the potential to facilitate program development and those currently acting as barriers.

Overview of facilitating factors in program development. This section provides insight into the factors perceived by participants to enhance the potential for development of a program. In three of the four cases a number of the recurring factors surfaced from the list in Chapter 2 along with other possible factors and potential program benefits, as follows.

Senior management belief in wellness. Senior management belief in wellness was raised spontaneously by participants from three of the four cases. This would relate to senior management commitment or support from the list of recurring factors. The manager in the non-manufacturing firm and the VP from the rural manufacturing case both expressed their belief in the connection between exercise and improvements in physical and mental health. The VP was emphatic.
I just believe in it. I believe in it {[participant emphasis]}.... I know people personally who have ... started exercising and were able to get off whatever blood pressure medications.... It works so I believe in it. And I think that would apply here; we have some smokers, we have some people with high blood pressure.... I also think it’s a big factor in mental wellness as well.... Today’s environment is hard for people to work and make ends meet and I think a good 45 minute exercise session is ... good for your mind.

In the large public case, a participant explained how the senior managers in other organizations have developed programs primarily based on personal belief in wellness. it was {CEO’s name} who believed in this stuff and sold it 100% and at {organization’s name} when the new president… came on board; {name} believes in this stuff 120%.... It’s motivational to hear him talk; … Without the leadership at the top, it’s not going to happen. That’s been my experience. And a sell job is one thing … but there is a certain level of faith that they have to believe in it, and if they believe in it, they support it and with {name} it was that simple.... {Name} led the charge and put the investment forward, said we’re going to do this, and it happened….

**Strategic plan that includes wellness.** In the large public case, the inclusion of wellness in the strategic plan had not been sufficient to ensure a program. However, the participating manager raised an interesting consideration regarding employees not holding management accountable for the strategic plan: He realized that:

when somebody makes a counter argument, we don’t have time to do this, we don’t have the resources to do this, we can open the document and say but you
ordered us to do this, here it is.... and then they have no choice.... so, we have to do this. The only question that comes and negotiation is as to schedule and the scale, and those kinds of things.... It's up to us to be a very proactive and energetic group that's down there before leadership team hammering on this and I don't think … the coherency of that approach has been there to this point.

Integration with other programs and use of external wellness resources. In the large public case, the EFAP participant mentioned the plentiful on-line wellness resources available through the new benefits provider. He was hopeful these resources “will over time stimulate some internal activity”. The participating manager confirmed the “strong relationship between … EFAP and wellness” and sees the EFAP as a potential pathway to a program: “the tail is kind of wagging the dog; it's almost like instead of wellness launching EFAP, the EFAP process may actually launch … a much larger wellness initiative … which is something that I wouldn't have expected”. The EFAP participant agreed that they “will be able to show resources available to us, by reduction in cost of EFAP which would be huge when you try to make a business case” for wellness.

Committees. According to both participants in the large public organization, wellness is currently being discussed at Health and Safety and EFAP Committee meetings. Given the interest on the part of other individuals within the two existing committees, there may be a possibility to add wellness to the mandate of either committee. The manager elaborated on the Health and Safety Committee discussions about the scope or mandate of the committee:
because there’s some sense in the organization … that {wellness} has nothing to
do with safety at all but there is a strong sense and an equal impetus in the other
direction that it has everything to do with … what you should be looking at … so
it’s an evolving … sense I think, of what properly falls within … the fence.
The EFAP participant in this case described how the EFAP committee had
recently transferred their program to a new provider. He reported on the committee’s
interest in wellness, as follows:

There are union representatives and management representatives from each of the
locals…. One of our hopes or one of the by-products of making the transition was
we were hoping that would free up time … so the EFAP Committee could
become more of a wellness committee as well because now … we will actually
get … statistics…. We are hoping that the committee will be able to recommend
wellness programs maybe to management…. and the governance of that we are
not 100% sure on that. It’s been an internal debate on how that would work and I
know some people very much against that and other people are very much for it.
So we don’t know how that’s going to pan out.

Activities. Ad hoc wellness activities had been organized in various units in the
large public organization. However, the effort was not sustained. The manager described
how the EFAP committee had organized a successful wellness fair as one example:

They were really interested in wellness aside from their role on EAP. It was just
kind of a self-organizing thing, where a group of people got together and said we
have to have a wellness fair … to get this information out to employees. Let’s
make it happen…. It was well done and it was very successful, unfortunately it
wasn’t sustained and … we did it without a budget…. We just did it…. we got some volunteers … and … the participating organizations were willing to come in … without cost…. It certainly attracted a lot of attention. It was well attended but…. it’s more important that it wasn’t repeated, than it actually happened. I think that says more about where we are with this thing.

**Organizational readiness.** In the small rural manufacturer, feedback in an employee survey that was part of a needs assessment resulted in the participating VP initiating a discussion with the management team regarding establishment of an on-site gym. She remarked that she thought the timing was right; “had it been 18 months to 24 months ago it wouldn’t have been a good thing but ... timing is probably good.” She explained that a couple of years earlier the company was preoccupied with reducing the size of the workforce. She considers there to be a better understanding of wellness within the organization now than in the past:

there’s definitely the desire, and the willingness, and the want for something because wellness for awhile was a buzz word.... but now, I think, where people are seeing ... maybe people are on anti-depressants, maybe people are on blood pressure medication. I think anything else that can support people in their daily lives is not just a buzzword anymore, it’s real for people.

In the small non-manufacturing firm, the precipitating event leading to a wellness discussion at the management table revolved around employees on long-term sick leave (absenteeism). The costs associated with hiring and training staff to replace absent employees raised management’s understanding of the business case for wellness programs. The participating manager speculated as follows:
I think they will be more open minded because … particularly in this office, in the last couple of years, we had two people in car accidents who were out on extended leave and then recently we had two people go out on stress leave…. I think they are starting to realize the cost of having people out on leave; I am not talking about the tangible costs…. I am talking about … the office does not operate as efficiently when you are short staffed; because they are out on medical leave you can’t really replace them…. So even if you bring somebody in on a temporary basis you are spending a lot of time and effort to train them…. I think we would have a bit more acceptance or at least the eyes are open.

Convenience. During the discussion, the VP in the small rural manufacturer mentioned convenience as a benefit, especially since the organization is isolated in a rural area. They currently offer flu shots every fall and she sees that as “very effective for convenience; you don’t have to block off an hour in your day to go to the doctor and get your flu shot.”

Morale and communication. Enhancing employee morale and communication with employees are other possible program benefits in her opinion; the VP commented that:

there’s a number of things that could be linked to morale.... One of the other things that came out in the employee survey was ... poor communication from the top down which I think is so [participant emphasis] common but if it was something around wellness.... and I think where a wellness program would be something for everybody. It ... could be communicated somehow on a regular basis, from management to the employee base.
Employee engagement. The EFAP participant in the large public organization raised employee engagement as another potential benefit from a program.

I think it’s huge…. if you expect everyone to get involved that’s not going to happen. And looking for 100% participation is not realistic. But wellness to 80% and 85%, I think you see some real significant improvements in engagement in the work place. People are talking, they’re having fun … they’re making competitions out of it, and I think that that’s a huge aspect of it…. It creates a bit of faith in management … when you give someone an hour or one and a half to go to the gym…. I think that speaks, that tells employees that management cares …. and again measuring engagement is hard to do…. What that means to the bottom line is difficult to measure.

Table 6.1 summarizes the opinions of participants on facilitating factors as potential pathways to programs in the three cases without programs.

Table 6.1: Participant opinions on facilitating factors in cases without programs

<table>
<thead>
<tr>
<th>Case #</th>
<th>Facilitating factors</th>
<th>Comments/perceived program benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case # 1</td>
<td>employee survey as a component of a needs assessment;</td>
<td>convenience;</td>
</tr>
<tr>
<td></td>
<td>good timing due to a better fiscal climate;</td>
<td>improvements in morale; &amp; improvements in communication with employees</td>
</tr>
<tr>
<td></td>
<td>managers have a better understanding of wellness</td>
<td></td>
</tr>
<tr>
<td>Case # 2</td>
<td>absenteeism related to employees on long-term sick leave yields better understanding of the business case for wellness</td>
<td>the participating manager sees the disruption to productivity caused by having employees out on long-term sick leave and the costs of training replacement staff</td>
</tr>
<tr>
<td>Case # 3</td>
<td>strategic plan mentioned wellness; previous ad hoc activities to build on;</td>
<td>strategic plan document can be used as a reminder to management of their previous commitment;</td>
</tr>
<tr>
<td></td>
<td>interest from Health and Safety &amp; EFAP Committees; on-line resources from EFAP provider</td>
<td>an employee with previous program experience could help facilitate development of a program;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>employee engagement seen as a potential benefit</td>
</tr>
<tr>
<td>1, 2, &amp; 3</td>
<td>senior management belief in wellness</td>
<td>mentioned in the three cases</td>
</tr>
</tbody>
</table>
**Overview of barriers to program development.** As mentioned in Chapter Two, a report from The Conference Board of Canada (2002) suggests common barriers to program development. The first section of Table 6.2 indicates if the factors from this report were mentioned by the participants from the four cases and the second section outlines additional barriers.

Table 6.2: Barriers to program development in four cases without programs

<table>
<thead>
<tr>
<th>Barriers from The Conference Board of Canada report (2002) mentioned in this study</th>
<th>Case # 1 Small Private Non-manufacturing</th>
<th>Case # 2 Small Private Manufacturer</th>
<th>Case # 3 Large Public</th>
<th>Case # 4 Small Not-for-profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>No budget</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>No staff</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Concerns over program costs</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Lack of wellness knowledge</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Unconvinced of savings associated with wellness</td>
<td>N/A*</td>
<td>N/A*</td>
<td>N/A*</td>
<td></td>
</tr>
<tr>
<td>Concerns over making wellness available to all employees</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inability to quantify results</td>
<td></td>
<td></td>
<td>X**</td>
<td></td>
</tr>
</tbody>
</table>

* participants believe in benefits from wellness programs

**lack of data
### Barriers to the development of programs.

The following information provides a case-by-case description of the barriers as outlined in Table 6.2.

**Case # 1: small; private; non-manufacturing; urban.** Although the participating manager understands the potential benefits from a program, she will need to convince the other managers. She sees a number of barriers, as follows: “a lot of it comes down to how much time is this going to take? How much is it going to cost to do it? What will we lose
in productivity as a result?” The current economy is a potential barrier: “in NB the recession has hit us this year…. so we’re now scrambling, because we’ve seen like a slow down and … we’re having to look at how we are spending more carefully.”

Another anticipated barrier involves obtaining buy-in from professional staff given their recent indifference to the Health and Safety Program. Even organizing training for support staff has been a challenge. Lunch and learns seem to work best “so that it is not affecting the {professional staff} and the {support} staff member is free to come and if we provide lunch then they are not feeling put out by having to attend a training session during lunch hour”. The manager will be challenged to be “innovative” in how any future wellness activities are implemented.

*Case # 2: small; private; manufacturing; rural.* In this case, a potential champion on the management team believes in wellness and is willing to take the lead with development of a gym on-site. However, the VP considers her “bigger challenge internally would be…. {that it’s} something that needs to be maintained on an ongoing basis”.

Other barriers relate to: a lack of expertise on how to proceed including the focus for the program itself and how to include all staff; a lack of structure within the organization to support a program; the need to maintain the program as a priority in view of daily business pressures; and a lack of both a budget and an employee assigned to coordinate a program and ensure program sustainability. Regarding a lack of expertise she commented:
the bigger thing is really ... how to bring it down to the daily lives of every individual within the organization, how to make sure what we are doing is effective and it's not just a make work thing, it's not just something we can tick off and say we have a wellness program.... How do we ... connect all the dots in all of it? How do we ensure that the objectives that are set out for it, whatever they may be, are measured ... on an annual basis, and if it needs to change then we modify it or if it's working then we build upon it? So I sort of see ... the biggest barrier really is going to be focus.

The VP expressed the need for wellness to be a priority in the corporate strategic plan. She described how other projects had failed: when not “connected to the strat plan they just sort of wane away and fall off the map ... but as long as there was somebody in executive committee ensuring that it was always part of the strategic plan”. She summed up by saying “if I was thinking barriers it would be focus, priority, and ongoing cause there’s got to be ownership, for anything in an organization”.

*Case # 3: large; public; urban.* The two participants identified a number of barriers within the organization. Reference to wellness in the strategic plan had not been sufficient to ensure a program. According to the EFAP committee participant “the strategic plan to me, that’s just words, they don’t mean anything unless you actually put the resources behind them.” The manager links the lack of resources to the fiscal climate:

when the wellness program initiative was launched here, there was suggested funding I think of $10,000 which was cut. So ... when it comes to actually looking at the place where the rubber hits the road, it’s been difficult.... for
reasons that we’re in the environment we are in and we’ve been facing nothing but cutbacks, work force adjustment programs, reductions in funding … from a senior level of government since 1994. And … when all the costs are now and all of the benefits are maybe years down the road and when some of those benefits are sort of mired in … conjectural productivity gains or avoidance of productivity losses as opposed to hard dollar savings it becomes really tough to sell the business case. It doesn’t become tough to make it, but it becomes tough to sell it.

He sees structural issues including the annual budgeting process, the nature of the work, and the decentralized nature of the organization. Specifically, “the outside work force gets a half hour for lunch and they have to stay there…. we have so many buildings … different sites”. An additional structural barrier related to the reduction of absenteeism and lost productivity as a reduction of “sunk costs”. He explained that “whether you’re sick or whether you’re here your employment costs are the same”. Productivity gains are “a little bit more, well I wouldn’t say intangible, but they are harder to wrap your arms around and measure”.

The manager mentioned the difficulty in sustaining previous activities and the perception of wellness as fun or “the flavor of the month”. Past wellness challenges have gotten staff excited and then “it dies”. Wellness fights a “stigma … of being fun stuff …. as opposed to something that might actually save your life or… improve your quality of life. Let’s … go out today and have some fun with this … wellness initiative”.

Based on previous experience with implementing HRAs in one work unit, the EFAP committee participant raised lack of trust as a possible barrier to a program:
for some reason, there's some employees, not all, … believed that somehow this is some kind of a 'Machiavellian scheme' to get personal information from them … to, I don’t know do what, I’m not sure…. the employees did not want to participate in HRA’s for that reason. They thought that the employer would have access to their blood work …. and it took a lot of work and time and effort and joint cooperation with the locals, to actually get people on board … we got there, but … to say that wasn’t a road block would be not true; it was a huge road block.

The manager disagreed. Although it may have been an issue in that particular unit, he speculates that it may be their personal fear of receiving negative HRA results:

- if they didn’t want to do that it wouldn’t be because they were afraid of the employer, it was because they don’t want to know the bad news, themselves, like do I have high blood pressure, do I have high cholesterol, am I … border line diabetic…. so they stay away from these things. On the other hand, we have had some very successful clinics and again ad hoc things…. And we have had in a couple of cases, and they were well publicized, employees come in and have their blood pressure taken and be sent to the hospital like that day, that day {participant emphasis}, a … life threatening situation.

The EFAP participant was asked, given his experience with a wellness program with a previous employer, what he thought would be needed to develop and implement a program. He responded:

- money and resources, human resources, because it does take … a dedicated program coordinator. All the other barriers could be overcome if you had the resources, and you can gain the trust of the employees and the belief from them
that … this is sustainable long term, and that it’s in their best interests. Those obstacles could be overcome, but we need money.

When further asked which factors he would consider most important to program development and implementation. He responded that “the resources are by far the key and the management commitment to the program is one and two for me…. it comes up to leadership for me…. leadership at the top believing in it to me is the key.”

The manager described how a leader’s perspective on wellness in this public organization may have acted as a barrier to moving forward with the commitment to wellness in their strategic plan.

The {name of position} once referred to the idea of wellness, as … fluff…. that wellness is about sort of eat your carrots programs, that have more to do with personal things than corporate things…. In other words, sort of looking at wellness as a personal issue as … opposed to a corporate issue and that’s why I think that the corporate culture to enforce it is really, really important.

Case # 4: Small; not-for-profit; urban. The head of the organization described the barriers to program development as a lack of time, money, and expertise and the ongoing need to focus on the survival of the organization given the contract nature of the work. we’ve really, really relied on ourselves to take care of ourselves; and a lot of it comes down to dollars and cents; there is just not the money; like I don’t know what I would do… I don’t know, you have kind of stumped me…. especially when you are working with contracts.

She went on to describe how her energy is focused on keeping the organization alive;
the pieces that did pop into my head... the time it would take to organize and why not ... what eats up that time and ... if we don’t do it why don’t we do it, and if we did do it what would need to change? ... I am just thinking that so much of our time and energy, so much of our time and energy is spent in staying alive. We are so much into survival mode.... you just don’t get up from your desk cause there hasn’t been the time and ... I know people will say you need to take the time and you’re right but if you are not alive tomorrow it doesn’t matter; and that’s a piece that we carry; we carry it a lot.

**Information sources useful for program development.** When the participants were asked what kind of information would be useful to establish a program and where they would look for such information, a number of suggestions were provided. The manager in the private non-manufacturing case responded that their “group insurance company” would have “some information on line” and she “would probably look to other organizations who have implemented” programs.

Regarding specific kinds of information that would be useful, she explained that:

if we could find almost like a template ... this is how you would go about starting a program, even an education session.... I think if you are going to ask people to be on the committee it is important to educate them as to what the committee is for and how you would go about getting it started.... so any education sessions we can find.... finding information on different things within the workplace that affects your health is important; and ... a lot of people are not aware that your work environment can have a significant effect on your health and that your home environment could affect your work environment.
The VP in the small manufacturing case stated that they “would probably look for expertise first…. a consultant to help get … started”. “She elaborated that she needs information on “how it all connects ... I think everybody understands the theory but as it affects the corporation and the organization, what’s the maintenance costs, what’s the ongoing ... how do you make sure there is something for everyone in it?”

The two participants in the large public organization were already aware of program information sources, including their EFAP provider and other local organizations with programs.

The head of the small not-for-profit, who was new to the concept of wellness programs, responded that:

it never hurts to have the … posters, as reminders, or the handouts…. we have a tendency that it is all about … the people we serve, so whatever we have is … for them; we don’t spend a lot of time on stuff for us and maybe that is a shift that I need to make, because … having posters up… even if it is a copy of Canada’s Food Guide … or some ideas for healthy lunches … that you can do cheaply.

Summary of Factors

The factors to facilitate program development in three of the four organizations without programs included senior management belief in wellness, enhancing senior management understanding of wellness through precipitating events, inclusion of wellness in the strategic plan, integration with other programs such as EFAP and use of external wellness resources, the possibility of adding wellness to the mandate of an existing committee, building on ad hoc activities, appropriate timing for the organization,
and employee feedback.

In two of the four cases, a precipitating event within the organization generated an interest in exploring wellness as a potential solution. In one case it was an annual employee survey expressing an interest in establishing a gym while in the second it was recognizing that several employees were out on long-term sick leave. Managers, as potential program champions, saw the connection between wellness activities and reduced health costs and loss of productivity within the organizations. The manager in the small non-manufacturing case thought that there might now be more openness to wellness. Similarly, the VP in the small private manufacturer speculated that the timing might be right. With these two organizations, there is potential to build on a precipitating event recognized by a manager with a belief in wellness coupled with opportune timing or openness within the organization. General information on wellness and specifics of program structure, costs, benefits, and activities is required. Preferred sources are benefit providers, consultants, and other organizations with programs.

The barriers to program development included the lack of resources, either money or staff time, a poor fiscal climate, the lack of wellness or program related information, concerns regarding possible losses in employee productivity associated with attending program activities, convincing other managers or professional staff of the need for wellness, the lack of structure within the organization to support a program, the lack of focus due to competing priorities, the need to have wellness recognized within the strategic plan, and the constant threat regarding organizational survival.
Chapter Seven: Conclusions and Recommendations

This final chapter provides: conclusions regarding the two research questions on the range of programs and the factors influencing WWPs; an expanded version of Edington’s continuum (2009) from Chapter 2; a Framework for Comprehensive WWPs that is drawn from the literature and the research results; and, recommendations for future research and action. The chapter closes with a summary of the study contributions.

Conclusions Regarding the Research Questions

This section considers the results from Chapters Four, Five, and Six in relation to the existing literature and the NB policy context for workplace wellness from Chapter Two. The conclusions address: the range of programs, the factors influencing program development and implementation in the six organizations with programs, and, the factors influencing program development and implementation in the four organizations without programs.

Program range. A wide range of programs exist within the six organizations as either stand-alone wellness programs or extensions of health and safety programs. Programs were linked to strategic planning in only two of the six cases. The programs tended not to address a broader vision of organizational health; however, such topics are also not included in resources published within the province. Management consistently demonstrated support for programs through allocation of financial and human resources but not always via direct participation in program activities.
Five of the six WWPs were implemented through a committee. External partnerships and resources supplemented in-house expertise. Program activities reflected the current health promotion priorities of GNB, along with other activities, such as health screenings and employee and family leisure activities. All six cases desired increased participation by employees in activities.

Perceived benefits from the programs included health benefits for individuals, improved workplace culture, and decreased absenteeism all of which are consistent with the literature in Chapter 2. However, most of the benefits were reported anecdotally and were not supported by data. Potential negative consequences of WWPs included raised expectations that are unfulfilled and disappointments when services are discontinued.

Although the six WWPs had been in place from three to 15 years, the lack of program sustainability is a potential issue in NB. There is no regular follow-up with individual organizations with programs by either GNB or the HSFNB. While the cases were being recruited, it was discovered that three award winning programs in smaller organizations were discontinued.

Evolution of the program sample in NB is consistent with Edington’s (2009) continuum. Program evolution has benefited from new ideas obtained through participation in local wellness networks organized by GNB and as a result of attending the annual workplace wellness conferences organized by the HSFNB. Networking to share information across organizations is perceived as useful in organizations both with and without programs. Program leaders and committees want to continue to learn and to keep their programs interesting.

Future policy and resources for WWPs in NB will need to support program

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evolution and sustainability through a broader vision of organizational health and comprehensive programming. The perception of wellness as “fluffy” is an underlying challenge. Achieving the full potential of wellness programming in NB is hampered by the perception by some that workplace wellness is less tangible and less important than workplace safety because there are no legislative requirements or incentives to drive action. It seems that the opportunity to improve population health through health promotion and prevention in the workplace setting is not understood fully in this province. Perhaps this relates to the limited provincial evidence base, funding, and resources for workplace wellness coupled with the need to raise awareness regarding the nature of comprehensive programming, potential benefits, and ROI.

**Factors that influenced organizations with WWPs.** None of the six programs had all the dozen recurring factors. However, each case had a sufficient combination of factors to have sustained a program from three to 15 years. It would seem that program sustainability relates to maintaining a sufficient combination of factors to facilitate program implementation.

Consistent with Edington’s (2009) findings, management commitment or support was the number one influencing factor identified by all six programs. Other important recurring factors in the six programs included dedicated program staff and funding and a wide variety of activities to garner employee participation. In all but one case program committees helped organizations better understand the needs of their diverse employee base.

The physical environments of the workplaces varied. Three facilities had gyms on site; all six provided lunch rooms for employees. Food available on-site was, for the
most part, not of high nutritional value. There were examples of policies to prevent smoking in company vehicles and to deal with drug and alcohol use. All six cases used aspects of the physical work environments to communicate about WWPs. Although all six cases had program related marketing and communication, not all were at the same level. Internal and external partnerships, including those with unions, external experts, and local wellness networks provided additional program support.

Enhancing employee participation was a concern of all six organizations. Challenges to participation included the decentralized locations of their workplaces, shift work and work pressures, repetitive wellness activities, distance to work, weather, and the physical nature of some of the jobs. Supports for participation included the convenience of on-site health services, a benefits package that supported health, and activities that involved employees' families. Incentives to promote participation were not used consistently.

The programs in this study are less formal than those described in the literature. Most organizations did not have strategic plans that mention wellness or program plans. While all six cases conducted some monitoring of their programs, in general, data gathering was a weakness and data were not used to evaluate programs or assess program impact. All six might benefit from improved data gathering, program documentation, goal setting, and monitoring and evaluation procedures.

**Factors that influenced organizations without WWPs.** Although all four organizations self-identified as not having WWPs and none of them met Aldana's (2001) definition of wellness programs, three of the four had ad hoc wellness activities and were interested in learning more about WWPs. The triggers for their interest included: a
request for an on-site gym identified through an employee survey, conveniences of on-site workplace wellness activities, a desire to improve communication, concerns about long term absenteeism, and the potential benefits of a program. Just as with the six organizations with WWPs, management’s role was deemed important.

The barriers to program development in the four organizations included lack of information on how to plan, implement, and sustain programs, lack of priority and resources for wellness, and the nature of the work and the difficulty it poses for organizing programs and activities. Potential sources of information about WWPs included insurance companies, the internet, networking with organizations with WWPs, and consultants. The fourth organization, a small not for profit, had no wellness activities and a lack of program awareness; the focus of the organization was on its survival and serving its client base.

**Expanding Edington’s Continuum of Management Commitment**

It would be useful to expand Edington’s (2009) continuum of management commitment. While the continuum provided a framework to inform this research, it did not account for differences in cases without programs. All organizations without programs are grouped in level zero as doing nothing for employee health yet considerable variability existed within this level. One participant stated that her organization was doing nothing for employee health; the participants from the other three cases without programs expressed existing interest or belief in wellness and/or a need for wellness-related information. Wellness related activities already occurred in these organizations on
an ad hoc basis. Expanding the continuum to include a new level of commitment for organizations ready to consider developing a program would broaden its application (see Table 7.1).

**Table 7.1: Continuum of management commitment to workplace wellness programs**

Expansion of Edington’s (2009) employer commitment continuum

<table>
<thead>
<tr>
<th>No Program; doing nothing for employee health</th>
<th>No Program; but ready to consider a program</th>
<th>Traditional Program</th>
<th>Comprehensive Program</th>
<th>Best Practice Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>no current interest and no existing potential</td>
<td>interest/belief and/or existing potential to build on; ad hoc activities</td>
<td>insufficient commitment within the organization and/or program evolution is incomplete</td>
<td>comprehensive program evolves from newly established to a mature program and is sustained over time</td>
<td>sustainable vision for a healthy organization; integrated in decision making; visible management commitment; the goal of program evolution</td>
</tr>
</tbody>
</table>

In this expanded continuum, of the four cases without programs, only the not-for-profit organization would meet the ‘no program and doing nothing for employee health’ commitment level. The additional level of commitment brings attention to a segment of organizations with no programs but with readiness to learn more about wellness and how to establish a program. Knowledge exchange with organizations at this level would be approached differently than conversations with organizations with no program and no interest or those with programming. Existing interest and activities could help make the business case for establishing a program.
Framework for Comprehensive Workplace Wellness Programs

The Framework for Comprehensive WWPs synthesizes literature on comprehensive programs (see Fact Sheet in Appendix D), common program factors (see Fact Sheet in Appendix E), and potential program benefits (see Fact Sheet in Appendix F) with the results from this study. The framework reflects current evidence in the literature and can serve to:

1. provide an evidence base for use in wellness and public health related policy development;
2. guide future knowledge exchange among the NB Workplace Wellness Community of Practice, other networks, GNB, the HSFNB, researchers, and organizations from all sectors to ensure that wellness related resources, decision-making, and future actions reflect evidence;
3. guide discussions with senior management when determining an organization’s position along the adapted continuum of management commitment (as per Table 7.1); and,
4. provide program leaders/ coordinators/ or committees with a process to follow to develop, implement, and sustain comprehensive or best-practice programs.

Programs are defined by Aldana (2001) as initiatives that enhance awareness, change behaviour, and create environments that support good health practices. The underlying goal should be to evolve to a sustainable and comprehensive (or best practice) program. Comprehensive WWPs are described by Edington (2009), Lowe (2004),
Makrides (2010), and others as integrated into the culture, values, philosophy, policy, and practices of healthy organizations. Regardless of whether an employer is striving for a comprehensive or best practice program, the primary consideration should be to ensure that an adequate combination of facilitating factors are in place to sustain the initial commitment. As Hannon, Garson et al. (2012) and Weiner (2009) suggest there is no point in beginning the process if there is: uncertainty regarding the need for a program or how the program will fit within the organization, uncertainty regarding capability to implement a program, or insufficient commitment from management to provide required financial and human resources. Failure to sustain the program may yield unintended negative consequences and contribute to a negative perception of wellness. Program development and implementation should be based on an integrated and sustainable commitment to wellness on the part of the entire organization.

The following framework elements combine facilitating factors that support comprehensive programs and a recommended process to help ensure sustainability:

1. **Senior management commitment and participation.** Recognition of the need for wellness surfaces within the organization through various pathways, such as a senior manager’s belief in wellness, recognition of the business case and perceived benefits, employee needs assessments, or a precipitating event such as chronic absenteeism. The next step is for senior management to determine if there is sufficient collective commitment to develop and implement a program. If wellness is a collective priority and a good fit for the organization, senior management formally commits to a wellness program for employees and their families (and affiliated organizations or partners, such as
suppliers, sub-contractors, if applicable). The decision is coupled with an expectation of future senior management participation. Once the program is developed, visible, on-going participation occurs from managers at all levels, which reinforces program support and encourages future employee participation. Management performance reviews should include participation in the wellness program.

2. **A vision for a healthy organization.** A vision for a culture of wellness and a healthy organization is developed to fit the particular circumstances of the organization. Wellness should become a lens in the decision making process within a healthy organization. Organizations are prepared to identify and address inherent organizational barriers that affect employee wellness.

3. **Strategic plan.** If the organization has a strategic plan, the objective of creating a culture of wellness and becoming a healthy organization should be included as a strategic priority. Early discussions with unions could yield joint commitment. Decisions are disseminated through a variety of communication channels to the entire organization with a request for employee feedback and expressions of interest from employees in developing a program plan.

4. **Integration.** Senior management must decide if the program will be a stand-alone wellness program or a component of health and safety. Large and/or decentralized organizations may find it beneficial to begin with a pilot project in one location. Regardless, the program is consciously linked to other organizational data, such as employee recruitment and retention;
management's performance reviews; employee surveys, injuries, and absenteeism; and the EFAP to define needs and inform program development.

5. **Program resources.** The management team demonstrates sustained support by ongoing allocation of a budget and human resources (program leader or coordinator) to the program. Union financial or in-kind support is welcomed, when applicable.

6. **Program committee.** Senior management delegates responsibility to a program committee consisting of a cross-section of interested managers and employees or adds the mandate for wellness to an existing committee with an interest in wellness. Union representatives are included, when applicable. Committee size depends on the nature of the organization; volunteers are welcome to support the committee in implementing activities. Sub-committees may be required in decentralized organizations.

7. **Program activities, resources, and partnerships.** Multiple activities are developed over time with ongoing input from employees (e.g., surveys and suggestions) to meet employee needs and interests, including healthy eating, physical activity, smoking cessation, addiction harm reduction, mental resiliency, sleep, shift work concerns, immunization, ergonomics, and injury prevention. Employee coaching and counselling on health risks should be available through an EFAP provider. Organizations examine their own practices to determine organization-wide steps required to support healthy employees. Program committees utilize information resources that are widely available from various sources (some at little or no cost). External
partnerships can provide expertise for specific activities when not available in-house. Decentralized organizations should encourage employee interest from all locations.

8. **Program participation.** Sustained employee participation is supported through the use of employee benefits, incentives, and challenges. Organizational barriers to participation should be removed, when feasible. Senior management leads by example through their participation.

9. **Supportive work environment.** Healthy choices can be promoted and supported through the work environment. For example, providing exercise opportunities and healthy food choices in cafeterias and vending machines help to reinforce program activities. Posting program materials on bulletin boards reinforces messages. Employee health benefits support the program and facilitate participation. Organizational practices and policies should be developed or amended to ensure consistency with the program, to remove conflicting interests, to reinforce program activities, and to support employee health (e.g., nutrition policies to ensure availability of healthy food, no-smoking policies for company vehicles, addiction policies, enhancing employee control over work, employee recognition and rewards, and enhancing internal communications, especially in times of change or uncertainty).

10. **Program marketing and communication.** A program marketing and communication plan includes a program name, logo, and slogan for all electronic and printed materials for branding purposes. Electronic technology
supports dissemination of program information to all employees and their families, in all locations. Efforts are mindful of the need to balance electronic and hard copy communications and employee literacy levels are considered. Ongoing communication from senior management encourages employees to suggest activities and to participate.

11. Baseline data and needs assessment. While ensuring the privacy of personal employee information, aggregate data are collected prior to beginning program activities to establish a baseline and to help determine program needs. Employee health risks and interests in activities are determined from various aggregate data sources such as population health trends, HRA summaries, screening clinic summaries, results from annual medicals (where compulsory), employee surveys, and data on absenteeism. A program plan is prepared in accordance with identified needs.

12. Monitoring and evaluation. An evaluation framework is developed with measureable program goals, criteria, and indicators for evaluation. Ongoing data collection, monitoring participation, and evaluation of results are used to: determine useful activities, measure progress against established goals, identify change over time, and establish or confirm the program business case.

13. Networking and knowledge exchange. Regular communication with other organizations, wellness networks, and/or the Community of Practice generates new ideas, rejuvenates and sustains programs, and supports program evolution towards best practice.
Recommendations

This section provides recommendations to enhance the potential of WWPs in this province and to encourage future research.

*Increasing management’s understanding of comprehensive WWPs and the important role organizational leaders play in program sustainability.* Management in this province should be provided with an enhanced understanding of: how wellness programming can positively impact population health; the potential costs, benefits, and ROI of comprehensive WWPs; the evolution of WWPs; and the required leadership commitment, active participation, and other factors that can influence program sustainability.

*Identifying and implementing strategies to motivate workplaces to implement comprehensive WWPs.* Workplace wellness policy makers and leaders in NB have the opportunity to identify and implement strategies to: motivate organizations to increase the number of WWPs, sustain existing programs, and support program evolution toward comprehensive WWPs. Examples include: legislating incentives that promote the establishment and maintenance of comprehensive WWPs; enhancing public health policy and practice in the workplace as a population health setting; and, increasing the links among health and safety, organizational health and productivity, and workplace wellness.

*Strengthening knowledge exchange on workplace wellness.* The potential for workplace wellness needs to be enhanced in all sectors, including public, private, and not-for-profit organizations. Difficulty in recruitment of cases for this study indicates that sustainability may be an issue for some programs. Participants from organizations
without programs suggest that networking with organizations with programs would be useful. Several participants spontaneously mentioned the usefulness of the HSFNB’s annual workplace wellness conferences and awards. Hence, the NB Workplace Wellness Community of Practice, GNB, the HSFNB, organizational leaders, and researchers should be partners in knowledge exchange to ensure that policy, resources, and decision-making consistently reflect evidence of best practices.

Mentoring of organizations, either with programs or considering a program, can improve program development, implementation, and sustainability. There should be regular communication with all HSFNB award winners and other organizations with programs to develop a knowledge exchange strategy that meets the evolving needs of present and future program leaders/coordinators.

Future HSFNB annual workplace wellness conferences or NB Community of Practice workshops could: provide offerings that target specific needs, contribute to a more consistent perception of wellness and comprehensive programming, enhance the sustainability of programs, and, enhance employee participation. Specific areas of focus that could be especially beneficial are:

- adopting an evidence-based definition/description of comprehensive programs to provide a common understanding of WWPs
- developing additional resources to address other pillars of wellness and a broader concept of healthy organizations and the conditions that are required to achieve them
• promoting an evidenced-based, comprehensive, and sustainable approach to workplace wellness and healthy organizations using the Framework for Comprehensive WWPs

• addressing the level of commitment and other requirements for establishing and maintaining WWPs and the potential unintended consequences of unsuccessful activities or discontinued programs

• tailoring resources and communications to meet the needs of organizations at different stages of evolution in the expanded Continuum of Management Commitment to Workplace Wellness Programs.

• responding to specific concerns identified by this research, including the role of management, employee participation, and programming for diverse organizations

• assisting organizations to collect data to monitor and evaluate program activities and to build a business case for a program (program documentation, goal establishment, and measurement of progress relative to goals).

Given the lack of specific program goals/objectives and measurement of progress in the six cases in this study, it may be useful to place more emphasis on these factors in the HSFNB workplace wellness awards criteria for the gold category.

**Future research.** Future studies could consider the following propositions and questions:

1. **Application of the Framework for Comprehensive WWPs.** While not all recurring factors identified in the literature review are necessary to ensure the sustainability of a comprehensive program, there is an essential combination of factors required to sustain a program. Conducting
additional studies with other organizations interested in developing a program while using the Framework for Comprehensive WWPs would provide further understanding of the most important factors in the sustainable development and implementation of comprehensive WWPs. What is the most important combination of factors required to sustain a comprehensive program? Does the combination vary by size or type of organization? Does use of the framework contribute to the development and sustainability of comprehensive programs? Does the framework require further development?

2. *Increased understanding of organizations without WWPs.* In this research it was difficult to recruit organizations without WWPs. Three of the four organizations that did participate were interested in WWPs and were implementing ad hoc wellness activities. The literature contains little information on organizations without WWPs. Further research is needed on how to include organizations without programs in research on workplace wellness. The not-for-profit sector may warrant special attention. Only one case was conducted in a not-for-profit organization. However, employees in this sector may be at increased risk of a gap in wellness programming due to a lack of resources (e.g., funding, staff, and access to information). How can the program needs be met for not-for-profit organizations, especially those with contract employees who are not permanently attached to organizations?
Study Contribution

This study contributes to the evidence base regarding the range of WWPs in NB and the factors that impact program development and implementation in organizations with and without programs. Providing detailed information on diverse organizations in Canada, especially in organizations without programs, adds to the work of authors such as Eakin, Lowe, and Makrides. This research confirms Edington’s (2009) findings that management commitment is the most important factor impacting programs. The results suggest the need to expand Edington’s (2009) continuum of management commitment to add a fifth category.

More specifically, the results provide evidence to: enhance future provincial wellness and public health policy and practice in the workplace setting; inform decision making by the HSFNB, the NB Community of Practice on Workplace Wellness, and other organizations and networks that have workplace wellness as part of their mandate; guide the development and expansion of wellness resources; and, better meet the needs of organizations that are interested in establishing, expanding, or sustaining programs.

The study draws attention to a potential concern with program sustainability coupled with the need for senior managers in this province to have a better understanding of the value of wellness in the workplace setting. The voices of the senior managers, program implementation staff, and committee members who contributed to this research have helped to inform future knowledge exchange in NB. The study results may be useful in other Atlantic provinces and elsewhere to enhance the potential to impact the health
and wellness of the working population. The Framework for Comprehensive WWP provides the basis for future conversations with organizational leaders about workplace wellness and the important contribution such programs can make to the health and wellness of New Brunswickers and NB organizations.
References


Guidotti, T. L. (2012). What key performance indicators can be used in occupational


Understanding the decision-making process for health promotion programming at small to midsized businesses. *Health Promotion Practice, 12,* 512-521. doi: 10.1177/1524839909349162


Sage.


Makrides, L., Smith, S., Allt, J., Farquharson, J., Szpilfogel, C., Curwin, S., ... Edington,


APPENDICES

Appendix A: Recruitment Instruments

Sample script of initial telephone call to recruit case studies for organizations with workplace wellness programs; a senior manager receives this introductory telephone call from the researcher to determine interest in participating as a case study.

Hello (contact name):

My name is Janice Campbell. I am a doctoral student under the Supervision of Dr. Mary McKenna at the University of New Brunswick.

I am calling about research that I am conducting on wellness in NB workplaces. The research is being sponsored by the Heart & Stroke Foundation of NB. I am looking for organizations with workplace wellness programs to participate in my research. I became aware of your organization through the workplace wellness awards information posted on the Heart and Stroke Foundation’s website.

Organizations that participate will receive a summary report of their organization’s results for their use. The results may be useful to you in providing ideas or information to improve your program or improve employee productivity, reduce employee absenteeism, or other health related costs. Participating organizations will remain anonymous in all reports and corporate information will be kept confidential.

Conducting research in organizations such as yours will greatly assist in obtaining information on the range of workplace wellness programs in NB and on factors that facilitate or create barriers to program development and implementation. The research would include visiting your organization and speaking with you and perhaps others, observing your work environment, and gathering summary data or documentation that you may have on workplace wellness.

Would you be interested in being considered as a case study?
If you are interested, I would be pleased to tell you more about the project.

If no interest, end call, as follows:
I understand. Thank you for your time

If interested:

I am looking for a variety of organizations to participate in my research. I have a few quick questions to help determine if your organization can be considered.

Recruitment Criteria:

Q.1. Do you consider that you have a workplace wellness program or wellness activities? A program would “enhance awareness, change behaviour, and create environments that support good health practices” (Aldana, 2001, p. 297).

If the response is no: I am sorry, I already have my quota of organizations without programs. End call. Thank you very much for your time. If yes,

Q. 2. Can you please tell me how many employees you have in this organization?

# of employees _____: if fewer than 9 employees:

I am sorry. I am not selecting organizations with fewer than nine employees. Thank you very much for your time.

If 9 or more employees and if type of work/sector are not known:
Q. 3. Can you confirm the type of work you do and the sector in which you work. By this I mean, are you a public sector organization, a private sector organization, or a not for profit organization?

Sector ____________________________________
Type of work _______________________________________

(I am sorry I already have my quota of organizations from ___________sector/ already have an organization in your line of work.)

If the organization is still a potential case study:
So far so good. You have met all the criteria

Now, I just have a few more quick questions to ask about your organization to determine how different your case might be from other possible cases.

Recurring factors

1. To what extent is management involved in the program?
2. Do you have staff assigned to the program?
3. Do you have a budget for the program?
4. Do you monitor or track program activities? Have you conducted a formal program evaluation?

Range of programs

5. Do you have the following activities/policies that address (for comparison to other cases)
   - Healthy eating ____________________________
   - Physical activity ____________________________
   - Stress management activities ____________________________
   - Tobacco-free lifestyle ____________________________
6. Do you offer personal health risk assessments for individual employees?

Decision Point:
Response:

☐ I am sorry, I already have my quota of organizations with programs in your size and sector and range of program activities OR
☐ Your program has unique characteristics that differ sufficiently from others. I would like to conduct a case study with your organization.

Are you interested in your organization becoming a case study?
If the contact agrees to participate:

Now I need to explain the research process to you. It will take a few more minutes. Do you still have time at the moment? If it is not convenient for you at this time could I arrange to speak with you at another time this week? Or would you prefer that I email you the information. Before I let you go, can I obtain your contact information so I can send you the details on data collection which we can then discuss during our next conversation?

Call back at ______________ or Email ________________________________
**Research process:** during the visit to your organization I will collect data as follows:

1. **semistructured interviews** of up to 60 minutes duration with you (or your delegate) as the organizational representative and the key staff person responsible for program delivery and/or a wellness committee member; the sessions will be recorded; do you have suggestions for others who should be interviewed?
2. **a focus group session** with your wellness committee of up to 60 minutes in duration. How best should I go about organizing this session?

The next three activities will involve little interaction or interruption of work time.

3. **observation of the work environment** by touring your facility (e.g., opportunities to exercise, food availability, attendance at wellness committee meetings);
4. **obtaining copies of documents and records** related to your program; this could include policies, minutes, needs assessments, evaluations; and,
5. **aggregate data on relevant health indicators**, (productivity, absenteeism, and health risk assessments, where available).

Who should I speak with about pertinent documents or aggregate data?

In order to gather data for your case study, I will need to visit your organization once or twice. Can we determine a tentative date and time for your first site visit?

**Informed consent:** I should also explain that participation is voluntary and participants are free to refuse to answer specific questions or to terminate participation at any time during the session. Individual participants from your organization will remain anonymous and personal information will be kept confidential. Data gathered from interviews and focus groups will be blended along with information received from documents and aggregate data, in the analysis.

You will receive a report of the results for your organization. However, any opinions expressed by individuals that may be traced back to specific participants will be omitted from this report and will only be considered for use in the analysis of all cases.

Your organization will remain anonymous in the final summary report and any company specific information revealed will remain confidential. A multiple case summary report will be posted on the Heart and Stroke website when completed and I will forward an electronic copy to you.

In closing, your input will be very helpful in my doctoral studies and will help to inform the development of future policy and initiatives in workplace wellness. I hope that the summary report will be useful for you as well. If you are still interested in participating, I will send you a letter to outline the project in detail, and to obtain your informed consent in writing. This is required for research ethics purposes in order to use your results.

Thank you for your time.

**Subsequent email:**

Your recruitment letter and consent form are attached. I will be happy to answer any questions you may have before you sign the consent form. A signed copy of the consent form is required for my files. Can we finalize the date for your visit? Thank you again.
Sample script of initial telephone call to recruit case studies for organizations without workplace wellness programs

The head of a potential case study organization receives this telephone call from the researcher to determine interest in participating as a case study.

Hello (contact name):

My name is Janice Campbell. I am a doctoral student under the supervision of Dr. Mary McKenna from the University of New Brunswick.

I am calling about research that I am conducting on wellness in NB workplaces. The research is being sponsored by the Heart & Stroke Foundation of NB. I am looking for a variety of organizations to participate in my research, including organizations without programs, and I am hoping that you might be interested in participating as a case study. I would need to visit your organization to interview you or your designate for up to one hour and to observe your work environment.

In return for your time, you will receive a report on your results along with a copy of the summary report for all participating organizations which may be helpful to you and your staff. Organizations will remain anonymous in all reporting.

Have you heard about workplace wellness?

If no interest, end call, as follows:
I understand. Thank you for your time

If continued interest:

Recruitment Criteria

I have 3 quick questions to determine if your organization can be considered as a case study.

Q. 1. Do you consider that you have a workplace wellness program?

If yes, I am sorry, I already have my quota of organizations with programs.

If unsure: Wellness programs are defined as “efforts that enhance awareness, change behaviour, and create environments that support good health practices”.
If no

Q. 2. My second question is as follows: Can you please tell me how many employees you have in the organization?

# of employees ______

If fewer than 9 employees:

I am sorry. I am not selecting organizations with fewer than nine employees. Thank you very much for your time.

If 9 or more employees and if the type of work/sector are not known:

Q. 3 And my final question: Are you a public sector organization, a private sector organization, or a not for profit organization?

Sector ______________________________
Type of work ________________________
(I am sorry I already have my quota of organizations from __________sector/ already have an organization in your line of work.)

Or

Thank you for this information. Conducting research in your organization will greatly assist in obtaining information for future planning of workplace wellness programs. Do you have any interest in your organization becoming a case study?

If you have a few more minutes I can provide you with more detail about the project. If it is not convenient for you at this time could I arrange to speak with you at another time this week? Or would you prefer that I email you the information? Before I let you go, can I obtain your email address/time to call you back?

If yes,

Subsequent conversation OR email content:

As a follow-up to our initial conversation......

In order to gather data for your case study, I will need to visit your organization. During the visit, I will collect data through:

1. semistructured interviews with you or your designate of up to 60 minutes to discuss your views on workplace wellness programs; and
2. observation of the work environment (e.g. opportunities for physical activity or healthy eating).

Can we determine a tentative date and time for the site visit?

Informed Consent: I should also explain that participation is voluntary and participants are free to refuse to answer specific questions or to terminate participation at any time during the session. Individual participants from your organization will remain anonymous and personal information will be kept confidential.

You will receive a summary report of the results for your organization. However, any opinions expressed by individuals that may be traced back to specific participants will be omitted from this report and will only be considered for use in the analysis of all cases.

Your organization will remain anonymous in the final report and any company specific information revealed will remain confidential. A multiple case summary report will be posted on the Heart and Stroke Foundation website when completed and I will forward an electronic copy to you.

In closing, your input will be very helpful in my doctoral studies to inform the development of future policy and initiatives in workplace wellness. I hope that the summary report will be useful for you as well. If you are still interested in participating, I will send you a letter to outline the research in detail, and to obtain your informed consent in writing. This is required for research ethics purposes. Thank you for your time.

Subsequent email:

Your recruitment letter and consent form are attached. I will be happy to answer any questions you may have before you sign the consent form. The original signed consent form is required for my files. Can we finalize the details for your interview at this time?

Thank you again.
Appendix B: Informed Consent

Follow-up letter of confirmation and organizational informed consent: with a program

If selected as a case study with a program, the following letter will be sent to obtain consent at the organizational level to proceed with data gathering. Individual letters will be modified slightly depending on their current involvement with workplace wellness.

Dear ...............:

Subject: Research study: Factors influencing the development and implementation of workplace wellness programs in New Brunswick workplaces

This letter is a follow-up to our conversation on Date during which we discussed your organization participating in my doctoral research being conducted at the University of New Brunswick. This project is on file with the UNB Research Ethics Board as # 2011-050.

UNB, with funding from the Heart and Stroke Foundation of NB, would like to gather information on workplace wellness in NB through detailed case studies with individual employers. The data gathered will assist in future research, planning, policy development, and the development and implementation of wellness programs by New Brunswick employers.

Your organization is currently recognized as a <leader> <award winner> in workplace wellness and conducting research in your organization will greatly assist in obtaining information on the current status of workplace wellness in NB.

Participation in the case study will involve visiting your organization to potentially collect data in five ways:

1. one-on-one interviews with you (or your delegate), as the organizational representative, a key program staff person and/or a workplace wellness committee member will be recorded; each interview will last up to 60 minutes;
2. a focus group session with the wellness committee of up to 60 minutes; the sessions will be recorded;
3. observations of the workplace environment through a tour of your facilities;
4. obtaining copies of program related documentation (needs assessments, evaluations, newsletters, etc.); and,
5. summary data on health indicators (absenteeism, productivity, and group results of health risk assessments, if available).

Data gathered from interviews and focus groups will be blended with information received from documents and aggregate data in the analysis. You will receive a report of the results for your organization. However, any opinions expressed by individuals that may be traced back to specific participants will be omitted from this report and will only be considered for use in the analysis of all cases.

Thank you in advance for your time. I greatly appreciate your participation. A summary report for the multiple case studies will be posted on the Heart and Stroke Foundation of NB website and I will forward you a final electronic copy. If you have questions regarding this study, please contact my doctoral supervisor, Dr. Mary McKenna, at 451-6872. Should you wish to speak to someone not directly associated with this research, please call Dr. Linda Eyre, Assistant Dean of Interdisciplinary Studies at 453-5161.

Yours truly,
Janice Campbell, MEd
Informed Consent:

**Participation in this study is voluntary and participants are free to refuse to answer specific questions or to terminate participation at any time during the session.**

I should also mention that I may need to follow-up with you for clarification during analysis. A draft summary of results will be returned to you to verify anonymity for your organization. Participants will remain anonymous and both personal and corporate specific information will be kept confidential. Individual participants will also be asked to read and sign an informed consent form. You will receive a final summary of results for your use.

Name: ___________________________ Position: ___________________________ Date: ___________________________

My signature hereby confirms informed consent at the organizational level to participate in this research. Date________________________ Position________________________

Please return a signed original to my attention at the address above.

**Follow-up letter of confirmation and organizational informed consent: without a program**

If selected as a case study without a program, the following letter will be sent to obtain informed consent at the organizational level to proceed with data gathering. Letters for individual organizations will be modified slightly depending on their current interest in workplace wellness.

Dear ...............:

Subject: Research study: Factors influencing the development and implementation of workplace wellness programs in New Brunswick workplaces

This letter is a follow-up to our conversation on Date during which we discussed the possibility of your organization becoming a case study in my doctoral research being conducted at the University of New Brunswick. This project is on file with the UNB Research Ethics Board as # 2011-050.

UNB, with funding from the Heart and Stroke Foundation of NB, would like to gather information on organizations both with and without workplace wellness programs. Your views on workplace wellness will be extremely useful. The data gathered will assist in future planning of wellness initiatives for New Brunswick employers.

Participation in the case study will involve a visit to your organization to conduct:
- a one-on-one, recorded interview of up to 60 minutes with you and/or your designate as the organizational representative(s); and,
- observations of the workplace environment through a tour of your facility; I will need you to designate a contact to accompany me on the tour.

Your results will be returned to you to verify anonymity. You will receive a final report of the results for your organization. However, any opinions expressed by individuals that may be traced back to specific participants will be omitted from this report and will only be considered for use in the analysis of all cases.

Thank you in advance for your time. I want to stress how much I appreciate your participation. A summary report for the multiple case studies will be posted on the Heart and Stroke Foundation of NB website and I will forward a final electronic copy to you. If you have questions regarding this study, please contact my doctoral supervisor, Dr. Mary McKenna, at 451-6872. Should you wish to speak to someone not directly associated with this research, please call Dr. Linda Eyre, Assistant Dean of Interdisciplinary Studies: 453-5161.

Yours truly,

Janice Campbell, MEd
Informed Consent:

Participation in this study is voluntary and individual participants are free to refuse to answer specific questions or to terminate participation at any time during the session.

A draft summary of your results will be returned to you to verify the anonymity of your organization. Participants will remain anonymous and both personal and corporate specific information will be kept confidential. You will receive a final summary report for use by your organization.

Name: __________________________  Position: __________________________  Date: __________________________

My signature hereby confirms informed consent at the organizational level to participate in this research. Please return the signed original to my attention at the address above.

Sample announcements for focus-group sessions: with programs

You are invited to attend a focus group session on workplace wellness. The session will be conducted by Janice Campbell, a PhD student, at UNB.

The session will last up to 60 minutes and will be recorded.

Date
Boardroom,
Start time........finish time

This is an opportunity to provide your input on factors affecting the workplace wellness program. Refreshments will be served.

Your participation is voluntary and you are free to refuse to answer specific questions or to terminate your participation at any time during the session.

Data gathered from interviews and focus groups will be blended with information received from documents and aggregate data in the analysis. However, any opinions expressed by individuals that may be traced back to specific participants will only be considered for use in the analysis of all cases.

You will be asked to sign a consent form as part of the research ethics process so that results can be used. The research is funded by the Heart and Stroke Foundation of NB.

This project is on file with the UNB Research Ethics Board as #2011-050.

For more information please contact:
Dr. Mary McKenna, at 451-6872.
Or
Should you wish to speak to someone not directly associated with this research, please call Dr. Linda Eyre, Assistant Dean of Interdisciplinary Studies: 453-5161.

Individual Informed Consent for Interview and Focus Group Participants

Dear Participant:

Subject: Research study: Factors influencing the development and implementation of workplace wellness programs in New Brunswick workplaces

This is to confirm your voluntary participation in an interview/focus group session with Janice Campbell, a PhD student, at UNB. The research is being funded by the Heart and Stroke Foundation of NB.

The interview/focus group will be recorded and will last up to 60 minutes. You will be asked questions about health and wellness activities in your organization. The results will be transcribed and coded and compiled in reports. You and your organization will remain anonymous in all reports. Any
specific personal or corporate information will be kept entirely confidential and will not be disclosed in any publication or report based upon the information gathered in this research. In addition, we ask focus group participants not to disclose the identity of other employees participating in the focus group or the opinions expressed by them. However, because of the nature of focus group research, absolute confidentiality obviously cannot be guaranteed.

**Data gathered from interviews and focus groups will be blended with information received from documents and aggregate data in the analysis. Further, any opinions expressed by individuals that may be traced back to specific participants will only be considered for use in the analysis of all cases.**

A summary multiple case report will be posted on the Heart and Stroke website. An electronic copy will be given to your organization.

Janice Campbell, MEd.

This project is on file with the UNB Research Ethics Board as # 2011-050.

**Please sign below to signify voluntary participation and informed consent and to approve the recording of this interview/focus group. You are free to refuse to answer any question or to terminate your participation at any time during the session.**

_________________________________________  Date__________

If you have questions regarding this study, please contact my doctoral supervisor, Dr. Mary McKenna, at 451-6872. Should you wish to speak to someone not directly associated with this research, please call Dr. Linda Eyre, Assistant Dean of Interdisciplinary Studies at 453-5161.
Appendix C: Data Gathering Instruments

Semistructured interview guide: with programs

The questions are used as appropriate, depending on the role of the interviewee, the extent of workplace wellness programming in the organization, and the results from previous interviews within the same organization or data already collected.

Introduction: Thank you for agreeing to be interviewed today.

Distribute informed consent document and obtain signature.

The interview will last up to 60 minutes. As pointed out on the informed consent document that you have just signed, I will be taping this interview.

If a specific question is problematic for you please feel free to skip the question. You are free to terminate your participation at any time during the session. Your answers will remain anonymous in the results and any specific personal/organizational information revealed will remain confidential. Data gathered from interviews and focus groups will be blended in the analysis along with information received from documents and aggregate data.

However, any opinions expressed that may be traced back to you will be omitted from this report and will only be considered for use in the analysis of all cases.

Do you have any questions or concerns before we begin? Okay, let’s get started

Field Visit:

Interviews in organizations with programs

Case # with program
Organization:
Location:
Name:
Number of Employees:
Date:
Start Time: End time:

Interviewee # 1 of

Notes from initial telephone call:
Interview Questions:

Part 1: Background

First I would like to ask some questions about you and the organization to give me context and help me interpret your answers.

How would you describe your role with the organization?

Prompts: How long have you worked here? How did you become involved in the workplace wellness program? What are your specific responsibilities regarding the program, if any? How long have you been involved in the workplace wellness program?

How would you describe your workforce demographics? (Prompt: age, gender, professional/technical)

How would you describe the overall health of your employees?

Program Description

The next set of questions relates to the main areas of emphasis of the workplace wellness program here in this organization.

Overall how would you characterize your program, in general terms? (Prompt: how is it administered or organized, how are decisions made, scope or breadth of activities, level of funding, level of participation)

Please describe your main program activities.

Prompts: (Depending on the extent of the program)

Lifestyle activities:

☐ Healthy eating: To what extent does your program promote healthy eating?

This would include food service or preparation facilities that promote healthy eating, nutrition education activities, any programs or policies, opportunities for healthy food choices in cafeterias, &/or vending machines; pricing of healthy foods; healthy coffee breaks, snacks at meetings.

☐ Physical activity: To what extent does your program promote physical activity?

This too would include on-site facilities for physical activity, education activities, any programs or policies, equipment on site, walking clubs, competitions, gym memberships or other subsidies.

☐ Stress management activities: To what extent does your program promote stress management or mental wellness?

This would include Employee and Family Assistance Programs, policies such as flex-time, reorganizing work; education activities on stress management or other aspects of mental wellness, on-site counselling, buddy system, use of external expert resources.

☐ Tobacco-free lifestyle: To what extent does your program promote a tobacco-free lifestyle?

This would include tobacco cessation programs, non-smoking policies, education sessions, smokers help line, providing patches).
Health Services:

- Medical doctor or other health care providers

Please describe the role of any health care provider on site with involvement in the workplace wellness program?

How about health screening sessions such as blood pressure, blood glucose, or cholesterol screenings?

Are there other activities you would like to mention?

How do you market your program?

How do you communicate with employees about your program?

Who do think is impacted by the program here? And in what ways?

Has your program been evaluated? (if so, ask for a copy)

Part 2. (Questions on Factors: explanation of program barriers and/or facilitators)

The next few questions for today’s session relate to your personal views about the workplace wellness program in this organization.

What do you think about the workplace wellness program? What are the reasons behind your answers?

What you would say are the overall strengths of the workplace wellness program? What are your reasons for selecting these strengths?

Now, looking at the program from the other perspective, I would like your opinion on what your challenges have been? What has contributed to these challenges?

What do you like best about the workplace wellness program?

What do you like the least about the workplace wellness program?

What would you say are the major program accomplishments over the past two years? What do you think has led to these accomplishments?

Have there been missed opportunities?

I now have some specific questions about the kinds of factors or components that benefit a program or that cause problems in program development and implementation (delivery). I would like to you look at a list of factors/components that have been identified by others as important to a program. A factor can have both a positive or negative impact on your wellness program. You may have mentioned some already.

I am wondering if they apply here?

Which are the most important in your opinion?
1. I am wondering if any of the following factors apply here?

Organizational Context: (outside of program control)
- a strategic plan that includes wellness
- corporate culture that supports the wellness program
- management commitment to the program
- nature of the work environment
- resources assigned to the program

Program Administration/Infrastructure:
- a workplace wellness program committee OR an employee who has taken on a leadership role with the program
- a program needs assessment
- program marketing/communications materials
- providing incentives to encourage participation

Program Activities and Participation:
- management participation in the program
- employee participation in the program
- conducting Health Risk Assessments for employees
- providing multiple program activities/interventions

Program Sustainability:
- monitoring program activities
- collecting program data
- program evaluation

2. Now, reviewing the list again, which are the most important in your opinion?

Others mention their program being integrated in their organization as a factor. To what extent, if any, is your program integrated into your organization? **Prompts:** For example, is the program part of your business strategy? How about corporate mission, values or vision? How about your recruitment strategy? Does the program relate to corporate policy?

How has integration or lack of integration impacted your program?

Are there other factors that have influenced your organization's program that you think I have overlooked?

**Turning to the Future for a moment:**

How would you like to see the program evolve in the future?

What are your future plans for your program?

How could that be facilitated? What barriers might prevent that from happening?

**In closing,** are there other comments that you would like to make?
Documentation/Data bases analysis:

If not already received: Before I leave, can I pick up copies of aggregate data or program related documents?

On behalf of UNB and the NBH&SF, I want to thank you for your participation.

A draft report of your organization’s results will be forwarded to <you or> the contact for your organization for review to ensure that no identifiable information is included. The final report for all the cases will be posted on the NBH&SF web site and your organization will receive an electronic copy.

Open-ended and semistructured Focus Group Guide

Thank you for being here today.

Obtain signed informed consent from each participant.

Ground Rules: The purpose of today’s focus group is to have a discussion about the workplace wellness program in your organization. My research relates to the range of workplace wellness programs in NB and the factors that influence the development and implementation of programs. I am not evaluating your program. I am here to facilitate the focus group discussion by asking questions. I hope that everyone will feel comfortable to participate. There are no right or wrong answers. The session will last up to 60 minutes and will be taped. Please speak clearly so the microphones can pick up your voice. As pointed out on the informed consent document that you have just signed, if a specific question is problematic for you please feel free toskip the question. You are free to terminate your participation at any time during the session. Data gathered from interviews and focus groups will be blended in the analysis along with information received from documents and aggregate data. However, any opinions expressed by individuals that may be traced back to a specific participant will not be included in the summary report for your organization.

Any specific personal or corporate information will be kept entirely confidential and will not be disclosed in any publication or report based upon the information gathered in this research. In addition, we ask focus group participants not to disclose the identity of other employees participating in the focus group or the opinions expressed by them. However, because of the nature of focus group research, absolute confidentiality obviously cannot be guaranteed.

Do you have any questions before we begin? If you have been bothered by any part of the discussion or if you wish to speak with me after the session is completed, I will be around and I will leave my contact information if you happen to think of anything you want to discuss after I have left. Any questions or concerns before we begin?

Case #____: Organization__________________________
Location________________________________________

Date____ & Start Time______ End Time: ____________

☐Wellness Committee or ☐ Health & safety Committee

How many in attendance? _______

Males_______ Females_________; approximate age range: ____________

Okay, let’s get started:
Icebreaker question:

1. Let’s begin by talking about how you became involved in the workplace wellness program at <name of organization>.

Questions on Factors: (program barriers and/or facilitators)

The next few questions for today’s session relate to your personal views about the workplace wellness program in the organization.

2. What do you think about the workplace wellness program here? What are the reasons behind your answers?
3. What you would say are the overall strengths of the workplace wellness program in your organization? What are your reasons for selecting these strengths?
4. Now, looking at the program from the other perspective, I would like your opinion on what your challenges have been? What factors have contributed to these challenges?
5. What factors do you think have a positive impact on the workplace wellness program in your organization?
6. What factors do you think have a negative impact on the workplace wellness program in your organization?
7. What do you like best about the workplace wellness program here?
8. What do you like the least about the workplace wellness program here?
9. What would you say are the major accomplishments in the program over the past two years? What do you think has led to these accomplishments?
10. What would you say are the missed opportunities in the program over the past two years? What do you think has led to this?
11. How would you like to see your program evolve in the future? How could that be facilitated? What barriers might prevent that from happening?

(Check against the handout of common factors and prompt for those not mentioned)

The next couple of questions relate to program reach (if time permits)

1. What do you hear your colleagues saying about the workplace wellness program in your organization, if anything?
2. Who do you think is impacted by the program in your organization? And in what ways? How have you reached these conclusions?
3. What are the benefits of the workplace wellness program in your organization, if any?
4. What would you say are the drawbacks, if any?

Prompt: I have a definition of a workplace wellness program I would like to read to you.

Definition: Wellness programs are defined as “efforts that enhance awareness, change behaviour, and create environments that support good health practices” (Aldana, 2001, p. 297).

5. What are your thoughts on this definition?
6. In closing, are there other comments that you would like to make?
7. Do you have any questions for me?

Wrap-up:

On behalf of UNB and the NBH&SF, I want to thank you for your participation. A draft of your results will be forwarded to your organizational contact to verify that your organization is anonymous. The
final multiple case summary report will be posted to the NBH&SF web site and your organization will receive an electronic copy.

Interview Guide: For organizations without a program

Case #
Organization Location
Name Position
Number of Employees
Date
Start Time End time:

Obtain signature on informed consent document

Let’s start with some background questions to give me context on you and your organization:

1. Please tell me about your role within your organization.
2. How long have you worked here?
3. How would you describe your workforce demographics? (Prompt: age, gender, professional/technical)
4. How would you describe the overall health of your employees?

Turning now to workplace wellness programs:

5. Thinking in general terms about any workplace, what role, if any, do you think an employer has regarding the health and wellness of employees?
6. Now thinking about this organization specifically, do you currently take any steps to promote the health and wellness of employees?
7. When you think about workplace wellness programs, what comes to mind, if anything? (What are your thoughts on such programs?)
8. Do you have any personal experience with workplace wellness programs? If so, please describe.

Prompt: To ensure that we are both on the same page, I have a definition of workplace wellness programs that I would like to read to you.

Definition: Wellness programs are defined as “efforts that enhance awareness, change behaviour, and create environments that support good health practices” (Aldana, 2001, p. 297).

9. How would you describe potential advantages of workplace wellness programs?
10. How would you describe potential disadvantages to such programs?
11. What, if anything, have you heard from others about workplace wellness programs?

The next set of questions is more specific to your organization.

12. Has the possibility of having a workplace wellness program ever arisen within your organization? If so, when did this occur? Please describe any action taken and what happened.
13. What factors influenced any actions taken?
14. What challenges did you encounter, if any?
15. What has influenced any decision, at this time, to not have a program?
16. What steps would need to occur within your organization to establish a workplace wellness program? How would the decision to have a program be approved?
The last set of questions is about information on workplace wellness programs

17. Where would you look for information on workplace wellness programs?
18. What information would be useful to you on workplace wellness programs?
19. What is the best method to use to provide you with information on workplace wellness programs?
20. Are you familiar with any business case information for workplace wellness programs, such as cost-savings on health benefits, ROI? If applicable, please describe your thoughts on this topic.

21. In closing, are there other comments that you would like to make?

**If applicable: Obtain copies of relevant documents and data before leaving**

**On behalf of UNB and the NBH&SF, I want to thank you for your participation.** A draft report for your organization will be prepared for your review to confirm anonymity of your organization. The final multiple case study report will be posted on the **NBH&SF web site** and you will receive an electronic copy.

**Observation of the workplace environment in organizations with or without a program:**

Adapted from:

trifit, (2005)


Wisconsin Worksite Assessment Checklist (n.d.)

**On-site:**
**Physical Activity:**
Is there a gym on site? Is there a variety of equipment? Are there shower facilities?
Are there trails on-site?
Are there bike racks available?
Do visual prompts encourage employees to take the stairs?

**Healthy Eating:**
Is there a cafeteria on site? Does the menu offer healthy choices?
Is there a staff room on site? Is it well equipped (stove, microwave, refrigerators, etc.)?
Are there vending machines on-site? Do they offer healthy choices (water, juice, yogurt, granola bars, etc.)?
Is drinking water readily available?
Are there picnic tables and/or a BBQ on site?

**Mental resiliency:**
Are EFAP materials displayed?
Is there on-site child or elder care?

**Smoking cessation:**
Are smoking cessation materials displayed?

**General:**
Are there bulletin boards available to display program related material?
Are there book shelves available for program related resources?
Is there a boardroom to accommodate program related activities?
Are workstations ergonomically designed?
Is there a sick bay on-site?
Are there other features available to support a wellness program (electronic screens, a quiet room, on-site gardening, a basketball net, etc.)?
Off site:
Is there a gym near-by?
Are there trails near-by?
Are there sports fields near-by?
Do the near-by restaurants provide healthy choices?
Is there a grocery store near-by? with a dietician on staff?

Documentation analysis: Look for copies of:

a. Needs assessment/HRA results/survey instruments/focus group results –
   What do they contain? Do they support or guide what is happening in the
   program? Do they describe resources, activities, and expectations?
b. Program materials – what topics? Relationship to needs assessment?
c. Communication materials: Newsletters? E-mail? Web-site? Are there
   orientation materials? Are incentive programs described? Web-site/intranet
   site contents – what type of information is distributed?
d. Committee minutes – What types of decisions are made? What priorities are
   set? How frequently are meetings held?
e. Strategic plan? Is wellness a component?
f. Policy documents: What kinds of policies are in place? Recognition/Award
   policies? No-smoking policies?
g. Evaluation reports: Do they exist? Internal or external? What kind of
   evaluation? What are the results? What changes are suggested? How were
   data gathered?
h. HR systems: absenteeism data?
i. Other data; collection methods?
j. Business case & cost-benefit analysis documentation? What are the
   benefits? What are the costs? What is the ROI? What components are
   considered in the business case?
k. Library of wellness materials for staff access – are educational materials
   available?
l. Do materials reflect cultural sensitivity: new immigrants?
m. Research reports: are there reports? What topics are addressed?
Fact Sheet

Comprehensive Programs

Comprehensive workplace wellness programs are integrated into the culture, values, and philosophy of workplaces. They connect with the organization’s physical and social environments, health and safety, and the lifestyle practices of employees.

A number of authors further describe comprehensive WWPs as:

- having senior management commitment
- being adequately resourced
- having a program committee responsible for implementation
- assessing individual employee health risks (needs assessment)
- providing a wide variety of wellness activities based on aggregate employee needs
- ensuring activities are sustainable and communicated effectively to employees
- involving all employees not just those with high health risk factors (Edington (2009) stresses keeping healthy employees healthy)
- focusing on the link between the individual and the environment in which the individual lives, learns, works, and plays
- integrated into the organizational structure and daily work life of the organization through a supportive culture and physical work environment
- linked to other initiatives such as employee benefits
- having ongoing monitoring of progress against measurable goals and evaluation of results against criteria and indicators, and
- an investment in remaining competitive.

Comprehensive programs use a variety of implementation strategies including:

- enhancing awareness
- health education
- coaching
- counselling
- healthy policies
- incentives
- employee benefit plan restructuring
- health risk assessments (HRAs) & biometric screening activities
- marketing, and tailored communications
- a supportive work environmental, and
- community partnerships.
The American Heart Association (n.d.) lists specific activities regarding tobacco cessation, physical fitness, stress management/reduction, early detection/screening, nutrition education, weight management, cardiovascular disease prevention, back pain prevention and management, immunization, alcohol and substance abuse assessment, and maternal and infant health education and guidance. The Association recommends that comprehensive programs include or address: motivational interviewing and assessment of readiness to change; the needs of all employees regardless of gender, age, ethnicity, culture or physical or intellectual capacity; modifications of the physical work environment that facilitate healthy behaviours; decision-making that promotes wellness; and active learning where outcome evaluation is an integral component. Further the Association suggests that organizations can achieve comprehensive programs through incremental efforts.

Appendix E

Fact Sheet
Top 12 Factors Impacting Programs

Development and implementation of comprehensive programs are impacted by a variety of factors that have been documented based on over 30 years of international programming experience. The factors can either facilitate or act as barriers to a program. There are 12 recurring factors that overlap with the previous description of comprehensive programs, as follows:

1. management commitment, support, and participation
2. a strategic plan that includes wellness
3. integration within the organization including linkage to business objectives and other programs offered by the organization
4. program resources, including staff and funding
5. a program committee or, in the case of a small organization, a wellness champion for program coordination
6. a needs assessment, such as HRAs
7. program activities that relate to the results of the needs assessment; targeting several health issues; tailored to specific employee and organizational needs
8. participation of employees, retirees, unions, and the community; engaging all employee groups in the process
9. a physical workplace environment that is supportive of the program, through organizational procedures and policies, benefit design, and incentives
10. program marketing and communication
11. management of necessary human resource and financial data, and
12. monitoring and evaluation to measure progress against established goals, criteria and indicators

References: Birken & Linnan, 2006; Chapman, 2004a, 2004b; Chu et al., 2000; Eakin, Cava, & Smith, 2001; Edington, 2009; Goetzel et al., 2007; Golaszewski et al., 2008; Grossmeier et al., 2010; Hannon, Hammerback et al., 2012; Health Canada, 2008; Lowe, 2003, 2004; Makrides, 2010; Makrides et al., 2007; Partnership for Prevention, 2001; Terry, Seaverson, Grossmeier, & Anderson, 2008; The Conference Board of Canada, 2002; 2010a; Weiner, 2009; Wellness Councils of America, 2008; World Economic Forum, 2008a
Appendix F

Fact Sheet
The Top 10 Workplace Wellness Program Benefits

Program benefits can be direct and measurable such as reductions in the costs of health benefits while others are indirect and less tangible such as employee turnover. The top 10 most frequently cited categories of program benefits include:

1. reduced health risks and associated costs (disability claims and the costs of health benefits for employees, retirees, and their families, and injuries and associated compensation claims)
2. reduced presenteeism (present at work physically but not fully productive) yielding increased productivity while at work
3. reduced incidental or casual absenteeism (one or two days in duration) linked to chronic conditions (yielding reduced costs for replacement employees and/or increased productivity)
4. reduced work disruption caused by absenteeism (yielding increased productivity for other employees)
5. enhanced job satisfaction (commitment, motivation, and improved morale)
6. reduced turn-over of employees (reduces time spent on staffing by Human Resources (HR) along with orientation and training of new staff)
7. enhanced recruitment and retention of employees (employer of choice)
8. enhanced corporate image and customer loyalty
9. enhanced work-life balance and stress reduction, and
10. increased profits and ability to compete in a global market

The benefits derived from programs are part of the business case rationale for offering WWPs. Workplace wellness is recommended as a business strategy. Canadian corporate examples of ROI vary by organization. Canada Life Assurance Co. cites a return of nearly seven dollars for each dollar spent after ten years of programming and found, over a one year period, that per capita medical expenses remained constant at $170 (1990 dollars) per participant versus an increase of 25 per cent for the control group. Telus BC and BC Hydro report returns of three dollars for every dollar spent on wellness.

Vita

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University of New Brunswick
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Master of Education (Counselling & Human Development)
2000-2002

University of New Brunswick
Fredericton, New Brunswick
Doctor of Philosophy
2007-2013

Conference Presentations: 10 Years at the Crossroads: Health Research of the New Millennium,
Dalhousie University, March 24, 2012
Factors Influencing the Development and Implementation of
Workplace Wellness Programs in New Brunswick Workplaces

Poster Sessions: Canadian Student Health Research Forum
University of Manitoba, June 7-9, 2011
The Gap Between Knowledge and Practice Regarding Workplace
Wellness Programs

Heart & Stroke Foundation of NB Annual Workplace Wellness
Conference, Fredericton Conference Centre, April 24th, 2012
Factors Influencing the Development and Implementation of
Workplace Wellness Programs in New Brunswick Workplaces:
Preliminary Results

Publications: Campbell, J. L. & McKenna, M. L. (2013). Workplace Wellness:
Learning from the Experiences of 10 Workplaces in New Brunswick.
Fredericton, NB.