The Healthy Workplace Model

Evidence-Based Tools for Teams, Leaders, and a Resilient Climate

Joel B. Bennett

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@orgwellness
Healthy social connection is fundamental to a healthy workplace.

This connection occurs through individual strength/resilience, peer-to-peer connectedness, empowered wellness champions (health advocates), healthy management, and positive leadership.

It is possible to design (socially embedded) interventions that facilitate this connection.

Multi-level experimental designs can further help to elucidated pathways for this facilitation.
1. Begin with two experimental case studies
2. Describe five fundamentals of workplace social connection
3. Two ideas: We in Wellness, Potentiation
4. An evidence-based model with examples
Part 1

two experimental designs
(set-up to tap socialization or ripple effects)
Emerging Adults (18-25)
At risk for psychological distress, substance abuse, sexual disease, onset of mental illness

High Risk Occupation
Restaurant workers

The period of life where we learn to find our own way
A time of...

Initiations & Turning Points

Are you making the right choices?

http://oas.samhsa.gov/NSDUH/
Team Resilience

Posters, cards, game board, newcomer packet
• Personal lack of direction or bothered by thoughts of where I am headed in life
• Personal problems with money (not enough, difficulty budgeting)
• Difficulty managing my time (work, family, school, other)
• Problems with boyfriend, girlfriend, spouse (like fights, arguments)

Cross-sectional (28 restaurants, random assignment)

Personal Stress

Team Resilience

Control

Pre-Training 6 Months 12 Months

ECONOMIC DOWNTURN

Social diffusion: role modeling, skills sharing, encouragement

Even Workers who were not exposed to the training and not even employed at the time of the training showed reductions, compared to employees in the control stores.
CRITICAL?} a **socially embedded** intervention

- Steering Committee
- HR Metrics
- Newcomer packets
- Iterative sessions
- Boosters
- Ambassadors
- Manager training

Randomized Clinical Trial

- Managers randomly assigned to receive or in control group
- Self-completion of biometrics and measures of health and leadership (pre-post)
- Experimental managers provided access to associates who rated them pre-and-post
- Associates also rated personal health pre-and-post

Diagram:
- Control
- Experimental
- Associates (sub-study)
Adjusted means, standard errors, and test statistics for changes in attitudes, behaviors, and health symptoms.

<table>
<thead>
<tr>
<th></th>
<th>Experimental</th>
<th>Control</th>
<th></th>
<th>Intervention Effect</th>
<th>Test Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>6 Months</td>
<td>Baseline</td>
<td>6 Months</td>
<td></td>
</tr>
<tr>
<td>Diet</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Attitude toward healthy diet</td>
<td>3.45 (0.06)</td>
<td>3.68 (0.08)</td>
<td>3.58 (0.06)</td>
<td>3.56 (0.06)</td>
<td>0.25 (0.08)</td>
</tr>
<tr>
<td>Dietary self-efficacy</td>
<td>3.63 (0.09)</td>
<td>4.08 (0.11)</td>
<td>3.82 (0.09)</td>
<td>3.85 (0.10)</td>
<td>0.43 (0.14)</td>
</tr>
<tr>
<td>Dietary stage of change</td>
<td>3.84 (0.13)</td>
<td>4.10 (0.16)</td>
<td>3.64 (0.13)</td>
<td>3.72 (0.14)</td>
<td>0.17 (0.19)</td>
</tr>
<tr>
<td>Exercise</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leisure time exercise</td>
<td>-4.67 (3.41)</td>
<td>51.85 (4.12)</td>
<td>41.47 (3.30)</td>
<td>43.78 (3.47)</td>
<td>8.87 (4.82)</td>
</tr>
<tr>
<td>Exercise stage of change</td>
<td>-4.05 (0.14)</td>
<td>4.43 (0.17)</td>
<td>3.78 (0.14)</td>
<td>3.94 (0.15)</td>
<td>0.22 (0.22)</td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
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<tr>
<td>Distress</td>
<td>15.02 (0.94)</td>
<td>11.50 (1.22)</td>
<td>12.37 (0.93)</td>
<td>12.67 (0.97)</td>
<td>-5.82 (1.48)</td>
</tr>
<tr>
<td></td>
<td>(1.47)</td>
<td>(1.84)</td>
<td>(1.44)</td>
<td>(1.54)</td>
<td>(2.41)</td>
</tr>
<tr>
<td>Hostile attitudes</td>
<td>16.60 (0.39)</td>
<td>15.83 (0.54)</td>
<td>15.13 (0.39)</td>
<td>15.35 (0.47)</td>
<td>-0.99 (0.59)</td>
</tr>
<tr>
<td>Stress stage of change</td>
<td>3.92 (0.18)</td>
<td>4.28 (0.21)</td>
<td>3.70 (0.17)</td>
<td>3.94 (0.18)</td>
<td>0.12 (0.25)</td>
</tr>
<tr>
<td>Mood stage of change</td>
<td>3.99 (0.16)</td>
<td>4.44 (0.19)</td>
<td>4.06 (0.16)</td>
<td>4.11 (0.17)</td>
<td>0.40 (0.24)</td>
</tr>
</tbody>
</table>

Note: Sample sizes vary from 136 to 142, owing to missing data.
### Table 3

Adjusted means, standard errors, and test statistics for changes in physical measurements, by gender.

<table>
<thead>
<tr>
<th></th>
<th>Experimental</th>
<th>Control</th>
<th>Intervention Effect</th>
<th>Test Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>6 Months</td>
<td>Baseline</td>
<td>6 Months</td>
</tr>
<tr>
<td><strong>Men (n = 41)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight (pounds)</td>
<td>203.63 (9.23)</td>
<td>204.62 (9.37)</td>
<td>195.15 (6.46)</td>
<td>196.43 (6.51)</td>
</tr>
<tr>
<td>Waist (inches)</td>
<td>38.35 (1.01)</td>
<td>38.23 (1.11)</td>
<td>38.09 (0.71)</td>
<td>37.52 (1.01)</td>
</tr>
<tr>
<td>Body Mass Index</td>
<td>29.89 (1.25)</td>
<td>30.27 (1.30)</td>
<td>27.42 (0.87)</td>
<td>27.30 (0.89)</td>
</tr>
<tr>
<td>Body Fat (%)</td>
<td>24.24 (1.38)</td>
<td>24.54 (1.49)</td>
<td>21.78 (0.97)</td>
<td>22.55 (1.01)</td>
</tr>
<tr>
<td><strong>Women (n = 85)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight (pounds)</td>
<td>160.30 (5.34)</td>
<td>159.16 (5.49)</td>
<td>158.22 (5.50)</td>
<td>158.66 (5.63)</td>
</tr>
<tr>
<td>Waist (inches)</td>
<td>33.39 (0.74)</td>
<td>32.60 (0.80)</td>
<td>33.62 (0.77)</td>
<td>33.88 (0.80)</td>
</tr>
<tr>
<td>Body Mass Index</td>
<td>26.83 (0.88)</td>
<td>26.56 (0.92)</td>
<td>26.90 (0.91)</td>
<td>27.00 (0.93)</td>
</tr>
<tr>
<td>Body Fat (%)</td>
<td>30.78 (1.01)</td>
<td>30.48 (1.08)</td>
<td>31.14 (1.03)</td>
<td>31.33 (1.08)</td>
</tr>
<tr>
<td>Leadership (MLQ components)</td>
<td>Experimental</td>
<td>Control</td>
<td>Intervention Effect</td>
<td>Test Statistic</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>--------------</td>
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<td>---------------------</td>
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</tr>
<tr>
<td>Idealized influence, attributed</td>
<td>2.87 (0.07)</td>
<td>2.85 (0.07)</td>
<td>0.12 (0.11)</td>
<td>F(1,113.10) = 1.61, p = .28</td>
</tr>
<tr>
<td>Idealized influence, behavior</td>
<td>2.89 (0.07)</td>
<td>2.82 (0.07)</td>
<td>0.21 (0.12)</td>
<td>F(1,113.60) = 3.28, p = .07</td>
</tr>
<tr>
<td>Inspirational motivation</td>
<td>2.94 (0.07)</td>
<td>2.85 (0.07)</td>
<td>0.02 (0.10)</td>
<td>F(1,106.71) = 0.05, p = .82</td>
</tr>
<tr>
<td>Intellectual stimulation</td>
<td>2.75 (0.07)</td>
<td>2.73 (0.07)</td>
<td>0.15 (0.11)</td>
<td>F(1,110.53) = 1.83, p = .18</td>
</tr>
<tr>
<td>Individualized consideration</td>
<td>3.09 (0.06)</td>
<td>3.07 (0.06)</td>
<td>0.19 (0.09)</td>
<td>F(1,113.15) = 4.33, p = .04</td>
</tr>
<tr>
<td>Effort and reward</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effort-reward imbalance *</td>
<td>1.17 (0.05)</td>
<td>1.03 (0.05)</td>
<td>-0.18 (0.06)</td>
<td>F(1,87.40) = 7.92, p = .01</td>
</tr>
<tr>
<td>Overcommitment</td>
<td>15.78 (0.39)</td>
<td>14.85 (0.38)</td>
<td>-0.62 (0.51)</td>
<td>F(1,100.78) = 1.46, p = .23</td>
</tr>
<tr>
<td>Productivity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absenteeism (relative)</td>
<td>-0.09 (0.02)</td>
<td>-0.08 (0.02)</td>
<td>0.04 (0.04)</td>
<td>F(1,112.34) = 0.81, p = .37</td>
</tr>
<tr>
<td>Presenteeism (relative)</td>
<td>1.18 (0.03)</td>
<td>1.12 (0.03)</td>
<td>-0.04 (0.05)</td>
<td>F(1,118.73) = 0.51, p = .48</td>
</tr>
<tr>
<td>Combined score</td>
<td>1.28 (0.04)</td>
<td>1.21 (0.04)</td>
<td>-0.12 (0.07)</td>
<td>F(1,107.41) = 2.55, p = .11</td>
</tr>
</tbody>
</table>

Note: Sample sizes vary from 139 to 141, owing to missing data. * Intervention effect also interacts significantly with worksite, see
An online intervention can have an impact on both those receiving the intervention and associates who indirectly benefit.
Implications?

• Carefully set up cluster randomized trials with attention to temporality and the social network

• Not everyone has to be trained in order for benefits to accrue to others

• Potential ramifications for how we think about intervention designs

• Cost effectiveness
Part 2

Fundamentals
For many, their dignity and fulfillment may only be found through the ability to work, hold a job, have a career. More than from money, they are inspired by their effort, to see results, to be of service. It helps to remember that these associates may be troubled by life challenges. So...the opportunity to create conditions for common well-being may bring relief to those who would not otherwise have any. It’s not only about productivity and health. It is about coaching the spirit of work, creativity, and growth, often for a greater good we cannot see.
The conversations that build relatedness most often occur through associational life, where we are unpaid and show up by choice, rather than in large systems where professionals are paid and show up by contract...The small group is the unit of transformation and the container for the experience of belonging.

Peter Block, Community (2009)
Social influence does not end with the people we know. If we affect our friends, and they affect their friends, then our actions potentially affect people we have never met.

We discovered that if your friend’s friend’s friend gained weight, you gained weight.

We discovered that if your friend’s friend stopped smoking, you stopped smoking.

We discovered that if your friend’s friend’s friend became happy, you became happy.
How well workers “feel” they get along with their coworkers and their immediate supervisor is likely the most reliable of all workplace-based predictors of employee health and disease risk.
Dozens of studies show that managerial practices (not only perception) influence the health of associates and subordinates. This includes long-term effects (positive and negative) on physical symptoms, burn-out, cardiovascular risks, behavioral health, and morbidity. This “ripple effect” appears universal in that it is independent of industry and organizational size.
Although these social factors have such a powerful role, workplace efforts at health promotion continue to focus on assessments, online programs, applications, and other innovative technologies that can be “commoditized.” Indeed, recent estimates suggest that more money is being spent on health incentives than on programs themselves.

All this, rather than focusing on the most basic protective factor:

our natural ability to (directly or indirectly) help each other.
Part 3

ideas whose time have come?
Total Worker Health without an inclusion of inclusiveness misses great potential.
<table>
<thead>
<tr>
<th>Perspectives</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Capital</td>
<td>Social capital refers to the collective value of all &quot;social networks&quot; [who people know] and the inclinations that arise from these networks to do things for each other <a href="#">&quot;norms of reciprocity.</a></td>
</tr>
<tr>
<td>Social Networks</td>
<td>Social networks refers to the degree to which individuals are connected to others through various degrees of separation. Healthy role modeling takes place across and within these networks.</td>
</tr>
<tr>
<td>Strategies</td>
<td></td>
</tr>
<tr>
<td>Group Wellness</td>
<td>When employees participate in any number of group-related health activities and campaigns (e.g., exercise, walking, weight-loss competitions) they experience benefits at the individual + group level.</td>
</tr>
<tr>
<td>Healthy Culture</td>
<td>Workplace culture effects how health promotion is engaged by workers; thus, it is critical to focus on the system as a whole with (1) strategy, (2) empowerment, and (3) monitoring.</td>
</tr>
<tr>
<td>Initiatives*</td>
<td></td>
</tr>
<tr>
<td>Team-based Prevention*</td>
<td>Employees can be given motivational and communication skills for helping, encouraging, and supporting each other in health. The use of these skills improves health and reduces risks.</td>
</tr>
<tr>
<td>Data-Driven Insights</td>
<td></td>
</tr>
<tr>
<td>Social Support</td>
<td>Social Support is a strong predictor of positive health outcomes.</td>
</tr>
<tr>
<td>Leader Ripple Effect*</td>
<td>Workplace managers at all levels can have a positive effect through 4 paths of influence: role modeling health, actively supporting wellness, interpersonal support, enhancing the environment.</td>
</tr>
<tr>
<td>Population-based metrics*</td>
<td>Through the growth of public health statistics data-bases and other large-scale health metrics, employers now have the opportunity to be aware of health risks and strength in their communities.</td>
</tr>
</tbody>
</table>

*OWLS focus

8 paths toward the We in Wellness
Potentiation
{1} Prevailing (Common/Lay) Paradigm

Stressor (as trigger) → Strain

{2} Classical (Scientific) Paradigm

{3} Emerging (Integral) Paradigm

Misguided Paradigms On Stress

Potentiation
Classical – Mechanical Model (Reactive; Emphasis on Stressor as THE Cause)

Stressor (as trigger) → Mediating Factors → Strain

- Personal
- Workplace
- Protect
- Exacerbate
Several lines of research point to a core capacity that allow individuals to actively “take on” stress and transform it into a growth opportunity. And all this exists at the collective or team level.
Classical – Mechanical Model (Reactive; Emphasis on Stressor as THE Cause)

- Stressor (as trigger)

- Mediating Factors
  - Personal
  - Workplace
  - Protect
  - Exacerbate

- Strain

Potentiation (Context Proactive; Primacy on Growth as THE Aspiration)

- Psychological Capital
- Self-leadership
- Self-determination
- Hardiness
- Efficacy
- Flourishing & Thriving
- Collective

- Challenge & Opportunity

- Resource Mobilization

- Growth

Phenomena in Other Disciplines That Support the Potentiation Model

- Neuroplasticity
- Post-traumatic Growth
- PTSD recovery
- Positive Psychology
- Mindfulness/ACT (clinical studies)
- Positive Organizational Scholarship
- Literature (Mythology)
- History of Civilizations
- Social Capital
- Social Networking

A Renewed Science of Stress Potential
Part 4

An Evidence-Based Model Of Healthy Workplace
We in Wellness

Group, team, crew, and informal peer-to-peer relations and situations that promote health (social, emotional, physical, etc.)

The “We” is hidden potential that can be promoted by embedding interventions in the culture

Potentiation
Peer-to-Peer Relationship

Leadership

Management

Champions (Health Advocates)

Individual Employee

LEARN MORE: http://organizationalwellness.com/resilience/
1995-to-2014: Team Awareness, Team Resilience, Team Awareness_{small business}, Team Readiness, TeamUpNow

- Clinical trials funded by SAMHSA, NIDA
- Multiple TOTs: to National Guard, Native Learning Center, EAPA, Commercial Clients in diverse industries

- Over 30,000 reached

LEARN MORE: http://www.slideshare.net/JoelBennett/team-awareness-team-resilience-evidencebased-background
• Team Awareness (evidence-based workplace program); clinical studies found improvements
  – Help-seeking
  – Stigma Reduction
  – EAP utilization
  – Supervisor Responsiveness
  – Stress levels
  – Work Climate
  – Policy/benefits knowledge
• While also reducing problem drinking and productivity problems
<table>
<thead>
<tr>
<th>Key Outcomes</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willingness to attend training, satisfaction with training and reported personal relevance; these results were achieved with high-risk employees</td>
<td>Bennett, J.B., Aden, C. A., Broome, K &amp; Mitchell, K. (2010). Team Resilience for Young Restaurant Workers: Research-to-Practice Adaptation and Assessment. <em>Journal of Occupational Health Psychology</em>, 15(3):223-236.</td>
</tr>
</tbody>
</table>
Independent Replications

Leadership

Management

Champions (Health Advocates)

Peer-to-Peer Relationship

Individual Employee

- Electricians (Oregon, Washington)
- Youth Corp (Colorado, California)
- Municipality (South Africa)
- Nursing Students (Oregon)[1]

Champions

Leadership

Management

Champions (Health Advocates)

Peer-to-Peer Relationship

Individual Employee

LEARN MORE

http://www.slideshare.net/JoelBennett2/wellness-champion-competencies-national-wellness-institute2014
Prevention Coordinator Competency Manual

Reported Improvements in Self-referral Process (% of 43 Prevention Coordinators reporting “Better”)

- Willingness of SM to approach you: 72%
- Self-Referral rates: 54%
- Either willingness or self-referral: 90%

Most Prevention Coordinators (PCs) reported that service members were increasingly willing to step forward to get help.

20,737 SM receive prevention
2,234 SM referred to treatment
195 SM self-referred
Personnel Costs (2013 $) and Retention Outcomes of Self-Referrals and Drug-Positive Referrals

For every 100 substance-using service members who self-refers instead of getting caught with a positive drug test, the National Guard reaps benefits:

- Save 2000 staff hours and $62,100
- Retain 18 additional service members
- Avoid $1.44M in training costs to replace discharged svc. members

Each substance-using service member has choices for getting help. The decision tree below shows some consequences of two choices, for the service member and for the National Guard.
As a manager do you…?

- Walk the wellness talk
- Model good work-life balance
- Maintain proper weight
- Make healthy nutrition choices
- Manage your stress well (coping skills)
- Respond well to crises and failures
- Are aware of your own “Achilles Heel” (family background risk factors for cardio, addiction, and depression)

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As a manager do you...?

- take the perspective of others
- treat them with respect
- balance interpersonal skill with work objectives
- avoid abusive or demeaning tones
- show interest in worker’s concerns
- maintain good business ethics
- speak to a higher vision/purpose at work

Heart-Centered

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Do you...?

- Talk about the value of programs
- Encourage participation in wellness events
- Make the connection between wellness and the business bottom-line
- Insure that your health insurance and benefits support healthy lifestyle behaviors
- View health as an indicator of business success
- Assure that workers are educated about the relationship between health and productivity
- Work as a team to remove barriers to wellness participation for ALL workers
In your role as manager, do you?

- Show support for health-related policies (smoking regulations, medical leave, child-care, etc.)
- Recognize workers such that they feel rewarded for their efforts
- Make efforts to reduce job strain (through flex-time, scheduling, or other means)
- Assure health in the physical environment (good lighting, heating, and ventilation)
- Show awareness and promote access for mental health services (e.g., EAP, community resources)
- Help to create a positive social environment
Leadership

Across all levels

• **Individual**: Self leadership
• **Team**: Train peers as leaders
• **Champions**: as leaders
• **Managers**: as leaders

ALSO....
• Surveys (leadership by example)
Leadership By Example (LBE) Instrument*

Assesses management commitment to worksite health promotion (e.g., managers are educated, see the business value, and promote)

<table>
<thead>
<tr>
<th>LBE ITEMS FROM Della et al.</th>
<th>Mean</th>
<th>Range</th>
<th>%Agree*</th>
<th>Mean</th>
<th>% Agree*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All levels of management are educated regarding the link between employee health and productivity cost management.</td>
<td>3.01</td>
<td>(2.18 – 3.93)</td>
<td>35.9%</td>
<td>3.76</td>
<td>76.4%</td>
</tr>
<tr>
<td>2. Employees at all levels are educated about the true cost of healthcare and its effects of business success.</td>
<td>2.80</td>
<td>(1.91 – 3.62)</td>
<td>32.1%</td>
<td>3.06</td>
<td>41.2%</td>
</tr>
<tr>
<td>3. Our work teams provide support for participation in health promotion programs.</td>
<td>3.35</td>
<td>(2.30 – 3.93)</td>
<td>50.0%</td>
<td>4.29</td>
<td>88.3%</td>
</tr>
<tr>
<td>4. Our health benefit and insurance programs support prevention and health promotion.</td>
<td>3.51</td>
<td>(2.50 – 4.15)</td>
<td>56.7%</td>
<td>4.24</td>
<td>88.3%</td>
</tr>
<tr>
<td>5. This site offers incentives for employees to stay healthy, reduce their high risk behaviors, and practice healthy lifestyles.</td>
<td>3.29</td>
<td>(2.11 – 4.25)</td>
<td>49.1%</td>
<td>4.47</td>
<td>100%</td>
</tr>
<tr>
<td>6. Our organization provides training to leaders in our specific work-site on the importance of employee health.</td>
<td>2.69</td>
<td>(1.82 – 3.53)</td>
<td>28.5%</td>
<td>4.00</td>
<td>82.3%</td>
</tr>
<tr>
<td>7. Our leaders view the level of employee health and well-being as one important indicator of the site’s business success.</td>
<td>3.11</td>
<td>(2.27 – 3.63)</td>
<td>40.0%</td>
<td>4.35</td>
<td>88.2%</td>
</tr>
<tr>
<td>8. Site leadership shares information with employees about the effect of employee health on overall business success.</td>
<td>2.53</td>
<td>(2.09 – 3.21)</td>
<td>19.2%</td>
<td>3.71</td>
<td>64.7%</td>
</tr>
<tr>
<td>9. All levels of employees are educated about the impact a healthy workforce can have on productivity/cost management.</td>
<td>2.78</td>
<td>(1.89 – 3.53)</td>
<td>31.1%</td>
<td>3.47</td>
<td>58.8%</td>
</tr>
</tbody>
</table>

*Those indicating either “agree” or “strongly” agree

Summary

✓ Set up designs to assess social cascade, dissemination, and ripple effects and identify critical pathways
✓ Consider underlying fundamental (relatedness, social contagion)
✓ Explore new ideas (we in wellness, potentiation)
✓ Embrace an integral (not piecemeal) model with key touch points of peers, champions, managers, leaders