Health at Work 4 All! Program Evaluation Report

MIDDLESEX-LONDON HEALTH UNIT

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Executive Summary

The majority of adults and many adolescents spend much of their waking lives at work. The work environment contributes to the development of adverse health outcomes but can also create or enhance supportive environments for health. The Health at Work 4 All! program, a model adopted by Middlesex-London Health Unit (MLHU) in 2010, provides employers with access to a vast array of resources to develop employee wellness committees and programs; discover the specific health and wellness concerns and priorities of the workforce; and, transform the workplace culture into one where health is valued and modeled by all.

In October, 2012 a survey was administered to all workplaces that have relationship with MLHU's Health at Work 4 All! program to:

- determine who was accessing information and resources and through what medium;
- the ways individuals and workplaces were utilizing information and resources provided through the program;
- if the program increased their knowledge level about healthy workplace programming; and,
- if the program influenced the development of healthy workplace programming.

Results of the survey indicated that the Health at Work 4 All! program reached workplaces of various sizes, primarily in the public sector. The program was successful in raising awareness and increasing the knowledge about the importance of healthy workplace programming and policies. The Health at Work 4 All! program experienced moderate success in assisting workplaces to develop healthy workplace programs and policies. The predominant barriers to development of healthy workplace programs reported were economic issues such as lack of time or resources to carry out healthy workplace activities.

The Middlesex-London area has a large number of workplaces that could benefit from a workplace wellness program. Further program expansion may be possible through determination of the workplaces most in need of resources. Given the great interest in online and self-help tools, this may represent an area of expansion for the workplace program to increase the reach of the program.

Introduction

The majority of adults and many adolescents spend much of their waking lives at work. The work environment—both physical and organizational—contributes to the development of adverse health outcomes directly through exposure to workplace hazards. Furthermore, the stresses and rewards of work can either undermine or enhance workers' ability to care for their own health (Davis, 2009). The amount of time employed Canadians spend in paid employment has increased dramatically over the past 20 years. Canadians spend an average of 36.6 hours per week at work (Human Resources and Skills Development Canada, 2014). For instance, 32% of employees report high work overload and only 3% report low levels of stress. Over half (54%) of employees take work home outside of regular hours and a quarter of employees feel "work extension technology", such as email, has increased their stress and workload. The working population reports one in five people in poor or fair health (Duxbury, 2012).

The Middlesex-London Health Unit Board of Health is mandated to "use a comprehensive health promotion approach to increase the capacity of workplaces to develop and implement healthy policies and programs, and to create or enhance supportive environments" (Ministry of Health and Long-Term Care, 2008). This is important because Canadians are not as healthy as they could be, and chronic diseases are on the rise (Conference Board of Canada, 2013). According to the 2006 Census, 67.5% of the 439,157 people who lived in Middlesex County and City of London participated in the labour force (Middlesex-London Health Unit, n.d.) and workers ranging in age from 25 – 64 years of age make up 82% of the workforce (Elgin Middlesex Oxford Workforce Planning and Development Board, 2013). Most health care costs are incurred later in life after retirement from the workforce; however most of the contributions to the health care system are made by those who are working. Therefore, the declining ratio of working to retired Canadians has major implications for health care sustainability. Trends in demographics and population health are not only increasing the demand for and cost of health care, but also threatening the economic performance of individuals, households, and the economy more broadly (Conference Board of Canada, 2013).
As discussions on the future of Canada's health care system continue, there is an opportunity to develop new approaches, revitalize existing programs, and create new solutions that will benefit not only individual organizations, but also the communities in which they operate (Bachmann, 2002). Employers, leaders and managers are introduced to an eight step process to aid them in the formation of a wellness committee, surveying the workers, determining priorities, and creating opportunities for education and change for the employees. The 2013 Sanofi Healthcare Survey noted that employers and employees see the value of health promotion in the workplace and 91% state that employers should do more in the area of prevention. An encouraging statistic shows that 80% of employers that provide health benefits intend to invest more resources into health and wellness in the near future (Sanofi Canada, 2013).

In 2010 the Healthy Workplace program at Middlesex London Health Unit adopted a new model and name for its program. The program was rebranded as Health at Work 4 All! and a framework created by the World Health Organization (WHO) was adopted as the base of the program (WHO, 2010). The WHO model, emphasizes four areas of influence; the physical environment (safety), the psychosocial work environments (culture), the physical (health) attributes of the employees, and the ways the business demonstrates enterprise community responsibility. The Health at Work 4 All! program provides employers with access to a vast array of resources and opportunities that help employers in their quest to develop employee wellness committees and programs; discover the specific health and wellness concerns and priorities of the workforce; and, transform the workplace culture into one where health is valued and modeled by all.

Purpose

In October, 2012 a survey was designed to evaluate the following objectives about the Health at Work 4 All! program:

- Who is accessing information and resources provided through the Health at Work 4 All! program and through what medium?
- In what ways are individuals and workplaces utilizing information and resources provided through the program?
- Has the program increased workplaces' knowledge level about Healthy Workplace programming?
- Has the program influenced the development of healthy workplace programming?

Survey Respondents

The target audience for the survey was all workplaces connected with the MLHU Health at Work 4 All!. All of these workplaces receive a monthly email newsletter or are mailed a newsletter and resource package semi-annually from the Workplace Program Coordinator. Some of the workplaces have an ongoing relationship with the Health at Work 4 All! Program and all of the workplaces have had contact with staff members at MLHU. A modification of the Dillman Tailored Design approach was used to

recruit survey respondents (Dillman, 2009). This approach uses principles of positive social exchange to increase response rates to surveys to produce more representative findings. Techniques such as personalizing communications and creating a social contract to motivate respondents are effective at increasing response rate and reducing errors from non-response bias. Through the month of October, 2012 a series of four personalized communications were sent to all workplaces within the MLHU workplace program database. Initially, an introduction letter was sent to the workplaces with the regular workplace mailing. Following the introduction, weekly emails containing a link to an online survey were sent encouraging participants to participate for the improvement of the Health at Work 4 All! program. After the survey was completed by a participant a personally addressed thank you note was sent.

Response Rate

The total population of workplaces who were surveyed was 191 and the total number of survey responses was 108 providing a 57% response rate, much higher than the average online survey response rate (Monroe, 2012). The completion rate for the survey was 88%. The incomplete survey responses were included because respondents provided a tracking code preventing duplicate responses.

Analysis

Proportions and counts were summarized for each survey question. In cases where a cross-tabulation was calculated between groups (i.e. size of organization) a Fishers Exact test were used to determine if there were statistically significant differences between groups.

Findings

Demographics

The highest proportion of survey respondents (27%, N=29) identified themselves as Human Resources staff (Figure 1). Other groups of respondents included those working in occupational health and safety, a member of the wellness committee or the owner or CEO. There were a wide range of other respondents from coordinator to educator to maintenance workers in the 'Other' category. All but one of the surveys was completed by one individual.

Only one survey was completed by the wellness committee, as was suggested in the survey instructions.

There was a fairly equal distribution of respondents in each organization size category (Figure 2). Aggregation of respondents by business sector showed that nearly three quarters of all respondents (69%, N= 75) were from health/government/education/social or public services (Figure 3). Specifically, 29 respondents were in health and social services, 21 were in education or child care services and 20 in government and public services (data not shown).

Figure 1: Please indicate your job title or position within your organization (N=108)

Response	Chart	Percentage	Count
Human Resources		27%	29
Health and Safety Committee Representative		19%	21
Owner / Manager / CEO		19%	20
Wellness Committee Representative		13%	14
Occupational Health Nurse		12%	13
Other, please specify...		32%	35
Did not respond		6%	6

Figure 2: How many employees does your organization employ? (N=108)

Response	Chart	Percentage	Count
less than 100		36%	39
100-500		36%	39
Over 500		26%	28
Did not respond		2%	2

Figure 3: What is your business sector? (N=108)

Response	Chart	Percentage	Count
Health/ Government/ Education/ Social Service		69%	75
Agriculture/ Construct/ Manufac/ Wholesale/ Transport		20%	22
Business/ Finance/ Insurance		9%	10
Retail/ Hospitality		6%	7
Did not respond		2%	2

Familiarity with the Health at Work 4 All! Program

The majority of the respondents (82%, N=89) indicated that they had heard of the Health at Work 4 All! program (Figure 4). There were no significant differences between different sized workplaces with respect to awareness of the program.

The most common way that respondents indicated that they heard about the Health at Work 4 All! Program was through the electronic newsletter (41%, N=34) (Figure 5). Following that, the mailed newsletter (17%, N=14) and the Fall Workshop (12%, N=11) were the most common methods described by respondents for how they heard about the program. Generally those who indicated 'Other' reported that they had some contact with the Healthy Workplace Coordinator or had a previous relationship with MLHU.

Figure 4: Prior to being contacted about this survey had you heard of the Health at Work 4 All! Program? (N=108)

Response	Chart	Percentage	Count
Yes		82%	89
No		17%	18
Did not respond		1%	1

Figure 5: How did you find out about the Health at Work 4 All! program? (N=89)

Response	Chart	Percentage	Count
Electronic Newsletter		38%	34
Mailed Newsletter		16%	14
Attended the Fall Workshop		12%	11
Word of mouth, please describe:		8%	7
Website, please indicate which one:		3%	3
Contact at a tradeshow		3%	3
Print Media, please describe:		0%	0
Other, please specify:		12%	11
Did not respond		7%	6

Of those workplaces that had heard of the program (N=89), 73% (N=65) had reviewed the electronic newsletter and 35% (N=31) had reviewed the mailed newsletter. Nearly half (45%, N=40) had reviewed one of the health unit websites and 21% (N=19) had read the Health at Work 4 All! manual (Figure 6).

The most common services that were accessed by workplaces were onsite consultations (22%, N=20) and attending the annual workshop in the fall (17%, N=15) (Figure 7). Services or activities provided by the Workplace Coordinator were accessed by a substantially lower proportion of respondents than resource review such as newsletters or website.

Figure 6: Which of the following resources from the Health at Work 4 All! Program have you read or reviewed? (N=89)

Response	Chart	Percentage	Count
Electronic Newsletter		73%	65
Health Unit Website(s)		45%	40
Mailed Newsletter / Resource Package		35%	31
Health at Work 4 All! manual		21%	19
None of the above		3%	3
Did not respond		7%	6

Figure 7: Please indicate which of the following activities offered by the Health at Work 4 All! Program coordinator you have accessed? (N=89)

Response	Chart	Percentage	Count
On-site, in person consultations with program coordinator		22%	20
Annual workshop (in October) on a topic of relevance to comprehensive workplace wellness program development		17%	15
Telephone consultation when resources/information/guidance needed for program development		11%	10
Help with Wellness Committee development		6%	5
Help with program planning		4%	4
Help with development of an employee survey		3%	3
Help with developing policies		3%	3
None of the above		47%	42
Did not respond		9%	8

Healthy Workplace Programming

The majority of workplaces (69%, N=74) indicated that they had management support for a healthy workplace program (Figure 8). The next most common components of a healthy workplace program that workplaces currently addressed were the development or completion of a wellness initiative or program (42%, N=45) and forming a wellness committee (39%, N=42). The least common components were creation or introduction of a new policy (19%, N=20) and evaluation of a policy (19%, N=20). Seventeen of the respondents (16%) had not done any of the components.

Analysis was done to determine whether workplace size had any bearing on implementation of each component of a workplace program. In general, size did not affect whether the components of a healthy workplace program were completed, except in the case of evaluating an initiative or policy. The proportion of organizations that had completed an evaluation of a policy in any size category was less than 10%.

Figure 8: What components of a Healthy Workplace Program does your workplace currently address? (N=108)

Response	Chart	Percentage	Count
We have management support		69%	74
We have developed and done a wellness initiative or program		42%	45
We have formed a wellness committee		39%	42
We have made improvements to initiatives or programs		35%	38
We have done an employee survey		30%	32
We have created and introduced a new policy		19%	20
We have evaluated our new initiative or program		19%	20
We have prioritized the results of the employee survey		18%	19
None of the above		16%	17
Did not respond		2%	2

Three quarters of the workplace respondents who had heard of the Health at Work 4 All! program had promoted healthy eating (75%, N=67) and physical activity (73%, N=65) resources (Figure 9). Work stress resources were also commonly reported (69%, N=61). Sun safety and Healthy Weights resources were less likely to have been promoted, both in 48% (N=43) workplaces.

Figure 9: Below is a list of health topic areas of some of the resources we provide. Please indicate if you have promoted any of them in your workplace. (N=89)

Response	Yes Count	Yes Percent	No	Did not respond
Healthy Eating	67	75%	9	13
Physical Activity	65	73%	11	13
Work Stress	61	69%	9	19
Tobacco	53	60%	13	23
Healthy Weights	43	48%	14	32
Sun / UV Safety	43	48%	16	30

Outcomes of Health at Work 4 All! Programming

To understand the impact that the Health at Work 4 All! program had made on program outcome objectives, participants were asked to respond to questions regarding the influence of the program on development of healthy workplace programming within their own workplaces.

Just over two thirds (69%, N=61) of the respondents who had heard about the Health at Work 4 All! program indicated that it increased their knowledge level about programing specific to healthy workplaces (Figure 10). In comments, respondents described how their knowledge increased, 21% (N=19) specifically mentioned that the program made them more aware of resources, 12% (N=11) indicated that they became more aware of services, 7% (N=6) became more aware of programming for workplaces and 4% (N=4) increased their awareness about the impacts of healthy workplaces.

Figure 10: Did the Health at Work 4 All! Program increase your knowledge level about Healthy Workplace programming? (N=89)

Response	Chart	Percentage	Count
Yes		69%	61
No		21%	19
Did not respond		10%	9

Nearly one third (30%, N=27) indicated that the resources from the Health at Work 4 All! program assisted in getting the workplace's healthy workplace programing to its current stage (Figure 11). Specifically, the most common themes from comments describe how the program assisted them to; increase the content or breadth of topic areas (4%, N=4), increase communication about health (4%, N=4), compliment a current larger corporate healthy workplace program (4%, N=4) and facilitate getting the program off the ground (4%, N=4) (Data not shown).

Figure 11: Did the Health at Work 4 All! Program resources assist you to get to the stage you are currently at in your Health Workplace programming?

Response	Chart	Percentage	Count
Yes		30%	27
No		22%	20
Not applicable because we do not currently have a Healthy Workplace program		38%	34
Did not respond		9%	8

One quarter of the workplaces that responded said that they had developed programs as a result of the Health at Work 4 All! program (Figure 12). Physical activity type programs were most common in six workplaces (7%) followed by healthy eating programs (4%, N=4)(Figure 13). A smaller proportion of workplaces indicated that the Health at Work 4 All! program helped them to develop healthy workplace policies (11%, N=10) (Figure 14). The most common policy developed was a Wellness Statement (3%, N=3) (Figure 15).

Figure 12: As a result of the Health at Work 4 All! program have you developed any Healthy Workplace programs? (N=89)

Response	Chart	Percentage	Count
Yes		26%	23
No		62%	55
Did not respond		12%	11

Figure 13: **If yes, please list the programs you have developed.**

Response	Chart	Percentages	Count
Physical Activity/ Fitness Session/ Run-Walk Club		7%	6
Healthy Eating		4%	4
Challenge or contest		3%	3
Lunch and Learn Program		2%	2
Artistic Sessions		1%	1
Bill 168		1%	1
Cancer Awareness		1%	1
Health Assessments		1%	1
Healthy Habits		1%	1
Healthy relationships incl. safe sex		1%	1
Smoking Cessation		1%	1
Speaker sessions		1%	1

Figure 14: As a result of the Health at Work 4 All! program have you developed any Healthy Workplace policies? (N=89)

Response	Chart	Percentage	Count
Yes		11%	10
No		75%	67
Did not respond		13%	12

Figure 15: **If yes, Please list the policies you have developed.**

Response	Chart	Percentages	Count
Policies already in place or developed by Head Office		6%	5
Wellness Statement/Policy		3%	3
Bill 168 Policy		1%	1
Healthy Eating Policy		1%	1
Infection Control Policy		1%	1
Scent Free Policy		1%	1
Volunteerism Polcy		1%	1

Barriers

A question was asked about the barriers that prevent development of healthy workplace programs. Half of the respondents indicated that the lack of time or resources was a barrier (51%, N=55) (Figure 16). Lack of employee interest (35%, N=38) and economic concerns (31%, N=33) were identified as the next most common types of barriers. Additional barriers included lack of a healthy workplace champion, lack of management support and a lack of understanding of the importance of a healthy workplace.

Figure 16: What barriers did you experience or still exist in the development of a Healthy Workplace program? (N=108)

Response	Chart	Percentage	Count
Lack of time, space and manpower resource allocation		51%	55
Lack of employee interest		35%	38
Economic concerns		31%	33
Lack of a champion		22%	24
Lack of understanding as to importance of a healthy workplace		16%	17
Lack of management support		15%	16
Workplace stress		14%	15
Not experiencing any barriers		10%	11
Union concerns		6%	7
Other, please specify...		4%	4
Uncertain future for the business		3%	3
Did not respond		17%	18

Future Direction

Online resources where the most highly desired resources: 51% (N=55) or workplaces indicated they want to be able to access online resources to help them develop and implement health policies and programs (Figure 16). Nearly half (46%, N=50) indicated that self-help toolkits for wellness coordinators would be helpful in the development of health policies and programs. The in-person education sessions and webinars were both requested by approximately 40% of the respondents. Nearly double the number of respondents indicated that they would like to receive the bi-weekly electronic newsletter (37%, N=40) compared to the bi-annual mail-out newsletter package (21%, N=23).

Figure 17: Please indicate which of the following information or services we could offer to help you develop and implement health policies and programs in the future. (N=108)

Response	Chart	Percentage	Count
Online resources		51%	55
Online self-help toolkits for wellness coordinators		46%	50
Monthly or quarterly education sessions on topics of relevance to comprehensive workplace health		42%	45
Education webinars		39%	42
Bi-weekly electronic newletter		37%	40
Train the trainer workshops		29%	31
Bi-annual newsletter and mail-out package		21%	23
On-site consultations		19%	21
Telephone consultations		11%	12
Did not respond		19%	20

Discussion

The respondents to the survey were those contacts that received either electronic or hard copy communications from the MLHU Health at Work 4 All! program. While many were in roles traditionally associated with administering healthy workplace type programs, nearly 30% of respondents classified themselves in the 'other' category. Although the Health at Work 4 All! program does not specifically target human resources personnel, many responded to the survey indicating they may be a potential target audience. The MLHU Health at Work 4 All! program appears to be reaching a broad range of size of workplaces. The vast majority of workplaces that responded to the survey were from the public sector.

Awareness of the program was relatively high at 82% among respondents. That was expected given that the survey was sent only to those who have an ongoing relationship (e.g. receive the newsletter) with the Health at Work 4 All! program at MLHU. The program has been successful in reaching workplaces to raise awareness and increase knowledge about the importance of healthy workplace programming. Over 80% of respondents were aware of the Health at Work 4 All! program and 60% indicated that the program had increased their level of knowledge about healthy workplace programming. It should be noted that the MLHU Health at Work 4 All! program has been in existence since 1998. Workplaces that have been using and receiving resources through this program may have done so before the name of the program changed from the "Blueprint to Success" to the "Health at Work 4 All!" program.

Nearly 85% of the workplaces that responded indicated that they had some components of a Healthy Workplace program in place. The majority indicated that they had management support – a preliminary step in the development of successful program. Other preliminary steps including forming a wellness committee and developing and delivering a wellness program were each reported by about 40% of the respondents. More advanced and time consuming components of a healthy workplace program had been completed by fewer workplaces (surveying staff, evaluating initiatives, program development and policy change).

While several workplaces responded that they were just beginning to develop workplace programming, about one quarter indicated that the Health at Work 4 All! program assisted them to develop programs and about 10% reported it assisted them to develop policies. The topic areas that were most likely to have been promoted were physical activity, healthy eating and work stress.

Many respondents reported currently using and requested future development of online resources to enhance healthy workplace programming. The MLHU website (www.healthunit.com) provides an excellent opportunity to communicate the information needed to assist organizations in healthy workplace program development. Approximately 20% of the respondents made use of the in-person services provided by the Healthy Workplaces coordinator and the education sessions offered during the annual workshop. This low rate of connection with the program coordinator may be due to the fact that the person now accessing the newsletter and resources may not be the same individual who originally contacted the program coordinator. Three quarters of respondents reported reviewing the e-newsletter and nearly half had accessed the health unit website. Given the propensity of workplaces to review the online resources a shift to more electronic training, self-help kits, and webinars may be warranted.

While 10% of workplaces that responded to the survey indicated that they do not experience any barriers related to the implementation of healthy workplace programming, for half of the respondents' lack of time or resources was described as a barrier. Lack of employee interest and economic concerns were identified as the next most common types of barriers. These conditions can be difficult for the MLHU Health at Work 4 All! to effect. Some additional awareness and knowledge building work can be done for workplaces that listed lack of a healthy workplace champion, lack of management support and a lack of understanding of the importance of a healthy workplace as barriers, though each was listed by 20% of respondents or less.

According to the Elgin Middlesex Oxford Workforce Planning and Development Board in 2013, there are currently 27,576 employers in London and Middlesex County that have 254,349 employees. This survey only gathered information from workplaces that already have a relationship with the Middlesex-London Health Unit. Given the large number of workplaces that are present in Middlesex-London area, further expansion may be required. Determination of the workplaces most in need of resources could assist in prioritizing expansion of the program. Additionally, the interest in online, self-help type tools might also help increase the reach of the program without additional MLHU resource investment.

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