Employee culture of health perceptions and the development of a training intervention

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Abstract

Purpose – The authors used a case study approach to explore employees' perceptions of one institution's culture of health. The authors then applied a needs-centered training model to create and test the effectiveness of a workplace wellness training program to improve the culture of health.

Design/methodology/approach – For study 1, the authors recruited 736 faculty and staff from an institution of higher education to complete an online culture of health survey measuring their perceived leadership support, peer support and institutional resources. In study 2, participants (n = 60) in follow-up focus groups described their experiences related to the culture of health at the institution. For study 3, university employees (n = 44) participated in the training intervention and reported on post-test outcomes measuring the training's effectiveness.

Findings – High levels of employee stress and lack of supervisor and coworker support were identified as significant issues in the needs assessment process. Therefore, the authors developed a needs-centered training intervention that focused on supportive and confirming supervisor and peer communication. Results suggest employees perceive the training to be effective, are ready to change their behaviors and are knowledgeable about the training content.

Originality/value – This study provides evidence regarding needs-based trainings focused on co-worker communication and how these trainings may incrementally improve the culture of health within organizations. Accordingly, the authors offer best practices, including the value of focusing on employee needs, advocating for employees, building community through trainings and enacting change through the training process.

Keywords Communication, Training and development, Workplace wellness programs, Culture of health

Paper type Case study

> I feel the [workplace wellness] program is a good concept but not enough buy-in by members of my immediate team . . . The sessions are treated more as niceties than health/wellness necessities by my immediate team . . .
>
> Stress is the most significant factor . . . contributing to my inability to get to the gym and to lose weight. I believe that for most people that is due to having too much work to do . . .

These quotes from university employees surveyed for the current study provide a snapshot into the occupational stress experienced by faculty and staff at one institution of higher education. Although university employees reported feeling distress prior to the outbreak of COVID-19 (Meeks *et al.*, 2021), the disruption to college campuses across the globe due to the pandemic heightened these experiences. For instance, Course Hero reported that over half of their sample of 570 higher education faculty indicated feeling stressed, frustrated and emotionally burnt out and approximately 40% were contemplating leaving their positions (Renfrow, 2020). The data for college and university staff members parallels that of faculty (Irandoost *et al.*, 2021; Kaiser *et al.*, 2021). Thus, administrators should have a renewed focus on helping their employees manage their wellness.

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One way to prevent or alleviate burnout may be through promoting a culture of health on campus (Gabriel and Aguinis, 2022). The Centers for Disease Control (2013) conceptualize culture of health as "a working environment in which employee health and safety are valued, supported, and promoted through worksite health and well-being programs, policies, benefits, and environmental supports." Despite recommendations to create a culture of health, little is known about how to improve the culture of health, especially in university settings. Consequently, the purpose of this study is to use a case study approach to explore employees' perceptions of one institution's culture of health to create an employee workplace wellness training intervention aimed at improving the culture of health. Using Beebe *et al.*'s (2021) needs-centered training model, this study applies case study data to the development of a training intervention focused on communication between supervisors and employees and among peers.

Needs-centered training model

The primary purpose of a successful training program is to create an intervention that responds to trainees' needs by developing their skills. Investing time to assess and adapt to unique trainee needs can positively change organizations by avoiding costly mistakes and retaining employees (Lucier, 2008). Beebe *et al.*'s (2021) Needs-Centered Training Model (NCTM) focuses on the trainees' needs at every step of the training process and served as the framework for this study.

The first step of the NCTM, analyze the trainee needs, centers the model. The remaining eight steps are anchored in what is discovered during this needs assessment. Beebe (2007) argues that everything presented during a training should directly correlate with what trainees need to successfully do their jobs. Once the needs are determined, the trainer can analyze the training task (step two), or steps required to perform the skills that address trainee needs. Step three is developing training objectives, or what the trainees should be able to accomplish during the training (Beebe *et al.*, 2021).

The trainer now begins plans, organizes and creates the training intervention. Thus, the fourth step is to organize training content by drafting the information trainees need to know to understand the skills being taught. Once the content is organized, the trainer can shift focus to the training methods or means by which the information will be delivered and the exercises or activities used to practice the skills (step five). Step six is selecting training resources that are most appropriate for both the material and the trainees.

The final three steps focus on planning, delivery and assessing the training program (Beebe *et al.*, 2021). Step seven centers on the plans for how the trainer accomplishes the training objectives. Step eight is delivering or presenting the training while attending to the needs of the trainees throughout the delivery and adapting in real time when necessary. The final step is assessing the effectiveness of the training and whether the trainees accomplished the training objectives (Beebe *et al.*, 2021). The assessment allows the trainer to make adjustments before delivering it again. Due to the model's flexibility to various training topics and its emphasis on employee needs, this model framed the culture of health analysis presented in this study.

Workplace wellness programs

A primary way that organizations, including colleges and universities, have tried to contribute to their culture of health is through workplace wellness programs (WWPs). WWPs are conceptualized as "programs and policies [that] can reduce health risks and improve the quality of life for American workers" (Centers for Disease Control and Prevention, 2017; para. 1). WWPs typically provide employees with the opportunity to evaluate their current state of wellness, as well as resources and programming to improve it (Soler *et al.*, 2010). From the employee perspective, benefits of participating in WWPs include health behavior change

(Song and Baicker, 2019) and increased perceived psychological well-being and connection with others in the organization (Dailey *et al.*, 2018). Employers benefit from WWPs by way of decreasing health care spending costs and limiting employee absenteeism (Chapman, 2012).

Although WWPs benefit organizations and employees alike (Goetzel *et al.*, 2014), employees report contradictory feelings about these programs. For instance, even if employees feel their organization values their wellness, they often report the primary goal of WWPs is saving money (Dailey *et al.*, 2018). Additionally, employees may experience a tension between the desire to participate in WWPs as an escape from their occupational stress and the experience of guilt, often as a result of negative reactions from supervisors and coworkers for their perceived lack of productivity during wellness leave (Dailey *et al.*, 2018). These tensions reveal several challenges associated with successfully implementing WWPs, thereby impacting the culture of health. Indeed, many WWPs fail as a result of the programs not being integrated into the culture of the organization (Goetzel *et al.*, 2014). Consequently, in this study, we adopt a case study methodology to examine employee perceptions of the culture of health at one university and to develop a training program focused on incremental changes to the culture of health within the organization.

Culture of health

Safeer and Allen (2019) discuss six dimensions that impact an organization's culture of health: leadership support, touch points, peer support, climate/morale, shared values and norms. These components are vital in facilitating prosocial outcomes, particularly when it comes to relational connections. For instance, employees are more likely to perceive their organization to be supportive of their health when they report receiving leadership and peer support and when they are more engaged in WWPs (Payne *et al.*, 2018). The value of these connections is further underscored by research suggesting that perceived coworker social influence impacts faculty and staff health behaviors via co-workers' supportive interactions (Burke *et al.*, 2017). These interactions reflect and sustain an organization's culture of health; however, less is known about how to effectively and incrementally improve an organization's culture of health. Thus, we now turn to the organizational context in which we explored employees' perceptions of their university's culture of health and developed and implemented the corresponding training intervention.

Case study organization

The setting for the case study was a large, southern university in the US that employs approximately 7,000 faculty and staff members. The WWP at this institution is a human resources (HR) initiative with a leadership team comprised of faculty from health and human performance, physical therapy, communication studies and nutrition, as well as staff and students who serve as wellness instructors and work in campus recreation. The authors of the study all serve on the leadership team for the WWP. The goal is to enhance the scholarly and practical understanding of employees' perceptions of the institutional culture of health and to subsequently improve the culture of health by increasing employee awareness of the WWP, clarifying employee knowledge of the wellness policy and health benefits and identifying and alleviating barriers to employee participation in the WWP.

Study one

The goal of study one was to explore employee perceptions of the culture of health through a large-scale, cross-sectional, mixed methods survey. After obtaining IRB approval, we worked with Redbrick Health, a technology company whose mission is to evaluate and enhance organizations' WWPs, to recruit and collect the data for study one between April 20, 2018 and May 4, 2018. The primary research question of interest in the study was:

RQ1. What are faculty and staff perceptions of the culture of health at the case study institution?

Method

Participants. A convenience sample of 736, or approximately 10% of all employees at the institution, participated in the study. Of these participants, 64% identified as employees, 31.3% identified as supervisors and 4.7% did not indicate their job status. The majority of the participants (69.70%) identified as women, while 25.54% identified as men (4.76% did not respond). For supervisors, their ages ranged from 21–75 years old ($M = 46.04$, $SD = 12.66$), and for employees, their ages ranged from 18–77 years old ($M = 43.97$, $SD = 12.70$). Employees and supervisors were incentivized to participate in the study by being entered into a drawing for a chance to win one of 20 gift cards valued at $50 each.

Measures. The survey items were developed by Redbrick Health, in consultation with the WWP leadership team, for the purpose of having an external entity evaluate the culture of health at the case study organization. In addition to completing the measures of interest (e.g. perceptions of leadership support, perceptions of peer support, health norms, touch points or awareness of structural and social resources, perceived health, culture of stress), participants were asked whether they would be interested in participating in a focus group to discuss the culture of health at this institution. Interested participants were contacted after the conclusion of the survey to sign up for one of seven focus group sessions, discussed in Study Two. Please see Table 1 for the descriptive statistics and reliability estimates for the key variables of interest in Study One.

Results

To explore the research question in study one, we conducted descriptive statistics for each component of the culture of health measured (e.g. leadership support, peer support, touch points, norms) as well as employees' perceived health outcomes (e.g. physical and mental well-being) and culture of stress. There was moderate agreement among participants in the sample that organizational leaders were supportive of the culture of health (see Figure 1). The results also suggested that coworker support varied depending on the health behavior in question; peer support was lower for encouraging a healthy diet and exercise regimen in comparison to general feelings of support and specific encouragement to stop smoking (see Figure 2). Additionally, employees did not perceive eating healthy (34.05% agreement) and exercising regularly (32.03% agreement) to be normative behaviors among their coworkers.

Moreover, employee awareness of the health and wellness touch points through the university varied depending on the resource or program. Participants seemed to be especially aware of physical activity class offerings and information sessions provided by the WWP. However, faculty and staff were unaware of online programing developed by the WWP and both extrinsic and intrinsic incentives associated with participating in the WWP (see Figure 3). Finally, although approximately 73% of the sample indicated they perceived their overall physical health to be "good" or "excellent," a concerning proportion of the sample (e.g. 82.4%) indicated that their stress had "some" or a large effect on their physical health during the past year. Moreover, only 33% of the participants agreed that their supervisor prioritized managing employee stress and approximately half of the participants agreed that their coworkers "often seem stressed at work" (See Figure 4).

Limitations and conclusions

One of the primary limitations to study one was that we did not collect data about employee perceptions of the climate/morale or shared values dimensions of the culture of health. Additionally, the results of study one indicated several areas of concern related to the culture

Variable with sample items	*M*	*SD*	*Reliability*
Leadership Support – 6 items	4.40	1.25	$\alpha = 0.89$
Item 1: My employer has a vision for supporting employee health			
Item 2: My employer does a good job of helping employees see the purpose of health and wellness programs and efforts			
Item 3: Employee health and well-being is an important part of where I work			
Item 4: A value here is that employee health is connected to the organization's success			
Item 5: Senior leaders are good role models for practicing a healthy lifestyle			
Item 6: Senior leaders put enough resources into supporting employee health			
Peer Support – 5 items	4.30	1.30	$\alpha = 0.86$
Item 1: My coworkers about each other's health and well-being			
Item 2: My coworkers encourage each other to take care of their health			
Item 3: My coworkers encourage each other to exercise regularly			
Item 4: My coworkers encourage each other to eat a healthy diet			
Item 5: My coworkers encourage each other not to smoke			
Health Norms – 2 items	3.38	1.91	$r = 0.68$**
Item 1: As coworkers, we eat healthy			
Item 2: As coworkers, we exercise regularly			
Touch Points – 8 items	1.97	0.44	$\alpha = 0.72$
Item 1: Awareness of health screening			
Item 2: Awareness of coaching services			
Item 3: Awareness of online programs			
Item 4: Awareness of information sessions			
Item 5: Awareness of physical activity classes			
Item 6: Awareness of other programs			
Item 7: Awareness of participation incentive			
Item 8: Awareness of outcome-based incentive			
Perceived Health – 2 items	2.99	0.75	$r = -0.27$**
Item 1: Overall physical health			
Item 2: How much stress impacts physical health			
Culture of Stress – 2 items	4.10	1.52	$r = -0.26$**
Item 1: My employer places a high priority on helping employees manage stress			
Item 2: My coworkers often seem stressed at work			

Note(s): Leadership support, peer support, health norms, and culture of stress were measured on a 7-point, Likert-type scale (1 = Very Strongly Disagree, 7 = Very Strongly Agree). Touch points was measured on a 3-point, Likert-type scale (1 = No Awareness, 3 = Very Aware). Perceived health was measured on a 4-point, Likert-type scale (1 = None, 4 = A Lot)
Source(s): Author's own work

Table 1.
Descriptive statistics for measures in study 1

of health that needed further study by gaining a deeper understanding of *why* employees responded in the way they did. For instance, although employees, on average, reported moderate levels of leadership and coworker support, the high levels of employee stress and a lack of supervisor support in managing employee stress led representatives from Redbrick Health as well as the WWP leadership team to conclude this was a primary area of needed improvement. Because we wanted to further explore employee experiences related to stress and supervisor/coworker support, we conducted focus groups allowing to elaborate on employee perspectives on the culture of health in Study Two.

Study two

Study two consisted of hosting focus groups with full-time employees that explored the aforementioned areas of concern. In particular, we explored the distrust that employees had

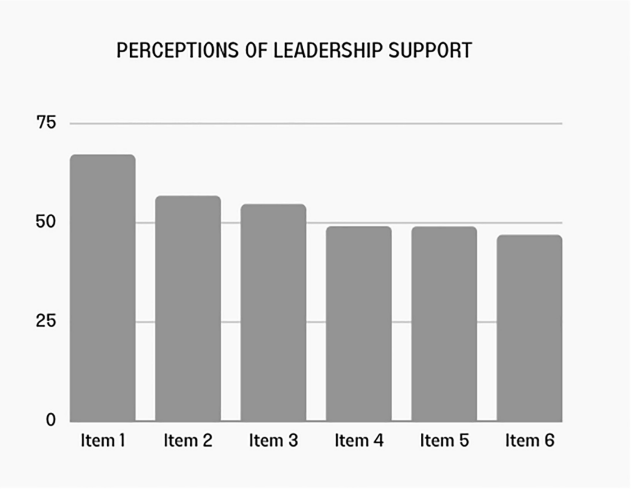

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Figure 1.
Percent of agreement and strong agreement for leadership support scale

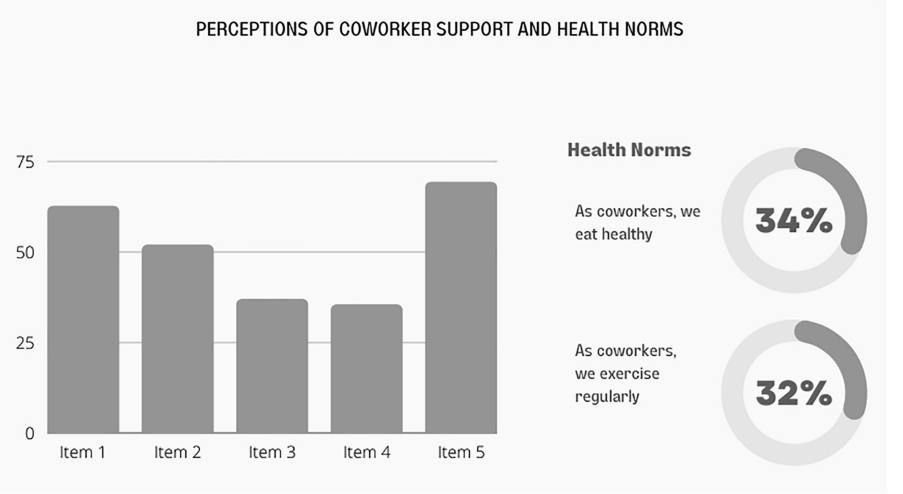

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Figure 2.
Percent of agreement and strong agreement for coworker support scale

with administration related to the culture of health, the perceived causes of the stress levels discovered in study one and their understanding of health policies and benefits. Focus groups were used to collect data to encourage participants to build upon each other's responses (Burns, 2015; Krueger and Casey, 2000). Focus groups also create an environment where participants feel comfortable self-disclosing and allow for in-depth exploration through open conversation (Burns, 2015; Krueger and Casey, 2000). We aimed to create a safe environment for employees to openly provide feedback and discuss the university's culture of health and inform the needs-based culture of health training intervention without fear of backlash.

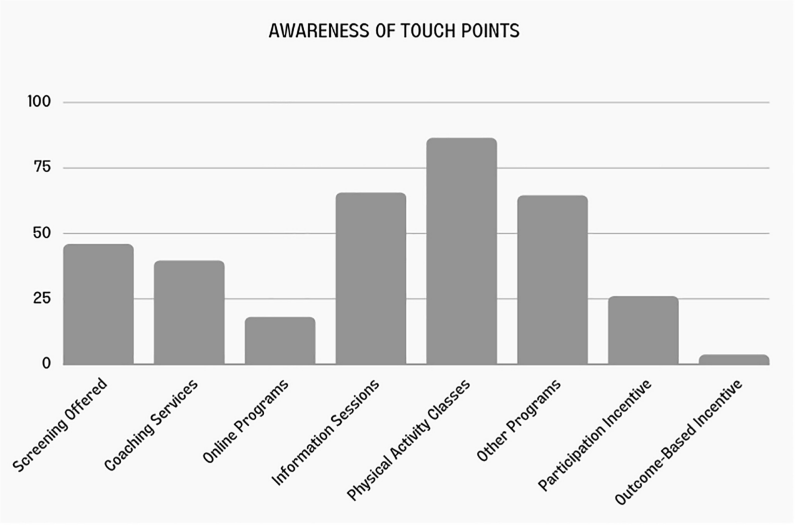

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Figure 3.
Percent of employees indicating awareness of WWP resources

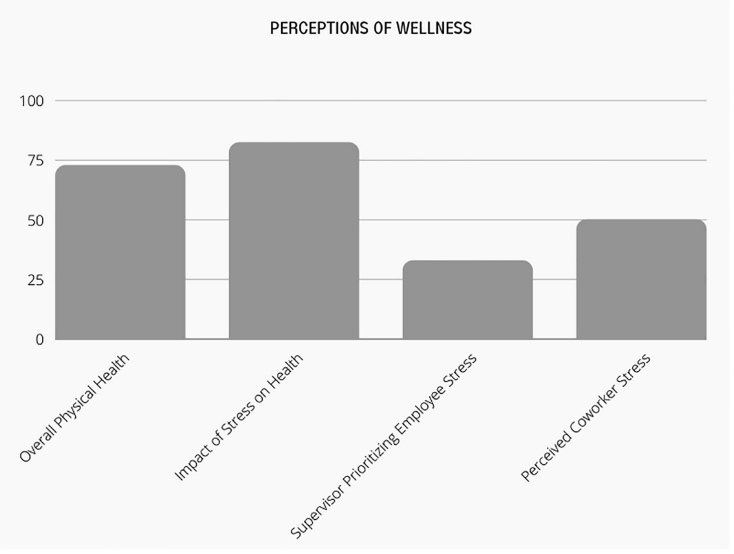

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Figure 4.
Percent of agreement and strong agreement of physical and mental well-being

Method

Participants. In June and July of 2018, 60 employees participated in one of seven focus groups. Fourteen participants identified as male, and 46 participants identified as female. Most participants (n = 56) were university staff – not faculty – representing various departments on campus (e.g. academic affairs, student affairs, facilities management,

human resources, business/finance, IT support, research/grant coordinators, vice president office support, marketing and communication). The employees' positions ranged from entry level to vice presidents. The other four participants were faculty, three of whom were tenured and one non-tenure track instructor.

Procedures. Participants who indicated that they were interested in participating in a focus group at the end of Study One were emailed and asked to sign up for a date and time using an online calendar tool. The focus groups consisted of 6–8 participants and were hosted by two interviewers and one note taker in a conference room. The focus groups lasted approximately one hour, and employees were provided lunch for their participation. The focus groups were audio recorded and transcribed producing 162 single spaced pages of text. The participants were asked a series of questions related to their perceptions of the culture of health, barriers related to health and wellness, their understanding of health policies and benefits, workplace conversations related to health and health benefits, questions related to specific findings from study one (e.g. stress, distrust, supervisor and peer support), the ideal culture of health, advice for administration and suggestions for training content.

Data analysis

Data analysis occurred in seven stages using a constant comparative method (Glaser and Strauss, 1967; Strauss, 1987). The first stage consisted of the second and third authors, individually reading the transcripts in their entirety to ensure a comprehensive understanding of the data. During stage two, the researchers reread the transcripts while listening to the audio files to ensure accuracy. Each interviewer then used open coding looking for repetitive, potential data categories. During stage four the interviewers individually reread the data to determine if any additional categories emerged. The interviewers then compared their codes from the open coding process and used axial selective coding (Strauss, 1987) to combine related codes and themes while also creating definitions for each code/theme. During stage six, the interviewers created a code book and hired and trained two research assistants to finalize the coding process. Finally, the research assistants met to compare their individual coding, discuss any discrepancies that emerged and to ensure intercoder reliability.

Results

Data from the focus groups yielded six themes. The themes were communicative in nature and helped the researchers develop the content for the training intervention. The themes included (1) leadership support, (2) promoting overall wellness, (3) equity, (4) guilt, (5) skepticism and mistrust and (6) desire for community.

Leadership support. Most participants noted a need for a top-down approach to facilitate a positive environment through leading by example. This means that employees wanted to see leadership participating in health and wellness activities but also encouraging their employees to take full advantage of their health benefits without fear of judgement or hesitation. When asked what leadership could do to shift the culture of health, one participant said:

> I have had two different bosses and one was much more supportive than the other. My first boss wouldn't approve my wellness time and gave me a ton more work right before I wanted to take it. My second boss encouraged us all to take the wellness time and said we needed the break. She was much more positive and we were all happier than the folks at my first job. She also would get mad at us if we were checking emails on vacation or when we were sick.

Participants in all seven focus groups had various examples of good and bad leadership support.

Promoting overall wellness. During the focus groups we discovered that very few participants knew about the wellness benefits and programs. Ideally, this information would

be disseminated to employees when they are hired and reinforced by their supervisors, yet participants spoke about how the benefits and programs could be promoted more effectively, as well as the need for promoting other forms of wellness besides physical and nutritional. For instance, one participant noted,

> I know emails go out but more needs to be done at meetings and beginning of the year events. I also have a hard time finding stuff on the website. Maybe it could be organized better and in one spot. If supervisors don't promote this stuff it needs to come from somewhere. And promote more than just the exercise classes.

The participants in all the focus groups provided many suggestions of both formal and informal promotional opportunities and how the training intervention could serve as a promotional opportunity for the WWP.

Equity. This theme represented the discrepancies in opportunities and differing viewpoints among supervisors related to the application of health policies and benefits. Many participants talked about how employees in certain departments are encouraged to take wellness time while others are told they are not allowed to use this benefit. One participant described how her boss refused to approve wellness, vacation and sick leave time during certain parts of the year,

> my boss sends us blackout dates for the year for when we are not allowed to take vacation or be sick or even take our wellness time. She says if the airlines can blackout holidays for frequent flyer miles I can for student registration and orientation.

Alternatively, other employees talked about supportive supervisors who often invited employees on a walk or to take their wellness time together. Thus, we observed major inconsistencies and inequities among the departments that were highly dependent on supervisors' interpretations of the wellness policies and benefits.

Guilt. In every focus group guilt emerged as a major factor for why people did not use their wellness time, sick leave and vacation days. Guilt was defined as the sense of judgement the participants perceived from supervisors or co-workers for focusing on wellness. One participant described the guilt she felt when she had her baby and was on maternity leave,

> I was so nervous about having my baby and felt so guilty for not being there to do the work. My co-workers complained openly before the baby was born about how much work they would have to do when I was gone. I was emailing between contractions and kept working the entire leave. I basically just worked from home for my maternity leave.

Other participants also spoke about co-workers rolling their eyes or saying comments under their breath when they would use their wellness benefits. One participant described his experience every time he came back from taking vacation or sick time, "every time I come back, I wait for the same two co\-workers to tell me how stressed they were while I was gone and how I owe them." This theme was the most prominent theme in all the focus groups.

Skepticism and mistrust. Participants in all seven focus groups were also skeptical that university administrators actually cared about their employees' health and felt these administrators did not trust the employees to use the wellness benefits appropriately. As one employee described, her supervisor's distrust of her led him to "ask me to tell him my exact jogging route so he could check from time to time if I was really jogging or just hiding and not doing my work." Participants also experienced mistrust of their supervisors based on these types of remarks. For instance, one participant described overhearing her supervisor on the phone, "I heard her say, 'stress, who isn't stressed? Sounds like a personal problem and they all just need to grow a set' so yeah, that doesn't make you feel great or trust anyone." The distrust between employees and supervisors/administrators was the second most prevalent theme from the focus groups.

Desire for community. When asked about changes they would like to see related to the culture of health, every focus group talked about ideas related to wanting to have a sense of community surrounding wellness. They described wanting to experience more supportive communication and encouragement. One participant described the walking group she and her coworkers created, "we started a walking group and I love the comradery ... We are happier and really, more productive." Another employee, who attended exercise classes provided by the university, said, "I find it really motivating to see the same people each week and getting excited for the progress we are making. I was terrible at first and my girls cheer me on, kickboxing can suck. It's nice to feel supported." The participants described what communication could also look like to help build community. One participant described how he wished his supervisor spoke to them, "she is so clinical. Even asking how my day is or providing me some resources when I am struggling would make me feel more a part of a community. I barely know who I work with." This theme played a major role in determining communicative components of the training program.

Conclusions

An overarching pattern emerged from study two that suggested employees at the case study institution were overworked and overstressed. Additionally, employee participation in the WWP, as well as the use of other HR benefits (e.g. maternity leave, sick leave, vacation days), seemed to be negatively affected by coworker and supervisor messages related to employees' absences and their effect on the office. Thus, after analyzing the data from studies one and two, the research team began working with human resources and the WWP leadership team to plan a university culture of health training intervention to address the aforementioned issues. Before creating the training, the research team completed a member check to ensure the themes resonated with other employees and were representative of their experiences. The research team presented the findings to a group of 41 student affairs employees at their annual symposium and asked for feedback. The themes were supported by all members, and these employees provided suggestions for the training after hearing about the results from the two studies.

Study three

The findings from studies one and two were integrated into a training intervention aimed at incrementally changing the culture of health at the university in which the case study occurred. The initial plan was to create and deliver an in-person training that would be taken over by the HR team through a train-the-trainer process. The research team started building the four-hour, in-person training in fall 2019 to pilot the training in January 2020. The in-person training was piloted with 22 housing and residential services employees. At the end of the training, participants provided feedback about the material, activities, and assessments. This feedback was integrated into the final training plans for in-person trainings that were scheduled to begin in March 2020. However, due to the COVID-19 pandemic, all in-person trainings were canceled, and the research team reassessed the culture of health training program in Summer (2020).

The research team, in conjunction with members of the HR and the WWP leadership teams, administered a second, mixed-method online survey to employees asking about how the pandemic impacted their perception of the culture of health at the university. These data were collected late Summer 2020 and were analyzed in Fall (2020) to determine how the training content should be adapted to account for the effects of the pandemic. At this time, the research team, the WWP leadership team and HR decided to move the training to a virtual, hybrid format that consisted of asynchronous pre-work through modules on the university's

learning management system and synchronous discussion and experiential application activities hosted via video conferencing technology. Though the training objectives did not change as a result of the most recent employee perception survey, the activities, delivery methods and examples used in the training were adjusted to meet the needs that emerged during the pandemic.

The data collected from the follow up survey showed that the results from studies one and two were intensified because of the pandemic, and there was a stronger focus in the data related to a lack of support from coworkers and supervisors and employee wellness. The adapted online hybrid culture of health training was released in January 2021. The research team facilitated the first four training intervention sessions to enable the HR team to observe and learn to continue offering the training sessions. HR took over the training in Fall (2021).

Training intervention

In response to the data collected through the various stages of research, the final online culture of health training focuses on three learning objectives: (1) demonstrate five forms of supportive communication to encourage co-worker wellness, (2) identify and correct disconfirming messages and behaviors and (3) confirm coworker and employee behaviors surrounding health and wellness. The training is designed to be completed in three hours: 1.5 h for the asynchronous pre-work modules and 1.5 h for the synchronous portion hosted via video conference (or eventually on campus).

Asynchronous pre-work modules. The asynchronous training is made up of four modules that were built and completed via the institution's learning management system and designed to prime the participants for the synchronous portion of the training. The four modules were devoted to clarifying the wellness policy for employees and supervisors, learning the types of supportive communication and the importance of each, identifying and avoiding the use of disconfirming messages in response to employee and coworker wellness leave and developing goals related to improvement. Each module consisted of short content videos created by three of the authors, discussion boards, case studies with questions, a role play video with questions and testimonials from past trainees and health and wellness program participants. Participants' responses from the asynchronous components of the training guide the discussions and activities during the synchronous portion.

Synchronous portion of training. The synchronous portion of the training currently takes place via video conference. During this portion, the trainers lead the participants through skill-based activities. All training materials, examples and hypothetical scenarios were crafted based on examples described in the focus groups in study two and the final employee perception survey from summer 2020. This synchronous component provides participants the opportunity to practice the communication skills described in the online modules and receive real time feedback from the trainers.

The synchronous training starts with introductions and talking through the examples provided by participants in the discussion boards from the online modules. After introductions, the first module focuses on supportive communication and practicing identifying and delivering supportive messages. The trainees work in groups to develop an email response to hypothetical questions and requests from a co-worker. Module two provides opportunities for participants to identify and correct disconfirming messages through a series of case studies, while the final module encourages participants to set goals related to their health and wellness and their use of supportive and confirming communication at work. While debriefing the exercises, the trainers encourage and correct participants and have them articulate how they will use the skills and knowledge in their work-lives moving forward.

Initial assessment of culture of health training intervention

Training participants. Forty-four employees (2 faculty; 42 staff) have participated in one of the four training sessions facilitated in the spring and summer of 2021. Eighteen of these training participants worked in university administration, while 16 identified as working in academic affairs and 9 identified as working in student affairs.

Post-training assessments. Readiness to change their supportive communication and disconfirming behaviors related to employee and coworker wellness was measured with five, Likert-type items, and response options were measured on a scale of *1 = Strongly Disagree* to *7 = Strongly Agree*. Sample items included, "I am trying to be more supportive and use messages that encourage my coworkers/employees to use wellness time," "I have just recently changed the way I show my coworkers/employees support by using messages that encourage and congratulate employees for using wellness time," and "I am actually changing the way I communicate support and use encouraging messages with my coworkers/employees regarding their wellness." The reliability estimate for the scale was deemed acceptable ($\alpha = 0.82$).

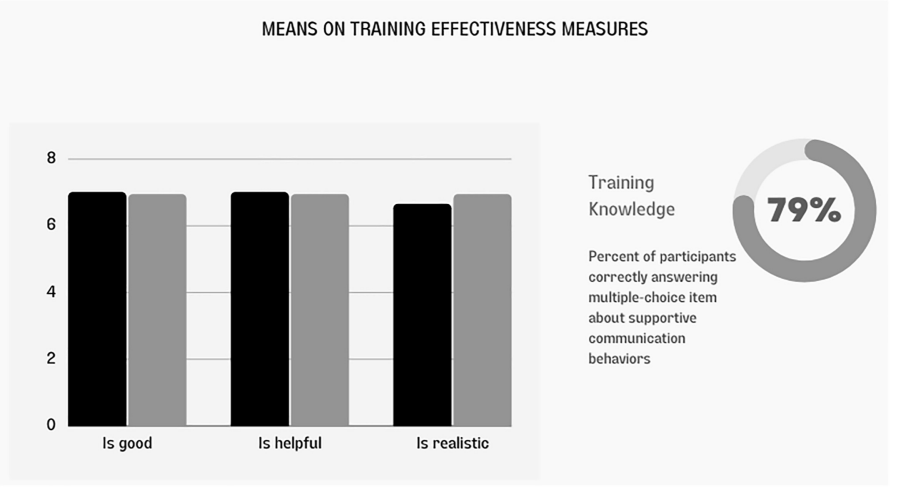
Knowledge of social support types was measured with one multiple-choice item asking participants to identify the five forms of support covered in the training. Knowledge of the wellness policy was measured with five multiple-choice items asking participants to identify the correct amount of wellness leave per week, the approved wellness activities, and to appropriately apply the wellness policy to various scenarios (developed from participant responses in studies one and two). Responses were coded with a 1 if the answer was correct and a 0 if the answer was incorrect. The reliability estimate for the knowledge of the wellness policy met disciplinary standards ($\alpha = 0.75$).

Training effectiveness was measured with six, semantic-differential items, and response options were measured on a scale of *1 = Strongly Disagree* to *7 = Strongly Agree*. Sample items included, "the content of this training was . . ." and "the behaviors recommended in this training were . . ." "bad-good," "helpful-unhelpful," and "unrealistic-realistic." Unfortunately, the reliability estimate for this measure suggests low internal consistency ($\alpha = 0.29$). Upon further investigation, the authors discovered that numerous items were removed from the analysis due to zero variance among the participant responses, leading to low internal consistency. Thus, we opted to report on the individual responses of each item as opposed to the scale as a whole in the following discussion of the preliminary assessment results.

Preliminary assessment results. We have currently facilitated four training sessions in which participants took part in the asynchronous and synchronous components of the culture of health training. Based on preliminary assessment results, the employees indicated that they are ready to change their supportive communication and disconfirming behaviors as a means of altering the culture of health at their institution ($M = 5.93$, $SD = 0.68$). Additionally, the participants also reported finding the training content and behaviors to be highly realistic, good and helpful (see Figure 5). Finally, participants were above average on their knowledge of the wellness policy ($M = 3.65$, $SD = 0.70$), and approximately 79% of the participants correctly answered the item identifying the types of support.

Discussion

The goal of the current study was to explore employee perceptions of one institution's culture of health in order to develop a needs-centered training intervention. Results based on an initial, large-scale quantitative survey demonstrated that employee perceptions varied in terms of how they perceived leadership support, peer support and touch points (e.g. institutional resources) as contributors to a culture of health at the case study site. A follow-up qualitative focus group



Source(s): Author's own creation/work

Figure 5.
Composite means for employee perceptions of initial training program effectiveness

study was conducted to further understand employees' varied experiences with the university's WWP and the overall culture of health. Based on the findings of both studies, we developed and evaluated a training intervention focused on incremental changes to the culture of health via employee and supervisor skills training in supportive communication and (dis)confirming communication as well as knowledge of the wellness policy. Preliminary assessment results of the training intervention suggest that employees and supervisors perceive the training to be effective, that they are ready to enact changes in their communicative behaviors, and that they gained knowledge about the wellness policy.

Taken together, this project provides support for the NCTM (Beebe *et al.*, 2021). We assert that prioritizing the understanding of employees' perceptions and experiences changed the nature of the training intervention we developed. For instance, prior to collecting data in studies one and two, the WWP leadership team assumed the primary problem related to employee awareness of and participation in the WWP on campus was the lack of knowledge regarding the wellness policy and benefits available to them. Thus, the original intent was to develop a training program focused solely on these components of the WWP.

Although this assumption proved to be partially true after surveying and talking with employees in focus groups, we also learned that a lack of supportive communication and the receipt of disconfirming messages from coworkers and supervisors discouraged employees from participating in the WWP. Previous studies focused on WWPs have reported similar results related to barriers and facilitators that exist to prevent and encourage employee participation in these programs (Dickson-Swift *et al.*, 2014; Hunter *et al.*, 2018; Leininger *et al.*, 2015). Our findings add a novel contribution to the scholarly conversation on WWPs by developing a training intervention to alter the organizational culture of health that ultimately leads to these barriers in the first place. This process is supported by additional extant research that the benefits of WWPs are limited if the organizational culture does not internalize the wellness values (Goetzel *et al.*, 2014). Consequently, we leveraged the knowledge gained from studies one and two to develop a training intervention aimed at incrementally changing the culture of health at the institution in the case study. This approach allowed us to be flexible during an uncertain and turbulent time and to address the changing needs of the employees during the novel coronavirus pandemic in real time. Given

that organizational change occurs incrementally through everyday conversations (McClellan, 2021) and that adaptive organizational cultures have better longevity and sustainability (Costanza *et al.*, 2016), the training intervention developed as part of this study is currently still being facilitated, and the university is continuing to learn about its effectiveness in facilitating this change in the culture of health that was driven by its employees' perspectives.

Limitations and future directions

The results of the current study provide evidence of the importance of integrating various longitudinal methods for assessing and enhancing employees' perceptions of the culture of health at an institution of higher education. However, these findings should be considered with the following limitations in mind. First, the demographic makeup of the samples from all three studies is homogenous in nature, and as a result, restricts the generalizability of the findings. Additionally, sample size in the third study limits the statistical power such that we were unable to analyze the data using more advanced analysis procedures. Consequently, future researchers should consider ways to incentivize participation in these research efforts to both diversify the study sample and to gather more data points to enhance explanatory and predictive power of the analyses. Given that participants in study three only completed post-test measures of the training's effectiveness, future research should implement a pretest-posttest design to gain a better understanding of how the training program increased employees' perceptions and changed employees' behaviors; this will provide additional validity of the claims of the training program's effectiveness. Finally, we relied exclusively on self-report data in the current study; future scholars should consider adding more objective measures that may be indicators of the change in employees' behaviors related to the culture of health via attendance markers at WWP events, for instance.

Although the current study enacted a case study approach to the investigation of this university's culture of health, the findings are likely applicable to other organizations. For instance, leaders from organizations within varying industries might consider adopting such a comprehensive approach to the NCTM to assess the culture of health within their organization. Industries that have been facing challenging landscapes in terms of employee wellness (e.g. education, healthcare, restaurant/hospitality) in the wake of the COVID-19 pandemic may be particularly interested in both conducting an immersive needs assessment of their organization's current culture of health as well as developing trainings to help improve that culture. Additionally, based on the results of the current study, we identified several best practices that other universities and organizations could consider when trying to implement changes to their culture of health.

Best practices

The research team has organized these training best practices around four themes: (1) focus on employee needs, (2) use training to advocate for employees, (3) build community through training and (4) use training to change the environment.

Focus on employee needs. The needs of employees cannot be assumed and must guide every step of the training process. The experience the research team had with this study demonstrates the impact the needs-centered model can have on organizational change. The WWP made assumptions about employee needs that were not accurate and realized the disconnect after collecting data from study one and two, which served as a comprehensive needs assessment for the culture of health training intervention. Simply assessing the employees' needs resulted in many staff members articulating they finally felt heard and were hopeful for change. Additionally, the data collected in the needs assessment served as real examples as we developed the training content. When decision makers are aware of employees' needs, they can better tailor their plans, communication and programs and

mitigate some mistrust. However, it is important to note that simply assessing needs is not enough, action must be taken.

Leverage training to advocate for employees. The needs assessment revealed many underlying concerns and trust issues employees had with supervisors within the organization. At the macro-level, the research team was able to use the results to advocate for changes that would improve the culture of health for faculty and staff alike. Having empirical evidence and providing a clear plan on how to positively impact the culture of health was persuasive to administrators. At the micro level, the skills taught in the training prepared and empowered employees to advocate for themselves and co-workers in regard to health and wellness policies and benefits. Providing needs-based instructional intervention is a form of employee advocacy that is often forgotten (Thelen, 2021).

Build community through training. The most rewarding part of this study was the cultivation of community focused on health and wellness. Employees who participated in study two and in the training connected with others who were interested in wellness and found support among their peers across campus. The training also provided suggestions for how the participants could build community using the skills they learned in the training. Trainings can serve as meeting point for like-minded people and also as a tool to teach skills associated with improving community-building (Black, 2005).

Use training to change organizational culture. Changing organizational culture and environment takes time and requires communication skills. Cultures and environments are built, maintained and changed through communicative acts (McClellan, 2021). Trainings can serve as a catalyst for organizational change because they use the needs of the employees who are working in that environment as the guiding principles of change. Trainings also serve as a safe environment to develop skills. Many employees may not be as skilled at communication as others and working on improving their abilities requires vulnerability. When training is part of the organization's culture, a safe and productive learning environment is created and embraced, which opens the door for both organizational and professional development.

Conclusion

Guided by the needs-centered model of training (Beebe *et al.*, 2021), the current study provides formative research findings related to employees' perceptions related to the culture of health at one institution of higher education. The findings from the current study informed the development of a training intervention focused on supportive and disconfirming communication with the aim of incrementally improving the culture of health at the case study site. Given the importance of the culture of health to the success of WWPs (Goetzel *et al.*, 2014), future scholars and practitioners should continue to center employees' needs as a means of understanding what specific factors might contribute to a culture of health. Additionally, future researchers should continue to investigate the effectiveness of training interventions in incrementally improving the culture of health for employees.

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