Participatory organisational interventions aim to improve working conditions and employee well-being through changing the way work is organised, designed and managed, and employees and managers jointly develop and implement the changes to work practices and procedures (Nielsen & Noblet, 2018). Although this type of interventions is generally recommended as they address the sources of poor well-being, i.e. working conditions (ILO, 2001; EU-OSHA, 2010), reviews have found inconsistent effects (Richardson & Rothstein, 2010). It has been argued that a one size fits all and a lack of understanding of the context and the implementation processes may be one part of the explanation as to why these interventions do not always achieve their intended outcomes (Nielsen & Miraglia, 2017; Nielsen & Noblet, 2018). Interventions are implemented in many different national and occupational context and it is important to understand how interventions can be fitted to the organizational context in order to develop an intervention process that takes into account the characteristics of the organization. When considering the characteristics of the organizational context it is important to understand the national context and the specific organizational context, i.e. whether we are trying to improve the characteristics of low-wage workers or university staff. This type of interventions relies on participants changing their behaviours and accepting the behaviour change of others and we need to understand how we can motivate and equip participants to change their behaviours and the behaviours of others.

In the present symposium, we present three different examples of intervention-person fit. We focus on how lie managers and safety representatives experience the intervention process and specifically focus on how we may optimize the fit between the intervention and the skills and competencies of drivers of change: In the second presentation the focus is on ordinary employees as change agents and in the second presentation, the focus is on line managers as change agents. Our first presenter will present the results of a study in the Norwegian context. The study takes place among university staff and although such staff have high time pressures their flexibility for engaging in intervention activities are greater. The intervention was developed to fulfil Norwegian legislation on psychosocial risk management. Key drivers of change are line managers and safety representatives, who in Norway play a key role in psychosocial risk management included a strong role of safety representatives in the intervention process. Line managers and safety representatives were interviewed about the process and we will learn about their experiences with the intervention process. In an extension of the third presentation focusing on the drivers of change, the next two presentations focus on the drivers of change.

The second presentation will focus on the implementation of an eHealth system in a Swedish hospital trust. In Sweden, ordinary workers are often tasked with the role of change agents. In this case, workers were trained in the role of change agents. The study explores the impact of a good perceived fit to the role, i.e. the impact of change agents' own well-being depending on whether they feel they have the required competencies to fulfil the role of change agent. In our third presentation, the presenter will introduce us to a Danish intervention. In a biotech company, Lean management was introduced to improve productivity. Lean management methods can both have positive and negative impacts on worker well-being and in the present study, line managers, who had been identified as key drivers of change were trained in implementing the change. The training methods were dialogue tools and board games and we will learn whether Lean was implemented according to plan and whether training helped protect worker well-being.

Independence Ballroom CD

Total Worker Health in Small Businesses

PAPER SESSION

Evaluation of a small business Total Worker Health leadership program

Natalie Schwatka (University of Colorado Denver)

Introduction. Leadership is a critical component of how a business develops and implements Total Worker Health¬ (TWH) policies, programs, and practices. Business leaders are positioned to develop and communicate their vision for TWH and allocate resources. Ultimately, they are responsible for ensuring that business practices align with their vision. This is important, because several meta-analyses demonstrate that leadership is associated with several health, safety, and well-being outcomes. However, workplace health and safety leadership intervention research is in its infancy and few intervention studies exist.

This presentation will describe a small business TWH leadership development and evaluation study and discuss preliminary results. In the context of small business, our research shows that senior leaders play a pivotal role in influencing TWH policies, programs, and practices, but they lack key skills to be successful TWH leaders. It is important to develop TWH leadership training in the small business context because smaller firms have fewer TWH policies and programs, and their employees are at risk for poor health and safety outcomes. The aim of our study is to evaluate the following hypotheses:

Hypothesis1: Leaders improve their TWH leadership practices from before to after the TWH leadership program.

Hypothesis2: Leaders meet their TWH leadership goals after participating in the TWH leadership program.

Hypothesis3: H1 & H2 relationships are moderated by leaders' readiness for change before the TWH leadership program such that leaders higher in readiness for change will observe greater improvements than leaders who are lower on readiness for change.

Methods. We developed the TWH leadership program as part of the Small+Safe+Well (SSWell). We are actively recruiting small businesses (<500 employees) from a variety of industries to participate. This presentation will describe the TWH leadership program including training components, evaluation methods, and preliminary results. Results from the larger SSWell study will not be discussed.

Program components. One owner/senior manager representing a unique small business was invited to participate in the TWH leadership program. They were able to bring one other individual from their organization (e.g., safety/wellness coordinator) if they wished. The 10-hour program was spread out over four months and included in-person and virtual components. First, leaders reviewed and reflected on TWH business- and employee-level TWH assessment results. Second, leaders participated in a 6-hour in-person training session with a small (~15-20) cohort of other small business leaders where they set at least three goals to work on over the next three months. Finally, for three months, leaders participated in an online, social goal-setting platform and three virtual, one-on-one coaching sessions.

Measures. We are evaluating the program using pre-post survey data, website use data from the goal setting platform, and post-program qualitative interviews. Before the in-person training, leaders

completed a survey containing questions about their TWH leadership practices (developed by researchers) and change readiness– stage, need, efficacy, and personal valence of change and training instrumentality and motivation (developed by other researchers). After they finished participating in the goal-setting platform and coaching sessions, they were asked about their TWH leadership practices in a survey. We also collected goal success information from the online goal-setting platform. Finally, after completing the program, we interviewed each leader 1) to understand their reactions to the program and 2) to learn about the ways in which they have changed their business's TWH practices and culture as well as their own health.

Analysis. We will use linear mixed modeling with a random intercept for leader to compare self-reported TWH leadership practice responses from before to after the program (H1). We will evaluate change readiness as a moderator of this change by including it in the model as a covariate and as an interaction with time (H3). Goal attainment (H2) will be evaluated by calculating the percent of successful goals completed within the goal-setting platform. All qualitative interviews will be content analyzed by two researchers to determine themes in leaders' responses to each of our questions.

Results. As of January 2018, we completed two cohorts of leaders and will complete two more cohorts by Summer 2019. In total, we expect to be able to share results from 47 leaders from 30 organizations. The organizations represent service (50%), public administration (17%), and retail (10%) industries and 20% of them are from rural communities. The businesses have on average 45 employees (Range=4-430). Results will be available to present by the time of the conference.

Conclusions/practical implications. Our study contributes to the TWH literature in several ways. First, it describes the first TWH leadership program evaluated in the empirical literature. Second, it focuses on underserved workplaces– small business. Third, we will be able to put our findings into context by evaluating leaders' readiness for change. In future research we plan to evaluate how the TWH leadership program impacts business and employee outcomes such as changes to TWH adoption and implementation, employee morale, retention, and health/safety.

Introducing Total Worker Health to Small Businesses: A Community-based Approach

Brenda Jacklitsch (CDC/NIOSH)

PROBLEM STATEMENT: Small businesses deliver fewer workplace health promotion and occupational safety and health activities than larger businesses [Linnan et al. 2008; Sims 2008], need more external assistance with integrated safety and employee health programs such as Total Worker Health [Newman et al, 2015], and endure a higher burden of occupational injuries and illnesses [Mendeloff et al. 2006]. Business size has also been shown to be one of the best predictors of a small business's involvement with workplace health promotion and safety activities [Linnan et al. 2008; Sinclair and Cunningham 2014]. Many factors, such as these, affect small businesses' lack of motivation to engage in prevention: lack of resources, isolation, low probability of inspection, and inaccurate perceptions of illness and injury rates [De Kok 2005; Hasle and Limborg 2006; Lentz and Wenzl 2006; Parker et al. 2007; Sinclair and Cunningham 2014].

Procedures. This study targeted two communities, Northern Kentucky and Greater Cincinnati. The goals of this study were (1) to understand perceptions of the cost and benefits of TWH approaches among small business owners/operators and employees; (2) to understand perceptions of TWH among community organizations that serve small businesses; and (3) to explore methods for encouraging use of TWH approaches by small businesses. Study steps included: (1) identifying and recruiting intermediaries, (2) deciding the best approach through discussions with the intermediaries, (3) small business recruitment and baseline interviews with the owner or manager, (4) engaging with small businesses via consultations and provided TWH-like services, (5) using exit interviews to determine small business reactions to TWH, and (6) asking intermediaries to reflect on the experience during a final debriefing.

Analyses. All interviews were recorded and transcribed. The transcribed interviews were analyzed by an inductive approach with thematic coding and a subsequent iterative process for further clarification of themes [Braun 2006; Gale et al. 2013]. First, the team independently reviewed the transcripts and then together reached consensus on important themes. Second, the team systematically coded interesting features, direct quotations, and patterns across the data set, reviewing coding differences until consensus was reached. Third, the data were reviewed, grouped, and collated into potential themes. Fourth, the team used the constant comparison method to examine and refine the themes by comparing and contrasting information within each interview and across all the interviews and focus groups [Boeije 2002; Corbin and Strauss and Corbin 2014]. Finally, the team conducted ongoing analysis to refine each theme and condense into a cohesive narrative.

Results. Small businesses in 3 Cincinnati communities and 4 Northern Kentucky sectors (i.e., construction, childcare, manufacturing, municipalities) participated, resulting in a total of 49 baseline interviews, 3 focus groups (Cincinnati only), and 26 exit interviews. Drivers to TWH varied from employers realizing the value of prevention to feeling that wellness and safety were the "right thing to do." Employers described barriers to TWH that included lacking knowledge, financial resources, time, interest; and some viewed wellness as an individual's responsibility. Participants' responses involved various themes, including: available resources (e.g., lack awareness and accessibility, matching needs, affordability), safety and wellness concerns (e.g., stress/mental health/burnout, community safety, unhealthy habits, health insurance cost, overall health), challenges implementing wellness initiatives (e.g., budget, time, staff interest, lack of leadership, employee privacy), and crossover combination safety and wellness (e.g., makes sense, too jumbled). Study participants described some of the outcomes and benefits, including: healthy/happy employees, productive/energized employees, business benefits, feeling valued, better teamwork, and a safer work environment. Participants also were asked about what they planned to do about TWH moving forward and themes included: individual responsibility, doing small things, motivation, and very specific ideas. During the final focus group with intermediaries, small business employers were described as caring for their employees and being receptive to the idea of TWH. Intermediaries felt that wellness was harder to sell than safety and therefore needs to be framed as a business proposition, a benefit to the company's bottom line, and needs to be tailored to the individual business. Another issue reported by intermediaries was that most small businesses lack resources or organizational structures to sustain TWH.

PRACTICAL implications. This study demonstrated how intermediaries and a variety of small businesses perceived TWH and interacted with each other when implementing TWH practices. Similar drivers, barriers, and themes might be expected in non-research settings,

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