The following papers, published between 2006 and 2015, describe research on workplace health promotion by the University of Washington Health Promotion Research Center (HPRC). Each paper is summarized briefly. HPRC is a CDC Prevention Research Center.

For PDF versions of any of these papers, please email khammerb@uw.edu

In Press

   An organization’s readiness for change is linked to positive implementation outcomes. The authors developed and pilot-tested a workplace readiness questionnaire appropriate for small workplaces considering offering workplace wellness programs, based on Weiner’s theory of organizational readiness to change. The final instrument has 30 items and can be administered in 5-10 minutes; each of the subscales was significantly associated with implementation of evidence-based wellness practices in the pilot-test.

   The goal of this pilot study was to evaluate a low-intensity, evidence-based approach to increasing adult influenza vaccination among restaurant employees. The study team recruited 11 Seattle-area restaurants and assisted them to arrange and promote free onsite-vaccination events. Employees’ vaccination rates increased from 26% at baseline to 46% at follow-up. The intervention was equally effective for English- and Spanish-speaking employees; there were significant differences in vaccination increases among restaurants.

2015

   Restaurant employees are under-studied, yet direct contact with customers means they are at elevated risk for contracting and spreading influenza. Restaurant employees (n=428) were surveyed on influenza vaccination status and attitudes toward influenza vaccination. Although attitudes toward influenza vaccination were more favorable among Hispanics than non-Hispanic Whites, restaurant employees of both ethnicities were positive toward receiving influenza vaccinations at the workplace.

Washington state employees (n=3,528) from six state agencies were surveyed about productivity and perceived workplace support for healthy living and physical activity. Higher perceived workplace support for healthy living and physical activity was associated with lower presenteeism (impaired work performance due to illness). Wellness programs may increase productivity through their positive effects on employee perceptions of workplace health support.

2014


Semi-structured interviews were conducted with 42 couples in which one or both members worked in a low-wage industry. Goals were to understand behaviors and attitudes around workplace health promotion, and to determine the potential for extending it to spouses/partners. Employees and their partners viewed workplace health promotion as appropriate and appealing, especially programs addressing healthy eating and physical activity, but were skeptical that employers would ever offer robust workplace health promotion at their worksites.


To explore attitudes toward group purchasing of workplace health promotion services for small employers (<250 employees), including barriers and facilitators, semi-structured telephone interviews were conducted with 11 employer-member organizations and 11 wellness vendors. Employer-member organizations were well positioned to group purchase workplace health promotion services, though few of them perceived member demand to do so, and vendors were receptive if they perceived potential profit.


Relatively little is known about how large employers (1,000+ employees) promote onsite vaccination programs. Large U.S. employers (n=583) representing a range of industries were surveyed by phone about their use of evidence-based practices to promote vaccination. Practices assessed included physical access, financial access, communication, norms, and mandates. Among the 84% of employers who offer onsite vaccination, use of evidence-based promotion practices was high. The most common practice increased physical and financial access by offering onsite vaccination for free.

This review article summarized knowledge of health promotion in smaller workplaces (<1,000 employees), which comprise 99% of U.S. workplaces and employ half of working adults. Compared to larger workplaces, they were less likely to offer health insurance or health promotion programs even while their employees are more likely to earn low wages and engage in risky health behaviors. Barriers to health promotion at small workplaces included cost, lack of executive commitment, and low internal capacity for program delivery. Research priorities include developing programs feasible for smaller workplaces, particularly those that employ fewer than 20 employees.

2012


A practical framework to assist in wider implementation of evidence-based health promotion practices is introduced and described by the authors who developed it. The main elements are: 1) a close partnership between researchers and a disseminating organization that takes ownership of the dissemination process, and 2) use of social marketing principles to work closely with potential user organizations. The authors presented two examples illustrating the framework, and discussed seven practical roles that researchers play in dissemination and related research. This paper won the 2012 RE-AIM Conceptual Paper of the Year award.


Five focus groups with human resources managers at midsized employers in low-wage industries addressed workplace health promotion appropriateness, implementation, and capacity. Although most employers viewed workplace health promotion as appropriate, many were concerned about being perceived as intrusive in their employees’ private lives. Barriers to offering workplace health promotion included cost, time, logistical challenges, and an unsupportive culture. Facilitators were turnkey approaches and partnership with nonprofit agencies such as the American Cancer Society.


A survey of 279 mid-sized employers (100–4,999 employees) across five industries assessed current workplace health promotion offerings, barriers, and facilitators. While employers saw clear benefits to workplace health promotion for both employees and their partners, implementation was low, and many expressed doubt about the feasibility of offering comprehensive workplace health promotion at their worksites. Employers can increase implementation success by devoting more resources, including money and staff time.

The goal of this randomized controlled trial was to adapt the American Cancer Society’s Workplace Solutions (WPS) program for midsized employers (100-999 employees) and test its efficacy. Employers participating in WPS increased their use of evidence-based health-related policies and communications but did not change insurance benefits design, programs, or tracking. Major barriers were the inability of these employers to modify insurance benefits and the time and cost of implementing the evidence-based practices.


The American Cancer Society’s HealthLinks program is an intervention for small workplaces that targets physical activity, healthy eating, tobacco, and cancer screening. The authors assessed implementation of evidence-based practices related to program, policy, and communication in 23 workplaces in a rural community at baseline and six months. There was a significant increase in implementation of evidence-based practices and high satisfaction with the program, suggesting that HealthLinks is an effective program for small workplaces with limited resources.

2011


Twenty-four small-to-midsized employers were interviewed to better understand the decision-making process for implementing and continuing health promotion programs. The aim was to help health promotion practitioners and researchers better market their services to businesses of these sizes. Employers depended on company success-related factors and cost-effectiveness when deciding whether to adopt workplace health promotion programs.


Effective tobacco cessation interventions in workplaces can improve workforce health and reduce healthcare expenses and absenteeism. Analysis of the 2008 Healthy Worksite Survey described current tobacco cessation practices implemented by Washington State employers with 50 or more employees. Few employers helped smokers connect to evidence-based, cost-effective tobacco cessation practices. Missed opportunities included promoting the state-sponsored tobacco cessation quitline, a proven approach to helping employees quit smoking.
Most employers contract with external organizations (community vaccinators) to provide workplace vaccination. Twelve national and local community vaccinators were interviewed about their experiences with workplace vaccination, business practices, barriers encountered, and delivery of other adult vaccines. Vaccinators consistently identified workers’ reluctance and out-of-pocket costs, and poor publicizing of workplace vaccination events, as remediable barriers to vaccination.

Using data from the Behavioral Risk Factor Surveillance System (BRFSS), the authors assess the independent effects of household income and educational attainment on health outcomes. Low household income (less than $35,000 per year) and low educational status (high school education or less) were strong predictors of chronic diseases, low health status, and poor-health days. Expanded health insurance and targeted health promotion programs in workplaces could substantially decrease disparities in chronic diseases and their associated productivity losses.

Data on employed adults (ages 18-64 years) from the Behavioral Risk Factor Surveillance System (BRFSS) were analyzed to provide employers and other workplace health promotion practitioners with state-specific prevalence data for obesity, physical inactivity, smoking, and missed influenza vaccination. Results showed significant differences across states and significant disparities related to social determinants of health — income, education, and race/ethnicity. These data can help inform workplace health promotion programs trying to reach underserved employee populations.

2010

Analysis of 2004-5 data from the Behavioral Risk Factor Surveillance System (BRFSS) indicated that many employed adults (age 18-64) with health insurance do not obtain clinical preventive services or engage in healthy lifestyle behaviors. Lower income, lower education, cost barriers, and lack of health care provider were associated with higher lifestyle-related risks and lower use of clinical preventive services. Employers and insurers should consider both overall poor health behaviors and disparities when designing insurance benefits and workplace health promotion.

Case studies from three CDC Prevention Research Centers (PRCs) conveyed the challenges and benefits of building public-private alliances to advance public health initiatives, including those implemented in a workplace setting. Challenges included navigating differences among academic institutions, public health organizations, and businesses in identity, values, ethics, operating principles, and expectations. However, each entity contributed unique attributes that created mutually beneficial alliances, which maximized resources and improved outcomes for the target population.


Although there are many effective interventions applicable to the workplace, they are underused. This paper outlined a five-stage public health approach to preventing chronic diseases in Washington State via the workplace that involves defining the problem, elucidating risk factors/behaviors, identifying effective interventions, implementing suitable interventions, and evaluating effectiveness. Implementation of this approach may help mitigate the effect of chronic diseases on employee productivity and decrease healthcare costs.


The American Cancer Society’s Workplace Solutions intervention, which draws heavily on the Guide to Community Preventive Services for evidence-based practices that prevent chronic diseases among employees, was pilot-tested with eight large (7,500+ employees) employers. Results from the pilot showed a significant increase in implementation of evidence-based practices aimed at preventing chronic diseases. Further testing is needed, but Workplace Solutions appears to offer large employers an approach to improving employee health that is both low-cost and effective.


The Guide to Community Preventive Services (the Community Guide) provides a range of evidence-based intervention strategies to improve cancer screening, but limited resources exist on how to apply these strategies to specific settings. This commentary offered guidance on implementing the Community Guide’s recent cancer screening recommendations in the workplace via health insurance benefits, and workplace policies, programs, and communications. Also discussed was the authors’ partnership with the American Cancer Society to test Workplace Solutions, a workplace intervention that includes the cancer screening strategies recommended by the Community Guide.
A comprehensive weight management program delivered to 516 overweight or obese employees at three Fortune 500 companies improved both physical health (decreased body weight, waist circumference, and blood pressure) and mental health (decreased depression and increased self-esteem). Studies among subgroups showed maintenance of weight loss and a decreased use of prescription drugs.

The American Cancer Society’s signature group physical activity program, Active for Life, was implemented and evaluated in a worksite setting to determine its long-term impact on physical activity. Participants increased physical activity by the end of the 10-week intervention, but these higher levels were not sustained over time. Recommendations for future interventions include extending the length of or repeating the program, and providing larger economic incentives.

The National Survey of Employer-Sponsored Health Plans provides data on clinical preventive services coverage by health plan type and employer size. Analysis on data from 2001 showed that the 2,180 participating employers covered a range of clinical preventive services in their health insurance and worksite benefits, but not all had both high impact and value. Those that did included tobacco cessation services, alcohol problem prevention, and influenza vaccination.