Published in final edited form as:
Am J Health Promot. 2012 ; 27(2): 103–110. doi:10.4278/ajhp.110204-QUAL-51.

Stakeholder Perspectives on Workplace Health Promotion: A Qualitative Study of Midsized Employers in Low-Wage Industries

Peggy A. Hannon, PhD, MPH, **Kristen Hammerback, MA**, **Gayle Garson, EdD**, **Jeffrey R. Harris, MD, MPH, MBA**, and **Carrie J. Sopher, MPH**
Health Promotion Research Center, Department of Health Services, School of Public Health, University of Washington, Seattle, Washington

Abstract

Purpose—Study goals were to (1) describe stakeholder perceptions of workplace health promotion (WHP) appropriateness, (2) describe barriers and facilitators to implementing WHP, (3) learn the extent to which WHP programs are offered to workers' spouses and partners and assess attitudes toward including partners in WHP programs, and (4) describe willingness to collaborate with nonprofit agencies to offer WHP.

Design—Five 1.5-hour focus groups.

Setting—The focus groups were conducted with representatives of midsized (100–999 workers) workplaces in the Seattle metropolitan area, Washington state.

Subjects—Thirty-four human resources professionals in charge of WHP programs and policies from five low-wage industries: accommodation/food services, manufacturing, health care/social assistance, education, and retail trade.

Measures—A semistructured discussion guide.

Analysis—Qualitative analysis of focus group transcripts using grounded theory to identify themes.

Results—Most participants viewed WHP as appropriate, but many expressed reservations about intruding in workers' personal lives. Barriers to implementing WHP included cost, time, logistical challenges, and unsupportive culture. Participants saw value in extending WHP programs to workers' partners, but were unsure how to do so. Most were willing to work with nonprofit agencies to offer WHP.

Conclusion—Midsized, low-wage employers face significant barriers to implementing WHP; to reach these employers and their workers, nonprofit agencies and WHP vendors need to offer WHP programs that are inexpensive, turnkey, and easy to adapt.

Keywords

Workplace; Fitness/Physical Activity; Nutrition; Smoking Control; Adults; Skill Building/ Behavior Change; Health Promotion; Prevention Research; Manuscript format: research; Research

Send reprint requests to Peggy A. Hannon, PhD, MPH, Health Promotion Research Center, Department of Health Services, School of Public Health, University of Washington, 1107 NE 45th Street, Suite 200, Seattle, WA 98105; peggyh@uw.edu.

purpose: descriptive; Study design: qualitative; Outcome measure: behavioral; Setting: workplace; Health focus: fitness/physical activity; nutrition; smoking control; weight control; Strategy: skill building/behavior change; policy; culture change; Target population age: adults; Target population circumstances: education/income level

PURPOSE

Workplace health promotion (WHP) programs have the potential to reach most working-age adults in the United States and improve their health behavior. The *Guide to Community Preventive Services* recommends several workplace interventions to promote health, including on-site access to free influenza vaccinations, smoke-free tobacco policies, and weight control programs.[1–5] The *Guide* also recommends providing access to telephone support and reducing costs of medications to increase tobacco cessation, expanding access to physical activity resources to increase physical activity, and using client reminders and small media to promote breast, cervical, and colorectal cancer screening.[6–8] Multiple studies found that *Guide*-recommended intervention strategies significantly improved the targeted health behavior.[1]

Despite the potential reach and power of WHP, implementation varies significantly across workplaces. The workplaces most likely to offer WHP have more than 1000 workers.[9,10] Most comprehensive WHP programs evaluated in the literature were implemented in large or white-collar workplaces,[11–14] although several WHP programs have targeted small or blue-collar workplaces.[15–18] Midsized employers (with 100–999 workers) are a relatively underexplored audience, but an important one. Midsized employers employ nearly 20% of United States workers, and most offer workers health insurance[19] and more WHP than small employers (but still offer less than large employers[20]).

Low-wage workers (those with annual household incomes <$35,000) have higher health risk behaviors than workers with higher incomes,[19,21] and these differences persist even when looking only at insured workers.[22] Blue-collar employers can successfully implement WHP programs,[16,17,23,24] and their workers are receptive.[15,18,25–27] Employer surveys present WHP implementation by employer size[9,10,28,29] but not by industry or average wage, making it difficult to gauge low-wage industries' WHP implementation.

The present study was designed to address the gaps in the literature described above and to better understand how to improve WHP implementation among midsized employers with low-wage workers. Research questions included whether employers perceive WHP as appropriate for employers to offer, the barriers and facilitators they encounter in offering WHP, and whether these employers are willing to offer WHP to workers' spouses and domestic partners (hereafter referred to as partners). Few WHP studies mention workers' partners, yet making WHP programs and resources available to partners could increase WHP effectiveness and reach at a relatively low cost. The final research question was whether these employers are willing to collaborate with nonprofit agencies to implement WHP. Some health-related nonprofits offer WHP programs to employers for free or at low cost; such programs may be one of the most viable ways for an employer with limited resources to offer WHP.

To address these questions, we used a qualitative approach rather than a survey. With the exception of one study,[30] there is limited qualitative research exploring these questions with midsized employers. A qualitative approach provides the opportunity to collect very rich data about these employers' attitudes and experiences with WHP.

APPROACH

The research team conducted five focus groups with human resources professionals representing midsized, low-wage employers in the Seattle metropolitan area. Focus groups are well suited to investigating phenomena that are relatively undefined. Successive groups allow for an evolving understanding of the nuances of a research question, leading to findings that inform intervention development and quantitative survey studies.

At the outset of each focus group, the moderator asked participants to respond to questions and engage in discussion based on the positions, policies, and norms of their employer organizations rather than their personal attitudes. Participants expressed comfort with acting as representatives of their organizations, and discussions centered on the employer's positions about WHP. Therefore, when describing results, the primary unit of analysis referred to is "employer" rather than "human resources professional" in order to indicate that participants' comments reflected the views of their chief executive officers and the norms and practices at their workplace in addition to their own experiences.

The Institutional Review Board at the University of Washington reviewed the study materials and protocol. The research team followed the guidelines of the consolidated criteria for reporting qualitative research for this manuscript.[31]

SETTING

Focus groups were conducted at a commercial focus group facility located in Seattle, Washington.

PARTICIPANTS

The research team recruited group participants by telephone from a list (purchased from Survey Sampling International) of companies employing between 100 and 999 workers in five industries (accommodation/food services, manufacturing, health care/social assistance, education, and retail trade). Among low-wage industries (mean salaries <$45,000), these five employ the most U.S. workers.[32] Additional participants were recruited from companies that participated in the research team's previous intervention study, which included the transportation industry. Participants were eligible if they were based at company headquarters and held responsibility for WHP.

The researchers offered participants dinner before the focus group session and $50 as incentives to participate. The first four focus groups were small (four to eight participants each) and had more participants from education and health care/social assistance than the other industries. The researchers changed the recruitment procedures for the final group to address this disparity and assure that the other industries were adequately represented. First,

focus group facility staff members recruited the last group, contacting only companies in the underrepresented industries. Second, the incentive was increased to $125. The final focus group included 12 participants from companies in accommodation/food, manufacturing, and retail trade. Table 1 presents participant characteristics.

METHOD

Discussion Guide

The researchers developed a discussion guide containing questions and probes to elicit comments and conversation around the four core research interests: (1) perceptions of WHP appropriateness; (2) WHP implementation challenges and facilitators; (3) extending WHP programs to workers' partners; and (4) willingness to offer WHP in collaboration with nonprofit agencies. These topics were chosen based on the lack of current research findings describing how midsized employers in low-wage industries think about, develop, and deliver WHP policies and programs for workers and their partners.

One team member (K.H.) wrote an initial draft of the guide, which was then reviewed by the research team. After multiple rounds of review, modifications, and two mock focus group sessions, the team approved the final instrument. The researchers made small adjustments to the guide midway through the data collection period, but the four primary categories of questions provided the discussion structure in all five groups.

Data Collection

The researchers conducted the focus groups between November 2009 and March 2010. One member of the research team (K.H.) moderated the sessions, with other team members observing and taking notes from behind a two-way mirror. The research team chose the moderator based on her previous experience moderating focus groups combined with her relative lack of familiarity with WHP research (she had less potential to be biased about the potential merits of WHP than other team members). Each participant provided written consent prior to the session. During consent, a researcher informed participants that the goal of the session was to better understand employers' WHP attitudes and behaviors. In opening remarks, the moderator encouraged participants to be frank about the views of their employers, noting that she was there to learn from them, "the experts." To minimize the potential for socially desirable responses, the moderator avoided making remarks that could be construed as either promoting or disparaging WHP. Each session lasted 90 minutes, with a short break midway through.

The research team met briefly after each focus group to review key findings that emerged during the session and identify any new issues that needed to be addressed in subsequent sessions. Following the final group, the research team met and determined that no new information was emerging and that further focus groups were not needed.

Data Analysis

Focus group sessions were audiotaped and transcribed verbatim, with identifying information deleted, by a commercial transcriptionist. A research team member present at

the sessions verified each transcript. Transcripts were imported into Atlas.ti, a software package for analyzing qualitative data.

A member of the research team trained in developing coding structures (K.H.) then systematically reviewed each transcript to derive and classify themes and subthemes. She used a grounded theory approach to expand and organize the codes through an iterative review process that included the research team. A comparative process of back-and-forth review continued until a final coding structure emerged (the coding structure is available from the authors on request). Themes and subthemes that emerged in multiple groups and were expressed by a diversity of participants across industry groups were emphasized.

Four team members (G.G., K.H., P.A.H., and C.J.S.) jointly coded the first transcript to ensure agreement and consistency in how individual codes were understood and applied, after which the codebook received further edits. Coding was done at the level of phrase and sentence. The research team split into teams of two to code the four remaining transcripts. The two coding pairs communicated often, allowing for consensus on difficult coding decisions and, when necessary, the creation of a new code, category, or subcategory. After coding the data, the research team met with a consultant with expertise in qualitative research for advice on the analysis and to minimize the potential for bias in interpreting the results. The consultant reviewed the transcripts and coding structure, advised the research team on their analytic approach, and reviewed the analyzed data to ensure that the research team's interpretation of key findings was consistent with her review of the original transcripts.

Findings are presented based on recurring themes. The research team emphasized the nature of a finding over its number of occurrences within or across groups. In the "Results" section, presented quotes typify the themes for which general agreement existed among group members (Table 2 presents a summary of the themes).

RESULTS

Midsized Employers' Perceptions of WHP Appropriateness

Participants generally agreed that worker health was important; in this sense, they saw WHP as both important and appropriate. Four themes emerged.

Health Care Cost Containment Strategy—Almost all participants saw WHP as a strategy to contain their health care costs. Most participants offered insurance to at least some of their workers, and rising health care costs were a near-universal concern.

> "…my guess is that everybody's health care costs are going up at a rapid pace."

> "Wellness is part of being able to afford a health plan going forward."

Improve Morale and Productivity—Employers saw WHP as potentially improving workers' morale and productivity.

> "You want them to feel well; you want them to be productive, and you want them to be at work…"

> "…a lot of the wellness stuff has to do as much with employee morale and employees feeling cared about as it does the bottom line…"

Delicate Balance Between Promoting Health and Being Intrusive—Even amid agreement that WHP can lower costs and improve morale, concerns about intrusiveness arose. Most employers were willing to offer WHP programs, but they did not want to appear to be attempting to force behavior change.

> "I don't want to get into people's business…"

> "…promoting health and quitting tobacco and losing weight—those are very personal subjects to people, and they're very touchy. You don't want to infer that somebody is not good because they are not doing this."

WHP Lacks Power to Improve Health or Reduce Costs—A few participants felt that WHP would not make a real difference in their workers' health because their workforce wouldn't respond to WHP, or that the needs of the least healthy of their workers would not be met with WHP.

> "They're just really unhealthy and that's not going to go away with a wellness program."

> "… there is a segment of your population that's incredibly unhealthy. They need one-to-one; they need somebody one-to-one working with them, and is that the employer's job?"

WHP Barriers, Facilitators, and Perceived Needs

Employers' WHP practices varied dramatically; some offered very little, and others described fairly comprehensive wellness programs. Several participants discussed their insurance providers' wellness programs; others described physical activity and weight loss programs that their companies had developed from scratch or modeled from television shows such as *The Biggest Loser*.

Barriers—Participants agreed about three things that make WHP challenging for them: cost, time, and logistics. All seemed to fall under a broader theme—these employers have very limited resources for WHP, in terms of budget, staff time, and communications capabilities.

Limited Budget: Many participants talked about the challenge of paying for WHP programs or services, particularly in the current economic climate.

> "Everything has higher scrutiny than 2 years ago."

> "It's hard to sell it in terms of putting more dollars into it if you're having to take those dollars out of other places."

Limited Staff Time to Implement WHP: Several participants expressed frustration that WHP falls to human resources, and most noted that they don't have time to create and manage WHP programs.

> "…most of us would say that wellness comes back to HR, and we don't really have enough people to keep it driving and moving forward the way we would like to."

> "We don't have the time or energy to do something beyond kind of what we do now."

Limited Ability to Reach All Workers: Several employers struggled with logistical barriers to reaching all of their workers via WHP, especially if they had multiple worksites, workers who do not have e-mail, or workers who do not speak English.

> "I'm trying to figure out how to do this in five states. We also have teleworkers and remote workers—probably a third of our workforce teleworks; they don't even come into an office."

> "E-mailing is out. Half of our employees don't even have e-mail accounts."

Participants raised two additional barriers to implementing WHP: evidence and culture.

Little Evidence That WHP Improves Workers' Health: Some participants felt that they needed data demonstrating that WHP has a positive effect, and expressed frustration because they could not acquire such data. They had difficulty acquiring evidence that their own WHP efforts were working, as well as finding evidence from other similar companies supporting WHP.

> "It's very difficult to get any metrics to justify that it's a better place to work…"

> "… we just had a tough time getting reports, because I wanted to know had four people signed on to the health profile or had 104?"

Challenges with obtaining data were particularly problematic for participants who needed upper management buy-in.

> "They want to know that there's going to be a return on investment in our industry."

> "As long as the benefit exceeds the investment, you can always have the conversation."

Culture Does Not Support WHP: Some participants felt that WHP was not realistic in their workplace culture based their workers' lack of interest in (or occasionally, hostility toward) WHP. Other participants felt that WHP was not very practical for their industry's workforce (e.g., very young workforce, high turnover rates, or workforce with lots of limited English proficiency speakers).

Facilitators—Most participants had experience with WHP on some level, so they were also able to discuss factors that make WHP easier to implement. These factors included engagement of workers and leaders and characteristics of WHP programs.

WHP Is Easier When It Is Employee Driven: Most participants agreed that WHP efforts driven by workers (vs. by management) were better received.

> "We've tried top-down. It's just that when you have an employee who is enthusiastic about something, it's just a lot easier for other employees to get around it."

> "What we really love is to respond to an employee group, or an employee who says, "We need this; will you do it for us and can you do it?"

WHP Is More Successful With Management-Level Champions: Conversely, several participants said that managers can facilitate WHP by acting as champions (visibly participating in WHP) and by making it easier for workers to participate.

> "…the general manager is totally okay with the company covering the time that the employees take."

> "My COO is working out, my VP is working out, and several people are working out."

WHP Is Easier With Turnkey Programs and Resources: Congruent with their time and capacity limitations, participants wanted programs and materials that were as turnkey as possible.

> "It needs to be turnkey. Here it is; now lay it out."

> "I need someone to give me the information, you know, canned."

WHP Is Easier With Programs and Resources That Can Be Tailored to the Workforce: Participants also felt that engaging their workers would be easier if the WHP programs or communications could be tailored to their industry.

> "We'd like to be able to tailor it to our industry."

> "You have to like just totally be switching it up and doing different things so that people pay attention."

Extending WHP to Workers' Partners

In general, participants saw WHP as appropriate for their workers. When the conversation turned to workers' partners, participants had a variety of reactions.

Partners Affect Health Care Costs—Those who felt that including partners in WHP is appropriate frequently cited health care costs.

> "They're affecting our claims, so why wouldn't it be our role to help them, you know?"

In contrast, participants who did not cover workers' partners on health insurance seemed much more ambivalent about whether they would want to do this.

Partners Affect Workers' Productivity—Some participants saw improving partner health as a path toward increasing workers' productivity.

> "…partners and families are a big reason why people miss work and aren't as productive."

Some participants also believed that partners would increase workers' likelihood of participating in WHP or successfully changing their behavior.

> "…there is a lot of data that supports that people working together supporting each other on the same plan—doing the same things and working towards the same goal—have better success."

Offering WHP to Partners Is Too Expensive—Given that participants found justifying the cost of WHP for their own workers difficult, it is not surprising that they identified cost as a significant barrier to reaching partners.

> "I think it's out of the question for them to even consider spouses for things that have a cost…"

Indeed, even if participants thought it would be appropriate and useful to include partners in WHP, most felt that they could not incur extra costs to do so.

Partners Are Difficult to Reach—Most participants' companies did not include partners; when asked if they would, they weren't sure how to communicate with them.

> "I have a hard time thinking our employees would actually get it to their spouses."

> "I just find it hard to impact the behavior of people who are not here."

Many participants expressed strong reservations about contacting partners directly. There was consensus that any WHP communications for the partner should include the worker, including sending mail to the home (addressed to the worker and family) or word of mouth. A few employers had sponsored events that were open to workers' families, and participants spoke positively about this as an efficient method for reaching partners.

Employers who offered insurance coverage to partners and who had wellness programs via the insurer usually included partners in these programs. It seems easiest for these employers to offer WHP to partners when the resources or programs are offered and coordinated by a third party, especially when the third party is willing to include partners without additional cost.

Participants' Willingness to Collaborate With Nonprofit Organizations

Focus group sessions concluded with a discussion about whether participants would be interested in offering WHP in partnership with a nonprofit organization. The focus group moderator offered as example organizations the American Cancer Society (ACS, with which the researchers have collaboratively designed and implemented WHP programs), the American Heart Association, and the American Diabetes Association. In general, participants were positive about collaboration. Three groups included one or two participants from organizations that had received an ACS WHP program in the past, but for most participants, this was a new idea.

Nonprofit Organizations Are Trustworthy Experts—Two key reasons for positive reactions were perceptions of health-related nonprofits as possessing expertise and credibility and as lacking ulterior motives for wanting workers to improve their health.

> "I think it's the expertise that would be appreciated."

> "It's not someone that is paid basically by the company… There's no ulterior motive there except helping you."

Fundraising Acceptability Depends on Approach—When asked what would happen if nonprofit organizations did any fundraising with their workers, participants' reactions were mixed. Participants agreed that direct solicitation of their workers was not an option, and some noted that this was against their organization's rules.

> "I don't see them coming to me for that, and then turning around and asking for a handout."

> "You cannot solicit, period."

In contrast, participants were very receptive to fundraising related to events (such as walks, races, etc.), and a few noted that their organizations do this already. Each group expressed these two conflicting reactions to fundraising. Even though events clearly have fundraising as a major goal, participants discussed them as distinct from solicitation.

> "If it was a race or a cancer walk or something of that nature where the employees are all going to get out and participate… It does feel different than if it's coming out of their paycheck."

> "There's a little bit of a 'feel good' thing that goes along with the 'we're getting some exercise.'"

One advantage that well-known nonprofit organizations have is name recognition and credibility. Offering free WHP services to midsized, low-wage employers is one path toward meeting their mission. However, these organizations may want to fundraise with employers to defray the costs of offering these free services. Participants' responses to this issue suggest that choosing an acceptable fundraising strategy is important.

CONCLUSION

Several surveys of employers in the United States have assessed employers' implementation of WHP.[9,10,28,29] These surveys show that most employers are doing far less than the comprehensive WHP programs recommended in Healthy People 2010,[10] and that implementation decreases with employer size.[10,20] Less information is available about employers' WHP implementation according to industry or worker income level, and far more is known about *what* employers implement than *why* they do or do not implement WHP. To address this gap, we conducted five focus groups with human resources professionals from midsized employers representing five low-wage industries.

Most participants' companies offered some type of WHP, although the amount and type varied substantially. The participants generally believed that WHP is a good idea, but they

also expressed some ambivalence. A few felt that WHP would not be effective for their workers, because of workers' resistance to WHP, lack of fit with their workforce, or perceptions that their workers were too unhealthy in their habits or existing health conditions to change. As one employer put it, "they all drink and smoke."

Participants in every session raised concerns about intruding on workers' privacy, and many implied that they had received push-back from workers in the past. One of the main themes was the delicate balance between offering WHP programs and being perceived as judging workers. Employers' nervousness about offending workers contrasts with other research indicating that most workers find WHP appropriate or appealing[29,33] and with WHP research in small or blue-collar workplaces that recruited the majority of workers to participate.[15,18,25,34]

A potential path to expanding the reach and effect of WHP is to extend WHP programs to workers' spouses and partners. Insurance-based wellness programs often include covered family members, but less information is available about how often workplace-based WHP includes partners. Participants were divided about including workers' partners in WHP. Those that included partners in their insurance benefits had more financial incentive to improve partners' health; some others were willing to include partners in WHP, based on the belief that it would have a positive influence on workers' productivity or participation in WHP. Participants were very concerned about intrusiveness and privacy issues, even more so with partners than with workers. Employers were willing to explore reaching partners with WHP if there were no added costs and they could solve the logistics of reaching the partner (most commonly by mailing something to the workers' homes addressed to the worker and the family). Future research should test the feasibility of including partners in WHP programs; if feasible, the effect on both workers' and partners' participation and health behavior change should be evaluated.

The WHP literature documents several successful WHP programs among employers. The large employers in these success stories often dedicate substantial resources to WHP, including a wellness coordinator, a budget, and/or intensive programs offered by their insurers or other vendors.[11,12,14] The successful small employers are often participants in WHP research studies; the research team often provides substantial implementation support.[15–17]

In contrast to employers in the studies described above, the midsized employers in this study had very limited resources to implement WHP. These employers represent a significant WHP opportunity, as there is much room for growth and improvement in their WHP practices. At the same time, these employers present significant barriers for WHP practitioners, as they are far more numerous than large employers and have far fewer WHP resources. To work effectively with these employers, it will be necessary to find creative, low-resource solutions. This study assessed employers' willingness to partner with nonprofits as one potential solution. Several nonprofits offer free WHP programs that feature turnkey materials and programs, such as health communication pamphlets and Web sites that can be directly distributed to workers and partners, or evidence-based physical activity programs that have built-in supports like Web-based tracking and management

tools.[35,36] Nonprofits also offer different models of partnering with employers, ranging from recognition programs for employers already implementing WHP (such as the American Heart Association's Fit Friendly program[37]) to programs that provide on-site WHP consulting and assistance (such as the ACS's Workplace Solutions program[38,39]).

The participants felt that workers would trust services offered by national nonprofits with high recognition and expertise. The few employers who had offered WHP in collaboration with nonprofits in the past were generally positive about their experiences doing so. Direct fundraising, however, raised red flags. Employers were very willing to sponsor workers to participate in event-based fundraising; they were completely unwilling to allow direct fundraising solicitations of their workers. These findings suggest that nonprofit agencies offering free WHP programs have a potential audience with midsized employers and the potential to do event-based fundraising with these employers. Further research is needed to assess nonprofit agencies' willingness and capacity to work with these employers and the effectiveness of the WHP programs they offer in this context.

The present study has several limitations. All of the employers were from one geographic area, so findings may not generalize to midsized, low-wage employers across the country. Employers willing to allow their HR leaders to participate may not be representative of midsized, low-wage employers even in the King County area; these employers may be unusually interested in WHP or offer more WHP than those who declined to participate. Several participants had minimal WHP in place, lessening the concern that only employers with extensive WHP participated. Almost all participants were human resources professionals, so participants' views may not have represented those of their CEOs. Most participants spoke freely about their CEOs' views about WHP and willingness (or lack thereof) to implement WHP, and were well aware of what would be supported by their senior leaders.

Most participants were female; as the human resources profession employs mainly women, this was difficult to avoid. The final focus group was recruited with a higher incentive to participate than the prior four groups, to attract participants from industries that were underrepresented in the first four groups. This approach was successful in recruiting participants from these industries, but participants recruited with the higher incentive might be different from participants in the first four focus groups (less interested in WHP, for example). However, the key themes were consistent across all groups.

This study also has several strengths, including the ability to explore the research questions in much more depth than a closed-end survey would allow and uncover new insights about the issues midsized, low-wage employers face regarding WHP, their willingness and ability to include workers' partners, and their interest in collaborating with nonprofit agencies. WHP vendors, practitioners, and nonprofit agencies wishing to reach midsized, low-wage employers and their workers can use these findings to craft WHP programs that are responsive to their WHP needs and capacity.

Acknowledgments

The authors would like to thank the 34 employers who participated in our focus groups. We would also like to thank Nadia Van Buren of Proof Positive Transcriptions for transcribing the focus groups, and Judith Yarrow for assistance with manuscript preparation. Finally, we would like to thank Kirsten Senturia for her assistance with data analysis and comments on an earlier version of the manuscript. This research was supported by grant R21CA136435 from the National Cancer Institute. Additional research support was provided by the University of Washington Health Promotion Research Center, one of the CDC Prevention Research Centers (HPRC cooperative agreement number U48 DP001911-01).

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SO WHAT? Implications for Health Promotion Practitioners and Researchers

What is already known on this topic?

Workplace health promotion (WHP) has the potential to improve workers' health, and many WHP programs have been implemented and evaluated with large employers. However, midsized, low-wage employers are understudied.

What does this article add?

Midsized, low-wage employers have the potential to reach a significant number of workers. Although positive toward WHP for workers and their partners and willing to collaborate with nonprofit agencies, these employers face considerable cost, time, logistical, and cultural barriers to implementing WHP effectively.

What are the implications for health promotion practice or research?

Nonprofit agencies, insurers, and WHP vendors wishing to reach midsized, low-wage employers and their workers need to offer WHP programs that are inexpensive and turnkey, with easy-to-adapt communication materials. Researchers should partner with such organizations to evaluate WHP programs with these employers; evidence that WHP is effective for their workers will further encourage these employers to implement WHP programs.

Table 1

Focus Group Participants' Characteristics (n = 34)*

Characteristic	Focus Group Participants
Sex, No. (%)	
Female	25 (74)
Male	9 (26)
Position title, No. (%)	
HR manager	14 (41)
HR director	7 (21)
Vice president of HR	4 (12)
HR assistant/associate director	3 (9)
Other HR	3 (9)
Non-HR	3 (9)
Mean time in current position, y	13
Industry, No. (%)	
Accommodation/food services	11 (32)
Education	4 (12)
Health care/social assistance	10 (29)
Manufacturing	3 (9)
Retail trade	6 (18)

*Some percentages do not sum to 100 because of rounding. HR indicates human resources.

Table 2

Key Themes From Focus Group Discussions*

Discussion Guide Topic	Themes
Is providing WHP appropriate?	Health care cost-containment strategy
	Vehicle for improving morale and productivity
	Delicate balance between promoting health and being intrusive
	WHP lacks enough power to improve health or reduce costs
Primary barriers and facilitators to implementing WHP	Barriers
	Limited resources available for WHP
	Little evidence that WHP improves workers' health
	Culture does not support WHP
	Facilitators
	WHP is easier when it is employee driven
	WHP is more successful with management-level champions
	WHP is easier with turnkey programs and resources
	WHP is easier with programs and resources that can be tailored to the workforce
Willingness to offer WHP to partners and spouses	Perceived benefits
	Partners affect health care costs
	Partners affect workers' productivity
	Perceived barriers
	Offering WHP to partners is too expensive
	Partners are difficult to reach
Willingness to offer WHP in collaboration with nonprofit, health-related agencies	Nonprofit health-related agencies are trustworthy experts
	Acceptability of fundraising depends on approach

*WHP indicates workplace health promotion.