

Partnerships to expand worksite wellness programs - A qualitative analysis of state and local health department perspectives

INQUIRY: The Journal of Health Care
Organization, Provision, and Financing
Volume 59: 1–10
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DOI: 10.1177/00469580221092822
journals.sagepub.com/home/inq



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Abstract

Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the U. S. Because the central mission of state and local health departments (HDs) is to protect, promote, and improve population health, these agencies are well-positioned to address risk behaviors for chronic disease. HD-employer partnerships could enhance worksite wellness programming, but few studies have explored this topic. Building upon previously published findings, the purpose of this qualitative study was to describe the context and environment for HDs' delivery of worksite wellness programs, including interest, barriers, facilitators, and decision-making processes. We conducted 12 interviews with directors of state chronic disease programs, 21 interviews with local directors, and three focus groups with local staff. We performed a thematic analysis of the data. Key themes include the following: (1) worksite wellness programs delivered by HDs were diverse in topic and scope and delivered both internally (at the HD for their agency) and externally (for other employers); (2) decisions made about chronic disease prevention were largely driven by funding priorities, with federal, state, and local entities playing roles in the decision-making process; and (3) HDs expressed potential interest in worksite wellness program delivery, dependent upon staff capacity, available funding, and employer buy-in. Our results suggest that funding should be increased for and reallocated towards chronic disease prevention, including worksite wellness. To overcome HD barriers to program delivery, key funders and stakeholders should prioritize and communicate the importance of worksite wellness.

Keywords

chronic disease, health promotion, qualitative research, business partnerships, worksite safety & health

Highlights

What do we already know about this topic?

Partnerships between health departments and employers may serve to enhance worksite wellness program efforts and improve the well-being of employees and their communities.

How does your research contribute to the field?

Our research presents new knowledge about the factors and decision-making processes that drive health departments' engagement with worksite wellness program delivery.

What are your research's implications towards theory, practice, or policy?

The information resulting from our findings can be used to inform efforts to disseminate wellness programs via health department-employer partnerships to improve chronic disease risk among employees.



Background

Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the US.¹ Because the central mission of state and local health departments (HDs) is to protect, promote, and improve population health, these agencies are uniquely positioned to address chronic disease risk behaviors^{2,3} such as tobacco use, physical inactivity, and poor diet. With nearly 60% of the U.S. population employed,⁴ worksites are an important venue for delivering wellness programs. The Guide to Community Preventive Services recommends several evidence-based strategies to reduce employees' health risks, including tobacco-free policies and physical activity and nutrition programs.⁵ Worksite wellness programs have demonstrated success in reducing tobacco use,⁶ increasing physical activity,⁷ and improving dietary intake.^{8,9}

Partnerships between community agencies like HDs and employers can enhance program efforts to improve employee health.^{10,11} Through these partnerships, HDs can offer expertise in health promotion, training and technical assistance, and access to services and programs relevant to worksites. In turn, employers offer reach into the community through employees and their families, and resources (e.g., staff time, funding) for worksite wellness program delivery.¹²

Connect to Wellness is a worksite wellness program designed for small, low-wage worksites. The development of the program was guided by the HPRC Dissemination and Implementation Framework.¹³ An interventionist trained by our research team provides employers with program recommendations, toolkit resources (e.g., smoke-free policy templates), and technical assistance via e-mail and telephone to help them improve implementation of evidence-based interventions (EBIs) for health promotion. The program is designed to help employers make changes to the worksite environment. Employers work with the interventionist to select a subset of EBIs from a broader "menu" of options based on current worksite practices in four health areas: cancer screening, healthy eating, physical activity, and tobacco cessation.¹⁴

Results from a randomized controlled trial testing Connect to Wellness conducted among 68 small, low-wage worksites in Washington State showed significantly higher EBI implementation (our primary outcome) in the intervention vs. control arms at 15- and 24-month follow up.¹⁵ In a subsequent pilot study, we trained staff members (e.g., health educators)

from six local health jurisdictions in Washington State to serve as interventionists and partner with employers to deliver Connect to Wellness to 35 worksites.¹⁶ The findings showed a significant increase in mean implementation of several EBIs at 6- and 12-month follow up.¹⁶

Taken together, the information above suggests that building and maintaining effective partnerships between HDs and employers offers a unique opportunity to reduce chronic disease burden through increased implementation of EBIs for health promotion. In a prior publication,¹⁷ we presented a portion of data from interviews with local directors (LHDDs) about their capacity to deliver worksite wellness programs. While participants saw value in partnering with employers, most lacked the capacity to do so effectively. Contextual and financial circumstances such as geographical location and available funding for chronic disease prevention also influenced the extent to which their department engaged in worksite wellness.¹⁷

In the current study, we analyze additional data from our LHDD interviews and explore additional perspectives from directors of state chronic disease programs (SCDDs) and local staff (LHDS). This study was done to help us prepare for a randomized trial of partnering with HDs to deliver Connect to Wellness to employers, so was undertaken prior to recruiting and training HD staff across the U.S. to deliver the program. **The aims of this qualitative study were threefold:**

1. Describe any worksite wellness programs being delivered by HDs, including those delivered to employers.
2. Describe how HDs make decisions about chronic disease prevention and worksite wellness, including key players involved in decision making.
3. Explore HDs' interest in, and potential barriers and facilitators to, delivering worksite wellness programs.

Our study addresses several gaps in the literature. Previous studies have described HD partnerships with other community agencies and healthcare systems.^{18–20} With noted exceptions,^{2,16,21} research on HD partnerships with employers and their delivery of worksite wellness programs is limited. Past studies have also typically used only one source of data (e.g., interviews with LHD staff) to understand partnership and program capacity. Since both state and local characteristics influence HDs' chronic disease prevention efforts,^{22–24} exploring and comparing the perspectives of state- and local-level staff

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Received 6 January 2022; revised 15 March 2022; revised manuscript accepted 21 March 2022

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can help to inform program delivery by understanding barriers and facilitators to delivery at both levels.

Our study also builds upon our previously published study¹⁷ which was specifically focused on understanding the capacity of LHDs, the intended audience for Connect to Wellness. This prior study also examined differences according to LHD jurisdiction size (urban, micropolitan, or rural). Here, we seek to understand the broader context for worksite wellness delivery across both state and local HDs, and include more detailed information on types of programs being delivered and decision-making processes related to chronic disease prevention. The information resulting from our findings can inform the development and sustainment of HD-employer partnerships, and will be also be used to inform future plans to disseminate Connect to Wellness.

Methods

Procedures

We conducted 12 semi-structured interviews with SCDDs (n=14, including two interviews with two SCDDs); 21 semi-structured interviews with LHDDs (n=22, including one interview with two LHDDs); and three small focus groups with LHDS (n=8 total). We conducted the interviews and focus groups by telephone or Zoom. To recruit SCDDs, one of the co-authors e-mailed SCDDs to request their participation in the study. To recruit LHDDs, we asked SCDD interview participants to refer us to LHDDs in their state. We also worked with the Northwest Center for Public Health Practice to identify additional LHDDs. Members of the research team followed up with all potential participants via e-mail. We recruited LHDS by e-mail via referrals from our LHDD participants. None of the participants in our study had ever heard of, or were delivering, Connect to Wellness at the time of our interviews and focus groups.

Study recruitment and data collection occurred between January and October 2019. The interviews lasted approximately 30 to 45 minutes, and the focus groups lasted one hour. The interviews and focus groups were audio-recorded and professionally transcribed. The University of Washington Institutional Review Board approved all study procedures. Prior to data collection, we provided consent-related information and an opportunity for individuals to ask questions before agreeing to participate in the study. We did not provide incentives for participation.

Measures

Our questions were broad and meant to capture information about any worksite wellness programs delivered by HDs; topics included barriers and facilitators to future delivery of programs like Connect to Wellness. The SCDD interview guide comprised 12 open-ended questions on: (a) background information, including governance structure and key

partners for chronic disease prevention; (b) relative priority of, and funding for, chronic disease prevention; (c) perceived interest from HDs to deliver worksite wellness programs; (d) HD-perceived capacity for and interest in delivering Connect to Wellness in the future; and (e) potential motivations for deciding to deliver Connect to Wellness in the future, including the role of key partners in decision-making.

The LHDD interview guide comprised 11 open-ended questions on: (a) background information, including key partners for chronic disease prevention and experience in worksite wellness program delivery; (b) funding and decision-making processes for chronic disease prevention; and (c) perceived organizational capacity to deliver Connect to Wellness in the future. At the end of the interviews, we also asked SCDDs and LHDDs to report their gender, race, and ethnicity. (Note: As demographic questions were added later in the study, we do not have complete data on all of these characteristics).

The LHDS focus-group guide comprised seven open-ended questions on: (a) partnerships with employers to deliver worksite wellness programs and related challenges; (b) potential interest in Connect to Wellness, including ideas for optimal program delivery and evaluation; and (c) individuals within their agency responsible for making decisions about chronic disease prevention programs. Prior to participating in the focus groups, LHDS completed a survey that asked about job position, tenure, gender, age, race, and ethnicity.

Data Analysis

We used Atlas.ti version 8 for analysis.²⁵ We conducted a thematic analysis²⁶ using multiple data sources. We applied an inductive constant comparison coding approach to our analysis of the transcript data.^{27,28} First, we developed an initial codebook based on the study objectives and interview/focus group questions. Two to three members of the research team used the codebook to double-code a portion of the transcripts for each group of participants. We came together to clarify discrepancies in coding; this process was facilitated by merging our coding into one file on Atlas and reviewing the transcript line-by-line to examine differences. We resolved discrepancies in coding through discussion and updated the codebook to reflect our discussion. We divided all transcripts among the research team to code independently, and met regularly to discuss progress.

We identified broad themes based on a careful read of the code reports and created a summary of themes for each of the three data sources. Based on guidelines from Miles and Huberman,²⁹ we compared our findings across data sources by reviewing the theme summaries and creating matrix displays summarizing relevant coded text by role (SCDD, LHDD, or LHDS). Below, we focus our discussion of findings from the LHDD data primarily on the delivery of worksite wellness programs and decision-making processes, as additional themes from the LHDD interviews are explored in Brown et al.¹⁷

Results

We conducted interviews and focus groups with participants in 17 states. The breakdown in HD governance structure³⁰ for these states is as follows: 10 decentralized or largely decentralized, five centralized or largely centralized, one shared, and one mixed. See Table 1 below for a detailed breakdown of participant demographics.

Worksite Wellness Programs Delivered by HDs

Of the 41 HDs represented in our sample by participants, 36 had experience delivering worksite wellness programs. Two themes arose from our analysis: (1) HDs delivered a diverse array of worksite wellness programs, and (2) HDs discussed delivering worksite wellness programs at their own agency (internal programming) as well as partnering with employers to deliver programs at their worksites (external programming). These themes are described in detail below. See Table 2 for illustrative quotes representing each theme.

Diversity in Programming The worksite wellness programs delivered by HDs were diverse in topic and scope. Health topics addressed included breastfeeding support, cancer screening, diabetes, nutrition, obesity, and tobacco cessation. Participants commonly described hosting physical activity challenges and supporting employers to make environmental and policy changes (e.g., implementing a tobacco-free policy). While some participants described creating their own materials, several delivered existing programs; for example, the Work@Health program offered by the Centers for Disease Control and Prevention (CDC). As expected, responsibility for delivering worksite wellness programs depended on the state's governance structure. In centralized states, SCDDs described state employees as being responsible for delivery of worksite wellness programs, whereas in others, local staff were primarily responsible for program delivery.

Programs Delivered Internally and Externally Among agencies who had experience with worksite wellness, 30 had partnered with employers in the community, and 22 were currently

Table 1. Participant Demographics.

Variable	SCDD (n = 14)	LHDD (n = 22)	LHDS (n = 8)
Gender			
Men	3	3	1
Women	11	19	5
Other gender identity	0	0	0
Race			
Asian	0	1	0
American Indian or Alaska native	0	0	0
Black or African American	1	0	0
Native Hawaiian or Pacific Islander	1	0	0
White	6	13	5
Other racial identity	0	0	0
Hispanic, Latino/a, or Spanish			
No	8	14	5
Yes	0	0	0
Age			
Less than 18	—	—	0
18–29	—	—	1
30–44	—	—	3
45–64	—	—	2
65+	—	—	0
Job tenure			
Less than 1 year	—	—	0
1–5 years	—	—	4
5–10 years	—	—	0
Greater than 10 years	—	—	2

Cell sizes are not equal to the final sample sizes for each group due to missing data. Information on age and job tenure was not collected from SCDDs or LHDDs.

doing so. Some participants described only delivering programs within their own department or among other state agencies. A few participants noted that while the focus on worksite wellness was internal, the programs being delivered at their department could be implemented across other worksites if employers were interested. Programs focusing on healthy eating and active living were most commonly delivered external to the HD.

Decision Making for Chronic Disease and Worksite Wellness

For our second aim, the following themes arose from our analysis: (1) decision making for chronic disease prevention and worksite wellness programming was largely driven by funding priorities, and (2) federal, state, and local entities played an important role in decision making.

Decision Making Driven by Funding Priorities Both SCDDs and LHDDs were asked questions about funding for chronic disease. SCDDs described funding as a key factor in making decisions about chronic disease prevention and worksite wellness programming. Consistent with LHDD findings, the most common sources of funding were the CDC and state funds, including tax revenue. Funding was often tied to specific diseases or illnesses. Notably, chronic disease prevention and worksite wellness were not always top funding priorities. While we did not ask LHDS questions about funding, one participant described temporarily discontinuing worksite wellness program delivery due to a change in their funded deliverables.

Federal, State, and Local Entities Influence Decision Making While SCDD and LHDS described multiple influences on decision making, federal agencies like the CDC strongly influenced chronic disease prevention efforts via their funding of HD activities. When we asked SCDDs to indicate if there were trusted partners whose approval of Connect to Wellness would be meaningful to decision-makers at local HDs, participants described agencies such as the American Cancer Society, CDC, National Association of Chronic Disease Directors, National Association of County and City Health Officials, and state-level entities like the governor and state chamber.

Within decentralized and mixed states, SCDDs described the local HDs themselves as key partners. Decisions about whether to adopt new chronic disease prevention programs generally occurred among leadership, with less bidirectional communication occurring between state and/or local department leaders and staff. That being said, some LHDDs described staff as being a part of the decision-making process. A few LHDS also noted their involvement in decision making in consultation with leaders. Additional partners that influenced decision making were community and non-profit organizations (e.g., Campaign for Tobacco-Free

Kids); healthcare organizations (e.g., hospitals, federally qualified health centers); legislators; research universities; and Indigenous tribes.

Worksite Wellness Program Interest, Barriers, and Facilitators

The three major themes for our third aim included the following: (1) lack of capacity to partner with employers on worksite wellness served as a major barrier to program delivery; (2) interest in worksite wellness was dependent upon alignment with current needs, programs, and funding; and (3) obtaining employer buy-in for worksite wellness was important for program success.

Lack of Capacity a Major Barrier Limited funding was the most commonly described barrier to worksite wellness program delivery among SCDDs and LHDS; SCDDs in particular noted declines in HD funding that had occurred over time. Similarly, LHDDs noted that developing new partnerships or re-engaging employers would be challenging without additional funding. A couple of LHDS noted that limited funding precluded them from offering direct incentives to employers, and this made it more challenging to engage employers in worksite wellness. Another common barrier was lack of staff capacity to deliver worksite wellness programs, as HD staff were often overburdened with other responsibilities and priorities.

Interest Dependent on Alignment with Current Needs and Programs cross all data sources, most participants described potential interest in delivering worksite wellness programs in the future, including Connect to Wellness. However, several participants emphasized that the programs would need to be aligned with current priorities. SCDDs expressed concern about the potential for duplication between Connect to Wellness and other worksite wellness programs currently being delivered in the community (e.g., Work@Health, Blue Zones). Some SCDDs noted the potential for “turf wars” if Connect to Wellness were to be implemented in communities where other agencies were already partnering with employers to deliver worksite wellness programs. Similarly, LHDDs noted the importance of complementing existing work.

Compared to SCDD and LHDDs, LHDS seemed to perceive a better potential fit between Connect to Wellness and current programs. LHDS were interested in the training and technical assistance (TA) that would accompany Connect to Wellness, and liked the fact that the program came “pre-packaged” with resources and materials. However, a few LHDS stated that the program was not aligned with current priorities or funded projects. Interest in worksite wellness programs was generally consistent across the three data sources and among participants from the same state.

Employer Buy-In Important for Program Success Both SCDDs and LHDS described employer buy-in for worksite wellness as important to program success. For example, one LHDD described not delivering worksite wellness outside of their agency because they didn't feel like employers placed value or importance on these programs. A few SCDDs stressed the importance of "making the case" for

worksite wellness by communicating program benefits important to the employer, and this was sometimes perceived as challenging to do. Participants described employers being most interested in low-cost, easy-to-implement programs that have a return-on-investment. LHDDs also described the importance of employer demand for worksite wellness.

Table 2: Illustrative Quotes from Thematic Analysis

Theme	Quotes
Worksite wellness programs delivered by HDs	
Diversity in programming	<p>"There are a number of different things from stairwell encouragement and walking with the director. There's Weight Watchers meetings and health fairs and fitness challenges between departments and brown-bag classes. There are employee surveys about what health policies we want to see. We have daily fitness classes... And then we have a number of quit lines for tobacco and gambling...I know that healthcare services is also doing something with healthy hospitals and like getting McDonald's out of children's hospitals. We have a Health in All Policies group that's in the director's office that has a foods procurement action plan that they've worked with, with a number of different state agencies." – SCDD, Female, Decentralized</p> <p>"So the prevention task force... is a mandate through the [state] tobacco program. They are focusing on a combination of education and outreach in the community, as well as policy change. And then other ones like the nutrition and physical activity task force have done everything from hosting food day events to participating in recreation exposés, nutrition proclamations at the board. It's sort of a combination of nutrition and the breastfeeding task force and the promotion of lactation spaces in workplaces and creating a safe environment for women to lactate at work; community education and outreach through articles advertising health fairs. That's I think a good collection of what's happening." – LHDD, Female, Decentralized</p>
Programs delivered externally and internally	<p>"[Program name] is our public/private collaboration with the not-for-profit organizations, other community-based organizations (CBOs) as well as agencies where their primary focus is nutrition, physical activity and obesity prevention. We've leveraged several partnerships within this space to I guess expand upon our existing work, but also support their efforts as well across the state." – SCDD, Female, Shared</p> <p>"We also have the workplace wellness which is more internal within the county vs. external partners. We also have the local oral health coalition which includes dental providers, the hospital, our local clinics, WIC, and [early childhood development program]. I've got listings of all of our partners, but basically a lot of us from the partnering agencies are at the table for many of these because we can't achieve the work alone." – LHDD, Female, Decentralized</p>
Decision making for chronic disease and worksite wellness	
Decision making driven by funding priorities	<p>"So then because we're so dependent on federal funds, what we end up finding is that then we aren't able to be nimble enough. Those federal funds most often are restricted to specific conditions or specific populations or specific activities, and so without an infusion of some state dollars or even some private dollars coming in — basically some other pot than these federal grants — it leaves us unable to kind of adapt or ebb and flow with the need." – SCDD, Female, Mixed</p> <p>"In this last year, however, they've switched some of our deliverables and so even though we still have that capacity inside our staff to do that work, in the last six months we have not done any worksite wellness, if that makes sense. We've done it for years except for the last six months, and hopefully it will get back into our funded deliverables in the next funding cycle." – LHDS, Male, Decentralized</p>
Federal, state, and local entities influence decision making	<p>"We're working with a number of LHDs and really supporting their coalitions. We also had a partner at the university called [partner name], which worked in kind of the nutrition and physical activity, policy, systems and environmental (PSE) change space to do some of the convening of partners using more of a collective impact approach. They were funded through more private foundation dollars through the university." – SCDD, Female, Decentralized</p> <p>"[State] does not have local health departments. We have a centralized public health system, and so our bureau is within the Center of Community and Preventive Health. The bureau director that manages all of our regional and parish health units, she and I are colleagues together. We partner on specific initiatives, but all of the activities that occur within our parishes are kind of operated and controlled out of our central office." – SCDD, Female, Largely Centralized</p>

(continued)

Wellness program interest, barriers, and facilitators

Lack of capacity a major barrier to program deliver	<p><i>“[The largest barrier is] the competitive nature of funding from CDC... We’ll be applying for new funding and we may get it and we may not... It’s not enough to do everything that we need to. So if we look at the chronic disease burden across the state — we look at the data and we look at the maps that tell us our communities with the highest burden of chronic disease. We know it’s going to take a lot more than we have to really make the difference that needs to be made.”</i> – SCDD, Female, Decentralized</p> <p><i>“I will say just from what I’m hearing from the LHDs, they’re very overwhelmed by the program. There has been some pushback in terms of the number of locals that were trying to get involved in that and their time commitments. They are overwhelmed, and I think honestly our state folks to have that are overwhelmed, too, just because it was a huge add to their existing work responsibilities. They’re committed to it, but it’s taking a lot of extra time.”</i> – SCDD, Female, Decentralized</p>
Interest dependent on alignment with current needs and programs	<p><i>“As you know, there’s just not enough funding in public health. Everybody is stretched so thin, and I’m sure all three of us are. So then why would a local public health agency take this on? I would say that it would need to align with their current community priorities. Since there is no additional funding, it has to align with something that they’re already trying to do in their communities, but they just don’t have the right resources yet.”</i> – SCDD, Female, Decentralized</p> <p><i>“I would think that it would be close to the top, but not the top. I would say that their most urgent priority is what is happening at that given time — like I referenced the flu outbreak. They’re always going to be reactionary first and so that’s going to come first, but then I think prevention is a close second. They’re always working to prevent that next outbreak, and so first is the reaction to what is happening at that given time and second would be prevention.”</i> – SCDD, Female, Decentralized</p>
Employer buy-in important for program delivery	<p><i>“I think that some have had good success in working with worksites — especially in some of our rural areas where they have large private employers that they’ve been able to make some of those connections. I think it’s really hard for people to get in the door, and then trying to show how it benefits the worksite. When they can do it, I think that it gives them a lot of satisfaction in seeing how it helps the community, but the burnout of trying to get in is frustrating. I think that it ebbs and flows.”</i> – SCDD, Female, Decentralized</p> <p><i>“For us to be involved in something like this or to be able to be trained by you guys with something we know already works, because that’s the hard part a lot of times is starting a brand-new program and are we doing something that’s going to appeal to people? Are we doing something that’s going to get people involved and keep people involved? How do we make it a successful program?”</i> – LHDS, Female, Decentralized</p>

HDs = State and Local Health Departments; SCDD = State Chronic Disease Director; LHDD = Local Health Department Director; LHDS = Local Health Department Staff. Listed after each quote is the participant’s role, gender, and their HD’s governance health structure.

Discussion

The purpose of this qualitative study was to (1) describe any worksite wellness programs being delivered by HDs; (2) describe how HDs make decisions about chronic disease prevention and worksite wellness programs, and which key players are involved in decision-making; and (3) explore HDs’ interest in, and barriers and facilitators to, delivering worksite wellness programs. While previous studies have described benefits to building and maintaining partnerships between HDs and community agencies,^{18–20} few studies have explored HD-employer partnerships specifically. Expanding upon previously published findings among LHDDs,¹⁷ we analyzed additional data from LHDDs and data from SCDD and LHDS to better understand the larger contextual environment for worksite wellness.

Nearly all HDs had experience delivering worksite wellness programs, and most expressed potential interest in partnering with employers to deliver programs like Connect to Wellness in the future. However, participants experienced

several barriers to program delivery. Consistent with Brown et al.,¹⁷ limited funding for worksite wellness substantially influenced the extent to which HDs could engage or reengage in worksite wellness efforts external to their department, as HD funding was not always earmarked for chronic disease prevention. While fewer studies have been recently published on this topic, our findings align with prior studies that have described capacity challenges related to delivery of chronic disease prevention programs,^{31,32} including worksite wellness.²

Entities internal and external to the HD seemed to strongly influence chronic disease prevention and worksite wellness efforts across participants. External agencies like the CDC and National Association of County and City Health Officials set priorities related to funding and/or were considered trusted partners for worksite wellness. In more decentralized states, partnerships between state and local departments were also important to worksite wellness delivery. Taken together, these findings speak to the value of developing and maintaining partnerships to better address chronic disease prevention,

and are consistent with recommendations set forth in Brown et al.¹⁷ Further, findings from this study and Brown et al. demonstrate a lack of capacity (e.g., time and funding) to deliver worksite wellness programming among HD staff, who weren't always involved in the decision-making process. Involving staff in this process could help to ensure an appropriate alignment between new programs and current capacity.

Similar to Brown et al.,¹⁷ SCDD and LHDS participants expressed the importance of aligning worksite wellness efforts with community and employer needs; activities perceived as duplicative or misaligned with these needs posed barriers to the future implementation of new programs like Connect to Wellness. Further, obtaining buy-in for worksite wellness posed a barrier to program delivery, as HDs were not always able to garner interest in these programs from employers. Our findings align with prior studies that have described leadership interest and support as important to worksite wellness program delivery and success.³³

Strengths and Limitations

A strength, our triangulation of data allowed us to better understand how HDs engage with employers and how contextual differences among SCDD, LHDD, and LHDS influence worksite wellness program delivery. A limitation, the sample sizes of the focus groups were small, reducing our ability to understand wider perspectives on worksite wellness among LHDS. For example, there may be other important barriers or facilitators to worksite wellness delivery among LHDS that were not captured among our small sample. Similarly, most HDs in our sample had experience delivering worksite wellness programs. The perspectives of these HDs may differ from other HDs, thus our findings may not be as relevant or apply to other HDs who lack experience partnering with employers. Regardless of these limitations, our study provides unique insight into the potential value of HD-employer partnerships for worksite wellness program delivery, and can help to inform future research and practice efforts to better sustain these partnerships to improve population health.

Implications for Practice and Future Research

Based on our findings, increased HD funding for chronic disease prevention, including worksite wellness, is needed to address the disproportionate burden of these diseases on population health. DeSalvo et al.³⁴ describe enhancing and substantially modifying funding for public health in order to achieve Public Health 3.0, an initiative focused on addressing the social determinants of health and health equity. DeSalvo et al. recommend that public health agencies forge new partnerships and expand funding sources,³⁴ which could help to address gaps in funding for chronic disease prevention and

worksite wellness. Similar to prior studies,^{2,17} we encourage major stakeholders and funding agencies like the CDC to advance priorities in chronic disease to reduce barriers associated with HDs' limited capacity to engage in prevention efforts, including worksite wellness. As one example, the CDC's National Breast and Cervical Cancer Early Detection Program awards funding to HDs and has more recently prioritized partnerships with employers to implement worksite policies around cancer screening.³⁵

Reinvestment of state revenue could also serve to better support worksite wellness. For example, the American Heart Association supports increased allocation of tobacco excise tax revenue towards health-related initiatives³⁶; these additional funds could be used by HDs to expand worksite wellness program delivery in key health areas, including tobacco control, prevention, and cessation, especially to worksites with limited access to wellness programs. A portion of this or other funding could also be used to provide financial incentives to employers. For example, HDs could implement a mini-grant program to support employers' wellness initiatives; these programs have shown promise in creating a more positive workplace culture for health.³⁷

In addition to increased funding, providing training and technical assistance to HDs can enhance staff capacity to partner with employers. For example, HD staff could be trained on how to recruit and "make the case" for worksite wellness to employers, something considered a challenge by some participants in our study. The provision of training and technical assistance is the model for Connect to Wellness, and has been implemented successfully in prior studies to increase capacity for HDs to address chronic disease prevention more broadly.³⁸ HD leadership support for program delivery is also critical.³⁹ In our study, several participants described not having time to partner with employers due to competing responsibilities. Ensuring that leaders provide time and a supportive environment for staff to engage in these activities can facilitate the development of partnerships with employers.

Several areas for future research exist. Exploring employer perspectives on worksite wellness and needed support from HDs should be considered. Several HDs believed that employers were not interested in worksite wellness, and there may be opportunities with audience research to help HDs and interested employers connect. There are also opportunities to learn additional information from a broader pool of HDs. While we spoke with participants from several states with diverse governance structures, potential themes could differ for states not included in our sample that experience higher levels of chronic disease burden and less HD funding. Lastly, the workflow of HDs has been heavily impacted by the COVID-19 pandemic; priorities around worksite wellness may have changed since we conducted our interviews and focus groups in 2019. Knowing how the pandemic has shifted HD priorities could help to inform future efforts seeking to build capacity for HD-employer partnerships to expand

dissemination of programs that reduce chronic disease burden and improve population health.

Acknowledgments

We would like to acknowledge Betty Bekemeier for her assistance with study recruitment. We would also like to thank the state chronic disease directors, local health department directors, and local health department staff who participated in the study.

Funding

This project was supported by grant no. 5R01CA160217 from the National Cancer Institute (NCI). This article is also a product of the University of Washington Health Promotion Research Center, a Centers for Disease Control and Prevention (CDC) Prevention Research Center, and was supported by Cooperative Agreement no. U48DP006398 from the CDC. The findings and conclusions in this article are those of the authors and do not necessarily represent the positions or policies of NCI or CDC.

Conflict of Interest Statement

The authors have no conflicts of interest to declare.

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