therefore intermediaries can ready themselves to address or discuss these topics when working with small businesses.

CONCLUSIONS: For potential intermediaries wanting to introduce the concept of TWH to small businesses, it would be important to describe how wellness and safety can be integrated, demonstrate to employers the benefit to the business, provide access to financial resources for mitigating at least part of the initial cost of new programming, and build a relationship with the business as you guide them through the setup and implementation of a TWH program tailored for their specific needs.

Assessment of Total Worker Health® Strategies as Indicators of Organizational Behavior in Small Business

Liliana Tenney (University of Colorado Denver)

Introduction: Emerging evidence suggests that a more holistic approach is needed to optimize worker health, safety, and well-being in businesses of all sizes. Job injuries and fatalities persist at unacceptably high rates (Concha-Barrientos 2005). The workforce, like the rest of society, suffers from chronic health conditions that are both related to work-related and non-work factors, also at increasing rates (Sorensen 2011). Worker well-being is gaining traction as a unifying central objective in the occupational safety and health field that can be achieved by enhancing the physical workplace environment, including organizational level policies and strategies that help shape a culture of well-being the contributes to the nature of work and the work experience (Schill 2013). The National Institute for Occupational Safety and Health's (NIOSH) Total Worker Health® (TWH) approach is defined as policies, programs, and practices that integrate protection from work-related safety and health hazards with promotion of injury and illness prevention efforts to advance worker well-being. While research on TWH approaches hold promise for establishing new ways of meeting the needs of workers in small businesses, most TWH intervention studies to date have been conducted in large organizations, with little evidence to support the generalization of results to the small business setting (McCoy 2014, Newman 2015) . Our understanding of the current practices in small businesses and of the barriers to adoption, effectiveness, and sustainability of TWH programs remain extremely limited.

Objective: In order to identify potential opportunities to improve OSH solutions in small businesses, the current study characterizes current TWH practices across multiple industrial sectors and across the spectrum of organization sizes. We hypothesized that larger businesses offer TWH programming than do smaller enterprises. In considering TWH integration, we hypothesized that businesses that address workplace safety would be more likely to also address health promotion, regardless of business size. Our study objective was to conduct a cross-sectional assessment of the adoption of Total Worker Health® (TWH) policies and practices by business size and evaluate extent and associations of their safety and health policies and programs.

Methods. We conducted an analysis of 382 businesses that participated in an assessment, advising, and certification program, Health Links™. We measured organizational adoption of policies, programs, and strategies to advance the health, safety, and well-being of workers. Organizations were scored on six benchmarks: organizational supports, workplace assessment, health policies and programs, safety policies and programs, employee engagement, and evaluation.

Results. Among the 382 participating businesses, 78 (20%) were microbusiness (2 to 10 employees); 133 (35%) were small businesses (11 to 50 employees); 71 (19%) were medium sized businesses (51-200 employees), and 100 (26%) were large businesses (> 200 employees). The six benchmark scores were statistically significant associated with business size. Larger businesses were more likely to score higher across each Health Links benchmark indicating they are implementing more TWH strategies. The mean score for each of the benchmarks were significantly different among the four size categories: organizational support ($p=0.003$); workplace assessments ($p<0.001$); health policies and practices ($p<0.001$); safety ($p<0.001$); engagement ($p=0.004$); evaluation ($p<0.001$). Conclusions. While small businesses are implementing TWH, the level of implementation differs by business size. The smaller the organization, the greater the opportunity to address safety as a priority. Practical interventions, as well as dissemination and implementation research, should take business size into account to ensure TWH is both effective and sustainable in meeting the needs of employees.

Discussion: Small businesses are implementing TWH, and the level and type of implementation differs by business size. Interventions, as well as dissemination/implementation research, should take business size into account to ensure TWH is both effective and sustainable in reaching employers and meeting the needs of employees. Future research is needed to understand what community, organizational, and leadership factors drive the most change for improving employee health, safety, and well-being outcomes.

Independence Ballroom A

Work, Parenting, and Family Outcomes

PAPER SESSION

Work breaks and upper respiratory infections among hospital patient care workers

Erika Sabbath (Boston College)

Background. Common colds are the epitome of a minor illness, but they are miserable for many of the 72% of U.S. adults who suffer from them annually. Economists and business owners have long recognized how costly colds, flu, and other upper respiratory infections are. Each year, the U.S. economy accrues $40B in direct and indirect costs for colds and $27B for influenza. Psychosocial stress is one known risk factor for cold and flu susceptibility, but very few studies have tested whether stress from interpersonal or organizational aspects of work are associated with susceptibility. We hypothesized that poorer break-taking practices would be associated with higher likelihood of physician visits for upper respiratory infections in a cohort of hospital patient care workers.

Methods. Data are drawn from the Boston Hospital Workers Health Study (BHWHS), a longitudinal cohort of 15,000 patient care workers at two large academic medical centers in Boston. We used data from a subset of BHWHS workers (n=979) who responded to a survey (response rate=72%) and were members of the company's group health plan. The survey was conducted in October 2012, shortly before the onset of cold and flu season. We linked participants' responses to questions about break-taking norms in their units and their own break practices with health claims data for upper respiratory infections in the 12 months following the survey. We used logistic regression to test for differences in break practices observed between those with and without

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