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Building Capacity for Workplace Health Promotion: Findings From the Work@Health® Train-the-Trainer Program

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Abstract

Small- and mid-sized employers are less likely to have expertise, capacity, or resources to implement workplace health promotion programs, compared with large employers. In response, the Centers for Disease Control and Prevention developed the Work@Health® employer training program to determine the best way to deliver skill-based training to employers of all sizes. The core curriculum was designed to increase employers' knowledge of the design, implementation, and evaluation of workplace health strategies. The first arm of the program was direct employer training. In this article, we describe the results of the second arm—the program's train-the-trainer (T3) component, which was designed to prepare new certified trainers to provide core workplace health training to other employers. Of the 103 participants who began the T3 program, 87 fully completed it and delivered the Work@Health core training to 233 other employers. Key indicators of T3 participants' knowledge and attitudes significantly improved after training. The curriculum delivered through the T3 model has the potential to increase the health promotion capacity of employers across the nation, as well as organizations that work with employers, such as health departments and business coalitions.

Keywords

health promotion; training; worksite safety and health

INTRODUCTION

Employer contributions to health care premiums have risen significantly every year since 2000. In 2016, the average annual employer contribution to family health coverage was \$12,865 per employee (The Kaiser Family Foundation and Health Research & Educational Trust, 2016). These increasing health care costs as well as decreasing employee productivity due to health-related factors are leading employers to examine strategies to improve employee health and minimize health care costs. Increasingly, employers are recognizing the role they can play in creating a healthy work environment and providing their employees with opportunities to make healthy lifestyle choices. In fact, 47% of companies that offer

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health insurance benefits offer some type of wellness program to their employees (The Kaiser Family Foundation and Health Research & Educational Trust, 2016).

Indeed, workplace wellness programs in the United States hold promise for improving health-related behaviors (Hutchinson & Wilson, 2012; Malik, Blake, & Suggs, 2014; To, Chen, Magnussen, & To, 2013), thereby improving population health and trends in chronic disease prevalence (Cahalin et al., 2014; Cahalin et al., 2015). Workplace wellness programs that improve overall well-being (including physical health, mental health, healthy behaviors, and satisfaction with one's work environment) have been shown to improve productivity outcomes (e.g., absenteeism, short-term disability, job performance), health care outcomes (e.g., emergency room visits, hospitalizations, medical and prescription spending), and retention outcomes (e.g., intentions to stay and voluntary and involuntary turnover; Sears, Shi, Coberley, & Pope, 2013).

Workplace health promotion programs that are comprehensive tend to have the greatest effects on worker well-being (Harris, Hannon, Beresford, Linnan, & McLellan, 2014) and include the implementation of strategic initiatives on multiple levels. To be considered comprehensive, workplace health promotion programs should include the following elements: health education, a supportive social and physical work environment, integration of the program into the organization's structure, connections to related programs (e.g., community resources and employee assistance programs), and workplace screening and education (Harris et al., 2014; U.S. Department of Health and Human Services, 2000). However, employers (particularly those of smaller size) often lack knowledge about how to implement organizational health promotion practices, a problem compounded by constrained resources (Harris et al., 2014). Because of this, many employers find it challenging to develop and implement evidence-based workplace health programs. In addition, employers who want to outsource their wellness programs may be unsure of the types of available programs, their effectiveness, and which would fit best for their organization.

Because of these challenges, employers increasingly look to the Centers for Disease Control and Prevention (CDC) and other public health experts for guidance and solutions to combat the effects of chronic disease on their employees and organizations. Training is one strategy for disseminating evidence-based solutions and resources and building awareness and skills. Conducting formative research for the Work@Health® Program, we identified workplace wellness-related certification training programs available through the National Wellness Institute (2013), the Chapman Institute (Chapman Institute, 2013), and Wellness Council of America (2013) that cost several hundred dollars and were geared toward aspiring wellness professionals. There were also fee-based courses or webinars through America's Health Insurance Plans (2013), the American College of Occupational and Environmental Medicine, and the Society for Human Resource Management. CDC found no free workplace health training options that offered step-by-step guidance on the design, implementation, and evaluation of workplace health programs. Overall, there was a lack of materials and knowledgeable and affordable trainers to guide employers on effective program development and implementation.

To fill this gap, CDC established the Work@Health program, an employer training program designed to promote workplace wellness through education, training, and technical assistance based on CDC's workplace health model. The program's overarching goals were to (1) improve understanding of the workplace health training needs of employers; (2) determine the best way to deliver skill-based training to employers; (3) increase employers' level of knowledge of workplace health program concepts and principles, as well as tools and resources to support the design, implementation, and evaluation of workplace health strategies and interventions; and (4) increase the number of evidence-based workplace health programs, policies, and practices in place at participating employers' worksites.

The project team designed the Work@Health program with two implementation components: an employer training component and a train-the-trainer (T3) component. In the first year of the program (2014–2015), the Work@Health program provided training directly to 173 employers. The evaluation of the employer training component showed that employers who completed the Work@Health program significantly increased their knowledge about workplace health promotion after the training, and significantly increased the number of evidence-based health promotion interventions at their worksites 1 year after they started the program (Cluff, Lang, Rineer, Jones-Jack, & Strazza, 2017). To build greater capacity, the Work@Health program also trained individuals from organizations that support health promotion (e.g., health departments) to deliver the Work@Health training to other employers. Previous studies support the train-the-trainer approach as a scalable and sustainable method to train adults about a range of health-related issues (Corelli, Fenlon, Kroon, Prokhorov, & Hudmon, 2007; Hiner et al., 2009; Orfaly et al., 2005), with outcomes comparable to those obtained using expert trainers (Trabeau, Neitzel, Meischke, Daniell, & Seixas, 2008). This T3 component of the program was designed to prepare new certified trainers to provide comprehensive core workplace health training to employers in their own communities. The intention of the T3 program was to efficiently scale up the number of employers trained in worksite health promotion program design and implementation by equipping a committed group of T3 participants with the skills and resources needed to deliver the training on an ongoing basis. This article describes the results from the first cohort of T3 participants in the Work@Health program.

BACKGROUND

The Work@Health[®] T3 Training Program

The Work@Health project team (the team) developed the program's core curriculum after conducting formative research that included a review of the literature and key informant interviews with national workplace health promotion experts and representatives from nine employers with workplace health programs. While there is no definitive theory or model representing a comprehensive, evidence-based workplace health program, the team reviewed best practices and consensus documents from the Health Enhancement Research Organization, the American College of Occupational and Environmental Medicine, the National Institute for Occupational Safety and Health, and others outlining key, foundational elements for establishing a culture of health critical to program success and sustainability. These elements reinforced the logic of the core employer curricula (Grossmeier, Terry,

Cipriotti, & Burtaine, 2010; Loeppke et al., 2003; Loeppke, 2012; National Institute for Occupational Safety and Health, 2015; Pronk, 2014). Additionally, CDC's comprehensive workplace health program model emphasizes implementation of evidence-based strategies to influence health at multiple levels of the organization, drawing from the socioecological framework (McLeroy, Bibeau, Steckler, & Glanz, 1988). These include individual-level, health-related programs such as health education and counseling, as well as organizational-level policies, health benefit design, and changes to the work environment (Koffman, Lang, & Chosewood, 2013; Sallis, Bauman, & Pratt, 1998).

T3 participants were trained to deliver the Work@Health core curriculum, which consisted of eight modules designed to guide employers through the assessment, planning, implementation, and evaluation phases of an evidence-based worksite health promotion program. The modules and their learning objectives included (1) *Making the Business Case*: to identify the value and benefit of a worksite health program and develop a business case to present to leadership; (2) *Assessing Your Worksite*: to describe health and productivity-related metrics, identify health promotion needs and interests, and assess organizational capacity; (3) *Building Leadership Support*: to secure and maintain leadership support at all levels and establish a health promotion committee and peer-support network; (4) *Developing Policy, Benefit, and Environmental Supports*: to implement policies, benefit changes, and environmental supports promoting preventive screenings, healthy lifestyles, and employee well-being; (5) *Designing Effective Communications*: to conduct a communications audit, develop a unique brand, and select communication channels to address programming goals; (6) *Evaluating Your Program*: to identify measures aligned with program objectives, establish baseline measures, and integrate evaluation within the planning process; (7) *Planning and Designing Your Program*: to identify and prioritize needs from the assessment process, create a strategic plan, and design program components to build and sustain a workplace culture of health; and (8) *Implementing and Sustaining Your Program*: to involve health promotion committees, implement a master schedule, identify operational approaches to manage and sustain programs, manage the evaluation process, and access Work@Health technical assistance for support.

The T3 training was designed to prepare participants to recruit and train other employers on the Work@Health core curriculum. For training purposes, train-the-trainers were required to train a minimum of five employers (and a maximum of 10) because the program was designed to allow T3 trainees to demonstrate their knowledge and skill on a small, manageable number of employers prior to becoming certified. T3 participants completed the Work@Health core curriculum and then completed six additional modules designed to enhance their training and facilitation skills. The Work@Health T3 curriculum was developed and implemented using a problem-based learning strategy built on the theories of cognitivism, constructivism, and adult learning (Cooper, 1993; Ertmer & Newby, 1993). Problem-based learning was selected as the learning strategy to ensure active and engaged learning experiences, reflection, and application of knowledge. When applied, participants were motivated to obtain a deeper knowledge of the content and skills they learned rather than to merely read slides or manuals. Research indicates that adults are more likely to retain the knowledge and skills gained through this strategy more readily than through traditional learning (Edutopia, 2011; Knowles, Holton, & Swanson, 2015). The goals of the T3

program were for participants to (1) become experts in the Work@Health core curriculum content, and workplace health promotion more generally and (2) develop the skills needed to effectively deliver the Work@Health core curriculum. T3 participants were given technical assistance on recruiting employers, conducting outreach, and setting up training logistics. The T3 participants were given guidance and up to \$1,000 to support marketing, recruiting, securing a training venue, and preparing to deliver a Work@Health live training session to employers. Last, they participated in a debriefing with their peers and Work@Health trainers to help them to identify areas for improvement.

The following sections describe the steps taken to recruit T3 participants, the implementation of the training, the data collected to evaluate the extent to which Work@Health effectively prepared T3 participants to train other employers, and the results from the initial full training group of T3 participants.

METHOD

Recruitment

The outreach and recruitment plan targeted individuals who had previous training experience and knowledge of workplace health programs (e.g., wellness coordinators and health educators), and who wished to train others. Outreach efforts focused on professional associations and organizations such as health departments and health-related professional associations. The team provided these professional associations and organizations with Work@Health materials that could be tailored and sent to their membership via newsletter, listserv, website, social media, and at conferences and meetings. The project team planned four regional T3 training workshops in April and May of 2014 in Baltimore, Oakland, Atlanta, and Chicago.

Interested individuals applied to participate in Work@Health by completing an online application with questions about current position and employer, prior training and workplace health promotion experience, and confidence in training other employers. The team reviewed and scored the applications based on applicants' experience and other factors.

Participants

Of the 265 individuals who completed an application for the T3 program, 103 met eligibility requirements, were selected and enrolled. A number of applicants did not meet one of two eligibility requirements (1) having a minimum of 1 year of experience in a leadership role implementing a workplace health or wellness program and/or (2) including a letter of recommendation/support from their parent organization as part of their application. There were also eligible applicants who did not enroll in the program because they did not complete enrollment requirements such as completing the pretraining survey used to establish a baseline of the participant's knowledge, motivation, and confidence levels, or were not scored as highly (scale of 1–10) as those accepted into the competitive program on criteria such as general training experience, workplace health practice experience, or number/type of professional certifications obtained. Last, a small percentage of applicants withdrew themselves from consideration prior to the start of the program and did not enroll

because of the time commitments, ability to train other employers as a condition of participation, or shifting work responsibilities that no longer aligned with the Work@Health program. Among those who were selected and enrolled, 87 completed the training portion of the program, and 51 completed the full program. Participants came from 30 states and Puerto Rico. More than one third of those who completed the program listed their job role as wellness manager or health program coordinator. The next most common roles were CEO/president/owner, followed by professional instructor/trainer. Table 1 presents the regions where participants resided, their job titles, and the types of organizations where they worked. About one quarter (27 of 103) of T3 participants came from public health departments, and another quarter (29) were from health or wellness vendors. Fourteen participants worked within a health care system, 12 were employed by insurance brokers, and the rest (21) fell into the “other/missing” category. Organizations in the “other” category included universities and business coalitions.

T3 Training

The focus of the T3 training was on facilitation skills for delivering the employer curricula. Prior to their T3 workshop date, participants completed the eight modules of the Work@Health core curriculum online and five T3 modules online. The modules and their learning objectives included (1) *Understanding the Landscape*: thoroughly understand the core elements of Work@Health, define their roles while training employers, and assess the match between their current skills and characteristics of effective trainers; (2) *Building the Roadmap*: to distinguish between different adult learning styles and deliver training and technical assistance using specific presentation and communication skills; (3) *Preparing for Delivery*: to develop techniques to create a positive learning environment and apply strategies to maintain the fidelity of the Work@Health core curriculum; (4) *Evaluating for Results*: to understand the importance of integrating evaluation into program goals and planning and apply evaluation tools in the worksite setting; and (5) *Supporting Technical Assistance*: to apply a range of technical assistance services to support employers. Participants had 3 weeks to complete the online work. Selected participants were notified of the date and location of a 1-day in-person training lab that completed their training following the online work, and each was assigned to work with a Work@Health coach. The coaches were experienced worksite wellness professionals who had received extensive training on the Work@Health curriculum. The Work@Health online learning platform provided tools for the participants to interact with their coaches and with other T3 participants who were assigned to the same workshop group. Each Work@Health T3 regional training lab lasted approximately 8 hours and was facilitated by a lead instructor and a subject matter expert (SME).

The training lab was designed to give all participants an opportunity to practice presenting the Work@Health curriculum and receive feedback from coaches and other T3 participants. Trainees completed four main training lab activities, usually working in small groups of three to four. All the activities were video-recorded and concluded with group members, the instructor, and the SME providing reinforcement, constructive feedback, and recommendations for improvement after viewing the recordings. Activities included

- *“TV News” One-Minute Oral Presentation*—To help them become conversational about the program, participants conducted mock interviews with one another and tried to clearly and succinctly describe the Work@Health program. This helped trainees prepare their “elevator speech” for communicating key messages and recruiting employers.
- *Practice Hands-on Training*—The small groups watched short videos each member had recorded prior to the training lab. In the videos, participants delivered one of the six core curriculum modules. As they watched, participants noted body language, projection, and confidence, and considered how to make improvements.
- *Customizing a Topic from Core Module 7: Planning and Design*—Small group members collectively developed and presented slides describing a hypothetical workplace health initiative (e.g., “Grocery Store” scenario). The focus of the exercise was on gaining support for the initiative by describing the planning and design process, thus ensuring understanding and buy-in from employees and organizational leadership. This exercise allowed participants to incorporate professional experiences into the curriculum and practice reacting to audience questions.
- *Customizing a Topic from Core Module 8: Implementing and Sustaining*—Small group members developed and presented slides using the same hypothetical workplace program, but focused this exercise on gaining support to implement and sustain the initiative by tailoring key messages to their audience.

After the training, participants received 6 to 10 months of technical assistance in the form of phone and online coaching, live and recorded webinars, and online interactions with peers (e.g., sharing experiences related to recruiting employers). During the technical assistance period, participants were expected to complete three milestones. The first milestone required participants to develop plans for marketing their training session to employers, recruiting employers, and tailoring the training session to meet their employers’ needs. The second milestone required participants to deliver the training and submit a 15-minute recorded segment from their training session. The final milestone required them to participate in an online debriefing session with their coach and a small number of their T3 peers to review the recording of their training and obtain constructive feedback. T3 participants documented progress toward milestone completion in progress reports they submitted to and discussed with their coaches. If all three milestones were successfully completed, participants were considered certified trainers, presented with a certificate, and allowed to continue to train employers independently (up to 25 employers at a time).

Measures

T3 Application Form—The team developed a 25-item application form to collect applicants’ contact and demographic information; current role; previous implementation experience, formal training, and credentials related to worksite health promotion; and commitment, readiness, and confidence related to their participation. T3 applicants also submitted a letter of support from their sponsoring organization.

T3 Participant Survey—The team developed this instrument to assess participants' confidence in their training skills, knowledge of workplace health training concepts, motivation for delivering the training, and perceived challenges related to recruiting and training employers. The knowledge portion comprised five questions about key skills of effective worksite health trainers and the importance of evaluation and technical assistance. Training participants were asked to complete the 21-item survey online prior to training in 2014 and again 12 months after the training, in 2015.

Reaction Survey—The team developed a 67-item reaction survey to assess participants' satisfaction with the content and delivery of the training, perceived clarity and utility of the material, and recommendations. In addition to the T3 participants, the employers later trained by the T3 participants completed a similar 47-item reaction survey.

Focus Groups—Approximately a week before the training lab, the team invited all participants at the Atlanta training session to participate in focus groups immediately following the session. Fourteen participants volunteered for the 1-hour discussion and were divided into two groups. Participants discussed their expectations, their perceptions of the online modules and the training lab, and their plans for training employers.

Design and Data Analysis

We used a single group pre- and posttest evaluation design to assess changes in T3 participants' knowledge and attitudes related to training others in workplace health promotion. We calculated descriptive statistics summarizing responses from data collection instruments and the milestone tracking system. We used SPSS statistical software to conduct paired *t* tests to compare participants' attitudes and knowledge before and after the training and technical assistance using data from the 82 participants who completed the Participant Survey in 2014 and again in 2015.

FINDINGS

T3 Participants' Reactions to the Training

Overall, participants gave favorable ratings to their trainers, the training content, and training delivery. Of the 103 individuals who started the training program, 90 provided posttraining ratings. The majority (84.4%) agreed that their trainers effectively delivered the training activities. Most participants (89.7%) agreed that they would be able to use what they learned at their jobs. A high percentage also agreed that they have the information they need to train others in worksite health programs (73.9%); they understood how to apply what they learned (72.7%); the training was effective (71.6%); and the training topics met their needs (70.5%). More than half agreed that the training prepared them to train others (65.9%); they would recommend the training to others in their position (63.3%); and the training met their expectations (51.1%).

Changes in Participant Knowledge and Attitudes

Changes in participant knowledge quiz scores, attitudes, and self-rated training skills are presented in Table 2. Scores on the knowledge item portion of the T3 Participant Survey

significantly increased between 2014 and 2015, from a mean of 65.9% of knowledge items correct to 69.6% correct, $t(81) = -2.61, p < .01$. Participants' mean ratings on the question, "To what extent do you feel prepared to train employers on a worksite health program?" was significantly higher in 2015 compared with 2014, $t(79) = -3.65, p < .01$. Participants' mean self-rated confidence in their ability to deliver a worksite health training program did not change significantly from where the group started in 2014 at "very confident." Participants self-rated their strength on nine training skills. Participants' mean ratings in 2015 were significantly higher than in 2014 for three skills: asking questions to gain information from individuals or a group, $t(80) = -2.21, p = .03$; encouraging individual and group problem solving, $t(80) = -2.40, p = .02$; and public and online speaking and presenting, $t(79) = -1.66, p = .02$.

Self-Reported Training Proficiency

Participants rated their proficiency in training employers in Work@Health on the 2015 version of the Participant Survey. As Figure 1 shows, 67.5% of participants reported that they fully understood how to conduct a worksite health training and another 22.5% reported that they partially understood how to conduct such a training.

Training of Employers by T3 Participants

On the 2015 Participant Survey, T3 participants reported the number of employers they trained and the number of training sessions they conducted. The goal was for each T3 participant to conduct one training session with five employers participating within 10 months after the training lab. A total of 51 T3 participants trained employers. Most (60%) of these participants trained five employers, but the number of employers varied between 2 and 10. Collectively, the T3 participants trained 233 employers.

Ninety-six employers trained by 15 of the T3 participants completed Reaction Surveys. Overall, the employers rated the T3 participants favorably as training facilitators. The majority of employers agreed that T3 participants demonstrated a good understanding of the material (96.9%), effectively delivered the training (98.5%), effectively delivered feedback assessments (98.5%), and did a good job generating participant interaction (87.5%).

Fifty-one (59%) of the 87 participants who completed the training component of the program successfully reached all three of the program's milestones (marketing, recruiting employers, and tailoring and delivering the training; and participating in an online debriefing session), becoming certified trainers. More than half (47) of these 87 participants signed an annual licensing agreement allowing them to continue training employers using the Work@Health curriculum.

Participant Challenges

To better understand participants' experience, the T3 Participant Survey included an item about the challenges T3 participants experienced when attempting to recruit and train employers. As shown in Table 3, the most common challenge from among the potential responses was recruiting employers, followed by marketing. Participants shared that these challenges were caused by a lack of strong connections to employers or employer groups in

the community, and not feeling comfortable cold-calling employers to build new relationships. More than half of the respondents indicated that they had experienced “other challenges,” which they specified as the amount of time required to schedule and conduct trainings, rescheduling training when employers canceled, the length of the training sessions, and the cost of conducting trainings.

DISCUSSION

Results indicate that the Work@Health T3 Program was successful on many levels. The team developed a core program curriculum, built the T3 model around it, and successfully recruited participants nationwide. After the training and technical assistance, T3 participants reported feeling more prepared to train employers and improvement on facilitation skills. The majority of T3 participants who trained employers trained at least five other employers. The employers trained by the T3 participants reported being very satisfied with their trainers’ facilitation skills. Finally, more than half of the participants who met all the T3 milestones signed licensing agreements to continue training employers, indicating the value they believe the training has. The licensing agreement does not allow the T3 trainers to profit financially from delivering the Work@Health training, but allows them to cover operating costs of delivering the training.

The focus group with T3 participants in Atlanta yielded useful information for future program improvements. Their comments about the online learning platform prompted substantial changes. Overall, the participants’ comments about the training content were favorable, as one T3 participant said, “I like how now it’s all put together. You learn all of these things, but now it’s all put together.” Although several were concerned about delivering all the content to employers within a single day, most participants successfully did it. Focus group participants also wanted to know about support that would be available through Work@Health to help the employers they trained. After T3 participants completed their milestones, CDC began offering several months of technical assistance to the employers trained by T3 participants, including webinars and online coaching.

There are limitations to the current study. First, when the data collection period ended, some T3 participants stated that they still planned to train employers. Therefore, our data may underrepresent the number of employers who were trained by T3 participants. Second, while we have data on the reactions of the employers trained by T3 participants, we do not have data to demonstrate whether and how their participation in the training translated into actual expansion of their worksite health promotion programs. Collecting this type of data in the future would allow us to evaluate the effectiveness of the T3 training in achieving the desired outcome of improving employer health and wellness programs to promote employee health.

CONCLUSIONS

The Work@Health T3 Program is one of the first of its kind, successfully teaching individuals how to train employers to implement workplace health promotion programs using a curriculum based on CDC’s workplace health model. The Work@Health program provided direct training to employers and T3 participants, with similar investments in time

and resources. Because the T3 participants went on to train more employers than the program directly trained, it could be argued that the T3 component provided a larger return on investment than the employer training. This study provides evidence that train-the-trainer programs are a promising avenue for scaling up current evidence-based workplace health promotion efforts. As T3 participants continue training employers, the Work@Health team may demonstrate the value of the training by evaluating the impact of the training on the employers who were trained, and then promote it more broadly. These employers and the T3 participants may have further suggestions about how to improve or streamline the training to increase its adoption.

Public health departments and other health-focused agencies could use the Work@Health program to improve the health in their communities by leveraging the worksite setting for health promotion. The Work@Health program is particularly promising because it trains employers on the process of building a program that is tailored to their specific needs, thus building their internal capacity to sustain health promotion efforts through internal and external changes. The T3 component offers a way for health promotion champions to help build the capacity of employers throughout their communities.

References

- America's Health Insurance Plans. Professional development courses: Wellness. 2013. Retrieved from <https://www.ahip.org/resources/online-courses/#>
- Cahalin LP, Kaminsky L, Lavie CJ, Briggs P, Cahalin BL, Myers J, Arena R. Development and implementation of worksite health and wellness programs: A focus on non-communicable disease. *Progress in Cardiovascular Diseases*. 2015; 58:94–101. [PubMed: 25936908]
- Cahalin LP, Myers J, Kaminsky L, Briggs P, Forman DE, Patel MJ, Arena R. Current trends in reducing cardiovascular risk factors in the United States: Focus on worksite health and wellness. *Progress in Cardiovascular Diseases*. 2014; 56:476–483. [PubMed: 24607011]
- Chapman Institute. Worksite wellness certification. 2013. Retrieved from <https://chapmaninstitute.com/courses/certification/>
- Cluff L, Lang J, Rineer J, Jones-Jack N, Strazza KM. Training employers to implement health promotion programs: Results from the CDC Work@Health® Program. *American Journal of Health Promotion*. (in press).
- Cooper PA. Paradigm shifts in designed instruction: From behaviorism to cognitivism to constructivism. *Educational Technology*. 1993; 33:12–19.
- Corelli RL, Fenlon CM, Kroon LA, Prokhorov AV, Hudmon KS. Evaluation of a Train-the-Trainer program for tobacco cessation. *American Journal of Pharmaceutical Education*. 2007; 71:109. [PubMed: 19503693]
- Edutopia. PBL research summary: Studies validate project-based learning. 2011. Retrieved from <http://www.edutopia.org/project-based-learning-research>
- Ertmer PA, Newby TJ. Behaviorism, cognitivism, constructivism: Comparing critical features from an instructional design perspective. *Performance Improvement Quarterly*. 1993; 6(4):50–72.
- Grossmeier J, Terry PE, Cipriotti A, Burtaine JE. Best practices in evaluating worksite health promotion programs. *American Journal of Health Promotion*. 2010; 24(3):1–9.
- Harris J, Hannon P, Beresford S, Linnan L, McLellan D. Health promotion in smaller workplaces in the United States. *Annual Review of Public Health*. 2014; 35:327–342.
- Hiner CA, Mandel BG, Weaver MR, Bruce D, McLaughlin R, Anderson J. Effectiveness of a training-of-trainers model in a HIV counseling and testing program in the Caribbean Region. *Human Resources for Health*. 2009; 7:11. doi: 10.1186/1478-4491-7-11 [PubMed: 19222839]
- Hutchinson A, Wilson C. Improving nutrition and physical activity in the workplace: A meta-analysis of intervention studies. *Health Promotion International*. 2012; 27:238–249. [PubMed: 21733915]

- The Kaiser Family Foundation and Health Research & Educational Trust. Employer health benefits: 2016 Annual Survey. 2016. Retrieved from <http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey>
- Knowles, MS., Holton, EF., III, Swanson, RA. The adult learner: The definitive classic in adult education and human resource. New York, NY: Routledge; 2015.
- Koffman DMM, Lang JE, Chosewood LC. CDC resources, tools, and programs for health promotion in the worksite. *American Journal of Health Promotion*. 2013; 28 TAHP 2-TAHP 5.
- Loeppke R. Guidance for a reasonably designed, employer-sponsored wellness program using outcomes-based incentives. *Journal of Occupational and Environmental Medicine*. 2012; 54:889–896. [PubMed: 22796935]
- Loeppke R, Hymel PA, Lofland JH, Pizzi LT, Konicki DL, Anstadt GW, Schraf T. Health-related workplace productivity measurement: General and migraine-specific recommendations from the ACOEM expert panel. *Journal of Occupational and Environmental Medicine*. 2003; 45:349–359. [PubMed: 12708138]
- Malik SH, Blake H, Suggs LS. A systematic review of workplace health promotion interventions for increasing physical activity. *British Journal of Health Psychology*. 2014; 19:149–180. [PubMed: 23827053]
- McLeroy KR, Bibeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs. *Health Education Quarterly*. 1988; 15:351–377. [PubMed: 3068205]
- National Institute for Occupational Health and Safety. Essential elements of effective workplace programs and policies for improving worker health and wellbeing. 2015. Retrieved from <http://www.cdc.gov/niosh/TWH/essentials.html>
- National Wellness Institute. Worksite wellness certifications. 2013. Retrieved from <http://www.nationalwellness.org/?page=WorksiteWellnessCert>
- Orfaly RA, Frances JC, Campbell P, Whittemore B, Joly B, Koh H. Train-the-trainer as an educational model in public health preparedness. *Journal of Public Health Management and Practice*, Supplement. 2005:S123–S127.
- Pronk N. Best practice design principles of worksite health and wellness programs. *ACSM's Health & Fitness Journal*. 2014; 18(1):42–46.
- Sallis JF, Bauman A, Pratt M. Environmental and policy interventions to promote physical activity. *American Journal of Preventive Medicine*. 1998; 15:379–397. [PubMed: 9838979]
- Sears LE, Shi Y, Coberley CR, Pope JE. Overall well-being as a predictor of health care, productivity, and retention outcomes in a large employer. *Population Health Management*. 2013; 16:397–405. [PubMed: 23480368]
- To Q, Chen T, Magnussen C, To K. Workplace physical activity interventions: A systematic review. *American Journal of Health Promotion*. 2013; 27:113–123.
- Trabeau M, Neitzel R, Meischke H, Daniell WE, Seixas NS. A comparison of “train-the-trainer” and expert training modalities for hearing protection use in construction. *American Journal of Industrial Medicine*. 2008; 51:130–137. [PubMed: 18067179]
- U.S. Department of Health and Human Services. *Healthy People 2010: With understanding and improving health and objectives for improving health*. 2nd. Washington, DC: Author; 2000.
- Wellness Council of America. WELCOA certifications. 2013. Retrieved from <http://www.welcoa.org/consulttrain/certifications.php>

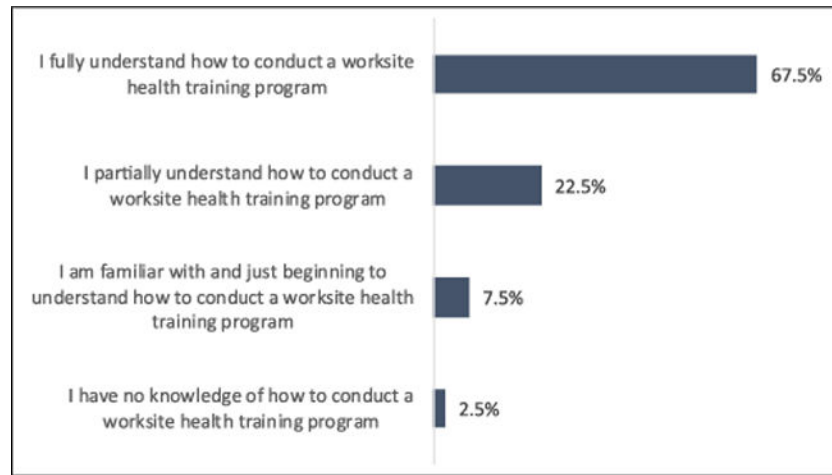


FIGURE 1. Participants' Self-Rated Proficiency in Training Employers 12 Months after Training (N = 80)

NOTE: Eighty participants provided a response to this item on the posttraining survey.

TABLE 1

Region of Residence, Job Titles, and Organization Type for All T3 Applicants, Those Who Participated, and Those Who Completed the Training

Characteristic	Total Applied, n (%)	Not Enrolled/Not Eligible, n (%)	Participated, Did Not Complete, n (%)	Completed Training Program, n (%)
Totals, n	265	162	16	87
Region				
South	110 (41.5)	75 (46.3)	6 (37.5)	29 (33.3)
Midwest	74 (27.9)	41 (25.3)	4 (25.0)	29 (33.3)
Northeast	44 (16.6)	27 (16.7)	3 (18.8)	14 (16.1)
West	35 (13.2)	19 (11.7)	3 (18.8)	13 (14.9)
Puerto Rico	2 (0.8)	0 (0.0)	0 (0.0)	2 (2.3)
Title				
Wellness manager	111 (41.9)	73 (45.1)	5 (31.3)	33 (37.9)
CEO/president/owner	27 (10.2)	12 (7.4)	3 (18.8)	12 (13.8)
Professional instructor/trainer	24 (9.1)	10 (6.2)	4 (25.0)	10 (11.5)
Vice president	13 (4.9)	7 (4.3)	1 (6.3)	5 (5.7)
Director, human resource	3 (1.1)	2 (1.2)	0 (0.0)	1 (1.1)
Director, benefits	4 (1.5)	3 (1.9)	0 (0.0)	1 (1.1)
Environmental health and safety representative	1 (0.4)	1 (0.6)	0 (1.1)	0 (0.0)
Other/missing	82 (30.9)	54 (33.3)	3 (18.8)	25 (28.7)
Type of organization				
Public health department	70 (26.4)	43 (26.5)	3 (18.8)	24 (27.6)
Health/wellness vendor	64 (24.2)	35 (21.6)	5 (31.3)	24 (27.6)
Health care system	36 (13.6)	22 (13.6)	3 (18.8)	11 (12.6)
Insurance broker	28 (10.6)	16 (9.9)	1 (6.3)	11 (12.6)
Other/missing	67 (25.3)	46 (28.4)	4 (25.0)	17 (19.5)

NOTE: T3 = train-the-trainer; CEO = chief executive officer.

TABLE 2

Comparison of Participants' Self-Rated Pre- and Posttraining Knowledge, Attitudes, and Self-Rated Training Skills ($N = 82$)

Outcome Measured	N	2014 Mean Score	2015 Mean Score	p
Percentage of correct responses on knowledge quiz	82	65.94	69.61	<.01
Participant attitudes				
Feel prepared to train employers	80	3.94	4.29	<.01
Confidence to deliver a worksite health training program	81	3.98	3.95	.83
Self-rated skill				
Asking questions to gain information from individuals or a group	81	4.19	4.36	.03
Encouraging individual and group problem solving	81	4.04	4.26	.02
Public and online speaking/presenting	80	4.09	4.28	.02
Maintaining individual and group focus	80	4.04	4.14	.25
Giving verbal and written feedback	80	4.01	4.08	.43
Adjusting to verbal and written feedback	80	4.08	4.15	.38
Providing guidance or direction for individual and group members	80	4.34	4.28	.45
Debriefing and summarizing discussions for individuals and groups	79	4.10	4.23	.17
Setting measurable goals and learning objectives	80	4.04	4.20	.10

NOTE: Boldface values are significant at $p < .05$.

TABLE 3Challenges T3 Participants Encountered Related to Training Employers ($N = 80$)

Potential Challenge	%
Recruiting employers for training	38.8
Marketing worksite training	15.0
Engaging participants during training	7.5
Lack of knowledge about worksite health programs	1.3
Locating space to conduct training	0.0
Other challenges	55.0

NOTE: Eighty participants provided a response to this item on the posttraining survey. Participants could select all challenges that applied. T3 = train-the-trainer.

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