The Booster Break program: Description and feasibility test of a worksite physical activity daily practice

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Abstract. Objective: Work breaks are underutilized opportunities to promote health. The Booster Break program is a co-worker led physical activity group session devoted exclusively to standard 15-minute work breaks. The purpose of this study was to report the fidelity, attendance, feasibility, and sustainability of the Booster Break program and to explore its potential impact.

Participants: The study site was a small business that provides legal and court reporting services to lawyers. The company’s services include legal videography, litigation, records retrieval, and videoconferencing to civil attorneys. Established in 1973, the organization has 14 employees (8 women and 6 men), from 32 to 66 years of age.

Methods: For six months, this small business implemented the Booster Break program. Booster Break facilitators conducted the group sessions according to protocol, which included describing, cueing, and executing the physical activity sequence.

Results: During the six month period, 117 sessions were conducted. The average monthly attendance ranged from 76% to 86%. Participants significantly improved HDL cholesterol ($p = 0.04$) and lost an average of 14 pounds.

Conclusions: The Booster Break program is a feasible physical activity program for small business settings. The implications of the Booster Break program for future research in worksite settings are discussed.

Keywords: Worksites, health promotion, physical activity, work breaks, employee health

1. Introduction

Work breaks are underutilized opportunities to promote health. Many employers provide full-time employees with a 15-minute break time from work in the morning and afternoon and a 30-minute break for lunch. During break times, typical practices include smoking cigarettes, drinking coffee, consuming high caloric, low nutritious snacks, and surfing the net [24,35,39]. Stress and sedentary behavior in the workplace contribute to Type 2 diabetes, obesity, heart disease, and other chronic conditions [18,23,30]. Physical activity breaks in the workplace have been proposed to mitigate the onset of these conditions. Typically, these breaks include some combination of flexibility, stretching, and toning movements as well as aerobic activity and have the potential to influence worker health directly and...
Previous studies have demonstrated the feasibility of implementing physical activity breaks within the work schedule. Pronk et al. [31] successfully implemented a program of 23 flexibility and strength exercises that were conducted 10 minutes each day for 6 months. Yancey et al. [45] reported the outcomes of a single 10-minute bout of physical activity at the work place indicating the feasibility of these breaks in large organizations. Lara et al. [22] reported on *Pausa para tu Salud* (i.e., Pause for Your Health) which was conducted with office workers for 30 minutes each day. Each intervention session was initiated by 10-minutes of light stretching and dance movements. Workers participated either in a group or individually at their workstations. Collectively, this research supports workplace physical activity breaks as a strategy to impact worker health. However, there is little empirical evidence to support the feasibility of this strategy in motivating employee participation over many months, achieving workplace sustainability, affecting psychosocial mediators of health behaviors, and motivating health behaviors beyond the workplace. Furthermore, there is no evidence from randomized controlled trials that these physical activity breaks improve health indices.

Booster Breaks represent an innovative approach to the work break and are defined as “organized, routine work breaks intended to improve physical and psychological health, enhance job satisfaction, and sustain or increase work productivity” [39]. The focus of the Booster Break is health promotion rather than injury prevention. This approach provides a unique focus on peer-led group sessions devoted exclusively to standard 15-minute work breaks during each workday in which participants perform the Booster Break routine in their work clothes. This paper describes the Booster Break program and pilot testing to determine its feasibility and sustainability in a small business setting. Also, exploratory assessments of program impact on physiologic, behavioral, and psychosocial variables are reported.

2. Methods

2.1. Study site and subjects

The study site was a small business that provides legal and court reporting services to lawyers. The company’s services include legal videography, litigation records retrieval, and videoconferencing to civil attorneys across the United States. Established in 1973, the organization has 14 employees (8 women and 6 men), from 32 to 66 years of age, with education levels ranging from high school to college graduates. This site exemplified a small business with a strong wellness mission and management support which included maintaining a non-smoking workforce, encouraging healthy snacks at work, and presenting seminars related to healthy lifestyles. This corporate culture provided an ideal site to pilot test the intervention.

2.2. Recruitment

The principal investigator (WCT) presented the Booster Break program and the purpose of the pilot study to all employees. During and after the presentation, employees had an opportunity to ask questions about the study. After the presentation, the principal investigator (WCT) provided consent forms for employees to read and sign. The owner and manager of the company supported the research study. In two days, all eligible employees, who included eight employees whose primary responsibilities were on-site, as contrasted to drivers, signed the consent forms to participate in the study. Participants in the Booster Break program were white collar employees who sat at least four hours each day.

2.3. Description of intervention (Booster Break program)

The Booster Break was a facilitated, group activity program designed for implementation in a work environment. The Booster Break concept and materials were developed in collaboration with an exercise physiologist, physical activity specialist with behavioral sciences training, instructional designer, health educator, and videographer. The development of the materials followed an established instructional design protocol [3]. The goals of Booster Break were to improve health, energize employees, reduce stress, and enhance productivity (Fig. 1). A Booster Break session was composed of four primary phases: warm up, toning, cool down, and relaxation. The session (Fig. 2) emphasized movement, strengthening, and stretching and was designed to increase a participant’s circulation, flexibility, and relaxation in a socially supportive context. The warm-up, toning, and strengthening phases were composed of 6, 4, and 3 activity move-
ments, respectively. Each session concluded with quiet time for visualization and self-reinforcement. Sessions were conducted in a work space that provided an arm’s length distance among participants. Employees wore their work clothes and only removed their shoes if needed for safety and comfort.

Sessions were group-based and lead by a trained/certified Booster Break worksite facilitator. Booster Break facilitators were employees who volunteered or were nominated by co-workers to lead the Booster Break sessions at their worksite. Certification training for facilitation required a 16-hour training that included...
experiential learning and assessment through a written test and successfully conducting a Booster Break session. The training incorporated Social Cognitive Theory strategies [2] that included observational learning, modeling, guided practice, and skill rehearsal. The objectives were to develop facilitator behavioral capability and self-efficacy to effectively lead the Booster Break sessions. Training materials for facilitators included a 56-page Booster Break training manual that described the steps in each activity, the primary muscle groups, benefits, tips, variations, a 15-minute Booster Break QuickTime® video modeling each activity, and a single page laminated “cheat” sheet summarizing the 15 minute Booster Break movements (Fig. 3).

2.4. Implementation of intervention (Booster Break program)

Three employees from the study site were trained and certified as Booster Break facilitators by a Booster Break trainer. Employees volunteered or were chosen based on their capacity to motivate co-workers, respect from co-workers, and commitment to the Booster Break philosophy. Booster Break facilitators demonstrated and taught proper form for each movement. During the session, the Booster Break facilitators were expected to impart information about the benefits of physical activity, increase self-efficacy for physical activity (i.e., verbal persuasion, mastery experiences, and vicarious experiences), encourage social support among the participants, and promote fun and enjoyment.

At the inaugural session, a “kick-off” luncheon was held to publicize the Booster Break Program and to officially incorporate Booster Break sessions as part of the organizational culture. After the inaugural session, the Booster Break sessions followed a similar pattern. The three facilitators took turns conducting the sessions throughout the 6-month study period. Booster Break sessions were held in the worksite conference room.
3.1. Program fidelity and behavioral components

Periodic assessments ($n = 4$) were conducted by the Booster Break trainer to determine the degree to which the Booster Break was conducted in accordance with the described protocol. Facilitators were rated on procedural skills in facilitating a Booster Break session including properly describing, cueing, executing the activity sequence, and facilitating the group respectfully and non-authoritatively. To assess competence, a checklist was developed based on Booster Break facilitator skill sets. Participant attendance was monitored daily. For each Booster Break session, individuals signed an attendance sheet indicating their participation for that day’s session.

The New Lifestyles Digi-Walker SW 200 pedometer objectively measured physical activity levels. This pedometer’s accuracy, reliability, and suitability for applied physical activity research, as well as a standard protocol are reported and accepted by the foremost experts in the field [4,10,36,37,40,43] and the Centers for Disease Control and Prevention. For one week, at baseline and at a time after six months, each participant wore the pedometer from the moment of getting up in the morning until going to bed at night. Each night, pedometer counts were recorded and each morning the pedometer was reset to zero. The pedometer was worn all day except when showering or taking a bath. Additionally, when swimming, weight training, or bicycling the participant removed the pedometer and used a conversion chart to add counts to the log sheet.

The International Physical Activity Questionnaire (IPAQ) (long version) was administered to assess physical activity patterns. The psychometric properties of the IPAQ have been documented with reported reliability of 0.8 and criterion validity of 0.3 [9]. The IPAQ assesses moderate- and vigorous-intensity physical activity and has five domains: job-related, transportation, household, and recreation physical activity as well as time spent sitting. IPAQ was selected for the self-assessment of physical activity because of strong psychometric properties [9] across the five domains. For each domain, the average time was reported during the previous seven days.

3.2. Physical activity mediator assessment

Physical activity mediators were included in the study to assess whether the Booster Break intervention influenced these constructs and to understand the underlying mechanisms for any behavioral changes. To assess physical activity mediators, questions about self-efficacy, enjoyment, benefits, barriers, and social support were part of the self-administered survey. In the health field, constructs such as self-efficacy, enjoyment, benefits, barriers, and social support are among the most consistent psychosocial correlates of physical activity [25,32]. These constructs were assessed using brief and previously validated measures. Self-efficacy or confidence in one’s ability to be physically active was assessed by a 3-item self-report scale for moderate and vigorous intensity physical activity with high internal consistency coefficients and concurrent criterion-related validity [34]. The enjoyment scale (6 items) was adapted from previous studies [21,29] that documented high internal consistency and test-retest reliability [21] and evidence of factorial validity and convergent evidence of construct validity [29].

Benefits, barriers, and social support [7,32,33] are consistent correlates of physical activity and were assessed by self-report scales in this study. The benefits scale (10 items) has documented reliability and validity [16,33]. Significant correlations ($r = 0.24$) between the benefits scale and vigorous-intensity phys-
ical activity have been reported [33]. Additionally, the unidimensional structure of the benefits scale has been confirmed [16]. The barriers scale (15 items) has documented reliability and validity [7,33]. Concurrent validity for this scale was demonstrated by significant and inverse correlations between the barriers score and vigorous-intensity physical activity [7,33]. The barriers scale has good internal consistency [7].

The social support scale (6 items) was an assessment of friends, family, and co-workers support for physical activity and has documented reliability and validity [17,33]. Retest reliability was high (0.86-family support; 0.91-friend support) [17] and validity has been supported repeatedly by significant associations with walking [17] and vigorous-intensity physical activity [33].

3.3. Employee and organizational psychosocial constructs

In addition to physical activity mediators, we assessed quality of life, work social support, and perceived stress. Quality of life and perceived stress can be potential moderator variables to understand levels of employee participation in the Booster Break intervention. Also, quality of life and perceived stress can be improved by the Booster Break experience. Various levels of work social support can facilitate or impede an organization’s capacity to successfully implement a worksite innovation such as the Booster Break intervention.

The following scales were administered in this study. The Quality of Life Scale (12-item short form) has physical and mental component summary scales with documented reliability and validity [41]. In the United States population, test-retest (2-week) correlations of 0.89 and 0.76 were observed for the physical and mental component summary scores, respectively. In 14 validity tests, the 2 summary measures of the 12-item short form closely mirrored those of the 36-item long form (with larger standard errors for the 12-item form) [41].

Participant’s quality of social relationships and perception of value were measured by a four-item scale (items 5, 6, and 7 of the original scale relate to the profession of physicians and were not included in this study) with documented reliability and validity [19]. The scale is reliable with a Cronbach’s alpha coefficient of 0.71 [19]. Evidence of construct validity was supported by a principal component factor analysis in which all items loaded strongly on a single factor, with an average loading of 0.62. The Perceived Stress Scale (PSS10) (10-items) has documented reliability and validity [8]. This scale demonstrated adequate internal reliability with an alpha coefficient of 0.78 and acceptable construct validity when compared to measures of appraised stress and potential sources of stress (i.e., event frequency) [8].

3.4. Physiologic assessments

A mobile team (transporting equipment and supplies to each screening location) from the Wellness Services department of a local hospital traveled to the participating site at baseline and six months to complete the physiologic assessments. Based on the American College of Sports Medicine’s Guidelines for Exercise Testing and Prescription (seventh edition) [1] and the International Standards for Anthropometric Assessment [26], three measurements were taken on each subject for height and weight using the Seca #214 Stadiometer [13,19] and Tanita # HD-314 digital scale [28] and waist girth (using a standard 60” tape measure). Blood pressure was taken three times (in the morning before the stress of the work day) in accordance with established protocol/procedures using a Critikon Dinamap Plus portable sphygmomanometer [42,44]. Also, a blood draw was conducted by a certified phlebotomist with three years of experience. Blood draw was a fasting draw in the morning prior to the employee starting the work day. Lipid assessments (total cholesterol, HDL, LDL) were conducted at a certified laboratory compliant with CLIA 88 Federal regulations.

4. Analysis of data

We compared 25 outcomes in 4 different domains before and after the intervention. Paired t-test was used to assess the intervention effect. Given the exploratory nature of our analysis with this restricted sample, we did not correct for multiple comparisons [5].

5. Results

The purpose of this study was to report the fidelity, attendance, feasibility, and sustainability of the Booster Break program and to explore the potential impact of this program.
5.1. Booster Break fidelity and behavioral components

All three Booster Break facilitators were able to lead the Booster Break session through all activities as originally designed and within the 15 minute break time (100%). At assessment one, the quality of facilitation varied with trainer competency ratings ranging from 60% to 90% for ability to describe activities, to cue movements within activities, and to execute activities. The most competent facilitator took the greatest level of responsibility for each Booster Break session and demonstrated the highest fidelity at assessment one (80%-90%). All three facilitators showed improved competency ratings from assessment one to assessment four. By assessment four, all facilitators had excellent ratings for their ability to describe, cue, and execute the activity sequence (100%). All facilitators were able to facilitate the group respectfully and non-authoritatively (100%).

The attendance data indicated that 117 of the 120 potential sessions were completed representing a 97.5% completion rate during the 6-month study period. Two sessions were cancelled because Hurricane Ike forced office closures and one session was cancelled because of competing business deadlines. The overall average attendance was greater than 80% with rates of: 76.3%, 82.5%, 85.6%, 81.2%, 77.5% and 80.6% for months one to six, respectively.

The behavioral data (Table 1) showed increases in physical activity, both objective and subjective, and decreases in sitting time, both weekdays and weekends, were observed, but the differences were not significant. For example, sitting time on the weekend decreased from 265 to 222 minutes \( (p = 0.50) \) and sitting time during the weekday decreased from 600 to 394 minutes \( (p = 0.34) \).

5.2. Physical activity mediators (Table 2) and employee and organizational psychosocial constructs (Table 3)

No significant changes were found for the psychosocial variables of self-confidence, enjoyment, benefits, barriers, and social support from friends, family, and co-workers. Although not statistically significant, social support for physical activity from co-workers increased during the six month study period.

For the employee and organizational psychosocial constructs there were no discernible patterns in the results. These variables included quality of life, work social support, and perceived stress. None of these variables were statistically significant.

5.3. Physiologic variables (Table 4)

Pre-post test HDL cholesterol significantly improved \( (p = 0.04) \) over the 6-month period. An average weight loss of 14 pounds (from 171 to 157 pounds) was observed but not statistically significant \( (p = 0.95) \). Systolic and diastolic blood pressure, waist circumference, total cholesterol, and LDL cholesterol were not significantly different from pre- to post-assessment.

6. Discussion

This pilot study evaluated the compliance of the Booster Break program. The strong attendance record at Booster Break sessions during the six months indicates that health-promoting work breaks are feasible and sustainable in a small workplace.

The high fidelity of the Booster Break sessions in terms of adherence to schedule (97.5%) and protocol (100% by assessment 4) indicates its potential for implementation in small business settings. This finding is particularly encouraging given the extent to which the sessions were conducted by the participants with minimal external influence from the researchers. Booster Break success was mediated by adaptability to address participant needs (e.g., prizes and raffles encouraging attendance and institution of new movement activities appropriate to maintain participant interest) as well as organizational needs (e.g., conducting sessions in the hallway when the conference room was being used).

The public health benefits of physical activity are extensively documented and well known [11]. For example, physical activity can have a positive effect on lipids, blood pressure, blood cholesterol, and body composition [11]. In this study, there was a statistically significant improvement in HDL cholesterol over the study period, but this finding should be interpreted with caution since there was no correction for multiple comparisons in the statistical analysis and no assessment of food intake. Nonetheless, HDL cholesterol is a physiologic variable consistently associated with physical activity [11]. Consistent with this finding were nonsignificant increases in objective and subjective assessments of physical activity and decreases in self-reported minutes in time spent sitting on weekdays and weekends. These trends support the Booster Break program goal of gently moving a predominantly sedentary workforce to have physical activity experiences that might translate to their lifestyles outside the workplace. The reductions in sitting time are particularly intriguing given the emerging science demonstrating the contribution...
<table>
<thead>
<tr>
<th>Variable</th>
<th>Baseline (SD)</th>
<th>Six months (SD)</th>
<th>Diff</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pedometer assessment</td>
<td>6596.76 (2522.39)</td>
<td>7119.31 (2360.09)</td>
<td>−522.6</td>
<td>0.58</td>
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<td>IPAQ</td>
<td>3772.36 (2082.40)</td>
<td>4118.50 (4549.91)</td>
<td>−346.1</td>
<td>0.81</td>
</tr>
<tr>
<td>Job-related physical activity (minutes)</td>
<td>230 (560.98)</td>
<td>247.86 (466.08)</td>
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<tr>
<td>Recreational, sport, and leisure-time physical activity (minutes)</td>
<td>93.57 (157.76)</td>
<td>301.43 (589.27)</td>
<td>−207.9</td>
<td>1.0</td>
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<tr>
<td>Time spent sitting on weekday (minutes)</td>
<td>600 (425.68)</td>
<td>394.29 (154.37)</td>
<td>205.71</td>
<td>0.34</td>
</tr>
<tr>
<td>Time spent sitting on weekend day (minutes)</td>
<td>265.71 (169.2)</td>
<td>222.86 (82.81)</td>
<td>42.86</td>
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<th>Six months (SD)</th>
<th>Diff</th>
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<tr>
<td>Self-efficacy for vigorous exercise (scale 1–5)</td>
<td>4 (1.02)</td>
<td>3.24 (1.4)</td>
<td>0.76</td>
<td>0.19</td>
</tr>
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<td>Self-efficacy for moderate physical activity (scale 1–5)</td>
<td>4.48 (0.72)</td>
<td>3.81 (0.79)</td>
<td>0.67</td>
<td>0.13</td>
</tr>
<tr>
<td>Enjoyment of vigorous exercise (scale 1–5)</td>
<td>4.48 (0.50)</td>
<td>3.95 (1.1)</td>
<td>0.52</td>
<td>0.25</td>
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<td>Enjoyment of moderate physical activities (scale 1–5)</td>
<td>4.62 (0.65)</td>
<td>4.33 (0.96)</td>
<td>0.29</td>
<td>0.38</td>
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<tr>
<td>Benefits of regular physical activity (scale 1–5)</td>
<td>4.03 (1.29)</td>
<td>4.09 (1.39)</td>
<td>−0.06</td>
<td>0.70</td>
</tr>
<tr>
<td>Barriers to regular physical activity (scale 0–4)</td>
<td>1 (0.37)</td>
<td>1.14 (0.64)</td>
<td>−0.14</td>
<td>0.70</td>
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<tr>
<td>Social support from family (scale 0–4)</td>
<td>1.5 (1.57)</td>
<td>0.277 (0.53)</td>
<td>1.22</td>
<td>0.13</td>
</tr>
<tr>
<td>Social support from coworkers (scale 0–4)</td>
<td>1.62 (1.64)</td>
<td>1.81 (1.35)</td>
<td>−0.19</td>
<td>0.30</td>
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<th>Variable</th>
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<th>Six months (SD)</th>
<th>Diff</th>
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<tr>
<td>Quality of life: physical (scale 1–5)</td>
<td>44.98 (4.28)</td>
<td>47.55 (4.52)</td>
<td>−2.57</td>
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<tr>
<td>Quality of life: mental (scale 1–6)</td>
<td>48.64 (6.36)</td>
<td>43.54 (7.54)</td>
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<td>0.38</td>
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<td>Work social support (scale 1–5)</td>
<td>3.75 (0.41)</td>
<td>3.64 (0.67)</td>
<td>0.11</td>
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<tr>
<td>Perceived stress (scale 0–4)</td>
<td>1.27 (0.66)</td>
<td>1.33 (0.65)</td>
<td>−0.06</td>
<td>1.0</td>
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<tr>
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<th>Baseline (SD)</th>
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<tr>
<td>Blood Pressure</td>
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<tr>
<td>Systolic (mm of Hg)</td>
<td>122 (9.02)</td>
<td>121.13 (14.46)</td>
<td>0.88</td>
<td>0.38</td>
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<td>Diastolic (mm of Hg)</td>
<td>77.21 (5.47)</td>
<td>76.17 (7.42)</td>
<td>1.04</td>
<td>0.38</td>
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<td>Waist Circumference (inch)</td>
<td>37.21 (3.78)</td>
<td>38.44 (3.28)</td>
<td>−1.23</td>
<td>0.27</td>
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<td>Weight (pounds)</td>
<td>171.58 (32.12)</td>
<td>157.42 (36.18)</td>
<td>14.16</td>
<td>0.95</td>
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<tr>
<td>Lipid (mg/dl)</td>
<td></td>
<td></td>
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<tr>
<td>Total Cholesterol</td>
<td>203 (19.84)</td>
<td>198.25 (25.59)</td>
<td>4.75</td>
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<td>HDL</td>
<td>50 (12.97)</td>
<td>56 (19.92)</td>
<td>−6.00</td>
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<td>LDL</td>
<td>127.63 (23.81)</td>
<td>121.5 (39.87)</td>
<td>6.13</td>
<td>0.45</td>
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of sedentary behavior and inactivity physiology to cardiovascular risk factors [14,15]. Basically, sedentary behavior has adverse health consequences independent of physical activity [20]. Reducing sedentary time has important public health benefits [14].

In our study, there was not an objective assessment of sedentary behavior (e.g., physical activity monitoring system to measure non-exercise activity) [27]. Nevertheless, the questions on sitting time from the IPAQ have strong psychometric properties [9]. Our research demonstrates that a physical activity worksite intervention can potentially influence sitting times during the weekdays and weekends. The Booster Break program was not designed as a weight loss intervention; however, the average weight loss of 14 pounds during the six months further supports the benefits in helping sedentary employees realize the advantages of increasing physical activity.

None of the changes in the behavioral variables or physical activity mediators were statistically significant from baseline to six months, likely due to the small sample size of this pilot study. Other worksite studies [12] have reported mixed findings related to physical activity mediators. Seven educational courses were taught over a three and one-half week period by either a peer or professional educator. For the peer led group, there was an increasing trend for self-efficacy. For the professional led group, there was a decreasing trend in self-efficacy. Our study emphasized the peer-led, experiential, and behavioral skill based approach to enhance
mediators, including self-efficacy. Perhaps, stronger educational and personalized strategies targeting barriers to physical activity are needed to change mediators. Although not statistically significant, social support for physical activity from co-workers increased during the six month study period. This finding is consistent with the premise that the Booster Break program involves co-workers supporting each other. Overall, the intensity of the intervention and specific strategies to improve physical activity mediators and change behavior in worksite settings merit further study.

Previous research focused on a single episode of physical activity [45], injury prevention physical activity breaks [31], and a combination of group and individual activity breaks [22]. The current study extends the limited research base by focusing on daily sessions for an extended period of time (i.e., six months), a general health promotion orientation, and structured peer-led group sessions. Moreover, our research uniquely contributes to the literature by assessing spillover effects and psychosocial mediators.

The potential limitations of the current pilot study are the pre- and post-design, small sample size (n = 8), the evaluation of a single worksite, and the absence of objective measures of sedentary behavior. In this study, there was no control group, and no assessment of eating habits and body fat. The small sample size diminishes the power to detect statistically significant differences in weight loss and behavioral variables. The generalizability of the findings is limited by methodological weaknesses. A large sample size with several worksites would provide a robust test of the Booster Break outcomes. Appropriate caution is needed in generalizing these results to larger organizations with more traditional worksite cultures.

7. Conclusion

This worksite study is the first research to assess the feasibility and impact of the Booster Break program (i.e., health-promoting work breaks) by including psychosocial mediators and assessment of sitting time and physical activity outside of the workplace. This research expands the research base on activity breaks and contributes uniquely to the literature. A national study reported that 71% of employees believed that employers should provide opportunities during the work day for physical activity [6]. Our results indicate that the Booster Break program is feasible and sustainable in a small organization. The Booster Break program is a convenient, minimal resource approach to workplace health and thus provides a potential solution to meet the expectations and needs of employees during the work day. Our findings confirm that the Booster Break program merits further research as a simple strategy to improve employee health.

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References

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