DISSERTATION

A QUALITATIVE INVESTIGATION OF WELLNESS PROGRAM IMPLEMENTATION STRATEGIES

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ABSTRACT

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The prevalence of occupational stress has been on the rise for decades. Now, with the emergence of COVID-19, employees face even more challenges that can lead to increased levels of occupational stress. To buffer against the negative health outcomes and costs associated with occupational stress, organizations often implement wellness programs. However, the way in which wellness programs are implemented can have significant effects on their success. Although various implementation models have been proposed, researchers have little understanding as to the extent to which practitioners implementing wellness programs use the prescribed steps and sequences provided. Additionally, with the nature of work rapidly evolving due to COVID-19, it is important for researchers to understand how the pandemic impacts program implementation. Thus, the current study explores: (1) the extent to which the steps and sequences characterized by both an occupational health model and an organizational change model are used by practitioners implementing wellness programs in the workplace; and (2) how the COVID-19 pandemic impacted wellness program implementation. Results suggest both models describe valuable steps practitioners use when implementing wellness programs, these processes are not linear, and COVID-19 affected wellness implementation by forcing wellness to the forefront of organizations, encouraging a greater emphasis be placed on a wider definition of wellness, and by introducing volatility in the workplace and in wellness programming.

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INTRODUCTION

Over the past several decades, employee strain, more commonly referred to as stress, has been on the rise; studies show that work-related strain is now the most common source of stress experienced by American adults (The American Institute of Stress, 2017). Job stress, or occupational stress, is defined as the negative physical and emotional responses that result from an imbalance between job demands and worker capabilities, resources, and needs (The National Institute for Occupational Safety and Health, 1999). Occupational stress has been a top concern for organizations since the 1980s, likely due to the negative effects it has on both employee health and organizational outcomes (Goh et al., 2016; Quick & Henderson, 2016). Now, with the ongoing COVID-19 pandemic, employees face additional challenges (e.g., social isolation, working from home, high workloads, etc.), which can lead to increased levels of occupational stress.

To buffer against the negative health outcomes and costs associated with occupational stress, organizations often implement wellness programs. However, the way such programs are implemented can have significant effects on their success (e.g., Berry et al., 2010; Goetzel et al., 2014). According to Nielsen et al. (2010), programs have an increased chance of success if they follow a structured and participatory implementation process. All implemented programs follow some type of "plan," whether it be ad hoc, based on prior rollouts, or based on theories and models of change. If we want to maximize program success, we need more research investigating how organizations actually implement wellness programs.

Although various implementation models have been proposed in both the occupational health and the organizational change and development academic literatures, researchers have little understanding as to the extent to which practitioners implementing wellness programs use

prescribed steps and sequences. Additionally, with the nature of work rapidly evolving due to COVID-19, it is important for researchers to understand how the current pandemic impacts program implementation.

One purpose of the current study was to explore the extent to which the steps and sequences embedded in occupational health and organizational change implementation models are used by practitioners implementing wellness programs in the workplace. Another purpose of this study was to explore how the COVID-19 pandemic impacted wellness program implementation. Thus, this study makes several contributions to both the occupational health psychology (OHP) and organizational change and development (OCD) literatures. First, it provides evidence of the content validity of two published implementation models by highlighting the extent to which practitioners implementing wellness programs actually use the prescribed steps and sequences. Second, this study addresses the ongoing changing nature of organizational interventions due to COVID-19. In turn, these study contributions can be used to improve the effectiveness of workplace wellness programs, which I discuss in more detail in the following section.

Wellness Programs

Examples of Wellness Programs. Wellness programs deliver a variety of services to employees. Some of the more traditional services include health screenings, diagnostic tests, counseling services, and financial tools (Global Wellness Institute, 2018). For example, health screenings measure common health indicators such as body weight, blood pressure, blood sugar, and cholesterol. Some organizations host screenings directly in the office, whereas other organizations will cover the cost of the service, but require the screenings take place at employees' primary care provider.

Another common wellness service provided by organizations are incentive programs. These programs typically give employees rewards or incentives (e.g., monetary rewards, prizes, or additional benefits) for engaging in healthy behaviors and maintaining healthy levels of biometric indicators such as blood pressure, body-mass index, cholesterol, and glucose levels.

Other wellness programs create health and fitness challenges by encouraging the use of wearable devices, such as Fitbit. These devices are capable of tracking step counts and time spent exercising. Organizations will create challenges to see which team or individual can log the most steps or time spent exercising over a certain period of time. To participate in these challenges, employees simply wear the device to log their steps or exercise time. The goal of these challenges is to encourage exercise by facilitating individual health goals and creating friendly competition. Examples of well-known companies that partner with Fitbit include BP, Bank of America, IBM, and Target (Farr, 2016).

A recent trend in wellness programs is introducing employees to mindfulness practices (Reb et al., 2020). Mindfulness-based stress management interventions aim to foster attention and awareness of present moment experiences (Creswell, 2017). This is typically done via mindful meditation and is sometimes combined with yoga. The mediation encourages the development of a particular kind of attention that is characterized as nonjudgmental awareness, openness, curiosity, and acceptance of present experiences (Chiesa & Serretti, 2009). Mindfulness interventions seek to improve wellbeing by facilitating attention regulation, engagement, body awareness, emotion regulation, change in self-perspective, and stress recovery (Hölzel et al., 2011; Reb et al., 2020). Previous studies provide evidence to suggest mindfulness interventions are not just the latest wellness trend; they are also effective at reducing stress levels in participants (e.g., Allen et al., 2015a; Chiesa & Serretti, 2009; De Vibe et al., 2013; Pipe et al.,

2009; Sharma & Rush, 2014). When taken together, the purpose of wellness services is to target broader health and wellness issues around exercise, healthy eating, sleep, chronic illness, obesity, addiction, depression, financial health, and stress (Global Wellness Institute, 2018).

The Business Case for Wellness Programs: Cost Savings. A survey conducted by the National Association of Professional Employer Organizations concluded that nearly 42% of organizations consider healthcare costs to be the most serious challenge to their bottom line (Harris, 2016). In response to this growing concern, many organizations seek to implement wellness programs that decrease the rising costs of healthcare. This increased interest in wellness has been deemed the "wellness revolution," (Kickbusch & Payne, 2003; Pilzer, 2002), and U.S. organizations are big consumers in the wellness market (Lieberman, 2019). In 2017, the global wellness market was valued at $4.2 trillion and is estimated to be growing by over 6% each year (Global Wellness Institute, 2018). A key sector of this market is workplace wellness. Currently valued at $48 billion, the workplace wellness market is projected to grow to $66 billion by the year 2022 (Global Wellness Institute, 2018). This rapid growth in spending is associated with the increased prevalence of wellness programs. Over 60% of all U.S. worksites offering a health promotion program were initiated between 2012 and 2017 (Centers for Disease Control and Prevention, 2018). According to the Centers for Disease Control and Prevention (2018), nearly 92% of U.S. worksites employing more than 500 people and almost 40% of worksites employing 10 to 24 employees offer some type of wellness program.

The Business Case for Wellness Programs: Outcomes. This increase in the prevalence of wellness programs is supported by abundant evidence suggesting wellness programs positively impact employee health, attitudes, and productivity, while yielding a significant return on investment through reduced health care costs, reduced absenteeism, and reduced turnover

(e.g., Aldana et al., 2005; Baxter et al., 2014; Berry et al., 2010; Chapman, 2003; Chapman, 2012; Goetzel et al., 2014; Gubler et al., 2018; Hamar et al., 2015; O'Donnell, 2002; Parks & Steelman, 2008). Berry et al. found that the return on investment for a well-implemented program can be as high as 6 to 1; for every $1 invested into the program, organizations saw a return of $6. Additionally, Aldana et al. explored the effects of wellness programs on absenteeism rates. They found that program participants averaged three fewer days of missed work compared to those who did not participate. Finally, Baicker et al. found that organizations' medical expenses dropped by $3.27 for every $1 spent on wellness programs.

In addition to the organizational benefits, wellness programs also benefit individuals within the organization. For example, one study found that wellness programs successfully improve weight reduction and physical fitness while decreasing stress (Person et al., 2010). Furthermore, Parks and Steelman (2008) found that employees who participated in organizational wellness programs reported significantly higher levels of job satisfaction. Berry et al. (2010) reported that organizations that deliver effective wellness programs tend to have greater levels of employee morale. Finally, due to decreases in absenteeism, participants in wellness programs perform better at work compared to their nonparticipating coworkers (Berry et al., 2010).

As illustrated above, investments in wellness programs can benefit organizations and individual employees by reducing absenteeism and turnover, decreasing healthcare costs, improving health outcomes, and increasing job satisfaction. However, these benefits are not a given. Studies have shown organizations with effective wellness programs report significantly less voluntary turnover than do organizations with ineffective programs (Berry et al., 2010) as well as greater medical and absenteeism cost savings (Baicker et al., 2010). However, not all

wellness programs are equally effective as some studies show limited or nil benefits (Baicker et al., 2010; Baxter et al., 2014; Gowrisankaran et al., 2013, Jones et al., 2019b).

The variability in effectiveness could be due to a variety of reasons. One is the initial health of the sample. For example, previous research shows that initial employee health is related to participation in wellness programs (Jones et al., 2019b). Specifically, healthier employees are more likely to enroll in wellness programs compared to unhealthy employees. Thus, the initial health of the community where an organization is located could be a factor in determining the success of the program. Another potential explanation for variability in wellness program success is how program outcomes are measured. For example, Zula et al. (2013) highlighted the difficulties many organizations face when attempting to evaluate their wellness programs, and the results of the Corporate Health Systems (2008) survey indicated that 67% of organizations do not evaluate their programs at all. Those that do evaluate their program measure outcomes such as satisfaction, absenteeism, productivity, and health claims. Given the lack of consensus regarding what to evaluate, it is plausible that the wrong outcomes are measured or that the outcomes are measured at the wrong time. While these other causes of variability are plausible, Nielsen et al. (2010) identified rigor of program implementation as the main reason for variability in program effectiveness. The challenges surrounding program implementation will be explored in the following section. For this study, I define implementation as the process in which a program is designed and delivered.

Implementing Change Initiatives

Implementing programs to improve organizational outcomes and employee well-being is characteristic of not only employee wellness programs, but more broadly of organizational change and development. For example, companies use organizational change and development

initiatives to adapt to market changes and remain competitive. Organizational change can be broadly defined as deliberate activities that move an organization from its current state to its desired future state (Harigopal, 2006). This desired future state includes internally-focused goals, such as changing the organizational culture, or externally-focused goals, such as increasing a company's market share. Occupational health interventions, often manifesting via wellness programs, can be considered a specific type of organizational change because their goal is to improve employee health and wellbeing.

Although change is necessary, creating and sustaining effective organizational change can be difficult. It is commonly cited throughout the OCD literature that organizational change efforts fail at a rate of about 70% (Burnes & Jackson, 2011). This high failure rate led to a considerable number of research studies aimed at identifying and managing the antecedents of both organizational change success and failure.

One challenge organizations face when implementing change initiatives is a lack of familiarity with, or expertise in, change management. Expertise is developed through repeated exposure and practice with a specific domain (Kahneman & Klein, 2009). However, organizational change is often a slow-moving process, often taking years for change results to manifest. This slow-moving process limits the abilities of change managers to receive meaningful feedback on what worked and did not work. This feedback is critical to improving the change agent's performance and expertise in change management (Stouten et al., 2018).

Another hurdle organizations face when implementing change initiatives is employees' resistance to change. Resistance to change is characterized as a less than favorable attitude toward change that manifests in terms of lack of buy-in, push-back, criticism, and reluctance to take actions that are needed (Ford & Ford, 2010). It often stems from employees' fear of the

unknown and desire to subscribe to old norms (Martins, 2011). Employees may resist change for a variety of reasons. One is the cognitive effort required to participate in a changing environment. For example, habits allow us to simplify our lives by encouraging us to function on "auto-pilot," however change forces us to break our habits through active thinking, which requires people to put more effort into their tasks (Martins, 2011). A lack of trust in management is another reason employees may resist change efforts (Oreg et al., 2011). Organizational change efforts are typically implemented from the top of the organization (e.g., upper level and middle level managers) down to employees. Thus, when employees do not trust management, they likely will not trust the change management is trying to implement.

Finally (and most relevant here), features of the change implementation, or the way the change is implemented, can greatly influence whether or not a change effort is successful (Jones et al., 2019a; Oreg et al., 2011). Jones et al. identified a number of key reasons for change failure, many of which were related to variability in implementation (i.e., time constraints, inadequate coordination, manager bandwidth, and inadequate training). In addition to resource availability, variability in implementation is likely due, in part, to scientific literatures and practitioner reports offering different solutions for how to implement change. The differing viewpoints make it difficult for change agents to identify and apply scientific "best practices." Thus, change agents often turn to popular press articles that have no scientific evidence backing them (Stouten et al., 2018).

Organizational Change Models. Researchers have attempted to mitigate these challenges by offering prescriptive steps and sequences to follow when implementing change initiatives. Broadly speaking, the organizational change and development literature offers an abundance of models on how to implement change. For example, Lewin's three-step model of

change is one of the first organizational change models (Lewin, 1947). Lewin outlined three important steps to facilitate change: unfreeze, transform, and refreeze. Although critics argued that Lewin's model is overly simplistic, it is one of the most well-known approaches to organizational change. Porras and Robertson (1992) proposed a more extensive model of planned change based on an extensive review of successful organizational change efforts. According to their model, in addition to the organization-level changes, both employees and management must enact specific behaviors for change to be successful. Their model is one of the few high-level change models because all-encompassing models are complex to develop and test. Another popular model of organizational change frequently used by practitioners is Kotter's Eight-Step Model (Kotter, 1996). This model clearly lays out eight steps that lead to successful organizational transformation and was developed to be simple and practical to implement. Other models include Beer's (1980) Six-Step Model, Burke and Litwin's (1992) Model of Organizational Change, Judson's (1991) Five-Steps Model, McKinsey's 7-S Model (Peters & Waterman, 1982), and Weick and Quinn's (1999) typology (Weick & Quinn, 1999). These models were developed to address many forms of organizational change including culture change, organizational restructuring, and implementing new technology.

In an effort to consolidate models and provide a consensus on basic organizational change processes, Stouten et al. (2018) proposed ten empirically-supported steps to organizational change: (1) gather evidence and diagnose the problem, (2) assess and address the organization's readiness for change, (3) implement evidence-based change interventions, (4) develop effective change leadership throughout organization, (5) develop and communicate a compelling change vision, (6) work with social networks and tap their influence, (7) use enabling practices to support implementation, (8) promote micro-processes and experimentation, (9)

assess change progress and outcomes over time, and (10) institutionalize the change to sustain its effectiveness. Because this model synthesizes implementation models based in the organizational change and development literature, this is one of two models I use to explore the extent to which the prescribed steps and sequences are used by practitioners implementing wellness programs in the workplace. The other model I use is based in the occupational health literature.

Occupational Health Models. In addition to general change models, models intended to address particular forms of organizational change have also been developed. The occupational health literature offers multiple implementation models that intend to address health-specific organizational initiatives such as wellness programs. For example, Elliot et al. (2012) proposed their model of translational effectiveness, suggesting leadership, scheduling, competing demands, and tailoring are important components when implementing health promotion programs. Additionally, Gleddie (2012) proposed an implementation model specific to health promotion programs within schools. In this model, the importance of qualified personnel, stakeholder involvement, communication, and integration into everyday life are emphasized. Other occupational health implementation models include the 4-S model (Äikäs et al., 2017), Best Practice Design Principles (Pronk, 2014), and ecological models (Richard et al., 2011).

Similar to Stouten et al.'s (2018) review of organizational change models, Nielson et al. (2010) identified and compared occupational health intervention models in an effort to consolidate the literature. Their review covered five models: The Risk Management approach (Cox et al., 2000), The Management Standards (Cousins et al., 2004), Work Positive (NHS Health Scotland, 2002), The Prevenlab method (Peiro, 2000), and The Health Circles method (Aust & Ducki, 2004). Based on their comparative analysis of these models, Nielsen et al. identified five essential steps for implementing occupational health interventions: (1)

preparation, (2) screening, (3) action planning, (4) implementation, and (5) evaluation. Similar to my reasoning for using Stouten et al.'s (2018) model, I use Nielson et al.'s (2010) model to explore the extent to which the recommended steps and sequences are used by practitioners implementing wellness programs in the workplace.

Although Nielsen et al.'s (2010) five steps and Stouten et al.'s (2018) ten steps are rooted in different literatures, there are similarities between the models. For example, "gather evidence and diagnose the problem" is similar to "screening," and "assess and address the organization's readiness for change" is similar to "preparation." There are also notable differences between the two. The occupational health model recommends first assessing readiness for change and then conducting a needs assessment, whereas the change model recommends starting with a needs assessment and then assessing readiness for change. Another difference is that the occupational health model places more emphasis on the planning stages before the delivery and evaluation stages, whereas the change model places more emphasis on the delivery steps. Finally, the occupational health model does not include an institutionalize stage to sustain the change effort over time. Since these models are rooted in different literatures, it is unclear whether model differences reflect distinct historical roots or different underlying paradigms for understanding change initiatives.

Due to the differences between the steps and processes characteristic of organizational change and occupational health implementation models, it is beneficial to investigate how practitioners implement wellness programs in the workplace. This will facilitate the development of best practices across literatures which, in turn, will guide organizations with future implementation efforts. The insight of those who have first-hand experience implementing wellness programs can provide valuable information regarding whether these published models

reflect the implementation steps and sequences employed by practitioners. Additionally, those with first-hand experience can speak to which steps and sequences they believe to be essential for successful wellness program implementation. Although investigating the steps and sequences is essential for developing a better understanding of wellness program implementation, it is also important to explore the context in which these programs take place. One such context that recently impacted organizations around the world is the emergence of the COVID-19 virus.

COVID-19

Using wellness programs to reduce occupational stress has become even more important in recent years. As mentioned previously, work-related stress is now the most common type of stress experienced by Americans (The American Institute of Stress, 2017). However, if organizations want to reduce employees' occupational stress, they need to ensure they are effectively implementing programs that reduce the experience of strain. To do this, organizations need to not only understand general best practices in wellness program implementation, but also how contextual variables can impact implementation strategies and overall program success. In this case, contextual variables are defined as the environmental factors (e.g., cultural and social) that influence a particular phenomenon (Funderburg & Levy, 1997). For example, the degree to which employees are willing to participate, the baseline health of employees, and the financial resources available for implementation are contextual variables that may impact wellness program success. Another contextual variable impacting implementation success may be organizational culture. A wellness intervention may successfully reduce burnout in employees at one organization that champions wellness, but not have any effect on the employees of a different organization that does not value wellness.

A contextual variable that sent shockwaves through the world of work is the spread of the COVID-19 virus. Since the World Health Organization declared COVID-19 a global pandemic in March 2020, the way we live our everyday lives was uprooted, as was the way we work. In the U.S. alone, one in five American workers filed for unemployment between the middle of March and early May 2020 (Tappe, 2020). For those who remain employed, many faced an increase in work-family conflict, the added stress of adapting to a virtual working environment, and a lack of boundaries between work and nonwork life (Rudolph et al., 2020). These three challenges will be discussed in more detail below.

One work-related stressor exasperated by COVID-19 is work-family conflict. Work-family conflict is defined as the inter-role conflict individuals experience when their job demands and family demands are incompatible (Greenhaus & Beutell, 1985). Work-family conflict was more elevated during the pandemic because most schools and childcare facilities were closed. Working parents must balance working from home with caring for and/or homeschooling children during the workday (Rudolph et al., 2020). Thus, it is likely that employees experiencing an increase in role conflict due to COVID are also experiencing increased levels of strain and reduced well-being (Nohe et al., 2015). Since it is likely contributing to increased levels of strain, COVID-19 is an important contextual variable to investigate with respect to how it is impacting wellness program implementation.

Another COVID-related stressor employees face is the need to quickly adapt to a virtual working environment. Telecommuting, sometimes referred to as telework, flex work, or remote work, emerged in the 1970s and grew to include about 16% of the U.S. workforce by 2018 (Bureau of Labor Statistics, 2019). Traditionally, telecommuting was offered by organizations as an alternative work arrangement that allowed employees to work a portion of their regular hours

away from the workplace, often at home (Allen et al., 2015b). Although 2020 statistics have not been released yet, telecommuting was adopted by most organizations to promote physical distancing for jobs that are suitable to remote work (Rudolph et al., 2020). As a result, many employees are now navigating how to complete their everyday job tasks, once done face-to-face in an office setting, in an online setting.

Telecommuting is causing increased stress among employees because of its intersection with work-family issues (Rudolph & Zacher, 2021). This is especially apparent when it comes to boundary management preferences. Boundary management preferences are people's preferences for how they manage their life roles. Some people prefer to keep strong boundaries between their life roles, whereas other prefer to integrate them (Ashforth et al., 2000). Telecommuting typically creates difficulties for people who prefer strong boundaries as both work and family events are occurring in the same location. As a result, employees working from home no longer have as much control over their boundary management preferences.

The nature of work rapidly evolved due to the global spread of COVID-19. However, no research has yet to emerge on how wellness program implementation is being impacted. As a result, researchers have no knowledge regarding whether programs are still being implemented, and if so, how the pandemic is altering the ways by which these programs are delivered. For example, due to the threat of changing working conditions on worker well-being, organizations may be particularly meticulous when planning to ensure their program meets participants' needs. On the other hand, some organizations may be feeling pressure to deliver a program as quickly as possible, resulting in steps being skipped. Exploring the ways COVID-19 impacted wellness program implementation will facilitate a better understanding of how implementation initiatives are affected by crisis situations and what unique challenges, if any, have arisen from COVID-19

in particular. A better understanding of these potential implementation challenges can lead to informed solution development that buffers these challenges. As occupational health professionals, we want to see successful wellness programs implemented. If COVID-19 poses a threat to that, we need to develop solutions so organizations can adapt and encourage successful program implementation during crises, a time when wellness is even more essential. Additionally, when organizational resources typically available to implement these programs are reduced, it is important to identify what steps are the most important for successful implementation. It might be the case that COVID-19 forces professionals to pare down typical implementation steps to only the most essential implementation components, which is something we may not normally do if not for these unprecedented times.

The Current Study

To address: (1) the lack of consensus regarding the steps and processes described in the organizational change and occupational health implementation models and (2) the need to better understand the ways COVID-19 impacted wellness implementation, I conducted a qualitative study investigating how wellness programs are implemented in the workplace. I chose to conduct a qualitative study to gather richer, more in-depth information that cannot be obtained via survey methodologies. In doing this, I explored four research questions.

First, I explored the extent to which the steps and sequences included in both the consolidated occupational health implementation model (Nielsen et al., 2010) and the consolidated organizational change and development model (Stouten et al., 2018) are used by practitioners implementing wellness programs in the workplace. Thus, my first research question is:

Research Q1: How do practitioners implement wellness interventions in the workplace?

My next two research questions evaluate whether certain steps within the steps they identified for *RQ1* tend to occur across successful program implantations and whether certain sequencing of steps identified for *RQ1* tend to arise in successful program implementations. These two questions allow me to assess patterns of steps and sequences within successful program implementations.

Research Q2: Among practitioners whose implementation models more closely resemble the published models, are certain steps more likely to be present?

Research Q3: What sequence of steps is more likely to occur among practitioners whose implementation models more closely resemble the published models?

Finally, in an effort to better understand the ways COVID-19 impacted wellness program implementation and what unique challenges, if any, have resulted, my final research question is:

Research Q4: How has COVID-19 impacted the ways in which wellness programs are implemented?

METHOD

Participants

Sixteen practitioners who have experience implementing successful wellness programs completed interviews. To meet inclusion criteria for this study, participants must have been currently employed in some type of applied or practitioner role and have some experience implementing successful organizational wellness programs. This included previous experience, meaning they implemented an organizational program that is no longer active, or current experience, meaning they were actively involved in implementing an organizational wellness program. A successful program was broadly defined as a program that: (1) reached its intended audience and (2) delivered content that aligned with the audience's wellness needs and interests.

Of the 16 total participants, 12 reported being internal employees, (they were directly employed by the company for whom they were implementing a wellness program), and four reported being external consultants (they were outside consultants hired to implement a program for a company). Participants also reported working in a wide range of industries including government (5), healthcare (2), higher education (2), construction (1), finance (1), manufacturing (1), marketing research (1), technology (1), travel (1), and nonprofit (1).

Participants completed an online consent form and screening survey to ensure they fit the selection criteria. The consent form contained information regarding the purpose of the study, how data would be collected, and what participation in the study would entail. The screening survey asked for background information regarding previous experience implementing workplace wellness programs and their primary role at the time (see Appendix A).

Procedure

Question Development. Interview questions were semi-structured, so I followed a pre-determined series of questions during each interview; however, I asked additional follow-up questions, and altered the order of the questions as needed and depending on participants' answers. This allowed me to return to certain parts of a participant's answer to explore it in more detail (McDonald et al., 2004).

The questions were designed to walk through each step participants used to implement wellness programs, the sequence of steps they used, and their experiences with how COVID-19 impacted wellness program implementation (see Appendix B for a complete list of interview questions). To ensure that my own past experiences and biases did not influence the question development process, I enlisted feedback from my advisors and peers (fellow graduate students studying occupational health psychology). Additionally, I pilot-tested the questions with a subject matter expert (SME) that fit my intended sample population. More information is provided in the following section on pilot testing.

Generally speaking, interview questions were designed with best practices in mind. For example, questions sounded conversational, used language familiar to participants, were straightforward, and simple (Kallio et al., 2016; Krueger & Casey, 2014; Roulston, 2010). Interviews began with warm-up questions, easy introductory questions aimed at helping the participant feel comfortable in the interview setting. These questions also allowed me to develop rapport with the participant. After the warm-up questions, I transitioned into the key questions that drove the study. The questions moved from general to specific and were logically grouped by the research questions listed above. Taken together, the ordering of the interview questions

was intended to facilitate better participant understanding and encouraging higher quality answers.

Interview questions intended to target the research questions regarding steps and sequences of program implementation were designed a little differently from the interview questions intended to target the COVID-19 research question. Since the purpose behind the questions regarding implementation steps and sequences were aimed at matching participant answers to already established steps and sequences identified in published models, this section of the interview included some open-ended questions and some more specific follow-up questions that were less open-ended. Using both types of questions allowed the participants to first describe the steps and sequences they use in their own words, without me priming them, and then allowed me to narrow in and make comparisons between their answers and the published models. This is a common question format in pattern matching studies, which aim to anticipate or predict a pattern of variables, phenomena, or outcomes (Lee et al., 2011). For these studies, a predicted pattern is assessed against actual data and is typically intended to falsify or corroborate models and theories. More information on pattern matching is provided in the Analytic Strategy section.

Interview questions addressing *RQ4* used only open-ended questions. Therefore, I analyzed these data using thematic analysis, which lends itself well to open-ended questions. For thematic analysis, themes were derived from the data by using hierarchical coding (King, 2004). More information on thematic analysis can be found in the section on analytic strategy.

Pilot Testing. After I developed my initial set of interview questions, I used several methods to further develop these questions. My initial items were based off the published literature and my perceptions of what will be relevant to the target population. Then, I enlisted

the help of my advisors (Drs. Gwen Fisher and Kurt Kraiger) and fellow occupational health psychology graduate students to further refine the questions. Specifically, I asked these SMEs to evaluate the questions with respect to clarity and their relevance to my research questions. More specifically, I asked them whether any items were redundant and should be removed, and whether they believe any items should be added.

I then pilot-tested the interview questions with a SME who matched the identified criteria of my target population. In an effort to better assess participant understanding of the questions, the pilot test employed a cognitive interview. During the interview, the SME verbalized his thought process after they heard each question and then provided his answer to the question. As a result of the pilot test, I identified interview questions that needed to be reworded to improve clarity, identify the need for new follow-up questions, identify improvements to the PowerPoint slides used to illustrate the published models to participants, and clarify the wording of the screening questionnaire.

Recruitment. Participants were recruited through a variety of outlets. Members of the Memphis chapter of the Society for Human Resource Management (SHRM) were recruited to participate at a chapter meeting arranged by committee member, Dr. Kurt Kraiger. Additionally, I enlisted the help of the Mountain and Plains Education and Research Center (MAP ERC). The MAP ERC has many connections with local businesses in the Denver metro region and Northern Colorado more broadly. I reached out to the center to ask them to distribute recruitment materials to their contacts. I also recruited for my study by posting study information on the social media platform LinkedIn and word-of-mouth referrals from my personal and professional contacts. Out of 16 total participants, seven were directed to my study via my LinkedIn network, one via the

Memphis chapter of SHRM, one via the MAP ERC, and seven via referrals from my personal and professional connections.

Recruitment materials contained information about my study, listed the criteria for inclusion, and provided a link to sign up to participate in the study. The link directed all interested candidates to the Qualtrics screening survey. After reviewing each completed survey, I reached out to the individuals who qualified to participate in the study and who provided their contact information to set up a one-on-one interview. Those who participated in the interview received a $50 gift card of their choice to either Target or Amazon. After interviewing 16 participants, I found saturation in the data. Saturation occurs when no new themes or no new major insights emerge from the data (Glaser & Strauss, 1967). Upon reviewing the transcriptions and creating 1st order codes, no additional themes were needed. All 1st order codes fit into the themes already identified in the template created by my research assistant and me. In addition to finding saturation, I also reached my allotted participant funds of $750, therefore I stopped my recruiting efforts.

Interviews. Each interview took place on the online video conferencing platform Zoom. I conducted one-on-one interviews, as opposed to focus groups, for several reasons. One is I did not want participants to influence each other's responses. Two is that the questions and follow-ups I asked were specific to each individual participant's experience implementing wellness programs. Three is that I covered more questions in a shorter amount of time. Thus, holding one-on-one interviews allowed me to collect more in-depth responses from each individual while respecting their time.

Before attending the interview, each participate received an email with a Zoom link and information about what to expect during the interview. At the very start of the interview, I

reiterated verbal consent from each participant to participate in the study and be recorded for transcription purposes. During the interview, I gave some background information about myself and the study and once again asked participants for consent to record the interview. During the interview, I took notes about anything that stood out or that I thought might influence the interview quality (i.e., one participant had to take a phone call in the middle of our interview).

Transcription. To further facilitate an accurate transcription of the verbal interview data into written data, I used an app called Otter A.I. Otter A.I partners with Zoom and uses artificial intelligence technology to transcribe live meetings. After each interview, I checked the Otter transcription for accuracy against the recording and then deleted the recorded Zoom file.

Coding Strategy

I used thematic analysis as the overarching analysis technique for coding the data. Thematic analysis is commonly used in qualitative studies to identify themes and patterns in the data (King, 2004). It does this by breaking down each participant's narrative into individual codes. For this study, a code is defined as a label attached to a section of text deemed important for the researcher's analysis and interpretation (King, 2004). These individual codes are aggregated into categories or themes. Once themes are identified, the researcher examines patterns across the data (King, 2004). This process of searching for themes and integrating them into a theoretical framework provides a deeper understanding of the phenomenon (Costa et al., 2016). Although I used thematic analysis as the overarching technique when coding all study data, more nuanced analytic techniques were needed depending on the research question. Specifically, I used pattern matching to answer *RQ1 - RQ3* and template analysis to answer *RQ4*.

Pattern matching allows me to make comparisons between published implementation models and the steps and sequences participants described in their interviews. The pattern

matching technique allows researchers to anticipate a particular pattern of phenomena based on formal theory and then measure it against actual data (Lee et al., 2011). As a result, the researcher can falsify or corroborate the formal theory. This technique was used in previous qualitative studies to test formal theory. For example, Lee et al. (1996) used pattern matching to test their unfolding model of voluntary turnover. The authors used interview data to classify how each participant's unique turnover process actually unfolded based on the categories identified in the voluntary turnover model. For my study, I facilitated the matching of implementation model steps and sequences by asking each participant a series of interview questions based on the steps and sequences in the models. Falsification or corroboration is determined in the coding process based on the extent to which the steps and sequences participants indicate they use in practice align with either model.

In addition to pattern matching, I used template analysis. Template analysis allows for more flexibility and adaptation during the coding process than does pattern matching (Brooks et al., 2015). This approach was more desirable to analyze *RQ4* because it allowed me to uncover richer information that techniques bounded by theory, such as pattern matching, do not allow (King, 2004). Additionally, since the emergence of COVID-19 is still a relatively new phenomena, its effects on organizations are largely unstudied. Therefore, we cannot rely on an existing theoretical framework or model to investigate *RQ4*. Template analysis organizes codes through a process called hierarchical coding, which means that lower-order codes are considered subcategories of higher-order codes (King, 2004). Higher-order codes provide a broad overview of themes found within the data, whereas lower-order codes are better at providing more specific details about what participants discussed in the interview. Specifically, the data structure I created consisted of 1st order codes, 2nd order codes, and 3rd order codes (See Figure 1). First

order codes are a close representation of the raw data. They are used to describe the point the participant was making in a more condensed way. For example, one participant said "COVID has done good things for me in terms of getting the awareness out about the wellness programs." As a result, I created the 1st order code "increased company awareness of wellness program offerings." Second order codes are 1st order codes organized into higher-order themes. These codes represent combinations of multiple 1st order codes based on theoretical similarities. For example, I grouped multiple 1st codes that talk about how COVID-19 increased awareness off wellness programs into a new 2nd order code called "Wellness is more recognized/valued." Finally, 3rd order codes are aggregated themes that are developed based on theoretically similar 2nd order themes. For example, I had multiple 2nd order codes that touch on the beneficial impact of COVID on wellness programs that I then grouped into the 3rd order code called "Increased promotion of wellness."

All researchers should consider how their own personal experiences can influence their research. For me, I have a background in occupational health psychology and a particular interest in workplace wellness programs. I believe that my own personal experiences with health and wellness have increased my quality of life, which I acknowledge may present a potential bias in the current study. While I cannot change my interests and past experiences, I include direct quotes to accurately reflect the data without my lens of interpretation. Additionally, I enlisted the assistance of a second coder to develop themes. The second coder was a graduate student research assistant also enrolled in Colorado State University's Industrial-Organizational Psychology PhD program. Introducing a second coder reduced the impact of researcher bias on the coding process because the second coder had less familiarity with the raw data and the

relevant literature. This encouraged the emergence of novel themes that I may not have otherwise identified due to my own familiarity with the data and the literature.

To begin the coding process, both coders separately reviewed a subset of the identified 1st order codes to develop 2nd order codes. After completing the first subsection of the data, we came together to discuss similarities and discrepancies between our codes and created an initial coding template. I calculated interrater reliability using Cohen's kappa. The kappa statistic varies from 0 to 1, with values closer to 0 indicating agreement equivalent to chance and values closer to 1 indicating perfect agreement. For this study, kappa was calculated at .81. According to McHugh (2012), values of .80 or greater indicate sufficient agreement. Thus, sufficient interrater reliability was reached. However, to further improve the reliability of the coding process, all coding disagreements were discussed until a consensus was reached. Using this template, we reviewed another subsection of the data and reconvened again. The same meeting protocol was followed, and small adjustments were made to the coding template until consensus was reach. This process was repeated until the 2nd order codes were complete. Afterwards, we revisited the first subsets of the data to ensure the most up-to-date template was applied consistently for all codes. This process was also followed for the 3rd order codes. All coding was done within Microsoft Excel to aid in the organization of the codes.

RESULTS

The goal of the section is to synthesize the themes that emerged from the data while also providing more specific examples of how those themes manifested. This can be done in a variety of ways, so King (2004) recommended that researchers determine which strategy to use based on the aims of their study and the content of the answers. King (2004) described a variety of interpretation strategies, one of which includes listing codes and indicating the frequency with which they occur. A benefit of this strategy is that the researcher can describe the distribution of codes and draw attention to commonly occurring themes. Although qualitative researchers typically warn about the dangers of using frequencies when interpreting the importance of themes, this strategy is appropriate for interpreting the results of the pattern matching for *RQ1 – RQ3*. Thus, these questions were answered with data that draw comparisons between published implementation models and the steps and sequences participants provided in their answers.

Another method King (2004) recommended is to focus on describing the main themes identified in the data while drawing on illustrative examples from the transcripts. Thus, *RQ4* was answered with summaries of the themes identified across the interview data. The benefit of this strategy is that it tends to produce a clear and succinct thematic discussion. Before describing the study findings, I will first provide an overview of the different types of wellness programs my participants designed and implemented.

Wellness Programs Descriptive Information

As outlined above, 16 participants from a wide range of industries described the programs they designed and implemented as well as what steps and sequences went into that process. Types of wellness programs described were mental health allyship, resiliency coaching,

biometric screening and coaching, physical health, and comprehensive wellness (i.e., including multiple dimensions of wellness such as physical, mental, social, financial, and environmental health). The purpose of these programs also varied. Although most programs were designed and implemented with the goal of providing a valuable health and wellbeing resource to employees, some organizations were interested in using wellness to increase employee engagement, decrease health care costs, improve employee retention, or simply abide by a mandate that directed government employee must have access to wellness programming.

Some programs were developed internally to the organization, others primarily relied upon offerings developed by third-party providers, such as a consulting firm or heath care provider, and still others utilized both internally developed programs and external offerings. Program budgets ranged from $0 up to $2.5 million. Programs with little to no budget tended to offer small incentives or rewards to participate, such as small wellness-related prizes, whereas programs with larger budgets offered greater incentives such as monetary rewards, paid time off, and reduced health care premiums. Reports of employee participation rates in all programs ranged from 6% to over 80%. Two of the 16 programs described in the current study were implemented after the start of COVID-19, whereas the other 14 were implemented before COVID and transitioned to a virtual platform.

Some examples of program offerings were lunch-and-learns/webinars, newsletters, staff-led wellness events (e.g., yoga, cooking class), health screenings, vaccination clinics, gym services, fitness challenges, meal services, social clubs, wellness fairs, mental health services, coaching services, and mindfulness/meditation classes.

Many participants described the design and implementation of an expansion plan to an already existing wellness program, whereas others described the design and implementation of a

new program. One participant described a program that was created to replace a previous program eliminated after a merger. Finally, some participants described the design and implementation of wellness programs from a third-party vendor standpoint. In these cases, the vendor offered a pre-designed program and tailored it to fit the needs of the client.

Pattern Matching

RQ1. My first research question asks, how do practitioners implement wellness interventions in the workplace? To assess this question, I first asked participants to describe, in their natural language, what steps and sequences they engaged in when implementing their successful wellness program(s). Afterwards, I verified how these steps and sequences overlap with the ones identified in the two published models. To do this, I took each step and sequence participants identified in their natural language and asked them whether it aligns with the language used in the published models. For example, if a participant said they communicate with leadership to gather support for a program, I would then ask the extent to which they believe this step aligns with the preparation stage of Nielsen et al.'s (2010) model. To facilitate participants' understanding of the models during this step of the interview, I displayed a graphic that illustrated the steps and sequences for each published model. This way, the participants could visualize the model and easily read all the steps and sequences listed while responding to my interview questions.

Most of the steps described by participants fit well within the categories outlined by both Nielsen et al. (2010; OHP model) and Stouten et al. (2018; OCD model). However, certain processes did not align well, which led to some steps being unclassified. Unclassified steps are steps described by participants that did not fall within any of the steps in the comparison model. For example, maintaining employee interest in programs, sending reports to external funders,

and following government mandates did not fit well into the steps of the OHP model and were thus unclassified. Additionally, participants who worked as external consultants described the need to bid for work (either through requests for proposals or by approaching the client on their own accord). This was another unclassified step when compared to the OHP model. For the OCD model, the only unclassified step was the development of program content. This did not fit well within the OCD model due to the lack of steps focused on planning. Instead, planning in the model is combined with the implementing evidence-based change interventions step.

Participants generally had an easier time aligning their steps with those in the OHP model than those in the OCD model. This is likely due to the OHP model having broader categories more tailored to occupational health interventions. Although participants had a harder time relating their steps to the OCD model, the matching process resulted in fewer unclassified steps. Taken together, the reported difficulty for participants to classify, along with fewer unclassified steps are likely a function of the OCD model containing more granular steps (ten as opposed to the OHP model's five). Although it took more cognitive effort for participants to identify which steps, if any, their processes fell into, the increased variety of steps to choose from led to fewer instances of steps being unclassified. Although participants experienced more difficulty with the OCD model, as seen through comments such as "I don't know" and longer pauses during the interview, participants did report the value they see in the model, including, "I kind of like this one better. I mean all of this happened," and "Both [models] you hopefully use from a wellness perspective because you'd have to have cultural buy-in in order to do anything successfully. They're very much intertwined."

RQ2. My second research question asks, among practitioners whose implementation models more closely resemble the published models, are certain steps more likely to be present?

To assess this question, I examined patterns of steps across participants and calculated the number and percentage of participants who indicated they used a particular step. See Table 1 for a summary of the OHP model findings and Table 2 for a summary of the OCD model findings.

Nielsen at al. (2010) model. For the OHP model, all 16 participants indicated that they used steps that align with Nielsen et al.'s (2010) fourth and fifth steps: implementation and evaluation. According to this model, implementation includes monitoring intervention activities, using middle managers as drivers of change, and communicating the ongoing progress of the initiative. In my study, participant examples of implementation included monitoring program progress to work out kinks that arise, training managers on how to better support employee wellbeing, and using email messages to communicate with employees about the program. Other popular implementation-type steps that did not perfectly align with the examples provided in the OHP model included hosting wellness conferences/fairs/townhalls to encourage engagement in the program and creating wellness committees/champions to encourage engagement and collect feedback about the program. Evaluation includes evaluating the effects of the program at various levels (e.g., organizational level, individual level), the processes used to implement the intervention, and the context within which the intervention was implemented (e.g., bureaucratic organization, small start-up, downsizing efforts, etc.). Participant examples of evaluation included sending Google forms to event participants, creating biannual benefits surveys, reviewing changes in health indicators over time, evaluating participation and satisfaction rates, and conducting annual budget reviews.

Although not unanimously, steps 2 and 3: screening and action planning, were also widely used. The OHP model describes screening as an assessment of risks to inform the wellness initiative. This step includes the selection of methods (e.g., a questionnaire, focus

groups, interviews), auditing existing systems, and reviewing the feedback from the questionnaire/focus groups/interviews and the audit. Participants described various screening-type steps such as conducting focus groups, collecting engagement survey data, and creating a benefits survey. Other steps included researching what other organizations in the local area were offering their employees, attending wellness conferences, and conducting literature reviews. The action planning step is described as focusing on the development and implementation of the initiative. This includes developing program activities, identifying the intended target of the initiatives, creating deadlines, establishing leadership, and determining criteria for success. My participants described action planning steps that included strategic planning, setting goals, developing activities, inviting staff to lead events, working with vendors to develop offerings, and developing logistic plans. Specifically, 13 participants reported engaging in at least one screening step and 14 reported engaging in at least one action planning step.

Lastly, this model's first step: preparation, was the least utilized step. Nielsen et al. (2010) described preparation as the step when organizations become familiar with the method and consultants learn about the organizational structure and culture. This step consists of establishing a steering group, assessing readiness for change (both employee and organizational readiness), gathering senior management support, sending initial communications about the upcoming change, and identifying who will be driving the change. Examples of this step from my participants were gathering support from senior management/executives, with one participant citing the need to collaborate with the internal legal team to gain their support and obtain their advice. Thus, most elements included within the preparation stage were not mentioned. No participant discussed using a formal readiness for change assessment. However, some participants mentioned that their organization's readiness for change was assumed, and therefore,

assessing readiness was not seen as a necessary step in their process. While participants did cite some degree of program communications, one of the elements of the preparation step, this communication typically occurred after the launch of the program, therefore classifying it under the implementation step. Finally, although not explicitly mentioned, it can be implied that at some point in the process participants were identified as a driver of the change (i.e., program) and part of the steering group, since qualifying for this study means that they were heavily involved in the design and implementation of a successful wellness program. Only 11 participants cited this step during their interview.

Stouten et al. (2018) model. For the OCD model, study results show much more variability in the frequency with which participants used the model steps. Usage ranged between one participant (for the step "developing effective change leadership") up to 16 participants (for the steps "implementing evidence-based change interventions" and "assessing change progress and outcomes over time").

All 16 participants indicated that they engage in Step 3, implementing evidence-based change interventions, and Step 9, assessing change progress and outcomes over time. Implementing evidence-based change interventions is described as identifying appropriate interventions to address the problems found in the diagnosis. Participants' examples of activities within this step include preparing annual plans, developing program activities, and conducting those activities. Since this step is what transforms the idea of a wellness program into a real program, it is not surprising that all participants mentioned some activity aligning with this step. The other step that was used by every participant, assessing change progress and outcomes over time, is defined as periodic assessment that provides feedback on the change's effects. Although all 16 participants reported some type of assessment, the formality of assessment varied. For

example, some participants described more informal assessments such as wellness committee self-evaluations, occasional participation surveys, or embedding a few wellness items within a larger employee engagement or benefits survey. Others described engaging in more formal evaluations such as conducting quarterly pulse surveys, evaluating changes in health outcomes over time, or obtaining monthly usage data from vendors.

The next most highly used step was Step 1, gathering facts and diagnosing the problem. This step is described as obtaining information to provide insight into the need for change and gathering information regarding preexisting conditions or constraints that may impact implementation. For example, some participants described conducting focus groups to gather information regarding what types of programs they would like to see, others conducted surveys to gather this insight. The few participants who did not describe using this step either worked in a government role where they received a mandate to implement a program or were an external consultant with pre-developed services. Thirteen participants described some element of a step that matched these conditions.

The next most widely used step was Step 7, using enabling practices to support implementation. This step is defined as using processes to support the initial rollout of the program and ongoing program processes. Stouten et al. (2018) highlighted the importance of encouraging employee participation in this stage, which aligns with the descriptions participants provided. Twelve participants noted having used this step, describing practices such as email communication, newsletters, and internal messaging platforms to promote engagement with the program. Other participants described hosting wellness conferences and hiring interns as ways to build a structure to support the program.

Step 2, assessing and addressing the organization's readiness for change involves assessing and addressing the organization and its members' capacity to take on the demands that effective change requires. A major component of this step is the capability of senior leadership to support the change. This was frequently mentioned by participants who noted activities such as bringing proposals to leadership for approval, working to create buy-in from leaders, and providing proof of concept to leaders in order to gain their support for a program. Eleven participants used this step.

The next most mentioned was Step 6, working with social networks and tapping their influence. This step describes the importance of social networks for influencing change. For this step, participants described the use of wellness committees, ambassadors, liaisons, and champions to encourage engagement and to provide feedback to program coordinators. The benefit of using these social networks is that employees are more likely to listen to and trust their own team members as opposed to human resources or corporate, thus they feel more comfortable providing their honest feedback to these ambassadors. Other uses of social networks described include working with other teams across the business (i.e., legal, financial) and asking staff members to lead wellness activities that they are passionate about. Ten participants used this step.

I then saw a large drop in the number of participants who describe using Step 5, developing and communicating a compelling change vision. The purpose of this step is to create and disseminate a vision that reflects a motivating goal that can be broadly shared. Seven participants described using this step, with examples including partnering with the marketing department to develop a communication strategy, having senior leaders contribute personal stories about what wellbeing means to them, hosting townhalls to introduce the program to

employees, and external consultants submitting requests for proposals and approaching potential clients with their proposed wellness plans.

Step 8, promoting micro-processes and experimentation, involves making small-scale or micro adjustments to promote program effectiveness. In the data, examples of this step include monitoring program implementation to work out kinks along the way, adding additional programming topics as needed or requested, and shifting programming logistics as contextual barriers arise (e.g., COVID pushing everything virtual). Only six participants described using Step 8.

I saw another big drop in the number of participants who noted using Step 10, institutionalizing the change to sustain its effectiveness. This final step is meant to integrate the program into the larger system of the organization including its culture and management systems. However, only three participants reported using this step. One participant described how their program is sustained because a donor continues to fund the program. Therefore, to sustain the program, they send reports to this doner describing how the program is helping employees. Another participant described how a wellness program manager was brought on as a result of a government mandate, thus institutionalizing the program within their department. Finally, the third participant described their efforts to maintain employee interest in the program to sustain its effectiveness.

Finally, the least frequently used step was Step 4, developing effective change leadership. This step emphasizes the important role leaders play when implementing change interventions. It specifically focuses on training and developing leaders in change-related skills. In my study, only one participant reported using this step. This participant explained how part of their program involves training managers on how to better support employee wellbeing.

RQ3. My third research question asks what sequence of steps is more likely to occur among practitioners whose implementation models more closely resemble the published models? Similar to *RQ2,* I examined patterns across participants to answer this question. Specifically, I had participants describe the order in which they engaged in each of the steps they listed. One pattern that kept coming up among participants is that the steps they engage in to implement wellness programs are not as linear as published models suggest. One participant said "Long term wellness programs don't really work like that" when talking about the clear sequence of steps that are displayed in each model. Another participant explained that linear processes do not make sense for them because "you have to be able to go back and forth" between steps. In other words, participants may be revisiting the same steps multiples times at various points in the implementation process. For example, someone implementing a wellness program may screen employees to gather more information about what health risks should be addressed in the program. After the program is developed and rolled out, they may need to engage in screening once again to determine whether they need to tailor the program offerings further to focus on new health risks or concerns. The need to skip back and forth between steps was especially relevant for participants who needed to tailor their wellness programming to target newly emerging social and mental health needs as a result of COVID-19. Finally, when discussing the OCD model, another participant stated that "all the steps are accurate, but the order was different." This was common as most participants indicated that a majority of their steps aligned with the steps in the published models, but the order in which they were executed tended to vary.

Nielsen at al. (2010) model. The most common difference between the OHP model sequence and the sequence described by participants is that preparation and screening were reversed. The OHP model outlines preparation as the first step, followed by screening. However,

out of the 11 participants that engaged in screening, nine reported engaging in screening processes first, whereas only two reported first engaging in preparation.

Overall, the first two steps of the model, preparation, and screening, tended to fall within the first few steps most participants described engaging in. The next two steps of the model, action planning and implementation, tended to fall within the middle steps most participants engaged in. Finally, the last step in the model, evaluation, was described by all 16 participants as the final step they engaged in during their implementation experience. See Table 3 for a summary of the sequence described by each participant.

Stouten et al. (2018) model. There was less agreement for the sequence of steps employed by participants for the OCD model compared to the OHP model. While most participants' first, second, and final steps aligned with the OCD model sequence, the order of the middle steps widely varied. For example, some participants followed the sequence very closely, whereas others did not follow the prescribed sequence. See Table 4 for a summary of the sequence described by each participant and Table 5 for a summary of the pattern matching trends.

Thematic Coding

RQ4. For *RQ4*, I used thematic coding to answer the question, how has COVID-19 impacted the ways in which wellness programs are implemented? Based on the coding methodology described in the Method section, I identified eight overarching themes (see Table 6 for a summary of the thematic codes). Some of these themes describe direct effects of the pandemic on wellness implementation, whereas other themes describe indirect effects. The indirect themes characterize how COVID impacted the organization more broadly, which could then indirectly impact wellness implementation. Direct themes were: (1) increased promotion of wellness, (2) program accessibility, (3) tailoring programming to fit employee needs, (4) changes

in participation rates, and (5) ramifications of operating in a virtual environment. Indirect themes were: (1) adapting to a new environment, (2) concerns about organizational and role stability, and (3) changing attitudes and behaviors based on new circumstances. I now discuss each of these overarching themes and describe the subthemes and codes that encompassed each one, beginning with the five direct themes.

Increased promotion of wellness. The first theme, increased promotion of wellness embodies the idea that COVID-19 brought wellness to the forefront of both organizations' and individuals' priorities. Participants noted that wellness is now recognized and valued more than ever before, is seen as a necessity, increased displays of empathy from the organization, and is now viewed in a more holistic way. Multiple participants claimed that their organization now has an increased awareness that wellness matters and overall, there is an increased company awareness of wellness program offerings. Other participants described how COVID-19 shifted their role into the forefront of the company, as they are now asked to speak at company-wide all-hands meetings, something they had never been asked to do prior to COVID. On an individual level, one participant claimed they think individual employees now recognize the value of the wellness program more than they did prior to the pandemic and another said that their wellness program is in higher demand now.

Participants also described how wellness is now seen as a necessity by their organization. This was exemplified when participants described how their wellness budgets remained intact, despite wide-reaching company budget cuts and layoffs. One participant explained that their wellness program "was never called into question" because it would have been a "high risk" to discontinue those services from a retention standpoint.

Another subtheme that emerged from the data is that change brought on by the pandemic drove more displays of empathy from the organization. This increase in empathetic behaviors is illustrated by participants who discussed how COVID encouraged employers to be empathetic towards the challenges their employees are dealing with by "humanizing people." One participant described how it became clear to employers that "we are not robots – we need support."

Finally, another subtheme embedded under increased promotion of wellness is that organizations are now taking a more expanded view of wellness. One participant predicted that COVID is going to lead to an increase in holistic wellness and another talked about how they believe the pandemic strengthened wellness programs and expanded what we consider to be "wellness." Specifically, participants described how COVID-19 opened peoples' minds in terms of the various components that make up wellness. Traditionally, wellness programs mostly focused on nutrition and exercise, but now, the impact of the pandemic on people's mental and social wellbeing paved the way for an expanded view of wellness that a wider audience can now relate to and more easily understand.

Program accessibility. Another major theme I pulled from the data is the accessibility of wellness programs. Most participants described how COVID forced wellness programs to become more accessible. This led to more programing designed for flexible implementation and dissemination and less barriers to participation. In terms of program design and implementation, one participant described how a new program they helped implement within the last year was designed to be fully virtual. This same participant described how COVID taught them "how to create a more global program." They emphasized how they used to travel to offices around the world to conduct wellness programming, but now, they had to "figure out ways around that" in

order to deliver the same quality of programming without traveling. They gave one example of how they implemented a virtual wellness conference that devoted three to four hours of the day to different regions of the world. This way, they could deliver programming to all global employees, while respecting their personal time zones. Most participants described preexisting programs that needed to be shifted to a virtual format. This often involved hosting virtual workshops, creating more recordings and videos that could be uploaded online, conducting coaching meetings over Zoom, offering more webinars, and offering access to at-home workouts as opposed to gym memberships.

Another subtheme that emerged was fewer barriers to participation. Some participants reported how forced virtual programming due to COVID provided more access to employees located in offices across the nation and globe. Thus, access is no longer restrained by location as it once was.

Tailoring programming to fit employee needs. The third direct theme identified is related to tailoring wellness programming to fit changing employee needs. This included being flexible with program requirements, making content shifts, and creating new content. The flexibility surrounding program requirements primarily had to do with extending the time allotted for employees to go to the doctor to do their physicals and not requiring biometric screening to be done in-person. Another participant described "finding ways for individuals to remain compliant" with program requirements. "One of the things we did is we actually didn't take anybody off our wellness program last year. Even if you didn't earn your quarterly wellness points, we did not take you off. We let you stay on. We're trying to keep everybody engaged to make sure they had access to that platform. That was obviously not cheap for us to keep everybody on there, but that is something that we did."

Beyond program requirements, other types of tailoring being done to wellness programs include content shifts. Participants described a need to shift their programming to tackle some of the specific challenges brought about by COVID, such as social needs and mental/emotional needs. To target employees' social needs, participants described hosting social events such as virtual coffee chats on Zoom and generally focusing on events that bring people from across their organization together. Participants also described shifting away from mostly physical wellness content to include more mental and emotional health content. This was done by offering free access to mental health apps, promoting employee assistance services, and providing workshops on dealing with change and uncertainty. This need to tailor programming based on employee needs was well-illustrated by one participant who said, "You have to be aware of all the potential programs out there and what the needs are and how these vendors can come in and fulfill those needs. You just have to be in-tune with what the pain points are at that time and have a solution for them."

Finally, some participants described how when tailoring their programs to fit employee needs, they needed to get creative and come up with new ideas they had never done before. One participant described how their organization started offering free "take-home kits" that included materials for various crafts and recipes (e.g., a wreath making kit or a pizza making kit). Employees who want to participate in the event could pick up their kit, take it home, and then attend a live Zoom session to complete the craft or recipe with other employees who signed up for the activity. Another participant described how their organization came up with the idea of a "lending library" from which employees could borrow items like outdoor sporting equipment (e.g., kayaks, snowshoes). Others described how their company started investing in new

technology, such as the internal messaging platform Slack, as a way for employees to connect while working-from-home.

Changes in participation rates. Another major theme is the changes in wellness program participation. Four participants reported seeing increased participation due to COVID-19, one reported no changes in participation, and one reported decreased participation. One of the participants who saw an increase in participation said, "we had the highest participation rate that we ever had last year."

Ramifications of operating in a virtual environment. The final direct theme that was uncovered is related to the ramifications of operating in a virtual environment. Although previous themes suggested that COVID increased the accessibility of wellness programing, participants also mentioned some downsides to operating in a virtual environment. Challenges faced include changes in effectiveness, loss of services, and burnout from the virtual environment.

In terms of the effectiveness of programing, one participant described how his coaching services are less effective over Zoom compared to in-person. He knows this because he tracked evaluation ratings over time. "The figures for the exact same material were much better. And I think it's just simply because it's in-person and not over Zoom." He further explained "You're trying to get people into Zoom rooms to share emotional trauma. I won't do it anymore. I don't care if it's uncomfortable, I will wear a mask all day long. I'd rather do that then try to help people via Zoom."

Another ramification of operating in a virtual environment is the loss of certain services. The services participants describe as being discontinued all were in-person activities and services. For example, gym memberships, subsidized food delivery services to the office,

physicals, health screenings, and flu shot clinics were mentioned. Although one participant mentioned that their organization hopes to reinstate their in-person services eventually, they have no current plan to do so. In addition to certain services being removed, others have described some services as being "put on hold." For a couple of participants, their wellness programs were put on the "backburner" during the initial months of the pandemic to focus on more pressing business functions. Another participant described how their wellness committee's budget was frozen. Thus, their efforts were put on hold until leadership unfroze the budget.

Finally, one participant described how their employees are experiencing burnout from being online all the time. "People are just sick and tired of being online. They want something new and fresh." As a result of this burnout, they expect to see a decline in wellness participation rates this year.

In addition to the five direct themes described above, three indirect themes also emerged from the data. These three themes describe the impact that COVID had on participants' organizations, whereas the other five themes described the impact COVID had on wellness program implementation. Although these themes were not described as directly impacting wellness program implementation, they are still noteworthy due to the potential trickledown effect they could have on wellness program implementation.

Adapting to a new environment. One indirect theme that arose from the data is that COVID-19 forced organizations to adapt to a novel work environment. Most participants described changes in structure for working procedures and some emphasized that navigating this novel landscape required a lot of learning and self-sufficiency. This learning and self-efficacy was especially relevant for participants who described needing to transition from office-settings to work-from-home settings and for essential employees who still worked in-person but needed

to quickly adapt to new safety protocols. In addition to safety protocols changes for frontline workers, one participant described how their company had to adjust their compensation structure, paid time off, and other benefits to comply with new CDC guidelines. Other structural changes reported include rapid hiring and shifting employees to different departments as needed. The rapid hiring was seen as necessary for one company whose workforce was reduced at the start of the pandemic due to budget cuts. Once this organization financially rebounded, they found themselves understaffed to handle the increased workload. The shifting of employees from one unit, or department, to another was described by a participant currently working in the healthcare industry. They described how the hospital system they work in was mandated to stop all elective surgeries in order to shift resources over to COVID-units. Thus, doctors and nurses who are typically conducting and assisting with surgeries were shifted over to assist with COVID cases.

Some organizations also had to adapt the focus of their services. Some participants described how the nature of their work shifted because of COVID. Specifically, one participant who worked for a nonprofit described how they shifted from offering school-related social services to helping clients get access to basic necessities such as food and house-hold items.

Another prominent subtheme that surfaced from the data is the creation of new norms based on changing circumstances. For example, most participants described how the new norm in their organization is to work remotely, and some participants explained that certain jobs at their organization will remain remote, even after the pandemic is over. Another participant described how attending training programs remotely or working remotely used to be frowned upon in a pre-COVID world. Now, just over one year since the start of quarantine in the United States, this norm shifted, and the organization is trying to “embrace this change to make sure people feel that sense of comfort that they can work remotely and it’s not something they’ll be

punished for." Although the shift to remote work is possible for some jobs, it is not possible for many frontline workers. This uneven distribution of changes in working condition was evident across participants who described working in industries that require in-person services (e.g., healthcare, grounds maintenance, and banking).

Concerns about organizational and role stability. Another major indirect theme that arose from the data was concerns regarding organizational and role stability. This was exemplified by decreases in employees resources, decreases in organizational resources, and decreases in workload. Examples of decreases in employee resources included frozen salaries and bonuses, pay cuts, and furloughs. One participant also described how working from home had led to a sense that peoples' contributions were no longer being noticed, resulting in a decrease in employee motivation. Decreases in organizational resources include organization-wide layoffs, budget cuts, hiring freezes, downsizing physical office spaces, and overall decreases in revenue. One participant described how during the start of the pandemic, their organization initiated a cost containment strategy and asked employees for ideas about how the organization could save money. Some participants also described a decrease in their organization's workload due to quarantine-related business closures and an overall loss of business in the 2020 fiscal year.

Although some participants described their business being hit hard economically by the pandemic, others described an overall consistent workload and resources remaining consistent. These participants indicated that their employees and organization did not experience any budget cuts and no layoffs occurred. One such participant was in the construction industry. She described that although the industry is seeing increases in the price of materials, the company's

workload remained consistent, likely because construction was considered an essential service throughout the pandemic.

Changing attitudes and behaviors based on new circumstances. Changing attitudes and behaviors based on new circumstances is the final indirect theme emerging from the data. This overarching theme is comprised of subthemes of changes in individual-level empathetic behaviors, perceptions of equality, and burnout. While the first theme we reviewed, increased promotion of wellness, encompasses increased empathy that is shown at the organizational-level, this theme emphasizes the increased empathetic behaviors being shown at the individual level. For example, one participant described how their manager promotes acceptance that work-from-home environments are not perfect by showing humor when a pet jumps into the video conferencing frame or by showing vulnerability when sharing their own personal challenges. One participant also described how their co-workers feel more equal now that all employees are working remote. Doing so reduced perceptions of inequality between employees who work at headquarters and those who work at satellite offices or remotely. Finally, multiple participants explained how the new working environment led to an increase in burnout. Specifically, some pointed out that the lack of social interaction between employees is hard on individuals and others emphasized how employees working in-person experienced increased emotional stress. This was illustrated by a comment from one participant who works in the healthcare industry who said, “the overall emotional stress on my clinicians has been very difficult.”

DISCUSSION

The purpose of the current study was to address: (1) the lack of consensus regarding the steps and processes included in an OHP implementation model and an OCD implementation model and (2) the need to better understand the ways COVID-19 impacted wellness implementation. To do this, I: (1) compared the steps and sequences described by participants to the steps and sequences of two published models and (2) identified overarching themes related to the impact of COVID.

Summary of Results

I explored four research questions. The first research question explored how practitioners implement wellness interventions in the workplace. Participants generally reported that both models are relevant and important for successful program implementation. However, these models did not fit quite as well for practitioners implementing programs from an external consulting perspective compared to practitioners implementing programs from an internal role. Thus, the two implementation models may not be equally applicable to external vs. internal consultants. One explanation for this effect is some of the steps described in the models may be done prior to external consultants entering their client's organization to implement the program. Those in external consulting roles may want to consider either distributing the same steps before formal entry into the client organization or adding additional steps to account for the request for proposals process and the different ways they form relationships with clients.

Another interesting finding is that participants had an easier time aligning their typical steps with those proposed by the OHP model. However, the OCD model resulted in fewer unclassified steps (i.e., steps followed by participants that did not match the steps in the

comparison model). This suggests that the OHP model may be more intuitive for practitioners to use, but the OCD model is more comprehensive. The OHP model may be more intuitive for practitioners because it contains fewer steps. Additionally, the steps are explained in a language that most individuals who do not have training in occupational health psychology would understand, whereas the OCD model uses language that requires some knowledge of organizational change and development to fully understand. For example, during the interview, I had some participants ask for further clarification regarding the OCD steps, whereas no participants asked for clarification regarding OHP steps. I consider the OCD model to be more comprehensive because practitioners were less likely to discuss steps that were not included in this model compared to the OHP model. Thus, the answer to *RQ1* is that there is no consensus regarding which model fits better; it depends on the criterion. The OHP model is better aligned with one criterion: comprehension, whereas the OCD model is better aligned with a different criterion: comprehensiveness. Since one model was not found to be more relevant than the other, practitioners who take a blended approach between the two models may be able maximize the effectiveness of their wellness program implementation strategy.

My second research question asked whether certain model steps were more likely to be present than others. This question is narrower than *RQ1* and allowed me to specifically investigate how the steps participants described in their interviews align with the outlined steps in the published models. I found that most steps participants described in their implementation process aligned with the steps in the published models. For the OHP model, the frequency with which participants used each of the five steps ranged from 69% to 100%. The most used steps were implementation and evaluation, and the least used step was preparation. For the OCD model, the frequency with which participants used each of the ten steps varied. All 16

participants described implementing evidence-based change interventions and assessing change progress and outcomes over time, but only one participant described developing effective change leadership. The importance of program evaluation to all participants contradicts the findings from the Corporate Health Systems (2008) survey which indicated that a majority of organizations do not evaluate their programs. Thus, the answer to *RQ2* is that implementing program activities and evaluating programs are the most frequently used steps, whereas preparation-type steps are the least used. These findings indicate that practitioners are well-versed with steps associated with the back-end of program implementation. They understand that it is important to have effective implementation and evaluation plans in places. However, less focus is given to the early-stage preparation steps. Perhaps more attention to wellness program preparation steps could further improve the effectiveness of their programs.

Another important takeaway from *RQ2* is that the steps emphasized within a practitioner's implementation strategy should vary depending on the organization's needs. For example, one participant who worked in the construction industry described how her organization did not have a culture that valued wellness, so she needed to spend more time "selling" the idea of a wellness program to top leaders. In this case, the participant emphasized the preparation step more than other participants. Organizations without a previous wellness program in place may need to spend more time developing and communicating a compelling change vision, and those who are offering programs solely as a benefit to employees and are not as interested in program outcomes may not spend as much time in the evaluation step.

Research Question 3 explored whether a specific sequence of steps was more likely to occur. While *RQ2* established which steps were more likely to occur, *RQ3* allowed me to understand the order in which participants used them to implement their respective wellness

programs. Participants expressed that the linear process described in both models does not apply to wellness program implementation. They frequently described needing flexibility to skip steps and to go back and forth between steps. This is when the difference between descriptive implementation models and prescriptive implementation models becomes important. Descriptive models attempt to describe how a model is used, while prescriptive models prescribe how a model should be used. Models such as those by Nielsen et al. (2010) and Stouten et al. (2018) attempt to be comprehensive and to describe steps in an order that is easy to follow for readers. Although it makes sense for published models to provide a prescribed order of steps to aid comprehension, it would be helpful for their authors to acknowledge that this order can be fluid and that adherence to the presented order does not necessarily lead to more successful implementation.

Deviation in step sequences varied by model. For Nielsen et al. (2010) the OHP model lists preparation as Step 1 and screening as Step 2, whereas most participants described these steps in reverse order. The OCD model had more variation in the order in which steps appeared. There was no clear sequence that a majority of participants identified. For example, implementing change interventions, developing and communicating a compelling change vision, working with social networks to tap their influence, and using enabling practices to support implementation were all listed as the third step in at least one participant's sequence. The same variation was also seen for Step 4. Assessing and addressing readiness for change, implementing change interventions, developing and communicating a compelling change vision, working with social networks to tap their influence, using enabling practices to support implementation, and promoting micro-processes and experimentation were all listed by at least one participant as the

fourth step in their sequence. Thus, there was no clear sequence of steps that stood out as occurring across the majority of participants.

While there were multiple differences between participants' ordering of steps and the published model, the first two steps from the OCD model - (1) gathering evidence and diagnosing the problem and (2) assessing and addressing readiness for change interventions - were generally described in that order by participants. Note that there is overlap between the initial steps in both models – screening and preparation in the OHP model and gathering evidence and diagnosing the problem and assessing and addressing readiness for change interventions in the OCD model. More generally, the findings across these two models suggest that practitioners first collect compelling data to indicate a wellness program is necessary before going to leadership to gather support for the program. Thus, the answer to *RQ3* is that screening/diagnoses steps, tend to come first, gathering support from organizational leaders tends to come second, implementation steps tend to come third, and evaluation steps tend to come last.

Finally, *Research Question 4*, asked how COVID-19 impacted the ways in which wellness programs are implemented. I addressed this question by directly asking participants what impact COVID had on their organization overall and on wellness programs more specifically. Results indicate that COVID had big impacts on both organizations and wellness programs. I identified eight overarching themes in the data. Participants described an increase in the promotion of wellness at their companies, needing to adapt to a new work environment, concerns regarding both organizational and role stability, changing attitudes and behaviors based on new circumstances, a focus on program accessibility, tailoring programming to fit emerging needs, changes in participation, and ramification of operating in a virtual environment. Some of these themes will be highlighted below.

The first answer to *RQ4* is that wellness is now at the forefront of most organizations' minds, as seen through the increased promotion of wellness theme. Although the global wellness market has been steadily increasing by 6% each year (Global Wellness Institute, 2018) and over 92% of all U.S. worksites that employ 500 employees or more offer a wellness program (Centers for Disease Control and Prevention, 2018), participants described how they have seen an substantial increase in the value placed on workplace wellness promotion since the start of COVID.

The second answer to *RQ4* is that organizations are broadening their definition of wellness, as seen in the tailoring of programming to fit emerging needs theme. Traditional workplace wellness programs tended to focus primarily on improving physical activity and nutrition (SHRM, 2019). The challenges brought on by COVID shined a light on the importance of other types of wellness, including social connectedness and mental health. Participants in my study tackled challenges like these through program initiatives such as virtual coffee hours, virtual social clubs (e.g., book clubs), and offering free access to mental health apps.

The third answer to *RQ4* is that COVID caused considerable volatility in the workplace and for workplace wellness programs in terms of rapid and unpredictable changes. Practitioners implementing these programs described needing to be adaptable, trying to make programs more accessible for employees, and tailoring programming to fit emerging employee needs. For example, one participant described how she constantly needs to be "in-tune" to what is going on in the organization so she can determine what the most pressing needs are.

A related issue for participants was the challenge of operating in a virtual environment. Examples of challenges include finding virtual programming to be less effective than in-person programming, having to reduce some services due to remote-only delivery, and navigating

employee burnout caused from working in a virtual-only environment. For example, one participant described how she is having trouble identifying new and exciting wellness program offerings, and that she expects to start seeing a decline in participation rates because employees are tired of the same virtual programming. These takeaways highlight that although there are some beneficial outcomes for workplaces wellness programs in the wake of COVID, it also caused a number of challenges that require solutions. These findings have theoretical as well as practical implications for wellness program research and practice.

Theoretical Implications

My study makes three important contributions to the literature. First, although previously established implementation models have identified specific steps and sequences deemed essential for implementation success, no studies have investigated the extent to which practitioners implementing wellness programs use these prescribed steps and sequences. Nor, prior to this study, did we did know whether the steps and sequence prescribed by the OHP or OCD model more closely resemble what practitioners use in the workplace, or whether a combination of the two is more representative. My study provides qualitative evidence regarding which steps and sequences are commonly used by practitioners and provides support for the applicability of both models. In a sense, this study provides evidence of the content validity of the published models. In psychometrics, content validity describes the extent to which a measure represents all facets of a given construct, which is typically some type of individual or organizational attribute, such as conscientiousness, readiness for change or climate for customer service. It is appropriate to apply content validity approaches to other theoretical concepts such models or frameworks. Content validity is typically assessed via subject matter expert judgment. Here, the study participants

provided expert judgments on whether certain steps and sequences are essential for wellness program implementation.

My second contribution involves comparing two intervention models from different research disciplines. Despite the OHP models and OCD models having similar purposes and having similar steps and sequences, their respective literatures do not reference one another. This is problematic because both models and their associated research bases are relevant to wellness program implementation. By isolating these research bases, researchers and practitioners miss out on the benefits the other literature has to offer. For example, when we only focus on OHP approaches, we miss out on the emphasis organizational change research places on institutionalizing programs to sustain their effectiveness. When we only focus on OCD approaches, we are likely to underemphasize the more specific planning steps seen in occupational health psychology. Synthesizing ideas across domains leads to a more comprehensive overview of implementation strategies and may also lead to more creative implementation developments in the future. Therefore, the second theoretical contribution of my study is that it integrates two disconnected, yet parallel literatures by providing evidence to suggest a combination of the two models is the most reflective of the process used by practitioners. Establishing a connection between the two disciplines begins to deconstruct empirical and theoretical silos and encourages synthesis of the two models.

Finally, my study addresses the ongoing changing nature of work due to COVID-19. This is seen through the eight themes that emerged from the thematic coding. Because of COVID, the way work is performed has been greatly altered within a very short amount of time. This study addresses how a novel and largely unexplored landscape is affecting wellness program implementation. Specifically, I found that in-person programs were adapted for a virtual

environment, wellness practitioners are making programs more accessible for all employees, and there is a need to tailor wellness programming to fit emerging employee needs.

Thus, my findings provide insight on how wellness initiatives are being impacted by the current pandemic. However, they may also generalize to other organizational interventions and other external contexts. First, my findings could generalize to other OHP and training interventions. For example, the ramifications of operating in a virtual environment are not exclusive to wellness programs. These challenges are also relevant for other interventions and training programs, such as stress management, work-life balance, or leadership development. Second my findings may generalize to other crisis situations (e.g., natural disasters, economic crashes). For example, the need to tailor programming to fit employee needs is essential for any type of crisis situation. While COVID prompted the need for more social support programs, a recession may encourage the promotion of financial wellness programs, and a natural disaster may push organizations to offer programs that encourage volunteering and giving back to the community. Identifying model elements across interventions and contexts provides insight into both essential model elements and important contextual factors. By identifying the changes brought on by the pandemic and unique challenges that implementation efforts face, researchers and practitioners can work together to develop creative solutions informed by research.

Practical Implications

In addition to the theoretical implications, this study also has practical implications for practitioners who design and implement workplace wellness programs. First, since results suggest that both models used in this study are important for successful implementation, practitioners should consider following a synthesized, or blended, version of these two models. Following a blended version will allow practitioners to harness the strengths of both approaches,

thus leading to more effective wellness program implementation. This is in some ways straightforward as there are overlapping steps between models (e.g., preparation overlaps with assessing and addressing readiness for change and developing effective change leadership; screening overlaps with gathering evidence and diagnosing the problem). Beyond that, I recommend retaining the OHP step classifications and adding in the more granular (i.e., more detailed) OCD steps as examples of the broader OHP step classifications. I recommend this approach (adding OCD steps to the OHP model) because one model was not found to be more relevant than the other. Therefore, practitioners who take a blended approach between the two models may be able maximize the effectiveness of their wellness program implementation strategy. See Table 7 for my proposed steps, sub-steps, and sequence.

For example, a synthesized model would contain preparation as a key step but include assessing and addressing readiness for change and developing effective change leadership as sub-steps. One OCD step that should be added is institutionalizing the change to sustain effectiveness. While few participants in my study implemented this step, the OCD literature provides overwhelming evidence to suggest that engraining change into the existing organizational culture is an essential component to creating long-lasting organizational initiatives (Stouten et al., 2018).

Second, my findings suggest that while most steps identified in both models are used to some degree, the emphasis placed on certain steps should vary based on the organization's acceptance of the program and previous history with wellness programs. For example, one participant described how their organization never had a previous wellness program and did not have a culture that valued wellness. As a result, she ended up spending more time "selling" their idea of implementing a workplace wellness program to leaders. In this situation, the participant

needed to emphasize the preparation step more than other participants in organizations with cultures that value wellness. Being aware of the organizational context and its unique challenges will be essential for practitioners looking to implement effective programs. This awareness will help practitioners plan their implementation strategy appropriately and increase the likelihood of program success. For example, if a practitioner is aware that senior leaders value wellness, but employees do not, that practitioner can plan their implementation strategy around obtaining employee buy-in. In this case, he or she may choose to spend more effort gathering employee feedback about what types of initiatives would be valuable to them and what types of events that they would participate in (i.e., screening). He or she may also choose to spend more effort developing and communication a compelling vision (action planning) and less effort gathering leadership support for the program (preparation).

Third, based on the themes that emerged from *RQ4*, it is apparent that wellness programs and implementation specialists are dealing with the consequences of operating in a completely virtual environment. Participants identified changes in effectiveness, loss of services, and burnout from the virtual environment as three major challenges they currently face. It is important for other practitioners to be aware of these challenges so they can attempt to prevent them from occurring or develop solutions to address them. For example, being aware of technological restrictions prior to program development will ensure events and activities that are not supported by the available technology are not offered in the first place. However, if a practitioner is trying to adjust a previously in-person event to a virtual format, they may need to consider different options. One participant described how Zoom events can only host about one-tenth of their department. Thus, they felt restricted by the available technology to host large departmental events over Zoom. In this example, being aware of technological restriction ahead

of time can give practitioners the opportunity to look for alternative platforms or develop solutions that work around the technology. For example, instead of hosting a live presentation over Zoom, perhaps they can create a recording of the presentation and upload the file so the whole department has access to it. Practitioners should reference the training literature for articles that propose best practices for converting live sessions to virtual sessions (e.g., Arbaugh, 2005; Cavanagh et al., 2021). In terms of the reduced effectiveness of programming, practitioners may want to investigate attributes of virtual programming causing decrease in effectiveness. For example, perhaps the decline can be attributed to a lack of interaction with coworkers. If this is the case, the practitioner implementing the program may find ways to include interactive components into their virtual programming or start implementing socially-distanced outdoor group activities that follow CDC guidelines. The latter suggestion may also be helpful for returning lost services that employees valued pre-pandemic and reducing the burnout many employees are experiencing from being online all day.

Limitations

One limitation of the current study is that the findings cannot be generalized statistically to the population of interest. One of the benefits of qualitative research is its ability to collect rich details that many quantitative methods lack. However, the methods used to gather this rich qualitative information (e.g., interviews, focus groups, ethnographies) tend to be time-consuming, making it difficult to collect qualitative data from large samples. Quantitative studies tend to use methods that are less time-consuming, such as online surveys, which makes it easier to collect and analyze data from large samples. Levitt et al. (2017) described how larger samples used in quantitative studies lead to more representative findings than those from qualitative studies. Thus, the tradeoff for the richer data gained from qualitative methods is the reduced

sample size. As mentioned above, these findings are not statistically generalizable to the wellness practitioner population in the same way a quantitative study would. However, qualitative studies tend to have greater naturalistic generalizability (Stake, 1978). The current study should be viewed as exploratory research that can be used to inform future work. For example, future research can address the issue of statistical generalizability by using the current findings as a foundation for a quantitative survey that can be distributed to a larger, more representative sample of wellness practitioners.

Another limitation of my study is the intentionality behind the way participants were recruited. As stated by Morrow (2005), the adequacy of qualitative data is determined not by a "magic number" of interviews, but instead by the extent to which the data are collected from diverse sources. Thus, qualitative researchers need to be strategic about gathering participants with diverse backgrounds and perspectives for their data collection (Osbeck, 2014). I recruited participants using word-of-mouth references and my LinkedIn network. All participants were referred to me by colleagues. Although my final sample included participants from a wide range of industries (e.g., healthcare, construction, finance, etc.) and types of organizations (i.e., government, private, nonprofit), I cannot be certain that I captured diverse perspectives on wellness program implementation. My participants likely share more similarities than those derived from random sampling methods since they are all connected by a similar network. Per Osbeck, I could have been more intentional about the type of industries or types of wellness program experiences I wanted for my participants.

A third limitation of the current study is the impact of COVID-19. Although I explicitly asked participants how program implementation was impacted by COVID, there is no guarantee that their answers to my other (non-COVID) interview questions were not affected by those

experiences. Participants described how their employees had to quickly learn and adjust to a new working environment and new working norms. They also discussed the burnout their employees feel from the social isolation brough on by the work-from-home environment. Although participants were describing changes that employees in their organization were dealing with, they have also dealt with these same challenges. In other words, answers to all questions may have been affected by participants' experiences with the pandemic. The contextual impact of COVID may have further impacted who participated in my study, possibly limiting the representativeness of my results. For example, perhaps only people who were not too burned out, or not too busy, could devote an hour of their time to participate in my research study.

Another limitation worth noting is the use of Zoom to conduct video interviews. Although Zoom allowed greater access to a geographically-diverse sample, it did come with some challenges. One challenge was building rapport with participants. When interviewing a participant in-person, there tends to be more informal discussion at the start of the interview. This time to chat informally allows interviewers to build rapport with their participants. Although this can still be done online, the use of online video conference platforms reduces the amount of informal discussion time. Instead, participants find it harder to relax into conversation naturally because more energy needs to be devoted to processing non-verbal cues when video chatting. Additionally, silence on videos tends to make people uncomfortable. Schoenenberg et al. (2014) found that delays on phone or video conferencing systems can negatively shape our views of the person on the other end. They found that delays in conversation made people perceive the other person as less friendly or focused. Another challenge associated with using video conferencing to conduct interviews is the inability to minimize environmental distractions. One of my participants took a phone call during our interview, while another was interrupted by

her son, who needed help logging in to his online class. Recent research has shown that working from home has led to an increase in distractions while working (Xiao et al., 2021), which could have impacted the quality of participant responses. Finally, a third challenge associated with using Zoom are technological issues. During some interviews, the video froze and/or the audio cut out, thus reducing the amount of data I was able to transcribe and code.

Finally, the results of the current study are largely dependent on the sample population. Although I obtained a diverse representation of programs and industries in my 16 participant sample population, I may have seen more variety in the types of programs, steps used, and sequences enacted had I collected a larger sample that included a larger variety of programs and industries. For example, five of the 16 participants designed and implemented programs for government employees. Their unique experiences in the government sector, due to wellness mandates, may be very different from practitioners working in the nonprofit sector, of which I only had one representative.

Future Directions

Wellness is now at the forefront of organizations and individuals' minds more than ever before. COVID-19 emphasized the importance of workplace wellness and highlighted the need for additional research around wellness program implementation strategies. This study provides a foundation for future wellness implementation work. Future studies should continue to investigate the extent to which the implementation steps and processes in the published literature are used by practitioners and the impact of COVID-19 on wellness implementation. An obvious future direction for this area of research is to conduct a quantitative study that captures a larger sample of the target population. This type of study could include questions about which implementation steps are used and have participants list the steps in the order that they are used.

This type of study could collect further validity evidence for the OHP model, the OCD model, and initial validity evidence for the synthesized model I proposed (see Table 7). Future research should also investigate the extent to which adhering to any of these models influences program success. This could be done by having participants rate adherence to each step and program success. The association between adherence and program success would then indicate the extent to which each implementation step contributes to the overall success of wellness programs.

Additionally, more work is needed to investigate which steps and sequences are most relevant for external consultants. As noted above, both models did not fit as well for external consultants compared to practitioners implementing programs from an internal role. This may be because some of the steps described in the models need to be executed prior to external consultants entering the client organization to implement the wellness program. For example, external consultants need to engage in a good deal of planning before the model "starts." Additionally, preparing the client organization for the intervention still occurs, however, it may have less to do with addressing readiness for change and more to do with identify available resources. Future research should investigate whether: (1) distributing the currently described model steps before formal entry into the client organization or (2) adding additional steps to account for the request for proposals process and the different ways relationships form with clients is more relevant for external consultants implementing wellness programs.

Future research should also investigate some of the challenges identified in *RQ4*. For example, one of the major themes identified was the ramifications of operating in a virtual environment. Specifically, participants identified decreased effectiveness of their programming and burnout from the virtual environment as challenges they faced. Future research should investigate differences in wellness program effectiveness based on delivery method (i.e., in-

person vs online). According to the training literature, media choices do not directly influence learning (Sitzmann et al., 2006). In their meta-analysis, Sitzmann et al., found that trainees learned the same amount from online and classroom instruction when the same instructional methods were used. Thus, instructional method, rather than delivery media, is the primary factor in determining how much trainees learn (Kraiger & Ford, 2021). Future studies should investigate the extent to which this phenomenon extends to wellness programming. This could be investigated in a quasi-experimental study assessing the impact of wellness program delivery method on program effectiveness. For example, one intervention group receives online wellness programming, and another intervention group receives in-person wellness programming. Additionally, the association between online program dissemination and burnout should also be further investigated. In my study, participant reports suggested that engagement in online programming declined over the course of the past year. Thus, a longitudinal study investigating the long-term impact of continued virtual programming on burnout is much needed.

These are important directions for future wellness program implementation research because many participants suggested their organizations would either continue remote work for the foreseeable future or move towards a hybrid model of work. A hybrid model of work involves a combination of on-site office work and remote work. Thus, it is likely that virtual wellness programs are here to stay. Although some organizations may return to fully in-person wellness programming, based on the rapidly evolving nature of how work is being performed, many wellness practitioners will need to continue delivering wellness programming in a virtual environment.

CONCLUSION

This study investigated the extent to which the steps and sequences characteristic of an OHP model and an OCD model are used by practitioners implementing wellness programs in the workplace. Results suggest the OHP model is better understood by practitioners while the OCD model is more detailed. Since one model was not found to be more relevant than the other, practitioners who take a blended approach between the two models may be able maximize the effectiveness of their wellness program implementation strategy. Additionally, this study explored how the COVID-19 pandemic impacted wellness program implementation and identified several overarching themes that emerged from the data. Results indicate that wellness programs and implementation specialists are dealing with challenges associated with operating in a virtual environment, including changes in program effectiveness, loss of services, and burnout from the virtual environment. It is important for practitioners to be aware of these challenges so they can attempt to prevent them from occurring or develop solutions to address them. These findings can be used to inform future wellness intervention research and serve as a guide to wellness practitioners.

Figure 1

Coding Hierarchy Example

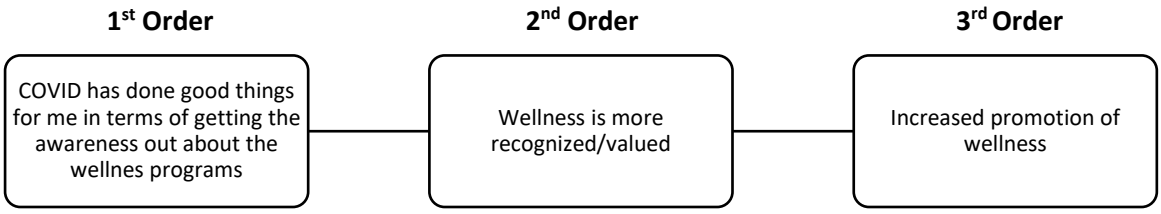

Table 1

RQ2 OHP Model Summary

Step Number	Step Name	Count Using	% Using	Example Activities
1	Planning	11	69%	• Gathering support from senior management • Collaborating with other internal teams/departments
2	Screening	13	81%	• Conducting focus groups • Collecting engagement survey data • Creating a benefits survey
3	Action Planning	14	88%	• Strategic and logistic planning • Setting program goals • Developing program activities
4	Implementation	16	100%	• Monitoring program progress • Training managers to support employee wellbeing • Email communications
5	Evaluation	16	100%	• Bi-annual benefits surveys • Reviewing changes in health indicators over time • Evaluating participation and satisfaction rates

Table 2

RQ2 OCD Model Summary

Step Number	Step Name	Count Using	% Using	Example Activities
1	Gathering facts and diagnosing the problem	13	81%	• Conducting focus groups • Collecting engagement survey data • Creating a benefits survey
2	Assessing and addressing the organization's readiness for change	11	69%	• Bringing proposals to leadership for approval • Working to create buy-in from leaders • Providing proof of concept to leaders
3	Implementing evidence-based change interventions	16	100%	• Preparing annual plans • Developing program activities • Conducting program activities
4	Developing effective change leadership	1	6%	• Training managers how to better support employee wellbeing
5	Developing and communicating a compelling change vision	7	44%	• Developing communication strategy with marketing dept • Hosting townhalls • External consultants submitting proposed wellness plans
6	Working with social networks and tapping their influence	10	63%	• Using wellness committees, ambassadors, liaisons, or champions to encourage engagement and provide feedback
7	Using enabling practices to support implementation	12	75%	• Email communications • Wellness newsletters • Internal messaging platforms used to encourage engagement
8	Promoting micro-processes and experimentation	6	38%	• Working out program kinks along the way • Adding additional programming topics as needed/requested

				• Shifting logistics to meet contextual challenges
9	Assessing change progress and outcomes over time	16	100%	• Bi-annual benefits surveys • Reviewing changes in health indicators over time • Evaluating participation and satisfaction rates
10	Institutionalizing the change to sustain its effectiveness	3	19%	• Send reports to program donor • Wellness program manager hired • Maintaining employee interest in the program long-term

Table 3

OHP Model Sequence by Participant

Participant Number	Preparation	Screening	Action Planning	Implementation	Evaluation
1	2nd 3rd	1st		4th 5th 6th	7th 8th
2	2nd		1st	3rd 4th 5th	6th
3		1st	4th 5th	2nd 3rd 5th	6th 7th
4		1st	2nd 3rd	4th 5th	6th
5		1st	2nd 3rd	4th 5th 6th 7th	8th 9th
6	3rd	7th		2nd 4th 6th	5th 8th
7		1st 2nd	3rd	4th 5th 6th 7th 8th	9th 10th
8		1st	2nd 3rd	4th 5th	6th
9	1st	2nd	6th	3rd 4th	5th 7th
10	2nd		4th	3rd 5th 6th	7th
11	1st	5th	3rd 6th	2nd 4th 7th	8th 9th
12	2nd	1st	3rd	4th 5th	6th
13	2nd		3rd	4th 5th	6th
14	2nd	1st	3rd	4th 5th 6th	7th

15	3rd	1st	2nd	4th 5th	6th
16	2nd 4th	1st	3rd 7th	5th 6th 8th	9th

Note: Any steps not listed above (e.g., Step 1 for participant 6) were unclassified

Table 4

OCD Model Sequence by Participant

Participant Number	Gather evidence	Readiness for change	Implementing interventions	Develop change leadership	Change vision	Social networks	Enabling practices	Micro - processes	Assess change progress	Institutionalize
1	1st	2nd	5th		3rd 4th	3rd	6th		7th 8th	ongoing
2		2nd	1st 4th				3rd	5th	6th	
3	1st		2nd		5th	4th	3rd	6th	7th	
4	1st		2nd 3rd 4th				5th		6th	7th
5	1st		3rd 5th		4th	2nd 8th	7th	6th	9th	
6	5th	3rd	4th 7th		1st 2nd	6th			8th	
7	1st 2nd		3rd 4th	5th	8th	7th	6th		9th 10th	
8	1st		3rd 4th			2nd	5th		6th	
9	2nd	1st	3rd			4th		6th	5th 7th	
10		2nd	3rd				5th 6th	4th	7th	1st
11	5th	1st	2nd 4th				3rd 6th 7th		8th 9th	
12	1st	2nd	3rd 4th			5th			6th	
13		2nd	5th		1st		4th		6th	
14	1st	2nd	3rd 4th			6th	5th		7th	
15	1st	3rd	2nd 4th			5th		ongoing	6th	
16	1st	2nd 4th	3rd 7th 8th		5th		6th		9th	

Note: Any steps not listed above (i.e., Step 3 for participant 13) were unclassified.

Table 5

Pattern Matching Trends

RQ1	RQ2	RQ3
Most steps fit within the categories outlined by the published models.	Most used OHP model steps: implementation and evaluation	Steps are not linear as both models suggest
Participants found it easier to align their steps with the OHP model.	Least used OHP model step: preparation	Preparation and screening sequence from the OHP model were reversed
Fewer unclassified steps with the OCD model.	Most used OCD model steps: implementing evidence-based change interventions and assessing change progress and outcomes over time	OCD sequence was less unanimous than the OHP model
	Least used OCD model step: developing effective change leadership	

Table 6

RQ4 Thematic Codes

1st Order Codes (Examples)	2nd Order Codes	3rd Order Codes
• Increased company awareness of wellness program offerings • Asked to speak at companywide all-hands meetings	• More recognized and valued • Seen as necessity • Increased displays of organizational empathy • Viewed in a more holistic way	Increased promotion of wellness
• Learning how to work remotely • Safety procedures developed for frontline workers • Implemented Slack to keep the culture alive	• Structural changes • Adapt focus of services • Creation of new norms	Adapting to a new environment
• Salary freezes • Layoffs • Budget cuts • Lost a lot of work	• Decreases in employee resources • Decreases in organizational resources • Decreases in workload	Concerns about organizational/role stability
• Promoting acceptance that WFH environments are not perfect • Everyone feels more equal • Overall company experience of burnout	• Individual-level empathetic behaviors • Perception of equality • Burnout	Changing attitudes/behaviors based on new circumstances
• All programming is virtual • Programming is more accessible for people • Learned how to create a more global program	• Programming designed for flexible implementation • Less barriers to participation	Program accessibility
• Found ways for employees to remain compliant with program	• Flexibility with program requirements • Content shifts	Tailoring programming to fit employee needs

• Encouraging social engagement • Had to get creative with programming to adapt it	• Brand new developments	
• Highest participation rate ever last year • Saw a drop in participation • Participation has remained consistent	• Increased participation • Decreased participation • No changes	Changes in participation
• Certain activities are restricted by technological capabilities • Providing emotional services at a distance is not as effective • In person-services have stopped	• Changes in effectiveness • Loss of services • Burnout from the virtual environment	Ramifications of operating in a virtual environment

Table 7

Proposed Model

Screen	Prepare	Action Plan	Implement	Evaluate	Institutionalize
Gather evidence and diagnose the problem	Assess and address readiness for change	Develop and communicate a compelling change vision	Implement evidence-based initiatives	Assess change progress and outcomes over time	Embed the program within the culture to sustain its effectiveness
Conduct a needs assessment	Developing effective change leadership	Formulate a clear action plan	Work with social networks to tap their influence		
Assess employee concerns and risks to health and wellbeing	Establish a steering group	Develop program activities	Use enabling practices to support implementation		
	Gather support from senior leaders		Promote micro-processes and experimentation		
			Monitor activities		
			Encourage engagement		

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APPENDIX A: INTERVIEW QUESTIONS AND PROTOCOL

"Welcome ____. Thank you for taking time to meet with me today. As a reminder, my name is Kelly and I am a graduate student at Colorado State University studying occupational health psychology, and more specifically, workplace wellness programs. I am very curious to learn more about your experiences with wellness programs, and your insights today will be extremely valuable, so thank you again for coming.

For today, my plan is for this to be an informal conversation; there are no right or wrong answers. I do have some questions prepared to guide us but feel free add other points that come to mind. I expect this interview will take about an hour, but if at any point you would like to stop the interview, please let me know.

Before we get started, I want to remind you that what you say today will remain confidential and no identifying information will be used in the transcription or the results of the study. If you agree, our meeting today will be recorded only for transcription purposes. Once the interview is transcribed, the recording will be deleted. Do you give consent to me recording our meeting today? (looking for verbal agreement here). One more thing I want to mention before we begin is that I'm using a transcription app that partners with Zoom to transcribe our meeting today. You may see a pop up in the top left of your screen. This is just the transcription app indicating that it is live. I recommend that you avoid clicking on this because watching the live transcription can be really distracting. I even have to close out of it because otherwise I find myself watching the transcription being written.

So with that, do you have any questions for me before we begin?"

1. Now, if you're ready, let's begin with some information about your background.
    a. Where are you currently employed?
    b. What is your current role?

If they have been involved in implementing a program at their current organization

c. I see from your screening survey that you have been involved in implementing a successful wellness program at your current organization. *If there are multiple: have them talk about a successful program they are the most passionate about or have the most to say about and explain why they chose that one.*

i. Can you describe that *specific* program?

1. Potential probing questions:

a. How did you encourage employees to participate?
b. Was participation required?
c. Were there any rewards for participating?
d. What was the goal of the program?
e. What employee/organizational outcomes were you targeting?
f. What was the size of the company?

g. What was the participate rate?

If they have been involved in implementing a program at their previous organization

a. I see from your screening survey that you were involved in implementing a successful wellness program at your previous organization. *If there are multiple: have them talk about a successful program they are the most passionate about or have the most to say about and explain why they chose that one.*

ii. What is the name of that organization?
iii. What was your role there?
iv. Can you describe the *specific* program you helped implement?

1. Potential probing questions:

a. How did you encourage employees to participate?
b. Was participation required?
c. Were there any rewards for participating?
d. What was the goal of the program?
e. What employee/organizational outcomes were you targeting?
f. What was the size of the company?
g. What was the participate rate?

"Thank you for providing that background information. From here on out, I ask that you please keep in mind the wellness program that you just described when answering the rest of the interview questions and only provide responses based on your experiences with that wellness program in particular."

2. Starting from the beginning and moving sequentially through the implementation process, please describe all the steps that were involved in developing and delivering this wellness program.
    a. If the participant needs further directions, I can provide examples of steps: obtaining executive support, conducting a needs assessment, etc.
    b. Potential probing questions:
        i. How did you determine the need for a wellness program?
        ii. To what extent did you engage in planning activities for the program?
        iii. To what extent did you prepare managers/employees for the program?
        iv. How did you deliver the program to your company?
        v. To what extent did you evaluate the program?

"To make sure I didn't miss anything, the steps you described were ____ *(read back the steps to the participant)*."

3. Are these the correct steps and correct order of steps?
    a. *If they answer yes, move on to next question*
    b. *If they answer no, correct the steps/sequence until correct and then move on to next question*

"Based on the steps you just described, I would now like to compare your experiences with some specific steps that have been described in a published article on how to implement occupational health interventions. I will share my screen now so you can visualize the model I will be walking us through. Before we begin, I want to take a moment to emphasize that there are no correct or incorrect categorizations here. Just because the publish literatures says something doesn't necessarily make it the best course of action – which is why I wanted to interview subject matter experts like yourself. I really want to gather the thoughts of people who are actually doing this kind of work in the field. So with that, I'm really interested in hearing what you truly think and there is no need to try to stretch or overfit any of your experiences to fit into these predetermined steps described in the literature." INTRODUCE CATEGORIES

4. To what extent do you believe your step of ____ aligns with: establishing a steering group, assessing employee readiness for change, organizational readiness for change, or gathering support from senior management?
    a. If I need to clarify: steering groups consists of employee and management representatives that make decisions about the program. Should include key stakeholders.

5. To what extent do you believe your step of ____ aligns with: conducting a needs assessment or assessing risks to employee health and wellbeing?
    a. If I need to clarify: A needs assessment is a systematic process for identifying and addressing gaps between current conditions and desired conditions (e.g., we want employees to report low levels of stress, however, they are currently reporting high levels of stress, so how do we change this?)

6. To what extent do you believe your step of ____ aligns with: formulating a clear action plan and developing activities?
    a. If I need to clarify: An action plan is a detailed plan outlining the actions that need to take place to reach a goal

7. To what extent do you believe your step of ____ aligns with: monitoring the activities and encouraging engagement from middle managers?
    a. If I need to clarify: Monitoring can include stopping by when an activity is going on or reaching out to a middle manager to ask how the program implementation has been going for them. It's about checking in and seeing if any changes need to be made to improve the program implementation.

8. To what extent do you believe your step of ____ aligns with: evaluating changes and outcomes due to the program?
    a. If I need to clarify: Evaluating changes and outcomes includes measuring the things you hoped the program would improve to see whether the program actually improved them.

"This next set of questions is very similar to the last, except this time, I will be comparing your experiences with specific steps that have been described in a published article on how to

implement general organizational change interventions. I will continue sharing my screen so you can visualize this new model that I will be walking us through." INTRODUCE CATEGORIES

9. To what extent do you believe your step of ____ aligns with: gathering evidence and diagnosing the problem?
    a. If I need to clarify: gathering facts to assist in a diagnosis of whether change is needed

10. To what extent do you believe your step of ____ aligns with: assessing and addressing the organization's readiness for change?
    a. If I need to clarify: the organization's capacity to take on the demands effective change requires

11. To what extent do you believe your step of ____ aligns with: implementing evidence-based change interventions?
    a. If I need to clarify: identifying plausible solutions based on scientific evidence with the help of stakeholders

12. To what extent do you believe your step of ____ aligns with: developing effective change leadership throughout the organization?
    a. If I need to clarify: Training and developing existing leaders in change-related skills

13. To what extent do you believe your step of ____ aligns with: developing and communicating a compelling change vision?
    a. If I need to clarify: must reflect a goal that can be broadly shared; communicating the change vision through multiple channels; replication

14. To what extent do you believe your step of ____ aligns with: working with social networks to tap their influence?
    a. If I need to clarify: Individuals in cohesive teams are more likely to be swayed by appeals directed to the team and efforts that engage the team as a whole; relational ties to influential members who support the change can sway fence sitters who remain resistant

15. To what extent do you believe your step of ____ aligns with: using enabling practices to support implementation?
    a. If I need to clarify: this can include goal setting, learning and skill development, employees are encouraged to participate in the change, using fair procedures when making decisions, using a gradual process of change implementation

16. To what extent do you believe your step of ____ aligns with: promoting micro-processes and experimentation?

a. If I need to clarify: allows change recipients to provide feedback and make local adjustments to broader change plans based on their own experiences

17. To what extent do you believe your step of ____ aligns with: assessing change progress and outcomes over time?
    a. If I need to clarify: Periodic assessments that allow you to determine whether the planned change is producing anticipated outcomes

18. To what extent do you believe your step of ____ aligns with: institutionalizing the change to sustain its effectiveness?
    a. If I need to clarify: integrating the change into the larger system of the organization (i.e., its culture, and management systems)

"Before we wrap up this section of the interview, is there anything else about your experience implementing this wellness program that you would like to share?" *E.g., any changes in leadership or key players leaving the company that may have impacted the program? Did you partner with any 3rd party companies to implement this program?*

"Thank you for sharing those experiences. There is one more topic I would like to cover during our time today, and it's about the impact of COVID-19."

19. From your understanding and experiences over the past year, how has your organizational unit (or department) been impacted by COVID-19?
    a. *If they answer yes:* How so?
    b. *If they answer no:* Why not?

20. More specifically, has COVID-19 impacted wellness program implementation efforts at your current organization?
    a. *If they answer yes:* How so?
        i. *Potential probing questions:*
            1. Are programs still being implemented?
            2. Are they being implemented differently?
            3. Have any of the implementation steps or sequences been impacted?
    b. *If they answer no:* Why not?

"Thank you for sharing. Is there anything else about the impact of COVID-19 on wellness programs that you would like to share?"

"That's all I have for you today. I cannot thank you enough for taking the time to meet with me and for sharing your experiences. Your interview answers are a critical part of my research on

wellness program implementation and I could not do this study without your participation. As a thank you for participating, you will receive a $50 gift card after our session today."

APPENDIX B: SCREENING QUESTIONS

1. Are you currently involved in, or have you ever been involved in, the **development and** delivery of a workplace wellness program **from start to finish** at the organization where you currently work?
   Wellness programs can include, but are not limited to, health screenings, diagnostic tests, counseling services, health incentive programs, health and fitness challenges, training programs to address worker well-being, mindfulness workshops, etc.
   a. Yes – currently
   b. Yes – previously
   c. Yes – both currently and previously
   d. No
   e. Unsure (included write-in box so they can explain the situation they are unsure about)

If they answer "yes – previously" or "unsure" to Q1

2. How long ago were you involved in the delivery?
   a. Less than 6 months
   b. 6 months – 1 year ago
   c. 1 -2 years ago
   d. More than 2 years ago
   e. If you'd like to further explain your involvement timeline, please do so here (included a write-in box)

If they answer "yes" or "unsure" to Q1

3. Which option **best** describes your primary role when you delivered the wellness program at your current organization?
   a. External consultant
   b. Executive/Director
   c. Internal professional (e.g., staff positions in Human Resources, Environmental Health, Training/Organizational Development, etc.)
   d. Tenure-track faculty member
   e. Instructor
   f. Other (include write-in box)

4. Thinking about previous jobs you have held, were you ever involved in the **development and** delivery of a workplace wellness program **from start to finish** when working for a previous employer?
   Wellness programs can include, but are not limited to, health screenings, diagnostic tests, counseling services, health incentive programs, health and fitness challenges, training programs to address worker well-being, mindfulness workshops, etc.
   a. Yes
   b. No
   c. Unsure (include write-in box so they can explain the situation they are unsure about)

If they answer "yes" or "unsure" to Q4

5. How long ago were you involved in the delivery?
    a. Less than 6 months
    b. 6 months – 1 year ago
    c. 1 -2 years ago
    d. More than 2 years ago
    e. If you'd like to further explain your involvement timeline, please do so here (included a write-in box)

If they answer "yes" or "unsure" to Q4

6. Which option **best** describes your primary role when you delivered the wellness program at your previous organization?
    a. External consultant
    b. Executive/Director
    c. Internal professional (e.g., staff positions in Human Resources, Environmental Health, Training/Organizational Development, etc.)
    d. Tenure-track faculty member
    e. Instructor
    f. Other (include write-in box)

7. Has **at least one** of the workplace wellness programs you have helped deliver been successful? A successful program is broadly defined as a program that (1) reached its intended audience **and** (2) delivered content that aligned with the audience's wellness needs and interests.
    a. Yes
    b. No
    c. I have never helped develop and design a workplace wellness program
    d. Unsure (include write-in box so they can explain the situation they are unsure about)