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Wellness Programs: Strategies for Increasing Employees' Productivity and Reducing Health Care Costs

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This is to certify that the doctoral study by

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Walden University
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Abstract

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MS, Interamerican University, Metropolitan Campus, 2005

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Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Business executives risk higher healthcare costs and absenteeism rates without implementing cost-effective strategies to support wellness within the organization. To offset rising healthcare costs and absenteeism, executives should implement wellness programs as a component of the benefits package provided to their employees and families. Grounded in the theory of planned behavior, the purpose of this qualitative multiple case study was to explore the cost-effective strategies that executives in the private and not-for-profit sectors implemented to encourage employees to adopt healthy habits for increasing productivity and decreasing organizations' healthcare costs. Six executives from the healthcare sector within the southern region of the United States participated in semistructured interviews and shared documents for thematic analysis. The four primary themes include cost-effective strategies to motivate employees, key barriers to wellness programs, a culture of wellness, and leadership roles and engagement. The key recommendation for private and not-for-profit executives is to implement an inclusive, accessible wellness culture for all members. The implications for social change involve possible reductions of health care costs when community members have access to holistic wellness programs.

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Dedication

I dedicate this doctoral study to my family. My dad and mom, Enrique Rentas Marcano and Ismenia M. Gonzalez Pilmentel, for educating me and sowing and cultivating strong values such as ethics, integrity, hard work, honesty, dedication, humbleness, commitment, empathy, independence, and honesty that will not give in, even in challenging times. Those values that culture with love and perseverance come to light and brighten the path for better outcomes as a person of good. To my sister and brother-in-law, Dr. Gisela M. Rents Gonzalez and Felipe Perez, for inspiring me as a family, couple, and professionals. For always looking for ways to maintain the spark of the family bond and love, no matter the years and circumstances. Thank you for showing that there is no better companion than your family, and there is never a bad day when you have them around. To my nephew, Yamil Perez Rentas, thank you for teaching the patience and dedication of pure love. For showing that anything is possible with the innocence of curiosity, creativity, dedication, and hard work alongside a strong, supporting family. For you my love, there is no limit except for the one you, and only you, create in your mind. Blessed to be able to complete the first phase of this journey and hopeful for a long and enriching continuation of this journey of love.

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Thank you for the participants, without your disposition, commitment, engagement, and genuine support this study will not be completed. Your commitment and engagement to your organization, students, personnel, and communities are invaluable. I hope that relationship build will continue to grow connecting knowledge for a better social good.

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Section 1: Foundation of the Study

Workplace wellness programs have been implemented in the United States to increase employee outcomes such as productivity and decrease absenteeism and health care costs. Workplace wellness programs are more likely to be implemented as an alternative strategy for organizations to cut down the cost of insurance premiums and rising employee claims, which may improve employees and their families (Cheon et al., 2020). A workplace wellness program is a coordinated and comprehensive set of health promotion and protection strategies implemented at the worksite that includes programs, policies, benefits, environmental supports, and links to the surrounding community designed to encourage the health and safety of all employees (Centers for Disease Control and Prevention [CDC], 2016b). Most employees in the United States spend more than 33% of their days at work (CDC, 2016b) and refer to the workplace as an exemplary place. An exemplary place is where the organization's leaders could provide positive peer support toward wellness by integrating the human resources department.

Background of the Problem

In the United States, rates of chronic diseases are rising exponentially, along with rates of obesity and physical inactivity, which are the leading causes of diabetes and cardiovascular diseases (Mattke et al., 2013). In particular, the onset of chronic disease is shifting to younger age cohorts still participating in the labor market, increasing the economic load related to illness-related productivity loss and medical care costs linked to chronic diseases (Mattke et al., 2013). The rising cost of health care is one of the most

prevalent and concerning issues facing the United States (Camarillo, 2021). For example, the effect of these costs on employers is substantial, with private-sector employers paying nearly $665 billion in 2016 in health-related costs, up 5% from the prior year (Sahadi, 2018).

To offset rising health care costs, leaders of organizations are taking advantage of health promotion and disease prevention strategies by engaging employees at an age when direct interventions may shift toward healthy behaviors, improving the path of their long-term health (Mattke et al., 2013). Health promotion and disease prevention strategies include creating a wellness culture within the organization, such as by incorporating healthy snacks or food options in cafeterias and offering comprehensive monthly interventions to encourage and support a shift toward sustainable, healthy lifestyles (Mattke et al., 2013). Many employers seek to address rising costs through initiatives establishing worksite wellness programs (WWPs; Camarillo, 2021). A wellness program educates employees about health-related issues, promotes healthy lifestyles, and encourages employees to make healthier choices (Stan, 2018).

Problem Statement

In the United States, researchers have identified that lifestyle diseases, such as heart diseases, cancer, and diabetes, are the leading cause of death, productivity loss due to a disability, and increased health care costs (Balwan & Kour, 2021). Lifestyle diseases are a major public health problem globally, as noted by Balwan and Kour (2021). The World Health Organization (WHO) estimated in 2018 that 71% of all deaths or 41

million globally are related to lifestyle disease. U.S. health care spending grew 4.6% in 2018, reaching $3.6 trillion or $11,172 per person, representing 17.7% of the nation's gross domestic product (Hartman et al., 2020). Health care costs have skyrocketed and will account for 20% (one fifth) of the U.S. gross domestic product by 2024, or $4.8 trillion (Soldano, 2016). The general business problem was that some executives failed to identify successful strategies that could help reduce health care costs and improve employees' health within organizations. The specific business problem was that some executives in the private sector and not-for-profit failed to appropriately identify cost-effective implementation strategies to align employees toward healthy habits for increasing productivity and decreasing organizations' health care costs.

Purpose Statement

The purpose of this qualitative multiple-case study was to identify cost-effective strategies that executives in the private and not-for-profit sector implemented to align their employees with healthy habits for increasing employee productivity and lowering organization health care costs. The target population consisted of leaders, executives, and managers from six private and not-for-profit health care organizations within the health care industry in the southern United States. Private health organizations are not owned or directly controlled by the government. The not-for-profit organizations used the money earned through donations or business activities to run the business organizations. A not-for-profit organization may be tax-exempt by Section 501(c)(3) or (c)(6) under the Internal Revenue Code. These leaders must have successfully implemented strategies to

increase employees' productivity and reduce health care costs. The sample for the study was from the lists of 100 healthy companies in 2019, 2020, and 2021 provided by Healthiest Employers (2019, 2020, 2021) and Fortune 500 One Hundred Best Companies to Work For (2019, 2020, 2021). This study has implications for positive social change, in that it identified opportunities to develop a workplace where employees engage in healthy habits that could benefit themselves, their colleagues, and their families and enhance a culture of well-being within their communities.

Nature of the Study

The appropriate methodology for the study was a qualitative method based on the inductive approach. Qualitative data are rich and full, based on the opportunity to explore a subject realistically (M. N. K. Saunders et al., 2019). Researchers conducting qualitative studies approach their subject in its natural setting, involving a diversity of empirical tools such as (a) case studies, (b) personal experiences, (c) semistructured and structured interviews, (d) observation, (e) narratives, and (f) historical archives, which could be visual or in the form of paper texts (Aspers & Corte, 2019). Qualitative research involves recording, interpreting, and analyzing nonnumeric data to uncover in-depth feelings and meanings of human experiences and behaviors (Renjith et al., 2021). Using a holistic, in-depth examination approach to phenomena, researchers can identify, observe, and code human behaviors, such as social interactions, thinking and thoughts, reasoning, patterns, and composition (Ebneyamini & Sadeghi Moghadam, 2018). With the use of a holistic, in-depth approach, the close relationship developed during the study of

phenomena between researcher and participants creates an efficient environment for the study's accuracy (Ebneyamini & Sadeghi Moghadam, 2018).

In contrast, the quantitative research methodology is a deductive approach where the researcher conducts an extensive review of scientific literature, because researchers derive interpretations by considering broader theories and populations from the characteristics of samples, looking to answer *when*, *what*, and *where* questions concerning the phenomenon under study (Renjith et al., 2021) The researcher in a quantitative study takes the position of an examiner of relationships between variables, which can be measured numerically and analyzed by adopting statistical and graphical techniques (M. N. K. Saunders et al., 2019). In a qualitative study, the researcher gains a broader perspective on the phenomenon by adopting two positions: that of an informant and a researcher. Presenting the results by combining an active informant's and researcher's voice provides more qualitative, exhaustive data–theory connections (Gioia, 2021). It provides confidence and credibility that any creative insight is grounded in the participant's experience. The inability of a quantitative method to obtain in-depth insight on participants' perspectives, as is possible with a qualitative method, made the quantitative methodology unsuitable for this research phenomenon. With mixed methods, the researcher applies both quantitative and qualitative data collection techniques, analysis procedures, and approaches for addressing complex research questions (R. Saunders et al., 2019). Mixed-methods evaluations often require timely collection and analysis of data, which can be quantitative (numbers) or qualitative (words), to provide

information on the intervention itself or the strategy used to successfully implement the intervention (Palinkas et al., 2019). The complexity of combining two methodologies, quantitative and qualitative, in addition to the time confusion and higher expenses associated with mixed-method approaches, made this methodology unsuitable for this research phenomenon. However, the design of this study included semistructured interviews to gather data on successful strategies from the leaders of the organizations and identify common themes, which did not include the collection of aggregated numeric data, making quantitative and mixed methodologies not suitable.

The research designs that may address the business problem in a qualitative study include documentary, action, narrative, and case study. The documentary research method refers to analyzing documents containing information such as policies, historical archives, and texts about the phenomenon studied (Fonseca & Segatto, 2021). The researcher applies a documentary research method in investigating and categorizing natural sources, most commonly written documents, which may be published or unpublished, intended to review key points of information required to reveal detailed findings on the research subject (Kurniawan et al., 2021). The requirement of using only secondary sources for the study made the documentary research design inadequate for the study. The action research design is an interactive inquiry process to develop solutions to real organizational problems through a participative and collaborative approach involving different knowledge forms (Coghlan, 2019). An action researcher identifies problematic situations or issues that may be considered essential for changes in practice. In action

research designs, when the researcher is actively involved, immediate information obtained may bias the data collected from the participants involved in the study (Normand & Bober, 2020). Because of this potential bias, the action research design was inappropriate for this study. The narrative researcher seeks to understand serial connections and the sequencing of personal life events as participants tell them to aid analysis and enrich understanding (M. N. K. Saunders et al., 2019). Narrative research is associated with a small and purposive sample because it entails time-consuming, in-depth investigation. Intensive, small investigations made this strategy inappropriate for addressing this study's focus.

The case study design was most appropriate for this study because of the capacity of the researcher to make an in-depth inquiry into a topic or phenomenon within its real-life setting (Yin, 2018) without compromising the study's integrity, confidence, and credibility. For example, in action research, the researcher takes an active voice by acting as a participant to create change within the organization, introducing personal bias (Lim et al., 2018). In narrative research, the researcher connects the data and presents a point of view on the study phenomenon after an intense, in-depth investigation of participants, which could lead to insightful information; in addition, bias could arise in the process (Nash, 2021).

In contrast, the case study research design involves empirical inquiry for investigating contemporary events within their real-life context, which best suits the understanding of case(s), reducing the unit of analysis into studying an event, program,

activity, or illness (Renjith et al., 2021). The capacity for providing insights into the study phenomenon using primary and secondary data supported the case study design for this study. Furthermore, the multiple-case study design used in this study was conducive to replicating similar positive outcomes in more than one case. The multiple-case study provided the opportunity to reproduce the study's data from a sample until data saturation, which provided a more compelling and robust study (Yin, 2018). When researchers have the available resources, they choose multiple-case study designs over single-case designs because of the vulnerability of putting "all the eggs in one basket" (Yin, 2018). Beyond the potential vulnerability of a single-case study, a researcher can analyze two or more cases that could provide substantial information and data in a multiple-case study.

Literal replication, where the cases corroborate each other, and theoretical replication, where the cases cover different theoretical conditions, are two approaches to establishing replication logic, which provided external validation to Ajzen's findings (Yin, 2018). Theoretical replication is a tool of analytical techniques for the case study. Theoretical replication involves examining cases where the theory provides different but predictable results and updating assumptions as they evolve since the initial study was conducted (Ebneyamini & Sadeghi Moghadam, 2018). Theoretical replications provide the opportunity to take advantage to improve the study design.

Research Question

What cost-effective strategies do executives from the private and not-for-profit sector implement to align their employees with healthy habits?

Interview Questions

1. What cost-effective strategies motivated the employees toward healthy habits?
2. What is the role of an executive in aligning employees toward healthy habits?
3. Based on experience, how does employee health influence organizational performance, as measured by productivity, profitability, and other metrics? What are some other thoughts?
4. How was the success of these cost-effective strategies measured and implemented to align employees toward healthy habits?
5. What were some of the key barriers to implementing these cost-effective strategies to align employees toward healthy habits?
6. How were the key barriers associated with implementing cost-effective strategies to align employees toward healthy habits addressed?
7. Is there additional information about the organization’s strategies for increasing employees’ productivity and reducing health care costs?

Conceptual Framework

Companies have supported health promotion programs in the United States, where employers are responsible for employees' health care costs (Ryan et al., 2018). Many theories facilitate the understanding of the multidimensional factors impacting

exercise participation, such as (a) belief-attitude theories, (b) competence-based theories, (c) control-based theories, and (d) decision-making theories (Downs & Hausenblas, 2003). The theory of planned behavior (TPB) is the most comprehensive and validated theory that can be used to predict, explain, and understand exercise behavior. The TPB is a belief-based social cognitive theory developed by Ajzen (1991) to understand and predict human behavior based on people's intentions or motivation or plan to perform or not perform a behavior (Downs & Hausenblas, 2003). Behavioral decisions result from a reasoned approach influenced by human attitudes, norms, perceived behavioral control, and intentions (Pickett et al., 2012). Applying the TPB to the study may facilitate understanding of successfully implemented strategies to align employees with healthy habits.

Operational Definitions

Cost-effectiveness analysis: Tool for informing treatment coverage and pricing decisions, yet no consensus exists about what threshold for the incremental cost-effectiveness ratio (ICER) in dollars per quality-adjusted life-year (QALY) gained indicates whether treatments are likely to be cost-effective in the United States (Vanness et al., 2021).

Employee productivity: Productivity is an assessment of the efficiency of a worker or group of workers that measures the success of a business based on quantitative criteria and factors selected by the leaders of the organization (Purwanti & Sitorus, 2018).

Health: As defined by the World Health Organization (WHO), “health is a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity” (Sartorius, 2006, p. 662).

Lifestyle diseases: Diseases linked to the way that individuals are living, based on people's daily habits (Balwan & Kour, 2021). *Lifestyle diseases* is an umbrella term that refers to ailments primarily caused by the daily habits or unhealthy behaviors of people (Balwan & Kour, 2021). Lifestyle diseases are associated with four modifiable lifestyle behaviors—smoking, unhealthy diet, physical inactivity, and alcohol consumption—resulting in the development of noncommunicable diseases (NCDs; Balwan & Kour, 2021).

Outcome-based: Health-contingent wellness program that requires an individual to attain or maintain a specific health outcome to obtain a reward, such as rewarding participants for not smoking or losing weight (Federal Register, 76(106), 2013).

Participatory wellness program: Participatory wellness programs are programs in which an individual satisfies a standard related to a health factor or programs that do not provide a reward (Federal Register, 76(106), 2013).

Patient Protection and Affordable Care Act: Title I—The Patient Protection and Affordable Care Act accomplished a fundamental transformation of health insurance in the United States through shared responsibility (Compilation of Patient Protection and Affordable Care Act, 2010). Systemic insurance market reform eliminated discriminatory practices such as pre-existing condition exclusions (Compilation of Patient Protection and

Affordable Care Act, 2010). Tax credits for individuals and families ensured that insurance is affordable for everyone (Compilation of Patient Protection and Affordable Care Act, 2010). These three elements were essential to reform (Compilation of Patient Protection and Affordable Care Act, 2010).

Productivity: Productivity measures the efficiency and effectiveness of resources, expressed as outputs divided by inputs (Halaweh, 2020).

Strategies: Strategy is a complex tool deemed to take effective actions toward achieving organizational goals (Yong et al., 2020).

Wellness program: A wellness program is a program of health promotion or disease prevention (Federal Register, 76(106), 2013).

Assumptions, Limitations, and Delimitations

Of all the elements in a standard doctoral dissertation, assumptions, limitations, and delimitations are critical to making a research study valid and reliable (Alkadash & Aljileedi, 2020). I identified the assumptions, limitations, and delimitations as part of the study. As a first step, a researcher needs to recognize the meaning and operational definitions of limitations, assumptions, and delimitations (Theofanidis & Fountouki, 2018).

Assumptions

Assumptions are issues, ideas, or positions found anywhere from the beginning of a study to the final report that, as stated by Theofanidis and Fountouki (2018), are taken for granted and viewed as reasonable and widely accepted. The first assumption of this

study was that the TPB was the appropriate framework to explain the executive's strategies of aligning employees toward healthy behaviors. The second assumption was that the organizational leaders answered the interview questions truthfully. The third assumption was that implementing successful strategies to align employees toward healthy habits increases productivity and reduces health care costs, given that employees choose if they want to engage in healthy habits, but, if chosen, will provide benefits for their health as a holistic approach.

Limitations

Limitations of a study are possible weaknesses in the study's design that are classified as imposed or out of the researcher's control related to possible funding restrictions, statistical model constraints, chosen research design, or other factors (Theofanidis & Fountouki, 2018). Limitations of a study are features of its design and execution that could have affected the findings' interpretation, validity, and applicability (Alvarez et al., 2021). A possible limitation of this study was the collection of data from a small sample focusing on the health care industry because of the external factors, such as environment and culture, that can influence the desire of the employee to align toward healthy habits and workers' productivity. Readers should be more concerned about systematic errors than an inadequate sample size (Negrini et al., 2019). The sample size deals more with the precision of the effect estimation and not necessarily with the study's validity.

Delimitations

Delimitations of a study are characteristics that arise from limitations in the scope of the study, mainly concerned with the study's theoretical background, objectives, research questions, variables under study, and study sample (Theofanidis & Fountouki, 2018). The first delimitation was the choice of the specific business problem: Executives in the private and not-for-profit sectors have limited knowledge to identify cost-effective strategies to promote healthy habits in employees. Identifying the limited knowledge of these strategies only addresses one situation without screening or rejecting other possible situations. The second delimitation of the study was narrowing the sample to the health care industry, limiting the possibilities of understanding strategies that other industries have successfully implemented toward healthy habits. The third delimitation was the southern United States' geographical selection, which limited the ability to understand the healthy habits of other regions in the United States. The fourth delimitation was the use of a sample of six organizational leaders, executives, and managers to identify successful strategies toward healthy habits from a population of 100 organizations for 2019, 2020, and 2021. The sample only represented 6% of the organization engaged in any workplace wellness strategy, which may not have included the view of other organizations. The fifth delimitation was the focus on only the perspectives of the organizational leaders, which may have provided biased information because the strategies were suggested and implemented by them.

Significance of the Study

During the 2010s, an epidemic of lifestyle diseases developed in the United States; unhealthy lifestyles such as inactivity, poor nutrition, tobacco use, and frequent alcohol consumption increased the prevalence of chronic diseases such as diabetes, heart disease, and chronic pulmonary conditions (Mattke et al., 2013). These chronic diseases or conditions may be one of the reasons for decreased quality of life, which can impact an organization through an employee's lack of productivity and an increase in health care costs. Leaders from organizations concerned with the impact of chronic conditions and unhealthy habits have taken advantage of the Patient Protection and Affordable Care Act by implementing and promoting workplace wellness programs since 2010. These wellness programs have allowed insurers to charge lower premiums to workers participating in them (Levy & Thorndike, 2019). Additionally, in 2019, the Centers for Medicare and Medicaid Services (CMS) announced the launch of a pilot program providing the opportunity for 10 states to participate in a health-contingent wellness program in the individual market. In 2013, CMS set the criteria for the participatory and health-contingent wellness programs permitted in the individual market. Implementing and expanding employer wellness programs may offer the United States the opportunity to improve the health of Americans and help control health care spending (CMS, 2012).

In collaboration with CMS, the private and not-for-profit sectors established and promoted wellness programs to lead employees toward a healthy lifestyle and goals. In 2017, the U.S. Bureau of Labor Statistics (2018) reported that 39% of private industry

workers and 63% of state and local government workers had access to such programs. They understood that the strategies that leaders in the private and not-for-profit sector implement, including accessibility, may be helpful in understanding behaviors to align their employees toward healthy habits to increase productivity and lower organizations' health care costs.

Contribution to Business Practice

Work is a fundamental aspect of life. Employees in the U.S. workforce spend many hours at work (Kaplan et al., 2017). Given the time that the U.S. workforce spends working, work relates significantly to overall well-being and life satisfaction (Bowling et al., 2010). Beyond affecting employee well-being, the working experience has much broader societal effects on the health and well-being of workers' children and families, organizational and societal productivity, health care costs, and the well-being of communities (Kaplan et al., 2017).

As part of wellness programs, executives of organizations seek methods to identify the needs of the health and well-being of their employees. Such programs' benefits include reducing health risks, improving individuals' quality of life, and developing personal effectiveness and efficiency, producing a positive result that benefits the organization (Jones et al., 2021). By improving organizations' performance, employers seek ways to reduce health care costs and improve their employees' health and productivity (Mujtaba & Cavico, 2013).

Implications for Social Change

The worksite provides an opportunity to promote employees' health and wellness because of employees' concentrated hours at work (Person et al., 2010). This study's principal implication for positive social change is that it may help reduce employees' insurance costs by identifying strategies that businesses can implement to assist employees in adopting healthier lifestyles (see CDC, 2016a). Being healthier will benefit employees' and their families' quality of life. The study's findings may also provide business leaders with strategies to promote employees' health and wellness and improve operating performance. Further implications for positive change include better work-life balance for employees.

A Review of the Professional and Academic Literature

A literature review is a detailed and justified analysis and commentary on the merits and faults of the literature within a chosen area that demonstrates familiarity with the research topic (M. N. K. Saunders et al., 2019). A literature review is an excellent way of synthesizing research findings to show evidence on a metalevel and uncover areas for more research, which is a critical component of creating theoretical frameworks and building conceptual models (Solnet et al., 2020). The literature review included in this proposal consisted of 165 peer-reviewed articles, reports, and textbooks obtained through the Walden University library and Google Scholar. Of those 165 articles, 85% were within the 5 years required, with 20% outside the 5-year timeframe. The databases for these peer-reviewed articles included Business Source Complete, Science Direct, Psyc

Info and Articles, Science Direct, Academic Search Complete, BMC Public Health, Business Source Complete, EBSC Open Source, Sage Public, PubReader, Medline, Gale Academic One File, and CINAHL Plus.

The purpose of this qualitative multiple-case study was to identify cost-effective strategies that executives in the private and not-for-profit sector implement to align their employees with healthy habits for increasing employees' productivity and lowering organizations' health care costs. The literature review contains four sections: (a) conceptual framework, (b) other behavior theories, (c) strategic implementation in an organization, (d) economic impact of wellness program on health care costs, and (e) employees' engagement with the program.

Table 1

Literature Review Source Counts

Literature type	Total	< 5 years	> 5 years	% < 5 years
Peer-reviewed journals	165	140	32	85
Dissertations	6	6	0	100%
Books	8	5	0	63%
Non-peer-reviewed journals	5	5	0	100%
Total	184	156	32	85%

Theory of Planned Behavior

The TPB and the theory of reasoned action (TRA) identify and explain patterns in human behavior, such as control and intention toward behavior in a certain context (Ajzen, 1991). The TPB predicts certain behaviors and explores the intentions that lead to them, influenced by attitude, subjective norms, and perceived control (Han & Hye, 2022).

In other words, intention is a proximal determinant of behavior. The more individuals want to engage in a particular behavior, the more likely they are to do so (Ajzen, 1991).

The TPB identifies the limitation of the TRA in explaining the behaviors for which people have incomplete volitional control (Ajzen & Fishbein, 1977, 1980). The condition of pure volitional control is accomplished by including beliefs regarding possessing requisite resources and opportunities for performing a given behavior (Madden et al., 1992). This given behavior is what Ajzen and Fishbein (1977) identified as the concept of perceived behavioral control.

As in the original theory, Ajzen (1991) noted,

> A central factor in the theory of planned behavior is reasoned action is the individual's intention to perform a given behavior. Intentions are assumed to capture the motivational factors that influence behavior; they indicate how hard people are willing to try or how much effort they are planning to exert to perform the behavior. (p. 181)

Ajzen (2015) detailed three significant determinations of behavioral intention to predict a person's behavior: (a) attitude toward the behavior, (b) subjective norms, and (c) perceived behavioral control. The three determinants and a person's intention to perform a behavior correlate strongly with the behavior (Ajzen, 2015). The relationship between the three variables is jointly dependent on motivation (intention) and ability (behavior) to influence performance.

Individuals' intentions are attitudes toward a behavior, subjective norms, and perceived control over their behavior (Lortie & Castogiovanni, 2015). The TPB has been used to explain and predict intentions and behaviors in all types of research fields, such as health sciences (Godin & Kok, 1996), leisure studies (Hagger et al., 2003), psychology (Austin & Vancouver, 1996), and marketing (Pavlou & Fygenson, 2006). As one of the main components of the TPB, intentions capture the stimulus or motivation factors that drive or influence individual behavior. Intentions provide support to identify the level of effort that an individual is willing to exert to perform the desired behavior (Ajzen, 1991). The stronger the intention to perform a behavior, the more likely an individual is to perform the behavior (Lortie & Castogiovanni, 2015). Attitudes or beliefs do not directly predict behaviors; instead, they are either fully or partially captured by intentions (Kolvereid, 1996).

Ajzen (1991) described the attitude that a person holds toward a behavior as the degree to which the person has a favorable or unfavorable evaluation or appraisal of the behavior in question. Depending on how favorably individuals evaluate behaviors, their intentions will manifest. Subjective norms refer to the perceived social pressure to perform or not perform the behavior in question. Subjective norms are attitudes that an individual holds about how important referent others or groups approve or disapprove of performing a given behavior (Ajzen, 1991). One's attitudes about the subjective norms for a given behavior reflect how positively or negatively others view the behavior in

question. Subjective norms are largely a function of salient normative beliefs (Armitage & Conner, 2001).

Perceived behavior control (PBC) refers to the perceived ease or difficulty of performing a behavior by the individual. Not only does one's attitude toward PBC refer to past experiences, but it also refers to anticipated obstacles and other factors impeding the performance of the behavior (Ajzen, 1991). Individuals who believe that they have much control over a behavior will develop subsequent intentions to perform the behavior. Together, attitudes, subjective norms, and PBC have an additive effect on an individual's intentions, implying that individuals have high intentions even though one or two of the antecedents preceding their intentions might be below the desire intentions. PBC affects not only one's intentions, but also directly affects one's behavior. This partially mediated relationship between PBC, intention, and behavior is the main difference between the TRA (Ajzen & Fishbein, 1977, 1980) and the TPB (Ajzen, 1991, 2005). Ajzen (1991) argued that intentions alone are sufficient to predict behaviors that individuals have complete volitional control over. However, Ajzen (1991) argued that as volitional control over the behavior begins to drop, PBC becomes increasingly essential, indirectly determining subsequent behavior.

Behavior management is an effective strategy to target lifestyle diseases (Teixeira & Marques, 2017). A wide variety of health-behavior-change theories have provided a conceptual organization of these determinants, including social cognitive theories such as the TPB, theories of motivation such as self-determination theory, theories distinguishing

between motivational and post motivational or volitional phases such as the health action process approach (HAPA), and self-regulation models such as control theory. The TPB is a useful theory that could support the understanding of health and other behaviors such as (a) smoking, (b) alcohol, (c) health services utilization, (d) nutritional choices, and (e) lifestyle choices. A private and not-for-profit sector executive can apply the TPB to identify cost-effective strategies that could align their employees toward healthy habits, increasing employees' productivity and lowering organizations' health care costs.

Other Behavior Concepts

TRA. The TRA facilitates understanding of the relationship between attitudes, intentions, and behaviors (Fishbein, 1967). Direct determinants of individuals' behavioral intentions are their attitudes toward performing the behavior and their subjective norms associated with it (Montano & Kasprzyk, 2015). Attitude derives from the individual's belief about outcomes or attributes of performing the behavior (behavioral beliefs), weighted by evaluating those outcomes or attributes (Montano & Kasprzyk, 2015). Individuals' subjective norms derive from their normative beliefs: whether influential referent individuals approve or disapprove of performing the behavior, weighted by their motivation to comply with those referents (Montano & Kasprzyk, 2015).

The TRA is a model for predicting behavioral intentions and or behavior (Ajzen & Fishbein, 1977, 1980). The development and testing of the TRA predicate that the studied behaviors were under complete volitional control (Madden et al., 1992). Behavioral intentions, the immediate antecedents to behavior, are a function of salient

information or beliefs about the likelihood that performing a particular behavior will lead to a specific outcome (Ajzen & Fishbein, 1977, 1980). As Ajzen and Fishbein (1977) alleged, the beliefs antecedent to the behavioral intention separate into two conceptually recognized sets: behavioral and normative.

Behavioral beliefs influence an individual's attitude toward performing a behavior. In contrast, normative beliefs influence the individual's subjective norm about performing the behavior. Ajzen and Fishbein (1977) specified three boundary conditions or assumptions that can affect the magnitude of the relationship between intentions and behavior: (a) the degree to which the measure of intention and the behavioral criterion correspond concerning their levels of specificity, (b) the stability of intentions between the time of measurement and performance of the behavior, and (c) the degree to which carrying out the intention is under the volitional control of the individual.

The TPB (TRB) is an extension of the TRA, providing a broader explanation of an individual's behavior when the degree of carrying specific intentions is not under the volitional control of an individual (Madden et al., 1992). When the assumption of volitional control is violated, the TPB provides a superior explanation for predicting the target behavior. The TPB explains more variations of intentional behaviors than the TRA regardless of the level of control (Madden et al., 1992) within the performance of the behavior.

Integrated Behavioral Model (IBM). The IBM extends Fishbein and Ajzen's TRA, planned behavior theory, and social cognitive theory integration (D'Urzo et al.,

2019). The IBM has been used to study various health behaviors in adults. The IBM indicates that those behavioral intentions are the strongest predictor of human behavior, barring any environmental barriers (including the social and physical environment) or deficiencies in skills and abilities toward engaging in a specified behavior (Branscum & Lora, 2017). Behavioral intentions significantly impact behavioral attitudes, perceived norms, and perceived behavioral control.

As proposed by Fishbein, the IBM provides for the integration of various behavioral change theories and is a useful framework for understanding the complexity of integrating patient centeredness (Archer et al., 2017). The model indicates that a person's intentions to perform or not perform a specific behavior are the most important determinant of that action. The intention is a function of three determinants: attitudes, social influence, and perceived behavioral control. The model further recognizes that background factors can directly or indirectly influence behavior. Finally, the IBM considers that there are situations where one cannot act upon one's intentions, where the person needs the necessary skills and abilities to perform the behavior, and whether environmental constraints may impede behavior (Archer et al., 2017).

Strategies for Wellness Program and Health Care Cost Reduction—Incentives

The rising cost of health care is one of the most prevalent and concerning issues facing the United States (Camarillo, 2021). The United States spends far more per capita on health care than other wealthy country, and such expenditures are increasing at an unsustainable rate (Crowley et al., 2020). The data provided by extensive research and

analysis indicated that in 2018, nearly 18% of the nation's gross domestic product, $3.6 trillion, was directed to health care, segregated as follows: Hospital services accounted for 33% of spending, physician and clinical services for 20%, prescription drugs for 9%, and other professional services for 3% (Crowley et al., 2020). The higher cost of health care presented in 2018 positioned the United States as one of the countries with the most expensive health care globally. The pricing of health care goods and services is substantially higher in the United States than in other developed nations (Crowley et al., 2020).

To control the rising cost of health care and provide an alternative for individuals' well-being, the U.S. Department of Health and Human Services (HHS) published on June 3, 2013 the Final Rule, Incentives for Nondiscriminatory Wellness Programs in Group Health Plans (the 2013 Final Rule). The Rule put forth the criteria that a wellness program must satisfy for a group health plan or group health insurance issuer to qualify for an exception to the prohibition on discrimination based on health status and participate in the individual market for insurance coverage (Federal Register, 2013). In 2018, U.S. health care costs totaled $3.6 trillion, translating to $11 for every man, woman, and child, a 4.6% increase over 2017 expenditures, with about half paid by employers or patients (Goetzel, 2020). Of that total, about 90% were patients with chronic physical and mental health conditions. Many of these health challenges could be prevented or better managed with the following lifestyle changes: (a) quit smoking, (b) have healthy diets, (c) get regular exercise, (d) avoid excessive alcohol consumption, (e)

receive recommended screenings, (f) get enough sleep, and (g) make healthy behavioral choices at work and in the community (Goetzel, 2020). For example, a study by Gingerich et al. (2018) on the relationship between sleep and productivity using data from almost 600,000 employees and 66 employers of several industries showed that having 7 to 8 hours of sleep correlated with the highest productivity and a reduction in medical hazard, which costs employers between $2,000 and $3,000 per year.

Song and Baicker (2019) found that workplace wellness programs have become increasingly popular as employers have aimed to lower health care costs and improve employee health and productivity. Many employers seek to address the rising costs through their initiatives, establishing WWPs (Camarillo, 2021). In 2018, 82% of large firms and 53% of small employers in the United States offered a wellness program, amounting to an $8 billion industry (Song & Baicker, 2019). The growth in wellness programs funded by public investment, such as those provided through the Affordable Care Act, provided funds for developing workplace wellness programs (Song & Baicker, 2019). Evidence shows that workplace health programs have the potential to promote healthy behaviors.

Goetzel (2020) and Roemer et al. (2019) found that the proper implementation of workplace health promotion (WHP) programs results in reduction, enhancement, and improvement in health care utilization and costs. For example, in a worksite program study adapted from the Chronic Disease Self-Management Program (CDSMP), Live Health, Work Healthy (LHWH), Wilson et al. (2021) validated, in a 12-month

randomized control trial (RCT), that both LHWH and usual care had a positive impact on employee health behaviors and self-management of chronic conditions. For example, the study findings aligned with those from the National Study of CDSMP, which included participants from 22 non worksite organizations across 17 states and documented significant improvements in general health status, fatigue, pain, medication compliance, communication, and unhealthy mental and physical days at 6 and 12 months post baseline (Wilson et al., 2021).

Workplace wellness programs, in most cases, focus on modifiable risk factors of the disease, such as nutrition, physical activity, and smoking cessation (Song & Baicker, 2019). An educational wellness program had the core idea of integrating evidence-based knowledge on improving working conditions and health in daily leadership practice, including health and work engagements, sustainable development, prevention, and decreased risk factors at work (Eriksson & Dellve, 2020). Educational wellness programs without incentives include health risk assessment, free blood pressure, or on-site exercise classes. Other wellness programs may offer financial incentives, such as a reduction in employees' share of the premium for health care coverage, reductions in the co-pays, cost-sharing, or payments of cash or cash equivalents (Stan, 2018). Either educational or financially driven wellness programs provide an alternative initiative to improve the health of the employees and community.

WWPs provide employees with avenues to set and achieve healthy lifestyle goals and outcomes. They vary widely in design and application, from online only programs

offered through health insurance to multi-component programs offering many activities such as nutrition workshops and group events (Camarillo, 2021). The 2010 Affordable Care Act (ACA) encourages firms to adopt wellness programs that deduct up to 30% of the total cost of health insurance coverage, and 18 states currently include some form of wellness incentives as a part of their Medicaid program (R. Saunders et al., 2019). Smith et al. (2018) showed that offering employee disease self-management interventions can substantially benefit employees and employers. These interventions could vary from company to company, including (a) health risk assessment, which assesses lifestyle health habits, (b) biometric screening, which provides clinical measures of health, and (c) wellness activities, which promote a healthy lifestyle by encouraging specific behaviors such as smoking cessation, stress management, or fitness (Jones et al., 2021).

Companies have tried various strategies to encourage employee participation in wellness programs, with different success levels depending on the desired behavior and how the incentive programs are designed (Szrek et al., 2019). For example, one of the most notable levels of success is the financial incentive of 50% for tobacco cessation, which helped increase the popularity of wellness programs among individuals in the organizations (Jones et al., 2021). Financial incentives are one of the most important strategies for improving wellness programs' participation and increasing preventive health visits (Perrault et al., 2020). In addition, financial incentives, such as tobacco cessation, increase productivity. Gubler et al. (2017) found that sick and healthy individuals who improved their health increased productivity by about 10%, with surveys

indicating sources in improved diet and exercise. A successful tool that is being implemented as part of the strategies to encourage participation in a wellness program is a completion of a survey as a simple behavior compared to quitting smoking or sustaining weight loss, which are complex behaviors and harder for incentive programs to change and address (Jenkins et al., 2019).

Incentives to encourage behavior change are offered widely within employee wellness programs but not for employees' incentives. Such preferences could have important implications for differing responses to incentives for participating in healthy behaviors (Jenkins et al., 2019). Using financial incentives or payments to encourage desired behavior is a technique that has a foundation in behavioral economics. The basic argument is that they increase the value of the desired behavior, making it more attractive to individuals than the competing behavior (Szrek et al., 2019). In the context of wellness programs, incentives are often only partially effective (Mattke et al., 2013), resulting in a problem: employers pay a substantial amount for wellness programs in terms of program costs and incentives to encourage enrollment. They anticipate potential benefits to employees and the organization, but they cannot take advantage of these benefits without enrolling employees (Szrek et al., 2019). As a motivation to participate in these wellness programs, Jenkins et al. (2019) noticed that organizations offer financial incentives via different incentive payment modes, including gift cards and money in employees' paychecks.

The wellness incentive programs vary, depending on the needs of the employer and employees. These wellness programs could include health promotion and prevention activities, such as health screenings, smoking cessation programs, healthy food options, cooking classes, paid gym memberships, or paid time to exercise (Fink et al., 2020). The success of incentive programs depends on other factors related to the type of behavior and how the incentive programs are designed (Szrek et al., 2019). Many factors characterize an incentive program and include the size of the financial incentive, the type of incentive, the frame of the incentive, communication of the incentive, and whether awareness and understating are achieved (Szrek et al., 2019).

Wellness Program and Impact on the Organizations

Wellness programs as a strategy to reduce health care costs are being implemented broadly within organizations. In the United States, between four to five larger employees offered wellness programs to their employees, with a minimum of one program during 2018 (Cheon et al., 2020). The ACA has established workplace wellness programs among the national public health strategies to reduce chronic disease in the U.S. The Centers for Disease Control and Prevention and the WHO have published guidelines for implementing wellness programs in the workplace (Cheon et al., 2020, p.31). The data and research indicate an increase in wellness initiatives among employers, providing evidence of comprehensive initiatives that can improve employee health and positively impact business outcomes. The impact of the wellness program in the organizations could vary depending on the program's complexity. One of the typical

structures of encounters is the integration of wellness screening and intervention. These two processes merge to fit the health necessities of the individual. Also, some organizations only integrate into their well-being program intervention process, which could vary depending on the health diseases, for example, diabetes, heart diseases, pulmonary diseases, and cancer. Investigations and research indicate that 72% of employers characterized their wellness program as a combination of risk screening and intervention (Mattke et al., 2013). Some of the programs established by the organizations could include employee assistance programs (EAP), occupational health services (OHS), on-site clinics, and absenteeism management. Survey results of 2017 Workplace health in America (Linnan et al., 2019) indicated that at least 40% of employers have an employee assistance program, and 24% report having OHS. In addition to it being in the organization's best interest to improve the well-being of their employees, there are other reasons and benefits for offering these programs. The results of the integration of the applications in the organizations indicate that there is an improvement in employee health, there are reductions in health care costs, there is an increase in productivity, and a decrease in absenteeism, which in the bottom line are quantifiable in the estimation of return on investment.

Health and well-being in organization programs are critical elements as part of the package of benefits provided by an organization to retain and attract new employees. Also, it is one of the essential measurements to identify if the organization is an excellent place to work. Despite the recently increasing attention, empirical studies on

organizational support toward employee subjective well-being at work are still lacking (Joo & Lee, 2017). Plenty of information on health and well-being related to work satisfaction and engagement of employees exists (Jones et al., 2021; Ott-Holland et al., 2019; Smith et al., 2018). However, clarity is lacking in identifying health and well-being components and how they correlate with the organization.

Well-being is a concept that is a portion of an individual's lifestyle, including life/non-work satisfaction, enjoyment, work, job-related satisfaction, and general health. Well-being is essential to organizational life and human resources management (Di Fabio, 2017). In scenarios where COVID-19 hit our health and economic system hard, our health and economic system globally, the well-being of the individuals is at risk (Nicola et al., 2020). To develop sustainable and well-being organizations, the leaders of the United Nations in 2015 proposed 17 sustainable development goals as follows: (a) good health and well-being; (b) quality education; (c) gender equality; (d) clean water and sanitation; (e) affordable and clean energy; (f) decent work and economic growth; (g) industry, (h) innovation, and infrastructure growth; (i) reduction in inequality; (j) sustainable cities and communities; (k) responsible consumption and production; (l) climate action; (m) life below water; (n) life on land; (o) peace, (p) justice, and (q) strong institutions. These development goals align with the concept of well-being by highlighting and prioritizing the importance of progress without excluding the promotion of individual, family, and community development. Well-being is considered an element of organizational life and human resources management (Di Fabio, 2017). These goals

emphasized the importance of opportunities for progress and promoting individuals, families, communities, and organizations to ensure sustainable development and global growth (Di Fabio, 2017). As researchers had indicated, well-being is "a state of complete physical, mental, spiritual, and social well-being and not merely the absence of disease or infirmity" (Di Fabio, 2017, para 1).

In the search to identify global similarities of well-being, the perspective of well-being among scholars should is for consideration. Crisp (2017) identified well-being as a prudential value because it refers to a particular property or state of something good for someone or something. Well-being presents challenges when examining well-being at work (Kowalski & Loretto, 2017). The Chartered Institute of Personnel and Development defined well-being at work as 'creating an environment to promote a state of contentment that allows an employee to flourish and achieve their full potential for the benefit of themselves and their organization' (CIPD, 2007). The most commonly referred to types of well-being are physical, psychological, and social (e.g., Grant et al., 2007). Employee well-being is a state of individuals' mental, physical, and general health and interactions with colleagues, teammates, and supervisors (Danna & Griffin, 1999). However, some researchers described health as a sub-component of well-being that engages or integrates the individual, mental, and psychological indicators. On the other hand, some researchers described health as a sub-component of well-being that engages or integrates the individual, mental, and psychological indicators.

Workplace wellness programs are intended to improve well-being, contain medical costs, and increase productivity (Jones et al., 2021). Lowensteyn et al. (2018) and Castaneda et al. (2018) identified employee health as a sub-division of employee well-being, providing evidence that psychological outcomes such as lack of distress, anxiety, and emotional exhaustion are present, there could be an impact on the employee well-being. For example, everyday lifestyle choices shape our perceptions, attitude, and behavior that affect health and performance (Qaisar et al., 2018). Also, personal problems stemming from lack of wellness may infiltrate organizations in the form of absenteeism, presenteeism, lack of interest, job dissatisfaction, and increased health care costs (Qaisar et al., 2018). Therefore, corporate wellness programs impact employee wellness and productivity (Gubler et al., 2017). Organizations are shifting toward the need to develop a balanced life and holistic wellness to improve employees' well-being. Implementing corporate wellness programs and health policies are long-term strategies that benefit the employee's well-being by incrementing productivity, translating to a major economic impact on the organization (Gubler et al., 2017).

As part of the wellness program, the organization identifies the needs for the health and well-being of its employees. Health, as defined by the WHO (2018), is characterized “by the state of complete physical, mental and social wellbeing and not simply the absence of a contagious disease or illness” (Sartorius, 2006, p. 662). By adopting this definition, it is possible to define wellness programs as a group of activities that support the employees by providing and sustaining the well-being and behaviors of

their employees. Wellness is the process of consciously and deliberately making choices for healthy living (Qaisar et al., 2018). Studies demonstrated that poor fitness and a stressful work environment contribute to chronic illness and performance issues (Harrington, 2017). WWPs yield positive results for employers and employees (Payne et al., 2018; Torres & Zhang, 2021). The positive outcomes are employees adopting healthier behaviors, reducing rates of chronic disease, controlling employers' health care spending, and minimizing absenteeism. Reducing health risks improves the quality of life, personal effectiveness, and efficiency while simultaneously producing a positive result that benefits the organization (Foy et al., 2019). Wellness programs could vary from organization to organization depending on the program's complexity, but some common characteristics of developing the plan are the combination of wellness screening and interventions. Organizations that perform wellness screening as part of employee wellness programs often seek to reduce health risk factors. Responses to the identified risk factors are individualized programs and interventions to improve, reduce, and prevent the identified health issues affecting employees.

The development and success of wellness programs depend on stable structures and pillars based on the organizations' shared values. Torres and Zhang (2021) identified vital components that contribute to the success of wellness programs. These six pillars are multi-level leadership, alignment, scope, relevance and quality, accessibility, partnership, and communications (Torres & Zhang, 2021). Payne et al. (2018) identified that employers should not simply introduce random interventions, expect health outcomes, or

reduce costs. Instead, they should strive to build a culture of health (COH) and develop an environment that places value on and is conducive to employee health and well-being (Payne et al., 2018). As mentioned in the first pillar, the integration of multi-level leadership is part of the program's success and a COH. Leadership, their actions, and support through the organization will influence the bottom-level employee, creating an environment of sharing, wellness, and trust for example, multi-level leadership as C-suites and top managers.

One of the necessary components strategies to promote the wellness program for success overall is organizational support of the program through direct leadership buy-in, program champion, comprehensive organizational commitment, alignment of the worksite wellness program to organizational goals, values, and missions, and integration into organizational operations (Camarillo, 2021). Programs must meet the organization's unique needs and be flexible for individual participants as additional components of success (Camarillo, 2021). Also, as a final component, there is evidence that indicates that programs which seek both behavioral (worker) and structural (worksite) changes are more likely to see success (Camarillo, 2021; Quirk et al., 2018). These components may elevate the value of the wellness program in the organization, building a COH, prioritizing the employee's well-being, and ensuring resources that support a holistic environment of health for the employee (Payne et al., 2018).

Approximately half of the U. S. population is living with a chronic disease that could be prevented or abated by lifestyle changes, which is a behavior problem of great

social significance (Normand & Bober, 2020). As defined by the WHO (1948, p.1), health is the state where an individual maintains a complete physical, mental and social well-being and is not merely an absence of a medically diagnosed disease. According to the 2016 National Survey on Drug Use and Health, more than 50 million people smoke cigarettes, roughly 65 million people binge drink, over 16 million engage in regular heavy alcohol consumption, and almost 29 million use illicit drugs (Substance Abuse and Mental Health Services Administration, 2017).

There are changes needed in individual behavior in order to improve health. Few people with chronic health conditions adhere to prescribed medical regimens, including lifestyle behavior-change recommendations (Normand & Bober, 2020). An estimated 92% of adults in the United States do not access the recommended preventive health care services identified as most likely to improve health (Borsky et al., 2018). Approximately 15% of the U.S. population does not see a physician in a calendar year (National Center for Health Statistics, 2016). According to one estimate, almost 65% of U.S. adults do not receive regular dental care, and only about half of U.S. children do receive dental care (Nasseh & Vujicic, 2017).

Organizations implemented health coaching or wellness coaching as a tool to design and deliver lifestyle changes to subside chronic disease. Health insurance plans in the U.S. use health coaching, workplace wellness programs, primary care clinics, and community health centers to promote health behavior change (McQueen et al., 2020). It

is a relatively new field within behavioral health, covering a range of activities that individually promote health and wellness (Normand & Bober, 2020).

Health coaching combines health education with psychosocial support and behavior modification techniques to meet patient determined goals, often involving lifestyle behaviors such as diet, exercise, smoking cessation, and stress management (Hill et al., 2015; Wolever et al., 2013). Studies of coaching interventions have shown positive effects on behaviors, including physical activity, nutrition, and weight loss (Hill et al., 2015), as well as improved medication adherence and health outcomes among those with chronic diseases (Wolever et al., 2013). As part of the strategies of wellness programs and interventions, health coaching provides both the psychological and education to achieve the desired results and impact the organization as a whole entity.

The Centers for Disease Control and Prevention (CDC, 2017) identified four specific health behaviors that can contribute to a longer, (a) healthier life, (b)avoiding excessive alcohol use, (c) tobacco, improving nutrition, and (d) engaging in physical activity. Studies suggest that workplace norms influence employee health behaviors, as does stress (Hoert et al., 2018). Highly stressed employees report having the most health problems and little confidence or support for health behaviors. Health coaching used by health insurance plans, workplace wellness programs, primary care clinics, and community health centers in the U.S. promotes health behavior change (McQueen et al., 2020). Health coaching combines health education with psychosocial support and behavior modification techniques to meet patient-determined goals, for example, lifestyle

behaviors such as smoking cessation. Studies of coaching interventions have shown positive effects on behaviors (McQueen et al., 2020), including physical activity, nutrition, and weight loss (Hill et al., 2015; Olsen & Nesbitt, 2010), as well as improved medication adherence and health outcomes among those with chronic diseases (Vale et al., 2003; Wolever et al., 2013).

It is easy to find employees who do not participate in wellness programs. Current researchers have suggested that participation rates in WWPs tend to be below the expected participation rate. Generally, the healthiest and least stressed employees have greater participation rates than the most stressed employees—the latter report the greatest health risks (Hoert et al., 2018). One of the emerging areas in research of wellness programs in the organization is the support of leadership as a tool to align employees toward healthy habits. Leadership support is an important factor influencing health promotion and WWPs (Hoert et al., 2018).

Organizational leaders are the face of the organization and strategically align employees toward the organization's goals. Also, organizational leaders empower employees and set the tone of the internal and external culture, that could include healthy habits, in other words, wellness. A multitude of reasons influences why employees choose not to participate in WWPs (Perrault et al., 2020). The lack of engagement in WWPs creates a gap between leaders and organizations that buy a COH. For this gap to be closed, an element is needed, passionate, persistent, and persuasive leadership. Possible factors that influence employee engagement toward worksite wellness programs

could include (a) employee perceptions of the value of employee wellness programs, (b) the employer's role in employee wellness and employee's responsibility for their wellness, (c) the commitment of the CEO, senior leaders, and company leaders to employee wellness, (d) the contribution of the work environment to employees wellness, (e) employer offered resources for maintaining wellness, (f) support for achieving wellness goals and (g) incentives for participation (Fink et al., 2020). For the organization to build a COH, leaders, such as senior managers, should support their employees by providing sustainable wellness programs and separate resources to fund these programs.

Wellness Programs and Employee Engagement and Satisfaction

Health care costs among organizations have risen dramatically during the last decades. In 2018, U.S. health care costs totaled $3.6 trillion, translating to $11,172 for every man, woman, and child, a 4.6% increase over 2017 expenditures, with about half paid by employers or patients (Goetzel, 2020). Of that total, about 90% were patients with chronic physical and mental health conditions. Many of these conditions are preventable or manageable if people quit smoking, have healthy diets, exercise regularly, avoid excessive alcohol consumption, receive recommended screenings, get enough sleep, and make healthy behavioral choices at work and in the community (Goetzel, 2020). To improve employees' health and well-being, employers engage in behaviors promoting well-being in the organizations, such as employer-sponsored wellness programs.

Most U.S. employers offer wellness programs for employees (Mattke et al., 2013), and research on the organizational outcomes of these programs demonstrated some positive effects. For example, meta-analytic research indicates that medical costs fall by $3.27 while absenteeism costs fall by $2.73 for every dollar spent on a wellness program (Ott-Holland et al., 2019). However, studies that have looked more specifically at different types of workplace health promotions show that medical cost reduction is affected more directly by disease management programs for those with chronic illness than by lifestyle programs (Mattke et al., 2013).

Organizations increasingly use employer-sponsored wellness programs, yet their purported positive outcomes for employers continue to be debatable (McCleary et al., 2017**).** Employers use several strategies to increase employee engagement in wellness programs, including offering discounts on health insurance premiums in exchange for employee participation (Fink et al., 2020). For example, findings from Koruda indicates that incentive programs for employees make low-income individuals, racial minorities, and individual vulnerable to health care shifting.

Income is not essential for employee perceptions of the value of the employer-offered wellness incentive program, the employee's responsibility for their wellness, the commitment of the CEO, senior leaders, and company leaders to employee wellness, the contribution of the work environment to employee wellness, employer offered resources for maintaining wellness, support for achieving wellness goals, or incentives for participation (Fink et al., 2020). Income is not important for whether employees feel like

they have to participate in or disclose personal health information in the program. Instead, income is a matter of how the employees perceive the engagement role of the leaders as conductors in promoting health and well-being during the organization.

The research and information related to the outcomes of the organization's wellness programs are still thin. When implementing wellness programs, some organizations consider the holistic approach to well-being, encompassing financial, mental, and physical health (Ott-Holland et al., 2019). For example, in response to the "epidemic burnout" in medicine, wellness initiatives at the Institution of Cumming School of Medicine are increasingly focusing on early prevention and intervention through engagement, advocacy, and scholarship. Wellness depends on a core principle of embracing individual differences and vulnerability, which reflects the Nussbaum (2001) human capabilities approach, based on the principle that "the freedom to achieve wellbeing is of primary moral importance. Freedom to achieve wellbeing is dependent on people's capabilities, that is, their real opportunities to do and be what they have reason to value" (Kassam & Ellaway, 2020, p. 9).

Wellness program participation is the extent to which employees behaviorally engage in a voluntary health program (Ott-Holland et al., 2019). For example, Cumming School of Medicine leaders attend the opportunity and competence to orient and integrate wellness activities, which is central to the Wellness Innovation Scholarship for Health Professions Education and Health Sciences (WISHES) approach. WISHES is taking a holistic approach that focuses on areas of wellness, such as mental, physical,

occupational, social, and intellectual domains for individual learners and teachers; health professions education/training programs; and the intersection of the higher education system and the health care system (Kassam & Ellaway, 2020).

Employees play a critical role in accomplishing organizational goals and objectives, which work at least eight hours, or, for example, in the health industry, more than 10 hours. Ferdian et al. (2021) recognized that employees play a crucial role in determining the organization's success in achieving its goals, specifically in this current environment characterized by intense competition. Further evidence relating to the importance of the level of engagement towards the achievement of company goals is increased job performance (Peng & Tseng, 2018), reduced turnover intention and burnout (Saks, 2019), and increased positive well-being and health perception (Bailey et al., 2017). Human resources practice (HRP) significantly influences employee engagement (Ajibola et al., 2019; Alola & Alafeshat, 2020). Policy and practice of human resource function in training and development, rewards management, and fair treatment can become sources of employee satisfaction, well-being, comfort, and motivation (Ferdian et al., 2021).

Employees' physical and psychological well-being are affected mainly by the work environment in which they work (Alex & Golhar, 2020). As an integral part of the holistic approach, human resources practices play the primary role in the engagement process of the employee as well as employee retention and satisfaction in the organization. Strategic human resource management (SHRM) research has established

how HR practices shape employee attitudes and behaviors and serve as a means for developing a more motivated, engaged, and productive workforce (Ott-Holland et al., 2019). Ambrosius (2018) categorized HR practices as transactional or discretionary, with required and regulated transactional practices, e.g., worker's compensation, and discretionary practices as nonobligatory and as investments in employees' training and development. They suggested that only discretionary practices will substantially affect employee attitudes and behaviors. Wellness programs are discretionary HR practices and should affect employee attitudes and behaviors (Ott-Holland et al., 2019).

Human resources practices should have the desire to have a positive effect on employees' attitudes and behaviors. If individuals interpreted an HR practice as due to positive motives on management rather than for control reasons, the practice could lead to more positive employee work attitudes and outcomes. This process suggests that employees believe the value of wellness programs is beneficial to them, and sincere organizational support will influence employees' subsequent willingness to engage in the program (Ott-Holland et al., 2019).

Employee well-being at work is the overall experience and functioning of the employee measured by job satisfaction, organizational commitment, and motivation (Mahajan, 2020). Many theorists have suggested that well-being has multiple domains and is thus a multifaceted construct (Diener et al., 2018; Forgeard et al., 2011). Diener et al. (2018) suggested six domains, and VanderWeele (2017) identified 10 items associated with flourishing, which are: (a) Oxford Happiness Inventory, (b) Subjective Happiness

Scale, (c) Approaches to Happiness Scale, (d) Authentic Happiness Inventory, (e) Satisfaction with Life Scale, (f) PANAS (Positive and Negative Affect Schedule), (g) Affect Balance Scale (ABS), (h) Psychological Wellbeing Scales, (i) Psychological Wellbeing Scale, (j) Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) and (k) Friedman Wellbeing Scale.

The companies with the most successful employee well-being program have integrated it into their work culture (Mahajan, 2020). Promoting employee well-being is not limited to decreasing medical costs but also increasing financial success, reducing employee turnover, fostering creativity, better customer service, and being recognized as an employer of choice to attract the best talent. For example, the workplace wellness market is worth 43 billion to the Global Wellness Institute. However, out of a global workforce of more than three billion, only nine percent have access to workplace wellness programs at their jobs.

Yeung and Johnston (2016) defined wellness at work as the right to work in a healthy, motivating, and edifying manner. Everyone, workers, managers, and business owners, should endeavor to work in a way that improves their wellness and the well-being of others. The Global Risk Report 2019, published by the World Economic Forum, technological and societal change links rapid transformations in the workplace; what happens at work can affect emotional and psychological well-being.

The Economic Impact of a Wellness Program on Health Care Cost

Workplace wellness programs have been implemented in the United States. There is further research needed on wellness programs' impact on health care costs about (a) systematic reviews suggest that more exhaustive design evaluations have reliability towards the effectiveness of workplace wellness programs, (b) in order to validate studies, there is a need to increase the analytical approach in various methodologies with different sample sizes, and (c) the effectiveness of strategies based on monetary incentives structure and the outcomes in the participation rates or financial impact, which rarely consider the impact depending in the design of the programs (Cheon et al., 2020). While designing programs, organization leaders should consider the topics like target goals, intensity, and possible impact in recruiting employees, having a mindset of optimizing cost and effectiveness (Cheon et al., 2020).

Gallups and West Health (2019) indicated that Americans borrowed $88 billion (all dollar amounts in U.S. dollars) in 2018 to pay for needed health care. The survey also provided the following: (a) 26% of Americans deferred treatment, (b) 15 million went without medications for serious health conditions, (c) 23% cut back household spending, (d) 41% avoided emergency care, and (e) 45% say they are concerned or extremely concerned that a major health event in their household could lead to bankruptcy. When asked about the reason for rising health care costs, 47% cited insurance company profits as the chief culprit, with 21% blaming better care and 16% higher prices.

A recent RCT of one employer's program found that workers at worksites exposed to wellness programs reported an 8.3% higher rate of regular exercise and a 13.6% higher rate of weight management behaviors, but the study failed to produce cost savings for the employer over 18 months (Goetzel, 2020). Researchers have found that certain health risks have a stronger relationship with health care costs than others, namely, high blood glucose, high blood pressure, tobacco use, high stress, and physical inactivity. Quantitative studies on high-risk factors to health care costs estimated changes in expenditures by tracking individuals' costs over an average of 3 years following risk measurement. However, they did not address the short-term impacts of having certain health risks, specifically, the relationship between health risks and health care costs in just one year following risk measurement (Goetzel, 2020).

The burden of premiums and deductibles on workers has increased sharply in recent years (Himmelstein et al., 2019). In 2017, employees' share of premiums averaged 6.9% of median income, up from 5.1% in 2008. During that same period, the average single-person deductible for employer-sponsored coverage increased to 4.8% of employees' median income, up from 2.7%. For example, a new study finds that people with diabetes whose employer forced them into health plans with a high deductible (more than $1,000) delayed getting care for macrovascular complications of diabetes like angina, transient ischemic attacks, and lower limb ulcers. High-deductible coverage also causes delays in care for women with breast cancer (Himmelstein et al., 2019).

Leaders of the organizations have implemented wellness programs to promise reduce health care costs and sometimes coerce their workers into participating (Himmelstein et al., 2019). Employees with modifiable health risks (i.e., high blood glucose, obesity, stress, depression, and physical inactivity) are significantly more costly than those at lower risk (Goetzel, 2020). Workplace wellness programs reduce health care costs, increase productivity, and provide a positive return on investment. These expected outcomes promise that the wellness program will help improve the health of those employees that participate in one of the programs.

Financial metrics for evaluating the total health care cost for the WWP include direct and indirect cost savings and return on investment (ROI). Direct cost is the actual amount spent on health care for covered individuals; indirect costs encompass a loss of productivity from employee absenteeism or disability. ROI is a financial metric used to calculate the amount of money gained or lost relative to the amount invested, which is considered the most relevant metric to determine the economic impact of a WWP (Astrella, 2017).

The ROI produced by implementing a wellness program in the organizations indicates that the program that provides the savings is the disease management (DM) programs, like diabetes and heart disease. For example, the wellness program of Pepsi Co. generated a positive ROI of $1.46 per every dollar invested (Kent et al., 2018). The data for this analysis indicated that the savings were attributable to the DM program and not lifestyle management (LM). Besides Pepsi Co.’s wellness programs, data from

additional organizations suggested that the employer saves more than a dollar spent. The results came from Pepsi Co's wellness programs. Citibank Health Management Program estimated saving $4.50 in medical expenditures per dollar spent (Mozaffarian et al., 2018). Citibank Health Management Program demonstrated that the wellness program is beneficial to the employee's health, and by creating savings in the health insurance, creating a positive ROI for the organization.

Employers are interested in supporting healthy, high-performing, fully employed workforces and mitigating temporary or permanent work disability. They face two interconnected challenges: (1) high rates of work-related injuries and fatalities persist, which contribute to the economic burden of work-related injury in society, and (2) second chronic health conditions in the workforce are increasing (Jinnett et al., 2017). Measurement must be at the employee level and in time sequence to assess the impact of personal health, job safety, and job demands. This sequence will facilitate an understanding of the relationship between the role that plays the personal health, job safety, job demands (work task difficulty), and the impact on productivity (Jinnett et al., 2017). In the Jinnett et al. (2017) study, two major measurement components were productivity and employer health. Employees' absenteeism due to injury and other health reasons is the easiest major component of productivity. However, presenteeism, when employees come to work but perform at a lower level, often accounts for more loss of productivity than absenteeism (Jinnett et al., 2017).

Employers have historically relied on analysis of the association between sick days and health care claims data. However, these analyses fail to consider the full range of physical and mental health conditions associated with decreased productivity levels (Jinnett et al., 2017). An employer's ability is limited when determining chronic illness resulting from underdiagnosis, undertreatment, and underreporting (Jinnett et al., 2017). Analysis that includes additional information, such as self-reported health risks and health conditions, presents a very different picture of what drives health costs and lost productivity. Such analysis suggested that the emphasis shifted from treatment to prevention through WHP and health protection policies and programs (Jinnett et al., 2017).

The Helsinki Statement on Health in All Policies (Ståhl, 2018) has considered the health implications of policy decisions across all sectors and levels of government. Creating and sustaining intersectoral partnerships is a core element of implementing a HiAP approach to health promotion (Corbin et al., 2018). Intersectoral partnerships include engaging partners from other sectors, identifying opportunities for collaboration, negotiating agendas, mediating different interests, and promoting synergy (WHO, 2014). The HiAP Framework for Country Action (WHO, 2014) acknowledges that the requisite knowledge and skills for facilitating effective partnerships across sectors need development. Partnerships are collaborative working relationships where partners can achieve more by working together than they can on their own (Corbin et al., 2018). Effective partnerships produce synergy when complementary skills, resources,

perspectives, and shared expertise lead to more effective solutions (Corbin et al., 2018). It is crucial that implementing a cross-sectoral partnership approach builds on the existing processes that are effective.

In 2010, the WHO proposed a model of a healthy workplace continual improvement process. Large companies such as Google, Microsoft, and Accenture seem to recognize the potential benefits of workplace initiatives to promote health, happiness, and productivity and run large-scale employee WHP activities (Emerson et al., 2020). Workplace health initiatives can reduce absenteeism and medical costs (Emerson et al., 2020). These initiatives include promoting healthy eating, encouraging active lifestyles, and awareness of mental health issues. For example, The Irish Heart foundation promotes several workplace health initiatives. Its "Healthy Eating Awards" encourage workplaces to offer nutritious food options, and its "Active@work" program supports and motivates employees to get more active (Emerson et al., 2020).

Health initiatives can benefit individuals and companies (Emerson et al., 2020). An increase in employee activity can positively affect an individual's mental well-being and physical health. For example, a "Steps Challenge" is a popular corporate health initiative that benefits individuals. Many employees work in a naturally sedentary setting. As many office workers do, sitting for long periods negatively affects one's health.

The Health Enhancement Research Organization (HERO) vision is that all workplaces will positively influence employees, families, and communities (Terry, 2020). To align the organization's culture toward healthy habits, the leaders of the

organizations should identify time dimensions, strategies, and funds to implement health promotion programs. For those health promotion programs to succeed, the organizations' leaders will need to identify if their employers are willing to participate and engage in these activities. A workplace health and wellness initiative does not guarantee employee participation or improved overall health of an organization's workforce (Emerson et al., 2020).

Quelch and Boudreau (2016) examined the interface of social and business trends and argued that four pillars are needed if the business is to accrue the advantages of leading with a COH. These four pillars, as identified by Quelch and Boudreau (2016), are:

1. Consumer health: How organizations affect the safety, integrity, and healthfulness of the products and services to their customers and end consumers.
2. Employee health: How organizations affect the health of their employees (e.g., provision of employer-sponsored health insurance, workplace practices, and wellness programs).
3. Community health: How organizations affect the health of the communities in which they operate and do business.
4. Environmental Health: How organizations’ environmental policies (or lack thereof) affect individual and population health.

Regarding the employee health pillar, Terry (2020), as part of the Workplace Health in America Survey in 2018, mentioned that 12% of companies took a comprehensive approach to employee health promotion which was up from 6.9% sponsoring comprehensive approaches in 2004, demonstrating the spread of WHP movement during the last decades. More businesses are owning up to the effects of WHP culture on employee health rather than merely blaming high health care costs on employee lifestyle choices (Terry, 2020).

Transition

Health care costs have skyrocketed and will account for 20% (one-fifth) of the U.S. gross domestic product by 2024, or $4.8 trillion (Soldano, 2016). Section I explained my business problem executives in the private and not-for-profit sectors have limited knowledge to identify cost-effective implementation strategies to align their employees with healthy habits for increasing productivity and lowering organizations' health care costs.

The TPB is a tool that facilitates understanding employees' engagement toward healthy behaviors to increase productivity and reduce health care costs. Section 2 included (a) the purpose statement, (b) the role of the researcher, (c) the study participants, (d) the research method and design, (e) the population and sampling, (f) the data collection method, and (g) reliability and validity.

Section 2: The Project

Purpose Statement

The purpose of this qualitative multiple-case study was to identify cost-effective strategies that executives and leaders in the private and not-for-profit sector implemented to encourage their employees to adopt healthy habits for increasing employees' productivity and lowering organizations' health care costs. The general population consisted of leaders, executives, and managers from six private and not-for-profit health care organizations within the health care industry in the southern region of the United States. Private and not-for-profit health care organizations are those individuals and organizations not owned or directly controlled by the government. These leaders had successfully implemented strategies to increase employees' productivity and reduce health care costs. The sample for the study was from the list of 100 healthy companies in 2019, 2020, and 2021 provided by Healthiest Employers (2019, 2020) and the 2019, 2020, and 2021 Fortune 500 one hundred best companies to work (Fortune, 2019, 2020, 2021).

The selection of these organizations was based on the following criteria. The organizations needed to (a) have an active workplace wellness program, (b) have successfully integrated their employees into the program, (c) have implemented the program for at least 5 years, (d) have collected segregated data that provide statistics about the impact of the wellness program on the health of their employees, and (e) have collected separated data that provide statistics of the economic effect on health care costs.

This study has implications for positive social change, in that it identifies opportunities to develop a workplace where employees engage in healthy habits that could benefit themselves, their colleagues, and their families and may enhance a culture of well-being within their surroundings and society.

Role of the Researcher

I identify myself as the researcher of this multiple-case study, with a role as the primary instrument for data collection. The purpose of the researcher in qualitative research is to acquire in-depth explanations, meanings, and understanding of the feelings and thoughts of the participants (Carminati, 2018). The aim of the study was to examine the participants' experiences and perceptions through the collection of events pertinent to the context of the study. In qualitative research, the researcher can bring together multiple perspectives, including contradictory viewpoints, deeply probing participants' feelings and thoughts while expanding the development of understanding and experiences of the participants toward the study (Flemming et al., 2019). The role of the researcher in the data collection process is to verify and provide details on a study, including (a) conducting surveys and interviews, (b) selecting the sample size and research participants, and (c) determining population transferability (Vasileiou et al., 2018). The success of the researcher’s role depends not only on gaining physical access to participants, but also on building rapport and demonstrating sensitivity to gain cognitive access to their data (R. Saunders et al., 2019). Qualitative research involves gaining access to people’s feelings, thoughts, and natural environment, which may provide more

insightful data for future qualitative research (Clark & Vealé, 2018). The researcher develops questions, conducts field research, interacts with participants, and collects, analyzes, and disseminates data (Yin, 2018).

In a previous capacity as an internal auditor for a health insurance company and government institution, I was able to review, assess, and provide recommendations in the process and policies of the organization regarding rules and regulations approved by official federal organizations and the local government. In addition, I formulated recommendations for possible new policies and control regarding the health insurance organization's operation, finance, and governance process. Regarding the position, job responsibility, and capacity as an Auditor II for the government sector, I was limited to gaining insight into the foundations, process, and rollout of a new integrated process of managed care for the Medicaid sector, which provides health care insurance for the low-income population.

The purpose of this qualitative multiple-case study was to identify cost-effective strategies that executives in the private sector implement to encourage employees to adopt healthy habits to increase employee productivity and lower organizations' health care costs. My experience provided knowledge in conducting the study and the specific subject that I desired to research. However, I had no direct relation with the organizations or executives targeted as part of the population and sample selection. As a component of my research responsibility in a qualitative study, I was reflexive before and after the research process. When being reflexive, researchers should not simply ignore or avoid

their own biases (as this would likely be impossible). Reflexivity requires researchers to articulate their position and avoid subjectiveness (worldview, perspectives, biases). Readers can better understand the filters through which questions asked were part of the data collection and analysis. Even though the probability of bias during the interview question and research process was low, my experience could have developed a personal bias.

A researcher must maintain ethical practices throughout a study. The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1979) created the Belmont Report, which includes principles and guidelines for ethically conducting studies with human subjects. The three basics principles that I, as a researcher, adhered to were (a) respect for persons, (b) beneficence, and (c) justice—I applying these general principles and considerations toward informed consent, risk/benefit assessment, and the selection of research participants during the research process. To ensure respect for and the consent of the participants, the participation of each interviewee was voluntary. If for any reason, during the interview process or collection of data, the participant decided that they no longer wanted to be involved in the research, they were free to retire from the research.

I sought to ensure that there were no limitations on the participants ' behavior by providing an adequate environment and climate to elaborate on and articulate their thoughts related to the research subject. The principle of beneficence was applied and extended by treating the participant ethically, respecting their decision, and protecting

their well-being. As an obligation, I did not harm participants and sought to maximize possible benefits to them, and measures were in place to prevent discomfort, possible stress, or any adverse reaction. The basis of the selection of participants was knowledge and contribution to the wellness programs of the organization that preserve the justice principle. Beyond this obligation as a researcher, I was trained and certified for Protecting Human Research Participants (PHP) by the National Institutes of Health (NIH) and the U.S. Department of HHS.

The research design provides the landscape of a study for which a researcher answers a research question (Tobi & Kampen, 2018). A research design contains the conceptual framework, which comprises the research objectives, theory or theories that are central in the project, the research questions and the sources of the data collection, detailed the method of data collection and analysis, and ascertained of any possible ethical issue encountered during the study process (Tobi & Kampen, 2018). I collected data for this study using an interview protocol (see Appendix B) aligned with the conceptual framework and research problem. The in-depth interview protocol (see Appendix B) included relevant issues related to cost-effective strategies that encourage employees to adopt healthy habits, increase productivity, reduce absenteeism, and lower health care costs. I ensured the reliability and validity of the data collected, the credibility of the participants, and the prevention of any principal ethical violation. I organized and processed the collected data using NVivo qualitative data analysis software. I used the

data collection process to recruit and interview six leaders or executives from the private and not-for-profit sectors until I reached data saturation.

Participants

The purpose of this qualitative multiple-case study was to identify cost-effective strategies that executives and leaders in the private and not-for-profit sectors implemented to align their employees with healthy habits for increasing employee productivity and lowering organizational health care costs. Therefore, the criteria for selecting participants indicated that they needed to be executives and managers within the health care setting. The sample consisted of six private and not-for-profit health care organizational leaders, including executives and managers, from the southern region of the United States, representing organizations on the list of 100 healthy employees provided by Healthiest Employees LLC and Fortune 100 during the years 2019, 2020 and 2021. Organizational leaders with comprehensive knowledge of the research subject were requested to provide their perspectives through an interview process. I sent letters with the study's intent to obtain organizational leaders' perspectives based on the selection criteria and sampling strategy.

I applied the purposive sampling strategy in the study. Purposive sampling is one way to achieve a manageable amount of data (Ames et al., 2019) and is extensively used in case studies to identify and select ample information related to a research topic (Palinkas et al., 2019). I obtained written permission from the selected participants before conducting open-ended interviews.

The following inclusion criteria facilitated the eligibility and selection of participants for the study. The organizations needed to have (a) an active workplace wellness program, (b) successfully integrated their employees into the program, (c) implemented the program for at least 5 years, (d) collected segregated data that provide statistics about the impact of the wellness program in the health of their employees, and (e) collected separated data that provide statistics on the economic effect on health care costs.

The following criteria facilitated the selection of the participants from the chosen organizations: (a) be a leader or executive of the organization in the area of human resources, wellness programs, and development programs; (b) have access to the Internet; and (c) have the consent of the participants by signing, filing, and acknowledging the consent to participate form (Appendix A) inserted as part of the data collection process. After verifying that the prospective participants were suitable for the interview based on the inclusionary criteria, I took the following steps to ensure a successful data collection process: (a) explained the purpose of the study, (b) explained the purpose of the interview, (c) worked with the participants to build rapport, (d) verified whether there was any conflict of interest, (e) verified their conflicts with the schedule, and (f) clarified with the participant any shift of perspective within the organization that might influence the answer. The purpose of the interview questions was to identify strategies implemented in these organizations by the leaders or executives to align employees

toward healthy habits, reduce health care costs, and improve the organization's employees' health.

The semistructured interview was used to obtain information on the leaders' strategies to encourage employees to adopt healthy habits to increase productivity and lower health care costs. Developing an interview guide composed mainly of open-ended questions is of paramount importance in conducting in-depth semistructured interviews. Unlike multiple-choice questions or single-answer questions (e.g., “yes”-or-“no” questions), open-ended questions must be answered in a few sentences, usually entailing detailed information (Das et al., 2021). As a component of a qualitative study in the case study, transferability is the researcher's ability to transfer the context of the study to a different setting, which was an indirect goal of this study.

A copy of the consent form (see Appendix A) was provided to each participant to obtain informed consent to participate in the study. The form was provided via email. Once informed consent was received, I explained to participants that the information collected was confidential and I would not disclose the participants’ identities. In addition, it was explained to the participants that, per Walden University guidelines, the data collected would be secured and conserved for 5 years to protect the participants' rights. The participants were able to request a copy of the approved study.

Research Method and Design

Research methods have strengths and weaknesses; certain concepts are more suitable for a research study than others (Abutabenjeh & Jaradat, 2018). The researcher is

responsible for selecting the most appropriate research methodology and the design for the studied phenomenon. The chosen method and design should be commensurate on the nature of the datasets or the problem-solving skills of the practitioner who will be using the results of the study (Abutabenjeh & Jaradat, 2018). Researchers, as noted by Abutabenjeh and Jaradat (2018), may select quantitative, qualitative, or mixed methods. I explored the methodologies most suitable for the study and applications within the health care industry.

Research Method

The methodology for a study may be quantitative, qualitative, or mixed (M. N. K. Saunders et al., 2019). The appropriate methodology for the study was a qualitative method based on the inductive approach. Qualitative data are rich, in-depth, and full of meaning (M. N. K. Saunders et al., 2019). Qualitative research is an iterative process improving the scientific community's understanding when the studies of various empirical materials, provide new significant distinguish results getting closer to the research study (Aspers & Corte, 2019). Qualitative research incorporates recording, interpreting, and analyzing nonnumeric data with the purpose of uncovering feelings and meanings of human experiences and behaviors in depth (Renjith et al., 2021). The intent and outcomes of qualitative research in health care made this method suitable for the study and understanding patterns of wellness programs based on the TPB (Renjith et al., 2021).

In contrast, quantitative research is a deductive approach in which the researcher extensively reviews the scientific literature and derives interpretations by considering broader theories and populations from the characteristics of samples, looking to answer *when*, *what*, and *where* questions concerning a phenomenon (Renjith et al., 2021). Unlike qualitative research, that relies on data via inquiry, quantitative research primarily involves analyzing the study's phenomenon (Frey, 2018). In a qualitative study, the researcher has a broader perspective on the study's phenomenon by adopting two positions, that of an informant and a researcher. In presenting the results, the researcher combines an active informant and researcher's voice and provides more exhaustive data–theory connections (Gioia, 2021). In addition, qualitative data provide confidence and credibility that any creative insight is grounded in the participant's experience. The inability of a quantitative method to obtain in-depth insight into participants' perspectives, as is possible with a qualitative method, made the quantitative methodology unsuitable for the research phenomenon. With mixed methods, the researcher applies both quantitative and qualitative data collection techniques, analysis procedures, and approaches for addressing complex research questions (M. N. K. Saunders et al., 2019).

A mixed-method study creates inevitable confusion when analyzing which of the two methods, quantitative or qualitative, applies when identifying the perspectives of individuals in the organizations. Mixed-methods evaluations often require timely collection and analysis of data, that can be quantitative (numbers) or qualitative (words), to provide information on the intervention itself or the strategy used to successfully

implement the intervention (Palinkas et al., 2019). The complexity of combining two methodologies, quantitative and qualitative, in addition to the time confusion and higher expenses associated with mixed-method approaches, made this methodology unsuitable for the research phenomenon. The design of this study centered on semistructured interviews to collect data on successful strategies from the leaders of the organizations to identify common themes, that did not include the collection of aggregated numeric data, making a quantitative or a mixed-method not suitable.

The aim of this study was to identify successful strategies that could help reduce health care costs and improve the employees' health within the organizations. Quantitative, qualitative, and mixed methodologies exhibit diverse approaches in how a researcher should tackle their research question. As a result, I pursued my research question using a qualitative method, that provided the interviewer's experience, perspectives, and understanding. The quantitative and mixed methods were not suitable approaches for the study to collect data based on the participant experience perspective.

Research Design

The research strategies that address the business problem in a qualitative study are documentary research, case study, action research, and narrative research. The documentary research method refers to analyzing documents containing information such as policies, historical archives, and texts about the phenomenon studied (Fonseca & Segatto, 2021). The researcher applies a documentary research method in investigating and categorizing natural sources, most commonly written documents, which may be

published or unpublished, intended to review key points of information required to conduct detailed analysis of the research subject (Kurniawan et al., 2021). Using only secondary sources for the study makes this strategy inadequate for this qualitative study. Yin (2018) described a case study as a process of in-depth inquiry into a phenomenon or issue in a real-life setting. Renjith et al. (2021) noted that case studies are best suited for understanding case(s), thus reducing the unit of analysis into the study of an event, program, activity, or illness. The capacity for providing insight into the study phenomenon using primary and secondary data identifies the case study strategy suitable for the study.

Action research is a participatory, democratic process concerned with developing practical knowledge to pursue useful human purposes, grounded in a participatory worldview in which its belief is emerging at this historical moment. It is a tool whose implementation ought to be promoted in the business/management field. It seeks to bring together action and reflection, theory, and practice, enhancing relevant, rigorous empirical studies and serving as a framework reference in research and practice, pursuing active collaboration between the researcher and participants (Erro-Garcés, & Alfaro-Tanco, 2020). The action research strategy commences within a specific context and with a research question but may change because the work occurs in several stages (R. Saunders et al., 2019). The possibility of a change in the research question through the study made action research inadequate for applying the business research question. Narrative research seeks to understand serial connections and the sequencing of personal

life events as told by participants to aid analysis and enrich understanding (R. Saunders et al., 2019). Because of the time-consuming, in-depth investigations, narrative research is associated with a small and purposive sample. Intensive, small investigations made this strategy inappropriate for addressing my study's focus.

I chose the case study design, instead of the action research, documentary research, and narrative research, because of the capacity of the researcher to in-depth inquiry into a topic or phenomenon within its real-life setting, as mentioned by Yin (2018), without compromising the integrity, confidence, and credibility of the study. For example, in action research, the researcher takes an active voice by acting as a participant to create change within the organization, introducing personal bias (Lim et al., 2018). In narrative research, the researcher connects the data and presents its point of view of the study phenomenon after an intense, in-depth inquiry into participants, that could lead to insight information band. The capacity for providing insights into the study phenomenon using primary and secondary data supports the case study design for this study.

In addition, I used a multiple-case study design, that allows for replicating similar positive outcomes in more than one case. The multiple-case study provides the opportunity to reproduce the study's data from a sample until data saturation, which provides a more compelling and robust study (Yin, 2018). When researchers have the choice and resources, multiple-case study designs are preferable to single-case designs because of the vulnerability of putting “all the eggs in one basket” (Yin, 2018, p. x). The multiple-case study allowed the researcher to evaluate more than two cases, broadening

the information and data related to the phenomenon. Literal and theoretical replication are two approaches to establishing replication logic, which provides external validation to the findings (Yin, 2018). The theoretical replication is a tool of analytical techniques for the case study. The theoretical replications examine cases where the theory provides different but predictable results and update the assumptions as they evolve since the initial studies (Ebneyamini & Sadeghi Moghadam, 2018). The theoretical replications provide the opportunity to take advantage of the improve the study design.

As part of the requirements of a qualitative study, the researcher needs to reach data saturation, the common standard for quality research (Johnson et al., 2020). A qualitative study focuses on the participants' various perspectives, which involves broadly stated questions about human experiences and realities, studied through the sustained contact with the individual in their natural environments and the produce of rich, descriptive data that help the understanding of individual's experiences (Renjith et al., 2021). Data saturation is probably the most common terminology when sufficient data is acquired and no new information is emerging (Johnson et al., 2020). Data adequacy is when no new information is available for data collection during a research study (Partridge et al., 2018). I obtained data saturation once the interviewers did not provide new ideas about the subject researched.

Population and Sampling

The researcher obtained a purposeful sampling of six executives, leaders, and managers within the health care industry in the southern region of the United States.

Selecting this sample from the list of 100 healthy companies in 2019, 2020, and 2021, provided by Healthiest Employers, LLC and Fortune 100, represented the full cases in a meaningful and justified way (R. Saunders et al., 2019). These executives implemented strategies to increase employee productivity and reduce health care costs. The selected organizations met the following criteria: (a) located in the southern region of the United States, which included the following states: Alabama, Arkansas, Delaware, the District of Colombia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia (b) have an active workplace wellness program, (c) have successfully integrated employees in the program, (d) the program has at least 5 years of implementation, (e) has collected segregated data that provides statistics about the impact of the wellness program in the health of their employees and (f) has collected segregated data that provides statistics of the economic effect on the health care cost.

Purposive sampling is an approach that better matches the aims and objectives of the research, thus improving the rigor and trustworthiness of the data and results (Campbell et al., 2020). Non-probability sampling could be by judgment or quota. In judgment sampling, a researcher may only want to survey those who meet specific criteria. Researchers, in judgment sampling, reach out to participants felt to meet the objectives of a study or subject of interest under investigation (Etikan & Babtope, 2019). Quota sampling improves the representativeness of a sample to ensure that the relevant characteristics are present in sufficient quantities. It is widely used in polls and

considered the non-probability version of stratified sampling because it often has reduced costs and requires less time (Etikan & Babtope, 2019).

In general, purposive sampling engages the researcher in a series of strategic choices about whom, where, and how one does research. Purposive sampling could mean the sampling strategy correlates with the study's objective. Purposive sampling is virtually synonymous with qualitative research because there are many objectives that qualitative researchers might have. Purposive sampling strategies move away from any random form of sampling. As noted by Campbel et at., (2020), purposive sampling ensures that specific kinds of cases are included in the final sample in the research study. Researchers may choose the sampling technique that plays a critical role in clinical and other experimental studies based on the subject population and the intended use of the results (Etikan & Babtope, 2019). Purposive sampling could not be considered statistically representative of the target population; instead, the logic should depend on the research questions and objectives (M. N. K. Saunders et al., 2019).

Selecting the appropriate sample in the study was imperative to reach data saturation. Data saturation is when the researcher determines that continuing sampling and data analysis does not appear to provide further theory, concept, or additional evidence, and redundancy is achieved (Aldiabat & Le Navenec, 2018). Renjith et al. (2021) noted that data saturation or the point of redundancy is the stage where the researcher no longer acquires new information. While quantitative research deals with massive amounts of data for producing statistical and numerical outcomes, qualitative

studies employ small samples (Alam, 2021). Qualitative research aims to gather information beneficial for understanding the difficulty, complexity, difference, or context within a phenomenon; instead of representing numbers as quantitative research, resulting in small sampling sizes (Alam, 2021).

If the selection was accurate, the proposed sample of six participants was enough to reach data saturation. If the data saturation was not unattainable with the sample selected, additional participants10 were going to be recruited within the character to reach the data saturation requirement. A larger sample size reduces the likely error in generalizing to the target population (R. Saunders et al., 2019). In selecting the number of participants, a sample of fewer than 20 would help the researcher make and maintain a close relationship and thus improve the open and thoughtful sharing of information (Crouch & McKenzie, 2006). Subsequently, as noted by Alam (2021), the perfect sizes of many qualitative types of research are 15 to 20 for homogeneous interview participants. With homogeneous participants, a suitable sample size of 10 might be adequate for a qualitative study (Alam, 2021; Sandelowski, 1995).

No guidelines are provided to the research to achieve data saturation. Instead, there are two concepts that the researcher should focus on, obtaining rich and thick data. It may be best to think of data in terms of richness and thickness because data saturation is approximately six participants, a subjective determination based on the convention of the field of study and research (Guest et al., 2020). Data saturation generally denotes

achieving the highest position of informational redundancy or similarity without adding new contributions to any beneficial information to the body of the study (Alam, 2021).

The interview environment was critical for collecting data in this study. Interviews facilitate the conduct of qualitative research, for which the researcher strives to understand the participant's subjective perspective rather than focusing on the general understanding of a larger group of people (McGrath et al., 2019). Many authors have argued that the main goal of an investigative interview is to gain as much reliable information as possible (Shepherd & Griffiths, 2021; Vrij & Leal, 2020). To achieve this reliable information, researchers must create an atmosphere that promotes the disclosure of information, such as building rapport and comfortable interactions, that enable the respondent to provide a rich and detailed account of the experiences at the center of the study (McGrath et al., 2019).

The environment in which an interview takes place affects its quality (Hoogesteyn et al., 2020). Studies in the health care field found that clients disclose personal information at a higher rate in a “soft,” intimate room (decorated with pictures, comfortable chairs, soft lighting) than in a “hard,” non-intimate environment (block walls, uncomfortable chairs, fluorescent lighting) (Chaikin et al., 1976). Another study indicated that room décor influences interpersonal communication, with a room decorated in a home-like, instead of office-like, style fostering more communication concerning general and intimate topics (Gifford, 1988). A home-like décor is not just more physically comfortable but can also be more psychologically comfortable, inducing

a sense of shelter associated with a home (Gifford, 1988). I conducted the interview virtually, as the circumstance related to COVID-19 allowed, creating a sense of a soft environment in the background and through the Zoom application. The application used to conduct these meetings was the decision and disposition of the participant. Interviewing in a comfortable setting, in this case virtually, allowed to build up trust, soften the process and gather more reliable information.

Ethical Research

The purpose of the Institutional Review Board (IRB) is to ensure researchers comply with the existing Federal Regulations, such as Guidelines on Human Research Protection, U.S. Federal Drug Administrative, and National Institute of Health of the Federal government (U.S. Food and Drug Administration, 2019). Part of the criteria that all universities, including Walden University, should follow is the Federal Policy for the Protection of Human Subjects (45 CFR 46) (U.S. Federal Registry, 2017). The IRB is required to review research proposals, funded or not, that are prepared by students, instructors, and staff ("Researchers"), which are not literature reviews and hypothetical research designs (U.S. Department of HHS, 1979). I am responsible that the Doctoral Research Study with approval number of 10-12-21-0762190 complied with the following IRB standards based on the regulations established by the Federal Policy, Protection of Human Subject 45 C.F.R. §46 (2009) and noted by Grady (2015):

1. Risk is justified in terms of related benefits to the participants and society.
2. Participants engage in research willingly and knowingly to the extent possible.

3. Research methods are appropriate to the objectives of the research.
4. Research methods are the safest possible and are consistent with sound research design.
5. Protection of all stakeholders' privacy.
6. Monitoring of research.
7. Researchers share study results appropriately with stakeholders.
8. Researchers use other researchers' data collection tools appropriately.

In addition to compliance with Federal Regulations, I am certified by the National Institute of Health as a PHP, number #2836974.

As a researcher, I am responsible for adhering to the standards of ethics and confidentiality of The Belmond Report. As part of that, I provided the participants a consent form that will establish the following: (a) the focus of the study, (b) the benefits of participating in the study, (c) key information to assist the prospective participant in understanding the reason of the study and (e) legally authorization of the prospective participant. Section §46.116 stated:

> Informed consent must begin with a concise and focused presentation of the key information that is most likely to assist a prospective subject or legally authorized representative in understanding the reasons why one might or might not want to participate in the research (King, 2019, para. 2).

Besides that, it is a personal responsibility to include in the consent form the requirements established in the Federal Policy for the Protection of Human Subjects 45

C.F.R. §46 (2009). King (2019) noted five conditions that every researcher can denote at the beginning of each consent form. Those five conditions are (a) consent is voluntary, (b) the purpose, duration, and procedures for the participant, (c) risks for the participant, (d) benefits for the participant, and (e) alternative procedures instead of the interviews. These five factors will match the first four factors of informed consent stated in Section §46.116(b). The four principles of informed consent include (a) disclosure, (b) comprehension, (c) competence, and (d) voluntariness (Sim & Waterfield, 2019).

The data generated during the interview provided insightful information on strategies the organization's leaders implemented and supported the research question and literature review provided in Section one. The ethical research guideline of informed consent ensured informants' autonomy and voluntary participation inherent in the informed consent form and these forms. Researchers usually promise the full anonymity of the informants (Oye et al., 2019). My participants being employees of the organizations could raise the doubt that the interviewers will be “squeezed” to being informants and loyal employees in providing insight into strategies implemented to increase productivity and reduce health care costs. It is my responsibility to acknowledge that the “squeeze” could undermine the quality of the research (Oye et al., 2019). Lack of ensured confidentiality can lead to distress at the moment of discussion and less honest information, as seen from the perspectives of researchers (Sim & Waterfield, 2019). I am responsible to safeguard the data collected for a minimum of 5 years in a secure place to

comply with Federal Regulations §45 and §46. If I can guarantee that the data will be secured, there is the possibility that I will retain the information indefinitely.

Data Collection Instruments

The data collection instrument for this doctoral study was a semistructured interview to acquire the authentic view and perspective of the participants in the study. Qualitative data are likely to be characterized by their richness and fullness, based on the opportunity to explore a subject in as real a manner as possible (M. N. K. Saunders et al., 2019). As stated by Johnson et al. (2020), qualitative research focuses on making sense of a lived, observed phenomenon in a specific context and specifically selected individuals and not attempting to generalize from a sample to a population (Johnson et al., 2020). As the primary source of the data collection, I selected from various strategies most suitable to understand the phenomenon study (Renjith et al., 2021). The principal researcher, as mentioned by Johnson et al. (2020), will ensure the trustworthiness and integrity within the data collection and analysis process, that runs concurrently in qualitative studies, by including peer review, audit trail, triangulation, negative cases analysis, and computer software to achieve the research goal.

Qualitative methodology refers to the in-depth broadest sense of research that produces descriptive data from the participants' own perspectives and observable behaviors that allow findings to emerge from the data rather than a predetermined hypothesis (Lawton et al., 2019). A qualitative methodology is more than a set of data-gathering techniques; it is a way of approaching the empirical world. For example,

qualitative researchers are concerned with the meaning people attach to things in life. A qualitative researcher develops concepts, insights, and understanding from patterns in the data rather than collecting data to assess preconceived models, hypotheses, or theories. Renjith et al. (2021) indicated that qualitative research examines the how and why of decision making from various lived perspectives of the participants.

Edwards and Holland (2020) provided broader insight into why qualitative data suited the selected research study. First, I took the approach, which could be abstract and general theoretical approaches oriented towards the type of communication with a modeling line or general explanations and fragmented, descriptive, and empirical approaches that will support the need to investigate qualitative research methods. Second is the need to prolong the duration of the inquiry and maintain position independence. Third, some of the supporting reasons for selecting a qualitative research method are: (a) setting the research objective, (b) treating the research objective concerning its context, (c) facilitating access to land and sources, (d) supporting the researcher in promoting critical analyzes, (e) need to prolong the duration of the investigation and to maintain position independence and (f) selecting the research method (Edwards & Holland, 2020).

The inductive approach allowed the researcher to explore a topic and develop a theoretical explanation as the data were collected and analyzed, resulting in a data-driven research study (M. K. N. Saunders et al., 2019). Some techniques used to collect data for a qualitative research study are interviews, observations, archival documents, and administrative records. The mentioned data collection techniques classify the researcher

as primary and secondary. Primary data consists of observations and structured, semistructured, unstructured, or in-depth interviews. Planning is an essential aspect of all research and as part of a qualitative study using semistructured interviews is the development of a research question and guidelines to follow along the interview process (Johnson et al., 2020). The interview guide underpins the interview process and therefore influences subsequent research stages. A healthy interview guide will likely help the researcher interview an individual with ASD rather than focusing on practical components. For example, the interviewer prefers to discuss topics of interest to them rather than discomfort topics.

The study included the use of semistructured, in-depth interviews. In the range of qualitative methods, for example, unstructured interviews, focus groups, observations, documentary studies, and semistructured interviews are among the most used in the research area (Busetto et al., 2020). The researcher has a list of themes and possibly some key questions to be covered, although their use may vary from interview to interview (R. Saunders et al., 2019). The questionnaire could facilitate the researcher to omit some interview questions, given a specific organizational context concerning the research topic. Semistructured interviews involve in-depth conversations between the researcher and interviewee, which purposely provides insight into the interviewee's subjective experiences, opinions, and motivations (Busetto et al., 2020). As a technical tool to collect data in qualitative research, semistructured interviews provide the most

advantageous and reliable data collection when the researcher aims to amplify the range of behavior information data (Cooper & Wickramasinghe, 2020).

To enrich the process of credibility and trustworthiness in the study, the researcher employed specific strategies within each phase of the research process, such as member checking during the semistructured interview and triangulation in the data collection and analysis (Johnson et al., 2020). Triangulation is the combination of methods or data sources in a single study. Data triangulation encourages the researcher to collect information from multiple sources to corroborate the findings (Yin, 2018). In addition, data triangulation helps strengthen the construct validity of the case study by providing various measures of the same phenomenon. Secondary data in research projects facilitate primary data collection (R. Saunders et al., 2019). Secondary data could include text materials and non-text materials found online. As part of the proposed research study, I used documentary data such as journals, organization reports, organizational policies and regulations, articles, and books to validate and reconcile the information acquired via the interview questions supported by data from other sources, scholars, and researchers.

Data Collection Technique

The research question and phenomenon of the study is: What health promotion strategies do executives from the private and not-for-profit sector implement to motivate their employees toward healthy habits? To fulfill the objectives of this study, I collected data using interview method as the primary source. The primary data source was a

semistructured interview, and organizational documents were the secondary data source. The inclusion criteria for the study was to select a purposive sample of three to six executives who could implement concrete strategies, such as policies and financial and operational plans to increase employee productivity and reduce health care costs. In this study, I sought to acquire extensive information related to the perspective and experience of the executives from the organization regarding strategies implemented to align employees toward healthy habits that can increase employees' productivity and lower organization health care costs. An email or phone call to the wellness program facilitator facilitated an explanation, and the collection data process continued as approved.

Qualitative interviews exist on a continuum, ranging from free-ranging, exploratory discussions to highly structured interviews (Magaldi & Berler, 2020). The interview is one of the dominant data collection techniques in case study approaches and can be distinguished by the degree of structure, such as open-ended questionnaire or semistructured interviews (Busetto et al., 2020). A semistructured interview has two roles, to help develop conversational relationships about the meaning of experience and allow the researcher to discover, with space to follow topical trajectories as the conversation unfolds (Magaldi & Berler, 2020). The semistructured interview is the primary data collection technique for this case study, which was conducted virtually and consisted of open-ended questions of the selected sample. As secondary data, I used the documentation provided by the organization, such as organigram, wellness policies and

regulations, possible performance metrics, and implementations and monitoring processes.

The interview protocol (Appendix B) was as follows: (a) introduce myself to the participant and set the stage of the interview, (b) read the introductory script or welcoming, (c) indicate recording of the interview to the participant for data collection, (c) turn on the recording (d) read and review the participant consent signed via email correspondence, (e) address any concern or questions that the participant could have, (e) initiate the interview process and data gathering with the participants through predetermined questions and follow-up questions, (f) reading the closing script, (g) check of participant status and contact information and (h) close the interview and ascertain appreciation and thank the participant. These semistructured interview questions aim to gain insights into a person's subjective experience, opinions, and motivations instead of facts or behaviors to a broader spectrum and enhance the credibility and trustworthiness of an analysis (Busetto et al., 2020). At the end of the interviews, I allowed room for open dialogue and follow-up questions.

I used Zoom to conduct the interview virtually. As part of the adjustment due to the recent spread of COVID-19, the interview process needed to be virtual. Zoom technology platform provided the tools to record and transcripts the interview. As a backup plan, I applied the software Skype for recording and analysis of data collection. Face-to-face interviews are traditional forms of generating data in qualitative studies (Creswell & Poth, 2018). However, meeting participants in person is not feasible when

they are in different locations, unable or unwilling to travel, or research funding does not allow it (Solnet et al., 2020). Video conferencing may provide researchers and participants with a cost-effective and convenient alternative (Gray, L. et al., 2020). Considering the high virulence of COVID-19, difficulty in traveling across countries and cities, inappropriateness of gathering a crowd, as well as new findings, theories, and technologies, organizing virtual meetings instead of conventional ones using a virtual conferencing system/platform seems safe and efficient (Scarlat et al., 2020). In addition, holding virtual meetings could solve a series of issues of the well-established, traditional interviews, including time and costs consumed in traveling, the impossibility to attend several meetings in different places at the same time, limitations in participation due to space and accessibility (Scarlat et al., 2020).

Interviewing is a useful method to collect qualitative research data about phenomena that cannot be directly observed (Irani, 2019). The researcher's advantages and disadvantages with the interview could vary depending on the context of the study. Traditionally, in-person interviews have been perceived as the gold standard because they represent a natural encounter where the interviewer communicates and builds rapport with participants while observing their body language and the environment (Irani, 2019). With the challenging conditions of COVID-19, in-person interviews were not possible. Instead, virtual interviews emerged as a substitute for the face-to-face interview process. Virtual interviews have advantages, including the flexibility to meet with the participants at any moment without having difficulty traveling using Zoom, which provides the

capability to record and transcript the interview and is more efficient in data collection. Possible disadvantages of a virtual interview include the limitation of seeing the interviewer's body language and missing possible relevant cues during the interview process. In addition, the inability to have physical contact with the interviewer limits the ability to create an agreeable environment. Among the challenges, virtual interviews are: (a) not suitable for all the qualitative research and participants, (b) limit physical proximity to provide comfort to the participant, (c) preclude observing a full range of body language and nonverbal communication because the participant's image is often displayed from the waist up, and (d) underrepresent participants who do not have access to the technology (Irani, 2019).

After completing the semistructured interview and reviewing the primary data, the researcher downloaded the transcript from the platform used to perform the interview. I reviewed the transcript and assigned corresponding codes, providing a more relevant, efficient, and reliable evaluation of the results. As I prepared the coding and re-read the interviews, I expected to gather an in-depth holistic approach to the wellness programs through the view of their executives and managers. In addition, I reviewed the documentary data provided by the leaders or executives of the organization in order to support the primary data collection, such as organigrams, policies and regulations, and reports related to wellness programs' implementation and performance. Content analysis is a research technique for the objective, systematic and quantitative description of the manifest content of communication (M. K. N. Saunders et al., 2019).

I conducted member checking for reliability and credibility by reviewing the interview records, transcripts, and code themes. In addition, I provided a follow-up interview for the participants to become active in interpreting data and transcript reviews. By the participants being active in member checking, I provided the opportunity to review and edit the information provided in the transcripts and data analysis and review. Member checking is when the researcher asks one or more participants to check the account's accuracy (Candela, 2019). Yin (2018) referred to member checking as the action of reviewing the draft case study claiming that returning the draft to participants can help corroborate findings and evidence and produce new evidence the participant may not have given during initial data collection. Yin (2018) cautioned the participants that the readers may have their perspectives and disagree with the conclusion and interpretation of the study, providing an opportunity to challenge the study's key findings. Member checking involves taking the findings back to the participants and asking them about the report's accuracy in writing or an interview (Candela, 2019). Participants can opine many aspects of the study, such as whether the description is complete and realistic, if the themes are accurate, and if the interpretations are fair and representative (Candela, 2019).

Data Organization Technique

Due to the novel COVID-19 virus and to safeguard the participants' and my safety, virtual interviews instead of in-person interviews were used to collect data. To conduct the semistructured interview, I used Zoom to collect data and NVivo software as

the platform to organize data efficiently. NVivo software provides a place to organize, store and retrieve data so the researcher can work more efficiently, save time and rigorously back up findings with evidence. While retrieving the data, I downloaded the recording of the interviews and transcripts and used personal notes to compensate for possible gaps in the data collection. I prepared the virtual room and confirmed that each participant's tools worked properly by providing a one-hour timeframe to test the devices. Reviews of the transcribed interview recordings facilitated the accuracy of data and the gathering of information.

I maintained the confidentiality and anonymity of each participant before and after the interview through a contract that included explicit language that guaranteed the data collection process and any ethical issues. The Doctoral Committee and IRB approved this document to assure the disengagement of personal/professional bias, ethical dilemmas, and the objective process of data collection and analysis. Upon completing the interview, the researcher thanked each participant via written letters, stating my appreciation for their commitment and volunteerism to participate in the data collection. The study provided beneficial insight into techniques already in place that could help other organizations align their employees to healthy habits, that could help improve productivity and decrease health insurance costs. The coding system implemented was based on letters and numbers ranging from Ea1 to Ea10. Capital-letter E represented the executives; the lower-case a represented the private sector. Coding of the corporate documentation (e.g., organigram, wellness policies and procedures,

performance metrics, and implementation processes) began with the capital-letter F followed by a number. According to the IRB guidelines, the information obtained from the data collection, files, articles, interviews, and transcripts will remain locked in a secure external location for five years. (Protection of Human Subjects 45 C.F.R. §46, 2009). After those five years of storage, shredding of all information related to my doctoral study will occur using the facility of a shredder company or a heavy-duty machine (2019).

Data Analysis

Data analysis is a tool that researchers utilize to achieve intelligent business decisions based on valuable data and data analysis of the study subject (Zhang et al., 2021). Lester et al. (2020) noted that if the researcher seeks to impact programs and policies through qualitative research, it may be imperative to engage the community in the phenomenon of study and translate the academic language to active and applied phraseology. The use of computer-assisted qualitative data analytics software (CAQDAS), as noted by Dalkin et al. (2021), has been used in the field to aid the methodology, analysis, and interpretation of the data. For example, software such as NVivo, which provides a supportive coded-based inquiry platform, gives the researcher the flexibility to explore, theorize, inquiry, categorize and edit complex quality data efficiently. Computer-assisted qualitative data analysis software retreated the data collection, analysis, and findings for the phenomenon.

The semistructured interview was the primary data collection technique for this case study, which was conducted virtually and consisted of open-ended questions of the selected sample. The data obtained from this semistructured interview were analyzed using thematic analysis. Braun et al. (2019) noted that a thematic analysis could be described asset of approaches taken by the researcher to identify patterns within the qualitative data. The theoretical flexibility makes this analysis suitable for the qualitative study as an analytical method, as noted by Lester et al. (2020), instead of a methodology. In addition, the theoretical flexibility facilitated the engagement of researchers from various disciplines and perspectives, providing a more meaningful, in-depth, and relevant field analysis (Lester et al., 2020). This analysis was composed of a series of phases for the researcher with insightful knowledge of the data to present meaningful and relevant results. These phases were composed as follows: (a) preparing and organizing data for analysis, (b) transcription of the data, (c) understanding the data, (d) memoing the data, (e) coding data, (f) translating the coding to categories and categories to themes and; (g) prepare the report.

The data collection technique applied to the doctoral study was semistructured interviews with six executives or leaders of private and not-for-profit organizations. The interview questions were designed to obtain an in-depth understanding and insightful information about the study's phenomenon. After completing the interviews, the researcher transcribed the recordings to familiarize herself with the data. During this process, the researcher memoed the data, taking notes of the recording as a form of memo

to add a layer of understanding and more profound knowledge of the participant's perspectives. Lester et al. (2020) noticed that the notes serve as an invitation for further analysis. The notes produced during this phase will lead to the subsequent data analysis stage, coding.

Deterding and Waters (2021) indicated that coding is an actual process where the interview data is categorized (encoded) in themes, common language, and categories that, once interpreted, provide meaning (decode) to the research study. The strategies implemented for encoding the data consisted of the primary and affective methods in the first coding cycle, which include statements of experiences and reflections of the participants that are analytically relevant. In the second encoding cycle, the pattern and focusing coding were implemented. In this second phase, the researcher evaluated the initial set of codes, identified patterns, and assigned additional codes to focus on the study phenomena. Lester et al. (2020) mentioned that the second coding layer was to connect participants' statements, perspectives, experiences, and reflections to the study's primary objective. The researcher developed a third coding layer recognized as a selective stage to connect the data to a specific concept or theoretical idea. In this stage, the researcher selected the data coded from the second stage, axial coding, and framed the data based on a conceptual theory to identify codes selectively to the focus of the study, the phenomenon. As mentioned by Williams and Moser (2019), the researcher seeks to frame the coded data to purposely and continually work toward the specific theme and, consequently, the possibility of theoretical creation. During this phase, the researcher

obtained a level of data analysis saturation to prepare and compose the possible results or findings of the study.

Qualitative data analysis (QDAS) software, NVivo, supported the process of manual coding by composing analytical memos, capitalizing, indexing for data reduction, and applying analytical coding to cross-reference data to identify patterns and focus the data obtained to the central theme of the research study. Mattimoe et al. (2021) indicated that QDAS are tools that support qualitative analysis with the capacity to import, organize and explore data from various sources in a relatively reduced time. The researcher develops a systematic configuration concerning information or evidence provided by the participants, that leads to an ability to identify similarities and manually categorize them by themes. Once organized by themes, the researcher identified common trends in the data obtained related to the research question and how, if any, to provide an in-depth explanation of the phenomenon. Maher et al. (2018) argued that qualitative analysis software does not provide the foundations of the data analysis process. For that, the researcher must implement the manual coding with the support of the QDAS.

Triangulation was the qualitative research strategy implemented to validate the findings and results from various sources. Substantial analysis and reviews of case study methods revealed that case studies with multiple sources of evidence were more reliable and rated higher in quality than those with a single source of information (Yin, 2018). Triangulation involves the employment of multiple external methods to collect data and the analysis of the data. Moreover, triangulation ensures the validity and optimization of

the study by identifying the convergence of data obtained through multiple data sources, methods to avoid or minimize error or bias, and the analysis process (Johnson et al., 2020). There are various methods of triangulation: (a) multiple data sources, (b) multiple data analysis techniques, (c) multiple researchers, (d) multiple methodologies, and (e) multiple triangulation (Natow, 2020). The triangulation method for this study was methodological. Multiple methodology triangulation occurs when a researcher employs more than one type of qualitative data collection procedure within a single data collection to acquire a broader perspective, i.e., data via interviews, observations, and documents (Denzin, 2017; Ebneyamini & Sadeghi Moghadam, 2018; Natow, 2020). The concept of multiple methodologies triangulation may confuse the researcher since collecting data could be similar to the method methodology. Moon (2019) noted that triangulation integrates multiple research data collection, such as data charts, interviews, and observations. By contrast, the multiple methodologies focused on one data collection, supported by at least two different data sources, such as observation or validation of documentation. As Rashid et al. (2019) noticed, verification of the observation process of an interview occurs through the actions on-site and from data collected.

The primary purpose and goal of the study was to collect data regarding strategies that executives and leaders from the private and not-for-profit sectors implemented to align their employers toward healthy habits that increased employee productivity and lowered organization health care costs. The focus of the study was information gathered from the semistructured interviews and documents provided by the corporations, such as

organigrams, policies and regulations, and reports regarding the implementation and performance of wellness programs. The documentary data collected from the interviews were corroborated and reconciled. The combined data provided a broader view of the research question by integrating the participating executives' and managers' perspectives and the documentary source of the corporations.

The purpose of gathering the data through the mechanism of interview and document data was to provide a holistic view of the circumstance regarding the cost-effective strategies implemented by the executives to align their employers toward healthy habits and the facts regarding the strategy. Triangulation is a research validation strategy that can occur through four different methods:

- data triangulation or the use of different data sources that can produce at other times or places, or with different people;
- investigator triangulation consisting of the use of different researchers to minimize subjective distortions arising from a single individual;
- triangulation of theories, in which an event is addressed and interpreted under different angles or multiple theories to increase knowledge about the object under study; and
- methodological triangulation, which can occur within a single method (intermeshed) or between distinct methods (intermeshed; Santos et al., 2020).

Methodological triangulation is a familiar aspect, generally subdivided into within-method and between-method triangulation (Farquhar et al., 2020). The former

uses multiple techniques within a given methodology, for example, qualitative evidence from focus groups and archival analysis (Farquhar et al., 2020). Gathering data from the perspective of executives and managers and documentary data from the organizations enhanced the understanding of the research question. It provided an in-depth validity of the findings.

I transferred each of the interviews to Word format. In addition, for each of the questions, an abstract was documented. Each participant received a copy of the abstract as a component of member checking and validated the accuracy of the information transcribed and recording the participant's collaboration. Each participant had the opportunity to edit the documents by adding or deleting information pertinent to the study and providing a broader view and accuracy of the findings of the theme of the study. Member checking covers a range of activities, including returning the interview transcript to participants, a member checking interview using the interview transcript data or interpreted data, a member checking focus group, or returning synthesized data (Candela, 2019).

The documentation data provided by the organization was reviewed and used as part of the triangulation method. The coding and labeling of the themes will begin with F1. As noticed by Yin (2018), the rationalization of using multiple sources of evidence in the research case study is to perform a case study, an in-depth study of the research topic in its real-world context. In particular, the novice researcher should remember that data triangulation can sometimes result in contradictory and inconsistent results. As

mentioned by Noble and Heale (2019), triangulation can enrich research by offering various datasets to explain the phenomenon, can refute where one dataset invalidates a supposition generated by another, and can assist in confirming a hypothesis.

Reliability and Validity

Reliability and validity are central to judgments about the quality of research in natural sciences and quantitative research in the social sciences (R. Saunders et al., 2019). The researcher uses these two strategies and tools to establish the quality of the research design. As noted by Forero et al. (2018), there are four dimensions or criteria to assess rigor and trustworthiness in qualitative research. These four criteria, (1) credibility, (2) transferability, (3) dependability, and (4) confirmability, are the ground base that a researcher will need to apply to validate my qualitative study. The strategies incorporated and the design created to ensure the findings' reliability (Rose & Johnson, 2020).

As a general assessment, a research strategy is a plan that the researcher develops to achieve the expected goal of the research study. As defined by M. N. K. Saunders et al. (2019), strategic research is a methodological plan developed by the researcher to achieve the researcher's goal: answering the research questions. The methods selected to achieve the goals may vary depending on the initial assessment of the researcher. For example, the method, design, and data techniques may be selected based on a methodological analysis developed by the researcher that better suits the needs of the study phenomenon. Lester et al. (2020) indicated that qualitative research supports the research by generating a deep, nuanced understanding of the study phenomenon. The findings of the qualitative

study, when spread and accessible, may provide a broad range of recommendations as providing a detailed description of a specific problem in practice, offering possible insights concerning the context of the practice, or approaching subjective issues of the qualitative research itself (Lester et al., 2020; Doyle et al., 2020; Haven & Van Grootel, 2019).

While there is not a single set of the wide range of data sets that a researcher may apply in a qualitative study (Lester et al., 2020), it may often align with a particular methodology and theoretical perspective, among others (Lester et al., 2020). The research strategy adopted to study the phenomenon was a qualitative multi-case study applying semistructured interview questions for data collection. For purpose of implementation and with the sole purpose of producing broad descriptive and structured narrative that proof the understand of the data and response the research question (Lester et al., 2020), the following phase was followed: (a) selection of sample of three to six organization focusing the area of health care in the Southeast region of the United States(b) selection of participants by connecting with executives and leaders of the selected sample and sending letter or email with intent to participate in the study (c) collection of data using semistructured interviews via Zoom, (d) transcribing the data and sent to participants for review and acknowledge, (e) coding the data obtained by themes and determine if data saturation was acquire, (f) if data saturation was not acquire, select from participants (selection will be depending on the need) from backup list and redo the cycle of interview, transcription and coding, (g) if or after reaching data saturation, proceed to

document results and findings for incorporation of the proposal and (h) draft and present conclusion of research study.

Reliability

Reliability is not pertinent to a qualitative study. The concept of dependability in qualitative research is arguably related to reliability in quantitative research. Furthermore, there must be creditability to have dependability. The objective of reliability is to ensure that if a researcher conducts the same procedures as stated in the research study, it will achieve the same findings and results. In a case study, research means studying the same case over again, not just replicating the results of the original case study by studying another case (Yin, 2018). The main goal of reliability is to minimize errors and biases (Yin, 2018). There are four types of errors and bias: (a) participant error, (b) participant bias, (c) researcher error, and (d) researcher bias. Reliability refers to replication and consistency. If a researcher can replicate an earlier research design and achieve the same findings, that research would be reliable (M. N. K. Saunders et al., 2019). Rose and Johnson (2020) noted that reliability refers to the soundness of the research and the scientific process concerning the appropriate methods chosen and the ways applied within the research study.

Reliability is consistency and care in applying research practices, analysis, and conclusions, reflected in the possibility that other researchers and participants could conduct the study and obtain the same findings (Ebneyamini & Sadeghi Moghadam, 2018). Boucerredj and Debbache (2018) disclosed that dependability refers to the

constancy of the data obtained within similar conditions and scenarios that guarantee the functional behavior's quality. Renjith et al. (2021) indicated that dependability refers to the assumption of repeatability and replicability of the study findings and stability of the findings over years when another researcher concurs with the results at each stage of the research process. The researcher's process and descriptions are dependable if the study findings are replicable with similar participants in similar conditions. The research could achieve dependability by members checking participant interview transcriptions, which is a strategy for creating trustworthiness in qualitative research (Candela, 2019). The concept of member checking refers to the ability of the researcher to continuously corroborate the findings and evidence with the participants and produce new evidence that participants may not initially provided, being a critical process in the qualitative research study (Candela, 2019). The purpose of member checking is to eradicate any bias from the researcher, but as Candela (2019) stated, could cause harm during research studies looking at experiences of marginalized populations or participant who have experienced trauma. I will provide dependability in my study by memberchecking the participant to eliminate any research bias.

Validity

Validity is the fidelity of the findings that reflect the data from the position of the researcher and participants, promoting the trustworthiness of the study (Rose & Johnson, 2020). In a valid study, the researcher proves the existence, by representing the reality of the findings and their accuracy, by whether the analyses depend upon the researcher

(Rose & Johnson, 2020). Validity refers to the pertinent and suitable measures used to achieve validity (rigor), the accuracy of the results, and the generalizability of the findings (M. N. K. Saunders et al., 2019). Validity techniques in qualitative research mean the pertinent use of tools that align with other aspects of the research study, such as processes and results of the data analysis (Rose & Johnson, 2020).

Credibility

Credibility refers to the truth of the data, which is a clear and precise description of the context, the participants' selection and characteristics, the data collection, and the analytical process (Nordfonn et al., 2019). Credibility is the truth value of the data and its interpretation, which can be obtained via the strategy of member checking (Renjith et al., 2021). As part of the credibility process, I used member checking during data collection and analysis. The member checking strategy involves establishing structural corroboration or coherence, it does not to have to be just about checking back in participants for validity measures, rather it may be use as a reflective tool for those who may impact and improvement of the practice (Candela, 2019). I discussed with the participants the interview questions. Second, I engaged the participant in an open dialogue to refine and clarify as needed. Third, I provided space to the participant for their feedback and interpretation of the review process.

Transferability

As stated by Renjith et al. (2021), transferability is the researcher's ability and degree to which the qualitative results are applicability to other settings, population or

contexts. This ability is met in a qualitative study if the results have meaning to individuals not involved in the study, and readers can associate the results with their own experiences. To achieve transferability in the study, the researcher provided sufficient information on the study participant population, study demographics, analysis, data collection, and findings. This information may provide the roots for a reader to engage in the study and participate actively through the reading. As noted by Rose and Johnson (2020), transferability is the ability of a researcher to transfer the analysis and results to other contexts and participants.

Confirmability

As indicated by Renjith et al. (2021), confirmability is analogous to the objective of the study and refers to the degree of the findings could be confirmed or corroborated by others. Confirmability is the ability of the researcher to support the finding of the study with the data connecting the conclusions and interpretations (Rose & Johnson, 2020) To confirm the study's accuracy, I supported my findings and conclusions with the data collection and analysis. These findings and conclusions will provide the reader with a summary of the similarities obtained with the data collection and analysis and the findings stated in the study.

Data Saturation

As part of the requirements of a qualitative study, the research needs to reach data saturation, which is the common standard for quality research (Johnson et al., 2020). Instead of relying on the number of participants, the qualitative study aims to ensure

information-richness, to see the issue and its meanings from as many angles as possible, which does not require a specific sample size (Busetto et al., 2020). Data saturation, as noted by Johnson et al., (2020), is reached once (a) the information obtained to replicate the study in various settings is sufficient and (b) no additional or new information is obtained, and (c) the coding process is no longer expanded. I focused on collecting rich and thick data and considering my study design to reach data saturation. I conducted semistructured interviews as part of the data collection and analysis to reach data saturation. Thus, the number of interviews or samples needed to reach data saturation in a qualitative study cannot be quantified because it could vary from population and research questions. (Johnson et al., 2020). Instead, the researchers take the maximum number of interviews needed to reach data saturation.

Transition and Summary

Section 2 restated the purpose statement, the role of the researcher, study participants, research methods, ethical procedures, and research design. This section included the population and sampling, an explanation of the data collection instruments, process, data organization, and data analysis for the reader to understand the techniques used to research the problem statement. As part of the procedures to research and validate the research question, Section 2 described the reliability and validity methods for this multiple-case study. Section 3 will include a presentation of the research findings, a discussion on the applications to professional practice, implications for social change,

recommendations for action and further study, reflections, and a summary and conclusion of the study.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The aim of this qualitative multiple-case study was to identify cost-effective strategies that executives in the private and not-for profit sector implement to encourage their employees to adopt healthy habits to increase employees' productivity and lower organizations' health care costs. The general population consisted of leaders, executives, and managers from 77 private and not-for-profit health care organizations within the health care industry in the southern region of the United States. Private health organizations are those individuals and organizations not owned or directly controlled by the government. Not-for-profit organizations are those that do not generate profits for their owners and instead are used to pursue the purpose of the organization. As a criterion for participation, these leaders had successfully implemented wellness programs as strategies to increase employees' productivity and reduce health care costs. The sample for the study was drawn from the list of 100 healthy companies in 2019 and 2020 provided by Healthiest Employers (2019, 2020) and the 2019 and 2020 Fortune 100 (Fortune, 2019, 2020).

The basis for selecting these organizations was the following criteria. The organizations needed to (a) have an active workplace wellness program, (b) have successfully integrated their employees into the program, (c) have implemented the program for at least 5 years, (d) have collected segregated data that provide statistics about the impact of the wellness program on the health of employees, and (e) have

collected separated data that provide statistics on the economic effect on health care costs. This study has implications for positive social change, in that it identifies opportunities to develop a workplace where employees engage in healthy habits that could benefit themselves, their colleagues, and their families and enhance a culture of well-being within their surroundings and society.

Presentation of the Findings

The overarching research question for this multiple-case study involved identifying cost-effective strategies that executives in the private and not-for-profit sectors implement to align their employees toward healthy habits for increasing employee productivity and lowering organizational health care costs. I used semistructured interviews with open-ended questions for the data collection and analysis. These questions were aligned to obtain in-depth inquiry, information, and data on the phenomenon based on the information provided by the six participants' expertise. The participants' expertise, experience, and real-time perspective provided in-depth content without compromising the study's integrity, confidence, and credibility. Purposive sampling was the strategy to obtain the data. Purposive sampling is one way to achieve a manageable amount of data (Ames et al., 2019) and is extensively used in case studies to identify and select ample information related to the research topic (Palinkas et al., 2019). I selected a sample of three to six participants, which was enough to reach data saturation based on the participants' expertise and content. The sample selected provided the data to

support the credibility of the analysis. To enrich the quality of communication with the participants, I used an interview protocol (see Appendix B).

The multiple-case study allowed the collection of the study's data from sample to sample until data saturation, which provided a more compelling and robust analysis (Yin, 2018). By selecting various organizations and applying the same techniques, such as semistructured interviews, I was able to reproduce data from each participant to the point where no further new data emerged, known as data saturation. After completing the semistructured interview and reviewing the primary data, I downloaded the transcript from the Zoom platform, that I used to perform and transcribe the interviews. I also used the online software Sonix as an alternative transcript resource. I reviewed the transcript and memoed the data to add a layer of understanding and more profound knowledge of the participants' perspectives. Lester et al. (2020) noticed that notes serve as an invitation for further analysis. The notes produced during this phase led to the next data analysis stage, coding.

Deterding and Waters (2021) indicated that coding is an actual process where the interview data are categorized (encoded) in themes, common language, and categories that, once interpreted, provide meaning (decode) to the research study. During the coding and themes process, I took an in-depth, holistic approach toward the wellness programs through the views of executives, leaders, and managers. As Williams and Moser (2019) mentioned, a researcher seeks the frame of the coded data to work purposely and continually toward the specific theme and, consequently, the possibility of theoretical

creation. The semistructured interview data collected from the health care leaders, executives, and managers were transcribed, memoed, coded, categorized into themes, and interpreted to provide an answer to the research question: What health promotion strategies do executives from the private and not-for-profit sector implement to align their employees toward healthy habits? To support the analysis process, the computer software NVivo was used to organize the data and facilitate the categorization of themes and patterns captured from the interview transcripts. Twenty-eight codes emerged from the NVivo coding exercise, and I segregated those codes into four themes. These four themes were (a) cost-effective strategies to motivate employees, (b) key barriers to wellness programs, (c) culture of wellness, and (d) leadership roles and engagement. In addition to the semistructured interview, I reviewed handbooks, policies relevant to employees' benefits within wellness, and public data supporting the participants' content. Following the data organization technique established in Section 2, and to protect participants' identities and organizations, I identified the participants using codes Ea1 to Ea6.

Table 2

Data Codes, Categories, and Themes

Codes	Categories	Themes
Top-down approach	Approach & strategies	Cost-effective strategies to motivate employees
Points-based approach		
Holistic approach		
Health assessment		
Health promotion strategies		
Cost-effective strategies		
Role modeling		
Reducing health care costs	Health care costs & premiums	
Monetary reward		
Community-based sites		
Cost savings		
Health rewards		
Key barriers	Barriers & organizations	Key barriers of wellness programs
Implementation		
Performance (metrics, participation, success rates)		
Education		
Impact		
Health policy	Health	Culture of wellness
Health promotions		
Wellness teams		
Evidence-based programs	Program	
Direct programs		
Healthy habits education		
Wellness programs		
Leadership styles	Leadership person & care	Leadership roles and engagement
Supportive environment		
Senior leadership		

Theme 1: Cost-Effective Strategies to Motivate Employees

The first relevant theme that emerged from the conversation with the participants was the importance of having cost-effective and sustainable wellness programs to align their employees toward healthy habits. Within the mentioned strategies, such as role-modeling, health assessments and cost-savings, health insurance, employee health team, and financial incentives, it was noted that the participants had similarities in the concepts of these cost-effective strategies. Primary research has suggested that the TPB could support the behavior of employers and employees to shift toward healthy habits. As noted by Gibson (2004), a role model is defined as a cognitive construction based on the attributes of people in social roles whom individuals perceive to be similar to themselves to some extent and desire to increase perceived similarity by emulating those attributes. As stated by Ea6,

> I think role-modeling is a cost-effective strategy for a leader. I understand the importance of the value of wellness and health and incorporating it at work and home. One strategy is talking about it myself, in my health. For example, I am sitting on this computer for 2 hours. I am going to walk around a little bit, eat healthy, or talk about an activity outside the office setting.

Leaders play significant roles as professional exemplars in employees' work lives, and the extent to which employees perceive their leaders as role models may influence the links between work engagement and career commitment (Son & Kim, 2021).

Sanghavi et al. (2022) noted that in the United States, employers often take a keen interest in the health of their employees because most Americans receive their health insurance through their workplace. Workplace and workplace health promotion programs (WHPPs) offer an important opportunity for delivering evidence-based interventions (EBIs) to promote healthy behaviors and decrease chronic diseases (Harris et al., 2022). As stated by Ea1,

> There are a couple of things we consider within the workplace health promotion. One of them is looking at our health care costs regarding team members and our organizations. For example, is it heart disease, diabetes, or asthma? What are the conditions that are costing the most? And then look at evidence-based programs that could decrease the cost of those specific conditions or best practices and implement those alongside our wellness team. For chronic diseases, such as diagnosis of heart disease, diabetes, overweight or obesity, high triglycerides, or high LDL cholesterol, there is a program that employees can enroll in called Disease Management Program. The participant works with a health coach in this program toward a specific goal. Also, get involved with other programs such as a free personal training program in the fitness center.

As employer health care costs continue to increase, companies are investing in workplace health promotion initiatives, such as health information campaigns, employer-sponsored physical fitness facilities, and personalized wellness coaching (Ott-Holland et al., 2019). However, according to Ott-Holland et al. (2019), studies have looked at different

workplace health promotions to show that medical cost reduction is affected more directly by disease management programs for chronic illness than by lifestyle programs.

One widely mentioned solution for the sustained growth of medical spending is to increase the use of "wellness programs" (Jones et al., 2021), interventions designed to encourage preventive care and discourage unhealthy behaviors. Workplace wellness programs cover over 50 million U.S. workers and are intended to reduce medical spending, increase productivity, and improve well-being (Jones et al., 2021). As stated by Ea2,

> What we do is we have a wellness program that is structured around three components. The first component is completing an annual wellness exam. The second component is conducting a confidential health assessment survey, and the third component is completing 50 worth of what we call wellness activities. We offer a variety of options to complete the activities that can include preventive screenings and community services. As well, we have some financial pieces to them. We have a step program with variety of choices that the participants can make and each option is worth certain number of points, up to 50 points. The wellness program is effective in creating healthy habits for employees because they are incentivized. If they complete all three required components for the year, then they will receive a lower annual premium for their medical coverage for the following year.

Fink et al. (2020) noted that employers offer wellness programs to employees to improve employee and organizational outcomes. Fink et al. (2020) found that 60% of the sample selected participated in the wellness incentivized program because their employer offered them a reward; 52% said they would participate without a reward; 48% felt like they must participate in the year program; and 34% felt like they would have disclosed information about their health at or below the current reward level.

A 2013 report indicated that more than 50% of organizations offered worksite wellness programs to enhance employees' health, including nutrition education, fitness, and weight management practice (Sandercock & Andrade, 2018). As noted by Baid et al. (2021), several studies provide evidence that worksite wellness programs can be cost-effective, meaning that they do not save money but improve health at a price that is considered a good value. Ea3 noted the following:

> We have cost savings on our health insurance if employees participate; we call it our Wellness Program. And it's an online portal, and we partner with a vendor who provides this online platform. And if employees engage in it, there are two tiers they can engage in. And the first engagement level is a health assessment and a tobacco attestation. And suppose they are tobacco-free, and they complete the health assessment. In that case, they get the first level of savings. If tobacco users need to complete a tobacco cessation program, they don't have to quit, but they have to complete it. And that is the same as being tobacco-free. And that's called the reasonable alternative standard, which we have to offer legally. That would be

> a tier one. And then, if they do additional activities, they can get to tier two and achieve the maximum savings. And different opportunities involve preventive exams or activities that people can engage in to perform this higher level tier status to get the higher level. We just kicked it off on February 1. It's the beginning of the year, and we run the program through September 30, at the end of the program, we can get everybody set up with payrolls. As we approach the new year, we can apply the savings or not to the employees.

Fink et al. (2020) showed that income is not important for the employee's perception of the value of the employer-offered wellness incentive program; the employee's responsibility for their wellness; the commitment of the CEO, senior leaders, and company leaders to employee wellness; the contribution of the work environment to employee wellness; employer-offered resources for maintaining wellness; support for achieving wellness goals; or incentives for participation. Studies have demonstrated that employees' perceptions of organizational leadership support for health promotion across organizations are associated with positive employee health behavior and outcomes (Hoert et al., 2018). Ea5 added the following:

> Over the years, a number of strategies have been used to improve employee health. Those with the greatest adoption rate and endurance have always been employee-led. An Employee Health Team or Employee Health Interest Group working to better the workplace health experience for all employees has shown the greatest return. This has resulted in walking trails on campus, an improved

> menu focused on healthy foods, healthier snacks in the gift and coffee shops, Weight Watchers on campus, yoga classes on campus, health club discounts, and more.

A 2013 report indicated that more than 50% of organizations offered worksite wellness programs to enhance employees' health, including nutrition education, fitness, and weight management practices (Sandercock & Andrade, 2018). In addition, as Höchsmann et al. (2022) mentioned, workplace curricula continue to emerge by offering programs directly to individuals to decrease the corporate burden of health care costs. Ea6 noted,

> Our tobacco-cessation program is a 4week class for the public and referred patients. The patient works alongside the yoga practitioner, a psychologist, and a certified wellness coach. We provide education about available tobacco-cessations programs and the risks of smoking for them, families, friends, and communities. The program does not provide monetary rewards and is a volunteer. In addition, the participants learn about breathing techniques, meditation practices, and how to manage withdrawal symptoms of nicotine. The participants also work alongside a pharmacist to determine the best options for nicotine replacement therapy at no cost.

Over the last 50 years, companies have spent millions of dollars incorporating employee wellness programs to curb rising health care costs by fostering a healthy and productive workforce (Ruvalcaba et al., 2022). Grénman et al. (2019) noted that wellness had

become a global multitrillion-dollar industry, embodying diverse sectors that help consumers incorporate wellness activities and lifestyles into their daily lives. Ea6 stated,

> The University of Florida sponsors our program through the Tabacco Free Florida Campaign, and it has an over 75% cessation rate. It was founded almost 16 years ago by a former smoker who wanted to create a holistic approach to tailored smoking patients.

In addition, Ea3 noted the following:

> It is essential as a health care leader to have our name out there and be recognized as a leader in health care and wellness. For that, we have different programs, such as walking challenge for fifty weeks, that engage the communities statewide and are non-cost to participants, that started almost 27 years ago.

Wellness programs provided by organizations to their employees are an investment strategy to motivate employees toward healthier lifestyles. As the primary human capital and the most valued asset in the organization, employers have committed to their employees' well-being by tackling health issues, such as chronic diseases, that may impact their operations. Although often used interchangeably with wellness, as noted by Davis (2019), well-being generally refers to the experience of health, happiness, and prosperity. It included having good mental health, high life satisfaction, a sense of meaning or purpose, and the ability to manage stress.

Keller et al. (2022) documented that a call to action to engage U.S. adults in preventing and managing chronic illness has taken center stage in efforts to improve their

health and reduce health care utilization and costs. For example, as noted by Höchsmann et al. (2022), obesity continues to be a highly prevalent disease that directly affects health, health care costs to individuals and employers, overall psychological health, and quality of life. In addition, studies such as Baid et al. (2021) have shown that individuals with non-communicable diseases (NCDs) account for 86% of health care expenditures, much of which are financed through employer-provided health insurance. Employee wellness refers to the collection of initiatives within an organization to promote healthy lifestyles among employees (Ruvalcaba et al., 2022). These initiatives, alongside the employee's choices to develop habits, have shown that workplace wellness programs can be cost-effective, as noted by Baid et al. (2021), meaning they do not save money but improve health at a price that is considered good value of money.

Theme 2: Key Barriers of Wellness Programs

The key barriers to wellness programs were the second relevant theme that emerged from the semistructured interviews with the participants. The participants stressed the importance of the program's communication, time, and complexity by keeping it simple to understand and manage and COVID-19 impact. As Passey et al. (2018) noted, wellness programs are initiatives and policies directed at chronic disease prevention and supporting healthy behaviors for employees. In addition to promoting health, employees view the access to and provisions of wellness programs as a sign of employer commitment to health and well-being (Passey et al., 2018). Through their organization, access to a wellness program is provided to the employees. How it is

communicated is imperative for the inclusiveness of their participants. Sotto-Santiago et al. (2021) revealed that we could not engage in a conversation about wellness without asking about equity because equity and inclusion lead to health. Ea1 mentioned, "Hospital has over 8,500 team members, and it can be a challenge to get the information to all of our team members regarding what health and wellness programs offer."

Sears et al. (2022) demonstrated that it is essential to identify strategies to effectively engage all workers, including those with work-related permanent impairments and other disabilities, to enhance equitable access to workplace wellness programs. To engage their workers, Ee5 noted the following: "communication strategies are important since we are a much segmented workforce and campus." Dawkins and Daum (2022) stated that effective communication is not just about using medical jargon but how the provider uses interpersonal communication skills to convey attentiveness and establish rapport. As Ea5 mentioned,

> Making certain that employees and students knew these were employee and student-led initiatives and not something dreamed up and handed down from on high by Administration. Being sure that the programs have real people with real stories that are told, real faces that coworkers recognize and work beside day in and day out.

Therefore, using appropriate communication techniques promotes clear communication and avoids the negative health consequences of poor communication (Rayner & Wadhwa, 2021). Ea2 noted,

> Communication is the most significant barrier, mainly when changing the program over time. We have over 6,000 teammates; we have to be sure we communicate effectively to understand the program and the requirements for each piece of it to be successful. We also have a small portion of teammates that do not have access to work e-mail. We acknowledge that those teammates need additional effort on our part to communicate with them.

How those words are used and how others perceive the use of those words matter (Dawkins & Daum, 2022). The nature of communication is complicated (Rayner & Wadhwa, 2021), as it encompasses aspects of culture, language, and non-verbal skills. Communication has proven a challenge for developing ways of overall improvement. Ea6 mentioned,

> Another barrier is language; we have non English speaking employees in our hospital. Ensure that the information is translatable and in the mission and the vision of what we are trying to do. On occasion, you may try to translate the words, but someone from another culture may not understand precisely what is a wellness program.

Stiehl et al. (2022) noted that there is also an issue of employees perceiving the need for more information, which may be provided by raising awareness of the programs, which benefits communicators using multiple communication channels with varying messages. Ee2 mentioned,

> For communication, one thing that we did was send a postcard to the home because one of the requirements is to complete the wellness exam. As well, we did early kickoff communication launches, and when we changed the program, we had sessions across the organization in different locations where teammates could ask questions and hear an overview.

Hashim (2017) indicated that patient-provider communication should be respectful and inclusive and encourage equitable participation. As mentioned by Ea3, "communicating the message is probably the biggest barrier." In addition, Ea5 noted, "Communication management is vital to the message being successful or not and keeping the statement positive, always focusing on the positive side of things, not the negative."

Health care providers should consider implicit bias associated with using stereotypes and intensive terminology, which may lead to poor communication, negative labeling, and the absence of person-first language, eroding the trust and impacting the patient outcome (Dawkins & Daum, 2022). As noted by Ea5, "use the carrot, not the stick, and offer incentives, not deterrents or punishments." Dailey et al. (2018) mentioned that because wellness health promotion activities are now a common feature in the organizational landscape, scholars must praise and critique programs' effectiveness and recognize how employees communicatively experience and make sense of wellness health promotions.

Within the last decade, more organizations have implemented workplace health promotion programs during work hours that are accessible to employees (Dailey et al., 2018). As mentioned by Ea1,

> Time is one of the key barriers that cause our team members to work more than one job. A team member may not be at our setting for 40 hours; perhaps they might be somewhere else for 10 or 20 hours.

Stiehl et al. (2022) showed that time had been described as a barrier to accessing or using health promotion programs of a general lack of time and the program's scheduling. Ea6 added the following: “The most significant barrier when you come to the individual level is time; it takes your time and money. Those are your two resources, and it takes time to meet the individual where they are located.”

Stiehl et al. (2022) also identified that hourly workers might have difficulty participating in wellness health programs because they lack flexibility. In addition, Perrault et al. (2020) acknowledge in their study that some employees may not participate in wellness programs because they lack time to participate or because the program is too much work. As Ea2 mentioned,

> The complexity of keeping the program simple enough that people understand the program. Our programs have different options, and we choose that intentionally to have a holistic approach. But, because there are many components and other options, it can be perceived as complex, especially in the first year of implementation.

For that, Stiehl et al. (2022) noted that organizations could work to enhance employees' self-efficacy or confidence in their likelihood to participate by emphasizing how simple and easy it is to participate. In addition, program requirements could be simplified and used as support and encouragement from coworkers, which could be a valuable strategy to encourage participation (Stiehl et al., 2022). Ea3 added, "They were sure that the programs have real people with real stories that are told, real faces that coworkers recognize and work beside day in and day out."

Ford and Scheinfeld (2016) claimed that workplace wellness programs intrude upon employees' privacy, often do not consider cultural and gender differences, and violate confidentiality and ethical boundaries between employers and employees. To tackle this and other potential adverse effects of the workplace wellness program, scholars began emphasizing the organization's role and responsibility in employee wellness (Stephens & Harrison, 2017). As reported by the Surgeon General: "If health care providers are not well, it is hard for them to heal the people for whom they are caring" (Friedan, 2016, para.3).

Harrison and Stephens (2019) noted that the whole person or holistic approach focuses on the organizational context rather than the individual, couple, or group context. As indicated by Dailey and Zhu (2017), these programs serve as bridges between personal health identities and organizational identities since wellness activities allow employees to communicate their identity to health and work simultaneously. As mentioned by Ea5: "Communication management is important to the message being

successful or not." During the response to the novel coronavirus disease, the well-being of our health care professionals was imperative to surpass the virus, continuum providing quality care and taking care of their well-being. As mentioned by Wu et al. (2020), the novel coronavirus disease is posing an extraordinary challenge to the health and well-being of persons across the globe; along with grave threats to social stability, economic prosperity, and human health, caring for patients places great stress on health care workers. For example, an infectious disease physician in Milan described his work caring for patients with the novel coronavirus (COVID-19):

> It is an impossible-to-understand situation, with people intubated in the hall, not enough ventilators, ethical decisions regarding who to intubate, shortage of masks and gloves, confusion, and exhaustion. Hell is probably like this. I have no time to understand, think, and express emotions. (Wu et al., (2020, p.1)

Health care professionals in different clinical units work under extreme pressure, and working on the front line may be a significant risk factor for psychological problems (Buselli et al., 2020; Jiang et al., 2020; Nie et al., 2020). In their study, researchers, such as Buselli et al. (2020), showed that burnout and secondary traumatization were associated with health care workers' depression or anxiety scores. As noted in their study Wu et al. (2020) identified that health care workers caring for patients with contagious, life-threatening illnesses, such as COVID-19, are likely to have anxiety and fear of being infected. As mentioned by Ea6,

> COVID-19 was horrible for the bedside care providers. We have a day where we have seven bodies in bags in ICU. Our ICU nurses, particularly in our COVID units, suffered tremendously. It is an unknown situation, constantly changing; our industry is dynamic. For example, you have this employee suffering a patient; perhaps they have a family with COVID, and they need to go to work surrounded by patients with COVID, which is something they cannot escape.

Studies from Cai et al. (2020) showed the presence of emotional stress during a corona outbreak among doctors, which reported that the medical fraternity was highly worried about passing the virus to their families and exhaustion due to extended working hours. As mentioned by Ea3: “Our health care workers are stretched thin and understaffed. I hope that what we are doing is helping them improve their wellbeing.” Wu et al. (2020) noted that workers feel they will be supported in a disaster and will be more resilient.

Liu et al. (2020) showed that frontline workers are, in fact, directly responsible for the caring process of patients with COVID-19 and have peculiar psychological risk factors such as depletion of PPE, lack of specific guidelines of treatment, and feelings of being inadequately supported, which may contribute to mental burden. Ea6 noted: “We decided to bring an in-house around-the-clock counselor so that employees can sign up and have time with them.”

In addition, researchers have demonstrated that the outbreak has markedly changed the working scenario and job demands, such as struggle and conflicting thoughts about balancing professional roles and families' duties. For example, Ea6 noted,

> We've never seen a turnover as high as it has been in the last year, as far as some bedside positions, especially in the nursing profession. There were a lot of turnovers, and we hired traveler nurses, who are high dollars. We created incentive programs for extra shifts to compensate our onsite employees and value their work. We changed our pay structure entirely to retain our staff because of COVID. We also realigned our positions to determine who needed to be on campus or who could work from home. These realign created the opportunity for new spaces on campus transitioning to an outpatient clinic, which helps us to add more service lines.

As Vecchi et al. (2022) mentioned, international marketing strategies to improve subjective well-being are significant, given the global scale of the current pandemic. Vecchi et al. (2022) noted that physical exercise effectively improves heart conditions, weight loss, and cognitive skills and reduces anxiety and depression. During COVID-19, most of the wellness programs were realigned. As mentioned by Ea2,

> During COVID, teammates had less access to get wellness exams. We adapted that by allowing virtual exams and giving them opportunities to earn wellness activity points. These wellness activity points were things people needed to do in groups or did not have social interactions in mind. But with COVID, we made enhancements strategically to give people additional opportunities to earn those points with social distancing in mind. For example, it wasn't as easy to get community service during that time, but we added a sleep diary. We also gave

> points for completing the vaccine for COVID. And the virtual exams I mentioned; the pandemic created an opportunity to expand into many different areas to earn wellness activity points. Still, we adapted the program to keep it moving and help people overcome those obstacles.

Ha et al. (2022) noted that since the COVID-19 pandemic has caused us to adjust to life indoors, efforts to reduce the spread of the virus have forced people to adapt to online exercise using Zoom, Instagram, and YouTube. Regular physical activity and good sleep play an essential role in preventing negative occupational and health consequences (Ha et al., 2022).

Theme 3: Culture of Wellness

The third relevant theme for this doctoral study is a culture of wellness in the organization. Passey et al. (2018) noted that wellness programs are initiatives and policies for chronic disease prevention and supporting healthy behaviors. Practitioners and researchers in health promotions, such as Passey et al. (2018), are interested in strategies to facilitate employee participation and reduce the potential barrier to wellness by including managers in the equation. Establishing a sustainable and comprehensive WHP program within the workplace (Mitchell et al., 2021) has a significant advantage over other health initiatives in communities or health care settings because of the extensive time individuals spend at the workplace. The commitment to wellness programs from all levels of management (senior, middle, and line) is thought to be essential for employee

participation because of the power to make decisions that influence their employees (Passey et al., (2018). As Ea2 mentioned,

> It is vital to allow employees or teammates to make the wellness program fun and engaging. When it feels like something you have to do to get an incentive on lower premiums or that emphasizing cost over teammates' well-being is negative.

Researchers such as Allen and Safeer (2019) noted that participation in the workplace wellness program varies significantly due to several factors, including social influences, which can impact the effectiveness of wellness efforts. Some of the factors stressed by Allen and Safeer (2019) in their most recent article on positive social influences on health and wellness practices are: (a) peer support to increase the adoption of healthy practices; (b) "touchpoints," which are formal and informal social systems reinforcing healthy behaviors, and (c) key factors for building a positive social climate, such as leadership support at all levels. For example, Ee2 mentioned,

> The best approach is to provide room for leadership and others to encourage teammates to participate out of a sense of the organization's culture and not much about a dollar incentive of some sort. I think for it to be successful, it needs to be embedded in the organization's culture to be healthy, and it needs to be adopted by the leaders from the top down.

According to Liu et al. (2020), culture influences how physicians practice medicine, engage with colleagues, measure success, and even value their contributions. Mitchell et al. (2021) stressed in their research that wellness champions are employees with a vested

interest in improving the health and well-being of their colleagues and offering support for a healthy lifestyle by extending the reach of their organization's WHP. As well as a low-cost strategy, they often self-select themselves into the program and volunteer their time and energy to the role (Mitchell et al., 2021). Ea5 noted,

> Certain groups may more readily embrace fitness and wellness. For example, physical therapy employees or nutritionists might have a stronger predisposition toward healthy habits. Psychology or psychiatry students may be more inclined toward holistic centering and mindfulness as part of their daily wellness routine. These can be strong advocates in teaching and sponsoring workshops and special interest groups that can offer extra credit, perhaps for students and other employee incentives.

In addition, Hoert et al. (2018) resulted in a seminal study investigating individual and organizational factors that influence employee wellness participation in worksite health promotion programs and found that supervisor support and control over work matters were significantly greater for wellness program participation. Ea1 noted,

> We tried to get senior leadership involved in some of the messaging and promotion around wellness related services. Perhaps if I sent an e-mail out, I would not have the same readiness outcome as if the CEO had sent it. Trying to use the senior leadership team as a support resource to push and promote some of the programs and services in hopes that people would be more likely to read, learn and participate.

A culture of health and wellness has come to be viewed, as researcher Melnyk et al. (2018) stressed, as a critical factor that influences positive outcomes for successful workplace health promotion, including an improvement in population health. Ea1 noted, "It will be challenging for team members to be healthy and well, mainly is an environment within the department is not healthy as it could be." A culture of health and wellness surrounds individuals with an environment, policies, and cues that facilitate healthy choices and encompasses the values and beliefs of people in an organization (Melnyk et al., 2018). For example, Ea1 mentioned,

> It is essential not just to have support from senior leadership. Still, you also need to have that midlevel manager that supports the program because the wheels can be pushed from the top-down, and individuals, for lack of better words, from the bottom-up can be motivated to want to be healthier and well. But if a midlevel manager does not create the environment to support, even if coming from the top-down, that it's a barrier in between.

Mioni et al. (2022) noted that well-being includes life experiences (i.e., joy, life satisfaction, happiness) and, in an organizational context, general work-related experiences (i.e., job satisfaction, retention) and specific dimensions (satisfaction with colleagues or salary). It is noted that individuals' experiences at work (i.e., physical, emotional, mental, social) directly impact a theme and have an impact outside the individual's career (Mioni et al., 2022).

Theme 4: Leadership Roles and Engagement

The fourth relevant theme for our Doctoral Study is the leadership roles and engagement among wellness in the organization. Hoert et al. (2018) mentioned that organizational leaders allocate the budget, define the policies, influence the organization's focus through their vision, mission, strategic plan, and goals, and determine the extent of support for wellness programming. Studies demonstrated that a shift of policies to reduce some of the burden of stress at work helps improve health care expenditures. Goh et al. (2019) indicated that recent comparatives findings suggested that if US workplaces shifted policies to reduce overall employee stress, more than $40 billion in health care expenditures could be saved annually.

Beyond the hindering workplace contribution (e.g., productivity, creativity), as noted by Shuck et al. (2021), negative work experiences may inadvertently contribute to damaged employee health, including compounding health problems that escalate the long term risk of disease. In addition, Shuck et al. (2021) noted that $6.8 billion are spent on US workplace wellness programs each year as a potential well-funded intervention to mitigate connected work experiences that influence health risk and health status. The overarching goal of such programs is to offset the cost of health risk and disease by intervening and empowering willpower and choice (Jones et al., 2021; Knippen et al., 2018). These programs may include insurance, incentives for making healthy choices, and programs like smoking cessation that support choice and reduce risk but rarely look at effective management practices, how to create supportive cultures or what sustainable

levels of capacity at work look and feel like (Shuck et al., 2021). Ea5 noted, “The executive serves as a champion for the health related programs and provides support and encouragement as well as some resources when there will be a clear return on investment to the organization that results from a particular event.” Ea1 mentioned, “There are some very effective programs, platforms, and services available regarding health and wellness. Still, we cannot consistently implement them because we do not have the money to do so.” In response to supporting employees' wellness, improving health behaviors among their employees, and reducing health insurance costs, a new leadership position has emerged in many large health care organizations and institutions, the chief wellness officer (CWO; Ripp & Shanafelt, 2020). Laker and Roulet (2021) noted that the chief wellness officer (CWO) is a C-suite strategic position stemming from a genuine need to bring more wellness into the post-pandemic workplace and help workers overcome their new-found stresses associated with the new normal. Ea2 noted,

> I think the best approach is to provide room for leadership and encourage teammates to participate out of a sense of the organization’s culture and not so much about dollar incentives of some sort. I think in order to be successful; it needs to be embedded in the culture of the organization to be healthy, and it needs to be adopted by the leaders from the top down.

Williams et al. (2019) noted that leaders have the power to inspire and empower staff to make choices within their work and home environment to support positive lifestyle behaviors. In addition, Williams et al. (2019) noted that organizational culture is also a

key component in supporting employee efforts to sustain and enhance their health and well-being. Williams et al. (2019) recommended that employers measure outcomes more indirectly related to monetary value with factors related to a culture of workplace well-being, such as general employee health, health-friendly work environments, access to health care, job performance levels, employee engagement, and job satisfaction. Ea1 stated,

> Whether it's you are talking about moral support attitude because that is what I have seen is the department in the hospital who have the most negligible turnover and who have the most engagement in health and wellness programs, then who in turn have healthier teams and lead by managers who create that supportive environment within their department.

According to the TPB, human behavior is guided by three kinds of considerations: beliefs about the likely consequences of the behavior (behavioral beliefs), beliefs about the normative expectations of others (normative beliefs), and beliefs about the presence of factors that may facilitate or impeded performance behavior (control beliefs) (Ajzen et al., 2020). For example, Laker and Roulet (2021) demonstrated that employees who received support from their chief wellness officer (CWO) for more than 3 months reported more affective commitment (39% more) and work engagement (38% more) and less intention to turnover (reducing churn by 24%) than those who did not. In addition, Laker and Roulet (2021) also followed a transformational impact on collaboration, with over 68% of respondents agreeing that their CWO helped them physically connect with

their co-workers psychologically (41%), resulting in a stronger bond between them and 92% of the participants also felt that regarding their well-being, the CWOs improved their work-life balance, leading to a decrease in anxiety (31%) and stress (35%). As mentioned by Ee3,

> It is important for leadership to understand the wellness program and ideally are engaged so that they can also help those who report to them that they can also encourage the program. It is essential to have leadership involved and engaged with the wellness program.

At a team level, Shanafelt et al. (2021) shared that leadership that cultivates well-being and professional fulfillment requires attending to the interrelationships among team members to create a shared sense of alignment toward the team's mission and goals. As mentioned by Fernandez and Shaw (2020), leadership ranks as the single most important factor in the success or failure of organizations, especially during times of crisis.

Applications to Professional Practice

Wellness programs in organizations are one of the most critical strategies leaders are using and implementing to increase productivity and reduce health care costs. As stressed by Kava et al. (2021), most adults in the United States are employed, amounting to nearly 154 million individuals who spend one-third of their day at work. These workers and their families contribute to the wellness of the organizations by being healthy and productive during their scheduled work time. These employees can also provide broader information to their leaders on how the wellness programs are working

for them and if any behavior change intervention efforts had impacted their healthy habits positively. Pascual et al. (2021) noted that wellness programs are diverse, but they all have unifying core components addressing physical, mental, and social well-being.

As stressed by Kava et al. (2021), workplaces that support health place value on employees' well-being and have cultural norms, policies, and procedures that align with and encourage a healthy work environment. During the second quarter of 2020, our workforce productivity increased by 10.1% due to the transition from working in the office to their homes in conformity with the COVID-19 restrictions (Laker & Roulet, 2021). The increase in productivity and shift in work environment presented new challenges and complexity to the already complex employee-employer relationship. Barr and Nathenson (2022) mentioned that this current workforce and their employers exist in the context of growing social and environmental problems such as climate change, civil unrest, economic inequality, and instability; global physical and mental health issues; and a worldwide pandemic has changed everything. These factors contribute to burnout, shifting in professions, higher turnover in the health care profession, shortage of staff, and limited resources as a whole in the complex health care structure. Barr and Nathenson (2022) noted that burnout is at an all-time high, heightened by the coronavirus disease 2019 (COVID-19).

From the qualitative data obtained through the semistructured interview, leaders in organizations must embrace the opportunities and benefits of wellness programs and exemplify them to their employees. Role modeling is one of the most effective strategies

to attract employees to wellness programs and increase their utilization. Wiederhold et al. (2018) observed that interventions to address burnout should consider the broad range of causes, including organizational culture and personal factors, not just enhance self-care. In addition, leaders in the organizations develop structured, holistic wellness programs that include health assessments, annual wellness exams, and wellness activities that could support a decrease in the health care premium and better health care outcomes as the employees progress during the programs and increase productivity. The engagement of the employee and the leaders in the program also provides the most significant return and impact by creating new programs such as walk trails in the office and nutritionist healthy foods and healthier snacks that enhance the organization's well-being as a whole.

For leaders in the organization to have successful wellness programs, they need to overcome challenges and barriers during the implementation of the continuous lifespan of the programs. The data obtained in this study suggested that critical barriers to the wellness programs were communication, time, the complexity of the programs, and COVID-19. Stiehl et al. (2022) stressed that several factors might influence participants in workplace health promotions, including work-related factors (e.g., job roles and responsibilities, staffing levels, and organizational support), environmental barriers or facilitators (e.g., social determinants of health) or personal preferences for certain workplace health promotion programs.

In order to facilitate communication among colleagues and the organization, is suggested to incorporate inclusive and diverse communication management strategies.

For example, consider your employees that are Hispanic, and incorporate media that connect in their own native language. These will provide a sense of belonging and care. For those bluecollar employees, create a center with intranet accessibility for integration and a feeling of belonging in the organization and communication via bulletin boards and flyers in common areas for networking and connection with colleagues. Burke et al. (2017) suggested that managers also consider creating physical and virtual spaces (e.g., a wall in the office, a social networking page) where coworkers can encourage one another with supportive health messages or engage in workplace wellness competitions or activities to facilitate healthy communication among co-workers. By incorporating this communications center, the organization is embracing a wellness culture and connecting its employees with supportive colleagues, which leverages the courage and perseverance to continue the wellness journey.

The data from the study stressed the lack of idle time employees had to participate in wellness programs. As a note in the concept of time, there is a need to clarify that some of the employers in the health care setting work around 60 hours; this could be 40 hours within the organization and perhaps 10 or 20 hours in a secondary job. Some strategies implemented by leaders in organizations tagging the time limitation stressed by employees include incorporating fitness centers within their facilities, nutrition bars, and floating wellness programs capturing the maximum of participants within the employees' schedule. Ott-Holland et al. (2019) noted that participation in wellness programs, to an extent, is a voluntary employee behavioral engagement.

In order to support participation and maximize time, leaders have developed policies that support wellness programs and their participation within work hours. Actions such as creating policies, developing inhouse fitness centers, healthy bars, vend machines, and floating educational programs manifest the desire of leadership to create and maintain a culture of wellness within the organization and in the community. Barr and Nathenson (2022) stressed that leaders need to shift consciousness beyond individual achievement and selfcare to focus on the well-being of the collective and community at large.

Leaders at the organization also implemented a holistic approach to incorporate physical, mental, social, and spiritual well-being. The complexity of the holistic approach could be overwhelming to the employees and sometimes challenging to understand. For these, leaders had to develop strategies to simplify the complexity of the content and benefits of the program by creating educational programs once a week, chats, counselor, nutritionist, and wellness counselors that participants can reach at any moment during their wellness journey programs. In addition, applications and technology, such as tablets, phones, and wearable devices, permitted the accessibility of wellness programs 24/7, no matter where the participant is located.

Torres and Zhang (2021) noted that employee wellness programs reduced health insurance claims at an average rate of $1,421 per year per participant. In addition to insurance claims, Torres and Zhang (2021) indicated that researchers discovered that employee wellness programs reduced sick leave by 28%, worker’s compensation claims

by 30%, and overall health care costs by 26%. Beyond the statistic mentioned above and the improvements in employee health, Peñalvo et al. (2021) suggested that workplace wellness programs might benefit companies through higher employee satisfaction, increased loyalty, improved productivity, and lower health care costs. Data obtained from the semistructured interviews suggested that employees that participate in wellness programs are more engaged with the organization by providing support to other employees, have less absenteeism, and are more productive. Okiakaose (2018) indicated that organizational culture where employees' goals align with the organizational goal is a thriving culture.

Implications for Social Change

The worksite provides an opportunity to promote employees' health and wellness because of employees' concentrated hours at work (Person et al., 2010). The study's principal implication for positive social change is to help reduce employees' insurance costs by identifying strategies businesses can implement to assist employees in adopting healthier lifestyles (see CDC, 2016a). Being healthier and having self-care will benefit employees, their family's quality of life, and the customers, clients, and patients they serve. During the past 2 years, the impact of a global pandemic that shut down the world, social unrest, and economic instability extrapolated mental health issues due to the long working hours and impacted our health care workers' stability. Knowing the impact that public safety policies established and guidelines by the CDC to control the spread of COVID, leaders in the organizations still are dealing with the side effects, such as

turnover, employees' preference to work from home, and short staffing in nurses, doctors, and administrative levels.

The creative buy in of leadership and a supportive wellness culture environment, including work and community, were some of the factors that helped leaders and workers from the organizations navigate the pandemic successfully. In addition, leaders from organizations developed, adjusted and repurposed programs to the virtual space for non-essential workers. These efforts were made with the purpose to secure the continuation of services, clients, customers, patients and to comply with the CDC guidelines, states, and federal orders. The study's findings show the importance of having a holistic wellness program that does not focus only on the monetary incentive but on the value of our employees and communities.

The last 2 years tested the resilience and tolerance of our employees not only in the health care sector but in all industries. For the workers in the health care sector, the competence, endurance, and unity demonstrated to surpass the pandemic showed that when the science community comes together during the journey, the success stories will weigh out those failed attempts, shining a light based on facts and results for a better world. The study's findings provided strategies that leaders from top health care organizations applied to maintain, adapt, promote and deliver their wellness programs and holistically safeguard their employees' health and work-life balance. Further implications of the study for a major positive change are integrating the hard data, that

HIPPAA laws protect, and analyzing the demographic health change of the employees and the surrounding communities for a better work-life balance environment.

Recommendations for Action

The purpose of this qualitative multiple case study was to identify cost effective strategies that executives in the private and not-for-profit sectors implemented to align their employees with healthy habits for increasing employee productivity and lowering organization health care costs. In our current times, leaders in the organization must recognize the importance and necessity of creating and maintaining wellness programs. In a 3-year prospective study of more than 300 employers, Schwatka et al. (2018) showed the potential benefits of employee wellness programs for organizations of all sizes, that if well implemented, can be highly beneficial for both company and the employees. Leaders of organizations within the health care sector struggle with short staffing due to exhaustion from the pandemic, which started in early 2020. The health care workers were exposed to one of the most challenging times, working long hours, hundreds of patients with a Nobel virus, following changing directions from the federal regulations, state policies, and protocols from their organizations. This study may provide insights to leaders and executives of the health care organization about successful strategies implemented to align employees toward healthy habits and reduce health care insurance.

It is known that health care workers are a high stress profession, but adding the 2 long years of COVID-19 provoked anxiety and mental illness exhilarated, creating waves of resignations, early retirements, shifting of positions, and short staffing in the industry.

Due to the COVID-19 crisis, working conditions have deteriorated, and those employees are more likely to experience mental health problems, such as stress, depression, and anxiety (Chaturvedi & Rathore, 2021). As an opportunity, leaders from the organization have been looking to address conditions such as stress, anxiety, diabetes, and other chronic conditions among employees by establishing employee wellness programs. Santa Barbara et al. (2022) mentioned that the World Health Organization (WHO, 2021) considers workplace wellness programs (WWP) important to both the physiological and psychological health of employees while having both financial and productivity benefits to employers. Some of the challenges that leaders from the organization encountered during the implementation and monitoring of the programs were: (a) communication, (b) time, (c) COVID-19, and (d) complexity of the programs.

The first recommendation in light of the findings of the study is for leaders from the organizations to have an inclusive and accessible interactive platform that all members of the organization can reach for information and knowledge of the benefits of the wellness programs employees have on the organization. The platform may include how to register, engagement among the organizations with on-site colleagues, and virtual community engagement. This platform may also contain a dashboard that could be updated monthly or quarterly with quantitative and qualitative data. In addition, the platform may send reminders to the participants and employees of pending activities, goals, and updated communication. The platform could be accessed via laptops, tablets, mobile phones, or common library center in the organization for those employees who do

not have a direct laptop station assigned to them. For example, as Arigo et al. (2019) mentioned, there has been a significant amount of research on using mobile technology (mHealth) to help facilitate health and wellness interventions.

As a second recommendation, it is imperative for leaders in the organization to develop a culture of wellness and engagement within the organization and their communities. During the study, it was noticed that leadership buy-in and engagement was a common theme among the participants. Leaders in organizations established wellness programs as an incentive to reduce health care costs and improve the well-being of employees, families, and communities. The value of implementing these wellness programs goes beyond the monetary impact in health care; it is the value added to their employees, their families, and the communities served. Leadership buy-in and engagement are needed for the success of these programs. The actions and influence of leaders from the top-down level will influence the employees' perspective toward participation in wellness programs. Ott-Holland et al. (2019) suggested that employee beliefs about the value of wellness programs as a benefit to them and sincere organizational support for the program will influence employees' subsequent willingness to engage in the program. In addition, a study from Camarillo (2021) showed that among twelve participants, the recognition that quantitative data measurement was important, those organizations with the strongest program successes had leadership that was less focused on claims data, at least initially, than on committing the organization to wellness for the benefit of the employees.

Recommendations for Further Research

The study focused on the strategies executives from the private and not-for-profit sector implemented to align their employees toward healthy habits. The study was limited geographically to the southern region of the United States. The study was also limited to the health care industry, which was hard hit by the pandemic (COVID-19) for more than 2 years. The pandemic created an unexpected limitation in data gathering because the industry short-staffed and high volume of work, that difficulted the data gathering and participation. Beyond the short-staffing and high volume, the participation of six executives and leaders from a top national health care organization may be considered limited. This limitation may be acknowledging the possibility of missing opportunities in different regions of the United States and industry. Perhaps, the possibility of expanding the sample and extrapolating it to other industries will create a broader spectrum in the validity of data.

Reflections

My DBA journey started in 2018 with the concept of embracing and expanding my knowledge, with the possibility of contributing to my organizations, communities and the sharing with my families and colleagues. The journey was not easy; long hours of researching, writing and joyfully sacrificing time with family to comply with professors' requirements, due date of assignments, Walden's requirements, and the Doctoral Committee's suggestions. The DBA journey taught me the importance of time management, patience and asking questions, the preciousness of learning, equipping

myself with techniques for better research, the humbleness of writing, and being criticized for better social good. As a student and professional, I was able to grow my skill sets and purposely look at my surroundings through another lens, the lens of a scholar constantly asking the why, looking for possible solutions. The opportunities offered during the course of the DBA journey and the milestone completed were achievable thanks to my support system from Walden University, colleagues from my organizations, and my family.

The research question was selected at the beginning of my DBA journey. During the course of the study, it was modified and shaped for the research question and the study that is currently presented. The most challenging section was the collection of data. More than 300 e-mails, calls, and mail letters were sent to possible participants among the organizations of the Southern Region of the United States. Seven months later, I completed the six interviews thanks to the participants who took their time during challenging times to be interviewed providing their insight, knowledge, and perspectives of the study phenomenon supporting students and providing social good. Forever grateful for all of them, the relationship build and continuing support of health care workers, families, and communities.

The study revealed strategies that executives and leaders of private and not-for-profit organizations in the health care industry implemented to align their employees toward healthy habits, increase productivity and reduced health care costs. To mitigate possible bias, the sample selected was not from any organization where I had worked or

currently work. I also did member checking and crafted semistructured, open-ended questions to provide the space and allow time for the participants to digest the question and answer to their best knowledge, based on experience, facts, and perspective. Aggregated data could not be collected, by being HIPPA-protected data, for more in deep study. For that, we cross-reference the data provided by the participants with public information that does not created conflict or violated any policy, regulation, or federal law. By completing this study hope to contribute to the field, sharing my findings and continue to research by publishing articles related to the study in a more concise manner.

Conclusion

This qualitative multiple-case study aims to identify cost-effective strategies that executives and leaders in the private and not-for-profit sectors implemented to encourage their employees to adopt healthy habits for increasing employees' productivity and lowering organizations' health care costs. The data was collected from six leaders and executives of the private and not-for-profit health care sector of the Southern Region of the United States. The findings of the study revealed the importance of having the buy-in of leadership and role models as one of the most cost-effective strategies to align employees toward healthy habits. The ability to have the support of leadership by creating policies and developing programs that support the wellness of the employees, families, and communities demonstrates engagement and responsibility toward a culture of wellness.

The opportunities that leaders provide by engaging in a culture of wellness benefit the organizations as a whole. Based on the fact that having healthy employees, less absenteeism are reported, there is higher increase in productivity and, in some cases, a lower cost of the health care premiums. The opportunities created by leaders as they engage in a culture of wellness by: (a)promoting the wellness programs inside and outside the organization, (b) communicating the education programs, (c) participating in events of the community, (d)colleagues support and (e) facilitating the participation by incorporating inhouse fitness centers, counselors, education program within scheduled working hours create the space and time for the employee to participate without fear of being penalized.

References

Abutabenjeh, S., & Jaradat, R. (2018). Clarification of research design, research methods, and research methodology: A guide for public administration researchers and practitioners. *Teaching Public Administration*, *36*(3), 237–258. https://doi.org/10.1177/0144739418775787

Ajibola, K. S., Mukulu, E., & Orwa, G. O. (2019). Performance appraisal as determinant of employee work engagement: Evidence from Nigeria manufacturing firms. *International Journal of Human Resources and Procurement*, *8*(2), 45–58.

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes, 50*(2), 179–211.

Ajzen, I. (2005). *Attitudes, personality, and behavior*. McGraw-Hill Education.

Ajzen, I. (2015). The theory of planned behavior is alive and well, and not ready to retire: A commentary on Sniehotta, Presseau, and Araujo-Soares. *Health Psychology Review*, *9*(2), 131–137. https://doi.org/10.1080/17437199.2014.883474

Ajzen, I., Bosnjak, M., & Schmidt, P. (2020). The theory of planned behavior: selected recent advances and applications. *Europe's Journal of Psychology*, 16(3), 352. https// doi: 10.5964/ejop.v16i3.3107

Ajzen, I., & Fishbein, M. (1977). Attitude-behavior relations: A theoretical analysis and review of empirical research. *Psychological Bulletin*, *84*(5), 888–918. https://doi.org/10.1037/0033-2909.84.5.888

Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior*. Prentice-Hall.

Alam, M. K. (2021). A systematic qualitative case study: Questions, data collection, NVivo analysis and saturation. *Qualitative Research in Organizations and Management: An International Journal*, *16*(1), 1–31. https://doi.org/10.1108/QROM-09-2019-1825

Aldiabat, K. M., & Le Navenec, C. (2018). Data saturation: The mysterious step in grounded theory methodology. *The Qualitative Report*, *23*(1), 245–261.

Alex, A., & Golhar, D. (2020). HRM practice and work environment: An analytical study with reference to retail organizations. *Studies in Indian Place Names*, *40*(27), 233–242. https://www.tpnsindia.org/index.php/sipn/article/view/1246

Alkadash, T. M., & Aljileedi, S. M. (2020). Corporate social responsibility, and employee commitment in Libyan. *International Journal of Intellectual Human Resource Management*, *1*(01), 28–40. https://doi.org/10.46988/IJIHRM.01.01.2020.004

Allen, J., & Safeer, R. (2019). Defining a culture of health in the workplace. *Journal of Occupational & Environmental Medicine*, *61*(11), 863–867. https://doi.org/10.1097/JOM.0000000000001684

Alola, U. V., & Alafeshat, R. (2020). The impact of human resource practices on employee engagement in the airline industry. *Journal of Public Affairs*, 21(1), 1–12. https://doi.org/10.1002/pa.2135

Alvarez, G., Núñez-Cortés, R., Solà, I., Sitjà-Rabert, M., Fort-Vanmeerhaeghe, A., Fernández, C., Bonfill, X., & Urrútia, G. (2021). Sample size, study length, and inadequate controls were the most common self-acknowledged limitations in manual therapy trials: A methodological review. *Journal of Clinical Epidemiology*, *130*, 96–106. https://doi.org/10.1016/j.jclinepi.2020.10.018

Ambrosius, J. (2018). Strategic talent management in emerging markets and its impact on employee retention: Evidence from Brazilian MNCs. *Thunderbird International Business Review*, *60*(1), 53–68. https://doi.org/10.1002/tie.21799

Ames, H., Glenton, C., & Lewin, S. (2019). Purposive sampling in a qualitative evidence synthesis: A worked example from a synthesis on parental perceptions of vaccination communication. *BMC Medical Research Methodology*, *19*(1), 26–34. https://doi.org/10.1186/s12874-019-0665-4

Archer, E., Bitzer, E., & van Heerden, B. (2017). Interrogating patient-centeredness in undergraduate medical education using an integrated behavior model. *South African Family Practice*, *59*(6), 219–223. https://doi.org/10.1080/20786190.2017.1386869

Arigo, D., Jake-Schoffman, D. E., Wolin, K., Beckjord, E., Hekler, E. B., & P agoto, S. L. (2019). The history and future of digital health in the field of behavioral medicine. *Journal of Behavioral Medicine*, *42*(1), 67–83. https://doi.org/10.1007/s10865-018-9966-z

Armitage, C. J., & Conner, M. (2001). Efficacy of the theory of planned behaviour: A meta-analytic review. *The British Journal of Social Psychology, 40*, 471–99. https://doi.org/10.1348/014466601164939

Aspers, P., & Corte, U. (2019). What is qualitative in qualitative research. *Qualitative Sociology, 42*(2), 139–160. https://doi.org/10.1007/s11133-019-9413-7

Astrella, J. A. (2017). Return on investment: evaluating the evidence regarding financial outcomes of workplace wellness programs. JONA: *The Journal of Nursing Administration, 47*(7/8), 379–383. https://doi.org/10.1097/NNA.0000000000000499

Austin, J. T., & Vancouver, J. B. (1996). Goal constructs in psychology: Structure, process, and content. *Psychological Bulletin, 120*(3), 338–375. https://doi.org/10.1037/0033-2909.120.3.338

Baid, D., Hayles, E., & Fainkeslstein, E. A. (2021). Return on investment of workplace wellness programs for chronic diseases prevention: A systematic review. *Am J Prev Med, 61*(2), 256–266. https://doi.org/10.1016/j.amepre.2021.02.002

Bailey, C., Madden, A., Alfes, K., & Fletcher, L. (2017). The meaning, antecedents and outcomes of employee engagement: A narrative synthesis. *International journal of management reviews, 19*(1), 31–53. https://doi.org/10.1111/ijmr.12077

Buselli, R., Corsi, M., Baldanzi, S., Chiumiento, M., Del Lupo, E., Dell'Oste, V., Bertelloni, C. A., Massimetti, G., Dell'Osso, L., Cristaudo, A., & Carmassi, C. (2020). Professional quality of life and mental health outcomes among health care

workers exposed to Sars-Cov-2 (Covid-19). *International Journal of Environmental Research and Public Health, 17*(17), 6180–6191. https://doi.org/10.3390/ijerph17176180

Balwan, W. K., & Kour, S. (2021). Lifestyle diseases: The link between modern lifestyle and threat to public health. *Saudi J Med Pharm Sci, 7*(4), 179–184. https://doi.org/10.36348/sjmps.202v07i04.00x

Barr, T. L., & Nathenson, S. L. (2022). A holistic transcendental leadership model for enhancing innovation, creativity and well-being in health care. *Journal of Holistic Nursing, 40*(2), 157–168. https://doi.org/10.1177/08980101211024799

Borsky, A., Zhan, C., Miller, T., Ngo-Metzger, Q., Bierman, A. S., & Meyers, D. (2018). Few Americans receive all high-priority, appropriate clinical preventive services. *Health Affairs, 37*(6), 925–928. https://doi.org/10.1377/hlthaff.2017.1248

Boucerredj, L., & Debbache, N. (2018). Qualitative and quantitative optimization for dependability analysis. *Informatica*, *42*(3), 439–450. https://doi.org/10.31449/inf.v42i3.1580

Bowling, N. A., Eschleman, K. J., & Wang, Q. (2010). A meta-analytic examination of the relationship between job satisfaction and subjective wellbeing. *Journal of Occupational and Organizational Psychology*, *83*(4), 915–934. https://doi.org/10.1348/096317909X478557

Branscum, P., & Lora, K. (2017). Using the integrated behavioral model of prediction to predict maternal monitoring of fruit and vegetable consumption among Hispanic

mothers. *Family & Community Health, 40*(1), 32–38. https://doi.org/10.1097/FCH.0000000000000130

Braun, V., Clarke, V., Hayfield, N., & Terry, G. (2019). Thematic Analysis. *Handbook of Research Methods in Health Social Sciences, 48,* 843–860. https://doi.org/10.1007/978-981-10-5251-4_103

Busetto, L., Wick, W., & Gumbinger, C. (2020). How to use and assess qualitative research methods. *Neurological Research and practice, 2*(1), 1–10. https://doi.org/10.1186/s42466-020-00059-z

Burke, T. J., Dailey, S. L., & Zhu, Y. (2017). Let's work out: Communication in workplace wellness programs. *International Journal of Workplace Health Management, 10*(2), 101–115. https://doi.org/10.1108/IJWHM-07-2016-0055

Cai, H., Chen, L., Fu, L., Jiang, Y., Ma, J., Tu, B., & Zhuang, Q. (2020). Psychological impact and coping strategies of frontline medical staff in Hunan between January and March 2020 during the outbreak of coronavirus disease 2019 (COVID-19) in Hubei, China. *Medical Science Monitor: International Medical Journal of Experimental and Clinical Research, 26,* 1–16. https://doi.org/10.12659/MSM.924174

Camarillo, E. (2021). Worksite wellness program implementation in county organizations: Exploring strategies for success. *The Social Science Journal*, *58*(3), 355–365. https://doi.org/10.1016/j.soscij.2019.06.003

Campbell, S., Greenwood, M., Prior, S., Shearer, T., Walkem, K., Young, S., Bywaters, D., & Walker, K. (2020). Purposive sampling: complex or simple? Research case examples. *Journal of research in Nursing, 25*(8), 652–661. https://doi.org//10.1177/1744987120927206

Candela, A. G. (2019). Exploring the function of member checking. *The Qualitative Report, 24*(3), 619–628.

Carminati, L. (2018). Generalizability in qualitative research: A tale of two traditions. *Qualitative health research, 28*(13), 2094–2101. https://doi.org/10.1177/1049732318788379

Castaneda, D., Esparza, A., Ghamari, M., Soltanpur, C., & Nazeran, H. (2018). A review on wearable photoplethysmography sensors and their potential future applications in health care. *International journal of biosensors & bioelectronics*, *4*(4), 195. https://doi.org/10.15406/ijbsbe.2018.04.00125

Centers for Disease Control and Prevention. (2016a). *Workplace health promotion-worker productivity measures.* Self. https://www.cdc.gov/workplacehealthpromotion/model/evaluation/productivity.html

Centers for Disease Control and Prevention. (2016b). *Workplace Health Model*. Self. https://www.cdc.gov/workplacehealthpromotion/model/index.html

Centers for Medicare and Medicaid Service. (2012). *The Affordable Care Act and Wellness Program.* FAQs/wellness11202012a

Chaikin, A. L., Derlega, V. J., & Miller, S. J. (1976). Effects of room environment and self-disclosure in a counseling analogue. *Journal of Counseling Psychology, 23*(5), 479–481. https://doi.org/10.1037/0022-0167.23.5.479

Chartered Institute of Personnel and Development (Great Britain) (CIPD). (2007). *Annual Survey Report 2007–Learning and Development*. https://hdl.voced.edu.au/10707/100537

Chaturvedi, S., & Rathore, A. S. (2021). Virtual wellness program for employees during pandemic COVID-19. *International Journal of Recent Advances in Multidisciplinary Topics, 2*(6), 218–221. https://www.ijramt.com

Cheon, O., Kash, B. A., & Naufal, G. (2020). When workplace wellness programs work: lessons learned from a large employer in Texas. *American Journal of Health Education, 51*(1), 31–39. https://doi.org/10.1080/19325037.2019.1687366

Clark, K. R., & Vealé, B. L. (2018). Strategies to Enhance Data Collection and Analysis in Qualitative Research. *Radiologic Technology, 89*(5), 482CT–485CT.

Coghlan, D. (2019). *Doing Action Research in your own Organization* (5th ed.). Sage.

Compilation of Patient Protection Act and ACA of 2010. 42 U.S.C. 300gg-11. https://housedocs.house.gov/energycommerce/ppacacon.pdf

Cooper, P., & Wickramasinghe, N. (2020). Precision wellness: An optimization model. *Delivering Superior Health and Wellness Management with IoT and Analytics.* Springer, Cham. https://doi.org/10.1007%2F978-3-030-17347-0_8

Corbin, J. H., Jones, J., & Barry, M. M. (2018). What makes intersectoral partnerships for health promotion work? A review of the international literature. *Health Promotion International*, *33*(1), 4–26. https://doi.org/10.1093/heapro/daw061

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage Publications.

Crisp, R. (Ed.). (2017). "Wellbeing," *The Stanford Encyclopedia of Philosophy* (Fall 2017 ed.). Stanford University. https://plato.stanford.edu/archives/fall2017/entries/well-being/

Crouch, M., & McKenzie, H. (2006). The logic of small samples in interview-based qualitative research. *Social Science Information*, *45*(4), 483–499. https://doi.org/10.1177/0539018406069584

Crowley, R., Daniel, H., Cooney, T. G., Engel, L. S., & Thomas, G. (2020). Envisioning a better U.S. health care system for all: Coverage and cost of care. *Annals of Internal Medicine*, *172*(2 Suppl), S7–S32. https://doi.org/10.7326/M19-2415

Cypress, B. S. (2017). Rigor or reliability and validity in qualitative research: perspectives, strategies, reconceptualization, and recommendations. *Research Dimension. 36*(4), 253–263. https://doi.org/10.1097/DCC.000000000000253

Dailey, S. L., Carberry, E. G., & Burke, T. J. (2018). For better or for work: Dual discourses in a workplace wellness program. *Management Communication Quarterly*, *32*(4), 612–626. https://doi.org/10.1177/0893318917746018

Dailey, S. L., & Zhu, Y. (2017). Communicating health at work: Organizational wellness programs as identity bridges. *Health Communication*, *32*(3), 261–268. https://doi.org/10.1080/1041023.62015.1120698

Dalkin, S., Forster, N., Hodgson, P., Lhussier, M., & Carr, S. M. (2021). Using computer assisted qualitative data analysis software (CAQDAS; NVivo) to assist in the complex process of realist theory generation, refinement and testing. International *Journal of Social Research Methodology*, *24*(1), 123–134. https://doi.org/10.1080/13645579.2020.1803528

Danna, K., & Griffin, R. W. (1999). Health and well-being in the workplace: A review and synthesis of the literature. *Journal of Management*, *25*(3), 357–384. https://doi.org/10.1177/014920639902500305

Das, A. K., Abdul Kader Jilani, M. M., Uddin, M. S., Uddin, M. A., & Ghosh, A. K. (2021). Fighting ahead: adoption of social distancing in COVID-19 outbreak through the lens of theory of planned behavior. *Journal of Human Behavior in the Social Environment*, *31*(1-4), 373–393.

Davis, T. (2019). What is well-being? Definitions, types and well-being skills. *Psychology Today.* https://www.psychologytoday.com/us/blog/click-here-happiness/201901/what-is-well-being-definition-types-and-well-being-skills

Dawkins, D. J., & Daum, D. N. (2022). Person-first language in healthcare: The missing link in healthcare simulation training. *Clinical Simulation in Nursing, 21*(13), 1–6. https://doi.org/10.1016/j.ecns.2022.03.002

Denzin, N. K. (2017). *The Research Act: A Theoretical Introduction to Sociological Methods*. AldineTransaction.

Deterding, N. M., & Waters, M. C. (2021). Flexible coding of in-depth interviews: A twenty-first-century approach. *Sociological Methods & Research, 50*(2), 708–739. https://doi.org/10.1177/0049124118799377

Di Fabio, A. (2017). The psychology of sustainability and sustainable development for well-being in organizations. *Frontiers in Psychology*, *8*(1534), 1–7. https://doi.org/10.3389/fpsyg.2017.01534

Diener, E., Lucas, R. E., & Oishi, S. (2018). Advances and open questions in the science of subjective well-being. *Collabra: Psychology*, *4*(1), 1–49. https://doi.org/10.1525/collabra.171

Doyle, L., McCabe, C., Keogh, B., Brady, A., & McCann, M. (2020). An overview of the qualitative descriptive design within nursing research. *Journal of Research in Nursing*, *25*(5), 443-455. https://doi.org/10.1177/1744987119880234

Downs, D. S., & Hausenblas, H. A. (2003). Exercising for two: Examining pregnant women's second-trimester exercise intention and behavior using the framework of the theory of planned behavior. *Women's Health Issues*, *13*(6), 222–228. https://doi.org/10.1016/j.whi.2003.09.004

D'Urzo, K., Johnson, A., McEachern, B., McPhee, I., Brennan, A., Fenuta, A., Lau, R., Shirazipour, C., Hefnawi, B., & Tomasone, J. (2019). Investigating gender differences in physical activity behavior and social cognitions among first-year

medical students. *MedEdPublish*, *8*(207), 1–16. https://doi.org/10.15694/mep.2019.000207.1

Ebneyamini, S., & Sadeghi Moghadam, M. R. (2018). Toward developing a framework for conducting case study research. *International journal of qualitative methods*, *17*(1), 1–11. https://doi.org/10.1177/1609406918817954

Edwards, R., & Holland, J. (2020). Reviewing challenges and the future for qualitative interviewing. *International Journal of Social Research Methodology*, *23*(5), 1–12. https://doi.org/10.1080/13645579.2020.1766767

Emerson, S., Heavin, C., & Power, D. J. (2020). Workplace health promotion: Effects of an mHealth application on employee behavior and wellness. In *Proceedings of the 53rd Hawaii International Conference on System Sciences*. https://scholarspace.manoa.hawaii.edu/bitstream/10125/64161/1/0338.pdf

Eriksson, A., & Dellve, L. (2020). Learning processes as key for success in workplace health promotion interventions in health care. *Frontiers in Public Health*, *8*(576693), 1–10. https://doi.org/10.3389/fpubh.2020.576693

Erro-Garcés, A., & Alfaro-Tanco, J. A. (2020). Action Research as a Meta-Methodology in the Management Field. *International Journal of Qualitative Methods*, 19. https://doi.org/10.1177/1609406920917489

Etikan, I., & Babtope, O. (2019). A basic approach in sampling methodology and sample size calculation. *Med Life Clin*, *1*(2), 050–054.

Farquhar, J., Michels, N., & Robson, J. (2020). Triangulation in industrial qualitative case study research: Widening the scope. *Industrial Marketing Management, 87*, 160–170. https://doi.org/10.1016/j.indmarman.2020.02.001

Federal Register – Final Rule, 76(106) 26 C.F.R.§ 54, 29 C.F.R. § 2590 and 45 C.F.R. 146 and 147 (2013). https://www.govinfo.gov/content/pkg/FR-2013-06-03/pdf/2013-12916.pdf

Ferdian, A., Azis, E., Prasetio, A. P., & Darmawan, M. I. (2021). Human resources practice and employee engagement: The mediation of organizational support and employee satisfaction. *European Journal of Molecular & Clinical Medicine, 7*(10), 2020. https://ejmcm.com/article_6765_17a2602f1c7b2ac80c62e112bb267c6a.pdf

Fernandez, A. A., & Shaw, G. P. (2020). Academic leadership in a time of crisis: The coronavirus and COVID-19. *Journal of Leadership Studies, 14*(1), 39-45. https://doi.org/10.1002/jls.21684

Fink, J., Zabawa, B., & Chopp, S. (2020). Employee perceptions of wellness programs and incentives. *American Journal of Health Promotion, 34*(3), 257–260. https://doi.org/10.1177/0890117119887687

Fishbein, M. (1967). *Attitude and the prediction of behavior: Readings in attitude theory and measurement*. John Wiley & Sons, Inc.

Flemming, K., Booth, A., Garside, R., Tunçalp, Ö., & Noyes, J. (2019). Qualitative evidence synthesis for complex interventions and guideline development:

clarification of the purpose, designs and relevant methods. *BMJ Global Health,* 4(Suppl 1). https://doi.org/10.1136/bmjgh-2018-000882

Fonseca, E. M. D., & Segatto, C. (2021). Teaching qualitative research methods in political science: Does one size fits all? *Journal of Political Science Education, 17*(3), 493–501. https://doi.org/10.1080/15512169.2019.1656081

Ford, J. L., & Scheinfeld, E. N. (2016). Exploring the effects of workplace health promotions: A critical examination of a familiar organizational practice. *Annals of the International Communication Association. 40*, 277–305. https://doi.org/10.1080/238 08985.2015.11735263

Forero, R., Nahidi, S., De Costa, J., Mohsin, M., Fitzgerald, G., Gibson, N., McCarthy, S., & Aboagye-Sarfo, P. (2018). Application of four-dimension criteria to assess rigour of qualitative research in emergency medicine. *BMC Health Serv Res,18*(1), 1-11. https://doi.org/10.1186/s12913-018-2915-2

Forgeard, M. J., Jayawickreme, E., Kern, M. L., & Seligman, M. E. (2011). Doing the right thing: Measuring wellbeing for public policy. *International journal of wellbeing*. *1*(1), 79–106. https://doi.org/10.5502/ijw.v1i1.15

Fortune. (2019, 2020, 2021). 100 Best Companies to Work For. *Fortune Magazine.* https://fortune.com/best-companies/

Foy, T., Dwyer, R. J., Nafarrete, R., Hammoud, M. S. S., & Rockett, P. (2019). Managing job performance, social support and work-life conflict to reduce

workplace stress. *International Journal of Productivity and Performance Management, 68*(6), 1018-1041. https://doi.org/10.1108/IJPPM-03-2017-0061

Frey, B. (Ed.). (2018). *The SAGE encyclopedia of educational research, measurement, and evaluation* (Winter 2018 ed). SAGE. https://doi.org/10.4135/9781506326139.n645

Friedan, J. (2016). Surgeon General concerned about physician burnout. *Medpage Today.* https://www.medpagetoday.com/publichealthpolicy/generalprofessionalissues/57280

Gallups and West Health. (2019). *The U.S. Healthcare Cost Crisis*. https://www.westhealth.org

Gibson, D. E. (2004). Role models in career development: New directions for theory and research. *Journal of Vocational Behavior, 65*(1), 134–156. https://doi.org/10.1016/S0001-8791(03)00051-4

Gifford, R. (1988). Light, decor, arousal, comfort, and communication. *Journal of Environmental Psychology, 8*, 177–189. https://doi.org/10.1016/S0272-4944(88)80008-2

Gingerich, S. B., Seaverson, E. L., & Anderson, D. R. (2018). Association between sleep and productivity loss among 598 676 employees from multiple industries. *American Journal of Health Promotion, 32*(4), 1091–1094. https://doi.org/10.1177/0890117117722517

Gioia, D. (2021). A systematic methodology for doing qualitative research. *The Journal of Applied Behavioral Science, 57*(1), 20–29. https://doi.org/10.1177/0021886320982715

Godin, G., & Kok, G. (1996). The theory of planned behavior: a review of its applications to health-related behaviors. *American Journal of Health Promotion, 11*(2), 87–98. https://doi.org/10.4278/0890-1171-11.2.87

Goetzel, R. Z. (2020). Commentary on the study: "what do workplace wellness programs do? Evidence from the Illinois workplace wellness study." *American Journal of Health Promotion, 34*(4), 440–444. https://doi.org/10.1177/0890117120906664

Goh, J., Pfeffer, J., & Zenios, S. A. (2019). Reducing the health toll from US workplace stress. *Behavioral Science & Policy, 5*(1), 1–13. https://doi.org/10.1353/bsp.2019.001

Grady, C. (2015). Institutional Review Boards: Purpose and challenges. *Chest, 148*(5), 1148–1155. https://doi.org/10.1378/chest.15-0706

Grant, A. M., Christianson, M. K., & Price, R. H. (2007). Happiness, health, or relationships? Managerial practices and employee well-being tradeoffs. *Academy of management perspectives, 21*(3), 51–63. https://doi.org/10.5465/AMP.2007.26421238

Gray, L. M., Wong-Wylie, G., Rempel, G. R., & Cook, K. (2020). Expanding qualitative research interviewing strategies: Zoom video communications. *The Qualitative*

Report, 25(5), 1292–1301. https://www.proquest.com/scholarly-journals/expanding-qualitative-research-interviewing/docview/2405672296/se-2

Grénman, M., Hakala, U., & Mueller, B. (2019). Wellness branding: insights into how American and Finnish consumers use wellness as a means of self-branding. *Journal of Product & Brand Management*, *28*(4), 462–474. https://doi.org/10.1108/JPBM-04-2018-1860

Gubler, T., Larkin, I., & Pierce, L. (2017). Doing well by making well: The impact of corporate wellness programs on employee productivity. *Management Science*. *61*(11), 4967–4987. https://doi.org/10.1287/mnsc.2017.2883

Guest, G., Namey, E., & Chen, M. (2020). A simple method to assess and report thematic saturation in qualitative research. *PLoS ONE, 15*(5), 1–17. https://doi.org/10.1371/journal.pone.0232076

Ha, Y., Lee, S. H., Lee, D. H., Kang, Y. H., Choi, W., & An, J. (2022). Effectiveness of a mobile wellness program for nurses with rotating shifts during COVID-19 pandemic: A pilot cluster-randomized trial. *International Journal of Environmental Research and Public Health, 19*(2), 1014. https://doi.org/10.3390/ijerph19021014

Hagger, M. S., Chatzisarantis, N. L. D., Culverhouse, T., & Biddle, S. J. H. (2003). The processes by which perceived autonomy support in physical education promotes leisure-time physical activity intentions and behavior: A trans-contextual model.

Journal of Educational Psychology, *95*(4), 784–795. https://doi.org/10.1037/0022-0663.95.4.784

Halaweh, M. (2020). Research Productivity Index (RPI): a new metric for measuring universities' research productivity. *Information Discovery and Delivery*, *49*(1), 39–35. https://doi.org/10.1108/IDD-01-2020-0003

Han, J. H., & Hye, H. J. (2022). Analysis of golf apparel purchase decisions using the extended model of goal-directed behavior. *Social Behavior and Personality: An International Journal*, *50*(10), 1–14. https://doi.org/10.2224/sbp.11955

Harrington, J. (2017). *Barriers to implementation of workplace wellness programs in career fire service organizations: An exploratory qualitative study* [Doctoral dissertation, Creighton University].

Harris, J. R., Kava, C., Chan, K. C. G., Kohn, M. J., Hammerback, K., Parrish, A., T. Helfrich, C. D., M., & Hannon, P. A. (2022). Pathways to employee outcomes in a workplace health promotion program. *American Journal of Health Promotion*, *36*(4), 662–672. https://doi.org/10.1177/08901171211066898

Harrison, M. A., & Stephens, K. K. (2019). Shifting from wellness at work to wellness in work: Interrogating the link between stress and organization while theorizing a move toward wellness-in-practice. *Management Communication Quarterly*, *33*(4), 1–34. https://doi.org/10.1177/0893318919862490

Hartman, M., Martin, A. B., Benson, J., Catlin, A., & National Health Expenditure Accounts Team. (2020). National health care spending in 2018: Growth driven by

accelerations in Medicare and private insurance spending: US health care spending increased 4.6 percent to reach $3.6 trillion in 2018, a faster growth rate than that of 4.2 percent in 2017 but the same rate as in 2016. *Health Affairs, 39*(1), 8–17. https://doi.org/10.1377/hlthaff.2019.01451

Hashim, M. J. (2017). Patient-centered communication: basic skills. *Am Fam Physician, 95*(1), 29–34. https://www.aafp.org/afp

Haven, T., & Van Grootel, D. L. (2019). Preregistering qualitative research. Accountability in Research: *Policies & Quality Assurance*, *26*(3), 229–244. https://doi.org/10.1080/08989621.2019.1580147

Healthiest Employers. (2019, 2020 & 2021). The healthiest 100 workplaces in America. *Springbick Health Intelligence*. https://www.healthiestemployers.com/h100/h100

Hill, B., Richardson, B., & Skouteris, H. (2015). Do We Know How to Design Effective Health Coaching Interventions: A Systematic Review of the State of the Literature. *American Journal of Health Promotion, 29*(5), e158–e168. https://doi.org/10.4278/ajhp.130510-LIT-238

Himmelstein, D. U., Woolhandler, S., & Fauke, C. (2019). Health care crisis by the numbers. *International Journal of Health Services, 49*(4), 697–711. https://doi.org/10.1177/0020731419867207

Hoert, J., Herd, A. M., & Hambrick, M. (2018). The role of leadership support for health promotion in employee wellness program participation, Perceived job stress, and

health behaviors. *American Journal of Health Promotion, 32*(4), 1054–1061. https://doi.org/10.1177/0890117116677798

Hoogesteyn, K., Meijer, E., & Vrij, A. (2020). Examining witness interviewing environments. *Journal of Investigative Psychology and Offender Profiling. 17*(3), 238–249. https://doi.org/10.1002/jip.1549

Höchsmann, C., Dorling, J. L., Martin, C. K., Earnest, C. P., & Church, T. S. (2022). Association between weight loss, change in physical activity, and change in quality of life following a corporately sponsored, online weight loss program. *BMC Public Health*, *22*(1), 1–10. https://doi.org/10.1186/s12889-022-12835-4

Irani, E. (2019). The use of videoconferencing for qualitative interviewing: Opportunities, challenges, and considerations. *Clinical Nursing Research, 28*(1), 3–8. https://doi.org/10.1177/1054773818803170

Jenkins, K. R., Fakhoury, N., Richardson, C. R., Segar, M., Krupka, E., & Kullgren, J. (2019). Characterizing employees' preferences for incentives for healthy behaviors: Examples to improve interest in wellness programs. *Health Promotion Practice, 20*(6), 880–889. https://doi.org/10.1177/1524839918776642

Jiang, F., Deng, L., Zhang, L., Cai, Y., Cheung, C. W., & Xia, Z. (2020). Review of the clinical characteristics of coronavirus disease 2019 (COVID-19). *Journal of general internal medicine*, *35*(5), 1545–1549. https://doi.org/10.1007/s11606-020-05762-w

Jinnett, K., Schwatka, N., Tenney, L., Brockbank, C. V. S., & Newman, L. S. (2017). Chronic conditions, workplace safety, and job demands contribute to absenteeism and job performance. *Health Affairs, 36*(2), 237–244. https://doi.org/10.1377/hlthaff.2016.1151

Johnson, J. L., Adkins, D., & Chauvin, S. (2020). A Review of the Quality Indicators of Rigor in Qualitative Research. *American Journal of Pharmaceutical Education, 84*(1), 138–146. https://doi.org/10.5688/ajpe7120

Jones, B. L., Cheng, C., Foglia, L. M., Ricciotti, H., & El-Amin, W. W. (2021). Promoting culture change within organizations. *Pediatrics, 148*(s2), 1–10. https://doi.org/10.1542/peds.2021-051440F

Joo, B. K., & Lee, I. (2017). Workplace happiness: work engagement, career satisfaction, and subjective well-being. In Evidence-based HRM: A global forum for empirical scholarship. *Evidence-based HRM: a Global Forum for Empirical Scholarship, 5*(2), 206–221. https://doi.org/10.1108/EBHRM-04-2015-0011

Kaplan, S., DeShon, R. P., & Tetrick, L. E. (2017). The bigger picture of employee well-being: Its role for individuals, families, and societies. *Society for Human Resource Management, Science of Human Resources Series.* 1–21. http://www.shrm.org/ https://www.infocoponline.es

Kassam, A., & Ellaway, R. (2020). Acknowledging a holistic framework for learner wellness: The human capabilities approach. *Academic Medicine, 95(*1), 9–10. https://doi.org/10.1097/ACM.0000000000003026

Kava, C. M., Passey, D., Harris, J. R., Chan, K. C. G., & Hannon, P. A. (2021). The workplace support the health scale: Reliability and validity of a brief scale to measure employee perceptions of wellness. *Am J Health Promotion, 35*(2), 179–185. https://doi.org/10.1177/0890117120949807

Keller, A. O., Berman, R., Scotty, B., & Pinto, D. (2022). Exploring corporate stakeholders' perspectives on building capacity for employee engagement in workplace wellness initiatives. *Journal of Patient Experience, 9*, 1–6. https://doi.org/10.1177/23743735221092619

Kent, K. B., Goetzel, R. Z., Roemer, E. C., McCleary, K., Henke, R. M., Head, M. A., & Fabius, R. (2018). Developing two culture of health measurement tools: examining employers' efforts to influence population health inside and outside company walls. *Journal of Occupational and Environmental Medicine, 60*(12), 1087–1097. https://doi.org/10.1097/JOM.0000000000001438

King, N. M. P. (2019). Key information in the new common rule: Can it save research consent? *Journal of Law, Medicine & Ethics. 47*(2), 203–212. https://doi.org/10.1177/1073110519857276

Knippen, K. L., Thompson, A., & Masters, A. (2018). Evaluation of employee behaviors, perceptions, and attitudes regarding worksite wellness in an urban environment. *Health Educator*, *50*(1), 31–37. https://etasigmagamma.org/membership-2/publications/the-health-educator/

Kolvereid, L. (1996). Prediction of employment status choice intentions. *Entrepreneurship: Theory &Practice, 21*(1), 47–58. https://doi.org/10.1177/104225879602100104

Kowalski, T. H. P., & Loretto, W. (2017). Well-being and HRM in the changing workplace. *International Journal of Human Resource Management*, *28*(16), 2229–2255. https://doi.org/10.1080/09585192.2017.1345205

Kurniawan, D., Bunau, E., & Wardah, W. (2021). The use of Rosetta Stone language learning software in teaching listening: Documentary research. *Journal of English Education Program*, *2*(2), 97–103. https://doi.org/10.26418/jeep.v2i2.45516

Lawton, J., Blackburn, M., Rankin, D., Allen, J. M., Campbell, F. M., Leelarathna, L., Tauschmann, M., Thabit, H., Wilinska, M.E., Elleri, D., Hovorka, R., & APCam11 Consortium. (2019). Participants' experiences of, and views about, daytime use of a day-and-night hybrid closed-loop system in real life settings: longitudinal qualitative study. *Diabetes technology & therapeutics*, *21*(3), 119–127. https://doi.org//10.1089/dia.2018.0306

Laker, B., & Roulet, T. (2021). How organizations can promote employee wellness, now and post-pandemic. *MIT Sloan Management Review*. *1*, 1–6. https://centaur.reading.ac.uk/94575/

Lester, J. N., Cho, Y., & Lochmiller, C. R. (2020). Learning to do qualitative data analysis: A starting point. *Human Resource Development Review, 19*(1), 94–106. https://doi.org/10.1177/1534484320903890

Levy, D. E., & Thorndike, A. N. (2019). Workplace wellness program and short-term changes in health care expenditures. *Preventive medicine reports, 13,* 175–178. https://doi.org/10.1016/j.pmedr.2018.12.019

Lim, C., Kim, M. J., Kim, K. H., Kim, K. J., & Maglio, P. P. (2018). Using data to advance service: managerial issues and theoretical implications from action research. *Journal of Service Theory and Practice*, *28*(1), 99–128. https://doi.org/10.1108/JSTP-08-2016-0141

Linnan, L. A., Cluff, L., Lang, J. E., Penne, M., & Leff, M. S. (2019). Results of the workplace health in America survey. *American Journal of Health Promotion*, *33*(5), 652–665. https://doi.org/10.1177/0890117119842047

Liu, C. Y., Yang, Y. Z., Zhang, X. M., Xu, X., Dou, Q. L., Zhang, W. W., & Cheng, A. S. (2020). The prevalence and influencing factors in anxiety in medical workers fighting COVID-19 in China: A cross-sectional survey. *Epidemiol. Infection, 148*, 1–17. https://doi.org/10.1017/S0950268820001107

Lortie, J., & Castogiovanni, G. (2015). The theory of planned behavior in entrepreneurship research: What we know and future directions. *International Entrepreneurship and Management Journal*, *11*(4), 935–957. https://doi.org/10.1007/s11365-015-0358-3

Lowensteyn, I., Berberian, V., Belisle, P., DaCosta, D., Joseph, L., & Grover, S. A. (2018). The measurable benefits of a workplace wellness program in Canada. *Journal of occupational and environmental medicine*, *60*(3), 211–216.

https://www.medicine.mcgill.ca/epidemiology/Joseph/publications/Medical/ilka2018.pdf

Madden, T. J., Ellen, P. S., & Ajzen, I. (1992). A comparison of the theory of planned behavior and the theory of reasoned action. *Personality and Social Psychology Bulletin, 18*(1), 3–9. https://journals.sagepub.com/loi/psp

Magaldi, D., & Berler, M. (Ed.). (2020). Semi-structured interviews. *Encyclopedia of Personality and Individual Differences.* Springer, Cham. https://doi.org/10.1007/978-3-319-24612-3_857

Mahajan, A. (2020). Employee wellbeing: Past, present and Future. *AIMA Journal of Management and Research*. *14*(1), 1–10. http://apps.aima.in/ejournal_new/articlesPDF/4-Arvind-Mahajan.pdf

Maher, C., Hadfield, M., Hutchings, M., & De Eyto, A. (2018). Ensuring rigor in qualitative data analysis: A design research approach to coding combining NVivo with traditional material methods. *International Journal of Qualitative Methods, 17*(1), 1–13. https://doi.org/10.1177/1609406918786362

Mattimoe, R., Hayden, M. T., Murphy, B., & Ballantine, J. (2021). Approaches to analysis of qualitative research data: a reflection on the manual and technological approaches. *Accounting, Finance, & Governance Review, 27*(1), 1–15. https://doi.org/10.52399/001c.22026

Mattke, S., Liu, H., Caloyeras, J. O., Huang, C. Y., Van-Busum, K., Khoduakov, D., & Shier, V. (2013). *Workplace wellness programs study*. RAND Health.

McCleary, K., Goetzel, R. Z., Roemer, E. C., Berko, J., Kent, K., & De La Torre, H. (2017). Employer and employee opinions about workplace health promotion (wellness) programs: results of the 2015 Harris Poll Nielsen Survey. *Journal of occupational and environmental medicine, 59*(3), 256–263. https://doi.org/10.1097/JOM.0000000000000946

McGrath, C., Palmgren, P. J., & Liljedahl, M. (2019). Twelve tips for conducting qualitative research interviews. *Medical teacher, 41*(9), 1002–1006. https://doi.org/10.1080/0142159X.2018.1497149

McQueen, A., Kreuter, M., Loughran, M., Thompson, T., & Poor, T. (2020). Perceptions of health coaching for behavior change among Medicaid and commercially insured adults. *Health Promotion Practice, 21*(2), 288–297. https://doi.org/10.1177/1524839918790936

Melnyk, B. M., Szalacha, L. A., & Amaya, M. (2018). Psychometric properties of the perceived wellness culture and environment support scale. *American Journal of Health Promotion*, *32*(4), 1021–1027. https://doi.org/10.1177/0890117117737676

Mitchell, L., Amaya, M., Battista, L., Melnyk, B., Andridge, R., & Kaye, G. (2021). Manager support for wellness champions: A case study for consideration and practice implications. *Workplace Health & Safety*, *69*(3), 100–108. https://doi.org/10.1177/2165079920952759

Mioni, G., Cellini, N., Romola, M., & Bruno, F. (2022). The association between balanced time perspective, personality traits, subjective well-being, and distress

during the COVID-19 Pandemic. *Timing & Time Perception*, *1*, 1-24. https://doi.org10.1163/22134468-bja10062

Montano, D. E., & Kasprzyk, D. (2015). Theory of reasoned action, theory of planned behavior, and the integrated behavioral model. *Health Behavior: Theory, Research and Practice*, *70*(4), 231–241. https://www.ssu.ac.ir

Moon, M. D. (2019). Triangulation: A method to increase validity, reliability, and legitimation in clinical research. *Journal of Emergency Nursing*, *45*(1), 103–105. https://doi.org/10.1016/j.jen.2018.11.004

Moraci, F., Errigo, M. F., Fazia, C., Campisi, T., & Castelli, F. (2020). Cities under pressure: Strategies and tools to face climate change and pandemic. *Sustainability*, *12*(18), 7743. https://doi.org/10.3390/su12187743

Mozaffarian, D., Angell, S. Y., Lang, T., & Rivera, J. A. (2018). Role of government policy in nutrition—barriers to and opportunities for healthier eating. *BMJ*, 361–372.

Mujtaba, B. G., & Cavico, F. J. (2013). Corporate wellness programs: Implementation challenges in the modern American workplace. *International Journal of Health Policy and Management*, *1*(3), 193–199. https://doi.org/10.15171/ijhpm.2013.36

Nash, C. (2021). Improving mentorship and supervision during COVID-19 to reduce graduate student anxiety and depression aided by an online commercial platform narrative research group. *Challenges*, *12*(11), 1–18. https://doi.org/10.3390/challe12010011

Nasseh, K., & Vujicic, M. (2017). The impact of the affordable care act's Medicaid expansion on dental care use through 2016. *Journal of Public Health Dentistry, 77*(4), 290–294. https://doi.org/10.1111/jphd.12257

National Center for Health Statistics. (2016). *Health, United States, 2015: With special feature on racial and ethnic health disparities*. National Center for Health Statistics. https://www.ncbi.nlm.nih.gov/books/NBK367640/pdf/

Natow, R. S. (2020). The use of triangulation in qualitative studies employing elite interviews. *Qualitative Research, 20*(2), 160–173. https://doi.org/10.1177/1468794119830077

Negrini, S., Arienti, C., Pollet, J., Engkasan, J. P., Francisco, G. E., Frontera, W. R., Galeri, S., Gworys, K., Kujawa, J., Mazlan, M., Rathore, F. A., Schillebeeckx, F., & Kiekens, C. (2019). Clinical replicability of rehabilitation interventions in randomized controlled trials reported in main journals is inadequate. *Journal of Clinical Epidemiology, 114*, 108–117. https://pdf.sciencedirectassets.com/

Nicola, M., Alsafi, Z., Sohrabi, C., Kerwan, A., Al-Jabir, A., Iosifidis, C., Agha M., & Agha, R. (2020). The socio-economic implications of the coronavirus pandemic (COVID-19): A review. *International journal of surgery, 78*, 185-193. https://doi.org/10.1016/j.ijsu.2020.04.018

Nie, A., Su, X., Zhang, S., Guan, W., & Li, J. (2020). Psychological impact of COVID-19 outbreak on frontline nurses: A cross-sectional survey study. *Journal of clinical nursing, 29*(21-22), 4217–4226. https://doi.org/10.1111/jocn.15454

Noble, H., & Heale, R. (2019). Triangulation in research, with examples. *Evidence-based nursing*, *22*(3), 67–68. https://doi.org/10.1136/ebnurs-2019-103145

Nordfonn, O. K., Morken, I. M., Bru, L. E., & Husebø, A. M. L. (2019). Patients' experience with heart failure treatment and self-care—a qualitative study exploring the burden of treatment. *Journal of clinical nursing*, *28*(9-10), 1782–1793. https://doi.org/10.1111/jocn.14799

Normand, M. P., & Bober, J. (2020). Health coaching by behavior analysts in practice: How and why. *Behavior Analysis: Research and Practice*, *20*(2), 108–119. https://doi.org/10.1037/bar0000171

Nussbaum, M. C. (2001). *Women and Human Development: The Capabilities Approach*. Cambridge University Press.

Okiakaose, H. (2018). Organisational culture and dynamics. *Global Journal of Management and Business Research (A)*, *18*(1), 1–8. https://pdfs.semanticscholar.org

Olsen, J. M., & Nesbitt, B. J. (2010). Health coaching to improve healthy lifestyle behaviors: An integrative review. *American Journal of Health Promotion*, *25*(1), e1–e12. https://doi.org/10.4278/ajhp.090313-LIT-101

Ott-Holland, C. J., Ryan, A. M., & Shepherd, W. J. (2019). Examining wellness programs over time: Predicting participation and workplace outcomes. *Journal of Occupational Health Psychology*, *24*(1), 163–179. https://doi.org/10.1037/ocp0000096

Oye, C., Dahl, H., Sørensen, N. O., & Glasdam, S. (2019). Tight ties in collaborative health research puts research ethics on trial? A discussion on autonomy, confidentiality, and integrity in qualitative research. *Qualitative Health Research. 29*(9), 1227–1235. https://doi.org/10.1177/1049732318822294

Palinkas, L. A., Mendon, S. J., & Hamilton, A. B. (2019). Innovations in mixed methods evaluations. *Annual Review of Public Health, 40*, 423–442. https://doi.org/10.1146/annurev-publhealth-040218-044215

Partridge, S. R., Howse, E., Llewellyn, G., & Allman-Farinelli, M. (2018). Adequacy of Data Sources for Investigation of Tertiary Education Student's Wellbeing in Australia: *A Scoping Review. Healthcare*, *6*(4), 136. https://doi.org/10.3390/healthcare6040136

Pascual, J. S. G., Ignacio, K. H. D., & Khu, K. J. O. (2021). Paving the path to wellness: A systematic review of wellness program for neurosurgery trainees. *World Neurosurgery*, *152*, 206–213. https://doi.org/10.1016/j.wneu.2021.06.047

Passey, D. G., Brown, M. C., Hammerback, K., Harris, J. R., & Hannon, P. A. (2018). Managers' support for employee wellness programs: An integrative review. *American Journal of Health Promotion, 32*(8), 1789–1799. https://doi.org/10.1177/0890117118764856

Perrault, E. K., Hildenbrand, G. M., & Rnoh, R. H. (2020). Employees' refusals to participate in an employer-sponsored wellness program: Barriers and benefits to

engagement. *Compensation & Benefits Review*, *52*(1), 8-18. https://doi.org/10.1177/0886368719899209

Pavlou, P. A., & Fygenson, M. (2006). Understanding and predicting electronic commerce adoption: An extension of the theory of planned behavior. *MIS Quarterly*, *30*(1), 115–143. https://ce.sharif.ac.ir/

Payne, J., Cluff, L., Lang, J., Matson-Koffman, D., & Morgan-Lopez, A. (2018). Elements of a workplace culture of health, perceived organizational support for health, and lifestyle risk. *American Journal of Health Promotion*, *32*(7), 1555–1567. https://doi.org/10.1177/0890117118758235.

Peñalvo, J. L., Sagastume, D., Mertens, E., Uzhova, I., Smith, J., Wu, J. H., Bishop, E., Onopa, J., Shi, P., Micha, R., & Mozaffarian, D. (2021). Effectiveness of workplace wellness programmes for dietary habits, overweight, and cardiometabolic health: A systematic review and meta-analysis. *The Lancet Public Health*, *6*(9), 648–660. https://doi.org/10.1016/S2468-2667(21)00140

Peng, J.-C., & Tseng, M.-M. (2018). Antecedent and consequence of nurse engagement. *The Journal of Psychology*, *153*(3), 342–359. https://doi.org/10.1080/00223980.2018.1536639

Perrault, E. K., Hildenbrand, G. M., & Rnoh, R. H. (2020). Employees' refusals to participate in an employer-sponsored wellness program: Barriers and benefits to engagement. *Compensation & Benefits Review*, *52*(1), 8–18. https://doi.org/10.1177/0886368719899209

Person, A. L., Colby, S. E., Bulova, J. A., & Eubanks, J. W. (2010). Barriers to participation in a worksite wellness program. *Nutrition Research and Practice, 4*(2), 149 –154. https://doi.org/10.4162/nrp.2010.4.2.149

Pickett, S. A., Diehl, S. M., Steigman, P. J., Prater, J. D., Fox, A., Shipley, P., Grey, D. D., & Cook, J. A. (2012). Consumer empowerment and self-advocacy outcomes in a randomized study of peer-led education. *Community Mental Health Journal, 48*(4), 420–430. https://doi.org/10.1007/s10597-012-9507-0

Protection of Human Subjects 45 C.F.R. §46 (2009). *Code of Federal Regulations.* https://www.govinfo.gov/content/pkg/CFR-2016-title45-vol1/pdf/CFR-2016-title45-vol1-part46.pdf

Purwanti, P., & Sitorus, M. (2018). Factors That Affect Employee Productivity (Case Study at PT. Sagami Indonesia). *Journal of Management Science (JMAS), 1*(1), 7–11. https://exsys.iocspublisher.org/index.php/JMAS

Qaisar, M. N., Mariam, S., & Ahmad, F. (2018). Employee wellness as predictor of productivity from public sector management perspectives: Conditional process analysis. *NUML International Journal of Business & Management, 13*(2), 104–116. Retrieved from https://ezp.waldenulibrary.org

Quelch, J., & Boudreau, E. (2016). *Building a Culture of Health: A New Imperative for Business*. Springer.

Quirk, H., Crank, H., Carter, A., Leahy, H., & Copeland, R. J. (2018). Barriers and facilitators to implementing workplace health and wellbeing services in the NHS

from the perspective of senior leaders and wellbeing practitioners: a qualitative study. *BMC public health*, *18*(1), 1-14. https://doi.org/10.1186/s12889-018-6283-y

Rashid, Y., Rashid, A., Warraich, M. A., Sabir, S. S., & Waseem, A. (2019). Case study method: A step-by-step guide for business researchers. *International journal of qualitative methods*, *18*, 1–13. https://doi.org/10.1177/16094069198624

Rayner, H. M., & Wadhwa, R. (2021). *Communication training tools in medical simulation*. StatPearls Publising. https://www.ncbi.nlm.nih.gov/books/NBK560868/

Renjith, V., Yesodharan, R., Noronha, J. A., Ladd, E., & George, A. (2021). Qualitative Methods in Health Care Research. *International Journal of Preventive Medicine*, *12*(2), 1–7. https://doi.org/10.4103/ijpvm.IJPVM_321_19

Ripp, J., & Shanafelt, T. (2020). The Health Care Chief Wellness Officer: What the role is and is not. *Academic Medicine*, *95*(9), 1354–1358. https://doi.org/10.1097/ACM.0000000000003433

Roemer, E. C., Kent, K. B., Mummert, A., McCleary, K., Palmer, J. B., Lang, J. E., Matson Koffman, D. M., & Goetzel, R. Z. (2019). Validity and reliability of the updated CDC Worksite Health ScoreCard. *Journal of Occupational and Environmental Medicine*, *61*(9), 767–777. https://doi.org/10.1097/JOM.0000000000001660

Rose, J., & Johnson, C. W. (2020). Contextualizing reliability and validity in qualitative research: Toward more rigorous and trustworthy qualitative social science in leisure research. *Journal of Leisure Research*, *51*(4), 432–451. https://doi.org/10.1080/00222216.2020.1722042

Ruvalcaba, C., Akdevelioglu, D., & Schroeder, J. (2022). Stakeholders as value creators: The role of multi-level networks in employee wellness programs. *Journal of Macromarketing, 42(*3). 414–432. https://doi.org/10.1177/02761467221084626

Ryan, T., Rice, V., J. Saunders, J., & Limbrick, S. (2018). Measuring the effectiveness of workplace health management programs: An Australian example. *Preventive Medicine Reports. 11*, 56–62. https://doi.org/10.1016/j.pmedr.2018.04.018

Sahadi, J. (2018). Warren Buffet is right: Health care costs are swallowing the economy. *CNN Money*. https://money.cnn.com/2018/01/30/news/economy/health-care-costs-eating-the-economy/index.html

Saks, A. M. (2019). Antecedents and consequences of employee engagement revisited. *Journal of Organizational Effectiveness: People and Performance*, *6*(1), 19–38. https://doi.org/10.1108/JOEPP-06-2018-0034

Sandelowski, M. (1995). Qualitative analysis: what it is and how to begin. *Research in Nursing and Health*, *18*(4), 371–375. https://doi.org/10.1002/nur.4770180411

Sandercock, V., & Andrade, J. (2018). Evaluation of worksite wellness nutrition and physical activity programs and their subsequent impact on participants body

composition. *Journal of Obesity, 8*(1), 1–14. https://doi.org/10.1155/2018/1035871

Sanghavi, K., Cohn, B., Prince, A. E. R., Gregory, F. W., Ryan, K. A., Spector-Bagdady Kayte, Uhlmann, W. R., Lee, C., Scott, R. J., & Mathews Debra, J. H. (2022). Voluntary workplace genomic testing: wellness benefit or Pandora box? *NPJ Genomic Medicine, 7*(5), 1–6. https://doi.org/10.1038/s41525-021-00276-8

SantaBarbara, N., Rezai, R., Terry, E., Shedd, K., & Comulada, W. S. (2022). Preliminary efficacy and acceptability of an online exercise and nutrition workplace wellness program: A brief report. *Workplace Health & Safety, 70*(2), 90–96. https://doi.org/10.1177/21650799211037528

Santos, K. D. S., Ribeiro, M. C., Queiroga, D. E. U. D., Silva, I. A. P. D., & Ferreira, S. M. S. (2020). The use of multiple triangulations as a validation strategy in a qualitative study. *Ciência & Saúde Coletiva, 25*, 655–664. https://doi.org/10.1590/1413-81232020252.12302018

Sartorius, N. (2006). The meanings of health and its promotion. *Croatian Medical Journal, 47*(4), 662–664. https://content.ebscohost.com

Saunders, M. N. K., Lewis, P., & Thornhill, A. (2019). *Research methods for business students* (8th ed.). Pearson Education Limited.

Saunders, R., Vulimiri, M., Japinga, M., Bleser, W., & Wong, C. (2019). *Are carrots good for your health? Current evidence on health behavior incentives in the Medicaid program*. Duke Margolis Center for Health Policy. Accessed.

Scarlat, M. M., Sun, J., Fucs, P., Giannoudis, P., Mavrogenis, A. F., Benzakour, T., Quaile, A., & Waddell, J. P. (2020). Maintaining education, research and innovation in orthopaedic surgery during the COVID-19 pandemic. The role of virtual platforms. From presential to virtual, front and side effects of the pandemic. *International Orthopaedics (SICOT), 44*, 2197–2202. https://doi.org/10.1007/s00264-020-04848-8

Schwatka, N. V., Smith, D., Weitzenkamp, D., Atherly, A., Dally, M. J., Brockbank, C. V., Tenney, L., Goetzel, R. Z., Jinnett, K., McMillen, J., & Newman, L. S. (2018). The impact of worksite wellness programs by size of business: A 3-year longitudinal study of participation, health benefits, absenteeism, and presenteeism. *Annals of work exposures and health, 62*(Suppl_1), S42–S54. https://doi.org/10.1093/annweh/wxy049

Sears, J. M., Edmonds, A. T., Hannon, P. A., Schulman, B. A., & Fulton-Kehoe, D. (2022). Workplace wellness program interest and barriers among workers with work-related permanent impairments. *Workplace Health & Safety*, *20*(10), 1–10. https://doi.org/10.1177/21650799221076872

Shanafelt, T., Trockel, M., Rodriguez, A., & Logan, D. (2021). Wellness-centered leadership: Equipped health care leaders to cultivate physician well-being amd professional fulfillment, *Academic Medicine: Journal of the Association of American Medical College*, *96*(5), 641–651. https://doi.org/10.1097/ACM.00000000000003907

Shepherd, E., & Griffiths, A. (2021). *Investigative interviewing. The conversation management approach* (2nd ed.). Oxford University Press.

Shuck, B., Hart, J., Walker, K., & Keith, R. (2021). Work determinants of health: New directions for research and practice in human resource development. *Human Resources Development Quarterly*, *3*(1), 1–18. https://doi.org/10.1002/hrdq.21468

Sim, J., & Waterfield, J. (2019). Focus group methodology: some ethical challenges. *Quality and Quantity*, *53*(6), 3003–3022. https://doi.org/10.1007/s11135-019-00914-5

Smith, M. L., Wilson, M. G., Robertson, M., Padilla, H. M., Zuercher, H., Vandenberg, R., Corso, P., Lorig, K., Laurent, D. D., & DeJoy, D. M. (2018). Impact of a translated disease self-management program on employee health and productivity: Six-month findings from a randomized controlled trial. *International Journal of Environmental Research & Public Health*, *15*(5), 851. https://doi.org/10.3390/ijerph15050851

Soldano, S. K. (2016). Workplace wellness programs to promote cancer prevention. *Seminars in Oncology Nursing*, *32*(3), 281–290. https://doi.org/10.1016/j.soncn.2016.05.008

Solnet, D., Subramony, M., Golubovskaya, M., Snyder, H., Gray, W., Liberman, O., & Verma, R. (2020). Employee wellness on the frontline: An interactional

psychology perspective. *Journal of Service Management*, *31*(5), 939–952. https://doi.org/10.1108/JOSM-12-2019-0377

Son, S., & Kim, D. Y. (2021). Organizational career growth and career commitment: Moderated mediation model of work engagement and role modeling. *The International Journal of Human Resource Management*, *32*(20), 4287–4310. https://doi.org/10.1080/09585192.2019.1657165

Song, Z., & Baicker, K. (2019). Effect of a workplace wellness program on employee health and economic outcomes: A randomized clinical trial. *JAMA*, *321*(15), 1491–1501. https://doi.org/10.1001/jama.2019.3307

Sotto-Santiago, S., Ansari-Winn, D., Neal, C., & Ober, M. (2021). Equity + wellness: A call for more inclusive physician wellness efforts. *MedEdPublish*, *10*, 1–9. https://doi.org/10.15694/mep.2021.000099.1

Ståhl, T. (2018). Health in All Policies: From rhetoric to implementation and evaluation–the Finnish experience. *Scandinavian Journal of Public Health*, *46*(20), 38-46. https://doi.org/10.1177/1403494817743895

Stan, O. M. (2018). Steps towards sustainability-human resource capital and employee wellbeing–benchmarking evidence. *Economics, Management and Financial Markets*, *13*(3), 290-300.

Stephens, K. K., & Harrison, M. A. (2017). Work as opportunity and problem when trying to impact health and risk perceptions. In R. Parrott (Ed.), *Encyclopedia of health and risk message design and processing*. Oxford University Press.

Stiehl, E., Bales, S. L., Jenkins, K. R., & Sherman, B. W. (2022). Unique Barriers to Workplace Health Promotion Programs by Wage Category: A Qualitative Assessment of Secondary Data. *American Journal of Health Promotion*, *36*(5), 843–852. https://doi.org/10.1177/08901171211069546

Substance Abuse and Mental Health Services Administration. (2017). *Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health* (HHS Publication No. SMA 17–5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/

Schwatka, N. V., Dally, M., Shore, E., Dexter, L., Tenney, L., Brown, C. E., & Newman, L. S. (2021). Profiles of total worker health® in United States small businesses. *BMC Public Health*, *21*(1), 1–11. https://doi.org/10.1186/s12889-021-11045-8

Szrek, H., Gyster, V., Darnowsky, P., & Farias, A. R. (2019). Messaging, monetary incentives, and participation in wellness programs. *International Journal of Workplace Health Management*, *12*(5), 289–297. https://doi.org/10.1108/IJWHM-11-2018-0148

Teixeira, P. J., & Marques, M. M. (2017). Health behavior change for obesity management. *Obesity facts*, 10(6), 666-673. https://doi.org/10.1159/000484933

Terry, P. E. (2020). Health promotion that saves people and the planet and an

interview with Dr. Sara Singer. *American Journal of Health Promotion, 34*(1), 9–14. https://doi.org/10.1177/0890117119888114

Theofanidis, D., & Fountouki, A. (2018). Limitations and delimitations in the research process. *Perioperative Nursing*, *7*(3), 155–163. https://doi.org/10.5281/zeno.2552022

Tobi, H., & Kampen, J. K. (2018). Research design: the methodology for interdisciplinary research framework. *Quality & Quantity*, *52*(3), 1209–1225. https://doi.org/10.1007/s11135-017-0513-8

Torres, E. N., & Zhang, T. (2021). The impact of wearable devices on employee wellness programs: A study of hotel industry workers. *International Journal of Hospitality Management, 93*, 1–10. https://doi.org/10.1016/j.ijhm.2020.102769

U.S. Bureau of Labor Statistics, The Economics Daily. (2017). *Employee access to wellness programs in 2017*. Self. https://www.bls.gov/opub/ted/2018/employee-access-to-wellness-programs-in-2017.htm

U.S. Department of Health and Human Services. (1979). *The Belmond Report, Ethical Principles and Guidelines for the Protection of Human Subjects of Research.* Washington, DC. Retrieved from: https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html

U.S. Department of HHS, Center for Medicare and Medicaid Services. (2019). *Insurance standards bulletin series: Opportunity for states to participate in a wellness program demonstration project to implement health-contingent wellness program*

in the individual market. Washington, DC: Retrieved from: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Wellness-Program-Demonstration-Project-Bulletin.pdf

U.S. Federal Registry. (2017). Federal Policy or the Protection of Human Subjects. *The Daily Journal of the United States Government, 82*(12), 7149–7274. https://www.govinfo.gov/content/pkg/FR-2017-01-19/pdf/2017-01058.pdf

U.S. Food and Drug Administration. (2019). *Guidance for Institutional Review Boards and Clinical Investigators.* Self. https://www.fda.gov/regulatory-information/search-fda-guidance-documents/institutional-review-boards

Vale, M. J., Jelinek, M. V., Best, J. D., Dart, A. M., Grigg, L. E., Hare, D. L., Ho, B. P., Newman, R. W., & McNeil, J. J. (2003). Coaching patients On Achieving Cardiovascular Health (COACH): a multicenter randomized trial in patients with coronary heart disease. *Archives of Internal Medicine, 163*(22), 2775–2783. https://doi.org/10.1001/archinte.163.22.2775

VanderWeele, T. J. (2017). On the promotion of human flourishing. *Proceedings of the National Academy of Sciences, 114*(31), 8148–8156. https://doi.org/10.1073/pnas.1702996114

Vanness, D. J., Lomas, J., & Ahn, H. (2021). A Health Opportunity Cost Threshold for Cost-Effectiveness Analysis in the United States. *Annals of Internal Medicine, 174*(1), 25–32. https://doi.org/10.7326/M20-1392

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterizing and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology*, *18*(1), 1–18. https://doi.org/10.1186/s12874-018-0594-7

Vecchi, M., Elf, P., Ueno, A., Dilmperi, A., Dennis, C., & Devereux, L. (2022). EXPRESS: Shall we dance? Recreational dance, well-being and productivity performance during COVID-19: A three-country study. *Journal of International Marketing*, *30*(2), 56–72. https://doi.org/10.1177/1069031X221079609

Vrij, A., & Leal, S. (2020). Proportion of complications in interpreter-absent and interpreter-present interviews. *Psychiatry, Psychology and Law*, *27*(1), 155–164. https://doi.org/10.1080/13218719.2019.1705197

Wiederhold, B. K., Cipresso, P., Pizzioli, D., Wiederhold, M., & Riva, G. (2018). Intervention for physician burnout: A systematic review. *Open Medicine*, *13*, 253–263. https://doi.org/10/1515/med-2018-0039

Williams, D. F., Chen-Bowers, N., Lankford, T., & Wolff, M. B. (2019). Designing an organizational profile to inform leadership of employee well-being. *EASNA Research Note*, *7*(3), 1–9. https://hdl.handle.net/10713/8849

Williams, M., & Moser, T. (2019). The art of coding and thematic exploration in qualitative research. *International Management Review*, *15*(1), 45–55.

Wilson, M. G., DeJoy, D. M., Vandenberg, R. J., Padilla, H. M., Haynes, N. J., Zuercher, H., Corso, P., Lorig, K., & Smith, M. L. (2021). Translating CDSMP to the

workplace: Results of the Live Healthy Work Healthy Program. *American Journal of Health Promotion, 35*(4), 491–502. https://doi.org/10.1177/0890117120968031

Wolever, R. Q., Simmons, L. A., Sforzo, G. A., Dill, D., Kaye, M., Bechard, E. M., Southard, M. E., Kennedy, M., Vosloo, J., & Yang, N. (2013). A systematic review of the literature on health and wellness coaching: Defining a key behavioral intervention in healthcare. *Global Advances in Health and Medicine*, *2*(4), 38–57. https://doi.org/10.7453/gahmj.2013.042

World Economic Forum. (2019). *The Global Risks Reports 2019 14th ed.*, Marsh & McLennan Companies and Zurich Insurance Group. https://www.weforum.org/events/the-davos-agenda-2021

World Health Organization (WHO). (1948). *Preamble to the Constitution of the WHO* as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the WHO, no. 2, p. 100) and entered into force on 7 April 1948. https://www.who.int/governance/eb/who_constitution_en.pdf

World Health Organization. (2014). *Health in All Policies (HiAP) Framework for Country Action*. https://www.who.int/cardiovascular_diseases/140120HPRHiAPFramework.pdf

Wu, A. W., Connors, C., & Everly, G. S., Jr. (2020). COVID-19: Peer support and crisis communication strategies to promote institutional resilience. *Annals of Internal Medicine*, *172*(12), 822–823. https://doi.org/10.7326/M20-1236

Yeung, O., & Johnston, K. (2016). The future of wellness at work. Global Wellness Institute, 1-103. https://globalwellnessinstitute.org/wp-content/uploads/2018/06/GWI_2016_Future_of_Wellness_at_Work.pdf

Yin, R. K. (2018). *Case Study Research and Applications: Design and Methods* (6th. ed.). Sage.

Yong, J. Y., Yusliza, M., Ramayah, T., Chiappetta Jabbour, C. J., Sehnem, S., & Mani, V. (2020). Pathways towards sustainability in manufacturing organizations: Empirical evidence on the role of green human resource management. *Business Strategy & the Environment (John Wiley & Sons, Inc)*, 29(1), 212–228. https://doi.org/10.1002/bse.2359

Zhang, Y., Ramanathan, L., & Maheswari, M. (2021). A hybrid approach for risk analysis in e-business integrating big data analytics and artificial intelligence. *Annals of Operations Research*, 1–19. https://doi.org/10.1007/s10479-021-04412-6

Appendix A: Letter of Intent

Dear Invitee,

My name is Lymari Rentas Gonzalez. I am a Doctoral Student at Walden University, School of Management and Information System. I am kindly requesting your participation in my Doctoral study named: Wellness Program: Strategies for Increasing Employee's Productivity and Reducing Health Care Costs. The study intends to successfully identify strategies that executives and leaders of the organizations implemented to motivate their employees toward healthy habits, impacting the productivity of the employees and reducing healthcare costs.

The study consists in completing a semistructured interview question via Zoom, Blue jeans, or Skype with an approximate duration time of 45minutes to One-hour, which will be recorded for the research. In addition, once the interview transcript is prepared, the participant will be able to read them for validation and accuracy of information.

Participation in this study is entirely voluntary, and you may withdraw at any moment. The study cannot be anonymous, but the researcher is required to protect your privacy, and your identity will be kept confidential within the limits of the law. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. If the researcher were to share this dataset with another researcher in the future, the researcher must remove all names and identifying details before sharing.

If you would like to participate in this study, please reply to this enclosed e-mail acknowledging the reading and understanding of the Consent Form as acceptance of the invitation to participate in the Research Study.

Respectfully,

Lymari Rentas Gonzalez, M.B.A, CICA, CCA, EA

Appendix B: Interview Protocol

Participant Name:

Organization:

Number od Sample:

You are invited to take part in a research study about workplace wellness programs and strategies for increasing employee's productivity and reducing healthcare costs. The researcher is inviting participants with the following characteristics:

- health care organizational leaders, including executives and managers,
- located in the southern region of the United States,
- identify in the list of 100 healthiest employees during the years 2019 and 2020 by Healthiest Employees LLC.

This study is being conducted by a researcher named Lymari Rentas González, who is a Doctorate Student at Walden University.

Background Information:

The purpose of the study is to identify cost-effective strategies that executives in the private sector implement to align their employees with healthy habits for increasing employee productivity and lowering organization healthcare costs.

Procedure:

This study involves the following steps:

1. take part in a confidential, audio recorded interview (1 hour),
2. read and review the participant consent signed via email correspondence,
3. address any concern or questions that the participant could have,
4. initiate the interview process and data gathering with the participants through predetermined questions and follow-up questions,
5. reading the closing script,
6. check of participant status and contact information,

7. close the interview and ascertain appreciation and thank the participant

Announce of Recording of Interview

Per described in the consent form, this interview will be recorded for purpose of data collection for the Doctoral Study described in the background information. The expected duration of the interview will be one hour and the recording is starting at this moment.

Form of Consent and Address Concerns of Participants:

Read the form of consent out loud submitted by participant for purpose of acknowledge.

Interview Questions:

1. What cost-effective strategies motivated the employees toward healthy habits?

2. What is the role of an executive in aligning employees toward healthy habits?

3. Based on experience, how does employee health influence organizational performance, as measured by productivity, profitability, and other metrics? What are some other thoughts?

4. How was the success of these cost-effective strategies measured and implemented to align employees toward healthy habits?

5. What were some of the key barriers to implementing these cost-effective strategies to align employees toward healthy habits?

6. How were the key barriers associated with implementing cost-effective strategies to align employees toward healthy habits addressed?

7. Is there additional information about the organization’s strategies for increasing employees’ productivity and reducing health care costs?

Closing Script:

Mr./Ms. ____, if there is no additional questions, we are going to concluded our interview for purpose of collecting data for the doctoral research study related to identify cost-effective strategies that executives in the private sector implement to align their employees with healthy habits for increasing employee productivity and lowering organization healthcare costs.

Please, let me validate that we have your contact information correctly, in order to send the transcripts of the interview for purpose of review and additional thoughts that will need to be added.

Thank you for your participation and providing insightful information of your experience and perspective with cost-effective strategies to align their employees with health habits for increasing employee productivity and lowering organization healthcare costs.