A 7-STEP STRATEGY FOR THE IMPLEMENTATION OF WORKSITE LIFESTYLE INTERVENTIONS: HELPFUL OR NOT?

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CHAPTER 6

ABSTRACT

Objective: To evaluate the use of and adherence to a 7-step strategy for the development, implementation and continuation of a comprehensive, multi-component lifestyle program.

Methods: Strategy use and adherence was assessed with twelve performance indicators. Data was collected by combining onsite monitoring with semi-structured interviews at baseline and follow-up (6, 12 and 18 months).

Results: Not all performance indicators were met so partial strategy adherence was obtained. The strategy could be improved on the following aspects: support among management, project structure, adaptation to needs of employees, planning and maintenance.

Conclusions: The results of this evaluation indicate that strategy adherence facilitated structured development and implementation. Based on the qualitative data this study suggest that when improvements will be made on both the content and performance, the 7-step strategy could be an effective tool to successfully implement a multi-component WHPP.
BACKGROUND

An unhealthy lifestyle is associated with overweight and obesity, which in turn are associated with lower productivity and higher sickness absence [1, 2]. A worksite health promotion program (WHPP) may effectively contribute to favorable lifestyle change and may contribute to company cost cuts, but successful implementation of such a WHPP remains a challenge. However, despite evidence for the effectiveness of WHPP’s in positively changing employees’ lifestyle [3-8], such programs are still not common practice in Dutch organizations. Implementation strategies that address the concerns and barriers of all stakeholders on all organizational levels may increase the uptake and sustainability of WHPP, thereby promoting the actual impact that interventions may have [9-11].

Literature applies many different terms and definitions for ‘implementation research’. In the present study we adopted Curran’s (2012) definition of implementation: “an effort specifically designed to get best practice findings and related products into routine and sustained use through appropriate uptake/adoption of interventions” [12]. Our main objective was to study the use of a 7-step implementation strategy, which was proposed by Wynne and Clarkin (1992). The 7-step strategy is developed based on the results of a survey among 1500 European companies across seven countries questioning the company’s health policies, worksite health promotion activities and case studies of good practices [13, 14]. The 7-step strategy provided means to systematically develop, implement and maintain health promotion programs at the workplace by addressing each of the following elements: 1) creating solid support, 2) formation of a project structure, 3) performing a needs assessment, 4) development of interventions, 5) implementation of interventions, 6) evaluation, and 7) maintenance.

The main focal point of this strategy is that it employs a ‘user-driven’ approach towards developing and implementing worksite health interventions. User driven means that employees and managers from different organizational levels are actively involved in the development and implementation process. By as project members going through the steps, ownership is stimulated and a fit with existing capacity, needs and values is ensured [15]. It is hypothesized that application of the 7-step strategy should ensure that developed and implemented interventions will be tailored to the needs of different stakeholders within a worksite. Thereby enhancing implementation success and ensuring the integration of implemented interventions in the organizations general occupational health policy. Currently the strategy is supported by the European Foundation for the Improvement of
living and Working Conditions [13]. However, to our knowledge it has never been evaluated whether such a strategy actually facilitates implementation.

Besides this gap in knowledge, studies evaluating WHPP mainly address the programs’ effectiveness, generally neglecting a systematic effort to gain insight into factors that either hinder or facilitate the implementation process. Therefore, the aim of this process evaluation is to describe the use of and adherence to the 7-step strategy and to assess whether this was associated with the development, implementation and continuation of a comprehensive, multi-component lifestyle program (i.e. physical activity, smoking, alcohol use, nutrition and relaxation).

**METHODS**

The process evaluation of the use of and adherence to the 7-step implementation strategy was carried out as part of the BRAVO@Work project, in which by means of a quasi-experimental design also the behavioral effects of the program were examined. The Medical Ethics Committee of the University Medical Centre of Utrecht approved the study protocol. Details of the study have been published elsewhere [16].

**Study participants and setting**

The implementation strategy was evaluated within the context of two different settings: an Academic Hospital and a University of Applied Sciences (hereinafter “the hospital” and “the university”) in Utrecht (the Netherlands). Both worksites were recruited in 2009-2010 through the personal network of the researchers. The upper management of the organizations signed a letter of intent stating that they were willing to participate in the study and that they agreed to the financial and organisational consequences of participating in BRAVO@Work. The population under study in this paper are the project members who were responsible for using and adhering to the 7-step strategy and thus for implementing the program in their respective organizations. Data was collected prior to implementation and 6, 12 and 18 months after implementation of the interventions. Interventions were implemented during one year. In addition, a researcher on site (referred to as the “embedded” researcher) continuously monitored the natural course of implementation of the BRAVO interventions, but without being actively involved in the development and implementation of the interventions.
The BRAVO@Work study

In the BRAVO@Work study both intervention departments used a 7-step implementation strategy to develop, implement and maintain interventions targeting multiple lifestyle behaviours. As mentioned earlier this strategy is based on a study in 1992 by Wynne and Clarkin [13] in which they determined five important aspects for successfully implementing a health policy at the workplace: A) Needs assessment: for the establishment of a health policy it is important that the wishes and needs of employees are analyzed. In this way, the intervention activities can be developed according to their needs; B) Participation: key figures from different levels in the company’s organization need to be involved in the development and implementation of the health promotion program to create a solid support for the health policy. This can be done by means of working groups; C) Flexibility: health promotion programs are similar at some basic points. However, they are not standard programs, since a WHPP needs to fit the specifics of the workplace; D) Integration: the health promotion program needs to include activities that are both aimed at the individual employee and at the work environment; and E) Multidisciplinary: several experts in the fields of human resources, communication, health management, psychology and working environment need to be involved in the development and implementation to increase program effectiveness. Wynne and Clarkin translated these five aspects into a generic 7-step implementation strategy for the systematic development and implementation of health promotion programs at the workplace [13, 14]. The implementation strategy consists of the following 7 steps: 1) creating solid support, 2) formation of basic structures, 3) performing a needs assessment, 4) development of the interventions and health policy, 5) implementation of the interventions, 6) evaluation of the implemented interventions, and 7) embedding the interventions in the general occupational health policy of the organization (table 1) [16].

The 7-step strategy was used to develop and implement interventions related to multiple lifestyle behaviors (i.e. BRAVO-interventions) at the worksite and to integrate these lifestyle interventions in the company’s general health policy. The main aspect of this strategy is the active participation of relevant stakeholders when passing through the 7 steps. So, the intervention departments had the sole responsibility for the development, implementation and continuation of the interventions and the researchers acted solely as embedded observers throughout the study. To ensure that the companies used the 7-step strategy, an external advisor from the Dutch Institute for Sport and Physical Activity (www.nisb.nl) was appointed. He informed the project groups of both organizations about the content and purpose of the strategy during the first project meetings. Additionally, all members received
the research proposal outlining the strategy. The external advisor was present during all project meetings to answer questions and to provide guidance, but he was specifically briefed to refrain from taking the lead at any time during the project.

In short, the 7-step strategy states that the upper management of both participating organisations was required to form their own steering committee and to appoint a project leader. The project leader was then required to establish a project group and was advised to include the following relevant stakeholders: managers and employees from different teams, a communications officer, a human resources officer, a facility manager and a company physician. Managers and employees were eligible for project membership if they were working at the intervention department. With guidance from the external advisor, the project members needed to conduct a needs assessment among all employees in their intervention department. Based on the outcome of the needs assessment and a list of evidence-based interventions, the project groups needed to select interventions fitting employees’ and organizational needs. The project leader then needed to draw up a project plan with the aim to facilitate implementation by means of describing the desired changes and project goals, the interventions, a timeline, a budget plan and persons involved, including their tasks and responsibilities. After approval had been given by the steering committees, the project groups needed to implement the interventions during the following 12 months. After the intervention year, the project groups needed to evaluate the project. This evaluation was the basis for the go/no-go decision about whether or not to embed the programme or specific interventions into the organizations general health policy.

The process evaluation

Following our own conceptual framework for process evaluations, we focussed on assessing fidelity to gain insight in the use and adherence to each step of the 7-step implementation strategy [16-19]. The complete theoretical framework has been described in more detail elsewhere [16].

Fidelity refers to the extent to which the 7-step strategy was used according to protocol. Strategy adherence by project members was assessed from the onsite monitoring and semi-structured interviews that included twelve performance indicators (PIs) found relevant by the research team (Table 1). PIs can be used to assess whether the most important recommendations of the 7-step strategy were carried out by the project members. Each PI that was met received a score 1, corresponding with strategy adherence for that PI. Each PI that was partly met received a score between 0 and 1, corresponding with partial strategy adherence in which not all relevant aspects of that PI were met. Each PI that was not met
received a score 0, reflecting no strategy adherence. An overall performance indicator for the whole strategy was calculated based on the average of all individual PIs, for which a higher overall performance score corresponded with higher strategy adherence [20]. The principal investigator (DW) was responsible for the initial scoring of each PI. One meeting was organized between researchers (DW, LE and PE) to discuss interpretation of the data to enhance the validity of the interpretation of the findings. In all cases consensus was reached by discussion.

**Data collection**

Data on fidelity were obtained among project members from both worksites by semi-structured interviews and by onsite monitoring.

The semi-structured interviews with all project members were held at baseline (T0; hospital n=8; university n=8), at T1 (hospital n=6; university n=11) and at T2 (hospital n=3; university n=7). The interviews were designed to gain more in-depth insight into the use of and adherence to the 7-step strategy and to address the PIs. At 18-months follow-up (T3), the project leaders of both organisations were contacted for a telephone interview to assess programme maintenance. All project members were invited through email for participation in the interviews. The principal investigator (DW) conducted all interviews during a telephone interview or face-to-face meeting at a time and location convenient for the participants. Prior to the start of the interview, all participants were informed about the purpose of the study and were reassured about confidentiality. All participants granted oral permission for recording the interview. All interviews were recorded and transcribed verbatim. Interviews with project members lasted 28 minutes on average (range: 10 – 56 minutes). An interview protocol was used including questions and prompts to guide the interview. The first open-ended question in interviews with project members was “How did you experience the implementation of the project so far?” Possible follow-up questions then included “What are in your opinion, positive points within the project?”, “What are points of improvement?”, and “How did you experience your participation in the project group so far?”. Field notes were written during the interviews regarding issues that could be relevant at the analytical stage.

Throughout the study period, an embedded researcher (DW) continuously monitored the implementation process by documenting relevant e-mail communications, minutes of project meetings and observations in pre-defined spread sheets (i.e. onsite monitoring). These sheets were developed before onset of the study and were based on the PIs and conceptual framework [16].
Data analysis

Data from the semi-structured interviews were analyzed using the constant comparative method, in which each item is checked or compared with the rest of the data to inductively establish analytical categories [21, 22]. First, transcripts and field notes were read to get a general understanding of the concepts under study and to get some insight into the dynamics of the interviews. Using MAXQDA version 11 (VERBI GmbH, Berlin, Germany), transcripts were then open-coded by the primary researcher (DW). That is, transcripts were read line by line and relevant passages were marked with a series of codes from text and from literature about the specific topic, with the goal to describe the content of the interviews. Interview codes included both “descriptive” (i.e. within the immediate domain of the interview questions) and “analytic” (i.e. emerging and overarching themes) codes. Throughout the coding process, continuous efforts were made to detect further examples of previously identified codes/themes and, if applicable, to identify new ones [21-25]. Second, all codes were grouped into central concepts underlying the descriptive and analytical codes, thereby making them more workable. These concepts were then categorized into themes in order to identify patterns and relationships between concepts. These themes were partly identified in advance based on literature [9, 10], but were also derived from the data. Various meetings between researchers (DW, LE and PE) were held over the course of data analysis in which identified codes, identified concepts, identified themes, and interpretations of the data were checked and discussed to enhance the robustness of the findings. In all cases consensus was reached through discussion.

RESULTS

Strategy adherence was assessed with twelve performance indicators (PIs) that reflect the use of the 7-step strategy. The PIs and their corresponding scores are presented in table 1. Based on the study by Wynne and Clarkin [13, 14] it was hypothesized that each PI would contribute to facilitation of program implementation. The overall performance indicator for the University was 0.76 and for the Hospital 0.54 both representing partial strategy adherence. Overall, lowest scores were found for creating support among middle and lower management (PI 2), formation of project structure (PI 3, PI 4 and PI 5), performing a needs assessment (PI 6), develop a project plan (PI 7), and maintenance (PI 11 and PI 12) (see table 1).
The 7-step strategy: helpful or not?

**Table 1.** Performance indicators of strategy adherence, their description and performance score

<table>
<thead>
<tr>
<th>Performance indicator</th>
<th>Required action to meet the performance indicator</th>
<th>Performance score University</th>
<th>Performance score Hospital</th>
</tr>
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</table>

**Step 1: creating solid support**
1. Ensured upper management support
   - Support from upper management was/ ensured by signing a letter of intent and reserving budget. Support from middle and lower management was ensured at start of the project.
   - Performance score: 1
2. Ensured middle and lower management support
   - Performance score: 0

**Step 2: formation of project structure**
3. Formation steering committee
   - A steering committee was installed with a chairman, preferably someone with decision-making authority. The steering committee needs to make the go-no-go decisions, but is not involved in substantive discussions.
   - A project leader was appointed by the chairman.
   - Performance score: 0.5
4. Appointing a project leader
   - A project group was formed that consisted of employees from different layers of the organization (managers, employees, communications officer, human resource staff member, facility management, health and safety executive, company physician) and optional a working group with only employees. These groups were responsible for the substantive development and implementation of the program.
   - Performance score: 1
5. Formation project group and option working group
   - Performance score: 0.5

**Step 3: needs assessment**
6. Perform a needs assessment among employees
   - A needs assessment was performed by the project group in order to map the wishes and needs of employees and managers, by using either a web-based questionnaire, physical examination, focus group sessions or a combination.
   - Performance score: 0.5

**Step 4: development of interventions**
7. Develop a detailed project plan
   - Based on the need assessment and characteristics of the organization, the project leader made a project plan with information about the following aspects:
     - desired changes
     - project goals
     - intervention template
     - timeline and communication plan
     - budget plan
     - list of responsible persons
   - The project plan was presented to the steering committee who decided on the go-no-go criteria of the plan.
   - Performance score: 0.8
8. Official decision on which interventions will be implemented
   - Performance score: 0.3
<table>
<thead>
<tr>
<th>Performance indicator</th>
<th>Required action to meet the performance indicator</th>
<th>Performance score</th>
<th>Performance score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 5: implementation</strong></td>
<td>All developed interventions have been implemented within the organizations.</td>
<td>0.84</td>
<td>0.85</td>
</tr>
<tr>
<td><strong>Step 6: evaluation</strong></td>
<td>During the project an integrative evaluation was part of the process so adjustments to the project plan could be made if necessary.</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Step 7: maintenance</strong></td>
<td>The steering committee needed to determine which interventions would be continued and become part of the organizations general health policy.</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Efforts were made by the steering committee to integrate the implemented interventions in the organizations general health policy.</td>
<td>0.5</td>
<td>0.5</td>
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| Total Performance Score | 0.76 | 0.54 |

*interpretation of performance indicators: score 0 = no strategy adherence, score between 0 and 1 = partial strategy adherence; score 1 = full strategy adherence.*

The interviews as well as the data gathered via monitoring showed that the presence of an external advisor facilitated the use of the 7-step strategy, and hence improved the strategy adherence, as evaluated with the performance indicators. As an interviewee stated:

“The external advisor from the NISB has added, in my opinion, important information and support. He was the expert. That’s needed in this organization because otherwise it would not be a priority and not be on the agenda anymore. Meaning that these project group meetings would not happen and subsequently the entire project. It [the presence of the external advisor] was really an extra reassurance, which was needed in light of all other projects in the organizations. Otherwise it would have collapsed”. [University_P10 T1]

Data from onsite monitoring and interviews showed that support from middle and lower management (i.e. PI2) could be improved. Both organizations scored a zero on this performance indicator, as middle and lower management were only actively involved in the last four months of the project. Interviewees stated that this hampered program implementation as this resulted in little support for the program from the management at the beginning:
“Well the support from managers is crucial. When you notice that the management is not supporting the program and do not facilitate participation in the program, then it [the program] will not lead to anything. But the fact that management just says ‘we need to do this’ is not enough. That does not ensure that the project becomes part of everyday culture among employees”. [University_P11 T2]

The results from the interviews with project members at the end of the program (T2; 12 months after initial start of the implementation) showed that, following the advice of the external consultant, the team meetings held at the end of the project resulted in more support for the program, both among middle and lower management and among employees, as is illustrated by the following quote:

“You see that there is a kind of dynamic that occurs when the external advisor and our project leader give a workshop about the program in regular team meetings. As discussed in the project meeting, I believe that when we did these meetings at the beginning of the project, it [the program] would have more support and become part of everyday culture in the organization. Also, actively involving lower management after these meetings is essential and will lead to higher participation rates and thus program success”. [Hospital_P05 T2]

With regard to PI 3 (i.e. installing a steering committee) differences could be observed between both organizations. The University met PI 3 (score=1) because a steering committee was formed with representatives of the upper management with decision-making authority regarding budget allocation facilitated implementation. We observed that each steering committee meeting was well prepared by the project leader with an agenda. The meetings were systematic and focused on making decisions without substantive discussions since these were already held in the project group. The onsite monitoring indicated that this facilitated effective program implementation. However, the University received a score of 0.5 for PI 3 as we observed that the steering committee turned into a project group in which all substantive discussions were held, but no one was responsible for making decisions on go, no-go aspects of the project plan and interventions that could be implemented. The lack of ‘authority’ regarding budget allocations seemed to lead to a considerably longer preparation phase (i.e. 15 months at the University compared to 6 months at the Hospital). Another factor that seemed to contribute to the delay of the initiation of the project at the
University was a high turnover among project leaders (i.e. PI 4) due to staff turnover and a lack of commitment and time. Hence, their score on PI 4 was 0.5. Observations from both worksites showed that assigning a project leader with 8 to 16 hours a week solely for the implementation of the project seemed to facilitate implementation. The Hospital did meet PI 4. However, onsite monitoring showed that at the beginning of the project, the project leader took sole responsibility, without actively involving project members. However, after a couple of months, she stopped being actively involved and tried to delegate this to the project members. However, the project members felt little responsibility and were not actively taking part in the development and implementation process. It appeared that this was the result of the lack of delegation from the project leader at the beginning of the project and overall hampered program implementation.

Both organizations partially met PI 6 (i.e. performing a needs assessment), because observations showed that they only gained insight into the current lifestyle behaviors of their employees, using the baseline web-based questionnaire that was conducted as part of the effect evaluation. No information on the actual needs and wishes of employees was obtained. Instead, only the wishes and needs of project members were assessed during a meeting in which they could indicate their preferences on a list of evidence-based lifestyle interventions of varying complexity [4, 7, 26-28].

The onsite monitoring showed that differences were observed between both organizations regarding the development of a project plan (PI 7). At the University the project plan focused more on the details and included 5 out of the 6 main aspects (i.e., project goals, intervention template, timeline and communication plan, budget per intervention and a list of responsible persons), hence a score of 0.8 was given for PI 7. Interviewees regarded their project plan as facilitating for implementation, which is illustrated by the following quote:

“A project plan is necessary; in particular to give direction about where to go and what to do. It [the project plan] can be a) guiding, and b) a tool to see where adjustments in the project were made. It’s like a benchmark. Which does not mean that you necessarily have to follow the project plan from A to Z, but you do need to have a plan in order to be clear on what we want. ... Where you actually want to go are the great ideas and intention, but you need to have a concrete plan in order to actually change behavior. Without a concrete plan you keep having meeting after meeting without concrete actions. Like we had the first 15 months. But from the moment we wrote down concrete actions this gave guidance to the project and we were able to implement actual interventions”. [Hospital_P08 T2]
At the Hospital the detailed aspects of the project plan (i.e., budget plan, intervention template, timeline and list of responsible persons) were lacking and the plan focused mostly on desired changes and project goals, hence a score of 0.4 was given for PI 7. We observed that it appeared that the lack of translation of the project goals to concrete interventions led to ad hoc intervention development, which is illustrated by the following example: “the Hospital choose to address four lifestyle theme’s, one theme every three months. There was a lack of anticipation on the next theme. Planning of the next theme only started after the previous theme had finished, which resulted in gaps in between themes. Hence, no interventions were delivered between September and December (2011) and between January and April 2012.

Finally, onsite monitoring and interviews suggested that improvements could be made regarding maintenance (PI 12). Both organizations only had partial strategy adherence (score=0.5). No long-term plans were made regarding follow-up of implemented interventions. Even though monitoring and interviews showed that both organizations decided to continue some of the interventions, no one was made responsible. At the Hospital, the project group choose to start a new pilot project in which managers would be trained in discussing sustainable productivity related to employees’ lifestyle in the yearly performance interviews. At the University only relatively simple interventions that did not require active employee participation (such as distribution of free fruit and posters) were continued for half a year.

**DISCUSSION**

The aim of this study was to describe the use of and adherence to the 7-step strategy and to assess whether this strategy had facilitated the development, implementation and continuation of a comprehensive, multi-component lifestyle program. For this purpose, a monitoring instrument with twelve performance indicators was developed which evaluated implementation factors that are targeted by means of the 7-step strategy and that have been found to be effective in implementing effective WHPP. Our findings showed that performance indicators were partially met by the organizations. This suggests lack of completeness of the execution of the 7-step strategy and thus partial strategy adherence, which is also represented in the overall performance score of both organizations. Incompleteness was linked to inadequate support among middle and lower management, project structure,
adaptation to needs of employees, planning and maintenance. Overall we identified several factors that had facilitated the implementation process: the presence of an external advisor, strong and adequate leadership (i.e., the presence of a project leader), solid support among all organizational layers, and fitting the program to the wishes and needs of employees. Factors that had hampered the implementation process included organizational culture, lack of higher management involvement in the steering committee, and lack of ownership among project members.

Based on the results of this study it is reasonable to assume that the 7-step strategy facilitated the formation of a hierarchic project structure with a broad variety of project members in terms of function and department within the organization. Both aspects facilitated the implementation of the program. This is in line with literature [29, 30] and the study of Wynne and Clarkin that showed that key figures from different organizational levels (participation) and employees with different expertise's like human resources, communication and worksite health promotion (multidisciplinary) need to be part of a project’s structure [13].

The results of this study showed that in order to successfully use the 7-step strategy as intended, the strategy may not have provided sufficient practical guidance or materials for the organizations to use in each step. First, the strategy should be more specific on which strategies to use for inclusion of middle and lower management right from the beginning of the project. In our study, the external advisor visited team meetings at the end of the project. Interviews showed that this personal approach was perceived as beneficial as it led to more support for the program. It is advisable that visiting team meetings as a means to create support among lower and middle management should be included in the 7-step strategy during step 1. By keeping all management levels up to date about upcoming interventions from the beginning, support could be ensured during the whole program. Second, the results showed that due to the lack of a clear format for a needs assessment both organizations were not able to perform a thorough analysis of the wishes and needs of the employees. Literature suggests that ensuring a fit of the program with the wishes and needs of the users and the organization, contributes to program participation and thus to implementation success [9-11, 31-32]. So in order to enhance the effectiveness of the strategy, it is necessary to develop and uptake a specific needs assessment in step 3 that focuses on both the users as well as the organization. For the users a specific needs assessment questionnaire could be included. At the organizational level it is important to leverage existing data to inform this phase. For example, data regarding sickness absence and health risk appraisals can
provide valuable information on the current health status of the organization and main focal areas. The tooling for step 3 should include information on which organizational data could be relevant and on how to make an organizational scan in which all data is integrated. Additionally, organizations would benefit from conducting an assessment in which barriers and facilitators can be identified for the development, implementation and continuation of health promotion activities. For this purpose the Dutch questionnaire MIDI can be used as part of step 3 of the strategy as a supporting tool [31]. The MIDI questionnaire can be used prior to the development and implementation of the program to determine possible barriers and facilitators for implementation of the program and respective interventions. The MIDI questionnaire can also be used during the implementation of the program to adjust the strategy of implementation to gain maximum success. Thirdly, to support the project members and organizations in developing a project plan during step 4, it would be beneficial to add an outline for a project plan that contains all essential paragraphs (i.e. overall goals, detailed intervention template, communication strategy, time-line and budget plan). Additionally, detailed examples of successful worksite health promotion programs could be added to the strategy. By presenting these examples (and potential factors for success) the organizations can have a clear view on whether or not interventions fit the needs and wishes of the employees. As stated by Wynne and Clarkin [13], flexibility and integration are two of the five aspects that are important for successfully implementing a health policy at the workplace. Meaning that WHPPs are similar at some basic points, but that WHPPs need to be adapted to fit the specifics of a worksite (e.g., organizational structure/culture type of workforce and vision), in order to reach its full potential. Finally, the performance indicators show that the low attention to maintenance of the program remains a problem, which has been found also in other studies [9]. Although both worksites in the current study evaluated the development and implementation of the interventions at the end of the program, they did not thoroughly discuss and determine long-term goals. Moreover, monitoring showed that within both worksites nobody felt highly responsible for making sure the program would be maintained over the years. We know that to date it remains difficult to achieve sustained attention for worksite health promotion programs [33]. Organizations need to make an extensive effort to make a considerable impact on the wellness and health of their employees and are thus not always willing to do so, as research has shown that only few programs are cost-effective [34]. Effects will only occur over a long period of time and for that to happen a program needs to be integrated in the organizations HR-policy (i.e., employability) To support organizations in doing so, more guidance seems
to be needed on how they can successfully achieve maintenance, preferably by examples of successful initiatives of other organizations [33]. Moreover, the 7-step strategy should be linked to existing structures, such as health risk appraisals to further stimulate maintenance of interventions and to encourage organizations to keep developing and implementing new interventions when necessary.

Methodological considerations
A strength of this study is that we applied qualitative research in a real-world setting, which can provide deeper and more explorative insights into the implementation process in addition to quantitative research. Because we performed our study in a real-world setting (i.e., the researcher was mainly an embedded observer) the generalizability of the results can be regarded as good. The generalizability of qualitative study results is not always good, because the aim of qualitative research is not to find results that are widely applicable, but to go in-depth and show underlying mechanisms [35, 36]. Inherent to qualitative research we need to take recall bias into account. However, we tried to control for this by combining the interviews with onsite monitoring (i.e., data triangulation) and by performing interviews at baseline, halfway through the project, and at the end of the project. Even though we invited all project members to participate in the interviews, not everybody was able to participate. Especially at the end of the project it proved to be difficult to include all project members at the Hospital since their involvement in the project had diminished over time. Furthermore response bias could be a problem with regard to the interviews. Project members may have provided more desirable feedback about the 7-step strategy when faced by the interviewer who was also the embedded researcher in the project.

However, prior to starting the interview, we stressed that we were not looking for desirable answers and that it was of great importance to be honest.

Conclusion
The results of this evaluation indicate that the 7-step strategy was partly used as intended as not all performance indicators were met. So partial strategy adherence was obtained. However, the results of the interviews with the users did indicate that strategy adherence seemed to facilitate the development, implementation and maintenance of lifestyle interventions. Due to the fact that we did not have a control organization that did not use the 7-step strategy to implement lifestyle interventions, it was not possible to link the performance indicators to quantitative outcome measures. Therefore no single component
of the strategy could be identified as more effective. However, based on the qualitative data this study suggest that when the improvements will be made on both the content and performance, the 7-step strategy would be a useful and effective tool to successfully develop, implement and maintain a multi-component WHPP. Suggested improvements include: better practical tools and materials for project members to execute some of the steps and providing examples of successful WHPPs. Moreover, an external advisor with experience is needed to ensure and maintain progress and to make sure that an organization does not drop out during the development phase. As implementing a WHPP by means of an implementation strategy enables successful reach, participation, dose delivered and satisfaction among employees, the 7-step strategy may have good potential for successfully implementing WHPP worldwide in different types of organizations. We believe that, with the suggested improvements, the 7-step strategy will enable organizations to successfully develop, implement and maintain a multi-component WHPP that fits the wishes and needs of that particular organization.
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