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Implementing Work Ability Management: A Multi-Method Study from Supervisors' Perspectives in Public Social and Health Care Organizations

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Background

Supporting work ability can reduce sick leave [1,2], increase the retirement age [3], and lower disability costs [4,5]. In Finland's public social and health care sector, effective Work Ability Management (WAM) is essential due to high rates of mental health- [6] and musculoskeletal-related [7] sickness absence, an aging workforce, and financial pressures [8]. After being under the responsibility of municipalities and hospital districts, public social and health care services were transferred in 2023 to the responsibility of 21 newly established wellbeing services counties funded by the Finnish government. Wellbeing services counties are responsible for organizing health care, social welfare, and rescue services. These services include, e.g., primary health care and services for people with disabilities, and are available to everyone [9]. Wellbeing services counties are major employers, collectively employing approximately 220,000 people [10].

WAM aims to promote and maintain employees' work ability and occupational safety while supporting continued employment [11]. It encompasses all planned actions implemented and monitored within an organization using its own resources and in collaboration with occupational health services (OHS) or other experts [11]. In Finland, workplaces are required to have a model for supporting employees' work ability. This model compiles practices and instructions for anticipating issues; promoting and supporting work ability; identifying support needs and reacting, reflecting, and evaluating implementation success; supporting employees' return to work; and supporting continued work. These practices must be documented, and each organization may decide how to describe the model [12]. In addition to these individual-level actions, workplaces aim to impact WAM at the organizational level [13]. Knowledge-based management and communication are crucial parts of WAM, where existing information systems play a key role [14]. Thus, WAM can be considered a multicomponent intervention, which has been shown to be more effective than single-component interventions [15]. Previous research suggests that interventions aiming to improve wellbeing at work should be implemented as routine programs and integrated into daily practices [16].

Despite the acknowledged importance of WAM, there appears to be a knowledge-doing gap [13,17,18], indicating challenges in translating policies and models into everyday practice. Supervisors play a crucial role in bridging this gap, as they are responsible for the daily implementation of WAM and require their

continuous attention [19–21]. However, supervisors in social and health care organizations often experience stress due to high job demands, heavy workloads, and inadequate resources [22]. Additionally, in Finland, these organizations have faced constant changes due to reorganizations. Such contextual factors, including constant change, resource and time constraints, have been identified as barriers to implementing work ability support [23–27].

Understanding how these conditions shape supervisors' ability to implement WAM requires a framework that captures both individual and contextual determinants of behavior. To address this, we applied the COM-B model [28] for behavior change was applied. In the COM-B model, behavior is viewed through the concepts of capability, opportunity, and motivation. Capability refers to the individual's psychological and physical capacity to implement, including the necessary knowledge and skills. Opportunity encompasses external factors, such as organizational structures and resources, that facilitate or hinder behavior. Motivation includes habits, emotions, and decision-making. By integrating these three dimensions, the COM-B model can be used to identify which behaviors and whose behavior needs to change for implementation to succeed. Thus, it provides a framework for analyzing the supervisors' role in WAM implementation and identifying targets for intervention [28].

Organizational-level interventions are often context-dependent and require adjustments to align with organizational goals, structures, and resources [29]. Additionally, workplaces seeking to implement an intervention need to analyze existing facilitators and barriers beforehand, develop an action plan, and determine how to overcome these barriers [30]. Although implementation tools, such as checklists tailored for social and health care contexts, have been published [31], to our knowledge, there are no tools or recommendations designed to support WAM implementation from supervisors' perspectives. Therefore, the aim of this study was to 1) examine the facilitators and barriers to WAM implementation from supervisors' perspectives and 2) as a synthesis, co-create a checklist and recommendations to support supervisors in implementing WAM in public social and health care organizations.

Methods

Participant Recruitment

This study was conducted within two Finnish wellbeing services counties between January and December 2025. Human resources (HR) personnel in these counties were contacted directly by email. The study was limited to these two counties due to resource constraints.

The research group met with key HR representatives to discuss the study and the expectations for participating organizations. They had the opportunity to review it internally before deciding whether to participate.

Both wellbeing services counties (Organizations A and B) were guided to select 1-2 service sectors, differing in their nature of work, to participate. As a requirement, the selected unit had to have sufficient supervisors to ensure that at least 10 survey responses were obtained while maintaining confidentiality. The researchers did not influence sector selection. The participating sectors were large, with personnel ranging from 450 to 1,380 employees.

Organization A selected two sectors to participate, totaling 135 supervisors, while Organization B chose one sector with 24 supervisors. The three resulting service sectors varied in size and in their work. One sector consisted mainly of shift work, while the other two consisted mainly of day work. Each sector had multiple units, with employees scattered across these units and potentially geographically distant from their supervisors. Participation in the study was voluntary, and participants could withdraw at any time. The researchers had no prior knowledge of or relationship with the participants.

The wellbeing services counties appointed an HR representative to serve as a contact person and coordinator between the research group and the participants, specifically supervisors and other individuals responsible for WAM. The research group organized a webinar for supervisors to provide information about the study. The meeting was recorded to accommodate those who could not attend, allowing them to watch it later. Otherwise, communication was conducted through the coordinators.

Data Collection

Before data collection, HR representatives from both organizations shared existing work ability support models to familiarize researchers with how workplaces guide supervisors through these processes and define roles and responsibilities. A multi-method design was then used. Facilitators and barriers to WAM

implementation were identified using both quantitative and qualitative data. The Consolidated Criteria for Reporting Qualitative Studies (COREQ) was followed when reporting the qualitative part of the study [32].

The quantitative data included Work Ability Management Overview Tool surveys [33] and supervisor surveys. A subset of supervisors who received these surveys was invited to participate in focus-group interviews as part of the qualitative data collection. The collected data were triangulated to answer the first study question, which examined the facilitators and barriers to WAM implementation from supervisors' perspectives.

The development of the checklist and recommendations was conducted during two co-creation workshops. These phases of the study are summarized in Table 1 and described in more detail in the following section.

Table 1 here

Quantitative data collection and analysis

Supervisors from three participating sectors (N=88) completed the Work Ability Management Overview Tool survey, which was designed to assess the current state of WAM at the organizational level. This tool, used in the Finnish Institute of Occupational Health's (FIOH) development projects in labor-intensive fields, includes 38 statements across five WAM areas: the strategic nature of WAM, knowledge-based management, operational models and implementation, information flow and collaboration, and organizational culture. Responses ranged from "Completely disagree" to "Completely agree" (1 to 5), with an option for "Cannot say" (0), which was excluded from analysis. The online survey is part of FIOH's freely available Mental Health Toolkit [33].

The anonymous Work Ability Overview Tool provides results once at least 10 respondents have completed the survey. Results are presented on a three-step scale (traffic lights), and the report shows averages for the various areas and per-question averages. Specifically, the survey sections (individual statements and sections) that needed the most development were analyzed.

Subsequently, supervisors (N=87) completed a second online survey, specifically designed for this study, focusing on each one's own role in WAM implementation. This survey aimed to deepen the understanding

of supervisors' daily management practices and included 56 positive statements based on the COM-B model [28,34]: capability to manage work ability (e.g., *I am familiar with the goal set for my organization's WAM*), opportunities available for WAM implementation (e.g., *My workplace's work ability support models are clear and easy to find*), motivation (e.g., *I feel that my workplace values my contribution to supporting the work ability of my employees*), and behavior (e.g., *I actively monitor the workload in my own unit and take proactive measures*). Responses followed the same scale as in the Work Ability Management Overview survey.

Distributions, proportions, and averages were used to analyze quantitative data. The statements were positive, and the portion that disagreed was examined. In addition, sector-specific averages were reviewed and compared to identify those areas where everyone needed development. The survey results were initially reviewed separately for each of the three participating sectors, then analyzed together to identify commonalities across sectors.

Qualitative data collection and content analysis

After completing the surveys, facilitators and barriers to WAM implementation were further explored through focus group interviews with supervisors, who could address issues not raised in the questionnaires. Participating organizations selected supervisors for these interviews using purposive sampling, with a recommendation of up to seven participants per sector. The focus group was facilitated in person by two researchers using guiding questions based on the COM-B model [28,34]. In addition to supervisors and researchers, no other people were present. Focus groups were chosen because they can produce richer insights into how an organization functions than other data collection methods, and participants can build on each other's ideas to provide a broader perspective than individual interviews might offer [35]. The interviews lasted between 84 and 89 minutes.

Altogether, 17 supervisors were interviewed (3 men, 14 women), and all sessions were audio-recorded and transcribed verbatim. No transcripts were returned to participants for comment. The data were analyzed deductively using content analysis [36,37] with the COM-B model as the coding framework. Capability, opportunity, and motivation served as the main coding categories. As the analysis progressed, subcategories such as *support from others (opportunity)* and *beliefs about consequences (motivation),*

guided by the Theoretical Domains Framework [34], were added. Additionally, interview data were coded as facilitators or barriers. Coding was conducted by the first author using Atlas.ti software to manage and categorize the data, and the analysis was discussed and further integrated with other data, together with the research group.

Co-Creating Checklist and Recommendations

Finally, a checklist and recommendations were co-created to support WAM implementation in workplaces, based on collected data, implementation research literature, and workshop discussions with supervisors. Ertz [38] emphasizes the importance of ensuring participants' commitment to co-creation processes, which was facilitated by HR representatives who invited experienced and motivated supervisors to participate in the workshops.

The two workshops were conducted online to enable participation from two different locations. Eleven supervisors (1 man, 10 women) attended both three-hour sessions to ensure continuity. All the authors served as facilitators.

During the first workshop, participants were introduced to a synthesis of the facilitators and barriers identified in the collected data. They were divided into small groups by sector to discuss three initially identified topics and related subcategories, spending 20 minutes on each. Guiding questions for each topic included: 1) What are the main barriers to WAM implementation? 2) What measures currently exist to address these barriers but remain underutilized? 3) What actions are needed to overcome these barriers? The topics were:

1. Knowledge and Skills: competence in knowledge-based management, supporting mental health, utilizing existing resources to support work ability, early identification and discussion, and managing people at various career stages.
2. Collaboration, Support and Information Flow: roles and responsibilities, policies and forums, atmosphere, information systems, and participation in decision-making.
3. Motivation: providing feedback, trusting supervisors, understanding WAM's importance, employee motivation, and monitoring WAM practices.

A researcher facilitated each group, taking notes on an interactive online wall. Later, participants reviewed all group outputs and voted on the three most important barriers and actions. A joint discussion then followed to identify any missing elements.

After the first workshop, researchers began developing the initial checklist by compiling all quantitative and qualitative data, the most central recurring issues, the barriers that received the most votes, and their proposed solutions, and the relevant previous literature on workplace interventions to support work ability [11,15,26,39].

The first version of the checklist was presented to participants during the second workshop, which consisted of two phases. First, participants evaluated the checklist using four criteria: clarity, usability, usefulness, and comprehensiveness [31]. Clarity assessed whether each item was clearly worded and easy to understand. Usability evaluated the item's feasibility in practice. Usefulness assessed the value each item would add to WAM implementation. Comprehensiveness focused on whether the checklist covered all relevant aspects. Feedback on each item was collected through facilitated group discussion.

In the second phase of the workshop, participants discussed how to disseminate the checklist and recommendations at their workplaces. The discussion was guided by the following questions: How can we ensure the checklist and recommendations are implemented at your workplace? What actions are needed at the organizational, service area, team, and support services levels (e.g., HR)? The goal was to identify concrete actions to support successful implementation.

Results

Facilitators and Barriers to WAM Implementation: Results from the Quantitative Phase

Work Ability Management Overview Survey Results

In only one sector, supervisors viewed supporting work ability as an integral part of the organization’s strategy, culture, and values, with a multidimensional approach to promoting personnel’s work ability. Across all sectors, areas needing improvement included clear and measurable objectives for WAM,

metrics to track these objectives, the executive team's involvement in monitoring and deciding necessary measures, sufficient resources, and partnership with OHS.

Supervisors reported several useful indicators for monitoring WAM, such as measures related to wellbeing at work, sickness absences, and accidents. However, the available information was insufficient to support decision-making on personnel work ability. Regular assessments of WAM effects and collaboration with OHS were identified as areas needing improvement.

Work ability support models were generally considered functional. Occupational safety issues were regularly addressed, professional competencies were well supported, early support models were actively used, and opportunities to modify work were available. However, concerns included the need for proactive measures to reduce workload and anticipate personnel adequacy.

Challenges in information flow and collaboration included ensuring that personnel received information on WAM plans and decisions, facilitating smooth communication among different actors, and fostering internal collaboration.

Despite minor differences across sectors, supervisors evaluated organizational culture positively, particularly for fostering a sense of community, trust, and work-life balance.

Supervisor Survey Results

A good understanding of the multidimensional factors influencing work ability was generally reported. Supervisors were familiar with their responsibilities and work ability support models, and they felt capable of addressing difficult issues and conducting early support discussions when needed. However, they reported a lack of systematic onboarding practices. Additionally, the goals of WAM and the origins of disability costs were often unclear.

An open organizational climate and support from peers and middle management were reported as facilitators. However, they faced constraints such as a lack of time to support employees' work ability, non-functional information systems, and the absence of systematic meeting structures to promote WAM implementation. Challenges in information flow were evident across all sectors, and support from HR and OHS was perceived as insufficient.

Supervisors aimed to intervene when employees or teams had concerns about their workload. However, in two of the three service sectors, supervisors reported that the WAM models were not beneficial and that the workplace did not sufficiently value their efforts to support employees' work ability.

Supervisors mostly agreed with the positive, action-related statements. They ensured employees had opportunities to develop skills and communicated with them about current issues and potential changes. They also considered employees at different career stages and promoted a sense of community, trust, and psychological safety. However, support for employees to maintain and improve healthy lifestyles and support work ability was reported as limited.

Facilitators and Barriers to WAM Implementation: Findings from the Qualitative Phase

Focus-Group Interview Findings

The facilitators and barriers to WAM implementation identified in the focus-group interviews are organized by supervisors' capabilities, opportunities, and motivation, and are supplemented with supervisors' quotations.

Facilitators

Supervisors experienced that they could support employees' work ability. Their familiarity with employees and the work in their units made it easier to implement solutions, enabling supervisors to quickly address issues related to work ability. They were approachable and aimed to stay available.

Yearly employee surveys supported knowledge-based management. Shared organizational operating models also facilitated WAM implementation. Work ability support processes were considered clear, and supervisors valued the flexibility to adjust employees' working hours, helping balance work and personal life. Organizations provided various training opportunities to strengthen supervisors' skills.

> *Supervisor4: "At least I feel that when I ask for training, I usually get it. Of course, it's largely my own responsibility to think about and look for what kind of training I need."*

Systematic risk assessments, actions based on them, and ongoing follow-up were seen as key facilitators of workplace safety. Having enough time for WAM and support from colleagues in addressing work ability issues were crucial. Some supervisors reported receiving support from middle management, occupational

safety representatives, and HR, although interactions were often limited or required supervisors to be proactive.

Consistent communication with employees across the organization, joint forums, and meetings facilitated WAM processes. An open culture for addressing difficult issues and trust between supervisors and employees were also highlighted as key enablers.

The implementation of WAM was facilitated by supervisors' motivation to promote and support employee wellbeing. This was evident in their efforts to allocate time for employees and to respond early and proactively to changes in work ability. They were motivated to lead and valued employees' work. Additionally, supervisors recognized that effective management benefited not only employees but also customer service. They acknowledged that upper management responded to concerning survey results, reinforcing their commitment to WAM, and expressed trust in upper management's capabilities.

Barriers

Knowledge gaps regarding OHS were common, with several supervisors unsure about their OHS contact person, procedures, available services, or how to access OHS contracts.

Some supervisors felt that no one was "drawing the big lines," especially regarding WAM objectives and communication, and they sought clearer direction from management. Changes were often seen as top-down and implemented without involving supervisors, which was interpreted as a lack of trust. Organizational mergers that combined different cultures and operating models added complexity. Supervisors described the need to filter and forward large amounts of information to employees amid unclear messaging and breakdowns in communication chains.

Supervisors described multiple reporting and information systems as complex, unreliable, and constantly changing. These issues discouraged their use, leading some supervisors to create their own tracking systems. Supervisors were expected to report work ability data but did not receive feedback from upper management on how it was used.

> *Supervisor9: "When you have these discussions with an employee and then you're supposed to record them in our system, it's a bit rigid and cumbersome. I always find myself*

wondering exactly where it should be saved, whether it needs to be entered here, when it needs to be dated, and where it needs to be updated... Because we get those absence alerts, or if I have a discussion with an employee about absences and coping at work, filling in that form feels particularly challenging. It creates this feeling that I'd rather not fill out the form at all because it's so complicated. I wish it were easier, because then I think all of us would actually use it in everyday situations, especially in the early stages of intervention."

Instructions for WAM were considered unclear, difficult to find, or inconsistent across sectors. Although organizational-level models for work ability support existed, goals and practical implementation did not always align. Supervisors perceived a limited understanding of unit-level work among top management and noted insufficient resources to support WAM.

Despite their efforts, supervisors felt unable to lead as they desired under current conditions. High workloads and geographical distances made it difficult for supervisors to observe employees' wellbeing. Furthermore, a lack of trust hindered discussions of the underlying issues.

Supervisor1: "I've received feedback that there's a need for more presence. I feel that too. When it starts to feel like I'm drifting away from the day-to-day work the employees are doing, that bothers me as well."

Collaboration with OHS was often viewed as inadequate. Supervisors faced conflicting expectations, inconsistent communication, and challenges in reaching OHS. Collaboration procedures were seen as being based on individual practitioners rather than being applied consistently. Limited interaction with HR also hindered efforts to support work ability, with HR support in complex cases seen as bureaucratic.

Supervisors also perceived inadequate onboarding, limited time to attend management training, and a preference for more structured, in-person options rather than web-based sessions.

Supervisor15: "When I jumped into this myself, I didn't receive any onboarding, and that's something we're really missing a lot. Having someone to walk the same path with. To be taken along and have this work opened and explained."

Additionally, supervisors viewed that expectations and workload were high, yet they did not receive adequate appreciation or compensation. The lack of feedback for their efforts contributed to their sense of being undervalued.

Synthesis of Results: Co-Creating the Checklist and Recommendations for WAM Implementation

Based on the collected quantitative and qualitative data and the first workshop, five themes were identified as essential to supporting supervisors in WAM implementation: 1) knowledge-based management, 2) models and practices, 3) collaboration and support, 4) information flow, and 5) organizational culture. These themes, together with the researchers' previous experience, formed the conceptual foundation of the implementation checklist. Each theme was divided into three to five statements describing concrete implementation activities, along with corresponding user instructions (see Additional file 1).

Knowledge-based management included subcategories such as defining objectives for WAM and interpreting and using work ability-related data (e.g., absences and turnover). *Models and practices* focused on the availability of organizational-level models to support work ability and on enhancing supervisors' ability to identify declines in employees' work ability. *Collaboration and support* included subcategories related, for example, to support from middle management. *Information flow* addressed aspects such as the adequacy of information received from OHS. *Organizational culture* included subcategories such as ensuring that supervisors and employees are heard in decision-making.

During the second workshop, participants reviewed the checklist and gave feedback on its content and user instructions. They highlighted the importance of clearly defining who is responsible for initiating the checklist process and who should participate in its use. Participants favored active phrasing, commented on the logical order of items, and suggested additions, such as clearer descriptions of the support needed from various organizational roles and specifying the levels at which changes should be visible.

Participants further emphasized that the importance and advantages of WAM should be acknowledged throughout the entire organization and its service sectors. Effective, targeted communication about the checklist was considered essential for its systematic implementation. Incorporating the checklist into existing processes, such as risk assessments, was considered to improve its practical usefulness.

Supervisors identified several structural challenges that could hinder the future implementation of the checklist and recommendations. These included the absence of higher-level or cross-administrative forums to systematically include supervisors' perspectives in decision-making and ensure a comprehensive flow of information. As a result, participants highlighted the need for clearer role definitions and responsibilities to advance WAM-related initiatives, as well as improvements in internal communication.

Additionally, participants emphasized the need to clearly define responsibilities at each organizational level when planning actions with the checklist. They recommended documenting the specific level at which each action will be implemented and identifying the responsible individuals. Regular updates on the impact of development measures at the organizational level were considered essential for tracking progress. They suggested that multiple supervisors complete the checklist to gather diverse input, and that a designated development team then oversee the implementation of the identified actions. This approach was viewed as effective for guiding efforts toward units with the greatest development needs.

After the second workshop, researchers refined the checklist and developed recommendations based on participant feedback and the specific actions identified during discussions. Following the workshops, feedback was also collected from HR and management representatives in the sectors involved in the study, as well as from the supervisors, but no additional comments were received. The final version of the checklist includes 24 statements organized under five themes. Each item is evaluated using a "Yes – No – Partly" scale, with space for additional notes. The electronic version of the checklist is available in Finnish on FIOH's website, and the English version is provided as Additional file (2).

Users are instructed to select up to three development areas at a time and identify one to three measures for each. They are encouraged to record how each measure will be developed, along with the implementation schedule and responsible parties. When planning development actions, users are also guided to refer to the accompanying recommendations.

The ten recommendations were developed based on practical solutions suggested by supervisors during the initial workshop and researchers' previous experience. These recommendations support the use of the checklist and are categorized into three groups:

- competence development, e.g., *"Orientation of new supervisors: The principles of knowledge-based management, such as the systems used, the information monitored, and the ways of using the information, will be included in the orientation of supervisors."*
- opportunities, e.g., *"Information needs: The leadership is involved in defining what information is needed to support work ability management, where the information is obtained from, and how it is used."*
- and motivation, e.g., *"Follow-up and communication: The top management regularly monitors how the objectives of work ability management are achieved and communicates the results and progress to supervisors, for example, in monthly reviews or team meetings."*

A complete description of each recommendation is available as Additional file (3).

Discussion

The aim of this study was to identify facilitators and barriers to WAM implementation from supervisors' perspectives and to synthesize the findings into a practical checklist and recommendations to support implementation in public social and health care organizations. Using a multi-method approach that included surveys, focus-group interviews, and co-creation workshops, five key themes affecting WAM implementation were identified: knowledge-based management, models and practices, collaboration and support, information flow, and organizational culture. These themes were operationalized into 24 checklist statements and ten recommendations outlining responsibilities, concrete actions, and monitoring requirements.

The checklist helps organizations assess their current WAM status and plan targeted development actions, bridging the gap between organizational models and their practical implementation at the supervisory level. The checklist and recommendations offer a tool for supervisors, middle and upper management, HR professionals, and occupational safety personnel to systematically plan and coordinate WAM implementation, while considering context.

Reflecting the Results on the COM-B Model

The COM-B model [28] was used to analyze behavioral factors influencing supervisors' roles as key implementers of WAM. Identifying barriers and facilitators within specific settings, such as social and healthcare services, helps develop theory-informed interventions more likely to lead to sustainable change [40]. The COM-B model helped identify factors related to capability, opportunity, and motivation, which guided the co-creation of the checklist and recommendations.

Our findings show that COM-B components influence supervisors' ability to engage in knowledge-based management. Although indicators for monitoring WAM existed, supervisors struggled to access reliable data due to fragmented, complex information systems, which hindered motivation. This adds to the limited research on social and health care managers' competencies in knowledge-based management [41] and aligns with existing research on information system challenges in public-sector organizations [42]. From a COM-B perspective, these findings emphasize the need to strengthen supervisors' capabilities (e.g., through training), opportunities (e.g., by involving supervisors in information system development), and motivation (e.g., through clear objectives and feedback).

Supervisors reported barriers such as a lack of resources, insufficiently defined objectives, and the absence of clear metrics. Successful implementation requires strategic leadership that sets clear goals, provides adequate resources, and evaluates outcomes [26,29,43]. Weak strategic alignment and inconsistent goal communication may lead supervisors to develop their own practices, potentially hindering unified implementation and the development of a collective culture.

Supervisors felt capable of addressing work-ability-related issues and were familiar with support processes. However, several barriers were identified, such as difficulty locating models, their perceived usefulness, and managing or anticipating workloads. These findings indicate that models for work ability support may be used primarily reactively, while anticipatory use remains limited. Similar to return-to-work processes [21], WAM should be integrated into daily management rather than treated as a separate activity. Recommendations include improving supervisors' opportunities by ensuring that models to support work ability clearly cover all phases, from early identification to reactive measures, and are easily accessible. Additionally, supervisors perceived WAM implementation as insufficiently monitored, which weakened their motivation to engage in its implementation. High-quality implementation, characterized by continuous monitoring and systematic evaluation, enhances the effectiveness of workplace interventions

[15]. Therefore, attention should be paid to evaluating both implementation processes and outcomes. Strengthening these structures may increase motivation by making progress visible. Furthermore, top management should actively support implementation by securing adequate resources, setting realistic objectives, and providing feedback.

Supervisors' support from other actors was often perceived as insufficient and dependent on their own initiative. Collaboration was limited partly due to a lack of knowledge and partnership, even though it is a key facilitator of successful work ability support [21,26]. HR representatives could provide informational support through training and guidance on workplace policies [44]. Clearer and more systematic collaboration practices would therefore strengthen supervisors' capability and opportunity.

Information flow was strongly linked to collaboration structures. Shared forums and regular meetings facilitated WAM implementation, whereas a lack of systematic meeting structures and communication bottlenecks hindered it, aligning with previous findings [45]. Challenges in information flow, particularly during organizational changes, affected supervisors' sense of trust. Therefore, improving communication is recommended.

Supervisors viewed organizational climate and culture largely positively. While culture is recognized as important for successful work ability support [44,46,47], its role in specific processes, such as return-to-work, remains mixed [44]. Contextual variation in complex, labor-intensive, and resource-constrained public social and health care settings may explain these inconsistencies. In such settings, openness and approachability are especially important for promoting communication and trust amid organizational changes [13].

Easy-to-use, community-based tools are essential for supporting work ability [23]. The checklist developed in this study bridges the gap between organizational models and practical implementation by facilitating situation analysis, prioritization, and follow-up. The accompanying recommendations provide concrete guidance and practical strategies across various organizational contexts and industries. To ensure consistent implementation across sectors, we suggest establishing a coordination group [17] to guide and support the tool's use.

Strengths & Limitations

To our knowledge, this was the first study to explore the kind of support supervisors need for successful WAM implementation and to publish a tool specifically designed to support the implementation. Building on earlier research on WAM in social and health care settings (Authors, 2024), this study focused on supervisors' perspectives, given that their work is often fragmented and demanding, which can affect their ability to manage WAM-related responsibilities. A multi-method approach, triangulating survey responses, interviews, and workshop data, allowed us to capture implementation challenges from multiple viewpoints, and the results supported each other. The three participating sectors differed in size, work characteristics, and organizational culture, highlighting variation within large public social and health care organizations. Additionally, the same supervisors participated in both workshops, ensuring continuity and fostering a trusting atmosphere that encouraged discussion.

However, time and resource constraints limit the researchers' ability to support the implementation and dissemination of the checklist and recommendations. Additionally, the relatively small dataset and focus on three sectors within a large public social and health care context may constrain the transferability of the findings to other contexts. Selection bias is also possible, as supervisors were recruited by HR representatives and may be more representative of individuals more engaged in WAM. Nonetheless, the development of the checklist and recommendations was informed not only by participants' input but also by previous literature and the authors' experience in the social and health care sector.

More research is needed to examine the tool's applicability across different organizations. Future research should therefore examine their actual implementation, the effectiveness of different implementation strategies, and their impact on both work-ability-related and organizational outcomes. Such research may also guide further refinement of the tool.

Conclusions

From supervisors' perspectives, successful WAM implementation is influenced by five key themes: knowledge-based management, models and practices, collaboration and support, information flow, and organizational culture. Drawing on this study and prior literature, we developed a practical checklist and recommendations to support WAM implementation, bridging the gap between organizational models and supervisory-level application.

Based on our findings, it is essential to strengthen communication and collaboration structures. Developing supervisors' capabilities through training, improving their opportunities by strengthening knowledge-based management practices, ensuring adequate support, and motivating them with clear objectives and feedback processes are crucial. Considering the context and establishing a coordination group can help ensure implementation of the checklist and recommendations across social and health care sectors.

List of abbreviations

COREQ Consolidated Criteria for Reporting Qualitative Studies

HR Human Resources

OHS Occupational Health Services

WAM Work Ability Management

Declarations

Ethics Approval

This study was performed in line with the principles of the Declaration of Helsinki. The study received research approval from the Ethics Committee of the Finnish Institute of Occupational Health in December 2024. Additionally, research approval was separately requested and obtained from the ethics committees of both participating organizations in February 2025.

Informed consent was obtained from all individual participants included in the study.

Consent for publication

Not applicable

Data Availability

The datasets generated during and/or analyzed during the current study cannot be made available.

Competing Interest

The authors have no relevant financial or non-financial interests to disclose.

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Author Contributions

All authors contributed to the study's conception and design. Material preparation and analysis were conducted by the third and first authors. All authors participated in data collection and in formulating the checklist and recommendations. The first draft of the manuscript was written by the first author, and all authors commented on versions and approved the final manuscript.

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- Additionalfile2ChecklistforWAMimplementation.docx
- Additionalfile3RecommendationsforWAMimplementation.docx