coveted C. Everett Koop (Koop) award. As a member of the Board of Directors who reviews the award applications each year, the first author can attest to the rigorous and systematic process used to select the organizations that are recognized. Dr Goetzel introduces the 4 Koop award recipients featured in this issue—American-USA, Delta Air Lines, Kaiser Permanente, and LG&E and KU—and shares how he has leveraged the published awardee applications to respond to inquiries about the effectiveness of workplace wellness initiatives. Coeditors, we conducted an informal content analysis on the case studies featured in this issue to identify the common factors that were credited as most essential to their organizations’ success and issue a call to action to all readers to identify the strategies they can leverage to increase the effectiveness of the initiatives with which they are associated.

References


What Factors Were Most Important to the Success of the Cleveland Clinic Employee Wellness Program?

David Pauer, MNO1,2, and Michael P. O’Donnell, MBA, MPH, PhD3

Thirteen years after launching its employee wellness program in 2005, program leadership staff of the Cleveland Clinic (Clinic) started sharing it had saved $260 million in medical costs and increased the number of employees with no (or improved) chronic disease biomarkers 7-fold in presentations at scientific meetings. During this time, the Clinic grew from 32 000 to 53 000 employees and maintained its ranking as one of the top hospitals in the nation. Primary findings are summarized in Figure 1 at the end of this article.

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A thorough quantitative report of these results will be submitted for peer review. The objectives of this article are to (1) provide a qualitative summary of changes implemented at the Clinic to improve employee health since 2005, with the goal of helping other employers understand the magnitude and breadth of sustained effort required to achieve similar outcomes, and (2) shed light on why superficial efforts to improve employee health are likely to fail.

Changes in leadership, organization integration, policies and physical plant, lifestyle change programming, and incentives are described in the first part of this article, followed by reflections on the factors most important for success.

**CEO and Senior Program Leadership**

Dr Delos “Toby” Gosgrove was appointed CEO of the Clinic in January 2004. A cardiothoracic surgeon since 1975, Gosgrove was widely regarded as one of the most skilled surgeons in the world and personally performed as many surgeries each year (450-600) as a typical entire community hospital. He was passionate about helping people quit smoking because his father had died of emphysema caused by smoking. He was dismayed by the growing global obesity epidemic because he knew that heart disease and diabetes were soon to follow. Years earlier, he had promised himself that he would attack tobacco with a vengeance if he ever reached a leadership role that allowed him to do so. He believed that a prerequisite to motivating the millions of Cleveland Clinic patients to improve their health was a workforce led by good role models in these areas, so smoking cessation and weight management were his top 2 priorities.² Dr Gosgrove’s appointment as CEO is probably the single most important factor in the success of the Clinic’s employee wellness program.

Several other key hires were made the following year. Dr Gosgrove’s first critical hire was one of the top scholars and most experienced clinical practitioners in anesthesiology as the new chair of the Department of Anesthesiology.³ He was also board certified in internal medicine, the best-selling author of several wellness books, and an effervescent TV personality and public speaker who would later be named Chief Wellness Officer. He was critical in raising the visibility of wellness among the tens of thousands of Cleveland Clinic employees. The same week, the second author of this article was hired as director of the newly created Employee Wellness Program and reported to the Chief Human Resources Officer, only one level below Dr Gosgrove in the organizational hierarchy, at the same level as the Personnel Director, which gave him easy access to the Clinic’s leadership. Soon after, the existing departments of Occupational Health and Employee Assistance became part of Employee Wellness, reporting to the new Employee Wellness Director. Several months later, a highly credentialed physician was hired to serve as medical director of occupational health and employee wellness. Several years later, he was promoted to also serve as medical director for the Cleveland Clinic Employee Health Plan. A team of 4 highly qualified managers with extraordinary people skills was also hired to design and implement the employee wellness program, including the first author of this article.

Critical staff already in place included a senior benefits manager who had successfully implemented an incentive program to stimulate medication adherence and would later play a leadership role in a more expansive incentive program (see below), as well as a marketing department that developed a sophisticated messaging strategy to reach the growing employee population. This combination of authority, visibility, expertise, and relationship skills was critical to making employee wellness efforts work.

**Organization Integration**

**Organizational Structure**

The organization structure of the Cleveland Clinic is unique from most employers and some health-care organizations in that it serves as employer, health plan, and provider within one organization. This integrated structure creates the potential to eliminate administrative overhead, provide efficient access to medical claims data, and retain efficiencies and savings within the organization. It also provides employees easy, fast, and affordable access to primary care and other forms of medical care.

In 2008, the Cleveland Clinic Wellness Institute was launched with the goal of providing comprehensive, high-quality, lifestyle-driven disease reversal programs to patients, corporate clients, and eventually, to make them available to Clinic employees. In 2009, the employee health plan started the processes of expanding the chronic disease management program, now called Coordinated Care Programs (CCP; see below), and integrating financial wellness incentives into health plan premiums through the program now called Healthy Choice, enhancing offerings by drawing on the resources of the Wellness Institute and focusing on offerings that could be scaled to reach the entire employee and spouse population in a standardized format.

**Outreach and Wellness Committees**

The first several months of the new health promotion director’s time were devoted to extensive one-on-one meetings with the senior administrative and medical leadership and then the mid-level leadership of Clinic hospitals, clinics, research, and other administrative locations of the organization. These meetings were easy to secure because of the reporting relationship close to the CEO. The message in each of these meetings was the same: (1) Employee wellness is becoming a core value of the Cleveland Clinic; (2) We hope it improves the quality of patient care, employee health, and productivity; and (3) We welcome and need your ideas on how to make these efforts successful. Subsequent meetings held by the newly hired employee wellness staff focused on forming several dozen wellness committees that represented all organizational units of the Clinic. Committees were formed in all 12 community hospitals, large departments with 900 or more employees, and clusters of smaller departments on the main campus.

Staff members met face-to-face with wellness committees for more than a year to help these committees through the process of developing and implementing health goals for their employee populations. Wellness committee chairs participated in monthly telephone conference calls to share successes and failures, support each other, and develop a sense of community. These outreach efforts helped the Employee Wellness Program staff understand the health needs of the entire employee population, document and replicate existing effective efforts to improve health, reduce the common phenomenon of ignoring employees who are not based at corporate headquarters, and most importantly, form human connections with several hundred champions in leadership, middle management, and rank and file positions within administrative and medical spheres. In the subsequent year, 15% of the employee wellness budget was distributed from the central Employee Wellness Program budget to the committees through a simple grant process. This reinforced the connections with the committees and allowed testing of innovative ideas. This collaborative inclusive approach continued throughout the program’s history, although the allocation of budget to the wellness committees and
The Cleveland Clinic’s per employee medical costs increased at an annual rate of 7.6% from 2004-2009, 4.8% from 2010-2013 and 0.3% from 2013-2017. Spending for 2004 -2017 was $261 million less than it would have been if the 7.6% trend had continued for the whole period. During the same time, employees on the health plan saved approximately $50 million in reduced health plan premiums by enrolling in the Healthy Choice program. It is important to note that all of the costs of the employee wellness program, including program staff, skill-building programs, fitness centers and related costs were covered by the health plan. It is likely that primary care costs and labs increased in the early years as employees and spouses established relationships with primary care physicians and incurred lab expenses for baseline biometrics and past due immunizations, so the change in health plan costs is net of these additional costs. Also between 2008 and 2018, the number of employees with confirmation of no (or improved) biomarkers for 6 chronic diseases increased from 6% to 43%. These are observational values, in the summary form that might be presented by a Chief Financial Officer concerned primarily about total costs and cash flow, different from a scientist whose primary interest might be in what factors influenced the reduced rate of annual increase. It is not yet possible to attribute these “savings” to the employee wellness program, or even to improved employee health. The savings may be caused in part by improved efficiency in medical care at the Cleveland Clinic, changes in medication purchasing protocols, or changes in employee demographics. For example, not hiring smokers starting in 2007 may have saved tens of millions of dollars in medical costs as the Clinic grew from 30,000 to 50,000 employees since then, assuming $2056/year in higher medical costs for smokers.6,12 Not hiring applicants for patient care positions who failed the fitness test starting in 2012 would be expected to further reduce avoidable medical costs related to occupational injuries. Similarly, medical cost trends would be expected to change if the age and gender mix of newly hired employees was different from the baseline composition. Shifting a higher portion of medical costs to employees would also reduce the employer cost trend, but health plan cost shifting did not occur at the Clinic during this period. Those factors need to be examined in the scientific reporting of these findings.

Figure 1. Medical cost savings and health improvements.

monthly calls occurred only during the critical early years when these trusted relationships were being established.

Policies and Physical Plant
Policies to Reduce Exposure to Toxic Foods and Secondhand Smoke
A few months after his CEO appointment in 2004, Dr Cosgrove made a commitment to remove junk foods from the main campus of the Clinic and encourage reduction or removal from other locations. This included not renewing the leases of a popular fast-food chain because of their focus on foods with high concentrations of saturated fats and salt and a bakery because of their aggressive promotion of high-sugar pastries and desserts. In 2007, he required all 57 food outlets on the main campus to eliminate trans fats from all menu items. This required several national franchise vendors to alter the formulation of the food on their menus. In 2010, he required that all vending machines and cafeterias remove any products containing added sugar. Vendors who served more nutritious foods moved into some of the vacated food locations and the Clinic expanded its contract food services in other locations, with preferred pricing, promotion, positioning, and labeling of healthy foods. In 2009, an outdoor farmer’s market was set up on a central courtyard that featured fresh fruits, raw vegetables, breads, and other nutritious foods grown and prepared by local farmers and bakers.3 These continue to be set up in May to October every year, and the market now features live music, free parking, and periodic health screening and education booths. The markets are also very popular with patients and nearby residents who have very limited access to nutritious food because there are very few grocery stores in the neighborhood.

Similar changes occurred to reduce exposure to secondhand smoke. One of Dr Cosgrove’s first executive actions was to announce that all of the Clinic’s many campuses would be smoke-free within 6 months. There were no exceptions for medical staff, employees, patients, or visitors, nor for parking lots, public bus stops, or construction sites. Employees who violated the policy would be given a citation, and 3 citations would result in termination of employment. Patients and visitors smoking on campus would be asked to extinguish their cigarettes on the spot. After some initial resistance, including employee threats to resign from the Clinic, the policy was widely embraced, and committees were formed to plan implementation. No employees ended up quitting their jobs because of the new policy, and an estimated 3000 smokers enrolled in free quit smoking programs. Compliance with the smoke-free campus policy was actively monitored and violations were very rare; compliance was estimated at 99% among employees and patients and 95% among visitors in an internal report prepared in 2006.

In 2006, the Employee Wellness Program secured a $1 million grant to develop a tobacco treatment clinic to help patients and employees quit smoking. This allowed the Employee Wellness team to develop a deep expertise in the most effective evidence-based tobacco treatment methods, establish direct referral relationships with all of the clinical departments, educate clinicians on the importance of tobacco cessation within their medical specialties, and add lifestyle factors to the first page of the electronic medical record used for every patient visit in every medical office in the Clinic. Cumulatively, these developments helped establish the scientific credibility and clinical relevance of the employee wellness program among physicians and other clinical staff.

Legislation and Community Support
The next foray into smoking policy was to join forces with antitobacco advocates throughout Ohio to help successfully pass “SmokeFreeOhio,” a 2006 ballot initiative that made public places smoke-free and required all Ohio workplaces and restaurants to implement smoke-free policies. Equally important, advocacy efforts helped defeat “SmokeLessOhio,” a ballot initiative covertly introduced by the tobacco industry that would allow smoking in some workplaces and public places and prohibit local communities from passing more restrictive policies. The Clinic’s efforts included mobilizing local media and sports celebrities as well as Clinic medical staff to expose the tobacco industry’s attempts to mislead the public and educating the public on the risks of secondhand
smoke. Several thousand Clinic employees staffed information tables in each of the hospitals and clinics and distributed more than 5000 yard signs and flyers in support of SmokeFreeOhio. The Clinic also supported a successful companion initiative on the local Cuyahoga County ballot that added an excise tax of $0.345 per cigarette pack. Immediately following the successful defeat of SmokeLessOhio and passage of the SmokeFreeOhio and excise tax ballot initiatives, the Clinic launched a Cuyahoga County-wide campaign that provided free nicotine replacement therapy (NRT) to any county resident who called the state quitline and engaged the same group of celebrities to promote the quitline. Call volumes tripled in the County during the 6 months of the campaign. These forays into tobacco advocacy were the first time the Clinic got involved in any public policy issue beyond hospital-specific issues. It solidified Dr Cosgrove’s external image as a health advocate, established the Clinic as an antitobacco stalwart, demonstrated the ability of the employee wellness program to mobilize employees, galvanized engagement of thousands of employees who were part of a successful campaign, and reinforced the culture of good health.

**Hiring Practices**

**Tobacco use.** The Clinic’s final action related to smoking policy was to stop hiring smokers in 2007, a rare policy among employers at the time. The CEO’s motive was to eliminate the embarrassingly poor role modeling of Clinic employee smokers gathering just outside the entrances to each of the hospital campuses. The local reaction to the policy was mild, and the policy stimulated several local colleges to establish smoke-free campuses to encourage their students to quit smoking, so they would not be excluded from job opportunities at the Clinic, the largest employer in town, after graduation. It also stimulated hospitals across the nation to implement similar policies. A secondary benefit of this policy was to avoid the extra $2056/smoker in annual medical costs.6

**Fitness.** In an effort to reduce occupational injuries, applicants for bedside nursing, patient transport, and maintenance positions had to pass a fitness test before being hired, beginning in 2012.

**Physical Plant**

In 2006, a member of the Employee Wellness Program team joined the construction committee which oversaw more than 100 major construction and renovation projects representing several million square feet of space, with the goal of helping the committee think about how to stimulate physical and other healthy activities as a core goal of all new construction and renovation projects. This influence has been subtle in some instances; for example, more natural light and higher quality artificial light, health promotion messages, artwork and music have been added to many existing stairways. In other cases, the influence has been more profound, including placement of visible, attractive stairways with directional signage in major public areas of new construction; building hallways and lobbies wide enough with good lighting to handle large flows of walkers; adding bicycle racks to many parking lots, shower rooms, and lactation rooms to some; and adding relaxation/rejuvenation spaces for nurses in several inpatient care areas. New small (1500 sq ft) fitness facilities were added at 6 hospitals and expanded on the main campus.7 Fitness center memberships grew from less than 2000 before expansion to more than 5000 by 2016. Landscaping has been enhanced with flowers and paths to make walking easier and scenery more attractive. These enhancements had minimal impact on construction costs and are consistent with goals of achieving LEED certification and providing more comfortable spaces for patients and visitors.

Collectively, these efforts helped establish the employee wellness program as a scientifically credible entity compatible with the culture of a world-class hospital that could mobilize thousands of employees, establish linkages with all levels of clinical and administrative units, enhance the visibility and stature of the Clinic in the public health community, and improve health. This helped build the foundation on which more intensive traditional lifestyle change programs could be built.

**Lifestyle Change Programs and Incentives**

Having the leadership team in place and the organization structure aligned provided a context that allowed the development of sophisticated lifestyle change programs and incentives that had the potential to attract a critical mass of employees and spouses.

**Coordinated Care Programs Focusing on Chronic Conditions**

The center piece of the Clinic’s lifestyle change program is the CCP. Initially created in 2003 and significantly enhanced in 2009, CCP focuses on reducing the prevalence of 6 chronic conditions that are most prevalent among Clinic employees and most expensive to the health plan. These include obesity, hypertension, tobacco use, hemoglobin A1c, cholesterol, and asthma. Telephonic coaching with a nurse or other health professional certified in treating that condition was provided for each of these conditions. Coaching components included an individualized assessment, collaborative articulation of improvement goals, treatment plan monitoring schedule, and referral to the wide range of program offerings in the Employee Wellness Program. The CCP plans complemented efforts of primary care physicians (PCPs). Some employees had already been working with their PCP, some engaged their PCP as a result of these programs, and others worked primarily with the CCP counselor. The treatment plan might consist of a combination of medical and cognitive-behavioral treatments. For example, for tobacco use, the medication plan might include NRT, bupropion, or Chantix and the cognitive therapy might include an online training program, telephone counseling, and in extreme cases, referral to more intensive psychotherapy. Disease management programs were offered in 21 other chronic disease programs, primarily in telephonic format.

The CCP may be the single most important element responsible for helping employees reduce chronic disease markers. Enrollment in CCP grew from approximately 1500 in 2009 to approximately 2000 by 2018. The many other programs offered by the Employee Wellness Program provided the tools necessary to help employees maintain motivation, gain the skills necessary to change health behaviors, and the opportunities necessary to practice them on a regular basis and make them habits. Employee Wellness Program offerings include health assessment tools; courses in nutrition, stress management, physical activity, and other topics; fitness center memberships; and opportunities to serve in peer leadership roles. These offerings are described in detail on the employee website.8
Healthy Choice: Extrinsic Incentives

Healthy Choice, the financial incentive linked to the employee wellness program, was first offered in 2010. Employees who choose to enroll in Healthy Choice and participate in CCP receive a 15% discount off the standard individual health premium, and those who meet specific health standards receive a 30% discount on an individual plan. For married couples, the discount is 7.5% for participation if the spouse or employee joins and participates, and 15% off the married health plan rate if both join and participate. Similarly, the discount is 22.5% if one spouse meets health goals and the other does not and 30% if both meet health goals. Participation is defined as having up-to-date health assessment on the 6 chronic conditions and participating in a coordinated care program for those chronic conditions or meeting the physical activity standard of at least 900 minutes/month or visiting an approved fitness center at least 10 times a month if the individual is not at risk for one of the 6 targeted conditions. Meeting the health standard is defined as meeting the goal set in conjunction with a care provider for each of the chronic conditions, being up-to-date on immunizations and screenings, and seeing a PCP at least once every 2 years. Other provider visits (eg, seeing a registered dietitian or having an eye examination or foot examination for those in the diabetes management program) may be part of the treatment protocol. No cost shifting from employer to employee was associated with implementation of Healthy Choice. The ratio of premium sharing between employee and employer, deductible amount, and co-pay were maintained, with one exception. The co-pay for emergency department (ED) visits was increased from $150 to $250 to encourage employees to use same-day primary care services rather than the ED for minor problems.

Reasonable alternative standards for meeting participation and health standards criteria have been developed as necessary based on employee’s health challenges. Data on the chronic health conditions are gleaned from health plan claims and medical records based on visits to PCPs rather than through health screenings. Employees with incomplete or out-of-date data are encouraged to schedule a follow-up visit with a PCP. Additional details on meeting the standards can be found at the Healthy Choice Program Guidelines website.5

Enrollment in Healthy Choice grew from approximately 30% of health plan employees in 2010 to 50% by 2014 and approximately 69% of health plan employees’ spouses by the end of 2018. Several thousand additional employees participate in Employee Wellness Programs but have chosen not to enroll in Healthy Choice. Health plan members who do not enroll in Healthy Choice have access to all of the employee health plan wellness program offerings including the CCP. Employees and spouses not enrolled in the health plan have access to most programs provided by the Employee Wellness department, but sometimes at a higher cost.

Integrating financial incentives into the health plan premium and the outreach associated with doing so is probably the most important factor in motivating such a large portion (69%) of eligible employees and spouses to enroll in the Healthy Choice program.

Acceptance of the Healthy Choice incentive program was also a process that required many years of groundwork before being implemented. The employee health plan had offered co-pay reimbursements to employees who followed prescription medication protocols beginning in the early 2000s. Participation was low, with only a few hundred employees involved each year. The impact of these incentives on adherence to medication protocols was never formally measured, but this experience introduced senior benefits managers to the idea of financial incentives. A lottery-based incentive system was introduced in 2005 with the goal of nudging employees to think about the dimensions of healthy lifestyle and enhancing the visibility of the employee wellness program rather than stimulating actual health behavior change. Each month, employees were encouraged to reflect on 5 dimensions of optimal health: physical, emotional, social, spiritual, and intellectual health by completing a questionnaire on activities they had completed in each dimension in the past month. Submitting the questionnaire entered them into a lottery. Monthly prizes included token gifts, dinners at local restaurants, and one $100 cash prize. The quarterly prize was a long weekend for 2 at a local resort, and the annual prize was a week in Hawaii including 5 days of vacation time. Average participation rates hovered around 40% of employees. Responses to questionnaires were tracked but not analyzed. Efforts to integrate financial rewards into the health plan premium for participating in lifestyle change programs or achieving health goals began in 2006. At the time, Health Insurance Portability and Accountability Act (HIPAA) regulations allowed a premium differential of up to 20% for participation and/or achieving health goals. However, the Personnel Director and Health Plan Medical Director vigorously opposed integrating financial incentives into the health plan and blocked implementation during their tenure. When they retired, they were replaced by people who embraced this approach and worked efficiently to refine and implement plans within a year. Healthy Choice was first offered to employees in 2010 and to spouses in 2015.

Factors Most Important for Success

The first part of this article provides a brief summary of changes in leadership, organization integration, policies and physical plant, lifestyle change programming, and incentives implemented at the Cleveland Clinic with the goal of improving employee health. The comments below are a subjective reflection of the authors’ opinions on the factors most important in improving employee health and reducing medical costs at the Clinic.

Championship Team

The CEO was an obvious critical champion, but the team of professionals he assembled to develop and manage these efforts was equally important. The dozens of mid-level clinicians and executives involved were necessary to engage employees throughout the 200+ Clinic locations and sustain interest over time.

Link to Core Organization Values

The CEO’s original motivation was to reduce preventable disease and premature deaths from tobacco and junk food and to nurture a workforce that could serve as positive health role models for patients suffering from diseases caused primarily by lifestyle. He never discussed cost savings and had no interest in measuring it in the earlier years.

Organization Integration

Placing Healthy Choice (incentives) and the CCP (chronic disease management) in the employee health plan, coordinating treatment efforts with primary care staff physicians, and drawing on the staff and programming services of the Wellness Institute wove employee health promotion efforts into the fabric of the Clinic. In fact, the
process of employees going to their PCPs to get help in achieving normal biometric values for 6 chronic diseases (“six normals”) caused these physicians to challenge their nonemployee patients to strive to achieve six normals as well, further meshing the program into the culture and core values of the Clinic.

**Allocating Resources to Improve Health, Not Treat Disease**

Beginning in 2010, all of the costs related to wellness initiatives at the Clinic were covered by the employee health plan, either directly through services provided by health plan staff or contractors or by purchasing services from other units of the Clinic. This did not eliminate pressures to control program costs but shifted those costs to be viewed through the lens of treatment costs of medical procedures, which were more expensive by orders of magnitude. For example, a freestanding annual program budget of several million dollars by itself would be perceived as significant on its own, but as an element within a health plan budget of $450 million, it would represent about 1% and be comparable in total cost to several neonatal intensive care visits or heart transplants.

**Long-Term View**

It took nearly a decade for leadership attitudes to be supportive of significant financial wellness incentives and 4 years to assemble and structurally align the full team leading this effort, integrate with the health plan and primary care, refine policies, alter the physical plant, and develop lifestyle change programs that could scale to reach the entire employee population. Several more years were then spent engaging a critical mass of employees and spouses. Furthermore, no changes in the health plan cost curve, that is, no indication of any savings, were detected until 2011, and a consistent trend of continual reductions in the rate of increase did not emerging until 2013, 8 years after launching these initiatives. If Clinic leadership expected a comprehensive program to engage a substantial portion of the population and structural changes to be implemented immediately, these efforts may have been terminated after a few years. Similarly, the medical care cost savings were an unexpected bonus, not part of the original stimulus for the program. If leadership had expected savings within a year, or even 5 years, the program may not have survived.

**Galvanizing Events and Early Wins**

The CEO’s decision to make public commitments to remove toxic foods and exposure to secondhand smoke from Cleveland Clinic campuses; play a critical advocacy role in passing statewide smoke-free workplace and county-wide tobacco excise tax ballot initiatives; and triple county-wide call volume to the tobacco quitline within the first 2 years of the launch of the Employee Wellness Program crystalized the Clinic’s identity as an organization that would take aggressive action to protect health and stimulate healthy lifestyle. This reinforced the CEO’s and C-suite leaders’ commitment to improving employee health and their receptivity to relevant budget requests and organization restructuring. It also enhanced employee and medical staff interest in becoming engaged and even patients’ expectations about the type of care they would receive at the Clinic . . . collectively providing the first tangible ripples in the evolution of cultural norms toward supporting healthy lifestyle.

**Therapeutic Dose**

The cumulative effect of changes in policy, physical plant, mobilizing champions, health plan incentives, collaboration with PCPs, supervised goal setting, access to lifestyle change skill building, opportunities to be physically active, eat nutritious foods, and breathe smoke-free air over more than a decade of time provided the therapeutic dose of influences necessary to help employees and families change unhealthy lifestyle habits they had formed over decades of time and maintain them long enough to have a measurable impact on health.11

**Conclusion**

The experience of the Cleveland Clinic shows that it is possible for employers to substantially improve the lifestyle practices and health conditions of employees and significantly reduce medical spending for employees and employer in the process. This article provides an example for other employers to consider as they strive to achieve similar outcomes. Cleveland Clinic senior leadership decided to invest substantial time and financial resources in this effort because nurturing a healthy workforce was consistent with, and perhaps even prerequisite to, its core organization value of providing high-quality patient care. That connection to core values may be the factor that predicts which organizations will be willing to make similar investments.

**References**

Whenever a news story breaks about the latest research in workplace wellness, I am often called by reporters unfamiliar with our work who then ask me to comment on the findings. The first thing I do is broaden their understanding of what it means to have a workplace health promotion program and what evidence-based HWB programs look like.

The conversation involves explaining that successful programs are not merely extensions of medical services whereby a provider (coach, clinician, or other health professional) attempts to change an employee’s behavior by having that employee start to eat right, exercise more, stop smoking, begin relaxation exercises, or go to the doctor to have a preventive examination. No, I continue, a successful program is one that is embedded in and supported by what is often referred to as a “culture of health.”

To make it personal, I illustrate some of the barriers to employee HWB. I note that an employer can’t expect you to adopt a healthy lifestyle if there are no healthy food options available, if you’re tied to your desk for 8 hours a day, if there is no opportunity to take physical activity breaks, if your supervisor is imposing unrealistic deadlines with no support to meet those deadlines, and because of long work hours and high demands you have little time for family, friends, or even sleep. We end our conversation by agreeing that the above scenario is not conducive to improving one’s individual health, never mind an entire workplace population’s health. No wonder health-care costs are rising, workers are being injured, absenteeism is up, morale is down, and finding qualified talent has become more difficult.

The reporter then often tells me about his or her work experience—woke up early, working late tonight, eating junk food, sitting all day, gaining weight, feeling stressed out—and that’s just today’s schedule. The final question from the reporter is usually as follows: “Can you point me to companies that have figured out how to build healthy workplaces by building cultures of health and applying strategic communications.”

That’s my opportunity to point the reporter to our website (www.thehealthproject.com). Since 1994, The Health Project has sought out organizations’ exemplary HWB programs with documentary evidence that their programs have enhanced workers’ health and delivered positive business results for the enterprise. Over 75 companies have been recognized and received the C. Everett Koop prize for outstanding workplace health promotion and disease prevention programs. These organizations have judiciously adopted evidence-based practices, which has allowed them to not only design and implement exemplary programs but also collect credible data showing the programs work. Their results are impressive on all fronts including outperforming the Standard & Poor’s average stock performance from 2001 to 2014.

In the remainder of this issue of TAHP, we feature 4 companies that have been recognized by The Health Project for their award-winning programs. They are American-USA, Delta Air Lines, Kaiser Permanente, and LGE-KU. We’ve asked program champions from each of these companies to reflect upon the factors that inspired them to design and build exceptional programs and how they went about gathering evidence of the program’s success. Specifically, we asked each of the company’s representatives to address the following topics:

- How did they go about designing an HWB initiative that is specific to your organization?
- What are the most critical aspects (success factors) of your program, and how have these contributed to your success?
- How did you gather data and present results to your key stakeholders to gain their buy-in and sustain ongoing support for your efforts?

The following short essays are mini case studies of successful programs—the what, why, and how these programs thrive—and how they went about building cultures of health and applying strategic communications.

References


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