



Published in final edited form as:

J Occup Environ Med. 2025 August 01; 67(8): 581–587. doi:10.1097/JOM.0000000000003414.

Advancing Employer Cultures of Health and Well-being: Lessons for Business Coalitions and Employers

Raymond Fabius, MD¹, Michele Bildner, DrPH², Neil I. Goldfarb, BA³, David Kirshenbaum, MBA⁴, Dixon Thayer, BS⁵, Ivor R. Kiwi, MBA⁶, Sharon E. Phares, PhD⁷

¹HealthNEXT, Newtown Square, PA, United States

²Independent Researcher (present), CDC Foundation (during the work), St. Louis, MO, United States

³Greater Philadelphia Business Coalition on Health, Philadelphia, PA, United States

⁴HealthNEXT, West Hartford, CT, United States

⁵HealthNEXT, Unionville, PA, United States

⁶HealthNEXT, Beachwood, OH, United States

⁷Tufts Medical Center, Boston, MA, United States

Abstract

Objective: To determine the impact of a collaborative effort by employers to improve their organizations' cultures of health and well-being.

Methods: The CDC Foundation partnered with two organizations to help employers use an established methodology - an industry-validated baseline assessment, along with a strategic roadmap and guidance from physician executive experts. Employers implemented this approach and simultaneously participated in a structured monthly learning collaborative.

Results: The average projected improvement in the culture of health scores from baseline to year-end was 80 points, moving from 60% to 71% achievement of the benchmark score.

Conclusions: This research demonstrates that employers working collaboratively and following an appropriate sequence of scientific-based approaches, can demonstrate a positive trend in

Sharon Phares, PhD MPH, Tufts Medical Center, Center for Biomedical System Design & NEWDIGS, 800 Washington Street, Box 63, Boston, MA 02111, Sharon.phares@tuftsmedicine.org.

Fabius: Project conceptualization, project management, data collection, analysis, manuscript contributions – Bildner: Project conceptualization, project management, data collection, analysis, manuscript contributions – Goldfarb: Project conceptualization, project management, data collection, analysis, manuscript contributions – Kirshenbaum: Project conceptualization, project management, data collection, analysis, manuscript contributions – Thayer: Project conceptualization, project management, data collection, analysis, manuscript contributions – Kiwi: Project conceptualization, project management, data collection, analysis, manuscript contributions – Phares: Analysis, manuscript contributions

Authors Fabius, Kirshenbaum, Thayer, Kiwi are employed by HealthNEXT, which provides health and wellbeing consulting services. However, their compensation was not dependent on the results obtained in this research. Authors Bildner, Goldfarb, and Phares NONE DECLARED

EQUATER Network – not applicable

NO AI utilized in any stage during research development & design, data collection, manuscript preparation

This project does not require Institutional Review Board (IRB) approval because it does not involve human subjects as defined by federal regulations, and therefore is not considered research subject to IRB oversight.

organizational cultures of health and wellbeing scores pointing to the possibility of sustainable culture change.

Keywords

employers; culture of health; population health; occupational health; well-being; collaborative approach; community health

INTRODUCTION

Employers provide health benefits for more than 50% of all Americans¹ and are interested in preventing and managing chronic conditions to advance workforce health and performance, work engagement, and worker retention.² Employers are also aware that improving population health helps lower direct costs, such as the cost of providing health benefits and health-related programs, and indirect costs, such as lost productivity associated with ill health for employees and the family members they serve as caregivers.³

In recent years, the employee health and well-being movement that grew exponentially at the turn of the century⁴ has been met with concerns about consumer engagement, the impact on outcomes, and the cost-effectiveness of outsourcing programs to wellness companies, chronic disease management companies, and other vendors and partners.⁵ The movement toward more comprehensive approaches with labels such as “well-being”, “total worker health”, and “whole person health” demonstrates progress but continues to face challenges such as low engagement among the highest-risk individuals; under-resourcing of internal staff needed for adequate coordination, implementation, and evaluation of programs; unrealistic expectations about time horizons to affect meaningful change; and prohibitive costs and administrative requirements for all but the largest employers.⁶

Recognizing the importance of advancing chronic disease prevention and management for employed populations and their families, the CDC Foundation invested resources in mapping the current environment for employee health and exploring the evidence base for effective employer-based programs. The resulting model of factors influencing a “workplace culture of health and well-being” aligns well with the years of work HealthNEXT has spent developing a systematic methodology for objectively measuring a culture of health, identifying actions that can advance this culture, and tracking employer progress in forging a comprehensive, nurturing culture of health.^{7,8} HealthNEXT and the Greater Philadelphia Business Coalition on Health (GPBCH), which brings employers in Southeastern Pennsylvania, Southern New Jersey, and Delaware together to improve population health and the value delivered by the healthcare system, share a commitment to not only improving the health for employed populations but to elevating health for everyone in the region, under the belief that employers lead by example and can significantly influence and contribute to building healthier communities and more equitable care, using an industry-validated, evidence-based framework. Together with the CDC Foundation, this trio of organizations provided a unique and innovative approach to improving health and well-being in the workplace.

The workplace has been recognized as ideal for helping employees and their families manage their health since at least the early 1980s.⁹ Employees spend about one-third of their waking hours working.¹⁰ Employers with established cultures of health and well-being surround employees with the environment, policies, and cues that support making conscious and unconscious healthy choices.¹¹ The benefits of improving a culture of health are many for employers, including managing healthcare spending, improved productivity, absence management, attracting and retaining quality employees, better employee engagement, enhanced workplace safety, improved organizational reputation, and even increased financial performance.^{12–16}

Quantifying a culture of health and well-being can be done using one or more tools developed to provide a corporate health assessment score (CHAS).⁷ While it is possible to track a population's medical and pharmacy claims information, health appraisals, biometric screening results, and other process measures as a proxy for measuring a culture of health and well-being, these measures alone express reductions in the collective illness burden or costs associated with healthcare, rather than genuinely measuring the multi-faceted concept of a culture of health and well-being. Developing a sustainable culture of health and well-being requires a systematic approach addressing transformational drivers of culture change, as well as comprehensive efforts to improve health and well-being to reduce costs and illness burdens. It also considers social determinants of health and emotional, social, and financial well-being.

This research aims to demonstrate the value of a systematic approach to advancing the culture of health and better addressing the prevalence and impact of chronic disease in employed populations. The research investigates the process for implementing an intervention combining a corporate health assessment score for baseline measures and identifying areas for improvement with expert consultation within the establishment of a learning collaborative across employers, followed by a projected reassessment score.

Participant Recruitment

Recruitment for participating organizations began in late 2021, with GPBCH contacting their coalition employer member organizations to inform them of the project aims and methods and inviting them to participate. Investigators from GPBCH and HealthNEXT explained the expectations for participating and the potential benefits to employers who expressed interest. Participation was completely voluntary. No incentive was provided beyond the value of the benefit from HealthNEXT's expertise and support from GPBCH and CDC Foundation personnel and technological/administrative resources, which was provided to participating employers at no cost to them throughout the project. Seven employers agreed to participate in the project, representing a total of 184,796 employees. As shown in Table 1, employers differed considerably by industry and size with number of employees ranging from 160 to 112,886.

PROGRAM DESIGN

Overview

The HealthNEXT methodology uses a CHAS tool designed to meet the needs of all employers. Each employer participant completed a baseline assessment, from which the results generated scores. The scoring prompts an output of recommended tasks to address gaps and be performed in the appropriate sequence to improve the employers' scores across ten pillars and corresponding factors, compared to the benchmark score. These tasks are highlighted in a comprehensive roadmap designed to improve performance in areas that the employer, working with a HealthNEXT physician executive advisor, prioritized to address for the length of the program. The CHAS tool for the assessment featured fifty factors required to build a sustainable culture of health, safety, and well-being. Each factor is scored with a maximum total of 1,000 points possible. The benchmark score or goal for organizations performing well in the areas of health and well-being is seven hundred and fifty (750). The ten pillars and the methodology behind scoring them are described in more detail in previously published work.⁷

Physician Executive Advisors

The program methodology included assigning every employer participant a population health expert with years of corporate clinical experience in medical management and leadership. These physician expert advisors are trained and certified in using the assessment tool and guiding the implementation of the generated strategic roadmap. The assigned expert collaborated with the employer to gather the needed data, which was uploaded into the CHAS platform to generate and document both an initial baseline assessment score as well as the reassessment score one year later.

Assigned advisors performed over four hundred hours of support to participating employers, identifying gaps from benchmarks, sharing best practices, helping members prioritize their efforts, and continuously reviewing progress against goals. During the last 3 months of the first year of implementation of the strategic plan (intervention period) they began to rescore where employers would be after implementing the generated strategic plan for a full year. This forecasting approach was done to comply with the scheduled closure of the grant. The assigned expert collaborated with the employer to gather the needed data, which was uploaded into the CHAS platform to generate and document a baseline assessment that identified gaps from best practices in areas that impact a culture of health and well-being and generated a multiyear plan to address these gaps. Working with the employer, the expert helped prioritize the blocks of work. The expert also provided ongoing support to help encourage progress on each block of work, as well as participating as desired by each employer in relevant health and well-being vendor partner meetings and assisting on project work.

Employer Learning Collaborative (ELC)

A unique feature of this program was the establishment of a GPBCH-led monthly Employer Learning Collaborative (ELC) with all participating employers, who were typically represented by an HR or benefits leader, director, manager, wellness leader, or

other interested and aligned role director. The ELC meetings were hosted as virtual sessions for the project period to provide participants a forum to share their experiences, wins, and concerns and identify best practices with each other and with the investigators. ELC sessions included guest speakers with subject matter expertise on shared scoring gaps from public health, population health, and C-suite business leadership to advance employer knowledge and engagement further. Participating in the ELC also served as an additional incentive for employer networking and an accountability structure for employers to make progress on their CHAS-guided improvement plans.

DESIGN

To answer these questions, data were collected from multiple sources and methods to foster a mixed- and multi-methods cross-sectional developmental evaluation design. Developmental evaluation aims to nurture learning with rapid, real-time feedback and diverse, user-friendly forms of feedback. The evaluator's primary functions are to elucidate the innovation and adaptation processes, track their implications and results, and facilitate ongoing, real-time, data-based decision-making in the developmental process.¹⁷

DATA COLLECTION/METHODS

An employer description questionnaire was completed by participating employers at the start of the project, describing characteristics of their workforce (e.g., age, gender, and race/ethnicity proportions) and health and well-being benefits offerings. Second, each participating employer completed an initial assessment using the CHAS tool with the assistance of their assigned physician executive advisor. After the assessment, employers and their advisors met to establish individualized improvement plans and schedule ongoing consultations throughout the project. Toward the end of the project period, each employer was assessed again, and each employer provided data on the progress made and where they felt their organization would be at the end of the intervention period – a full year after the baseline assessment was completed. The time for all employers to complete the initial assessment took three months, given the detail needed to fully assess baseline metrics. Given that all employers were also managing the additional burden being placed on leadership, human resource personnel, and employees due to the COVID-19 Pandemic, the follow-up assessment was started at month nine following the beginning of the intervention period to allow enough time for the follow-up assessment to be completed. During the final three months while the follow-up assessment was taking place, the employer and physician executive expert continued to track progress.

The data from the follow-up assessment was used together with input from their physician executive advisor to project expected progress by the end of the year. Additionally, qualitative data on barriers, experiences, and best practices were collected during the Learning Collaborative meetings and at the end of the project. At the end of the period, employers participated in individual exit interviews to provide insights on what they learned, their perspectives, and suggestions for celebration and improvement. All employer participants received a projected model reassessment, scoring them on anticipated improvements one year post the original assessment.

It should be recognized that the employers were initially scored and reassessed by their assigned physician executive advisor. Due to potential concerns of inter-reviewer reliability, all CHAS scores were validated by review with a second independent physician executive advisor. The scores on each item were then compared and any discrepancies receiving an additional data review and discussion by both physician executive advisors.

ANALYSIS

Quantitative

Quantitative methods were used to evaluate certain aspects of the program in relation to research questions 1 and 2. The quantitative analysis first consisted of developing a baseline score of each participating employer to identify each employer's gaps and best practices for fifty unique factors under ten pillars. For example, under the pillar of Marketing & Communication, one factor scored was whether or not there was a brand and logo for the health and well-being efforts. The resulting scores were weighted based on their impact of the factor on the overall culture of health and well-being. The scores were aggregated across all participating employers in order to establish the range of scores and identify factors that have already been most fully implemented and those with deficits, offering common or shared opportunities for improvement across the participating organizations. Additional information on the assessment and scoring process can be found in previously published work.¹⁸

At the project's conclusion, based on progress and in-depth discussions between the assigned physician executive advisor and the employer, anticipated progress, each employer was re-assessed and documented to determine progress. All actual or projected improvements for the 12 months following the initial assessments were documented and placed inside the assessment platform for review. The physician executive advisor reviewed the documentation and scoring with a second advisor to ensure the reliability of the scoring. At the end of the program, GPBGH administered a questionnaire using a Likert scale to evaluate the program's value to the employer. See Table 2 for the questionnaire and results.

Participants: All participating employer organizations and their representatives participated in the quantitative analysis (N=7).

Qualitative

In addition to the discussions between the physician executive advisors and participants to assess and forecast progress, qualitative methods were used to evaluate certain aspects of the program in relation to research questions 3 and 4. Participant interviews and an open-ended survey were administered to collect the data. The interviews also included a numerical assessment of the following project components using a scale of 1 to 10: the assessment process, the strategic roadmap, the physician executive guidance, best practice sharing in the Employer Learning Collaborative (ELC), expert presentations in the ELC, and the overall focus and effort required. The written responses were designed to provide insights into the project's sustainability.

Participants: The participant organizations varied by the organizational roles of their representatives, their professional experience with employer health and wellbeing, their organization's health, and wellbeing efforts, and how they describe an employer culture of health and wellbeing. As indicated in the findings below, these differences were material to how the participants experienced the project and what they found valuable. A total of eight (8) individuals were interviewed, representing six (6) of the seven (7) participating employers. Written responses were received from five (5) of the six (6) organizations where discussions were held.

RESULTS

Quantitative

The project's short-term results were very promising. Projected scores showed a significant narrowing of the gaps from the benchmark in many factors. The average improvement from baseline to projected year-end score was eighty points (e.g., 450 to 530), moving from 60% to 71% of the benchmark. The lowest-scoring employer organization improved the most, improving over 125 points.

As shown in Figure 1, upon completing the baseline assessments by all seven participating companies, the lowest scoring pillars were health and wellness strategic plan, leadership and management, marketing and communications, vendor oversight and integration, and engagement and navigation. The cohort of employers improved the most in leadership and management, marketing, and communications, and having a health and wellness strategic plan. Improving many of the pillars, such as vendor oversight and integration and incentives and benefits design, typically takes longer than a one-year period due to contracts and the complexity of making changes involving other organizations. For example, benefit design changes are typically done, at most, once annually.

At the individual factor level within each of the pillars, the highest scoring factors at baseline were having multiple components of well-being (e.g., physical, financial, social, etc.), having a population health perspective, having access to health promotion offerings during the workday, first aid and first responder training, and having onsite, near-site, or virtual fitness offerings.

Projected improvement at the end of the first year was lowest for having multi-vendor summits, having onsite or near-site clinical affiliation, having completed a barriers analysis, home communications for employees and their families, and having completed an annual goals and assessment process.

Documentation collected during the assessment process showed that for these employers, the most challenging barriers to advancing the culture of health included prioritizing health and wellbeing initiatives with other corporate initiatives and projects, such as open enrollment. Having the right people engaged in the success of improving the culture of health and wellbeing is also critical. Two key barriers related to personnel, including not having an internal benchmark champion such as someone focused on disability and workers compensation claims review, the marketing of vitality, and recruiting and onboarding, as well as when

there is turnover of key personnel that the program team was working with, impeded progress towards goals.

The greatest improvement over time from baseline to reassessment was in the three pillars: Leadership and management, marketing and communications, and health and wellness strategic plan. Success is primarily attributed to leadership and management being engaged in the project and strategic planning. This is beneficial because resources are allocated accordingly. Additionally, when the physician executive advisors are heavily engaged on a weekly/monthly basis, the tasks and initiatives move to completion at a more rapid pace.

Although not generalizable given the small within group sample size, we also analyzed whether organization size (e.g., number of employees) and industry affected improvement by pillar. Overall improvement from baseline did not appear to be impacted by size with the smallest organization (160 employees) total baseline to projected score improving by 21% (92 points), midsized organizations (1,240–6,500 employees) improving by an average of 13% (64 points), and large organizations (19,200 – 112,886 employees) by 22% (91 points). Improvements by pillar did not have any discernable pattern by organization size, although large organizations tended to score higher on both initial and projected scores on the pillars of health and wellness activities. The largest overall improvement from baseline score was by a large organization whose score improved 67% (126 points). This organization also had the lowest baseline score (187) yet made tremendous improvements raising their score to 313 and showed improvements in eight out of ten pillars. No differences by industry type were found.

The questionnaire administered by GPBCH at the end of the program returned a response rate of 85.7% (6 out of seven employers). The results are shown in Table 2.

The results were overwhelmingly positive. Program components that participants found particularly helpful, with all responding that they agreed or strongly agreed, included:

- Participating in the program met the expectations I had when my organization agreed to participate.
- Participating in the program helped advance their organization's culture of health and well-being.
- As a result of participating in the program, I expect that the organization's leadership will be more supportive of our efforts to build a culture of health and well-being.
- Participating in the program will benefit the health and well-being of our workforce.
- As a result of having participated, I believe I will be more successful in my role of promoting population health and well-being.

Qualitative

As shown in Table 3, the overall assessment of the project impact was favorable, with an overall average score of 7.5 out of 10, with scores ranging from 5.48 to 8.33. Average

scores ranged from 8.70 for focus/effort, 7.82 for the physician advisor, 7.67 for the learning collaborative experts, and 7.65 for the strategic plan. The assessment and learning collaborative sharing during meetings averaged 6.96 and 6.58, respectively. The assessment scored lower because of the time commitment to gather and complete the data. The learning collaborative meetings themselves had considerable variation in scores, with participants noting variation in the cohort ranging from companies just starting to think about health and well-being to organizations with more mature offerings, as well as logistical issues for some participants.

Participant quotes provide context beyond the program's impact scores from Table 3. These include:

- “I wish we could keep this going for many, many years, because I know that’s what it’ll take to get us to where we want to go. During that time, there’s going to be things in the market that will change, and it would be great to have a group and an expert to be able to bounce ideas off of.”
- “It was a great experience because it opened my eyes to where the holes are, where we’re lacking, what we really could do better, and also it highlighted for me what we’re really great at.”
- “The single biggest impact is being able to organize everything we want to do in a meaningful way.”
- “The project has clearly demonstrated that messaging and plan has to be clearly defined, articulated, and be a constant force in order to facilitate change and truly promote a culture of health.”

The written responses expressed participants’ expectations for the future after participating in the well-being collaborative. All five respondents strongly agreed or agreed that they expected the leadership of their organization to be more supportive of a culture of health and well-being, that their organization could accomplish the actions identified as their next steps, that their organization to dedicate more resources to promote a culture of health and well-being in the future, and that the strategic plan developed with their physician executive advisor will be the primary guide for actions over the next five years. Responses were varied on expectations for measurable improvements in the health and well-being of their employees, belief in more personal success in their role promoting health and wellness in their organization, and that they have a different perspective about what employers can do to promote health and well-being among employees.

DISCUSSION

This program set out to answer four research questions, including which attributes of a culture of health most often fall below the benchmark, which implementation barriers are the most challenging to address among employers, what factors facilitate improvement, and what successful approaches to advancing a culture of health were most observed. Additionally, the study hoped to determine if an aggregated business community score

across multiple employers in the same community was perceived as valuable in improving population health by fostering public-private partnerships.

Employers in this study cohort shared many of the same challenge areas, such as multi-vendor summits to coordinate all the partnerships which can impact the health and well-being of a population, communicating health and well-being offerings to employees and their families at home, conducting formal barriers analysis, and having frequent and systematic tracking of health and well-being data. Improvement was seen most in areas under employers' full control, including engaging leadership and management, marketing, and communications, and having a culture of health strategic plan, where those that involved outside partners were more challenging to implement during the one-year study period.

This program demonstrated the power of a collaborative learning approach to engage and empower employers to learn best practices from their peers and external evidence-based best practices. Learning from each other allows for collective approaches to challenges and supports organizations as they embark on improving health and well-being. The collaborative experience was noted as being a helpful way to discuss ideas, learn about everyday struggles and how to overcome them, and adopt best practices from other employers in the same community.

Additionally, operational excellence was encouraged by using a systemic process improvement approach. Evidence-based processes require baseline and periodic remeasurement to track progress over time along with mechanisms to close gaps from best practices. The standardized approach was noted as being extremely helpful. For example, in the qualitative assessment one participant said, "The single biggest impact is being able to organize everything we want to do in a meaningful way." Employee health and well-being work can be overwhelming, so a structured process helps organize and prioritize work for incremental success. The challenges noted by the program participants in collecting baseline data indicate the lack of regular collection of and measurement in areas critical to creating a culture of health, wellness, and safety and show employers how important it is to measure what they want to maintain or improve.

More important than short-term changes in CHAS scores, the participating employers noted shifts in how they approached health and well-being efforts. For example, increased senior leadership support led several participating organizations to add dedicated or designated staff focused on health and well-being efforts. It also empowered human resource professionals to integrate more with other areas such as safety, marketing, and communications. Leadership support and management alignment for health and well-being are foundational for program success and sustainability.

The participants also appreciated that many of the recommended blocks of work were internal and did not require additional funding or years of effort, such as organizing a broad-based corporate health and wellbeing committee to direct and review progress over time.

Many companies value improving their organizations' health, well-being, and safety by investing time and other resources. Engaging multiple employers in a larger collaborative

learning project was made possible by contractual funding but could be done by a collection of interested organizations willing to invest in coordination over several years.

Limitations

Due to limited funding and employer recruitment taking longer than anticipated, this project was limited by a short intervention period and only a one-year projected follow-up score. At the time of the grant application, the project was originally planned to encompass a longer period. However, funding was only available for the period described. Many areas of health, well-being, and safety may take longer than the study period to obtain best practices or must follow other blocks of work in time. Creating and maintaining a culture of health, well-being, and safety is best approached as an ongoing effort that builds upon early successes.

Additionally, recruitment of employers took place just as the nation was still in the midst of the COVID-19 Pandemic Public Health Crisis, which complicated recruitment and willingness by employers to engage in additional programs given the already elevated level of stressors felt by senior leadership and human resource staff. This also contributed to the initial assessment taking longer for all employers to complete before formal program interventions began.

Other limitations are those found in research of this nature including that scoring on CHAS instruments is only as accurate as the data available and the time available to employer staff working on this initiative. Additionally, although precautions were taken to reduce bias in the scoring by physician executive advisors via having a second physician advisor, there is always the possibility of bias, albeit small.

Additional research on projects of this type is needed to in order to assess generalizability across other industries and a wider range of employer sizes. However, this research points to the potential utility of engaging physician executive experts and employer learning collaboratives to improve the health and well-being of employers and other organizations. It is encouraging to see the advent of fractional chief medical officers in the marketplace, which can make this level of expertise available to small and medium-sized organizations who might not be able to fund a full-time medical advisor.¹⁹

Changes in CHAS scores were encouraging, especially across the range of employer sizes and industries. However, as common in studies of this type, we are not able to assess if this was fully the result of the intervention or if other environmental factors influenced them. Employer selection was voluntary. This voluntary sample selection likely indicated a readiness for change and may bias the results. Our earlier published work provides case studies that demonstrated impact of these types of interventions that do not include external support and were sustained over several years.^{8,18} Additionally, this research did not assess any changes in the culture of health from the viewpoint of the employees at large. Comprehensive assessments benefit from the “voice of the customer” and would be strengthened in future research by including employee-level feedback from health assessment questionnaires, surveys, or focus groups.

Through efforts to improve health, well-being, and safety, employers and other organizations have many scorecards to choose from. However, scoring alone is not enough to ensure improvement. This program was unique in several ways, including the HealthNEXT methodology, the assignment of a population health expert to assist and encourage the participants, a regional community focus (i.e., the Delaware Valley), and the collaboration created by the shared experiences across participating organizations.

CONCLUSION

This article demonstrates the effectiveness of a learning collaborative where many employers join together to pursue an enterprise culture of health and well-being best practices using an industry-validated, evidence-based framework. In just one year, all participating employers gained insights and documented significant improvements in their culture of health and wellbeing as measured by a validated CHAS. The scores also reinforced that the pursuit of benchmark performance can be shared with companies of varying sizes and industries. Based on previous research, improvements in this score will likely cause these companies to experience some moderation of their medical spending. While recognizing multiple other enterprise benefits this impact alone justifies the efforts exerted.

The systematic approach taken in this program has the potential to be used as a platform for other organizations interested in improving employee health and, even more impressive, to improve public health. This one small program touched seven employers and 185,000 employees. Moreover, the potential impact is even greater. Assuming the average of 2.3 covered lives for each employee, approximately 425,500 people were touched by improved health and well-being efforts. This equates to almost 12% of the population of the city of Philadelphia.

Future research building on this framework can seek to answer questions about the impact on outcomes, such as how repeated CHAS scores over several years as well as the specific pillars and factors correlate with improvements in health and economic outcomes. Additionally, it might answer whether advancing the culture of health, safety, and well-being helps reduce disparities in health delivery and prevalence and severity of chronic illness, to what extent do use of preventive care services and management of chronic illness improve over a multi-year period, and whether employee-reported outcomes including overall health, workplace productivity, and job satisfaction improve in parallel with improvements in measures of a culture of health.

Resources to help others in how they can help their organization improve their culture of health and well-being include the CDC's Workplace Health Resource Center,²⁰ HERO,²¹ the National Safety Council's Workplace Wellbeing Hub,²² and the National Academy of Medicine.²³

Acknowledgements:

This project is supported by a sub-award from the CDC Foundation and is part of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS) financial assistance award totaling

\$300,000.00 with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.

Data Availability –

data available upon request

References

1. Kaiser Family Foundation. 2024 Employer Health Benefit Survey. October 9, 2024. <https://www.kff.org/health-costs/report/2024-employer-health-benefits-survey/>. Accessed December 23, 2024.
2. Bildner M Bridging the Gap: Communicating about Public Health to Employers. June 16, 2021. <https://www.cdcfoundation.org/blog/bridging-gap-communicating-about-public-health-employers>. Accessed December 23, 2024.
3. Grossmeier J, Seaverson E, Mangen D, et al. Impact of a comprehensive population health management program on health care costs. *J Occup Environ Med* 2013;55(6):634–643. DOI: 10.1097/JOM.0b013e318297306f [PubMed: 23722943]
4. Litchfield P, Cooper C, Hancock C, Watt P. Work and Wellbeing in the 21st Century. *Int J Environ Res Public Health*. 2016;13(11):1065. doi: 10.3390/ijerph13111065. [PubMed: 27809265]
5. Society of Actuaries Research Institute. Effectiveness of Health and Wellness Programs. February 2024. <https://www.soa.org/493879/globalassets/assets/files/resources/research-report/2024/effectiveness-of-wellness-programs.pdf>. Accessed December 23, 2024.
6. Work McLellan R., health, and worker well-being: roles and opportunities for employers. *Health Affairs*. 2017;36(2):206–213. 10.1377/hlthaff.2016.1150 [PubMed: 28167707]
7. Fabius R, Frazee SG, Thayer D, Kirschenbaum D, Reynolds J. The Correlation of a Corporate Culture of Health Assessment Score and Health Care Cost Trend. *J Occup Environ Med* 2018;60(6):507–514. [PubMed: 29465516]
8. Gunther CE, Peddicord V, Kozlowski J, Li Y, Menture D, Fabius R, Frazee SG, Nigro PJ. Building a Culture of Health and Well-Being at Merck, Population Health Management. 2019; 22(5):449–456. [PubMed: 30570425]
9. Flynn JP, Gascon G, Doyle S, Koffman DMM, Saringer C, Grossmeier J, Tivnan V, Terry P. Supporting a culture of health in the workplace: A review of evidence-based elements. *Am J Health Promotion*. 2018;32(7):1–34.
10. Wilson V and Jones J. Working harder or finding it harder to work. Economic Policy Institute Report. February 22, 2018. [https://www.epi.org/publication/trends-in-work-hours-and-labor-market-disconnection/#:~:text=Prime%2Dage%20adults%20who%20typically,fifth%20\(to%202%2C047.2%20hours\)..](https://www.epi.org/publication/trends-in-work-hours-and-labor-market-disconnection/#:~:text=Prime%2Dage%20adults%20who%20typically,fifth%20(to%202%2C047.2%20hours)..) Accessed December 23, 2024.
11. Fabius R and Frazee S. The culture of health. *Health Prod Manage*. 2009;7 (Winter):13–15.
12. Fabius R and Phares S. Companies that promote a culture of health, safety, and wellbeing outperform in the marketplace. *J Occup Environ Med* 2021;63(6):456–461. [PubMed: 33560071]
13. Fabius R, Thayer D, Konicki DL et al. The link between workforce health and safety and the health of the bottom line: tracking market performance of companies that nurture a "culture of health." *J Occup Environ Med* 2013;55:993–999. [PubMed: 24013656]
14. Grossmeier J, Fabius R, Flynn JP, et al. Linking workplace health promotion best practices and organizational financial performance: tracking market performance of companies with highest scores on the HERO scorecard. *J Occup Environ Med*, 2016;58:16–23. [PubMed: 26716844]
15. Lerner D, Rodday AM, Cohen JT, Rogers WH. A Systematic Review of the Evidence Concerning the Economic Impact of Employee-Focused Health Promotion and Wellness Programs. *J Occup Environ Med* 2013;55(2):209–222. [PubMed: 23287723]
16. Oscilla KC, Van Busum K, Scher C, Larkin JW, Eibner C, Mattke S. Systematic review of the impact of worksite wellness programs. *Am J Manag Care*. 2012;18:e68–e81. [PubMed: 22435887]

17. Better Evaluation. Developmental evaluation. <https://www.betterevaluation.org/methods-approaches/approaches/developmental-evaluation>. Accessed December 23, 2024.
18. Personett K, Fabius R, Kirshenbaum D, Thayer D, Phares S. The power of commitment: Creating an award-winning culture of health and well-being at DTE Energy. *Population Health Management*. 2024. Published online ahead of print. August 30, 2024. 10.1089/pop.2024.009
19. Brown NA. Need a CMO? Fractional Health Executives Are a Win-Win. *MedPage Today*. November 1, 2024. <https://www.medpagetoday.com/opinion/prescriptionsforabrokensystem/112690>. Accessed March 10, 2025.
20. Workplace Health Promotion [CDC web site]. https://www.cdc.gov/workplace-health-promotion/php/?CDC_AAref_Val=https://www.cdc.gov/workplacehealthpromotion/ Accessed March 14, 2025.
21. All Resources [HERO web site]. <https://hero-health.org/resources/all-resources/> Accessed March 14, 2025.
22. Workplace Wellbeing Hub [National Safety Council web site]. <https://www.nsc.org/workplace/workplace-wellbeing-hub> Accessed March 14, 2025.
23. National Plan for Health Workforce Well-Being [National Academy of Medicine web site]. <https://nam.edu/publications/national-plan-for-health-workforce-well-being/> Accessed March 14, 2025.

SMART Learning Outcomes

- Learn the importance of identifying gaps in best practice implementation.
- Articulate barriers and facilitators for improving employee health and well-being among business leaders.
- Identify which pillars and factors of employee health and well-being present the most common strengths and opportunities.

RESEARCH QUESTIONS

The following research questions were explored throughout this study:

- What are the attributes of the culture of health for participating organizations, as measured at baseline?
- What deficits and suggested strategies are most identified across this cohort of employers?
- How does the culture of health advance over one year, as measured by the CHAS tool at baseline and follow-up?
- What do employers identify as the most challenging barriers, facilitating factors, and most successful approaches to advancing the culture of health using this framework?
- Is an aggregated “business community score” across multiple employers perceived by participating employers, other employers, and public health professionals as a valuable tool in improving population health and fostering public-private partnerships?

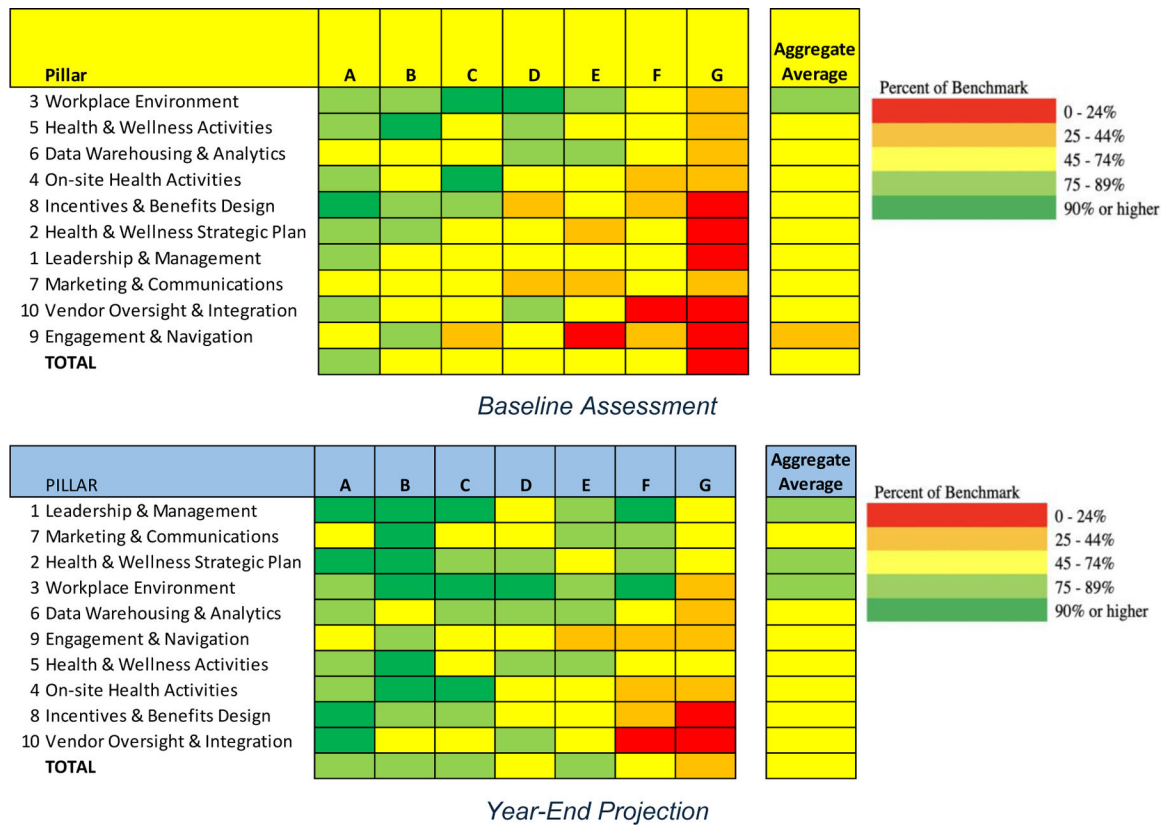


Figure 1:
Baseline Assessment and Year-End Projection

Table 1:

Participating Employer Demographics (n=7)

Employer #	Industry	Employee Count
1	Service	112,886
2	Legal	1,240
3	Municipality	6,500
4	Non-Profit	160
5	Retail	19,200
6	Retail	43,210
7	Non-Profit	1,600
		184,796

Table 2:
GPBCH Questionnaire Results from Participating Employers (n=6)

Questions	Strongly Disagree/ Disagree % (n)	No Opinion/ Not Sure % (n)	Agree/ Strongly Agree % (n)
Participating in the project met the expectations I had when my organization agreed to participate	0% (0)	0% (0)	100% (6)
Participating in the project helped advance my organization's culture of health and well-being	0% (0)	0% (0)	100% (6)
Participating in the project helped advance my own understanding of how to build an organization culture of health and well-being	17% (1)	0% (0)	83% (5)
As a result of participating in the project, I expect the organization's leadership will be more supportive of our efforts to build a culture of health and well-being	0% (0)	17% (1)	83% (5)
As a result of participating in the project, I expect leaders to dedicate more resources to our efforts to build a culture of health and well-being	0% (0)	33% (2)	67% (4)
I believe that our organization's participation in the project will benefit the health and well-being of our workforce	0% (0)	0% (0)	100% (6)
I believe that our organization's participation in the project will help to moderate (bend) our medical cost trend	0% (0)	17% (1)	83% (5)
I believe that our organization's participation in the project will help to reduce employee turnover and contribute to our reputation as an employer of choice	0% (0)	17% (1)	83% (5)
As a result of having participated, I believe I will be more successful in my role of promoting population health & well-being	0% (0)	0% (0)	100% (6)

Table 3:
Qualitative Assessment Project Component Ratings

	Avg. on 10-pt scale
Focus/effort	8.70
Physician Expert Advisor	7.82
Learning Collaborative-experts	7.67
Strategic Plan	7.65
Assessment	6.96
Learning Collaborative- sharing	6.58
Overall	7.50