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The HERO Employee Health Management Best Practice Scorecard

In collaboration with Mercer

Annual report 2010

A message from the HERO/Mercer Scorecard team leadership

We are pleased to share this first annual report on the HERO Employee Health Management (EHM) Best Practice Scorecard. This report is intended to provide an introduction to the Scorecard, a progress report on employer participation and research activity and – perhaps most importantly – some of the early findings gleaned from analysis of the aggregated Scorecard data.

In the 18 months since the Scorecard was formally launched, nearly 450 employers have participated and the response has been overwhelmingly positive. We are grateful to the two organizations featured in this report that were willing to share their experiences using the Scorecard. We have also launched the Scorecard Partner Program, described on page 2, which has helped to extend the reach of the Scorecard considerably. We have also been issuing quarterly reports, each with an expert analysis of one area of the Scorecard results. These collected commentaries form the bulk of this report.

Our objective in creating the Scorecard – to advance the field of employee health management – was simple but ambitious, and undertaken in the spirit of collaboration that such a goal requires. We thank you for your interest and welcome your reactions, comments and suggestions – in particular, your ideas for applications for the Scorecard. All replies will be acknowledged and considered confidential.

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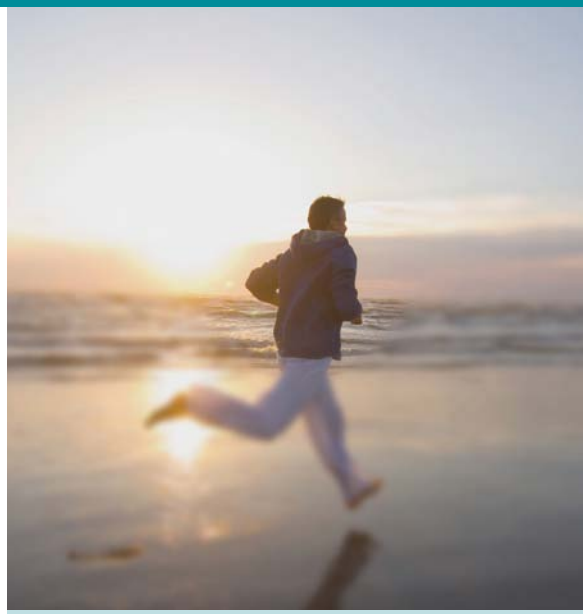

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The HERO Best Practice Scorecard: An introduction and progress report

The HERO Best Practice Scorecard helps employers, providers and other stakeholders identify and learn about employee health management best practice.

The online Scorecard questionnaire is divided into six sections representing the foundational components that support exemplary EHM programs. While no inventory of best practices will include all innovative approaches to EHM, the Scorecard utilizes those most commonly recognized among industry thought-leaders and in published literature.

Employers answer detailed questions about their EHM program design, administration and experience. Once they submit their responses, they are immediately sent an e-mail with their overall score and scores for each section. While a score of 200 is theoretically possible, it is not likely or even desirable for an employer to have every possible EHM program and strategy in place, and employers are encouraged to use the average score of all employers in the database (or of a subset of their peers) as a benchmark. The Scorecard also includes a separate section on program outcomes. Responses in this section do not contribute to an organization's best practice score, but are used for benchmarking and to study relationships between specific best practices and outcomes.

The Scorecard development: An ongoing collaboration

While the online survey was launched in 2009, earlier versions of the Scorecard have been available since 2006. The Scorecard was developed in consultation with authoritative sources on EHM best practices, including the Health Project's C. Everett Koop National Health Awards criteria, the WELCOA Well Workplace Awards criteria (Platinum level), Partnership for Prevention's Health Management Initiative Assessment, and the Department of Health and Human Services' Partnership for Healthy Workforce 2010 criteria. Selected elements from these sources were considered in the original construction of the Scorecard; however, most Scorecard content originated with the HERO Forum Task Force for Metrics.

In 2009, HERO and Mercer formed a working collaboration to update the Scorecard content and scoring system and make it widely available in a web-based format. The rigorous development process continued. A complete list of contributors is included on the inside back cover.

The scoring system

A panel of EHM authorities from a variety of organizations assisted in developing the scores using a consensus-building exercise. Each panel member was asked to distribute 200 points (the proposed maximum score) across the six sections of the Scorecard, based on his or her judgment about the relative importance of each foundational component to a successful EHM program ("successful" was defined as able or likely to improve total health care spend). The maximum section scores were then distributed across the questions within each section using the same criteria. Finally, the maximum question scores were distributed across the individual response items in each question. The panel members' scores were aggregated and either the mode or average (mean) score was used as the final score.

This process generated robust debate and discussion. Given the limited amount of solid research evidence to support or refute the presumed impact of specific programmatic elements on health care cost trend, the contributors offered their scores based on the best research and anecdotal evidence available, recognizing that a more definitive review is necessary to support the relative weighting of the scores. For now, the elements with higher weighted scores can be considered promising practices, which achieve their greatest impact as part of a comprehensive EHM strategy.

To see the scores assigned to each section, question and response item in the Scorecard, visit the Scorecard page on the HERO website (**www.the-HERO.org**).

Taking it to the next level: The Scorecard Partner Program

Initially, the HERO Scorecard, in collaboration with Mercer, could be accessed only through the HERO and Mercer websites. Within six months, about 100 employers had submitted responses. While this was a strong start, we recognized that more robust participation was necessary to advance our dual goals of helping employers learn about and determine EHM best practice, and building a major national database for research and benchmarking purposes. With positive feedback from health plans and specialized health management vendors that found the Scorecard to be a valuable resource in their work with employers, we realized that we could extend the reach of the Scorecard by allowing qualified organizations to make it available to clients on their own websites. In return, we would support them by providing data and reports.

The pilot phase of the Scorecard Partner Program was launched in June 2010, with four organizations participating. Each organization was provided with a custom link to the Scorecard, along with website content and template marketing materials to assist in rolling out the Scorecard to its clients. Partners are provided with a database of all Scorecard responses received through their own custom links (with individual company identifiers only if the respondent has indicated that the partner organization may see their answers). The pilot partners participated in monthly calls to provide feedback on the Scorecard and the Partner Program. The pilot phase will end in March 2011; at that time, we will open the program to other interested organizations.

As of January 2011, Scorecard participation had grown to 442 employers, with good representation of large, mid-size and small organizations.

Putting HERO Scorecard data to work

Comprehensive HERO Best Practice Scorecard Benchmark Reports that provide the aggregated responses to every question asked in the Scorecard are available now. Drawn from the full Scorecard database, the benchmark reports compare program strategy, design and outcomes for all Scorecard respondents and for benchmark groups based on industry, employer size or geographic location. Individual benchmark reports may be purchased for $125 through the HERO website. In addition, we can run custom benchmark reports based on selected employer groups of 10 or more.

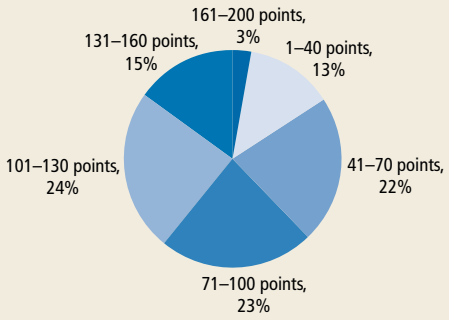
HERO recently commissioned a research project to review what knowledge base exists regarding the role of corporate culture in EHM success. This project will also utilize the Scorecard database to assess responses and scores related to the subject. As the database grows, we anticipate that it will be used for other research projects in the future.

Figure 1
Scorecard respondent profile

Number of respondents

All employers	442
Employers with fewer than 500 employees	78
Employers with 500–4,999 employees	187
Employers with 5,000 or more employees	166

Distribution of respondents by best practice score



Relating best practice scores to outcomes

Beth Umland

Director of Research for Health & Benefits
Mercer
HERO Scorecard V3 Committee
HERO Research Study Subcommittee Vice Chair

The HERO Scorecard is grounded on the assumption that EHM programs based on best practices will produce better outcomes – higher participation rates, improved population health risk and better medical plan experience – and one of the key objectives is to produce a database that will allow us to test and quantify the relationship between specific EHM practices and outcomes. Before that, however, we needed to test the Scorecard itself. Did it include the most important program elements and practices? Did the scoring system give the right weight to these elements and practices? The first analysis we conducted with the Scorecard database, six months after it was launched, was simply to learn whether respondents with higher scores also reported better outcomes than respondents with lower scores. The results of that analysis, based on only about 100 respondents, validated the Scorecard design and we began to promote it more vigorously. For this report, we repeated the analysis using a database of more than 400 respondents. The results are presented below.

The analysis compared three roughly equal groups of respondents – those with low, average and high scores – to examine the relationship between the use of best practices (as indicated by the respondents' scores) and program outcomes. Out of a possible 200 points, the low-scoring group had an average score of 45; the average-scoring group, 90; and the high-scoring group, 136 (Figure 2). Employers in the low-scoring group were less likely to answer the questions in the outcomes section (which do not contribute to the score) because they are less likely to have measured outcomes. Employers in the high-scoring group have outcomes data for the longest period, suggesting that their programs are older. They also have made a bigger financial investment: The median cost per eligible person per month for all components of the EHM program is $13 for the high scorers, but just $11 for the average scorers and $6 for the low scorers.

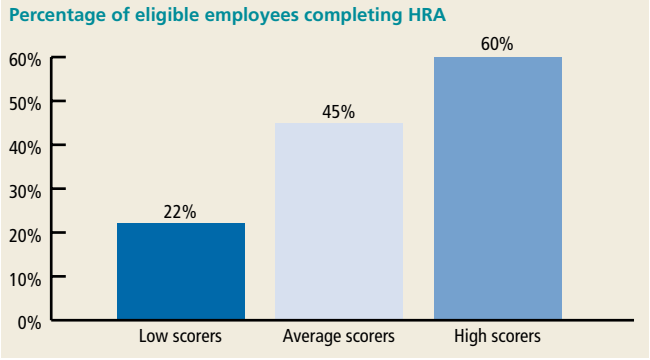
Figure 2
Comparing EHM programs based on best practice score

	Low scorers	Average scorers	High scorers
Best practice score (average for group)	45	90	136
EHM spending per eligble per month (median)	$6	$11	$13
Number of respondents	144	149	149

Program participation rates

EHM participation rates, while not the ultimate indication of program success, are easier for most employers to measure than the impact on health plan cost or health risk. The high-scoring group reported higher participation rates than the low-scoring group for every type of program. The biggest difference was in the rate of health risk assessment (HRA) completion, with the high scorers reporting that 60% of eligible employees completed an HRA during the last plan year; the average scorers reporting a completion rate of just 45%; and the low scorers, just 22% (Figure 3).

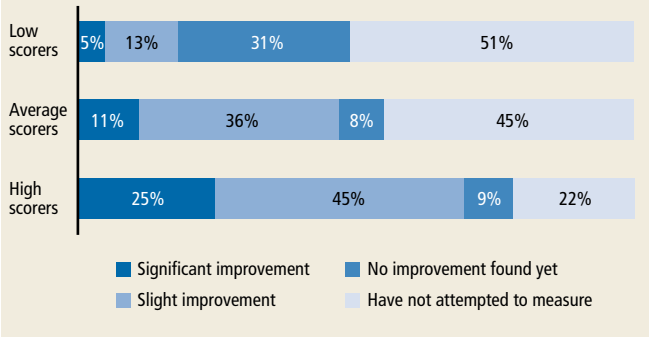
Figure 3
Health risk assessment participation rates



Improvement in employee health risk

Respondents were asked whether they had been able to measure an improvement in employee health risk during the longest period for which they had outcomes data. There was a notable difference in the responses of the high- and average-scoring groups. Over two-thirds of the high scorers (70%) had measured at least some improvement (slight or significant), compared with 47% of the average-scoring group. Importantly, the high-scoring group was much more likely to report a "significant improvement" in health risk: 25%, compared with just 11% of the average-scoring group (Figure 4).

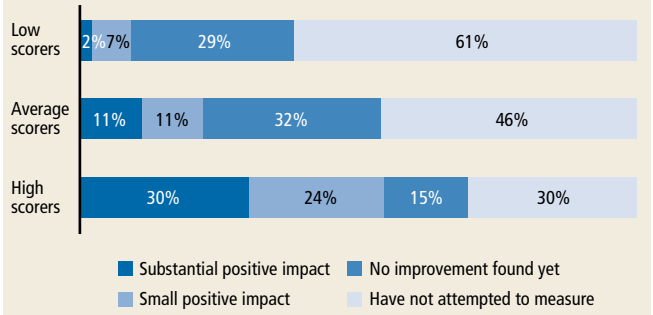
Figure 4
Perceived EHM outcomes: Employee health risk



Improvement in medical plan cost

Perhaps most strikingly, 30% of the high-scoring group have been able to measure a "substantial positive impact on medical cost trend, greater than the cost of the EHM program," and another 24% have been able to measure a "small positive impact, less than the cost of the EHM program." Just 15% say they have measured impact on medical cost trend and found that the program has had no effect so far. Almost one-third has not yet attempted to measure the program's effect on cost or was not confident of the results. By contrast, only 11% of average scorers have found a substantial improvement in medical trend. Although 11% have measured a slight improvement, 32% say that medical trend has not been affected, and 46% have not yet attempted to measure trend or are not confident of the results (Figure 5).

Figure 5
Perceived EHM outcomes: Medical plan cost trend



The results of this analysis seem to validate both the importance of best practices and the Scorecard's ability to identify the employers that make the most use of them. Most encouraging is the finding that respondents whose EHM programs incorporate best practices to the highest degree are more likely to achieve lower medical plan trend. If the success rate for respondents who have not yet measured cost impact is similar to that of respondents who have, then virtually all high-scoring employers have been able to improve medical cost trend with EHM.

Strategic planning and EHM program success

Steven P. Noeldner, PhD

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One of the benefits of the HERO Scorecard is that it outlines best practices for the various elements that are believed to be associated with successful EHM programs. The first section of the HERO Scorecard addresses strategic planning. Strategic planning is the bedrock of all successful endeavors, and EHM programs are no exception. If you don't know where you want to go, it's difficult to get there, and even if you do know, it's good to have a plan for getting there efficiently. Few of us would set out to an unfamiliar destination without a roadmap or GPS to guide us there. Likewise, organizations that don't have effective strategic plans are less likely to have successful EHM programs.

Elements of strategic planning

The best way to achieve success is to plan for success. In the strategic planning phase of program development (or review of an existing strategy), organizations answer questions that help them establish or revise goals and objectives for their EHM programs. An organization will ask questions such as, what are the health issues and what is driving health care expenses for our organization? What kinds of programs should we offer? Should spouses, retirees or dependents be included? Are there individual or group differences we need to address (for example, different languages, cultures, generations; computer access versus no computer access)? What will a successful program look like? Will the EHM program address the full continuum of health management programs for those who are well, at risk, with chronic conditions or in need of catastrophic case management? What participation, impact and outcomes targets do we want to set for our programs?

Scorecard results

Nearly three-quarters (71%) of the 262 organizations that completed the Scorecard as of March 31, 2010, reported that they have conducted an employee health needs assessment within the last two years. HRAs or employee health surveys are the most common measure used, followed by claims analysis and biometric screenings.

Figure 6
Employers that set formal EHM targets report better results

	Have set target	No formal target
Average HRA participation rate	62%	38%
Reported "significant improvement" in health risk	31%	5%
Reported "substantial impact" on medical trend	28%	6%

While less than one-half of the respondents have a formal, written strategic plan for the EHM program (26% have a multi-year plan and an additional 17% have an annual plan), data analysis suggests that a formal strategic plan is a key factor in program success. Most strategic plans included measurable targets for participation (86%), changes in health risks (75%), clinical metrics (58%) and financial outcomes (70%). Employers with targets for participation in EHM programs reported an average HRA participation rate of 62%, well above the participation rate of 38% for employers without targets (Figure 6). Employers with targets for health risk improvement were six times as likely to report a "significant improvement in health risk" than those without (31% compared with 5%),

while employers with financial outcomes targets were more than four times as likely to report a "substantial positive impact on medical plan trend" than those without: 28% compared with 6%.

Finally, employers with a formal, written strategic plan seemed well aware of its value. When asked to assess their organization's strategic planning for EHM, 84% of the Scorecard respondents who have written strategic plans say that their strategic planning is effective or very effective, compared with just 35% of employers who don't have a formal, written plan. The moral of this story is, as with a good meal, if you spend adequate time on mise en place – planning and preparation – you're more likely to have successful results.

Leadership engagement

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Most EHM experts agree that nothing is as critical to creating a healthy workplace culture as engaged senior leadership. While leadership support for EHM seems reasonable given the profound effect of health on employee performance, it is not a given even among many companies recognized for their EHM strategies and results.

A key benefit of the HERO Scorecard is its identification of best practices believed to be associated with successful EHM programs. The Scorecard includes a series of questions on leadership engagement in acknowledgement of the important role of leadership support in driving healthy culture change.

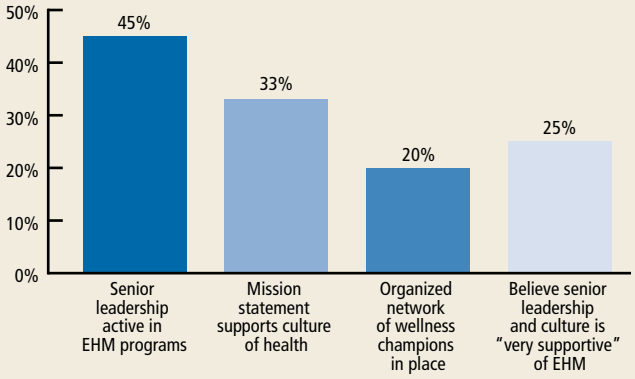
Elements of leadership engagement and culture

Healthy workplace culture is a broad, multi-faceted component of EHM best practices. While capturing its full complexity is a daunting challenge, the HERO Scorecard assesses best practices in the major elements of culture identified by research and practitioners in the EHM field, including senior leadership commitment, management and supervisory support, wellness "champions" or ambassador networks, physical work environment factors and organizational policies. Examining the contribution of these best practices will enable us to better understand the role of leadership engagement and culture in EHM success.

Scorecard results

Of the 303 organizations that completed the Scorecard as of June 30, 2010, fewer than half (45%) reported that their senior leadership actively participates in EHM programs and only a third reported that the company vision/mission statement supports a healthy workplace culture. Even fewer, 20% of those responding, reported having an organized network of wellness ambassadors at most worksites with formal communication channels and periodic meetings. Overall, just 25% reported that their senior leadership and culture were "very supportive" of their EHM strategy (Figure 7).

Figure 7
Room for improvement in leadership engagement in EHM



To what extent does leadership engagement affect program success?

The minority of organizations reporting strong leadership and cultural support for their EHM strategy experienced significantly better participation in population-level EHM programs. HRA participation was substantially higher, on average, for organizations reporting very supportive leadership and culture (59%) than for those reporting little or no leadership and culture support (41%). Average participation rates for biometric screenings followed a similar pattern (53% versus 38%). Senior leadership participation in EHM programs and fully functioning wellness ambassador networks were also associated with higher employee HRA participation rates (averaging 57% and 59%, respectively) compared to the average for all Scorecard respondents (50%).

Strong leadership and cultural support was most strongly associated with positive impacts on health risks and medical trend. About two-thirds (66%) of organizations with strong leadership and cultural support reported improvements in health risks, compared with only 26% of organizations with little or no support. Similarly, 50% of organizations with strong leadership and cultural support reported a net positive impact on medical trend, versus only 14% of organizations with little or no support.

Most strikingly, organizations with strong leadership and cultural support were 10 times as likely as those with little or no support to report a substantial positive impact of EHM programs on their net medical trend – 30% versus 3%. This result gives important new meaning to the phrase "culture always wins" for employers seeking maximum value from their EHM strategy.

Capital BlueCross

Employer Scorecard experience: Testing assumptions, finding new opportunities

With a well-established wellness program in place, Capital BlueCross was interested in benchmarking its programs against others, both to test and validate its current approach and to establish a baseline for comparison going forward. The organization knew that on its own it would be tough to conduct a comparative survey that had the breadth of employer participation and consistency of measures found in the HERO Scorecard. "Plus," says Kieran Hull, Senior Director of Human Resources, "the Scorecard is a very well-respected, independent resource developed by wellness experts, adding instant credibility to our results."

Kieran worked through the Scorecard questions with Gina McDonald, Senior Health Education Consultant; both are members of the Capital BlueCross Wellness Committee. One benefit of the exercise was learning how their program components stacked up against national benchmarks; another became clear when they shared the results with executive management. Although management was already fully supportive of the organization's wellness efforts, it was helpful to show them the value of their support. ("Leadership engagement" is one of the six foundational elements covered in the Scorecard and contributes significantly to a respondent's overall best practice score.) The Scorecard results demonstrated to management that the wellness program was indeed a worthwhile investment.

Effective programs and services

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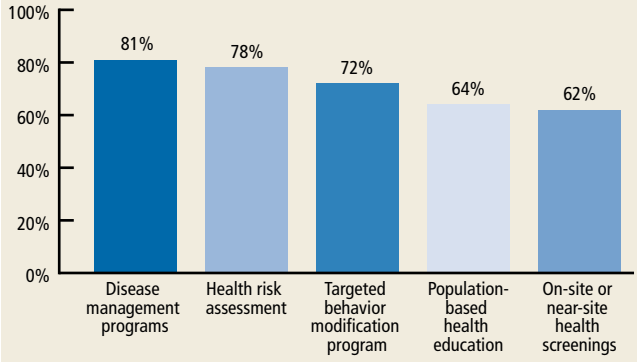
The HERO Scorecard incorporates a number of characteristics of best practice EHM programs which have been cited in the literature. Ultimately realizing a positive impact on population health and health-related costs comes down to two core ingredients: high participation and effective interventions. Leadership, culture, communication and incentives are critical to achieving strong participation. Having an effective program strategy is also essential.

Program elements

How does an organization offer effective programs and services? One fundamental step is to identify the needs and interests of the employee population and to offer a variety of accessible programs and services that address those needs and interests. Offering high-quality programs that have demonstrated outcomes is also important.

HRAs have long been used to assess the needs and interests of a population. They are useful in raising awareness, assessing readiness to change and encouraging participants to develop an action plan for improvement. In addition, the aggregate reports from HRAs can be used to target interventions to specific populations. More than three-fourths (78%) of the 398 employers completing the Scorecard as of September 30, 2010, offer HRAs to their employees, with an average of 49% of eligible employees participating. Of those employers offering an HRA, 75% use the information to target interventions. Additionally, 62% of respondents offer on-site or near-site screenings, and 64% proactively distribute population-based health education information (Figure 8).

Figure 8
EHM programs offered



Targeted behavior modification programs (for example, telephonic health coaching, seminars and web-based classes) are offered by 72% of respondents. The programs most often offered are: weight management, tobacco cessation, physical activity, healthy eating, and mental and emotional well-being. The majority of respondents providing behavior modification programs offer phone-based coaching (76%), web-based coaching (68%) or paper-based/mail programs (51%). A future focus of the HERO Scorecard and database will be the impact of each of these program types on health risk reduction and health-related costs.

More than four-fifths of respondents (81%) reported that they offered disease management programs. The majority of programs are described as phone-based facilitation of care (95%) or paper-based/mail-based (61%). An average of 23% of identified individuals reportedly participated in such programs. Scorecard responses, however, do not allow us to distinguish how many individuals receive each type of service. Historically, employers have often found that the majority of employees identified by health plans with chronic conditions received health education brochures in the mail, and very few employees received phone-based disease management facilitation. This may be changing, however, as new benefit plan designs incorporate more proactive health coaching into their health management practices.

The Scorecard results confirm one of the significant challenges for organizations in the future – increasing participation in programs designed to promote healthy behaviors and achieving positive outcomes. Although 72% of respondents reported offering targeted behavior modification programs and services, only 22% of identified persons on average participated in such programs. It is possible that a portion of individuals may be practicing healthy behaviors through other means than the programs offered by their employers or health plans. Ultimately, overall program effectiveness will be determined by population health change over time.

When considering the effectiveness of programs, it is also important to consider the significance of the role of organizational and community cultures in supporting healthy behaviors. For example, some people may not choose to participate in formal programs, but nonetheless may be influenced by social norms and environmental/structural supports to improve their own health practices.

It is interesting to note the number of respondents that are collecting outcomes but have less than two years of data (43%). It is expected that as these programs evolve, their data will contribute significantly to the understanding of EHM best practices. It is encouraging that 51% of respondents reported some improvement in population health risks, and 35% reported a positive impact on medical cost trend. These are the programs that should be further studied to help us learn more about effective EHM practices.

Engagement methods

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While the term "engagement" is widely used in EHM, its definition varies widely. While participation rates are sometimes used to represent employee engagement in health management programs, most EHM experts agree that engagement involves more than simply enrolling in programs and activities; it implies that individuals participate in meaningful ways that ultimately lead to behavior change and health maintenance or improvement.

To engage individuals in health-promoting activities, they must both be informed about the programs and encouraged to enroll and participate. The HERO Scorecard outlines best practices for employee engagement in two areas: communication and incentives.

Communication

The importance of effective communication for EHM program success is often underestimated. For many organizations, communication begins and ends with a letter or newsletter article announcing the start of a new program. However, about two-fifths of respondents (41%) have an annual or multi-year communication plan and – not coincidentally – these organizations also reported significantly higher participation rates for the HRA (56%) than those with no communication plan (25%). Pre-launch communication and regular communication with stakeholders were also associated with high HRA participation rates (57% and 58%, respectively).

Because disease management and lifestyle management are typically targeted to individuals in need of these programs, it is important to provide detailed information that not only informs, but compels people to accept the invitation to participate. Higher-than-average participation rates were associated with respondents providing communications focused on purpose, components, value and deadlines for these programs.

Many organizations recognize that their communication efforts are not as effective as they could be. Only 9% of respondents said their communication program was "very effective" at promoting employee engagement in EHM programs, while 49% said their communication efforts were "not very effective" or "not at all effective." Most organizations likely have an opportunity to improve their communication efforts by adopting best practices.

Incentives

The use of incentives to encourage participation and engagement is a widely used best practice. Respondents are most likely to provide an incentive to complete an HRA (82%) or to participate in a lifestyle management program (61%). However, just 25% of employers offering disease/condition management programs provide an incentive to participate. Because these programs are often provided through the health plan, organizations are less likely to take an active role in promoting services with communication initiatives and incentives, and instead rely on the health plan to engage members (Figure 9).

Figure 9
Use of incentives in EHM program

	HRA	Disease management	Behavior modification
Offer any incentive	82%	25%	61%
Cash/gift card	37%	13%	35%
Lower premiums/cost-sharing	30%	8%	18%
Contribution to spending account (FSA, HSA, HRA)	12%	4%	6%
Average value of incentive	$225	$148	$154
Average participation rate when value of incentive is:			
In the top third	63%	*	37%
In the bottom third	43%	*	24%

**Insufficient number of responses to report*

Health risk assessment

While cash or gift cards are still the most common incentive used to boost HRA completion (37%), many employers are now tying HRA participation to lower health plan costs, most often a reduction in the premium (30%). A few provide either lower copays (2%) or lower deductibles (2%). Contributions to health spending accounts (HSA, FSA or health reimbursement account) were offered by 12% of organizations. The average value of incentives (across all types) was $225. The higher the incentive, the higher the participation rate. Among respondents providing incentives valued at $75 or less, the participation rate was 43%; it rose to 63% among respondents offering incentives valued at $200 or more. While the great majority of incentives were considered rewards or positive incentives, 4% of respondents said that participation in the HRA was required to enroll in the health plan, which could be interpreted as a penalty for non-participants.

Disease/chronic condition management (DM)

Only 25% of responding organizations provided incentives for participation in DM programs. Of those that did, 13% offered cash/gift card, 8% offered lower health plan costs and 4% offered contributions to health spending accounts. The average value of incentives for DM participation was $148. Not enough data was available to cross-reference the value of incentives and their association with participation rates.

Lifestyle management/behavior modification

As mentioned previously, 61% of responding organizations offered some type of incentive to encourage participation in lifestyle management programs. The average value of the incentive was $154. Cash/gift card was the most prevalent form of incentive (35%), followed by raffles (20%), lower health plan costs (18%), intra-company competitions (10%) and contributions to health spending accounts (6%). For those organizations that reported the value of their incentives as under $150, the average participation rate was 24%; among those offering incentives valued at $150 or higher, it was significantly higher, at 37%.

Engagement best practices related to outcomes

One valuable application of the HERO Scorecard database is to compare the use of EHM best practices to outcomes. While the outcomes section uses a mix of quantitative and qualitative measures, it provides insight into how the responding organizations perceive their EHM program outcomes. The comparison of scores for the engagement methods section to reported outcomes suggests that organizations that employed more best practices achieved higher levels of participation, greater risk reduction, and more positive medical trend cost experience than those organizations that employed fewer best practices. For example, over a quarter of high-scoring respondents (27%) reported that their EHM program has had a substantial positive impact on medical trend, compared with just 12% of respondents with average scores.

While the engagement methods section of the Scorecard focuses on communication and incentives, a broader view of best practices for EHM suggests that other program elements also contribute to optimal engagement in programs, including leadership support and culture of health, which are covered in other sections of the Scorecard. It is important to remember that none of these elements stand in isolation from the others. Research evidence suggests that participation, program impact and financial outcomes are subject to the effectiveness of most or all of the elements that contribute to engagement. For example, an incentive of the same type and value offered by an organization with an excellent communication plan and execution is likely to get better program participation and results than one that does moderately well at communicating the incentive and the EHM program.

It is encouraging that scores for the engagement methods section are directionally associated with participation rates, health risk impact and self-reported financial outcomes. This supports the value of using the Scorecard to guide the development of successful EHM programs.

Prudential

Employer Scorecard experience: Building consensus for progress

The HERO Scorecard presented Prudential with a great opportunity to bring together a variety of health-focused contributors and functions that don't regularly connect. The different areas collaborated to complete the Scorecard and the result was a uniquely comprehensive view of the company's health standing. According to Dr. Andy Crighton, Vice President and Chief Medical Officer for Prudential, "It became a launch pad for integration of programs and services which complimented each other but had existed more or less in silos."

The Scorecard contributors continued to work together completing a gap analysis in lower-scoring areas. "This informed a new multi-year strategy to improve our outreach and impact on individuals and our businesses," said Dr. Crighton.

Measurement and evaluation inform data-driven best-practice programs

Jessica Grossmeier, PhD

Director, Research – StayWell Health Management
HERO Research Study Subcommittee Vice Chair
HERO Scorecard V3 Committee

Numerous publications and peer-reviewed research studies cite ongoing, comprehensive program evaluation as a key strategy for a successful EHM program. The measurement and evaluation section of the HERO Scorecard includes three questions focused on what data are collected, how they are used and how effective these actions are to the EHM program's success.

What data are collected?

Measures that matter for EHM programs include program participation and attrition rates, health status change, health care utilization, health care costs and productivity data. Of the 442 Scorecard respondents, 69% indicated program participation data were used for reporting while 53% reported health care utilization and cost data were used to identify their most costly conditions and evaluate program impact on clinical outcomes. Nearly as many (46%) reported ongoing monitoring of health status improvement. More surprisingly, just over one in five companies (22%) reported not collecting any of the listed data as part of their programs. This overall result was driven by smaller companies (that is, those with fewer than 500 employees) with 46% of the 76 companies indicating none of the listed data elements were collected. In contrast, only 11% of the 164 large employers (that is, those with 5,000 or more employees) reported no data collection (Figure 10).

Figure 10
Larger organizations more likely to collect and use EHM data, but opportunities remain

	Fewer than 500 employees	500–4,999 employees	5,000 or more employees
Average total section score (maximum score: 11 points)	3	4	5
Data captured and used in managing the EHM program			
Participant satisfaction data	22%	35%	44%
Program participation data	38%	70%	82%
Process evaluation data (contact, opt-out, withdrawal rates)	5%	33%	41%
Population health/risk status data (physical and mental health)	25%	45%	59%
Health care utilization and cost data to evaluate EHM impact	21%	53%	69%
Productivity and/or presenteeism data to evaluate EHM impact	4%	13%	16%
Outcomes evaluation by independent expert	1%	12%	16%
None of these data collected	46%	20%	11%

**Using a control or comparison group, follow-up data are compared to baseline data, and statistical methods controlled for demographic differences.*

Relatively few employers (13%) use productivity data to demonstrate program impact. While larger companies were more likely to report use of productivity data (16%) than the smallest companies (4%), this seems to be an area of opportunity for most HERO Scorecard respondents. Health care organizations were most likely to use productivity data (27%). An equally significant opportunity exists in the use of independent third-party experts to conduct high-quality outcome evaluation. Only 12% of responding companies relied on third-party support for evaluation, with the larger employers more likely to seek this support (16%) compared to the smallest employers (1%).

How are data used to manage programs?

Embedded within items in the measurement and evaluation section of the HERO Scorecard is information on how data are used to influence ongoing program improvements. More than a third of respondents (36%) use program satisfaction data and 31% use process evaluation data in the form of opt-out or withdrawal rates to drive program improvements. Consistent with the patterns noted above, larger companies are more likely to use data to drive program improvements than smaller companies. An additional question asks how frequently program performance results are communicated to senior management or stakeholders. More than one-third of the companies (35%) reported that performance data were not shared with stakeholders on a regular basis, and an additional 33% shared such information only once a year. A minority of companies (14%) provide quarterly updates to stakeholders, but larger companies were three times as likely (21%) to do quarterly reporting than the smaller companies (7%).

Opportunity knocks

The HERO Scorecard was developed on the premise that EHM as a field needed to demonstrate best practices associated with superior outcomes. Foundational to that goal is the adoption of solid evaluation practices by the individual companies that make up the national collective. While it is somewhat understandable that smaller companies would be more challenged in their ability to evaluate their programs, there is a significant opportunity for larger organizations to enhance their use of data-driven performance management. Mid-size and larger companies, on average, failed to reach at least 50% of the available points in the measurement and evaluation section of the Scorecard. Although 77% of responding employers offer employees a health risk assessment, it's surprising that only 46% use that data as an evaluation tool to monitor program impact on population health status over time. Additionally, 30% of companies stated that they have measurable objectives to improve health risks over time, while 24% seek to improve clinical indicators of health. More information is needed to better understand the challenges associated with aligning these measurement goals with measurement practices. In the meantime, we must consider how we can make the best use of the data we do collect to more effectively manage the programs we work so hard to establish and implement.

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