



THE HERO HEALTH AND WELL-BEING BEST PRACTICES SCORECARD IN COLLABORATION WITH MERCER[®]

2018 PROGRESS REPORT



MAKE TOMORROW, TODAY



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FROM A DECADE OF DEFINING EXCELLENCE TO AN ERA OF CONTINUOUS IMPROVEMENT

Our 2018 Progress Report for the HERO Health and Well-being Best Practices Scorecard in Collaboration with Mercer®

Professionals who are dedicated to continuous improvement in the field of workplace-based health and well-being share a passion for data. The business school bromide that “if you can’t measure it, you can’t manage it” has guided administrators, engineers and researchers alike. Now, thanks to advances in the collection and use of data by employers, it increasingly applies to those organizations that aspire to provide strategic, metrics-driven approaches to improving health and human performance. In the hopes of accelerating this movement toward organizational excellence, we are proud to provide health promotion professionals – both those working in HR departments and those who assist them in designing and implementing strategies – with this **2018 Progress Report** for the HERO Health and Well-being Best Practices Scorecard in Collaboration with Mercer® (HERO Scorecard).

As you will learn from reading the commentaries and research findings featured in this report, our profession is entering a new era in the use of data to inform program design and measure performance. As we near the end of the HERO Scorecard’s first decade, we believe it has an even bigger role to play in future years for those intent on achieving organizational excellence.

Results from the HERO Scorecard reported here and in years past have built a convincing case for the vital roles played by leadership, grassroots champions, the judicious use of

incentives, progressive policies, strategic planning and comprehensive programming in producing beneficial health and well-being outcomes. Because these reports are based on cross-sectional data – that is, based on one-time use of a Scorecard – we can confidently show that select practices are related to outcomes of interest, but we’re still left wondering whether those relationships are causal. When we have information about the same group of organizations over a number of years, we will begin to have deeper insights into causation. Studying cause and effect can tell us whether organizational changes made one year had a positive, measurable and statistically significant impact on the outcomes we hoped to improve in subsequent years.

What will it take to uncover causal relationships that will allow us to confidently show how culture change, leadership influence, programming and other such factors can improve business performance and organizational and individual health and well-being? We think there are three key ways to launch this new era of insights – and we need your help!

First, we need to accelerate our “global” awareness, measures and data-gathering methods. By global, we are referring to the need to broaden both our understanding of the variables that contribute to health and well-being in the workplace, in families and in communities and our understanding of how



America's wellness movement compares to similar efforts internationally. The movement from wellness to well-being has been accompanied by renewed efforts to intervene in financial well-being, increase community engagement and even factor in the roles of life meaning and purpose in advancing well-being. Alongside this broader value proposition, the 2016 launch of our HERO International Health and Well-being Best Practices Scorecard in Collaboration with Mercer, with 200 organizational completers to date, affords us the opportunity to learn from initiatives abroad. In this progress report you can learn more from HERO's researchers, Drs. Jessica Grossmeier and Mary Imboden, who share comparative data between the US and three other countries.

The second key to understanding cause and effect in worksite health couldn't be more accessible and straightforward. We simply need more employers and researchers to use the HERO Scorecard more frequently. Virtually all research based on scorecards (both in this report and elsewhere) is based on one-time use. This past year HERO launched a communications campaign that urged our users to acquire the habit of completing the HERO Scorecard every year or every other year. Not only does this undergird strategic planning and program assessment with critical comparative data, repeat measurement is also imperative if we are to build "prospective research" findings – that is, studies that show improvements because they include baseline measures as well as the same measures collected over the years that follow.

A final step to usher in a new generation of data for you and the field is to collect more information on program outcomes in the optional section of the HERO Scorecard. Where the first six sections of the Scorecard offer the chance to compare best practices currently used, greater use of the optional section of the Scorecard would enable us to better understand how each practice contributes to outcomes.

As you will learn when you read Mercer's Beth Umland's commentary in this report, we urge all HERO Scorecard users to complete as many of these optional items as apply to their organizations. We hope it will soon be commonplace for organizations to pair information about the best practices they use with the outcomes they see as a result,

especially over a number of years. We see this kind of data collection and reporting as an organizational marker of excellence.

This progress report offers some of the most current and best examples of how a Scorecard, used with excellence in mind, can help inform practice improvements as well as fuel much-needed research. Even though "research is HERO's middle name," and as much as we are enthusiastic about analyzing data for and with partners like you who are reading this report, we also know the HERO Scorecard is but a means to an end. We hope that reading the commentaries and research findings in this report will energize you in our shared, lofty aim that someday all workplaces will positively influence the health and well-being of employees, families and communities.

Paul Terry, PhD
President and CEO, HERO

Steven Noeldner, PhD
Partner, Mercer

To learn more about the HERO Scorecard or to download the report, visit <http://hero-health.org/scorecard>.

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INCREASINGLY GLOBAL!

HERO SCORECARD PROGRESS REPORT, HIGHLIGHTS AND KEY ACCOMPLISHMENTS

JESSICA GROSSMEIER, PHD, MPH, HERO VICE PRESIDENT OF RESEARCH, AND MARY IMBODEN, PHD, HERO MEMBERSHIP MANAGER AND RESEARCH ASSOCIATE

The HERO Health and Well-being Best Practices Scorecard in Collaboration with Mercer® (HERO Scorecard) was initially launched in 2006 to provide employers with guidance on employee health and well-being best practices. Available free of charge, the HERO Scorecard is a web-based survey tool with questions organized into six sections that represent the foundational components associated with exemplary health and well-being programs: Strategic Planning, Organizational Support, Integration, Programs, Participation Strategies, and Program Evaluation & Measurement. Once an organization submits its responses to the HERO Scorecard's online system, it is sent an email that provides an overall score and section scores. This brief report also allows employers to compare their practices with the national average.

Now in its fourth version, the US HERO Scorecard has expanded far beyond its initial role as an educational tool, with demonstrated usefulness for strategic planning, benchmarking and research on the health and well-being practices associated with superior program participation rates, health improvement, healthcare cost trends and productivity outcomes. Due to increased interest from organizations based outside

the US, the international version was launched in 2016, and by 2018 enough organizations had responded for HERO and Mercer to be able to provide a benchmark report with results for employers in Brazil, Argentina and Canada. Over time, as more employers outside the US complete the international version, national benchmarks will become available for additional countries around the world.



HERO also launched the international Preferred Provider program in 2018, which aims to provide health and well-being providers and consultants with the resources to support their clients' use of the HERO Scorecard. Currently the Scorecard is available in English, Spanish and Portuguese, and we welcome collaboration with groups in countries who are interested in translating the HERO Scorecard for their own use.

HERO SCORECARD PREFERRED PROVIDER NETWORK

One of the fundamental goals of HERO is to promote the use of best practices and standard outcomes measurement in workplace health and well-being. For this reason, we want organizations with constituencies that would benefit from easy access to the HERO Scorecard to have the opportunity to offer it directly to their clients by becoming a Preferred Provider. Preferred Provider organizations have access to exclusive training and resources to support strategic planning and benchmarking with their clients. See the HERO website for more information about [Preferred Provider benefits](#).

2018 PREFERRED PROVIDERS

- American Specialty Health Management
- Bupa
- Capital BlueCross
- HealthFitness
- Kaiser Permanente
- Mercer

GROWING DATABASE

When employers complete the HERO Scorecard, they not only benefit by understanding how their programs compare to other organizations' health and well-being efforts, they also contribute to a rapidly growing database that supports ongoing benchmarking and research. In the five years following the 2009 launch of version 3 of the HERO Scorecard, more than 1,200 employers completed it, enabling HERO to conduct analyses linking specific practices on the HERO Scorecard to employer-reported

outcomes. The current US version (version 4) was launched in 2014 and has garnered more than 1,000 unique responses, and about 200 organizations have completed the international version. Many organizations are also retaking the HERO Scorecard to enable time-over-time data analysis. Each quarter, HERO partners with members of the HERO Research Study Subcommittee to explore relationships in the data, and this report shares previously published commentaries leveraging the HERO Scorecard database.

NEW RESEARCH INSIGHTS

HERO also uses the database to support more formal research studies. The 2014 HERO Scorecard Report summarized the first such study, which found companies with higher HERO Scorecard scores had lower medical plan costs. That study was published in a 2014 issue of the *Journal of Occupational and Environmental Medicine* (Goetzel et al, Volume 56 [2014], pp. 136–144).

The 2016 progress report shared the results of another study based on HERO Scorecard data, which linked higher HERO Scorecard scores with company stock price. The study was published in a 2016 issue of the *Journal of Occupational and Environmental Medicine* (Grossmeier et al, Volume 58 [2016], pp. 16–23).

The latest research study went deeper than these early studies by examining the role of specific practices listed in the HERO Scorecard on outcomes such as employee perceptions of organizational support and organizationally reported turnover rates. Although the study was still in progress during the development of this report, published findings from the 2014 and 2016 studies are available on the HERO research [website](#).

BENCHMARKING REPORTS

The HERO Scorecard database is also leveraged to support benchmarking. Comprehensive benchmark reports are produced quarterly with aggregated responses to every question asked in the HERO Scorecard. The benchmark report provides organizations with a means for assessing how common it is for other employers to implement a specific type of program, policy or environmental support for employee health and well-being. They can also compare their HERO Scorecard responses to organizations of similar size, industry type or geographic location. For information on available reports, see the HERO [website](#).

UNITED STATES – BASED ON US VERSION 4

	Average score (n=984)	Maximum points possible
Overall score	91	200
Section 1: Strategic Planning	10	20
Section 2: Organizational & Culture Support	23	50
Section 3: Programs	22	40
Section 4: Program Integration	5	16
Section 5: Participation Strategies	23	50
Section 6: Measurement & Evaluation	9	24

ARGENTINA – BASED ON INTERNATIONAL VERSION

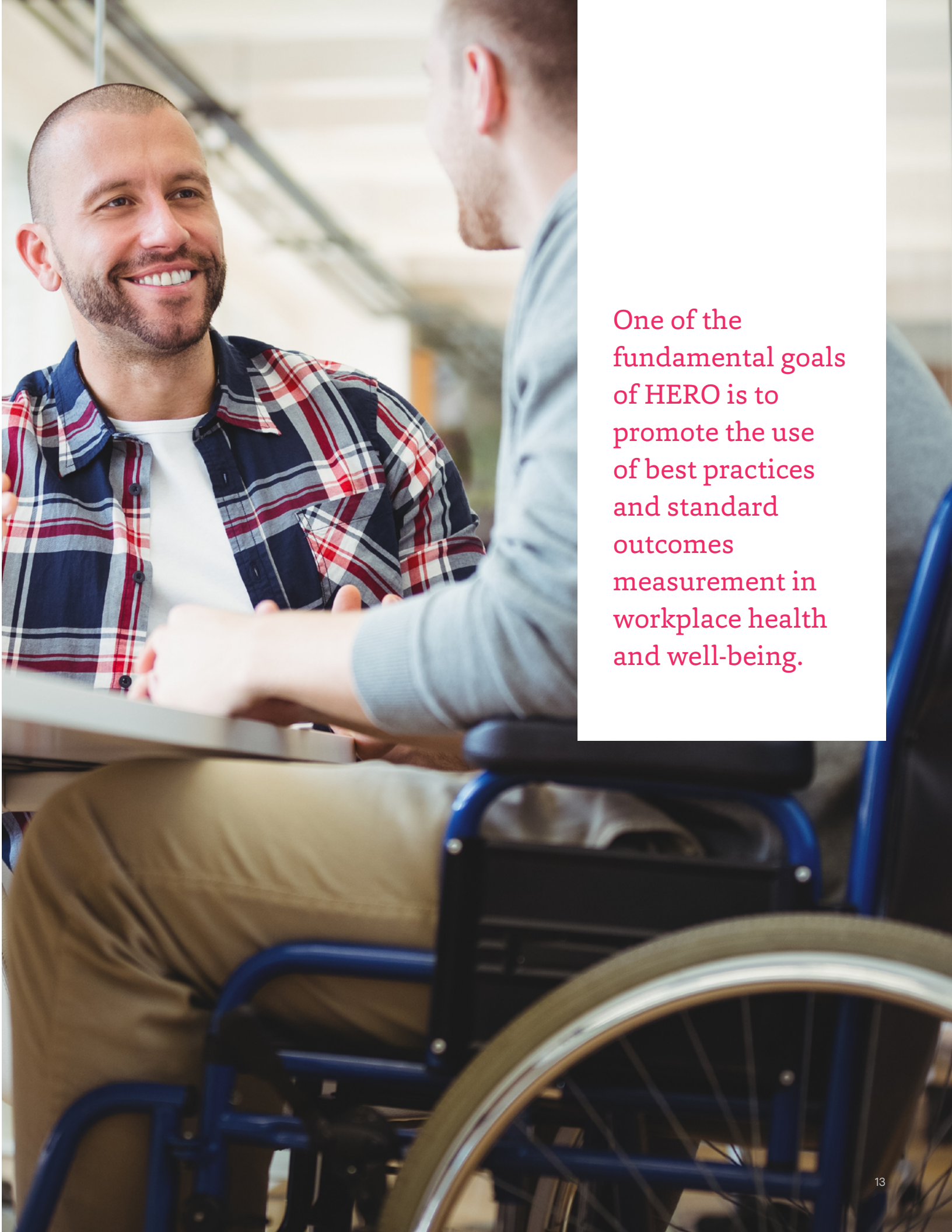
	Average score (n=36)	Maximum points possible
Overall score	63	200
Section 1: Strategic Planning	10	20
Section 2: Organizational & Culture Support	20	50
Section 3: Programs	11	40
Section 4: Program Integration	3	16
Section 5: Participation Strategies	12	50
Section 6: Measurement & Evaluation	7	24

BRAZIL — BASED ON INTERNATIONAL VERSION

	Average score (n=66)	Maximum points possible
Overall score	87	200
Section 1: Strategic Planning	11	20
Section 2: Organizational & Culture Support	24	50
Section 3: Programs	17	40
Section 4: Program Integration	4	16
Section 5: Participation Strategies	21	50
Section 6: Measurement & Evaluation	10	24

CANADA — BASED ON INTERNATIONAL VERSION

	Average score (n=19)	Maximum points possible
Overall score	65	200
Section 1: Strategic Planning	9	20
Section 2: Organizational & Culture Support	18	50
Section 3: Programs	15	40
Section 4: Program Integration	4	16
Section 5: Participation Strategies	13	50
Section 6: Measurement & Evaluation	6	24



One of the fundamental goals of HERO is to promote the use of best practices and standard outcomes measurement in workplace health and well-being.

3

A FRESH LOOK AT QUANTITATIVE OUTCOMES DATA FROM THE HERO SCORECARD

BETH UMLAND, DIRECTOR OF RESEARCH | HEALTH AND BENEFITS, MERCER

Most organizations that invest time and money in an initiative want to be able to evaluate how well it is meeting objectives and how the results they achieve compare with similar efforts by other organizations. This has proven difficult in the field of employee health and well-being (HWB), partly because outcomes in these areas are hard to measure, but also because no standard set of metrics has been agreed upon.

The HERO Health and Well-being Best Practices Scorecard in Collaboration with Mercer® (HERO Scorecard) includes an optional section on program outcomes that introduces a set of core metrics developed as part of a joint project undertaken by HERO and the Population Health Alliance. The full report, [Program Measurement & Evaluation Guide: Core Metrics for Employee Health Management](#), can be accessed on the HERO website. Our objectives for including a core set of metrics in the HERO Scorecard were to:

- Provide an inventory of best-practice metrics for evaluating program success, just as the HERO Scorecard serves as an inventory of well-being initiative best practices
- Direct employers and industry professionals to the *Measurement and Evaluation Guide*
- Build a database of outcomes data for research purposes

Although completing the outcomes section of the HERO Scorecard is optional, about 400 employers have provided at least some of the outcomes requested (as of September 2018). This commentary summarizes some of the findings for which we had an adequate numbers of responses. For now, these results can be used for benchmarking purposes. Going forward, we will use these data to examine the relationships between outcomes and specific best practices, to learn more about which practices have the biggest impact.

Metrics included in the HERO Scorecard address:

- Participation in health assessments, biometric screening and coaching
- Employee assessments
- Health measures
- Lifestyle behaviors
- Financial impact

PARTICIPATION RATES

On average, 50% of respondents' employees and 36% of eligible spouses completed a health assessment. Biometric screening rates were similar, at 49% of employees and 40% of eligible spouses. Participation rates fell somewhat for coaching programs: 29% of eligible employees had an initial interactive contact with a coach, 23% had multiple interactive contacts, and 22% completed a coaching program.

EMPLOYEE ASSESSMENTS

Nearly 200 respondents were able to provide results from employee assessments. The HERO Scorecard asked respondents to provide results to two questions that might be part of an employee assessment. The first was the degree of satisfaction with the company's HWB programs. Respondents reported that, on average, just under three-quarters of their employees (71%) were satisfied with the company's programs. The second question can be used to gauge success in creating a culture of health: asking employees whether they agree with the statement "My employer supports my health and well-being." Although somewhat fewer HERO Scorecard respondents provided results from this assessment than for the question on satisfaction with the program (172 compared to 189), the average percentage of employees who agreed was similar: 73%. This finding suggests that satisfaction with HWB tracks very closely with perceived organizational support.



HEALTH MEASURES AND LIFESTYLE BEHAVIORS

HERO Scorecard respondents are asked to provide results for a range of health measures. More than 100 respondents provided results for basic biometric measures — specifically, the percentage of employees in the normal range for total cholesterol (59% of employees, on average, were in the normal range), blood pressure (44%), glucose* (68%) and BMI (55% of employees were not obese).

For lifestyle behaviors reported on a health assessment, respondents reported the following average results: employees not using

tobacco, 85%; not depressed, 77%; not at risk for stress, 67%; averaging 7–9 hours of sleep/day, 60%; obtaining moderate physical activity, 56%; and eating an average of 5+ servings/day of fruits and vegetables, 32%.

We asked respondents to provide results for two years to demonstrate improvement (or lack of improvement). As the database grows, it will be interesting to analyze year-over-year changes in these measures for respondents based on their overall best practice score, or the level of perceived organizational support.

*Percentage with fasting glucose test <100 or nonfasting test <140 (normal).



FINANCIAL IMPACT

The majority of respondents reporting on the financial impact of their HWB initiatives said they review medical/pharmacy claims experience to determine savings. Most commonly, respondents using claims experience compare their population's actual cost trend with the expected normative trend (46%). Some organizations (28%) compare their population's cost trend with industry peer organizations, and a few (5%) perform an adjusted comparison of program participants versus nonparticipants using a matched control group. Among the 27 respondents providing savings per enrolled employee per year, the median savings was \$372. Among the 29 providing savings as a percentage of total health plan cost, the median savings was 5%.

In addition, some respondents said they measure the financial impact of their HWB

initiatives on such nonmedical areas as absence (10% of respondents), disability (9%), productivity/performance (12%) or business results (6%).

While any data demonstrating a positive financial impact is intriguing, it's important to keep in mind that the average medical plan savings amounts were based on a small number of employers. As the database grows, we hope to provide more solid evidence of the potential for savings — along with an analysis showing the types of programs that achieve the best results. And as more employers attempt to measure the impact of their programs on productivity and business results, the broader value of investing in employee well-being will become clearer.





The business views the HERO Scorecard as a means to supporting employers in creating an inventory of health and well-being best practices, benchmarking their performance and understanding how they can improve over time.

CASE STUDY 1

HELPING BUSINESSES HAVE HEALTHIER WORKFORCES THROUGH EVALUATION WITH THE HERO SCORECARD

In 2018, Bupa Global partnered with HERO to launch the international version of the HERO Health and Well-being Best Practices Scorecard in Collaboration With Mercer® (HERO International Scorecard) to its business customers. Bupa Global is the international health insurance arm of Bupa, serving millions of customers around world. It provides products and services for globally minded and mobile people who want the most premium coverage and access to the healthcare they need anytime, anywhere in the world, whether at home or when studying, living, traveling or working abroad.

The business views the HERO Scorecard as a means to supporting employers in creating an inventory of health and well-being best practices, benchmarking their performance and understanding how they can improve over time.

While employers recognize workplace health initiatives as a key way to attract and retain talent, such initiatives need to be underpinned by strong strategic planning, health-supporting policies, leadership buy-in and measurement. Bupa Global recognizes the value of the HERO International Scorecard to help businesses compare its results with those of other companies and to track progress in its health and well-being initiatives over time.

Once Bupa Global made the decision to launch the HERO International Scorecard to its customers, the business invested in the development of training materials, communications and reporting templates to support client management teams to integrate the HERO International Scorecard into client consultation. The initial response from the training has been positive, as the Scorecard data have proved helpful in identifying evidence-based ways clients can build on their existing programs and get leadership support for improvements and expansion of health and well-being initiatives.

One of the most useful tools that Bupa Global has developed to support the launch of the HERO International Scorecard to its clients is a reporting template that each client manager will tailor to report best practice scores, comparative benchmarks and strategic recommendations for the improvement and expansion of health and well-being programs.

Although adoption of the HERO International Scorecard will take a phased approach, Bupa Global believes that the partnership with HERO will support the provision, promotion and execution of evidence-based practices that improve employee health and well-being.

4

THE IMPACT OF PERCEIVED EFFECTIVENESS OF HWB INITIATIVES ON PARTICIPATION, HEALTH AND MEDICAL COST IMPROVEMENT

MARY IMBODEN, PHD, HERO MEMBERSHIP MANAGER AND RESEARCH ASSOCIATE
ORIGINALLY PUBLISHED IN Q4 2018

Health and well-being (HWB) initiatives have been introduced into the workplace over the past few decades. The goals are improving overall health, reducing health-related costs and increasing employee performance and productivity.¹ These initiatives have been implemented using different evidence-based designs.² Few studies have focused on the employer's perceived effectiveness of an organization's HWB initiative, even though it is well-established that perception and evaluation of worksite HWB initiatives are associated with participation and engagement.³ As a result, perceived effectiveness could be indirectly associated with improvements in health and related costs. The HERO Health and Well-being Best Practices Scorecard in Collaboration with Mercer© (HERO Scorecard) includes questions on the perceived effectiveness of strategic planning, organizational and cultural support, participation strategies, programs, program integration, and measurement and evaluation to inform the development and implementation of effective HWB initiatives. The HERO Scorecard also assesses organizationally reported impact on health risks and health plan cost.

EMPLOYER'S PERCEIVED EFFECTIVENESS OF HWB INITIATIVE

In an attempt to capture employer perceptions about an organization's HWB initiatives, the HERO Scorecard asks respondents how effective they believe their organization's implementation of recommended practices is in each major domain assessed by the scorecard. Overall, a higher percentage of employers perceived their organization's HWB initiatives as effective versus not effective. Specifically, 58% (n=964) of employers perceived the strategic planning for HWB in their organization as effective and 54% (n=970) of employers perceived their organizational and cultural support strategies as effective. When it came to programs and program integration, 61% (n=972) of employers perceived their HWB initiatives as effective in promoting a healthier workplace, and 42% (n=965) found the integration between their health-related vendors or programs as effective in contributing to the success of their HWB initiatives. When asked about participation strategies, 61% (n=964) of employers perceived their organization's strategies as effective in encouraging program participation.

IMPACT ON PARTICIPATION, HEALTH RISK AND MEDICAL COST

Overall, 41% of the 558 organizations providing these data reported that their initiatives were associated with significant (n=56) or slight

- 1 Serxner S, Gold D, Meraz A, Gray A. (2009) "Do Employee Health Management Programs Work?" *American Journal of Health Promotion*, Volume 23, pp. 1-12.
- 2 Goetzel RZ, Henke RM, Tabrizi M, et al. (2014) "Do Workplace Health Promotion (Wellness) Programs Work?" *Journal of Occupational and Environmental Medicine*, Volume 56, pp. 927-934.
- 3 Street TD, Lacey SJ. (2018) "Employee Perceptions of Workplace Health Promotion Programs: Comparison of a Tailored, Semi-Tailored, and Standardized Approach," *International Journal of Environmental Research and Public Health*, Volume 15, p. 881.

(n=171) improvement in health risk. Among the 560 organizations that provided information on medical cost trend, 29% reported a small (n=103) to substantial (n=60) positive impact on medical cost trend in association with their HWB initiatives. Only 11% that measured health risk and 14% that measured medical cost trend reported no improvement. However, 37% had not attempted to measure change in health risk and another 12% were not confident that their results were valid. A similar pattern was found for medical cost trend, as 45% of organizations had not attempted to measure the change in medical cost and 12% were not confident about the validity of their results.

Subsequent analysis examined the association between organizational reports of perceived effectiveness and three organizationally reported outcomes, including participation rates, health impact and medical cost trend. Among the smaller sample of organizations that provided information on these outcomes, those that reported their HWB initiatives were effective had higher reported rates of health improvement and medical cost trend improvement. Details about how perceptions of effectiveness for the six areas of practice were related to these outcomes follow. Analyses for each section of the HERO Scorecard were limited to the number of organizations that provided responses to these optional questions. As a result, sample size varied slightly for each analysis (168–237 organizations provided information on health improvement and 143–197 organizations provided data on medical cost improvement, depending on the analysis). Between 388 and 394 organizations provided data on health

assessment participation and biometric screening, depending on the analysis. However, far fewer organizations (162–170 organizations, depending on analysis) reported on coaching participation rates.

STRATEGIC PLANNING

Organizations that perceived their strategic planning as effective, compared to those that did not find their strategic planning effective, had a much higher rate of reported health improvement (83% vs. 61%) and improvement in medical cost trend (71% vs. 54%). Of the organizations that provided data, respondents that perceived their organization's strategic planning as effective reported higher health assessment participation (53% vs. 44%) and biometric screening participation (52% vs. 43%) rates. However, participation in health coaching did not vary depending on perceived strategic planning effectiveness.

ORGANIZATIONAL AND CULTURAL SUPPORT STRATEGIES

Respondents that perceived their organizational support strategies as effective, compared to those that perceived their organizational strategies as ineffective, also had a higher prevalence of reported health improvement (88% vs. 55%) and improvement in medical cost trend (74% vs. 49%). Among the organizations that provided data, respondents that perceived their organizational strategies as effective reported higher participation in health assessments (52% vs. 45%), biometric screening (51% vs. 45%) and health coaching (32% vs. 22%).

PROGRAMS

Employers that perceived their organization's HWB initiatives as effective in supporting a healthier workforce, compared with those that perceived their HWB initiatives were not effective, reported a higher rate of health improvement (82% vs. 74%) and medical cost trend improvement (70% vs. 62%). Employers that perceived their initiatives as effective in supporting a healthier workforce reported higher participation in HWB programs, including health assessment (51% vs. 47%), biometric screening (49% vs. 47%) and health coaching (30% vs. 26%).

Additionally, those that perceived their organization's HWB initiatives as effective in promoting a healthier workforce also reported a higher prevalence of health improvement (85% vs. 53%) and medical cost trend improvement (74% vs. 41%). Among the organizations that provided data, those that perceived their initiatives as effective in promoting a healthier workforce reported higher participation in health assessments (53% vs. 43%), biometric screenings (52% vs. 40%) and health coaching (30% vs. 25%).

PROGRAM INTEGRATION

Similar to the patterns observed for the Programs section of the HERO Scorecard, respondents that perceived their program integration effective in contributing to the success of their HWB initiative, compared with those that perceived their program integration was not effective, reported a higher prevalence of health improvement (87% vs. 69%) and medical cost trend improvement (74% vs. 59%). Respondents that perceived program integration as effective reported higher participation in health assessments (53% vs. 46%) and biometric screenings (53% vs. 45%). No meaningful differences were found for participation rates in health coaching based on how organizations perceived the effectiveness of their program integration (29% vs. 28%).

PARTICIPATION STRATEGIES

Organizations that perceived their participation strategies were effective, compared to those that found them not effective, also reported higher prevalence of health improvement (86% vs. 48%) and medical cost trend improvement (74% vs. 41%). Respondents that perceived their participation strategies were effective reported higher participation in health assessments (54% vs. 39%), biometric screenings (53% vs. 37%) and health coaching (31% vs. 22%).

MEASUREMENT AND EVALUATION

Respondents perceiving their data management and evaluation activities as effective, compared to those that perceived their participation strategies were not effective, had higher prevalence of health improvement (84% vs. 64%) and medical cost trend improvement (74% vs. 47%). Organizations perceiving their data management and evaluation activities as effective reported higher participation in health assessments (52% vs. 46%), biometric screenings (54% vs. 41%) and health coaching (31% vs. 24%).

Figure 1. Impact on Health Improvement Based on Perceived Effectiveness

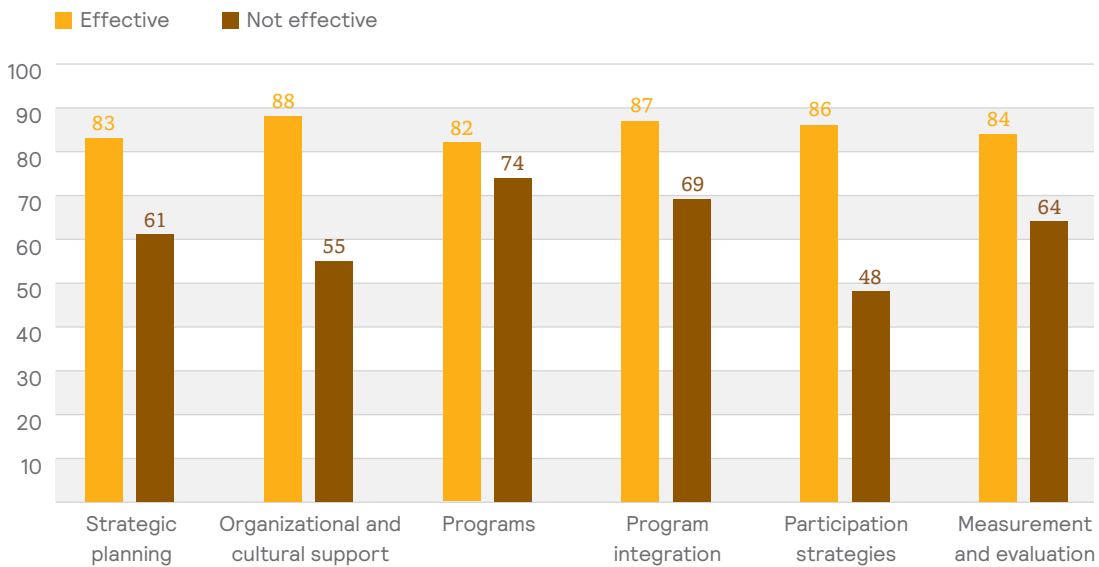
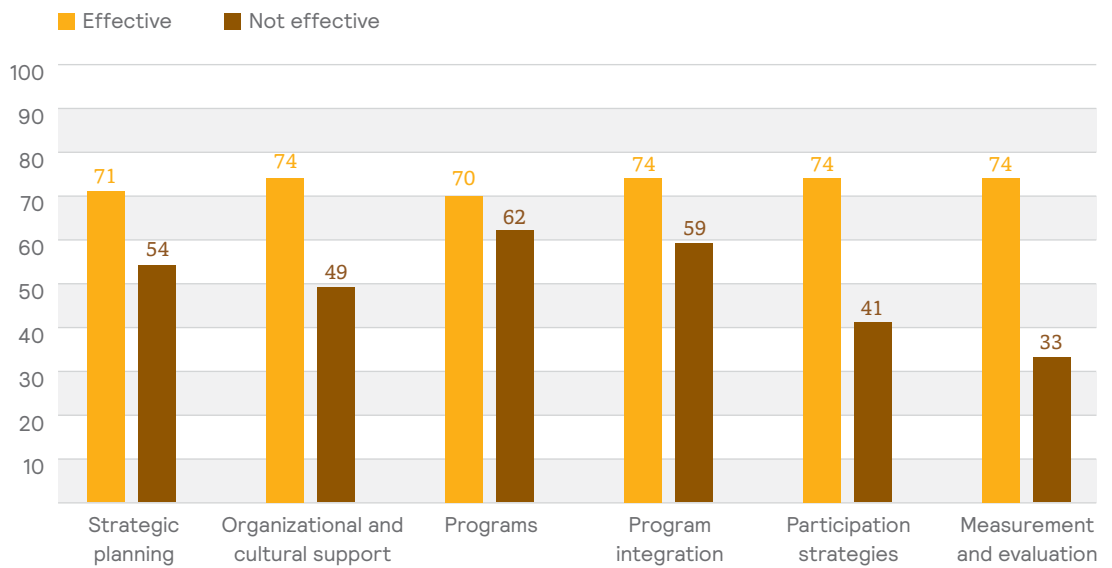


Figure 2. Impact on Medical Cost Based on Perceived Effectiveness



CONCLUSION

Overall, the results showed the following:

1. Organizations that perceived their organization as effective in strategic planning, organizational strategies, programs, program integration, participation strategies, and data management and evaluation reported higher rates of health and medical cost trend improvement.
2. Organizations that perceived their organization's HWB initiatives as effective in the six domains assessed by the scorecard had higher rates of participation in health assessment, biometric screening and health coaching. In general, these results demonstrate the value of measuring and reporting on outcomes.
3. Over half of respondents did not provide data on health improvements and medical cost trends. Employers should be encouraged to measure these outcomes to better understand the relationship between perceived effectiveness, participation and health outcomes.

It has been reported that perceived effectiveness of HWB initiatives is associated with participation and engagement.⁴ The HERO Scorecard data support this, as higher participation rates were reported for health assessments, biometric screenings and coaching when employers perceived each of the six areas of practice assessed as effective.

4 Street TD, Lacey SJ. (2018) "Employee Perceptions of Workplace Health Promotion Programs: Comparison of a Tailored, Semi-Tailored, and Standardized Approach," *International Journal of Environmental Research and Public Health*, Volume 15, p. 881.

Whether perceived effectiveness of HWB initiatives has a direct association with health and medical cost trend improvement or an indirect association through the higher rates of participation, employers that perceived their organization as effective in strategic planning, organizational strategies, programs, program integration, participation strategies, and data management and evaluation reported higher rates of health and medical cost trend improvement.

The health and medical cost trend improvements in this analysis relied on employers' responses on the HERO Scorecard. Because we do not know whether their

responses were based on rigorous analysis of objectively measured health, biometric and medical claim data, these findings should be interpreted with caution. Despite this limitation, the results provide important information on the relationship between perceived effectiveness, participation and health outcomes. This research may also help to inform future research on the relationship between perceived effectiveness and changes in health risks and medical costs.

This commentary is based on data from the HERO Scorecard Benchmark Database through June 30, 2018.



5

LIFESTYLE MANAGEMENT SERVICES ASSOCIATED WITH EMPLOYEE HEALTH RISK AND MEDICAL COSTS

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BAYLOR COLLEGE OF MEDICINE
ORIGINALLY PUBLISHED IN Q3 2018

Health and well-being initiatives have been introduced to employers over the past few decades with goals ranging from improving employees' health, performance and productivity to reducing medical costs, disability and absenteeism. There is no simple answer to the question, "Do employee health and well-being initiatives work?" because it depends on the specific goals of each organizational sponsor, the quality of the initiatives implemented and the contextual environment supporting them. Effective initiatives are characterized by strong engagement strategies, ongoing program monitoring and management, and years of long-term maintenance.^{1,2} The HERO Health and Well-being Best Practices Scorecard in Collaboration with Mercer® (HERO Scorecard) includes questions on the use of best practices such as strategic planning, participation strategies and program evaluation to inform the development of effective program implementation. The HERO Scorecard also assesses employer use of individually targeted lifestyle management services and the impact of the overall health and well-being initiative on health risks and medical plan cost.

PREVALENCE OF INDIVIDUALLY TARGETED LIFESTYLE MANAGEMENT SERVICES AND FORMS OF DELIVERY

Of 628 organizations that completed the HERO Scorecard, 77% offer individually targeted lifestyle management services that allow for interactive communication between an individual and a health professional or an expert system. The most commonly used approach to deliver an intervention is phone-based coaching (77%), followed by web-based interventions (65%), onsite group classes (54%), email or mobile (SMS) communications (51%), onsite one-on-one coaching (43%) and paper-based bidirectional communication between the organization and the individual (17%).

IMPACT ON HEALTH RISK AND MEDICAL COST

Overall, 42% of the 484 organizations providing these data reported improvement in health risk and 30% reported a positive impact on medical cost trend. Only 10% that measured health risk reported no improvement, and only 12% that measured medical cost trend reported no improvement. Notably, however, 36% had not attempted to measure change in health risk and another 12% were not confident that

1 Serxner S, Gold D, Meraz A, Gray A. (2009) "Do Employee Health Management Programs Work?" *American Journal of Health Promotion*, Volume 23, pp. 1-12.

2 Goetzel RZ, Henke RM, Tabrizi M, et al. (2014) "Do Workplace Health Promotion (Wellness) Programs Work?" *Journal of Occupational and Environmental Medicine*, Volume 56, pp. 927-934.

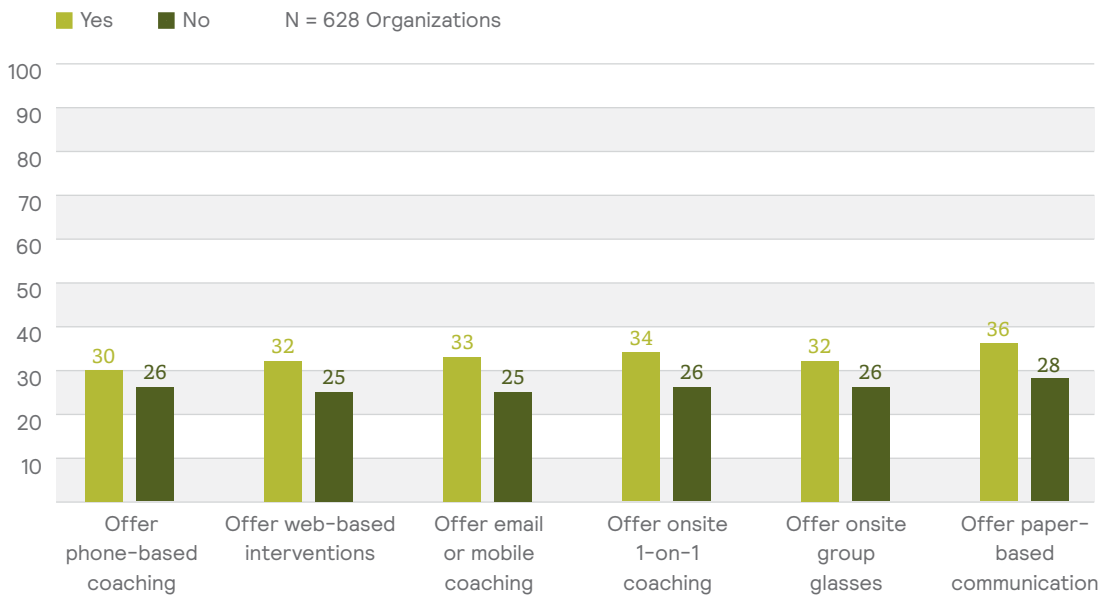
the results were valid, even though they had attempted to measure them. Similarly, 45% had not attempted to measure change in medical cost, and another 12% had measured but were not confident that the results were valid.

Among 836 organizations responding to the health improvement question, a much higher prevalence of reported health improvement was found among organizations that offered targeted lifestyle management services than those that did not offer services (29% vs. 9%, respectively). Among the much smaller sample of 628 organizations responding to the question about providing specific lifestyle

management services, meaningful prevalence differences of reported health improvement were also found between organizations providing and not providing those services, respectively: phone-based coaching (30% vs. 26%), web-based interventions (32% vs. 25%), email or mobile (SMS) communications (33% vs. 25%), onsite one-on-one coaching (34% vs. 26%), onsite group classes (32% vs. 26%) and paper-based bidirectional communication (36% vs. 28%).

A similar pattern was found for medical cost trend: A much higher prevalence of improvement in medical trend (36% vs. 10%)

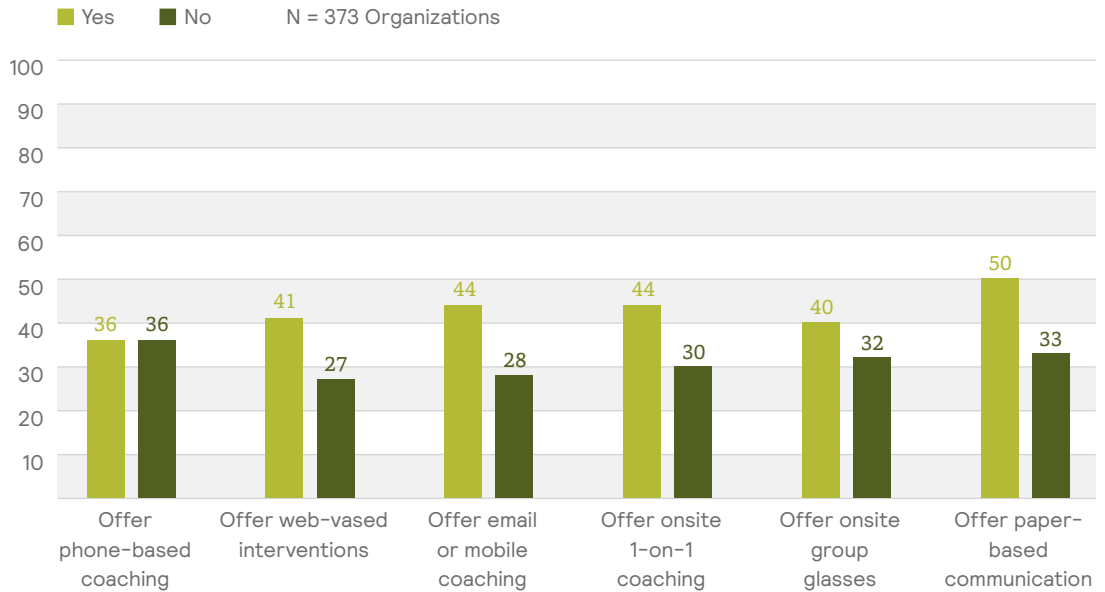
Figure 1. Impact on Health Improvement Based on Provision of Coaching



was found among organizations offering and not offering lifestyle management services. With one exception, differences were found in the prevalence of improved medical cost trend between organizations that provided lifestyle management services and those that did not: web-based interventions (41% vs. 27%, respectively), email or mobile (SMS) communications (44% vs. 28%), onsite one-on-one coaching (44% vs. 30%), onsite group classes (40% vs. 32%) and paper-based

bidirectional communication (50% vs. 33%). Somewhat surprisingly, the prevalence of reported improvement in medical cost trend was the same (36%) among organizations that did or did not offer phone-based coaching. However, it is important to recognize that these are descriptive statistics unadjusted for organizational differences, participation rates and other factors that may have affected the observed results.

Figure 2. Impact on Medical Cost Based on Provision of Coaching



CONCLUSION

This analysis yielded three informative, actionable findings.

1. Individually targeted lifestyle management services are prevalent in organizations and are delivered in a variety of ways. Offering a combination of learning and behavior change experiences is common among organizations seeking to improve population-level health and medical cost outcomes.
2. Over half of the organizations did not report having valid data related to employee health risk or medical cost trend. For organizations intent on understanding the effectiveness of their various interventions, these results demonstrate the value of measuring and reporting on outcomes.
3. Offering individually targeted lifestyle management services was associated with much higher rates of improvement in health risk and medical cost trends.

While these findings provide additional support for the value of implementing and evaluating lifestyle management services within a best-practice health and well-being strategy, they

must be interpreted with caution. Because the results were correlational, causal relations cannot be determined. This study was also based on company-level, self-reported data rather than medical claims analysis. Similarly, health improvement findings were based on employee self-reports, not on an analysis of objectively measured health or biometric data.

Despite such limitations, the results are very helpful for benchmarking and shed further light on the relationship between the use of lifestyle management services and subsequent health and medical cost trend improvements. The fairly small incremental improvements tell us that a very significant amount of work remains to be done to improve individual outcomes and achieve medical cost savings for employers. Well-controlled internal or vendor evaluation is necessary for those organizations intent on determining the impact of their specific health and well-being initiatives on employee health risks and medical costs.

This commentary is based on data from the HERO Scorecard Benchmark Database through December 31, 2017.

3 Musich S, White J, Hardley SK, et al. (2014) "A More Generalizable Method to Evaluate Changes in Healthcare Costs With Changes in Health Risks Among Employers of All Sizes," *Population Health Management*, Volume 17, pp. 297-305.

4 Serxner S, Alberti A, Weinberger S. (2012) "Medical Cost Savings for Participants and Nonparticipants in Health Risk Assessments, Lifestyle Management, Disease Management, Depression Management and Nurseline in a Large Financial Services Corporation," *American Journal of Health Promotion*, Volume 26, pp. 245-252.

6

LEADERSHIP SUPPORT AND THE EFFECTIVENESS OF WELLNESS INITIATIVES

BY OCTAVIA ZAHRT, STANFORD UNIVERSITY GRADUATE SCHOOL OF BUSINESS
ORIGINALLY PUBLISHED IN Q2 2018

Workplace wellness initiatives have become increasingly prevalent in US organizations. According to a 2016 Mercer national survey, 70% of large employers invest in health and well-being programs in addition to what might be offered through the employer-sponsored health plan.¹ Despite employers' substantial investments in wellness, employee participation rates vary widely among employers and among different types of wellness activities. For example, the HERO Health and Well-being Best Practices Scorecard in Collaboration with Mercer® (HERO Scorecard) indicates that participation in health assessment surveys or biometric screenings can vary from 25% to more than 75% of the eligible employee population.² Moreover, studies evaluating the impact of wellness initiatives have found inconsistent results.³ Why might that be? One important factor shaping the impact of wellness is leadership support. Even if an organization invests in a top-notch initiative, employees may not feel comfortable taking advantage of its offerings unless they feel supported by their leaders.^{4,5}

The HERO Scorecard includes valuable data to better understand the role of leadership support in the impact of wellness initiatives on employee health and medical plan costs. An analysis was conducted of the HERO Scorecard database, including responses from 811 unique organizations.

COMMUNICATING LEADERSHIP SUPPORT

Leaders can express their support for employees' pursuit of wellness in various ways, including public recognition and role modeling. However, descriptive analyses found that these types of leadership supports are quite rare. Specifically, among the 811 organizations represented in the HERO database, only 28% reported that leaders publicly recognize employees for healthy behaviors and outcomes. Furthermore, only 23% of organizations said leaders are role models for prioritizing health and work/life balance (for example, by not sending emails while on vacation, taking activity breaks during the work day and so on).

- 1 Mercer. (2017) *National Survey of Employer-Sponsored Health Plans: 2016 Report*, available at www.mercer.com.
- 2 HERO Scorecard Health and Well-being Best Practices Scorecard in Collaboration With Mercer. HERO Scorecard Benchmark Database through September 30, 2017.
- 3 Osilla KC, Larkin JW, Eibner C, Mattke S. (2012) "Systematic Review of the Impact of Worksite Wellness Programs," *American Journal of Managed Care*, Volume 18, pp. e68-e81.
- 4 Limeade and Quantum Workplace. (2016) *Well-being and Engagement Report*, available at www.limeade.com/2016/09/well-being-engagement-report.
- 5 Flynn J. (2014) "Understanding the Importance of Organizational Support" in *HERO Health and Well-being Best Practices Scorecard in Collaboration With Mercer Annual Report*, pp. 12-13.

LEADERSHIP ACCOUNTABILITY

Organizations can encourage leaders to be more supportive of employee well-being by holding them accountable, but again, this is rarely practiced in organizations. In the HERO sample, only 17% of organizations indicated that leaders are held accountable for supporting the health and well-being of their employees. Furthermore, only 14% reported that leaders hold their front-line managers accountable for supporting the health and well-being of their employees. Of course, accountability may not be enough. Front-line and middle managers may also need appropriate support to be able to improve the health and well-being of their teams, such as training, adequate budgets and resources. However, only 13% of organizations reported that managers are given a lot of support. Another 37% said managers are given some support, and more than half (51%) of organizations said managers are given little or no support.

LEADERSHIP SUPPORT AND THE EFFECTIVENESS OF THE TOP 25% WELLNESS INITIATIVES

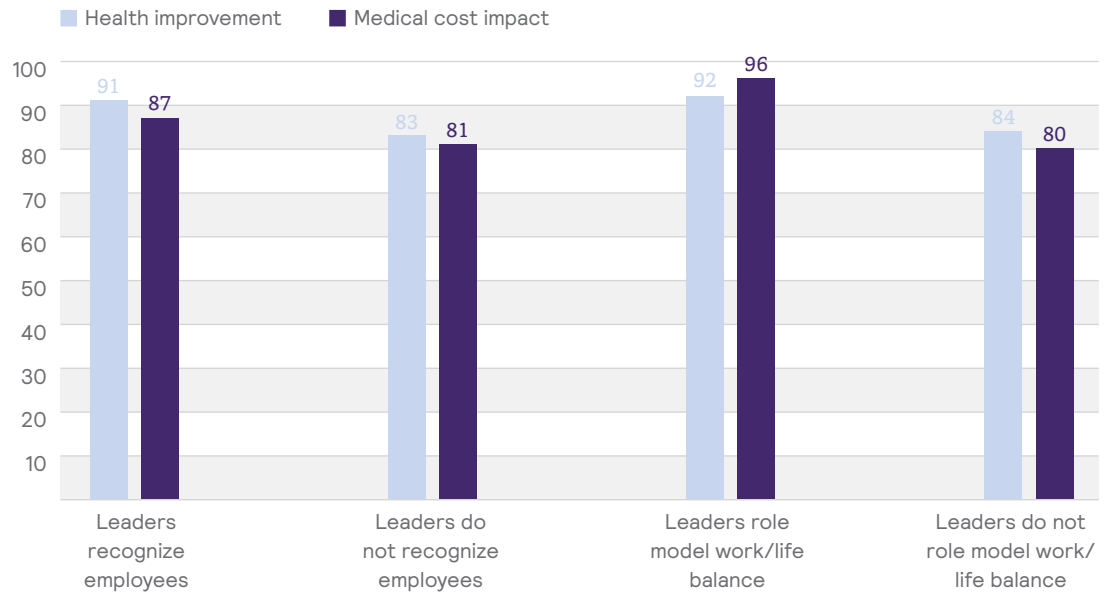
Might leadership support, a relatively low-cost approach, be a critical factor shaping the effectiveness of highly comprehensive well-being initiatives? To address this question, subsequent analyses focused specifically on

organizations whose well-being initiatives scored in the top 25% in terms of their comprehensiveness (henceforth: “top-scoring organizations”). Within this top-scoring group, further data analyses examined the association between the different types of leadership support and outcomes for those organizations that provided data on health impact (n=242) and medical cost impact (n=196) of their wellness initiatives.

First, the different forms of communicating leadership support (that is, public recognition and role modeling) were analyzed:

- Top-scoring organizations whose leaders publicly recognized employees for healthy actions and outcomes were more likely to report employee health improvements (91%) and medical cost improvements (87%), as compared to top-scoring organizations whose leaders did not publicly recognize employees’ healthy actions and outcomes (83% and 81%, respectively).
- Top-scoring organizations whose leaders were role models for prioritizing health and work/life balance were more likely to report employee health improvements (92%) and medical cost improvements (96%), as compared to top-scoring organizations whose leaders were not role models (84% and 80%, respectively).

Figure 1. Health and Cost Impact by Leadership Support Behaviors



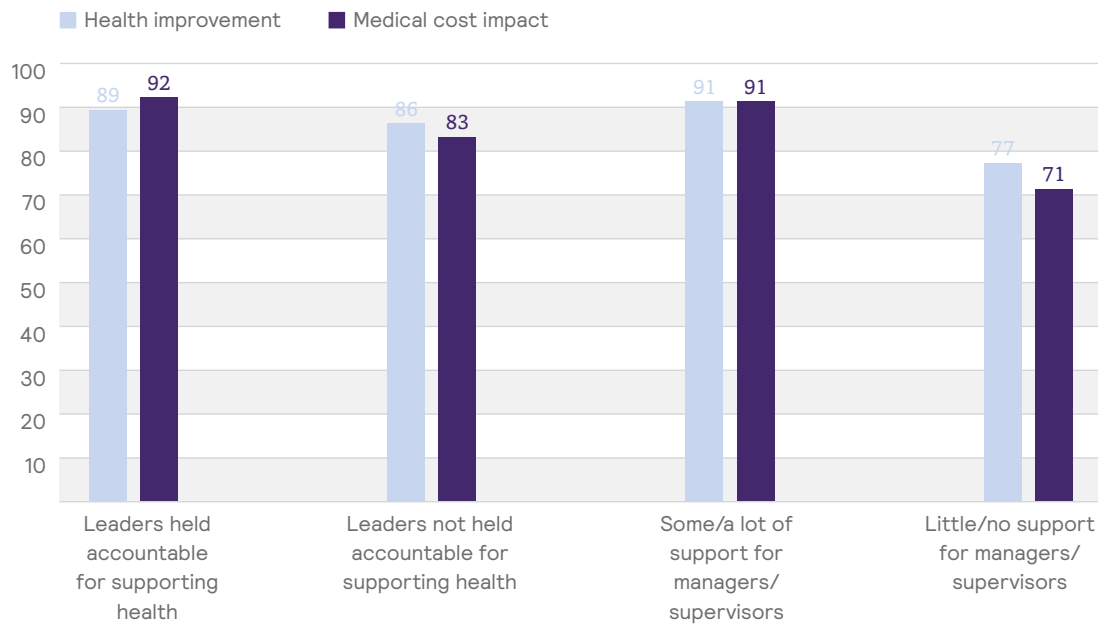
Thus, even among a select sample of organizations that have invested in very comprehensive wellness initiatives, when leaders celebrated employees' pursuit of well-being and shared their own healthy goals and actions, their organizations were much more likely to experience cost reductions and health improvements.

Next, leadership accountability and support for managers' efforts were analyzed:

- Top-scoring organizations whose leaders were held accountable for supporting employee health were more likely to report employee health improvements (89%) and medical cost improvements (92%), as compared to top-scoring organizations whose leaders were not held accountable (86% and 83%, respectively).

- Top-scoring organizations whose leaders held front-line managers accountable for supporting employee health were more likely to report medical cost improvements (90%) than organizations whose leaders did not hold front-line managers accountable (84%). However, no material differences were found in organizations' likelihood to report employee health improvements.
- Top-scoring organizations whose mid-level and front-line managers were given some or a lot of support in their efforts to improve their teams' health were more likely to report employee health improvements (91%) and medical cost improvements (91%), as compared to top-scoring organizations whose mid-level and front-line managers were given little or no support (77% and 71%, respectively).

Figure 2. Health and Cost Impact by Leadership Accountability and Support




These findings support the idea that holding senior leaders accountable for supporting employee health is associated with greater employee health improvements and medical cost savings, within the context of a comprehensive health and well-being initiative. Additionally, holding front-line managers accountable was associated with greater medical cost savings, though no material differences in employee health improvements were found. Furthermore, top-scoring organizations that gave mid-level and front-line managers at least some support in their efforts to improve their teams' health were much more likely to report cost and health benefits than top-scoring organizations who were less supportive of managers. Given the cross-sectional nature of the data, more research is needed to establish causality and to examine the mechanisms linking leadership support with employee health and medical costs.

CONCLUSION

These findings suggest that organizations motivated to improve their employees' well-being and save medical costs should consider the importance of leadership support. Even in organizations that offer very comprehensive well-being initiatives – including health screenings, behavior change workshops, onsite gyms and others – employees' perceived lack of leadership support might act as a barrier to their participating in and benefiting from these initiatives. Importantly, it appears that leaders may be able to substantially boost the effectiveness of their wellness initiatives at a negligible cost: Behaviors as simple as celebrating employees' health promotion efforts and sharing leaders' own well-being practices might empower employees to become happier, healthier and more productive.

This commentary is based on data from the HERO Scorecard Benchmark Database through September 30, 2017.

An aerial photograph of a city skyline at dusk. The sky is a deep blue with some light clouds. In the foreground, there are several tall, modern skyscrapers with glass facades, some of which are illuminated. The middle ground shows a dense urban area with many smaller buildings and streets. The background features more skyscrapers, including a prominent one with a curved top. A white rectangular text box is overlaid on the right side of the image, containing two paragraphs of text.

There is a lot of variability among their operations. Although many countries have a lot of good local initiatives, some countries are way ahead of others.

Having a country-by-country inventory is helping HR to get leadership support and determine where to focus first.

CASE STUDY 2

USING THE INTERNATIONAL SCORECARD TO TAKE STOCK OF WELL-BEING INITIATIVES AROUND THE WORLD

Given its strong focus on employee well-being and safety, a global beauty company is striving to create a workplace culture that fosters not only physical health but all aspects of well-being, such as flexible work arrangements, volunteerism, family friendly policies and other initiatives that will make a difference in employees' lives.

To create a strategy and determine what to prioritize, the company wanted a baseline showing what programs and policies are in place today. Leadership considered asking each country to fill out an Excel spreadsheet (too basic and/or administratively cumbersome) or having a third-party interview the country HR managers (too expensive). The best alternative turned out to be the HERO International Scorecard, which they found to be a “slick, fantastic tool.”

Eleven countries completed the Scorecard. The HR team pulled together the results and circulated them internally. The key finding was that there is a lot of variability among their operations. Although many countries have a lot of good local initiatives, some countries are way ahead of others.

Having a country-by-country inventory is helping HR to get leadership support and determine where to focus first. In the short term, HR is planning to pilot a mental health program, build a champion network and create a global well-being brand.

7

ORGANIZATIONAL SUPPORT FOR WELL-BEING: SENIOR LEADERSHIP AND MANAGERIAL SUPPORT REQUIRED

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LIMEADE INSTITUTE
ORIGINALLY PUBLISHED IN Q1 2018

Organizational support for well-being is the extent to which an organization provides the resources, communication, reinforcement and encouragement to enable employees to improve well-being. When individual improvement or behavior change happens, the “ecosystem” around that change has to be supportive — if it isn’t, change either won’t happen or will be less likely to be sustainable. In the workplace, the organizational “ecosystem” has to provide the policies and practices, visible leadership and manager support, role modeling, nudges and defaults to fully support well-being improvement.

The concept of perceived organizational support is not a new one¹ — but it’s relatively new as applied to employee health and well-being. For example, research has shown that safety behaviors improve when employees perceive that there is organizational support.²⁻⁴ More recent research⁵ has found that participation in a variety of health screenings and health and well-being programs increases as the degree of organizational support increases.

The HERO Health and Well-being Best Practices Scorecard in Collaboration With Mercer® (HERO Scorecard) offers valuable data to better understand the role of organizational support in well-being programs. To examine the relationships between types of organizational support and employee perceptions of it, an analysis was conducted of the HERO Scorecard database, including responses from more than 811 unique organizations.

SENIOR LEADERSHIP SUPPORT

One of the more well-accepted contributors to organizational support is leadership support, and the HERO Scorecard asks organizations about several specific leadership support practices. Descriptive analyses found that just over half (53%) of the organizations completing the HERO Scorecard reported that their leaders actively participate in health and well-being programs. However, there was a large gap between participating and the next most frequently reported type of leadership support. Specifically, the next three types of support reported were as follows:

- 28% of organizations have leaders who publicly recognize employees who participate in health and well-being programs

1 Rhoades L, Eisenberger R. (2002) “Perceived Organizational Support: A Review of the Literature,” *Journal of Applied Psychology*, Volume 87, Number 4, pp. 698–714.

2 Credo KR, Armenakis AA, Feild HS, Young RL. (2010) “Organizational Ethics, Leader-Member Exchange, and Organizational Support: Relationships With Workplace Safety,” *Journal of Leadership & Organizational Studies*, Volume 17, Issue 4, pp. 325–334.

3 Hofmann DA, Morgeson FP. (1999) “Safety-Related Behavior as a Social Exchange: The Role of Perceived Organizational Support and Leader-Member Exchange,” *Journal of Applied Psychology*, Volume 84, Issue 2, pp. 286–296.

4 Mearns KJ, Reader T. (2008) “Organizational Support and Safety Outcomes: An Un-investigated Relationship?” *Safety Science*, Volume 46, Issue 3, pp. 388–397.

5 Flynn J. (2014) “Understanding the Importance of Organizational Support,” in *HERO Employee Health Management Best Practices Scorecard in Collaboration With Mercer: Annual Report*.

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- 27% of organizations have leaders who articulate business relevance of well-being
 - 23% of organizations have leaders who are role models for health and well-being

More than a quarter of responding organizations (26%) said “none of the above,” meaning leaders don’t support well-being in any of the ways assessed by the HERO Scorecard.

MANAGERIAL SUPPORT

Only 14% of organizations said managers are held accountable for improving well-being in their organizations. When asked whether mid-level managers and supervisors are supported in their efforts to improve the health and well-being of employees within their work groups or teams, only 13% of organizations said managers were given a lot of support. Another 37% said managers were given some support, and more than half (51%) of organizations said managers were given little or no support.

A recent Limeade study found that participants who reported high levels of well-being had more favorable perceptions of organizational support than those reporting low well-being.⁶ The same study also found that managers were the most important contributor to overall perceptions of organizational support. Other important contributors included having tools and resources that support well-being and having senior leadership support.

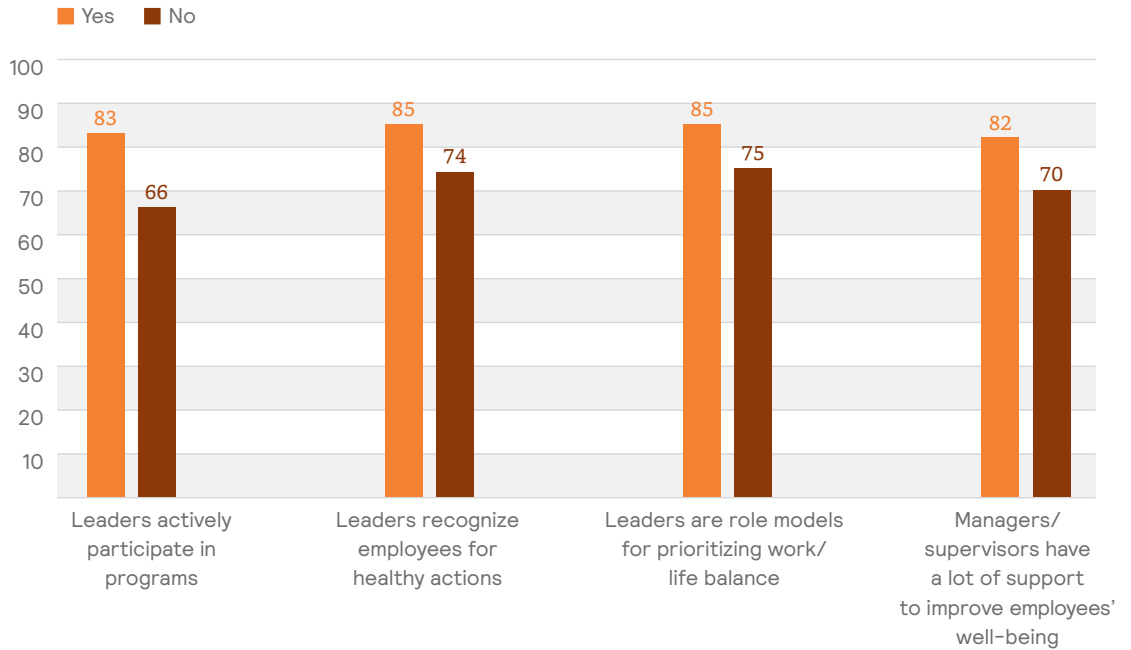
LEADERSHIP SUPPORT AND OUTCOMES

Subsequent HERO Scorecard analyses compared organizations with higher levels of leadership support to organizationally reported employee satisfaction rates. One HERO Scorecard question asks employers to report the percentage of employees who say they are satisfied with the employee health and well-being program. Another question asks employers to report the percentage of employees who agree that their employer supports their health and well-being.

- Organizations whose leaders actively participate in health and well-being programs reported much higher median employee satisfaction rates with health and well-being programs (83%) and also reported employee agreement that their organization supported their well-being (85%), compared to organizations whose leaders did not actively participate (66% and 67%, respectively).
- Organizations whose leaders publicly recognize employees for healthy actions and outcomes reported higher median employee satisfaction rates (85%), and employee agreement that their organization supported their well-being (85%) compared to organizations whose leaders did not recognize employee healthy actions (74% and 70%, respectively).

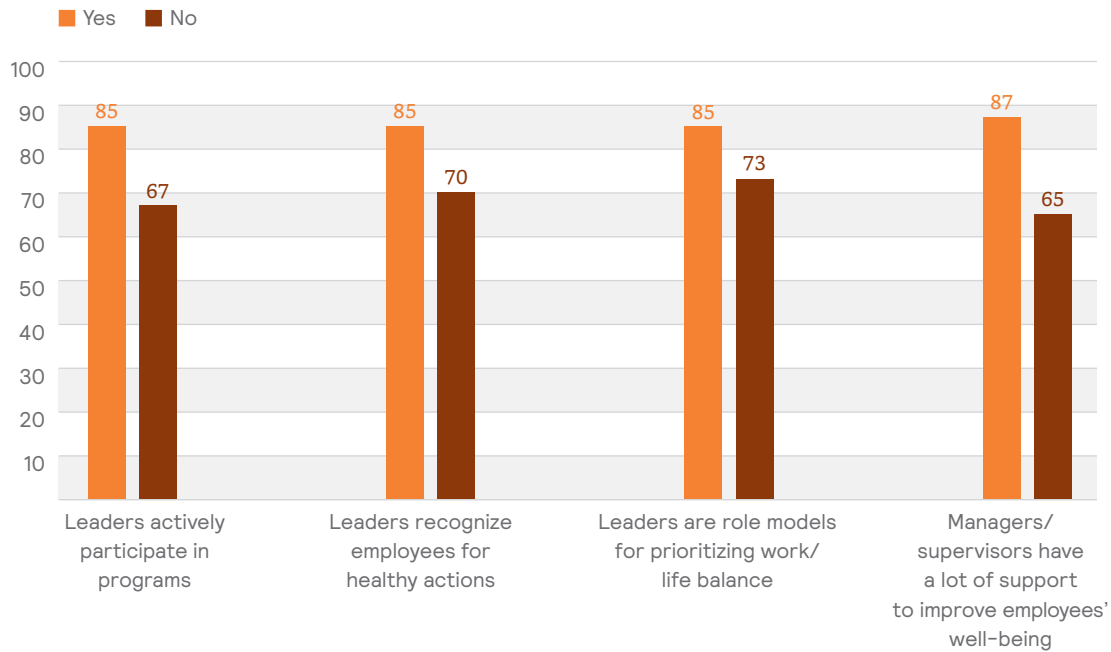
⁶ Limeade and Quantum Workplace. (2016) *Well-being & Engagement Report*, available at www.limeade.com/2016/09/well-being-engagement-report.

Figure 1. Employee Satisfaction With Health and Well-being Programs



- Organizations whose leaders are role models for prioritizing health and work/life balance reported higher median satisfaction rates (85%) and employee agreement of organizational support (85%), compared to organizations whose leaders were not role models (75% and 73%, respectively).
- Manager support was measured based on responses to the question, “Are mid-level managers and supervisors supported in their efforts to improve the health and well-being of employees within their work groups or teams?” Organizations whose managers and supervisors were provided “a lot of support” had much higher levels of employee satisfaction with wellness programs (82%) compared to organizations reporting “some support” (76%), “not much support” (78%) and “no support” (70%). Likewise, organizations whose managers and supervisors were provided “a lot of support” reported higher median levels of employee perceptions of organizational support of their health and well-being (87%) compared to organizations reporting “some support” (80%), “not much support” (71%) and “no support” (65%).

Figure 2. Employee Perceptions of Organizational Support of Health and Well-being



CONCLUSION

These findings suggest that organizations that want to be perceived as caring about the well-being of their employees and having employees who are satisfied with their well-being initiatives need to enable, reinforce and encourage leaders and managers to care about the well-being of their people. Employers need to stop thinking of well-being initiatives as “plug and play” programs that check the well-being box, and, instead, consider how the culture and practices of the organization support people as people.

This commentary is based on data from the HERO Scorecard Benchmark Database through September 30, 2017.

8

INFLUENCE OF INCENTIVES AND INCENTIVE DESIGN ON PARTICIPATION AND SATISFACTION

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ORIGINALLY PUBLISHED IN Q4 2017

Wellness incentive design is a hotly debated topic when it comes to structuring programs designed to drive high participation and improve health outcomes. The HERO Health and Well-being Best Practices Scorecard in Collaboration With Mercer® (HERO Scorecard) assesses employer use of three types of incentive designs.

The assessed incentive designs include:

- Participation-based incentives: providing rewards for participating in one or more aspects of health and well-being programs or offerings, such as a health assessment, biometric screening or coaching
- Outcome-based incentives (health contingent): providing rewards for achieving, maintaining or showing progress toward a health-status target
- Activity-based incentives (health contingent): providing rewards for completing a specific activity related to a health factor, such as taking 10,000 steps per day

When formulating an incentive design, various elements come into play: the balance between participation and nonparticipation rates, employee satisfaction with the wellness program, employee feelings of support for health and well-being from the company, and the impact of the incentive on initiating and sustaining behavior change. As companies broaden their value proposition for wellness beyond the traditional health and healthcare cost outcomes, employee satisfaction and perceived support for health and well-being increasingly become measures of assessing the value of a program. Indeed, high levels

of participation and employee satisfaction are leading indicators of potential well-being initiative success and are validated by the lagging measures of effectiveness, including behavior change, improved well-being and other desired outcomes.

The purpose of this analysis is to leverage questions on the HERO Scorecard to give real-world insight into the influence of incentive design on employee participation, satisfaction and perceived employer support. It relies on data from the 777 organizations that completed the HERO Scorecard to determine how incentive design (participation-based, outcome-based, activity-based or combination of two or more of those) is associated with employee participation in programs, satisfaction with programs and perceptions of employer support for their health and well-being. Not evaluated in this study are other factors that play into the success of the program, such as company culture, marketing strategy, amount of incentive or leadership support. This analysis addresses the influence of type of incentive on participation, satisfaction and perceptions based on descriptive characteristics of these variables. The impact of incentives on behavior change was excluded because of limited availability and precision of outcome data in the HERO Scorecard database.

PREVALENCE OF FINANCIAL INCENTIVES AND INCENTIVE DESIGN

Of the organizations that responded to questions about their use of financial incentives for health and well-being programs (n=765), 63% use financial rewards or penalties, 16% use token gifts as rewards and 21% offer no financial incentives.

Breaking down those that use financial rewards in their incentive design (n=484), the most common incentives were solely participation-based (36%), a combination of participation- and activity-based (25%) and a combination of all three incentive types (20%). The least common incentive designs are a combination of outcome-based and activity-based (1%), activity-based only (2%), outcome-based only (2%) and a combination of outcome- and participation-based (10%). A small number (3%) did not answer the question about incentive type even though they provide financial incentives.

The low rate of outcome-based only (n=11) and activity-based only (n=12) approaches was notable, as were the findings that most employers use participation-based incentives alone or in combination with other approaches, and that 63% (n=306) do not use any type of outcome-based component. This observation was

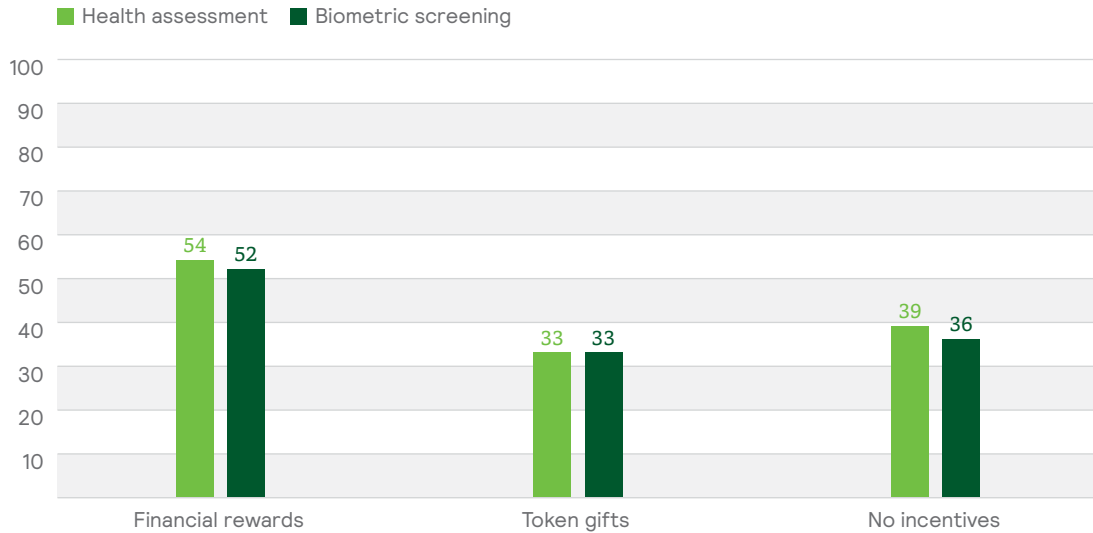
consistent with recent survey results from the National Business Group on Health, which suggests that employers may be moving away from outcome-based incentives, as indicated by a decrease in use from 44% of employers in 2015 to 24% in 2016.¹

EFFECTS OF FINANCIAL INCENTIVES AND INCENTIVE DESIGN STRUCTURE ON PROGRAM PARTICIPATION

This analysis found that financial incentives are associated with higher participation rates for health assessments (54% participation) and biometric screenings (52% participation). Incentives significantly influence reported participation rates in these two transactional activities, compared to rates when token gifts or no financial incentives are used. However, participation rates are higher for organizations using no incentives, compared to those using token gifts for both health assessments (39% versus 33%) and biometric screening (36% versus 33%). This finding suggests that token gift incentives for these activities may not be worth the cost if similar participation levels can be achieved without them (that is, relying on intrinsic motivation alone), but more research is required to understand and interpret this finding. The majority of organizations that provide coaching participation data use financial incentives, so comparisons cannot reliably be made against organizations not using financial incentives.

¹ National Business Group on Health. (2016) *Issue Update: Summary of the Current Use of and Evidence Base for Financial Incentives*, available at www.businessgrouphealth.org/pub/?id=f30a5067-2354-d714-5100-e34a0d78c5fc.

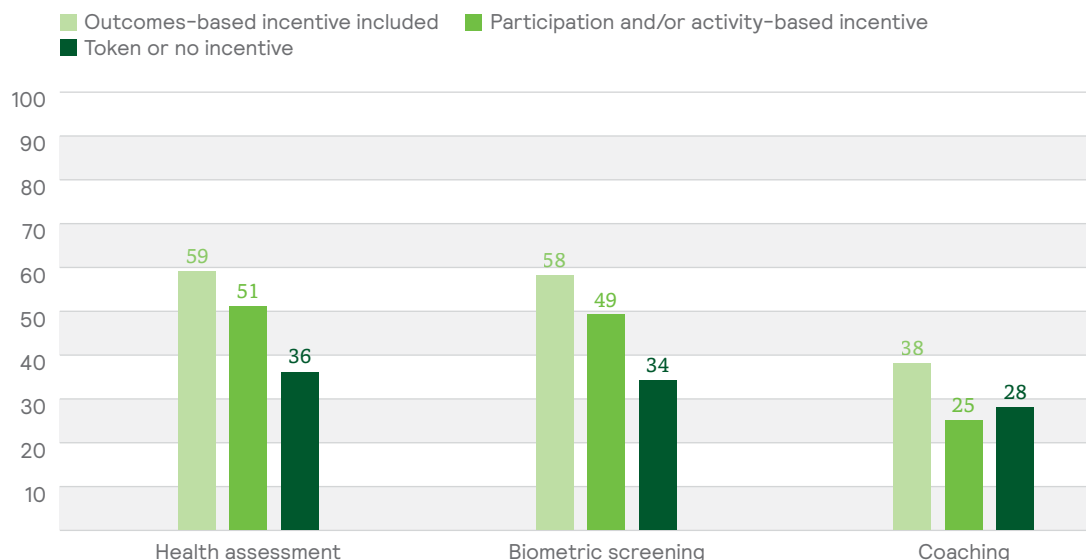
Figure 1. Participation Rates by Incentive Type



To get a better understanding of the influence of outcome-based incentives, data were combined for those respondents that included an outcome-based component (alone or in combination with participation- and/or activity-based incentives) compared to those that used participation-based and/or activity-based incentives or no incentive. Participation rates for biometric screenings and health assessments were noticeably higher when at least a portion of incentives were based on health outcomes. Coaching participation

was also higher for outcome-based incentive programs, perhaps due to participation in coaching programs serving as a reasonable alternative standard to earn an incentive if an individual did not meet biometric requirements. However, an alternative explanation for these findings is that the size of the incentive may have been higher for outcome-based incentive designs. The lack of data on incentive size provided by HERO Scorecard respondents precluded assessing the role of incentive size in this analysis.

Figure 2. Participation Rates by Incentive Design



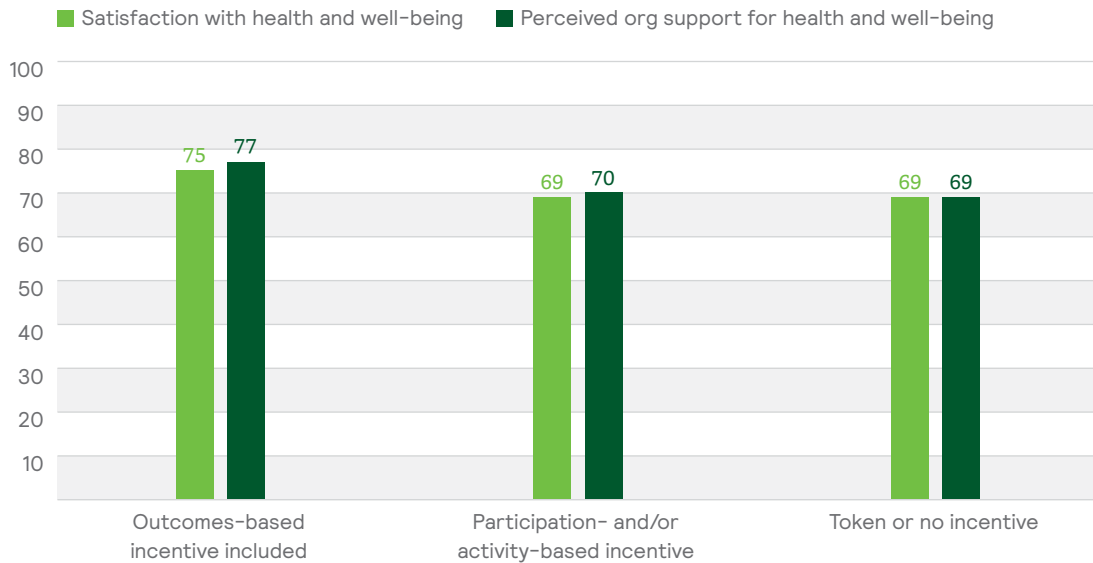
RELATIONSHIP BETWEEN INCENTIVE DESIGN STRUCTURE AND SATISFACTION AND PERCEIVED SUPPORT

As seen above, financial incentives clearly influence participation rates. When looking at satisfaction levels, use of token gifts (76% satisfaction) and financial incentives (72% satisfaction) was associated with higher levels of satisfaction compared to organizations not using incentives (66% satisfaction). These data counterbalance the finding of slightly lower participation rates when token incentives are used, indicating these small rewards may be worthwhile if larger incentives are not feasible and employee satisfaction is important to the employer. However, employee perceptions of organizational support for their health and well-being were lower when token gifts or no

financial incentives were offered (69% each), as opposed to financial incentives (74%).

Organizations that included an outcome-based incentive component versus participation-and/or activity-based incentives reported higher satisfaction (75% versus 69%) and greater perceived support (77% versus 70%). Levels of perceived support were similar for organizations that relied on the use of token or no incentives (69%). More research is needed to understand the factors driving these differences (for example, marketing, company culture, incentive amounts, variety of programs offered, leadership support).

Figure 3. Employee Perceptions About Health and Well-being by Incentive Design



CONCLUSION

HERO Scorecard respondents reported less use of outcome-based incentives versus participation-based incentives, activity-based incentives or no incentives. Companies appeared to rely heavily on participation-based incentive designs or a combination of incentive approaches to try to engage employees in certain health and well-being activities. Based on the results reported in this commentary, organizations considering incorporating incentives into their initiatives may want to ask the following questions:

- What types of program participation rates or employee behaviors are we striving to achieve?
- How might this incentive design influence the culture of our company?
- Is employee satisfaction with programming and perceived support important? How would one incentive design versus another be perceived in our company?
- If we were to change our incentive design, would this positively or negatively impact participation or satisfaction within the context of our organizational culture? And what is most important to our employees?
- Is the health and wellness culture at our company strong enough to achieve desired levels of participation without financial incentives or sole reliance on token incentives? If offering no incentives, are we capturing only those employees who would participate regardless of program design (that is, already motivated individuals)?
- Is participation in transactional activities an appropriate success measure if individual, optimal state of health and well-being are the goals?

It will be interesting to monitor trends in incentive design as companies strive both to increase participation in health and well-being activities and to ensure employees perceive that the company values their health and well-being. As more organizations take a more comprehensive view of well-being and look for appropriate success measures, will participation in traditional wellness activities maintain the same weight? The role of organizational culture must also be considered when determining the most appropriate incentive strategy to advance an organization's goals for program participation, employee satisfaction and employee perceptions of organizational support.

This commentary is based on data from the HERO Scorecard Benchmark Database through June 30, 2017.



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THE RIGHT MIX OF STRATEGIES FOR PARTICIPATION IN HEALTH AND WELL-BEING PROGRAMS

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Companies and consultants alike are always searching for the next “silver bullet” that will drive employee participation in health and well-being programs, asking questions such as:

- How much incentive money is needed to increase participation in programs?
- How do we engage our leaders to promote our programs when they have so many other responsibilities?
- What does it take to get someone to take action to improve their health?
- Do we have the right members in the right program?
- What is the right mix of strategies to make an impact?

Employers want higher participation rates because even the most effective programs won't be impactful if not enough of the right people are exposed to them. The HERO Health and Well-being Best Practices Scorecard in Collaboration With Mercer® (HERO Scorecard) assesses the use of strategies to drive participation in wellness activities (for example, incentives, leadership support and different delivery modalities or choices) and collects information on organizations' employee participation rates. This commentary examines which strategies are associated with higher participation rates.

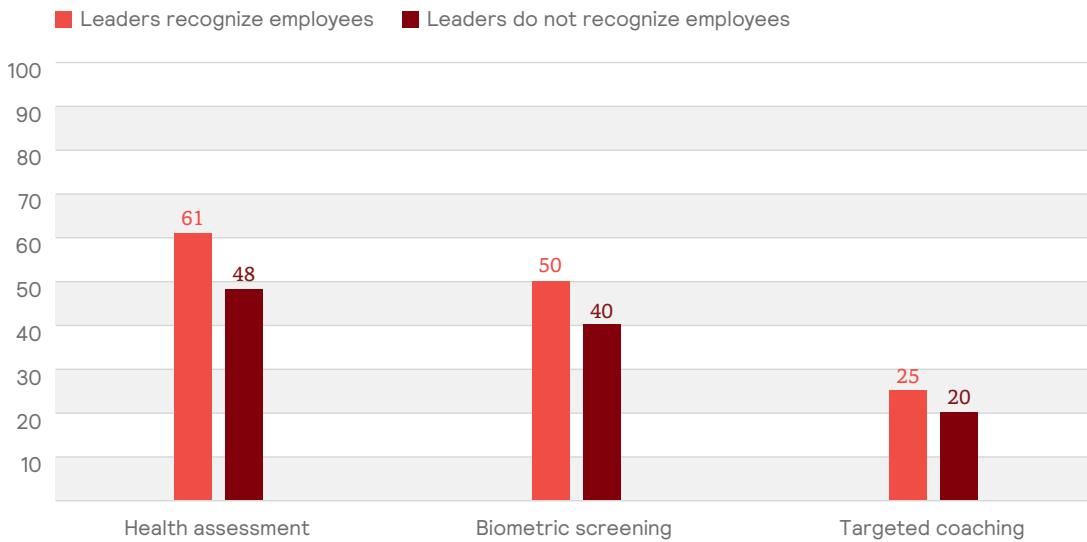
Data from 623 organizations that completed the HERO Scorecard were analyzed to determine how specific practices influenced participation rates in health assessments, biometric screening and interactive health-coaching programs. A preliminary review of respondents' self-reported participation rates revealed a small number of organizations with extremely low or high participation, so this analysis consistently relies on medians as a measure of central tendency rather than means. The median represents the value at which half of the responding companies are distributed above it and half below.

Nearly 300 (n=296) organizations provided participation data on their health and well-being programs. Of these employers, 43% reported high participation in at least one program element, including health assessment, biometric screenings or coaching. The analysis that follows examines how specific practices are associated with participation rates in those program elements. For the purposes of this analysis, “high participation” is defined as the point at which the top third of employers are distributed: 70% for health assessment, 66% for biometric screening and 39% for coaching programs.

ORGANIZATIONAL AND LEADERSHIP SUPPORT

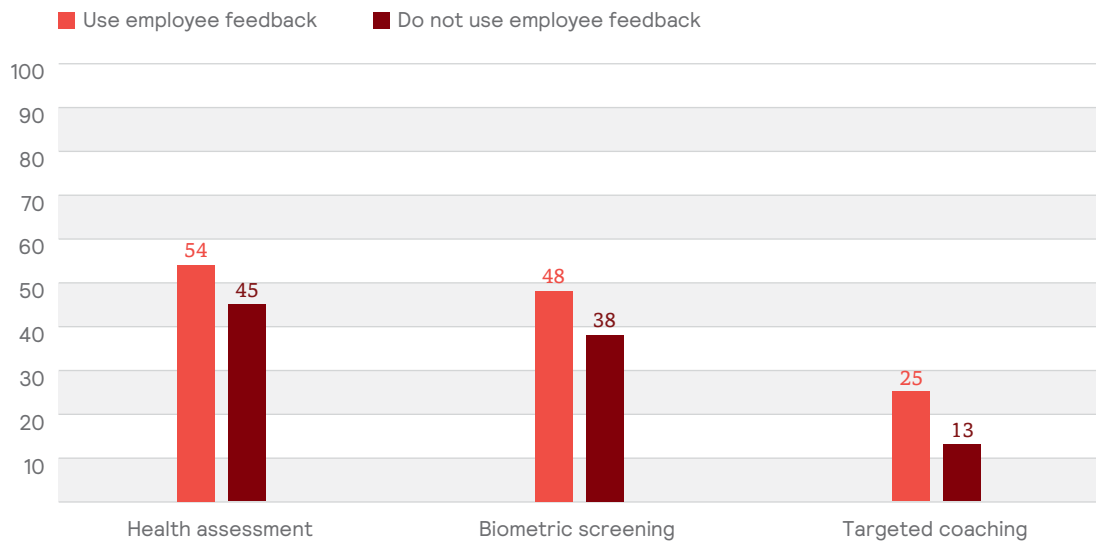
The practice most associated with higher participation rates is the presence of leadership that publicly recognizes employees for their wellness efforts and achievements (see Figure 1). Such organizations report participation rates of 61% for health assessment (versus 48% when leaders do not recognize employees), 50% for biometric screenings (versus 40%) and 25% for targeted coaching programs (versus 20%). When leaders serve as role models by actively participating in health and well-being programs, participation rates tended to be similarly distributed.

Figure 1. Participation Rates Based on Leadership Support



Using employee feedback to inform decision-making about health and well-being content and program offerings is also associated with higher participation rates in health assessment (54% with employee input versus 45% without input), biometric screening (48% versus 38%) and health coaching (25% versus 13%) (see Figure 2).

Figure 2. Participation Rates Based on Using Employee Feedback to Inform Program Offerings

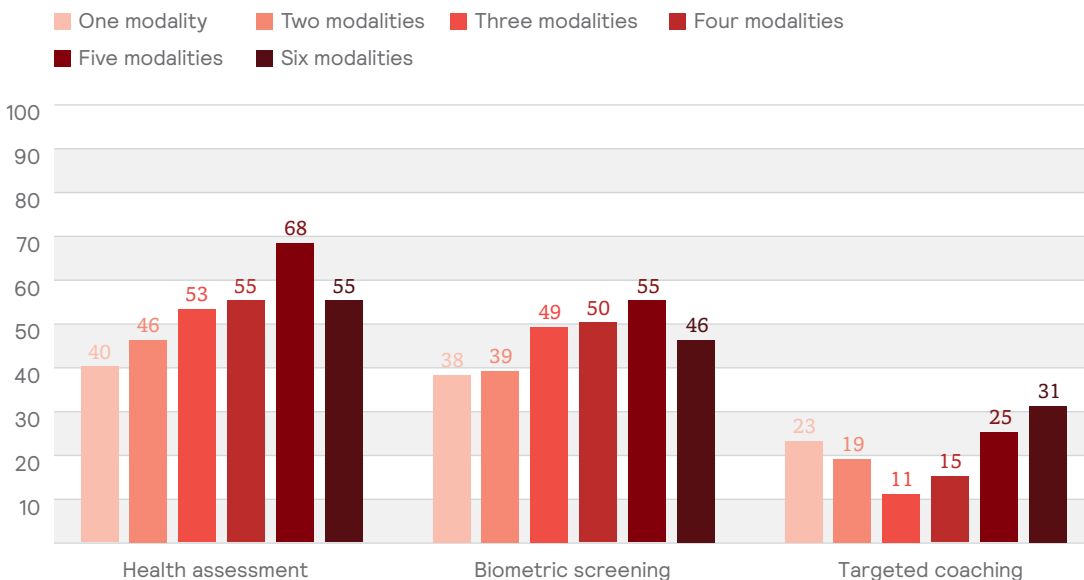


CHOICE

Behavioral science research suggests that the availability of choice can increase individual action, but that too many choices can cause choice paralysis, leaving individuals unable to determine which is the “right choice.” Offering choice in delivery modality is a way to present available options in a familiar setting using a format they prefer. One question on the HERO Scorecard asks what delivery options are available for targeted health-coaching programs; some respondents offered as many as six choices: phone, email or mobile SMS, web-based, onsite one to one, onsite group and interactive paper-based. When participation rates were examined based on the number of coaching choices offered, more choices were

associated with higher participation rates (see Figure 3). Health assessment participation rates increased with each additional delivery choice until the highest choice level, at which point the rate dropped (40% for one choice, 46% for two, 53% for three, 55% for four, 68% for five and 55% for six). Biometric screening participation rates increased in a similar fashion (38% for one choice, 39% for two, 49% for three, 50% for four, 55% for five and 46% for six). This pattern was not observed for coaching participation, which increased at the two highest choice levels (23% for one choice, 19% for two, 11% for three, 15% for four, 25% for five and 31% for six). Much more research is required to fully understand the role of choice in participation rates.

Figure 3. Participation Rates Based on the Number of Delivery Modalities Offered for Targeted Coaching Programs



INTRINSIC MOTIVATION

Thirty-eight percent of companies completing the HERO Scorecard reported using intrinsic motivation as the primary focus for their participation strategy; in other words, these employers sought to create a strategy focused on increasing the internal value employees associate with health, independent of any direct financial reward. Respondents that relied on intrinsic motivation strategies as a primary focus did not appear to have higher participation rates than companies using them as a support to other strategies, such as extrinsic motivators. Not enough information is provided on the HERO Scorecard to understand what additional strategies are used by organizations relying primarily on an intrinsic motivation strategy, so more research is required in this area.

FINANCIAL INCENTIVES

Nearly two-thirds of respondents (65%) provide a financial reward or penalty in connection with a health management program, 15% provide only token incentives and 20% offer no incentives of any kind. Clearly, a sizable majority of employee well-being programs continue to rely on extrinsic motivating factors to encourage action. Consistent with numerous published research studies, companies that offer large financial incentives tend to report higher participation rates than companies offering smaller incentive amounts. To examine alternative strategies for increasing participation, our analysis targeted companies with no, token, or small financial incentives (\$100 or less annually per employee for any type of incentive) that reported high participation rates.



The data suggest that large financial incentives are not the only way to encourage participation. Employers can leverage modest incentives to gain high participation rates with the right mix of programmatic and organizational support. Sixteen of the companies in the HERO Scorecard database that reported offering small or no financial incentives had high participation rates for health assessment, biometric screenings or targeted health coaching. When analyzing this group's use of strategies, more than half of these organizations relied on one or more of the following practices: branded communications with a unique program name, logo and tagline; collection of employee input on program content and delivery; group goal-setting or activities with a common goal; and competitions or challenges. Although 16 organizations is too small of a group to conclude that the identified strategies will drive high participation rates in all organizations, the findings suggest possible practices to augment the use of financial incentives alone.

CONCLUSION

Employers can combine intrinsic and extrinsic motivation with other program strategies to drive program participation. Practices that drive higher participation include leadership support through role modeling and employee recognition, multiple modalities to access programs, branded communications to promote programs, wellness champion networks and incorporation of social elements into programs. Many employers continue to rely on financial incentives as a primary mechanism for driving participation, but combinations of intrinsic incentives and other program strategies may yield comparable results. Further research is needed to determine the right mix of strategies to optimize participation in health and well-being programs.

This commentary is based on data from the HERO Scorecard Benchmark Database through December 31, 2016.



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STRATEGIC PLANNING AS A FUNDAMENTAL STEP FOR ACHIEVING OUTCOMES

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Published studies support the use of benchmarking data from the HERO Health and Well-being Best Practices Scorecard in Collaboration With Mercer® (HERO Scorecard) to identify employer practices associated with superior outcomes.

Previously published HERO Scorecard commentaries have discussed the connection between having a formal strategic plan for employee health and well-being programs and the reported success of those programs, including higher participation rates, better health outcomes and improved healthcare cost containment. As stated in the 2015 HERO Scorecard commentary, an effective strategic plan requires written goals that extend beyond participation and satisfaction metrics to determine the impact of the program over time.¹ The 2013 commentary reported that organizations with effective strategic plans were more likely to experience health improvement and medical plan cost savings.² Thus, effectively setting the stage for health-risk change involves the development of a strategic plan with defined goals and objectives to measure impact in these areas.

STRATEGIC PLANNING PRACTICES REMAIN RELATIVELY STABLE

A year has passed since our last analysis. This year's commentary considers how employer practices have changed over time and seeks to confirm the relationship between strategic planning practices and observed program outcomes. Data analysis was conducted using data from 555 organizations that completed the HERO Scorecard Version 4 through

June 30, 2016. Similar to the 2015 analysis, 56% of these employers report that they have a formal, written strategic plan in place possibly consisting of a long-term plan, an annual plan or both. Of the organizations with a strategic plan, two-thirds (66%) reported having written objectives for health-risk change.

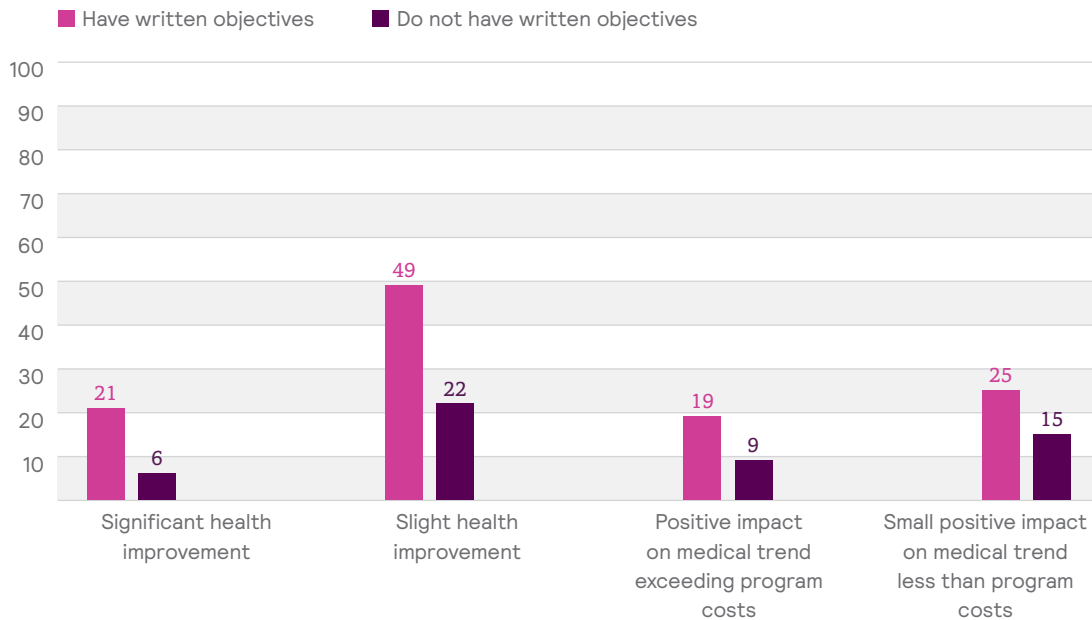
ASSOCIATIONS BETWEEN STRATEGIC PLANNING AND REPORTED OUTCOMES

Of the organizations that responded to the strategic planning questions, 205 of them also provided information on reported outcomes from their health and well-being efforts. Nearly 21% of respondents with written objectives report significant health-risk improvement and 49% report a slight improvement (see Figure 1). In comparison, only 6% of those without written objectives note significant improvement and 22% report slight improvement. Not surprisingly, 46% of employers without objectives have not attempted to measure change in health risk. Though we cannot infer causation from this analysis, it stands to reason that organizations with focused goals for their programs will be more intentional about tracking progress toward their goals over time and so may also make necessary quality improvements if expected outcomes are not being achieved.

1 Grossmeier J. (2015) "Got Strategy? Despite Link to Outcomes, Many Employers Lack a Strategic Plan for Health and Well-being," *2016 HERO Scorecard Report*, available at www.hero-health.org/scorecard.

2 Serxner S. (2013) "Strategic Planning: A Path to Greater Impact," *2014 HERO Scorecard Report*, available at www.hero-health.org/scorecard.

Figure 1. Reported Outcomes for Companies with and without Written Objectives



A similar number of HERO Scorecard respondents provided feedback on their medical plan cost trends, and we again found a positive relationship between strategic planning and outcomes. Of those with written objectives for health-risk change in their strategic plan, 19% report substantial positive impact on medical trend – that is, greater cost savings than the cost of the employee health and well-being program. Over 25% report a small positive impact – that is, savings less than the cost of the employee health and well-being program. The remaining organizations reported no impact or did not measure impact. These findings are consistent with published research demonstrating a link between health-risk change and medical cost trend, which demonstrates health risk improvement is one potential contributor to reduced or flatter medical cost trends over time.

Despite the importance of strategic planning and measurement of objectives, a significant opportunity remains for employers to adopt these recommended practices. Forty-four percent of respondents do not have a formal written strategic plan. Of those with a written strategic plan, one-third of them do not have written objectives for health improvement. Moreover, nearly half (49%) of the respondents that do not have written objectives have not attempted to measure impact, and over a quarter (26%) with written objectives for health risk change have also not measured impact on medical cost trend.

IMPLICATIONS FOR PRACTICE

Though strategic planning encompasses a variety of objectives, improvement in health risk and positive impact on medical cost trend represent perhaps the most meaningful markers of program effectiveness and return on investment.

Unsurprisingly, without written objectives for health-risk change, employers are less likely to measure outcomes related to health status or medical cost trend. Findings from the current analysis support the importance of a formal strategic plan with measurable objectives for health-risk change, since formal plans are associated with improvements in health risk as well as positive impact on medical trend.

CONCLUSION

A formal strategic plan should define what outcomes are important to the organization and what measures will be used to determine success. Improvement in health risk and healthcare cost savings are strong indicators — but certainly not the only indicators — of an effective, results-oriented employee health and well-being program. Employers are more likely to experience success if they have a written, strategic plan for employee health and well-being over multiple years, and if they develop specific objectives for health-risk change. The HERO Scorecard can provide guidance for employers on the types of goals to include in a strategic plan, data sources that might be used to evaluate achievement of goals and reasonable benchmarks that have been achieved by other organizations.

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