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HERO EMPLOYEE HEALTH MANAGEMENT BEST PRACTICE SCORECARD IN COLLABORATION WITH MERCER

ANNUAL REPORT 2012

A MESSAGE FROM THE HERO AND MERCER SCORECARD TEAM LEADERSHIP

It is a pleasure to introduce the second annual report on the HERO Employee Health Management Best Practice Scorecard in Collaboration with Mercer®. While our first report was released in February 2011, we decided to release future publications at the HERO Forum each fall. It has been 18 months since our last report, and a lot has happened that we are eager to share with you.

Employer participation has nearly doubled since our last annual report. The database now includes almost 800 responses (not counting repeat submissions by employers wanting to assess their progress over time), which makes the HERO Scorecard by far the most widely used resource of its kind. Much of the credit is due to the growing number of organizations that have become members of our Preferred Provider Program. These organizations have greatly extended the reach of the Scorecard by making it available on their websites and using it in their work with their clients. We are also grateful to the many employers – in particular, the three featured in this report – that have shared stories of how they have used the HERO Scorecard to support successful health management strategies in their organizations.

As the HERO Scorecard database grows, it is able to support more precise benchmarking and more ambitious research. Every few months we invite an expert in employee health management to analyze Scorecard data and write commentary on a relevant topic. The most recent commentaries are provided in this report.

To ensure that the Scorecard continues to help identify and advance the use of best practices, we have to keep evolving. To that end, we have assembled a team to begin work on Version 4, which will be launched next year. To learn more, read on! As always, we welcome your ideas and reactions.

Jerry Noyce
CEO, HERO

Steven Noeldner, PhD
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THE HERO BEST PRACTICE SCORECARD: A PROGRESS REPORT

Both a self-assessment tool and an ongoing research survey, 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 employee health management (EHM) programs. While no inventory of best practices will include all innovative approaches to EHM, the Scorecard includes those most commonly recognized by 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 email with their overall score and scores for each section. This brief report also includes the average score for all respondents nationally and for three employer size groups so that employers may compare themselves to a peer group. 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.

With the Scorecard, learning is a two-way street. When employers complete the Scorecard, they are also feeding a rapidly growing database with information about their program strategy, design and management – and about the participation levels and outcomes their program achieves. These data are already being used for benchmarking and research. Six studies based on analyses of the HERO Scorecard database are presented in this report; they examine such topics as the differences between EHM programs offered by small and large employers and whether including spouses in programs improves participation and outcomes. In addition, an article citing HERO data on the role of corporate culture was published this year in *Journal of Occupational and Environmental Medicine*.[1]

Comprehensive benchmark reports that provide the aggregated responses to every question asked in the Scorecard are also available. Drawn from the full Scorecard database, these benchmark reports compare program strategy, design and outcomes for all Scorecard respondents and for groups based on industry, size and geographic location. Individual benchmark reports may be purchased through the HERO website.

THE SCORECARD DEVELOPMENT: AN ONGOING COLLABORATION OF THE EHM COMMUNITY

The Scorecard was first developed in 2006 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, Partnership for Prevention's Health Management Initiative Assessment, and the Department of Health and Human Services' Partnership for Healthy Workforce 2010 criteria.

In 2009, HERO and Mercer collaborated to update the Scorecard content and scoring system and make it widely available in a web-based format. Again, a broad panel of experts was recruited to assist with the questions and the scoring system, which was developed using a consensus-building exercise. Panel members distributed 200 points (the proposed maximum score) across the six sections of the Scorecard and the questions within each section based on his or her judgment about their relative importance to a successful EHM program. ("Successful" was defined as able or likely to improve total health care spend.) Given limited evidence available on the impact of specific programmatic elements on health care cost trend, the contributors offered their scores based on the best research available, as well as anecdotal evidence. Research is currently under way to develop a more definitive, evidence-based scoring system for the Scorecard V4, slated for release in April 2013.

As you will read in the case studies included in this report, some employers find the greatest value of the Scorecard is simply as an inventory of health management best practices compiled by leaders in the field. Others find that comparing their scores to national norms helps to validate current strategies, identify opportunities for improvement and set goals for improvement.

1. Aldana SG, Anderson DR, Adams TB, et al. "A Review of the Knowledge Base on Healthy Worksite Culture". *Journal of Occupational & Environmental Medicine*, Volume 54 (2012): pp. 314–419.

THE SCORECARD PREFERRED PROVIDER PROGRAM

Broad employer participation is a priority for the HERO/Mercer Scorecard team for two reasons. First, a larger database can support more and better research. But just as important is the goal of advancing the field of EHM by giving employers easy access to the latest best thinking on how to build a successful program and a way to share information about their programs with one another. When the first web-based Scorecard was launched in 2009, it could be accessed only through the HERO and Mercer websites. Over the first year, as we received 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 Scorecard Preferred Provider Program was piloted in 2010 and launched in 2011. Currently, eight organizations participate. Each organization is 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. At the end of each quarter, members 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 provider organization may see their answers). The members participate in regular calls to provide feedback on the Scorecard and the Preferred Provider Program.

As of September 2012, Scorecard participation has grown to about 800 employers, with good representation of large, midsize and small organizations.

THE HERO SCORECARD PREFERRED PROVIDERS

Alere
Capital BlueCross
Healthy*Fit*
Healthyroads
Kaiser Permanente
Mayo Clinic
Mercer
StayWell Health Management

KEEPING THE SCORECARD CURRENT

One of the many benefits of the Preferred Provider Program is access to industry experts who regularly use the Scorecard as a tool in their work with their clients. Their feedback was essential in developing a *Users' Guide*, introduced earlier this year, which has made the Scorecard easier for employers to complete and is helping to improve the consistency of the responses in the database.

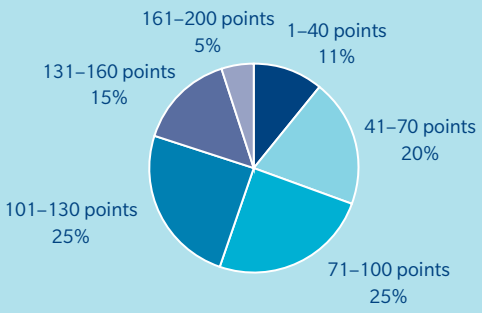
We also recognize that the Scorecard must be updated regularly to stay abreast of the rapid evolution of the field of EHM and, to that end, a task force has been assembled to begin work on Version 4 of the Scorecard, slated to go live in April 2013. For example, in the three years since the Scorecard V3 was launched, employers have become more creative and proactive in the area of employee engagement. Some of the new tactics being used barely existed in 2009, such as gaming, social networking and outcomes-based incentives. In addition, much progress has been made in the area of outcomes measurement. Scorecard V4 will draw on work currently under way to create standardized outcomes measures.

Our goal is to enhance the Scorecard while keeping the core questions consistent to permit employers to measure progress over time. One planned enhancement is the addition of questions on absence and productivity; another is to produce a shorter version that will be easier for small employers to complete and advance our goal of making the Scorecard a resource that benefits all employers.

Scorecard Respondent Profile

Number of respondents	
All employers	788
Employers with fewer than 500 employees	168
Employers with 500–4,999 employees	347
Employers with 5,000 or more employees	260

Distribution of respondents by best practice score



RELATING THE USE OF BEST PRACTICES TO OUTCOMES

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Beth Umland
Director of Research for Health & Benefits, Mercer

Analysis conducted July 2012

The basic assumption behind the HERO Scorecard is that EHM programs based on best practices will produce better outcomes – greater employee participation, improved health risks and better medical plan cost experience. In our first Annual Report, we demonstrated that respondents with higher scores also report better outcomes than respondents with lower scores. Now, with a larger database to work with, we can begin to explore the relationship between specific EHM practices and outcomes.

For this initial analysis, we included only those respondents that measured outcomes. Out of 747 total respondents, 228 employers had measured the impact of the EHM program on medical plan trend and were confident of the results. Of these, 26% reported that their EHM program has had a substantial impact on medical cost trend (more than the cost of the EHM program) and 32% have seen a slight impact (less than the cost of the EHM program). The rest of the respondents (42%) have not seen an impact on medical cost trend from their EHM program.

EHM PROGRAMS THAT BEND THE TREND – WHAT ARE THEY DOING RIGHT?

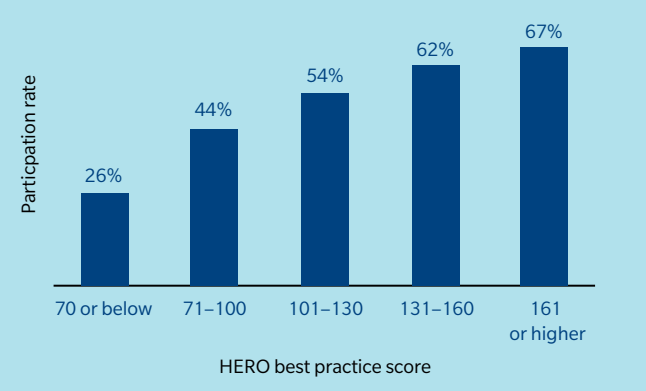
Respondents reporting that the EHM program has had an impact on medical cost trend (either significant or slight) had an average score of 129 – 35% higher than the average score of 95 among those whose programs have not yet produced a measurable improvement in medical plan trend. When average scores for each of the six sections of the Scorecard for these two groups are compared, in each case employers reporting improvement in medical cost trend had higher average scores. However, the gaps between scores were of different magnitudes, perhaps suggesting that while each element of an EHM program contributes to overall program outcomes, some have a stronger impact than others. Notably, employers with cost savings had an average subscore for engagement methods (which includes both employee communication and incentives) that was 50% higher than the average for employers without cost savings.

Difference in Average Best Practice Scores Between Respondents That Have and Have Not Seen Improvement in Medical Cost Trend

Scorecard section	Percentage difference in average scores
Engagement methods	50%
Measurement and evaluation	39%
Strategic planning	31%
Leadership engagement	28%
Programs offered	28%
Program-level management	25%

This makes intuitive sense because cost savings are possible only if the workforce is engaged in the EHM program. One indication of the degree of engagement is the participation rate for the health assessment (HA), which often serves as the gateway to other health management programs. Our analysis found that HA participation is tied to the use of best practices, as indicated by the overall HERO best practice score. The average HA participation rate among employers with the highest scores (above 160) is more than double that of employers with the lowest scores (70 or below).

HA Participation Rate Rises With Best Practice Score

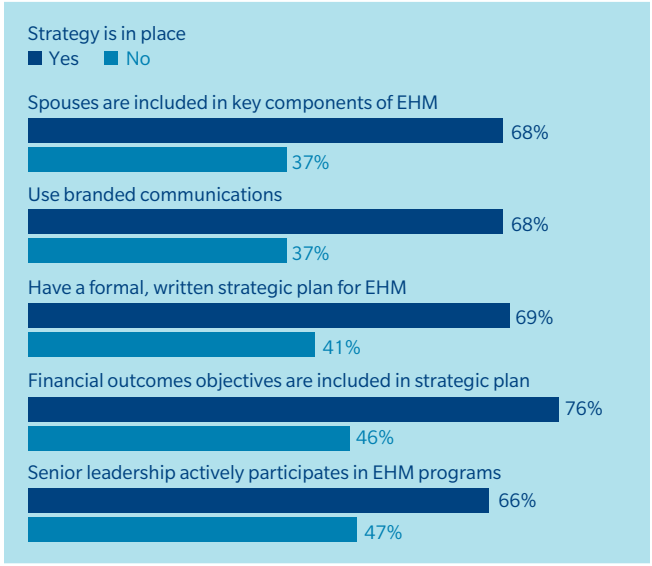


Looking at the difference in average participation rates between employers with and without a specific best practice in place may suggest which best practices have a particularly strong impact on employee engagement. Based on this analysis, best practices that seem to be tied to higher participation rates include providing an incentive to complete the HA, conducting an employee health needs assessment, active participation by senior leadership in EHM programs, using branded communications and supportive health benefit design.

Five Key Influences on the HA Participation Rate
Average participation rate

This same type of "gap analysis" can also be used to identify specific best practices that are linked to improvements in medical cost trend. Here, we find that employers that include spouses in key components of the EHM program are significantly more likely to experience improvement in cost trend (68%) than employers that do not include spouses (37%). The use of branded communications is also linked to better cost outcomes, as is having a formal, written strategic plan for EHM. Not surprisingly, employers that include financial outcomes objectives in the strategic plan are much more likely to report improvement than those without stated objectives.

Five Key Influences on Reported Medical Savings
Percentage of respondents reporting savings due to EHM



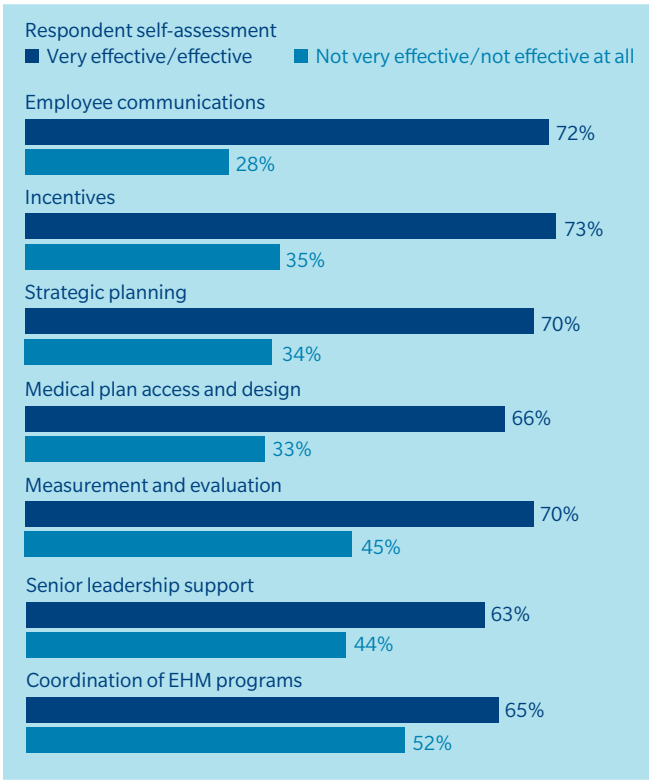
EMPLOYEE COMMUNICATION EMERGES AS AN IMPORTANT KEY TO EHM SUCCESS

While most of the questions in the Scorecard are matters of fact – for example, asking employers whether they provide face-to-face lifestyle coaching, or whether employees are given a financial incentive to complete an HA – in each of the six sections of the Scorecard, employers are asked to rate themselves on a four-point scale of effectiveness for the program component covered in that section. In this analysis, for each of these self-assessment questions we divided employers into two groups based on their response (very effective/effective versus not very effective/not at all effective).

As would be expected, in each case employers reporting that the program component is effective were more likely to say they have experienced cost savings. However, the effect was strongest for employee communication. Among those employers saying that employee communication was effective, 72% reported a positive impact on medical cost trend, compared with just 28% of those saying that employee communication was not effective. In terms of potential impact, employee communication was followed by incentives and then by strategic planning.

Employers With Effective Employee Communications Very Likely to Report Improvement in Medical Cost Trend Due to EHM Program

Percentage of respondents reporting improved trend



CONCLUSION

While this analysis has highlighted a number of specific EHM features, it is important to keep in mind that in each case other factors not controlled for in the analysis also likely influenced the results. For example, the use of a particular best practice may be correlated with the use of other best practices that are also contributing to better outcomes. However, the data support directionally that those organizations using certain specific best practices are more likely to report higher participation rates and improved medical cost trend. In examining their own programs for areas to improve, employers might do well to carefully consider best practices that seem to have the strongest potential impact.

EMPLOYER SCORECARD EXPERIENCE: MAYO CLINIC

Mayo Clinic is a not-for-profit worldwide leader in medical care, research and education serving more than a million people each year. As an employer, Mayo Clinic has provided a health and productivity program to its employees and dependents for many years. While Mayo has been collecting data and implementing a clinical approach to population health, it was missing an important component in its planning: benchmarking its program against those of other companies. The HERO Scorecard offered an opportunity to evaluate how Mayo Clinic's program design measured up in terms of industry best practices associated with successful health management programs.

Kurt Hobbs, MS, Director of Account Management and Strategic Consulting for Mayo Clinic Global Business Solutions, led the organization through the HERO Scorecard process with Mayo Clinic Benefits Manager Becky Pautz. "Companies with health management programs can usually pinpoint their program's strengths and opportunities," says Mr. Hobbs. "Being able to objectively evaluate their program against a well-respected industry benchmark tool like the HERO Scorecard provides the documentation required to make the case for devoting resources to identified health improvement opportunities."

Based on the HERO Scorecard results, Mayo Clinic saw two immediate opportunities. First, it would use low scores to bolster the business case for continued support from Mayo Clinic leadership. Second, the organization prioritized the need for a long-term strategic plan that included the tactics defined in the six sections of the HERO Scorecard.

Like other employers, Mayo Clinic is trying to find the "right" combination of programs and resources to support the health and wellness of employees. "Our HERO Scorecard report opened the door for an objective evaluation of our initiatives, which can be difficult in a complex, diverse institution like Mayo," says Ms. Pautz. But it's well worth the effort. She adds, "We see improving the health and well-being of employees as inextricably linked to achieving our mission: to put patients' needs first."

Moving forward, Mayo Clinic is well-positioned with best-practice recommendations built into a new strategic plan that will guide its planning and implementation for the future.

PROGRAM-LEVEL MANAGEMENT

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Originally published Juy 2011

EHM programs don't exist in a vacuum. In the most successful programs, the different components of EHM – prevention, lifestyle management, disease management, Employee Assistance Programs (EAPs), disability and so on – are closely coordinated or integrated to provide a seamless experience for employees. Perhaps most important is that health plans should support EHM objectives because the majority of employees interact with their health plan each year.

Scorecard respondents were asked which EHM programs were coordinated or integrated with each other. The degree of coordination might range from simply ensuring that communications refer to other programs as necessary, to consolidated reporting, to "warm transfer" of participants from one program to another, and to written coordination plans or process flows. While the Scorecard doesn't assess coordination at this level of detail, some sophisticated programs apply independent clinical oversight to member identification, referral tracking and clinical outcomes. Apart from the health plan, the programs most likely to be coordinated are disease management (65%), EAP/behavioral health (60%), case management (59%) and nurse advice lines (55%). Employers were less likely to report that EHM programs were coordinated with safety (36%), workers' compensation (34%) or disability programs (30%). Lack of coordination may result in missed opportunities to improve employee health and productivity. For example, an overweight worker with recurring back pain and related depression is likely to need assistance from multiple programs over time. Focusing on the member's experience across health, disability and safety instead of managing a series of disparate events in an uncoordinated fashion can yield savings in medical, disability and workers' compensation costs, as well as improve member experience and outcomes.

About half of the Scorecard respondents believe that effective program coordination is contributing significantly to their program's success. The other half see room for improvement. It's not surprising that HA participation was substantially higher, on average, for organizations reporting effective coordination (55% of eligible employees completed an HA) than those with the least effective program coordination (37%). Strongly integrated programs that use HA data to identify members proactively for health and safety risks, and have processes in place to refer members to the right services and then follow up with them, will produce greater employee engagement and better outcomes.

When EHM Programs Are Integrated and Coordinated, Employers Report Better Health Results

	Believes EHM program integration ...	
	... is contributing to success	... is not contributing to success
Average HA participation rate	55%	37%
Reported "significant improvement" in health risk	26%	4%
Reported "substantial impact" on medical trend	27%	11%

Employers were also asked whether health benefit design supports prevention and risk reduction (for example, by covering or facilitating smoking cessation or weight management programs and preventive exams). A slight majority of respondents (57%) believe that their health plan is very supportive of prevention and risk reduction, 40% believe it is somewhat supportive and just 3% believe it is not at all supportive. Respondents that believe that health benefit design is very supportive of prevention and risk reduction were far more likely to report that EHM programs have had a substantial positive impact on medical plan cost trend (25%) than those who believe that the health plan is only somewhat supportive of risk reduction (7%).

For many employers, encouraging employees to take more responsibility for their health is tied to encouraging them to take more responsibility for their health care expenditures. The Scorecard asks respondents whether health benefit design supports consumer accountability and informed decision making (for example, with health spending accounts or the use of coinsurance rather than copayments). One-fourth of respondents say that the health plan promotes consumerism to a great extent; another 56% believe it promotes consumerism to at least some extent. The respondents reporting the highest levels of consumerism are far more likely to report a substantial positive impact on medical plan cost trend – 30%, compared with 15% of those reporting moderate levels and just 6% of those who say that health plan design does not promote consumerism at all.

One sophisticated form of consumerism is the use of value-based (or evidence-based) design – providing financial incentives for members to choose or comply with specific treatments proven to be effective in the medical literature. About one-fifth of respondents (19%) will waive or reduce employee cost sharing (copayment/coinsurance) for specific drug therapies (not simply all generic drugs), and 14% use some other form of value-based design.

Just under two-thirds of Scorecard respondents say that medical plan access and design support EHM program objectives "effectively" (55%) or "very effectively" (9%). Among the "very effective" group, 49% reported a significant improvement in employee health risk, compared with 17% of the "effective" group – and just 6% of those reporting that the medical plan is "not very effective" in supporting EHM. Taken altogether, the Scorecard provides substantial evidence that when the EHM program components and the health plan are most in concert, both the employee and the employer benefit.

EMPLOYER SCORECARD EXPERIENCE: WOOD-MODE INCORPORATED

Although Wood-Mode has had a wellness program for several years, the success of this program was measured primarily by two factors: employee participation rates and employee feedback. "We knew there had to be a more objective way to evaluate the overall effectiveness of our program," says Vice President of Human Resources Tom Morgensen. "When we learned about the HERO concept from Capital BlueCross, it became very clear that this missing element – a measuring tool to benchmark ourselves – could be satisfied by utilizing the HERO resource." He, along with Wellness Coordinator Alice Herrold and Steering Committee Chair Eric Rowe, went through the questions individually. The three then met as a group and thoroughly discussed their answers before forming a consensus.

A major benefit of completing the Scorecard was that it reinforced that Wood-Mode's wellness program was generally on the right path. But it also identified areas in need of improvement. The team discovered opportunities to improve in each of the six foundational areas identified in the Scorecard. First – and perhaps most important – the organization developed a strategic three-year plan that gives direction to EHM programming over a longer period and defines goals and objectives. The program started providing onsite health coaching for employees. And all employees were invited to attend a 45-minute educational session, where they were given a self-care manual. While the program already includes some incentives, the organization plans to begin giving more public recognition to program participants to further build employee engagement.

"In the past, some of what we did was by trial and error," says Mr. Morgensen, "but going forward, we will use the recommendations from the Scorecard as a roadmap to get us where we want to be in our EHM programs."

CHALLENGES AND OPPORTUNITIES FOR SMALL EMPLOYERS IN EHM

Jesse Hercules
President, Extracon Science LLC

Originally published October 2011

How much does employer size matter when it comes to EHM? Specifically, can small employers, with their more limited resources, hope to achieve as much success with EHM as larger employers? This analysis uses data from the HERO Scorecard to compare large, midsize and small employers in their use of EHM best practices.

For the purposes of this analysis, small employers have fewer than 500 employees, midsize employers have 500 to 4,999 employees and large employers have 5,000 or more employees. About one-fifth of the current Scorecard respondents are small, while about two-fifths are midsize and two-fifths are large.

Certainly, larger employers tend to have higher overall scores on the Scorecard, indicating more comprehensive EHM programs. Small employers have an average of 72 points; midsize employers, 91 points; and large employers, 100 points. Further, the gap is wider between the scores of small and midsize employers than between midsize and large employers.

However, it is instructive to look at how employers of different sizes compare on their average scores for the six sections of the Scorecard. Relative to large employers, small employers score the lowest in the areas of programs, engagement methods, and measurement and evaluation.

HERO EHM Best Practice Scores, by Employer Size
Average section scores

	Fewer than 500 employees	500–4,999 employees	5,000 or more employees
Strategic planning	4	5	6
Leadership engagement	16	17	16
Program-level management	9	10	11
Programs	19	27	31
Engagement methods	21	27	30
Measurement and evaluation	3	4	5

However, size is much less of a factor in the use of best practices in strategic planning and program-level management, and small employers posted the same average score as large employers in the important area of leadership engagement.

While these results confirm the perception that health promotion programs are more comprehensive among larger companies, it's encouraging to note that small employers do achieve levels of leadership engagement as high as large companies.

Small employers offer fewer programs than larger employers; HAs, disease management services and lifestyle interventions such as coaching are all less prevalent among small employers. However, these programs have become widely available from vendors on a remote basis, so small employers' lack of usage seems more a matter of culture and priorities than necessity. On the other hand, the low prevalence of onsite medical clinics among small employers reflects legitimate problems of scale – the fixed cost of a facility and full-time clinicians must be spread across a larger population to make sense.

While small companies use fewer communication methods than large or midsize companies – perhaps because fewer are needed to reach a smaller, less dispersed workforce – companies of all sizes communicated a similar number of EHM themes. Small companies use HA incentives at a rate similar to that of midsize and large companies, but they are less likely to use incentives that are linked to benefits, such as a lower employee premium contribution (now the most common incentive among large employers). The most common HA incentives provided by small employers are still cash or gift cards. Large, midsize and small companies use incentives in similar ways for lifestyle coaching programs.

The Scorecard areas of strategic planning and measurement and evaluation seem to offer some of the best opportunities for improvement for smaller employers. Small organizations may find these processes easier to manage than large, complex organizations. For example, a strategic plan for EHM for a small employer with one or two sites could be much more concise and targeted than a plan that must cover dozens of dissimilar sites across the globe for a large organization. Surveys and focus groups could also be easier to manage at a smaller organization – it will be easier to get a representative sample in person if there are fewer sites, and it will be easier to manage a smaller data set.

Scorecard results to date support the conventional wisdom that larger organizations tend to have more comprehensive programs for EHM, even though relatively few programs – such as onsite clinics – truly require a substantial employee population. However, there is significant variation within each employer-size group, with examples of employers of all sizes that have outstanding EHM programs. An earlier analysis of the entire Scorecard database demonstrated that higher best practice scores are associated with better program outcomes. When the same analysis is performed on just the small employers in the HERO database – arraying respondents by score and dividing them into low-, average- and high-scoring groups of equal number – the same pattern emerges: The high-scoring group of small employers reported significantly better outcomes than the average- or low-scoring groups. In fact, high-scoring small employers reported outcomes in terms of health risk reduction that were similar to high-scoring large and midsize employers.

While further study is needed – with a more robust database of small employers – this analysis supports the assumption that, regardless of size, employers that follow best practices will achieve better EHM outcomes.

Readers interested in a case study on a successful, comprehensive EHM program in a small-employer setting should read "The Impact of Worksite Wellness in a Small Business Setting," published in the February 2011 issue of the *Journal of Occupational and Environmental Medicine* and accessible through the HERO website at http://the-hero.org/Research/Studies.htm.

EMPLOYER SCORECARD EXPERIENCE: DOVER CORPORATION

Dover is a diversified, global manufacturer with more than 30 distinct operating companies (OpCos) and more than 100 US locations. While benefits management historically had been decentralized, in 2011 Dover implemented a corporate-wide benefits strategy that maintained some local flexibility while recognizing the benefits of common ownership. Dover's Health and Wellness Benefits Manager, Amy Katzoff, and her team used the Scorecard to help bring the OpCos onto the same page to measure, understand and improve EHM. By requiring each OpCo to complete the Scorecard, Dover was able to establish baseline information on the EHM activities of the OpCos. The Scorecard helped create a common language and unified approach to EHM strategies across all of the distinct and culturally unique OpCos, and teach them the basics of EHM best practices.

With this information, Ms. Katzoff was able to create recommendations and next steps for both Dover and the OpCos. "We created an average score for all the Dover OpCos and compared that to the national average to see where we wanted to improve overall," she said. They also looked at each OpCo's individual score. Those below the Dover average were tasked with improving their scores over time, but given the flexibility to choose what programs would work best in their sites. For example, a site with a high percentage of overweight employees hired an onsite health coach and established a weight management and gym membership reimbursement program.

"Going forward, we'll use the Scorecard as a tool to gauge the OpCos' yearly progress on their programs," Ms. Katzoff said.

UNDERSTANDING EMPLOYER USE OF BIOMETRIC HEALTH SCREENING SERVICES

Jessica Grossmeier, PhD, MPH
Director, Research, StayWell Health Management

Originally published January 2012

Employer investment in onsite screening services and "know your numbers" campaigns is on the rise. A recent survey of employers indicates that 54% of employers provided biometric health screenings to their employees in 2010, which was an increase from 49% in 2009.[2] One driver of this trend may be employers' growing interest in outcome-based incentives. These incentives provide financial rewards to employees for achieving specific targets for health screening measures such as blood pressure, cholesterol and weight.

In addition to providing screenings as a way to support an outcome-based incentive strategy, there are several other reasons employers may choose to adopt onsite or near-site screenings. In addition to the obvious – helping employees become aware of potential health risks – these include sending the message that the organization cares about employee health, supporting efforts to build an organizational culture of health, and generating employee excitement about EHM programs. While anecdotal evidence suggests that offering screenings can produce these types of benefits for organizations, there is little hard evidence that screening programs reduce health risks or lower medical spending.

The purpose of this analysis was threefold: (1) describe employer use of health screening services; (2) compare the use of health screenings by high-scoring and low-scoring companies; and (3) for the highest-scoring companies, compare program outcomes based on the level of investment in screening services. It was based on a question in the HERO Scorecard that asked about the provision of onsite or near-site screening services and use of awareness campaigns about the importance of screenings.

This analysis was based on HERO Scorecard responses provided by 624 organizations. Of the employers represented, 19% were small employers with fewer than 500 employees and 81% were larger employers with 500 or more employees.

Across all respondents, 70% of organizations provided some type of support for screenings, either by offering actual onsite or near-site health screenings or by conducting awareness-raising campaigns about the importance of screenings.

High-scoring organizations provided significantly more support for health screening than average- or low-scoring organizations. Specifically, 47% of high-scoring organizations provided both onsite and near-site screenings and awareness campaigns, compared with only 16% of average-scoring and 5% of low-scoring companies.

Of the 203 companies with the highest HERO Scorecard scores, 90% provided onsite or near-site health screenings. Nearly half (47%) conducted both an awareness-raising campaign and health screenings, while 42% conducted only onsite or near-site health screenings. An analysis was done to compare program outcomes for high-scoring companies with both components to high-scoring companies that provided only the onsite or near-site health screenings. The small number of high-scoring organizations offering no support for screening or only conducting awareness campaigns was excluded from this analysis.

2. Source: *National Business Group on Health/Fidelity Investments Benefits Consulting Survey, January 2011*

Program Participation Rates and Outcomes by Provision of Screening Services
Among high-scoring respondents

	Provided screenings only	Provided screenings and conducted awareness campaigns
HA participation rate	61%	61%
Health screening participation rate	53%	50%
Disease management participation rate	19%	30%
Lifestyle coaching participation rate	22%	30%
Reported significant improvement in health risk (% of employers)	21%	37%
Reported substantial positive impact on medical trend (% of employers)	19%	34%

Awareness campaigns did not appear to influence participation rates in HAs or in the screenings themselves. However, provision of both elements was directly related to higher participation rates in targeted follow-up programs (30% compared with 19% for disease management programs, and 30% compared with 22% for lifestyle coaching). Reported EHM health and financial outcomes were also substantially better when both elements were used:

- Thirty-seven percent of companies that provided both onsite and near-site screenings and awareness campaigns reported significant health risk improvement, compared with only 21% for those who did onsite and near-site screenings but did not offer awareness campaigns.
- Thirty-four percent of companies with both elements reported seeing a substantial impact on medical trend, compared with only 19% of high-scoring companies with no awareness campaigns.

It cannot be concluded from this analysis that the difference in these outcomes was due solely to providing an awareness campaign along with screening services, because organizations that offered both aspects of screening also differed in other important ways.

Companies that provided both elements of screening services had slightly higher overall HERO Scorecard scores (mean = 143) than companies that provided onsite or near-site screenings only (mean = 136). These slightly higher scores appeared to be driven primarily by higher program section scores and, to a lesser extent, by higher leadership engagement, employee engagement, and measurement and evaluation scores.

CONCLUSION

While final conclusions cannot be drawn from these descriptive statistics alone, they do provide preliminary support for the idea that screening services contribute to achieving EHM goals. The data demonstrates that organizations offering both onsite and near-site screenings and awareness campaigns have better health and financial outcomes; however, these organizations also have stronger leadership engagement, program engagement and measurement/evaluation. More rigorous analytic approaches that control for the presence of these other best-practice elements will be needed to isolate the independent contribution of screening-related services. As the HERO Scorecard database grows, these more robust analytic approaches will become more feasible.

HEALTH BEHAVIOR CHANGE THROUGH PERSONAL COACHING

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Anyone who has ever attempted to change an old habit knows how difficult it can be. The same holds true for changing behavior that affects health, such as nutrition and exercise. It often requires a major life event – or the help of a strong personal advocate, in the form of a buddy or coach – to spur the necessary motivation to attempt major behavior change.

The need for help in making important health changes is realized by most EHM experts. The organizations that provide these services to their employees are gaining a greater understanding of the importance of support in improving population health status and, ultimately, their own bottom line.

PREVALENCE OF HEALTH COACHING

Many EHM programs – 77% of those represented in the HERO Scorecard database – now make some form of lifestyle or behavior modification program available to employees. While these may include mail or paper-based programs and onsite group classes, the focus of this analysis is health coaching. Phone and web-based coaching are the most common, but one-on-one onsite coaching, although the most resource-intensive, is found in about a third of the lifestyle programs offered by HERO Scorecard respondents.

Because organizations have realized the importance of coaching in assisting with behavior change, many are also offering some form of incentive to encourage employees to participate in the coaching process. This may be for a one-time interaction to review the participant's health risk appraisal results and to identify his or her specific health risks, or it may be a broader program that provides multiple coaching sessions and may also offer incentives for program participation. Of the Scorecard respondents that provide coaching, 60% provide an incentive to participate. The average participation rate is 28% among employers that provide an incentive and 16% among those that do not.

IMPACT OF HEALTH COACHING

An analysis of the Scorecard data suggests that coaching contributes to better EHM program outcomes. Of the respondents that provide some form of coaching, 57% reported an improvement in health risks due to the EHM program, and 42% reported improvement in medical plan cost trend. Among those not offering any coaching programs, these figures were just 18% and 13%, respectively. In other words, employers that provide coaching are three times more likely to report that their EHM programs have helped to improve employee health risks and medical cost. While coaching may be an important contributor to this difference, employers offering coaching are also more likely to include other best practice elements in their programs.

Prevalence of Health Coaching

	Reported improvement in health risk	Reported impact on medical trend
No coaching	18%	13%
Any form of coaching	57%	42%
Web-based coaching	58%	46%
Phone coaching	58%	43%
Face-to-face coaching	68%	57%

It should be noted that many employers are not yet able to measure the impact of their EHM programs on health risk or medical trend. As stated earlier, 57% of respondents with coaching programs reported that their EHM program had improved employee health risk. Of the remainder, 24% had not yet attempted to measure the impact on health risk, and 8% had attempted to measure but were not confident about the results. Only 12% had measured and found no improvement in health risk.

While coaching programs are becoming a more common component of EHM, the delivery of these programs differs from one venue to the next, and the standards of delivery are likely also variable. The variation in delivery, along with subjectivity in the measurement process, may hinder the ability to adequately compare the impact of one type of program to another. In addition, there is some overlap among the employers providing face-to-face, phone and web-based coaching – 54% provide two types, and 17% provide all three. Still, while all three of these venues for coaching are associated with better outcomes, employers offering face-to-face coaching are the most likely to report a positive impact on medical trend (57%) than those offering phone coaching (43%) or web-based coaching (46%).

IMPROVING HEALTH RISKS AND COST TRENDS

Most health care economists and researchers suggest that any positive bend in the health care cost trend line should be considered a success. While not all Scorecard respondents that include coaching as a part of their EHM program measured medical cost trends, many that did found a positive change in their medical cost trends. Although these results do not document the direct contribution of coaching, they do indicate that coaching is a common element in best practice EHM programs that yield superior health and financial outcomes.

THE CASE FOR INCLUDING SPOUSES IN EHM PROGRAMS

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There is evidence that comprehensive communications, the use of incentives and a strong culture of health all can help drive increased participation in EHM programs. An often-overlooked element that also contributes to the long-term success of EHM programs, however, is the role of family support – specifically, spouses. In fact, it is missing from the term "employee health management" itself.

Health behavior research has found that other individuals and groups can have a profound impact on an individual's behavior, with spouses being key influencers. Social support is a predictor not only of initial engagement, but also of long-term success. Spouse support has been associated with higher quit rates for tobacco users and can predict weight-loss adherence as well. While social support contributes to initial participation, its crucial role is in the maintenance of changed behaviors.

Given that a primary objective for most EHM programs is to reduce medical cost trend, it would seem even more important to include a group of members that is driving nearly a third of the health care costs of an organization. Although spouses typically represent only about one-fifth of covered members, the average cost in an average population is about 30% higher for spouses than for covered employees, adding a greater opportunity for savings.

This analysis of HERO Scorecard data investigated the impact of including spouses in an EHM program. Specifically, it examined whether making key components of EHM programs available to spouses (1) increased employee engagement, (2) improved the program's likelihood to impact health or (3) increased the program's likelihood to demonstrate savings. The analysis also examined whether including spouses in an overall EHM strategy is associated with the use of other best practices (as demonstrated by higher best practice scores). Because a key focus was on participation rates, the analysis was limited to employers offering, at a minimum, HAs and lifestyle coaching.

IMPACT OF SPOUSES ON PARTICIPATION AND OUTCOMES

About two-thirds of all Scorecard respondents indicated that they include spouses in key components of their EHM program. Of those that offer both an HA and a lifestyle management program, about three-fourths said that spouses are included.

Employers that included spouses in key components of EHM[3] had a higher HERO score than those that did not (117 versus 100). Both groups were above the database average of 94 because this analysis was limited to employers offering at least an HA and lifestyle coaching, which drove up the average score for these subgroups.

While spousal involvement had only a minimal effect on average employee HA participation rates (52% in programs that included spouses and 50% in those that did not), a more dramatic impact was seen in the behavior-change programs. Employers that included spouses in key components of EHM reported lifestyle coaching employee participation rates twice as high as those that did not (28% versus 14%). The average employee participation rate in tobacco-cessation programs was higher in EHM programs that included spouses (10% versus 8%). As other research also suggests, these findings imply that social support likely has a greater impact on engagement in specific interventions than on initial participation.

3. Responded in the affirmative to the following question: Has your organization taken steps to make key components of the EHM program available to benefit-eligible spouses/domestic partners or dependents?

Employees More Likely to Participate in Coaching Programs When Spouses Are Included

Among respondents that offer HAs and lifestyle coaching and have measured EHM outcomes

	Spouses included in key components of EHM	Spouses not included in key components of EHM
Participation rate in lifestyle coaching	28%	14%
Reported improvement in health risk (% of employers)	88%	81%
Reported positive impact on medical trend (% of employers)	70%	64%

To assess the impact on health risks and savings, an analysis was conducted on two sets of questions. Respondents were first asked if they measured the impact of their program on health risks and/or medical costs, and if they did this measurement, what they found.

Among those that measured risk change, 88% of respondents that included spouses in their strategy reported at least some improvement in health risks, compared with 81% of respondents that did not include spouses. In addition, 70% of respondents that included spouses reported at least some improvement in medical trend, compared with 64% of respondents that did not include spouses. While the magnitude of the impact was not evaluated, the findings suggest, at least directionally, that the likelihood of a program's success is greater when spouses are included.

CONCLUSION

While the evidence is supportive, it is important to note that the analysis was descriptive in nature and does not necessarily suggest causation. Other factors, not controlled for in the analysis, also likely influence the results. For instance, larger organizations are more likely to include spouses in their EHM strategies, and as reported in a past commentary, employer size is related to the HERO score.

However, the data support, at least directionally, that those organizations that include spouses in their overall EHM strategy were able to demonstrate increased employee participation, especially in the interventions that matter, as well as a greater likelihood of health improvement and medical cost savings.

While it was encouraging to see that including spouses in EHM strategy is becoming more of the norm, there is still a ways to go. Until we can shift employee health management to true population health management, we will be limiting the potential impact of these programs.

For further information, please visit our websites at:

www.the-HERO.org

www.mercer.com

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