THE HERO HEALTH AND WELL-BEING BEST PRACTICES SCORECARD

IN COLLABORATION WITH MERCER©

HIGHER EDUCATION INDUSTRY BENCHMARK REPORT

September, 2017

MAKE TOMORROW, TODAY MERCER

A benchmark report from

The HERO Health and Well-being Best Practices Scorecard In Collaboration with Mercer

About the HERO Scorecard

The HERO Health and Well-being Best Practices Scorecard in Collaboration with Mercer (HERO Scorecard) is designed to help employers, providers, and other stakeholders learn about and determine employee health management best practice. It's also an effective means of gathering data on the state of health and well-being in the US today -- data that can be used to develop benchmarks. The HERO Scorecard is divided into six sections representing the foundational components that support exemplary health and well-being programs. While no inventory of best practices will include all innovative approaches to health and well-being, we have included those most commonly recognized among industry thought-leaders and in published literature.

The HERO Scorecard asks detailed questions about employers' health and well-being program design, administration, and experience, and assigns respondents an overall best practice score out of a possible 200 points. While a Scorecard score of 200 is theoretically possible, it is not likely nor even desirable for an employer to have every possible health and well-being program and strategy in place. A separate Program Outcomes section is included to serve as a guide for a "dashboard" of measures that may be useful in assessing program success. Information in this section does not contribute to an organization's best practice score, but is used to develop outcomes benchmarks.

About this Benchmark Report

This Benchmark Report is based on the responses of the 777 employers that have submitted completed the HERO Scorecard as of June 30, 2017. It provides both their aggregated scores and their aggregated question responses. These results have been sorted by various demographic factors to allow employers to compare their programs to those of similar employers, based on industry, size, and geographic location. As the database grows, we will be able to look at results in increasingly precise demographic break-outs.

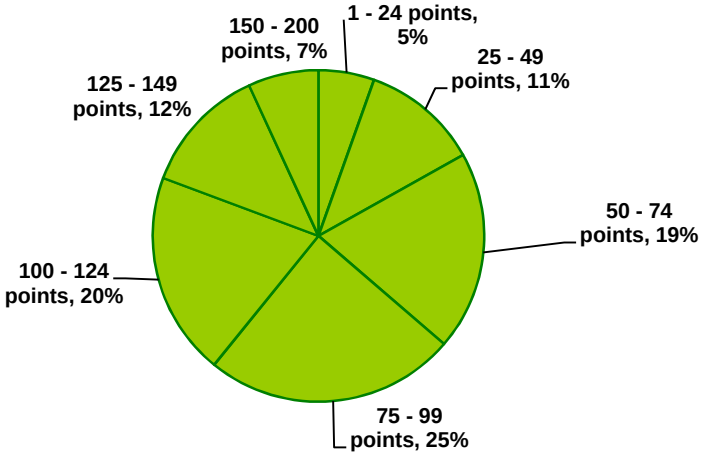
For more information, please visit the HERO web-site at www.hero-health.

NUMBER OF PARTICIPANTS

All employers	777
Employer size*	
Employers with fewer than 500 employees	243
Employers with 500-4,999 employees	330
Employers with 5,000 or more employees	187

*Among employers providing data

DISTRIBUTION OF SCORES ACROSS RESPONDENTS



Scorecard Commentary

Universities and Colleges Lead the Way with Best Practice Approach to Health and Well-being

HERO has a substantial amount of experience working with colleges and universities. These organizations also comprise a significant ratio of HERO members and, many years ago, they proactively created their own forum for networking at HERO events. In fact, 2017 marks the 5th year that our University Summit will precede the annual HERO Forum. What we've learned about institutions of higher education (higher ed) is that they are highly likely to take an evidence-based, data-driven approach to developing, implementing, and evaluating their health and well-being initiatives. They are also highly collaborative and strategic in their approaches. On top of that, the individuals from these organizations who gather at HERO events are among the smartest and most passionate of attendees. When one considers these traits in combination with the fact that higher ed often has unique resources within its population and organizational infrastructure (e.g., in-house experts and thought leaders in the form of faculty, researchers and evaluation resources; rich physical environment opportunities to support wellness), it's no surprise that higher ed leads all other sectors when it comes to implementing health and well-being best practices.

The HERO Health and Well-being Best Practices Scorecard in Collaboration with Mercer© (HERO Scorecard) assesses six different areas of practices highly correlated with health, performance, and financial outcomes.[1-2] These areas include (1) strategic planning; (2) organizational and cultural support; (3) programs; (4) program integration; (5) participation strategies; and (6) measurement and evaluation. According to a recent analysis conducted on the HERO Scorecard normative database, higher ed as a sector logs higher scores than all other industry groups assessed. This commentary shares key findings from this analysis and identifies several areas where even this over-achieving sector might strive to further improve its health and well-being initiatives.

The analysis was based on 777 unique organizations that completed the HERO Scorecard through June 30, 2017. Of this total group of Scorecard completers, 36 organizations self-identified as universities or colleges and all but one of them provided information on number of full-time and part-time employees. Because numerous previous HERO Scorecard analyses demonstrated that larger organizations tend to score more highly, it is important to assess the role of organizational size when evaluating industry differences. For this analysis, three organizations represented small employers (less than 500 employees); 16 represented medium-sized employers (500 to 4,999 employees), and 16 represented large employers (5,000 or more employees). One organization did not provide information on organizational size so was excluded from the sub-analyses. Comparisons of overall and section scores by organizational size reveals that small and medium-sized higher ed organizations have lower scores than large organizations, similar to the overall HERO Scorecard database. For this reason, the subsequent analysis provides comparisons amongst the following groups: all higher ed (n=36); all industries ("national", n=777); a combined group of small and medium-sized higher ed ("smaller", n=19); and large higher ed (n=16). It is essential to note two important caveats about these HERO Scorecard comparison groups. First, HERO Scorecard completers represent a convenience sample of organizations and are not likely to be representative of all organizations nationally or within a given industry. For example, previous analyses (unpublished) demonstrate that larger organizations tend to complete the HERO Scorecard. Additionally, because HERO does not aggressively market or promote use of the HERO Scorecard to a representative sample of all US organizations, it's likely that HERO Scorecard completers take a more active interest in the health and well-being of their employee population than other organizations. Second, none of the comparisons featured in this commentary were examined for statistical significance, in part because of the small sample size. All observations are offered as a way for higher ed organizations interested in advancing the health and well-being of their employees to identify areas of strength or opportunity for their own initiatives.

Best Practice Scores

As already noted, higher ed scores more highly than any other industry group measured on the HERO Scorecard. Only two industry groups follow closely behind the average overall score for the higher ed group (108 points out of 200 maximum): healthcare services (105 points) and financial services (100 points). All other industry groups have an average score below 100 points. Within higher ed, large organizations score higher than smaller organizations (113 versus 101 points).

Higher ed also scores higher than most industry groups on most Scorecard sections:
- strategic planning (11 out of 20 maximum points, exception healthcare services with 12 points);
- organizational and cultural support (28 out of 50 maximum points);
- programs (27 out of 40 maximum points);
- program integration (7 out of 16 maximum points);
- participation strategies (25 out of 50 maximum points, tied with healthcare services and financial services); and
- measurement and evaluation (10 out of 24 maximum points, tied with financial services, healthcare services, and other health services).

The sub-analysis comparing large higher ed organizations to smaller higher ed organizations reveals that the difference in the overall higher ed score is driven by large organization practices in the areas of:
- programs (29 points versus 25 points);
- program integration (8 points versus 6 points);
- participation strategies (28 points versus 24 points); and
- measurement and evaluation (13 points versus 8 points)

While a two-point or three-point difference within each section may seem small, it is a meaningful difference relative to the total number of points possible for each section. For example, the program integration section has a potential maximum of 16 points: thus, a two-point difference represents 13% of the total points available.

Specific Practices

A detailed comparison of all practices assessed on the HERO Scorecard is beyond the scope of this commentary. However, a list of the most meaningful strengths and opportunities observed in the analysis is worth noting.

Strengths
Higher ed organizations score substantially more points than other types of organizations in the organizational and cultural support section of the HERO Scorecard. Particularly, they are far more likely to implement health-supporting policies and encourage healthy behaviors through a supportive "built" environment. Higher ed organizations are also more likely to include employee input, perceptions, and support in the development and implementation of programs.

Higher ed organizations also tend to offer more comprehensive program options to employees, with offerings that support employees at every level of health status along the full continuum of health. This includes incorporating more recommended practices for effective disability management.

A broader array of participation strategies is used by higher ed organizations when compared to others. They are especially likely to incorporate social support strategies into program structure, relying on a robust and comprehensive communications strategy. Higher ed organizations also focus on intrinsic motivation strategies, rather than financial incentives, to promote participation.

Opportunities
While higher ed organizations are more likely than other organizations to incorporate many of the practices recommended on the HERO Scorecard, there are some opportunities for them to strengthen their approach to health and well-being. The highest potential score on the HERO Scorecard is 200 total points and higher ed organizations average 113 points. Based on the points available for specific practices, incorporation of the following practices would generally increase higher ed organization scores and, in turn, drive a more effective health and well-being initiative.
- Encourage senior leaders to more consistently articulate the value and importance of health and well-being, for example, by making the connection between employee health and well-being and organizational goals.
- Encourage leaders to be role models for making healthy behaviors a priority, to publicly recognize employees who are role models for health and well-being, and to hold front-line supervisors accountable for supporting the health and well-being of the employees they lead.
- Integrate health and well-being activities and support in the areas of lifestyle management, disease management, behavioral health management, case management, disability management, and safety in communications, reporting, referrals, and use of data for effective outreach.
- Rely on targeted and tailored communications to increase participation of senior leaders, managers, and spouses.

- Increase use of process evaluation, health improvement outcomes, and organizational culture outcomes to demonstrate the value of health and well-being initiatives and ensure programs are operating as intended.
- Increase the breadth and frequency of communications about program performance and impact to managers, wellness champions, employees, and other stakeholders.

Conclusion

Higher ed organizations lead the way when it comes to incorporating evidence-based approaches into their health and well-being initiatives. Despite this leadership, however, these institutions still have ample opportunities to continue to strengthen their initiatives. They can still use the HERO Scorecard to identify gaps in their current practices; then take action to address these gaps.

Jessica Grossmeier, PhD, MPH

References

1. Grossmeier J, Fabius R, Flynn JP, Noeldner SP, Fabius D, Goetzel RZ, Anderson DR. Linking workplace health promotion best practices and organizational financial performance: Tracking market performance of companies with highest scores on the HERO Scorecard. *Journal of Occupational and Environmental Medicine.* 2016;58(1):16-23.

2. Goetzel R, Henke RM, Benevent R, Tabrizi M, Kent K, Smith K, Chung RE, Grossmeier J, Mason S, Gold D, Noeldner S, Anderson DR. The predictive validity of the HERO Scorecard in determining future healthcare cost and risk trends. *Journal of Occupational and Environmental Medicine.* 2014; 56(2):136-144.

The HERO Health and Well-being Best Practices Scorecard in Collaboration with Mercer©

Note: The HERO Scorecard is based on a convenience sample and therefore, not representative of all organizations in the nation or within a specific sub-group. Data are not provided when cell sizes are less than 10 organizations (**).

		Colleges and Universities (all sizes)	Colleges and Universities (<5,000 EEs)	Colleges and Universities (5000+ EEs)	National Results
	Number of respondents (of organizations with data)*	36	19*	16*	777
	Overall average score (maximum score: 200 points)	108	101	113	89
	Section 1: Strategic Planning				
	Average score for section 1 (maximum score: 20 points)	11	11	12	10
1	**Data sources used in strategic planning for health and well-being program**				
	WORKFORCE HEALTH MEASURES				
	Medical / pharmacy claims	83%	68%	100%	71%
	Behavioral health claims	56%	32%	81%	35%
	Health assessment	67%	58%	81%	60%
	Biometric screening	67%	63%	69%	59%
	Fitness assessment	17%	16%	13%	13%
	Disability claims	42%	16%	69%	28%
	Absence / sick days data	25%	0%	50%	21%
	None of the above	14%	26%	0%	14%
	Number of respondents	35	19	16	772
	EMPLOYEE SURVEYS				
	Employee interest / feedback	77%	89%	69%	64%
	Employee morale / satisfaction / engagement data	80%	78%	81%	57%
	None of the above	6%	0%	13%	22%
	Number of respondents	35	18	16	759
	BUSINESS MEASURES / ORGANIZATIONAL ASSESSMENT				
	Employee / business performance data	26%	26%	20%	31%
	Employee retention / recruitment data	34%	32%	33%	34%
	Culture / climate assessment	49%	47%	47%	40%
	None of the above	34%	32%	40%	40%
	Number of respondents	35	19	15	722
2	**Formal, written, strategic plan for health and well-being**				
	Have a long-term plan (2 or more years) only	25%	26%	25%	14%
	Have an annual plan only	17%	21%	13%	24%
	Have both a long-term and annual plan	28%	21%	31%	19%
	Don't have a formal plan	31%	32%	31%	44%
	Number of respondents	36	19	16	770

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		Colleges and Universities (all sizes)	Colleges and Universities (<5,000 EEs)	Colleges and Universities (5000+ EEs)	National Results
3	**Measurable objectives included in health and well-being strategic plan (among employers with a plan)**				
	Participation in health and well-being programs	96%	100%	91%	88%
	Changes in health risks	76%	69%	82%	62%
	Improvements in clinical measures / outcomes	48%	39%	64%	46%
	Absenteeism reductions	24%	0%	46%	20%
	Productivity / performance impact	28%	23%	36%	20%
	Financial outcomes measurement (medical plan cost or other health spending)	56%	39%	73%	52%
	Winning health and well-being program awards (e.g., Koop award)	44%	46%	46%	39%
	Recruitment / retention	24%	31%	18%	25%
	Employee satisfaction / morale and engagement	72%	85%	64%	59%
	Customer satisfaction	40%	39%	36%	22%
	None of the above	0%	0%	0%	3%
	Number of respondents	25	13	11	433
4	**Key components of the health and well-being program are available to various populations (among employers with each population segment)**				
	Union employees	95%	100%	91%	83%
	Spouses / domestic partners (DP)	88%	94%	81%	68%
	Dependents other than spouses or DPs	59%	63%	50%	48%
	Part-time employees	76%	78%	73%	78%
	Employees located outside of the U.S.	73%	60%	73%	38%
	English as a Second Language (ESL) employees	92%	82%	93%	85%
	Retirees	73%	73%	63%	26%
	Employees on disability leave	91%	88%	94%	82%
	Number of respondents	33	18	15	669
5	**Program specifically addresses the needs of employees with different health statuses**				
	Healthy	97%	95%	94%	94%
	At risk	91%	84%	94%	93%
	Chronically ill	91%	84%	94%	74%
	Acute health needs (or catastrophic health incidents)	77%	68%	81%	58%
	Number of respondents	35	19	16	703
6	**Employer opinion: To what extent is your health and well-being program viewed by senior leadership as connected to broader business results?**				
	To a great extent	22%	11%	31%	27%
	To some extent	56%	63%	50%	52%
	Not seen as connected	22%	26%	19%	21%
	Number of respondents	36	19	16	760
7	**Employer opinion: How effective is the strategic planning process for health and well-being?**				
	Very effective	6%	0%	13%	12%
	Effective	53%	58%	44%	47%
	Not very effective	25%	26%	25%	34%
	Not at all effective	17%	16%	19%	8%
	Number of respondents	36	19	16	763

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		Colleges and Universities (all sizes)	Colleges and Universities (<5,000 EEs)	Colleges and Universities (5000+ EEs)	National Results
Section 2: Organizational and Cultural Support					
	Average score for Section 2 (maximum score: 50 points)	28	28	28	23
8	**Methods of communicating health values**				
	Company vision / mission statement supports a healthy workplace culture	36%	42%	25%	34%
	Employee health and well-being is included in organization's goals and value statements	56%	58%	56%	37%
	Senior leaders consistently articulate the value and importance of health (for example, by connecting health to productivity / performance and business results)	39%	26%	50%	41%
	None of the above	14%	11%	19%	37%
	Number of respondents	36	19	16	771
9	**Policies relating to employee health and well-being**				
	Allow employees to take work time for physical activity	44%	53%	31%	30%
	Provide opportunities for employees to use work time for stress management and rejuvenation	44%	53%	38%	35%
	Support healthy eating choices (for example, by requiring healthy options at company-sponsored events)	69%	79%	63%	59%
	Encourage the use of community health and well-being resources (for example, community gardens, recreational facilities, health education resources)	67%	79%	56%	54%
	Tobacco-free workplace or campus	69%	58%	81%	67%
	Policies promoting responsible alcohol use	61%	68%	56%	39%
	Support work-life balance (for example, with flex time or job share options)	81%	79%	81%	55%
	None of the above	0%	0%	0%	6%
	Number of respondents	36	19	16	772
10	**Components of company's physical ("built") environment**				
	Healthy eating choices are available and easy to access	83%	84%	81%	68%
	Physical activity is explicitly encouraged by features or resources in the work environment	94%	100%	94%	66%
	Stress management and mental recovery breaks are supported	67%	63%	75%	37%
	Safety is a priority within the environment	97%	100%	94%	85%
	None of the above	0%	0%	0%	4%
	Number of respondents	36	19	16	768

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		Colleges and Universities (all sizes)	Colleges and Universities (<5,000 EEs)	Colleges and Universities (5000+ EEs)	National Results
11	**Leadership's support of health and well-being**				
	Leadership development includes the business relevance of worker health and well-being	31%	21%	44%	28%
	Leaders actively participate in health and well-being programs	60%	63%	56%	53%
	Leaders are role models for prioritizing health and work/life balance (for example, they do not send e-mail while on vacation, they take activity breaks during the work day, etc.)	31%	26%	38%	24%
	Leaders publicly recognize employees for healthy actions and outcomes	37%	42%	31%	28%
	Leaders are held accountable for supporting the health and well-being of their employees	23%	21%	19%	17%
	Leaders hold their front-line managers accountable for supporting the health and well-being of their employees	26%	32%	19%	15%
	A senior leader has authority to take action to achieve the organization's health and well-being goals	60%	58%	63%	39%
	None of the above	14%	21%	6%	26%
	Number of respondents	35	19	16	767
12	**Employee involvement in health and well-being program**				
	Employees have the opportunity to provide input into program content, delivery methods, future needs and communication channels	83%	79%	81%	61%
	Wellness champion networks are used to support health and well-being	63%	58%	63%	53%
	Employees are formally asked to share their perception of organizational support for their health and well-being (for example, in an annual employee survey)	54%	58%	50%	47%
	None of the above	6%	5%	6%	21%
	Number of respondents	35	19	16	766
13	**Resources used to support employee champions or ambassadors (among employers with wellness champions or ambassadors)**				
	Training	64%	64%	60%	48%
	Toolkit including resources, information, and contacts, etc.	82%	64%	100%	60%
	Rewards or recognition	73%	73%	70%	56%
	Regularly scheduled meetings for champion team	91%	91%	90%	79%
	None of the above	0%	0%	0%	6%
	Number of respondents	22	11	10	406
14	**Level of support for mid-level managers and supervisors in their efforts to improve the health and well-being of employees**				
	Managers / work group supervisors are given a lot of support	6%	11%	0%	13%
	Some support	57%	53%	60%	36%
	Not much support	23%	21%	27%	28%
	No support	14%	16%	13%	23%
	Number of respondents	35	19	15	764

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		Colleges and Universities (all sizes)	Colleges and Universities (<5,000 EEs)	Colleges and Universities (5000+ EEs)	National Results
15	**Employer opinion: How effective are your current organizational support strategies in promoting the health and well-being of employees?**				
	Very effective	6%	0%	13%	10%
	Effective	60%	63%	53%	45%
	Not very effective	31%	32%	33%	38%
	Not at all effective	3%	5%	0%	7%
	Number of respondents	35	19	15	768

Section 3: Programs

	Average score for section 3 (maximum score: 40 points)	27	25	29	22
16	**Approaches used to assess the health of individuals / population**				
	Health assessment questionnaire(s)	80%	79%	75%	69%
	Biometric screenings	80%	84%	75%	67%
	Employee surveys	83%	95%	69%	50%
	Claims data mining (medical, pharmacy, behavioral health, disability)	77%	63%	88%	62%
	Monitoring or tracking devices	34%	32%	38%	23%
	Other	0%	0%	0%	5%
	Do not currently assess population health	0%	0%	0%	11%
	Number of respondents	35	19	16	771
17	**Methods of promoting biometric screenings**				
	Provide on-site or near-site biometric screenings	77%	84%	73%	66%
	Offer biometric screenings through a lab, home test kits, or other off-site options	31%	21%	47%	32%
	Conduct awareness campaigns / actively promote getting biometric screenings from health care provider	49%	42%	60%	43%
	Do not provide biometric screenings or conduct awareness campaigns	20%	16%	20%	22%
	Number of respondents	35	19	15	765
18	**Referral and follow-up process is in place for individuals whose biometric screening results are out of the normal range**				
	Yes	73%	73%	73%	60%
	No	27%	27%	27%	40%
	Number of respondents	30	15	15	659
19	**Provide health behavior change programs that are offered to all individuals eligible for health and well-being program, regardless of health status**				
	Yes	89%	73%	73%	80%
	No	11%	27%	27%	20%
	Number of respondents	35	15	15	769

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		Colleges and Universities (all sizes)	Colleges and Universities (<5,000 EEs)	Colleges and Universities (5000+ EEs)	National Results
20	**Method of delivery of health improvement programs (among employers that provide health behavior change programs to all, regardless of health status)**				
	Phone-based (can include group conference calls)	63%	50%	73%	56%
	Email or mobile (SMS)	80%	86%	73%	62%
	Web-based method (other than email)	93%	86%	100%	72%
	In person (includes individual or group meetings or activities)	93%	93%	93%	75%
	Number of respondents	30	14	15	609
21	**Features incorporated into one or more health improvement programs (among employers that provide health behavior change programs to all)**				
	Program incorporates use of tracking tools such as a pedometer, glucometer, or automated scale	70%	71%	73%	58%
	Program is mobile supported (allows individuals to monitor progress and interact via smart phone)	77%	79%	80%	55%
	Program incorporates social connection (for example, allows individuals to communicate with, support, and/or challenge other individuals or to form teams)	77%	79%	73%	62%
	None of the above	7%	7%	7%	19%
	Number of respondents	30	14	15	609
22	**Offer any individually targeted lifestyle management services that allow for interactive communication between an individual and a health professional or expert system**				
	Yes	91%	84%	100%	76%
	No	9%	16%	0%	24%
	Number of respondents	35	19	15	768
23	**Types of interventions provided by targeted lifestyle management program (among those that provide targeted lifestyle management services)**				
	Phone-based coaching	84%	69%	100%	78%
	Email or mobile (SMS)	63%	56%	67%	52%
	Web-based interventions (other than email)	69%	63%	80%	65%
	On-site one-on-one coaching	53%	50%	60%	43%
	On-site group classes	75%	75%	80%	54%
	Paper-based bi-directional communication between the organization and the individual	13%	25%	0%	17%
	Number of respondents	32	16	15	583

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24	**Resources provided by organization to support individuals in managing their overall health and well-being**				
	On-site or near-site medical clinic	60%	58%	67%	30%
	Employee Assistance Program (EAP)	97%	95%	100%	87%
	Child care and / or elder care assistance	77%	63%	93%	34%
	Initiatives to support a psychologically healthy workforce	60%	58%	60%	30%
	Legal or financial management assistance	89%	90%	93%	63%
	Information about community health resources	83%	74%	93%	48%
	Health advocacy program	43%	47%	33%	36%
	Executive health program	17%	5%	33%	16%
	Medical decision support program	31%	42%	20%	27%
	Nurse advice line service	83%	68%	100%	67%
	None of the above	0%	0%	0%	5%
	Number of respondents	35	19	15	766
25	**Offer disease management (DM) program(s) that addresses the following conditions**				
	Arthritis	60%	63%	53%	34%
	Asthma	86%	84%	87%	63%
	Autoimmune disorders (multiple sclerosis, rheumatoid arthritis, etc.)	51%	53%	47%	31%
	Cancer	71%	68%	73%	49%
	Chronic obstructive pulmonary disease (COPD)	86%	84%	87%	59%
	Congestive heart failure (CHF)	77%	84%	67%	60%
	Coronary artery disease (CAD)	80%	84%	73%	63%
	Depression	69%	74%	60%	47%
	Diabetes	94%	95%	93%	72%
	Maternity	83%	84%	80%	57%
	Metabolic syndrome	46%	32%	60%	32%
	Musculoskeletal / back pain	57%	58%	53%	39%
	Obesity	63%	53%	73%	44%
	Don't offer any DM programs	3%	5%	0%	20%
	Number of respondents	35	19	15	761
26	**Provide or use electronic consumer tools to assist participants with managing health data, utilizing health resources, or tracking benefits**				
	Yes	89%	84%	93%	69%
	No	11%	16%	7%	31%
	Number of respondents	35	19	15	763
27	**Employer opinion: How effective are your health and well-being programs in promoting a healthier, more productive workforce?**				
	Very effective	9%	5%	13%	11%
	Effective	69%	74%	60%	51%
	Not very effective	23%	21%	27%	33%
	Not effective at all	0%	0%	0%	5%
	Number of respondents	35	19	15	767

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		Colleges and Universities (all sizes)	Colleges and Universities (<5,000 EEs)	Colleges and Universities (5000+ EEs)	National Results
28	**Steps taken to manage employee disabilities**				
	Formal goals for disability programs	26%	17%	40%	13%
	Performance standards to hold leaders, managers, and supervisors accountable for disability management program goals	6%	6%	7%	10%
	Written return-to-work programs with policies and procedures covering all absences	65%	67%	67%	53%
	Modified temporary job offers for employees with disabilities ready to return to productive activity but not yet ready to return to their former job	71%	61%	80%	57%
	Complex claims receive clinical intervention or oversight (by in-house or outsourced staff)	53%	50%	60%	35%
	Standards for ongoing supportive communication with employee throughout the duration of leave	65%	56%	73%	43%
	Developed metrics to regularly monitor and manage disability trends with emphasis on established key performance indicators	38%	22%	60%	19%
	Strategies to triage individuals with certain disabilities into relevant health and well-being program	26%	22%	33%	14%
	None of the above	12%	17%	7%	22%
	Number of respondents	34	18	15	741
29	**Employer opinion: How effective are your disability management programs in promoting a healthier, more productive workforce?**				
	Very effective	6%	6%	7%	7%
	Effective	48%	56%	36%	46%
	Not very effective	45%	39%	57%	34%
	Not effective at all	0%	0%	0%	14%
	Number of respondents	33	18	14	733

Section 4: Program Integration

	Average score for section 4 (maximum score: 16 points)	7	6	8	5
30	**Integration of different health and well-being programs**				
	Health and well-being partners (internal and external) refer individuals to programs and resources provided by other partners	71%	63%	75%	51%
	Health and well-being partners provide “warm transfer” of individuals to programs and services provided by other partners	54%	42%	63%	35%
	The referral process (by employer or third-party) is monitored for volume of referrals	31%	16%	50%	19%
	All partners collaborate as a team to track outcomes for individual employees	23%	16%	31%	11%
	All partners collaborate as a team to track progress towards common organizational goals and outcomes	31%	21%	44%	14%
	None of the above	20%	32%	6%	39%
	Number of respondents	35	19	16	768

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		Colleges and Universities (all sizes)	Colleges and Universities (<5,000 EEs)	Colleges and Universities (5000+ EEs)	National Results
31	**Health and well-being program components are integrated in at least one way indicated in item 30 above (among employers that have at least some degree of integration)**				
	Lifestyle management and disease management	53%	33%	79%	52%
	Lifestyle management and behavioral health	67%	53%	86%	44%
	Disease management and behavioral health	47%	40%	57%	42%
	Disease management and case management	60%	60%	64%	50%
	Case management and behavioral health	53%	33%	79%	38%
	Specialty lifestyle management (e.g. tobacco cessation, obesity, stress, etc.) with any health management program	67%	47%	86%	62%
	None of the above	10%	20%	0%	13%
	Number of respondents	30	15	14	540
32	**Integration of disability management program and health and well-being programs**				
	Individuals in disability management are referred to health and well-being programs	23%	16%	31%	19%
	Individuals who participate in appropriate health and well-being programs receive more generous disability benefit	0%	0%	0%	2%
	Disability data is combined with health and well-being program data for identifying, reporting, and performing analytics	3%	0%	6%	9%
	None of the above	77%	84%	63%	75%
	Number of respondents	35	19	16	745
33	**Integration of worksite safety program and health and well-being program**				
	Safety and injury prevention are elements of the health management program goals and objectives	54%	68%	33%	36%
	Health management elements, such as physical activity, healthy nutrition or stress management are included in your worksite safety program	31%	32%	33%	23%
	Safety data is combined with health management program data for identifying, reporting, and performing analytics	17%	11%	27%	14%
	None of the above	29%	16%	47%	43%
	Do not have a worksite safety program	9%	16%	0%	14%
	Number of respondents	35	19	15	765
34	**Employer opinion: Compared to organizations of a similar size, how would you rate your organization in terms of providing access to health care coverage to all employees?**				
	Provide far greater access to health coverage than most of our peer organizations	34%	21%	47%	33%
	Provide good access to health coverage, a bit more than our peers	40%	42%	40%	35%
	Provide about the same access to health coverage as our peers	23%	32%	13%	30%
	Provide less access to health coverage than our peers	3%	5%	0%	1%
	Don't provide a health plan; employees are covered in public exchanges	0%	0%	0%	1%
	Number of respondents	35	19	15	764

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		Colleges and Universities (all sizes)	Colleges and Universities (<5,000 EEs)	Colleges and Universities (5000+ EEs)	National Results
35	**Employer opinion: To what extent do you think the integration between your health-related vendors or programs contributes to the success of the health and well-being program?**				
	Program integration contributes very significantly to success	31%	26%	33%	15%
	Contributes significantly	20%	21%	20%	28%
	Contributes somewhat	43%	42%	47%	40%
	Does not contribute	6%	11%	0%	17%
	Number of respondents	35	19	15	764

Section 5: Participation Strategies

	Average score for section 5 (maximum score: 50 points)	25	24	28	21
36	**Social strategies used to encourage participation in health and well-being programs**				
	Peer support	68%	68%	71%	48%
	Group goal-setting or activities	68%	68%	71%	45%
	Competitions / challenges	82%	79%	86%	73%
	Connecting participation to a cause	38%	26%	50%	42%
	None of the above	9%	11%	7%	18%
	Number of respondents	34	19	14	766
37	**Technology-based resources used**				
	Web-based resources or tools	86%	79%	88%	75%
	Onsite kiosks at work place	17%	16%	19%	21%
	Mobile applications	57%	58%	56%	48%
	Devices to monitor activity	66%	68%	63%	49%
	None of the above	11%	16%	6%	18%
	Number of respondents	35	19	16	762
38	**Components of health and well-being program communications**				
	Annual or multi-year communications plan that articulates the key themes and messages	63%	58%	63%	52%
	Multiple communication channels and media appropriate for targeted population (newsletter, direct mailings, e-mail, website, text messaging, etc.)	86%	84%	81%	65%
	Communications are tailored to specific sub-groups of the population (based on demographics or risk status) with unique messages	46%	32%	63%	26%
	Year-round communication (on at least a quarterly basis)	77%	79%	69%	69%
	Communications are branded with unique program name, logo, and tag line that is readily recognized by employees as that of the health and well-being program	86%	84%	88%	59%
	Regular status reports to inform stakeholders such as employees, vendors, and management of program progress	49%	42%	50%	40%
	Employee meetings or webcasts where management discusses and promotes health and well-being programs	60%	47%	69%	35%
	Communications are directed to spouses and family members as well as employees	46%	42%	50%	29%
	None of the above	6%	5%	6%	13%
	Number of respondents	35	19	16	766

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		Colleges and Universities (all sizes)	Colleges and Universities (<5,000 EEs)	Colleges and Universities (5000+ EEs)	National Results
39	**Separate health and well-being program communications targeted to employees with different roles in organization**				
	Senior leadership	31%	21%	38%	23%
	Managers (including direct supervisors)	31%	26%	38%	22%
	Wellness champions	51%	37%	63%	36%
	None of the above	37%	58%	13%	55%
	Number of respondents	35	19	16	762
40	**Engagement strategy intentionally includes a focus on increasing employees' intrinsic motivation to improve or maintain their health**				
	Using intrinsic motivation as the reward is the primary focus of our engagement strategy	43%	58%	27%	38%
	Our program may provide some intrinsic rewards but it's not the primary focus of our engagement strategy	57%	42%	73%	62%
	Number of respondents	35	19	15	764
41	**Employer opinion: How effective are your program's communication and/or social strategies in encouraging employees to participate in programs, monitor their biometrics or activity levels, or take other action to improve their health?**				
	Very effective	11%	5%	20%	12%
	Effective	63%	63%	60%	49%
	Not very effective	26%	32%	20%	31%
	Not at all effective	0%	0%	0%	8%
	Number of respondents	35	19	15	765
42	**Offer employees incentives in connection with the health and well-being program**				
	Yes, financial rewards or penalties (includes sweepstakes and charitable contributions)	46%	32%	67%	63%
	Yes, but only token gifts (t-shirts, water bottles, etc.)	40%	58%	20%	16%
	No financial incentives	14%	11%	13%	21%
	Number of respondents	35	19	15	765
43	**How incentives are communicated (among employers that offer incentives)**				
	Reward	87%	**	80%	82%
	Penalty	0%	**	0%	3%
	Both rewards and penalties	13%	**	20%	15%
	Number of respondents	15	**	10	472
44	**Financial structure of incentives (among employers that offer incentives)**				
	Incentives are considered a program expense	86%	**	**	74%
	Incentives are designed to be cost neutral	7%	**	**	19%
	Incentives are treated as a source of additional funding	7%	**	**	8%
	Number of respondents	14	**	**	472

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		Colleges and Universities (all sizes)	Colleges and Universities (<5,000 EEs)	Colleges and Universities (5000+ EEs)	National Results
45	**Requirements for earning incentives (among employers that offer incentives)**				
	Participating in one or more aspects of health and well-being programs or offerings, such as HA, biometric screening, or coaching (participatory incentives)	100%	**	100%	94%
	Achieving, maintaining, or showing progress toward specific health status targets (health-contingent outcomes-based incentives)	33%	**	30%	35%
	Completing a specific activity related to a health factor, such as taking 10,000 steps per day (health-contingent, activity-only incentives)	53%	**	60%	51%
	Number of respondents	15	**	10	469
46	**Maximum annual value of all incentives a person could earn (among employers that offer incentives)**				
	Median value of participatory incentives per employee	**	**	**	$300
	Number of respondents	**	**	**	392
	Median value of health-contingent, outcomes-based incentives per employee	**	**	**	$300
	Number of respondents	**	**	**	127
	Median value of health-contingent, activity-only incentives per employee	**	**	**	$163
	Number of respondents	**	**	**	104
47	**Percentage of employees eligible for incentives that earn the incentive (among employers that offer incentives)**				
	Average percent of eligible employees earning any incentive	**	**	**	57%
	Number of respondents	**	**	**	379
	Average percent of eligible employees earning maximum annual incentive	**	**	**	38%
	Number of respondents	**	**	**	305
48	**Use point system for earning rewards (among employers that offer incentives)**				
	Yes	67%	**	70%	49%
	No	33%	**	30%	51%
	Number of respondents	15	**	10	470
49	**Financial incentives provided for participating in assessment-related activities (among employers that offer participatory incentives)**				
	Separate incentive for completing an HA (no biometric screening is required)	40%	**	40%	29%
	Separate (or additional) incentive for biometric screening	27%	**	20%	23%
	Combined incentive for completing both an HA and biometric screening (both are required to earn the reward/avoid the penalty)	53%	**	50%	53%
	No financial incentive is provided for assessment-related activities only	7%	**	10%	13%
	Number of respondents	15	**	10	432

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		Colleges and Universities (all sizes)	Colleges and Universities (<5,000 EEs)	Colleges and Universities (5000+ EEs)	National Results
50	**Type of financial incentives offered for completing an HA and / or biometric screening (among employers that offer financial incentives for participating)**				
	Cash / gift card	**	**	**	43%
	Maximum annual value (median)	**	**	**	$100
	Number of respondents	**	**	**	153
	Financial contribution to an employee spending account (FSA, HSA or HRA)	**	**	**	23%
	Maximum annual value (median)	**	**	**	$280
	Number of respondents	**	**	**	74
	Lower (higher) employee premium contributions	**	**	**	44%
	Maximum annual value (median)	**	**	**	$450
	Number of respondents	**	**	**	141
	Lower cost sharing (deductibles, copays or coinsurance)	**	**	**	4%
	Other financial incentive	**	**	**	13%
	Number of respondents	**	**	**	364
51	**Benefit-eligible spouses / partners are able to earn the incentive for assessment-related activities (among employers that offer financial incentives for participating)**				
	Yes, the same incentive as the employee	29%	**	**	30%
	Yes, a different incentive	29%	**	**	8%
	Yes, both the employee and spouse must complete the assessment to receive the incentive	7%	**	**	10%
	No, spouses / partners are not eligible	36%	**	**	51%
	Number of respondents	14	**	**	372
52	**Type of financial incentives offered for participating in a LM or DM coaching program (among employers that offer financial incentives for participating)**				
	Cash / gift card	**	**	**	18%
	Maximum annual value (median)	**	**	**	$100
	Number of respondents	**	**	**	62
	Financial contribution to an employee spending account (FSA, HSA or HRA)	**	**	**	9%
	Maximum annual value (median)	**	**	**	$175
	Number of respondents	**	**	**	30
	Lower (higher) employee premium contributions	**	**	**	11%
	Maximum annual value (median)	**	**	**	$360
	Number of respondents	**	**	**	33
	Lower cost sharing (deductibles, copays or coinsurance)	**	**	**	3%
	Other financial incentive	**	**	**	10%
	No financial incentive is provided	**	**	**	56%
	Number of respondents	**	**	**	371
53	**Benefit-eligible spouses / partners are able to earn the incentive for participating in a coaching program (among employers that offer incentives for participating)**				
	Yes, the same incentive as the employee	47%	**	50%	24%
	Yes, a different incentive	13%	**	10%	5%
	Yes, both the employee and spouse must participate to receive the incentive	0%	**	0%	3%
	No, spouses / partners are not eligible	40%	**	40%	68%
	Number of respondents	15	**	10	375

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		Colleges and Universities (all sizes)	Colleges and Universities (<5,000 EEs)	Colleges and Universities (5000+ EEs)	National Results
54	**Health status targets included in outcomes-based incentive program (among employers that offer outcomes-based incentives)**				
	Body mass index (BMI) or waist circumference	**	**	**	74%
	Weight loss target (even if short of BMI target)	**	**	**	43%
	Blood pressure	**	**	**	69%
	Cholesterol	**	**	**	60%
	Tobacco-use status	**	**	**	60%
	Glucose / HbA1c	**	**	**	57%
	Other	**	**	**	15%
	Number of respondents	**	**	**	141
55	**Benefit-eligible spouses / partners are able to earn outcome-based incentives (among employers that offer outcomes-based incentives)**				
	Yes, the same incentive as the employee	**	**	**	33%
	Yes, a different incentive	**	**	**	9%
	Yes, both the employee and spouse must meet the requirements to receive incentives	**	**	**	8%
	No, spouse / partners are not eligible	**	**	**	51%
	Number of respondents	**	**	**	141
56	**Employer opinion: How effective are your program's incentives in encouraging employees to participate in programs, comply with treatment protocols, or take other action to improve their health?**				
	Very effective	25%	**	30%	20%
	Effective	56%	**	50%	55%
	Not very effective	19%	**	20%	23%
	Not at all effective	0%	**	0%	3%
	Number of respondents	16	**	10	478

Section 6: Measurement and Evaluation

	Average score for section 6 (maximum score: 24 points)	10	8	13	9
57	**Data captured and used in managing the health and well-being program**				
	Participant satisfaction data	80%	84%	75%	46%
	Program participation data	80%	84%	69%	73%
	Process evaluation data (contact, opt-out, withdrawal rates)	40%	32%	50%	24%
	Population health / risk status data -- physical health	46%	26%	69%	50%
	Population health / risk status data -- mental health	37%	26%	50%	26%
	Health care utilization and cost data	66%	53%	75%	55%
	Disability & absence data	40%	16%	63%	22%
	Productivity and / or presenteeism data	9%	5%	13%	10%
	Organizational culture data	37%	32%	38%	26%
	None of these data are used to influence program decisions	3%	5%	0%	14%
	Number of respondents	35	19	16	764

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		Colleges and Universities (all sizes)	Colleges and Universities (<5,000 EEs)	Colleges and Universities (5000+ EEs)	National Results
58	**Stakeholders that regularly receive health and well-being program performance data and information**				
	Senior leadership	71%	58%	81%	61%
	Managers / supervisors (outside of health and well-being program)	26%	21%	31%	26%
	Employee population	20%	16%	25%	22%
	Spouses / DPs	0%	0%	0%	2%
	Program vendors	29%	21%	31%	22%
	Do not regularly share performance data with any stakeholders	23%	37%	6%	32%
	Number of respondents	35	19	16	758
59	**Frequency of communicating program performance data to senior leadership (among employers that regularly share performance data with stakeholders)**				
	4 times a year or more	4%	0%	0%	26%
	2-3 times a year	33%	17%	50%	29%
	Once a year	63%	83%	50%	41%
	Performance data are not shared with stakeholders on a regular basis	0%	0%	0%	4%
	Number of respondents	27	12	14	513
60	**Employer opinion: How effective are your data management and evaluation activities in terms of how they contribute to the success of your health and well-being program?**				
	Very effective	3%	0%	7%	7%
	Effective	51%	47%	53%	42%
	Not very effective	43%	47%	40%	38%
	Not at all effective	3%	5%	0%	13%
	Number of respondents	35	19	15	751

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Demographics				
Average total number of US worksites	15	**	23	68
Number of respondents	17	5	10	491
Average total number of employees in US	8,987	1,765	17,563	5,951
Number of respondents	35	19	16	760
Percentage of employees that are full-time	72%	71%	76%	85%
Number of respondents	32	18	13	725
Percentage of employees that are part-time	30%	32%	26%	13%
Number of respondents	32	19	12	723
Primary type of business:				
Manufacturing – Mining, construction, energy / petroleum	0%	0%	0%	4%
Manufacturing – products (equipment, chemicals, food / beverage, printing / publishing, etc.)	0%	0%	0%	18%
Transportation, communications, utilities	0%	0%	0%	3%
Services – colleges and universities (public and private)	100%	100%	100%	5%
Services – other educational organizations (public and private)	0%	0%	0%	9%
Services – financial (banks, insurance, real estate)	0%	0%	0%	10%
Services – health care (hospitals and health services)	0%	0%	0%	12%
Services – other technical / professional	0%	0%	0%	7%
Services – other	0%	0%	0%	9%
Retail / wholesale / food services / lodging / entertainment	0%	0%	0%	6%
Government (federal, state, city, county)	0%	0%	0%	4%
Number of respondents	36			770
Average age of active employees	46	46	46	43
Number of respondents	34	19	14	720
Average percent of male employees	44%	43%	49%	50%
Number of respondents	34	16	14	716
Average percent of employees in a union	16%	12%	22%	14%
Number of respondents	34	19	14	725
Average turnover rate	15%	11%	16%	15%
Number of respondents	29	17	11	597