



HERO EMPLOYEE HEALTH MANAGEMENT BEST PRACTICES SCORECARD IN COLLABORATION WITH MERCER[®]

ANNUAL REPORT 2014





A MESSAGE FROM THE HERO AND MERCER SCORECARD TEAM LEADERS

With this report, we look back with satisfaction on Version 3 of the HERO Scorecard while looking forward to even greater success with Version 4, which launched in June 2014. First, let's recall how far we have come. HERO and Mercer launched Version 3, the first online Scorecard, in 2009. More than 1,200 employers completed it, and many used it more than once to track progress over time. We published 18 commentaries using Scorecard data, looking at how specific best practices contribute to better outcomes. Articles citing Scorecard data, including a validation study showing that Scorecard participants with higher scores had lower medical claim costs, have appeared in peer-reviewed journals. Contributing immensely to this success have been the Scorecard Preferred Providers, now numbering 10 — these are organizations that use the Scorecard with their clients and serve as our advisors, lending their knowledge and experience to ensure that the Scorecard best meets employers' needs.

We have been thrilled with how well Version 3 was received and are proud of its role in advancing the use of best practices in employee health management programs. But the health management field has not been static — far from it — so we had to change, too. The HERO Scorecard Version 4 is the result of more than a year of discussions (and sometimes debates) among a panel of employee health management (EHM) experts, with review and input from some of the best thinkers in the field. We have added questions on practices that either did not exist or were just emerging when Version 3 was created — for example, outcomes-based incentives and gamification strategies. We have also been able to use our findings on which best practices have the biggest impact to shift emphasis in both the number of questions asked and the number of points allocated.

We are excited that nearly 100 employers completed the new Scorecard in just its first three months, and in this report we share a sneak preview of some of the aggregated responses, along with commentaries based on Version 3 results. Although it will take time to rebuild our benchmarking database to its former size, with a solid infrastructure in place and the learning curve behind us, we expect to power up very quickly. We believe you will agree that the up-to-the-minute inventory of EHM best practices, enhanced by what we have learned from hundreds of Scorecard participants over the past five years, will make the new Scorecard an even more valuable tool for the industry.

We thank you for your interest and support.

Jerry Noyce
CEO, HERO

Steven Noeldner, PhD
Partner, Mercer

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THE HERO BEST PRACTICES SCORECARD: A PROGRESS REPORT

Both a self-assessment tool and an ongoing research survey, the HERO Best Practices Scorecard helps employers, providers, and other stakeholders identify and learn about employee health management best practices.

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

Employers answer detailed questions about their EHM strategy 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 practices score but are used for benchmarking and to study relationships between specific best practices and outcomes.

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 for the first time in a web-based format — Version 3. 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 across the Scorecard questions 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 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 their experience and anecdotal evidence. Work on Version 4 began in 2013. A core team overhauled the Scorecard questions and an additional panel of experts reviewed their work (all contributors are listed on the HERO website). Analyses of Scorecard Version 3 data were used to refine the scoring system, although, particularly with the newer best practices, panel members again relied on judgment and other available research. Version 4 was released in June 2014.

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

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. Data from the earlier version of the Scorecard have been used for benchmarking and research. Five studies based on analyses of the Version 3 database are presented in this report; they examine such topics as the role of organizational support in successful EHM programs and whether wellness champion networks are associated with higher participation rates and behavior change. (A complete list of the commentaries based on Version 3 data, with synopses, is available on the HERO website: <http://www.the-HERO.org>.) In addition, an article describing a study that examined the claims data of HERO Scorecard participants and found that higher scores were related to lower medical plan costs was published earlier this year in the *Journal of Occupational and Environmental Medicine* (Goetzel et al, 2014;56(2):136–144).

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. Currently, benchmark reports based on Version 3 data may be purchased through the HERO website; we expect that reports based on Version 4 data will be available by the end of 2014.

THE SCORECARD PREFERRED PROVIDER PROGRAM

Broad employer participation is a priority for the HERO/Mercer Scorecard team for two reasons. First, a bigger 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. The Scorecard Preferred Provider Program, launched in 2011, extends the reach of the Scorecard by allowing qualified organizations in the EHM field to make it available to clients on their own websites. Currently, 10 organizations participate.

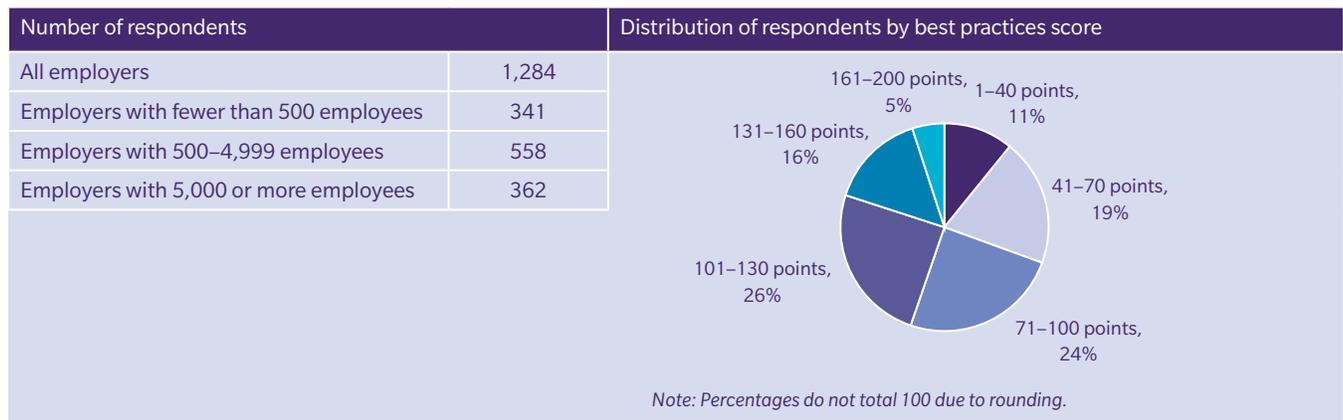
Each organization is provided with a custom link to the Scorecard, along with website content, template marketing materials, and training to assist in rolling out the Scorecard to its clients. At the end of each quarter, members are provided with a database of all Scorecard responses received through their own custom links (with individual company identifiers if the respondent has granted permission). The members participate in regular calls to provide feedback on the Scorecard and the Preferred Provider Program.

THE HERO SCORECARD PREFERRED PROVIDERS

<ul style="list-style-type: none"> Alere Health Blue Cross/Blue Shield of North Dakota Capital BlueCross Healthy Fit Healthyroads 	<ul style="list-style-type: none"> Kaiser Permanente Mayo Clinic Mercer Providence Health Care StayWell
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As of June 2014, participation in Version 3 of the Scorecard (now closed) had grown to more than 1,200 employers, with good representation of large, midsize, and small organizations. As of September 2014, more than 80 employers have completed Version 4.

Scorecard Respondent Profile (Version 3)



A FIRST LOOK AT VERSION 4 DATA

Beth Umland
Director of Research for Health & Benefits, Mercer

Taken together, the differences between Versions 3 and 4 of the HERO Scorecard tell the story of how the field of EHM has evolved over the past five years. While employers who have completed the prior version of the Scorecard will recognize many of the questions, about half of the questions are new or substantially revised. Key changes include:

- New questions on incentives, including outcomes-based incentives and intrinsic reward strategies.
- New questions on participation strategies to drive engagement, including the use of mobile apps and devices, challenges, and other social networking strategies.
- Updated questions on program design, including more detailed questions on lifestyle coaching.
- New questions on program integration, including disability and safety programs.
- A new section on program outcomes, with quantitative questions permitting the study of return on investment/value of investment.
- Additional demographic questions for more precise benchmarking.

In addition, the scoring system has been modified to shift points away from programs and participation strategies to organizational culture, program integration, and measurement. As a result, the same company might receive significantly different scores in Versions 3 and 4 of the Scorecard. When we launched Version 4, we assumed that, in general, average scores would be lower relative to Version 3 scores, reflecting the addition of relatively recent best practices not yet in common use.

More than 1,200 employers had completed Version 3 before we took it offline in June 2014, and by the end of August 2014 about 80 organizations had completed Version 4. Clearly, it is too soon to draw conclusions about the state of EHM programs based on this relatively small sample.

However, we can provide some early results that suggest how far the industry has moved in the past few years — with the caveat that any numbers cited here will likely change as the database grows. The Version 4 data represent the current status of programs in 2014, while the Version 3 data include information collected as early as 2009 from Scorecard completers (when employers have responded multiple times, the database includes only their most recent response).

STRATEGIC PLANNING

Past analyses of Scorecard data have shown that employers with a formal, written strategic plan for EHM in place were more likely to report that their program had helped to reduce health risks and lower medical plan cost. Just over half of the new Version 4 respondents (53%) have a formal strategic plan in place, compared to 44% of the Version 3 respondents. In both groups, participation is the most common measurable objective included in the plan. Version 4 respondents are somewhat more likely to include financial objectives — which, in past studies of Scorecard data, have been shown to increase the likelihood of positive financial outcomes. The Version 4 Scorecard includes a new objective — employee satisfaction, morale, and engagement — and half of the respondents with strategic plans say this measure is included in their plan. This section also includes a new question to gauge whether leaders understand the strategic importance of EHM: “To what extent is your EHM program viewed by senior leadership as connected to broader business results?” About a third responded “To a great extent,” while 17% reported that it is not seen as connected at all to results. Once we have accumulated enough responses, it will be valuable to compare the program outcomes between these two groups of employers.

ORGANIZATIONAL AND CULTURAL SUPPORT

Expanding on the leadership and organizational support components of Version 3, the Version 4 Scorecard incorporates critical organizational and cultural support strategies for EHM. For example, Version 4 asks about specific policies that support this commitment, such as allowing employees to use work time for physical activity

(36% of respondents do) or stress management (28% of respondents do). While 60% say that healthy food choices are available at the workplace, surprisingly, only 57% of respondents have a tobacco-free workplace or campus. More than a third of Version 4 respondents say that their company vision or mission statement supports a healthy workplace culture.

Analyses of Scorecard Version 3 data have shown that when leaders participate in EHM programs, participation rates are higher and outcomes are better. However, there was no improvement in this best practice from Version 3 (53% of respondents said leaders actively participate) to Version 4 (51%). And only 32% of Version 4 respondents say that leaders are role models for prioritizing health and work/life balance (for example, they do not send email while on vacation, they take activity breaks during the work day, and so on).

PROGRAMS

Version 3 of the Scorecard asked detailed questions about core EHM programs targeted to at-risk or chronically ill individuals. In recognition of the importance of creating a culture of health within an organization, Version 4 added questions about health behavior change programs that are offered to all individuals eligible for EHM, regardless of health status. Fully three-quarters of respondents offer these types of programs, and many incorporate new technologies and social strategies to promote engagement.

Using Technology and Social Strategies to Promote Engagement

Program incorporates use of tracking tools such as a pedometer, glucometer, or automated scale	46%
Program is mobile supported (e.g., allows individuals to monitor progress and interact via smartphone)	39%
Program incorporates social connection (e.g., allows individuals to communicate with, support, and/or challenge other individuals to form teams)	44%

PROGRAM INTEGRATION

Version 4 respondents still have plenty of room for improvement in terms of ensuring that their EHM programs are effectively integrated with each other, the health plan, the safety program, and disability programs. For example, just 29% of Version 3 respondents said that “stakeholders are required to provide warm transfer of employees to another program.” Similarly, just 33% of Version 4 respondents say that “EHM partners provide warm transfer of individuals to programs and services provided by other partners.” Furthermore, only 21% of Version 4 respondents say that the EHM program is integrated in any way with disability programs.

PARTICIPATION STRATEGIES

Participation strategies, which include communication and incentive design, significantly affect participation rates and program outcomes. Our past research had shown that financial incentives help drive participation rates, but communication efforts are even more strongly related to positive health and financial outcomes. Branding the EHM program with a unique name and logo was found to be especially helpful in earlier analyses, but only 59% of Version 4 respondents use this tactic, little changed from 56% of Version 3 respondents.

Looking at incentive design, nearly three-fourths of Version 4 respondents use some type of financial reward or penalty in connection with the program, with most of these incentives (nine out of 10) communicated as rewards. While incentives for participating are the most common, a third of respondents that use incentives say that employees have a financial incentive to achieve, maintain, or show progress toward specific health status targets. Respondents report that, on average, 59% of eligible employees earn at least some of the available incentive and 42% earn the maximum incentive. While financial incentives are widely used, 33% of respondents say that their engagement strategy intentionally includes a focus on increasing employees’ intrinsic motivation to improve or maintain their health. The majority use some type of social strategy to build engagement. For example, 67% use competitions or challenges, and 40% connect participation to a cause. This is an area that we will study closely as the database grows, as participation strategies are diverse and best practices are still being determined.

MEASUREMENT AND EVALUATION

To continually improve an EHM program, an employer needs to measure its performance. Despite the importance of measurement and evaluation, this work is still challenging for employers. Fewer than half of Version 4 respondents believe that their data management and evaluation efforts are contributing significantly to the success of their program. While 68% capture participation data and 61% look at health care utilization and cost data, about half use health risk data and only 20% use productivity data to evaluate EHM performance.

OUTCOMES

One of the big challenges facing the EHM community is proving the value of investment. One of the goals of the new Scorecard is to assist in this task by providing employers with a set of metrics to use in measuring the full range of

outcomes — not just financial returns. The metrics included within the Version 4 Scorecard reflect the measures outlined within the *HERO/Population Health Alliance Program Measurement and Evaluation Guide: Core Metrics for Employee Management*. The inclusion of these recommended measures within the outcomes section of the Version 4 Scorecard will not only allow HERO to guide employers in their measurement but also provide a valuable benchmark to HERO Scorecard completers. Although it is too soon to report on the outcomes data collected in Version 4, we expect to use these results to evaluate the impact of using EHM best practices more precisely than was possible in the past.

EMPLOYER SCORECARD EXPERIENCE: CAPITAL BLUECROSS

For more than 75 years, Capital BlueCross has served residents and businesses in central Pennsylvania and Lehigh Valley as the region's leading health insurer. Additionally, employers turn to Capital BlueCross to develop, implement, and evaluate worksite wellness programs.

The premise of worksite wellness programs is to apply strategies that promote good health and lower the risk of chronic disease. These programs have the power to lower health care costs, decrease absenteeism, and increase productivity. Capital BlueCross believes that it helps organizations create effective worksite wellness programs by working from the inside out. The organization views its efforts to help employees live healthier as a key component of the employee engagement strategy for business success. The HERO Scorecard has been a valuable tool for the organization's Wellness Committee and supportive senior management, as they have worked together with employees to build a comprehensive wellness program that garnered top favorability scores in a recent employee engagement survey.

"Just from the nature of our work to improve the health of the community, we have always maintained a focus on the health of our own employees," says Gina McDonald, senior health coach at Capital BlueCross. "As with most organizations, however, it has been an evolutionary process to build the robust worksite wellness program we have at our company today. Fortunately, we have a senior

leadership team that believes in the importance of creating a culture of health and an employee base willing to embrace it."

Capital BlueCross' wellness program has grown to provide a comprehensive array of traditional programs and services with high participation, as well as state-of-the-art mobile applications and both digital coaching and face-to-face health coaching. Nutrition-related classes and collaborative efforts with the food service vendor have been well-received, as have self-defense classes for the predominantly female workforce. The rewards structure has evolved over time, gradually shifting emphasis to taking action to improve one's health from participating in awareness campaigns and self-reported activities. Achieving and maintaining high levels of mid-management support are aided by a CEO who regularly highlights the importance of employee wellness at company-wide management meetings.

"Using the HERO scorecard as a benchmark each year has enabled Capital BlueCross to identify areas of strength and areas of augmentation within our programming," says McDonald. "Now we have quantitative data that support our worksite wellness offerings, changes, and improvements. Simply put, the HERO Scorecard provides us a trusted framework for employee wellness programming and continued improvement. That's important to Capital BlueCross, because our workforce truly is our most important asset."

CAN THE HERO SCORECARD PREDICT HEALTH CARE COST TRENDS AND EMPLOYEE HEALTH RISKS?

Ron Z. Goetzel, PhD
Truven Health Analytics

Originally published January 2014

In 2013, HERO commissioned Truven Health Analytics and Emory University to conduct a research study that would examine the HERO Scorecard's ability to predict health care cost trends for large employers, as well as their employees' risk profiles. The study was published in the *Journal of Occupational and Environmental Medicine* in February 2014, in an article authored by researchers at Truven Health and Emory University and several HERO members, including Jessica Grossmeier, Shawn Mason, Dan Gold, Steve Noeldner, and David Anderson. Funding for the research was provided by HERO Research Partners Charter Members, including Alere, HealthFitness, Healthways, Kaiser Permanente, Plus One Health Management, Prudential Financial, StayWell Health Management, and University of Pittsburgh Medical Center.

WHY DID HERO COMMISSION THIS STUDY?

We know that well-designed, comprehensive, and evidence-based workplace health promotion programs can improve the health risk profile of employees and lower their health care costs. However, too few US employers provide effective programs, often because they lack the tools and knowledge to design and implement world-class EHM programs.

The HERO Scorecard was developed to help employers measure the extent to which their programs align with industry best practices. The Scorecard is now one of the most widely used organizational health assessment tools, with over 1,000 employers completing the survey. Employers who complete the survey use their scores to evaluate their program's success, but until now, they did not really know whether a good score could predict outcomes important to businesses — health care cost trends and employees' health risks.

This study tested the validity of the HERO Scorecard by asking a question: Are higher scores on the tool associated with reductions in health care costs? The study also looked at the Scorecard's ability to predict changes in employee health risks.

HOW DID WE CONDUCT THE STUDY?

The study team identified organizations that completed the HERO Scorecard and contributed medical claims and health risk data to the Truven Health MarketScan databases. MarketScan contains longitudinal, fully integrated, and de-identified person-level claims data (inpatient, outpatient, drug, lab, and health risk assessment) collected from Truven Health employer clients. We isolated the data for the 33 HERO Scorecard contributors identified and then measured their employees' annual health care expenditures and health risks for the period of 2009–2011.

Over 700,000 employees from the 33-company sample were studied across three years. First, we looked at overall cost and health risk trends for these employers and then separated the experience of companies scoring "high" on the HERO Scorecard (with scores between 100 and 200) compared to those scoring "low" (with scores of 0–99). We developed a multiple regression model to predict health care costs and employee health risks based on employers' high or low scores.

WHAT DID WE FIND?

In general, the 33 companies in our study scored higher in each of the six sections of the HERO Scorecard and overall compared to the "average" HERO Scorecard respondent. This is likely because the study sample group comprised Truven Health clients that are generally larger companies with more extensive resources and "know how" to direct at workplace health promotion programs.

Predicted Average Annual Health Care Expenditures (Adjusted to 2012 Dollars) for Organizations With High and Low HERO Scores



When comparing the low-scoring to high-scoring HERO companies, those with low scores maintained their health care spending while organizations with high scores experienced an average of a 1.6 percentage point annual reduction in health care expenditures during the study period (adjusted for medical inflation).

We also found that low-scoring organizations had more employees at high risk at the start of the study period, compared to organizations with high HERO scores. However, over the three-year study period, organizations with low HERO scores achieved significantly greater reductions in three of the four risk factors studied (obesity, high blood pressure, high total cholesterol, but not high blood glucose) when compared to organizations with high HERO scores that also reduced their employees’ health risks but at a slower pace.

WHAT CONCLUSIONS CAN BE DRAWN FROM THE STUDY?

Organizations scoring high on the HERO Scorecard experienced better (reduced) health care cost trends compared to low HERO scoring companies. Interestingly, almost all of the organizations achieved either a reduction in health care costs or stabilization in those costs during the study period. This may be because these companies were more focused on managing employees’ health and related costs, which may have prompted them both to complete the Scorecard and to seek solutions to the root causes of increasing health care costs and poor health among their employees.

Our analysis of health risk trends was limited by the small number of organizations contributing health risk data on their employees to the MarketScan databases. In this secondary analysis, we found that low-scoring companies achieved greater reductions in three out of four health risks studied when compared to the high-scoring companies, but these low scorers had employees at higher risk at baseline. In the *Journal of Occupational and Environmental Medicine* article, we discuss some possible explanations for these results, but, in the end, we concluded that the small number of employers in the study (especially in the health risk analysis) limits our ability to draw broad generalizations from the data. As might be expected, we call for additional research on the predictive power of the HERO Scorecard.

In sum, building and validating an organizational assessment tool takes time and effort. The HERO Scorecard has undergone extensive scrutiny by experts and laypersons alike, and will continue to be refined and enhanced. Its widespread adoption by the business community speaks to its ease of use and face validity. While more testing is certainly needed, employers can today confidently employ the Scorecard to design, implement, and evaluate their worksite health promotion programs.

STRATEGIC PLANNING — A PATH TO GREATER HEALTH IMPACT

Seth Serxner, PhD, MPH
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Originally published January 2013

Over the past few years, employers have been increasing their investment in EHM, adding new programs and offering employees financial rewards for participating. Among employers completing the HERO Scorecard in 2009–2010, the median EHM program cost per eligible person per month was \$10; among those responding in 2011–2012, it was \$13. However, the use of formal strategic planning for EHM has not kept pace, and some employers may be missing an important opportunity to maximize their growing investment in EHM.

The HERO Scorecard assesses six broad dimensions of EHM best practices: strategic planning, leadership engagement, program-level management, programs, engagement methods, and measurement and evaluation. Each of these sections is scored individually. A recent analysis of the HERO Scorecard database looked at both respondents' section scores and individual best practices within each section to gauge their impact on various measures of EHM program performance. As discussed below, this analysis suggests that strategic planning is a critical success factor in engaging employees, improving health, and achieving health care cost savings.

STRATEGIC PLANNING ACTIVITY

The Scorecard section on strategic planning asks employers about their use of best practices, such as having a written plan, measurable objectives, and strategies for addressing different portions of the population. At the end of the section, employers are asked to rate the effectiveness of their planning process. More than half of respondents — 57% — said they did not have a formal written strategic plan regarding EHM, and 18% take planning one year at a time. Only 25% have a multi-year strategic plan in place.

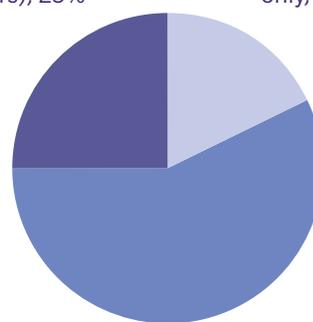
These findings seem surprising since most business decisions involving significant human capital and financial investment occur within a strategic business planning context. Why would investment in EHM be any different? This finding sets the context for the results of the self-assessment question — almost half (47%) of respondents do not believe that their strategic planning for EHM has been effective.

EHM: Relatively Few Employers Plan Ahead

Have a formal, written, strategic plan for EHM

Have a long-term plan
(2 or more years), 25%

Have an annual plan
only, 18%



Don't have a formal plan, 57%

STRATEGIC PLANNING IMPACT ON ENGAGEMENT, HEALTH, AND COST SAVINGS

While strategic planning may seem like an obvious element in successful program implementation and outcomes, this analysis pointed to a direct relationship between the two. In fact, of the six best-practices categories, strategic planning was among the top three in terms of driving greater engagement, improved health, and medical plan savings. Strategic planning had the greatest impact on health improvement of all the categories. Nearly nine out of 10 respondents who rated their organization as having very effective or effective strategic planning for EHM (86%) reported seeing health improvement, compared to only 5% of those who rated their strategic planning as ineffective. These two groups also reported very different health assessment participation rates (a key measure of employee engagement) — 59% of eligible employees compared to 35% for those rating their strategic planning as, respectively, effective and ineffective. Only the use of incentives had a bigger impact on health assessment participation rates.

Finally, effective strategic planning was also closely linked to medical plan cost savings, with only communications and incentives having stronger relationships. One important reason employers with strategic plans report better outcomes is that many of these plans include measurable objectives. Most (85%) include objectives for program participation, while 71% include objectives for health risk reduction and 56% include financial objectives.

Overall, strategic planning, which in many cases drives communications strategy, leadership involvement, employee engagement, and programming, is a critical best practices that can often be overlooked in the rush to “get started” and just implement a program — and then be overlooked again as the program grows from a small initiative to a significant investment. This analysis supports the importance of the strategic planning process to increase the likelihood of achieving positive program outcomes.

EMPLOYER SCORECARD EXPERIENCE: THE VALLEY HEALTH ALLIANCE

The Valley Health Alliance (VHA) was established in 2013 by five employers* within the Colorado Roaring Fork Valley to foster health care and wellness activity that:

- Is affordable and accessible.
- Focuses on improved health, appropriate care, and controlled costs.
- Fosters collaboration among employers, providers, and patients.
- Is financially sustainable for employees, employers, and providers.

As a first step, the VHA engaged in a three-year pilot project focused on creating a culture of health within its community, taking an evidence-based, best-practices approach. The launch of the HERO Scorecard Version 4 was well-timed for the VHA, as it helped each member organization identify priorities for enhancing population health.

In an effort to establish a baseline, identify opportunities, and prioritize the strategic approach, each of the five VHA employer organizations completed the HERO Scorecard with assistance from Mayo Clinic Global Business

Solutions, a HERO Scorecard Preferred Provider. “The process allowed each organization to identify strengths and opportunities within each best practices area and aggregate VHA data to identify key opportunities to accomplish specific goals,” says Jennifer Flynn, MS, Mayo Clinic strategy consultant.

After reviewing its HERO Scorecard results, the VHA decided to develop a brand and work on creating a strong image for the organization. It will also launch campaigns around health risk assessments, biometric screenings, and flu shots, as well as capture key metrics to use for strategic planning going forward.

As executive director of the VHA, Kathleen Killion noted that “the HERO Scorecard allowed VHA to identify best practices that are already in place, opportunities for collaboration, and enhancements that can significantly impact the success of our initiative.” The VHA is now armed with actionable data to strategically focus its efforts on the needs and health of the community and build a culture of health.

*Aspen School District, Aspen Skiing Company, Aspen Valley Hospital, City of Aspen, Pitkin County

UNDERSTANDING THE IMPORTANCE OF ORGANIZATIONAL SUPPORT

Jennifer Flynn, MS
Strategy Consultant, Mayo Clinic

Originally published April 2013

Although supporting the health and well-being of employees might seem to be a given within organizations that provide EHM programs, we are learning that organizational support is a key factor in program effectiveness. Experts in the field have been working to define the elements of organizational support and demonstrate how the degree of support (type, quantity, and quality) correlates with program outcomes.

Organizational support can be defined as the degree to which an organization commits to the health and well-being of its employees. Furthermore, the formal and informal programs, policies, and procedures within an organization that “make the healthy choice the easy choice” are recognized as the deliberate steps that define organizational support. Recognized as an important dimension of an organization’s culture, companies have begun to focus on organizational support within their overall strategy and programming in an effort to create a “culture of health.”

The Scorecard assesses many of the foundational elements of organizational support — which are by no means found in all organizations. For example, 34% of Scorecard respondents report that their corporate mission statement supports a healthy workplace culture. Senior leadership participates in program initiatives in 52% of Scorecard organizations. Employees are recognized for healthy behaviors in 50%. Fitness facilities or walking trails are provided by 60%. While no one best practices will make or break a health management program, analysis of the Scorecard database suggests that programs that incorporate the most organizational-support best practices are the most likely to report overall program success.

ORGANIZATIONAL SUPPORT LENDS ITSELF TO GREATER USE OF BEST PRACTICES

Using the HERO Scorecard database, an analysis was conducted to test the hypothesis that companies that provide a greater degree of organizational support reap

the benefits of better outcomes. Three degrees of organizational support were created (low, medium, and high), based on the use of best practices in the areas of leadership support, employee involvement, supportive environment, health policies, programs/resources, strategy, and rewards. We learned that those companies that report a higher level of organizational support not only have an overall higher score on the HERO Scorecard but also have higher scores within each section of the Scorecard. In other words, the companies that provide a greater degree of organizational support are stronger in all best practices areas.

GREATER ORGANIZATIONAL SUPPORT, BETTER OUTCOMES

Many companies judge the success of their programs based on employee participation and engagement, positive health trends, and improvement in health care spend. When we reviewed these outcomes for companies with high organizational support and compared them to those with a low degree of support, we found that the average participation in health assessments, biometrics screenings, disease management programs, and lifestyle change programs increased as the degree of organizational support increased.

Participation Rates Rise With the Level of Organizational Support for Health

Program component	Average program participation rate		
	Low support	Moderate support	High support
Health assessment	30%	46%	59%
Biometric screenings	33%	45%	53%
Disease management programs	15%	24%	27%
Lifestyle change programs	13%	21%	28%

In addition to participation, we also found that companies with higher degrees of organizational support reported greater success in managing health trend and cost spend: 71% of companies with a high score in organizational support reported a slight or significant improvement in health risk, in comparison to 23% for those companies with a low score in organizational support. In addition, 27% of companies with a high organizational support score reported that the program has had a substantial positive impact on medical trend, in comparison to 9% of companies with a low organizational

support score. High-scoring companies also collected more data for the management of their programs and reported program performance more frequently to key stakeholders.

The role of organizational support in creating a culture of health is drawing a great deal of attention among those working in EHM today. This analysis helps confirm the value of support by the organization and its importance in achieving positive outcomes.

EMPLOYER SCORECARD EXPERIENCE: UNIVERSITY OF SAN DIEGO

As a nationally ranked Catholic university, the University of San Diego (USD) is committed to advancing academic excellence, expanding liberal and professional knowledge, creating a diverse and inclusive community, and preparing leaders dedicated to ethical and compassionate service. This commitment extends to faculty and staff.

USD found value in completing the HERO Scorecard prior to the implementation of an EHM program. USD has always offered wellness-related events to its employees. However, in 2012, the Human Resources department took the first steps to create a comprehensive, coordinated program, called Being Well @USD. USD worked in tandem with its carrier partners to design the program. It was through its relationship with Kaiser Permanente that USD first learned of the HERO Scorecard.

USD's first use of the HERO Scorecard, taken prior to any actual implementation, resulted in a low score — 64 out of 200 points. The Being Well @USD team understood the value of a baseline from which it could chart progress.

Furthermore, the team understood that the Scorecard could serve as a valuable primer to EHM because each question in itself is a best practices. During the first program year, the team focused on improving USD's score on the sections in which it scored low, in particular Programs and Engagement Methods. Prior to the start of the program's second year, the team used the HERO Scorecard again, achieving a score of 159. Besides serving as a design and implementation guide, the HERO Scorecard, with its strong research base, lent much-appreciated academic credibility.

As Nina Sciuto, director of employee relations for USD, states, "We knew generally where we wanted to go with Being Well @USD, but the HERO Scorecard gave us definitive directions to get there. In the process, it also has given us both more confidence and a more robust picture of what the program really could be."

THE ROLE OF STAKEHOLDER AND EMPLOYEE ASSESSMENT IN GUIDING EHM PROGRAMS

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To build or expand an EHM program, it is important for organizations and their leaders to understand their current program. An organizational assessment can help determine the progress, limitations, and future strategies and goals for a program. To be most effective, the assessment should look not only at current wellness programming but also at the many factors that affect it: workplace culture, leadership support, environment, communication methods, employee health benefits and policies, and access to data to evaluate the program. Ideally, comprehensive EHM assessments are done prior to developing new initiatives and then repeated every two to three years to measure progress and to identify opportunities for improvement.

The Scorecard was designed to help organizations gather information about their EHM programs and to provide them aggregate information for use in benchmarking — on national, regional, industry, and employer size bases. As best practices evolve, so does the Scorecard, and a significant revision was released this year with Version 4. The HERO Scorecard and other employee health assessment instruments emphasize the importance of leadership engagement and employee involvement. One way to build engagement among leaders and employees is by actively involving them in the assessment process. This can be accomplished in a number of ways, including key stakeholder interviews, focus groups, and employee surveys. These assessment tools are described below.

KEY STAKEHOLDER INTERVIEWS

The purpose of the key stakeholder interview is to better understand the link between business operations and employee health and performance while identifying potential causes of poor health and loss of productivity. Key stakeholders usually include the chief executive officer or president, chief financial officer, and one or more vice presidents. Results from the interviews help shape a program's overall mission, goals, and strategy. Interview questions usually include gathering information about the organization's current commitment to, and understanding of, employee health as it relates to business operations; the

current participation and involvement in programs from all levels of the organization; an understanding of what success in optimizing employee health looks like and how stakeholders would like it measured; and perceptions of critical health issues. Key findings from the interview should be summarized and reported to the stakeholders and used in strategic planning for the program.

FOCUS GROUPS

Employee focus groups can help organizations elicit suggestions for ways that EHM programs may better meet the needs of employees and their family members. Each focus group is usually composed of an experienced facilitator and six to 10 individuals, with enough groups conducted to ensure good representation from across the organization. The focus group session will usually last up to one hour. Focus groups can serve as an opportunity to collect information on the health and wellness issues about which employees are concerned, as well as to explore options for the best delivery of programs and services, which may include individual coaching sessions, group classes, online courses, self-guided study programs, books, or brochures. Additionally, key questions include barriers to participation in current program offerings and methods to help gain additional support for the program. This feedback will help organizations better design effective communication tools and health improvement opportunities that best meet employee needs and preferences.

EMPLOYEE SURVEYS AND DEMOGRAPHIC ANALYSIS

To better understand the opportunities for enhancing participation levels, program managers should consider important employee and plan member demographics. Working with the organization's human resources, finance, and health and safety departments allows an organization to capture data on employees and dependents based on gender, age, educational level, and job role, as well as information on absenteeism due to personal illness, health care costs, and worker's compensation costs for the previous three years. This information assists in the design of health and safety interventions.

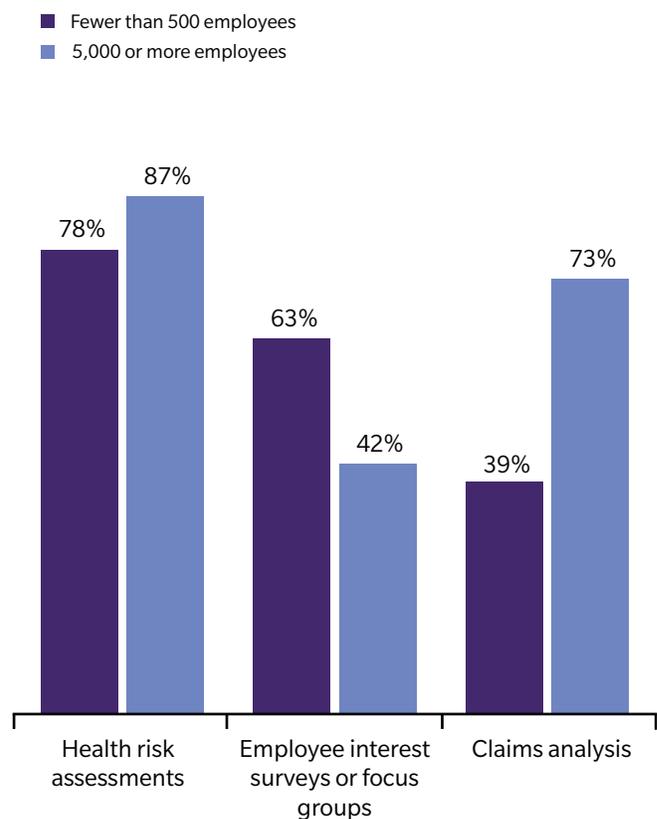
Another aspect of program planning is to explore health disparities that may exist among people of varying race, ethnicity, gender, age, income level, and geographic location. In considering the demographic profile of an organization, several significant issues must be considered in disseminating information and resources. Health resources must be provided to address differences in health literacy and be time sensitive to attract all segments of the workforce. Efforts must also be made to target health improvement solutions not only for the employee but also for the employee’s spouse and family members.

In addition to gathering data from employee surveys, an organization may want to consider gathering health care cost data. By gathering these data, an organization can identify the most critical health issues for its particular workplace based on the category of disease and cost of medications. Information may include a review of the past three years for health care claims and other health-related information.

The majority of the HERO Scorecard respondents — 81% — have assessed employee health needs. However, fewer than half of these assessments included focus groups or employee surveys. Interestingly, the largest employers are the least likely to use surveys or focus groups. Among respondents with 5,000 or more employees, most say they use claims data (73%) and health risk assessments (87%) to learn about their employees’ health needs, while just 42% use employee interest surveys or focus groups. Among employers with fewer than 500 employees, 63% use employee interest surveys or focus groups; 78% use health risk assessments, but just 39% use claims analysis.

Although smaller employers may not have the technology platforms or access to health-related claims information, such as medical claims and disability data, they have higher rates of participation in employee interest surveys and focus groups. If they are not already doing so, larger employers may wish to consider enhancing their current efforts by incorporating such surveys and focus groups into their assessment process.

Methods Used to Learn About Employee Health Needs



The role of stakeholder and employee assessment in shaping an organization’s employee health goals and strategy, and ultimately in creating a healthy work environment and culture, continues to be a valuable opportunity for all organizations.

WELLNESS CHAMPION NETWORKS ASSOCIATED WITH MORE SUCCESSFUL PROGRAMS

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Many US-based companies create employee wellness champion or health ambassador networks to build grassroots support for their health management programs. Of 1,154 organizations that completed a HERO Scorecard, 52% reported having such a network in place. One reason that nearly half of the responding organizations have not established wellness champion networks might be that there is little research on their effectiveness. Much of the existing effectiveness research is based on models in which individuals are trained to provide support for peers addressing a specific health need (such as weight management or diabetes self-care), rather than to encourage good health practices and participation in local-level wellness programs (*The Art of Health Promotion*, September/October 2013). Additional research is needed to support the value proposition and outcomes associated with this broader wellness champion role.

An analysis of HERO Scorecard responses was conducted to determine whether organizations with wellness champion networks had higher participation rates in programs, better health outcomes, or better financial cost impacts than organizations without wellness champion networks in place. Of the organizations represented in the analysis, approximately a fourth (26%) had fewer than 500 employees.

While about half of respondents had wellness champion networks, 29% reported having an organized network of individuals at most worksite locations with formal internal communication channels and periodic meetings — in other words, a very robust initiative — while 23% reported having wellness champions at some worksite locations who received internal communications. As might be expected, those with higher overall HERO Scorecard scores were more likely to have the most robust wellness champion networks. When the respondents were divided into three groups of equal size based on score, 53% of those in the highest category of HERO Scorecard scores had the most robust level of wellness champion support, compared to only 9% of the lowest-scoring organizations.

Since larger organizations tend to have higher scores, the analysis was stratified based on organization size. Unlike trends observed for many of the health management practices in the HERO Scorecard, smaller organizations were more likely to have the most robust levels of wellness champion network support for their EHM program in every score category. In the highest-scoring category, smaller organizations were about 11% more likely than larger organizations to have an organized wellness champion network. One reason for this may be because smaller organizations have fewer locations, making the network easier to develop and manage.

Respondents are asked to provide program participation rates and an assessment of the impact of their program on health risk and medical plan cost; about 400 employers provided responses to these optional questions. An analysis of this data found little association between the level of wellness champion support and participation rates in various program components. However, in examining the influence of wellness champion networks on outcomes, a much stronger association was observed. Since the earlier descriptive analysis indicated that organizations with higher levels of support also had higher HERO Scorecard scores, a stratified analysis was conducted based on organizations with the highest category of scores. Among organizations with an organized wellness champion network or wellness champions at some locations, 61% reported significant impacts on health risks, compared to only 35% of organizations that recruit volunteers or with little or no grassroots support. Similarly, 56% of organizations with the highest levels of support reported a substantial positive impact on medical trend, compared to 44% of organizations with the lowest levels of support.

While the lack of association between wellness champion support and participation rates may be surprising, this analysis is consistent with findings reported in a research study published in the *Journal of Occupational and Environmental Medicine*. The study was based on HERO Scorecard data for 57 companies working with a single national provider of wellness programs. As was reported

Employers With Wellness Champion Networks Report Better Outcomes

	Have seen significant improvement in:	
	Health risks	Medical trend
Employers with robust wellness champion networks	35%	28%
Employers with wellness champions at some locations	26%	28%
Employers that recruit volunteers to help with EHM activities	14%	23%
Employers with little or no grassroots support for EHM	21%	21%

here, the researchers found that use of a wellness champion network was strongly associated with behavior change, but they did not detect a significant association with participation rates in telephonic coaching programs.

CONCLUSION

While firm conclusions cannot be drawn from these correlational analyses, the results provide preliminary support for the value of wellness champion networks. The data demonstrate that organizations with an organized wellness champion network have better health and financial outcomes. It would be helpful to better understand the roles and responsibilities of wellness champions as well as determine the mechanisms underlying the observed relationships.





For further information, please visit our websites at:

www.the-HERO.org

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