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naspe

ROUNDTABLE DISCUSSION: EXPERT VIEWS ON STATE EMPLOYEE HEALTH CARE

JULY 1, 2011



Acknowledgements

State health care, personnel and benefits officials who manage employee health care plans are responsible for some of the largest programs in state government, and today they face unprecedented challenges. Written as an update to a white paper produced in 2010, this paper is intended to help state officials understand the current environment, and serve as a resource to those proposing and implementing changes that will help their states and plans weather an ongoing economic storm.

Like the 2010 paper, this work is the result of meaningful contributions from several organizations and individuals that deserve acknowledgement. University of Chicago graduate students¹ Jonathan Birnberg, M.D.; Katie Meyer; and Cassie Yarbrough took direct ownership of this initiative and the white paper. The insights captured during the roundtable of state experts and the creation of this document is due entirely to their tremendous work. The roundtable participants included Dan Hackler, IN; Vinita Biddle, CO; Karen Fassler, CO; Susan Rodriguez, RI; Nicole Oishi, WA; Eva Santos, WA; Dean Fausset, WY; and Tammy Till, WY. These officials generously agreed to share opinions and anecdotes about successes and challenges in their states. Finally, I also want to again thank the University of Chicago and Laura Botwinick, Director of the University's Graduate Program in Health Administration and Policy.

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During this time of unprecedented challenges, our partnerships and collaboration will continue to hold the keys to our success. We hope this paper helps in that effort.

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Introduction

THE IMPORTANCE OF WELLNESS AND DISEASE MANAGEMENT PROGRAMS

In 2010, the University of Chicago, the National Association of State Personnel Executives (NASPE) and UnitedHealthcare³ collaborated on a white paper entitled “Challenges & Current Practices in State Employee Health Care,” which documented widespread investment among interviewed states in wellness and disease management programs. While nearly every state surveyed identified wellness and prevention and/or disease and chronic care management as top priorities, challenges to program effectiveness – and overall health care administration – were also identified. These challenges included employee engagement, data quality, proving return on investment, and rising costs.

As a follow-up to the paper’s release in July, a roundtable of state personnel executives convened at the University of Chicago on October 22, 2010. The roundtable consisted of personnel from Colorado, Indiana, Rhode Island, Washington and Wyoming. Officials from these states discussed in-depth the selection and implementation of wellness and disease management programs. Following the roundtable and additional subject matter expert interviews, this paper was produced to offer insight into program adoption and implementation challenges, as well as the steps taken to overcome them.

BACKGROUND OF WELLNESS AND DISEASE MANAGEMENT PROGRAMS

Broadly defined, wellness programs are designed to reduce the occurrence of chronic illnesses and mitigate the risk factors for disease by encouraging healthy lifestyle choices and preventive health measures. Examples of wellness program components may include checkups, vaccinations, and diet and exercise regimens. Disease management programs typically address specific conditions, such as diabetes or hypertension, with the goal of improving adherence to recommended therapies and reducing complications associated with chronic disease. The goal of each: Improve the health of participants and reduce health care costs.

The United States health care system currently emphasizes secondary care for individuals that are already sick, as opposed to preventive care to avoid the onset of illness and disease. While primary care physicians concentrate on preventive screening, health behavior practices, and effective treatment of chronic conditions, this type of care is not rewarded in the health care payment system. In addition, the country’s current shortage of primary care physicians challenges the system’s ability to manage chronic conditions, and drives reliance on expensive specialist care.

Given the rise of chronic diseases, the shortage of primary care physicians, a fragmented health care delivery system, and the lack of wellness and preventive health care, soaring health care costs are inevitable. Curbing these costs requires enhanced prevention of disease, better

care coordination, and improved self-care. To that end, wellness and disease management programs have gained widespread appeal in the private sector and have the potential to demonstrate a large return on investment (ROI).⁴ While state governments have not had extensive experience implementing and evaluating these programs, they have the potential to recoup even larger savings compared to the private sector. This is due to the fact that state governments tend to have an older workforce with higher risk and prevalence of chronic conditions. In addition, states have a lower rate of employee turnover than the private sector, allowing the states to realize the long-term benefits of effective wellness and disease management programs.

On the other hand, state personnel executives face unique political and budgetary pressures that present challenges to wellness and disease management program implementation. With most states facing severe budget deficits, new programs must either refrain from adding debt or promise a measurable return on investment. While state personnel executives agree that wellness and disease management programs have the potential to realize significant savings, designing and implementing such programs can be initially expensive, politically controversial, and fail to realize returns in the short-run.

Therefore, this paper focuses on the steps that executives recommend for proposing, designing and implementing effective wellness and disease management programs, including:

- Building stakeholder support
- Driving employee engagement
- Measuring impact and return on investment

SECTION I: Building Support

To build support for a wellness or disease management program, it is important to develop and present a plan to key stakeholders. Components of the plan should include program selection, required resources and an implementation timeline. The type of key stakeholders to engage in the proposal process may include the governor's office, the state's budget office, state employee union leaders and members, and the legislature. A champion for the program should also be identified from among these or other stakeholder groups.

PLAN STRATEGY

Program Selection and Challenges

Selecting a program is the first step. There is wide variation between wellness and chronic disease management programs, but most focus on encouraging healthy behaviors and cost-effective health care utilization.

Wellness programs may use a combination of interventions, such as health risk assessment and onsite health screenings, to identify health risk factors and provide suggestions to

Washington's Data-Driven

Approach: Washington's state employee health plan, UMP, offers a Medication Therapy Management program to its members who take more than eight different medications on a daily basis. After review of members' prescription drug claims histories, it was discovered that many members could benefit from better prescription drug management. The program is inexpensive and the plan covers a one-on-one consultation session between the member and their normal pharmacist, resulting in fewer prescriptions being covered by the plan.

address these risks. Other wellness programs may simply encourage employees to visit their primary care physician or comply with recommendations for preventive health, such as mammograms and annual checkups. Wellness programs may also be less specific to the individual and involve changes to the work environment, such as providing nutritious meals and snack options, or an onsite workout facility.

Many disease management programs are based on the Chronic Care Model that promotes better coordination of care and improved patient engagement.⁵ Improved coordination of care may focus on identifying gaps in care and sending notifications to doctors' offices. For example, vendors can use medical claims data to identify patients with diabetes that do not participate in treatment programs. Upon identification, vendors can notify a patient's physician in an effort to increase patient participation – in some cases through a phone call, email or text message.

The strategies that state personnel executives employ to choose a wellness or chronic disease management program will vary by state. For example, the state of Washington described two approaches to program selection.⁶ The first is a data-driven approach that determines the number of patients

that would benefit compared to the cost of the program. The second approach requires employee benefit board approval. In many states, changes to employee benefit programs stem from government mandates. Additionally, vendors and insurance companies may propose new ways to streamline delivery of care for diseases such as diabetes and heart disease.

RESOURCES FOR IMPLEMENTATION: BUDGET AND TIMELINE

For most stakeholders, the decision to support a new program relies heavily on financial considerations. In an ideal scenario, states would pick the program first, and then create a budget. However, given current fiscal challenges, states will most likely start with an estimation of available funds and then pick a program that maximizes health outcomes. States not only have to detail the budget, but must also outline the expected return on investment. Estimating return on investment requires an effective evaluation plan, which is detailed in the third section of this paper.

KEY STAKEHOLDERS

Any successful initiative begins with winning over stakeholders to gain support and funding. The October roundtable participants agreed that winning support from key stakeholders is critical during the current political and economic climate.

While government decision-making positions vary by state; in most states the governor, legislature, budget officers, and employee unions have a role in program approval and funding.

Governor's Office

Any large initiative that would alter benefits is best undertaken with top-down support from the governor's office. Whether from the Governor or the Governor's staff, visible senior-level leadership is a must. The Governor's leadership does not necessarily need to take the form of a policy or legislative push. Hosting wellness kick-off events, issuing press releases, and engaging in healthy activities are all beneficial methods toward building support for an effective wellness program. Hank Scheff, Director of Research and Employee Benefits for AFSCME Council 31, states, "Without some type of high-profile, public support from state leaders, new programs are not likely to be successful."

Budget Office

The state budget office will inevitably be consulted regarding any program seriously considered for implementation.⁷ Leaders such as Scott Pattison, Executive Director of the National Association of State Budget Officers (NASBO), stress the importance of accurate data concerning actual costs and savings when presenting a program to the budget office. Presenters should also include accurate projections for when cost savings will occur, providing the budget office with a realistic ROI.

Relationships are also important. State personnel executives should approach budget office personnel assigned to benefits and human resources (HR) issues. The appropriate way to contact budget staff varies by state. Additionally, defensible assumptions and forecasts are a vital part of any presentation to budget staff. State personnel executives should anticipate problems and challenges, and formulate potential solutions. It is important that programs are not over-sold; wellness and disease management programs will never capture 100% participation from the targeted population, and suggesting that level of engagement may prompt a negative reaction.

State Employee Unions

Employee union leaders are also key stakeholders to consider when creating or re-designing a wellness or disease management program. Implementing significant changes to state employee contracts without data illustrating the benefits to union members may prove difficult. The timing of contract bargaining, and the way in which new options are presented to union members, is critical when one attempts to modify benefit plans. Establishing relationships with union leaders and involving them in the proposal process early on is vital to winning union support for wellness and disease management programs.

"Bottom line – budget personnel are most interested in immediate payoffs, but a well-articulated savings projection over three or four years can also be persuasive."

–Scott Pattison,
Executive Director,
National Association of State
Budget Officers

“There is a consistent voice for disease management – we are not there yet with wellness. Wellness has a stigma; everyone knows what they are doing wrong but they still refuse to fix the problem.”

–Nicole Oishi,
Assistant Administrator,
State Health Care Authority,
Washington

For example, employees and union leaders have embraced Rhode Island’s Rewards for Wellness Program, and the results are noteworthy. The collaboration resulted in a 500% participation increase with Health Assessments at the outset of the program. As J. Michael Downey, President, Rhode Island Council 94 said, “Council 94 wholeheartedly appreciates the value of the Rewards for Wellness program and its potential to impact the health and wellbeing of our members and their families.”

Legislature

With state governments suffering from significant budget deficits, general assemblies are hesitant to invest state funds in programs that do not guarantee immediate savings. Individuals serving in a general assembly may remain non-committal on health and wellness issues unless the state’s leadership shows interest in the program.

The Governor, budget office, employee unions, and legislature are not the only critical stakeholders that must be educated with regard to the merits of wellness or disease management programs.

They are highlighted in this paper because they are consistent players across all 50 states. Any one of these players can block potential programming, making it difficult to improve health outcomes and curb health care spending. Engaging these stakeholders at the start of the program-planning process will increase the likelihood of program implementation.

OTHER STRATEGIES FOR BUILDING SUPPORT

Champions

Just as executive leadership is essential for program success in the private sector, programs in the public sector also need support from highly visible leaders.⁸ Wellness champions can help promote employee engagement and disseminate information concerning wellness programs.⁹ Rhode Island and Wyoming have had particular success in this area. In Rhode Island, the governor actively supports wellness programs and established an executive order appointing an employee wellness steering committee. Additionally, Rhode Island utilizes wellness champions within each state agency. A program supported by the governor in Wyoming rewards participation with the opportunity to earn credit to use as annual leave. The governor also holds press events, participates in publicized wellness activities, and provides general media attention around the state’s wellness and disease management programs. This strategy provides state employees with a highly visible example of how wellness programs can benefit each individual while offering attractive rewards that greatly increase program participation.

Non-State Funding

Given current fiscal constraints, additional funding and resources outside of the state budget can assist in building support for a program. For example, the state of Colorado successfully implemented a diabetes disease management program by leveraging vendor and research group relationships.¹⁰ As Vinita Biddle, Benefits Strategist for the Colorado Division of Human Resources explained, it is “easier to get funding for insured benefits and build programs into our medical insurance or other insurance rates when an outside party is supplementing the cost.” The Colorado program was piloted and funded by third-party researchers that also gave the state access to their data.

Whether funded with public or private resources, it is still vital to enlist the support of key governmental stakeholders, who may become champions in the event that additional state resources are required to sustain the program.

SECTION II: Employee Engagement

It is impossible to have a discussion about the development and implementation of wellness and disease management programs without addressing employee engagement. The October 22, 2010, roundtable allowed state personnel executives to discuss employee engagement challenges and successes, elaborate on concerns from the previous paper, highlight program achievements and discuss new directions. Roundtable participants concluded that there is no one-size-fits-all approach to employee engagement.

PLAN DESIGN TO DRIVE EMPLOYEE ENGAGEMENT

A critical success factor for any wellness and disease management program includes the implementation of a comprehensive employee communication and education strategy. However, this has been a difficult task for most of the roundtable participants. According to Carol Calvin, the National Director of Health and Wellness Strategies for UnitedHealthcare, the three emerging plan design trends are consumer-driven health plans (CDHPs), condition-based management plan designs, and value-based plan designs (VBP). A CDHP refers to health insurance plans that allow members to use personal Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), or similar medical payment products to pay routine health care expenses directly. These plans tend to engage consumers and increase consumer engagement, and also allow employers to track costs and gauge whether their members are making good health care choices. A condition-based management plan incentivizes outcomes, not just participation, and sets goals for members such as attaining a specific body mass index (BMI) or a healthy blood pressure reading. This type of plan provides all members with the incentive to be healthier.

Finally, VBPs seek to improve health outcomes and reduce medical costs by rewarding better health care decisions. Benefits packages encourage members to comply with medication regimes and see a physician regularly for testing and monitoring. By requiring compliance

with preventive care in exchange for a reduction in member out-of-pocket costs, health outcomes may improve and costs should decrease [See inset, below].

Indiana currently offers two CDHPs to its members, and 85 percent of their employees participate. The remaining 15 percent of employees have opted into a Preferred Provider Organization (PPO). The Director of the Indiana State Personnel Department, Dan Hackler, shared an audit of these plans that he recently received from Mercer, a human resources consulting company. According to Hackler, "everything you want to measure is down: emergency room visits, length of stay, and there is a renewed interested in wellness. The incentive for members of the CDHP is that the out-of-pocket expense that you do not spend is now yours." According to Hackler, "All of our costs for the CDHPs are down, which may be due to adverse selection as healthier individuals may have selected these plans, but we have also provided significant education to our members which has included actual examples of 'Joe' on a CDHP and 'Joe' on a PPO to illustrate the cost differentials."

After learning about the successful CDHP programs in Indiana, the moderator asked the other participants how crucial plan design was in order to implement a wellness or chronic disease management program. State employee executives from Colorado and Washington stated that they felt these programs are all about plan design. Rhode Island participants discussed the idea of adverse selection and how unions avoid endorsing a CDHP because they fear that the state will only subsidize the cheaper plan and ask high-risk individuals to bear increased costs. Rhode Island negotiated a change in co-pay costs for specialist and emergency room visits while keeping the co-pay for primary care visits the same. Susan Rodriguez, Deputy Personnel Administrator of Employee Benefits of Rhode Island shared the results of this change, "We did see primary care visits go up about 4 percent and specialist visits go down 4 percent – there was an impact."

Seven Steps of Value-Based Purchasing Programs – RWJ Foundation

- 1** Draft specific and measurable performance requirements, identify top priorities that the contractor is required to address during the contract period and award the contract only to a contractor that best meets the requirements and demonstrates a commitment to be a long-term partner.
- 2** Assess the contractor's performance when it is procured relative to the agreed upon benchmarks and expectations. Develop a performance indicator dashboard that identifies key aspects of performance for the contractor to report on and will be monitored by the purchaser to ensure contractor accountability.
- 3** Identify opportunities for improvement, focusing on gaps between desired performance and actual performance.
- 4** Set improvement goals to enhance performance accountability and improvement in areas of high priority.
- 5** Collaborate with the contractor to improve on one overarching objective; specifically, contractor performance that achieves desired levels of performance improvement.
- 6** Re-measure performance at least twice a year and review the performance with the contractor.
- 7** Apply incentives and/or disincentives to motivate and recognize contractor performance.

Outreach Strategies to Inform and Engage the Population

State personnel executives utilize a variety of strategies to inform members of new wellness and chronic disease management programs. These strategies include newsletters, phone calls, health fairs, and wellness coordinators. States also offer incentives such as gift cards, cash rewards and prize drawings. The feedback from this roundtable on the use of these strategies was mixed – communication and incentives had varying degrees of success.

For example, when a new disease management program was rolled out in Washington, state personnel executives launched a comprehensive member-communication campaign. According to Nicole Oishi, Assistant Administrator for the Washington State Health Care Authority, “We had a huge campaign with monthly newsletters containing all types of information, a wellness department with wellness coordinators in different agencies that promoted the program, educational support, and follow-up phone calls – we did a lot of outreach to try to get members engaged.” Washington also offered members gift cards for enrollment and completing a health risk assessment (HRA). After a significant amount of education and outreach, only twenty-two percent of the Washington employee population completed the HRA. Due to low participation, Washington will discontinue the program in 2012.

Wyoming has also utilized extensive communication and incentives to attract members into their wellness program. The state’s communication efforts include newsletters, e-mail blasts and employee benefit meetings. Members that complete an annual physical receive a monthly premium discount in addition to a small cash payment for completing a health risk assessment. Tammy Till, Director of Wellness in the Wyoming Division of Human Resources stated, “We are trying to do all forms of media coverage and incentives; we have cash gifts and a prize drawing. We have had an increase in participation and almost fifty percent of our population has completed their health assessments.” Although there have been similar efforts in terms of communication and incentives, the engagement and experience for Wyoming has been much more successful than the engagement and experience for Washington.

Challenges and Barriers to Engagement

Lack of employee engagement was identified as a significant barrier to enrollment and participation in wellness and disease management programs. Some programs ask members to complete a health risk assessment, or have a nurse call to provide education or a follow-up to a physician visit. This approach, however, may make employees uncomfortable for fear that a “wrong” answer may result in loss of coverage. An additional reason for lack of patient engagement was attributed to providers, some of whom are not educated in motivational interviewing and may lack the skills required to motivate patients.

Taking the aforementioned barriers into consideration, the most frustrating challenge discussed by state personnel executives at the roundtable is their inability to change individual member behavior. One representative expressed frustration that members do not return phone calls and ignore letters. As stated by Susan Rodriguez from Rhode Island, “If a member does not want to take control and make the changes, how far do we go? How much can we do? In terms – of programming, it is very frustrating to see such little take-up of disease management

programs – what do you do as an employer?” Nicole Oishi from Washington said, “I’m thinking of the seatbelt campaign utilized by schools to increase seatbelt use, by having kids tell their parents to ‘buckle up.’ It is this type of educational piece – how do we get to the right people at the right time?”

Despite these challenges, educating employees about healthy behavior should continue across the states. Before individuals change their behavior, they must be provided with information about risk levels for specific diseases or chronic conditions. Individual behavior can only begin to change once people are aware of their health status and understand what steps are necessary for improvement. As Carol Calvin said at the roundtable, “Giving individuals a screening in order to show them their current health status may provide a new sense of awareness and perhaps even fear that their health is not where it should be – thus, influencing and creating behavior change.”

An Organizational Approach to Wellness & Disease Management Programs

A recent study conducted by the Families and Work Institute¹¹ found that employees working in highly effective workplaces were twice as healthy as employees working in less effective workplaces. Ideally, an organization should start with the vision of what is a healthy and effective workplace and define how it supports the organization’s business plan, as an extension of its identity and aspirations.

This approach helps senior leaders of the organization understand how the initiative will help them achieve their objectives and why they must both fund and champion the initiative. As Steve Cyboran, Vice President, Consulting Actuary with Sibson Consulting, a Division of Segal explained, “It starts with defining the vision of the desired state and the corresponding healthy behaviors of both the people and the organization. Employees won’t participate in an initiative if they are working in a toxic work environment where there is a lack of trust and respect or time to do what is necessary to improve their health.”

Sibson’s Healthy Enterprise study¹² found that more mature organizations on its healthy enterprise index achieved much better outcomes in terms of health costs, turnover, extended absence, and workers’ compensation costs. The wellness and/or disease management programs should be designed as integral parts of achieving a vision that seeks to not only address the issues and health risks of the population, but to optimize the health and behaviors of the people and the organization.

Implementing a wellness program as a strategic business initiative is an approach that can produce favorable results. The most successful programs have some essential elements: engaged leadership at multiple levels, strategic alignment with the organization’s identity and goals, a design that is broad in scope and high in quality, accessibility, internal, and external partnerships, and effective communication.¹³ When these elements are included in wellness and disease management programs, the rewards may include lower health care costs, greater productivity, and higher employee morale.¹⁴ While cultural shifts take time, this long-term approach will engage more employees and result in a healthier population – ultimately leading to a more effective, cost-efficient organization.

Positioning the workforce as an enterprise allows a wellness program to be proposed in

terms of a potential return to the state through increased employee retention and productivity – messages that should resonate strongly during a budget crisis.

SECTION III: Measurement and Return on Investment

Once states have implemented a program and promoted engagement, evaluation is necessary and required. To ensure program sustainability, the state roundtable participants agreed on the necessity of demonstrating programmatic success and demonstrating ROI. Given the pressure to show almost immediate and positive results, states face challenges in determining what data to use to show ROI. Recent efforts have measured participation rates, clinical outcomes, and medical costs; but obtaining that data and completing the analysis is often difficult.

Deciding What to Measure

Participation

Demonstrating participation is one of the first steps in making the case for a return on investment. According to Susan Rodriguez, Deputy Personal Administrator for Rhode Island, the best method for tracking participation is to examine the percentage of eligible employees engaging in each activity. Although there is no common definition of an acceptable participation rate, 32 percent for one of Rhode Island's wellness initiatives was considered low, given that all other wellness activities in the program generated over 60 percent participation. Acceptable participation rates appear to vary by state, but there was consistency in using the participation rate as a metric for measuring a program's success. Nicole Oishi from Washington, confirmed that a program with low participation is vulnerable to being cut. Alternatively, high participation in a program helps sustain support for the program among key stakeholders. Even if early clinical results from a program are modest, high participation rates can convince stakeholders that continuing the program may lead to improvement. According to Tiffany Parker, National Director of Public Sector Analytics at UnitedHealthcare, a participation rate of 50 percent is a reasonable goal, but she cautioned that state officials should also focus on the type of participants, because achieving ROI depends on measuring impact among members with modifiable, high-risk clinical factors.

Clinical Outcomes

In addition to participation rates, most states stressed that obtaining clinical outcomes was essential for demonstrating engagement and behavior change among members. According to Vinita Biddle, Benefits Strategist, Division of Human Resources, Colorado, "It is important to show improvements in these benchmarks on a longitudinal basis to demonstrate changes in behavior and biometrics." Benchmarks may include the number of annual wellness visits, preventive screening tests, number of admissions, length of stay, and readmission rates. Additional benchmarks may include biometrics such as weight, body mass index, blood pressure, and laboratory tests. As Dr. David Ellis of UnitedHealthcare explained, "A successful wellness program should demonstrate increased annual physician visits and preventive screening compliance early on."

An examination of biometric clinical indicators is also important for programs that must demonstrate immediate results. If measures that are focused on utilization and biometrics improve early in the program, it may be easier to convince stakeholders that better management and prevention as well as costs will improve in the future. For example, a wellness program could demonstrate increases in preventive visits and screenings in year one, which could lead to cost savings in subsequent years. In addition, a diabetes program could show that employees have better compliance with glucose monitoring in year one, with the goal of actually improving control in subsequent years. Obtaining clinical outcomes may be important for states just starting to implement wellness and disease management programs; acquiring clinical data can provide additional evidence and support for expanding these programs or the need to reassess existing programs. For example, Rhode Island experienced an increased BMI in population, which helped make the case for program improvements. It also gave Rhode Island state personnel executives the opportunity to present aggregate data to state employees to build additional support for the program.

In Washington, the lack of improvement in clinical outcomes led to the end of a diabetes disease management program. The state engaged 1,800 people and experienced a decrease in emergency room and hospital utilization. However, there was no improvement among biometric measures such as glucose levels, cholesterol levels and blood pressure. This led to serious skepticism that the program was having any long-term effects. In fact, the lack of clinical improvement implied that the decrease in emergency room visits was actually a coincidental finding rather than an effect of the program. As a result, the program was cancelled.

Conversely, Washington initiated a bariatric surgery program three years ago that involves tracking clinical outcomes. The program has several stipulations: Employees must go to a center of excellence, participate in a dietary program, and lose 5% of their body weight before receiving referrals to a bariatric surgeon. Those that underwent surgery experienced initial weight loss, decreased medication use, and fewer instances of weight-related diabetes. However, bariatric patients are now experiencing complications from the surgery including the need for additional operations and increased nutritional support. According to Nicole Oishi from Washington, "We spent \$25,000-\$40,000 per person and we'll never recoup that money." While there is still support for the program, continued tracking of clinical outcomes allows Washington the opportunity for re-evaluation in order to consider changes to the program in the future. Other states, such as Colorado, recently developed a bariatric surgery program, and they now understand the importance of tracking clinical outcomes to evaluate the program.

Costs

A reduction in medical costs is among the most compelling measures of program success. According to Wyoming state personnel executives, evidence of cost savings is essential "to build the case that the health dollars for employee benefits are well placed." Participants felt that wellness programs face a larger burden of evidence to show cost savings. As Vinita Biddle from Colorado explained, "They just want to know if it is going to save me money; if so, great, if not, go away." Most states focus on obtaining claims data to show trends in medical expenditures. The major advantage of claims data is that it shows real costs, as opposed to other methods that utilize projections. According to Tiffany Parker, National Director of

Public Sector Analytics at UnitedHealthcare, program evaluation requires that states identify the participating members of the program so they can be compared to non-participants – a comparison that requires a definition of program engagement. An effective program should demonstrate an initial increase in costs resulting from increased utilization of preventive health services when participants are compared to non-participants. As the participants' general health care costs decrease, the health care cost curve will decline such that it is also below that of non-participants. Rhode Island used this method of analysis to demonstrate a return on investment for its wellness program after only one year of program implementation.

In an effort to remove barriers to diabetic care, Colorado reduced the co-payment for all diabetic medication and supplies to the Tier 1 level, which resulted in fewer emergency room visits and hospitalizations. However, the state saw a large increase in the use of brand name medications, which offset much of the utilization cost savings. By reducing medication costs, they were able to somewhat increase employee compliance. The state decided to continue the diabetes disease management program, but no longer makes all diabetes related pharmaceuticals available at Tier 1. In the future, they hope that this will result in reduced spending on brand name medications and lead to a decrease in total costs.

Cost savings projections and estimates are often utilized by the states. Dee Eddinton, PhD, Director of the University of Michigan Health Management Research Center, extensively researched the evaluation of wellness and disease management programs utilizing an annual HRA.¹⁵ An HRA gives participants a score that compares health among members and tracks each individual's score. Higher risks on HRAs have been associated with higher medical expenditures, allowing risk shifts to be correlated with projected cost savings. One downside is the risk of under-reporting and bias due to an HRA's reliance on individuals to self-report medical problems.

Rather than focusing on one source of data to show ROI, Steven G. Aldana, PhD, adjunct faculty member of the University of Illinois School of Medicine, emphasizes the importance of a comprehensive approach. Dr. Aldana believes that it is essential to focus on direct and indirect medical costs. He proposes that wellness programs can affect indirect medical costs through absenteeism, reduced productivity, worker's compensation, disability, employee turnover, and recruitment.¹⁶ He believes these factors should be included in ROI calculations.

Data Collection and Analysis

The process of collecting data can be challenging. Due to the fragmented nature of the U.S. health system, there is not a single source of comprehensive data on all state employees. For instance, states may use several different insurance carriers, all with different claims systems. Therefore, it is often difficult to obtain reliable data on clinical measures, outcomes, member level decisions and real costs. The best place to start is usually with a health insurance carrier, which may be able to provide medical and pharmaceutical claims data. Some carriers may provide this data as part of their contract, while others may charge an additional fee.

Data Collection Strategies
from David Hunnicutt, PhD,
president of Wellness
Councils of America:

- Program registration sheets to track participation
- Participant satisfaction surveys
- Self-reported behavior
- Health risk assessments
- Biometric testing
- Screening results
- Productivity questionnaires
- Medical claims comparison

There are other strategies that state personnel executives can employ to identify reliable data sources. Todd Maxwell, Vice President at Ingenix, suggests the creation of data warehouses that capture participants' data throughout the course of a program.¹⁷ In addition to program evaluation, the data warehouse can be used for claim reviews to detect fraud, waste and abuse. Recapturing these costs may offset any initial costs to set up a data warehouse. For this reason, pursuing a data warehouse strategy may be appealing to state personnel executives that also administer the state's Medicaid program. They could use the data warehouse to improve their Medicaid programs while simultaneously tracking wellness and disease management programs in a budget-neutral fashion.

Maxwell also suggests that states increase utilization of health information exchanges (HIE). HIEs are "electronic bridges" that allow providers to connect clinical information from disparate health systems, such as those found at different clinics, pharmacies, and radiology testing sites. HIEs allow providers access to their patients' clinical data when utilizing other health care systems. The infrastructure for HIEs is currently being built

and organized by states through grant funding and could eventually serve as a comprehensive health care data source.

Even if states obtain patient data, they may still lack capabilities to conduct meaningful analysis. The state of Washington benefits from the co-location of its state benefits office and the Health Care Authority. This allows Washington personnel executives to have continuous access to data and maintain contact with in-house health care experts that perform comprehensive program analysis. Washington roundtable participants felt that this arrangement provided a huge advantage as it allows for ongoing program changes based on reliable information. In other states, executives must rely on partnerships with vendors or other stakeholders for this level and frequency of analysis. For example, Colorado's aforementioned diabetes program was initially funded through collaboration with an outside research group, which provided analysis free of charge. However, once the research partnership ended, Colorado personnel executives lost the ability to continue tracking patient outcomes. While state personnel continue to have access to data, they lack the required software and technical resources for analysis as well as the funding for hiring an external analyst firm. Colorado is not able to track outcomes, making the case for funding increases more difficult to support.

CONCLUSION & RECOMMENDATIONS

Based on discussion from the October 22, 2010, roundtable of state personnel executives, this paper examined the challenges of selection, implementation and support of wellness and disease management programs, and may serve as a resource for state personnel executives nationwide. In conclusion, the authors provide the following recommendations:

- Work with officials such as those in the Governor's Office to persuade the legislature to support new programs. Visible state officials make effective champions for new and innovative programs.
- Stress the long-term benefits and cost-saving potential of your wellness program. The retention rate of state employees is high, so investing in employee health is a smart budgetary move.
- Attempt to partner with vendors and researchers when promoting wellness and disease management programs. Such partners may supplement startup costs, making it easier to earn state government support.
- Involve the employee population as stakeholders in the development of wellness and chronic disease management programs.
- Engage employees through assessments and other practices that develop their proficiency as informed health care consumers.
- Offer employees an incentive for program participation and healthy choices through monthly premium discounts.
- Approach wellness in the workplace as requiring a cultural shift that transcends health issues, demanding overall organizational effectiveness and sound business practices.
- Ensure that underlying assumptions regarding cost and saving estimates in your ROI presentation are defensible.
- Effectively evaluate your program's focus on participation, clinical outcomes, and direct and indirect health care costs. If possible, leverage vendor relationships to obtain reliable data.

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1. About the authors: Jonathan Birnberg MD received his Master of Health Studies from the Department of Health Studies June 2011. Katherine Meyer received a Master of Public Policy from the Irving B. Harris School of Public Policy Studies and a Master of Arts from the School of Social Service Administration in June 2011. Cassandra Yarbrough received her Master of Public Policy from the Irving B. Harris School of Public Policy Studies in June 2011. All three students participated in the University's Graduate Program in Health Administration and Policy (GPHAP), a multi-disciplinary certificate program for students interested in health administration and policy that attend the Harris School, the Social Service Administration School, the Health Studies program, and the Chicago Booth School of Business. GPHAP students must complete a supervised practicum as part of their training, providing the opportunity to apply theoretical knowledge to real life administrative and policy challenges. This white paper project was funded in part by the GPHAP program and met the practicum requirement for all three students. After receiving his Master of Health Studies, Jonathan Birnberg MD took a position as the Director of Clinical Quality for Engaged Health Solutions, a worksite wellness company. In addition, he continues to practice as a primary care physician. After receiving her Master in Public Policy and Master of Arts, Katherine Meyer took a position as a Senior Research Analyst for the National Opinion Research Center (NORC) in their Department of Public Health. Her primary social policy interests include wellness and disease management, public health program evaluation, and cost-effective prevention programming. She received a B.S. in Psychology from the University of Wisconsin-La Crosse in 2004. After receiving her Master of Public Policy, Cassandra Yarbrough joined the Department of Health and Human Services Office of Inspector General, Office of Evaluation and Inspections as a program analyst, evaluating the efficiency and effectiveness of federal health programs. Her primary policy interests include child health and wellness, childhood obesity, access to health services, and Medicare/Medicaid funding. She received a B.A. in Sociology from the University of Illinois Urbana-Champaign in 2008.
2. The National Association of State Personnel Executives is the recognized authority on state government human resource issues, trends, practices, and policies and serves as a leader and catalyst for the development of state human resources and is dedicated to enhancing the image of state public service.
3. UnitedHealthcare supported this project with financial and logistical aid to the students. The interviews were conducted and paper written solely by the students. As a result, the statements and positions in this paper should not be construed as being the statements or positions of UnitedHealthcare
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