Take Charge of Your Health Care!

Employer Guide to Health Care
Benefit Design for
Vermont Companies

VERMONT BUSINESS ROUNDTABLE
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VERMONT BUSINESS
ROUNDTABLE

INTRODUCTORY NOTE

For a number of years, the Vermont Business Roundtable has been actively engaged in research and policy analysis related to health care issues. Most recently, the Roundtable produced a series of three policy papers addressing the economics of health care. After completing our last health care policy paper in 2000, the Roundtable decided to undertake a project that focused on what employers themselves could do within their own businesses to positively affect the health of their employees and the cost of health care. In no way is this a step back from the Roundtable's interest in and commitment to research and analysis related to health care policy. Rather, we view this publication as a complementary effort.

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This publication is also available on the Vermont Business Roundtable Web site at *www.vtroundtable.org.*

The Vermont Business Roundtable is a non-profit, non-partisan organization of 110 chief executive officers representing geographic diversity and all major sectors of the Vermont economy. The Roundtable is committed to sustaining a sound economy and preserving Vermont's unique quality of life by studying and making recommendations on statewide public policy issues.

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INTRODUCTION

Congratulations! If you are reading this, you have decided that it's time to take charge of health care – for your employees, your business, and yourself. Health care benefits design and implementation – in Vermont and around the nation – can become a confusing maze ... for the employer and employee alike.

HOW TO USE THIS RESOURCE

This guide has been created to assist the employer who has a small to middle-sized company, and who wants to learn how to reduce health care costs while improving health outcomes. Although large companies have staff to research and implement programs, smaller businesses may need to rely on one or two people to help with the work.

With this in mind, this guide is divided into four informative, hands-on sections:

- **Emerging Trends – The Future of Health Care** – general information, emerging trends, programs, and options
- **Program Funding and Cost** – information on the causes of increases in health care premiums; types of programs; rating classifications and explanations; insurance program options; sample cost models; health care purchasing criteria, and price and cost sharing; self-insurance; and mandated benefits
- **Benefit Plan Models and Design Considerations** – medical plan options, including in-depth charts; prescription drug plans, glossary of terms, and plan outline chart; mental health and substance abuse benefits; benefit design considerations; and sample cost/plan design chart
- **Improving Health Outcomes** – wellness program planning needs assessment survey tools; prevention and behavioral change; disease management; demand management; and a variety of pull-out resources

Make no mistake – health care is a multi-faceted, complicated issue. And change – whether improved wellness, cost reduction, higher morale, or greater productivity – will take place over the long term, not the short term. Any employer who is seeking measurable gains must be prepared and willing to be self-insured and exercise extreme patience, and to be realistic in that gains in wellness and morale will occur well before any decrease in premiums.

This is due, in large measure, to the fact that Vermont is a state with community rating. This creates a community, or pooling, of employers (and their insured employees) meaning that any sought-after improvements resulting in lower rates have to come from a much larger accumulated group of employers – not just one company.

ACRONYMS USED THROUGHOUT THIS GUIDE

CAM - Complementary Alternative Medicine
EAP - Employee Assistance Program
HMO - Health Maintenance Organization
IDS - Integrated Delivery System
MCO - Managed Care Organization
MH/SA - Mental Health/Substance Abuse
PCP - Primary Care Physician
POS - Point of Service Plan
PPO - Preferred Provider Organization
UR - Utilization Review

Emerging Trends - The Future of Health Care

THE EMERGING ROLE OF THE CONSUMER

The shift in enrollment from managed care "heavy" to managed care "light" is accelerating. Preferred Provider Organizations (PPO's) now enroll 48% of employees, up from 41% in 2000 and 28% in 1996.

Increases in health care costs have a profound economic impact on businesses. In 2002, it is estimated that businesses will expect to spend 13% more on health benefits as compared to 2001. The managed care system was designed as a health payment and delivery system that could contain both costs and patients' access to services. However, even that system has been unable to control medical inflation.

Since the managed care concept began in the 1980s to take root in the way health care is designed and delivered, there has been much resistance from physicians, patients, hospitals, and other providers. Resistance focuses on the belief that insurance companies and other payors have intruded into practice pattern management and negatively impacted the way consumers access health care services.

As managed care evolved over the past 20 years, the focus of health care cost control shifted from the physician/patient relationship to the insurance company. This has brought about the current debate among the media, consumers, and health care professionals as to the best way to access and pay for care - and more importantly, who should be in control of health care utilization.

In this debate, the notion of managed care has come under intense pressure to change. The principles behind managed care are excellent - they strive to insure that the patient is seen by the most appropriate provider and receive the best care in the most effective delivery setting.

Cost is the biggest determinant when employers select heath care plans. Other factors considered are provider choice and range of benefit options.

The principle players in care management - government, employers, physicians, and consumers – have wrestled over who should exert the controlling influence over health care utilization. In reviewing new models of delivery, the question that remains is who of these principle players will become the primary player?

It is the belief of this taskforce that the primary player/controller of health care utilization should be the consumer. After all, consumption and cost are directly related to the consumer and how the consumer uses health care. For this to occur, health plan designs will need to be structured so that cost and care decisions are customer driven, allowing the consumer greater flexibility and responsibility in making health care decisions that affect their well being.

New medical plans should be designed more in line with the open access philosophy. However, with that added flexibility comes the added responsibility for consumers to stay informed and to take charge of their own health management. In that manner, consumers can make the best possible decisions pertaining to individual health care plans and share in the costs associated with those decisions.

Numerous studies have found that plan choice is one of the best predictors of employee satisfaction with health plans.

BECOMING SMART HEALTH CARE SHOPPERS

America is a nation of shoppers. We shop in malls, on the Internet, and by telephone. We watch for sales or hunt for the best price, and at other times we are more willing to pay a premium for brand name recognition or for what we consider a "quality" product.

91% of all small firms (between 3 and 199 employees) that provide health care coverage offer just one health plan.

What if we approached shopping for health care services and products in the same way we approach shopping for other goods and services? After all, the cost of health care coverage is a significant expense. Employers' contribution for coverage is a significant part of our overall compensation. Our goal as consumers should be to make health care purchase decisions that give us value and satisfaction. Our health - and the health of our family members - is worth the time invested in making thoughtful and informed choices.

TRENDS IN THE HEALTH CARE INDUSTRY

Between spring of 2000 and spring of 2001, monthly premiums for employer-sponsored health insurance rose 11%.

Most purchasers of health care understand the importance of quality health coverage. Over the years, both as employers and as consumers, we have felt the impact of rising health care costs firsthand.

Many Americans today have health insurance. Approximately 83% of individuals under age 65 have some form of health coverage and nearly two-thirds of all people with a health plan in the United States are covered under employment-based plans. Most employers today recognize the importance of offering workers and their families protection from the financial impact of a serious illness or injury.

Surveys indicate that health care is the benefit most valued by workers and their families. In 1999, 65% of workers stated that employment-based health coverage was the most important benefit. Most employers also view their health care benefits as critical components of a total reward strategy. For this reason, employers continue to review their health care programs to ensure that they remain competitive and up to date.

HEALTH CARE COSTS ON THE RISE

Almost half of all firms expect to increase the amount that employees pay for health insurance in the upcoming year.

Employer plans and other purchasers of health care have struggled to contain health care costs for the past several decades. In the 1980s and early 1990s, health care costs grew faster than any other employer-provided benefit.

During that time, managed care emerged as a cost control strategy. Managed care is a system of health care delivery that is designed to deliver cost-effective health care without sacrificing quality or access. Managed care programs, such as HMOs, PPOs, and POS plans include some features designed to ensure that services and providers are used appropriately. By focusing on cost management, managed care was able to help control spiraling health care costs.

While managed care features have become the standard in most plans, the last several years have seen health care costs on the rise again with annual increases moving into the double digits. The key drivers of this trend are increases in utilization health care services brought about by an aging population, increased use of new technology, innovation in pharmaceutical interventions, and desire on the part of government to influence health care public policy in the form of mandated coverage requirements.

Another area of rapid change in health care is the application of the information gained from the Human Genome Project and genetic testing in general to the care of individuals and populations. Probably the best - and most up to date - example is the recent recommendation of the American

Society of Medical Geneticists and the American College of Obstetrics and Gynecology to offer screening for cystic fibrosis to women, both preconceptually and as part of prenatal care. Such testing is very expensive - on the order of one quarter to one third of the total professional fees for prenatal care and delivery - and cannot offer 100% detection of a potentially affected fetus. In addition, the time required for care providers to explain such a complex test and its implications to patients places a significant time burden on current care standards.

As we go forward, it will be possible to screen for more diseases and pressures will be placed on clinicians to offer such testing. From an insurer point of view, the additional revenue needed to finance new developments such as this represents the need to trim services in some other area, provide services more efficiently, raise premiums, or some combination of the above.

WHAT'S NEXT?

The next major trend in health care will focus on consumerism. Ultimately, informed and involved consumers will have a better understanding of their options, be more satisfied with their decisions - and may even save some money. Essentially, if utilization is the key driver of health care cost, the consumer needs to return to the driver's seat in having a far greater influence in how health care is utilized.

ROLE OF THE EMPLOYER IN HEALTH PLAN DESIGN

Employers play a pivotal role in health care utilization by how they design their health care benefits and the extent to which they help their employees be informed consumers of health care services.

For example, while health care costs have been rising in recent years, the cost of prescription drugs has been spiraling upward even faster. Drug costs have been increasing at double-digit rates that are far above the general rate of inflation. The high cost of prescription drugs is due in part to an increase in prescription drug use and a growing reliance on new, more expensive drugs.

Prescription drug costs are expected to continue rising; however, there are some things employers can do to save money on prescriptions. For example, using generic or preferred brand drugs whenever possible can reduce costs significantly. Taking advantage of mail-order programs for maintenance medication through discounted prices for large quantity orders will provide additional savings.

Employers want to offer competitive health care for employees as a way to attract and retain the necessary talent that will build successful businesses. The real issues are at what cost and how can small employers influence heath care plan design to promote cost-effective utilization while offering a competitive benefit?

To answer these questions, and many others, we have put together a comprehensive guide for Vermont's small employers. We believe that this guide will provide the tools and insight to help in the management of your health care dollars and design of your health care plan.

EMERGING DEVELOPMENTS

There are always new developments and trends in the delivery of health care benefits. Most have a common theme of reducing costs, simplifying administration, or improving the health and productivity of employees.

Defined Contribution Plans

Perhaps the most intriguing new trend in health care benefit delivery is "defined contribution plans." In concept, an employer would give each employee a specified amount of money (e.g., $5,000); the employee would be responsible for securing his/her own health care coverage. If the employee purchased a plan that cost more than $5,000, s/he would be responsible for the difference.

The premise behind this type of plan is simple: pass an increasing amount of responsibility for choosing and paying for a plan on to the employee. This would create a direct relationship between the employee's financial stake and a more judicious use of health care services.

The disadvantages are immediately obvious, and are the primary reason the concept as defined is largely untested. Employees would have difficulty finding good coverage without the leverage and buying power of their employers. The payment would be taxable as ordinary income, further diminishing its buying power. Employees in poor health might find it impossible to purchase any coverage at all.

The more likely approach involves the employer contracting with an organization whose primary business is delivering administrative and design aspects of a health care program including:

- negotiating with several insurers or MCOs to deliver care;
- communicating benefits;
- enrolling employees in coverage frequently via Web-based or voice response systems;
- accessing various e-health products and services; and
- providing customer service.

There are a number of organizations providing this type of defined contribution approach at varying levels of development and sophistication. Several of these "demand aggregators" may only be able to deliver certain plans that are not suitable or the most competitive for a particular region. Others lack the administrative sophistication to deliver turnkey enrollment, communications, and customer service. However, others are fully operational and provide a full spectrum of benefit plans and administrative capability.

The concept of defined contribution plans continues to emerge and gather interest. High front-end deductible programs with partial employer funding of deductibles that could be carried over from year to year are also beginning to gain interest. To date, these arrangements are reserved mostly for medium and large employers who desire to outsource much of the effort involved in benefits delivery and administration.

Complementary Alternative Medicine (CAM)

Originally viewed very narrowly as the addition of chiropractic and acupuncture to a health plan, CAM benefits now include a broad range of healing philosophies such as herbs, homeopathy, therapeutic massage, nutritional counseling and supplements, Eastern medicine, and other mind-body therapies.

The National Institutes of Health separates comple mentary alternative medicine into five different categories:

- Alternative medical systems
- Mind-body interventions
- Biologically-based treatments
- Manipulative and body-based methods
- Energy therapies

The demand for these services has increased significantly in the last 10 years although recognition as a covered service in health plans remains far behind the apparent demand. While chiropractic benefits have become very much an expected and mainstream benefit, only acupuncture appears to have made some inroads into benefit plan coverage.

There are several reasons why the inclusion of CAM benefits in health plans has not occurred with greater frequency:

- uncertainty and lack of knowledge regarding effectiveness on the part of the employer and insurance community;
- insufficient data to support arguments that CAM benefits will not add to costs; and
- inability to define and fit many CAM providers into the classic managed care models associated with conventional medicine.

However, studies and surveys have been conducted that demonstrate the effectiveness of many CAM therapies. Some employers have taken it upon themselves to contract with specialized CAM networks out of a desire to improve health care outcomes, respond to demand, or differentiate their benefits package with the addition of these services.

Program Funding and Cost

By any measure, the cost of health care benefits (including dental, vision, and prescription drugs) has continued to rise. In real dollar terms, the average cost per employee of a health care program in 2001 was around $4,900 annually and we are in the midst of a period of continuing escalation in premiums.[1]

THE BIG PICTURE - WHAT CAUSES INCREASED HEALTH INSURANCE PREMIUMS?

Interestingly, the main culprit is typically not unit price, cost, Consumer Price Index (CPI), or what many refer to as inflation. Key drivers of health care premiums are commonly identified as:

- **Increases in utilization** - In 2000, the average covered member used 8.57 prescriptions per year, up 16% from 7.4 prescriptions per member per year in 1997.[2] If the unit cost of a prescription, service, or diagnostic test does not increase, health insurance premiums will still increase because more services are rendered year after year.
- **Technology** - This is sometimes referred to as "intensity of utilization." Advances in technology to enhance diagnostic capabilities and sophistication are occurring every day. Fifteen years ago, a simple shoulder injury might have entailed an x-ray and office visit, combined with instruction to rest and apply ice. Today, the same injury may include a $1,000 MRI, physical therapy, and multiple visits to specialists.
- **Government cost shifting** - Hospitals and physician practices derive revenue from three principal sources: private health insurance, government programs, and self-paying patients. As the Federal government cuts back reimbursements for Medicare and Medicaid programs, inevitable pressure is exerted on the private pay programs to pick up the slack.
- **Provider consolidation** - In recent years there have been a significant number of hospital mergers, and the combining of physician practices and hospitals under a common ownership umbrella known as an Integrated Delivery System (IDS). Beyond obvious operational and clinical efficiencies, the IDS acquires greater leverage with which it can negotiate reimbursements with HMOs, insurers, and other MCOs.

The CPI, or inflation component, of health care costs may be at or around 3% to 4% in recent years. However, the combined impact of these other influences results in overall health benefit trends of 8% to 14% per annum depending generally on the plan of benefits, area of the country, and demographic makeup of the insured population. Clearly, there is a difference between inflation and trend as they relate to cost increases in health care benefits, and any discussion of costs should be sure to differentiate these terms.

EMPLOYER'S VIEW

The health care cost equation in its most basic form is relatively simple:

Cost = Price x Utilization (plus the expenses and profit of the insurer)

The more health care services are used by an insured population, the greater the cost. How these costs are converted into insurance premiums is a function of actuarial and insurance underwriting principles.

In very general terms, the smaller the number of insured employees, the less predictable the cost of future health insurance claims and the cost of premiums to charge the employer. The larger the covered population, the more predictable future claims; thus, premium charges can more accurately reflect the true cost of the program.

There is a variety of insurance terms and jargon used to describe how directly an employer participates in, or is charged, for the cost of health care services used by employees. The spectrum ranges from *community rating*, also known as fully pooled programs, to completely self-insured programs.

Funding Spectrum Premium Determination Models

Predictability of future claims	Size of employer	Financial "risk" assumed by employer	Premium arrangement
Low	Small	None	Community Rated
	1-150		
	50-150		Prospectively Rated
	150+		Retrospectively Rated
	500+		Self-insurance w/Stop-loss
	5000+		
High	Jumbo	All	Fully Self-insured

Note: None of the general size parameters referred to should be viewed as absolute. There is a range of hybrid arrangements and one employer's willingness to accept more or less financial risk may be different from another's. The key is to understand your current program and be equipped to properly analyze alternatives.

CONVENTIONAL INSURANCE PROGRAMS

Before determining which premium or funding mechanism is appropriate for your company, it is important to define and understand your current arrangement. For simplicity, most insurance arrangements in Vermont are either community or prospectively rated. Very large employers (1,000 to 2,000 employees and larger) frequently use some form of self-insurance. The precise location on the funding spectrum is a function of the company's size and ability to absorb financial risk for the cost of employees' claims plus expenses.

Community Rating

Community rating is a rating process that produces an average premium rate for a defined community of insureds, for a given policy period and a specific plan design/model. In determining an average rate for the community of insureds, consideration is often given to the overall community's demographics and claim experience.

Community rating in its purest form is most prevalent in the small group market (1-50 employees). Community rating is intended to afford longer term rate stability than could be realized by small

groups under a rating methodology that factors in individual group experience and demographics. In Vermont, insurers are required to adhere to a community rating methodology for all groups with up to 50 employees.

Adjusted Community Rating

Adjusted community rating is a rating process that allows for variances in rates among members of a community of insureds. Certain individual group characteristics may warrant a premium under or over the pure community rate. Allowed variances to the community rate are usually limited to plus/minus 10-15%.

Factors that may be considered can include - but not be limited to - experience, industry, group specific demographics, and geographic location. In Vermont, adjusted community rating is most prevalent with HMOs in the market serving companies with 50 employees or more. Adjusted community rating is often seen as beneficial to those groups consistently presenting favorable demographic and low claims utilization. It represents a reasonable alternative for those groups considered too large for pure community rating but too small to be fully experience rated; usually groups with 50-500 employees.

Prospective Rating

Prospective rating uses all or some portion of past claim experience to project future cost. How much weight the claim data is given is also a function of group size and is known as the underwriting credibility ("believability"). For an employer of 400 employees, an insurer may take into account 40% to 50% of actual claim experience, with the balance of premiums blended with community rates. In any given year, it is conceivable, if not likely, that one catastrophic claim could occur and distort the accuracy of the entire picture. An insurer may include or insist upon an internal "pooling" program, or smoothing technique, for which an additional charge is added to premium rates.

As an example, for a 400-employee company the pooling limit might be that future premiums would reflect the cost of past claims trended forward except that any individual claims over $75,000 would be excluded from the base of claims used in the projection.

With this smoothing technique (designed to enhance the stability of future premium increases) an insurer might add a pooling charge of anywhere from 4% to 7% of total premiums.

The larger the employer, the more willing an insurer would be to increase the pooling limit to $100,000 or $150,000 in exchange for a reduced premium. The smaller the size of an insured population, the lower the pooling limit or possibly premium based fully on community rating.

Retrospective Rating

This is similar to prospective rating in terms of how future premiums are determined; however:

- deficits can be added to premiums in whole, or part; and
- dividends or refunds reflecting lower than expected claims can be refunded in cash, used to reduce future premiums, or credited with interest to a fund maintained by the insurer.

Upon termination the funds are/should be returned to the employer.

Retrospective rating arrangements are not as commonplace as they were 10 to 15 years ago.

SELF-INSURED PROGRAMS

For years, the most uncertainty and confusion has existed in the definitions associated with self-insured programs. Most of the confusion exists for employers with 50 to 500 employees, where the decision to self-insure is not as clear or certain.

What is self-insurance?

In its purest form, it is the full acceptance of financial risk for the cost of health care claims and expenses incurred by employees. For a large employer, the cost of administrative expenses of the claims payer or administrator (which can vary from 10% to 20% of total costs) is typically known and agreed upon in advance of each year. Self-insurance becomes a commitment from an employer to pay the full cost of health care services incurred by its employees and dependents during any given period, typically a plan or policy year. (Note: The use of the term "financial risk" is used specifically to highlight the predicted value of future claims compared to the actual value of claims – with the benefit of hindsight – and can vary significantly.

To illustrate this point, let's return to the concept of actuarial credibility; or to use a common mutual fund term, is past experience an accurate indicator of future results?

If you employ 50 employees and incurred $200,000 in claim expenses last year, can you afford the risk of self-insurance in light of a proposed 18% premium increase delivered by your insurer? Which leads to the following questions:

- How much risk can you afford?
- If you cannot afford the 18% increase, can you afford an even larger cost should claims be higher than predicted?
- Does $200,000 constitute a good year, an average year, or a bad year?
- Do you have more than one year of claims experience to make an informed judgment call?
- What is the probability of significant variance from $200,000 for any given year, or for any given 5-year period?
- Has the demographic composition of your employees changed significantly such that it will have a positive or negative impact on the ability to predict future claims cost?
- If you self-insure and it turns out to be a poor decision, what are the cash flow and cost implications of returning to an insured program?

If you employed 4,000 employees and had $16,000,000 in claims experience last year, how would the answers to the above questions differ?

This illustrates the point that, in any given situation, there is not a precise technical answer to the question of whether or not to self-insure. Unfortunately, and like many decisions in business, the evaluation is frequently made with incomplete information and limited time for analysis.

Stop-loss Insurance

Stop-loss insurance operates in the same manner as pooling coverage in the prospectively rated insurance arrangements referred to previously. The main difference is that pooling coverage is designed to protect the insurer from large deficits and provide stability in cost increases from year to year. Stop-loss insurance is identical but protects corporate assets from large random swings in claims experience.

Stop-loss insurance comes in two forms: specific (or individual) coverage and aggregate coverage.

Specific (individual) Stop-loss Insurance

The smaller the covered population, the greater is the likelihood that a single large or catastrophic claim could result in large differences between expected and actual claims. To cover, or insure, this risk an employer purchases specific stop-loss insurance. The basic insurance proposition is that the insurer will reimburse claims on any one individual exceeding an agreed upon amount during the policy year (e.g., $50,000, $75,000, $100,000).

Aggregate Stop-loss Insurance

This type of insurance provides protection in the event the cost of claims for an entire insured group exceeds an agreed upon amount. The attachment point, or point at which the insurance protection begins, is typically 120% or 125% above expected or predicted claims. At 125%, a self-insured employer is assuming substantial financial risk.

Again, the smaller the employer, the greater the possibility that actual claims will exceed projected claim levels. For very large employers, this risk diminishes and many self-insurance arrangements use specific stop-loss insurance only.

Incurred But Not Reported (IBNR) Claims

In any given policy year, the cash basis cost of a health insurance program equals the value of claims paid during the year. However, at the end of the initial year of a self-insured program there may be as much as 20% to 30% of all claims incurred during the year that have yet to be processed and paid by an administrator or insurer. This difference, known as Incurred But Not Reported claims (IBNR), results in a one-time cash flow advantage for an employer in the initial year, and the initial year only, of a self-insured program. While cash costs in a policy year may be 20% less, the true accrual basis cost of the plan reflects all claims incurred during the year. Another common term for IBNR claims is a claim reserve.

Reconsider the employer with $200,000 in predicted claim costs. If the plan were self-insured, cash claim costs during the initial year might be as low as $150,000 or 75% of incurred claims. The liability for incurred but not reported claims of $50,000 would not be processed by the insurer until the first two to three months of the subsequent policy year. In the next policy year the claim lag, or processing delay, disappears and the cash basis cost of the plan will return to normal or mature claim levels, plus the increased cost of inflation and utilization trend, as follows:

YEAR 1

Claims incurred and paid (cash basis cost) **$150,000**
Incurred but not reported claims (at year end) ..... **+ 50,000**
Total incurred claims (accrual basis cost) **$200,000**

YEAR 2 (assume 10% trend)

Claims incurred and paid **$215,000**
Incurred but not reported claims (prior year) ..... **(-50,000)**
Incurred but not reported (at year end) ..... **+ 55,000**
Total incurred claims **$220,000**

The true cost of the program has increased 10% from $200,000 to $220,000. However, the cash basis cost of the plan increased 43% from $150,000 to $215,000. An employer focused only on the potential for a $150,000 cash expense in the first year encounters a large increase in the second year of the self-insured plan.

Accounting principles require the recognition of IBNR claims on an organization's financial statements. Any auditor who is made aware of the change in funding approaches will require financial statements to reflect the liability. The improved cash flow in the initial plan year is not savings, but the mere deferral of a liability until the next plan year.

Insurance companies are required to maintain sufficient assets (reserves) to pay these liabilities as they emerge. Self-insured employers rarely set these funds aside to pre-fund the liability. The first year cash flow advantage is typically used to fund continuing operations, and therefore has a positive opportunity value (savings) associated with retaining it for use in the business.

When to Self-insure

Self-insurance is very popular and is used by many employers as a means to gain greater control over the cost of the health care programs. As the calculations above illustrate, the term control is frequently overused and does not automatically imply savings.

Self-insurance advocates frequently reference the ability to reduce the administrative expenses of a program as an advantage. This is true and lack of risk charges, premium taxes, contributions to statutory reserves, and the opportunity value associated with maintaining reserves are all real "savings." However, administrative expenses typically make up only 10% to 20% of the cost of a program. Savings associated with reduced expenses typically do not exceed 3% to 6% of plan costs. The possibility that actual claims might exceed expected claims in any given year remains the real risk associated with a self-insured program since it makes up the other 80% to 90% of plan cost.

In general terms, self-insurance is appropriate under the following circumstances:

- Your plan is prospectively or community rated and your claims are consistently lower than the insurer's projections. To properly evaluate this situation, you need to have the necessary claim data from your existing insurer. Reasons for consistently out-performing an insurer's projections are typically found in the overall favorable health and demographics of the insured population (e.g., lower average age than the insurer's covered population).
- Your plan is sufficiently large so that each year the cost of claims is typically close to the insurer's projected cost. In this situation you might perceive that you are merely "trading dollars" with the insurer each year and can afford the risks of self-insurance in exchange for reduced administrative expenses.

Self-insurance is a viable and popular alternative to the payment of conventional insurance premiums. However, care must be taken to fully understand your current funding arrangement, properly evaluate financial projections, and ensure that all facts and historical data are available and reviewed as part of any decision to self-insure.

Mandated Benefits

State insurance departments regulate insurance companies and HMOs. When a state legislature mandates that a particular benefit must be provided in all health insurance plans, that regulatory authority extends only to insured plans issued by insurers and HMOs licensed to do business in that state. For example, in Vermont coverage for mental health services, chiropractic care, and diabetic supplies is required to be included in all insurance plans. Self-insured plans are not regulated by state insurance authorities and are not required to include mandated benefits in the scope of covered services.

The ability to avoid the cost of mandated benefits is a potentially attractive by-product of self-insurance. However, the analysis to self-insure rarely includes the ability to avoid state mandates as a primary driver of the decision. Self-insurance provides the flexibility for an employer, rather than a legislature, to determine if a particular benefit should be a part of its health care program.

HEALTH CARE PURCHASING CRITERIA – EVALUATING NETWORKS

Cost continues to be the most important and frequently cited criteria for health plan purchasing. However, the emergence of managed care and network-based programs has resulted in the quality and depth of provider networks as a nearly equally important criteria.

In the Northeast, the perceived quality of many networks is frequently measured by the number of hospitals and physicians contained in a network; the larger the network, the better. Beyond size, employees typically look to two common criteria:

- Are their physicians in the network?
- Are the hospitals with which they are most familiar in the network?

While many objective criteria exist to evaluate networks, understandably, these are typically the most important issues in the eyes of employees.

In Vermont and other states, it is common to see physicians and hospitals participating with up to four, five, or more different managed care plans at the same time. In an effort to control costs, many managed care organizations establish fee schedules and maximum reimbursement rates for health care services that will be paid to network health care providers. While influenced by several other important factors, the amount or depth of such discounts is frequently a key driver of the managed care organization's premium costs. If a health care provider determines a reimbursement rate is unacceptable and is unable to negotiate a satisfactory "price" for its services, it always has the option not to participate in that particular network.

If a network is large and popular in a geographic region, the provider faces the possibility of lost business as employees gravitate to network providers to avoid deductibles and co-insurance costs for out-of-network benefits. On the other hand, if the provider is well known and has an excellent reputation locally, the loss of that provider from an MCO's network may hurt the stability and growth of the network.

There are a number of techniques and objective criteria available to evaluate the depth and quality of managed care networks. The two most common are:

- The National Committee on Quality Assurance (NCQA) is the recognized stamp of approval for HMOs around the country. The NCQA evaluates HMOs according to a rigorous set of standards including access and service, provider qualifications, wellness and prevention programs, treatment outcomes, and disease management programs. (See *www.ncqa.org*.)

  NCQA accreditation ranges include excellent, commendable, accredited, provisional, or denial. Many employers, especially large ones with locations in many states, use NCQA accreditation as the threshold criteria for whether they will even consider offering the program to employees.

- Health Plan Employer Data and Information Set (HEDIS) is a standard set of performance data that provides employers and consumers much of the information needed to objectively compare health care plans. The ability to differentiate one health plan from another is one of the most difficult challenges for employers to grasp and evaluate. It is also potentially becoming a legal concern as the possibility of legislation enabling employees to sue HMOs and employers alike becomes more of a reality.

  HEDIS was originally developed by a consortium of health plans and large employers and is now maintained and supported by the NCQA. HEDIS data consist of a wide variety of statistical measures that provide information regarding the effectiveness of care, access and availability of care, cost of care, and member satisfaction. HEDIS data does serve a useful purpose but is difficult for many small and medium-size employers without sufficient resources to understand and interpret.

PRICING AND COST SHARING

It is common to see health insurance premiums in Vermont of $700 a month for a family, or $8,400 a year. For small employers in particular, once a health insurance plan is purchased, the next decision becomes how much to charge employees who elect coverage and how much will the company pay each month. While fully employer-paid programs still exist, they are becoming rare even in collective bargaining arrangements and public sector programs.

The amount of employer contribution varies by size, region, industry, benefit level, and the type or model of plan purchased. While there are many published surveys, it is difficult to point to an overall average employer contribution for health care benefits that properly blends all these characteristics. Large employers, again depending on industry and size, typically contribute anywhere from 70% to 90% of overall plan cost. Small and medium-size employers generally contribute less, with a much wider variation.

The amount of company subsidy is typically a function of several factors:

- **Affordability** – Business conditions, the economy, and past practice all influence the amount of employer contribution. Small employers in particular may have difficulty even offering a program and commonly contribute substantially less toward the cost of the program than larger organizations.

- **Competition** – The desire to keep good, qualified employees impacts the amount an employer will pay for health insurance. This is an especially difficult decision for small employers attempting to balance a stable workforce with the ability to afford coverage.

- **Benefit levels** – A plan containing higher deductibles, co-insurance, and co-payments costs less than plans with 100% reimbursement and low co-payments. An employer (regardless of size) may determine that it can pay more on average toward the cost of this lower benefit program. However, those employees actually incurring health care costs and using the plan will incur higher out-of-pocket costs than those who do not.

Contribution formulas or techniques are frequently a function of a corporate policy although such policies may change based on business conditions and plan costs. The approaches vary, but contain a few common themes.

Health insurance premiums are typically structured according to coverage tiers, or whether an insured employee also has a spouse and dependents to be included in the coverage. A typical "three-tiered" plan provides coverage for the individual employee, the employee and spouse, and family coverage (or the employee, spouse, and dependent children). A common premium structure for a PPO program might be:

Coverage Tier	Monthly Premium
Individual	$300
Employee and Spouse	$600
Family	$750

A straightforward and common employer contribution scheme is the payment of 70% of the cost of coverage.

Coverage Tier	Monthly Premium	Employee Cost @ 30%
Individual	$300	$90
Employee and Spouse	$600	$180
Family	$750	$225

As stated earlier, the determination of the amount is frequently a function of affordability, competition for employees, and past practice.

An alternative approach provides a disproportionately higher company contribution for an employee's coverage and a lesser amount for coverage of a spouse and dependent children. For example, the employer might contribute 80% of the cost of individual coverage and 60% of the cost of the other coverage tiers.

Coverage Tier	Monthly Premium	Employee Cost
Individual	$300	$60 (20%)
Employee and Spouse	$600	$240 (40%)
Family	$750	$300 (40%)

In this example, the incremental cost of coverage for dependents includes a small company contribution for the spouse and/or children, but the cost of this coverage is largely borne by the employee.

While not as prevalent as it might have been 15 to 20 years ago, the above approach is still seen today. It combines an obvious need to control or reduce costs, with a philosophy that the employer will make a significant contribution toward the cost of coverage for the employee. If the employee has dependents, a contribution is made, but the commitment is not as great. While this approach may imply a degree of equitable treatment among all employees, it defies the reality of how premiums are structured and runs the risk of not being competitive with other employers' programs.

Offering Multiple Plans

It is common to see an employer offer more than one health insurance program. Some very large employers frequently offer many plans. For example, in Vermont, it would not be unusual to see an employer offer a Blue Cross/Blue Shield Point of Service Plan, a BCBS HMO, and an HMO provided by MVP.

Multiple plan offerings can be a challenge for employers and insurers alike. In some instances, an insurer may prohibit the offering of a competing program, or require that a certain percentage of eligible employees join the plan to continue offering the coverage.

When developing a contribution strategy for multiple plan offerings a few issues must be addressed. Is it important to the employer which plan the employees choose? Does the employer want to drive enrollment into the least costly or most desirable plan?

Assume our same PPO plan above with an additional HMO plan offered to employees with premiums 10% less than the PPO.

Monthly Premium Coverage Tier	PPO	HMO
Individual	$300	$270
Employee and Spouse	$600	$540
Family	$750	$675

The PPO offers free choice of any provider which has been deemed important to the employer, albeit via out-of-network benefits. The employer believes that to attract good employees it must offer a plan that retains freedom of provider choice.

Given this objective, the employer wants to ensure a reasonable number of employees continue to participate in the PPO to keep its price stable and assure it meets enrollment requirements. The employer also knows, based on past experience, that most employees will pay more for this flexibility as long as the price difference remains reasonable.

A 70% employer contribution, regardless of the plan, selected results in the following costs to employees:

Monthly Employee Cost @ 30%		
Coverage Tier	**PPO**	**HMO**
Individual	$90	$81
Employee and Spouse	$180	$162
Family	$225	$203

In this instance, the HMO plan costs less, but not so much less that most employees join the HMO and give up the ability to use any provider desired. This approach also meets the employer's objective of offering a stable, affordable plan that contains freedom of provider choice.

In another situation the employer may be much more concerned about cost and has developed a policy of also contributing 70% of plan cost, but only toward the lowest cost program. If an alternate plan costs more, the employee must make up the full difference as follows:

Monthly Employee Cost @ 30%		
Coverage Tier	**PPO**	**HMO**
Individual	$111	$81
Employee and Spouse	$222	$162
Family	$278	$203

In this situation, the dollar amount of the employer's contribution remains constant at 70% of the cost of HMO coverage. This results in a much different relationship in cost among the plans from the employee's perspective.

The examples above are only a few of the more common approaches used to develop a corporate contribution strategy for health insurance. The possible variations and different schemes are innumerable. Although the two most common issues are affordability and competitive practice, these are not necessarily the only objectives and philosophy used to establish a contribution policy.

Benefit Plan Models and Design Considerations

MEDICAL PLAN OPTIONS

Vermont employers have a spectrum of health plan models to choose from ranging from traditional indemnity plans to HMOs. The following chart compares major features of each plan model. Plans on the left side of the spectrum tend to provide the highest level of provider choice and the least amount of utilization management; historically they tend to be high in cost. Plans on the right side of the spectrum tend to have reduced provider choice and more intensive utilization management, resulting in lower cost. Employers should determine which plan model has the appropriate balance of provider access, utilization management, and cost effectiveness. Managed care plans are "network-based" plans. Organizations selling these products have established contracts with providers of medical services/supplies and have agreed to certain financial and administrative arrangements. Contracted providers are referred to as "In-network" providers. Non-contracted providers are referred to as "Out-of-Network" (OON) providers.

Generally speaking, the degree of provider choice can impact the cost of your benefit plan. Managed care plans characterized by greater provider choice tend to be less effective at managing utilization than those plans with less provider choice.

Table 1. Health Plan Models

PLAN OPTIONS	Traditional Indemnity	Network-based Managed Care Products: Preferred Provider Organization (PPO)	Point of Service Plan (POS)	Health Maintenance Organization (HMO)
Negotiated discounts with network providers?	Not applicable; indemnity plans are not network-based	Yes	Yes	Yes
Does the plan include Out-of-Network benefits allowing members to receive reimbursement for care provided by non-contracted providers?	Yes	Yes	Yes	No (see exceptions)
Is plan reimbursement affected by the member's choice of provider(s)?	No	Yes; lesser benefits apply if you go Out-of-Network	Yes; lesser benefits apply if you go Out-of-Network	Yes; there is no coverage if you go Out-of-Network
In what situations will care provided by Out-of-Network providers be reimbursed as an In-Network expense?	Not applicable; indemnity plans are not network-based	Some PPOs make exceptions for life-threatening emergencies and some urgent care	POS plans usually have exceptions for life-threatening emergencies and some urgent care	HMO plans usually have exceptions for life-threatening emergencies and some urgent care
TYPICAL UTILIZATION MANAGEMENT FEATURES				
Inpatient pre-certification	Yes	Yes	Yes	Yes
Outpatient procedure review	No	Yes	Yes	Yes
Prior approval for specialty care visits	No	No	Yes	Yes
Case management	Optional	Yes	Yes	Yes
Disease management	No	Limited availability	Yes (new)	Yes (new)
Who is responsible for managing utilization?	Insurance company or contracted UR vendor	Insurance company or contracted UR vendor	PCP/health plan; members must choose a PCP	PCP/health plan; members must choose a PCP

TYPICAL PLAN DESIGN FEATURES		In-Network	Out-of-Network	In-Network	Out-of-Network	Out-of-Network
Deductible	Yes	Optional	Yes	No	Yes	No
Co-insurance	Yes	Yes	Yes	No	Yes	No
Co-pays (office, surgery, inpatient)	No	Yes	No	Yes	No	Yes
Emphasis on preventative care	No	Yes	No	Yes	No	Yes

PRESCRIPTION DRUG PLANS

Prescription drug costs have been and continue to be the highest trending component of medical cost. Employers have a variety of options to consider when providing members with coverage for prescription drugs. Increasing member awareness of cost-effective drug options is essential to controlling the financial impact of this benefit. The chart below summarizes available prescription drug benefit models available in the Vermont marketplace. Some key terms include:

Generic Drugs - Drugs with the same active chemical composition and same potency that can be offered in the same form as a brand name equivalent. Generic drugs must meet the same FDA standards as brand drugs and must be certified as effective as their brand name counterparts.

Brand Drugs - Drugs which are marketed by brand name, and may or may not have a generic equivalent.

Formulary - A list of extensive, safe, and effective brand name and generic drugs. This list includes quality drugs at a reasonable cost. These drugs have successfully passed federally required clinical testing and have been proven effective. This formulary is usually used by prescription drug card vendors to categorize drugs under their 3-tier co-pay plan designs. Drugs listed on the formulary are covered at either the generic or preferred brand co-pay level. Brand drugs not listed on the formulary are usually considered at the non-preferred co-pay level.

Open (soft) Formulary - Use of formulary is strongly encouraged but not required.

Closed Formulary - Use of formulary drugs is required; non-formulary drugs are not covered.

Mandatory Generic Requirement - Members pay applicable co-pay plus difference in cost between the brand name drug and the generic drug if they purchase brand name when a generic equivalent is available. In some instances, brand name may not be covered if there is a generic available.

Covered Expenses Under Medical Plan - Usually only an option if you offer an indemnity plan. Under this approach, members pay for their prescription claims and they submit them for reimbursement under the medical plan; usually a deductible and plan co-insurance apply.

Prescription Drug Card Plan (Cash-and-Carry) - Members present a drug card at the pharmacy. The pharmacy uses the drug card to verify eligibility and benefits. The pharmacy dispenses the approved drug to the member and collects the member share of the cost. No claim filing necessary. Most prescription drug cards require you to use a participating list of pharmacies that the vendor has negotiated discounts with.

Flat Co-pay - Plan design under which the member co-pay for drugs is the same for both generics and brand name.

Split Co-pay - Plan design under which a lower member co-pay is set for generic drugs, and a higher co-pay is set for brand name drugs.

3-tier Co-pay - Plan design that sets the lowest co-pay for generic, a higher co-pay for preferred brand (formulary), and an even higher co-pay for non-preferred (non-formulary) drugs.

Percentage (%) Co-insurance - Setting a fixed percentage of cost that the members and plan will pay for drugs. Can vary for brand name versus generic.

Mail Order Drug Feature - Allows members taking maintenance drugs to obtain a 90-day supply of drugs via mail, usually at a lesser cost than obtaining three separate 30-day supplies at a retail pharmacy.

Table 2. Prescription Models

AVAILABLE MODELS	Covered expense under medical plan	Prescription drug card options			
		% Co-insurance	Flat co-pay	Split co-pay	3-tier co-pay
Is this typically available if the medical plan I offer is:					
Indemnity	Yes	Yes	Yes	Yes	Yes
PPO	depends on provider	Yes	Yes	Yes	Yes
POS	No	Yes	Yes	Yes	Yes
HMO	No	Yes	Yes	Yes	Yes
Claim filing or Cash-and-Carry	Claim filing	Cash-and-Carry	Cash-and-Carry	Cash-and-Carry	Cash-and-Carry
SAMPLE PLAN DESIGN **Retail (30-day supply)** Deductible	Overall medical plan deductible and co-insurance usually apply	Optional	Optional	Optional	Optional
Co-insurance	see above	50-80% co-insurance	n/a	n/a	n/a
Generic co-pay	–	–	$10 co-pay	$10 co-pay	$10 co-pay
Preferred brand co-pay	–	–	$10 co-pay	$20 co-pay	$20 co-pay
Non-preferred brand co-pay	–	–	$10 co-pay	$20 co-pay	$40 co-pay
Mail order (90-day supply)	n/a	–	2 co-pays (1 co-pay savings)	2 co-pays (1 co-pay savings)	2 co-pays (1 co-pay savings)
Pharmacy discounts	No	Yes	Yes	Yes	Yes
Open or closed formulary	n/a	Options vary depending on vendor	Options vary depending on vendor	Options vary depending on vendor	Open (soft) formulary
Mandatory generics	n/a	Options vary depending on vendor	Options vary depending on vendor	Options vary depending on vendor	Options vary depending on vendor

MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS (MH/SA)

Typically, MH/SA benefits are included in the medical plans purchased from insurers or administrators. These benefits are accessed in the same manner that all other benefits are accessed. Under POS and HMO plans, MH/SA providers are considered specialists and you must receive prior authorization for such care. Depending on your insurer, prior authorization must be obtained from your Primary Care Physician or a managed behavioral care provider.

Employers may also have the option of "carving out" their MH/SA benefits with a Managed Behavioral Care vendor. Usually a MH/SA carve-out plan is funded on a fully insured or capitated basis thereby sheltering the employer from the claim risk associated with the MH/SA benefits. Some Managed Behavioral Care vendors will also allow employers to self-fund their MH/SA benefits. Fees paid to the behavioral care vendor cover costs for network management and access to discounts, claims processing, and utilization management. Carving out MH/SA benefits can benefit employers with more intense cost management focus and plan design flexibility.

Legislation passed in Vermont requires that mental health benefits provided under a fully insured plan be treated as any other covered medical condition (in terms of cost sharing and plan limits).

BENEFIT PLAN DESIGN CONSIDERATIONS

Employers should consider several issues before choosing a benefit model and plan design. These issues include, but are not limited to:

- Budget constraints/affordability
- Human Resources goals; benefits as a means to attract and retain members
- Competitive environment
- Administrative capabilities
- Tolerance for "managed care"

Several factors influence the cost of benefits plans, including:

- Amount of member cost sharing through:
  - Member contributions toward cost
  - Member cost sharing through plan design (co-pay, co-insurance, deductibles, etc.)
- Level of managed care incorporated into plan:
  - Provider choice
  - Utilization management controls (hospital pre-certification, outpatient procedure review, access to specialty care, case management, disease management, etc.)
- Decisions regarding what to cover under the benefit plan
- State and federal mandates such as HIPAA (Health Insurance Portability and Accountability Act), state MH/SA and chiropractic mandates, COBRA (Consolidated Omnibus Budget Reconciliation Act), etc.

Plan design can be used as a tool to influence behavior. Some examples include:

- Use of co-insurance or 3-tier co-pay design for prescription drug benefits. These plan designs increase member awareness of high-cost drugs and incent them to consider more cost-effective and therapeutically equivalent alternatives. A meaningful difference in co-pay amounts for each tier is necessary in order for these plans to positively impact utilization. A typical co-pay structure would be $10 for generic, $20 for preferred brand, and $40 for non-preferred brand.
- Split co-pays under managed care plans (PPO, POS, HMO) which require higher member co-pays for specialists than for primary care doctors. This design feature creates a more appropriate balance between the member out-of-pocket cost and the total cost of services provided. It heightens member awareness of the difference in cost between primary care physicians and specialists.
- Co-insurance versus co-pays as a preferred cost-sharing approach can increase member awareness of the cost of medical services. When services are simply subject to co-pay, members are not affected by the cost of services. Furthermore, as healthcare costs increase, members' cost sharing under a co-insurance benefit design does not remain stagnant (as it would with a co-pay approach). This can help reduce an employer's medical cost trend.

Assessing your needs and designing appropriate solutions within the confines of the market is complicated. For many employers, taking on this task alone can be time consuming and intimidating. A qualified employee benefits consultant/broker can provide to be a valuable resource in managing the cost and quality of your health benefits.

Improving Health Outcomes

Benefits of health management programs

Tangible benefits
- Improve productivity
- Reduce sick leave/abstenteeism
- Reduce use of health benefits
- Reduce workers' compensation
- Reduce injury
- Reduce turnover (lowers high costs of recruitment and training)

Intangible benefits
- Improve employee morale
- Increase employee loyalty
- Reduce organizational friction (leads to productivity)
- Improve employee decision making

Ten years ago, the key issues in the American health care system were classic: containing cost while improving access and quality of care. The rapid rise in health care costs caused our society to take a closer look into how to control costs while improving the health of our nation. Despite the fact that the United States spends more on health care than any other nation in the world, American health outcomes consistently rate lower. For example, infant mortality is twenty-second lowest in the world while male life expectancy is the twenty-fourth highest.

Corporate wellness and health management began in earnest as an industry when it was determined that corporations paid 30% to 50% of health care costs nationally. With over 110 million people in the workplace, managing employee health and changing unhealthy lifestyles will undoubtedly have an impact on cost.

In Vermont, health care expenditures are lower, on average, than nationally; however, we still face rising costs. As the cost of providing health insurance for employees has risen, employers are exploring ways to manage the cost. A year 2000 survey by the Champlain Initiative determined that the majority of employers surveyed indicated that they pass on the rising premium costs by increasing employee co-pays and deductibles. The average deductible ranges from $2,000 to $5,000 for the employee. The challenge is to determine what will motivate the employee to stay well if out-of-pocket costs are seen as a barrier?

One answer to this is found by comparing the leading determinants of health with the factors causing death in the United States. Research indicates that over 50% of the two million deaths annually in the United States are related to non-genetic factors: diet, tobacco, obesity, alcohol, etc. Chart 1 shows the impact that each of four factors has on the health of individuals: behavior, genetics, environment, and health care.

Chart 2 is another way to look at how behaviors relate to the causes of death in the United States.

Chart 1.
Determinants of Health

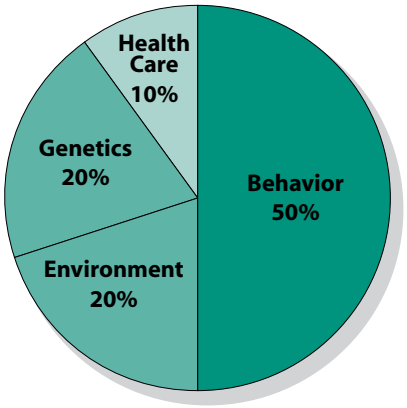
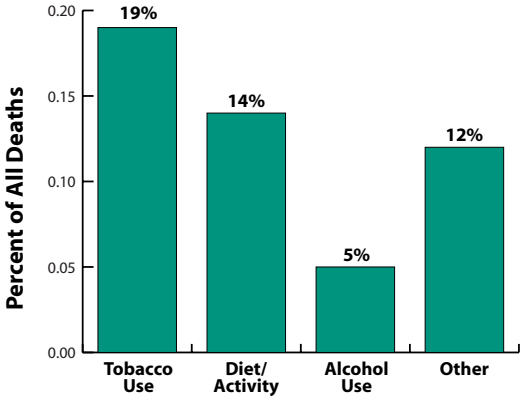


Chart 2.
Cause of Death by Health Factors



Half of all deaths in the U.S. can be attributed to these factors.

Early corporate wellness programs offered by employers were delivered as additional services for employees but remained difficult to measure and were considered "feel good" programs. There was little evidence that the approaches actually worked. Today's programs are incorporated as long-term business strategies and have proven effective on improving health outcomes.

Common terms such as "health management" and "health improvement" are used and the approach is to integrate programs based on best practices for individuals and populations. Effective programs have measurable results in improving health outcomes, and in decreasing absenteeism, workplace injury, and employee turnover. These, in turn, improve the financial bottom line for businesses.

This section is divided into the following categories:

HEALTH MANAGEMENT AT-A-GLANCE

- **Putting the Pieces Together** - Creating a Healthy Workforce
- **Where Does a Company Start?** - Assessing Employee Needs
- **Dealing with the Young and Healthy** - Prevention
- **Changing Habits for Better Health** - Behavior Change
- **Dealing with Disease** - Disease Management
- **Employee Participation** - Demand Management

Read the entire document or use sections that apply to your company and needs. Each section offers discussion about issues and applications, and suggests worksheets for data collection and resources for assistance; the worksheets and other resources are located in *Resources* at the back of the guide.

It is recommended that *Putting the Pieces Together* section be read so the individual can understand the context of the effort to integrate health management and wellness into business strategy.

If you are interested in learning how to implement some efforts, start by asking the question, "What are the health issues in my company?" Complete the steps in *Where Does a Company Start?* This section guides you to the next step, whether it is prevention – *Dealing with the Young and Healthy* – or disease management – *Dealing with Disease* – or both.

Changing Habits for Better Health introduces the reader to the concept of prevention practices in the workplace and offers tools and best practices to help even a small employer provide programs that make a difference.

Finally, *Employee Participation* will help you, as the employer, understand how you can keep employees involved, since it is these individuals who will help or hurt efforts to keep people healthy and manage the use of health care services.

Where does a company start?

Using surveys to assess employee needs

- Provides data sources to help determine where to start.
- Acts as a benchmark to track changes from year to year.

Who are my employees and what are their risks?

Dealing with the Young and Healthy – Prevention
Younger employees with no or fewer behavior risk factors

Changing Habits for Better Health – Behavior Change
Employee behaviors that may contribute to illness poor health (i.e., smoking)

Dealing with Disease – Disease Management
Employees living with disease need support to live well and prevent complications

Employee Participation – Demand Management: Empowering individuals to participate through self-care, shared decision making, and behavior modification to reduce the burden of illness and inappropriate or unnecessary use of health services.

PUTTING THE PIECES TOGETHER - CREATING A HEALTHY WORKFORCE

The goal of "health management" is to help employees adopt healthier lifestyles through integrating human resources, health insurance, and individual behavior strategies. The challenge for an employer is to reach employees and their families with initiatives that work. Worksite programs need to create awareness, encourage workers to take action, and sustain the gain over time.

The commitment to staying well is a state of mind. To succeed, risky behaviors need to be changed. Employers need to evaluate and implement various strategies and policies, and to provide the resources to support and encourage employees to make positive behavior changes.

Participation is the key to success and there are a variety of tools to motivate employees to take greater responsibility for their own health.

This section provides tools and strategies that an employer should review in order to begin a health management initiative, small or large:

- Integrating Health Management into Corporate Business Strategy
- Creating a Healthy Culture Improves Health Outcomes
- Motivating Employees through Incentives Improves Participation
- From Start to Finish: Planning, Implementing, and Evaluating a Program

Integrating Health Management into Corporate Business Strategy

A supportive work environment includes health management initiatives that are completely integrated into the core business strategies. Promoting healthy behaviors needs to be the long-term "norm." In some cases, organizational policy may prevent employees from adopting healthier lifestyles.

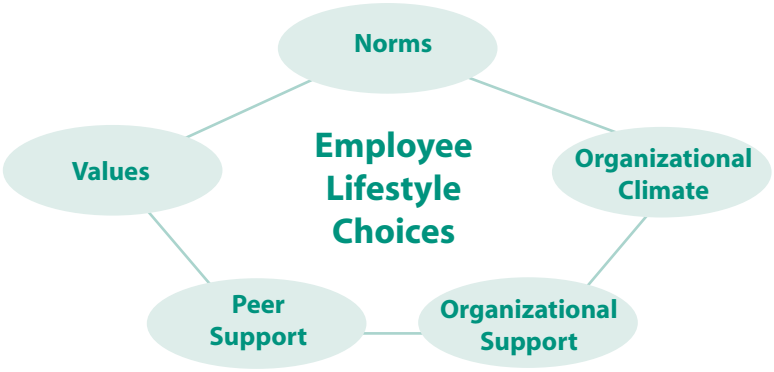
Taking the time for review of human resource policies and efforts to create employee benefits that motivate changes in behavior is critical to success. This may include:

- Choosing a health insurer that is a partner in prevention
- Offering an Employee Assistance Program (EAP) for counseling and other issues
- Providing prescription drug benefits to promote greater use of generics (i.e., tiered pharmaceutical benefit; "Smart Meds" education, a consumer education program on the use of generics versus brand name medications)
- Providing flexible work options
- Introducing life skills training such as time management, self-care, volunteerism, etc.
- Being supportive of work/family needs such as childcare, eldercare, and family leave policies
- Using effective communication vehicles to educate (i.e., newsletters, e-mail, meetings, open forums, payroll stuffers)
- Providing appropriate financial and other incentives for healthy behaviors (see *Motivating Employees Through Incentives Improves Participation*)
- Providing insurance cost benefits for participation in health maintenance programs
- Supporting a smoke-free work environment policy, including in company vehicles

Creating a Healthy Culture Improves Health Outcomes

The work environment and how valued an employee feels strongly influence the health of employees in an organization. If the environment supports employees to adopt healthier lifestyles then individuals will be more motivated to make positive behavior changes. There are many factors that affect employee lifestyle choices.

Chart 3. Factors Affecting Lifestyle Choices and Health Outcomes



An employer can measure organizational culture in a variety of ways. First, be aware of the surroundings. Are there healthy choices in the vending machines? Do employees get adequate break times to stretch or take a walk? Are managers good role models for healthy behaviors? Are employees overworked with little time to get lunch?

A review of worksite policy and organizational culture assessment will help you see where the issues are. Creating a culture that values self-care may be as simple as supporting existing policies: taking lunch breaks and vacation time. If there is a need to change the culture, starting with management behavior. An employee "Wellness Committee" may be a good place to begin the culture shift.

An employer can measure values by examining employees' attitudes by using a questionnaire. An example is included later in this section, however, more extensive questionnaires are available through many vendors including the Health Culture Audit, available through *www.healthyculture.com*.

The Wellness Councils of America (WELCOA, *www.welcoa.org*) suggests that there are five major ideas that should be considered when striving for a healthy environment. They are as follows:

1. Friendly facilities
2. Proactive policies
3. Consistent recognition and support
4. Managers model and support healthy behavior
5. Ongoing health management initiatives

Creating a healthy culture is a strategy that is invaluable for any size employer. The existing culture has an enormous impact on what is valued and how that impacts behavior among employees. Encouraging open communication, creating a sense of community, and implementing the strategies offered here support healthier and more productive employees.

Motivating Employees Through Incentives Improves Participation

People become motivated to make changes in their lives for several reasons and there are many types of incentives. An individual can create their own motivation to improve their own health, which is considered an "internal motivation" (i.e., birth of a new child). An employer can encourage participation and behavior change through "external incentives" such as money, days off, prizes, etc. Smaller incentives are used for starting a program and reaching identified benchmarks, while larger incentives are used for successfully completing a program and sustaining the behavior change.

To understand what external incentives employees want, simple focus groups or surveys are an excellent way to start (see *Resources* for survey tools).

Table 3.

Relative Strengths of Various Incentives[3]

(+ = low, ++++ = high)

Types of Incentive Rewards	Administrative & Clerical	Executive Managers	Professional & Technical	Production Worker
Cash	+	++	+++	++++
Belonging	++	++	+++	+++
Lottery	+	++	+++	+++
Recognition	+	++	+++	+++
Material goods	+	++	+++	+++
Competition	+++	+++	++++	+++
Time off	+	+	++++	+++

Employers frequently ask about involving employees in their own health and tying this into health benefit costs without having problems with laws such as the Health Insurance Portability and Accountability Act (HIPAA). The best tip for creating an employer incentive program is to understand that HIPAA rules apply to insurance coverage while providing financial incentives for participation in programs that are reserved for the employer. The creation of a program that promotes health maintenance and change measurement can include cost sharing for benefit expenses if the criteria is focused on participation and not the presence or absence of disease. (See *Financial Incentives*.)

One example of tying financial incentives to an insurance benefit plan is Southwestern Vermont Health Care's *WellPro* program. A summary of this program is included in the resource, *Proactive Benefit Models*. An example of encouraging use of prevention through reduced barriers to primary care provider access is seen in The Vermont Country Store's *Prime Care Choice* also outlined in *Proactive Benefit Models*.

FROM START TO FINISH – PLANNING, IMPLEMENTING, AND EVALUATING A PROGRAM

This section of the guide presents tools to help the employer understand where to start, provide information and programs to help change behaviors, and put all of the pieces together through corporate culture. The keys to successfully changing behavior and reducing cost are starting with a focused need, understanding what measures of success will be, and choosing a time to evaluate whether the expected outcomes were achieved.

Some businesses have a human resource team that is capable of reviewing outcome data. The outcome data can measure participation, employee comments, behavior changes, and medical claims. The best way to review outcomes is by continually evaluating and documenting programs as they occur. A review of data should be done annually (see the resource, *Data Collection Worksheet*). Many employers seek guidance from their insurance provider and/or a wellness vendor to help in this area. An example of how a company may evaluate success in a program is included in the *Sample Evaluation Tool*.

A healthy workforce can save employers thousands of dollars in health care costs. The return on investment for health management can vary from employer to employer. Effective programs have shown anywhere from $1.11 to over $8 return for every dollar invested. The following *Documented Return on Investment* chart illustrates this.

Table 4. Documented Return on Investment[4]

Study	Program area	Program design	Study period	Outcome variables	Benefits to cost
General Mills, Wood, 1989	Lifestyle modification and disease screening	Participants must complete one of three lifestyle activities every 3 months	2 years	Absenteeism	$3.1-3.9 to $1
General Motors, Foote, 1991	Blood pressure	Blood pressure screening with various intensity of intervention	4 years	Total health care costs	$3.94-4.91 to $1
Blue Cross of California, Lorig, 1985	General self-care	Self-care books, newsletters, group sessions	15 months	Outpatient costs	$9.2 to $1
Group Health, Fries, 1997	Arthritis and self-care	Health assessment, recommendation letters, periodic updates, self-care books	6 months	Absenteeism and outpatient costs	$2.7-10.7 to $1
Spohn Memorial Hospital, Branwell, 1998	Diabetes disease management	Education sessions that span a 6-week period and one-on-one interaction with a nurse educator	1 year	Total health care costs	$8.88 to $1
Citibank N.A., Ozminkowski, 1999	Lifestyle modification and self-care	Risk appraisal, follow-up reports, educational materials, self-care books	32 Months	Absenteeism and total health care costs	$6.47 to $1

Other benefits of such activity include increased productivity, morale, and employee retention. Whether the company is large or small, a comprehensive program can be successful with a long-term commitment (2 to 5 years).

The Wellness Councils of America (WELCOA, *www.welcoa.org*), experts in corporate health management and wellness, list the following seven critical elements of success in health management:

1. Senior level support
2. Cohesive wellness team
3. Data collection
4. Operating plan design and implementation
5. Effective programming to involve employees
6. Supportive and healthy environment
7. Evaluation of outcomes

Where to find vendors for health promotion services

- Hospital health promotion programs
- Occupational health companies
- Independent health companies
- YMCA, fitness facilities
- Local health department offices
- Community organizations such as American Cancer Society
- Colleges and universities

Designing a health management program with these seven elements can appear overwhelming but it also can take years to grow a successful program. Employers have help all around them, from local wellness vendors and hospitals to on-line resources full of useful information and products (see sidebar, "Where to Find Vendors"). A list of Web sites for health promotion efforts is found in the *Resources* section.

Financial Incentives

Larry Chapman, chair and senior consultant for Summex Corporation, presents 12 models for health promotion-oriented financial incentives used by employee and managed care health promotion programs; they are:

- **Benefit design modifications** - Employees who meet health promotion criteria receive improved medical care coverage. This could include differential co-pays, additional nontraditional therapies, or greater provider choice.
- **Cost-sharing offsets** - Employer provides cash-equivalent offsets for meeting wellness attributes.
- **Direct financial payments** - Individuals who attain certain wellness achievements qualify for a cash reward.
- **Health care reimbursement accounts** - Employer links wellness activities to company-provided funds placed in a health care reimbursement account.
- **Merchandise awards programs** - Employees earn points for health improvement efforts to qualify for a cash reward.
- **Retirement or savings bonus** - Employees who meet wellness attributes receive cash rewards deposited into retirement savings accounts.
- **Risk-rated premium contributions** - Employees receive discounts on health insurance premiums based on risk variables.
- **Serial feedback requirements** - Employees who participate in a series of wellness activities, including health risk appraisals, receive discounts on insurance premiums.
- **Time and travel reward systems** - Employees who participate in health promotion activities enter a lottery for vacation and travel coupons.
- **Wellness flex credits** - Companies give additional flex-plan credits or benefit dollars to employees who participate in health promotion programs or improve health independently.
- **Wellness gainsharing** - An organization shares aggregate health care savings with all employees; disbursement may be based on wellness attributes.
- **Wellness medical savings accounts** - Incentives for wellness behaviors are part of the medical savings account structure.

Proactive Benefit Models

Southwestern Vermont Health Care's *WellPro* Incentive-based Wellness Program

What is *WellPro*?

- This is a fully integrated prevention and health promotion program linking the employee's share in cost of health insurance with self-care activities.
- Age-appropriate prevention screening, behavior modification, and disease risk management are encouraged.
- The provider manages the program but the employer does not see health data. Instead, the employer receives verification from the provider that the individual is following management guidelines.

How does *WellPro* work?

The three established levels of performance linked to the amount the employer contributes to the cost of health insurance are described in the table below.

Table 5. *WellPro* Health Care Plan Level Criteria

Level	Criteria	% of premium paid by employer
Level I	Always wear seatbelts. Never drive or come to work under the influence of drugs or alcohol. Remain free from use of illegal drugs. Exercise 20-30 minutes at least 3 times per week. Stay up-to-date on vaccinations or toxoids. Annual health visit or examination. Complete annual mental health screening. Annual dental examination.	71%
Level II	Meet all Level I requirements. Be tobacco-free or participate in a tobacco cessation program.	76%
Level III	Meet all Level I requirements. Be tobacco-free. Meet defined blood pressure parameters or be under care and compliant with treatment. Meet defined blood sugar parameters or be under care and compliant with treatment. Meet defined blood cholesterol parameters or be under care and compliant with treatment. Meet weight table requirements or achieve a 20% improvement in the difference between the extreme value and weight at time of annual exam or a weight change meeting target established by care provider.	77% 78% 79% 80%

- The employee participates voluntarily by signing an enrollment form and taking a health assessment to be completed by the health care provider.
- The employee understands risk factors that need to be addressed, works with his or her provider to manage the issues, and has the provider verify active participation.
- All completed enrollment and health assessment forms are returned to Human Resources for determination of which of the three levels the employee qualifies.
- Enrollment occurs annually during benefit enrollment time. An employee who participates qualifies for improved employer contribution the year following enrollment.

WellPro Goals

- Decrease health care utilization through improved overall health.
- Lower health care expenditures resulting in decreased health insurance premiums.
- Create a program that has measurable results.

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Proactive Benefit Models

The Vermont Country Store *Prime Care Choice*

What is *Prime Care Choice*?

- The employer contracts directly with Primary Care Providers (PCP) through a capitated contract for services. This allows the company to pay the provider/group a set amount per month for each employee enrolled at the practice.
- The employee can see a participating PCP without incurring any expense for co-pays or out-of-pocket cost, or the individual can choose a non-participating PCP and pay co-pays and out-of-pocket expenses.
- A traditional indemnity plan covers any service beyond regular prevention or simple sick care. The employee pays monthly premiums and co-pays.

How does *Prime Care Choice* work?

- Employees choose the plan during open enrollment. They must choose regular indemnity in order to participate in *Prime Care Choice.*
- Employees in the *Prime Care Choice* program sign up to be a part of a selected provider group and incur no financial barriers to see their PCP.
- The employer enters a contract directly with the PCP group and pays monthly fees per member per month based on a value system established by the U.S. Health Care Financing Administration.
- In this plan, the PCP assumes the financial risk for overuse of services and becomes an active participant with the patient to manage health.
- If an employee needs services outside of regular primary care, the insurance carrier plan is activated and the employee incurs additional co-pays and out-of-pocket expenses.
- If the employee chooses to see a primary care provider outside the network, the individual pays the out-of-pocket and co-pays from the indemnity plan.

Prime Care Choice Goals

- Decrease health care utilization through improved overall health.
- Encourage employees to use preventative services by removing cost as a barrier.
- Engage the primary care provider in managing care and acting as an informal "gatekeeper" for services.
- Reduce administrative expenses by eliminating paperwork for primary care services.
- Help control the cost of insurance premiums.

Prime Care Choice Contact

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Data Collection Worksheet Flowchart

If your data shows:

- Younger employees
- No major health issues
- Young families
- No specific, identified issues

- Demographic of any age
- Issues with unhealthy habits (smoking, alcohol, etc.)
- Absenteeism patterns indicating stress management issues

- Slightly older population
- Specific diseases are issues
- No seeking of care until crisis arises
- Absenteeism for long periods around illness episode(s)

Your assessment leads you to:

Prevention
See page 42

Behavior Change
See page 47

Disease Management
See page 48

WHERE DOES A COMPANY START? – ASSESSING EMPLOYEE NEEDS

Sources of information to help you learn more about the health of your workforce

- Demographic information
- Group medical claims
- Health risk appraisals/ screening data
- Workers' compensation claims/injury reports
- Facilities assessment
- Absenteeism reports
- Employee interest surveys
- Organizational culture assessment
- Employee Assistance Program (EAP) utilization

The past "shotgun" approach to wellness has failed to help high-risk individuals who are the drivers of health care costs. Typical programs drew the "worried well"; those who already practiced healthy habits and wanted to monitor their health.

In Vermont, a 1999 survey of small employers demonstrated that although 82% offered insurance, less than 10% assessed employees' needs. Before embarking on a health management program, an employer needs to identify where to target programs that address current and potential risk factors. How does an employer know what those risk factors are? A variety of data (see sidebar) exists that provides good baseline information about health and demographics of the employee population. Sources of this data include medical claims, employee health risk appraisals, injury and disability reports, and absenteeism reports, among others. The *Data Collection Worksheet* (see *Resources* section) will walk you through various sources of information, where to find them, and how to use the information collected.

Small employers (approximately 50 employees or less) may have difficulty finding enough information internally to assess the health of their employees. Any size company can look at certain types of information that may be available to them. The list at the left (see sidebar) suggests some sources.

For example, if you have 10 employees your demographic information may tell you they are young trades workers. What does the absenteeism look like? Are they getting hurt on the job? Do they have young families or smoke? Simple information like this may lead you to seek an insurance provider that invests in prevention and early prenatal care. Your money may be well spent in paying for a tobacco cessation class or worksite safety efforts. In this case, the employer does not have good data about disease and illness risk. However, the Vermont Department of Health Web site (*www.state.vt.us/health/*) is a good source of information to compare illness trends in Vermont.

Small employers can use short, concise surveys that will assess health status and employee interests. Samples of the surveys, *Organizational Health Inventory, Employee Interest Survey*, and *Employee Health Practices* are found in the *Resources* section.

DEALING WITH THE YOUNG AND HEALTHY – PREVENTION

Prevention initiatives

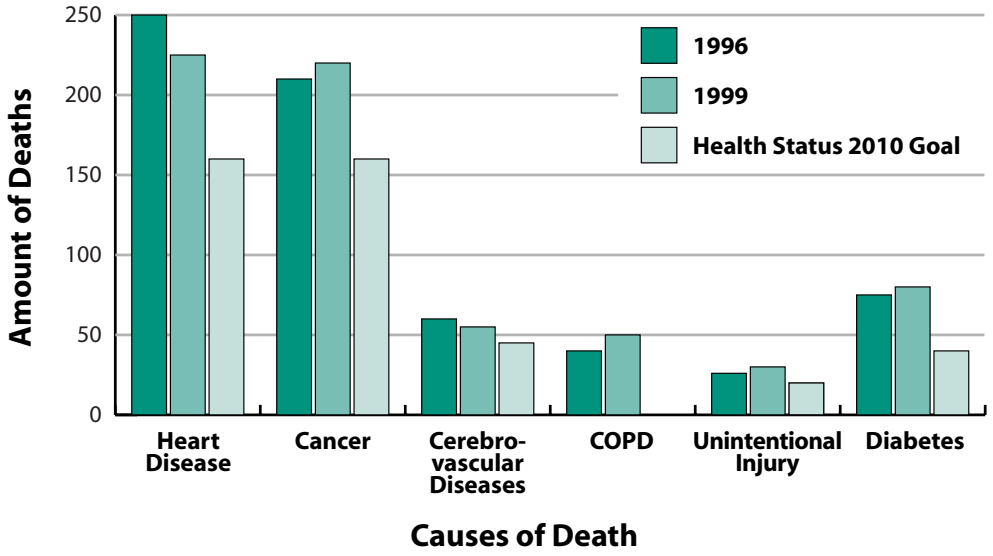
- Age-appropriate preventative health exams
- Immunizations
- Flu shots
- Early prenatal care
- Seminars (i.e., nutrition, exercise, etc.)
- Written material (i.e., newsletters, posters, payroll stuffers, etc.)

Primary Prevention

Employee assessment helps the employer understand what the employee health issues and risks are. Creating a campaign to influence health behaviors now will help improve health outcomes down the road. (See *Data Collection Worksheet* in the *Resources* section.)

Chart 4 (below) shows that heart disease, cancer, and diabetes remain the leading causes of death in Vermont. In fact, cancer and diabetes are on the rise. What is the employer's role if employees are young and don't have these diseases? Prevention education, an easy and low-cost intervention, is the first step in helping employees adopt healthier lifestyles. "Primary prevention" is based on awareness and/or education around prevalent issues such as heart disease, breast cancer, and smoking (see sidebar, *Primary prevention educational topics*). Prevention incorporates a large audience, such as all employees, while behavior change, "secondary prevention," targets specific individuals. For small employers, health information is available outside the company and employees should be informed on how and where to access the information.

Chart 4. Leading Causes of Death in Vermont



Techniques to inform employees about health issues and prevention include purchasing a pre-developed health and wellness newsletter, subscribing to health magazines, participating in monthly health observance days, and others. See *Choosing an Employee Newsletter* and *Health Promotion Theme Calendar* in the Resources section. These interventions can be simple and boost morale. For example, one small Vermont business pays for half of the employee's expense for fitness activity whether it is expense for a piece of equipment or a membership at a local fitness club.

Primary prevention educational topics

- Cholesterol/heart health
- Nutrition
- Physical activity
- Smoking
- Self-care
- Family health
- Eldercare
- Cancer prevention
- AIDS prevention
- Stress management
- Back care
- Alcohol and drug use
- Safety belt use
- Injury prevention
- Occupational safety and health
- Mental health

Another important role for the employer in prevention of illness is to support age-appropriate screening and immunization. For example, if your employee population is primarily over 50 and healthy, encouraging appropriate screening for colorectal cancer may prevent severe illness and death due to the second leading cause of cancer death in Vermont.

The following *Immunization Guidelines* and *Sample Screening Guidelines* tables offer age-specific recommendations.

Table 6. Immunization Guidelines

Age Group	Immunization Type	Age at Which Immunization is Recommended
Birth to 23 months old	H-Flu Type B (HIB) Oral Polio Vaccine (OPV) Diptheria/Pertussis/Tetanus (DPT) Measles/Mumps/Rubella (MMR) Hepatitis B	2, 4, 6, and 12-15 months old 2, 4, and 6-15 months old 2, 4, 6, and 15 months old 15 months old Birth, 1, and 6 months old or 2, 4, and 10 months old
2-6 years old	Oral Polio Vaccine (OPV) Diptheria/Pertussis/Tetanus (DPT)	4-6 years old 4-6 years old
7-12 years old	Measles/Mumps/Rubella (MMR)	12 years old
13-18 years old	Diptheria/Tetanus	14-16 years old (recommended more frequently if child has ever had a serious open wound)
19-39 years old	Diptheria/Tetanus Influenza Pneumonia vaccination Hepatitis B	Every 10 years Annually, if at risk At least one time, if at risk If at risk
40-64 years old	Influenza Pneumonia vaccination Diptheria/Tetanus	Annually, if at risk At least once, if at risk Every 10 years

Table 7. Sample Screening Guidelines

Gender/Screen	Less than 19 years old	20-24 years old	25-39 years old	40-49 years old	50-64 years old	65+ years old
BOTH GENDERS						
Health visit/exam	Every 2 years	Every 5 years	Every 5 years	Every 2 years	Every year	Every year
Blood pressure	Annual	Annual	Annual	Annual	Annual	Annual
Measure of diabetic control (HbA1C, if diabetes present)	Annual	Annual	Annual	Annual	Annual	Annual
Blood sugar	Annual	Annual	Annual	Annual	Annual	Annual
Cholesterol ratios	Baseline prior to age 30, then every 5 years		Baseline prior to age 30, then every 5 years		Every 5 years	Every 5 years
Visual acuity	Baseline by age 10		Every 2 years after age 25	Every 2 years	Every 2 years	Every 2 years
Fecal occult blood					Annually	Annually
Flexible sigmoidoscopy					Every 5 years	Every 5 years
Colonoscopy					Every 10 years	
Hearing test	At birth					Every 5 years
FEMALES						
Breast self-examination education	Annually after age 16	Annually	Annually	Annually	Annually	Annually
PAP smear/ pelvic exam	Annually once sexually active		Annual at age 25, every 3 years after 3 negative PAP tests			
Chlamydia screen	Annually once sexually active until age 25					
Mammogram				Every 1-2 years	Every year	Every year
Clinical breast exam			Initial at provider visit	Annually	Annually	Annually
MALES						
Testicular self-exam education	Annually after age 15	Annually	Annually	Annually	Annually	Annually
Digital rectal exam				Annually	Annually	Annually
Prostate Specific Antigen (PSA)					Annually	Annually

Information presented in this chart was compiled from several sources that may not be exactly the same.

Table 8. Return on Investment for Demand Management Programs[5]

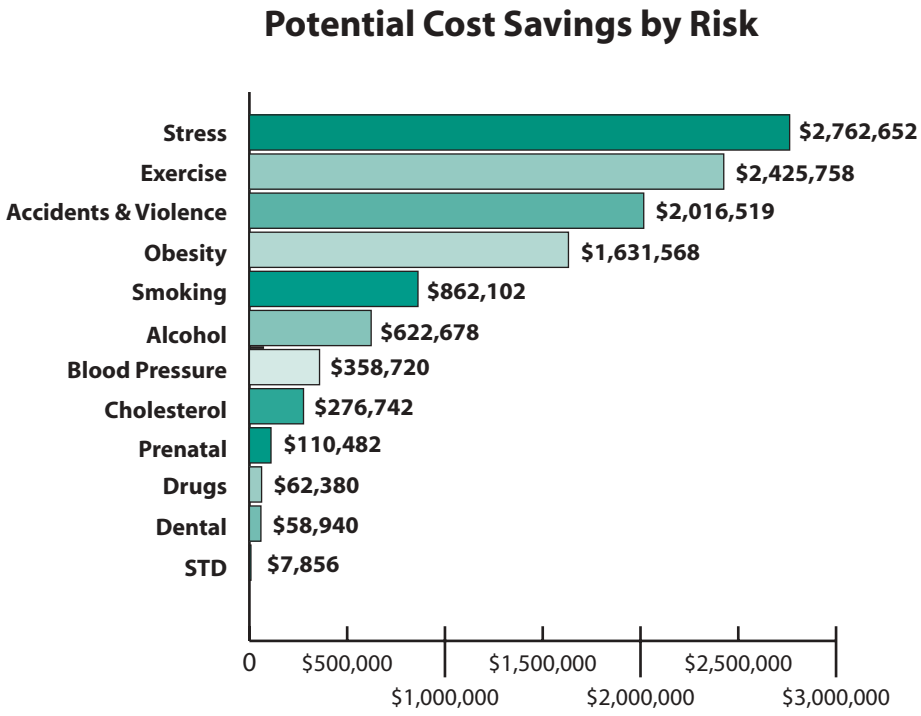
Program format	Cost savings potential ($=low, $$$$=high)	Timing of effect	Sustainability
Case management	$$$$	Immediate	Can be sustaining
End-of-life programs	$$$$	Immediate	Not sustaining
Pre-surgery counseling	$$$$	Immediate	Not usually sustaining
Cost sharing through benefit design	$$$$	Immediate	Sustaining
Disease management	$$$$	Immediate	Can be sustaining
Benefit design incentives	$$$	Immediate	Sustainable
High risk health interventions such as diabetes	$$$	1-5 year lag	Can be sustaining
Incentive programs	$$$	Immediate	Can be sustaining
Medical self-care	$$$	Immediate	Can be sustaining
Prenatal care	$$$	Immediate	Can be sustaining
Reminder systems	$$$	Immediate	Not usually sustaining
Resource referral services	$$$	Immediate	Rarely sustaining
Biometric screening such as cholesterol and blood pressure	$$	Depends on type of screening	
Consumer health education	$$	Immediate	Can be sustaining
Health Risk Appraisal and feedback	$$	1-2 year lag	Possibly sustaining
Behavioral change programs such as tobacco cessation	$$	1-5 year lag	Can be sustaining
Health advice lines	$	Depends on type of advice	

Determining the potential cost savings for either prevention or behavior modification may involve seeking the assistance of a professional to study employee health utilization data, workplace injury, absenteeism, etc. Many organizations across the nation have performed such studies and determined significant potential and actual cost savings.

The *Documented Return on Investment* chart, mentioned previously in the *Putting the Pieces Together* section, provides a list of published cost savings.

Below is one company's claims risk analysis indicating dollars spent in health insurance claims, worker's compensation, and absenteeism due to modifiable behaviors.

Chart 5. One Company's Summary of Modifiable Claims



CHANGING HABITS FOR BETTER HEALTH – BEHAVIOR CHANGE

Typical behavior modification programs, where to find them

- **Tobacco cessation**
  1-877-yes-quit, hospitals, providers
- **Weight management**
  Weight Watchers, hospitals, wellness programs
- **Stress management**
  EAP, wellness programs
- **Increasing activity**
  fitness clubs, YMCA, VT Council on Physical Fitness

Behavior change programs are proactive and focus on individuals who engage in habits that are known to lead to poor short- and long-term health. The most successful programs help individuals move through various stages of readiness to change until they successfully modify their unhealthy behavior. Habits can be difficult to overcome, so many programs are now based on the *Stages of Change* model explained in the sidebar. This model helps focus efforts on the individual who is ready to change behavior while at the same time providing information to those who are not yet ready. These programs are often focused on smoking cessation, weight management, exercise, and stress management and may be found by contacting the Vermont Department of Health, local hospital wellness programs, fitness centers, or they may be purchased online.

Changing employee behavior can use more resources than prevention education programs because behavior change initiatives focus on the individual and typically a counselor or practitioner presents a series of classes over a longer period of time. However, since these programs focus on the highest risk individuals, some immediate returns on investment such as employee morale and absenteeism may be seen.

Stages of Change Model – The five well-defined stages of change are:

- **Precontemplation**
  not thinking about changing habits
- **Contemplation**
  understands the need for change but not ready
- **Preparation**
  ready to make a change within coming month
- **Action**
  making the change in behavior
- **Maintenance**
  maintaining the behavior change

Lower cost interventions include creating an employee activity challenge or offering information about the next weight management or smoking cessation class available in the community (see sidebar, *Typical behavior modification programs*). Many vendors and wellness programs will bring the class to the workplace and often employees are willing to share in the cost.

Greater participation in the workplace is evident when an incentive-based program is available. These programs use small or large incentives to encourage the individual to participate and for successfully completing the program.

Programs to Help with Behavior Change

- Incentive-based health management programs
- Prevention education
- Time management
- Employee Assistance Program (EAP)
- Support groups
- Other resources available in community

DEALING WITH DISEASE - DISEASE MANAGEMENT

Insurance provider checklist

- Offer disease management programs
- Cover preventative screening
- Cover programs designed to help people stay well (i.e., smoking cessation)
- Provide self-care resources (i.e., telephone support)
- Have risk assessment tools
- Provide focused prevention services (i.e., prenatal programs, well baby)

One of the most challenging issues for an employer is to understand what can be done to help employees who live with long-term diseases. If well managed, many require no intervention or additional support from the employer, while others require workplace modification or flexible scheduling to help the employee.

Be aware that some diseases such as high blood pressure and diabetes, if left undetected and untreated, can be devastating - both to the individual and to the employer. Encouraging regular provider check-ups provides a significant opportunity to make sure these issues get addressed. Larger employers with employee health programs may be able to effectively support individuals who have been diagnosed using disease management programs in collaboration with providers. This is more difficult for smaller employers who hire fewer people with such issues. The advantage of a managed care program is that, by design, they have programs to help people diagnose and manage long-term diseases.

Employer activities that affect employee demand for medical care

Employee benefits:
- Health benefits
- Health promotion programs
- Fitness programs
- Health incentive programs
- Health advice line
- Annual health risk appraisal
- Food services
- Recreation programs
- Training and development
- Benefit communications

Policies and cultural norms:
- Sick leave policy
- Personnel policies
- Employee health-related polices
- Physical plant characteristics
- Organizational development activities
- Shift-work patterns
- Cultural norms

Employee health services:
- Occupational health services
- Employee Assistance Programs
- Disability management
- Return-to-work programs
- Safety
- Ergonomics
- Health screening
- Worker compensation

However, all insurance carriers in Vermont are guided by Rule 10, a state mandate that requires them to have quality improvement programs in place. The majorities have diabetes, smoking cessation, and asthma management programs, for example. All employers, both large and small, can take advantage of prevention programs when they purchase health insurance. Managed care organizations often have the most comprehensive programs available. A call to the insurance provider may help an employer get such a service at low or no cost to the organization or the employee (see sidebar, *Insurance Provider Checklist*.)

If a benefit analysis demonstrates that there are issues with disease, look closely at the insurance provider's disease management capability.

The following are components of good disease management programs:

- Good medical leadership
- Program education for employees
- Patient/physician communication
- Phone support/counseling (nurse)
- Approved guidelines for common diseases
- Ongoing program with continued evaluation

Alternative sources of disease management information and help in adapting the work environment to employees' needs can be found by contacting non-profit organizations, local hospitals, and the Vermont Department of Health.

EMPLOYEE PARTICIPATION - DEMAND MANAGEMENT

"40% of all health care demand is avoidable."

Source:
American Compensation Association Journal, Winter 1996.

Demand management is the term used to describe the difference between medical care supply and the amount individuals use. While insurance strategies control the supply of medical services, demand management focuses on educating consumers to use medical resources wisely and to make them more aware that more health care is not always better. A variety of demand management strategies at the workplace include self-care and decision support via phone and/or the Internet (among others). Consider the *Types of Demand Management Services* list (below) and *Documented Return on Investment* chart (located in the *Putting the Pieces Together* section).

Previous discussion in this section covered prevention, behavior change, and disease management, and described focused interventions that reduce the demand for health services. This section will provide tools to help the employer decrease the use of medical services and engage employees in appropriate use of health care services.

How individual view affects health care utilization

Jaime has been diagnosed with Type 2 diabetes. Her provider tells her that exercise, proper diet, and weight loss will help her manage the illness.

For some reason Jaime hasn't done any of these. Why?

Asking her, she has a story: "My Aunt Sue had diabetes years ago. It was terrible; she had to go through dialysis for years. It's useless, I will always be unhealthy."

Types of Demand Management Services[6]

Disability Management - This telephone service works with individuals who are on short-term disability or workers' compensation. Proactive case management is available to get employees back to work as soon as possible. Counselors work with employees on short-term medical compliance and other factors such as the individual's attitudes concerning work and disability.

Disease Management - This service is targeted primarily to individuals who have chronic illnesses and require ongoing treatment. The goal is to improve compliance through periodic telephone follow-up, education, and support.

Health Care Decision Counseling - This "core" telephone counseling service is the fastest-growing demand management option. The primary goal is to empower individuals to make better health care decisions. Information is available on treatment options, risks, and costs.

Healthline - A telephone-accessed health information service that provides health education on a variety of topics. These services usually provide general education and no counseling.

Medical Self-care Education - A very popular demand management program, medical self-care usually uses a variety of self-management tools such as self-care books, newsletters, and group seminars. These tools help individuals make better decisions about their own health.

Proactive Risk Counseling - This demand management strategy integrates health screening and health risk appraisal with proactive counseling from medical counselors. The goal is to help individuals understand their health risks and how to manage them.

The following table[7] defines the four influences on why a person seeks medical care. Surprisingly, research has shown that the mere presence of an illness is not the greatest influence on someone seeking care. The most significant influence is how a person sees his or her own health and need for care.

Table 9. Influences on Medical Care Use

Why a person uses medical care	How this impacts use of medical care	How to influence individual behavior
Person is ill	Does not accurately predict that a person will use medical care system.	Prevention practices (i.e., screening and education)
What a person believes to be true about their health status	The most significant factor influencing use of health care.	• Improve knowledge about risks • Educate about effective treatments • Use of self-care materials
A person's level of participation in informed decision making	Fully informed individuals are likely to use less invasive, less risky, and less expensive services.	Decision support systems • Employee educated about health plan • "Ask-a-Nurse" programs • Computer-assisted decision making programs
Use of medical care for non-medical reasons (i.e., sick leave, worker's compensation, disability, etc.)	Difficult to influence and measure.	• Changing culture within organization • Incentives for health maintenance • Use of flex-time and part-time options

Suggested self-care guides

- **Healthy Life Self-Care Guide: An Apple a Day Isn't Enough.** Powell, Don R. 9th edition.
- **A Practical Guide to Everyday Medical Decisions: Take Charge of Your Health.** Terry, Paul E., et al.
- **Healthwise Handbook: A Self-Care Manual for You.** 12th edition. Healthwise, Inc.
- **Take Care of Yourself: The Complete Illustrated Guide to Medical Self-Care.** 6th edition.
- **Mayo Clinic Guide to Self-Care.** 2nd edition. Mayo Clinic.

Self-care assists individuals in choosing the most appropriate care for the health problem. The primary goal of self-care programs is to improve quality of health care with better information, improved care provider and patient communication, and increased self-confidence in making health decisions thus improving the quality of care a person receives.

Companies, including those focusing on unhealthy behaviors and pharmaceutical manufacturers, have all recognized the value of "direct to consumer marketing." They have discovered, with great success, the value of educating the consumer through the media to influence use of their products. To counter this, education and increased awareness efforts must take place in both written and visual format. The most popular tools to do this include self-help books and Internet-based health resources. A review of these tools follows.

Self-care Books

A good self-care book will:

- Be easy to read
- Provide summaries for each issue listing: when to help self, seek M.D., or go to emergency facility
- Contain accurate basic health information in *lay terms*
- Be written by a reputable organization (i.e., health care, wellness company, or government organization)

For a list of reputable books, see sidebar, *Suggested self-care guides*.

Internet Resources

The Internet is a great source of information to help employees learn more about specific health issues, risk factors for disease, or organizations that can help. It is worth noting that access to information alone does not create healthier practices, so making sure a person living with disease works closely with his or her primary care provider for management is an essential part of any program.

A great deal of discussion has been ongoing about the risk of "bad" information that is available on the Web since anyone can host a Web site. When looking for information, make sure the Internet resource is provided by a reputable non-profit organization, health care organization, or government agency. In Vermont, hospitals and Area Health Education Centers (AHEC) have partnered to provide a site for accessing resources through regional Health Resource Centers. These can be accessed by contacting your local hospital or on the Internet *(www.med.uvm.edu/ahec/)*.

For a list of reputable Web sites see *Internet Health Resources* in the *Resources* section.

Other Technology

Providing these guidelines as an incentive to participate in programs adds value in two ways: motivating people to start participating and providing tools for individuals to use on an on-going basis.

"Decision support systems" is the term used for helping a person make the most appropriate decision for his or her own situation. If individuals have been diagnosed with a certain disease, the more they can educate themselves on how to manage their illness, the better the decisions they will make. (This can be a very complex process.)

Some managed care insurance companies provide assistance through a telephone-based system. These work by providing a toll-free number for people to ask health questions. The counselor or nurse on the line follows specific guidelines to help determine what level of care is necessary.

Other tools for this type of system include interactive video and computer technology. One example of computer technology is the Comprehensive Health Enhancement Support System (CHESS). CHESS is an easy to use, online source of services designed to help individuals and their families with specific medical concerns. The computer program helps them access up-to-date and timely information, assist in problem solving, and provide self-monitoring tools and social support systems. Access to such systems can be made through Health Care Resource Centers. The CHESS program provides modules on breast cancer, heart disease, managing menopause, prostate cancer, and asthma. It also offers support for people with dementia and is available free through *www.fahc.org/chi/chess/chess.html*.

Resources

CHOOSING AN EMPLOYEE NEWSLETTER

Employee newsletters are a great way to educate employees about wellness, nutrition, fitness, prevention of various diseases, and productivity. Fill each newsletter with ideas employees can use to create a more balanced life; tips on easing stress, enhancing diet, boosting energy, effective parenting, and so much more. Newsletters can be as simple as one-page handouts developed in-house, or an in-depth publication purchased from a vendor.

Creating an In-house Newsletter - To create this type of in-house newsletter, consider the following:

- What is the purpose of the publication? To inform? Educate? Create awareness? Motivate? Entertain?
- What will it contain?
- Where will you get your information?
- How long will it be?
- Who is the main audience? Employees? Families?
- What health promotion objective will be achieved?
- What is the projected budget for the year? Cost per issue?
- Will it be published monthly? Quarterly?
- How will it be distributed? Paychecks? Mailed to home addresses? Delivered around the building?
- Define available resources to produce the publication?
- What will you name it?
- What will it look like?
- How will you measure its effectiveness?

Purchasing an Employee Newsletter - Ask these questions (and others) before deciding on going to an outside supplier:

- What is the overall budget for the year, per issue?
- What size and how many pages should the letter be?
- How will the employees receive it? At work? At home?
- How frequently?

After answering the basic questions, it's time to research vendors and request quotes. Newsletter Web sites are listed in *Consumer Health Web Sites* in the *Resources* section.

Additional considerations to keep in mind when reviewing newsletters to purchase:

- Review editorial content and credibility.
- Do articles address prevention and lifestyle-related information?
- Does the publication meet your overall objectives?
- Can you sample a few of the letters for employee review?
- Are they priced competitively?

CONSUMER HEALTH WEB SITES

Employer Resources for Employee Benefits/Health Decisions

Vermont Businesses for Social Responsibility "Livable Jobs Toolkit"
(flexible work arrangements - keeping a business profitable through wages, workplace practices, and employee benefits)
(802) 862-8347
www.vbsr.org
e-mail: *info@vbsr.org*

Vermont Ethics Network: Advance Directive Planning
(802) 828-2909
www.vtethicsnetwork.org
e-mail: *ethics@vtethicsnetwork.org*

Health Information from Regional Hospitals

Area Health Education Centers
www.med.uvm.edu/ahec/

Brattleboro Memorial Hospital
Brattleboro, VT
(802) 257-0341
www.bmhvt.org

Central Vermont Medical Center
Berlin, VT
(802) 371-4100
www.cvmc.hitchcock.org

Comprehensive Health Enhancement Support System (CHESS)
www.fahc.org/chi/chess/chess.html

Copley Hospital
Morrisville, VT
(802) 888-4231
www.copleyhealthsystems.org

Dartmouth Hitchcock Medical Center
Lebanon, NH
(603) 650-5000
www.hitchcock.org

Fletcher Allen Health Care
Burlington, VT
(802) 847-2278
www.fahc.org

Gifford Medical Center
Randolph, VT
(802) 728-4441
www.giffordmed.org

Grace Cottage Hospital
Townsend, VT
(802) 365-7357
www.gracecottage.org

Mt. Ascutney Hospital
Ascutney, VT
(802) 674-6711
www.mtascutneyhosp.hitchcock.org

North Country Hospital
Newport, VT
(802) 334-7331
www.nchsi.org

Northeastern Vermont Regional Hospital
St. Johnsbury, VT
(802) 748-8141
www.nvrh.org

Northwestern Medical Center for Health and Wellness
St. Albans, VT
(802) 524-5911
www.nmcinc.org

Porter Medical Center
Middlebury, VT
(802) 388-4723
www.portermedical.org

Rutland Regional Medical Center
Rutland, VT
(802) 775-7111
www.rrmc.org

Southwestern Vermont Medical Center The Wellness Connection
Bennington, VT
(802) 442-6361
www.svhealthcare.org

Springfield Hospital
Springfield, VT
(802) 885-2151
www.springfieldhospital.org

CONSUMER HEALTH WEB SITES CONTINUED

VA Medical and Regional Office Center
White River Junction, VT
(802) 295-9363
www.visn1.med.va.gov/wrj/

Health Organizations

American Heart Association
Heart at Work Online
(214) 706-1143
www.americanheart.org/haw/

American Lung Association of Vermont
(802) 863-6817, 1-800-586-4872
www.lungusa.org

Centers for Disease Control and Prevention
1-800-811-3435
www.cdc.gov

Vermont Department of Health
1-800-464-4343
Healthy Vermonters 2010:
www.state.vt.us/health/pubs.htm

Health Risk Appraisals

Fletcher Allen Health Care
Community Health Resource Center
Burlington, VT
(802) 847-2278
www.fahc.org/health_improvement/

Gordian Health Solutions, Inc.
(866) 676-3975
www.gordian-health.com

Health Calc Network
(888) 999-1007
www.healthcalc.net

Johnson & Johnson Health Care Systems
1-800-554-7389
jnj.ncstech.com

Summex Corporation
(317) 713-3901
www.summex.com

Wellsource, Inc.
(503) 656-7446
www.wellsource.com

Internet Health Resources

(The following listing was compiled by Community Health Resource Center at Fletcher Allen Health Care; last updated June 19, 2001. Fletcher Allen does not endorse any of the links and resources; they are presented for information only.)

AARP (American Association of Retired Persons)
www.aarp.org/healthguide/

American Academy of Family Physicians
www.familydoctor.org

American Academy of Pediatrics
www.aap.org/family/

American Cancer Society
www.cancer.org

American Dietetic Association
www.eatright.org

Drug Information
www.nlm.nih.gov/medlineplus/druginformation.html

Exercise
www.nlm.nih.gov/medlineplus/exercisephysicalfitness.html

Healthfinder
www.healthfinder.gov

KidsHealth
www.kidshealth.org

MEDLINEplus
www.nlm.nih.gov/medlineplus/

National Dairy Council
www.nationaldairycouncil.org

NOAH (New York Online Access to Health)
www.noah-health.org

Nutrition
www.nutrio.com
www.nutrition.gov
www.noahhealth.org/english/wellness/nutrition/nutrition.html

CONSUMER HEALTH WEB SITES CONTINUED

Smoking Cessation
www.nlm.nih.gov/medlineplus/smokingcessation.html

YourSurgery.Com
www.yoursurgery.com

Wellness Manuals and Tools

American Journal of Health Promotion
1-800-783-9913
www.healthpromotionjournal.com

Health Culture Audit
Human Resources Institute, Inc.
(802) 862-8855
www.healthyculture.com

Health Management and Behavior Change Programs
Staywell Health Management
(651) 454-3577
www.staywell.com

National Committee on Quality Assurance (NCQA)
www.ncqa.org

Summex Corporation
www.summex.com

The Worksite Wellness Buyer's Guide
Wellness Councils of America
(402) 827-3590
www.welcoa.org

Wellness Newsletters

Health Ink and Vitality
(856) 778-0011
www.vitality.com

Hope Health
1-800-334-4094
www.hopepublications.com

DATA COLLECTION WORKSHEET

Collecting and analyzing company data helps identify where heath care dollars are being spent and why. Organizational information narrows the focus of a health management program and justifies implementation.

All data should remain confidential and protect individual privacy. Data collected should be saved to compare changes over time.

Demographic Information

- Number of males and females
- Age breakdown
- Part-time vs. full-time status
- Educational level
- Ethnicity
- Work site location
- Job type or category
- Years of employment in company

Demographic data is available through human resources departments or by surveying employees. This information is crucial when determining needs, and what programs or services will work. For example, if the company is made up of middle-aged males then heart disease or prostate health may be an important topic for education.

Group Medical Claims

- Total medical care costs
- Highest cost claims categories
- ICD9 (International Classification of Disease Version 9, a numerical classification of diagnoses uses for billing and reporting purposes) codes for highest claims
- Drug utilization costs and categories

A medical claims analysis can determine where medical dollars are being spent. Medical claims only reflect those employees who have entered the medical system but an inference can be made to what medical conditions are being treated and the health risks associated with those diseases. For example, if lung disease or respiratory ailments are common, then smoking may be a risk factor and a cessation program may be the best investment. A medical claims review over time can determine if health management programs are successful. A claims analysis can be very brief, looking at what expenses "jump out" at you. Often, insurance providers, wellness programs, or vendors will perform this for you free of charge.

Health Risk Appraisals and/or Screening Data

- Assess employee health risks before illness occurs
- Determine what behaviors are most prevalent in employees
- Provide immediate feedback for the employee
- Great tool for a small employers
- Screenings provide objective data about cholesterol, blood pressure, etc.
- Aggregate reports provide important information for the employer
- Must be confidential and voluntary

Health Risk Appraisals (HRAs) are health questionnaires that rely on self-assessment of behaviors. When attached with a screening component of blood pressure, cholesterol, and weight then a complete health profile determines individual risks. The HRA is a valuable tool when done annually to track changes in health risks over time and determine whether improvement is seen in behaviors. HRAs can be provided through insurance providers, wellness programs, or purchased from vendors.

Workers' Compensation Claims/Injury Reports

Use this data to identify:

- Overall case rates per year
- Highest claims categories
- Highest frequency categories
- Average time away from work
- Demographic profiles of injured workers

Like the medical claims analysis, workers' compensation claims and injury reports reveal how safe the work environment is for the employees. Back pain is one of the most common complaints of the American worker. Injury prevention and ergonomic evaluations can reduce the injury rates and lost time, and have been shown to significantly reduce cost. Evaluations are available through claims carriers, occupational health and wellness programs, and through independent vendors.

Facilities Assessments

- Health and safety of the workplace
- Lighting and air quality
- Workstations
- Vending machines, available food choices
- Ergonomic assessment

Time and time again, health issues are linked to environmental factors such as shelving height and weight of boxes. It is important to be aware of the environmental risks that contribute to employee health including the types of food offered to employees. A safety consultant or company safety officer can do this assessment.

Absenteeism Reports

- Indicates reason and timing of absences
- Determines morale and productivity

Absence data are available from human resource departments. Analyzing how much and when people call in sick can lead to efforts in flexible scheduling, identifying employees at high risk, and other issues. Look at when people call in sick: after weekends, after working overtime, and extended periods of time. Is the overall rate increasing or decreasing?

Employee Interest Data

- Indicates what employees want to learn about
- Surveys that are quick and easy to complete
- Meetings or focus groups provide useful forums
- Individual interviews are possible for small employers

Objective employer health data, coupled with understanding what employees want to learn about helps focus efforts on successful programs. Surveys are a simple way to gather information (see sample surveys in *Resources*).

Organizational Assessments (for small employers)

- Short, concise questionnaires
- Contains majority of above
- See *Organization Health Inventory*, *Employee Interest Survey*, and *Employee Health Practices* surveys in *Resources*.

Once data has been collected, use the "Data Collection Worksheet Flowchart" (p. 41) to determine the next step(s).

Health Practices Survey

This inventory is designed to assess what your current health practices are and how interested you are in modifying your current lifestyle. The findings from this survey will help your company implement wellness programs that are important to you. Please take the time to answer the following questions. Thank you!

EXERCISE

1. Do you take part in 30 minutes or more regular physical exercise during most days of the week? ◯ yes ◯ no
2. Do you exercise strenuously (that is so you breathe heavily and your heart and pulse go up for at least 20 minutes) three days or more a week? ◯ yes ◯ no
3. Is your job physically exhausting? ◯ yes ◯ no
4. Would you like to know how to start a personal fitness program? ◯ yes ◯ no

NUTRITION

1. Do you eat a low fat diet? ◯ yes ◯ no
2. Do you eat a high fiber diet? ◯ yes ◯ no
3. Do you consider yourself to be less than 10 pounds over your desired weight? ◯ yes ◯ no
4. Have you had your cholesterol checked in the past two years? ◯ yes ◯ no
5. Would you like to learn more about developing a healthy diet? ◯ yes ◯ no

SMOKING

1. Do you smoke or chew tobacco? ◯ yes ◯ no
2. If you do smoke, have you ever tried to quit? ◯ yes ◯ no
3. Would you like to quit smoking now? ◯ yes ◯ no

ALCOHOL

1. Do you have more than one alcoholic drink a day on a regular basis? ◯ yes ◯ no
2. Do you sometimes have more than five drinks in one setting? ◯ yes ◯ no
3. Do you feel that you should cut down on your drinking? ◯ yes ◯ no

DRUGS

1. Do you use non-prescription "recreational drugs"? ◯ yes ◯ no
2. Do you feel that you should cut down on your drug consumption? ◯ yes ◯ no

STRESS

1. Do you often feel over-stressed? ◯ yes ◯ no
2. Do you feel "blue" a lot of the time? ◯ yes ◯ no
3. Do you feel good about yourself? ◯ yes ◯ no
4. Are you meeting your needs for spiritual growth? ◯ yes ◯ no
5. Does your stress sometimes interfere with your health, personal happiness, or ability to be productive at work? ◯ yes ◯ no
6. Is your job emotionally stressful? ◯ yes ◯ no
7. Is it difficult for you to balance work, rest and play? ◯ yes ◯ no
8. Would you like to learn some relaxation techniques or other skills for going or avoiding stress? ◯ yes ◯ no

JOB SATISFACTION

1. Do you enjoy your work? ◯ yes ◯ no
2. Are your relationships with your coworkers supportive? ◯ yes ◯ no
3. Do you feel your supervisors treat you with respect and fairness? ◯ yes ◯ no

SAFETY

1. Do you wear a seat belt at all times? ◯ yes ◯ no
2. Do you have health hazards at your workplace? If yes, what are they?_____ ◯ yes ◯ no
   _____
   _____
3. Do you utilize personal protective or mechanical aids to perform your job? ◯ yes ◯ no

OTHER

1. Do you have a regular health screening or annual medical examination? ◯ yes ◯ no
   a. If so, do you follow the recommendations you received? ◯ yes ◯ no
2. Do you go to a dentist at least once a year for treatment or check up? ◯ yes ◯ no
3. Have you had an episode of back pain in the last six months? ◯ yes ◯ no

Health Practices Survey Cont.

ORGANIZATIONAL SUPPORT

How well is your company doing in actively and consistently encouraging your efforts to:

	Almost Never	Sometimes	Always
1. Engage in a regular, planned program of physical exercise?	○	○	○
2. Stop Smoking?	○	○	○
3. Understand the significance of stress/change and what can be done to avoid its negative impact on personal health?	○	○	○
4. Understand and follow sound nutritional practices?	○	○	○
5. Avoid overuse and misuse of drugs and/or alcohol?	○	○	○
6. Have regular medical and dental examinations or health screenings?	○	○	○
7. Follow safety practices at work, home, and on the highway?	○	○	○
8. Understand the importance of good mental health and deal effectively with mental health and emotional problems?	○	○	○
9. Understand the importance of achieving a healthy lifestyle?	○	○	○

PERSONAL INFORMATION

Please tell us about yourself:

1. Are you:
   - ○ Male
   - ○ Female

2. What is your age?
   - ○ Under 30
   - ○ Between 30-40
   - ○ Between 41-50
   - ○ Between 51-60
   - ○ Over 60

3. What is your highest level of education?
   - ○ Less than high school degree
   - ○ High school degree
   - ○ College Associate Degree
   - ○ College BS, BA, or Equivalent
   - ○ Graduate college degree

4. Are you employed:
   - ○ Full-time
   - ○ Part-time

5. What shift do you work?
   - ○ Day
   - ○ Evening
   - ○ Night
   - ○ Rotating

6. Which best describes your job function?
   - ○ Executive
   - ○ Manager/Supervisor
   - ○ Professional
   - ○ Sales
   - ○ Technical
   - ○ Clerical/Office
   - ○ Production
   - ○ Support
   - ○ Service

7. What is your department or worksite?

   _____

   _____

Employee Interest Survey

I. Please rank the 5 most important issues that you would like to learn more about?

(1 being least important, 5 being most important)

____ Nutrition
____ Workplace Stress
____ Workplace/Ergonomic Assessment
____ Stress Management
____ Fitness Activities
____ First Aid
____ Heart Health
____ Meditation/Relaxation
____ Cancer Risk Management
____ Wills/Power of Attorney (Advanced Directives)
____ Anxiety/Depression
____ Smoking Cessation
____ Women's Health Issues
____ Controlling Blood Pressure
____ Drug and Alcohol Use
____ Men's Health Issues
____ Social Support/Loneliness
____ Medical Self-care
____ HIV/AIDS
____ Cholesterol Management
____ Parenting Issues
____ Retirement
____ Time Management
____ Back Care and Safety
____ Financial Planning
____ Weight Management
____ CPR

II. Which of the following ways can we get health information to you at the worksite?

○ Lectures and Courses
○ Contest/Incentive Programs
○ Newsletter
○ Employee Letters
○ Phone/Email
○ Payroll Stuffers
○ Videos
○ Bulletin Boards
○ Pamphlets/Flyers
○ Health Fair
○ Health Screenings
○ Employee Assistance Program

III. Would you sign up for:

○ Health Screenings
○ Mini-Courses (meetings weekly for one hour for 2-8 weeks)
○ Am not interested in participating
○ Single Lecture Lasting 30-60 minutes
○ Ongoing fitness activities (i.e., walking program)

IV. When would you be most likely to participate? (Check all that apply)

○ Monday
○ Tuesday
○ Wednesday
○ Thursday
○ Friday
○ Breakfast
○ AM before work
○ Lunch
○ PM after work
○ Evenings
○ Built into inservice time

V. Would you consider becoming part of a worksite wellness team?

○ Yes *If Yes, please make it be known!* No ○

VI. Additional Comments:

Health Promotion Theme Calendar

	THEMES	AWARENESS	LECTURES/EVENTS	RESOURCES
January	Birth Defects	Prenatal Screening	Having a Healthy Baby	March of Dimes
February	Back Health	Proper Lifting	Healthy Back Exercises	Occupational Health Dept.
	Heart Health	Building a Healthy Heart	Eating for Your Heart	American Heart Association
	Medical Consumerism	Choosing the Right Doctor	Medical Self-care	Managed Care Plan
	Good Nutrition	The Five-a-Day Plan	Fast Food Savvy	Local Hospital Nutrition Dept.
March	First Aid	Choking	First Aid/CPR Classes	American Red Cross
	Cancer Awareness	Common Signs of Cancer	Breast/Prostate Cancer Awareness	Local Hospital Managed Care Plan
April	Alcohol Awareness	Do You Have a Drinking Problem?	Promoting Your EAP	Your E.A.P.
	High Blood Pressure	Highs and Lows of B.P.	Hypertension Screening	American Red Cross
May	Fitness	Exercise Life: How Much?	Employee Fitness Day	President's Physical Fitness Council
	Drug Awareness	Signs of Drug Abuse	Talk to Your Child About Drugs	Employee Assistance Program
June	Women's Health	Getting Calcium in Your Diet	Preventing Osteoporosis	National Dairy Council
July	Summer Fitness	Avoiding Hyperthermia	Self-care for Sports Injuries	Local Sports Medicine Center
August	Blood Drive	Donating Blood: The Facts	Company Blood Drive	American Red Cross
	Skin Cancer	Summer Skin Care	Skin Cancer Screening	American Cancer Society
	Walking Programs	Selecting Walking Shoes	Lunch Hour Walking Club	Health Promotion Dept.
	Cholesterol Awareness	Understanding the Numbers	Cholesterol Screening	Local Hospital
September	Men's Health	Prostate Problems	Prostate Screening	American Cancer Society
	Mental Health	Lowdown on Depression	Managing Stress	Mental Health Association
October	Fire Prevention	Know Your Fire Extinguisher	Fireproofing Your Home	Local Fire Department
November	Smoking Cessation	Supporting a Friend to Quit	Great American Smoke Out	American Cancer Society
December	Diabetes Awareness	Diabetes Facts	Diabetes Screening	State Dept. of Health
	AIDS Awareness	AIDS: Know the Facts	Talking to Kids About AIDS	American Red Cross
	Drunk Driving	Alcohol: Know Your Limits	Designated Driver Program	MADD

Association of Worksite Health Promotion. *Worksite Health*. Winter 1996.

Organizational Health Inventory Survey page 1 of 2

This assessment is designed to provide information on the demographics and the dynamics of your company. The survey looks at employee health, interests, and behaviors, as well as at policies, procedures, and initiatives.

The first part of this assessment is the employer section. The second is an employee survey. When both sections are completed and returned, the data will be analyzed and a FAHC wellness consultant will summarize the findings.

Please respond to the following questions. Thank you!

ORGANIZATIONAL ASSESSMENT SECTION

1. What best describes the nature of your business?
   _____

2. What is the age of your company?
   - ○ 1 to 5 years old
   - ○ 6 to 10 years old
   - ○ 11 to 20 years old
   - ○ 21 to 50 years old
   - ○ 50 plus years old

3. What is your fiscal year? _____

4. What is your total number of employees?
   ____ Home Office ____ Field Office(s)

5. How many of those employees are eligible for health care benefits? _____

6. What is the distribution of males to females? (approximate %)
   ____ % Males ____ % Females

7. What is the average age of your employees?
   - ○ Under 30
   - ○ Between 30 and 40
   - ○ Between 40 and 50
   - ○ Between 50 and 60
   - ○ Over 60

8. How many employees in each job category?
   ____ Executive ____ Technical
   ____ Manager/Supervisor ____ Clerical Office
   ____ Professional ____ Production
   ____ Sales ____ Support/Service
   Other (What?) _____

9. What percentage of workers are: [number lines]
   ____ % Full Time ____ % Part Time

10. What shifts do employees work? (approximate %)
    ____ % Day ____ % Night
    ____ % Evening ____ % Rotating

12. Do you have a medical or health department?	○ yes	○ no
13. Is there an Employee Assistance Program?	○ yes	○ no
a. Does it cover family members?	○ yes	○ no
14. Do you subsidize health club memberships?	○ yes	○ no
15. Are there policies in place to support wellness activities?	○ yes	○ no
(i.e., time off to participate in programs, teams, etc.)	○ yes	○ no
16. Is there a dedicated physical space for training and/or education?	○ yes	○ no
17. Is there a budget in place for wellness programs?	○ yes	○ no
18. Is there an incentive/recognition for employees to participate in wellness programs?	○ yes	○ no

a. If yes, please explain: _____

_____

19. Do you have a wellness committee in place? ○ yes ○ no

20. Who is the contact person responsible for wellness initiative?

_____

Organizational Health Inventory Survey

ABSENTEEISM

1. Do you have programs or policies on absenteeism? ○ yes ○ no
2. What was the average number of days absent per employee in the past twelve months? _____ ○ Don't know
3. Do you record costs due to absenteeism? ○ yes ○ no
4. Do first line supervisors receive information on absentee rates in their own departments (including dollar costs)? ○ yes ○ no

TURNOVER

1. Does your company have a program or policy to reduce turnover? ○ yes ○ no
2. What was the turnover rate for the last twelve month period? _____ % ○ Don't know
3. Do you track reasons for turnover? ○ yes ○ no
   a. If not, do you have access to this information from your insurance carrier? ○ yes ○ no
4. Do you track the costs relating to turnover? ○ yes ○ no

INSURANCE

1. Do you have a health and benefits administrator? ○ yes ○ no
2. Are insurance costs (current and historical) available? ○ yes ○ no
3. Can you track medical claims and expenditures? ○ yes ○ no
4. Does your current insurance carrier provide wellness services? ○ yes ○ no

ACCIDENT PREVENTION AND SAFETY

1. Does your company have a safety committee? ○ yes ○ no
2. Do you have OSHA surveillance requirements? ○ yes ○ no
3. Are there programs in accident prevention and safety? ○ yes ○ no
4. Are you tracking workers compensation claims? ○ yes ○ no
5. Do you track the costs to the company for work related injuries? ○ yes ○ no
6. List the top three causes of an occupational accident or illness (if known).
   1. _____
   2. _____
   3. _____
7. Do first-line supervisors receive regular reports on work related injuries? ○ yes ○ no
   a. If yes, are they informed of the cost of the injury to the company? ○ yes ○ no
8. Would you like more information on how an occupation Health and Safety Program could assist in your corporate objectives? ○ yes ○ no

Thank you for your time!

A survey developed and distributed by the Community Health Improvement Division of Fletcher Allen Health Care, Burlington, Vermont

Sample Evaluation Tool

In order to determine whether efforts to improve health are effective, an organization must measure outcomes over a period of time – even several years. The following is an example of how you may evaluate the effectiveness of your efforts.

1. State reason for implementing a program (i.e., improve morale, reduce absenteeism, reduce rate of tobacco use)

_____

2. How will you know when you have achieved your desired outcome? (Results must be specific and measurable.)

_____

3. What population do you intend to impact? (i.e., specific demographic group, shift, job category)

_____

4. What are the baseline measures for these issues?

Employee satisfaction survey_____
Absenteeism rates in total population_____
Absenteeism rates among participants_____
Smoking rate_____
Other _____

5. Short-term measures (process, program implementation):

Number of participants_____
Participant satisfaction_____
Demographic measures of participant group _____
Number of participants completing a program _____
Measure of knowledge gained _____
Other measures (i.e., number of pounds lost in a weight management group, number of miles walked in exercise group)_____

6. Long-term measures (outcomes over 1-3 years)

Rate of smoking_____
Specific rate of health care utilization (i.e., cost of prescription medications decreasing, disease-specific data decreasing) _____
Absenteeism rate_____
Employee turnover rate _____
Workplace injury data_____

Endnotes

[1] Towers, Perrin. "50th percentile of composite reported data for active employees." *2001 Health Care Cost Survey*.

[2] *Drug Trend Report*. June 1999 and June 2001. Express Scripts.

[3] Chapman, Larry. 1991.

[4] Goetzel, Ron Z. et al. "What's the ROI?" *Worksite Health*. Summer 1999.

[5] Chapman, Larry. *The Art of Health Promotion*. Volume 2, Number 4, September 1998.

[6] Douma, Allen. "The Art and Science of Demand Management." *Association of Worksite Health Promotion*. Summer 1995.

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