

HERO Employee Health Management Best Practice Scorecard[©]

VERSION TWO

Developed by the HERO Think Tank

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HERO Employee Health Management Best Practice Scorecard®

About HERO

The Health Enhancement Research Organization (HERO) is a national coalition of corporate and provider members that became operational in early 1996. The initial mission was to facilitate research that would impact health care by shifting the paradigm from a system that was largely dependent on the diagnosis and treatment of health conditions toward one with major emphasis on prevention and a more healthy and disease-free population. In this process, HERO has facilitated and published some of the most meaningful and respected employee health management (EHM) research. Several years ago, the interest, acceptance, and effectiveness of EHM started to grow exponentially. In order to perpetuate and accelerate this trend, HERO determined there was a critical need for EHM national policy, strategy, leadership, and infrastructure. To address and respond to these needs, the HERO Think Tank was created.

For eleven years, HERO has been distinguished by its ability to bring together a cross section of the most respected corporate and provider EHM thought leaders. They meet and communicate on a regular basis to investigate, plan, and implement new cutting-edge efforts that constantly move the EHM discipline forward. The development of the HERO Employee Health Management Best Practice Scorecard (Scorecard) is a result of such collaboration.

Background of the EHM Scorecard

In 2003, HERO initiated and facilitated a series of meetings to stimulate dialogue between corporate executives and a variety of providers regarding the future of EHM. The objective of the meetings was to determine the current status of EHM activities, and to identify strategies to better inform corporate senior executives about the health and economic values of EHM. More than 100 organizations participated in these highly interactive sessions. From a list of over 50 different strategies, two emerged as the most essential for the future success of EHM:

- Create, test, and distribute new and more meaningful financial, best practice, and other EHM measures that better resonate with corporate executives.
- Create venues so that employers and providers can interact personally with corporate thought leaders who are responsible for the most mature, meaningful, and data-rich EHM programs.

The Scorecard responds to the need for information and recommendations about what constitutes a best practice EHM program and its associated measures. The strategy supporting the Scorecard is based on identifying the critical core components that are generally accepted as the key building blocks common to today's most successful, respected, and data-rich EHM programs. At this point, there has been no attempt to rank the core components relative to importance because this often depends on organizational experiences, values, and goals.

Development of the Scorecard

The first step in development of the Scorecard was to consult with authoritative sources on best practices and parameters used to identify exemplary EHM programs. These authoritative sources included The Health Project's C. Everett Koop National Health Awards criteria, the WELCOA Well Workplace Awards criteria (Platinum level), Partnership for Prevention's Health Management

Initiative Assessment, and the Department of Health and Human Services' Partnership for Healthy Workforce 2010 (PHW2010) criteria. Selected elements from these sources were considered in the original construction of the Scorecard; however, most Scorecard content originated with the HERO Forum Task Force for Metrics. The rigorous development process included peer review from HERO Forum Think Tank members as well as national authorities on best practice programs.

A Work in Progress

The Scorecard defines “best practice” based on the experiences and recommendations of the HERO Think Tank and Research Committee and the HERO Task Force for Metrics. Many of the Scorecard's components are common elements among programs that have been recognized as best practice models of EHM through credible award programs or published literature. Although considerable effort has gone into creation of Version One and Version Two, the HERO Think Tank expects that there may be some disagreement with some of the information and recommendations contained in the Scorecard. Its developers see the Scorecard as a springboard for dialogue and welcome feedback. Over time, the HERO Think Tank anticipates that the Scorecard will continue to evolve as the EHM field evolves, and as we gain experience using the tool. It was released with the expectation that the Scorecard was a work in progress and that Version One would lead to additional versions.

Although the original Scorecard was considered a work in progress, there was an overwhelmingly positive response to Version One. Since the Scorecard's release in the fall of 2006, approximately 3,000 copies have been requested and distributed. This does not include the number of copies that were downloaded from the HERO Web site. Early feedback from users indicated that the Scorecard was a helpful tool for strategic planning and design of new programs, benchmarking existing programs, and evaluating best practice programs. Based on these applications, pilot users confirmed the value of the Scorecard for these various uses, but also identified areas for improvement. A revision committee was formed in the winter of 2007 to address gaps and redundancies in the first version of the Scorecard, and to revisit definitions and the rating system for the criteria. Many additional drafts have been added to the 23 drafts created during the development of the Version One Scorecard. The revision team recognizes this also represents a work in progress and invites users to contribute feedback for the further refinement of the Version Two Scorecard. Please refer to Appendix A for a list of members of the HERO Think Tank Task Force for Metrics and the HERO Scorecard Revision Team.

Invitation to Contribute Feedback

There is nearly universal interest across stakeholders to conduct more sophisticated EHM benchmarking to identify best practices and drive innovation in the field. For this reason, HERO encourages you to review and use the Scorecard as appropriate in your setting. Your reactions, comments, and suggestions to improve the Version Two Scorecard, as well as your suggestions for applications are most welcomed. Please direct your thoughts and critique to **info@the-hero.org**. All replies will be acknowledged and considered confidential. Thank you in advance for your feedback, suggestions, and ideas for the future refinement of the Scorecard.

Using the Scorecard

Since the Scorecard was released, several uses have been identified. At its most fundamental level, the Scorecard functions as a simple inventory of the various elements that might comprise an exemplary EHM program. There is consensus that its core value is as an educational tool to assist employers and practitioners with:

- Program design
- Strategic planning
- Vendor selection
- Gap analysis
- Program evaluation

Features

The Scorecard is composed of nine components, each with a variable number of subcomponents, which include:

- Corporate culture and leadership commitment
- Strategic planning
- Communications, marketing, and promotion
- Program components
- Benefit design
- Incentives
- Program coordination
- Data management and evaluation
- Program outcomes

The first eight components represent the foundation supporting an exemplary EHM program, with the Program Outcomes section serving as a guide for a “dashboard” of measures indicative of program success. While the inventory is not exhaustive as an inventory of all elements that could comprise an EHM program or associated measures of success, these elements represent those that are most commonly recognized among industry thought leaders and publications.

Several additional features of the Scorecard warrant further explanation. Next to each subcomponent is a **description**, which is intended to support consistent interpretation of each subcomponent. The revision team recognizes that there must be room for flexibility in interpretation of some of the subcomponents due to the diversity of organizations that might use the Scorecard. There also is a column for **rating** the extent to which the subcomponent has been implemented across the organization in terms of both the number of sites and the subpopulations that are eligible for EHM programs. The application of these two features influences the **scoring** aspect of the Scorecard, which can be used at several levels.

Level 1 – As an Inventory

At its most basic level, the Scorecard can be used as a simple inventory to guide strategic program planning. By using the rating system and the Scoring Grid, which follows the inventory, one can easily identify the components that contribute the most strength to a program as well as the gaps that may remain.

Level 2 – As an Indicator of Program Success

Exemplary EHM programs are those that are successful in their: attraction and retention of eligible program participants; provision of programs that are satisfying for participants; beneficial impact of programs on health risk status; investment in preventive programming; and achievement of a positive return on investment after two years of programming. These measures represent a starting point for development of a “dashboard” approach to measurement of program success. The suggested benchmarks were the result of vigorous debate among Task Force members during the development of the original Scorecard and were only slightly modified in the revised version. Modification of the benchmarks will occur based on Scorecard use and feedback.

Level 3 – As a Comparative Tool

The application of the Scorecard as a tool to formally aid in vendor selection or to compare programs remains in its infancy. At least one pilot study by one of the Task Force member organizations has demonstrated the utility of the tool for this purpose but much work remains to be done in this area. The Think Tank invites users with access to information on numerous programs to use the Scorecard to rank the comprehensiveness of the programs and evaluate the extent to which they achieve minimal benchmarks of program success. This application can inform descriptive studies, comparative research, or aid in the identification and recognition of exemplary EHM programs.

Sources

1. Health Enhancement Research Organization. HERO Forum Think Tank
2. Partnership for a Healthy Workforce 2010 Criteria. Department of Health and Human Services
3. Partnership for Prevention. (2005). Health management initiative assessment. In: *A Call to Action: Leading by Example*. Partnership for Prevention/The WorkCare Group, Inc.
4. The Health Project. (2005). C. Everett Koop National Health Awards Criteria
5. Wellness Councils of America. (2007). Well Workplace Awards Criteria (Platinum Level)

Appendix A – Contributors to HERO Employee Health Management Best Practice Scorecard

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Rate each cell from lowest (0) to highest (2) as follows:

- 0 = Element not included
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CORPORATE CULTURE & LEADERSHIP COMMITMENT		
1- Senior Leadership Commitment and Support	Senior leadership, including Union Leadership, has been informed of the program and has demonstrated a commitment to employee health and well-being as an important investment in human capital. This is exhibited by at least two of the following: articulation of corporate health culture vision; belief that organizational goals and values support employee health and well-being; involvement in employee communications; resource allocation; active involvement as participants; endorsement of plan to Board of Directors.	
2- Management and Supervisor Education and Support	Managers and supervisors are educated about and supportive of the program; Training and resource information is provided to managers/supervisors; Managers/supervisors can effectively articulate the link between health, productivity and total economic value; Managers/supervisors encourage employee participation.	
3- Employee Buy-in and Engagement	Employees are educated about true cost and total value of personal health and quality of life. Employers play an active role in making sure their employees are well-informed about health care costs (including dollars, longevity and vitality), and the possible solutions.	
4- Employee Leadership Network (e.g., wellness champions)	Employees who (in addition to their company work role) communicate, participate, motivate and support health management initiatives at the workplace.	
5- Supportive Environment	Employees are provided with the following: access to fitness centers and/or walking trails; a smoke-free environment; healthy food options; a safe work environment (which includes ergonomics); well-lit and accessible stairwells; stress management facilities, and other strategies to support a healthy environment.	
6- Company Policies Advocate Optimal Health	Includes policies on flex-time, return to work, smoke-free environment, recognition and reward policies for healthy behaviors, and other policies which advocate a healthy work environment.	
		Category Sub-Total
STRATEGIC PLANNING		
7- Needs Assessment	Needs assessment is conducted based on one or more of the following: claims analysis, risk assessments, and/or employee surveys.	
8- Initiative Goals and Objectives Defined	Long-term and annual plans are in place with measurable objectives, processes, and outcomes measurements.	
9- Availability of Key Program Components to Employees	Key components are available to all segments of the employee population including full- and part-time shift workers, dispersed employee groups or dispersed single employees, and English as a Second Language (ESL) employees.	
10- Availability of Key Program Components to Retirees/Disabled	Strategies are included to reach out to benefit-eligible retirees and the disabled for key program components that support prevention, risk reduction and disease management, whether those services are offered through health plans, community programs or by employer-sponsored health management and wellness vendors.	
11- Availability of Key Program Components to Spouses/Dependents	Strategies are included to reach out to benefit-eligible spouses/dependents for key program components that support prevention, risk reduction and disease management, whether those services are offered through health plans, community programs or by employer-sponsored health management and wellness vendors.	
12- Population-Based Approach	Program addresses needs of all employees across the entire health continuum including healthy, at-risk and chronic disease segments.	
13- Availability of Health Care Benefits	Employers offer access to health care benefits to a majority of employees.	
		Category Sub-Total
COMMUNICATIONS/MARKETING/PROMOTION		
14- Comprehensive Communications Plan	Annual communications plan is developed and focused on education, promotion, marketing of program to all constituents. Uses multiple communication tactics and media elements.	
15- Pre-launch and Ongoing Education and Program Promotion	Programs and resources are marketed 60 to 90 days prior to launch with subsequent reminders and ongoing education. Communication is focused on purpose, components, value and deadlines.	
16- Regular Stakeholder Status Reports	Key stakeholders are regularly informed of program progress including communications to employees, dependents, external affiliates (e.g., carriers), supervisors, management, wellness champions.	
		Category Sub-Total

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PROGRAM COMPONENTS		
17- Health Assessment (HA) with Follow-up and Referral	Uses HA to educate participants of risks and preventive measures for which data is used to target intervention to appropriate population segments and increase program impact on health-related issues.	
18- Health Screening and Participant Reports	Employer offers and develops strategies to achieve high participation (either directly or through its health plan) in screening and immunizations in accordance with "A and B Recommendations" from U.S. Preventive Services Task Force. These range from blood pressure, cholesterol, cervical cancer, HIV, lipid disorders, TB, and glucose screening programs. Participants receive reports with results of the screening.	
19- Population-based Wellness and Health Education	Includes education resources and campaigns that address general healthy living, prevention, immunizations, nutrition, physical activity, stress management, safety, and ergonomics.	
20- Targeted Lifestyle Management Programs	Includes programs targeting lifestyle-related risk factors. Programs include smoking cessation, weight management, stress management, physical inactivity, cholesterol, and high blood pressure management. Interventions may be phone-based coaching, online, paper-based or onsite intervention programs. Incorporates science-based behavioral change principles (e.g., goal-setting, support system, record-keeping, etc.).	
21- Consumer Medical Decision Support	Includes self-care programs, nurse advice lines, consumer medical decision support programs, and tools.	
22- Disease Management Program	Includes programs targeting high-cost chronic illnesses management. Programs target diabetes, asthma, COPD, CAD, musculoskeletal, arthritis, etc. Interventions may be physician-based, phone-based, online, paper-based or onsite intervention programs. Incorporates science-based behavioral change principles (e.g., goal setting, support system, record keeping, etc.).	
23- Disability and Absence Management Programs	Medical case management/care coordination, coordinated claim administration, return-to-work programs.	
24- Safety and Ergonomics	Programs in place. Integrated with other related EHM programs.	
25- Personal Electronic Health Records	Personal electronic health records are promoted and available to all employees. Data is protected and kept confidential at all times.	
26- Employee Assistance Programs	Includes Employee Assistance Program counseling and referral services for employees and their families.	
27- Worksite Clinics	Health clinics are available at the worksite to provide services related to two or more of the following: work-related injury and illness care, medical surveillance and regulatory exams, primary care, pharmacy, physical and occupational therapy, immunizations, preventive screenings, etc.	
		Category Sub-Total
BENEFIT DESIGN		
28- Health Benefits Support Prevention and Risk Reduction	Health benefits cover preventive and risk reduction services and facilitate participation in such services (e.g., preventive exams, smoking cessation classes, weight reduction programs, physical activity programs, etc.).	
29- Health Benefit Design Supports Consumer Accountability and Informed Health Care Decision Making	Benefit design, communication and education supports consumer accountability and informed health care decision making. Design includes information and incentives for encouraging consumers to make wise and cost-effective health care decisions. Examples might include benefit programs like consumer driven health plans that educate members about how to manage their health care dollars to get the most benefit.	
		Category Sub-Total
INCENTIVES		
30- Use of Incentives	Incentive program incorporated into overall program design to foster participant engagement, responsibility, and compliance. Incentives models will vary based on budget and program goals. Incentives can be built into overall benefit design (e.g., medical premium discounts, HSA/ HRA contributions, deductible credits, co-pay reductions) or involve a variety of alternatives (e.g., merchandise, raffles, gift cards, cash, etc.).	
		Category Sub-Total
PROGRAM COORDINATION		
31- Coordination of Services Across the Health Status Continuum	Coordination of services regularly occurs including joint planning, communication, cross-referral, data sharing, evaluation, and other coordination with two or more programs like Wellness and Risk Reduction, EAP/Behavioral Health, Occupational Health, Disease Management, Safety, Disability Management, Workers Compensation, and Benefits.	
32- Partnerships Established with Health Plans and Health Promotion Vendors	Regular communication, joint planning, and data sharing is conducted with health plans and vendors.	
		Category Sub-Total

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DATA MANAGEMENT & EVALUATION		
33- Comprehensive Data Analysis and Reporting	Comprehensive data analysis and reporting supports program planning and evaluation across various service areas. Data is shared between various service areas and used for joint planning and evaluation.	
34- Participant Satisfaction Data	Participant feedback and satisfaction data are captured for core programs and the information is used to drive program improvements or enhancements.	
35- Program Participation Data	Frequency, duration, and type of participation are captured for all programs and used for integrated reporting across collaborating program providers (e.g., internal departments or external vendors).	
36- Process Evaluation Data	Process evaluation data (e.g., contact, opt-out, withdrawal rates) are collected and used to drive program improvements.	
37- Population Health Status Data	Health status data (for both physical and mental health) are collected for the eligible population and used to monitor health status improvements.	
38- Health Care Utilization and Cost Data	Health care claims data are analyzed to identify most costly physical and mental health conditions, and to determine program impact on clinical outcomes, health care utilization, and/or health care costs.	
39- Productivity and Presenteeism Data	Productivity data are collected and analyzed to determine program impact on health-related lost work time and presenteeism, which includes disability management, absenteeism and return-to-work tracking.	
40- Quality of Outcome Evaluation	Outcome evaluation is conducted for the overall program and major program components, by an individual or group with expert knowledge of analytic methods. Evaluation uses a control group or comparison group; compares follow-up data against baseline data; and statistical methods control for demographics and baseline health care costs.	
		Category Sub-Total

The eight components above represent the foundation supporting an exemplary EHM program.

The **Program Outcomes** section below serves as a guide for a “dashboard” of measures indicative of program success. This component is not included in the overall score calculated in the Scoring Grid.

Rate each cell from lowest (0) to highest (2) as follows:

- 0 = Benchmark not measured
- 1 = Benchmark not achieved
- 2 = Benchmark fully achieved

PROGRAM OUTCOMES		
1- Annual Participation	Benchmark: Minimum of 50% of population participates in at least one core program element annually.	
2- Cumulative Health Assessment Participation and Health/Biometric Screening	Benchmark: Minimum of 80% of population participates in Health Assessment and other lifestyle/health risk reduction programs during the most recent three-year period.	
3- Participant Satisfaction	Benchmark: ≥90% or more of participants are satisfied with core elements of the program.	
4- Health Risk Reduction	Benchmark: Annual health risk shift of 2+% is defined as a decrease in the high-risk group and increase in the low-risk group; or comparable performance on a functionally equivalent population-based measure.	
5- Annual Calculation of Program Investment	Benchmark: Program stakeholders are aware of annual investment in EHM (e.g., primary, secondary, and tertiary prevention including disease/condition management) as a percent of total health care expenditures.	
6- Annual Calculation of Individual Investment	Benchmark: Program stakeholders are aware of annual calculation of dollar investment per eligible employee in EHM (and other eligible population segments, for example, spouses).	
7- Return on Investment (e.g., benefit/cost ratio, net present value)	Benchmark: Return on investment (ROI) ratio of 0.5:1 at the end of the first year of full program implementation; 2:1 at the end of second year; and 3:1 at the end of three years based on comparing cumulative impact on medical expenditures of participants versus non-participants to cumulative program analysis of claims data or valid claims-based statistical model; not based solely on self-reported data. Net present value will depend on future program investment benchmark.	
		Category Sub-Total

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SCORING

INSTRUCTIONS	
Category Sub-Total	Sum the numeric rating for each element in a category. For example, if all elements in the Corporate Culture & Leadership Commitment category are fully implemented, the Category Sub-Total would equal 12.
Number of Items Rated	Some of the items in a category may not apply to the program being rated so the item may be left blank. Sum the number of elements in a category that are rated. For example, if all elements in the Corporate Culture & Leadership Commitment category are rated, the Number of Items Rated would equal 6.
Average Category Score	Calculate an average for each category by dividing the Category Sub-Total by the Number of Items Rated columns. For example, if the Category Sub-Total for Corporate Culture & Leadership Commitment is 12 and the Number of Items Rated is 6, the Average Category Score would be 2.
Total Sum of Scores	Sum the Average Category Score column. If all Average Category Scores equal 2, the Total Sum of Scores would equal 16.

SCORING GRID				
Category	Category Subtotal	Number of Items Rated	Average Category Score	Maximum Score
Corporate Culture & Leadership Commitment				2
Strategic Planning				2
Communications/Marketing/Promotion				2
Program Components				2
Benefit Design				2
Incentives				2
Program Coordination				2
Data Management & Evaluation				2
Total Sum of Scores				16

INTERPRETATION OF SCORES
<p>If each element in a category is fully implemented across the organization, the organization will achieve the maximum score of 2 for that category. Calculating a score for each category allows an organization to identify strengths and opportunities for improvement across each of the key components of a comprehensive employee health management program.</p> <p>The maximum overall score is 16 if an organization has fully implemented every category. Calculating an overall score allows an organization to determine the extent to which the program is meeting its maximum potential. Since the scoring reflects only the items rated in each category (i.e., relevant items for an organization), the maximum category scores and overall score represent achievable benchmarks for organization-wide implementation of a comprehensive employee health management program.</p> <p>The eight components in the Scoring Grid represent the foundation supporting an exemplary EHM program. The Program Outcomes section, while not included in the overall score calculated in the Scoring Grid, should be used as a guide for a “dashboard” of measures indicative of program success. An Average Category Score can be calculated for this component as for the others above, with a maximum potential average score of 2. Higher scores on the components are likely to be associated with better program outcomes. HERO hopes to conduct research using the Scorecard to develop a better understanding of the association between specific components and specific outcome performance.</p>