



The Impact of Employer Health and Productivity Management Practices

RESEARCH BY THE INTEGRATED BENEFITS INSTITUTE

Executive Summary

This report is a follow-up to an IBI report published earlier in 2010 on employers' health and productivity management (HPM) programs.

IBI, with Harris Interactive (authors of the Harris Poll), polled 450 employers in summer 2009 to detail the prevalence of prevention, wellness, disease-management and disability-management/return-to-work initiatives they implement; their plans over the next two years; the goals for these programs; the measures used to assess key program outcomes; and their views of how well HPM initiatives are meeting the desired goals.

This report discusses in more detail employer opinions about the relative success of the various HPM programs in meeting their health-related goals.

Generally, employers report that their important HPM practices have a positive effect on their health and productivity goals. HPM practices have the highest impact in reducing sick-day/disability absence outcomes, followed by reductions in medical/pharmacy costs, health-related lost productivity and presenteeism. Results also show that high-impact practices often are less prevalent than low-impact practices. Several practices have relatively high impacts across several health outcomes measured—sick-day/disability absences, medical/pharmacy costs and health-related lost productivity—and thus, may be viewed as best practices. Nurse case management positively impacts all three HPM outcomes, while five other practices span two HPM outcomes.

Results show that employers vote with their pocketbooks to sustain HPM programs despite a general lack of empirical data on the outcomes of these efforts.

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Key Findings:

- **Employers say that health and productivity management (HPM) practices have a positive impact on key outcomes.** Employers report that their most important practices generally have improved overall health and productivity outcomes. HPM impact scores are highest for sick-day/disability absences, followed by medical/pharmacy costs, health-related lost productivity and presenteeism. Although employee satisfaction with their work is not a traditional health and productivity outcome, HPM practices have a particularly strong, positive impact on employee satisfaction.
- **No single HPM program area has a lock on high-impact practices.** Among the top 10 high-impact practices, four are associated with disability management/return to work, four are related to health promotion and two are associated with disease management.
- **High-impact practices often are less prevalent than low-impact practices.** The three highest-rated HPM practices—early disability reporting, transitional return to work (RTW) and on-site providers—are used by less than half of the employers in the sample. In contrast, the two most prevalent HPM practices—an employee assistance program and smoking cessation—are used by more than three quarters of the employer respondents but have a relatively low impact.
- **Several practices have high impacts across several outcomes.** Six practices—nurse case management, transitional RTW, health risk coaching, on-site providers, participation incentives and weight management—have positive impacts on at least two important health and productivity outcomes and therefore should be considered an essential part of an effective and efficient HPM program.

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Introduction

In the spring of 2009, IBI and Harris Interactive—known for the Harris Poll—conducted an online survey of more than 480 U.S. employers about their use of health and productivity management (HPM) practices.

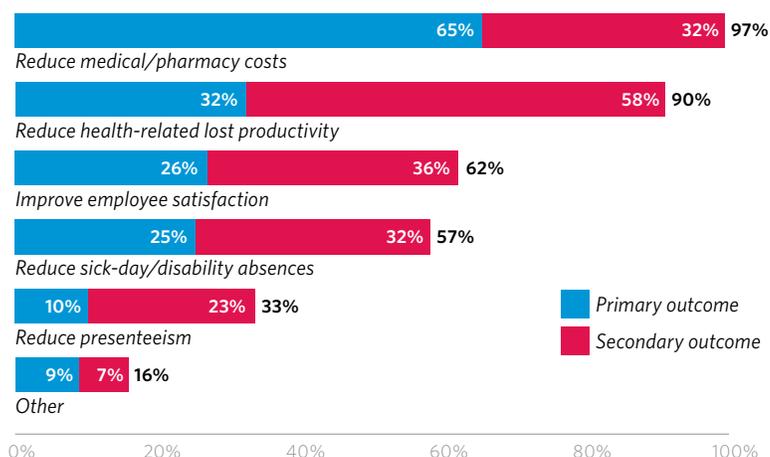
The survey's purpose was to provide insights into how employers currently manage their employees' health and productivity (H&P), what their plans are for the near term, the specific goals of their HPM efforts, the practices they view as most important, how effective their practices are in achieving these goals, and how they measure the impact of their efforts.

The first analysis of the survey results, which IBI published in January 2010,¹ showed that nearly all respondents implemented at least one of 26 health promotion, disease management or return-to-work/disability management practices. While implementing an average of 15 practices, nearly all surveyed employers identified reducing medical/pharmacy costs as a primary or secondary goal of their programs. Nine in 10 employers also identified reducing health-related lost productivity as a key goal. As noted in the graph above, productivity-related outcomes such as reducing sick days and disability lost time also were prominent employer responses.

¹ *More Than Health Promotion: How Employers Manage Health and Productivity*. Integrated Benefits Institute, 2010. The survey description from that report and the list of HPM practices are reproduced verbatim in Appendix 1 and Appendix 2, respectively.

INTENDED OUTCOMES OF EMPLOYERS' HPM PRACTICES

By percentage of employers responding



The Impact of HPM Efforts

While our first report focused primarily on the number and the type of HPM efforts, this report focuses more deeply on the impact of these HPM practices.

We do this in two ways. First, we explore employer views about the impact of their HPM practices in regard to four specific health and productivity outcomes: (1) reducing sick-day/disability absences, (2) reducing medical/pharmacy costs, (3) reducing health-related lost productivity and (4) reducing presenteeism.²

Second, we assess the relative performance of each practice based on ratings from employers in the sample that adopted the practice. Understanding how respondents rate the impact of their HPM efforts gives other employers a basis upon which to make decisions about their own HPM initiatives. This is particularly true for organizations that are just beginning to develop an HPM program, but it also provides guidance and insight to those that do not know how well their current practices are performing. As we reported in our previous research,³ a great many employers do not measure sick-day/disability absences, health-related lost productivity or presenteeism, and many that do still do not know the impact their practices have on these outcomes.

² We designed our survey to gather information on as many different practices as feasible given limits on respondents' time. While this provided a rich breadth of view into how employers manage workforce health and productivity, the practicality of survey length and respondent burden limited our ability to explore the performance of each practice in depth. Instead, performance questions focused only on those practices identified by employers as among their three most important. Therefore, this report does not assess the effectiveness of all HPM programs but instead identifies those considered by employers to be among the top three based on their own attitudes and experience.

³ IBI (2010).

Scoring the Health and Productivity Impact of Each HPM Practice

IBI used the following method to assess the employer-rated impact of each HPM practice on each H&P goal:

- 1** Employers/respondents were given a list of 26 HPM practices and asked to indicate those that their organization offered.
- 2** Respondents were asked to identify the three practices that were most important to their HPM efforts and to note whether these practices were primarily or secondarily intended to reduce sick-day/disability absences, medical/pharmacy costs, health-related lost productivity or presenteeism.
- 3** The employers were then asked whether each of their top three HPM practices had worsened or improved the intended H&P outcomes, had no effect on the outcomes, or if they did not know if it had an effect. IBI then scored these impact responses using the following scale:
 - a** Practices that respondents said improved a given outcome were scored +1 or +2, depending on whether the outcome had moderately or greatly improved.
 - b** Practices that respondents said worsened outcomes were scored -2 or -1.
 - c** Practices that respondents said had "no effect" were scored 0.
 - d** If a respondent did not know if an HPM practice was effective, no score was assigned.
- 4** IBI then averaged the impact scores for each practice/outcome combination to obtain an employer's overall assessment of the impact of each important practice.
- 5** Impact scores for each practice were averaged across all employers to obtain an overall assessment of the practice. *Practices that were assessed by fewer than 10 employers are not reported.*

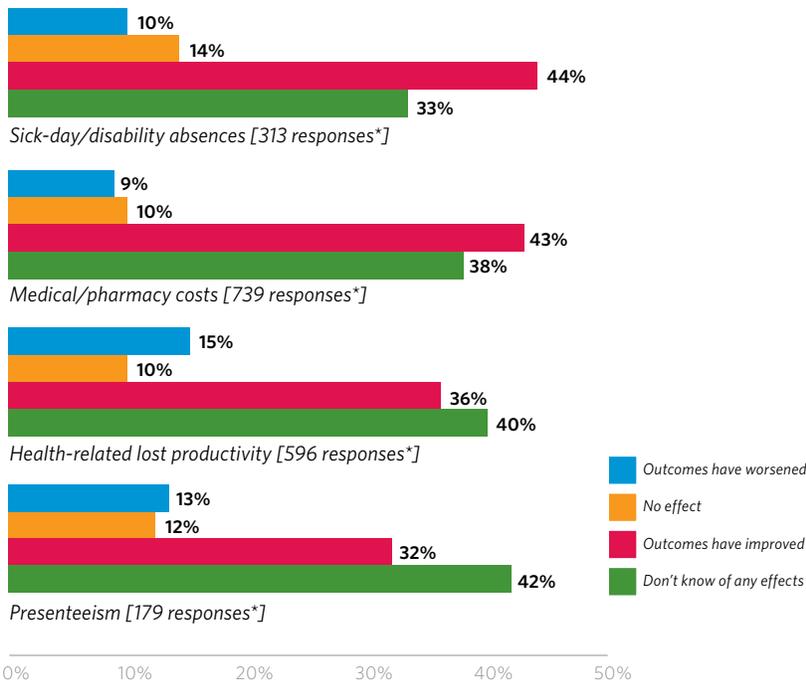
Employer Assessments of Their HPM Programs

How well do various HPM efforts meet employer expectations? The graph below summarizes the impact scores for the intended outcomes and shows that employers generally report that their most important HPM practices improve intended outcomes.

Nonetheless, a relatively large share of employers do not know the impact of a practice on specific outcomes—between 33% and 42%, depending on the outcome. Not surprisingly, employers that made efforts to measure outcomes were better positioned to assess the impact of their HPM efforts, and these employers were more likely to cite improvements in their HPM outcomes.⁴ That such a significant share of employers does not know the impact of a practice underscores the need for employers and their benefits partners to increase their focus on measuring outcomes.

IMPACT OF IMPORTANT HPM PRACTICES ON INTENDED OUTCOMES

By percentage of employers responding



⁴ IBI (2010).

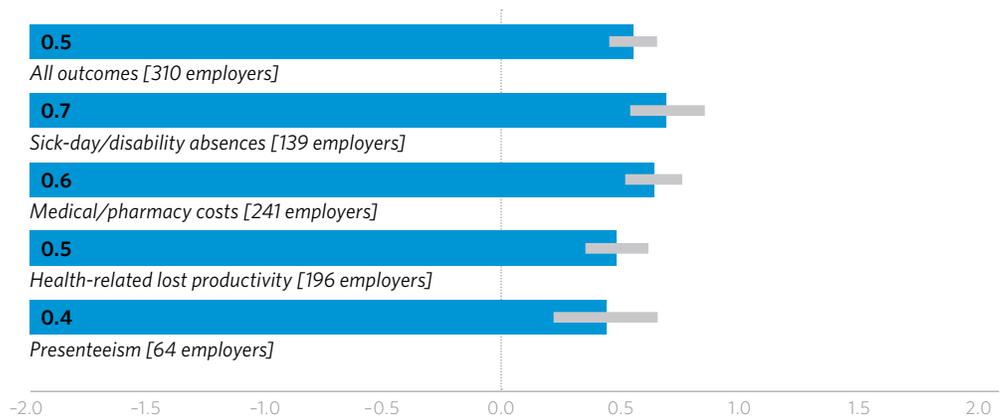
*The number of responses represents the number of instances in which respondents were asked about the impact of a practice on an intended outcome.

The graph to the right shows the impact ratings that employers assigned to their three most important practices, averaged across all respondents.⁵ Although the impact scores had a maximum value of +2 and a minimum of -2, the average impact scores are within a far more narrow range. Employers generally report that their three most important HPM practices result in improvements to their intended outcomes, with impact scores averaging 0.5 out of a maximum of 2 points for all outcomes combined.⁶ Employers rarely chose the minimum (-2) or maximum (+2) values on the scale when evaluating the impact of their programs, resulting in the narrow range of the score distribution. Individually, all of the HPM outcomes receive positive average scores, ranging from 0.7 points for sick-day/disability absences to 0.4 points for presenteeism. The impact scores for presenteeism show more variability than other

IMPACT OF EMPLOYERS' THREE MOST IMPORTANT PRACTICES

By employers' average impact score:
-2 = outcome worsened; 0 = no impact; +2 = outcome improved

Gray bar indicates 95% confidence interval



productivity outcomes, as indicated by the wider confidence interval around the average impact estimate, perhaps due to the difficulty employers have in conceptualizing and objectively measuring presenteeism, which is less understood than other H&P outcomes.

⁵ These results exclude respondents' assessment of practices for which they did not know of any impact on intended H&P outcomes. Early specifications of the practice impact scores were weighted by whether or not an employer measured outcomes. These did not materially change the overall rank orders of the practices. The results reported in the current document are unweighted.

⁶ Throughout this document, when a thin gray bar appears at the right end of a colored bar in graphs, it represents the 95% confidence interval of the estimate around the mean. As the name suggests, a confidence interval indicates the reliability of a sample mean as an estimate of the average score in the population from which a sample is drawn. A wide interval means a broader range of scores; a narrow interval indicates less variability. A second or third sample of employers drawn from the same source might have a higher or lower average, but we would expect to see sample means fall within the lower and upper confidence limits about 95% of the time. Generally speaking, confidence intervals will encompass a wider range—that is, the estimate of the population mean is less precise—when there is less consensus among the sample but also when the number of respondents making assessments is relatively small.

Description of Appendices

Appendix 1 provides a description of the survey.

Appendix 2 provides a detailed list of the HPM practices that were included in the survey.

Appendix 3 shows the employer scores, the total number of employers reporting for each HPM practice and for each goal and the percentage that were unable to report impacts. The Appendix 3 information should help readers more fully understand the confidence intervals shown in the graphs throughout this report.

The Impact of Specific HPM Practices

While employers typically report improved outcomes for their three most important practices overall, the performance of specific practices—while generally positive—is more mixed.

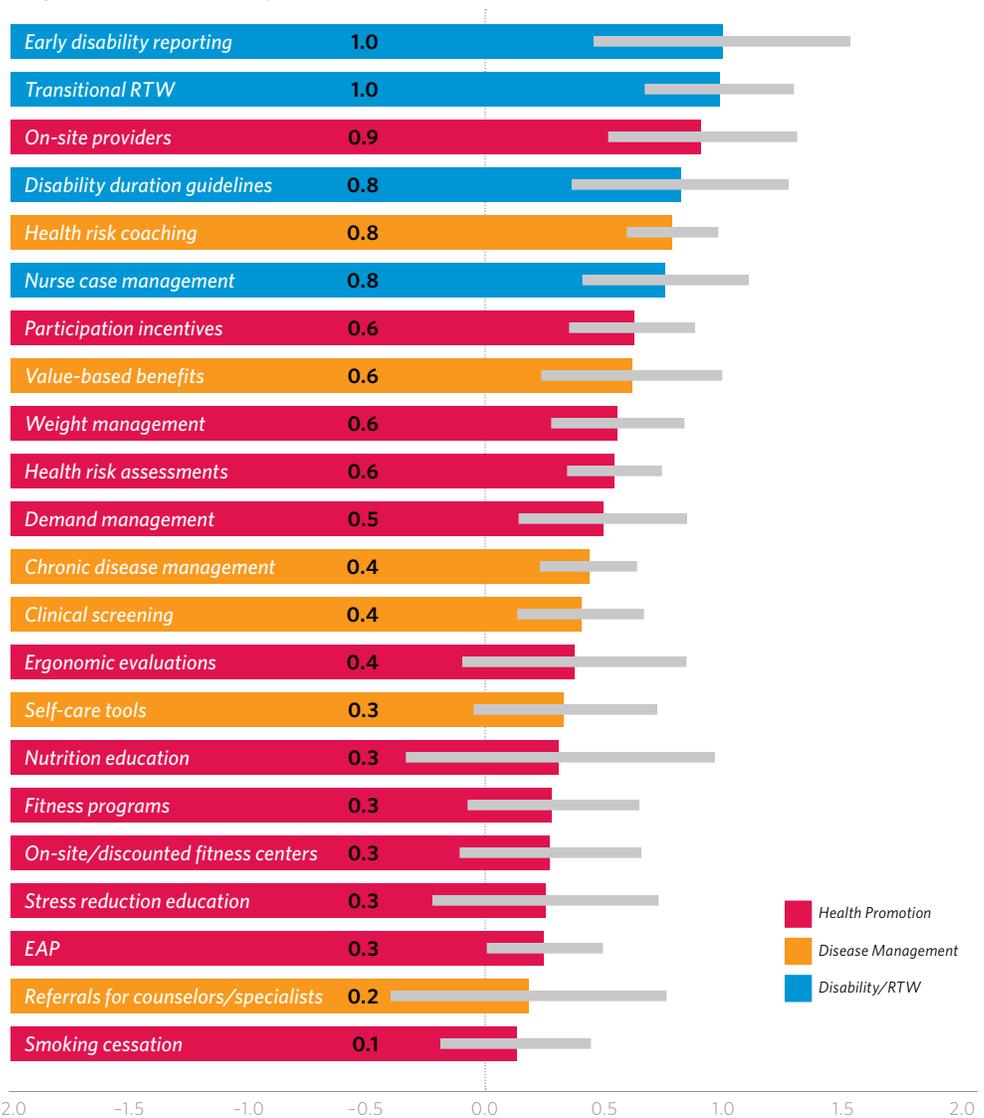
The graph to the right shows the impact scores for important HPM practices⁷ identified within each of three broad program areas.⁸

Employers give early disability reporting and transitional return to work (RTW) the highest impact scores, followed in importance by on-site providers. Although no practice has a negative average performance rating, the employer scores for several practices are so broadly distributed across the rating scale that the average performance assessment is ambiguous, as indicated by the confidence interval (CI) brackets that include zero. For all intents and purposes, the summary assessment for the practices where the CI includes zero indicates that we cannot tell if these practices have a discernible impact (influenced both by the variability in the employer scores and the number of employers able to report). The greatest variability is in the ratings for nutrition education and referrals for counselors/specialists, suggesting that these programs may be inconsistently

OVERALL IMPACT ON HPM OUTCOMES BY PRACTICE

By employers' average impact score:
 -2 = outcome worsened; 0 = no impact; +2 = outcome improved

Gray bar indicates 95% confidence interval



⁷ Four HPM practices (RTW incentives, RTW education, nutritious meal/snack options and administrative chargebacks to encourage RTW) were not assessed as important by at least 10 employers, the minimum for inclusion in our analysis, and therefore are not shown in the graph on this page.

⁸ To keep the focus squarely on direct H&P outcomes, we exclude employee satisfaction from the calculation of overall practice impact scores.

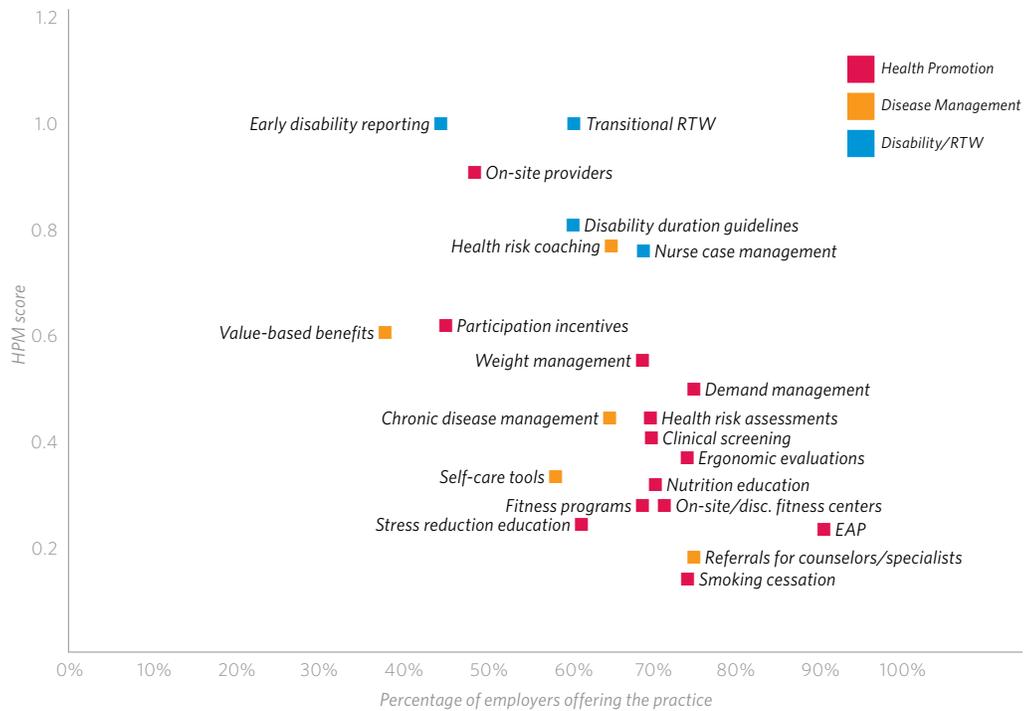
managed and/or hard to define or assess reliably. Other factors that undoubtedly influence the employer's assessment of its specific HPM program outcomes include whether the employer attempts to measure the impact, the structure of the practice (e.g., one employee assistance program [EAP] may not be comparable in structure to another EAP program) and how long the practice has been in place.

The employer assessments of the impact of specific HPM practices found high-impact practices to be fairly broad-based, falling within three different program areas: health promotion, disease management and disability management/RTW. For example, of the 10 HPM practices that employers say have the most impact, four are classified as disability management/RTW, four are health promotion programs and two involve disease management. Bottom line: The high-impact HPM practices are not concentrated in any single program area.

Prevalence Versus Impact

Ideally, those practices that employers find to be the most effective in meeting their intended goals also would be the most widely utilized. The graph on this page shows, however, that practices with the highest overall impact scores are not necessarily the most prevalent in the sample. Early disability reporting—with an impact score of 1.0 out of a possible 2.0—is offered by 45% of surveyed employers and was assessed by

HPM IMPACT SCORES BY PREVALENCE OF ADOPTION



15 respondents as one of their top three HPM programs. By contrast, EAP and smoking cessation, with much lower scores (centered on “no effect”), are offered by 91% and 75% of surveyed employers, respectively. It appears that employers may not make their choice of practices based on their impact on key goals. Perhaps, as we saw in Figure 2, this is a result of employers’ inability to measure impact. We examine factors that may affect employers’ HPM choices in detail later in this report.

Important Practices by Outcome

Because employers adopt different practices to affect different outcomes, we also examine employer opinions on the impact on specific outcomes of each individual practice,⁹ including sick-day/disability absences, medical/pharmacy costs, health-related lost productivity and employee satisfaction.¹⁰ In addition, by comparing the high-impact practices across different employer objectives, we can begin to identify the practices that best cut across more than one dimension of HPM outcomes.

Practice Impact on Sick-day/Disability Absences. The graph on this page shows the perceived impact of HPM practices on sick-day/disability absences. After tallying the impact scores, we found eight HPM practices that 10 or more employers identified as important and assessed. All eight have average scores above zero, and for three of these practices (transitional RTW programs, early disability reporting and nurse case management) the confidence intervals around the average scores do not include zero, so we are confident that employers assess these practices positively. In addition, these three practices had among the highest share of employers able to report outcomes. It may be easier for employers to measure the link between a practice like return to work and an outcome like absence compared with other practices such as EAPs. On the other hand, the confidence intervals for

the remaining five practices are too wide to give us confidence in the positive effect from this sample of employers. For example, 17 employers cited sick-day/disability absences as an intended outcome of their ergonomics practices; however, ergonomic evaluations in particular have highly variable ratings, even though three-quarters of the employers using the practice reported outcomes. This could be due to a variety of factors, such as poorly trained ergonomic evaluators and/or inconsistent adherence to ergonomic practices.

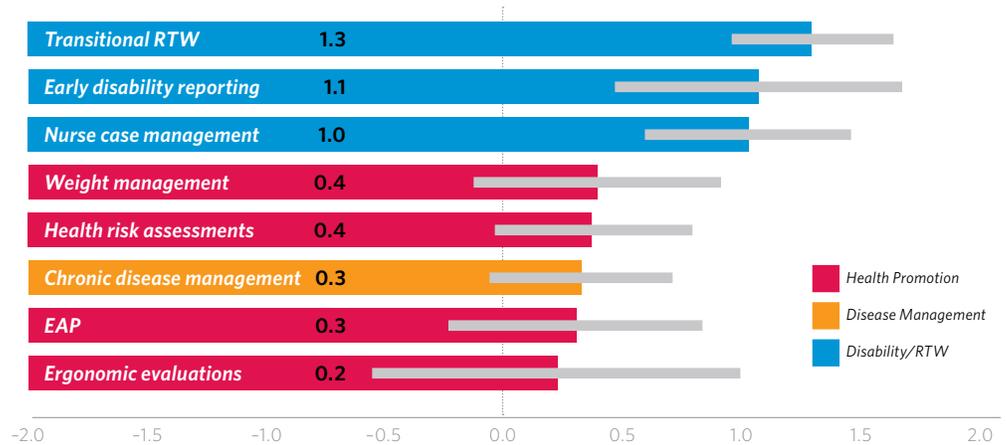
The distribution of scores for EAPs—one of the most frequently

adopted practices by employers—are wide and include zero, so this analysis cannot determine if they have an effect even though the mean impact of the practice is positive. Of all employers with EAPs, 60% were able to assess sick-day/disability absences and 40% could not, even though this outcome was a goal of their EAP. Although there was wide variation in impact scores, the largest share was in the “no effect” category. This does not mean that EAPs are never effective; it simply means that this surveyed sample did not show that EAPs have a consistently positive impact.

IMPACT OF PRACTICES ON SICK-DAY/DISABILITY ABSENCES

By employers' average impact score:
-2 = outcome worsened; 0 = no impact; +2 = outcome improved

Gray bar indicates 95% confidence interval



⁹ Practices were assessed when there were at least 10 employers providing a rating.

¹⁰ Presenteeism as an HPM goal was not included in this section because only one practice—EAP—met the minimum criterion of a rating by at least 10 employers. EAP average impact on presenteeism (0.2) indicates overall improved outcomes, but we found the spread of responses centered on “no effect.”

Practice Impact on Medical/Pharmacy Costs. Almost all of the employers surveyed for this research identified saving medical/pharmacy costs as a primary or secondary objective of their HPM efforts. Two-thirds of these employers stated that it was their primary objective. The graph on this page shows the impact of 15 HPM practices on medical/pharmacy costs. As we have seen in earlier analyses, all practices had positive average scores. All but two practices—ergonomic evaluations and smoking cessation—had a discernible positive impact on the medical/pharmacy cost savings objective. Again, these programs could be effective across a random sample of programs in the United States, but in our survey sample we find no consistent positive effect.

The most frequently cited employer goal of smoking-cessation programs is reducing medical/pharmacy spending. Of the 48 employers providing information on smoking cessation as it relates to medical/pharmacy costs, however, four in 10 couldn't quantify the impact. For those that could, there is wide variability in their assessed impact: Although 29% cited a moderate improvement, 15% reported that costs had moderately worsened and 10% reported no effect. The variability of these scores, and the share of employers that don't measure the impact, may indicate the difficulty employers have making a sound quantitative judgment of the impact of this practice on this key outcome. It could be that certain types of therapy, such as group therapy, individual counseling and nicotine replacement therapy, may be more effective than other types such that

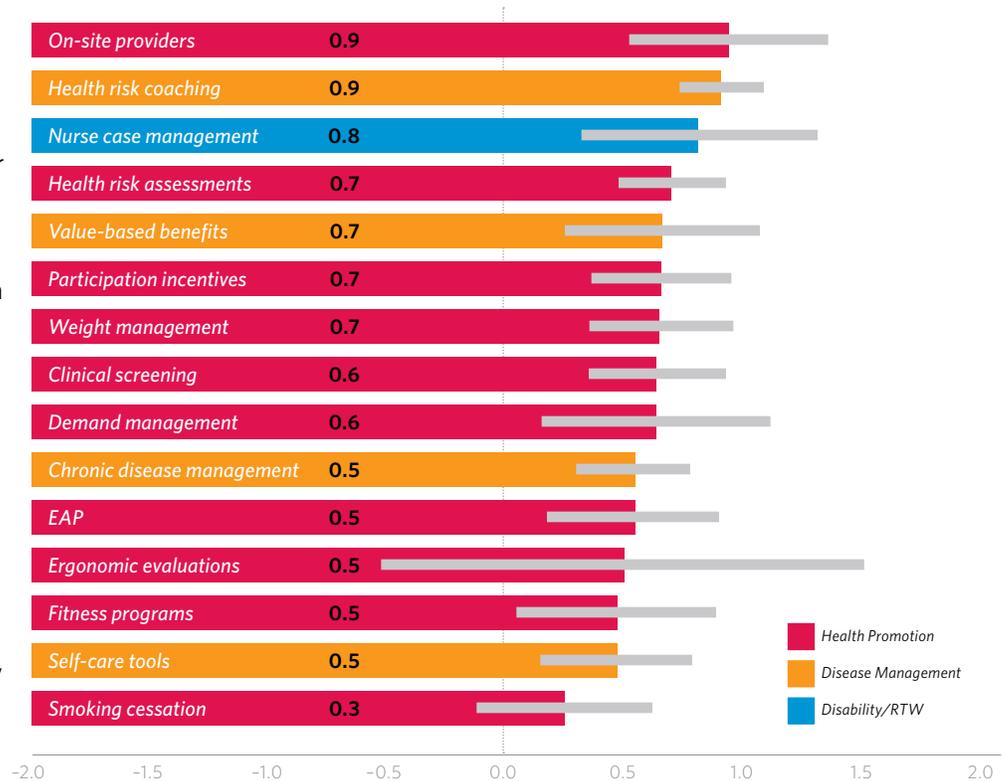
variation in the types of smoking-cessation programs offered might account for the variation in impact ratings. In addition, it is challenging to link smoking cessation—a program that is aimed at behaviors—to specific medical/pharmacy cost outcomes. It is also highly likely that the length of time an employer has a program in place will influence the employer's impact assessment as well.

As was observed with the scores for sick-day/disability absences, ergonomic evaluations are widely variable, possibly for the same reasons. Although only 10 employers provided information on ergonomic programs, all 10 reported impact scores, which may indicate that ergonomic interventions may be more effective for particular conditions (low back pain, for example) than for other conditions.

IMPACT OF PRACTICES ON MEDICAL/PHARMACY COSTS

By employers' average impact score:
-2 = outcome worsened; 0 = no impact; +2 = outcome improved

Gray bar indicates 95% confidence interval



Practice Impact on Health-related Lost Productivity. Employers rated the impact of HPM practices on health-related lost productivity as often as they did medical/pharmacy costs, as shown in the graph on this page. Fourteen of the 15 practices within this category have a positive average impact score. Given the variability in the sample, we can be confident that six out of the 15 practices—health risk coaching, transitional RTW, on-site providers, weight management, nurse case management and participation incentives—have a positive impact. Eight of the nine remaining practices also have an average positive score, but we cannot be certain of their positive effect because the confidence interval generated from the sample information includes zero. Employer evaluations also may be clouded because there undoubtedly is significant variation in how each employer defines lost productivity in its own organization and in how employers judge the impact of a specific practice on productivity loss (wholly apart from the impact of a practice on absence and presenteeism).

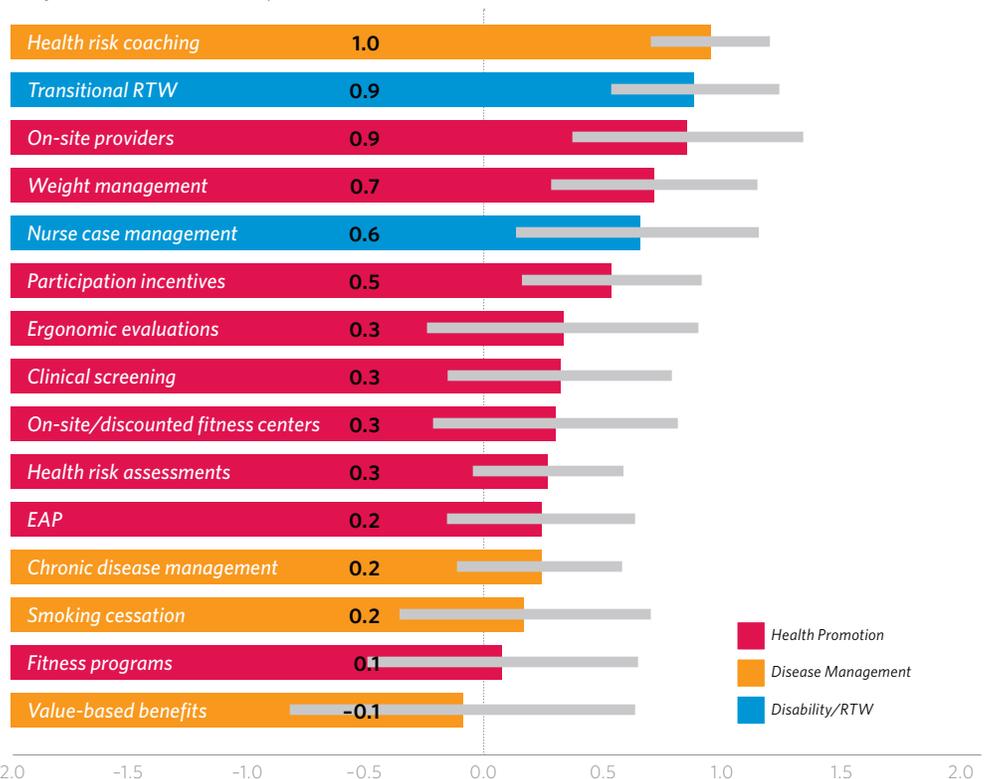
Two practices—smoking cessation and fitness programs—yield positive average scores but also show confidence intervals that include zero, with limits that extend well into both the negative and the positive impact ranges. We see two phenomena at work in both: relatively few employers that can measure impact¹¹—18 for smoking cessation and 13 for fitness programs—and wide variation in the impact of the practice.

Only one practice—value-based benefits—has a negative average score on productivity, but the spread of responses centers on zero among the 11 employers providing impact scores. While value-based benefits has a positive effect on reducing medical/pharmacy costs, in terms of the impact on lost productivity employers indicate that the effects of these benefits may extend toward the negative. In this case, we do not know the particular type of lost productivity measure used nor whether the effects of conditions on lost productivity were assessed separately from the effects of the intervention

itself. Furthermore, we cannot be certain that there is a positive effect because the impact score includes zero in the confidence interval. At a minimum, this finding suggests ambiguity among this pool of employers around the effects of value-based benefits on lost productivity. It may be that most value-based benefits are focused on medical/pharmacy treatment at present rather than absence, disability and other work outcomes, thus employers may see lost productivity as a future and not proximal outcome. They also may not be measuring lost productivity adequately.

IMPACT OF PRACTICES ON HEALTH-RELATED LOST PRODUCTIVITY

By employers' average impact score:
 -2 = outcome worsened; 0 = no impact; +2 = outcome improved
 Gray bar indicates 95% confidence interval



¹¹ These impact scores are necessarily among individuals that can make an assessment of impact. If they are unable to assess impact, they are excluded from the impact scores.

Practice Impact on Employee Satisfaction. Although employee satisfaction is not considered a H&P outcome per se, it is nonetheless the third-most-cited intended employer outcome for HPM practices overall. Moreover, research links business-unit-level measures of employee satisfaction to organizational outcomes such as profitability, productivity and safety.¹² The graph to the right suggests that employers consistently rate the impact of their HPM practices on employee satisfaction more highly than all other outcomes. Out of 13 HPM practices, all have unambiguously positive impact scores on employee satisfaction. Perhaps not surprisingly, fitness centers and fitness programs have the highest average score, followed by participation incentives and transitional RTW. Though it was assessed by only 14 respondents and had a relatively wide interval, even the score for the lowest-rated practice—stress reduction education—remains positive.

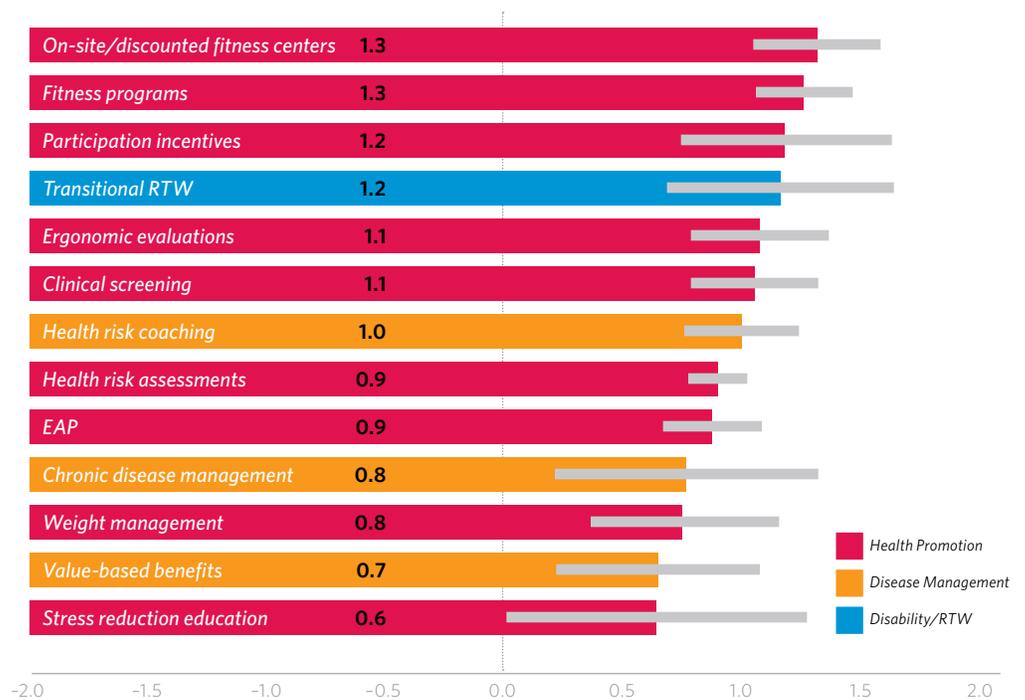
This may indicate that employers see the implementation of health and productivity practices as a message to employees that the employer is building a culture of health and is willing to commit resources to assist its workers with H&P improvements. The potential “win-win” between the employer’s interests in controlling medical/pharmacy costs and improving health-related productivity and the employees’ interests in improving their health

and quality of life and in getting back to work as quickly as possible may be recognized by both parties. Employers should not miss the opportunity to communicate these mutual interests in their employee communications initiatives.

IMPACT OF PRACTICES ON EMPLOYEE SATISFACTION

By employers’ average impact score:
 -2 = outcome worsened; 0 = no impact; +2 = outcome improved

Gray bar indicates 95% confidence interval



¹² See for example a meta-analysis by Harter, James K., Frank L. Schmidt, and Theodore L. Hayes. Business-Unit-Level Relationship Between Employee Satisfaction, Employee Engagement, and Business Outcomes: A Meta-Analysis. *Journal of Applied Psychology*. 2002; 87(2):268-279.

Limited Resources, Maximum Opportunities

The table to the right shows all of the practices with unambiguously positive responses for at least one HPM outcome (with average scores for each outcome). The blank cells indicate that there was too much variation in the impact score to generate an unambiguous, positive score.

Out of all 26 HPM practices, four have unambiguous positive ratings for their impact on reducing both medical/pharmacy costs and health-related lost productivity: health risk coaching, on-site providers, participation incentives and weight management programs. Transitional RTW programs are positively rated for reducing both sick-day/disability absences as well as health-related lost productivity. One practice—nurse case management—has an impact on all three important HPM outcomes: sick-day/disability absences, medical/pharmacy costs and health-related lost productivity. Because these six practices affect multiple objectives, *employers should consider them essential elements of an effective and efficient HPM program.*

Importantly, employers have made their commitments to HPM in the absence of consistent, readily available evidence that shows the effect of practices on H&P outcomes. In many instances, employers in our sample remain in the dark about how well their practices achieve their intended outcomes. As we have shown in earlier research, implementing efforts to measure

PRACTICES WITH POSITIVE IMPACT SCORES

	Sick-day/ disability absences	Medical/ pharmacy costs	Health-related lost productivity
Nurse case management	1.0	0.8	0.6
Transitional RTW	1.3	—	0.9
Health risk coaching	—	0.9	1.0
On-site providers	—	0.9	0.9
Participation incentives	—	0.7	0.5
Weight management	—	0.7	0.7
Early disability reporting	1.1	—	—
Health risk assessments	—	0.7	—
Value-based benefits	—	0.7	—
Clinical screening	—	0.6	—
Demand management	—	0.6	—
Chronic disease management	—	0.5	—
EAP	—	0.5	—
Fitness programs	—	0.5	—
Self-care tools	—	0.5	—

outcomes can close this knowledge gap considerably: Informed employers tend to view their practices more favorably than their uninformed peers. For organizations that do not know the impact of their practices, or that have not yet implemented an HPM strategy, the experiences of our sample employers can provide a starting point for evaluation.

We also see in this survey the great difficulty employers have in measuring the effects of individual HPM practices. For employers to truly judge the impact of practices, they need randomized controlled trials, or at least matched

participant and comparison groups, along with a consistent and rigorous definition of the practice—evaluation procedures and processes that can be complex, time-consuming and expensive. Therefore, in evaluating the impact of their HPM efforts, employers and their benefits partners may want to take a more “programmatic” approach, that is, examine how various HPM practices work together. This would prevent the employer from determining the impact of one practice relative to another; but if the goal is directional, this strategy may be sufficient.

Even during good economic times, employers will seek to maximize their investment in health and productivity. This will mean selecting not only the high-impact practices for a particular objective but also the practices that serve multiple objectives. The good news for all involved is that organizational leaders recognize that they must play an active role in promoting the health and resulting productivity of their workforce. Almost all surveyed employers practice some form of HPM, and they frequently offer practices across the spectrum of health promotion, disease management and disability return to work.

If employers have suffered from a deficit of outcomes-based information when formulating HPM efforts, ultimately their own experiences will be the deciding factor on whether to retain or abandon specific practices. In our sample, employers are generally positive about those practices deemed most important to their HPM efforts. In this light, it is small wonder that two out of three respondents expect to see a net increase in their HPM resources over the next two years and that fewer than one in 10 will decrease resources for at least one of their practices.¹³

That employers are voting with their pocketbooks to sustain HPM programs despite a general lack of empirical data on the outcomes of these efforts suggests the increasing prominence of workforce health as a business strategy. The case for HPM as a “best practice” will be further strengthened in subsequent IBI research that examines the relationship between employers’ HPM efforts and their business performance.

¹³ IBI (2010).

Appendix 1: Survey Description

IBI developed an online survey of employers' health and productivity management practices in partnership with Harris Interactive—best known for the Harris Poll, one of America's longest-running independent opinion polls. The survey addressed four main areas:

- 1 The strategies and the practices that organizations use to manage medical costs, lost time and health-related lost productivity, and their planned adoption of additional practices
- 2 The specific business goals employers seek to accomplish through their HPM efforts
- 3 How employers measure progress toward these goals
- 4 How well employers think their HPM efforts are working

The survey also inquired about employers' plans to change their resource commitments to existing HPM practices over the next two years, as well as their perceptions of looming health and productivity challenges.

Representatives from 447 unique employers completed the survey.

A majority of respondents represent employers in three industries: manufacturing (29%), education and health services (24%), and trade, transportation and utilities (11%). Employers involved in professional and business services (8%), public administration (8%), financial activities (7%) and other services (7%) also are well represented. The remainder of employers represented information, leisure and hospitality, construction, mining and agriculture.

Thirty-six percent of respondents represent for-profit, publicly traded organizations, 33% represent for-profit, privately owned organizations, and the remainder are nonprofit organizations (17%), government entities (12%) or unspecified (2%).

One-quarter of responding employers have fewer than 500 full-time-equivalent (FTE) workers, one-third have at least 500 but fewer than 5,000 FTE workers, and the remainder have at least 5,000 workers.

Participating organizations employ workers across the United States. We asked respondents for the region of the country in which most of their employees reside. Twenty-eight percent of employers indicated that the majority of their employees reside in the Midwest, 25% of employers indicated the South, 23% indicated the West, and 15% indicated that most of their employees reside in the Northeast. Eight percent of employers stated a majority of workers are located outside the United States or could not determine the U.S. region within which most of their employees work.

More than half of employers have a majority female workforce. The typical (mean) employee age distribution for employers in the sample shows 24% of their employees are aged 34 and below, 37% are between ages 35 and 54, and 26% are 55 years of age or older. Only 4% of employers in the sample indicate that a majority of their employees are at least 55 years of age.

Six in 10 survey respondents identify themselves as benefits managers, HR directors, or health and productivity managers. Only about 5% identify themselves as CEOs, CFOs and COOs—the majority of whom represent small employers (fewer than 500 employees). The remaining respondents are medical directors and administrative personnel, or declined to state their position in the organization or held another, unlisted position.

Appendix 2: HPM Practices

Description of Surveyed Health Promotion or Injury/Disease Prevention Practices

Practice	Description Provided in Survey
Nutrition education	Diet/nutritional education (e.g., weight management, cholesterol guidelines, etc.)
Weight management	Weight management
Fitness	Fitness or events (e.g., sponsorship of employee athletic participation, weight-loss contests, etc.)
Demand management	Demand management (e.g., nurse care hotlines, employee decision-support tools, benefits education, etc.)
On-site or discounted fitness centers	On-site fitness facilities or discounted/free memberships at local health clubs
Nutritious meal/snack options	Healthy meal or snack options in on-site cafeterias or vending machines
EAP	Employee Assistance Program (for work-family balance guidance, substance abuse issues, etc.)
Stress reduction education methods	Instruction in stress reduction methods
Ergonomic evaluations	Ergonomic evaluations of the workplace
Health risk assessments	Health risk assessments (e.g. a survey to evaluate employees' health status)
Clinical screening	Screening for conditions such as high blood pressure, cancer, high cholesterol, etc.
Participation incentives	Adjusted premiums, co-payment/deductibles and/or job characteristics to encourage participation in specified health promotion or disease prevention
On-site providers	On-site clinic, pharmacy, nurse or other health practitioner
Smoking cessation	Smoking or substance abuse cessation
Self-care tools	Tools, information or equipment to help employees diagnose their own conditions or monitor their own care
Referrals for counselors/specialists	Referrals for counselors/specialists
Health risk coaching	Health/lifestyle coaching for employees with health risks
Chronic disease management interventions	Coordinated healthcare interventions for employees with specific chronic conditions (e.g., asthma, back pain, cancer, cardiovascular disease, diabetes, high blood pressure, depression, obesity, etc.)
Value-based benefits	Value-based benefit design (e.g., altering cost tiers for certain conditions or pharmaceuticals)

Practices to Help Your Employees Return to Work from a Disability

Practice	Description Provided in Survey
Early disability reporting	Early/expedited disability claim reporting
Transitional RTW	Transitional RTW
RTW education	"Just-in-time" employee education about RTW opportunities
RTW incentives	Employee incentives for RTW participation
Administrative chargebacks to encourage RTW	Financial incentives for management and supervisors to accommodate RTW (e.g., cost chargebacks to organizational units)
Disability duration guidelines	Disability duration guidelines
Nurse case management	Nurse case management

Appendix 3:

Impact of Practices on Employer HPM Goals

Average Impact of Practices on Primary and Secondary Outcomes

	No. of employer ratings	Percentage of Employers Responding					
		Significantly worsened (-2 to -1.5)	Moderately worsened (-1 to -0.5)	No effect (0)	Moderately improved (0.5 to 1)	Significantly improved (1.5 to 2)	Don't know (no score)
Nutrition education programs	20	5.0%	5.0%	15.0%	25.0%	5.0%	45.0%
Weight management	62	0.0%	6.5%	11.3%	30.7%	3.2%	48.4%
Fitness programs	39	2.6%	10.3%	12.8%	35.9%	0.0%	38.5%
Demand management programs	20	0.0%	5.0%	20.0%	40.0%	0.0%	35.0%
On-site or discounted fitness centers	28	0.0%	10.7%	17.9%	28.6%	0.0%	42.9%
Nutritious meal/snack options*	11	0.0%	9.1%	0.0%	9.1%	0.0%	81.8%
EAP	93	3.2%	10.8%	16.1%	25.8%	3.2%	40.9%
Stress reduction education methods	35	0.0%	17.1%	11.4%	20.0%	5.7%	45.7%
Ergonomic evaluations	34	11.8%	8.8%	20.6%	23.5%	20.6%	14.7%
Health risk assessments	119	0.8%	6.7%	14.3%	29.4%	5.9%	42.9%
Clinical screening programs	77	2.6%	11.7%	9.1%	35.1%	5.2%	36.4%
Participation incentives	49	0.0%	4.1%	22.5%	32.7%	6.1%	34.7%
On-site providers	37	5.4%	5.4%	0.0%	37.8%	29.7%	21.6%
Smoking cessation programs	57	3.5%	12.3%	12.3%	28.1%	1.8%	42.1%
Self-care tools	28	3.6%	7.1%	21.4%	35.7%	0.0%	32.1%
Referrals for counselors/specialists	20	0.0%	25.0%	5.0%	30.0%	5.0%	35.0%
Health risk coaching	69	0.0%	4.4%	5.8%	46.4%	4.4%	39.1%
Chronic disease management	112	1.8%	13.4%	8.0%	40.2%	4.5%	32.1%
Value-based benefits	51	5.9%	11.8%	5.9%	33.3%	17.7%	25.5%
Early disability reporting	19	0.0%	10.5%	10.5%	26.3%	31.6%	21.1%
Transitional RTW	47	2.1%	12.8%	4.3%	34.0%	40.4%	6.4%
RTW education*	4	0.0%	50.0%	0.0%	0.0%	25.0%	25.0%
RTW incentives*	4	0.0%	0.0%	25.0%	25.0%	50.0%	0.0%
Administrative chargebacks to encourage RTW*	3	0.0%	0.0%	0.0%	33.3%	33.3%	33.3%
Disability duration guidelines	21	0.0%	4.8%	14.3%	33.3%	14.3%	33.3%
Nurse case management	63	7.9%	9.5%	4.8%	22.2%	38.1%	17.5%

*Not shown in figure due to too few responses.

Impact of Practices on Medical/Pharmacy Costs

	No. of employer ratings	Percentage of Employers Responding					
		Significantly worsened (-2)	Moderately worsened (-1)	No effect (0)	Moderately improved (1)	Significantly improved (2)	Don't know (no score)
Nutrition education programs*	12	0.0%	0.0%	16.7%	16.7%	8.3%	58.3%
Weight management	52	0.0%	5.8%	9.6%	30.8%	3.9%	50.0%
Fitness programs	24	4.2%	0.0%	20.8%	37.5%	0.0%	37.5%
Demand management	16	0.0%	6.3%	18.8%	37.5%	6.3%	31.3%
On-site or discounted fitness centers*	14	0.0%	14.3%	14.3%	35.7%	0.0%	35.7%
Nutritious meal/snack options*	8	0.0%	12.5%	0.0%	12.5%	0.0%	75.0%
EAP	23	0.0%	4.4%	17.4%	34.8%	0.0%	43.5%
Stress reduction education methods*	12	8.3%	0.0%	25.0%	8.3%	8.3%	50.0%
Ergonomic evaluations	10	20.0%	10.0%	10.0%	20.0%	40.0%	0.0%
Health risk assessments	98	1.0%	5.1%	11.2%	33.7%	7.1%	41.8%
Clinical screening	60	1.7%	6.7%	8.3%	38.3%	5.0%	40.0%
Participation incentives	43	0.0%	7.0%	16.3%	37.2%	7.0%	32.6%
On-site providers	21	4.8%	0.0%	0.0%	61.9%	9.5%	23.8%
Smoking cessation	48	2.1%	14.6%	10.4%	29.2%	2.1%	41.7%
Self-care tools	23	0.0%	4.4%	26.1%	34.8%	0.0%	34.8%
Referrals for counselors/specialists*	11	0.0%	18.2%	9.1%	27.3%	0.0%	45.5%
Health risk coaching	55	0.0%	1.8%	5.5%	49.1%	3.6%	40.0%
Chronic disease management	96	2.1%	11.5%	6.3%	40.6%	5.2%	34.4%
Value-based benefits	46	6.5%	10.9%	4.4%	34.8%	19.6%	23.9%
Early disability reporting*	8	0.0%	0.0%	0.0%	25.0%	37.5%	37.5%
Transitional RTW programs*	12	0.0%	8.3%	8.3%	41.7%	8.3%	33.3%
RTW education*	0	—	—	—	—	—	—
RTW incentives*	2	0.0%	0.0%	0.0%	0.0%	50.0%	50.0%
Administrative chargebacks to encourage RTW*	2	0.0%	0.0%	0.0%	0.0%	50.0%	50.0%
Disability duration guidelines*	5	0.0%	0.0%	0.0%	40.0%	0.0%	60.0%
Nurse case management	38	7.9%	5.3%	2.6%	31.6%	23.7%	29.0%

*Not shown in figure due to too few responses.

Impact of Practices on Health-related Lost Productivity

	No. of employer ratings	Percentage of Employers Responding					
		Significantly worsened (-2)	Moderately worsened (-1)	No effect (0)	Moderately improved (1)	Significantly improved (2)	Don't know (no score)
Nutrition education programs*	13	7.7%	7.7%	7.7%	30.8%	0.0%	46.2%
Weight management	29	0.0%	3.5%	13.8%	24.1%	6.9%	51.7%
Fitness programs	21	4.8%	14.3%	14.3%	28.6%	0.0%	38.1%
Demand management programs*	5	0.0%	20.0%	20.0%	20.0%	0.0%	40.0%
On-site or discounted fitness centers	16	0.0%	12.5%	18.8%	31.3%	0.0%	37.5%
Nutritious meal/snack options*	6	0.0%	0.0%	0.0%	16.7%	0.0%	83.3%
EAP	48	4.2%	12.5%	12.5%	27.1%	4.2%	39.6%
Stress reduction education methods*	15	0.0%	20.0%	6.7%	20.0%	0.0%	53.3%
Ergonomic evaluations	23	8.7%	8.7%	21.7%	26.1%	13.0%	21.7%
Health risk assessments	54	0.0%	11.1%	13.0%	24.1%	0.0%	51.9%
Clinical screening programs	41	2.4%	14.6%	4.9%	26.8%	4.9%	46.3%
Participation incentives	26	0.0%	7.7%	11.5%	38.5%	0.0%	42.3%
On-site providers	24	4.2%	8.3%	4.2%	45.8%	20.8%	16.7%
Smoking cessation programs	30	6.7%	10.0%	13.3%	26.7%	3.3%	40.0%
Self-care tools*	13	7.7%	15.4%	0.0%	23.1%	0.0%	53.9%
Referrals for counselors/specialists*	12	0.0%	16.7%	8.3%	25.0%	8.3%	41.7%
Health risk coaching	41	0.0%	2.4%	2.4%	41.5%	4.9%	48.8%
Chronic disease management	60	1.7%	16.7%	6.7%	30.0%	1.7%	43.3%
Value-based benefits	20	5.0%	20.0%	10.0%	15.0%	5.0%	45.0%
Early disability reporting*	10	0.0%	10.0%	20.0%	20.0%	20.0%	30.0%
Transitional RTW	29	0.0%	20.7%	3.5%	31.0%	34.5%	10.3%
RTW education*	3	0.0%	33.3%	33.3%	0.0%	0.0%	33.3%
RTW incentives*	1	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Administrative chargebacks to encourage RTW*	1	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
Disability duration guidelines*	16	0.0%	6.3%	18.8%	25.0%	6.3%	43.8%
Nurse case management	39	10.3%	10.3%	7.7%	20.5%	30.8%	20.5%

*Not shown in figure due to too few responses.

Impact of Practices on Sick-day/Disability Absences

	No. of employer ratings	Percentage of Employers Responding					
		Significantly worsened (-2)	Moderately worsened (-1)	No effect (0)	Moderately improved (1)	Significantly improved (2)	Don't know (no score)
Nutrition education programs*	4	0.0%	0.0%	50.0%	25.0%	0.0%	25.0%
Weight management	17	0.0%	11.8%	11.8%	35.3%	0.0%	41.2%
Fitness programs*	6	0.0%	0.0%	0.0%	50.0%	0.0%	50.0%
Demand management programs*	8	0.0%	0.0%	12.5%	50.0%	0.0%	37.5%
On-site or discounted fitness centers*	5	0.0%	0.0%	20.0%	20.0%	0.0%	60.0%
Nutritious meal/snack options*	0	—	—	—	—	—	—
EAP	27	3.7%	7.4%	22.2%	18.5%	7.4%	40.7%
Stress reduction education methods*	8	0.0%	12.5%	12.5%	25.0%	0.0%	50.0%
Ergonomic evaluations	17	11.8%	11.8%	17.7%	17.7%	17.7%	23.5%
Health risk assessments	25	0.0%	8.0%	16.0%	28.0%	0.0%	48.0%
Clinical screening programs*	15	0.0%	0.0%	33.3%	26.7%	0.0%	40.0%
Participation incentives*	8	0.0%	0.0%	37.5%	12.5%	0.0%	50.0%
On-site providers*	11	0.0%	9.1%	0.0%	18.2%	54.6%	18.2%
Smoking cessation programs*	13	0.0%	15.4%	15.4%	15.4%	0.0%	53.9%
Self-care tools*	2	0.0%	0.0%	50.0%	50.0%	0.0%	0.0%
Referrals for counselors/specialists*	3	0.0%	0.0%	0.0%	33.3%	33.3%	33.3%
Health risk coaching*	7	0.0%	0.0%	14.3%	28.6%	0.0%	57.1%
Chronic disease management	32	0.0%	12.5%	12.5%	31.3%	0.0%	43.8%
Value-based benefits*	4	0.0%	0.0%	25.0%	25.0%	25.0%	25.0%
Early disability reporting	16	0.0%	12.5%	6.3%	25.0%	37.5%	18.8%
Transitional RTW	33	3.0%	3.0%	3.0%	36.4%	45.5%	9.1%
RTW education*	2	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
RTW incentives*	2	0.0%	0.0%	50.0%	50.0%	0.0%	0.0%
Administrative chargebacks to encourage RTW*	3	0.0%	0.0%	0.0%	0.0%	66.7%	33.3%
Disability duration guidelines*	13	0.0%	0.0%	23.1%	30.8%	15.4%	30.8%
Nurse case management	32	3.1%	12.5%	0.0%	34.4%	37.5%	12.5%

*Not shown in figure due to too few responses.

Impact of Practices on Presenteeism

	No. of employer ratings	Percentage of Employers Responding					
		Significantly worsened (-2)	Moderately worsened (-1)	No effect (0)	Moderately improved (1)	Significantly improved (2)	Don't know (no score)
Nutrition education programs*	2	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Weight management*	5	0.0%	20.0%	20.0%	20.0%	0.0%	40.0%
Fitness programs*	5	0.0%	20.0%	0.0%	0.0%	0.0%	80.0%
Demand management programs*	2	0.0%	0.0%	50.0%	0.0%	0.0%	50.0%
On-site or discounted fitness centers*	2	0.0%	0.0%	50.0%	0.0%	0.0%	50.0%
Nutritious meal/snack options*	1	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
EAP	35	2.9%	14.3%	8.6%	25.7%	2.9%	45.7%
Stress reduction education methods*	16	0.0%	12.5%	12.5%	25.0%	6.3%	43.8%
Ergonomic evaluations*	6	16.7%	0.0%	0.0%	33.3%	33.3%	16.7%
Health risk assessments*	18	0.0%	0.0%	16.7%	22.2%	5.6%	55.6%
Clinical screening programs*	10	0.0%	10.0%	10.0%	30.0%	0.0%	50.0%
Participation incentives*	5	0.0%	0.0%	20.0%	60.0%	0.0%	20.0%
On-site providers*	5	0.0%	0.0%	0.0%	60.0%	0.0%	40.0%
Smoking cessation programs*	8	0.0%	25.0%	25.0%	12.5%	0.0%	37.5%
Self-care tools*	5	0.0%	0.0%	20.0%	60.0%	0.0%	20.0%
Referrals for counselors/specialists*	5	0.0%	40.0%	0.0%	20.0%	0.0%	40.0%
Health risk coaching*	11	0.0%	18.2%	9.1%	36.4%	0.0%	36.4%
Chronic disease management*	12	0.0%	8.3%	16.7%	25.0%	0.0%	50.0%
Value-based benefits*	5	0.0%	0.0%	20.0%	40.0%	0.0%	40.0%
Early disability reporting*	1	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Transitional RTW*	6	0.0%	16.7%	16.7%	33.3%	16.7%	16.7%
RTW education*	1	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
RTW incentives*	2	0.0%	0.0%	50.0%	50.0%	0.0%	0.0%
Administrative chargebacks to encourage RTW*	0	—	—	—	—	—	—
Disability duration guidelines*	3	0.0%	0.0%	0.0%	0.0%	33.3%	66.7%
Nurse case management*	8	12.5%	25.0%	0.0%	25.0%	25.0%	12.5%

*Not shown in figure due to too few responses.



**INTEGRATED
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The **Integrated Benefits Institute** (IBI) provides employers and their supplier partners with resources to prove the business value of health. As a pioneer, leader and nonprofit supplier of health and productivity research, measurement and benchmarking, IBI is the trusted source for benefits performance analysis, practical solutions, and forums for information and education. IBI's programs, resources and expert networks advance understanding about the link between—and the impact of—health-related productivity on corporate America's bottom line.

For 15 years, IBI has been in the forefront, leading businesses from concept to reality in integrating health, absence and disability management benefits as an investment in a productive workforce. IBI's independent, cutting-edge approach and innovations consistently provide added value to a prestigious roster of employers, from leading corporations to small companies as well as their benefits management business partners.

IBI is committed to and invested in groundbreaking analysis of health, productivity, disability and absence issues as they cut across traditional health-related benefits, as well as expanding and enhancing its proven suite of measurement tools. Tackling the latest business challenges with state-of-the-art research, insights and thought leadership, IBI provides companies with robust and actionable integrated health and productivity benefits strategies. In close collaboration with frontline experts working on today's critical business issues, IBI helps employers blaze a new trail both to superior benefits management in alignment with company objectives and to proving the business value of their health investment.

For more information about IBI's programs and membership, go to IBIWEB.ORG.