



National Business
Coalition on Health

Health and Productivity: The Business Imperative

National Health Leadership Council

June 27-29, 2007

Boston, Massachusetts



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Message from the President

October 2007

The National Health Leadership Council (NHLC) of the National Business Coalition on Health (NBCH) brings together leaders from business, health coalitions, and other stakeholders in the health care system to discuss issues at the cutting edge of health care financing, organization, access, and quality. Recent NHLC meetings have explored consumer-centered health care and consumer-directed health benefit models, the uninsured, trends in pharmaceutical benefits, evidence-based health benefit design, health information technology, physician performance measurement, physician payment reform, and the role of health plans in today's evolving marketplace.

In June 2007, the NHLC met in Boston, MA to discuss an increasingly important topic—the relationship between health and productivity, and the resulting business imperative for employers to promote employee health as a means of boosting worker productivity and improved competitiveness in a global marketplace. In two rich days of presentations and conversation, NHLC participants had an opportunity to discuss critical issues surrounding health and productivity, including the business case for health and productivity management and the best strategies for selling that business case to the “c-suite.” Attendees heard from a variety of thought leaders on this topic, including representatives from the Integrated Benefits Institute (IBI), Matria Healthcare, Riedel & Associates, and I-Trax, Inc., who have collaboratively developed an educational course on health and productivity management, known as the HPM Clinic™. Attendees were briefed on each of the modules that make up this course. In addition, representatives from Caterpillar, Inc. and Carlson Companies discussed how their organizations have applied lessons from the course, while a representative from the National Committee for Quality Assurance (NCQA) discussed the potential role of NCQA accreditation and certification programs in promoting the spread of practices that boost employee health and productivity.

NBCH's primary goal is to promote health care reform through value-based purchasing. One of the four pillars of value-based purchasing, moreover, is also a critical component of any effort to boost health status and productivity—that is, the empowerment of individual consumers to make better decisions related to health, including choices related to lifestyle and accessing services, providers, and treatments. NBCH's objective is to integrate the health and productivity agenda with the value-driven health care agenda, with the ultimate goal of improving employee and community health and health care.

As with all NHLC gatherings, this meeting represented an opportunity for stakeholders in health care to get out of their silos, to come together to build trust and reach consensus on needed changes that can lead to higher quality, more cost-effective health care. By identifying and promoting best practices and by forging multi-stakeholder consensus on important issues, the NHLC and NBCH hope to accelerate the process of health system reform through community-by-community adoption of value-based purchasing. Employers, as purchasers, can encourage this much-needed innovation by working collaboratively with other stakeholders in supporting employees in their efforts to make better choices that will lead to improved health status and higher levels of productivity. Our hope is that this report will help with that effort.

Sincerely,



Andrew Webber
President and CEO, NBCH

The National Health Leadership Council (NHLC) of the National Business Coalition on Health (NBCH) is a vehicle for high-level discussions of issues that are important to coalition members and to all major parties in health care, including purchasers, providers, insurers, suppliers, and consumers. The expectation is that NHLC meetings will produce statements of agreement among the stakeholders that will promote the advancement of a more value-based health care system. The goal is to encourage community-based changes founded on market principles.

In June 2007 NBCH held an NHLC meeting in Boston, MA. The meeting focused on the business imperative for employers to promote employee health as a means of boosting employee productivity. Poor health status is currently costing employers significant amounts of money, not just in terms of direct health and short- and long-term disability costs, but more importantly in terms of excess absenteeism and presenteeism (i.e., when an employee is on the job but performing at suboptimal levels due to health issues). The first day of the meeting included an in-depth review of the HPM Clinic™ course, a multi-module curriculum that makes a compelling case to employers about the need to focus on health and productivity management, as well as strategies for selling that notion to senior executives. The afternoon of day one and most of day two featured presentations from employers that have adopted lessons from these modules to their organizations.

This report summarizes and synthesizes the key points from the presentations and discussion that took place during the meeting. It is organized into the following sections:

- **Introduction to the HPM Clinic™**
Thomas Parry, PhD, President, Integrated Benefits Institute; John Riedel, MPH, MBA, President, Riedel & Associates Consultants
- **A Detailed Examination of HPM**
 - **The Cost of Lost Productivity**
William Molmen, JD, General Counsel, Integrated Benefits Institute
 - **Health and Productivity: Making the Case to the C-Suite**
Ronald Loepke, MD, Executive Vice President and Chief Strategic Officer, Matria Healthcare
 - **Health and Productivity Relationships**
John Riedel, MPH, MBA, President, Riedel & Associates Consultants
 - **Occupational and Environmental Medicine and Human Resources/Health Benefits: Bridging Common Areas of Interest**
Raymond Fabius, MD, President and Chief Medical Officer, I-Trax, Inc.; Michael Taylor, MD, Medical Director for Health Promotion, Caterpillar, Inc.
- **Employer Examples of Health and Productivity**
Charles Montreuil, Vice President, Corporate Human Resources, Carlson Companies
- **Role of the National Committee for Quality Assurance**
Richard Sorian, Vice President of Public Policy and External Relations, National Committee for Quality Assurance
- **Key Issues in Moving Forward**

Section I:

Introduction to HPM Clinic™ and Health and Productivity Management

*Thomas Parry, PhD, President,
Integrated Benefits Institute
(IBI)*

*John Riedel, MPH, MBA,
President, Riedel & Associates
Consultants*

Both employers and employees have an interest in the health of individual workers, and there is growing evidence that employers have an important role to play in supporting employee health. For example, a recent *New York Times* article highlights IBI research that shows a relationship between pharmacy plan design and employee productivity. This research suggests strongly that employer policy decisions can have a significant impact on employee health and productivity.

What Is HPM and Why Do We Need It?

The direct costs of poor employee health include not only the “above-water” costs, such as direct medical costs (which represent 22% of overall employee health-related costs) and disability (which represent 4% of total costs), but also productivity-related costs, which represent the vast majority (74%) of the total. Productivity loss has been largely ignored by companies for many years. Productivity-related costs include a variety of things, including lost productivity, worker overtime, temporary staffing, and other costs that accrue due to employee absence, as well as suboptimal work by employees in ill health who are present (a concept known as “presenteeism”). (See box for more on absenteeism and presenteeism.) Other costs include the potential for employee and customer dissatisfaction, excess employee turnover, and missed deadlines.

Health and Productivity Management (HPM) is a systematic approach that allows companies to focus on improving productivity. HPM is designed to quantify, evaluate, and optimize a company’s investment in its workforce. It focuses on improving corporate competitiveness by investing in human capital rather than considering labor-related expenses (including health benefits) as an operating cost that needs to be reduced to the extent possible. In the past, initiatives to improve employee health were considered a strategy for controlling a top-line expense. Today, however, employee health must be considered a key driver of overall performance. Investments in employee health not only help to control direct expenses, but also protect, support, and enhance human capital, which is fundamental to a healthier bottom line.

Human capital is defined as the proportion of an individual employee’s total productivity output in the service of the firm. Health is an important component of human capital, along with education, skills, knowledge, and attitude. Consider the following:

Core Elements of Health-Related Productivity Loss

There are two core components to health-related productivity losses.

- **Absenteeism:** Health-related productivity loss includes absenteeism, which can occur when an employee is injured on the job (and draws workers’ compensation), goes on short- or long-term disability, is sick, takes family medical or unpaid leave, or is lost to the workforce (e.g., due to a chronic illness). Absenteeism can lead to increased use of substitute temporary workers and overtime, and can also create team dysfunction. Many companies find it difficult to develop tracking systems that measure all elements of absenteeism.
- **Presenteeism:** Presenteeism refers to time when an employee is on the job but not performing at full productivity due to health-related issues. Studies consistently show that the costs of presenteeism are much larger than the costs of absenteeism. Specific components of presenteeism include the following:
 - **Time when employee is not focused on the task at hand:** Lack of focus is common when an individual is first diagnosed with a chronic illness. Over time, they often learn to live with the illness and can return to normal levels of productivity.
 - **Poor quality of work:** For example, individuals with depression may not be able to concentrate on their work and produce the same level of quality as someone who is not depressed. In fact, depressed individuals have lower absenteeism rates (i.e., they show up for work more often) but much higher presenteeism rates than do typical employees.
 - **Reduced quantity of work:** Individuals with health problems often cannot complete the same amount of work.

- Over 22% of working-age adults report health-related work impairment in the past 30 days from chronic illness. Those with impairment averaged 6-7 lost days. In total, this is equivalent to 2.5 billion impaired days per year.
- The top five reasons for productivity loss collectively result in \$180 billion in lost time.
- Illness and disability reduce total work hours by approximately 8.6%. Nearly 8.7 million Americans are completely unable to work. The total loss to the U.S. economy is roughly \$468 billion.

Some Employers Beginning to Focus on HPM

Company leaders are starting to focus on HPM, as they recognize the inextricable link between employee health and their company's well-being. In fact, a May 2005 survey by IBI found that 61% of employers agree that the best long-term means of managing the economic burden of ill health is to manage in concert with absence, disability, and productivity. Only 15% believe that the best strategy is to seek to minimize annual medical cost increases. This survey was consistent with the findings of a later survey of chief financial officers (CFOs).

A separate survey from the American College of Occupational and Environmental Medicine (ACOEM) found that 93% of corporate benefits managers believe that keeping employees healthy is a key goal of the company; 86% believe that workforce health is key to company performance, and 64% believe that benefits can be designed so that they pay for themselves in terms of productivity gains. A quick, informal survey of NHLC attendees revealed similar beliefs. Less than half of respondents (43%) to the ACOEM survey believe that direct medical costs are a bigger problem than productivity loss, while less than one in five (19%) doubt that productivity losses are as large as direct medical costs. In short, the survey reveals that benefits managers believe in the value of HPM. The key going forward, however, is to get senior executives (the "C-suite") to buy into the concept. Many executives have a "show-me" attitude when it comes to HPM. CEOs and CFOs need to see the hard data that supports investing in HPM. But if they are convinced, they will act on the information. Some chief executives already are believers, as evidenced by the quotes in the box to the right. Overall, however, adoption of HPM is still in its infancy. On a standard adoption-diffusion curve, HPM has already been adopted by the innovators (representing roughly 2.5% of employers), as well as many early adopters (13.5%) and some of the early majority (34%).

A number of trends are contributing to this increased focus on employee health:

- **The escalating cost of health care:** Rising health care costs are top of mind with employers, who are increasingly questioning the value they get for their money. While the growth in health care costs slowed to 9.2% in 2005, cost increases are still well above the rate of inflation and wage growth. While many employers are focused on shifting costs to employees, this is not a long-term solution. The HPM approach views spending on health care benefits as an investment in the health and productivity of the workforce. Today approximately 15 conditions account for more than half of the cost increases in health care, and these same conditions account for the majority of productivity losses as well.
- **Demographics (aging boomers):** More workers are remaining in the workforce well into their 50s and 60s. By 2020, there will be 45% more Americans over the age of 65 than there are today. These trends will lead to higher health costs and a greater incidence of long-term disability.
- **Prevalence of chronic illness:** The number of people with chronic conditions rose from 118 million in 1995 to 133 million in 2005, and is expected to reach 171 million by 2030. Older adults are more likely to have multiple chronic conditions. In fact, two-thirds of those over the age of 65 have two or more chronic conditions. People with chronic illnesses and activity limitations have more physician visits, which affects productivity negatively.
- **Consumerism:** Different employers have different strategies when it comes to consumerism, although most consumer-driven plans have a cost-shifting element. The key issue is how much information employees have to manage their own health. Many employers provide information on health to employees, and some also use case management, nurse coaching, and other programs to support employees in making better decisions. Depending on how they are implemented, consumer-directed plans can have a

Leading by Example

- "Investment in health delivery is consistent with a long-term view of maximizing return on human capital."—Michael Critelli, CEO, Pitney Bowes
- "A healthy, engaged, and productive workforce is critical to maximizing business performance and driving sustainable growth."—Dean Oestreich, President, Pioneer Hi-Bred International, Inc.
- "Our profit potential is inextricably linked to the capability and performance of our employees."—Andrew Liveris, President and CEO, The Dow Chemical Company

Thomas Parry, PhD, is president of the Integrated Benefits Institute (IBI), a San Francisco-based independent, national organization incorporated in 1995. IBI provides research, benchmarking, and analysis to improve health and productivity management through the integration of employee benefits. More than 250 employers, insurers, health care providers, brokers, third-party administrators, consultants, and others interested in the development of new integrated benefit systems support IBI's work. Dr. Parry is currently the principal investigator on a project examining physician incentives and disincentives to more fully manage functional capacity and disability. Before co-founding IBI, Dr. Parry served 11 years as research director at the California Workers' Compensation Institute (CWCI). His research at CWCI encompassed a wide variety of topics in workers' compensation, including medical treatment patterns, vocational rehabilitation costs and effectiveness, legal costs and trends, medical utilization, mental stress claims, and physical therapy patterns of care. While at CWCI, Dr. Parry was engaged in some of the earliest research and analysis on 24-hour coverage and integrated benefit issues. Dr. Parry received his Bachelor's, Master's and Ph.D. degrees from the University of California, Berkeley.

large impact—positive or negative—on productivity. While many employers feel that consumer-directed plans will dominate in the future, there has been somewhat of a slowdown in the growth of high-deductible, consumer-driven plans.

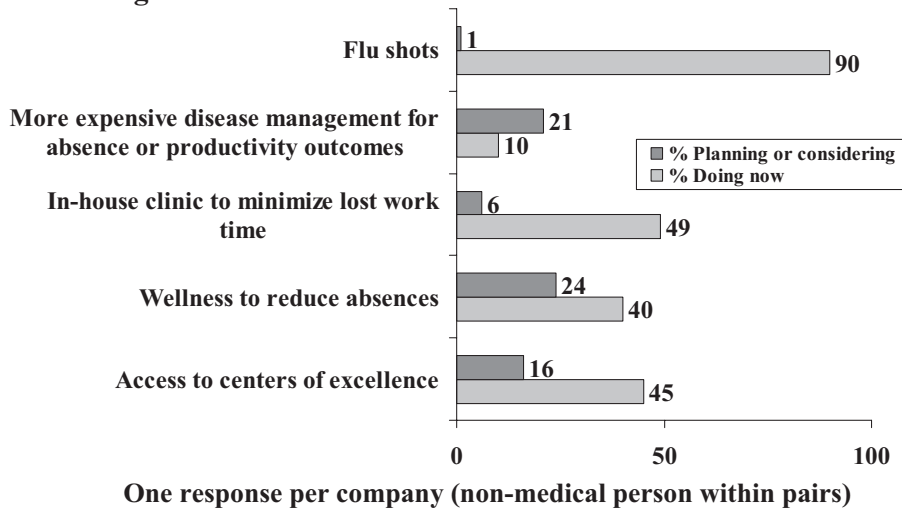
What Are Employers Doing in HPM?

The ACOEM survey asked benefits managers about specific programs they are engaged in that are aimed at increasing productivity. The survey inquired about 32 specific activities within five broad categories: absence management and health plan activities, programs (disease management, wellness), drug benefits, provider activities, and individual incentives. The results suggest that many companies are engaged in productivity-enhancing activities, even though some of them do not perceive the programs to be related to productivity. In other words, companies may already be engaged in HPM activities but are not making the explicit connection to productivity. In fact, the average company in the survey was engaged in 6 of the 32 activities. Not surprisingly, larger companies tend to be engaged in more activities than smaller ones. But even companies with less than 1,000 employees were involved in an average of 3 activities. As shown in the charts on the following page, some activities, such as flu shots, are already commonplace, while others are more likely to be in the planning stage or under consideration.

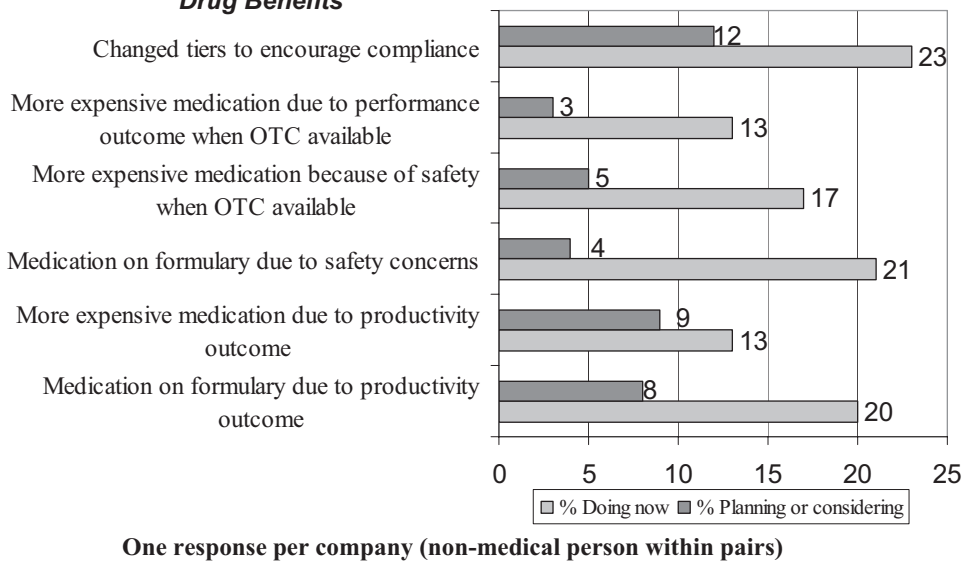
These survey results suggest that the movement toward HPM is in its early stages, and that the connection to productivity may not always be made. Many employers are starting with familiar activities and are still in the planning stages for others. Looking ahead, it will be critical for all key stakeholders to play a role if HPM is to become more commonplace. Specifically, senior management will be critical to selling the idea internally. In addition, human resources and benefits managers have to be on board (many already are), as does OEM, risk management, disability management, front-line supervisors (who may be the most critical to getting employees to change behavior), and of course the employees themselves. A recent IBI survey shows that human resource/benefit managers, CEOs, and COOs are critical both to creating motivation and support for HPM, and to developing and implementing the specific programmatic components of any effort to reduce health-related productivity losses. Fortunately, many resources already exist to help with this effort, including potential partners such as health care coalitions, professional organizations (e.g., ACOEM), health plans, third-party administrators, providers, disease management firms, occupational health, behavioral health providers, disability insurers, case managers, health educators, pharmacy benefits managers, and health promotion providers. These partners can play a variety of potential roles, including providing information resources, training, data collection and analysis, measurement and evaluation, and strategic advice.

Value-Based Activities Aimed at Productivity Improvement

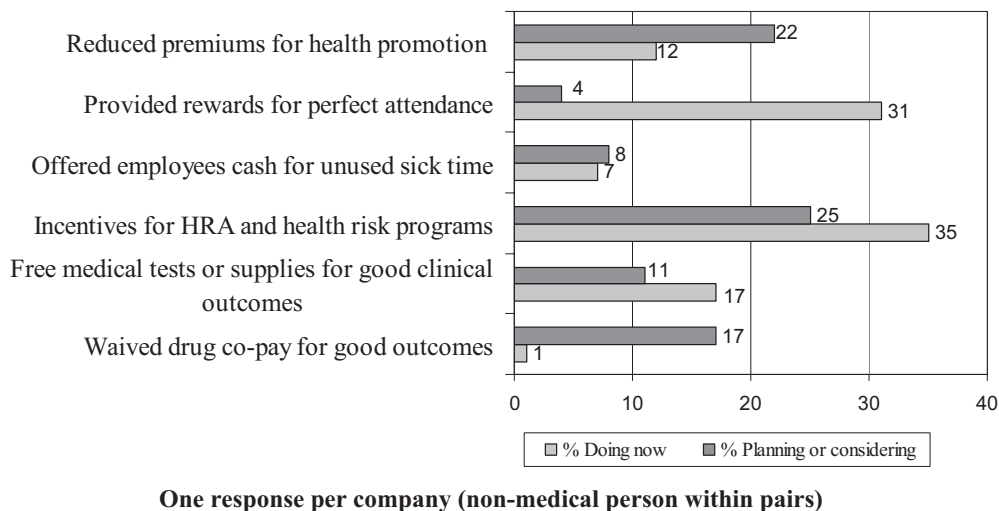
Programs



Drug Benefits



Individual Incentives



John Riedel, MPH, MBA, is president of Riedel & Associates Consultants, Inc. He provides strategic consultation to employers, managed care firms, pharmaceutical companies, hospitals, and provider groups, helping them integrate and market demand management services. Mr. Riedel is a national thought leader in the field of health and productivity, having founded and co-directed the Academy for Health and Productivity Measurement, an initiative of the Institute for Health and Productivity Management. He also co-authored a health and productivity guidebook entitled *Measuring Employee Productivity: A guide to self-assessment tools*. Mr. Riedel earned a Master's Degree in Public Health from the University of Illinois and a Masters in Business Administration in Organizational Effectiveness from George Williams College.

Section II: A Detailed Examination of HPM

*William Molmen, JD,
General Counsel,
Integrated Benefits
Institute*

This section provides a more detailed examination of the concept of HPM, focusing on four key components:

- The cost of lost productivity
- Making the health and productivity case to the C-suite
- Measuring the relationship between health and productivity
- Bridging common areas of interest between OEM and health benefits/human resources

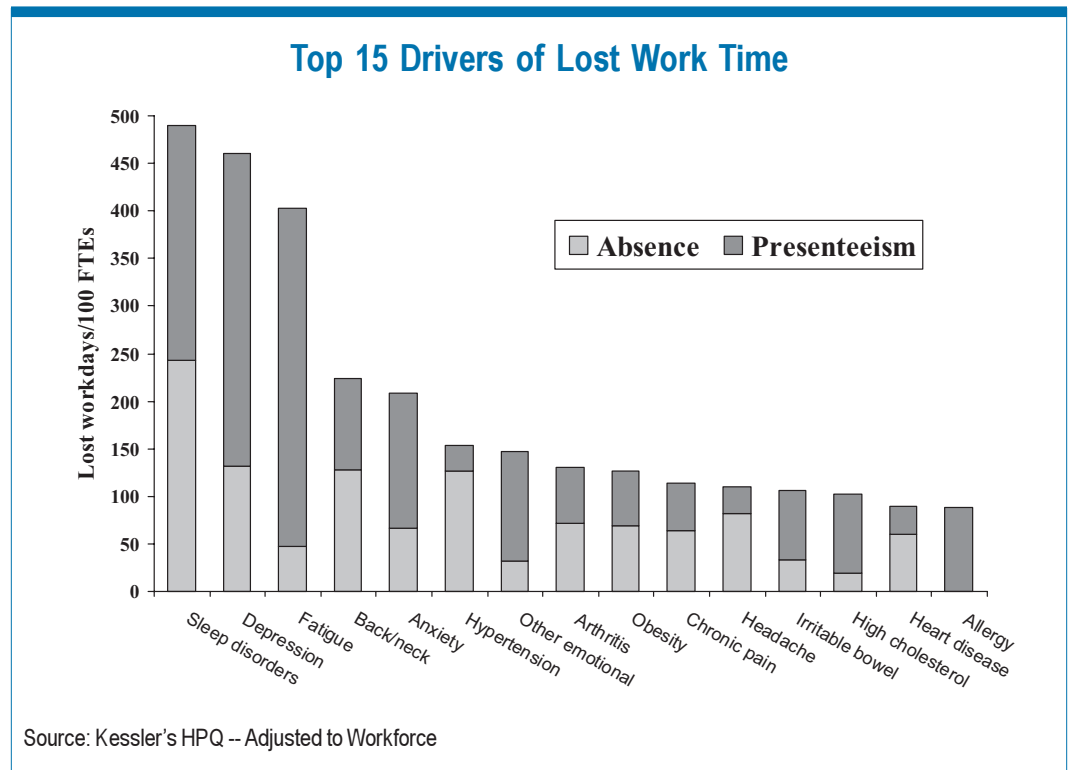
The Cost of Lost Productivity

The cost of productivity loss due to health-related issues can be quite large, although many employers do not measure these costs.

Productivity Costs Dwarf Direct Benefit Costs

Most employers analyze only the direct costs of their paid benefits. For the average company that participated in IBI’s full-cost benchmarking project, this analysis finds that health benefits are responsible for 66% of total health-related costs, with incidental absences (16%), workers’ compensation (9%), and short- and long-term disability (12%) making up the bulk of the remainder. But a more expansive analysis, including lost productivity from absence, reveals a very different picture. Health benefits make up only 37% of the total, while incidental absenteeism (30%) and short- and long-term disability (25%) make up a much larger share. The difference is due to the productivity losses that occur due to absenteeism and having people on short- and long-term disability.

These costs, moreover, do not include presenteeism (lost time from ill health for people at work), which can dwarf the costs of absenteeism. In fact, as shown in the chart below, for many of the top 15 drivers of lost work time, the costs of presenteeism are larger than the costs of absenteeism. This is especially true of sleep disorders, depression, and fatigue, which are major drivers of lost work time.



Presenteeism is an especially big problem for individuals suffering from chronic conditions. Studies show that the average days lost due to absenteeism ranges from 1.35 to 10 days lost per year, while for presenteeism the range is 17.9 to 91 lost days per year. In fact, the costs of presenteeism for individuals with chronic illness can often be larger than the combined costs due to absence and direct medical expenses. While costs vary across occupations, research studies have found that presenteeism is typically between 9.1 and 13.2 times more costly than absenteeism.

Chronic illness is not the only driver of lost productivity. Individuals with health risks also are more likely to suffer productivity loss. Once again, for these individuals, presenteeism dwarfs absenteeism as a cause of productivity loss. Research studies suggest that individuals with health risks miss an average of 1.8 to 12.6 days per year, while presenteeism ranges from 15.5 to 31.1 lost days per year. The ratio of presenteeism to absence costs for individuals with health risks ranges from 2.6 to 8.6, depending on the occupation in question.

The Need for Multipliers

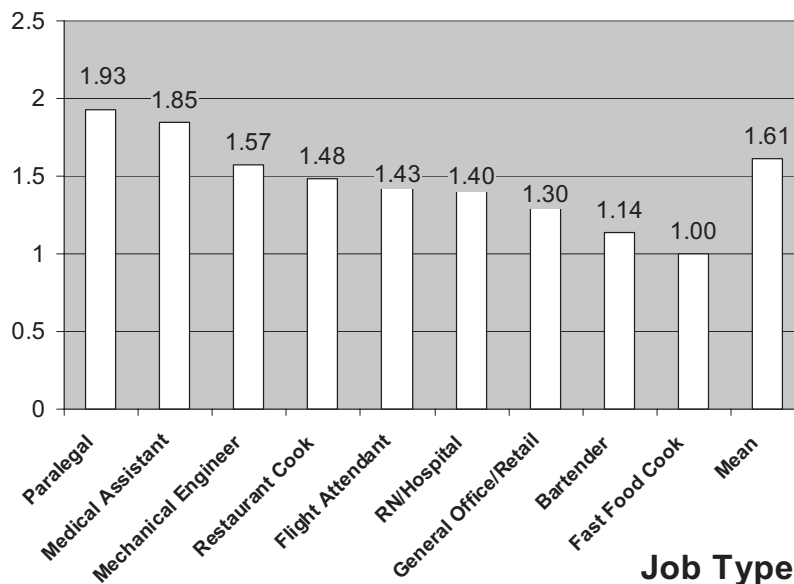
Absenteeism and presenteeism costs expressed as lost wages do not reflect the full costs of health-related productivity losses. In fact, the cost of absenteeism may be significantly understated due to three factors:

- The inability to find the perfect replacement worker
- The fact that production must occur in a team setting
- Drops in price or revenue if output is lost or postponed

To get around this problem, a multiplier is used that estimates the cost of an absence in proportion to the absent worker's daily wage. Sean Nicholson, PhD, of Cornell University has calculated absence multiplier for various job types, with the average being 1.61 for the set of jobs shown in the chart below.

Cost of Absence Multipliers

- by Job Type -



Nicholson, et al. *Health Economics*, 2006; 15(2):111-23.

William Molmen, JD, is a co-founder and serves as general counsel of IBI, where he directs the forum and information functions and is involved in the analysis, writing, and presentation of IBI research and benchmarking results. Mr. Molmen has an undergraduate degree in economics and a law degree from the University of California at Berkeley. He is a member of the California state bar and an active volunteer in local community programs.

Measuring the Costs of Health-Related Productivity Loss

Calculating the costs of absenteeism and presenteeism directly can be difficult, since much of the data are not captured in a medical claims database (e.g., absences due to sleep disorders or fatigue will not show up in a medical claims database). Fortunately, a number of validated self-report tools exist that can measure both incidental absence and presenteeism. While some employers still question the validity and reliability of these tools and surveys, research shows a strong correlation between self-reported and objective data. More importantly, perhaps, to the extent that any bias exists, it would be for employees to report that they are healthier than they really are, since employees will be reluctant to admit to having problems focusing on work due to illness. Thus, projections of presenteeism based on self-reported data will likely be conservative.

To convince senior executives of the need to address presenteeism, there is a need to conduct further research that directly ties presenteeism to an employer's bottom line. In addition, research is needed on how specific interventions can reduce presenteeism and improve productivity.

Despite the limitations and difficulties involved, individual companies can make external productivity data relevant and useful to their situation through the following steps:

- Gauge the full cost impact of poor health on the company.
- Expand the cost-benefit potential of health programs and interventions. Most employers track only health benefit costs, not the productivity benefits that accrue from existing programs.
- Target interventions to conditions and risks for maximum gain. (See box at left for more details.)
- Make the case for working with other corporate areas that would benefit from improved productivity.
- Frame the case for working with external resources such as health plans, third-party administrators (TPAs), and benefit consultants.
- Establish benchmarks to determine effectiveness and comparisons within industry segments.

In any calculation, it is important to compare the cost of a program to the cost of doing nothing. To that end, employers should estimate the following:

- The percentage of employees with chronic conditions that can be identified
- The percentage who will participate in program
- The potential improvement in employees' chronic condition due to the program
- The related productivity improvements and related reductions in direct medical costs due to this improvement

This calculation can then be used to make decisions on the most cost-effective interventions. It is important to remember, however, that the costs of health care, absence, and work impairment are maldistributed, with a few people costing a lot and most people costing very little. Those people who are high cost today will not necessarily remain high cost next year (due to a phenomenon known as "regression to the mean"); in fact, 59% of those in the most costly group will have lower costs next year. These are realities that need to be taken into account for the effective introduction of policy, interventions, vendor management and goal setting, and other approaches aimed at improving health or reducing costs. It might make sense, in fact, to focus interventions on those who are still healthy, rather than spending all resources on those who are already at risk or sick.

Target Interventions to Conditions and Risks for Maximum Gain

The following steps can help to focus interventions on areas that will yield the maximum gain:

- Assess productivity loss and direct medical cost by conditions and/or risk factors.
- Assess prevalence rates of various conditions and risk factors in the workforce.
- Determine the highest cost conditions and/or risk factors.
- Assess the costs of interventions and their effectiveness.
- Target investments in areas with the highest benefit-cost ratio.

For example, suppose a 1,000-employee company finds a 50% prevalence rate for a health condition, and that company has an average compensation of \$400 per eight-hour day. In other words, 500 of the company's employees have the condition. If absenteeism due to the condition ranges from 1.35 days to 10 days per year and presenteeism from 17.9 to 91 days, the cost of absenteeism would be between \$270,000 (1.35 days times 500 workers x \$400 per day) and \$2,000,000 (10 days x 500 workers x \$400 per day), while the cost of presenteeism would range from \$3,580,000 (17.9 days times 500 workers x \$400 per day) to \$18,200,000 (91 days x 500 workers x \$400 per day). As this analysis demonstrates, costs of this magnitude are very likely to be viewed as significant (i.e., "real money") by virtually any CEO. These figures, moreover, do not include any multipliers that may be needed to gauge the true costs.

Health and Productivity: Making the Case to the C-Suite

*Ronald Loeppke, MD,
Executive Vice President and
Chief Strategic Officer, Matria
Healthcare*

The “C-suite” refers to the group of senior executives in an organization who have primary responsibility for running the enterprise. While those included in the C-suite will vary across organizations, the group typically includes the CEO, chief operating officer (COO), CFO, and executive vice presidents of human resources, law, labor relations, marketing and sales, information technology, and safety. This group of individuals is critical to the launch and ultimate success of any initiatives designed to improve employee health and productivity. In many companies the size of the C-suite is growing as the traditional occupational medicine function expands to encompass corporate health by integrating the management of population health and productivity, disease, absences, drug benefits, health care quality and total health-related costs. Some organizations are creating the position of chief health officer (CHO) who focuses on the health assets and human capital of the company in much the same way the CFO focuses on economic assets and financial capital. The CHO may have a seat at the table within the executive suite, and/or may participate in formal reporting in management metrics.

Step I: Build the Financial, Clinical, and Cultural Business Case

The first step in making the case to the C-suite is to build the financial, clinical, and cultural business case for HPM. The basic message is relatively straightforward. The total costs of poor health are ballooning. The traditional approach of focusing only on financial transactions (i.e., the direct costs of health benefits) is not effective in lowering total costs. Rather, this strategy tends to shift costs to another part of the cost “balloon”—for example, cutting direct costs through financial cost-shifting to employees may encourage employees to forego needed care, which ultimately has a negative impact on productivity through increased absenteeism and presenteeism. A better approach is to manage proactively the total burden of illness and reduce the overall health risks of employees, which leads to lower total costs and improved productivity. The core strategy should be to empower a wiser consumer with tools, technologies, and transparency around cost and quality, as well as to align incentives to get them actively engaged in managing their own health and chronic diseases.

The key to convincing the C-suite of the need to pursue this strategy is to share data on the unsustainability of the status quo, including the following:

- The high costs of absenteeism and presenteeism, especially for common conditions such as back and neck pain, depression, fatigue, sleeping problems, chronic pain, arthritis, hypertension, and obesity.
- The increased risk of on-the-job injury faced by those with chronic disease.
- The impact of lifestyle choices on mortality and productivity. Roughly 70% of all deaths are linked to lifestyle choices such as tobacco use, poor diet, and sedentary lifestyle.
- The impact of obesity on the nation and on employers, including excess health costs due to greater long-term risks of heart disease, diabetes, and other chronic conditions. Between 1987 and 2001, obesity was responsible for over one quarter of the increase in health costs. The leading nutritional disorder globally is no longer hunger, but rather obesity. Shedding as little as 5% to 10% of body weight can lead to dramatic reductions in risk.
- The failure of the U.S. health care system to consistently deliver evidence-based care. Adherence to clinical quality indicators for diabetes, low back pain, depression, asthma, and other chronic conditions is roughly a 50/50 proposition—in other words, around half of patients routinely fail to receive recommended, evidence-based care.

The second part of the message to the C-suite is that something can be done about the rising costs of poor health among employees. Corporate leaders need to know that there are interventions they can use to reverse the trend, and thus decrease health risks and increase productivity. The key is to create a health-oriented corporate culture and environment that encourages behavior change, such as eating more healthfully (e.g., following a Mediterranean or Asian diet), quitting smoking, engaging in regular physical activity, and drinking no more than moderately. Those who make these changes can see huge reductions in their risk of poor health.

In addition to having the right culture in place, C-suite leaders must also develop specific programs that focus on the whole person. Interventions must be integrated and aligned across disease management, health management, case management, demand management, and any other corporate programs that may be in place. Today patients may be getting different advice from different people involved in their care management; the better strategy is to take a holistic approach from the patient's perspective.

Step 2: Deliver the Business Case

Once the business case is developed, it must be delivered at the appropriate time in the appropriate way to the appropriate people.

The Right Timing

Most company executives must manage through a competitive business cycle that will inevitably involve financial “ups and downs.” Publicly traded companies must manage their quarterly results, including both revenues and profits. So it is important to know where a company is in its cycle, and to make the business case at a time when management will be most receptive to the message. That said, good companies with visionary leaders tend to balance quarterly results with long-term investment strategies, and thus they will recognize the need to make investments in the long-term health of their human capital. For example, a recent survey showed that 61% of CFOs see a strong link between health, productivity, and the bottom line. Some leaders, in fact, refer to their employees as “corporate athletes” who must be kept healthy, safe, and productive on the “playing field” of the workplace.

A Tailored Message

Different corporate leaders have different concerns, and thus messages need to be tailored to those concerns. CFOs tend to care most about cash flow and revenues and earnings growth. Other leaders, including the COO, tend to care most about efficiency, production, expense control, and resource management. For their part, human resources leaders look at staffing levels, benefits design, employee satisfaction, employee retention, and other similar measures, and they need to understand how investing in employee health will affect these indicators over the long term. So key messages need to be tailored to the audience, focusing on how employee health relates to the specific measures that are of concern. The overarching message, however, should be to encourage leaders to stop focusing on getting a return on their investment, but rather focus on the value they are generating from their investment in health. Understanding this value requires integrated measurement that looks across the whole population, including but not limited to those who are at risk of poor health.

Some leaders will want the data presented in a simple, straightforward way, without “all the gory details.” One CFO, for example, wanted simple calculations of how much reduced productivity due to poor health was costing the company, and what impact it was having on earnings and payroll/benefit costs. He also wanted to see how various improvements in productivity, ranging from 1% to 12%, would affect overall costs and the bottom line, and how much top-line revenue growth would be necessary to yield an equivalent impact on earnings. This analysis allowed him to see just how “leveraged” a productivity-enhancing strategy can be. Some company leaders may also want to see how much of an impact health-related productivity loss (or improvement) can have on the company's market capitalization and share price.

The bottom line is that different metrics will be appropriate for different audiences. CEOs often focus on the impact on share price and market capitalization, while CFOs may be more concerned about the impact on the bottom line and overall costs. The key is to understand the needs of the audience and what metrics motivate them, and to tailor both the message and the level of detail accordingly. It is often helpful, moreover, to put costs in terms of specific products made by the company (such as costs per car for a car manufacturer), since any executive should be able to relate to that calculation.

“We are in a battle for better health, with chronic conditions and destructive health risks as our enemies. If this growing burden of risk and illness continues unabated, it will bring our economy to its knees. And it's not just a U.S. issue, but a global one. We have an unparalleled opportunity and responsibility in this area—it is time to act.”

—Ronald Loepke, MD

A Case Study: Integrated Health and Productivity Enhancement in the Workplace

The Centers for Disease Control and Prevention provided a three-year grant to research an employer initiative around integrated population health and productivity enhancement to improve health and productivity. The first step in the project was to assess the employee population's burden of illness, health risk, and health-related productivity loss, and then to determine a blueprint for action, including the following steps:

- Present a health and productivity business case to senior management.
- Communicate the action plan throughout the company.
- Align incentives among patient/consumers and providers around better health quality and prevention.
- Deliver well-designed integrated services for population health enhancement.
- Monitor the impact through integrated data for population health measurement.

The company put in place a suite of integrated population health and productivity services for employees and dependants who wanted to maintain their good health as well as those who were at risk or in need of care. These programs included disease management and care management focused on the 10% to 15% of individuals dealing with chronic conditions, those with conditions requiring acute care, and those with conditions requiring complex care, which drive 80% to 85% of the annual claims costs for the employer. Conversely, as in most organizations, 85% to 90% of employees fell into the lower cost, healthier category. Even though these employees account for only 15% of total annual costs, it is critical to focus on them so that they stay well and do not develop conditions or become high-cost cases. As Dr. Dee Edington has shown in his research, it is important to keep the healthy people healthy while also improving the health of those who already have medical conditions.

While the company is still evaluating the productivity impact from the program, the early results are quite compelling and the bottom-line conclusion from this case study is quite clear—good health is good business.

Conclusion

The health of the workforce is inextricably linked to the productivity of the workforce and therefore the health of the bottom line for corporate America. From this vantage point, the industry is on the threshold of a tectonic plate shift, from being a reactive, illness-oriented medical care system to a more proactive, wellness-oriented health care system. The key going forward is to continue to encourage corporate leaders to implement programs at a local level and influence policy at a national level by sharing well-documented economic and scientific business cases for investing in health and human capital.

Measuring Health and Productivity Relationships

This section provides a more in-depth discussion of the potential data sources and tools for quantifying the relationship between health and productivity.

Approaches to Measurement

There are two basic approaches to measuring the relationship between health and productivity. The first approach is to focus on using whatever data are easily available. While this strategy can be tempting, it is not optimal. The better strategy is to focus on what benefits questions need to be answered, and then to figure out ways to get the data and information necessary to answer those questions. For example, one critical question to answer is “how well is the STD program working?” To answer this question, one needs to know how much lost work time the STD program generates. Data such as lost workdays per 100 covered lives, lost workdays per active claim, or lost calendar days per closed claim can help. Other key questions include “how does absence due to the STD program affect the business?” and “what impact does lost productivity have on the business?” Data such as lost productivity as a percentage of net income or of human capital costs (payroll and benefits) can help in answering these questions.

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John Riedel, MPH, MBA, President, Riedel & Associates Consultants, Inc.

Potential Data Sources

There are many potential data sources for quantifying health and productivity costs, which means there is no need to “recreate the wheel.” Data sources include the following:

- Medical data (group health, pharmacy, mental health, health risk appraisals, disease prevalence, employee assistance program (EAP) utilization)
- Lost-time data (STD and LTD, family and medical leave, sick leave)
- Human resources and payroll (employee demographics, time reporting, employee surveys, turnover, overtime, performance appraisals)
- Workers’ compensation/safety data (occupational safety and health, accident reporting, drug testing, workers’ compensation claims)
- Productivity metrics (staffing and overtime, per-employee costs and revenues, self-reported presenteeism)
- Business data (customer satisfaction, production, quality, operations, net income, gross revenue, human capital costs)

Data on productivity are often the weakest for many employers. Nonetheless, there are some emerging data sources in this area, including:

- Integrated health and productivity databases from large employers, employer coalitions, and providers of medical and disability insurance
- Improved employer/payroll technology for tracking absenteeism and workforce health issues
- Presenteeism survey instruments
- Researchers

In addition, several data sources can provide benchmark information related to health care (e.g., costs, condition, and health risk prevalence) and productivity, including the following:

- Cost data from the Medical Expenditure Panel Survey (www.meps.ahrq.gov), National Health Care Survey (www.cdc.gov/nchs/nhcs.htm), Kaiser Family Foundation (www.statehealthfacts.org), and various consultant/vendor-sponsored surveys
- Coalition and health risk prevalence data from the Kaiser Family Foundation (www.statehealthfacts.org), National Health Information Survey (www.cdc.gov/nchs/nhis.htm), and National Health and Nutrition Examination Survey or NHANES (www.cdc.gov/nchs/nhanes.htm).
- Lost-time data for workers’ compensation from the Bureau of Labor Statistics (www.bls.gov), Workers Compensation Research Institute (www.wcirnet.org), California Workers’ Compensation Institute (www.cwci.org), the National Council on Compensation Insurance (www.ncci.com), and IBI (www.benefitsintelligence.org)
- Lost-time data due to short- and long-term disability from insurance carriers that can provide book-of-business benchmark data, and from IBI benchmark data.
- Presenteeism and absence data from data warehouseers (e.g., Medstat, Ingenix, University of Michigan), tool developers (which often have their own survey data), and IBI

The evidence would suggest that CFOs seldom get this kind of information. An IBI survey found that only 51% of CFOs ever get reports on the occurrence of absenteeism, while only 22% get reports on its financial impact. Data on presenteeism is even rarer, with only 22% of CFOs ever getting a report on the occurrence of presenteeism and only 8% getting reports on its financial impact. But CFOs clearly want this kind of information. In fact, the same survey found that 79% of CFOs want information on human capital costs related to lost work/presenteeism, 51% want to know costs in terms of total health-related costs, 45% want to know the costs as a percentage of revenue, and 13% want to know the impact of these costs on the organization’s share price. Armed with this kind of data, 75% of CFOs would use it to evaluate the cost of health coverage and of absenteeism, while nearly as many would use it to manage all health-related costs (73%), to examine the business impact of health plans (70%), and to reduce presenteeism (65%). In short, CFOs are not getting much information today, but they are interested in it and have a pretty good sense of how they would use it.

Continuum of Measures

There are four primary categories of measures related to absenteeism and presenteeism:

- Time lost to the workplace (e.g., due to permanent disability, early retirement due to health issues, premature death)
- Time not at work (e.g., due to unscheduled absence, disability, workers' compensation, replacement workers)
- Time not doing work (e.g., due to breaks, unfocused time, health calls on work time, information gathering)
- Measures of not doing well while working (errors, reprimands, delays, customer complaints, team breakdown).

As noted earlier, the costs of absenteeism will vary by occupation, but should include a multiplier beyond the fully-loaded salary of the individual who is absent. The full costs should consider the following:

- Fully-loaded salary (replacement worker cost)
- Temporary employee and/or overtime costs
- Loss of value to the team
- Average daily revenue per employee or lost revenue per absent worker
- Cost of missed deadlines

A tool known as EMPAQSM can be used to measure health benefit and absenteeism costs. It uses a variety of metrics to estimate these figures, including benefit costs per employee, average benefit cost per claim, benefit cost as a percentage of payroll, lost days per 100 employees, average claim duration, annual claim incidence, employee satisfaction, return-to-work effectiveness, and family and medical leave measures.

Presenteeism is more difficult to measure, but typically is gauged through the following kinds of measures:

- Personal factors affecting productivity, such as physical, mental/cognitive, emotional, and social issues
- Work capacity or quantity (e.g., the amount of work done)
- Work quality (e.g., incidence of mistakes or accidents)
- Other factors, such as work environment, corporate culture, team effects, and specific health conditions or risks

Tools for Measuring Health-Related Productivity Costs

As noted earlier, a number of tools are available to help measure productivity, with a particular focus on presenteeism. Self-assessment surveys are the most practical, particularly for presenteeism, as they can be integrated with health risk appraisals (HRAs) or conducted as standalone surveys. The survey instruments vary based on the productivity elements' scope and level of detail. These instruments have generally been tested by researchers and found to be both reliable and valid. They are widely applicable across industries, occupations, disease states, and conditions. They have been shown to support effective business decision-making, in large part because the metrics can be translated into dollars. They are practical to use, generally easy to administer at low cost, and available in multiple languages at appropriate reading levels. That said, the tools range in terms of their ease of use and other factors.

One such tool is IBI's *Health and Productivity Snapshot*, which is a relatively easy-to-use modeling tool for employers who do not have the time, data, or financial resources to measure their own health-related outcomes. This model matches participant's corporate characteristics to Dr. Ron Kessler's large employee database on lost productivity and other health-related impacts due to common conditions. The model requires nine basic corporate descriptors. More information is available at www.benefitsintelligence.org.

A second model, developed by ACOEM and the National Business Group on Health (NBGH), is known as *Blueprint for Health*. This tool estimates medical costs, absences, and work impairment for companies that do not have access to data or lack the resources for their own data analysis. Inputs include the number of employees, salary, gender, marital status, age, exempt status, deductible levels, and zip codes. The tool estimates average medical costs and the distribution of those costs, along with absence days, work impairment, and the migration of people from one cost level to another over a two-year period.

A number of other proven tools are also available for measuring presenteeism through employee surveys. Certain tools are more effective depending on the areas of interest.

Considerations When Planning a Measurement Project

A number of questions should be considered when planning a project to measure health-related productivity, including the following:

- What is the budget?
- What data are already collected?
- Why is the measurement being done?
- Who is eligible to participate?
- How will eligibility be determined?
- Which concepts need to be measured?
- How frequently should measurement occur?
- What benchmarking will be done, if any?
- When does the survey need to be completed?
- What proportion of the workforce needs to participate?
- Who are the audiences or consumers for the results?
- What do they expect in terms of feedback?

Employers need to be comfortable with the validity, length, and confidentiality provisions of any survey instrument, as well as their ability to benchmark, the anchors being used, the recall timeframe (more than four weeks can be difficult), the survey's ability to trend over time, and the availability of multi-media options. It is also important to remember when analyzing trends that regression to the mean commonly occurs, and thus it is critical to distinguish between causation or just association when analyzing the link between health and productivity.

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President and Chief Medical
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*Michael Taylor, MD, Medical
Director for Health Promotion,
Caterpillar, Inc.*

Bridging Common Areas of Interest Between OEM and Human Resources/Health Benefits

Current State of Affairs

Two departments within most employers—Occupational and Environmental Medicine (OEM) and Human Resources (HR)/Health Benefits—have a vested interest in employee health and productivity. Yet traditionally each has operated in its own silo, with little integration or coordination between the two. OEM generally focuses on keeping employees safe and protecting them against unhealthful exposures. OEM has historically done a great job in this regard, operating at a six-sigma level of quality in terms of mortality and morbidity in the workplace. The HR department traditionally focuses on health benefits, employee assistance programs (EAPs), disease management, and wellness programs. But there are a number of common areas of interest between the two, including the company's overall success, workforce productivity, human capital management, workplace safety, employee satisfaction, the quality of health care received by employees, and controlling medical costs.

Potential Benefits of Integrating OEM and HR

Most health care benefits and programs are bought on a piecemeal basis, with little attention paid to the potential duplication or overlap between services. It is not uncommon for the OEM or HR departments to hire separate vendors for occupational health, workers' compensation, disability management, case management, travel medicine, and other programs. Sometimes individual workers have four or more case managers, each of whom may give different advice.

This fragmented approach is far removed from Six Sigma, the Toyota Production System, LEAN processing, or any of the other systems process optimization efforts being employed by the most productive companies in the world. Integration can lead to better risk management, improved quality, and cost savings. Most importantly, perhaps, integration can help to make an employer the "employer of choice" in the community.

Identifying the Gaps

Recent surveys by ACOEM and Watson Wyatt/NBGH have identified the gaps that exist between corporate health functions, and thus they highlight the need for integration. ACOEM recently conducted interviews that were designed to assess these gaps by asking questions such as the following:

- How much regular interaction occurs between OEM and HR/benefits?
- What is the perceived importance of integrating competencies of HR benefits with OEM?
- What are the issues that detract from creating and executing corporate-wide health strategies?
- What are some good success stories?

Interviews were conducted with the director of benefits or chief medical officers at a number of large companies, including Bell South, Caterpillar, Dow Corning, Exxon Mobil, IBM, Kodak, and Merck, among others. Interviewees emphasized the importance of regular communication between HR and OEM, and consistently believed that integrating the functions of HR/benefits, OEM, and other relevant departments is extremely important to creating effective, corporate-wide health care strategies. Integration helps to prevent the "balloon effect" that occurs with today's fragmented approach, when squeezing the benefit costs in one area leads to the "swelling" of costs in another. The interviews identified two key issues that need to be addressed to make integration a reality:

- **Organizational structures:** When responsibility is siloed within different, unrelated areas, the opportunity to work collaboratively is limited. Siloed information also limits the ability to see the whole picture.
- **Getting beyond the "less-is-better" business philosophy:** Health benefits are too often viewed as a cost of doing business that should be reduced. The philosophy that links health and productivity has not yet been embraced by many in senior management.

Moving Toward an Integrated Approach

The first step in moving toward a more integrated approach that focuses on employee health and productivity is to get a better understanding of one's colleagues and how their views might be similar or dissimilar to one's own. A recent survey sheds some light on the varying views of different constituencies:

- In a question about orientation toward health, most corporate medical leaders (56%) felt that it was their responsibility to keep employees safe and well, and that doing so is crucial to overall business success. But non-physicians (e.g., benefits managers) tend to believe that employees are responsible for their own health, and that the company's job is just to provide tools to help them in doing so. Bridging this philosophical divide is a big challenge.
- Physicians were more predisposed to believe in the importance of health status and productivity, including the ability to design benefits in such a way that they pay for themselves in terms of productivity gains. Benefits managers were more concerned with controlling direct health benefit expenses.

"As Dr. Loeppeke has said, all these carve-outs lead patients to feeling 'carved up'."

—Raymond Fabius, MD

- No one appears to be paying attention to employee turnover issues.
- Benefits managers have more control over health benefit design and strategies for reducing absenteeism.
- Physicians perceive more barriers to making value-based decisions that take productivity into account.

A Case Example of Bridging the Silos: Health and Productivity Management at Caterpillar

As noted, having responsibility for health and productivity “siloes” in unrelated areas limits the opportunities to work collaboratively. The good news is that a number of company leaders are beginning to understand the need for integration and collaboration. One such company is Caterpillar, Inc., a Fortune 100 company with \$41.5 billion in revenues and \$3.5 billion in profits in 2006. Caterpillar, the world’s largest manufacturer of construction and mining equipment, natural gas and diesel engines, and industrial gas turbines, and a leader in forestry, logistics, and energy solutions, employs more than 94,000 employees worldwide, with roughly half of employees (and more than half of sales) being outside the U.S. Caterpillar has manufacturing facilities in 40 countries. The company is self-insured and covers 150,000 lives, including 30,000 retirees. The average age of an employee is 42 years, with average turnover being below 10%.

Disability Management: Then and Now

Prior to 1997, Caterpillar had no disability management system. Disability benefits and costs were neither measured nor monitored, and there was no communication between the corporate medical and HR/benefits departments. When an employee missed work, his or her supervisor would call the corporate medical department, a registered nurse would call the employee, and a benefits clerk would approve the continuation of pay. The HR department had no role in that individual’s return to work. The net result was a huge productivity loss. The company had no idea who was actually out of work or when absent employees would return. This created production line inefficiencies, staffing problems, and inappropriate payments to workers.

The strategy for changing this fragmented approach began when representatives at one plant decided they wanted to improve the situation. A multidisciplinary team consisting of representatives from HR/benefits/payroll, corporate medical, labor relations, safety, and operations designed a new program related to STD for all hourly workers in the plant. The idea was to address this one area first through an integrated, multidisciplinary approach, to measure outcomes continuously, and to make corrections as problems developed. Over time, new areas, such as long-term disability, could be added, and the program could be expanded to other U.S. facilities.

Under the new disability management process, any employee who is off of work for more than three days receives a call from a disability case coordinator to activate a tracking system. If the employee remains off work for seven days, a registered nurse case manager calls the employee to conduct a complete intake of that individual. The case manager coordinates with various stakeholders as needed, including EAP, disease management, benefits, the patient’s private physician(s), and the corporate physician.

The program’s success led to its adoption throughout the U.S. by mid-2005. Today Caterpillar has 11 case coordinators who work on-site in large plants or via telephone in regional centers for smaller plants. The corporate medical director oversees the program, and also takes responsibility for communicating with community physicians. (Caterpillar remains dependent on these physicians to get employees back to work, as they make all return-to-work determinations.) Caterpillar’s occupational medicine physicians retain control over the kind of work that returning employees can do, including any restrictions they may have on their work. The following activities have helped with this process:

- Orthopedic surgeons were invited to the corporate office to discuss care coordination and practice guidelines. After 1.5 days of meetings, the surgeons accepted the guidelines.
- Primary care physicians toured plants to understand work conditions.

Results

Caterpillar has seen tremendous benefits from the new, integrated approach. The number of days lost per case fell from an average of 35 in the fourth quarter of 2002 to 18 by the second quarter of 2004, and they have remained relatively stable since (except for a jump in early 2005, when the turnover rate among Caterpillar case managers was high).

In addition, employees receive better and more timely medical care. They are more engaged, and now believe that the company really cares about them. Employees view the care managers as advocates who help in navigating a complex system. For the company's part, Caterpillar management now has a better understanding of its available workforce. Costs have declined from reduced absenteeism. In addition, medical (rather than HR) personnel are now making clinical decisions, and communication among team members has been enhanced, which has led to better clinical decision making.

Lessons Learned and Next Steps

Caterpillar learned the following lessons from this project:

- STD and absenteeism were bigger problems than ever anticipated.
- Solving this problem was difficult and required an integrated, multidisciplinary (rather than a siloed) approach.
- Employees have accepted the new process, while production managers are very enthusiastic about it.

Based on this success, Caterpillar launched a psychiatric disability program in 2006. Clinically trained psychologists now manage psychiatric cases that were not being managed at all before. In the past, individuals with mental illness missed months or even years of work. The new program has cut the overall case load and total disability time by roughly 70% in 18 months. Those people who have psychiatric illnesses, moreover, are getting the care that they need (something that did not often happen in the past).

Looking ahead, Caterpillar plans to focus more on long-term disability. The company has also introduced a Unified "People" Scorecard, a program designed to bring information on disease prevalence, costs, health risks, and other metrics into a comprehensive database. This tool will lay the groundwork for the development of a more comprehensive, integrated HPM model at Caterpillar.

Conclusions and Lessons Learned

As the Caterpillar example demonstrates, it is critical to use a multidisciplinary approach to HPM. It is also important to dig deep into the details, to coordinate with the physician community on the outside, to use metrics to show success, and to use that success to expand to other programs.

Fortunately other organizations are beginning to learn these lessons as well. A growing number of large employers are boosting their efforts to improve workers' health and productivity, with 41% of surveyed companies currently having such programs in place, and 32% planning to do so within the next year. But managing health and productivity can be difficult. The same survey cited lack of actionable metrics (46%), inadequate access to data (43%), organizational structures (40%), lack of knowledge on which practices to use (32%), and lack of case studies or research proving quantifiable results (31%) as being barriers to managing health and productivity. In addition, some known best practices are not widely used yet, including integrating health and disability data (done by only 23% of surveyed employers), pay for performance/gain sharing (29%), integrating health and disability programs (29%), on-site medical clinics (33%), and charging program costs back to department/location (38%).

Companies are also beginning to take an integrated approach to health-related benefits, including integrating the following: workers' compensation with disability programs (13% of surveyed employers have done this), STD with LTD (20%), STD and LTD with other absence programs (12%), group health with disability (20%), and group health with disability and workers' compensation (21%).

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Michael L. Taylor, MD, is the medical director of health promotion for Caterpillar, Inc., where he focuses on expanding programs in the company's Healthy Balance Initiative with an emphasis on disease management and tobacco cessation. Prior to joining Caterpillar, Dr. Taylor was the corporate medical director for Progressive Health Systems in Perkins, IL. Board-certified in internal medicine, he received his medical degree from the University of Illinois College of Medicine.

The bottom line is that multiple practices bring about successful outcomes. While barriers exist, organizations that capture and manage costs have better results. Integration, moreover, seems to drive a multiplier effect across benefit programs, which suggests there is a great need to address organizational turf issues. While accountability for health is a core belief, it has yet to be incorporated into many companies' health and productivity strategies. That said, HPM is clearly past the early adopter stage with respect to innovation diffusion. Further adoption will be critical to the competitiveness of American businesses going forward, as these activities create competitive advantages for companies. In fact, making workers more productive allows companies to pay higher wages without increasing the cost of final goods—i.e., wages rise without driving up price inflation. Rising productivity drove the last bull market in the mid- to late 1990s, thanks largely to technology-induced productivity gains. The combination of improved health status and higher productivity has the potential to contribute to the next bull market. To realize this potential, companies need to invest in the health of their human capital, which should lead to competitive advantage, community prosperity, and greater global competitiveness for American corporations, workers, and communities.

“In the past, human resource leaders would seek and develop well-trained and motivated workforces. Today we are suggesting that great companies cultivate employees with the skill and the will, but also take steps to ensure that they are not ill.”

- Raymond Fabius, MD

Background

In 1938, Curtis L. Carlson established the Gold Bond Stamp Company, and a legacy of building strong relationships with corporate clients and consumers began. Mr. Carlson started the business with \$55 and ended up being worth roughly \$9 billion. His basic premise was simple—to reward people for their loyalty. This was the philosophy behind his first business, Gold Bond Stamps, and it is still the philosophy today. Carlson is now a \$20.9 billion company (in revenues) that operates in more than 140 countries and employs 190,000 people worldwide, including franchise operations. Carlson owns Radisson Hotels, Country Inn & Suites, TGI Fridays restaurants, and other well-known businesses. Carlson employs a diverse group of employees, including young and old, union and non-union, and full- and part-time workers.

Health Costs and Productivity Loss at Carlson

Like many companies, Carlson’s leaders feel “under attack” when it comes to health care. Costs are rising rapidly due to inflation, new technology, health-related productivity loss, chronic disease, and the like. The company is trying to combat the rising costs, but finding it difficult to do so. Carlson’s leaders truly believe that the health of Carlson as a business depends on the health of its employees. As a result, the company spends a lot of time on employee engagement, which is the centerpiece of Carlson’s “people” strategy. Through surveys, rewards and recognition programs, and other initiatives, Carlson tries to keep its employees engaged, motivated, and healthy (since health and productivity are inextricably linked).

Carlson’s focus on productivity is relatively new. Like many other organizations, the company used to focus just on the direct costs of health benefits. In 2006, Carlson spent \$77 million on direct health care benefits. By 2009, that figure is expected to exceed \$95 million. The demographics of Carlson’s employees are similar to those of most other companies, with the only exception being at TGI Friday’s, where most employees are young and healthy. Carlson translates the overall health costs into a cost for each business unit. When costs increase, Carlson informs each business unit how much additional revenues they need to generate just to cover the increased health care costs in their unit. In recent years it has become obvious that these cost increases are not sustainable. This lack of sustainability becomes especially clear when productivity is considered. Carlson estimates that the 78,000 annual sick days taken by employees cost the company \$14 million, while the 22,500 annual doctor visits cost \$3 million in lost productivity, thus bringing total health benefit and absenteeism costs to \$94 million. These costs do not include presenteeism, which, as noted earlier, can exceed the costs of health benefits and absenteeism combined.

Selling the Need for Change

The HR Department at Carlson shared information on health and absenteeism costs due to sick days and doctor visits with the C-suite, highlighting the aforementioned figure of \$94 million. Because the goal was to keep the message simple and understandable, data on presenteeism were not shared. But data were provided on the average medical cost and lost productive time due to the major diseases affecting Carlson employees and dependents, including asthma (\$3,740 average cost; 3 days average unproductive time), depression (\$4,000; 12-30 days), diabetes (over \$13,000; 3 days), and flu (\$200; 3 days). Trend data were also presented to show that the problem is getting worse as the prevalence of chronic illness increases.

The strategy worked, as the data got the attention of the C-suite, which gave approval for the launch of Carlson’s *Be Well Program*. To help sell this program, Carlson’s HR department provided an estimated return on investment (ROI) calculation, including both hard and soft dollar savings. The ROI calculation was also translated into a net present value (NPV) figure, which is something that the CFO understood.

Section III:

Employer Example: Selected Health and Productivity Initiatives at Carlson Companies

*Charles Montreuil, JD,
Vice President, Corporate
Human Resources,
Carlson Companies*

“Senior executive leadership must be on board. If they are not, it all falls like a house of cards.”

—Charles Montreuil

The Be Well Program at Carlson

Carlson's culture of wellness focuses on giving employees the tools and resources they need to live a healthy, productive life. Carlson asks its employees to be engaged, and holds them responsible for taking an active role in their health and well-being. Carlson's leaders believe that informed, empowered employees are better able to serve customers and themselves.

Carlson's *Be Well* program is branded, and this brand helps to promote the lifestyle and the culture within the company. The *Be Well* web site reinforces the message of healthy body, mind, and spirit. The site tries to keep messages simple, with a focus on health. All material is organized into one of three categories—know (e.g., cholesterol levels, blood pressure), live (e.g., eat healthfully, exercise regularly), and choose (e.g., health plans, health care services). The site describes tools and programs that can assist in each of these areas, such as consumer education to improve knowledge, cost and quality information to facilitate better choice, and the Smart Steps chronic condition program, lifestyle management advice (e.g., smoking cessation), and financial incentives to encourage healthier living. Carlson is currently developing an electronic health record for each employee and his or her family, which will be available by the beginning of 2008.

As a part of the *Be Well* program, Carlson has also embarked on a number of specific programs designed to improve employee health and productivity. These initiatives occur at three distinct levels—the company itself, the community at large, and with colleagues. An example of each type of program follows.

A Company-Specific Initiative: The MinuteClinic

Carlson is working with MinuteClinic (an outside company originally owned by an investment group and now owned by CVS) to establish convenient locations where Carlson employees can receive basic care. In April 2004 the first on-site MinuteClinic was established at Carlson. Now there are 26 located throughout the Minneapolis metropolitan area, many of which are convenient to Carlson employees. Each clinic uses a qualified non-physician provider to treat 30 common conditions in a standardized manner using established, well-accepted protocols. In 2005, Carlson employees made 2,866 visits to MinuteClinics in the Twin Cities, with roughly 72% of them being to the on-site clinic at Carlson. (Visits declined slightly to 2,542 in 2006.) Prices of visits and procedures are posted clearly on the door, so that employees know the cost of any visit, and can easily compare it to the much higher prices of logical alternatives. A MinuteClinic visit costs \$40, compared to \$93 for a physician visit, \$127 for an urgent care visit, and \$280 for an emergency department visit. MinuteClinics offer many basic services, including blood pressure and weight measurement, routine immunizations, and laboratory work (e.g., strep throat test, cholesterol screenings), with some of these services included in the visit price and others offered for an additional charge.

Looking ahead, Carlson is now working with CIGNA to match Carlson employees around the nation with other clinics. The company believes that the potential savings from national expansion of the concept could be an additional \$320,000. The national expansion is scheduled to begin in January 2008.

A Community Initiative: Bridges to Excellence

Carlson participates in the *Bridges to Excellence* (BTE) pay-for-performance initiative as a part of a collaborative effort with other community stakeholders. The Minneapolis market has a number of building blocks in place that allow these types of collaborations to flourish. The Buyers Health Care Action Group (BHCAG), for example, is a coalition of private and public employers working to redirect the health care system to focus on the collective goal of optimal health and total value. (Carlson Companies is a BHCAG member.) The Institute for Clinical Systems Integration (ICSI) is a non-profit organization that develops evidence-based guidelines and standards for care, while Minnesota Community Measurement is a non-profit organization that collects, analyzes, and publicly reports performance data. BTE is the pay-for-performance component of this public reporting effort. As a part of BTE, Carlson and other local employers have agreed to reward providers and clinics that offer high-quality care.

In addition, Carlson and several other companies have developed the *Champions of Change* awards, which recognize the “best of the best” clinics. In this instance, “best” is defined as

having 10% of patients achieve optimal outcomes within an area. Even with this liberal definition, however, only 9 of 54 groups meet the threshold. The good news is that data for 2007 has improved over 2006, with the overall percentage of diabetes patients achieving optimal outcomes increasing from 9% to 14%, a 60% jump. Data are now being reported at a more granular level (site-specific data rather than clinic-wide performance), which should help to stimulate quality improvement. The *Champions of Change* program is being expanded to cardiovascular disease in 2007, and will likely be expanded to depression in 2008 through the Diamond Project (see below for more on this initiative).

But current P4P rewards are still not enough, as a disconnect remains between clinical success and plan payments to these clinics. Clinics are not being reimbursed adequately by plans for some of the innovative processes they have developed, such as using certified diabetic nurses/educators. Too often these programs are funded through temporary grants; once funding ceases, the programs frequently do as well. Carlson is currently working with BHCAG to develop new language to match coverage and payment policies with best practices. Too much of the language is antiquated in nature, and expressly prohibits payments for things such as supplies, education from non-physicians, etc. But these activities should be reimbursed because they help to get employees healthy and back to work. Several other champions-of-change employers understand this and are changing their reimbursement policies as well. The goal going forward is to get the rest of BHCAG employers to follow suit.

Carlson is also working with ICSI on the Diamond Project, which is an attempt to apply the chronic care model to depression. ICSI has been developing optimal guidelines/best-practice treatment for depression, and as part of this work has endorsed the concept of putting a clinician in the doctor's office to serve as a liaison between the employee and doctor, which allows for extra time with each patient. Research suggests that this approach can help to improve outcomes for depressed patients. As a result, Carlson and other employers are making this a part of BTE in 2009.

An Initiative Focused on Colleagues: Palliative Care

Palliative care is an approach that improves the quality of life for patients and families facing life-threatening illness through the prevention and relief of suffering by means of early identification, assessment, and treatment of pain and other problems—physical, psychological, and spiritual. Palliate is derived from the Latin word “palliates” which means to “cloak” or to “cover.” Palliative care wraps the patient with support from a cross-disciplinary team. Data from the EAP program at Carlson shows that at least 10% of the workforce is under some type of severe emotional distress. Family issues, including dealing with end-of-life concerns, are the number one EAP issue, while end-of-life informational resources are the third most commonly requested type of information in the EAP program.

The local Minnesota press recently ran several stories on palliative care, including the consequences that can occur when wishes are not made clear. In response to these articles and internal data, Carlson conducted a palliative care survey in conjunction with the University of Minnesota School of Medicine. The randomized survey elicited a tremendous response rate (650 surveys out of 900 were returned within 10 days), and it showed that roughly 70% of Carlson employees have had to care for a seriously ill family member, with nearly 50% caring for someone who lived more than one hour from their home. In addition, 70% of respondents have taken personal days or sick leave, or required flexible work arrangements, in order to provide or arrange for palliative care, while 84% had taken bereavement leave at some point. The survey found that 78% of employees thought that it was important or very important to have an experienced professional help them and their family deal with end-of-life issues. In response to these results, Carlson is adding a palliative care benefit in 2008. The benefit provides a \$4,000 lifetime maximum benefit to employees and their parents. A Palliative Care Team consisting of registered nurses, social workers, and spiritual care coordinators will be available to employees and their family members to provide an ongoing assessment of the person's status, including the need for pain and symptom management, nursing intervention, medication management, patient and family education, and communication and coordination with physicians and the health team. Palliative care services can be provided to the covered individual and their family in a variety of settings, including the home, clinic, hospital, or long-term care facility. The hope is that this initiative will not only improve productivity, but will also send a clear signal to current and prospective employees that Carlson is a great place for people to work, and that it emphasizes a culture of wellness.

Charlie Montreuil, JD, joined Carlson Companies in 1997 and currently holds the position of vice president of corporate human resources. In this role he is responsible for managing the company's compensation, benefits, and corporate and international human resource functions. Mr. Montreuil is also chairman of BHCAG, a board member of LifeScience Alley and BTE, and a member of the employee benefit subcommittee of the US Chamber of Commerce. He earned his Bachelor's Degree from St. Cloud State University in Minnesota and his law degree from William Mitchell College of Law. He also holds a Master's Degree in human resources and industrial relations from the Carlson School of Management at the University of Minnesota. Mr. Montreuil is certified by the Society for Human Resource Management as a senior professional in human resources.

Section IV:

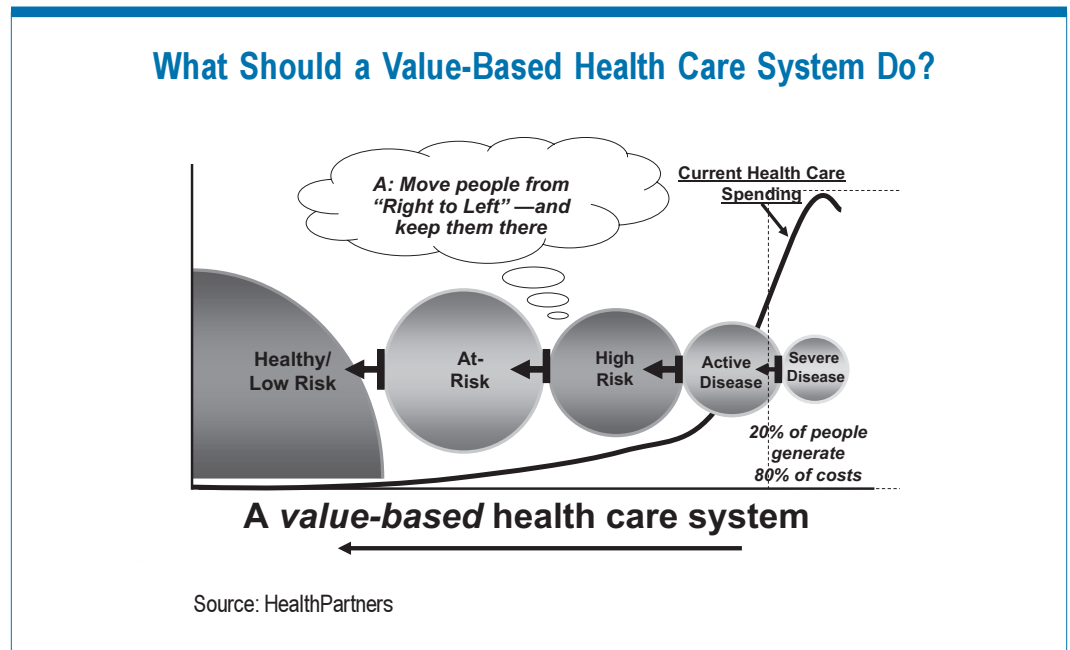
The Role of the National Committee for Quality Assurance

Richard Sorian, Vice President of Public Policy and External Relations, National Committee for Quality Assurance

The National Committee for Quality Assurance (NCQA) is developing several new programs, including its 2008 health plan accreditation program, a medical home certification program, and a back pain recognition program that will use 17 measures to gauge the performance of a wide spectrum of providers, including primary care physicians, surgeons, and chiropractors.

Growing Interest in Health Promotion

NCQA is interested in developing an evaluation program in the area of health promotion, which is seeing burgeoning interest due to double-digit increases in health care costs, a growing recognition that employee health ties directly to productivity, and a growing need to attract and retain employees in a tight labor market. As shown in the chart below, the focus of health promotion activities is to keep individuals on the left side (i.e., healthy and at low risk). This is in contrast to the focus of the past several decades, which was to shift the 20% of the population that generates the vast majority (80%) of costs from the right to the left (and keep them there).



The underlying assumption has been that those who are already healthy do not need much help. But that assumption is being called into question, in part due to the shifting (but modifiable) health risks of healthy individuals (e.g., increasing weight problems, which can lead to diabetes and other health problems and related comorbidities) and growing frustration with the health care system, which leads to the conclusion that the best strategy is to keep people healthy and therefore avoid interactions with the system. A variety of players are involved in health promotion, including traditional wellness companies, disease management companies, behavioral health organizations, EAPs, health plans (that offer integrated or freestanding add-on programs for employers), and employers themselves.

What Works in Health Promotion

According to NCQA, a number of trends can be seen in the health promotion programs being offered by these players:

- Greater use of high-tech tools to engage participants in long-term change
- Growing emphasis on telephonic and online coaching
- A return to on-site programs
- Growing employer recognition of the rising impact of stress and psychosocial factors, and a concomitant increase in expectations for integration between EAPs and stand-alone behavioral health vendors

Employers are shifting their focus away from single, activity-centered projects to more results-oriented projects. They are rapidly increasing the use of participation incentives (e.g., gift certificates, extra vacation, extra cash) that are being integrated into benefits plans in order to increase employee participation in HRAs (use of which is spreading rapidly), screening, and risk-reduction programs. These programs help to address employee concerns that their employer's primary goal is cost-cutting.

NCQA recently convened a group of experts who concluded the following about what program characteristics are most effective in health promotion activities:

- Using features and incentives consistent with an organization's mission, goals, and culture.
- Achieving buy-in at all levels of the organization, including senior management, middle management, and rank-and-file employees.
- Having a visible leader or "champion," as seeing top people involved can have a major impact on the rank-and-file employees.
- Setting specific program goals and objectives and clear measures of success.
- Targeting the most important health issues among employees, using information obtained in HRAs or other surveys that are administered in a secure and confidential manner and used only to establish company-wide priority areas. NCQA has used HRA and survey information from its employees to determine that depression and stress are high-priority areas (depression was a surprise to management). NCQA also still focuses on smoking cessation, even though there are only 9 smokers among its 175 employees.

Opportunities for NCQA to Support Health Promotion

NCQA is eager to support health promotion activities in the workplace and elsewhere by assisting multiple stakeholders in recognizing what a good program is, and helping buyers to understand how to buy high-quality health promotion services. Several potential opportunities exist for NCQA to play this role:

- Evaluation programs that measure the structure, process, and outcomes of health promotion activities. NCQA could provide benchmarking, accreditation, and/or certification programs for employers and health plans to use in evaluating the health promotion activities of vendors and other organizations.
- Clinical performance measures for health plans, physicians, and vendors
- Public education and advocacy initiatives

NCQA recently released its latest *Quality Profiles* publication, which describes the activities of employers and health plans in wellness and prevention. This report is available free of charge at www.qualityprofiles.org.

NCQA is also considering the development of a tool that will qualify "medical homes," which is an important new strategy for improving care for those who see multiple providers. The goal of the program would be to help stakeholders evaluate whether a medical home has the appropriate structure, processes, and/or outcomes, regardless of where it is located.

Richard Sorian is vice president for public policy at NCQA, the nation's leading organization committed to improving health care quality through the measurement and public reporting of performance results. In this role, he is responsible for the development and implementation of NCQA's public policy strategy and its work with the federal government and the states. Prior to joining NCQA, Mr. Sorian was a senior researcher at the Center for Studying Health System Change. From 1998 to 2001 he was on the faculty of Georgetown University's Institute for Health Care Research and Policy. From 1993 to 1998, Mr. Sorian was a senior official in the Clinton administration, serving in a variety of roles including deputy director of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, where he directed the development of a Patients' Bill of Rights. From 1980 to 1993, Mr. Sorian was an award-winning journalist and editor of *Medicine & Health*. He is the author of three books including *The Bitter Pill: Tough Choices in America's Health Policy*. Mr. Sorian is a graduate of The George Washington University and was awarded the Harvard Journalism Fellowship for Advance Studies in Public Health.

Section V:

Key Issues in Moving Forward

“Eyes still glaze over when you start talking about the link between workforce health and productivity.”

—Marianne Fazen, Executive Director, Dallas-Fort Worth Business Group on Health

This section captures key insights from discussions held during the NHLC meeting on two important overarching issues that are critical to moving forward with the health and productivity agenda.

Issue #1: Getting Buy-In Among Chief Executives

The data suggest a relatively clear potential “sales pitch” to CEOs—that their employees are not nearly as healthy as they could be, and that investments in making them healthy could have a huge, positive impact on productivity and costs, particularly indirect costs. The key question is whether this is a credible message. Key points made during the discussion include the following:

- Businesses care about their bottom line, and they care about employees only to the extent that they help the bottom line. Just as occurred with the quality movement, progress on the health and productivity front will be made when an effective case is made that such initiatives will have a significant bottom-line impact. While there is substantial “soft” evidence to make this case, better measures that show real, “hard” savings and productivity improvements are still needed. There is still substantial skepticism about the tools and surveys used to measure presenteeism, and about the link between improved presenteeism and improvements in cash flow and the bottom line.
- The best approach is to use a simple message with the CEO, as was done at Carlson Companies, where the focus was on easy-to-understand costs such as time missed from work due to illness and physician visits. This information alone was enough to sell the CEOs. Executives want to see “hard dollars” that they understand, such as time lost due to illness, STD, LTD, and workers’ compensation. That said, ultimately an attempt should be made to measure presenteeism in a credible way, since this calculation can double or triple the potential value of any intervention.
- Not all employers are ready for the message about health and productivity, but some clearly are. In some areas, such as Tennessee, the link between health and productivity has not yet been made to employers. But now may be the time to do so.
- The sales pitch should be tied to value-based purchasing, which encompasses informed consumer engagement and choices at every level of the system— lifestyle choices, prevention, screening, and choosing the right health plan, provider, and treatment.
- Small employers need to come to the table, since they are most likely to be dropping health benefits (or not offering them in the first place). The private sector has failed to provide high-quality, affordable insurance options to the small employer market. As a result, small employers with one high-risk employee are consistently unable to get affordable insurance. The upcoming presidential election is sure to focus on this issue. Coalitions that represent small- and mid-sized employers need to find solutions for their smaller members.

Issue #2: Implementing Specific Interventions That Boost Health and Productivity

NHLC attendees discussed specific strategies and programs that they are using to help boost workforce health and productivity. These initiatives generally fall into one of two categories— programs that encourage employees to change their lifestyles—diet, physical activity, smoking, stress levels—so that they can get a better sense of meaning and control in their lives and careers, and programs that encourage individuals to be more compliant when they get sick by sticking with treatment and medication regimens. Specific initiatives highlighted during the discussion include the following:

- Adopting the Asheville model program that uses consumer coaches and peer counseling for people who are chronically ill, so that they can learn to self-manage their conditions. The program also uses incentives by waiving copayments for medications that are needed to manage chronic disease. NBCH has endorsed this model, and a number of coalitions are adopting it.

- Varying cafeteria prices to encourage healthier eating by having lower prices for healthy meals and higher prices for unhealthy ones (e.g., \$1.85 for soup versus \$5 or more for a hamburger).
- Adopting the American Diabetes Association guidelines for meeting and workplace food choices. These guidelines discourage serving cookies, muffins, doughnuts, and other unhealthful foods.
- Providing free smoking cessation programs for those smokers who agree to try to quit.
- Holding meetings in “smoke-free” cities, as the CDC has done and encouraged others to do as well.
- Collaboratively hiring a doctor to serve a coalition of employers and their employees, which helps to improve timely access to services and minimize time lost from work.
- Opening on-site primary care clinics where a critical mass of employees exists. These clinics can also reinforce educational messages related to disease management.
- Adopting a smoke-free worksite campus.
- Creating incentives for employees to fill out HRAs, and providing coaching/counseling to those who complete them.
- Creating copayment differentials that encourage employees to use higher-performing physicians and hospitals.
- Developing incentive and reward programs to encourage patient compliance.
- Making participation in a wellness program a pre-condition to enrolling in an employer-sponsored health plan.
- Providing a discount on health premiums to employees who demonstrate certain healthy behaviors (within HIPAA guidelines).
- Providing discounted or free wellness services, including immunizations, diabetes screenings, and the like.
- Offering on-site diabetes classes where employees can talk to counselors. One company is providing six weeks of 30-minute classes during work hours.
- Sponsoring workshops and conferences to encourage employers to invest in prevention and health promotion, including presentations by organizations that have initiated such programs on a limited budget.
- Sponsoring smoking cessation and substance abuse programs.
- Working with regional health information organizations (RHIOs) to develop performance-based reporting programs.
- Developing electronic medical records for employees and family members.

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