

Wellness, Hard to Define, Reduces Trend up to 4%

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Abstract

The purpose of this qualitative study was to identify a common language for “wellness” and a correlating health cost trend reduction through incentive-driven prevention and wellness. Mapping the results of the survey with the trend lines reported by innovative employers could uncover increased financial value in health investments. A 10-question survey was designed for telephone interviews with 26 businesses (Innovators) from the Board of the Center for Health Value Innovation; a paper-based survey with the same questions was completed by attendees at a seminar. Then, an online trend survey was conducted with members of the Board (Innovators) to track the total health cost trends in their companies over the past 3–4 years. Responses were compared and analysis of alignment and differences were recorded by graphing. The trend survey results were mapped and tracked with weighted averages. Innovators’ responses to the phone survey showed broader definitions of “wellness” than other companies, with little difference in the Innovators’ responses when subdivided by size of company. The online trend survey showed that companies that provided incentives for wellness averaged a trend of 4% over the past 3–4 years—approximately 50% of the national trends of 8%–10% over the same time frame. Innovators have defined wellness in ways that would accelerate adoption in the broader business community and drive implementation of wellness programs. The bigger win could be the community-level shift to a culture of health as employees carry these health competencies to the next business in the community. (*Population Health Management* 2010;13:xx–xx)

THE ESCALATION OF health care costs, coupled with the volatility of the financial markets, has caused a new wave of cutbacks in benefits for America’s workforce with varying degrees of exiting and cost shifting. This has happened just as the adoption of wellness strategies has begun, enhanced by legislation that defines the Health Insurance Portability and Accountability Act requirements for wellness implementation. In a recent article in *Health Affairs*,¹ the question of prevention or treatment services is addressed as the wrong debate. Instead, the author states the focus should be on the cost-effective ways to improve population health. Further, in 2006 US health spending exceeded \$2 trillion, with three fourths of that spending directed at treating chronic disease. Almost two thirds of the growth is attributable to American’s worsening health habits, particularly the epidemic rise in obesity.

This article examines the definitions and perceived impact of wellness strategies at the worksite and through service providers. The prime motive for the qualitative survey that forms the basis of this paper is simple: If wellness can be defined and quantified in business terms, then purchasers

can be educated to identify the programs and services that support effective wellness initiatives, therefore leading to better value in health purchases made. Additionally, the information is fortified with an online survey of companies with wellness programs; the survey gathered 3–4 years of health cost trends for 26 companies as their wellness strategies were implemented and measured.

Methods

The Center for Health Value Innovation (Center) was launched to create an information exchange in value-based design among private and public entities (corporations, municipalities, counties, states—all as employers). The mission of the Center is to identify value and amplify the evidence of improved health status, reduced health cost trend, and increased productivity in the populations served because of investments in the health of the population (as opposed to cost-compression or cost shifting). As a result of tools and programs that promote personal health management and access to care for appropriate services, the body of

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knowledge that has been accumulated is cataloged and data are shared in blinded reports and case studies or snapshots. Companies are “qualified” into the Innovators’ group through online and phone-based interviews that gather information on (a) the suites of programs that improve population health in these companies and (b) how these companies leverage outcomes to influence better health in their communities. The movement, level of innovation, and degree of cultural change is tracked to show the changing sophistication and acceleration in the value-based design movement.

With the rising focus on the value of wellness and dividends to a company at large, a phone-based survey (Survey #1–Innovators) was constructed that would promote a quick set of multiple-choice answers on the definitions of wellness used by these innovative companies and would also allow the respondent to share thoughts and viewpoints on the questions. The goal of the survey was to use both finite choice and qualitative interview to discern common definitions and applications of wellness programs that support healthy behaviors and health improvement. The phone-based wellness interviews were followed up by paper-based surveys (Survey #2–Attendees, a paper-based survey of the exact questions asked of the Innovators) with attendees of seminars that the Center co-sponsored in late Fall 2008. The attendees were human resource/benefits representatives, and they were not prequalified into the value-based innovation space. They were curious about how to implement a value-based design and were, therefore, presumed to not have as robust a suite of programs for personal health improvement at their worksite. (This was borne out in the responses to the survey.)

An additional online survey (Survey #3) was conducted in January 2009 with the board members (Innovators) of the Center to catalog total health cost trends over the past 3–4 years (2005–2008, where data were available) for their companies and to compare these trends with market trends for the same years.

The qualitative survey (Survey #1 Innovators) on wellness definitions and programs was begun in October 2008 with 26 members of the Board of the Center, both directors and advisors. These board members are some of the most innovative, ingenious, and “color outside the lines” people in health management today; they are disruptive thinkers who test new approaches, measures, and outcomes for success. They include chief medical officers, vice presidents and senior

managers of human resources, directors of health promotion, and risk managers. Their companies include jumbo, large, medium, and small employers, plus health plans, health systems, physician organizations, coalitions, and brokers-consultants, all of various sizes, representing a total of 18.7 million lives (most reported employees, although some of the coalitions and service providers reported covered lives). Survey #1 (Innovators) was conducted by phone with members of the Center (Innovators), and followed up with a paper-based survey (Survey #2) for attendees (Attendees) at a conference conducted by the Center to teach value-based decisions to mostly small (under 100 employees) companies; there were 16 respondents in this second group, most of whom remained anonymous. The Attendees were human resource/benefits directors and managers across multiple sectors and sizes of companies.

The Wellness Surveys (Surveys #1 and #2) were designed to elicit answers to multiple-choice questions as well as more robust discussion or commentary on the questions. There were a total of 10 questions, with some allowing more than 1 answer. Not all respondents, from either surveyed group, answered all of the questions. The “Innovators” answers have been sliced to determine if there is a difference in response between larger employers (>5000 employees) and smaller (<5000 employees). The Attendees’ responses were not segmented by size.

Finally, the online survey on health cost trend (Survey #3) was completed by 32 members of the Board of the Center, tracking total health spend across 3–4 years. The survey asked for “total health cost trend” over years 2005, 2006, 2007, and 2008 (some companies did not have 2008 data at the time). The companies’ cataloged programs in the Center database were tracked for similarities and differences, and then average trend for each company was calculated.

Results

In Survey #1 (Innovators) there was no common definition of “wellness,” but there was some consensus in the impact of “wellness” on the corporation (Fig. 1). (Note that the darker bars represent the subsegmented Innovators with over 5000 employees and under 5000 employees, and the lighter bar represents the Attendees’ response from Survey #2—the paper-based survey from the conferences). Respondents were allowed to choose more than 1 answer on the responses to “impact.”

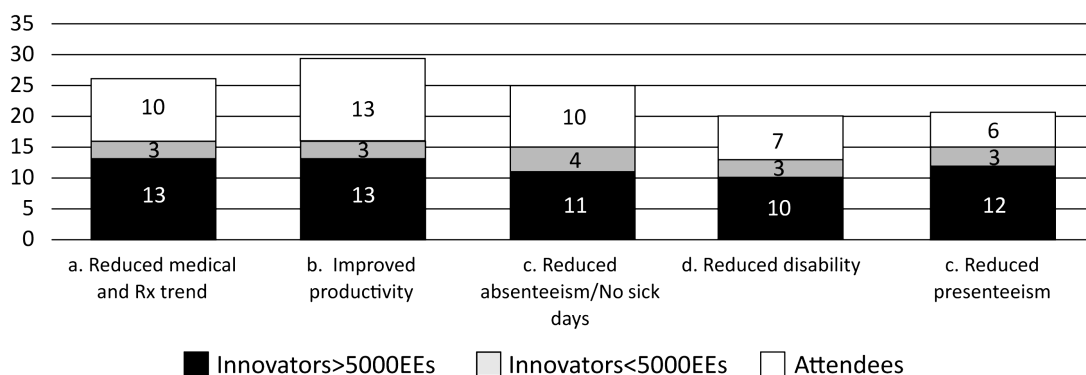


FIG. 1. The impact of wellness on the company bottom line.

TABLE 1. IMPORTANCE OF OUTCOMES TO THE RESPONDENTS AND THEIR COMPANIES

Which outcome(s) is most important to: (more than one answer is allowed)	Respondent		Company		Which outcome(s) is measured?	
	Innovators		Innovators		Innovators	
	Total (# with <5000 EEs)	Attendees	Total (# with <5000 EEs)	Attendees	Total (# with <5000 EEs)	Attendees
a. Reduced medical and Rx costs	10 (2)	5	15 (3)	7	17	6
b. Improved productivity	6 (1)	6	5 (1)	3	9	0
c. Reduced absenteeism/No sick days	0	2	0	3	6	1
d. Reduced disability	1	0	0	0	9	0
e. Reduced presenteeism	1 (1)	1	0	0	2	0
f. Other	11	1	5	1		
Hard to measure	0	0	1	0		
All of the above	1	1	0	1		
Engagement	2	0	2	0		
Retention	1 (1)	0	1	0		
Improved Health Status	7	0	1	0		

Each respondent was asked which outcome measurement was most important to them and which was most important to their company (Table 1). Included are the answers to these questions with Innovators’ responses as a whole (then the subsegmented answers from Innovators in companies with < 5000 employees in brackets). The next 2 columns show the answers to question #4a: Which outcomes do you measure (ie, do they measure what they have indicated is important)?

The survey then asked about actual components of the programs and services that respondents offer to support or improve “wellness” in their populations. Respondents from both groups were allowed to choose as many as were applicable and to suggest additional answers (Fig. 2). The next question pushed the respondents to align risk levels to the organization with wellness, if there was such an alignment (Fig. 3).

To push the concept further, the survey asked if a diagnosis of chronic disease limits the achievement of “wellness” (yes/no). If yes, does it matter which disease (yes/no to suggested high-cost drivers). Finally, respondents were asked which disease(s) limits the ability to achieve “wellness” (Fig. 4).

The next section of the survey consisted of 2 questions that showed what the respondents knew about their “well” employees/covered lives. The first question asked what percentage of their employees/covered lives are “well.” The second question asked how they knew these employees are well. Respondents were asked if self-reported questionnaires on “wellness” are valid (Fig. 5).

The final section of the survey asked what information or technologies could help the respondents achieve or support “wellness” in their organizations; this was an open-ended question with no pre-populated responses.

Then, using Survey #3, overall trend analysis was performed to create a weighted average of health cost trend in the reporting companies (Innovators from the Center across size and sector).

Discussion

The concept of creating a survey that could be tested within the Innovators’ group (leading members of the Center who share information on innovation, health improvement, and health cost trend change), and then compared to the

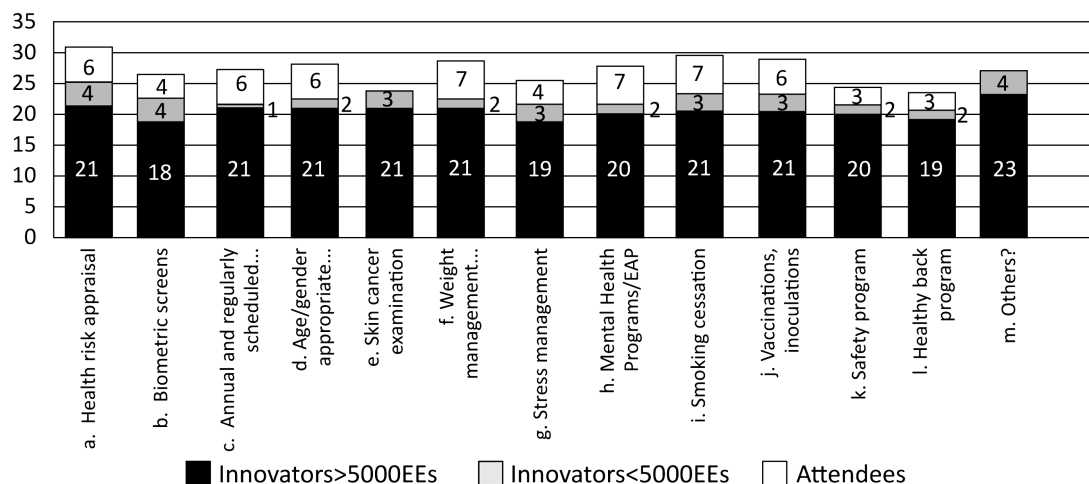


FIG. 2. Components offered as part of wellness programs.

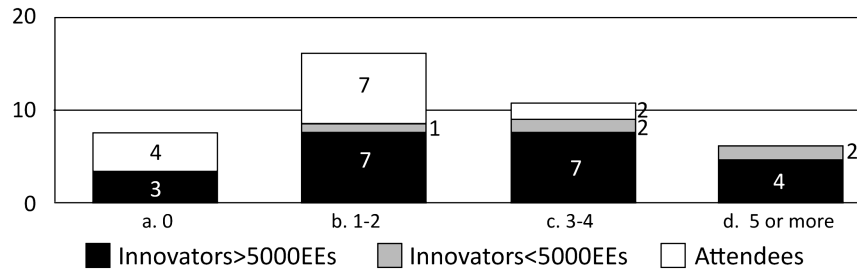


FIG. 3. Risk factors and wellness.

Attendees’ group (general human resources-benefits respondent) proved revealing in the attempt to drive a business-based definition of “wellness.” There was alignment on some conceptual ideas, but overall the Innovators were not only more disruptive in their thinking, they pushed definitions, applications, measures, and risk to achieve better outcomes for their populations, with no difference in responses between the large companies and the smaller companies. The overall health cost trend analysis verified their thinking that innovation and a broader perspective of the possible—key components of value of benefit designs—actually encourage appropriate wellness and prevention activities, resulting in a year-over-year trend of 4% compared to the market 8%–10% for the same time period. This is not merely a philosophical shift; the philosophical shift is the first step, driven by review of comprehensive data beyond medical claims, to instituting new programs and services that cause the trend shift. This has been demonstrated in the interviews cataloged in the Center over the past 3 years.

It is important to reinforce that Innovators are *not* representative of the business community at large. They have spent much of their careers re-crafting the health cost trend issues into a focus on person-centric care, asking the question, “What can we do to support a better-educated health care consumer?” They are bolder in their approach to solving this problem, showing the leadership to drive a different suite of answers to obtain new results. This has been demonstrated through online interviews, phone-based interviews, and surveys from the Center for Health Value Innovation that show that Innovators think and act differently, engaging Fast-Followers (those who buy in to the Innovator leader

ideas and align to implement and track the outcomes). Further, note that there is still little difference in response when the answers within the Innovators’ group are segmented by size (fewer than 5000 employees and more than 5000).

The attempt was made to graphically show the impact of more wellness programs, or other programs, with the decrease in trend over time. Because value-based designs use the data of each company to develop a design that meets the need of that company alone, it was not possible to graph this. Some companies do more (eg, on-site services and education, team-based evaluations); others have only installed a health risk appraisal (HRA)/biometric screen/incentive for completion. Yet, the trends were startlingly similar across all of the companies that have shifted the thinking to consumer-centered questions and solutions that drive better outcomes based on population behaviors instead of cost shifting.

Attendees at the seminars are those who are interested in learning more, but who either have not independently thought of the new perspectives or have not implemented any value-based concepts until there is more proof. This description of Attendees has been accumulated from conference evaluations from attendees at 7 conferences that the Center has held for value-based designs over the past 15 months, through the distillation of what they want to know, what barriers exist, and how much risk they are willing to absorb.

Definition and quantification of “wellness”

Innovators were more focused on broad achievements in health through wellness programs; Attendees were focused

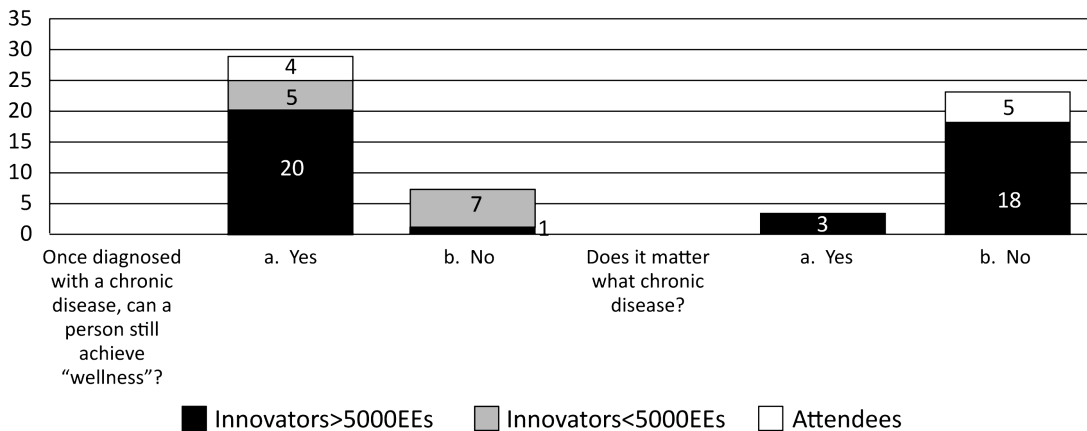


FIG. 4. Chronic disease and wellness.

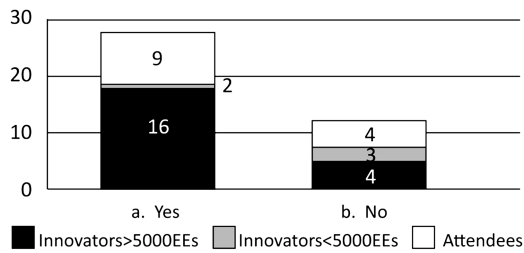


FIG. 5. Validity of self-reported questionnaires to determine wellness.

on measures. Innovators appeared more willing to expand the definition beyond clinical measures, sometimes wrapping spiritual and even safety/security components into the definition. It is important to note that there is little difference in response between the groups of Innovators from larger companies compared to those from smaller companies: Innovators from smaller companies voiced similar concepts and broad definitions of “wellness.” Innovators as a whole had more focus on improved health and maintenance of same, with some identifying more esoteric qualities beyond clinical health (eg, “end state that we aspire to achieve,” “beginning that provides a basis for improvement”). There were conversational definitions including investment in health and productivity of the company, continually striving for improvement, feeling of competency and self-actualization, personal responsibility, maximal capacity, a culture of health, balance of stress, and optimal health. Yet, there were still 12 “traditional” responses that reflected wellness attributes of reduction of risk and reduction of health cost—a clear focus on clinical status and associated costs.

Components of “wellness”

When it came to implementation, the Innovators resorted to the same component parts as Attendees, leaving the broader components (financial and spiritual/holistic programs) outside their “wellness” programs; Innovators large and small relied instead on HRAs, screenings, safety programs, and musculoskeletal improvement. Both groups, and the subsegmented smaller-sized Innovators, chose items across all of the choices of answers, reflecting the holistic viewpoint of most experienced Innovators: They look for impact and success beyond the reduction of medical costs or the reduction of insurance premiums. Innovators seek success in reduction of health risk, reduction in safety risks, and reduction in unscheduled absences, appropriate use of outpatient visits or employee assistance programs (EAP), and persistence to evidence-based treatments - to name a few “outside the box” metrics.

Specifically, Innovators did recognize EAP/mental health, safety, skin cancer screenings, stress management, maternity, care/case management, and other, more broadly defined “wellness” components (eg, healthy cafeterias, on-site clinics, on-site and off-site nutritional and exercise programs) as part of their implementation packages, reflecting the maturity of the programs, the increased evidence for early detection and management of these components, and the probable larger budgets to manage them. Attendees cited few of these programs.

Asked to name the outcomes they measured, respondents demonstrated that there is some alignment of business strategy and outcomes (what is most important to you/your company) with the measures they used. Yet there were still gaps in the components noted and the measures made, even in the Innovators’ group. Innovators answered that they measured “wellness” through the reduction in direct medical costs/trend, plus improved productivity and disability, while fewer than 1 of 4 answers reflected reduced absenteeism or sick days, and only 2 measures were focused on presenteeism. Retention and presenteeism were mentioned only by the Innovators who represent fewer than 5000 employees; it is unclear if this is due to oversight or if the smaller company Innovators have actually figured out how to create meaningful measures of presenteeism and retention as a result of wellness activities. The Attendees’ measures showed much less focus on any measure beyond clinical (medical, lab, and pharmacy)—in fact, no one chose improved productivity, disability, or presenteeism, and only 1 included reduced absenteeism or sick days.

Achieve and report optimal health and wellness

Innovators were far more accepting of the achievement possibilities within a diagnosed population than were the Attendees. Only 3 Innovators thought that certain identified diseases predisposed the patient to not achieve “wellness,” and these were all catastrophic illnesses. In contrast, 7 Attendees thought that chronic disease would limit the attainment of “wellness,” which once again shows a less-expansive definition of the word “wellness” in the Attendee group. Once either group could identify the boundaries of wellness (in the face of chronic disease), the question of how to measure the “wellness” became important. The answers to the question, “Are self-reported questionnaires valid?” were similar across all respondents: the self-reported questionnaire was only slightly more accepted within the Innovators’ responses than in the Attendees (66% compared to 60%).

Tools/technologies needed

Alignment was achieved in this category of responses, as both Innovators and Attendees cited the need for more information at the point of decision, more electronic medical record/personal health record usage and application, more use of targeted technology (eg, using a wider variety such as Internet/intranet, phone, web, print, coaching), but always with the consumer at the center of the relevant information. In some of the responses there were several messages of exasperation that health plans and service providers could not integrate and deliver total health management costs or actionable messages for the purchaser (usually the employer), the physician (linking evidence and benefit design to the patient/consumer at the point of service) and the health system (managing use of emergency services or disability/absenteeism). This was more often revealed in the interviews of the Innovators than in the paper-based responses of the Attendees, perhaps because the interviews encouraged more discussion.

Innovators’ responses reflect more the integration of information and potential broader definitions of “wellness” than those of the Attendees. They use the 4-step process of a value-based design—data, design, delivery, and

dividends—to identify the needs of the population and influence better health care decisions. This is not a philosophical shift alone; their renegade philosophy of doing something different and convincing others to follow is documented in the database of the Center, and it has been highlighted at the conferences on value-based designs. They are ready to push the envelope on definitions and conceptual applications, and they are hindered only by the depth and breadth of programs that are in the market. The level of wellness innovation may be one of program accessibility (ie, is their service provider offering more traditional, medically-based services that only reach and treat the “ill,” with little focus on the “well”?). There may be a disconnection between what they wish and perceive (the achievement of wellness even in the diagnosed population) in order to achieve optimal health. There may even be a break between what they, as risk takers, are willing to pursue and what they can budget or persuade upper management to permit them to do.

While there was an attempt to graph the health cost trend reduction overall, it became almost impossible. Twenty-six reporting Innovators all instituted different wellness programs in order to achieve their results. These programs were driven by data, budget, and how long they had been innovating in their companies. (Some companies were newer to this field than others. All had at least a 3-year runway; some had more than 15 years.)

However, when enhanced with the trend results of total health cost trend for 3–4 years of 4%, compared to market trends of 8%–10%, the evidence is that value-based investing in workforce health through benefit designs that improve population health is a wise business strategy. Ultimately, Innovator answers align with the concepts of building a culture of health: understand the needs of the population and how they align with the corporate goals; engage senior leadership in the design and implementation; communicate often and support literacy and competency.

The fundamental difference between the Innovator companies and the Attendee companies is that value-based designs—using incentives to change population health—have not been installed in the Attendee companies. That question is asked at the beginning of every seminar for value-based design that the Center conducts. Innovators use a suite of carrots—and sometimes sticks (eg, a carrot could be a richer health benefit when the HRA and biometric screen are completed; the stick would then be the less-rich plan for those who do not participate).

The study of worksite health, coupled with surveys, public health studies, and interviews, has shown that businesses are affected by similar cost drivers, such as chronic conditions (heart disease, asthma, diabetes, depression, musculoskeletal disease, cancer, hypertension, smoking, cholesterol), productivity losses (absenteeism, presenteeism, short-term and long-term disability, workers’ compensation, safety), and economic impact (capital supply, growth, shareholder value). By removing those variables, the surveyors could compare the raw responses to innovation and wellness across the two groups, Innovators and Attendees.

There was consistency overall between the responses of Innovators in large companies and small, which is an attribute that is found throughout the 70-plus interviews that the Center has conducted on innovation: Innovators start as renegades, folks who rethink the range of possibilities and

come up with new answers and suites of services. They tend to do their best innovation in the areas they can control and in which they can create; innovation tends to lose its impact when purchasing services because the range of services lags behind the innovation. Innovators have a unique perspective on the “possible,” which leads to the innovation in implementation. The implementation is measured for impact, revised or enhanced, and redeployed, creating a culture of health and an increased competency level across the worksite. Without the innovative programs, this adoption and acceleration to better health sustainable financial trend is hindered. This, then, becomes the call to action, particularly for the condition management/disease-care management/life coaching sectors of the supply chain.

Attendees’ responses showed that they were approaching the boldness to achieve broader value through wellness, mirroring some of the actions of the Innovators over the years of experience. Attendees had the theoretical background to draw some boundaries larger than what may have been expected, yet they fell back to older definitions of “wellness” and their responses showed that they had little expertise in modeling beyond some of the clinical definitions of low risk and low cost. This focus on cost will not help them move into the value-based purchasing space, as value-based decisions require an investment philosophy to improve the management of total trend, and total trend includes data that may not be accessible or integrated in the smaller or less-sophisticated companies. This, then, is an opportunity not only for education but also for building a more comprehensive business case for the learning companies.

Conclusion

Innovators use data to identify risk, implement programs and services to moderate the risk, measure, and report the results. They tend to think disruptively, not using traditional definitions of a problem nor suites of “solutions” to remedy the situation. However, the definition of wellness is not clearly defined and not readily measurable, which could inhibit the adoption of a business case to implement wellness-driven benefit design.

The implementation and measurement of the success of “wellness” initiatives will continue to be elusive until a more concrete definition is conceived. The adoption rate of wellness activities or wellness-based incentive design will expand some of the boundaries (some will take the risk and implement, then others who are emboldened will follow their lead), but that actually requires more risk on the part of the Innovators and subsequent Fast Followers. These wellness pioneers will be implementing more on acts of faith and intuition than on hard evidence that the investment in wellness will improve their total health and reduce health cost trend in a timely fashion that can help build the business case. The Innovators’ showcasing of implementation and results is creating a platform for others to learn and to share that could accelerate the adoption of new technologies and services to drive wellness outcomes.

The business community often complains that dividends that accrue beyond the 3-year mark due to employee health improvement are “soft,” as employees tend to stay with any given employer for approximately 3 years. (Note: this is much more perception based than evidence based.) Yet, the

trend survey shows that Innovators' companies implemented a suite of levers to improve population health through prevention and wellness strategies, resulting in a total health cost trend of approximately 50% of the market trend (4% vs. 8%–10%) over 4 years; this should be enough to convince the market that value-based investments are a reasonable health improvement and financially sound strategy.

With the trend reduction as a consistent theme in value-based designs, the impact could potentially be much more important regionally and nationally, as the initiation of wellness activities may have a longer term dividend beyond any one employer in a community. Prevention and treatment designs could very well foster the emergence of sustainable multi-stakeholder community health improvement and a shift to grassroots cultures of health. This community-level shift to a culture of health, as employees leave the original company but carry their health management competencies to the next business in the community, would drive the reduction in community health cost trend, freeing resources that can be better deployed for those who are uninsured or underinsured, and improving the tax burden on businesses in the community. These cultures of health would support the personal persistence and expectation of accountability and responsibility in consumers, businesses, health systems, and governments, driving the total health cost trend down while improving the risk profiles and health status of stakeholders.

More evidence and analysis will be required to see if Innovators and Emerging Adopters (which is really what the Attendees could be called) can be further subsegmented by predictable actions based on the size (revenues), market sector (service vs. manufacturing), and number of covered lives, among others. If this were the case, then technology applications could be developed that would target the different sectors. Once tested, the application and insertion into

the Adopting community—the Learners, such as the Attendee group—could be used strategically to moderate risk, cost trend, and/or retention of talent.

The Center will continue to call the Innovators' attention to the "what-ifs" and model new management technologies for health management improvement. Once tested, the Center will bring the new ideas to the general marketplace, encouraging rapid adoption for the improved health of organizations and communities. Improved health and reduced financial burdens for all stakeholders should be the ultimate goal.

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