



MERCER

The HERO Best Practice Scorecard[®]

In collaboration with Mercer

Version 3.0

An editable PDF of the questionnaire to help you prepare to complete the Scorecard online

Introduction

The HERO Employee Health Management (EHM) Best Practice Scorecard is designed to help you learn about and determine EHM best practice. Many existing sources of information on EHM best practice were used to create the original Scorecard, which was introduced in 2006. The updated Scorecard, developed in collaboration with Mercer, has been reviewed and refined by a broad panel of industry experts. We believe it represents the current best thinking on what constitutes a successful EHM program.

Why complete the Scorecard? First, the questions themselves serve as an inventory of EHM best practices and, as such, may contribute to your organization's strategic planning. Second, when you submit the Scorecard online, you'll receive an automated email response, free of charge, with your organization's best practice scores compared to national averages. Finally, by sharing your organization's information, you'll be helping to build a major, national normative database to further the industry's understanding of best practice approaches to EHM. As the database grows, we'll make benchmark reports available that will allow employers to compare the details of their programs with those of relevant benchmark groups based on industry, employer size and geography.

About this PDF

This PDF of the Scorecard questions is provided for informational purposes only. This form may be useful in gathering information to assist with completing the online survey but should not be submitted. All data are being collected through the online survey. For more information on the Scorecard, including background and history and a discussion of the scoring system, please see page 18.

Statement of permissible use

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Individual, identified responses to the Scorecard will be released only with the permission of the respondent. The names of the organizations completing the Scorecard (but no contact information) will be available upon request and may be published.

I agree to these terms _____



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The HERO Best Practice Scorecard

In collaboration with Mercer

Organization information

Organization name _____

Headquarters location (specify state) _____

Number of US worksites (geographically dispersed worksites not managed as a single location) _____

Name of person completing the Scorecard _____

Email address (required to receive Scorecard results) _____

Total number of employees in the US (please estimate, if necessary) _____

How many are full-time _____

How many are part-time _____

Total number of employees eligible for health benefits in the US _____

Primary type of business

- Manufacturing – Mining, construction, energy/petroleum
- Manufacturing – Products (equipment, chemicals, food/beverage, printing/publishing, etc.)
- Transportation, communications, utilities
- Services – Education (public and private)
- Services – Financial (banks, insurance, real estate)
- Services – Health care (hospitals and health services)
- Services – Other (technical, professional, food/lodging/entertainment, etc.)
- Wholesale/retail
- Government (federal, state, city, county)
- Other (diversified companies, farms, etc.)

North America Industry Classification System (NAICS) Code # _____

What is the average age of your organization's active employees? _____

What percentage of your organization's active employees are male? _____

What is the average annual salary for full-time employees (total earnings as computed for employees' W2 forms, excluding partners' earnings)? \$ _____

If your organization employs union workers, are they eligible to participate in employee health management (EHM) programs?

- None of our employees are in unions
- Yes, some or all union workers are eligible for the EHM program
- No, union workers are not eligible for the EHM program

Section 1: Strategic planning

1. Has your organization conducted an assessment of employee health needs within the past two years?
 - Yes, we have conducted a health needs assessment within the past two years
 - No, but we plan to conduct an assessment within the next year
 - No – skip to Q.3

2. If yes, on which of the following measures was the needs assessment based (or will it be based)? Please check all that apply.
 - Medical/pharmaceutical claims analysis
 - Health risk assessments/employee health surveys
 - Biometric health screening
 - Employee interest surveys/focus groups
 - Disability and/or behavioral health data
 - None of the above

3. Does your organization have a formal, written, strategic plan for EHM?
 - Yes, a long-term plan (two or more years) only
 - Yes, an annual plan only
 - Yes, both a long-term and an annual plan
 - No – skip to Q.5

4. If yes, does the plan include measurable objectives for any of the following? Check all that apply.
 - Participation in EHM programs
 - Changes in health risks
 - Improvements in clinical measures/outcomes
 - Productivity gains (including reductions in absenteeism/presenteeism)
 - Financial outcomes measurement (medical plan cost or other health spending)
 - None of these

5. Approximately what percentage of the active employee population (full-time and part-time) has access to the key components of the EHM program?
 - 0–24%
 - 25%–49%
 - 50%–74%
 - 75%–99%
 - 100%

6. Has your organization taken steps to make key components of the EHM program available to any of the following hard-to-reach segments of the active employee population? Check all that apply.
 - Full-time or part-time shift workers
 - Physically challenged employees
 - Geographically dispersed employee groups or individuals within the US
 - Employees located outside of the US
 - English as a Second Language (ESL) employees
 - We don't have any of these populations
 - We have one or more of these populations, but we don't yet provide EHM services to them

7. Has your organization taken steps to make key components of the EHM program available to benefit-eligible retirees and/or employees on disability leave (including services offered through health plans or community groups)?
 - Yes
 - No
8. Has your organization taken steps to make key components of the EHM program available to benefit-eligible spouses/domestic partners or dependents (including services offered through health plans or community groups)?
 - Yes
 - No
9. Does your organization use a population-based approach to EHM, addressing the needs of all employees across the entire health continuum, including healthy, at-risk and chronic-condition segments?
 - A population-based approach is fully implemented
 - A population-based approach is a goal, but it is not fully implemented at this time
 - Our focus of the EHM program is on those with chronic conditions
 - A population-based approach is not a priority
10. Taken altogether, how effective is strategic planning for EHM in your organization?
 - Very effective
 - Effective
 - Not very effective
 - Not at all effective

Section 2: Leadership engagement

11. Has senior leadership demonstrated its commitment and support of EHM through any of the following actions? Check all that apply.
 - Involvement in employee communications on EHM programs
 - Active participation in EHM programs
 - Endorsement of EHM strategic plan to Board of Directors (or equivalent)
 - The corporate vision/mission statement supports a healthy workplace culture
 - Employee health and well-being are included in organizational goals and value statements
 - Have allocated adequate budget for EHM resources and programs
 - None of the above
12. How are managers and supervisors involved in EHM, in general? Check all that apply.
 - They receive periodic training and information about EHM programs and resources
 - They can articulate the link between health, productivity and total economic value
 - They encourage employee participation in EHM programs
 - They provide flexible scheduling so that employees can attend EHM programs
 - The majority of managers/supervisors actively participate in EHM programs
 - EHM goals are linked to annual manager performance metrics
 - They receive reports with EHM engagement metrics
 - None of the above

13. Does your organization use employee champions or ambassadors to promote EHM? These individuals are typically volunteers who, in addition to their normal work role, help communicate, participate in, motivate and support health management initiatives in the workplace. Please select the one response that best represents the situation at your organization.
- There is an organized network of individuals represented at most worksite locations, with formal internal communication channels and periodic meetings
 - There are wellness champions/ambassadors at some worksite locations who receive internal communications
 - We occasionally recruit volunteers for wellness events
 - Little or no “grass-roots” employee leadership is provided to the EHM program
14. Does the physical work environment support employee health and well-being with any of the following elements? Check all that apply.
- Fitness centers, walking or biking trails, etc.
 - Smoke-free environment
 - Healthy food options in cafeterias, vending machines and/or at catered events
 - Safe work environment, including ergonomics
 - Well-lit and accessible stairwells
 - Quiet/relaxation areas
 - Lactation rooms
 - None of these
15. Does your organization have any of the following policies in place? Check all that apply.
- Flextime or work-at-home
 - Policies to support early return to work following disability, such as modified work schedules and/or modified duty
 - Recognition and rewards for healthy behaviors
 - Allow participation in EHM activities during work time
 - None of the above
16. Taken altogether, how supportive of EHM is senior leadership and the corporate culture in your organization?
- Very supportive
 - Supportive
 - Minimally supportive
 - Not supportive at all

Section 3: Program level management

17. Which of the following EHM programs in your organization are integrated or coordinated with each other? Check all that apply.
- Prevention/health risk reduction
 - Employee Assistance Program/behavioral health
 - Disease management
 - Case management
 - Nurse advice lines
 - Occupational health
 - Safety
 - Disability and absence management
 - Workers' compensation
 - Health benefits
 - Other
 - None of these programs are coordinated with any of the other EHM programs
18. In what ways are the EHM programs described above integrated or coordinated with each other? Please consider the level of coordination among stakeholders, including both vendors and internal staff, in managing any EHM programs offered. Check all that apply.
- Joint planning with all stakeholders
 - Written coordination plan/process flows
 - Communications refer to other programs, as appropriate
 - Communications are fully integrated and focused on EHM as a whole rather than on separate programs
 - Claims data from multiple plans and sources are grouped (evaluated) to identify priorities and evaluate results
 - Vendors are required to share data to allow integrated reporting, predictive modeling or outreach to employees
 - Stakeholders are required to provide warm transfer of employees to another program
 - Consolidated reports are generated (by vendors or your company)
 - Dedicated position to facilitate coordination
 - None of the above
19. Taken altogether, to what extent do you think that effective coordination between health-related vendors or programs contributes to the success of the EHM program?
- Program coordination contributes very significantly to EHM success
 - Program coordination contributes significantly to EHM success
 - Program coordination contributes somewhat to EHM success
 - Program coordination does not contribute to EHM success

Questions 20–24 address the role of your medical plan(s) in supporting EHM goals.

20. Compared to other organizations of your size and industry, how would you rate your organization in terms of providing access to health care coverage to all employees? Please consider eligibility waiting periods, eligibility of part-time and seasonal employees (if any), and contribution levels for employees and dependents in your response.
- We provide far greater access to health coverage than most of our peer organizations
 - We provide good access to health coverage – a bit more than our peers
 - We provide about the same access to health coverage as our peers
 - We provide less access to health coverage than our peers
21. To what extent is health benefit design structured to support prevention and risk reduction by covering and/or facilitating services such as smoking cessation, weight management and preventive exams?
- Health benefit design is very supportive of prevention/risk reduction
 - Health benefit design is somewhat supportive of prevention/risk reduction
 - Health benefit design is not supportive of prevention/risk reduction
22. To what extent does health benefit design support consumer accountability and informed decision making and encourage members to manage their health care dollars to get the most benefit? This would include such tactics as using coinsurance rather than copayments, providing an employee spending account such as a health savings account (HSA) or health reimbursement account (HRA), etc.
- Health benefit design promotes consumerism to a great extent
 - Health benefit design promotes consumerism to some extent
 - Health benefit design does not promote consumerism
23. Does the health plan incorporate evidence-based design – cost-sharing provisions that provide an incentive to select or comply with specific treatments proven to be effective in the medical literature? Check all that apply.
- Yes, waived or reduced copayments/coinsurance for specific drug therapies (not simply all generic drugs)
 - Yes, other form of evidence-based design incentives
 - No
24. Taken altogether, how effectively do medical plan access and design support your EHM program objectives?
- Very effectively
 - Effectively
 - Not very effectively
 - Not at all effectively

Section 4: Programs

25. Does your organization offer a health risk questionnaire (HRQ)? These are also called health risk assessments (HRA) or health assessments (HA).
- Yes, first implemented in _____ (specify year)
 - No – skip to Q.27
26. If yes, which of the following reports does your HRQ produce? Check all that apply.
- The questionnaire provides an individualized report that educates participants about their health risks and preventive measures
 - Data from the HRQ is used to place participants into risk groups (low, medium or high risk) to target interventions to appropriate population segments
 - An assessment of the participants' readiness to change
 - An assessment of the participant's productivity or presenteeism
 - An aggregate report of the participant results for your organization
 - None of the above
27. Does your organization offer onsite (or near-site) preventive health screenings or conduct special campaigns to promote screenings (beyond providing coverage for screenings through a health plan)? Check all that apply.
- Yes, we provide onsite or near-site screenings
 - Yes, we conduct awareness campaigns about the importance of screenings
 - No, we do not provide onsite health screenings or screening campaigns – skip to Q.29
28. If yes, is a feedback process in place for referrals and follow-up for those individuals whose results are out of the normal range?
- Yes
 - No
29. Does your organization provide population-based health education (proactively distributed information and resources for defined populations)?
- Yes
 - No – skip to Q.31
30. If yes, which of the following topics are addressed in educational resources and campaigns? Check all that apply.
- Immunizations (including flu shot program)
 - Healthy eating, nutrition
 - Physical activity
 - Tobacco-use cessation
 - Weight management
 - Mental and emotional well-being (including stress management)
 - Safety and ergonomics (such as back care)
 - First aid or CPR
 - Environmental health
 - Emergency preparedness
 - Health care consumerism
 - Other
 - None of these topics

31. Does your organization offer any targeted lifestyle management/behavior modification programs? These programs may provide telephonic health coaching, seminars, web-based classes or other forms of intervention.
- Yes, first implemented in _____ (specify year)
 - No – skip to Q.35
32. If yes, which lifestyle management/behavior modification program(s) do you offer? Check all that apply.
- Tobacco-use cessation
 - Weight management
 - Mental and emotional well-being (including stress management)
 - Physical activity (for example, pedometer/walking programs)
 - Healthy eating, nutrition
 - Cholesterol management
 - Blood pressure management
 - Safety and ergonomics (such as back care)
 - None of these programs
33. What types of interventions are provided by the lifestyle management/behavior modification program(s)? Check all that apply.
- Phone-based coaching
 - Web-based coaching
 - Paper-based or mail-based programs
 - Onsite one-on-one coaching
 - Onsite group classes
34. Does the lifestyle management/behavior modification program(s) include science-based behavioral change principles, such as readiness to change, commitment building, goal setting, support/accountability system, recordkeeping, etc.?
- Yes
 - No
35. Does your organization offer consumer medical decision support programs?
- Yes
 - No – skip to Q.37
36. If yes, which of the following decision support programs are offered? Check all that apply.
- Self-care education programs
 - Nurse advice lines
 - Consumer medical decision support programs focused on treatment options for specific diagnoses
 - None of these
37. Does your organization offer any programs to assist employees and family members in managing specific chronic diseases or conditions?
- Yes, first implemented in _____ (specify year)
 - No – skip to Q.42

38. If yes, which of the following conditions are addressed by the disease management (DM) program(s)? Check all that apply.
- Diabetes
 - Asthma
 - Chronic obstructive pulmonary disease (COPD)
 - Coronary artery disease (CAD)
 - Congestive heart failure (CHF)
 - Musculoskeletal/back pain
 - Arthritis
 - Maternity
 - Depression
 - Cancer
 - Other
 - We don't offer any DM programs – skip to Q.42
39. What types of disease/condition management interventions are provided? Check all that apply.
- Phone-based coaching and facilitation of care
 - Web-based coaching
 - Paper-based education
 - Onsite intervention (counseling, classes, etc.)
40. Does the program(s) include science-based behavioral change principles, such as readiness to change, commitment building, goal-setting, support/accountability system, recordkeeping, etc.?
- Yes
 - No
41. How are the disease/condition management program(s) provided to employees? Check all that apply.
- Through our health plan – standard services only
 - Through our health plan – some optional services
 - Through one or more specialty DM vendors
 - Through an onsite medical clinic
42. Does your organization offer any of the following disability and absence management programs? Check all that apply.
- Coordinated claim administration
 - Early intervention for active disability management/return to work
 - Disability case management by a medical professional
 - Care coordination (coordination of interdisciplinary medical team whose members may be located within different health systems)
 - Return-to-work program for occupational disabilities
 - Return-to-work program for nonoccupational disabilities
 - Vocational rehabilitation
 - None of these

43. Does your organization offer electronic personal health records to employees?
- Yes
 - No
44. Does your organization offer an EAP?
- Yes
 - No
45. Does your organization offer any non-executive employees the use of a worksite or near-site medical clinic?
- Yes
 - No – skip to Q.47
46. If yes, which of the following services are provided by your onsite or near-site medical clinic? Check all that apply.
- Work-related injury and illness care
 - Medical surveillance and regulatory exams
 - Primary care services (including acute, episodic care)
 - Pharmacy (including onsite dispensing services)
 - Physical and occupational therapy
 - Preventive screenings and/or immunizations
 - New-hire testing/periodic drug screening
 - Fitness for duty/return to work
 - Health education classes/services
 - X-ray
 - Dental services
 - Vision services

Section 5: Engagement methods

47. Do EHM communications include any of the following? Check all that apply.
- Annual or multiyear plan that articulates the key themes and messages to be conveyed
 - Multiple communication channels and media (newsletter, direct mailings, email, website, podcasts, etc.)
 - Year-round communication (on at least a quarterly basis)
 - Pre-launch communications (programs are marketed 60–90 days prior to launch)
 - Communications focused on purpose, components, value and deadlines
 - Communications branded with unique program name, logo and tagline that are readily recognized by employees as that of the EHM program
 - Regular stakeholder status reports (to inform employees, vendors, management, etc., of program progress)
 - None of the above

48. Does the organization play an active role in educating employees about the following? Check all that apply.
- Poor health habits and choices contribute to higher health care costs
 - Improving health contributes to better quality of life
 - The true cost of health care, such as charges for office visits, prescription drugs, surgery and other services, or the employer's share of premiums
 - The role consumers play in keeping health coverage affordable for themselves and the organization
 - How to appropriately access and utilize the health care system and their health plan
 - None of these
49. Taken altogether, how effective are employee communications in promoting employee engagement in EHM?
- Very effective
 - Effective
 - Not very effective
 - Not at all effective

Questions 50–59 ask about incentives used for specific EHM programs.

50. If your organization provides a health risk questionnaire (HRQ), do you offer any type of incentive to promote its use? Check all that apply.
- Don't offer an HRQ – skip to Q.53
 - No incentives used with the HRQ – skip to Q.53
 - Token non-cash reward
 - Intra-company competition for high HRQ participation
 - Cash/gift card
 - Raffles/prizes
 - Financial contribution to a health savings account (HSA)
 - Financial contribution to other employee spending accounts (flexible savings account or HRA)
 - Lower co-pays
 - Lower deductibles
 - Lower employee premium contributions
 - Participation on company time
 - Require HRQ completion to be enrolled in health plan
51. If you offer an incentive for completing an HRQ, what is the value of the incentive to the participant receiving it? For example, if you reduce the employee's premium contribution by \$100, you would enter \$100. Please provide the total annual value of the incentive, even if you provide the incentive incrementally.
- \$ _____ value of the incentive to participant
52. Are benefit-eligible spouses able to earn the HRQ completion incentive?
- Yes
 - No

53. If you provide a disease/condition management program(s), do you offer any type of incentive to promote participation and/or compliance? Check all that apply.

- Don't offer any disease/condition management programs – skip to Q.56
- No incentives used with this program – skip to Q.56
- Token non-cash reward
- Intra-company competition
- Cash/gift card
- Raffles/prizes
- Financial contribution to a health savings account (HSA)
- Financial contribution to other employee spending accounts (FSA or HRA)
- Lower co-pays
- Lower deductibles
- Lower employee premium contributions
- Participation on company time

54. If you offer an incentive for disease management participation or compliance, what is the value of the incentive to the participant receiving it? For example, if the premium is reduced by \$100, you would enter \$100. If you provide different levels of incentives for participation and compliance, please answer for the most common incentive (the one that is easiest to earn). Please provide the total annual value of the incentive, even if you provide the incentive incrementally.

\$ _____ value of the incentive to participant

55. Are benefit-eligible spouses able to earn the disease management incentive?

- Yes
- No

56. If a lifestyle management/behavior modification program(s) is offered, do you offer any type of incentive to promote participation and/or program completion? Check all that apply.

- Don't offer any behavior modification programs – skip to Q.59
- No incentives used with this program – skip to Q.59
- Token non-cash reward
- Intra-company competition
- Cash/gift cards
- Raffles/prizes
- Financial contribution to a health savings account (HSA)
- Financial contribution to other employee spending accounts (FSA or HRA)
- Lower co-pays
- Lower deductibles
- Lower employee premium contributions
- Participation on company time

57. If an incentive for lifestyle management program participation or completion is offered, what is the value of the incentive to the participant receiving it? For example, if the premium is reduced by \$100, you would enter \$100. If you provide different levels of incentives for participation and compliance, please answer for the most common incentive (the one that is easiest to earn). Please provide the total annual value of the incentive, even if you provide the incentive incrementally.

\$ _____ value of the incentive to participant

58. Are benefit-eligible spouses able to earn the lifestyle management incentive?
- Yes
 - No
59. Taken altogether, how successful are your program's incentives in encouraging employees to participate in programs, comply with treatment protocols and/or make responsible financial decisions regarding their health care?
- Very successful
 - Successful
 - Not very successful
 - Not at all successful
 - Too soon to tell

Section 6: Measurement and evaluation

60. Please indicate which of the following data are captured and used in managing the EHM program. Check all that apply.
- Participant satisfaction data are used to drive program improvement
 - Program participation data are used for reporting
 - Process evaluation data (contact, opt-out, withdrawal rates) are used to drive program improvement
 - Population health/risk status data (physical and mental health) are used to monitor health/risk status improvement
 - Health care utilization and cost data are analyzed to identify costly conditions and evaluate EHM impact on clinical outcomes, utilization and/or cost
 - Productivity and/or presenteeism data are used to evaluate EHM impact on health-related lost work time and overall productivity
 - Quality of outcome evaluation is conducted by independent experts using a control or comparison group; follow-up data are compared to baseline data; and statistical methods control for demographic differences
 - None of these data are collected
61. How often are program performance data communicated to senior management or other key stakeholders?
- Four times a year or more
 - Two to three times a year
 - Once a year
 - Performance data are not shared with stakeholders on a regular basis
62. Taken altogether, to what extent do you think that effective data management and evaluation contributes to the success of your organization's EHM program?
- Data management/evaluation contributes very significantly to our program's success
 - Data management/evaluation contributes significantly to our program's success
 - Data management/evaluation contributes somewhat to our program's success
 - Data management/evaluation does not contribute to our program's success

Programs outcomes

While this final section is *optional*, it is important. Information you provide here will not contribute to your organization’s best practice score. However, we hope that if you have data on program outcomes – participation rates and impact on health risks and medical plan cost – you will share them here to assist in efforts to explore the relationships between outcomes and program design. We invite you to use the comment box at the end of the survey to share your thoughts on how these questions might be improved.

Participation rates

1. Please provide participation rates for the following programs for your most recent full EHM program year. If you offer more than one type of program in a particular category (for example, separate DM programs for asthma or diabetes), please provide the participation rate for all programs combined and/or for any of the individual programs listed.

Health risk questionnaire

_____ % of eligible employees who completed a health risk questionnaire (please do not include spouses in the calculation, even if they are eligible)

Biometric screenings

_____ % of eligible employees who participated in any biometric screenings offered (for example, blood pressure, body mass index (BMI), blood glucose, cholesterol, etc.)

_____ % of eligible employees who participated in blood pressure screenings

_____ % of eligible employees who participated in BMI screening

_____ % of eligible employees who participated in blood glucose screening

_____ % of eligible employees who participated in cholesterol screening

Disease management

_____ % of identified persons actively engaged* in any disease management program offered

_____ % of identified persons actively engaged* in an asthma management program

_____ % of identified persons actively engaged* in a diabetes management program

_____ % of identified persons actively engaged* in a chronic obstructive pulmonary disease (COPD) management program

_____ % of identified persons actively engaged* in a coronary artery disease (CAD) management program

_____ % of identified persons actively engaged* in a congestive heart failure (CHF) management program

*Please provide the percentage of persons identified as having the condition who have completed at least one nurse call beyond the initial (or “welcome”) call.

Targeted behavior modification with phone-based coaching

_____ % of identified persons actively engaged* in any targeted behavior modification (lifestyle management) program offered

_____ % of identified persons actively engaged* in a tobacco-use cessation program

_____ % of identified persons actively engaged* in a weight-management program

_____ % of identified persons actively engaged* in a mental and emotional well-being program (including stress management)

_____ % of identified persons actively engaged* in a physical activity program

*Please provide the percentage of persons identified as meeting the risk criteria who have completed at least one coach call beyond an initial enrollment (or “welcome”) call. Please do **not** include participation in face-to-face, online or paper-based programs.

Program cost

2. If you have calculated the total cost of your organization's EHM activities, please provide the cost per eligible person per month (for the current program), excluding any incentives provided. (If you have not aggregated all or most costs associated with your EHM program, but you can provide costs for separate program components, please skip to Q.4 below.) Please include the cost for wellness programs, health promotion, health management, nurse advice line, medical decision support, disease management and any other EHM activities. Do not include health and disability plan costs.

\$ _____ per eligible per month for all or most EHM programs

3. In addition to typical program/service costs (fees paid to health plan carriers or specialty vendors), are any of the following costs included in this amount? Please check all that apply.

- Program/product development
- Dedicated staff (internal or vendor-provided)
- Consultant fees
- Printing and/or postage
- Onsite fitness facilities
- Onsite medical clinic or pharmacy
- Flu shots
- Other (please specify)
- None of the above

4. If you can provide a separate cost per eligible person per month for any of the four program components listed below, please provide those as well as (or instead of) the total EHM cost requested above.

\$ _____ per eligible per month for health risk questionnaire

\$ _____ per eligible per month for biometric screenings

\$ _____ per eligible per month for all disease management programs

\$ _____ per eligible per month for all targeted behavior modification (lifestyle management) programs

Program impact on health risk and medical plan cost

5. If you indicated in Section 6: Measurement and Evaluation that you attempt to measure EHM program outcomes, what are your results to date? Please provide results for the longest period for which you have data and specify the approximate length of the period used below:

- Less than a two-year period
- Two-year period
- Three-year period
- Four-year period
- Five-year period
- Six-year period or longer

Employee health risk

- No improvement in health risk was found so far
- A slight improvement in health risk was found
- A significant improvement in health risk was found
- We have not attempted to measure change in health risk
- We have attempted to measure, but we're not confident that the results are valid

Medical plan cost

- No improvement in medical cost trend was found so far
- Small positive impact on medical trend (less than the cost of the EHM program)
- Substantial positive impact on medical trend (greater than the cost of the EHM program)
- We have not attempted to measure impact on medical plan cost trend
- We have attempted to measure impact on cost, but we're not confident that the results are valid

More information about the HERO Best Practice Scorecard

Background

The HERO Best Practice Scorecard is designed to help employers, providers and other stakeholders learn about and determine employee health management best practice. Earlier versions of the Scorecard have been available since 2006. It was developed in consultation with authoritative sources on EHM best practices, including The Health Project's C. Everett Koop National Health Awards criteria, the WELCOA Well Workplace Awards criteria (Platinum level), Partnership for Prevention's Health Management Initiative Assessment, and the Department of Health and Human Services' Partnership for Healthy Workforce 2010 criteria. Selected elements from these sources were considered in the original construction of the Scorecard; however, most Scorecard content originated with the HERO Think Tank Task Force for Metrics. This rigorous development process was continued with the design of the current Scorecard (Version 3.0), which included input and peer review from HERO Think Tank members, Mercer Total Health Management Practice leaders and other national authorities on EHM best practice programs (see page 20 for a list of contributors).

HERO Best Practice Scorecard in collaboration with Mercer

HERO and **Mercer** have created a working collaboration to develop the HERO Scorecard Version 3.0 and create, co-own and operate a large-scale EHM benchmarking and best practice normative database. After an adequate number of organizations have provided benchmarking data, this database will permit organizations to compare their program practices with benchmark groups they select based on industry, size, geographic location or other criteria. Such comparisons will enable contributors to benchmark their programs against like organizations and also further the industry's understanding of best practice approaches to EHM.

The process of defining best practice divides EHM programming into critical core components, that are featured in the six sections of the Scorecard:

- Section One: Strategic planning
- Section Two: Leadership engagement
- Section Three: Program level management
- Section Four: Programs
- Section Five: Engagement methods
- Section Six: Measurement and evaluation

All sections represent foundational components that support exemplary EHM programs. While the inventory is not a comprehensive list of all elements that could comprise an EHM program or associated measures of success, these elements represent those most commonly recognized among industry thought leaders and in published literature. A separate Program Outcomes section is included to serve as a guide for a "dashboard" of measures (or metrics) that may be useful in assessing program success. Information in this section will not contribute to an organization's best practice score but will be used and expanded over time to develop outcomes benchmarks.

Uses for the Scorecard

Level 1 – As an inventory

At its most basic level, the Scorecard can be used as a simple program inventory to guide strategic planning. In each of the six sections, representing six foundational elements of an EHM program, the questions serve as a checklist of best practice in that area. In addition, the metrics included in the Program Outcomes section of the Scorecard may be used as a starting point for the development of a "dashboard" approach for measurement of program success.

Level 2 – As an indicator of program success

Exemplary EHM programs are those that are successful in attracting and retaining eligible program participants, providing programs that are satisfying for participants, improving the health status of the population, and achieving a positive return on investment after several years of programming. The free report you receive upon submitting a completed Scorecard, comparing your organization's scores to the aggregate scores of all employers in the Scorecard database, will help you identify opportunities to incorporate best practice approaches into your program.

Level 3 – As a comparative/benchmarking tool

The Scorecard asks detailed questions about employers' EHM program design, administration and experience. It also includes a number of demographic questions that, as the database of Scorecard responses grows, will permit increasingly precise benchmarking. The Scorecard database will be used to produce benchmark reports that will allow employers to compare their programs to those of similar employers, based on industry, size, geographic location, employee demographics or other criteria. These benchmark reports will be available for purchase after the database reaches the minimal threshold size required for valid comparisons. We anticipate that this powerful normative database will also be used to support research on best practices in EHM.

Data confidentiality

Your individual responses to the Scorecard will be kept strictly confidential. The online Scorecard data collection tool and automated scoring system are maintained by a third-party vendor and hosted on its servers, under the supervision of Mercer. Aggregated data with no individual company identifiers will be used for normative and research purposes, and aggregate results of research studies may be published. Any use of your individually identifiable data for research or other purposes will require your prior written consent.

Understanding your score

After you submit your data to the online Scorecard, you will receive a score for each of the six sections and an overall score. While the scoring system is based on a maximum number of 200 points, the highest score attained when the system was tested on a number of programs was 160 for a very advanced and widely acclaimed program. We don't anticipate that any program will ever receive the maximum score of 200; a program that includes every possible element of an EHM program is neither likely nor probably even desirable, since not all scored elements are appropriate for all organizations! *We recommend that your organization's score be considered relative to those of peer organizations or to emulator organizations.*

How the scoring system was developed. A panel of EHM authorities from a variety of organizations assisted in developing the scores using a consensus-building exercise. We began with a proposed maximum score of 200. Each panel member was asked to distribute these 200 points across the six sections of the Scorecard, based on their judgment about the relative importance of each foundational component to a successful EHM program ("successful" was defined as able or likely to improve total health care spend). The maximum section scores were then distributed across the items within each section using the same criteria. Finally, the maximum item scores were distributed across the individual responses in each item in each question. The panel members' scores were aggregated and either the mode or the average (mean) score, as appropriate, was used as the final score.

As with previous versions of the Scorecard, the contributors to the scoring system for version 3.0 engaged in robust debate and discussion. Given the lack of solid research evidence to support or refute the presumed impact of the individual programmatic elements on health care cost spend, the contributors offered their proposed scores based on the best research and anecdotal evidence available, recognizing that more definitive research will lead to ongoing refinement of the relative weighting of the scores. For now, the elements with higher maximum scores can be considered promising practices that the contributors believe achieve their greatest impact only as part of a comprehensive EHM strategy.

Please visit the HERO website at www.the-hero.org to see the maximum scores assigned to each section, item and response item in the Scorecard.

Invitation to contribute feedback

If you would like to communicate with the HERO Think Tank about this version of the Scorecard, please do so by sending an email to info@the-hero.org, with

“Scorecard” in the subject box. We welcome your reactions, comments and suggestions for improving the Scorecard, as well as ideas for applications for the Scorecard. All replies will be acknowledged and considered confidential. Thank you!

HERO Scorecard contributors

Scorecard revisions

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Sample email reply with your score

From: scorecard@the-hero.org [mailto:scorecard@the-hero.org]
Sent:
To:
Subject: HERO Scorecard results

Thank you, again, for submitting the HERO Best Practice Scorecard.

Here are your organization's scores.

Section	Your score	National average	Maximum points
Section 1: Strategic planning	6	5	11
Section 2: Leadership engagement	20	17	33
Section 3: Program level management	15	10	22
Section 4: Programs	38	27	56
Section 5: Engagement methods	47	27	67
Section 6: Measurement and evaluation	5	4	11
Total score	130	90	200

Understanding your score

While a score of 200 is theoretically possible, it is not likely nor even desirable for an employer to have every possible EHM program and strategy in place. The greatest value of the Scorecard is in providing an inventory of EHM best practices for consideration; your scores simply provide an indication of where you might find opportunities to enhance your program. Average scores vary based on employer size, and it might be most useful to compare your score to those of employers of similar size. Looking at the 443 employers that have completed the Scorecard as of December 31, 2010, respondents with fewer than 500 employees have an average total score of 71; those with 500–4,999 employees have an average total score of 91; and those with 5,000 or more employees have an average total score of 101.

These average scores will be updated quarterly to include new respondents and posted on the HERO website at www.the-hero.org/.

Complete Scorecard results now available!

Benchmark reports that show the aggregated results to every question in the Scorecard are now available for purchase on the HERO website. These reports go beyond the scores to show the prevalence of each of the best practices included in the Scorecard. Reports include results broken out by industry and employer size, to answer such questions as: What percentage of manufacturing respondents provide a worksite medical clinic? What is the average dollar value of incentives for HRA completion? What's the average participation rate for disease management programs among health care employers?

To find out more, visit the HERO website at www.the-hero.org. If you would like to communicate directly with the HERO Think Tank about this version of the Scorecard, please send an email to info@the-hero.org, with "Scorecard" in the subject box. We welcome your reactions, comments and suggestions for improving the Scorecard, as well as ideas for application for the Scorecard.

If you have questions or concerns about this email, please contact www.the-hero.org.



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our websites at:

www.the-HERO.org
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