Leading by Example

CREATING A CORPORATE HEALTH STRATEGY:
The Kansas City Collaborative Experience
Rapidly increasing health care costs and decreased productivity due to poor employee health continue to be major issues for employers. In the past decade, a consensus has formed that health and well-being need to be part of the business strategic imperative. Therefore, employers must integrate health into the core of their business, aligning workplace policies and procedures with the vision of each organization.

Since its inception, Partnership for Prevention’s Leading by Example initiative has been a highly successful peer-to-peer communications campaign targeted to CEOs of organizations of all sizes on the value of worksite health promotion. CEOs who have incorporated new, successful approaches to employee health and productivity share their experiences and knowledge with other CEOs and business leaders.

We are pleased to present Creating a Corporate Health Strategy—The Kansas City Collaborative Experience. This 2011 Leading by Example publication highlights a health strategy initiative sponsored by the Mid-America Coalition on Health Care (MACHC), the National Business Coalition on Health (NBCH), and Pfizer Inc. This document describes the culmination of three years of work by 16 diverse employers headquartered in the Kansas City Metro area—the Kansas City Collaborative (KC²). The Collaborative has now evolved into the American Health Strategy Project, helping other coalitions across the country empower their employers to adopt and further apply the tools and methods originally developed as part of KC².

The Collaborative used existing data to support corporate health strategies and drive decision-making around workforce health and wellness, promoting prevention, eliminating barriers to healthy behaviors and encouraging use of evidence-based health care. “Real world” examples from 13 of the participating employers provide others the opportunity to identify processes and practices that may be relevant and impactful within their organizations. Leading by Example and KC² have a complementary goal: leveraging the “C-suite” to generate organizational action in primary prevention and disease management.

Partnership for Prevention, MACHC, NBCH and Pfizer are proud to have jointly developed this guide as a powerful tool for companies and public health entities invested in the health of their organizations and communities. We encourage you to review the information and case studies in this publication and consider adopting strategies that support health initiatives within your environment and corporate setting. The employers represented here truly “lead by example.”

Christine T. Wilson, JD
President and CEO
Mid-America Coalition on Health Care

Andrew Webber
President and CEO
National Business Coalition on Health

Jud Richland, MPH
President and CEO
Partnership for Prevention
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In 2008, the Mid-America Coalition on Health Care and 16 of their employer members recognized that companies were increasingly paying for more health care without unlocking its full value. In the United States, employers fund approximately 60% of healthcare, but do so without understanding fully how to measure the return on their investments. As health care costs continued to rise, the employers recognized the value of tailoring benefits to the specific health risks common among their workforces and their covered dependents.

Historically, the employers did not have the ability to understand the complete picture of their unique populations' health due to a multitude of issues related to:

- Structure and integration of internal health management teams, including:
  - Communication barriers within and across functional lines
- Poor integration and collaboration between external partners
- Employee engagement
- Access to, understanding of, and ability to synthesize various health-related data:
  - Benefits and program participation data
  - Population health measures
  - Productivity and absenteeism

With the leadership of the Mid-America Coalition on Health Care (MACHC), these Kansas City employers, representing a total of 358,000 covered lives, embarked on a journey to improve workforce health through better aligning health benefits and developing a range of interventions that offer high value. The employers involved in the project were diverse in their size, industries, geographical reach and structures. MACHC and the National Business Coalition on Health (NBCH), in collaboration with Pfizer Inc, which provided financial and technical support, launched the KC² program focused on using value-based benefits concepts and “real world” principles to help employers, both large and small, to improve the health of employees and their families, to promote employee wellness, and to manage long-term health care costs through sophisticated benefit strategies and health improvement programs.

The project was centered on four core principles.

To participate in the project, an employer had to subscribe to these four principles:

- A strong health management team and
- Actionable data
- Will foster healthier, more productive employees and
- Achieve higher value for every dollar invested

These principles created the foundation of the models, processes, educational resources and tools that were developed throughout the project. This document is structured around these core principles, and employer cases demonstrate where and how they were put into practice.

A structured, data-driven learning process (Figure 1) encouraged each employer to look at its own organization's high-level summarized, aggregate data (blinded, not individual employee-level data) from a variety
of sources, including health claims, workers’ compensation claims, employee assistance programs, health risk assessments and pharmacy benefits. Employers then determined those health strategies that would be most helpful in directly addressing the identified health risks in their specific workforce, identified and implemented interventions and ultimately, evaluated outcomes. This approach was grounded in process improvement theory with application to employee health and wellness. A model (Figure 2) of supportive education and tools was developed to guide employers through three phases, including employer activation, value-based benefit intervention design and implementation, and evaluation of outcomes.

**ACTIVATING EMPLOYERS**

The first phase involved activating employers to stimulate dialogue with senior leadership and ensure a common understanding of value-based benefit design across and within participating employers. Educational forums, leveraging the knowledge of national experts and built around facilitated, collaborative foundational discussions, were conducted to ensure a consistent understanding and common language around the initiative. Employers undertook a series of initial assessments to gain a better understanding of the current state of employee health and productivity in their organizations, available data sources, vendor integration and offerings, and the impact of employee health interventions. The initial assessment included:

- Completion of a baseline survey
- Individual interview with project team
- Data source identification and mapping exercise
- Completion of employer data tracker

A synthesis of this initial assessment was documented in both an individual employer report and an aggregate report. Both were provided back to participating employers to help guide subsequent phases of the project. The assessment also provided a baseline with which to evaluate the results of the project.
IDENTIFYING AND IMPLEMENTING
VALUE-BASED BENEFITS

The second phase of the model guided employers through designing corporate health-related goals and objectives, and strategies and tactics that aligned incentives for desired health-related behaviors and removed barriers to evidence-based screenings and interventions with a focus on evaluation planning. Based on the baseline assessment and the predominant conditions common across employers, the KC² employers collectively selected cardio-metabolic risk as their area of focus. Employers were asked to identify feasible interventions for their individual worksites that were employer-specific, measurable, evidence-based and optimized outcomes. They chose goals and interventions that were grounded in their specific data to improve identification, prevention and/or adherence to a therapeutic regimen in any one or more of five population health areas:

- Overweight/obesity
- High blood pressure
- High blood cholesterol
- High blood sugar
- Smoking

Additionally, employers chose from two business health-related goals:

- Making health a core business strategy
- Participating in building a healthier community

Educational offerings, tools and resources provided guidance and opportunities for peer-to-peer interaction and were grounded in evidence-based literature and best practices.

OUTCOMES

Thirteen out of 16 employers remained engaged throughout the life of the project. The final phase of the initiative determined the effectiveness of the interventions by comparing post-intervention with baseline measures. Employers completed a scorecard document to evaluate intervention-related data, thus tracking progress toward their designated intervention goals. Through case studies and platform presentations, we were able to share individual employer results as well as a high level project summary of what KC² accomplished in the aggregate.

Employers were encouraged to develop a health-related data strategy. Therefore, each assessed the value and utility of the data they collected. However, not all employers utilized the same metrics. Additionally, some employers elected to eliminate and/or add metrics during the course of the project based on the value these brought to each of their organizations. Results in this document are summarized categorically and based on populations achieving an overall metric (e.g., employer-defined goal attainment), rather than focusing on results for specific individual measures.
Quality improvement initiatives and systems change efforts have the greatest chance of success and sustainability when implemented by a strong multi-disciplinary team. This principle holds true for making changes to the way health interventions and benefit programs are managed.

**LEADERSHIP SUPPORT**

In his book *Zero Trends: Health as a Serious Economic Strategy*, Dr. Dee Edington, of the University of Michigan, describes five pillars that are fundamental to creating, supporting and sustaining a successful health strategy. These pillars involve integrating the health management strategy into the environment and culture of the organization to create a true “Culture of Health.” As with other *Leading by Example* publications, senior leadership, C-suite

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**KC² CORE PRINCIPLE:**

**Strong Health Management Team**

**KEY COMPONENTS**

- Leadership support and multidisciplinary in nature
- Integration of vendor partners
- Expanded view of who is considered an external partner
- Inclusion of employees as part of the team

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**FIGURE 3:**

**EMPLOYER DATA MAP**

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**DATA GAPS**
support, and a clear, shared vision for employee health and wellness are imperative to the success of corporate health initiatives. In the KC² project, leadership support and involvement came from all levels within an organization.

**MULTIDISCIPLINARY PERSPECTIVE**

The primary employer representatives for the project were health benefit management professionals. However, throughout the project a variety of individuals participated. Internal silos within organizations frequently existed; participating employers were urged to include team members from other departments such as risk management, safety, payroll, middle managers and potentially employee representatives to increase the frequency and importance of communication throughout all levels of the organization. Employers reported that building a well-rounded health management team that included diverse representation helped make health management a core business function.

**VENDOR INTEGRATION**

According to an annual Hewitt survey described in *The Road Ahead: Driving Productivity by Investing in Health*, 80% of employers surveyed indicate that integrating vendor information and program design is important to improve the health of covered individuals. To get the most out of their vendor relationships, it is important for health management professionals to incorporate their vendors as partners and as an integral part of their health management team. Employers can better integrate and maximize service offerings across vendors, and define opportunities to improve the value of health interventions by working with their vendors as partners. Together, they can work toward shared goals for employee health management. Integrating

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**COMPANY OVERVIEW**

- Type of industry: Health care and social assistance
- Number of employees: 6,100
- Self-insured full consumer directed health plan
- Primary KC² Goals: Weight management; physical activity; nutrition; environmental change

**KEY WELLNESS PROGRAMS**

- Health Management Team encouraged increased physical activity through availability of internal stairwells and installation of a walking trail at neighboring park.
- Health Management Team worked closely with cafeteria vendor to: 1) post nutritional information in cafeteria and on intranet; 2) implement pricing strategies to encourage healthier purchases; 3) reduce portion size; and 4) replace high-calorie cooking methods with healthier, low-calorie methods.
- With assistance from the Health Management Team, the Food Service department established a Community Supported Agriculture (CSA) Program, which increased consumption of fresh fruits and vegetables through a nearby parking lot drive-through location.

**HIGHLIGHTS**

- Employees walked more while at work.
- Improved employee nutrition with the salad bar as the centerpiece of the cafeteria, with fresh, low-calorie, and, when possible, locally grown fruits and vegetables
- One of the largest CSA sites in the region

**Randal L. O’Donnell, PhD**

President and CEO

*As a health care organization, we strive to be a leader in promoting healthy lifestyles for everyone, beginning with our own employees. We have launched a comprehensive initiative to create a culture of health at Children’s Mercy and are taking numerous steps to encourage our staff in making positive changes in their own health. Our staff can then serve as examples and role models to the children and families we serve. The changes we have made, such as healthier options in our hospital cafeteria and the park and walking trail immediately adjacent to the hospital, benefit not only our own staff, but also the patients and families who are cared for at Children’s Mercy.*
vendors can also assist in providing employees with a coordinated approach to messaging and education. The Data Source Identification and Mapping Process, one of the baseline assessment activities, assisted participating employers in identifying their vendors, vendor relationships and data flow, as well as the reporting frequency. The resulting “Employer Data Map” (Figure 3) generally revealed a complex environment with numerous handoffs and an opportunity to improve communication, collaboration and integration among internal and external partners.

EXTERNAL PARTNERS

Edington provides guidance during discussion of the operational leadership pillar, on whom to consider and include as a partner, and what their role should be. External partners can provide expert guidance and support. Health plans, benefit consultants, primary care physicians, pharmaceutical companies, health enhancement companies, health systems, and community and state governments should be thought of as partners, not vendors. Partnership denotes a sharing of goals and creates an environment of mutual understanding and shared commitment. Chris McSwain, a pioneer in vendor integration efforts, provided an educational session and workshop for the KC2 employers that led many to focus on implementing vendor partnership initiatives. Subsequently, the Integrated Benefits Institute (IBI), working with Johnson and Johnson, has developed a DVD, Winning Together: Turning Vendors into Partners for Workforce Health and Productivity, that can help assist employers with creating vendor partnerships.

KC2 employers engaged a variety of vendor partners in planning and implementing their interventions.
Brokers/consultants, health plans, wellness partners and pharmaceutical companies were a few of the partners that worked collaboratively with the employers throughout this project to design, implement and evaluate the impact on the health of their population. Many partnerships were solidified and several new ones were formed over the course of the project.

**Inclusion of Employees**
Employees are also critical members of the health management team. According to Edington’s third pillar, employees must be empowered to become self-leaders in their health status and overall well-being. Not unlike other employers, employee participation and engagement was a concern for all KC² employers. Wellness teams and focus groups were instrumental in soliciting information from employees regarding programming, motivation and engagement. Senior leadership support, development of a cohesive wellness team and creating a supportive culture are three of WELCOA’s 7 Benchmarks.⁸

**Baseline Findings:**
- 92% of participating employers reported no concerns over leadership support.
- Only 18% were involved in vendor partner integration efforts.
- Peer-to-peer sharing was one of the core reasons for participation in MACHC initiatives.

**Follow-up Results:**
- 100% of employers implemented interventions to address corporate culture and health management team.

**Company Overview**
- Type of industry: Financial services
- Number of employees: 14,800
- Self-insured
- Primary KC² Goals: Cancer prevention; weight management; addressing high cholesterol; addressing high blood pressure

**Key Wellness Programs**
- Employee engagement by health management team in decision making about health issues, using online tools, a plan cost estimator, and a generic prescription plan.
- Medical plan choice offered and highly incentivized with employee deductible health plans.
- Wellness activity rewards with incentives for non-tobacco use discounts, premium credit and cash for wellness program participation, and utilization of network providers.

**Highlights**
- Health risk assessment participation rates increased 27% from baseline in 2011.
- Screening participation rates increased 178% from baseline in 2010.
- The percentage of employees at high risk (>5 risks) decreased from baseline of 16% to 9% in 2010.

**Tammy Serati**
Senior Vice President, Human Resources

At H&R Block, we are true believers in designing our benefit programs to fit the unique composition of our workforce—full time, part-time and seasonal associates. We seek to offer a health program that provides relevant plan offerings to our workforce which ensures associate engagement including their active involvement in preventive and wellness programs that drive productivity at work... and also at home.
When employers are able to collect and organize data in a way that “builds a base of reliable facts,” they can then analyze the data for major trends identifying and classifying health risks and subsequently make decisions about interventions.7

THE RIGHT DATA
Research has revealed that health-related productivity costs may be more than 4 times greater than medical and pharmacy costs combined. Despite this, health care claims are often the only data used to understand the impact of poor health on corporate operations. According to the 2008 annual employer health care survey conducted by Hewitt Associates, 75% of employers are measuring their behavioral health program through utilization and cost metrics alone, while only 15% of employers are measuring their behavioral health program using measures of effectiveness such as productivity, absence, disability and overall health care costs.2 Through an intense data collection and identification process, the KC2 employers were able to determine what data they collectively had access to and where opportunities for improvement existed.

The wide range of data that typically are available to help employers make health decisions is included in Figure 4.

**Figure 4: Employer Potential Data Sources**
Source: KC2 Project Advisor, Jack Mahoney

| Demographics | Disability Claims |
| Health Risk Assessments | Short-Term Disability |
| Biometric Screenings | Long-Term Disability |
| Medical Claims | Disease Management |
| Pharmacy Claims | Program Enrollment |
| | Workers Compensation Claims |
| | Employee Assistance Program |
| | Employee Satisfaction and Survey Participation Rates |
| | Incidental Absence, Sick Leave, Paid Time Off |
| | Family Medical Leave |
| | Productivity, Absenteeism and Presenteeism |
| | Workplace Safety |
Experts suggest considering a range of data sources or “building blocks” when looking for the RIGHT data to determine how and what health risks can be impacted.\(^6\)

Data sources for absence and productivity were frequently not available to the participating employers. Additionally, other internal data sources, for example claims data on short- and long-term disability, workers compensation and family and medical leave, were not routinely utilized by the health management professionals who were involved in the project.

**Utilize Data to Determine Health Risks and Make Decisions**

Sixty-three percent of employers indicated in a Hewitt study that they would let health care data and measurement drive their health-related strategy in the next 3 to 5 years.\(^4\) However, data alone do not impart knowledge or understanding. Relationships and associations between different data elements need to be analyzed and synthesized to effectively drive benefit and programming decisions that yield value to an organization.\(^7\)

To assist participating employers in understanding their population health risks and inform intervention decisions during the baseline assessment for the KC\(^2\) project, a standardized spreadsheet tool called The Employer Data Tracker, EDT (Figure 5) was used to...

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**Figure 5: Sample from Employer Data Tracker (EDT)**

Source: KC\(^2\) Project Team

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**Company Overview**

- Type of industry: Public administration/government
- Number of employees: 3,407
- Partially self-insured
- Primary KC\(^2\) Goals: Tobacco cessation; weight management; addressing high blood pressure

**Key Wellness Programs**

- Smaller venue locations for health risk assessments and screening
- Strong focus on weight management and blood pressure wellness programs
- Tobacco cessation pilot program in 2009; full tobacco cessation benefit implemented in 2010

**Highlights**

- HRA participation increased 17% over 3-year period (2007-2009).
- Health screenings increased 250% over same 3-year period.
- Weight management program
  - Participants lost 35% more in 2009 compared to previous year
  - 444 employees either maintained or lost weight during the 7-month challenge.
  - 70 employees lost 5% or more of body weight.
  - 12 employees lost 10% or more of body weight.
  - Percentage with appropriate BMI levels increased from 15% in 2008 to 17% in 2010
  - Percentage with non-hypertensive blood pressure increased from 73% to 81% over 2-year period (2008-2010).
  - Percentage of non-tobacco users increased from 76% to 79% over same 2-year period.

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**Sly James**

Mayor

Not unlike most municipalities, Kansas City, Missouri, employs a diverse workforce across a large geographical area. Our focus on increasing access to our health-related programming has had a dramatic impact on our participation rates. More importantly, we believe this has led to healthier, more productive employees.
facilitate data collection and organization. The employers were instructed to utilize the information that they routinely receive from their health care and data partners rather than to request additional information from these third parties. The level of data completeness varied considerably across participating employers. The resulting data were aggregated into a report that was shared with all participating employers to help guide the project.

Additionally, each employer received an individual summary report from all of the baseline assessments with benchmarks for their industry. These reports identified relationships, and consistencies and inconsistencies in the information provided by the employers. Additionally, it was put into context with the rest of the information from collaboration participants with potential opportunities for action.

In the book *Zero Trends*, Edington writes that there is a natural flow from low to high that applies to both health risks and costs. To stem this natural tide toward worse health or more costly care it is imperative that organizations develop strategies to help people at low risk for health problems to stay low risk and to reverse or slow the flow of individuals from low risk to high risk of disease.  

**USE DATA TO MEASURE AND DEFINE THE VALUE OF INVESTMENT**

Despite a corporate tendency to define and assess value in monetary terms, the number of employers using hard dollar return on investment calculations as part of health care decision-making has risen over the past 3 years by only 5%. Fifty-four percent of consistent performers, defined as those organizations that have been able to maintain health care trends at or below the norm on the NBGH/Towers Watson survey year-over-year, report that they base decisions on independent estimates of financial savings and return on investment.  

There are several limitations inherent in determining causality for many health outcomes achieved as well as for defining the value of investment in benefits, which change annually. These limitations need to be kept in mind:

- Programs most often aren’t initiated in isolation, but rather occur in a broader, complex context.
- Many vendors provide similar solutions, so determining the impact of one versus another is difficult.
- Many outcomes are measured at the aggregate population level, rather than at the level of individual participants who are not a homogeneous group.

The evaluation workbook and scorecards created as part of the Kansas City Collaborative were intended to provide employers with tools to track and trend a variety of metrics over time, to determine short, intermediate and long-term measures and to create a plan to define and measure value. The metrics outlined in these tools were intended for use in messaging the value of investments to senior leadership within an organization. Many participating employers have also shared their experiences and findings at national forums and through case studies. The content highlighted their particular set of interventions, benefit designs and the settings in which they are implemented.
RECOGNIZE AND ADDRESS PRIVACY CONCERNS ABOUT THE USE OF DATA

Employers must be aware of a number of anti-discrimination and privacy laws at both the federal and state level, such as Health Insurance Portability and Accountability Act (HIPAA), Genetic Information Nondiscrimination Act (GINA) and Americans with Disabilities Act (ADA). Compliance is non-negotiable. Additionally, many employees harbor privacy concerns about disclosing personal health and risk factor information with their employer. Changing the dialogue to one of health and wellness or vitality instead of focusing on disease can enhance trust. The KC2 participating employers had the same issues and concerns, however they persevered through collaboration and peer networking. Participants learned how to address employee concerns and how to work with in-house legal counsel to ensure compliance with applicable state and federal laws.

BASELINE FINDINGS:

- 23% of participating employers reported access to data was a barrier to implementing value-based benefits.
- Fewer than half of all participating employers were able to access data on absenteeism, short- and long-term disability, family medical leave and workers compensation.
- All KC2 employers participating in the baseline assessment have access to self-reported data obtained through health risk assessment (HRA) and biometric data from health screenings, available either in-house or obtained from vendors.

FOLLOW-UP RESULTS:

- 100% of employers implemented interventions to improve access to or utilization of data.

COMPANY OVERVIEW

- Type of industry: Academic medical health care organization
- Number of employees: 5,500
- Health Maintenance Organization; Preferred Provider Organizations (2 options available); and supplemental medical plan that allows members to use hospital facilities and providers at a reduced out-of-pocket cost
- Primary KC2 Goals: Weight management; addressing high blood pressure; addressing high cholesterol

KEY WELLNESS PROGRAMS

- Revised benefit design with credits towards employees’ health care premiums for participation in health and wellness programs
- Implementation of outcomes-based incentive strategy focused on weight management
- Incentives structured around three scenarios (within national BMI guidelines, outside national guidelines, late participation) that matched options to employees’ personal situations and defined next steps

HIGHLIGHTS

- Positive employee response to new health messages and wellness program
- Incentive program and communications campaign contributed to significant increases in both health risk assessment and biometric screening participation rates for 2 straight years

ROB PAGE
President and CEO

We participated in this program because we wanted our employees to take care of themselves with the same passion as they care for our patients. We are pleased to report our employees improved their overall health and well-being last year by surpassing University of Michigan benchmarks in 13 out of 14 risk factors, increasing their overall wellness scores, and reducing both their waist circumferences and blood pressure levels. The University of Kansas Hospital employees reduced the number of personal risk factors, which according to industry standards, should show an annual savings of $2,414,030 on our medical plan spending, accompanied by gains in productivity.
KC² CORE PRINCIPLE: Healthier, More Productive Employees

KEY COMPONENTS
- Align the continuum of health
- Address your employee health risks
- Identify opportunities to address utilization and cost

A comprehensive understanding of health, from health promotion through disease management, can facilitate the design and implementation of effective interventions. By approaching health management with an awareness of this continuum, employers can more effectively align incentives and high-value services that will, in turn, more effectively manage the health risks of their workforce. An integrated approach to total health management involves designing a health strategy that is intentionally designed to meet a variety of needs and utilizes different methods to reach participants based on where they are in the health continuum.¹¹

ALIGN THE CONTINUUM OF HEALTH
Using actionable data, participating employers were able to classify employees into stages on the continuum of health and develop interventions that address varying levels of intervention needed to reduce risk.

In a 2010 report, the CDC notes that chronic diseases accounted for 7 out of 10 deaths and that almost 50% of Americans live with at least one chronic disease. Treatment for individuals with chronic disease is thought to account for more than 75% of the $2 trillion spent annually on medical care in the United States. Much of chronic disease can be attributed to preventable health risk factors such as tobacco and excessive alcohol use, insufficient physical activity and poor nutrition.¹²
Preventive care continues to be underutilized in spite of its availability and evidence showing that timely preventive care is beneficial. One source revealed that in 2005 half (52%) of adults received preventive care and screenings according to guidelines for their age and sex.¹³

**ADDRESS YOUR EMPLOYEE HEALTH RISK**

The baseline assessment of health care claims data revealed several common disease states, including cardiometabolic risks, depression, respiratory disorders and musculoskeletal pain. Through group dialogue, the KC² participating employers reached consensus that cardiometabolic risks would be the selected population health “condition” of focus, with employers planning a vast array of interventions to address overweight and obesity, high blood pressure, high cholesterol, high blood sugar and smoking in their populations (Figure 6).

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| # (%)       | 10 (78%) | 9 (69%) | 5 (38%) | 5 (38%) | 6 (46%) |

**FIGURE 6: SPECIFIC EMPLOYER POPULATION HEALTH CONDITION TARGETS**

Source: KC² Project Team

**COMPANY OVERVIEW**

- Type of industry: Professional association
- Number of employees: 375
- Fully insured
- Primary KC² Goals: Weight management; addressing high blood pressure

**KEY WELLNESS PROGRAMS**

- Vendor collaboration to increase employee participation in health risk assessments (HRAs), health screenings, and telephonic coaching
- Premium discounts for participation in health and wellness programs

**HIGHLIGHTS**

- HRA and health screening participation both increased 29%.
- Self-reported weight management behavior change
  - Nearly 3 times as many employees above the goal planned to lose weight in next 6 months.
  - Five times as many employees above the goal planned to increase physical activity in next 6 months.
- Percentage of employees in the high risk category decreased by almost 5%, with those in the low-risk category increasing by about the same amount (percentage of employees at medium risk remained relatively the same).

**DOUGLAS E. HENLEY, MD**

Executive Vice President and CEO

*Family physicians recognize that good health starts at home. By providing onsite health risk assessments and screenings for our employees, we have been able to raise their awareness of potential health risks and encourage them to follow up with their personal physicians. As a result, we have been able to contain our overall health case costs and have experienced below-norm annual insurance increases. Furthermore, the aggregate data we receive from the health screenings helps guide us in the development of targeted wellness initiatives—both internally and in conjunction with our insurance provider.*
The project team wanted to ensure that employers had a similar understanding of how prevention and risk reduction occurs throughout the health continuum. The bullets below outline three stages along the continuum where interventions could be targeted.

- **Health promotion** is an intervention that targets the entire workforce, regardless of health status, seeking to prevent risk factor development. Health promotion can include wellness offerings for the entire workforce, policies and interventions around healthy eating and increased physical activity, and health education campaigns. Interventions in this area were designed to prevent risk through health environments and behaviors.

- **Primary prevention** is targeted to those employees who have already developed at least one risk factor but have not developed a chronic condition or had an acute event due to this risk. The goal of primary prevention is to prevent development of these costly, usually life-long conditions, and may include targeted screenings, referrals and medication adherence programs. Most interventions here involved identifying risks, engagement with the health care system and adherence to a regimen.

- **Secondary prevention** addresses the needs of the subset of employees with established conditions. Its goal is to better manage the condition to prevent further complications or a second acute event. If not controlled, this sub-set of employees can have a significant impact on disability claims and absence management. Employers can address this through disease management and medication adherence programs. Interventions here were on adherence to a regimen.

The participating employers were led through a structured planning process based on their data to design and implement key intervention types that were defined by the coalition and project team.
The intervention types were:

- Health management team
- Actionable data
- Environment and policy
- Benefit design
- Employee engagement
- Vendor and provider value

Tools and materials were developed to assist the participants in this planning process and include:

- Intervention Grids: Business Goals & Population Health Goals
  - Intervention grids in the form of worksheets that provide employers with a framework to better understand evidence-based, value-based benefit interventions.
  - The population health intervention grids include evidence-based programmatic recommendations, based on a robust review of current literature. References and web-links are provided to link users with resources that can support their interventions.

- Implementation Workbook
  - A stand-alone workbook that provides employers with a step-by-step process for selecting and implementing value-based benefit interventions, starting with setting goals and identifying interventions, and culminating with the creation of an implementation plan.
  - A glossary of intervention types and visualization models for Business Goals (Figure 7) and Population Health Goals (Figure 8).
Identify Opportunities to Address Utilization and Cost

Utilization: Analyzing the distribution of health care claims by costs can provide valuable information to an employer. Dr. Jack Mahoney and David Hom, both formerly of Pitney Bowes, Inc., suggest categorizing overall claims/member in four distinct categories:

1) % of lives with $0 in claims annually
2) % of lives with claims greater than $0 but less than $1000 annually
3) % of lives with claims totaling $1000 to $9999 annually
4) % of lives with $10,000 or more in claims annually

Each category provides a unique insight into an employer’s population. For example, a high percentage of non-users could indicate a potentially dangerous situation because they aren’t seeking routine/preventive care that could identify risks and disease early and decrease costs in future years.

Additionally, Mahoney and Hom suggest employers track and trend various hospital and outpatient utilization figures, in addition to claims paid, to compare with industry and market benchmarks to determine opportunities for improved value. The Kansas City employers were asked to provide this information on the EDT as part of the baseline assessment.

In the Price Waterhouse Coopers report, Behind the Numbers: Medical Cost Trends 2010, more employers are using high deductible or consumer-directed health plans (HDHPs/CDHPs) to increase employee cost sharing and inhibit utilization. This trend is evident in the Kansas City market where at baseline a high percentage of employers had CDHP plans in place and over the life of the project a number of employers implemented consumer-directed plans. Although
many employers had offered these types of plans, the employers continued to incentivize preventive services at low or no cost share and subsequently drove utilization as part of their health strategy.

**Costs:** Paid claims broken down into segments such as inpatient, emergency room, outpatient and pharmaceutical costs, high cost and prevalent conditions and prescriptions, as well as average employee contributions to premiums and co-payments for care and administrative costs per employee are all important numbers to understand and trend according to Mahoney and Hom. Looking at data from a variety of sources, and digging deeper to understand the health risks and behaviors that may be contributing to these costs and conditions, enables employers to target health-related investments to areas that will be of greatest organizational value.

**Baseline Findings:**
- Biometric screening revealed that an average of 28% of participating employees had high blood pressure, while only 19% self-reported high blood pressure on HRAs.
- Approximately one-fourth of employees self-reported poor nutrition and inadequate physical activity.
- Average BMI rates for both men and women were greater than 28, which is in the overweight range.

**Follow-Up Results:**
- 100% of employers made changes in environment and policy that included cafeteria and/or vending changes to support healthy eating, increased physical activity opportunities and/or smoke-free policies.
- Vendor partners were engaged and integrated more fully.

**Company Overview**
- Type of industry: Construction
- Number of employees: 2,200
- “Cost Plus” – a hybrid between self and fully insured. Fixed fee that covers administrative costs with payment for claim costs as employees incur them. If costs fall below the expected actuarially-determined amount, employer keeps the savings.
- Primary KC2 Goals: health risk assessment (HRA); tobacco cessation

**Key Wellness Programs**
- Dunn Well: A Blueprint for Healthy Living—maximized vendor offerings, used data to guide decision making, and implemented tobacco cessation program.
- Smoke-free and tobacco-free worksite policies.
- Free and Clear tobacco cessation program: behavioral counseling; access for family members; cost coverage of prescription tobacco cessation medications; implementation of monthly health care premium surcharge for tobacco users (waived for those who complete program)

**Highlights**
- Sixty percent of JE Dunn’s employees completed the HRA; approximately 10% were current smokers.
- All facilities are now tobacco-free.
- Prevalence of tobacco use, as indicated by the HRA, has dropped from 17% in 2007 to 11% in 2010, with declines in tobacco use with the introduction of health plan premium incentives for tobacco-free status starting in 2011.

**Terrence P. Dunn**
President and CEO

JE Dunn’s wellness efforts, including a companywide tobacco cessation program, have truly been an investment in our valuable employees. Over the last 6 years, our wellness investments have helped lower the growth trend of our health care costs. Through these programs, JE Dunn has saved nearly five million dollars in medical plan costs on an investment of just $600,000. Our employees know it’s not just about saving costs; it’s about being healthy so they can best contribute to the company, their families and our communities.
Traditionally, value has been defined as the amount of health gained per dollar spent.\textsuperscript{15} The Kansas City Collaborative (KC\textsuperscript{2}) broadened this to include the total organizational value gained. This may include factors such as reduced absenteeism, increased productivity and increased employee satisfaction. A recent publication called for stakeholders to shift their focus to the creation of value when measuring the effects of health care. This approach includes recognizing employees as human capital and health care costs as investments in that capital.\textsuperscript{16}

\textbf{DEFINE VALUE WITHIN THE CONTEXT OF YOUR CORPORATE CULTURE}

The project broadened the definition of “value-based benefits” to one that encompassed more than insurance design alone. In early 2008, a more traditional definition, which involved minimizing or eliminating out-of-pocket costs for high-value services in defined patient populations, was thought of when the term “value-based benefits” was used. These services are identified by the scientific evidence according to a model that assigns share of costs according to clinical and cost-effectiveness such that the more clinically beneficial and cost-effective a given therapy is for a patient group, the lower the out-of-pocket costs.\textsuperscript{17} The definition used throughout KC\textsuperscript{2} supported the traditional approach and expanded it to include a comprehensive strategy for investing in health benefits and wellness program offerings to ensure that beneficiaries receive high-quality, evidence-based and cost-effective care. This is accomplished by aligning incentives and removing barriers, and using data to drive both decision-making and evaluation of
health benefit and wellness programming. It is imperative that employers and their vendor partners continue to refine measures and methods to demonstrate impact beyond narrow direct health care costs reductions. The true value or impact of an initiative on the workforce can best be determined if one looks beyond traditional pharmacy and medical claims to include absence, disability and job performance.  

**APPLY THE CORE PRINCIPLES OF VALUE WITHIN YOUR ORGANIZATION**

The project involved helping each employer operationalize the core principles outlined in this document within their organization and in the context of their health strategy. The sustainable change cycle utilizes process improvement methodology to improve the quality and value of employee benefits, and it is intended to be a dynamic, living process. The tools and resources developed to support the process are available to employers for use as they see fit.

In an era of increasing pressure on budgets for employee health benefits, value is a critical component to assess. Employers were led through a process that began by looking at their “current state” and assessing the value of existing interventions against those health risks that were identified in the baseline assessment. A foundation of strong management teams and actionable data provided the foundation for this assessment. Throughout the process, employers were asked to establish population and business goals that related to their corporate health strategy, and then define and trend metrics which would align with those goals. Finally, employers were asked to evaluate their programming against those goals and then make changes as needed.
AliGn incEntivEs And rEducE bArriErs to vAluE-bA sEd bEnEfit dEsiGn

As outlined in BeneFIT Design™ Seven Steps to Value-Based Health Benefit Decisions, higher value can be driven significantly through health risk segmentation, alignment of appropriate incentives and removal of barriers to care that can yield the most health impact. Several employers evaluated and adjusted their use of incentives throughout the project. Once the preventable conditions in the workforce were identified, employers began to identify opportunities to align incentives to drive improved health behavior across the full health continuum. For example, knowing that cardiovascular disorders are costly and often preventable, employers can review incentives to encourage smoking cessation, drive adherence to medications and increase participation in disease management for these employees.

EnGAGE EMPloyEes in AdoPtinG v AluE-bA sEd PrinciPlEs And usinG hiGh- vAluE sErvicEs

The Agency for Healthcare Research and Quality (AHRQ) states that all successful incentive programs have two components: informational and financial. Having high-value benefits in place doesn’t do any good if employees don’t take advantage of them. Through educational programming focused on branding wellness messaging and peer-to-peer sharing of effective messages, the participating employers worked to improve employee knowledge and utilization of high value services (such as annual physicals and preventive screenings). As with most employers, this continues to be one of the challenges. “Employee resistance” is often determined as a barrier to adoption of value-based benefit concepts and behavior change initiatives.
**BASELINE FINDINGS:**

- At baseline, employers were aware that most employees are not using the health care delivery system in the optimal way for high value care. Participating employers shared innovative ideas, suggestions and best practices that support communication and education of employees to utilize their benefits correctly and appropriately. Many KC2 employers also made environmental or benefit changes to enable employees to make healthy choices or change behaviors.
- Experts report growing evidence that patient use of life-saving interventions such as immunizations, cancer screening and essential drug prescription use is declining in response to the increase in cost-sharing efforts. This will likely result in poorer health outcomes overall. As mentioned earlier, the clear trend at baseline for KC2 employers toward CDHPs raised the awareness of employers to the importance of targeting desired behaviors and services in the design of their health benefits, prevention and wellness offerings, and incentive plans.

**FOLLOW-UP RESULTS:**

- Employee engagement was addressed by all employers with a focus on employee educational initiatives and messaging, incentive program changes, departmental competitions and coaching/goal setting.
- All employers made some benefit design or incentive changes. Most employers provided first dollar coverage for preventive screenings and premium differentials for participation or healthy behaviors, and some provided no or limited co-pays for medications if enrolled in disease or case management programs.

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**COMPANY OVERVIEW**

- **Type of industry:** Insurance brokerage and consulting services
- **Number of employees:** 4,100
- **Self-insured
- Primary KC2 Goals:** Tobacco cessation; physical activity

**KEY WELLNESS PROGRAMS**

- **Premium discounts to employees practicing healthy behaviors and incentives for employees who complete a health risk assessment (HRA) and adhere to medication or treatment regimens.**
- **Employee educational sessions on health-related issues and health coaching and advice for goal setting.**
- **Health messages through company Intranet, promotion of corporate physical activity events, and utilization of a geographical approach to target specific worksite health programs nationally and globally.**
- **Healthier food options in the worksite cafeteria and vending areas.**
- **Onsite fitness facility and Walkstations for employee use.**

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**RICK KAHALE**

President, KC Employee Benefits

Lockton’s decision to embrace a Consumer Driven Health Plan coupled with a robust Health Risk Management component was guided by several reasons. Lockton’s prior path was unsustainable—our health plan had experienced double digit claim cost increases for 4 straight years, and approximately 70 percent of our medical claims—$14 million in cost—were driven by “lifestyle related” claims. We believe that our strategic approach to Health Risk Management is consistent with Lockton’s mission of being the best place to work for our Associates.
As described in the project overview section (page 3), employers were encouraged to establish meaningful population health and business health strategies that were specific and aligned with their larger organizational goals. As part of the collaborative approach, participating employers agreed to target similar conditions and/or establish common business health goals; however, each chose unique interventions to accomplish these goals and objectives. The project team worked with each employer to identify individual metrics that they could reasonably track and trend over time.

A custom employer scorecard was created for each employer to reflect their stated goals and objectives. In the first half of 2011, the project team collected the scorecards to assess results for each employer individually and across employers to understand what they achieved collectively. Nine employers completed scorecards that could be analyzed in the aggregate across participating employers. Process metrics have been reported previously in each of the Core Principle sections. This section highlights results on metrics that could be aggregated across participating employers.

**Population Risk Reduction**

Six employers tracked changes in self-reported employee health risk status over time through an annual health risk assessment (HRA). Individuals were classified as high, medium and low risk based on the total number of health risks identified through the HRA. All six of the employers observed a desirable shift in risk severity. Figure 10 depicts these results.

The project team utilized the risk distribution changes and the net difference in costs adjusted to 2010 dollars to model the financial impact of a
reduction in self-reported health risks over the course of the initiative (Table 1, page 26). To approximate the financial impact of a reduction in health risks, Dee Edington’s research on the financial value of changes in risk severity in an employed population were applied to risk distributions tracked by six KC2 employers that reported HRA data during both time periods. Based on DEE EDINGTON’S research on the financial value of changes in risk severity in an employed population, the financial impact of a reduction in health risks was approximated. Dee Edington’s research on the financial value of changes in risk severity in an employed population were applied to risk distributions tracked by six KC2 employers that reported HRA data during both time periods. Based

**COMPANY OVERVIEW**
- Type of industry: Health care insurance
- Number of employees: 995
- Fully insured
- Primary KC2 Goals: Data driving decision-making; employee engagement on health status; environmental change

**KEY WELLNESS PROGRAMS**
- Destination Health Road to Wellness programs—fitness; lifestyle choices; specialized care resources; nutrition; health education; and relaxation, rejuvenation and stress management
- Incentives include premium differentials, lower co-pays for certain medications and internal incentives
- Health and Wellness Month each October with onsite health screening, access to an electronic health risk assessment and telephonic health coaching
- Free onsite 24/7 fitness center for employees and spouses with free personal training and classes
- Smoke-free environment; assistance with smoking cessation; commitment to hire nonsmoking employees
- Partnership with food services provider to encourage healthy food choices
- Support for Weight Watchers at Work through 50% tuition reimbursement with successful participation
- Participation in community challenges such as the KC Fittest Executive Challenge, KC Slimdown Challenge, Corporate Challenge and Walk at Lunch Program

**HIGHLIGHTS**
- Greater than 5-point increase in Aggregate Wellness Score (82.4 to 87.5 out of 100) from 2005 to 2010
- Employees in low health risk category (0-2 health risk factors) increased by 20% from 2005 to 2010
- Increase in employees moving from high- to medium-risk category

**FIGURE 10: CHANGES IN RISK FACTOR CATEGORY FOR THOSE EMPLOYERS REPORTING METRIC**

Source: KC2 Project Team

**DAVID GENTILE, President and CEO**
As the wellness leader in Kansas City, we walk the talk. The wellness programs, incentives and other resources we offer to our clients are always offered to our own employees, and all are encouraged to participate. These programs are often enhanced to reflect the commitment to our employees and their individual health. Prevention is a repeating theme throughout our wellness efforts, and our employees and clients reap the benefits.
on this modeling approach, reported changes in health risk levels may have been associated with approximately $11 million in lower aggregate medical costs across these six employers over time realizing some cost reductions accumulate over time, such as smoking cessation, and are therefore not realized in a calendar year. This would yield average per-employee medical costs in 2010 that are approximately $194 lower than baseline costs.

**EMPLOYEE PARTICIPATION**

**Health Risk Questionnaire:** Increased participation in annual HRAs were observed by nine out of nine employers submitting final data. On average, HRA participation increased by 24% across all nine employers reporting data.

**Biometric Screening:** Additionally, increased participation in biometric health screening was observed among 6 out of 9 employers that conducted health screenings as part of their interventions (Figure 11). Three of the nine employers that provided final data did not offer

![Percent Improvement in Biometric Screening Participation](chart)

**FIGURE 11:** IMPROVEMENT IN BIOMETRIC SCREENING PARTICIPATION FOR THOSE EMPLOYERS REPORTING METRIC

Source: KC Project Team
biometric health screenings in the intervention period. There was wide variation in changes in biometric screening rates across employers.

**BIOMETRIC MEASURES:**

The aggregate numbers in Table 2 represent the percentage of metrics that reflected improvements. As stated above, goals were determined by the employer so their definitions varied greatly. Some of the employers also included multiple measurements of one parameter (e.g., waist circumference or HDL metrics by gender, BMI by categories). These data are reported as the total number of employers with a metric, the percent that were deemed to be improvements, followed by the raw data. Details concerning the magnitude of improvements can be seen in the individual cases reported previously.

**BEHAVIORAL MEASURES:**

The aggregate numbers in Table 3 represent the percentage of employer metrics that were considered improvements. Similar to the biometrics, each employer had different foci depending on their population health goals, with many utilizing multiple metrics in a category.

<table>
<thead>
<tr>
<th>Metric (n=number of employers)</th>
<th>Percent of Metrics Representing Improvements</th>
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<tbody>
<tr>
<td>Weight</td>
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<tr>
<td>BMI (n=5)</td>
<td>75% (6/8 metrics)</td>
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<tr>
<td>Waist Circumference (n=3)</td>
<td>33% (1/3 metrics)</td>
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<td>Blood Pressure</td>
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<tr>
<td>Goal (n=4)</td>
<td>88% (7/8 metrics)</td>
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<tr>
<td>Cholesterol</td>
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<tr>
<td>Total (n=3)</td>
<td>60% (3/5 metrics)</td>
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<tr>
<td>LDL (n=2)</td>
<td>100% (2/2 metrics)</td>
</tr>
<tr>
<td>HDL (n=3)</td>
<td>100% (7/7 metrics)</td>
</tr>
<tr>
<td>Triglycerides (n=2)</td>
<td>100% (2/2 metrics)</td>
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</table>

**TABLE 2. BIOMETRIC MEASURES RESULTS**

<table>
<thead>
<tr>
<th>Metric (n=number of employers)</th>
<th>Percent of Metrics Representing Improvements</th>
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<tr>
<td>Exercise</td>
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<tr>
<td>Goal (n=4)</td>
<td>100% (4/4 metrics)</td>
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<tr>
<td>Diet</td>
<td></td>
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<tr>
<td>Goal (n=2)</td>
<td>100% (3/3 metrics)</td>
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<tr>
<td>Preventative Services</td>
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<tr>
<td>Total (n=5)</td>
<td>71% (5/7 metrics)</td>
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</table>

**TABLE 3. BEHAVIORAL MEASURE RESULTS**
In 2010, the American Health Strategy Project was developed to leverage and expand the tools and methods originally developed as part of the Kansas City Collaborative. Five pilot sites were selected and announced in June of 2010 by the National Business Coalition on Health.

- Dallas-Fort Worth Business Group on Health;
- Midwest Business Group on Health;
- Oregon Coalition of Health Care Purchasers;
- Pittsburgh Business Group on Health;
- Virginia Business Coalition on Health.

These pilot projects are aimed at helping employers improve the health of employees and their families, promote wellness and prevention, and manage health care costs in various markets throughout the country. The pilots, launched in collaboration with Pfizer Inc, provide both hands-on technical and financial support to the selected NBCH member coalitions and their employer members interested in improving the health of their employees and their dependents through the implementation of a range of value-based benefits. American Health Strategy Project employers will each introduce a complementary array of employee health offerings and incentives that better align health promotion and prevention strategies with medical and pharmaceutical plans, and other benefits such as disability and workers’ compensation.

The American Health Strategy Project (AHSP) has emerged as a significant model to support employers in addressing the many health care challenges they face today. AHSP exists to empower employers with the knowledge and tools necessary to achieve sustainable change in how they approach and manage health care benefits.

Specifically, AHSP provides a structured yet flexible toolkit designed for employers to ensure that their employees and dependents have access to high-quality, evidence-based, cost-effective health care that reduces barriers to essential services and motivates employees to make wise lifestyle and health care decisions. The tools, resources, additional information and case studies are archived on a website www.americanhealthstrategy.com. (Figure 12)

AHSP is proving that employers with strong health management teams who have access to and utilize actionable health care data are better able to foster a worksite environment that sustains a healthier, more productive employee population, and are likely to achieve higher value for every health care dollar invested.
FIGURE 12: AMERICAN HEALTH STRATEGY PROJECT WEB SITE HOME PAGE
Source: KC Project Team

The AHSP website is currently available for NBCH member coalitions and their employers interested in adopting the model and tools. To learn more about this program or to obtain log-in information, please contact Sara Poage at spoage@nbch.org. You can also check the page at http://americanhealthstrategy-stg.pfizer.com/Passcode.aspx.
The KC² project team consisted of:
- Bill Bruning, Sara Poage, and Sally Baehni—MACHC representatives
- Duane Putnam, David Hanson, Marcia Wright, Vicki Karlan, Gene Gosselin and Barbara Kaplan-Machlis—Pfizer representatives and Troy Ross (formerly Pfizer)
- Dennis White—NBCH representative
- The 13 Kansas City employers that stayed with us until the finish are at the core of this collaborative: American Academy of Family Physicians; American Century Investments; Blue Cross & Blue Shield of Kansas City; BlueScope Steel NA; Cerner Corporation; Children’s Mercy Hospitals and Clinics; City of Kansas City, Missouri; H&R Block Inc.; JE Dunn Construction Group; Lockton Companies; Saint Luke’s Health System; Sprint; and the University of Kansas Hospital Authority.

**ABOUT THE MID-AMERICA COALITION ON HEALTH CARE**

The Mid-America Coalition on Health Care (MACHC) is one of the oldest health care business coalitions in the country, representing over 400,000 covered lives. MACHC is an employer-driven, non-profit collaboration of all health care stakeholder groups in the bi-state Kansas City region. Members include major employers, health plans, physicians, hospitals, brokers and consultants, academic institutions, public health, government and pharmaceutical companies. [www.machc.org](http://www.machc.org)

**ABOUT PFIZER INC**

Founded in 1849, Pfizer is the world’s largest research-based pharmaceutical company taking new approaches to better health. Pfizer discovers, develops, manufactures and delivers quality, safe and effective prescription medicines to treat and help prevent disease for both people and animals. Pfizer also partners with health care providers, governments and local communities around the world to expand access to its medicines and to provide better quality health care and health system support. [www.pfizer.com](http://www.pfizer.com)

**ABOUT THE NATIONAL BUSINESS COALITION ON HEALTH**

The National Business Coalition on Health (NBCH) is a national, nonprofit, membership organization of 60 business and health coalitions, representing over 7,000 employers and 34 million employees and their dependents across the United States. NBCH and its members are dedicated to value-based purchasing of health care services through the collective action of public and private purchasers. [www.nbch.org](http://www.nbch.org)

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