

Review & Commentary on Health Policy Issues for a Rural Perspective – September 1st, 2007

Employees & Employers Getting Prevention

From “Employers Shift Focus to Health Care Prevention and Incentives to Change Employee Behavior,” by Midwest Business Group On Health, 5/10/07:

“U.S. employers continue to be concerned about reducing health care costs, however, there is a growing focus on improving workforce health, creating incentives to change employee behavior and adoption of consumer driven approaches. While disease management continues to play a critical role, **employers are increasingly focusing on efforts to prevent employees from becoming sick.**”

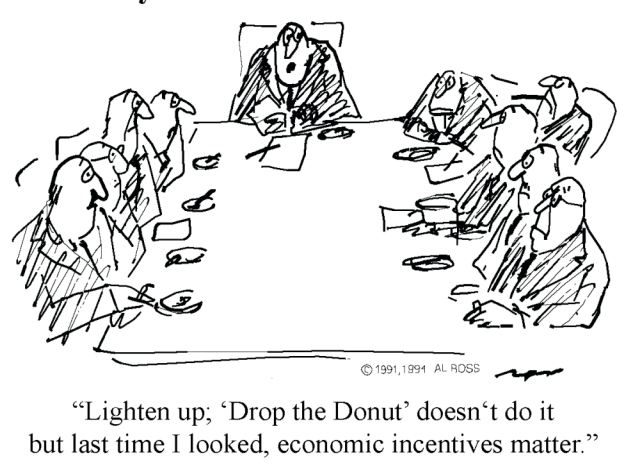
“The survey was developed to determine employer understanding, use of and readiness to adopt value-based benefit design (VBBD) strategies and to identify which strategies and experiences are currently being promoted or utilized by employers. Key survey components included employer demographics, positions on benefit philosophies and data activities.”

“ ‘Employers are realizing that a good health care strategy includes health benefits and programs that incentivize employees to manage their own health,’ said Larry Boress. ‘If employers offer benefits that help keep employees healthy, in the long run, the individual and the company profits. And, our survey

results clearly show that leading edge employers are almost twice as likely to provide incentives to employees to obtain preventive services and to choose doctors and hospitals based on quality.’ Highlights of the Survey findings include:

- 95% of employers agree that there is a link between an employee’s health and their productivity
- 62% of employers who view themselves as “leading edge” will provide cash or other incentives to motivate employee use of preventive services; compared to 34 percent of other employers
- 60% of employers believe employees would change to better performing providers if they understood how quality varies and affects outcomes.”

RWHC Eye On Health



“Employers were asked to rate their organizations’ benefit design philosophy as leading edge (21%), careful watcher (54%) or conservative (25%). The employers that defined themselves as leading edge plan to offer more programs to prevent illness and complications from illness in the next one to two years. Benefit strategies for these types of employers will rely more heavily on making employees aware that quality matters.”

“ ‘We’re encouraged to see ‘enlightened’ employers increasingly instituting worksite health and productivity and value based purchasing programs to continuously improve health care and demand quality to

keep employees and dependents well,' said Andrew Webber, president and CEO of the National Business Coalition on Health."

Move from cost-shifting towards more strategic value-based benefits?—Nearly 50 percent of all employers and 68 percent of leading edge employers reported that employee cost-sharing reduces doctor visits. Employer strategies for the next one to two years point to moving away from cost-shifting and towards implementing value-based benefits such as waived employee cost-sharing for chronic disease drugs, waived employee cost sharing to get employee to participate in a disease management program, and mandated generic use where generic is available."

No longer willing to pay for poor care or medical mistakes—"Results from the survey indicate that employers are concerned about the lack of quality information on hospitals and doctors made available to employees as well as the need to educate employees about what constitutes a quality provider. Employers are no longer willing to pay for poor care, unnecessary care or medical mistakes."

Wellness Requires Knocking Holes in Silos

The following article, "Seeking SatisfACTION: Personal reflections of a recent graduate" was written by Stacey Lindenau, MPH, MSIE as a narrative summarizing her experience as a graduate student with the Rural Wisconsin Health Cooperative. For a year she did an extensive literature review and over forty key informant interviews to form the foundation of a policy development agenda for the Rural Health Development Council's Strong Rural Communities Initiative at Wisconsin's Department of Commerce. Her field placement was generously supported by the Robert Wood Johnson Health & Society Scholars Program at the University of Wisconsin-Madison.

"How do you feel about dying," I asked, between queries over flower arrangements, sentimental verses, music and other funeral plans. Grandma Margaret and I chatted as we poked about the local shopping mall, aghast at the new "styles" while having a surprisingly easy conversation. Pushing her about in a

wheelchair, we looked for necessities she used to be able to purchase on her own. Though an eternity ago now, we danced away the evening in celebration of her 80th birthday just two short months before. She is smiling and joyful. Laughing at the half clad Lindsay Lohan look-a-likes she declares that, perhaps, just perhaps, Elvis hadn't been such a bad influence after all.

"It is just so inconvenient," she finally answered back, "there is so much more I wanted to learn." "Inconvenient...wanted to learn", typical word choices by a woman whose generation I admire greatly. This generation knows hard work, doing it with honest acceptance. 80 years young, withering away quickly from an aggressive, painful cancer yet holding fast to the pursuit of knowledge, giddy with the joy of a life fully lived and content to do her share. Her words are powerful, her character flawed but without fault. They convey an accurate picture of an approach to life dying with a generation of greats; a generation that respects knowledge, challenge, hard work, integrity and grit. They listen instead of speak. They act instead of ponder. They save instead of charge. They walk, dance, laugh and live each moment instead of watching someone else do so on "reality" TV. They stretch beyond comfortable limits. They are the generation of doers, though not always "do gooders". They know the only foolish question is the one not asked.

Her passing came quickly. Mind boggling amounts of money were spent on health care those last few weeks.

The **Rural Wisconsin Health Cooperative (RWHC)** was begun in 1979 as a catalyst for regional collaboration, an aggressive and creative force on behalf of rural health and communities. RWHC promotes the preservation and furthers the development of a coordinated system of health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

Eye On Health Editor:
Tim Size, RWHC
880 Independence Lane, PO Box 490
Sauk City, WI 53583

office@rwhc.com

<http://www.rwhc.com>

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Expenditures seemed absurd in comparison to the scarce resources she had used over the course of her life. Watching her wither away created a deep sense of urgency within me to re-direct my career, to strive to improve a health care “system” seriously out of balance. Our American “**non-system**,” though blessed with the best technology in the world continues to produce the worst results per dollar spent. Our non-system continues to focus on illness treatment rather than prevention, health optimization and wellness.

The power of prevention and wellness are well accepted in many other countries. For nearly thirteen years I lived overseas as a senior manager for a major Wisconsin manufacturer. As an observer, patient, consumer and business executive I witnessed the good and bad of various forms of health care delivery systems, their impact on business and community vitality. Though individual systems varied greatly between countries the respect for preventive medicine, health preservation and wellness seemed universal. Equipped, capable and funded to use modern technology there was a discernable preference for preventing the need for illness care through active wellness, health programming and policies.

Upon returning to the United States I enrolled in my alma mater the University of Wisconsin—Madison for a pair of Master’s degrees: Master of Public Health (MPH) and Master of Science in Industrial and Systems Engineering. To fulfill degree requirements I secured a field placement as Project Assistant at the Rural Wisconsin Health Cooperative, on an exciting initiative called the Strong Rural Communities Initiative (SRCI). SRCI was developed by members of the Rural Health Development Council (RHDC). This council serves at the discretion of the Governor, sits in the Wisconsin Department of Commerce and has the role of making specific policy recommendations on rural health care issues. My position was charged with informing the development of RHDC policy recommendations relative to wellness and prevention programming through community collaborative efforts.

SRCI’s role is to inform the council on how best to improve the uptake of this information and how to broaden the discussion of wellness from a strictly traditional public health concept to the larger issue of business competitiveness and community vitality.

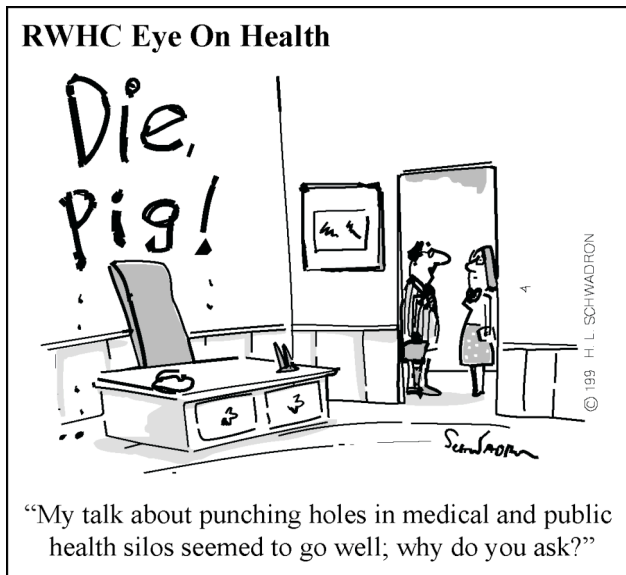
Wellness, healthy populations, healthy employees and workforce development have long since been related to workforce productivity, corporate profits and market competitiveness. ROI, return on investment, is understood across many health professions. Yet decades after the original work began, field interviews demonstrated that these findings are only now being put into practice, the pace of information dissemination remarkably slow. Why then are ideas of health promotion and disease prevention becoming universally acceptable now? What can be done to facilitate the change from idea to action?

Why now? Evidence of return on investment for health and wellness programming has long been available but the pain of health care expense has only

recently been more obvious to the general public. Each day more employers either drop insurance coverage altogether or drastically increase required co-payments, either way personal health expenditure levels on health care are beginning to affect family budgets. Once only murmurs, the economics of health and prevention work have become verbose dinner table conversation for frustrated families, small employers and politicians alike.

As public discontent and economic disadvantage grow health promotion and disease prevention have become desirable and actionable concepts. Desirable in their simplicity and projected disconnect from a “system” unfavorably viewed by many. Prevention is the one thing that the public can do while bureaucrats, academics and politicians argue over the validity and applicability of “evidence”, competing values, priority setting, funding and jurisdiction.

In business challenges are identified, root causes articulated. Natural levels of “business savvy” have



long been recognized as critical to success. Masters of the deal must also have mastery over analytic tools. When methods are found inadequate teams reconvene, re-analyze, re-direct, then re-start. To achieve goals, the focus is on action, satisfaction is found through ACTION. “Evidence based” for businesses is found in the doing. If it hasn’t been proven—try it. Reason, logic and action; do, don’t idealize. The challenge I faced adjusting to the compartmentalized culture of academia from the dynamic, multi-dimensional teams of business is representative of the silos, turfism and competing ideologies SRCI was designed to unravel then weave anew.

Strong Rural Communities Initiative (SRCI), a relatively new community project series in six different communities across Wisconsin, is designed to support the Healthiest Wisconsin 2010 goals of improved health indicators. (Details of the SRCI can be found in the February, 2007 issue of RWHC’s “*Eye on Health*.”) We know health promotion and disease prevention works but we still don’t know how best to make the efforts toward it sustainable. SRCI focuses specifically on rural communities and the means to significantly accelerate the establishment of multi-sector collaboration as the means for population health improvement. By implementing sustainable models for private medical, governmental public health, and business collaboration SRCI hopes to make a significant impact on population health. First, SRCI intends to better understand the role of collaboration in rural communities and second, SRCI intends to increase collaboration for preventive health services among rural medical, public health, and business partners.

Complimenting the lessons learned from our six participating communities the initial eight months of my placement focused on extensive literature reviews. Since the completion of this phase, we have been conducting field interviews across the state. Academic leaders, private practitioners, government agencies, governmental public health professionals, professional trade organizations, health care financial bodies and private businesses have all graciously shared their insights and experiences with SRCI to help guide our policy development work

“Business” and public health need each other. Paul A. Simon and Jonathan E. Fielding, in their 2006 Health Affairs article *Public Health and Busi-*

ness: A Partnership That Makes Cents make clear the reason for this new awareness when they said “The US business community has its largest economic stake ever in promoting and maintaining workforce health. Aggregate US health care spending soared from \$73 billion in 1970 to \$1.7 trillion in 2003. ... more than one quarter of [this] spending was borne by private business. [Such levels of] higher spending, compared with all other trading partners, contributes to the erosion of the preeminent US economic power, which places US businesses at a disadvantage in an increasingly competitive global marketplace,”

Likewise, in the same publication, Georges C. Benjamin in his article *Putting the Public in Public Health: New Approaches*, said “Improving health ... means adopting a new approach that engages the public, the business community and public policy makers ... It requires a business community that views public health as an essential component of a healthy business climate and productive workforce.”

The divide in “public” health continues to elude resolution decades after the first attempts to do so. Traditionalists, futurists, academics, practitioners and others continue to imprudently sustain their professional silos, preposterous fiefdoms. Perhaps we are looking for the wrong solution. Are the dissolution of silos and the tactical dismantling of turf the necessary answer? Perhaps the public would be better served by a new set of questions altogether. How can we bridge the divide between the silos? How can we punch holes in them so information and ideas can flow freely? What does the PUBLIC think public health is? What does the PUBLIC want? What action does the public want to see? Or perhaps the only relevant questions are: WHY aren’t citizens acting on the information they have already? WHAT are the root causes to our poor health results? What does the PUBLIC know keeps them from acting in the best interest of their individual health? Then again, the most basic of questions might simply be; who IS the public?

America’s diverse and increasingly fragmented population appears to be losing its sense of “public”, its’ concepts and feelings of community and social cohesion. In an attempt to find the answers to our questions from this perspective we conducted dozens of key informant interviews. To date the lessons of SRCI have been many. Three of the key findings include:

Insurance provider mandates and the development of *new* insurance products “If only insurance companies would be forced to provide coverage for ...” is a common though useless phrase. Often considered an effective prescription to force social consciousness on insurers, mandatory coverage levels and conditions have limitations. Many medium and large firms self insure making them exempt from federal or state regulations on insurance policy mandates. The only policies affected by a mandate are those purchased from insurance companies on the open market. Smaller, younger firms then face even *more* costly product options in a market already plagued by cost restrictive entry.

Significant levels of non-insurance and disparities in access to health care have long been noted yet remain dismal. Instead of having the same discussions over and over again it seems logical to explore new options. What about the development of new insurance products; products that target existing and emerging social need in ways never before attempted? What would encourage insurance groups to develop products that address the changing health and prevention needs of the current US population?

Marginal utility of a unit of time and the status of time as a luxury good We need to turn this vague concept of wellness into a product, into something tangible enough for citizens to grab hold of. People will exchange time for another valuable good, they already do this in respect to their wages. We exchange our time and services for wages. We earn money today by forgoing the use of our time so that we can spend it at some future time. Why can't we frame health as a wage, or a product or benefit? If we forgo unhealthy life choices today the value of our exchangeable good—time is higher. Our discussion has come right back to ROI but this time for the benefit of individuals.

Continual blaming and shaming of the American people for their level of health/fitness is not solving the societal issue—nor will it. A frank *economic* discussion needs to be held on the economic and social contributors to why health and fitness levels of Americans are declining so rapidly. Though many people say it is as simple as “properly aligning priorities” this phrase has no universal meaning.

The marginal utility of a dollar compared to the marginal utility of unit of time varies greatly between individuals. This is especially true for marginalized workers who need two or three low wage jobs just to make ends meet. Marginalized workers suffer not only from a disabling lack of disposable income but also from a severe shortage of time itself.

We must find a way to shift the sands of our social climate; to enable the population to take action on its own behalf, to understand the responsibility for their decisions and accept the consequences of their actions. SatisfACTION above Idealism: Do the doable don't idle with the idealists.

Understanding what the small in “small business” means—Most people have a vision of what “small business” means to them, a vision that is strikingly different than that considered in most policy development work. Even organizations like the Small Business Association, the Chamber of Commerce, and the National Federation of Independent Businesses, all national champions for small businesses, classify “small” as much larger than is relevant to most rural communities.

To redefine the concept of “small business”, to draw attention to its economic and social relevance the discussion must be framed in terms of truly small, particularly rural, businesses and communities. Most discussion about “small business” continues to refer to firms of 200 or fewer employees, truly large in terms of the typical rural community. Attention needs to focus on the types of small employers typically found in rural communities (self employed, family businesses, and firms with less than 25 employees).

Pre-determinants of health are more than access to care and insurance coverage. I believe that the most pressing crisis in “health care” is that we don't seem to be practicing “health care” at all. Rather, we focus on illness treatment, on prolonging our last earthly breath instead of improving all those that come before.

Lessons learned from extensive research and key informant interviews have convinced me that population level health, wellness and prevention services, grounded in community wide collaborative efforts are the solution for this country. I believe that our international business competitiveness will continue

to suffer until the health and welfare of our workforce is secure. I believe that the small business, truly small businesses, community leaders and local collaborations are the key to a strong, healthy future.

I believe that ACTION is necessary and can begin with the following steps:

1. Drop the blame game; widen discussions in support of social change as means to population wide health and wellness. Address the marginal utility of a dollar compared to the marginal utility of a unit of time.
2. Engage and encourage the insurance industry to develop *new* products. Products which address current and projected social needs of health promotion and disease prevention.
3. Expand upon and make common knowledge, the connection between occupational health and safety, worksite wellness, workforce productivity, commercial competitiveness and community vitality.
4. Redefine political interpretations of the concept of “small business” and draw attention to the economic and social relevance of truly small enterprises such as firms with fewer than 25 employees.
5. *Satisfaction* requires ACTION; doing the doable instead of idling with idealists. Focus on the importance of changing what we can with those resources already available.

There are solutions to the problems that plague the health of our population. There always are. Individually each sector of society contributes its great minds and provides the tools, logic, analysis and heart to inform change. Individually each sector, each silo, is great and good but can not provide solutions in isolation. As necessary as the ivory towers of academia are, or the grounds of government agencies, our social solutions will not be found among their halls alone. Solution can spring from the streets of our communities,

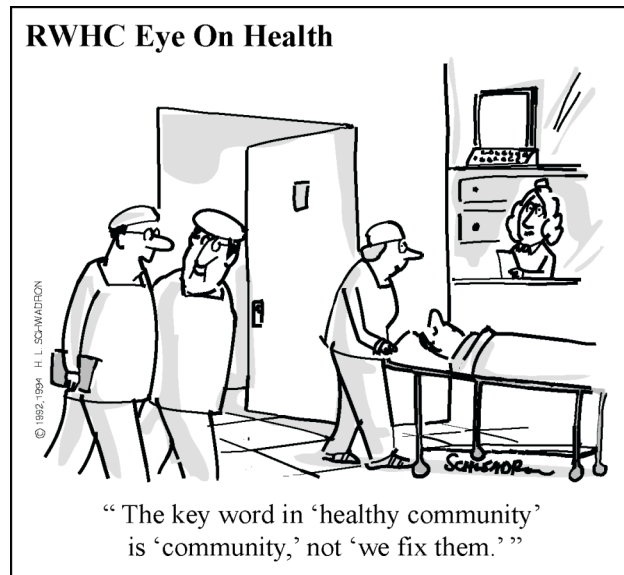
the offices of professionals, the shops of tradesmen, the floors of manufacturing facilities, places of worship, minds of teachers, hearts of caregivers, imaginations of our children or the boardrooms of businesses but they won't if sectors continue working alone. So-

lutions, truly revolutionary solutions will only be found through acts of premeditated courage, through coming together, through mutual respect, shared responsibility and collaborative effort.

As a society we have “much more to learn” but we have even more to do. To achieve social satisfaction more *action*, fueled by reason, is required and it starts by remembering the most of basic of American ideals; that this

nation was made great by its willingness and ability to be a true “melting pot.” To achieve the success we seek whether it be health care, social equity, economic justice or any other public good we will need to become a nation of communities, one nation, instead of a conglomeration of egos.

This article in WORD, complete with a list of suggest readings, is available at <http://www.RWHC.com/>



Profile of a Rural Community Success Story

From “Innovative Community Partnerships: Jackson County’s proACTIVE Wellness Initiative by Liz Lund, Business Development Manager, Black River Memorial Hospital in rural Wisconsin (for more info contact Liz at (715) 284-1386 or lundl@brmh.net):

Jackson County recognizes that strategies and approaches to overcome obesity and preventable health problems cannot be developed and implemented by health agencies alone. This summary describes a community initiative that is successfully incorporating the hospital, public health, school district, and local businesses to build and launch worksite wellness programs that are making a difference.

Jackson County's Public Health Department initiated the CRUNCH Campaign Committee in October 2003 and has been convening community partners to develop strategies to reduce obesity ever since. A subcommittee formed in 2005 to research community wellness behaviors and needs. Data was gathered from the following populations: youth, working adults, disabled, and elderly. Of the working population, 21% noted no current physical activity with 52% not achieving the recommended level of exercise. Time, energy, and childcare were most often cited as deterrents to maintaining good wellness habits. Needs identified included: Programming to accommodate the working population and work-site wellness programs.

Because of these findings, the partners determined to focus on worksites. In 2006, the collaborating partners sought additional members, became the proACTIVE Wellness Initiative (pAWI), and applied for implementation funds under the direction of Black River Memorial Hospital (BRMH) and the Wisconsin Office of Rural Health (WORH). WORH funded three rural county initiatives targeting worksite populations: Jackson, Hayward, and Sauk Counties. Each was invited to take part in a statewide Strong Rural Communities Initiative (SRCI) so that information could be shared and analyzed.

In 2006, the proACTIVE Wellness Initiative designed two unique wellness programs for D&S Manufacturing and the Black River Falls (BRF) School District. Hart Tie & Lumber operated as the control in this project—health risk assessments were conducted; however, no intervention was implemented.

At the onset, wellness surveys, Health Risk Assessments (HRA's), and food and exercise diaries were instrumental in determining health indicators and providing measures for improvement in behavioral habits relative to fitness and nutrition. Private consultations were held with each participant, discussing individual results and setting realistic goals to overcome any noted deficiencies.

Participants then completed nine weeks of programming held at the worksite on work time. Nine weekly programs covered a wide range of areas: nutrition, weight loss, cooking, everyday exercise, fitness training, tobacco use, stress management, depression, and local wellness resources. Related challenges and in-

centives were proposed each week along with a 2-month voluntary fitness challenge. One-on-one coaching, weigh-ins, and blood pressure checks with pAWI's Worksite Wellness Program Coordinator were options for all participants to monitor progress, applaud successes, and address challenges.

Approximately six months after the onset, HRA's and Wellness Surveys were repeated to determine whether the educational programming, challenges, incentives, and coaching had a positive impact on behaviors and health status. Food and exercise diaries were repeated so any changes in behavior could be further quantified.

Outcomes—The proACTIVE Wellness Initiative:

- 1) Enhanced access to primary and preventive health services through the collaboration of local health agencies, schools and businesses.
- 2) Educated and encouraged the worksite population to establish and maintain healthy lifestyles using supportive employers as an effective agency.

Some individuals experienced significant behavioral changes and improvements. D&S Manufacturing had an impact with tobacco users as six participants have successfully quit. When comparing the total number of HRA results in the high to extreme categories, results either stayed the same or improved except for cholesterol tests within the control site. When individual screening tests and wellness survey results are reviewed, improvements can be verified, showing that behavioral impacts were made—more so when intervention was implemented. A secondary benefit included positive influences on spouses, family, co-workers and students at BRF schools.

Involvement of the business community and the long-term potential to reduce health care costs is a particular emphasis of this initiative. Through this program, area businesses are becoming more cognizant of the benefits of a healthier workforce—increased productivity, reduced turnover and fewer lost workdays due to chronic illness and fatigue. In turn, healthier employees will reduce health care costs and insurance premiums. The employers have proven to be an effective agency to encourage healthy lifestyles within Jackson County and are committed to promoting primary and

preventive healthcare services to their employees. This project continues to gain support as community members are learning of its effect.



**RURAL HEALTH CAREERS
WISCONSIN**

Partners—The proACTIVE Wellness Initiative Committee members are dedicated to sharing their expertise to make this project a success. BRMH's Therapy Department provided input for fitness education and surveys; Ho-Chunk Nation Nutritional Services Department and BRF School District provided input for nutritional components; BRMH's ER Nurse Manager and Employee Health Coordinator along with the Public Health Department and BRF School District Nurse provided expertise for the HRA's, Screenings, and programming; a Worksite Wellness Coordinator has assisted in coordinating the project, as well as monitoring and coaching participants for program adherence; BRMH's Business Development Manager developed many of the tools and processes, compiled data, and directed the program; and the participating employers allowed employees to participate on work time and were prominently engaged in the design, implementation, and evaluation of

the programs. Other partners connected through the CRUNCH Campaign Committee that are not listed include: UW-Extension and Western Dairyland.

The pAWI meets regularly with other SRCI, sharing and learning from their challenges and successes. The WORH is utilizing the Center for Health Systems Research & Analysis (CHSRA) to evaluate these coalitions. CHSRA's results are pending; however, because of this project, partnerships with other health agencies and area businesses have been enhanced, employers are becoming more involved in promoting health, and a liaison between health care services and the community is strengthening. In the communities' eyes, these partnerships are being formed not only to benefit from each other's resources, but to benefit the community. This is a win-win situation for everyone involved.

The pAWI continues its work with two new worksites in 2007: Regal Beloit Motor Technologies and another division of the Black River Falls School District, and looks forward to another year of improvements.

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