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Presents at the:


EBPA Breakfast Seminar Series
EMPLOYEE BENEFITS PLANNING ASSOCIATION

Health & Productivity in the Workplace:
An Integrated Approach

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February 4, 2010

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Health & Productivity in the Workplace:
An Integrated Approach

- Presented By: Mary K. O'Neill, MD, MBA
 - Chief Medical Officer for CIGNA in the Pacific Northwest
 - Board Certified in Physical Medicine and Rehabilitation
 - Graduate of the University of Washington
 - Prior to joining CIGNA, Dr. O'Neill was the medical director for the State of Washington at the Uniform Medical Plan. Prior to that she was the head of Physical Medicine at Virginia Mason Medical Center.

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Session objectives

- Understand value and results of integrated health and productivity programs in improving outcomes and costs
- Recognize the latest workplace and market trends that continue to drive the need for integrated health and productivity solutions
- Understand the link between health risks, medical, disability and productivity costs and impact to employer's total costs
- Understand how to design a comprehensive solution for your clients

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Topics to be covered

- Health and productivity management overview
- Demonstrating the value: Does it really work?
- Trends impacting employers and employees
- Connection between health risks and costs
- Putting together a comprehensive and proactive solution

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Health and productivity management overview

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What is integrated health & productivity management?

- A comprehensive approach to managing the health, well-being and productivity of employees
- Goal: maximize the **health and well-being** of employees while effectively managing the **total cost of injury and illness** for employers
- Total costs = medical costs + wage replacement costs + lost productivity costs

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What is the scope?

- Medical
- Behavioral health
- Short and long-term disability
- Incidental absence
- Productivity on the job (presenteeism)
- Family medical and other leaves
- Worker's compensation

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Key components

- Identification and effective management of those with health risks and/or established illness to:
 - Improve health outcomes
 - Reduce the likelihood of a disability
 - Mitigate the severity of disabilities that cannot be avoided
 - Control absence and lost productivity while at work (presenteeism)
- Coordination of medical and return to work management around the time of a disability event to:
 - Improve disability durations
 - Improve return to work
 - Improve health outcomes
 - Reduce health care cost trend
- Integrated data, analytics and reporting to:
 - Track and measure outcomes and impact across programs
 - Provide insight for program enhancements

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Demonstrating the value: Does it really work?

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Health risks are common

In a typical population of 100 people:

- 48 are overweight
- 44 suffer from stress
- 24 don't exercise
- 26 have high blood pressure
- 30 have high cholesterol
- 21 smoke
- 31 use alcohol excessively
- 20 don't wear seatbelts



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Department of Health and Human Services, 2007
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What health risks have the greatest costs?

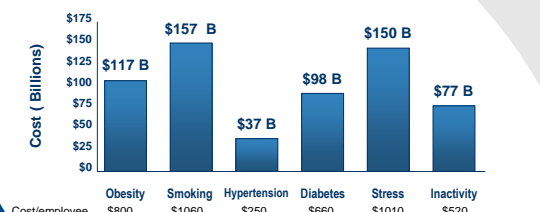
- Obesity
- Smoking
- Hypertension
- Diabetes
- Stress
- Inactivity

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Economic impact of health risks: the cost of "un-wellness"

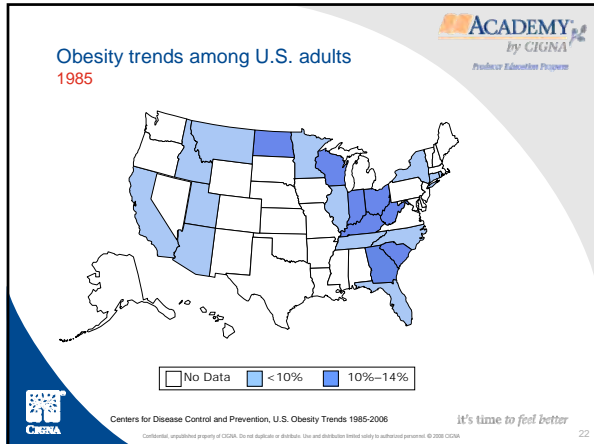


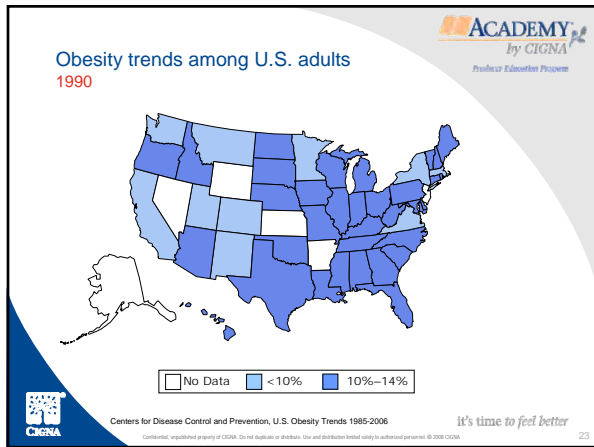
Health Risk	Total Cost (Billions)	Cost/employee
Obesity	\$117 B	\$800
Smoking	\$157 B	\$1060
Hypertension	\$37 B	\$250
Diabetes	\$98 B	\$660
Stress	\$150 B	\$1010
Inactivity	\$77 B	\$520

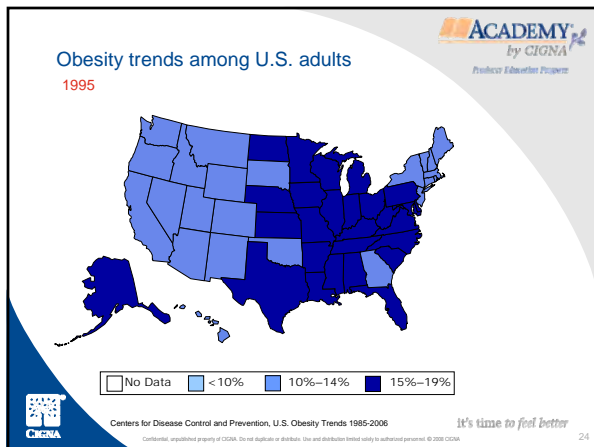
Health Promotion Advocates, www.healthpromotionadvocates.org, from statistics kept by:
 • CDC, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Journal of Occupational & Environmental Medicine
 Cost/employee calculation uses size of civilian workforce per U.S. Bureau Labor Statistics, November, 2005

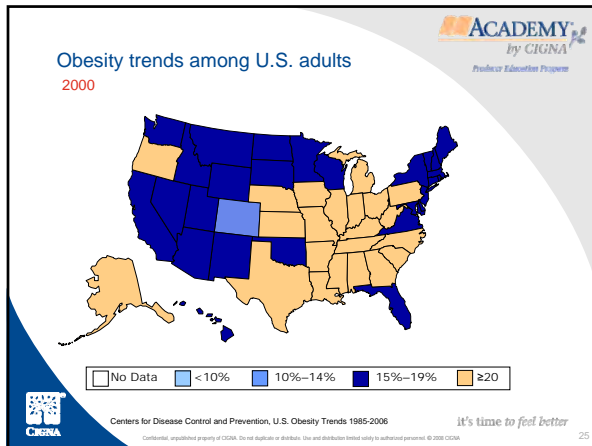
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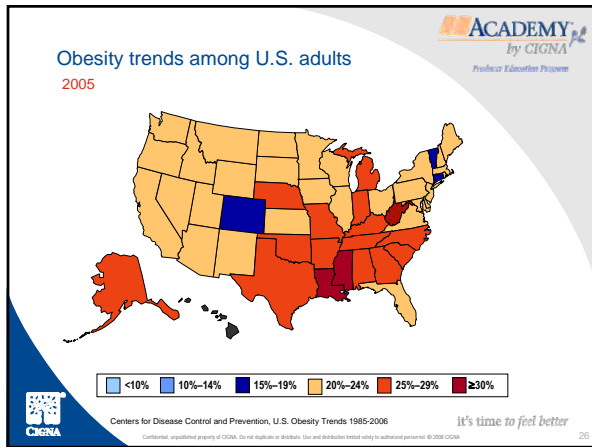
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Impact of rise in obesity*

- Obesity is associated with the fastest growing causes of disability (diabetes and musculoskeletal) and plays a major role in disability at all ages
- Obese adults spend more on health care services and medications
- Obese adults are more likely to be limited in performing Activities of Daily Living (ADL) limitations
- Obesity is linked to higher health care costs than smoking or drinking
- Obese workers have the highest prevalence of work limitations – 7%, compared with 3% among normal weight employees

Obesity-related disabilities can cost employers up to \$8,720 per claimant per year

*Centers for Disease Control and Prevention, 2003

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Chronic illness facts

- In 2005, 133 million Americans (almost half of the population) suffered from one or more chronic conditions¹ - expected to reach 157 million by 2020²
- 75 percent of the nation's \$2 trillion medical care costs attributed to people with chronic diseases¹
- 1 in 3 Americans born in 2000 will develop diabetes²

¹Centers for Disease Control and Prevention, March 2008
²Centers for Disease Control and Prevention, 2003

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Chronic illness facts (cont)

Per the Milken Institute report, the 7 common chronic conditions are:

- Cancer
- Diabetes
- Hypertension
- Stroke
- Heart disease
- Pulmonary conditions
- Mental disorders

An Unhealthy America: The Economic Burden of Chronic Disease Milken Institute 2007

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Chronic illness facts (cont)

- Reducing overweight and obesity rates back to 1998 levels (32.2% and 19.0%, respectively) by 2023 could result in:
 - Reduction in the number of cases of chronic illnesses by 15 million
 - Decrease in medical costs by about \$60 billion
 - Increase in productivity by about \$250 billion in 2023
- Based on current trends adult smoking rates are projected to fall to 19% by 2023 - if we can achieve a 15% rate, that could result in:
 - 9.4 million fewer chronic illnesses
 - \$31 billion less in treatment costs
 - \$79 billion in added productivity

An Unhealthy America: The Economic Burden of Chronic Disease Milken Institute 2007

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Traditional versus Total Cost view of top 10 conditions

	Medical	Pharmacy	Medical and Pharmacy	Productivity	Total Cost
1	Other cancer	High cholesterol	Other cancer	Fatigue	Back/neck pain
2	Back/neck pain	GERD	Back/neck pain	Depression	Depression
3	Other chronic pain	Arthritis	CHD	Back/neck pain	Fatigue
4	CHD	Diabetes	Other chronic pain	Sleeping problem	Other chronic pain
5	Sleeping problem	Depression	High cholesterol	Other chronic pain	Sleeping problem
6	High cholesterol	Hypertension	GERD	Arthritis	High cholesterol
7	Hypertension	Asthma	Diabetes	Hypertension	Arthritis
8	Diabetes	Allergy	Sleeping problem	Obesity	Hypertension
9	Headache	Anxiety	Hypertension	High cholesterol	Obesity
10	Depression	CHD	Arthritis	Anxiety	Anxiety

American College of Occupational and Environmental Medicine, 2007 GERD = gastroesophageal reflux disease
CHD = coronary heart disease

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Lost productivity related to absence & presenteeism compared to medical & pharmacy costs

Presenteeism Lost Productivity 34%

Medical Costs 25%

Absenteeism Lost Productivity 36%

STD/LTD/WC 5%

IBI Research Insights, May 2007 - Single employer example

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Components of lost productivity costs

Direct cost

- Wage replacement
- Overtime pay
- Temporary staff
- Hiring & training new staff

Indirect cost

- Lost productivity
- Lost revenue from:
 - Goods and services not produced
 - Customer dissatisfaction due to work not being completed

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Putting together a comprehensive and proactive solution

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Putting together a comprehensive and proactive solution

"If employers do nothing, up to 2% of their population will automatically migrate to a higher risk status each year."

Dee Edington, Ph.D.
Director, Health Management Research Center
University of Michigan

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Traditional focus - managing the event

Medical/Disability Event

Disability Management
Utilization Management
Case Management
Disease Management

High Risk Medium Risk Low Risk

Original chart source: Musich, Schultz, Burton, Edington. DMAHO. 12(5):299-326, 2004

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Practical strategies that make an impact


- Employers can improve health and productivity by following a model that brings together medical, behavioral, pharmacy, disability, dental, vision, disease management, leave management, and other employee programs to sustain and improve worker health and productivity:
 - Match the right people to the right programs
 - Provide the right resources at the right time
 - Use the right information to connect employee health and productivity to the health of your business

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A model for integration




identification

- **Identification** – Using employee information and leveraging clinical interactions to identify, early, those at risk of a disability claim and then matching the right people to the right programs



intervention

- **Intervention** – Providing the right combination of programs and resources at the right time to impact employee health and productivity



information

- **Information** – Using robust data analytic and reporting tools to help connect the health and productivity of employees to the health of the employer's business

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Identifying those at risk of lost productivity

Strategy: Identification – based on data from various sources

- Health risk appraisals
- Predictive tools and models:
 - Medical, pharmacy and behavioral claim data
 - Data re: historical disability and absence patterns
 - Data re: satisfaction with job, manager, co-workers

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Future trends and opportunities

- Predictive models and health risk assessments
- Single intake/outreach
- "Stay at work programs"
- Create a work environment that engages employees in health & productivity
- Incentive programs
 - Rewards but also leverage all benefits programs to incent employees to do the right thing



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Summary

- Integration does work!
 - Medical and return to work management can result in improved outcomes
- The challenges are daunting but must be addressed
 - Aging population, increasing rate of health risks, chronic illnesses poses a major health, medical cost and lost productivity cost problem
- Health risks drive cost
 - Lost productivity related to disability, absence and presenteeism represents a large portion of the total cost of injury and illness to an employer – health risks drive costs
- There are solutions that are working
 - We have an opportunity to improve health and address those lost productivity costs by working with consumers to mitigate health risks and better control established illness

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A case for integration

- Case Study 1: Integration in action: identification
- Case Study 2: Integration in action: intervention

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Integration in action: identification

Scenario:


- 38 year-old female with a history of high risk pregnancies
- Assigned to bed rest and treatment with weekly progesterone injections

What CIGNA did:

- Disability nurse case manager contacted medical high risk case manager, who worked to negotiate a substantially reduced treatment cost for injections
- Disability nurse case manager and medical high risk case manager stayed in touch with the employee and the medical high risk case manager monitored her compliance with the treatment plan

Results:

- Employee delivered healthy, full-term baby and returned to work full-time four weeks after delivery, ahead of schedule

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Integration in action: intervention

Coordination of disability, health care, and behavioral health services helps employee with traumatic brain injury return to work

Scenario:


- 31 year-old male who suffered a motor vehicle accident resulting in multiple injuries
- Treated by multiple physicians with multiple therapies – occupational, speech, physical

What CIGNA did:

- Disability nurse case manager worked with medical nurse case manager who coordinated employee's cognitive therapy and monitored employee's compliance with his therapies
- Disability nurse case manager referred mother to a behavioral health counselor to help with emotional issues

Results:

- Employee recovered and returned to work full-time to his former position 15 months after accident

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Closing comments and questions



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