Population Health Management: Improving Health Where We Live, Work, and Play

We will begin at 12:00 PM (EST)

Thank you for joining us today. Today’s webinar features broadcast audio. Please make sure your computer speakers are on.
Population Health Management: Improving Health Where We Live, Work, and Play

We will begin shortly.

The findings and conclusions in this webinar are those of the presenters and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
Population Health Management: Improving Health Where We Live, Work, and Play

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Welcome and Introductions

Pam Allweiss, MD, MPH
Medical Officer
CDC Division of Diabetes Translation
Today’s Presenters

Ron Loeppke, MD, MPH, FACOEM, FACP
Vice Chairman
U.S. Preventive Medicine

Jeanette May, MPH, PhD
Principal Investigator
Robert Wood Johnson Foundation Grant
Why are we here?

Hot off the press from CDC researchers

• We have an epidemic of diabetes AND in the past two decades, managing diabetes has become more expensive, mostly due to the higher spending on drugs.
• CDC researchers also asked whether costs were higher because people used health services more, or because the price of the service had risen.
  • The answer? Both
  • Patients now use more medication, and the costs of the drugs have also risen.
Goals

• Learn about the benefits of population health management where people live, work, and play.
• Learn strategies for collaboration between worksites and communities to improve health.
• Learn about resources in the public domain that can used to improve health management in worksites and communities with an emphasis on the launch of the new Diabetes at Work website.
What Is The National Diabetes Education Program (NDEP)?

• Established in 1997 as an initiative of the U.S. Department of Health and Human Services to:
  – Promote early diagnosis.
  – Improve diabetes management and outcomes.
  – Prevent/delay the onset of type 2 diabetes in the United States and its territories.
• Jointly sponsored by Centers for Disease Control and Prevention (CDC) and National Institutes of Health (NIH).
• Involves 200+ federal, state, and private sector agency partners.
What Is the NDEP Business Health Strategies Stakeholders’ Group?

• Public and private partners such as:
  – Business coalitions
  – Occupational health providers (ACOEM and Association of Occupational Health Nurses)
  – Population Health Alliance
  – Health plans
  – State health departments
Making the Community an Integral Part of Your Care Team

• Better health, better healthcare and better value
Population Health Management
Ron Loeppke, MD, MPH, FACOEM, FACPM
Population Health Management: Overview of Presentation

• **WHY?**
  Delineate the converging trends that are advancing the value of health and the power of prevention in Population Health Management

• **WHAT?**
  Discuss the solid business case for why employers are interested in Population Health Management

• **HOW?**
  Examine the attributes and results of successful workplace oriented Population Health Management initiatives
Converging Trends Driving the Need for Population Health Management

• Epidemiological trends
• Political trends
• Cultural trends
• Financial trends
  o The Problem
    o The cost crisis is due in large part to the health crisis
  o The Bigger Problem
    o Total cost impact of poor health to employers
  o The Solution
    o Evidence based population health management
Converging Trends Driving the Need for Population Health Management

Epidemiological Trends

• The global burden of health risk and chronic illness
• The Age Wave—Silver tsunami about to hit the healthcare system
• The compression of morbidity
The Challenge – The Epidemic of Non-communicable Diseases (NCDs)

- Global drivers of mortality due to unhealthy lifestyle behaviors:
  - Five lifestyle behaviors
    - Physical inactivity
    - Poor nutrition
    - Smoking
    - Alcohol
    - Medicine non-adherence
  - Five chronic conditions
    - Diabetes
    - Heart disease
    - Lung disease
    - Cancer
    - Mental illness

75% of deaths worldwide
When the Age Wave Hits the Shore: Implications for Caring for Aging Baby Boomers
Healthcare Costs: Which Matters More
Age or Health Risk?

Age Range

- 19-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75+

Annual Medical Costs

- $0
- $3,000
- $6,000
- $9,000
- $12,000

Low Med Risk

High Med Risk

Personal Health Behaviors are the Main Causes of Death

Health Behaviors: The Main Mortality Risk Factors in U.S.

Lifestyle 51%
Heredity 20%
Environment 19%
Health Services 10%

The compression of morbidity relates to postponing the age of onset of morbidity, disability and cumulative health costs—even though life expectancy-- is increased largely by reducing health risks.

Converging Trends Driving the Need for Population Health Management

• Epidemiological Trends
  – Global burden of risk and illness
  – The Age Wave—Silver tsunami about to hit the healthcare system
  – Compression of morbidity

• Political Trends
  – ACA National Prevention Strategy
  – Aligning incentives among consumers, providers, and employers
  – ACOs/PCMHs
ACOs/PCMH Definitions

• **Accountable Care Organizations (ACOs)**
  – Care model that makes physicians and hospitals more accountable
  – Outcomes oriented, performance-based with aligned incentives
  – Goal: improve value of health services, control costs, improve quality
  – ACOs share in a portion of any savings gained

• **Patient Centered Medical Home (PCMH)**
  – “Whole-person” and “Whole Population” orientation
  – Integrated and Coordinated Care
  – More emphasis on quality, safety, better access to physicians
  – Aligned incentives for improving health as well as better clinical outcomes
Converging Trends Driving the Need for Population Health Management

- **Epidemiological Trends**
  - Global burden of risk and illness
  - The Age Wave—Silver tsunami about to hit the healthcare system
  - Compression of morbidity

- **Political Trends**
  - Aligning incentives among consumers, providers, employers
  - ACOs/P4P/PCMH…Consumer-centered health home

- **Cultural Trends**
  - Health is the new green: The ultimate sustainability strategy
  - Social networking/game theory innovations in health
  - Mobile/wireless tech transforming the healthcare industry
Mobile Technology: The World’s Most Ubiquitous Platform

• More people have access to cell phones than drinking water, electricity or a toothbrush.

By 2020, ~160 million Americans monitored and treated remotely for at least one chronic condition

Prescription Apps – Wireless Engagement

- Poised to transform healthcare as we know it
- Effective channel to deliver behavior change interventions to large groups at lower costs (Noar & Harrington, 2012)
- Perpetual Connectivity/Communication
  - Information into knowledge
  - Reminders/notifications
  - Knowledge into action
  - Clinical and social support
  - Action into results
- Always with you, always on
Converging Trends Driving the Need for Population Health Management

Epidemiological Trends
– Global burden of risk and illness
– The Age Wave—Silver tsunami about to hit the healthcare system
– Compression of morbidity

Political Trends
– Aligning incentives among consumers, providers, and employers
– ACOs/PCMHs

Cultural Trends
– Wellness is the new green: The ultimate personal sustainability
– Social networking/game theory innovations in wellness
– Mobile/wireless tech transforming the healthcare industry

Financial Trends
– The Problem: The cost crisis is largely due to the health crisis
Patients with chronic diseases account for 75% of U.S. healthcare costs

Of the $3 trillion spent on U.S. health care

Of every dollar spent…

…75 cents went towards treating patients with one or more chronic diseases

In public programs, treatment of chronic diseases constitute an even higher portion of spending:

More than 96 cents in Medicare…

…and 83 cents in Medicaid

“The United States cannot effectively address escalating health care costs without addressing the problem of chronic diseases.”

-- Centers for Disease Control and Prevention
Population Health Management:
Good Health is Good Business

• As health risks go so go health costs
• Dr. Dee Edington
  – Zero Trends
Learning from the Past

An Ounce of Prevention is Worth a Pound of Cure
- Benjamin Franklin -
Converging Trends Driving the Need for Population Health Management

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Political Trends
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Cultural Trends
- Wellness is the new green: The ultimate personal sustainability
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- Mobile/wireless tech transforming the healthcare industry

Financial Trends
- The Problem: The cost crisis is largely due to the health crisis
- The Bigger Problem: Total cost impact of poor health to employers
The Bigger Problem: The Full Cost of Poor Health

Medical Care
- Pharmaceutical costs

Productivity Costs

Absenteeism
- Short-term disability
- Long-term disability

Presenteeism
- Overtime
- Turnover
- Temporary staffing
- Administrative costs
- Replacement training
- Off-site travel for care
- Customer dissatisfaction
- Variable product quality

Top 10 Health Conditions by Med + Rx Costs
Per 1000 FTEs for Employers

Top 10 Health Conditions by Full Costs for Employers
(Med + RX + Absenteeism + Presenteeism) Costs/1000 FTEs

The Business Value of Better Health and Productivity

• Market cap value impact from regaining one day of productivity per year per FTE
• 58,000 employees, current 8 days per FTE of health-related productivity loss

1 day per FTE of regained productivity = $18.8M EBITDA impact

13x (EBITDA Multiple)

$244.4M estimated market cap increase ÷ 292M shares

$0.84 in additional per share value

Converging Trends Driving the Need for Population Health Management

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Financial Trends
- The Problem: The cost crisis is largely due to the health crisis
- The Bigger Problem: Total cost impact of poor health to employers
- The Solution: Evidence Based Population Health Management
Evidence-Based Preventive Medicine a Key Component

• Centers for Disease Control and Prevention has found that:
  – 80 percent of heart disease and type 2 diabetes
  – 40 percent of cancer are *preventable*
  – If people just:
    – stopped smoking
    – ate healthy
    – exercised
Whole Population Health Management

**Primary Prevention**
- Wellness/Health Promotion

**Secondary Prevention**
- Screening/Early Detection

**Tertiary Prevention**
- Early Intervention/Care Mgmt

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Better Health, Better Healthcare and Better Value

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86 million Americans have PRE-DIABETES

29 million Americans have DIABETES

21 million of those are DIAGNOSED

17 million of those are TREATED

8.5 million have their disease CONTROLLED

77 million are UNAWARE

8 million are UNDIAGNOSED

4 million are diagnosed but NOT TREATED

8.5 million are treated but NOT SUCCESSFULLY CONTROLLED

20.5 million have Diabetes that is NOT CONTROLLED

Goal: Reduce or Eliminate Risk Factors and Avert Disease

Goal: Find and Treat Disease in Its Earliest Stages to Stop Its Progression

Goal: Manage Disease to Avoid Complications and Disease Progression

Goal: Manage Disease to Avoid Complications and Disease Progression

Goal: Avert Onset of Diabetes or Costs due to Untreated or Uncontrolled Disease

Sources: NIH, CDC, ADA.
The Association of Technology in a Workplace Wellness Program With Health Risk Factor Reduction

Ron Loepke, MD, MPH, Dee Edington, PhD, Joel Bender, MD, MPH, MSPH, and Ashley Reynolds, MSN, RN

Objective: Determine whether there is a relationship between level of engagement in workplace wellness programs and population/individual health risk reductions. Methods: A total of 704 employees from 15 employers completed health risk appraisal and laboratory testing at baseline and again after 2 years of participating in their personalized prevention plan. Population and individual health risk transitions were analyzed across the population, as well as by stage of engagement. Results: Of those individuals who started in a high risk category at baseline, 48% moved down to medium risk and 19% moved down to low risk category after 2 years on their prevention plan. In the group that only engaged through the Web-based technology, 24% reduced their health risks (p < 0.0001). Conclusions: Engaging technology and interactive Web-based tools can engage individuals to be more proactive about their health and reduce their health risks.

Chronic illness and health care costs are advancing at a staggering rate worldwide. The World Economic Forum, in its Global Health 2010 report, indicated that the impact of developing countries as well as advanced economies from the “silent pandemic” of chronic illnesses (diabetes, heart disease, and cancer) is a critical global risk that is destructive and debilitating to individuals as well as nations and that the only sustainable solution is a greater emphasis on prevention. These epidemic increases are largely attributable to lifestyle- or behavior-related causes such as unhealthy eating habits, smoking, or sedentary lifestyles. Given the converging epidemiological, political, cultural, and financial trends, delivering accountable care organizations and patient-centered medical home initiatives is the need for better health at lower cost. This requires a sustainable prevention strategy in concert with benefits at work, therefore, engagement interventions to the growing burden of health risks leading to the expanding burden of chronic illness as not only a fiscal imperative but also a clinical and moral imperative.1,2

The current risk model in the United States is not designed to meet the real health and wellness needs of people. Therefore, employers fund the majority of the economic burden of this broken system, because they pay for the ever increasing costs of medical care while our system spends less than $0.05 of every health care $1.00 on prevention to help promote a healthier, safer, more productive workforce. A large percentage of 137 million employees in the United States receive health benefits at work, therefore, employers have a unique opportunity to play a stronger role because lifestyle risks and medical conditions directly influence productivity. Workplace health and wellness initiatives now reach millions of workers, with occupational health professionals designing and delivering wellness and prevention services typically impacting employees many hours per year compared with the minutes spent in a primary care physician’s office each year. Occupational health providers are a critical medical resource for the nation’s workers and their dependents. With its emphasis on prevention, the relevance of occupational health and its sphere of influence on population health management are a great resource of medical support for patient-centered medical homes and accountable care organizations. By embracing a prevention and health promotion strategy, employers have the capability and expertise to meet the challenges of creating a more resilient, healthier workforce and improving their bottom line.

US Preventive Medicine, Inc (Brentwood, TN), has created an innovative information technology solution for a personalized prevention plan, the Prevention Plan. The Prevention Plan leverages social cognitive concepts such as efficacy building, self-regulatory mechanisms like goal setting and self-monitoring, which facilitate health behavior change.3 This Web-based prevention plan allows individual users to complete a health risk appraisal (HRA), biometric reporting, and laboratory testing to develop a customized prevention plan. The plan provides users with knowledge of their health risks as well as suggestions to reduce those risks. In addition, each user is provided a suite of support tools, recommended risk-reduction activities, and information that allows them to translate knowledge into action.

Users were able to complete an HRA, virtual coaching, live coaching, or social challenges to reduce their risks and were able to determine for themselves what level of engagement they preferred. All coaching programs were structured using risk-appropriate educational modules. Live coaches completed the modules telephonically, while virtual coaching was completed using the same content, through self-directed online programs. Both coaching interventions used recommended action programs related to the risks identified from the risk appraisal, laboratory testing, and biometric screening. They were based on identification of barriers, goal setting, and self-monitoring activities aimed at increasing self-efficacy. Live coaches used motivation interviewing as a method for engaging members in the coaching process, which was the only significant difference from the virtual coaching intervention.

NATURAL FLOW OF HEALTH RISK

The tool used to initiate awareness of health, determine health risk status of populations, and raise consciousness about health is the HRA. The health risk and cutoff points used in the HRA have been described previously.4 The most commonly used risk stratification is low-risk status (zero to two risk factors), medium-risk status (three to four risk factors), and high-risk status (five or more risk factors). The first HRA provides baseline information to individuals, with future HRA's indicating the direction individuals are moving on a continuum of health.5 The transition of individuals or percentage of individuals moving from one risk status to another when individuals are not engaged in wellness programs has been described by Dr Dee Edington as the natural flow of health risks. The transitions are measured using Markov chain analyses, a mathematical technique used to examine longitudinal data from the same individuals, which is described in our previous work.6 The risk transitions for the population studied in this article were also analyzed using this same type of Markov chain analyses. It becomes obvious from the diagrams used to display the risk transitions that slowing upward migration into
Significant Overall Health Risk Reduction of Population Participating in a personalized Preventive Plan for 2 Years

Net Movement of Health Risk Levels in Cohort Baseline vs Year 2 on Preventive Plan

N = 7,804

<table>
<thead>
<tr>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>4666</td>
<td>2291</td>
<td>847</td>
</tr>
<tr>
<td>71%</td>
<td>29%</td>
<td>11%</td>
</tr>
<tr>
<td>60%</td>
<td>23%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Population Health Risk Transitions in Markov Chain Analysis After Two Years on a Personalized Preventive Plan

Individual Health Risk Reductions after Participating in their Personalized Preventive Plan for Two Years (Total N = 7,804)

<table>
<thead>
<tr>
<th>Individual Risks</th>
<th># People and % of overall population (7804) with High Risk in Baseline Year</th>
<th># People and % of the Baseline High Risk Group remaining High Risk after Year 2</th>
<th># People and % of the Baseline High Risk Group Reducing Risk out of High Risk after Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>923 (12%) (M=142/90)</td>
<td>179 (19%) (M=143/90)</td>
<td>744 (81%) (M=123/77)</td>
</tr>
<tr>
<td>HDL</td>
<td>328 (4%) (M=31)</td>
<td>134 (41%) (M=30)</td>
<td>194 (59%) (M=41)</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>836 (11%) (M=263)</td>
<td>353 (42%) (M=265)</td>
<td>483 (58%) (M=208)</td>
</tr>
<tr>
<td>Fasting Blood Glucose</td>
<td>1616 (21%) (M=116 mg/dL)</td>
<td>926 (57%) (M=123 mg/dL)</td>
<td>690 (43%) (M=92 mg/dL)</td>
</tr>
<tr>
<td>Body Mass Index (BMI)</td>
<td>3338 (43%) (M=33)</td>
<td>2937 (82%) (M=34)</td>
<td>401 (12%) (M=26)</td>
</tr>
</tbody>
</table>

# Total Medical and Pharmacy Claims Costs for an Employer

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Claims Paid</td>
<td>$125,154,540.78</td>
</tr>
<tr>
<td>Medical Paid</td>
<td>$94,318,172.00</td>
</tr>
<tr>
<td>Rx Paid</td>
<td>$30,836,368.78</td>
</tr>
<tr>
<td>Total Paid</td>
<td>$125,154,540.78</td>
</tr>
</tbody>
</table>
## Example of data analysis evidence-based CARE GAPS

<table>
<thead>
<tr>
<th>Condition</th>
<th>Care Guide</th>
<th>Care Guide Total</th>
<th>Condition Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>Patients with asthma related ER visit</td>
<td>161</td>
<td>4680</td>
</tr>
<tr>
<td>Asthma</td>
<td>Patients with asthma related hospitalization</td>
<td>138</td>
<td>4680</td>
</tr>
<tr>
<td>Asthma</td>
<td>Patients without inhaled corticosteroids or leukotriene inhibitors</td>
<td>2785</td>
<td>4680</td>
</tr>
<tr>
<td>Asthma</td>
<td>Patients without office visit</td>
<td>643</td>
<td>4680</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Patients with CHF or pulmonary edema related ER visit</td>
<td>98</td>
<td>722</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Patients with CHF or pulmonary edema related hospitalization</td>
<td>262</td>
<td>722</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Patients without ACE inhibitors or ARBs (HEDI3)</td>
<td>328</td>
<td>722</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Patients without beta-blocker drugs (HEDI3)</td>
<td>271</td>
<td>722</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Patients without LDL-C or lipid profile test in the last 12 months</td>
<td>611</td>
<td>722</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Patients without office visit in the last 12 months</td>
<td>311</td>
<td>722</td>
</tr>
<tr>
<td>Depression</td>
<td>Patients taking SSRI and bupropion</td>
<td>235</td>
<td>3842</td>
</tr>
<tr>
<td>Depression</td>
<td>Patients with depression related ER visit</td>
<td>121</td>
<td>3842</td>
</tr>
<tr>
<td>Depression</td>
<td>Patients with depression related hospitalization</td>
<td>261</td>
<td>3842</td>
</tr>
<tr>
<td>Depression</td>
<td>Patients without office visit in the last 12 months</td>
<td>2168</td>
<td>3842</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Patients with antiplatelet agent (HEDI3)</td>
<td>328</td>
<td>1638</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td><strong>Patients without HbA1c test in the last 12 months</strong></td>
<td><strong>525</strong></td>
<td><strong>1638</strong></td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td><strong>Patients without lipid profile test in the last 12 months</strong></td>
<td><strong>647</strong></td>
<td><strong>1638</strong></td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td><strong>Patients without nephropathy screening in the last 12 months</strong></td>
<td><strong>1033</strong></td>
<td><strong>1638</strong></td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td><strong>Patients without retinal eye exam in the last 12 months</strong></td>
<td><strong>103</strong></td>
<td><strong>1638</strong></td>
</tr>
</tbody>
</table>
Employer Case Study of Diabetes Care Management:

Inpatient Days and PMPM Costs - Across 3 Years on Diabetes Care Mgmt. Program

N = 299
Employer Case Study of Diabetes Care Management:

Total Annual Costs for 299 Individuals with Diabetes Across 3 Years in Program

*Total Cumulative Cost Savings
After Accounting for the Costs of the Diabetes Care Management Program

N = 299

Pre-Program: $4,528,594.20
Year 1: $3,046,821.96
Year 2: $2,482,357.80
Year 3: $2,393,913.60

*3 Year Cumulative Cost Savings: $5,662,689
# Value-Based Population Health Management

<table>
<thead>
<tr>
<th>Features</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member/Patient</strong></td>
<td><strong>Employer</strong></td>
</tr>
</tbody>
</table>
| - HRA, Lab/Biometric Screening  
  - “Health Home” Concierge  
  - Personal Health Coach/Navigator  
  - Incentives for Engagement | - Personalized Annual Preventive Plan  
  - Establish Dr/Pt (Medical/Health Home)  
  - Warm Transfers/Integrated Services  
  - Financial Rewards/Better Health | - Corporate Culture of Health  
  - Promote/Enhance Well-Being  
  - PHM Value Based Benefit Design  
  - Healthy/Productive Workforce | - Population Health Management  
  - Aligned Incentives for Dr & Pt  
  - Data Driven Outcomes/Results  
  - Public/Private PHM Alignment |
| **Employer** | - Healthy Workplace/Environment  
  - Healthy and Engaged Workforce  
  - Employee Recruitment/Retention  
  - Reduce Total Costs (ROI/VOI) | - Actively Engaged/Informed Patients  
  - Reduce Dr & Pt Hassle Factor  
  - Enhance Capacity of Provider Practice  
  - Financial Rewards/Better Care/Value | - Better Health, Better Care, Better Value  
  - Greater Physician/Patient Satisfaction  
  - Manage Clinical Risk & Financial Risk  
  - Healthier Communities & Economies |
| **Providers/Hospitals** | - Pop Health/Care Mgmt/Coaching  
  - Integrated/Coordinated Care  
  - Leverage High Tech/High Touch  
  - Outcomes Based Incentives | - Personalized Annual Preventive Plan  
  - Establish Dr/Pt (Medical/Health Home)  
  - Warm Transfers/Integrated Services  
  - Financial Rewards/Better Health | - Corporate Culture of Health  
  - Promote/Enhance Well-Being  
  - PHM Value Based Benefit Design  
  - Healthy/Productive Workforce |
Population Health and Public/Private Partnerships

Jeanette May, MPH, PhD
County Health Rankings – Take Action Cycle
Compliance-Driven
- e.g. meeting minimal regulatory standards for worker safety

Charitable
- e.g. corporate giving campaigns that enhance company brand, image

Strategic
- e.g. core business and management systems deployed to generate health and business value

Systemic
- e.g. systemic solutions designed to intentionally generate population health, business value, and address social determinants of health

Adapted from: Visser W. J Bus Systems, 2010; A New CSR Frontier. BSR, 2013; HERO: Role of Corporate America in Community Health, 2014
Efforts to Enhance Public – Private Partnerships

Health Workplaces, Healthy Communities
- HERO Environmental Scan
- HERO Executive Convening
- Dissemination

- Clinton Health Matters
- RWJF Culture of Health
- Health Workplaces, Healthy Communities
- IOM Population Health Roundtable
- Employer Roundtable – Building the Business Case
- Bluezones Prevention Partners, etc.
- HERO Measurement and Metrics
- HWHC Website
- NDEP National Diabetes Education Program
- A program of the National Institutes of Health and the Centers for Disease Control and Prevention

Prevention Partners, etc.
Exploring the Role of Measures

• RWJF – HERO Work (Phase 1,2,3)
  – Explore the role of measures in culture of health community wide efforts
  – Identify measures that resonate with all stakeholders
  – Offer insight into measures that will incentivize the employer community to initially engage and continue to be involved in community health/culture efforts
Resources in the Public Domain

Diabetes at Work website
• www.diabetesatwork.org
• 10 year anniversary
• Completely updated by an NDEP Task Group chaired by Dr. Loeppke

General NDEP materials
• http://www.cdc.gov/diabetes/ndep

Primary Prevention of Diabetes
• http://www.cdc.gov/diabetes/prevention
Diabetes accounts for 15 million work days absent and 120 million work days with reduced performance.

Let’s prevent and manage diabetes. It’s good for employees and good for business.

Spotlight On...

Diabetes is a Common Disease

Diabetes is a common disease, yet every individual needs unique care. We encourage people with diabetes ...

More success stories

What’s New

Use wellness programs to help obese workers, attorneys say

4th of July. Celebrate health... and diabetes.

Featured Resources

→ GAME PLAN Fat and Calorie
→ Diabetes Snapshot

Quick Links

→ Lesson Plans
→ Depression CE
• **Featured Resources**
  – GAME PLAN Fat and Calorie Counter
  – Diabetes Snapshot

• **Quick Links:**
  – Lesson Plans
  – Depression CE
  – Fact Sheets

• **Ask The Expert**
  – Find answers to your questions from experts in diabetes and worksite wellness.
• Diabetes Basics
  – What is Diabetes
  – Diabetes and the Workplace
  – Employees with Diabetes
  – Diabetes Prevention
  – Diabetes Management
  – Emotional Health
  – Healthy Lifestyles
  – Diabetes and Pregnancy
• Plan
  – Understand Your Environment
  – Conduct a Health Risk Assessment
  – Make the Business Case
  – Set Goals, Timeline, Budget
  – Work with Third-party Providers
www.diabetesatwork.org

• **Build**
  – Developing a Culture of Wellness
  – Program Activities
  – Lesson Plans
  – The Health Care Team
  – In the Community
Q&A

Send us your questions through the chat box
Thank you!

Please remember to fill out the survey you will receive immediately after this call.

Visit [www.cdc.gov/diabetes/ndep](http://www.cdc.gov/diabetes/ndep) for more resources for health care professionals and patients.

This presentation will be posted on the NDEP website in a near future. We will send an announcement once it becomes available.
For more information, call 1-800-CDC-INFO (800-232-4636)
TTY 1-888-232-6348 or visit www.cdc.gov/info.
To order resources, visit www.cdc.gov/diabetes/ndep.

Or contact:
Pam Allweiss MD, MPH
Medical Officer
Centers for Disease Control and Prevention
Division of Diabetes Translation
pca8@cdc.gov