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

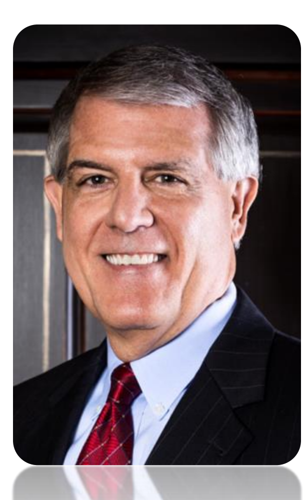
The findings and conclusions in this webinar are those of the presenters and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Welcome and Introductions

Pam Allweiss, MD, MPH

Medical Officer
CDC Division of Diabetes Translation

Today's Presenters



Ron Loeppke, MD, MPH, FACOEM, FACPM
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.

Published online before print January 15, 2015, doi: 10.2337/dc14-1687 *Diabetes Care January 15, 2015*

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)?

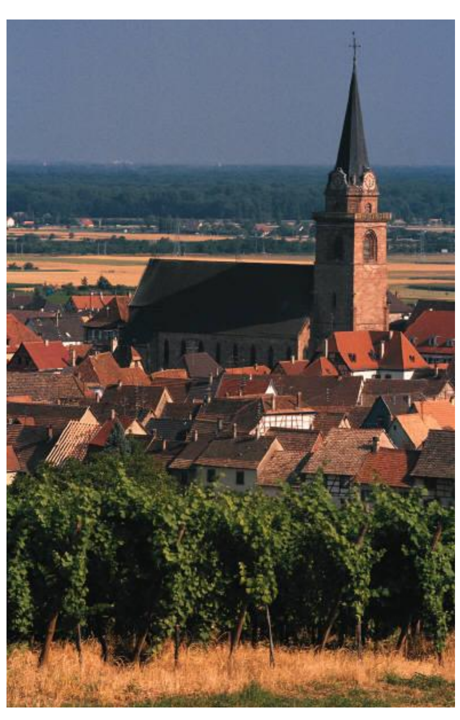
- Established in 1997 as an initiative of the U.S. Department of Health and Human Services to:
  - Promote early diagnosis.
  - Improve diabetes management and outcomes.
  - Prevent/delay the onset of type 2 diabetes in the United States and its territories.
- Jointly sponsored by Centers for Disease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

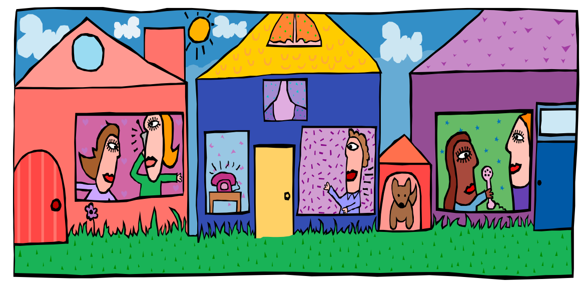
What Is the NDEP Business Health Strategies Stakeholders' Group?

- 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
  - The Problem
    - The cost crisis is due in large part to the health crisis
  - The Bigger Problem
    - Total cost impact of poor health to employers
  - The Solution
    - 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

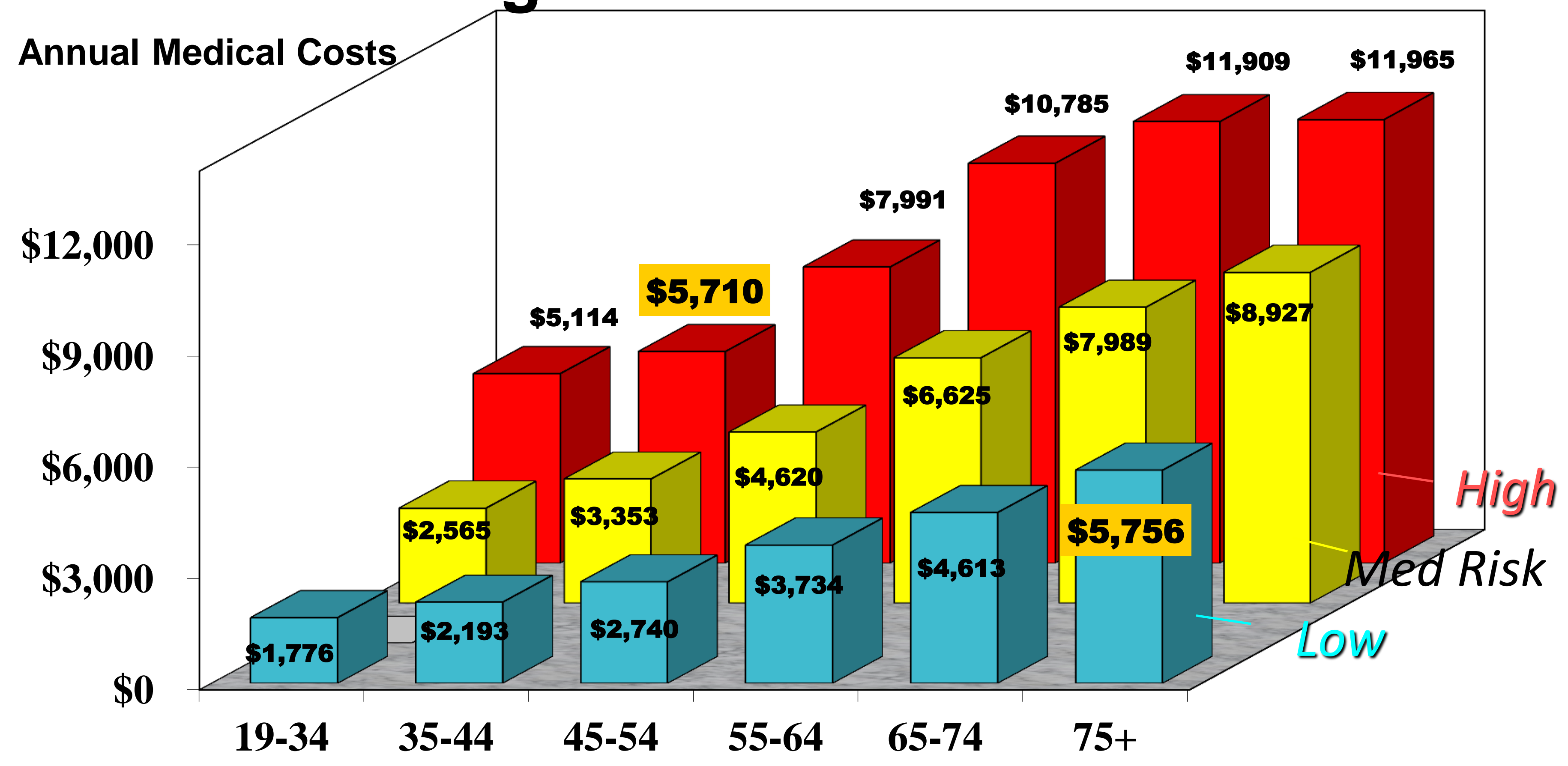
➢ *Five chronic conditions*
- Diabetes
- Heart disease
- Lung disease
- Cancer
- Mental illness

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?



Edington. AJHP. 15(5):341-349, 2001

Personal Health Behaviors are the Main Causes of Death

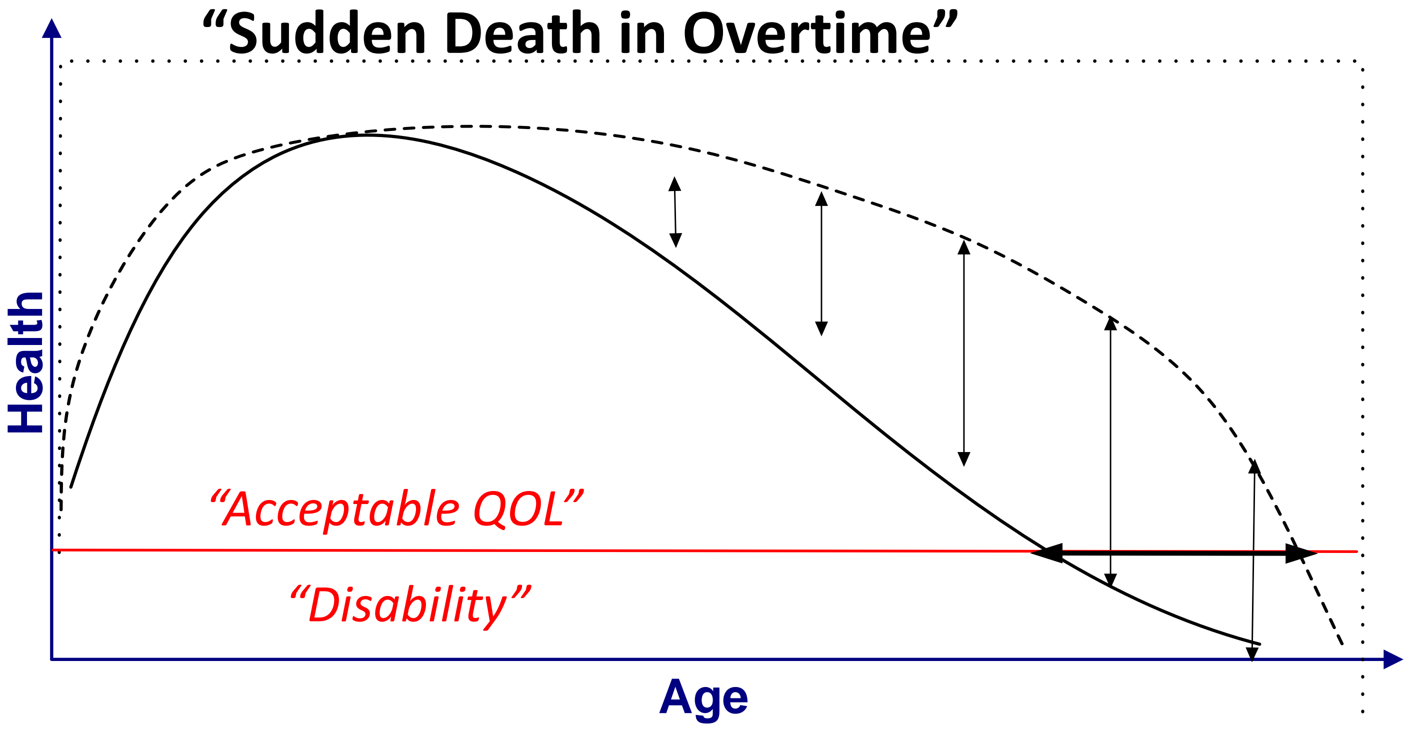
Health Behaviors: The Main Mortality Risk Factors in U.S.

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

Lifestyle
Heredity
Environment
Health Services

Mokdad AH, et.al. Actual Causes of death in the United States, 2000. JAMA. 2004; 291:1238-1245.

Live Healthier Longer and Die More Suddenly at Lower Cost



- 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.

Hubert, Bloch, Oehlert and Fries. Lifestyle Habits and Compression of Morbidity. J Gerontol A Biol Sci Med. June, 2002; 57 (6) M347-51

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.

Source: IMS Report: *The World Market for Internet Connected Devices, 2012.*

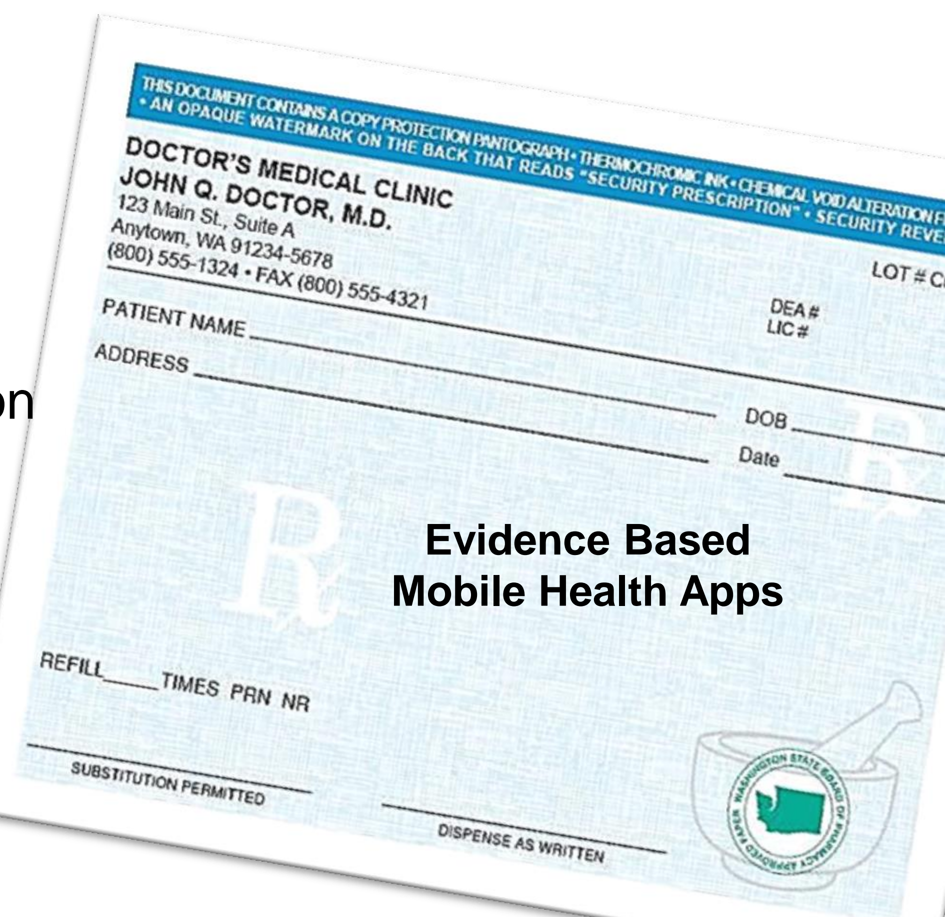
Transforming Healthcare

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

Johns Hopkins University. *Chronic Conditions: Making the Case for Ongoing Care.* Retrieved 10/20/12, from http://www.partnershipforsolutions.org/DMS/files/chronicbook2004.pdf

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**

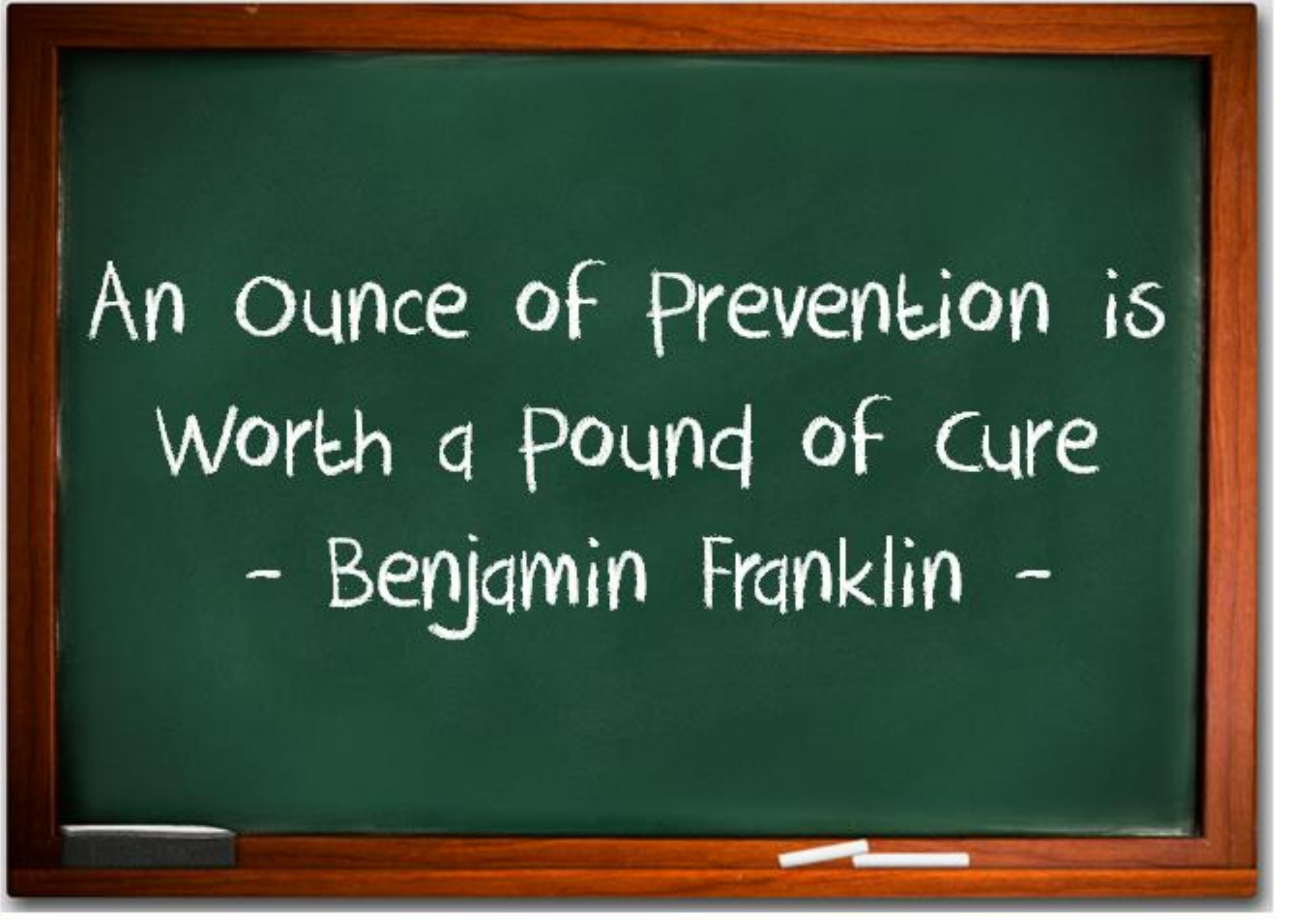
"The United States cannot effectively address escalating health care costs without addressing the problem of chronic diseases."

-- 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



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
- **The Bigger Problem: Total cost impact of poor health to employers**

A program of the National Institutes of Health and the Centers for Disease Control and Prevention

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

30%

Personal Health Costs

Iceberg of Full Costs from Poor Health

70%

Productivity Costs

Sources: Loeppke, R., et al., "Health and Productivity as a Business Strategy: A Multi-Employer Study", JOEM.2009; 51(4):411-428. and Edington DW, Burton WN. Health and Productivity. In McCunney RJ, Editor. A Practical Approach to Occupational and Environmental Medicine. 3rd edition. Philadelphia, PA. Lippincott, Williams and Wilkens; 2003: 40-152

Top 10 Health Conditions by Med + Rx Costs

Per 1000 FTEs for Employers

$200,000
$180,000
$160,000
$140,000
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
$0

Drug
Medical

Other Cancer
Back/Neck Pain
Other Chronic…
Coronary Heart…
High Cholesterol
Arthritis
Depression
Hypertension
Diabetes
GERD

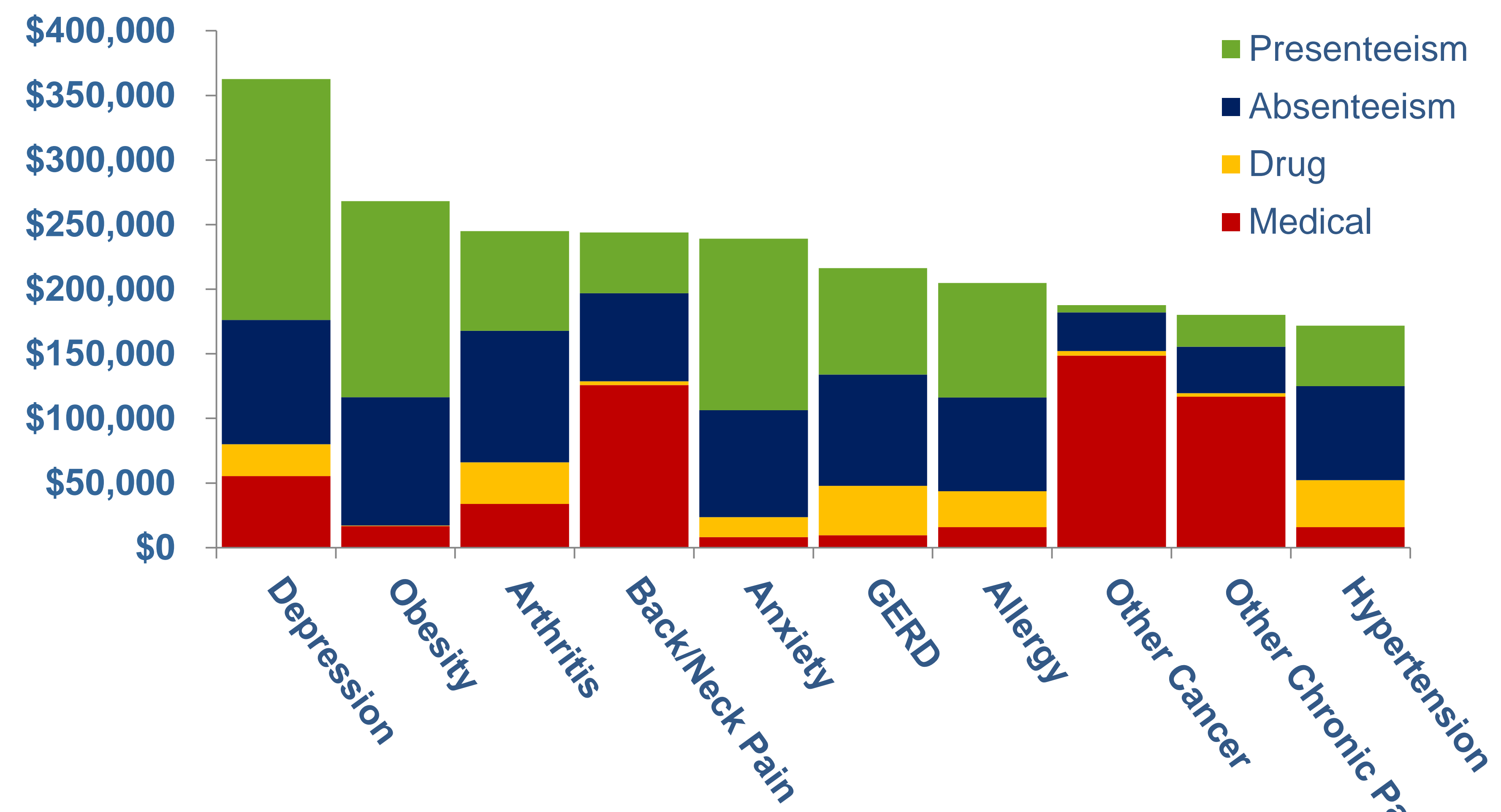
Loeppke, R., et al., "Health and Productivity as a Business Strategy: A Multi-Employer Study". *JOEM*. 2009;51(4):411-428.

NDEP National Diabetes Education Program

A program of the National Institutes of Health and the Centers for Disease Control and Prevention

Top 10 Health Conditions by Full Costs for Employers

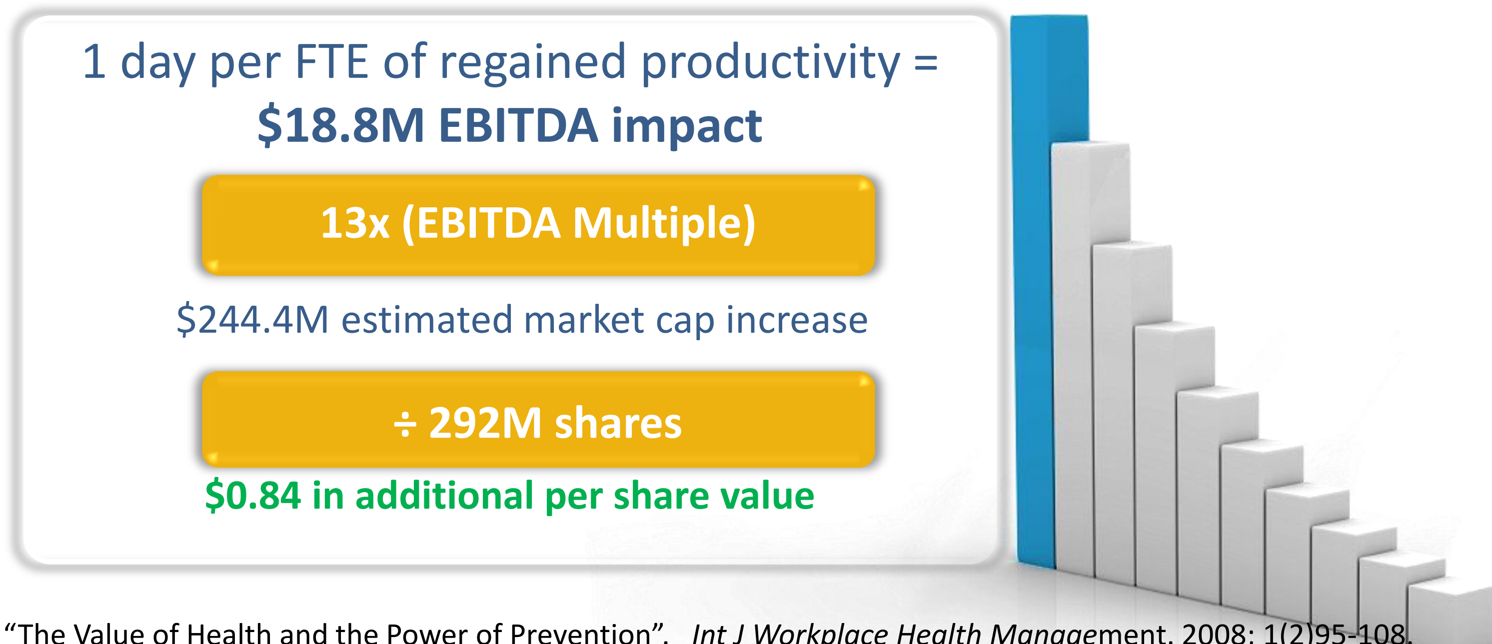
(Med + RX + Absenteeism + Presenteeism) Costs/1000 FTEs



Loeppke, R., et al., "Health and Productivity as a Business Strategy: A Multi-Employer Study". *JOEM*. 2009;51(4):411-428.

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



Loeppke R. "The Value of Health and the Power of Prevention". *Int J Workplace Health Management*. 2008; 1(2)95-108.

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
- 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

STOP

Whole Population Health Management

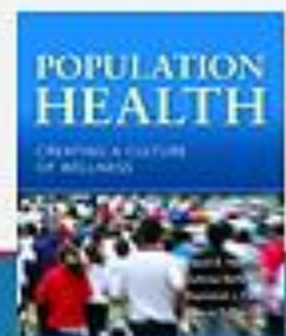
PRIMARY PREVENTION
Wellness/Health Promotion

SECONDARY PREVENTION
Screening/Early Detection

TERTIARY PREVENTION
Early Intervention/Care Mgmt

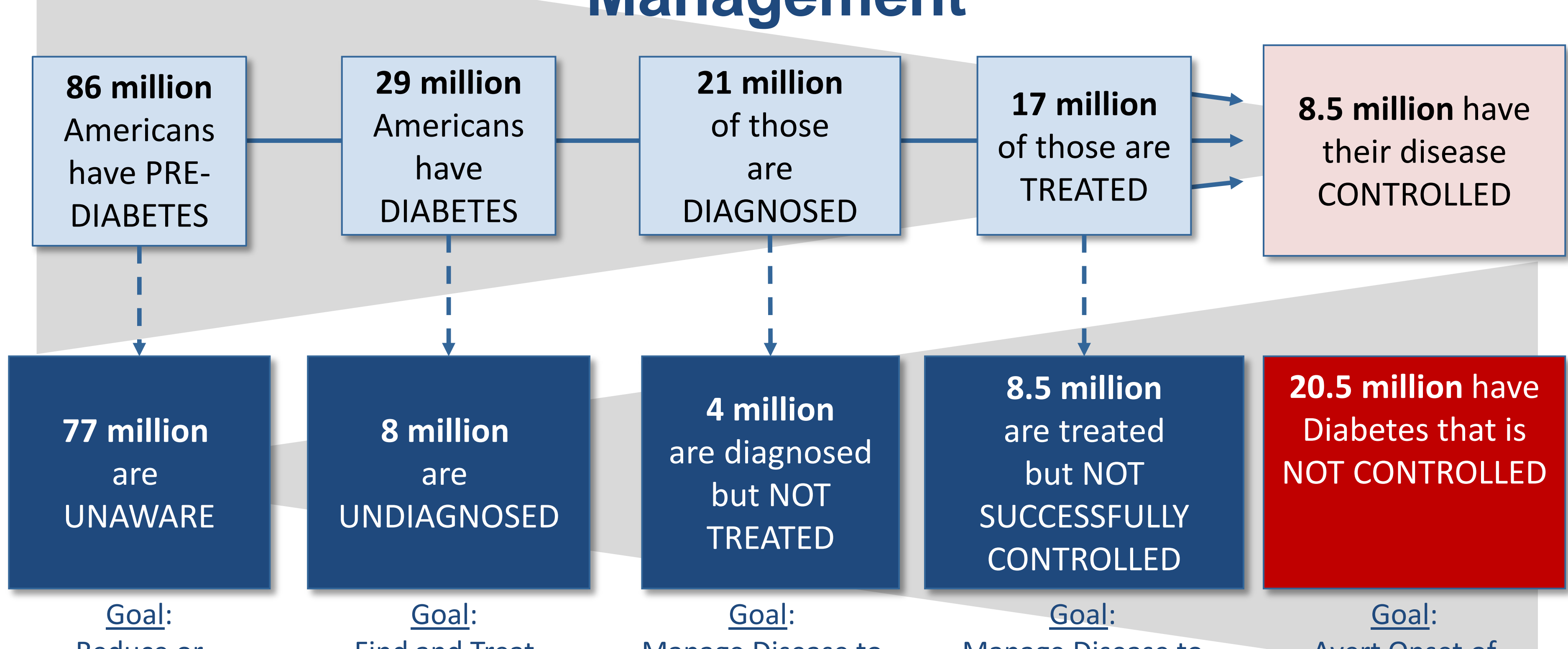
Better Health, Better Healthcare and Better Value

Population of One



Loeppke, R. "Making the Case for Population Health Management: The Business Value of Better Health," Chapter 7, pp 121-138 in Nash, D., et.al., *Population Health Textbook*. Jones and Bartlett Learning. Sudbury, MA. 2010.

Need for Better Diabetes Population Health Management



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.

Full Text
OVID

March 2013 ❍ Volume 55 ❍ Number 3

www.joem.org

JOEM

Journal of Occupational and Environmental Medicine

AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE

❍ New-onset Asthma and Occupational Exposures

❍ Rheumatoid Arthritis Impact on Annual Incremental Health Benefit Costs and Absenteeism

❍ Modifiable Health Risks and Illness Absence from Work

❍ Patient-reported Depression Severity Measured by the PHQ-9 and Impact on Work Productivity

Fast Track Article

❍ Association of Technology in a Workplace Wellness Program with Health Risk Factor Reduction

Wolters Kluwer Health | Lippincott Williams & Wilkins

The Association of Technology in a Workplace Wellness Program With Health Risk Factor Reduction

Ron Loeppke, MD, MPH, Dee Edington, PhD, Joel Bender, MD, PhD, 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 7804 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, 46% 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 empower 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 Risk 2010* report, indicated that the impact on developing countries as well as advanced economies from the "silent pandemic" of chronic illnesses (like 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 dramatic 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, driving 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 effective population health management interventions to reduce 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.[1–3]

The current sick care 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 month 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 solution, the Prevention Plan. The Prevention Plan leverages social cognitive concepts such as efficacy building and self-regulatory mechanisms like goal setting and self-monitoring, which facilitate health behavior change.[4] 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-based educational modules. Live coaches completed these 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 focused on identification of barriers, goal setting, and self-monitoring activities aimed at increasing self-efficacy. Live coaches used motivational 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 risks and cutoff points used in the HRA have been described previously.[5] 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 HRAs indicating the direction individuals are moving on a continuum of health.[6] 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.[7] 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

From US Preventive Medicine, Inc (Drs Loeppke and Bender and Mr Reynolds), Brentwood, Tenn; and Health Management Research Center (Dr Edington), University of Michigan, Ann Arbor.

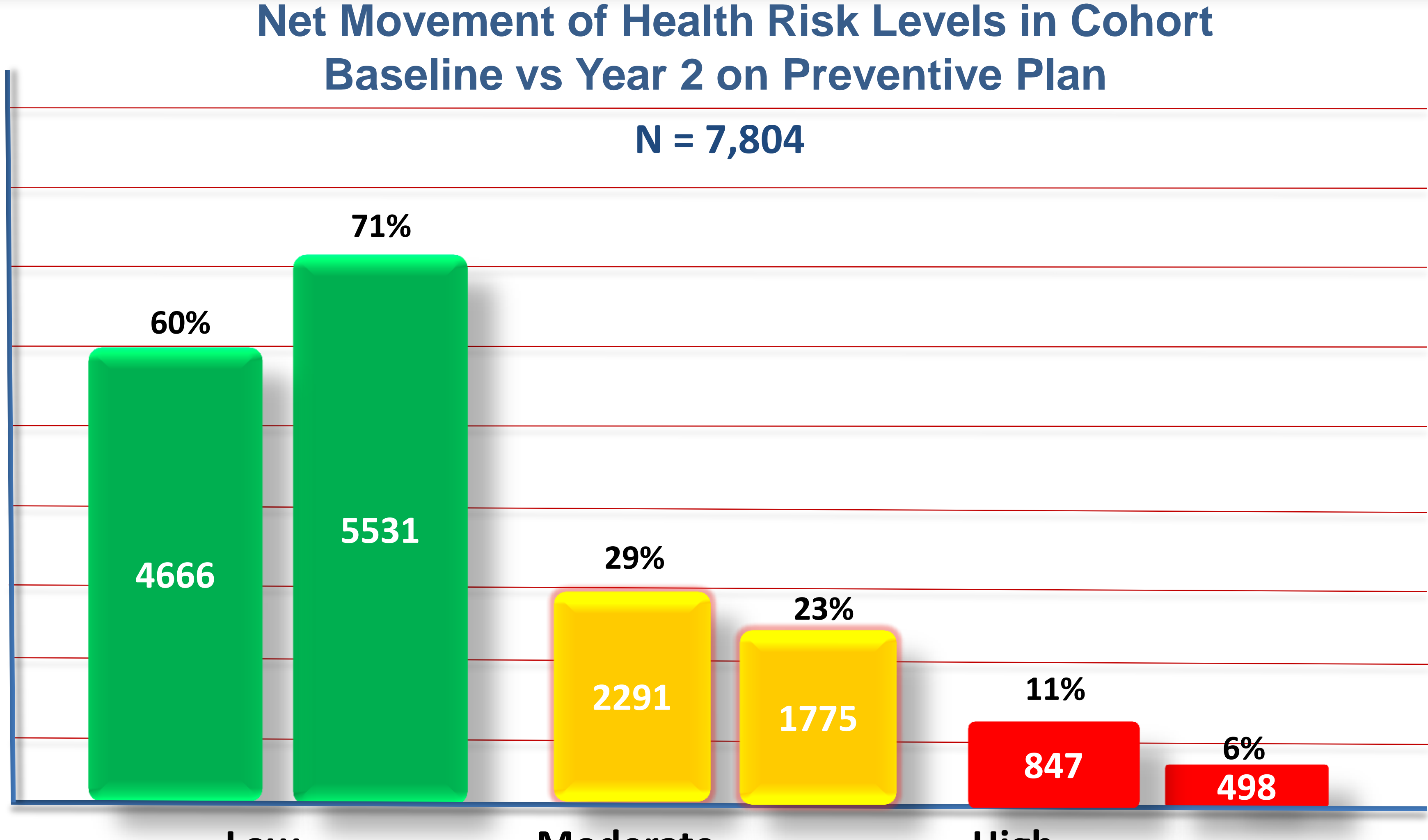
The authors declare no conflict of interest. No funding was received. Dr Ron Loeppke, Dr Joel Bender, and Mr Ashley Reynolds are employees of US Preventive Medicine, Inc, and Dr Dee Edington is a consultant and member of the US Preventive Medicine International Advisory Board.

Address correspondence to: Ron Loeppke, MD, MPH, 5166 Remington Dr, Brentwood, TN 37027 (RLoeppke.MD@USPM.com).

Copyright © 2013 by American College of Occupational and Environmental Medicine

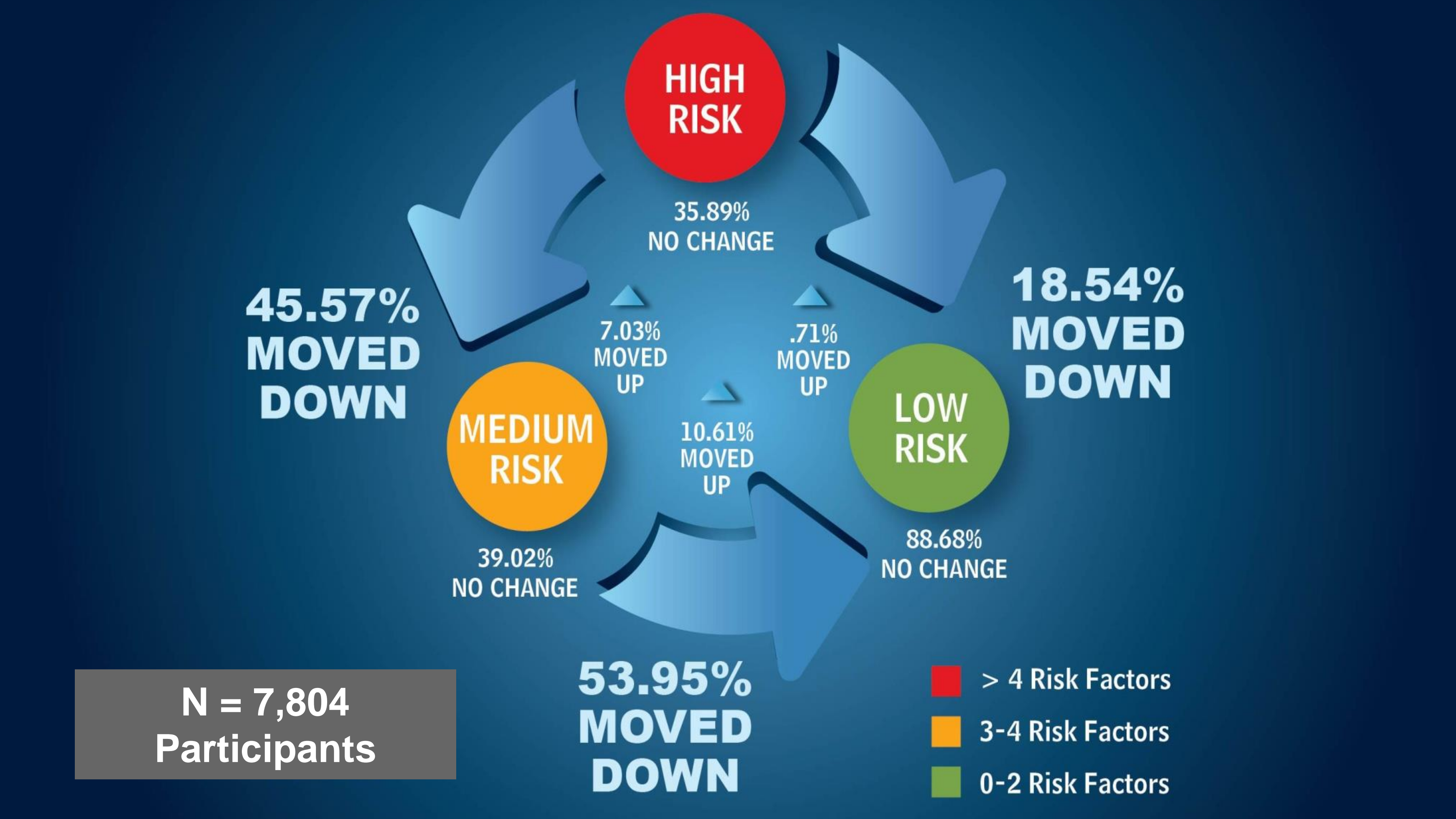
DOI: 10.1097/JOM.0b013e3182898639

Significant Overall Health Risk Reduction of Population Participating in a personalized Preventive Plan for 2 Years



Loeppke, R; Edington, D; Bender, J; Reynolds, A. "The Association of Technology in a Workplace Wellness Program with Health Risk Factor Reduction" Journal of Occupational and Environmental Medicine: March, 2013; Volume 55, Number 3: pp 259–264.

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



Loeppke, R; Edington, D; Bender, J; Reynolds, A. "The Association of Technology in a Workplace Wellness Program with Health Risk Factor Reduction" Journal of Occupational and Environmental Medicine: March, 2013; Volume 55, Number 3: pp 259–264.

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

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

Loeppke, R; Edington, D; Bender, J; Reynolds, A. "The Association of Technology in a Workplace Wellness Program with Health Risk Factor Reduction" Journal of Occupational and Environmental Medicine: March, 2013; Volume 55, Number 3: pp 259–264.

Total Medical and Pharmacy Claims Costs for an Employer

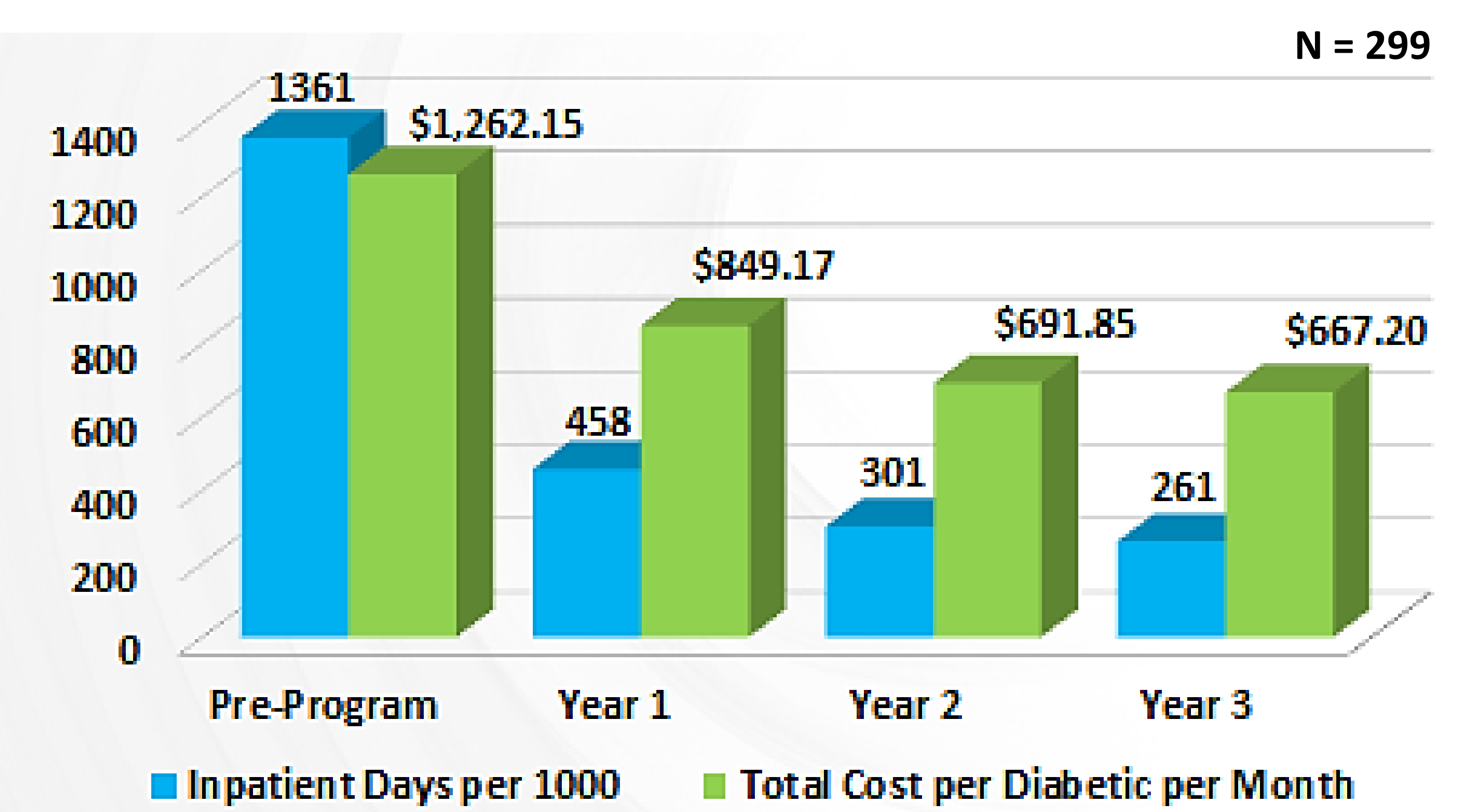
Total Claims Paid between 6/1/2012 - 5/31/2013	
Medical Paid	$ 94,318,172.00
Rx Paid	$ 30,836,368.78
Total Paid	$125,154,540.78

Example of data analysis evidence-based CARE GAPS

	GAPS in EVIDENCE BASED CARE		
Condition	**Care Guide**	**Care Guide Total**	**Condition Total**
Asthma	Patients with asthma related ER visit	161	4680
Asthma	Patients with asthma related hospitalization	138	4680
Asthma	Patients without inhaled corticosteroids or leukotriene inhibitors	2786	4680
Asthma	Patients without office visit	643	4680
Congestive Heart Failure	Patients with CHF or pulmonary edema related ER visit	88	722
Congestive Heart Failure	Patients with CHF or pulmonary edema related hospitalization	252	722
Congestive Heart Failure	Patients without ACE inhibitors or ARBs (HEDIS)	328	722
Congestive Heart Failure	Patients without beta-blocker drugs (HEDIS)	271	722
Congestive Heart Failure	Patients without LDL-C or lipid profile test in the last 12 months	611	722
Congestive Heart Failure	Patients without office visit	311	722
Congestive Heart Failure	Patients without office visit in the last 12 months	577	722
Depression	Patients taking SSRI and bupropion	236	3342
Depression	Patients with depression related ER visit	121	3342
Depression	Patients with depression related hospitalization	261	3342
Depression	Patients without office visit in the last 12 months	2168	3342
Diabetes	Patients with antiplatelet agent (HEDIS)	328	1638
Diabetes	**Patients without HbA1c test in the last 12 months**	**525**	**1638**
Diabetes	**Patients without lipid profile test in the last 12 months**	**647**	**1638**
Diabetes	**Patients without nephropathy screening in the last 12 months**	**1033**	**1638**
Diabetes	**Patients without retinal eye exam in the last 12 months**	**103**	**1638**

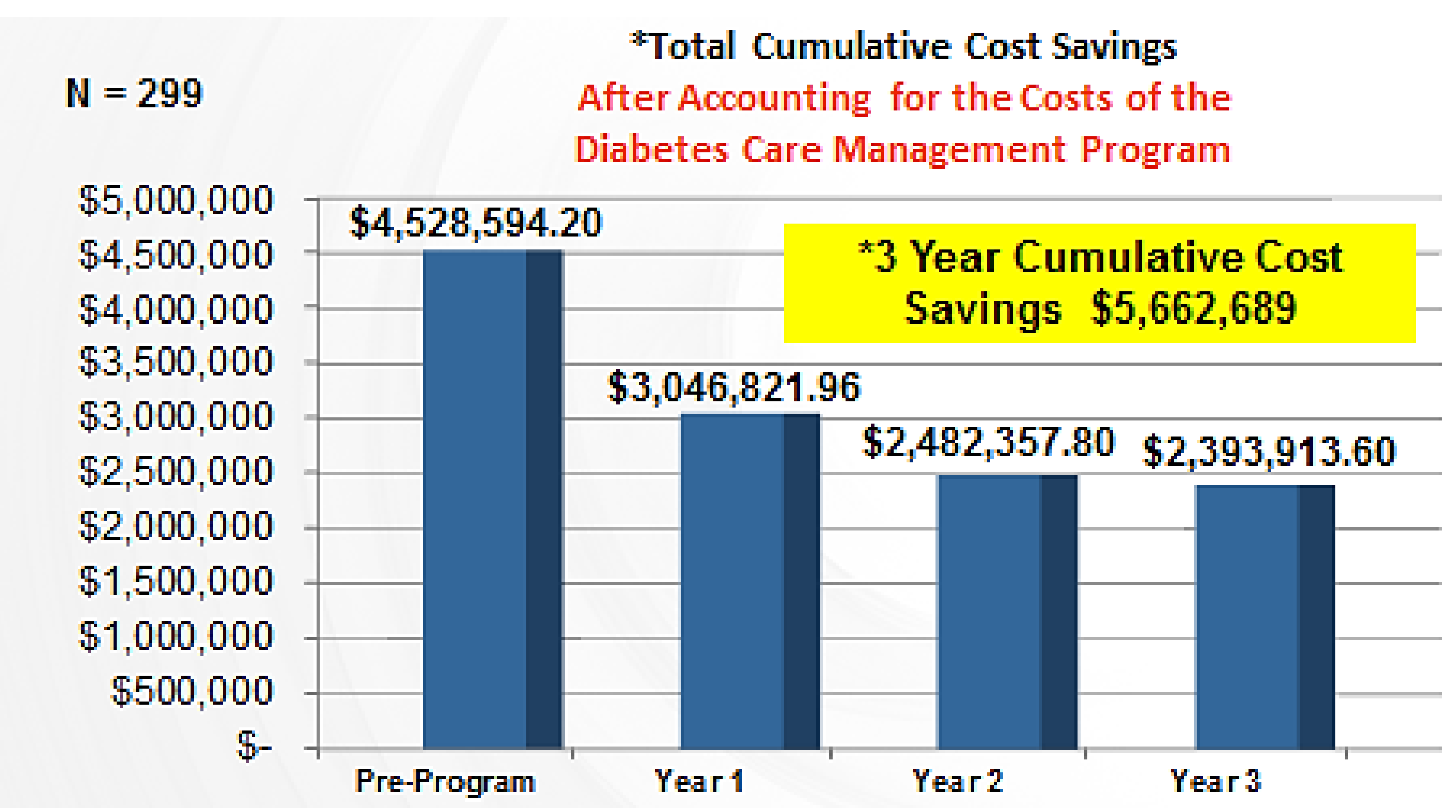
Employer Case Study of Diabetes Care Management:

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



Employer Case Study of Diabetes Care Management:

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

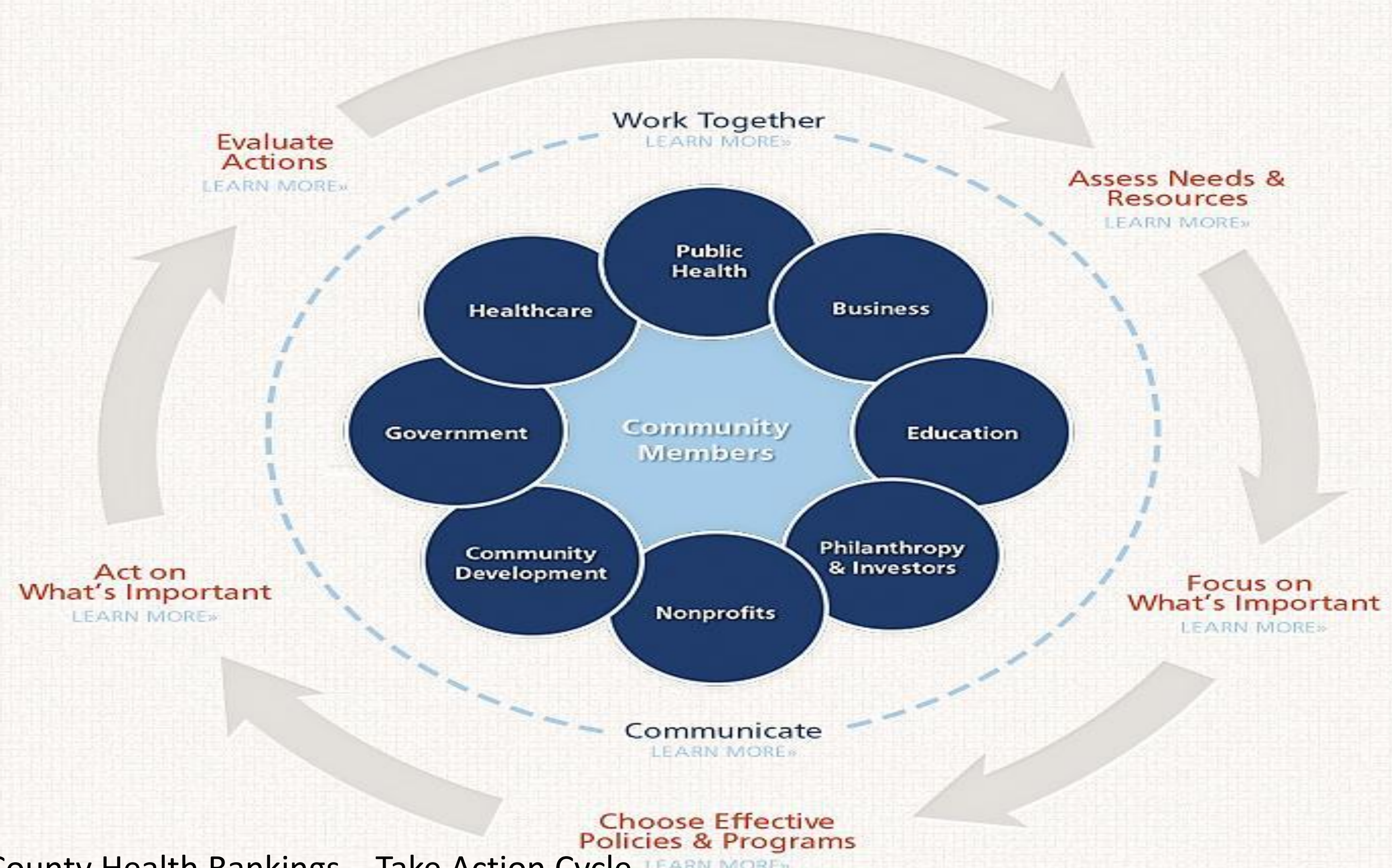


Value-Based Population Health Management

	Features	Benefits
Member/ Patient	▪ 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
Employer	▪ Corporate Culture of Health ▪ Promote/Enhance Well-Being ▪ PHM Value Based Benefit Design ▪ Healthy/Productive Workforce	▪ Healthy Workplace/Environment ▪ Healthy and Engaged Workforce ▪ Employee Recruitment/Retention ▪ Reduce Total Costs (ROI/VOI)
Providers/ Hospitals	▪ Pop Health/Care Mgmt/Coaching ▪ Integrated/Coordinated Care ▪ Leverage High Tech/High Touch ▪ Outcomes Based Incentives	▪ Actively Engaged/Informed Patients ▪ Reduce Dr & Pt Hassle Factor ▪ Enhance Capacity of Provider Practice ▪ Financial Rewards/Better Care/Value
Public/Private Partners	▪ Population Health Management ▪ Aligned Incentives for Dr & Pt ▪ Data Driven Outcomes/Results ▪ Public/Private PHM Alignment	▪ Better Health, Better Care, Better Value ▪ Greater Physician/Patient Satisfaction ▪ Manage Clinical Risk & Financial Risk ▪ Healthier Communities & Economies

Population Health and Public/Private Partnerships

Jeanette May, MPH, PhD



County Health Rankings – Take Action Cycle

Business Case Development and Evolution

Compliance-Driven	Charitable	Strategic	Systemic
e.g. meeting minimal regulatory standards for worker safety	e.g. corporate giving campaigns that enhance company brand, image	e.g. core business and management systems deployed to generate health and business value	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

- RWJF Culture of Health
- IOM Population Health Roundtable
- HERO Measurement and Metrics
- HWHC Website
- Clinton Health Matters
- Bluezones Prevention Partners , etc.
- Employer Roundtable – Building the Business Case

HOME | CONTACT US | NEWS & EVENTS | SEARCH:

Why Invest In a Healthy Community | What To Do | How To Get Involved | Resources

Why Invest in Community Health?

LEARN MORE

What You Can Do

LEARN MORE

How To Get Involved

LEARN MORE

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 Preventrion of Diabetes

- http://www.cdc.gov/diabetes/prevention

Diabetes at Work

A project of the National Diabetes Education Program

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

Featured Resources

- GAME PLAN Fat and Calorie...
- Diabetes Snapshot

Quick Links

- Lesson Plans
- Depression CE

www.diabetesatwork.org

- **Featured Resources**
  - GAME PLAN Fat and Calorie Counter
  - Diabetes Snapshot
- **Quick Links:**
  - Lesson Plans
  - Depression CE
  - Fact Sheets
- **Ask The Expert**
  - Find answers to you questions from experts in diabetes and worksite wellness.

www.diabetesatwork.org

- **Diabetes Basics**
  - What is Diabetes
  - Diabetes and the Workplace
  - Employees with Diabetes
  - Diabetes Prevention
  - Diabetes Management
  - Emotional Health
  - Healthy Lifestyles
  - Diabetes and Pregnancy

www.diabetesatwork.org

- **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** 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

February 2015