The number of “baby-boomers,” often defined as persons born during the period from 1946 to 1964, peaked at almost 79 million in the 2000 U.S. Census. As this massive group dominates the population within the U.S., important issues relating to productivity are arising along with imminent changes in the labor force caused by the exit of this population from the workforce. Consequently, American employers are beginning to think in terms of “human capital.” As human resources become scarcer and knowledge-based work and expedited production demands increase, the health and wellness of employees become even more vital to businesses. As historical performance gains through capital investments and training are maximized, the new realm of enhanced productivity will focus on improving employees’ health and functioning and on decreasing lost productivity as health-related, cost-containment strategies.

On November 3 and 4, 2003, the Institute for Health and Productivity Management (IHPM) held a conference through its Academy for Health and Productivity Management (AHPM) division. The conference featured multiple lecturers and consultants from academia, industry, and the private sector. The IHPM is a non-profit research, development, and education organization whose mission is “to establish the value of employee health as a business investment in corporate success.”

HEALTH AND PRODUCTIVITY MANAGEMENT

Health and productivity management (HPM) is an emerging concept and is one of the last unmeasured areas in the workplace. HPM aims to use productivity metrics and to initiate organizational change to reduce the burden of illness within organizations while promoting health and well-being as the ultimate outcomes.

Dr. Ron Goetzel, vice president of consulting and applied research in the Medstat Group and director of the Cornell Institute for Health and Productivity Management, discussed the mental, psychological, behavioral, and organizational risks that lead to decreased health and productivity in the workplace. He emphasized that employers should advocate health as a goal to be supported and pursued by all divisions of a company in order to create an environment conducive to improvement. Leaders of employee-assistance programs, group health plans, health promotion, risk management, and disease-management programs must all work together to create a business case for the value of health in a given organization. The integration of HPM can be achieved only through collaboration; thus, macroevaluation, microevaluation, and benchmarking must occur before a diagnosis of the problem can be made and change instituted.

Although many employers are beginning to recognize the value of disease management as a cost-containment tool to better manage employees’ health and improve productivity, they do not often take note of the problem of absence and disability in the workplace. Dr. Goetzel presented an economic model that connects costs to risk factors for individual workers based on the type of risk intervention programs that a company offers. These links are then used to predict that a risk reduction of just 1% per year over 10 years can have a tremendous financial impact in terms of decreased costs to organizations. In a world of organizations demanding instant return on investment (ROI), evaluation and cost-effectiveness of such programs must be proven. Interventions such as disease management, work-related disease management, disability management, medical case management, and health promotion (e.g., screenings and immunizations) are all examples of programs that should be implemented, because the resulting cost reductions will ensure continuous quality improvement within the organization.

DISEASE MANAGEMENT

In a real-world example, Dr. Wayne Lednar, vice president and director of Eastman Kodak’s Corporate Medical Division, focused on disease management as one of the initiatives that his company is undertaking. He emphasized that disease management in corporate America is often independent from the clinical improvement and process measures. The “missing piece” in disease management is the measure of return to work, and it should be an integral part of every patient’s therapeutic plan. He argued that “usual and customary” disease-management programs (e.g., programs to manage asthma, congestive heart failure, diabetes, and coronary artery disease) need to be expanded to include other productivity-reducing diseases (e.g., migraine and arthritis), whereas problems such as alcohol abuse, hearing and vision loss, which are not often incorporated into disease-management programs, should be managed as well.

In many instances, the most expensive medical claims do not correlate with the costliest pharmacy claims submitted by patients (e.g., as with the cost of migraine medications). Tailoring disease-management programs to include more comprehensive care can often bridge the gap between these areas and can reduce costs in both “silos.”

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Meeting Highlights: IHPM

Dr. Lednar talked about the many barriers to be overcome: from structural barriers in the health care system to individual, person-to-person barriers, such as patients’ knowledge; their commitment to health; costs; fear; cultural background; nonadherence to regimens; and lack of time. Similarly, overcoming barriers within the health care system requires change and adaptation in many areas as well. General system-wide barriers that must be confronted in order to promote health productivity include:

- employers that are switching from point-of-service networks to preferred provider networks
- the slow adoption of provider “report cards” (i.e., physician profiling or physician quality indicators)
- the lack of automation
- the need for immediately tangible ROIs
- the slow implementation of evidence-based medicine

MEASURING PRESENTEEISM

Dr. Deborah Lerner presented several productivity-measurement tools, including the Work Limitations Questionnaire (WLQ). This questionnaire can be used to assess on-the-job disability and productivity loss, commonly called “presen teeism.”

The WLQ contains four scales that measure time, physical demands, mental–interpersonal demands, and output demands on workers, and it quantifies their results on a scoring system from 1 to 100. The survey, which has proved to be both valid and reliable, has been used in clinical trials as well as by large employers to document lost productivity in the workplace. These types of surveys should be incorporated into disease-management evaluations and interventions, because they show how these diseases affect employees at work. This allows for the linking of clinical disease improvement to functional improvement through increased productivity in the workplace.

In another year of double-digit health care cost increases, employers must realize the value of investing in their own employees and should become aware that health and productivity are interwoven concepts. Disease management and productivity are intricately intertwined in patient management. It is only fitting that organizations should consider both in order to reduce costs and to improve comprehensive care for their employees.

REFERENCES