THE HEALTH PROJECT

APPLICATION INSTRUCTIONS FOR THE 2024 C. EVERETT KOOP NATIONAL HEALTH AWARDS

Documenting Excellence in Improving Employee Health and Well-being and Enhancing Organizational Returns

The mission of The Health Project is to define, promote and increase the adoption of organizational health and well-being practices that translate into measurable operational impact. To win the C. Everett Koop National Health Award, health and well-being programs need to be rigorously evaluated and applicants must be willing to share their results as evidence of their accomplishments.

ELIGIBLE PROGRAMS

To be eligible for Koop Award recognition, a health and well-being program must employ comprehensive evidence-based strategies designed to improve the health and well-being of the entire eligible population across the health continuum. The program must have been implemented for a minimum of three years after baseline data collection. The application must demonstrate that the program is well integrated into the organization's culture; includes evidence-based components combined to deliver a *therapeutic dose* (i.e., components of sufficient intensity delivered in an appropriate sequence); and has yielded significant improvement in population health and noteworthy business results. Business results may include medical cost savings, reduced absenteeism, fewer accidents, increased worker productivity, or improvements in other value indicators such as improved attraction/retention of talent, job satisfaction, engagement, and morale.

Programs should include components addressing physical and emotional dimensions of employee health and well-being and may include components addressing other dimensions such as social, intellectual, financial, and spiritual well-being. It is essential that program components be integrated into an organizational culture that promotes workforce health and well-being.

The application submission deadline for this year's Koop Award is 5:00 EST, May 31st, 2024.

HELPING YOU PREPARE A STRONG APPLICATION

We recognize that preparing an application for the C. Everett Koop Award can be a daunting task for some applicants, and we are committed to helping with the process from beginning to end. This commitment includes the following resources and learning opportunities for all organizations planning to apply. ***To receive invitations to the series of interactive learning webinars, organizations must indicate their intention to apply for the Koop Award by sending an email to info@thehealthproject.com requesting to be on the Potential Applicant list.***

1. Koop Award Application Instructions

These Award Application Instructions provide details on how to prepare a strong application. We recommend you read these instructions closely as a first step in the process, followed by a second close reading after listening to the "Ready to Win" webinar and doing a selective review of "Applications of Award Winners" described in items 2-3 below, respectively.

2. **Webinar: Ready to Win? Applying for the C. Everett Koop National Health Award**

   This recorded webinar reviews the goals of the award and provides details on the application process. The webinar features two professionals who played leading roles in submitting winning applications.

3. **Applications of Award Winners – 1994-2023**

   We have made the applications of all past Koop Award winners available for you to read. Many include comments prepared by reviewers. The application and review criteria have evolved over time, and these differences are reflected in these winning applications.

4. **Webinar Specific to the 2024 Koop Award Application**

   We will present a live webinar focusing on the 2024 award application in January of 2024. This webinar will review the elements of the 2024 application, factors considered by reviewers, and forms the reviewers complete during their review process. The webinar will be open to the professional public, and you will receive a personal invitation if you have sent an email to info@thehealthproject.com asking to be on the Potential Applicant list.

5. **Private Group Video Conference Call among Prospective Applicants**

   This interactive call, available only to those on the Potential Applicant list, will focus on the early stages of the application preparation and will be held in late February. This call will be most helpful if participants have completed items 1-4 above and begun to organize the information necessary to complete the 2024 application. We encourage participants to submit questions in advance, and we will organize the call around these questions. We will address additional questions that arise during the call as time permits.

6. **Private Group Video Conference Call among Current Applicants**

   This interactive call, held in late April, will be available only to those on the Potential Applicant list who are actively preparing applications. The call will focus on the middle and final stages of preparing an effective application, including the optimal amount of detail to provide in the application, word limits, mandatory tables on evaluation measures and results, supplementary material limits, and questions raised by participants.

7. **Quality Control Check**

   Organizations that submit applications by May 17, (14 days before the May 31 final submission deadline) can request a quality control check. This quality control check will examine the core elements of the draft to ensure that all required elements are included, and that word count and page limits are not exceeded. It will not include a review of the clarity or quality of the application content. Health Project staff will review these draft applications and return them to you with comments within 7 days of receipt. Applicants must make any needed changes and submit a final application by the submission deadline.

SUBMITTING YOUR APPLICATION

Please create a PDF copy of your application and e-mail to: **info@thehealthproject.com**

- *We will not accept paper applications*

Include the following information on the cover page of your application:

Name of Program:
Company/Organization:
Number of Employees:
Address:
City/State/Zip:
Contact Person:
Telephone:
Email address:
Program URL, if applicable:
Vendor(s), if applicable:[1]
Word count:

Please adhere to the highlighted word counts. We require a font size of 12 for the narrative. This font size is not required for graphs and tables, but all content should be legible.

DEADLINE FOR SUBMITTING PROGRAM APPLICATIONS IS 5:00 PM EST ON MAY 31, 2024

[1] Report all individuals and organizations that assisted you in the completion of your application. Specifically, report vendors or other third parties that helped prepare the application and their role (e.g., designed programs, managed programs, provided individual services (health screenings, skill building programs, web portals, evaluated programs, stored and/or analyzed data).

APPLICATION GUIDELINES AND REQUIREMENTS

Health Project reviewers judge programs for the Koop Award based on credible evidence of improved employee health and well-being, as well as a compelling business case for investing in the health and well-being of populations. Therefore, the majority of the Koop Award application focuses on a description of program evaluation methodology and results. To the extent possible, highlight evidence that establishes a connection between your program design and your outcomes. Outstanding applications provide information that establishes a credible link between measurable outcomes and related program components, thereby demonstrating how results can be attributed to the organization's efforts.

The structure of the health and well-being program is important, so your application should address leadership commitment and organizational culture; strategic planning; communications, marketing, and promotion; intervention components; integration into benefit design; program coordination; data management; and evaluation. We recognize that an employee health and well-being program is most effective when it is offered in the context of broader organizational efforts related to business strategy and practices, benefit design, absence policies, career development, and other relevant policies. We are interested in how you integrated the program with these complementary efforts to increase its effectiveness, but you should focus your application on core employee health and well-being initiatives. Make the best case for the impact your program has had on population health improvement, risk reduction and improved business results. This includes describing innovative approaches that contributed to the success of your health and well-being program.

The table below summarizes the application requirement categories and their respective weights.

Application Category	Weight (% of total score)
HEALTH IMPROVEMENT EFFORTS	
1. Organizational	16.7%
2. Individual	16.7%
OUTCOMES	
4. Evaluation Methods	16.7%
3. Participation	16.7%
4. Health Outcomes	16.7%
5. Business Outcomes	16.7%
Total	**100 points**
BONUS POINTS	
1. Comparative Financial Analyses	5 points
2. Innovation	5 points
3. Employer size (< 1,000, < 2,000 employees)	5 points

APPLICATION CHECKLIST

Please use the checklist below to confirm that your application fully meets our requirements by entering "YES" in each of the 3 spaces: 1. Three or more years of implementation; 2 Does not exceed 7,500 total word count limit and 3. The Application includes a table of contents listing all of the and subheadings listed below. We will evaluate whether you have met these requirements if you take advantage of the optional Quality Control Check. Your final application will not be reviewed if it does not conform with all these requirements.

__ **1. Three or more years of program implementation.** The program described in your application must have been delivered to your workforce for a minimum of three years. We will not review applications that do not meet this minimum implementation-period requirement.

__ **2. Total word count and font.** Total word count may not exceed **7500** words, excluding the tables and supplemental material. We provide recommended maximum words for each section to assist you in achieving this overall maximum word count. All text (excluding tables, charts, and graphs) must be in 12-point font.

__ 3. **Table of contents with headings, subheadings and page #'s**. A table of contents should be placed after the cover page listing the headings and subheadings shown below and the page #'s on which they begin.

I. Executive Summary
II. Narrative Description of Program
    A. Organization Description
    B. Health Improvement Efforts and Strategy
        1. What are the organization's health and well-being goals?
        2. How did the organization develop these goals?
        3. Scientific Principles
        4. What is the organization doing to achieve its health and well-being goals?
            a. Individual-level Efforts
            b. Organization-level Efforts
III. Evaluation Methodology
IV. Outcomes
    A. Participation
    B. Health Outcomes
    C. Organization Outcomes
    D. Comparative Analysis (optional)
V. Innovation and Other Important Factors
VI. Tables
    A. Methodology
    B. Outcomes
VII. Supplemental Documentation (optional: 5-page maximum)

APPLICATION CONTENT

Your application should include the content described in Sections I-IV below. The maximum overall length is 7,500 words, excluding tables and supplementary documentation. We will not review applications exceeding this word limit. We score eight elements of the application, while the rest of the content provides important context that helps reviewers assign these scores.

Reviewers score six core elements based on best-practice standards detailed in Appendix A (Evaluation Methodology Standards Required to Meet Award Standards), Appendix B (Methodology Details for Participation Measures), and Appendix C (Table Template on Methodology for Health and Organizational Outcomes). These six core areas are: (1) Individual Health Improvement Efforts and Strategy; (2) Organizational Health Improvement Efforts and Strategy; (3) Evaluation Methodology; (4) Participation Levels; (5) Health Outcomes; and (6) Organizational Outcomes. Reviewers score each of these six elements on a five-point scale relative to standards specified in Appendix D: significantly above standards, somewhat above standards, meets standards, somewhat below standards, significantly below standards or missing. Applicants meeting standards in these six core elements are strong candidates for Honorable Mention recognition, and those above standards in multiple elements are strong Koop Award candidates.

Reviewers also score two additional elements: Comparative Financial Analyses and Innovation. These elements are optional but offer an opportunity to earn bonus points that may influence the final award level. Reviewers score these two elements on a five-point scale ranging from excellent to poor/missing, since they are not compared to specific standards.

Section I: Executive Summary (Recommended maximum: 500 words)
Provide a succinct overview of the population health and organizational goals for health and wellbeing efforts, the target population, and the organizational and individual-level strategies used to pursue goals. Summarize the evaluation methodology and the impact of health and well-being efforts on participation, health outcomes, and organizational outcomes. Briefly mention any unusual challenges the organization faced, and creative approaches you developed to address them.

Section II: Narrative Description of Program (Recommended maximum: 2,000 words)

A. Organization Description (500 words)

Briefly describe your organization. Your application may include such items as the organization's culture, business strategy, location, core products, number of employees, and any major benefit design changes that occurred during the period covered by the evaluation and how these changes may have affected results. If applicable, please include information regarding the unique characteristics of your employee population, which may include the number and percentage of employees who are racial/ethnic minorities, low-wage workers, have a work disability, are field-based, work from home, or are members of union groups.

B. Health Improvement Efforts and Strategy (1,500 words)

1. What are the organization's health and well-being goals?

You may address such issues as: What specific elements of individual health and well-being are prioritized? What specific organizational or business outcomes (e.g., medical spending, productivity, engagement) are prioritized?

2. How did the organization develop these goals?
You may address such issues as: Were goals the result of challenging trends in employee health status and related costs or productivity reductions, expressions of employee interest, a shift in organizational purpose or values, a champion or advocate in leadership, or some other factor? To what extent were goals informed by data or best practice scorecards? Which stakeholders were involved? Who were the target populations (e.g., employees and their families, customers, community)? How have goals evolved over time?

3. Scientific Principles
You may address such issues as: What, if any, underlying scientific principles in health behavior change, culture change, and organizational development have been important to you or your vendors in guiding health and well-being efforts? This background helps reviewers understand the context in which your program was developed but will not affect scoring.

4. What is the organization doing to achieve its health and well-being goals?
Describe relevant organization-level and individual-level efforts to improve health, well-being, safety, and business results and the timeline of these efforts.

a. Individual-level Efforts. What has the organization done to support individuals in their efforts to improve their health-related behaviors? If applicable, describe these for employees and spouses/domestic partners. You may address any of the issues below:
- What are the components of the program and which segments of the population can access them?
- How is the organization enhancing awareness of the link between lifestyle habits and relevant program offerings?
- What intrinsic (e.g., sense of pride, being part of a team, gaining a new skill) and extrinsic (e.g., financial incentives) strategies is the organization using to motivate individuals to engage in program offerings and practice healthy lifestyles?
- What is the organization doing to help the eligible population build the skills necessary to change and maintain healthy lifestyle habits?
- What is the organization doing to increase the opportunities for employees to practice a healthy lifestyle?

b. Organization-level Efforts. What changes has your organization made to create a culture that supports health and well-being? You may address such issues as:
- Staffing structure: leadership, program staff, partners, and vendors
- Executive, manager, and grassroots support
- Resources allocated: out-of-pocket budget, value of leadership time invested, value of volunteer staff, value of space and sources of these resources
- Integration of employee well-being into organization-level purpose / values / beliefs statements
- Integration into health plan, hiring, compensation, training, performance review, paid time-off or absence, flextime, remote work, tobacco, and other policies

- Realignment of health-related departments or shifts in the organizational hierarchy
- Onsite or community facilities to support physical activity, nutritious eating, emotional well-being, medical care access, and other aspects of good health
- Strategies to enhance psychosocial work climate and work practices such as manager sensitivity training, team building, expectations for working during off hours
- Strategies to address disparities in race, age, ethnicity, cultural background, gender or gender identity, education, job type (salary vs. non-salary), work location (headquarters vs. remote offices), shift schedule, or other characteristics
- Other strategies important in health and well-being efforts

Section III. Evaluation Methodology (Recommended maximum: 4,000 words for Sections III + IV)

Please list the methods used for participation, health, and organizational outcomes. The description should include: (1) evaluation design (including variables of interest and structure of the evaluation); (2) population/sample size and composition; (3) measures, measurement tools, and information about their validity and reliability; and (4) statistical analyses including their appropriateness given the measures described.

See Appendices A-C for guidance on appropriate methodologies for measuring different outcomes.

Section IV. Evaluation Results (Recommended maximum: 4,000 words for Sections III + IV)

Strong applications demonstrate success in engaging a large portion of the employee population in health and well-being initiatives, resultant sustained health improvements, and business outcomes. Your application should describe these evaluation results following the format below. In reporting your results, please use the standard notation convention of "N" to represent a total population (e.g., all eligible employees, all spouses) and "n" to represent segments of populations (e.g., participants, samples).

A. <u>Participation</u>

Provide descriptive statistics demonstrating overall reach and sustained participation in core components of the program for the eligible population. For example, you may report:

- Which employees, spouses and dependent children were and were not eligible?
- What portion of the total eligible population (N) participated in at least one aspect of the program each year? Please provide annual participation rates, including both the number of participants (n) and the percent (%) of the eligible population this represents, for each year of program implementation. To the extent available, report the demographics of participants versus non-participants.
- In which aspects of the program did employees participate? Where available, report separate annual participation rates and multi-year trends (n, % of eligible) for assessment components (e.g., health assessment questionnaire, biometric screening) and lifestyle behavior change components of the program.
- Was participation sustained year-round? Where available, provide data (n, % of eligible) demonstrating that participants remained involved in the program at least periodically throughout the year. This may include data on the number of months / quarters participants engaged in program activities, or data on the number of program activities participants completed during the year.

- Passive exposures. Where available, report the level of population exposure to interventions that do not require intentional joining, enrollment, or engagement, such as marketing campaigns, smoke free campuses, enhanced nutritional offerings, walking paths, or other forms healthy environments.

The strongest applications will include a "participation cascade" table or graph that reports the number and percent of employees eligible for the program, enrolled, and engaged, long-term participants.

B. Health Outcomes

Provide data demonstrating that the program has yielded meaningful health improvements in the population. Data may include improvements in health behaviors or biometrics that are the focus of the program (e.g., weight loss/maintenance for a weight management program). An organization's results are strengthened by demonstrating positive changes in the health of the population compared to national health guidelines (e.g., percent having normal blood pressure).

Please report the results you have in the order of the questions below.

- Did participants in the program make positive changes in lifestyle knowledge, behaviors, biometric risk factors (e.g., BMI, blood pressure, cholesterol), health conditions or diseases? Data addressing this question should typically compare each participant's baseline and most recent follow-up result for all program participants or, alternatively, for participants in specific program components.
- Did lifestyle knowledge, behaviors, biometric risk factors, conditions, or diseases improve more among participants than among eligible non-participants? Demographic and other relevant baseline differences between the participant and non-participant groups should be controlled in the data analysis to the extent possible.
- Did the health of the eligible population improve more than in comparable populations external to the organization? Differences between the organization's population and the comparison group's population should be addressed to the extent the organization has access to demographic and baseline health data for this purpose.

C. Organizational Outcomes

Provide data demonstrating that the program and related health outcomes have yielded meaningful improvements in business results important to the organization. These might include improvements in medical utilization or costs, absenteeism, productivity, or other outcomes valuable to the organization.

Please report the results you have in the order of the questions below.

- Have organizational outcomes improved among participants in the program? Responses to this question would ideally include baseline and three implementation years of data. The analysis would ideally demonstrate a change in trend following program implementation.
- Have organizational outcomes improved more in sites or individuals exposed to the program than in sites or individuals not exposed? Responses to this question would ideally include baseline and three implementation years of data and control for baseline differences between groups.

- Have overall organizational trends improved more than in comparable organizations since the organization implemented its health and well-being program? The strongest evaluation approach is comparing prior and current trends in the organization versus prior and current trends in similar organizations. Ideally, one or two years of pre-program trend data and three years of implementation data should be provided for the applicant's organization and comparison organizations. If you do not include comparison organization data in the evaluation, you should ideally provide one or more additional years of the organization's trend data (5+ years total).

Section V. Comparative Financial Analyses (Recommended maximum: 500 words)

If you have conducted value-on-investment (VOI), return-on- investment (ROI), or cost-effectiveness (CEA) analyses of your program, we encourage you to report your results. These advanced analyses are optional but offer you an opportunity to earn bonus points in application scoring.

Section VI. Innovation (Recommended maximum: 1,000 words)

If your organization has developed innovative approaches to enhance the program or address difficult challenges, please share them. This content is optional but offers an opportunity for you to earn bonus points in application scoring. Potential areas of innovation include but are not limited to innovations in the following areas:

- Meeting the needs of diverse segments of the workforce or enhancing health equity
- Overcoming difficult challenges such as COVID-19 or natural disasters affecting its workforce
- Adaptations to serve remote, hybrid, and distributed workforce segments
- Incorporation of epigenetic testing or other clinical innovations into health assessment offerings
- Developing strategies in any aspect of planning, implementing, or evaluating program efforts
- Creative strategies to support the health of the broader community beyond employees and dependents.

Section VI: Tables

a. Methodology

Report important elements of your evaluation methodology for each participation measure, health outcome, and organizational outcome in your application. Appendix B provides details for reporting your methodology for participation measures. Appendix C provides a table format for reporting your evaluation methodology for health and organizational outcomes. We encourage you to use these formats in your application. You may prepare one table for each of these three broad categories of evaluation results, i.e., a table for all participation measures, a second table for all health outcomes, and a third table for all organizational outcomes. Alternatively, you may prepare separate tables for each outcome in your evaluation. In either case, you should number tables and include the heading "Methodology", followed by the measure(s) you are reporting in the table (i.e., "Participation, Health, Organizational").

b. Results

Provide tables, charts, or graphs detailing the results for your participation measures, following the "participation cascade" approach described in section IV. Provide separate results tables, charts or graphs describing the results

of the program for each set of health outcomes and organizational outcomes (i.e., if you report on five sets of outcomes, you should provide a minimum of five tables, charts, or graphs). For example, one set of outcomes may describe your health assessment outcomes, a second set your biometric screening outcomes, and third set your medical spending outcomes. The tables should be numbered and include the heading Outcomes, followed by the Outcome reported (e.g., "health risks" or "medical spending").

Section VII. Supplemental Documentation (5-page limit)

You may optionally provide non-duplicative documentation supporting the information provided in the application. This might include senior management letters of support, abstracts of articles published in peer-reviewed journals, consultant summary reports, insights from best practice scorecards, survey results, internal memoranda, or other helpful material. If you submit more than five pages of supplemental materials, Health Project staff will delete the excess pages before distributing your application to reviewers.

APPENDIX A

Evaluation Methodology Required to Meet Award Standards

Introduction

The most important requirement to win the Koop Award is conducting a rigorous analysis of program and organizational data that demonstrates:

(1) high levels of year-round participation in the initiative,
(2) meaningful health improvements in the population,
(3) meaningful organizational improvements linked to the program.

Historically, many applicants with seemingly outstanding programs fell short because they failed to use or clearly communicate the required rigor in their evaluation, provided incomplete data, or failed to demonstrate a credible link between their program and the organizational outcomes they report. We created this Appendix to guide you on the rigor we require in evaluations to meet the standards of the Koop Award and the level of detail we require to demonstrate that rigor in your application.

Basic Methodology Requirements

The strongest applications use rigorous actuarial or statistical methods to measure health and organizational outcomes. Both approaches involve analyzing trends from a baseline period through the required minimum of three years of program implementation.

You may use any of the approaches we describe in this Appendix in conducting your evaluation depending on your organization's priorities and access to program, organizational and comparison data, and the expertise of those conducting the analysis. Your application should include descriptions of your evaluation design, population and sample size and composition, measurement tools including any available information about validity and reliability, and statistical or actuarial methods appropriate to the data distributions. Regardless of the approach you use, your methodology must represent best-practice standards for applied evaluation.

Many past Koop Award applications have evaluated health outcomes based on changes in participants' health assessment and screening results and have evaluated organizational outcomes based on changes in the medical costs of participants compared to non-participants. If you use these basic approaches, your analysis should include all employees (and eligible spouses and other dependents) in the eligible population who have both baseline measures and one or more follow-up measures during the 3+ year program implementation period. If your application describes enhancements to a pre-existing program, you can use the year before you implemented the enhancements as your baseline year.

If you use these basic methods, you should evaluate program impact by comparing the baseline health or cost measure with the most recent measure during the multi-year implementation period. These measurements must be at least one year apart, and you must report the average time between measurements in the application. Applications merit the strongest award consideration if they report time-over-time impact based on a large portion of the eligible employee population.

Organizational outcome evaluation should include all eligible employees (e.g., all health-plan eligible employees). Your evaluation may use a "differences-in-differences" approach that compares the differences between the baseline measure and the most recent post-implementation-year measure for the participant versus non-participant groups. The evaluation should include all employees, spouses, and other dependents eligible for the program. For example, your evaluation of medical cost impact might include all employees continuously enrolled in the health plan, excluding outliers based on standard actuarial practices. Applications merit the strongest award consideration if they account for baseline demographic and health-status differences in the participant and non-participant groups, either through an actuarial weighting scheme or by using an appropriate statistical approach such as covariate analysis or propensity score matching. The best applications report statistical significance testing to demonstrate that seemingly favorable results are not due to random variation.

Evaluation Design Options

This section summarizes four general evaluation designs that meet the standards for Koop Award consideration. Not all these designs are appropriate for evaluating all health and organizational outcomes, and we note this in the relevant summary.

A. **Pre-Post Participant Change:** This approach evaluates changes in the participant population following program implementation and is acceptable for evaluating a program's health outcomes (e.g., changes in tobacco use or BMI) if you do not have comparison data, which is often the case if you measure these outcomes using components of the program such as health assessments or worksite-based screenings. Analyses typically compare each participant's baseline and most recent follow-up health assessment questionnaire and biometric screening result for all program participants or, alternatively, for participants in specific program components. To provide reasonable evidence that changes in participant health trends are related to the program, applicants must include at least one year of pre-program baseline data and three or more post-implementation years in their analysis. You may use measures collected in the first year of the implementation period (e.g., health assessment) as baseline data for this evaluation approach. This approach is not appropriate in evaluating overall organizational outcomes since it excludes employees who do not participate in the program.

B. **Participant vs. Non-Participant Change:** This approach compares changes in participants versus non-participants in the eligible population to determine whether participants show more positive change following program implementation. At minimum, the evaluation must include one baseline year and three or more implementation years of data and compare individuals' baseline status with their most recent status following implementation. Applicants should not limit the participant group to those who have participated every year, since this self-selected subset of employees is likely to represent the most motivated segment of the population. If you collected data (e.g., health assessment, biometric screening) at the beginning of the first year of implementation as a gateway to intervention programs, you may use them as the baseline data in evaluating these programs. Because the participant and non-participant groups may differ in demographics, health status and motivation, your analysis should control for these differences to the extent possible. Using established statistical matching techniques to control for differences when comparing participant vs. non-participant changes is a best-practice approach in evaluating workplace programs.

C. **Pre-Post Eligible Population Change:** Appropriate for evaluating both health and organizational outcomes, this approach evaluates time-over-time changes following program implementation in an organization's entire eligible population, (e.g., slowed growth or reductions in medical costs, reduced illness absences, improved customer satisfaction or net promoter scores). To provide reasonable evidence that changes in an organization's trends are related to the program, applicants should include a minimum of two years of pre-program baseline data and three or more post-implementation years in the analysis. We encourage applicants to increase the number of years beyond these minimums, since this more convincingly demonstrates changes in trends following program implementation in the absence of an external comparison group.

D. **Eligible Population vs. Comparison Population Change:** This approach compares trends in the entire eligible population to changes in an external comparison population. The comparison group may be business units within the applicant's organization that have not implemented the program, other similar organizations, or another appropriate source. At minimum, the evaluation should include a baseline year and three or more implementation years of data and compare individuals' baseline status with their most recent status following implementation. Because the eligible population and the comparison group are likely to differ in demographics and health status, the analysis should control for these differences to the extent possible. Although often not feasible, this "quasi-experimental" approach to comparing change in the entire eligible population versus an external population, while controlling for group differences, may be the strongest evaluation design available for workplace program evaluation.

Common Health and Organizational Outcomes

We welcome applications to measure program impact on a wide range of health and organizational outcomes, including but not limited to those listed below.

Health outcomes to consider in program evaluation include changes in health-related knowledge, behaviors, biometric risk factors, conditions, and diseases. Health data sources may include self-reports (e.g., health assessment surveys), biometric health screenings (e.g., BMI, blood pressure, cholesterol, glucose), devices (e.g., steps, sleep, weight), fitness assessments, medical records (e.g., claims-based risk scores, biometric values, chronic conditions), or other health-related data sources.

Organizational outcomes employers have traditionally used in evaluating their programs include medical costs, absenteeism, disability rates and costs, and workers compensation claims. More recently, employers have incorporated presenteeism, turnover/retention, employee engagement, performance, net promoter score (NPS) or other customer satisfaction measure, employee experience such as employee NPS (eNPS) or other employee satisfaction measure, and external/customer/community reputation into their value equation.

The following sections provide requirements for several popular evaluation approaches.

Health and Cost Risk Migration

Applicants may evaluate changes in health or cost risk using a "risk migration" approach. The health risk migration approach evaluates movements over time in the number and percent of employees with health risks identified through a health assessment questionnaire or biometric screening that can be classified as low-, moderate-, and high risk, or similar categories. The cost migration approach tracks movements over time in the number and percent of employees classified as low-, moderate-, and high-cost, or similar categories.

In risk migration evaluations, classifications are based on a health risk index that simply counts the number of health areas where a participant is "at risk" based on national health guidelines. Health areas included may encompass self-reported health risk behaviors (e.g., tobacco use, physical activity, nutrition, stress), as well as biometric risk factors (e.g., BMI, blood pressure, cholesterol/HDL) if screening data are available. Risk classification varies across providers, but a typical classification is 0-2 (low risk), 3-4 (moderate risk) and 5+ (high risk) elevated health risks. Risk migration evaluation normally includes statistical testing to determine whether the observed risk movement demonstrates true change. In cost migration evaluations, evaluators often establish goal-appropriate cost cut-points using percentiles in their baseline cost distribution. For example, they may define the low-cost group as baseline costs below the 50th percentile, the moderate-cost group as baseline costs between the 50-89th percentile, and the high-cost group as baseline costs of 90th percentile and above.

While demonstrating overall risk and cost migration using this index approach meets our standard for evaluating change in health status and medical spending, applicants using the risk migration approach should report migration/change in risk status in at least 3-5 specific health areas their program prioritizes.

Reporting on specific health areas should include all individuals with baseline and current data and report the number and percent at different risk levels at both points in time (e.g., number and percent who smoke, get adequate physical activity, eat healthy, etc.). Risk and cost migration analysis must also use single cohorts with both pre- and post-implementation data to demonstrate individual migration, although the risk migration cohort and the cost migration cohort do not need to be the same if this approach is used to evaluate both health and organizational outcomes.

Medical Cost Trend

A growing number of employers measure the overall rate of annual increase in medical spending to evaluate the impact of their programs. This is sometimes called "Medical Trend," sometimes with a goal to reach "Zero Trend" (i.e., no annual increase in medical spending per employee). This approach makes a lot of sense for employers who implement programs to control medical spending because it incorporates the net effect all elements of a program, including engaging a critical mass of employees in meaningful health enhancement efforts that yield improved health and, ultimately, result in reduced medical utilization. In this approach, employers calculate medical cost savings by comparing the annual rate of increase in the employee population to the rate expected or to the rate experienced by peer employers.

The challenge in this evaluation approach is identifying the medical cost savings achieved by improved health from other causes, such as changes in policies, plan design, or eligibility. Applicants need to make a concerted effort to exclude savings achieved by health improvements from other causes by reporting other possible causes and quantifying the impact of each factor as described below. This requires identifying organizational

initiatives implemented during or within two years prior to the program implementation and evaluation period that could potentially account for savings in medical spending. These might include benefit plan changes that shift costs to employees, change in provider networks, insurer, or provider price reductions; absence and related policy changes; a policy of not hiring smokers; adding a fitness standard for some new hires; and changes that impact age, gender, or health status mix of the employee population, including lay-offs, mergers, acquisitions, divestitures, and natural attrition or growth. In addition to savings attributed to the health and well-being program, applicants using this approach should estimate and report the portion of the overall reduction in trends that was due to these other factors, separate from the health and well-being program. In addition to reporting organizational cost trends, applicants using this approach should also report trends in premiums paid by employees for individual and family coverage, as well as trends out-of-pocket spending by employees not paid by the plan. Overall trends and these components should be reported for at least six years, including 1-2 years prior to program implementation.

Comparative Financial Analyses

Comparative financial analyses provide a mechanism to compare medical cost savings, productivity improvements, and other positive organizational outcomes to program costs, as well as comparing the cost of achieving improvements with a health and well-being program versus other strategies. The most common comparative financial analyses include return-on-investment (ROI), value-on-investment (VOI), and cost-effectiveness analysis (CEA).

For the purposes of this application, **ROI** measures the total financial benefits of the program divided by the total financial costs. Evaluators typically use this approach to determine savings in medical spending and/or enhanced productivity that can be measured quantitatively. If you conduct an ROI analysis, it should clearly articulate the specific financial benefits and time periods, the cost categories and amounts included in the analysis, and any cost categories not included.

VOI is a variation of ROI in which organizational "values" derived from a program are broader than direct medical cost savings, productivity and other monetary organizational outcomes included in ROI analysis. These might include morale, subjective forms of well-being, and other priorities that motivated the organization to focus on enhancing employee health. These values do not need to be monetized, but their values do need to be quantified as relevant to the measures in this analysis.

CEA provides a mechanism to estimate costs per unit of benefit. For example, evaluators can use CEA to measure overall program impact, such as total program cost per health risk improved, or subunits of program impact, such as cost per successful smoking quit, or per attempt. They can also use it to measure the impact of elements within a program, such as cost of marketing efforts per program participant enrolled. One of the most important emerging uses of CEA is to measure the impact of some of the difficult-to-quantify values often included in VOI, like morale, engagement, or similar outcomes. An extension of CEA is comparing the cost per unit of change achieved from a health and well-being program to the cost for achieving the same benefits from other organizational expenditures including salary and other benefits or strategies.

Randomized Controlled Trials

Some economics and medical researchers argue that randomized controlled trials (RCT), in which evaluators randomly assign employees to a treatment (receive program) or control group (not receive program) is the only valid evaluation design to accurately measure the health or organization impact of a health promotion program. In practice, however, most experts in the employee well-being field consider the RCT to be an inferior design for evaluating organizational outcomes in workplace health and well-being programs because it is not feasible to randomize many factors most important to program success, such as leadership support, policies, organizational culture, natural and built environment, food supply and multiple other community or organization-level factors. Because of this inherent limitation, appropriate uses of RCT evaluation design in the workplace are largely confined to time-limited program elements that can be randomized such as specific skill building activities (e.g., smoking cessation interventions) or incentive amounts.

APPENDIX B
Methodology Details for Participation Measures

Provide the following information for each participation measure you include in your evaluation:

Measure Name
e.g., Overall Program Participation, Health Assessment participation, Health Screening participation, Health Coaching completion, etc.

Measure Definition
e.g., Overall Program Participation: participated in any component of program during evaluation period; Health Coaching completion: completed 3 or more coaching calls during evaluation period

Measurement Timeframe
e.g., monthly, quarterly, annual, program-to-date

Reporting Statistics
These statistics should be reported for each participation measure you include in your evaluation:

- Population eligible for program / program component, e.g., all employees and spouses, full-time employees, health assessment completers
- Number of participants (N) in program component
- Participation percentage: Number participating divided by number eligible for program component

APPENDIX C

Methodology Table Template for Health and Organizational Outcomes

Please prepare a table following the format below that summarizes the methodology you used for each set of outcomes reported (e.g., health risks, medical costs, absenteeism).

Title: Table # (e.g., 1a,1b,1c,1d,1e, etc.), Methodology, Outcome grouping (e.g., participation, health, organizational) or Individual outcome (e.g., medical spending, absenteeism, etc.)

	Outcome #1	Outcome #2	Outcome #3	Outcome #4
Evaluation structure				
Measurement timing				
Population and Sample				
Measurement Tools and Data				
Statistical Analyses				

Definitions of column headings

Outcome
e.g., health risk prevalence, medical cost trends, absenteeism, etc.

Evaluation structure
e.g., pre-post only, pre-post with comparison group, time series, etc.

Measurement timing
Timing of outcome measurement: e.g., baseline, annual for 3 years, etc.

Population and Sample
Size of target population and sample analyzed

Measurement Tools and Data Source
e.g., administrative records, health screening, health insurance claims

Statistical Analyses
e.g., descriptive statistics, differences in difference, trend analysis

APPENDIX D

Program Outcomes Required to Meet Award Standards

Participation:

- Meets standards: 40%-70% of all employees (not just those eligible) participated in some aspect of the program
- Exceeds standards: > 70% of employees (not just those eligible) participated in some aspect of the program and at least half of them participated more than once

Health outcomes:

- Meets standards: Measurable improvements in at least 2 targeted diseases, health conditions, or behaviors
- Exceeds standards: Measurable improvements in at least 3 targeted diseases, health conditions, or behaviors

Organizational outcomes:

- Meets standards: Measurable improvements in at least 2 targeted organization priorities
- Exceeds standards: Measurable improvements in at least 3 targeted organization priorities

Comparative Health and Organizational Outcomes Analysis

- Meets standards: none required
- Earns bonus points: at least 1 form of analysis (ROI, VOI, CEA) conducted for at least 1 outcome