

SmartHealth Effectiveness

3rd Quarterly Report

Second Engrossed Substitute House Bill 2376, Subsection 213 (2)(b)(i), Chapter 36, Laws of 2016, 1st Extraordinary Session

December 30, 2016



SmartHealth Effectiveness

Acknowledgments

This report, and the ongoing assessment of SmartHealth effectiveness, is the result of a collaboration between the Health Care Authority (HCA), the Washington State Institute for Public Policy, the Office of Financial Management, and Limeade, the SmartHealth portal vendor. HCA appreciates the contributions of its public and private partners in providing data, analysis, and evidence-based research on employee health and well-being efforts.



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Executive Summary

Participation in SmartHealth in 2016, compared with 2015, showed mixed results, but as with many new wellness programs compared to other employers, the first five years present a period of adjustment. Similar to other wellness programs, we are seeing registration increasing, but participants' completion of the Well-being Assessment (WBA) and incentive qualification declined. Most importantly, the powerful data that our vendor, local Washington company Limeade, has been able to provide to the State, demonstrates strong evidence that the program is working well for those who are registered and participating. Without this program, the state would not be able to provide this and other important health and wellness data that we can use in conjunction with other employee survey data. See Appendices A and B for examples of the data that is available from Limeade as well as the analysis it makes possible.

Consequently, it appears that the program is meeting its primary objectives: maintaining and improving overall employee well-being, improving the productivity of the workforce, and contributing to state agencies' capacity to accomplish their mission. Yet, as with many similar wellness programs, we must continue to improve and help our employees engage more to improve their well-being. That will be our continued focus going forward.

The three takeaways are:

1. **SmartHealth matters, a lot.** Well-being is good for employees and good for the state.
2. **SmartHealth works and provides powerful data to help improve employee well-being.** SmartHealth is improving employee well-being and high well-being correlates with better performance and improved people metrics (see data).
3. **We need to reach more people.** Increased organizational support for well-being is needed. We've experienced high value and success when individual agency leaders and wellness committees specifically engage agency employees. We will focus on these measures.

Highlights of our data show: Registration was up 4.5%—increasing from 51,147 in 2015 to 58,021 in 2016. While the absolute increase is roughly 7,000 new registrants, when “churn” is taken into account (individuals leaving state employment and therefore leaving the SmartHealth program), the program added more than 10,000 new registrants in 2016.

Even with a decline in WBA completions and incentive qualifications, over 61 percent of registered SmartHealth subscribers completed their WBA and over 41 percent qualified for the \$125 incentive. WBA completions declined from 48,021 in 2015 to 35,648 in 2016, while incentive qualifications declined from 27,757 in 2015 to 24,763 in 2016.

For those who are participating, the program appears to be having a positive effect. Limeade conducted a cohort analysis, comparing the average scores from the well-being assessments (self-reported) for the participants who started in 2015 and continued in 2016. 27,123 individuals completed the well-being assessment in both 2015 and 2016 and represent the SmartHealth cohort.

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The cohort of participants who identified themselves as having one or more health risks showed improvement in their health scores across all 34 dimensions of well-being in 2016, when compared to their scores in 2015.

Notable score increases that show positive well-being include:

- +29.2% for Life Meaning,
- +23.3% for Healthy Blood Sugar, and
- +21.9% for Back Health.

Known obstacles continue to hinder the program's ability to reach and engage eligible employees, including the inability to reach all eligible members through email and the complex structure of state government that includes 450 different work organizations with different and distinct cultures. We've seen great successes in agencies that have high leadership engagement and an individual agency wellness committee.

The plan for 2017 is to focus on encouraging continuous engagement from leadership; supporting wellness coordinators by providing them with aggregate participation data and turnkey communications; and providing ongoing value to registered subscribers, particularly after the deadline to qualify for the financial incentive has passed. Small incentives (such as Amazon and REI gift cards provided by Limeade) will be added at 3,500 and 5,000 points, and quarterly promotional campaigns linked to specific SmartHealth activities are planned. Finally, there will be an enhanced focus on addressing the unique needs of the higher education population, such as reaching across geographic distances and communicating across diverse populations.



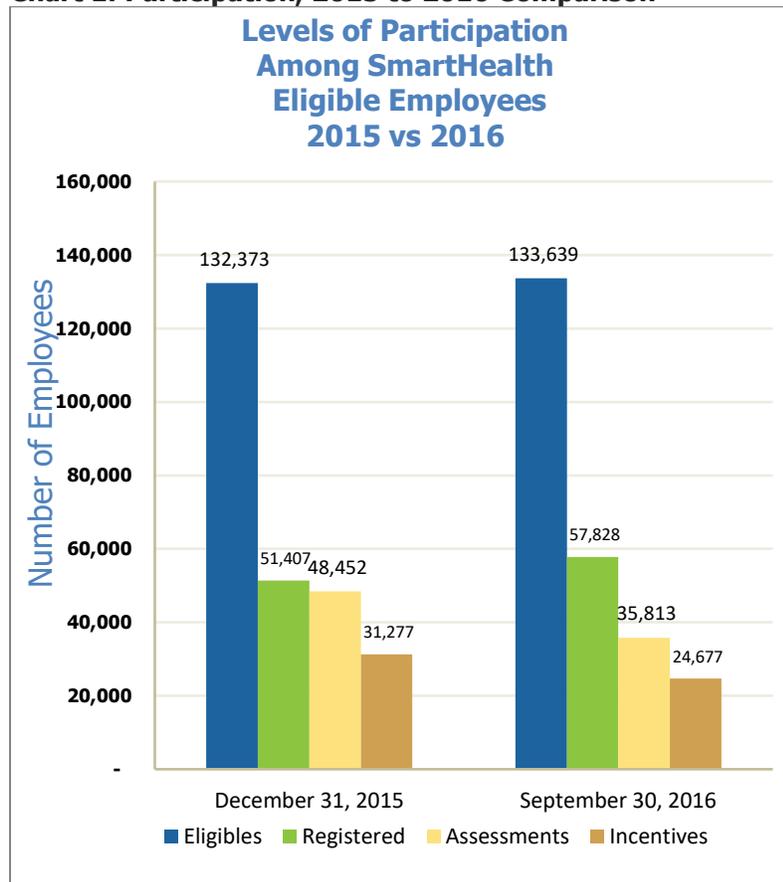
Comparing Participation in 2016 and 2015

Findings

Registrations for the SmartHealth program increased in 2016; close to 1 in 5 SmartHealth participants in 2016 were new. 3,700 previously registered participants left SmartHealth-eligible status in 2016 and 10,767 new participants registered for the program, resulting in *7,000 net new registrations in 2016*. Registrations carry over from year to year, even for those who choose not to participate, which explains why the registrations were higher than in the previous year while the number of those taking the well-being assessment and qualifying for the incentive were lower.

35,813 participants completed a well-being assessment by September 30, 2016. 27,123 of these individuals had also completed a well-being assessment in 2015.

Chart 1: Participation, 2015 to 2016 Comparison



Charts 2 and 3 compare participation across age groups from year to year. While registrations increased, completion of the assessments and qualification for the financial incentive decreased.

Chart 2: 2015 Participation, by Age

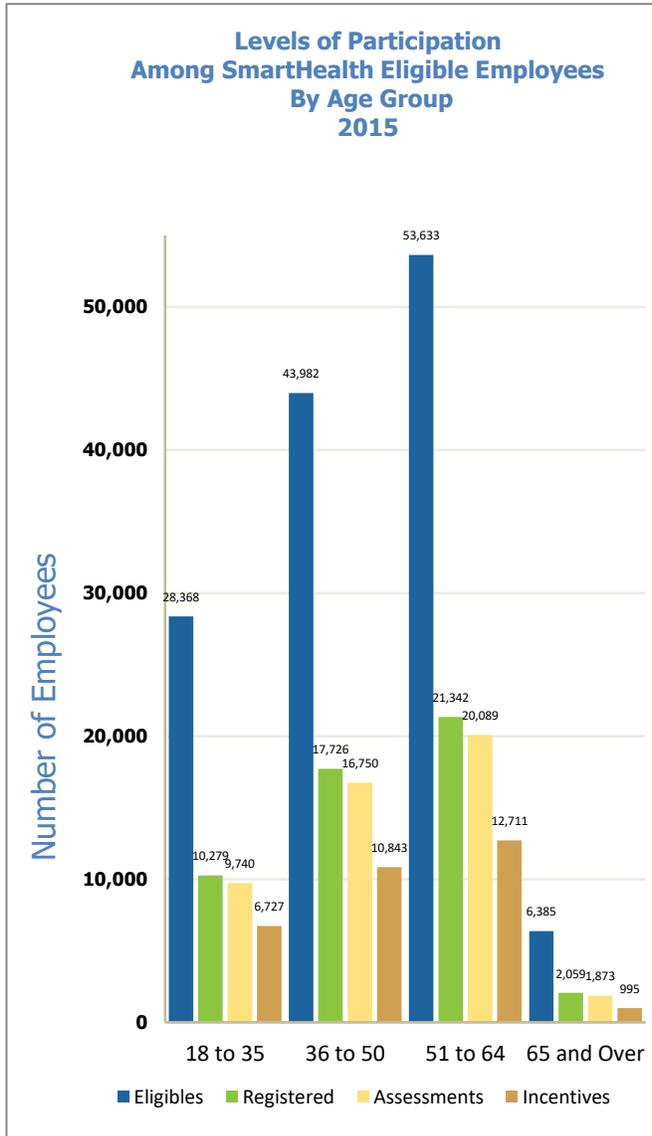
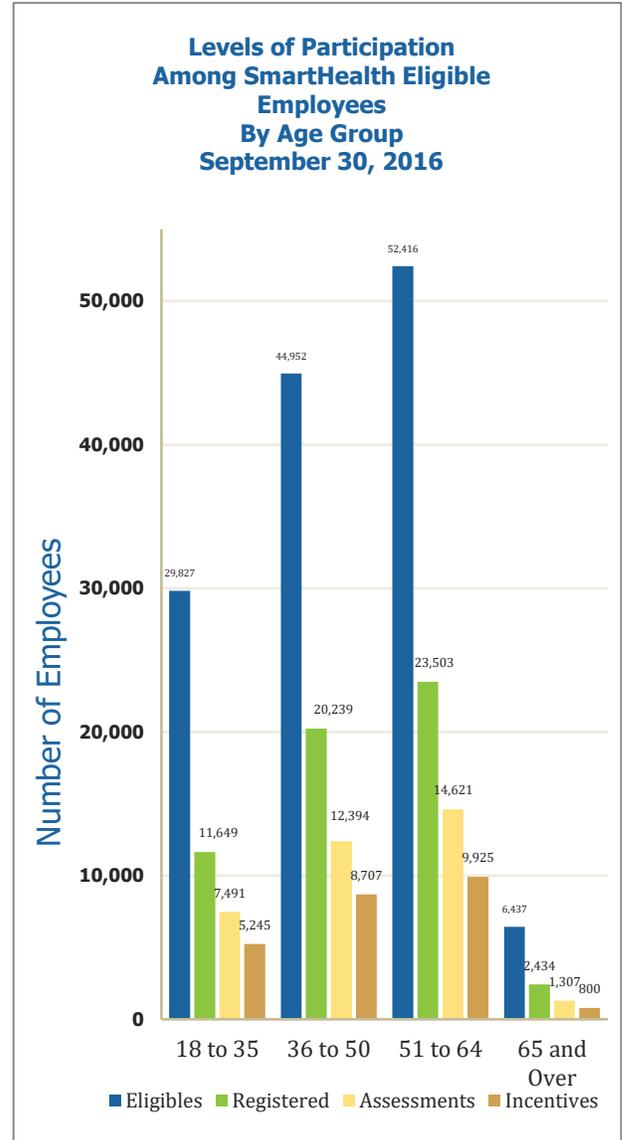


Chart 3: 2016 Participation, by Age



Charts 4 and 5 compare participation by gender from year to year. Again, while registrations for both groups increased in 2016, completion of the assessments and qualification for the financial incentive decreased. In addition, more women participated in SmartHealth than men, and at a higher percentage.

During 2016, 50 percent of SmartHealth-eligible women registered and 32 percent completed their Well-being Assessment. During that same period, only 35 percent of men registered and 20 percent completed their well-being assessments.

Chart 4: 2015 Participation, by Gender

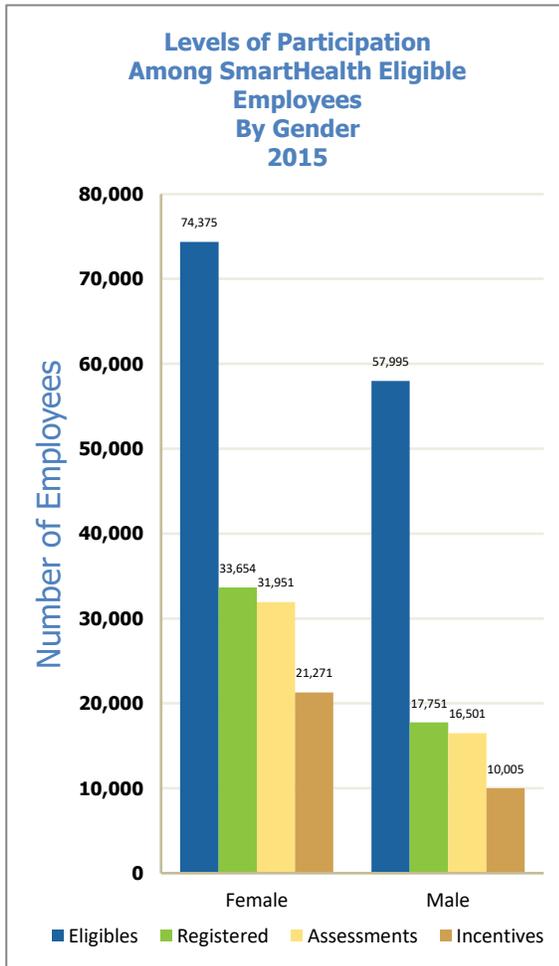
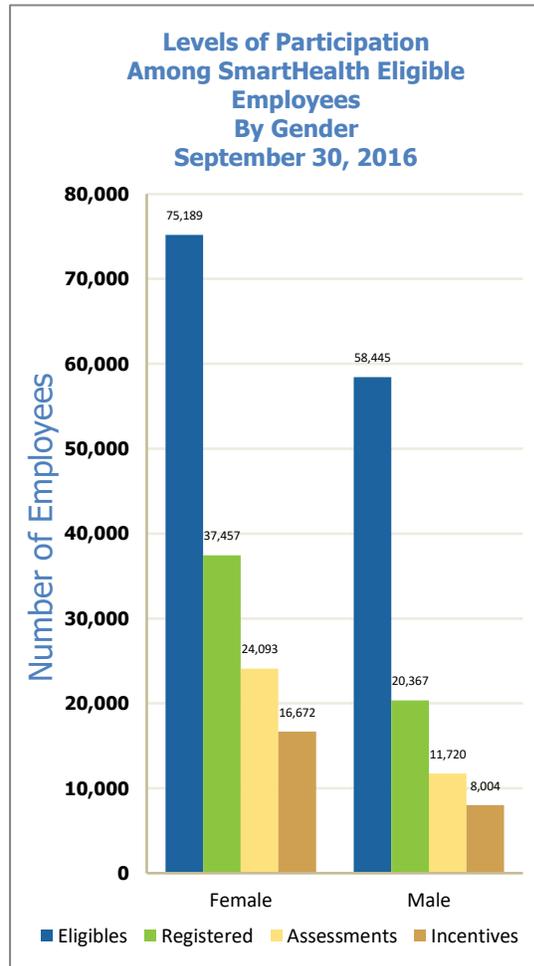


Chart 5: 2016 Participation, by Gender



Participation by employer type, as measured by WBA completion and incentive qualification, declined from 2015 to 2016 (see Charts 6 and 7), with a significantly larger decrease among the eligible individuals within the higher education institutions. Agencies experienced a smaller decrease in participation with an 18 percent decrease from year to year.

Chart 6: 2015 Participation, by Employer Type

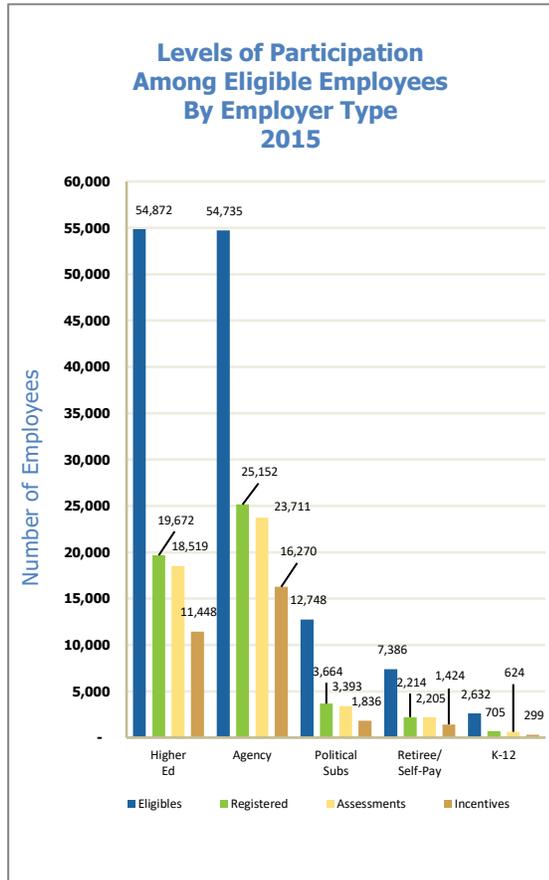
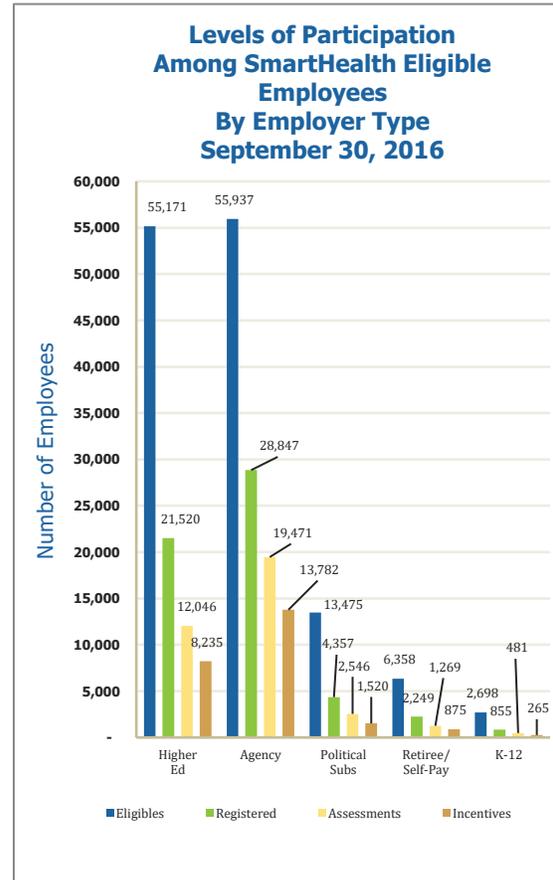


Chart 7: 2016 Participation, by Employer Type



Charts 8 and 9 (next two pages) show the percentage of eligible participants completing the well-being assessment during 2016, broken out by agency and by institution of higher education. Engaging senior leadership at these organizations is the key to reaching the goal levels of participation in SmartHealth. Twenty-one out of the forty-seven total agencies either met or exceeded the 2016 completion rate goal of 45 percent while two of them exceeded the long-term completion goal of 65 percent. Of the 21 that exceeded the 45 percent goal, all have SmartHealth-engaged leadership and wellness coordinators that participate with Washington Wellness. Clearly, the work organization is the most influential unit for increasing participation.



Chart 8: 2016 Completion Rates for Well-being Assessments, by Agency

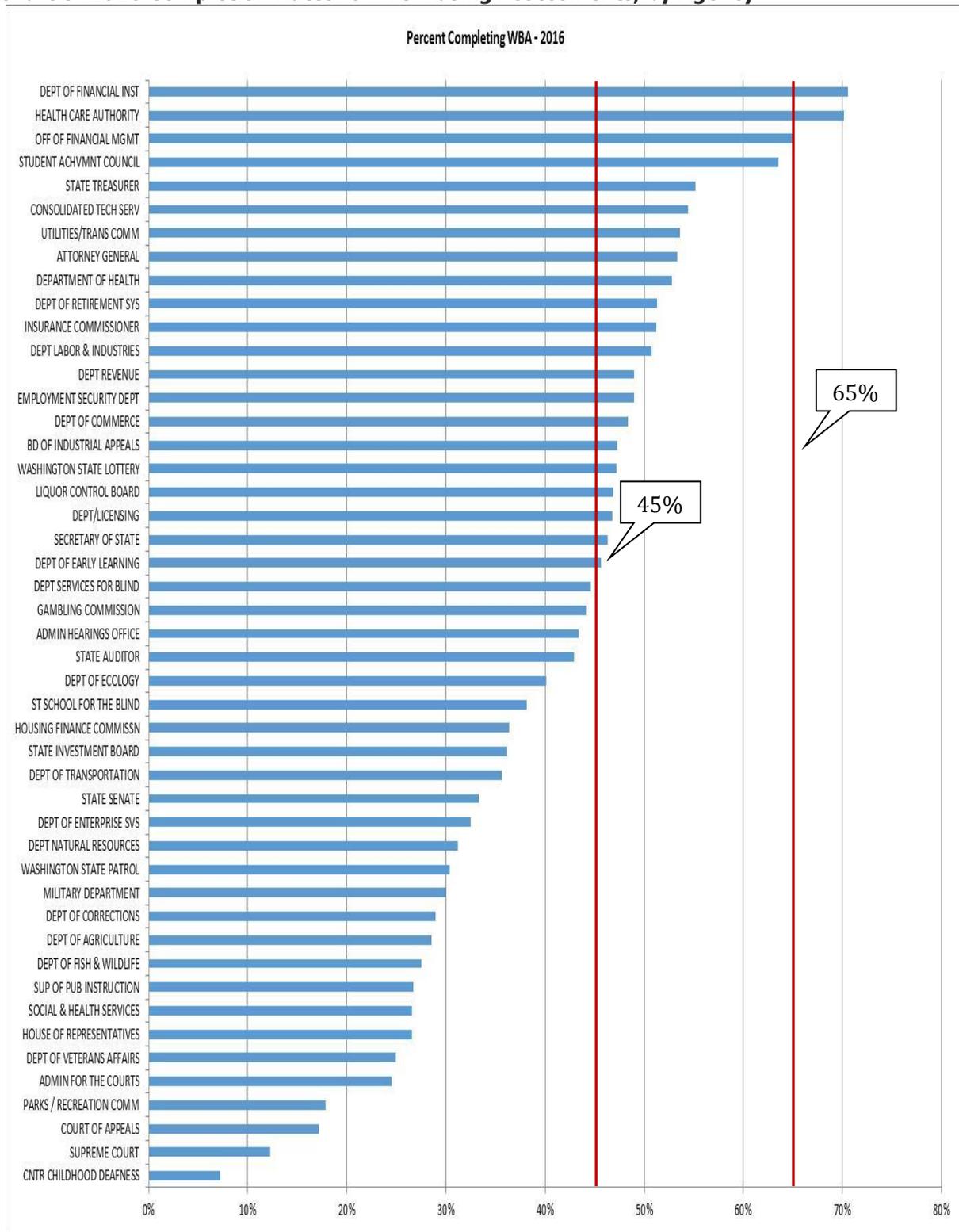
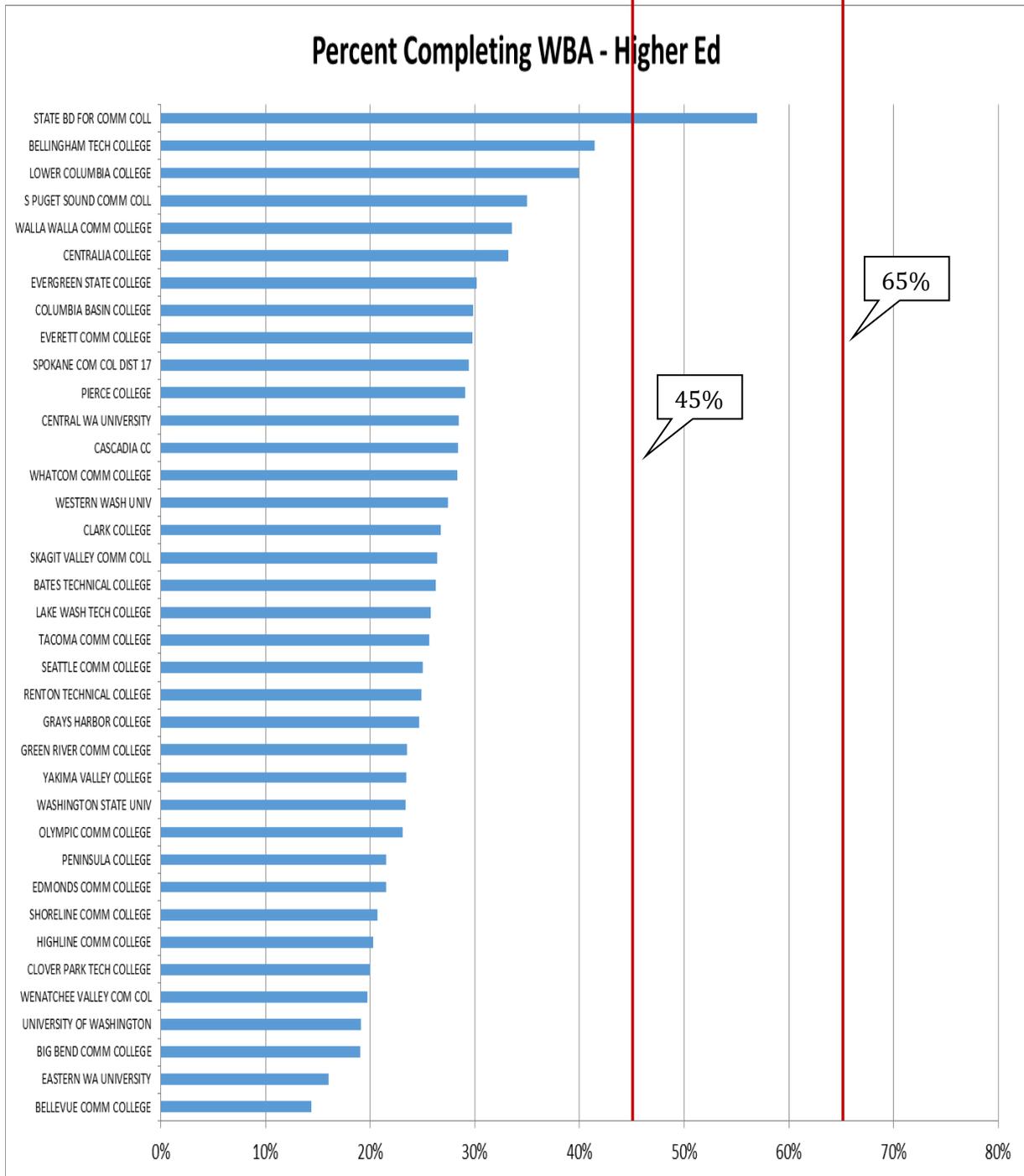


Chart 9: Completion Rates for Well-being Assessments, by Higher Education Institution



Charts 10 and 11 summarize the previous charts, showing the change in the percentage of members qualifying for the incentive in each category from 2015 to 2016.

Chart 10: 2015 Incentive Qualification

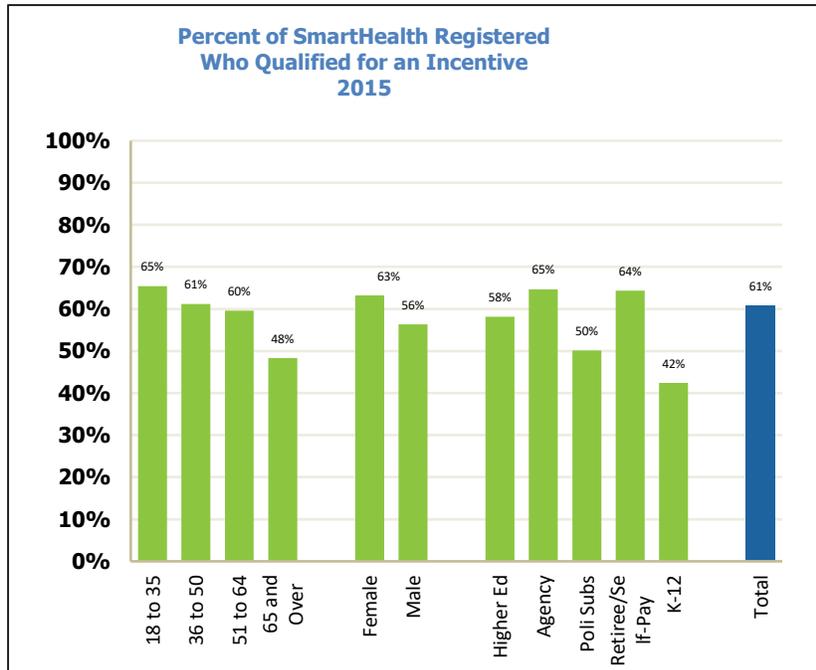
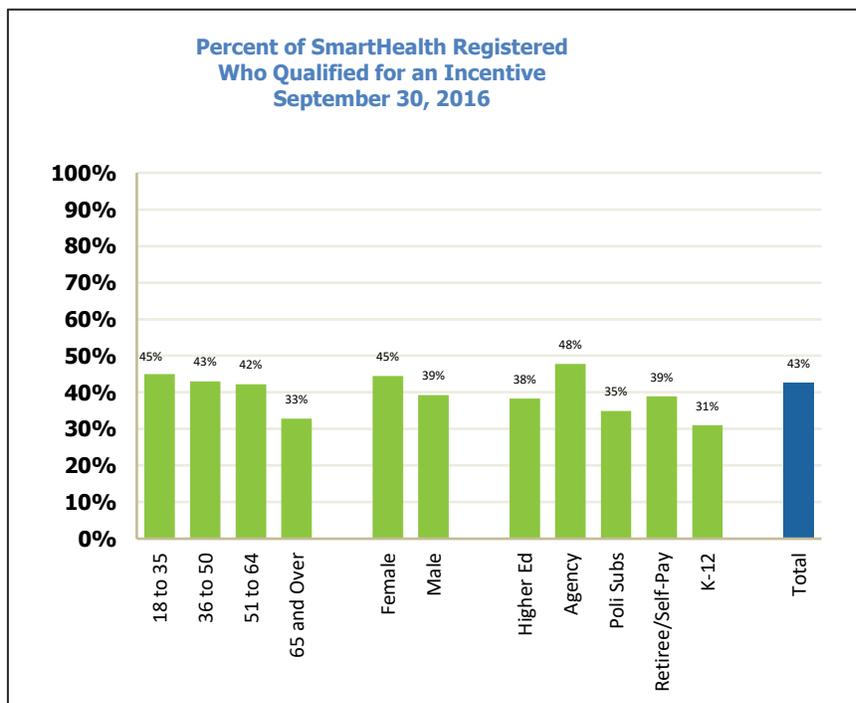


Chart 11: 2016 Incentive Qualification



Charts 12 and 13 show the point totals for participants who qualified for the incentive in 2015 and 2016. While overall participation dropped, many who achieved the incentive went on to earn additional points. In 2017 the incentive levels will change and additional incentives will be added for levels 2 and 3 to encourage participants who want to continue earning points at a higher level.

Chart 12: 2015 Participant Point Totals

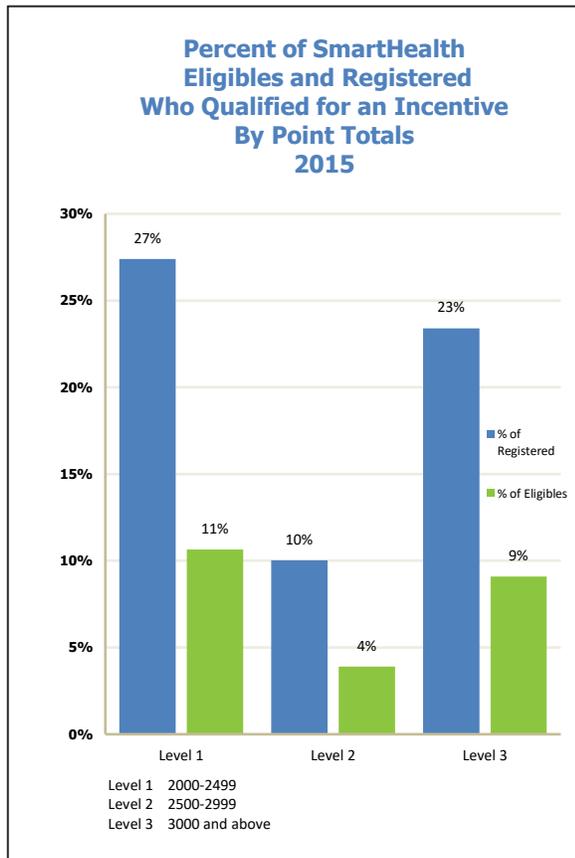
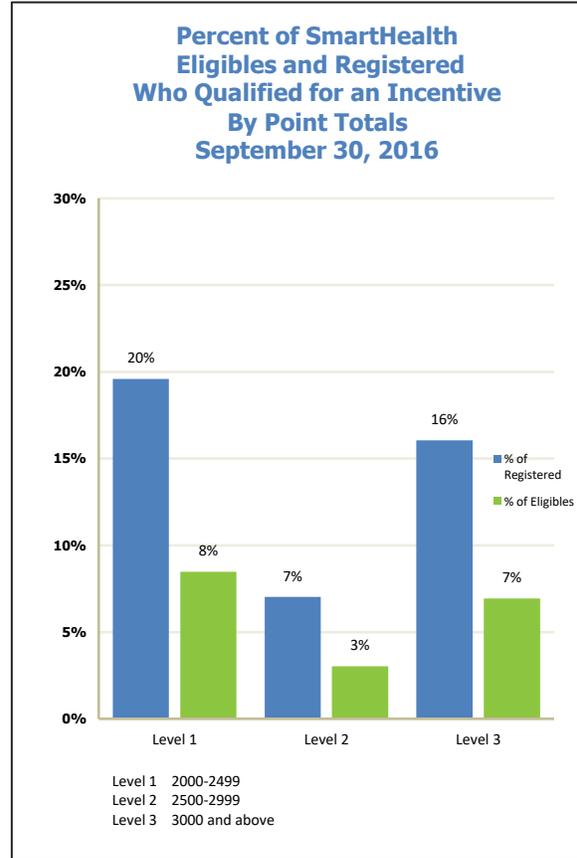


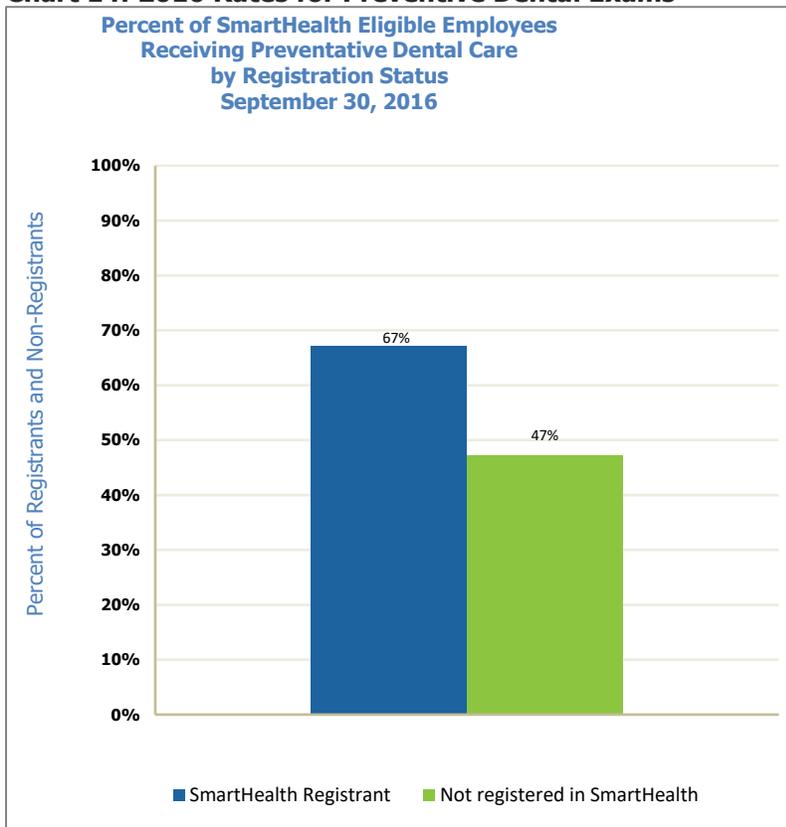
Chart 13: 2016 Participant Point Totals



As reported in the second SmartHealth Effectiveness Report (September 2016), SmartHealth participation may have had an impact in 2016 on the percentage of employees receiving preventive dental care. Previous data from the PEBB Dental Plans showed a low percentage of members receiving preventive dental care exams. In 2016, the SmartHealth program promoted preventive dental exams by including an activity that provided points for getting an exam, which was then verified by claims data. In 2016, 67 percent of SmartHealth-registered enrollees received a preventive dental care exam, compared with only 47 percent for the cohort that was not registered in SmartHealth (Chart 14, next page).



Chart 14: 2016 Rates for Preventive Dental Exams



The percentage of members receiving dental care from year to year tends to remain stable so the increase observed in the SmartHealth cohort constitutes a dramatic change and may be driven by the introduction of the SmartHealth program. While this is potentially an important finding, the data is correlative only, and direct causality cannot be proven.

Delta Dental has provided data showing that those who get regular annual preventive dental care cost \$292 less per year. While too early to ascribe direct cost savings to SmartHealth, if the positive correlation continues, the program could help contribute to over \$2 million in cost savings each year.

Chart 15 (next page) shows that over half of eligible individuals completing the SmartHealth well-being assessment indicated having one or more risk factors, while Chart 16 (also on the next page) shows that the vast majority of individuals in this cohort report that they are in good or excellent health.



Chart 15: Risk Categories for Those Who Complete Well-being Assessments (self-reported)

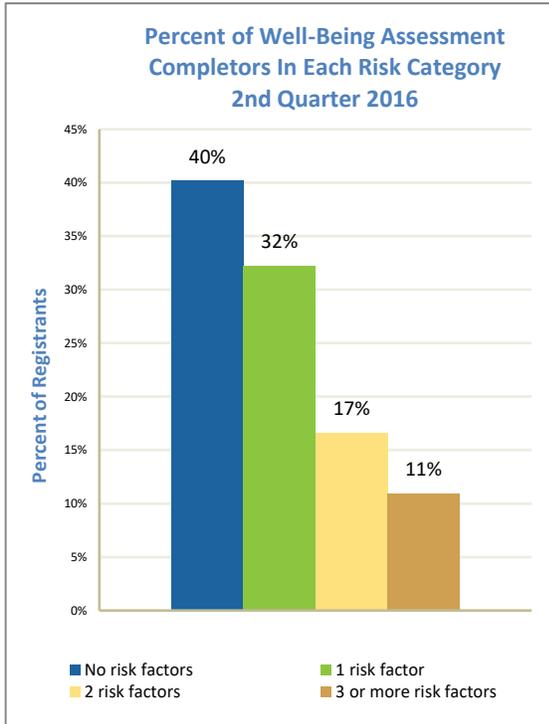
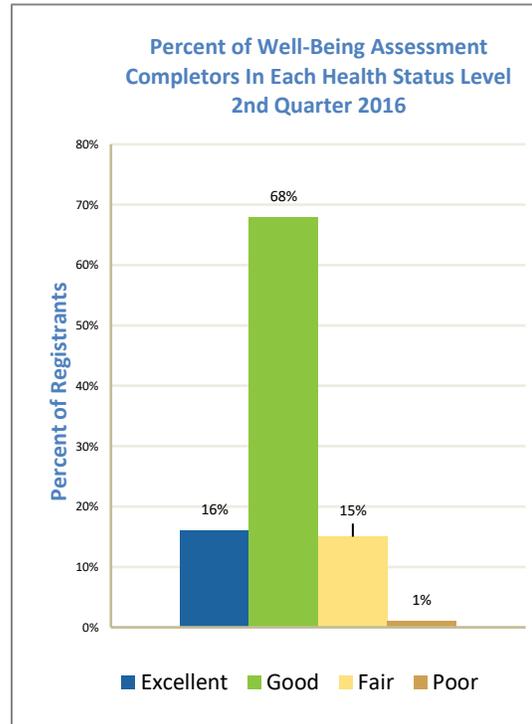


Chart 16: Health Status for Those Who Complete Well-being Assessments (self-reported)



Conclusions

The program is working for those who register and participate. While participation in 2016 was mixed—registration increased, but WBA completion and qualification for the incentive declined—the program continues to reach and engage a majority of eligible individuals. HCA and Limeade, the vendor for the SmartHealth program, continue to adjust and improve the program for all users. But, to accomplish the goals—increasing reach (registration) and engagement (WBA completion and qualification for the incentive)—the program will need to develop more robust and effective communication channels outside of the SmartHealth platform. Also, offering additional financial incentives and more frequent rewards, as planned for future years, will likely increase participation.



Data from the Well-being Assessments

Overview

Limeade, the vendor for the SmartHealth program, defines well-being as “a state of optimal health, happiness, and purpose.” Their research indicates that when employees feel that they have higher well-being, they’re more likely to be engaged in their work and feel supported by their organization. Well-being can be self-reported at an overall level or it can be derived by looking at a set of predictors of well-being.

Developed in 2006, the Limeade Well-being Assessment represents a holistic model of well-being, combining work, financial, emotional, and physical well-being (including health risk factors). It highlights the interdependencies and intricacies of relationships among diverse outcomes, such as organizational commitment, job engagement, resilience, the quality of relationships, stress, and physical health.

Limeade followed several guiding principles to develop the assessment. First, they used positive psychology literature and behavioral science to develop the underlying theoretical model. Second, the assessment is the result of extensive research that demonstrates evidence of the interconnectedness of the well-being dimensions. Third, the assessment was developed following test development guidelines provided by the American Psychological Association (updated in 2014).

The initial step was to conduct a thorough literature review of related research, which informed ongoing discussions that led to the formation of the Limeade well-being model. After experts and stakeholders developed and reviewed the initial well-being model, they created a structured assessment. The assessment underwent multiple iterations and content validity sessions, which involved participants with characteristics resembling those in the target user groups. Results from these sessions led to additional revisions. Some of the early adopter customers piloted the revised assessment, providing feedback about the user experience and their reactions to assessment items. The feedback informed further modifications to the assessment. The model is revisited on a regular basis and updated as appropriate.

Findings

48,452 SmartHealth registrants completed the SmartHealth Well-being Assessment in 2015 and 35,813 registrants completed it by September 30, 2016. The assessment consists of 200 questions related to 34 dimensions of health. (See Table 1 on next page.) 27,123 individuals completed the well-being assessment in both 2015 and 2016 and represent the SmartHealth cohort analyzed by Limeade.



Table 1: SmartHealth Well-being Assessment, Dimensions of Health

Appreciating Life	In the Flow	Resources & Support
Back Health	Job Satisfaction	Self-Acceptance
Belief in Company	Knowing Yourself	Self-Care
Belief in Your Abilities	Life Meaning	Self-Leadership
Drinking Moderately	Making & Keeping	Sense of Team
Energy Level	Managing Depression	Sleep
Exercise & Fitness	Managing Stress & Anxiety	Smoke-Free Living
Feeling Energized	Nutrition	Work Growth
Fit with Culture	Openness & Optimism	Work Meaning
Healthy Blood Sugar	Positive Living	Work-Life Balance
Healthy Weight	Positive Relationships	Resources & Support
	Resilience	Self-Acceptance

Based on a participant’s answers, Limeade assigns a score for each of these dimensions, using a five-point scale. In addition, the assessment provides a comparison with the averages of other participants. Limeade groups these dimensions into six “Life Areas”: Reaching Potential, Emotional, Physical, Capacity for Change, Work, and Health Risk.

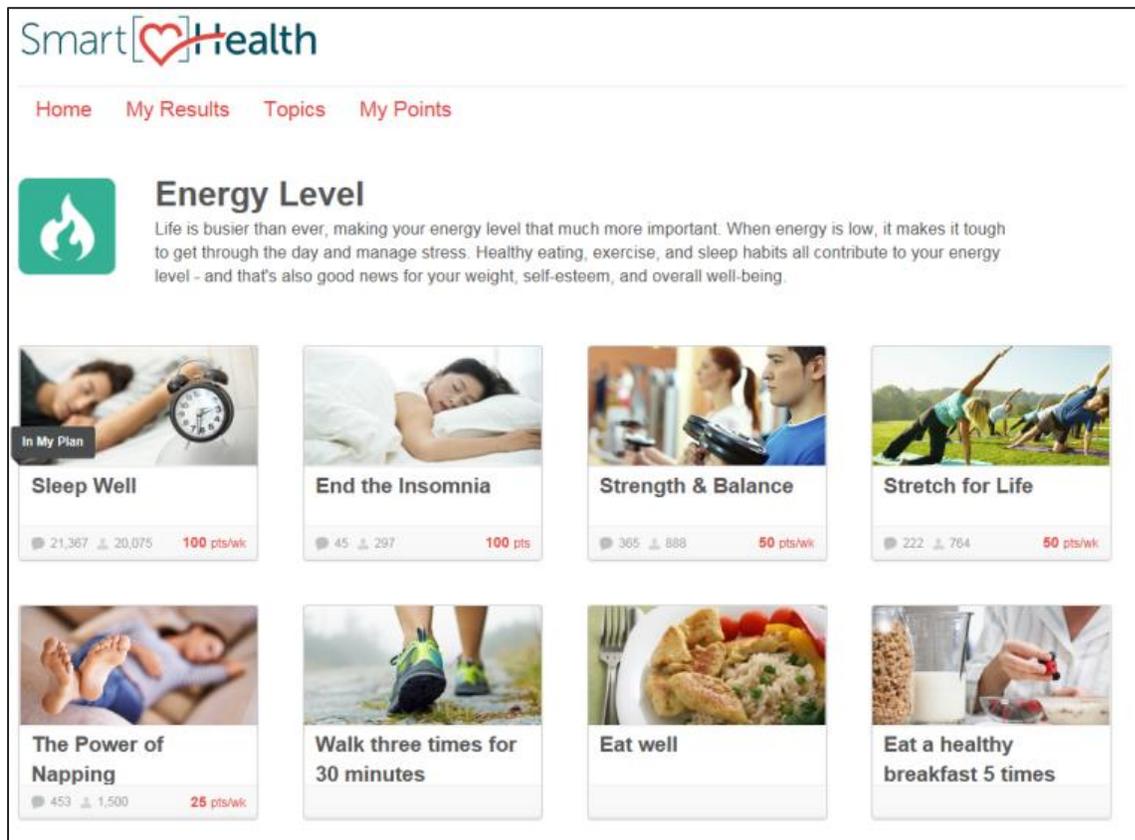
Figure 1 shows an example of one participant’s scores in the Physical Life Area, compared with other participants’ scores, as well as the score for one of the 34 dimensions of health: Self-Care.

Figure 1: Sample Well-being Assessment Scores, Physical Life Area



Based on the participant's score, Limeade suggests relevant activities for the participant to become involved in. Figure 2 shows an example of some activities and their related points for the Energy Level dimension.

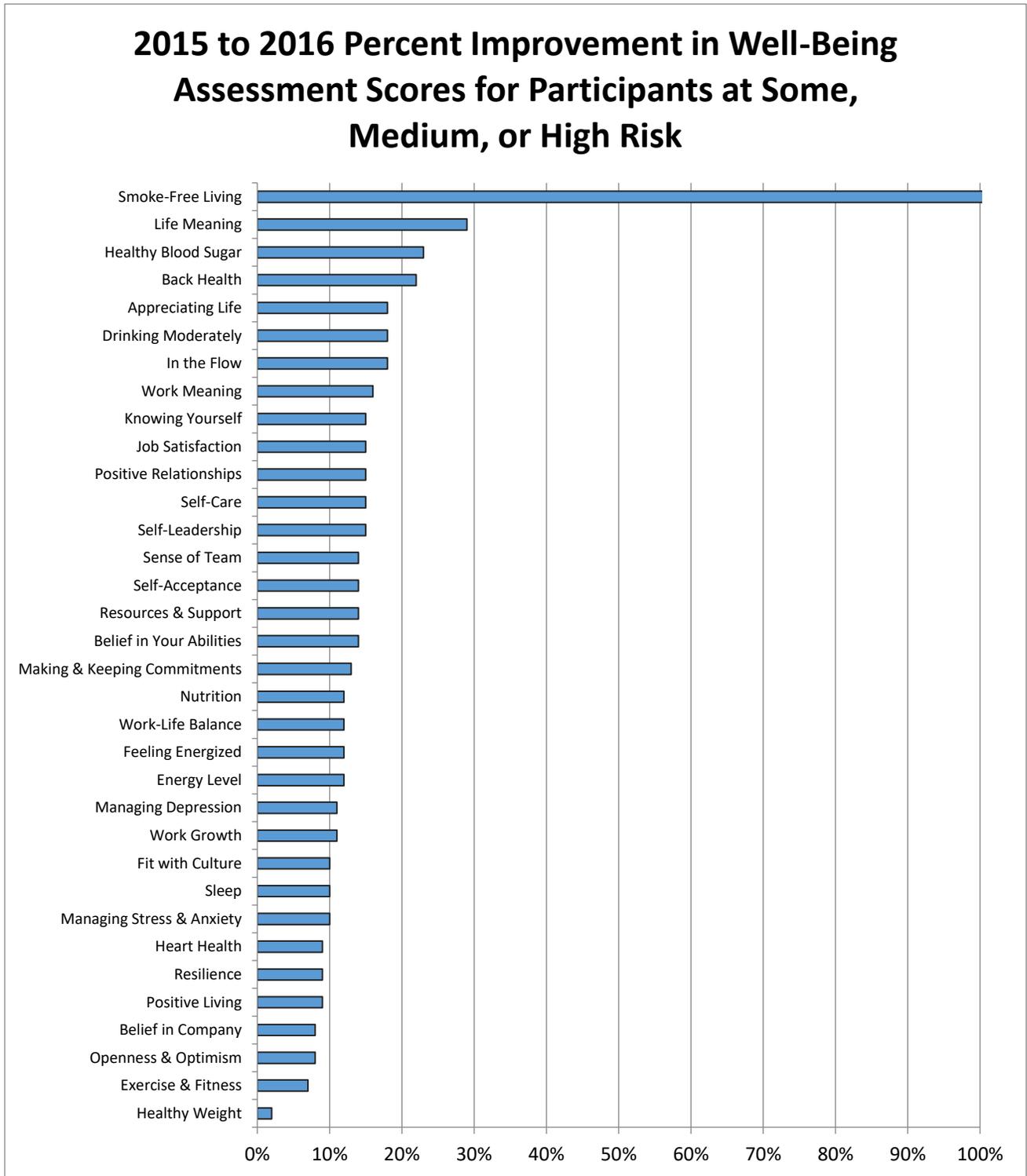
Figure 2: Individual Recommendations for Energy Level Dimension



A comparison of the aggregate scores on each of the 34 dimensions for the SmartHealth cohort found a striking change from 2015 to 2016. Chart 17 (next page) shows the relative change in score for each of the dimensions from 2015 to 2016 for participants who reported being at some, medium, or high risk. This would indicate that, at least for the slightly higher risk SmartHealth cohort, participating in the program may have resulted in improved well-being on every one of the 34 dimensions. From 2015 to 2016, 26 percent of smokers reported that they had quit smoking. Unlike other dimensions, the smoke-free living dimension is based only on scores of either 1 (smoker) or 5 (non-smoker). Because twice as many participants said they were non-smokers in 2016, chart 17 reflects a doubling of the risk score improvement for the smoke-free living dimension.



Chart 17: Change in Well-being Assessment Scores for Participants in SmartHealth Cohort



In addition, our analysis found that, for all but four of the dimensions, higher participating organizations had better two-year outcomes improvements than lower participating agencies (see Table 2).

Table 2: Agencies' Changes in Well-being Dimensions, Based on Participation Rates

Dimension	2015-2016 dimension change (positive = better, negative = worse)		Difference
	Lowest participation agencies	Highest participation agencies	
Back Health	-0.7%	0.9%	1.6%
Exercise & Fitness	0.1%	1.3%	1.2%
Sleep	0.6%	1.5%	0.9%
Energy Level	0.4%	1.3%	0.9%
Work-Life Balance	-0.6%	0.1%	0.7%
Belief in Company	-1.9%	-1.2%	0.7%
Nutrition	1.2%	1.8%	0.6%
Managing Depression	0.2%	0.8%	0.6%
Appreciating Life	0.6%	1.1%	0.6%
Fit with Culture	-1.4%	-0.8%	0.6%
Positive Living	1.0%	1.5%	0.6%
Self-Leadership	0.2%	0.7%	0.5%
Positive Relationships	-0.2%	0.3%	0.5%
Drinking Moderately	-0.4%	0.1%	0.5%
Belief in Your Abilities	0.2%	0.6%	0.5%
Job Satisfaction	-0.2%	0.2%	0.5%
Resilience	0.5%	1.0%	0.4%
Resources & Support	-0.4%	0.0%	0.4%
Self-Care	0.4%	0.8%	0.4%
Heart Health	-0.2%	0.2%	0.4%
Smoke-Free Living	-0.1%	0.2%	0.3%
Openness & Optimism	0.2%	0.6%	0.3%
Self-Acceptance	0.2%	0.5%	0.3%
Managing Stress & Anxiety	0.7%	1.0%	0.3%
Knowing Yourself	0.7%	1.0%	0.3%
Feeling Energized	-1.1%	-0.9%	0.3%
Work Growth	-0.8%	-0.5%	0.2%
Work Meaning	-0.7%	-0.5%	0.2%
Life Meaning	-0.1%	0.1%	0.2%
Making & Keeping Commitments	0.5%	0.7%	0.2%
Sense of Team	-0.3%	-0.3%	0.0%
In the Flow	0.4%	0.3%	-0.1%
Healthy Blood Sugar	-0.2%	-0.3%	-0.2%
Healthy Weight	-0.1%	-0.9%	-0.9%



For example, in the Back Health dimension, participants in the high participating agencies scored themselves 1.6% higher on the well-being assessment than participants in the low participating agencies. While this analysis is not necessarily statistically significant it does show a general trend.

“High participation agencies” were defined as those agencies with the greatest per capita completion of the Level 2 incentives, and those that had over 500 people complete the 2015 and 2016 well-being assessments. This cohort includes the Department of Labor and Industries, the Department of Health, and the Department of Transportation.

“Low participation agencies” were defined as the agencies with the lowest per capita completion of Level 2 incentives, and those that had over 500 people complete the 2015 and 2016 well-being assessments. This cohort includes the Department of Corrections, the University of Washington, and the political subdivisions.

“Dimension change” refers to the average change in dimension scores among people who completed the well-being assessment in 2015 and 2016.

Conclusion

The SmartHealth program is working for those who are registered and participating. It appears to be meeting the primary program objectives of maintaining and improving overall well-being, improving the productivity of the workforce, and contributing to state agencies’ capacity to accomplish their mission. Individuals who started with lower well-being scores appear to be improving. The cohort with any amount of risk, i.e., those with well-being scores of less than 3.5, improved in every one of the 34 dimensions of health. In 23 of these dimensions, the improvement was greater than 10 percent. Notable increases were in the dimensions of life meaning (+29.2%), healthy blood sugar (+23.3%), and back health (+21.9%).

In addition, those who started with high well-being are maintaining their well-being. Across the entire SmartHealth cohort, well-being scores improved or stayed the same in 29 out of 34 well-being dimensions.

Finally, engaging senior leadership at the agencies is the key to reaching the desired goal levels of participation in the SmartHealth program and having a positive impact on the workforce.



History of the Well-Being Assessment

“The focus on worker and workforce well-being is of critical national importance because of the role and significance of work to national life. The growing incidence of mental disorders, stress-related outcomes, and chronic diseases in the population and the organizational features of work related to safety and health outcomes require attention to their linkage to well-being.”

~ Considerations for Incorporating “Well-Being” in Public Policy for Workers and Workplaces¹

A large body of research has pointed to the positive association between employee health, well-being, and productivity. Overall well-being refers to perceived and experienced satisfaction with life overall, and with domains of life such as work, finances, physical health, and community.²

The health risk assessment (HRA), was the measurement tool of choice in the 1980s for worksite wellness programs. Designed to identify employees with significant health risks such as smoking or high blood pressure, it was used by employers offering these employees an intervention. Higher health risks have been associated with higher absenteeism, but now there is growing evidence that factors beyond physical health have an impact on productivity. The research on well-being and productivity indicates that well-being is made up of a range of factors that together define an individual’s experience or well-being. The well-being assessment acknowledges the important role of physical health, but takes a much broader view of factors that influence the health of an individual.³

¹ Schulte, Paul A., Guerin, Rebecca J., Schill, Anita L., Bhattacharya, Anasua, , Cunningham, Thomas R., Panalal, Sudha P., Eggerth, Donald, and Stephenson, Carol M. (August 2015). *Considerations for incorporating “well-being” in public policy for workers and workplaces*. American Journal of Public Health, 105:8.

² Wu, Hao, Sears, Lindsay E, Coberly, Carter R. , and Pope, James E. (January 2016). *Overall well-being and supervisor ratings of employee performance, accountability, customer service, innovation, prosocial behavior, and self-development*. Journal of Environmental Medicine, 58:1.

³ Gandy, William M., Coberley, Carter R., Pope, James E., and Rula, Elizabeth Y.. (January 2016). *Comparison of the utility of two assessments for explaining and predicting productivity change, well-being versus an HRA*. Journal of Environmental Medicine, 58:1.



Plan for 2017

While participation in 2016 was mixed, i.e., registration was up, but well-being assessment completion and incentive qualification was down, the program continues to reach and engage a majority of registered users. Nevertheless, known obstacles continue to hinder our ability to reach and engage eligible employees, including:

- A continued inability to reach all eligible members via email;
- A complex structure: 450 work organizations, with different and distinct cultures;
- The difficulty of maintaining continuous engagement from leadership, who are managing competing priorities;
- Wellness coordinators: Educating them on the new program and providing them with aggregate participation data and turnkey communications to help support their efforts;
- Continued member participation: providing ongoing value to registered subscribers, particularly after members' deadlines to qualify for financial incentives; and
- Higher-education population: addressing their unique needs, such as reaching across geographic distances and communicating across diverse populations.

The program continues to adjust and improve in order to address these known barriers. Improvements include evolving intrinsic messaging and introducing new extrinsic rewards for 2017. These include a promotional campaign focused on encouraging participants to identify their personal motivation for behavioral change; gift cards for WBA completion; and additional drawings for levels 1, 2 and 3.

In addition, the program is developing more effective, action-inducing communications, creating a more meaningful level structure, and increasing program visibility through high-profile events, such as SmartHealth Week.

In 2016, SmartHealth Week resulted in:

- 7,700+ people joining their first activity,
- 995 new registrations, and
- 2,936 new individuals completing their well-being assessment completions.

Another area of focus that was tested in 2016 and will be expanded in 2017 is engaging large organizations to increase their program reach. In 2016, for the first time, the program had the University of Washington and Washington State University competing in the "Apple Cup Fitness Challenge". This resulted in the most participation of any custom activity to date, with:

- Over 650 active participants,
- More than 1600 comments, and
- 297,561 minutes—or almost 5,000 hours—of total activity tracked.



Developing more robust and effective communication channels *outside* of the SmartHealth platform will be critical for accomplishing the program goals and improving participation, including.

1. *Increasing organizational support for well-being, e.g.:*
 - Research shows the most important aspect of organizational support is manager support, followed by well-being tools and resources, and leadership support.
 - 72 percent of employees with higher well-being say they receive organizational support, compared to only 8 percent of those with lower well-being.
2. *Increasing support from key stakeholders, i.e.: agency partners. labor and higher education.*
3. *Find new ways to encourage and incent wellness coordinators including recognition, thank you rewards, and bonus points for Wellness Champion targeted activities.*
4. *Immediate and tangible rewards will continue to spark interest in the program. These are actively being developed for 2017 and involve small incentives such as gift cards, provided, for the most part, by the vendor.*



Appendix A

SmartHealth

2016 Program Insights

12/20/2016

limeade®
it's totally possible.

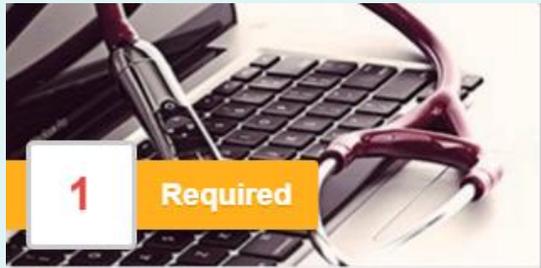


Overview

- 2016 program design drove real results in areas with biggest need for improvement
- Wide array of activities allowed SmartHealth members to find and participate in activities that met their needs
- Those with the highest risks are seeing significant change in needed areas, e.g.:
 - Improved WBA scores in EVERY area, including significant gains in areas of need
 - The vast majority of at risk population is decreasing or maintaining risks across all well-being dimensions (health, productivity, work, etc)
 - The vast majority of at risk population is decreasing or maintaining risks across self-report biometrics
- Program strategy is driving real improvements

2016 activity focus...

Used 2015 input, data and insights to better inform strategy



1 Required

Complete Your Assessment

800 pts

Top Health Risks

Back pain
Eating better
Energy
Sleep
Weight

2016 Focus - Activity Samples



New

Cardio for Beginners!

2,734 4,278 **125 pts/wk**



New

Eat Real to Heal

1,596 3,012 **35 pts/wk**



New

Sleep Well

3,280 5,066 **100 pts/wk**

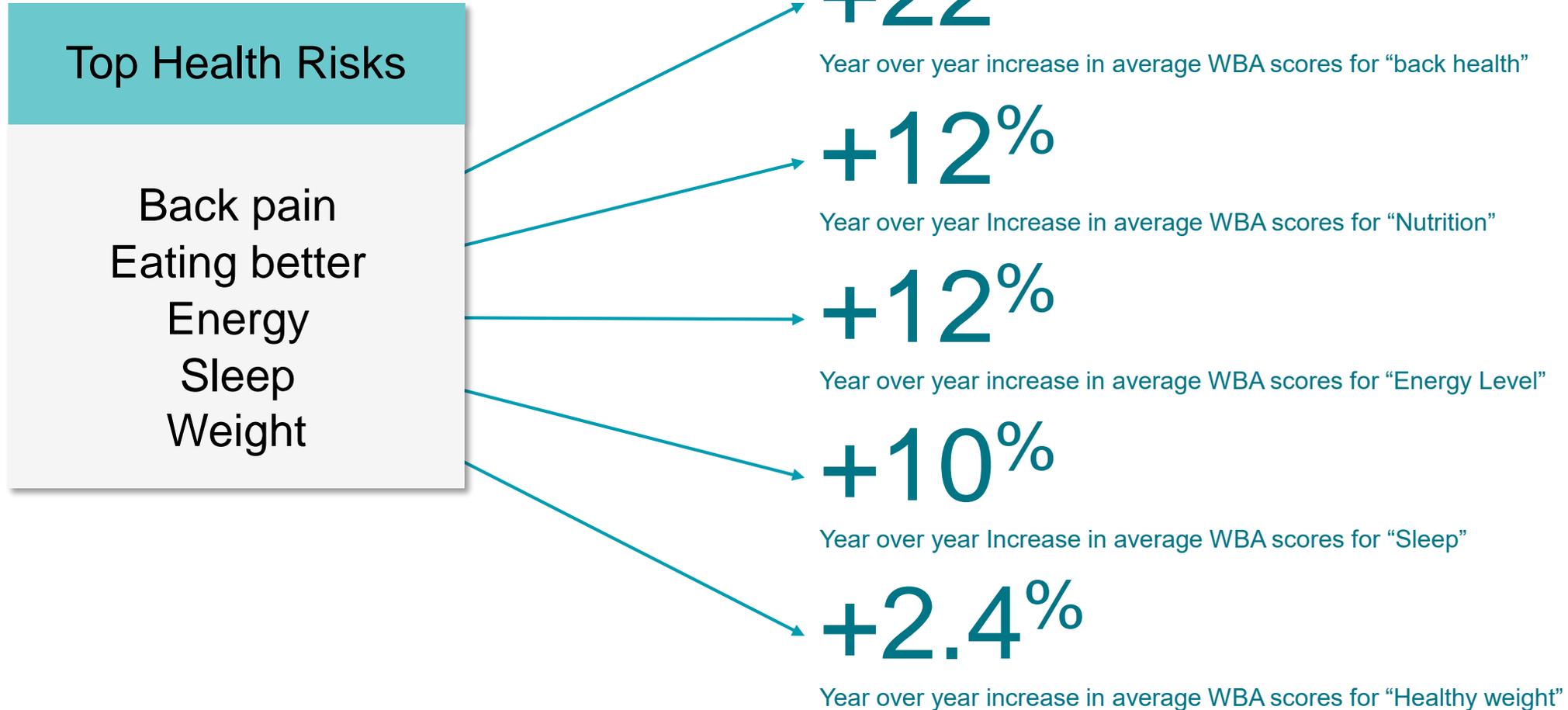


New

Heal Your Back

1,823 3,204 **75 pts/wk**

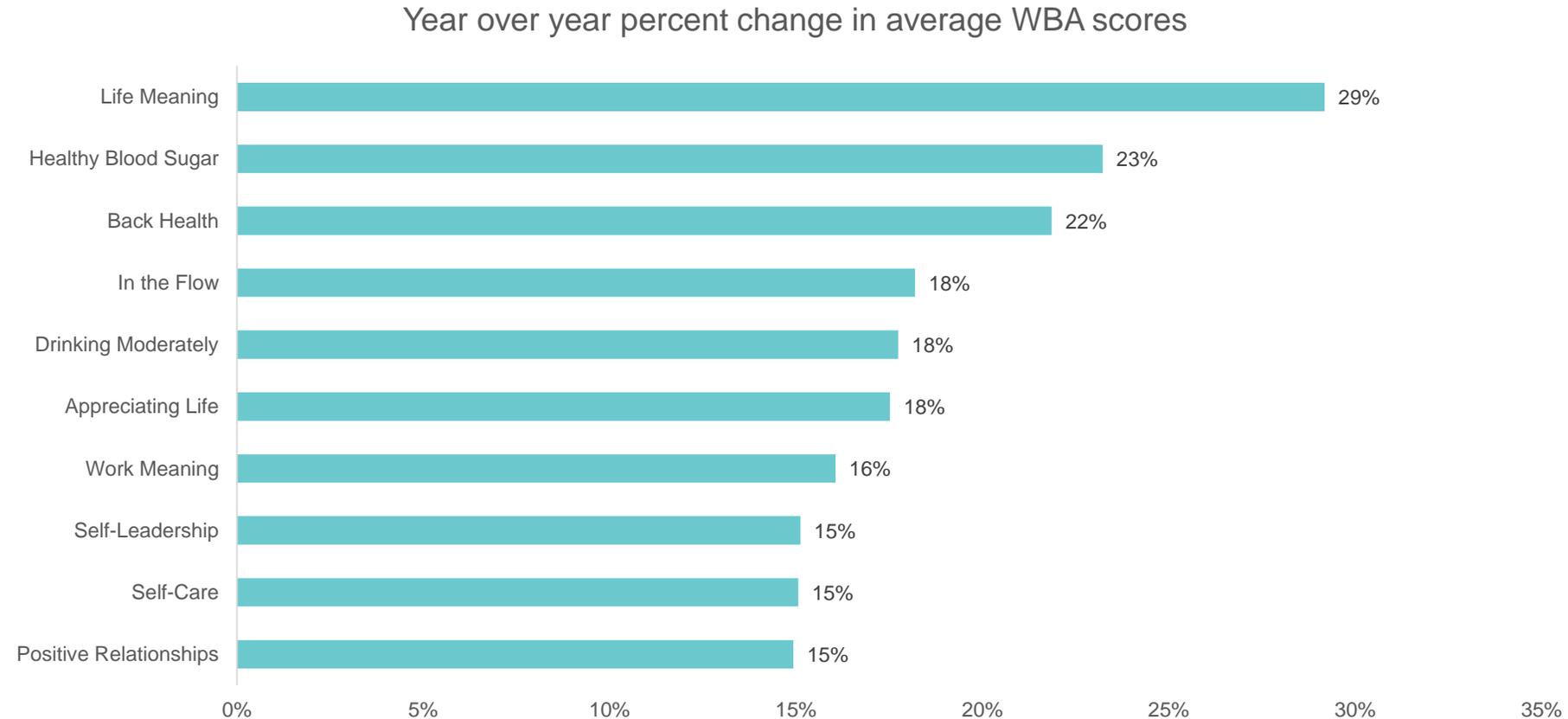
...drives real results



*all results for those who started with any amount of risk in 2015

Top Ten Improvements

Those with the highest risks are seeing significant change in needed areas

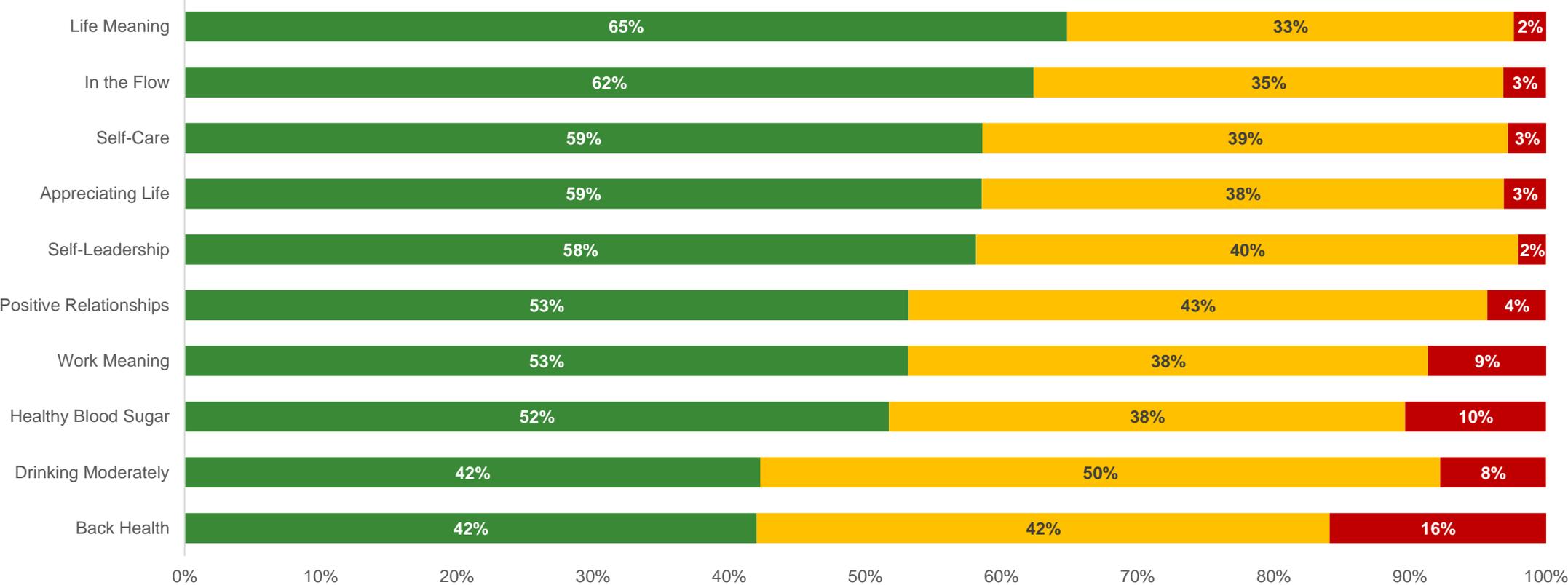


*all results for those who started with any amount of risk in 2015

WBA YoY Risk Status Change

The vast majority of those with risk are substantially decreasing or maintaining risk

WBA risk status change – 2015 v 2016 (some, moderate, high risk)



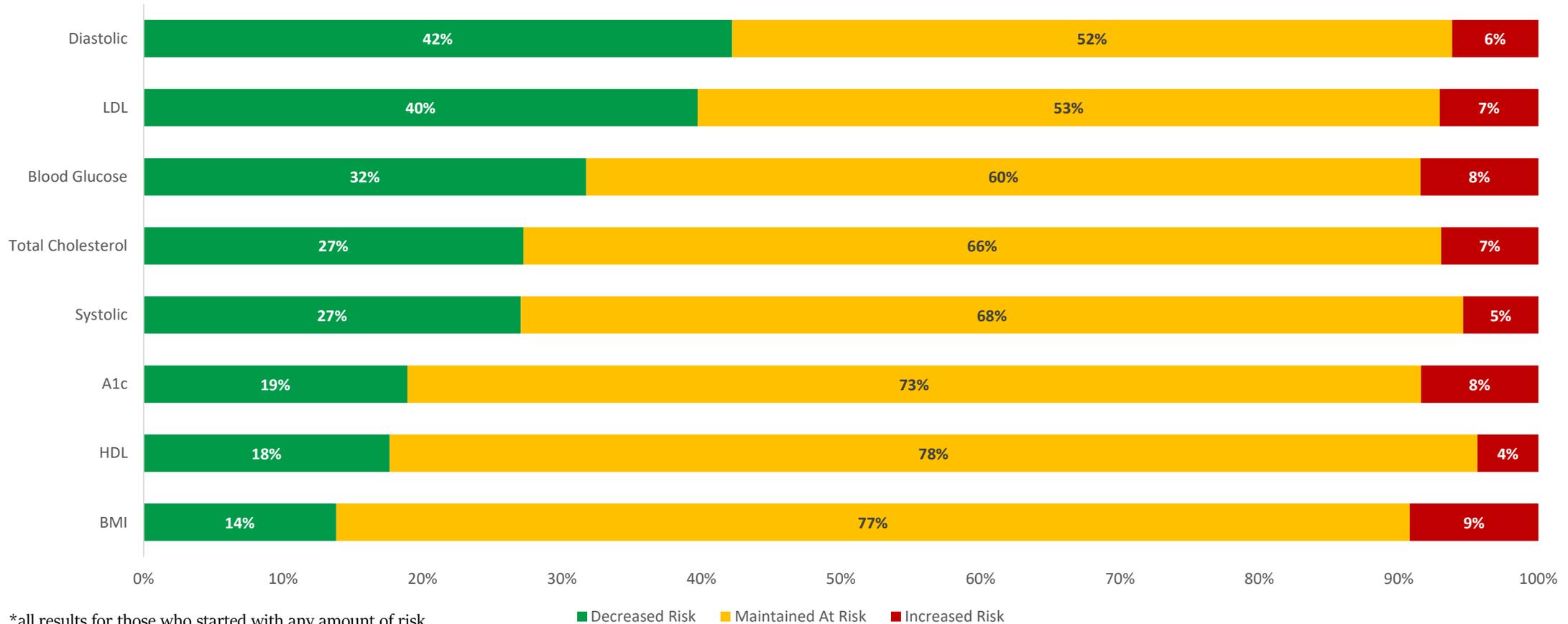
*all results for those who started with any amount of risk in 2015

■ Decreased risk ■ Maintained Risk ■ Increased Risk

Biometrics YoY Risk Status Change

Vast majority of those with risk are substantially decreasing or maintaining risk

Self reported biometric risk status change – 2015 v 2016 (some, moderate, high risk)



*all results for those who started with any amount of risk in 2015

Self Reported Biometrics

Sample size by risk factor

A1c	Blood Glucose	BMI	Diastolic	HDL	LDL	Systolic	Total Cholesterol
1,344	1,635	16,746	4,617	1,468	594	6,897	1,550

Risk Dimension	2015	2016	Change in Avg	% Change YoY
A1c	7.7	7.4	-0.31	-4.03%
Blood Glucose	122.1	118.7	-3.45	-2.82%
BMI	31.6	31.5	-0.07	-0.22%
Diastolic	84.8	80.0	-4.81	-5.67%
Systolic	127.0	124.0	-3.02	-2.38%
Total Cholesterol	223.3	215.8	-7.55	-3.38%
LDL	152.6	138.5	-14.11	-9.24%
HDL	45.9	48.9	3.04	6.63%

*all results for those who started with any amount of risk in 2015

Appendix B

OFM Performance analytics project

Project goals

Who

Washington State Health Care Authority, Office of Financial Management – State Human Resources and Limeade (the SmartHealth wellness platform partner)

Goals

1. link and analyze the SmartHealth program's Well-Being Assessment and wellness program participation data, State Employee Engagement Survey data, and HR Management report data (workforce data)
2. explore predictors of employee engagement and employee and organizational outcomes
3. identify key organizational, HR, and wellness program practices and initiatives to positively impact employee and organizational outcomes

Data used

All data was shared and reported as summary measures by agency and for the executive branch as a whole (excluding higher-education institutions), not at the individual level:

1. Summary data from the SmartHealth program (e.g., responses to WBA, program participation)
2. Summary data from the State Employee Engagement Survey (e.g., % positive responses to survey questions, survey completion rates)
3. Summary workforce data from HRMS/BI and agency and statewide HR Management Reports (e.g., turnover rates, over time use, agency age and gender breakdown)
4. 37 agencies were represented

Employee Engagement
Survey completion rate



Employee Engagement Survey response rates are correlated with SmartHealth assessment completion rates

Why well-being matters

Higher employee job satisfaction

78% positive job satisfaction for higher well-being agencies (compared to 71% for lower well-being)

Lower use of sick leave



Average sick leave days used per year
■ higher well-being ■ lower well-being

\$260 saved per employee per year in sick leave



\$1.6 Million or **3X more**

spent on employee replacement by low well-being agencies

25%
higher inter-agency mobility rate

Higher fit with organization

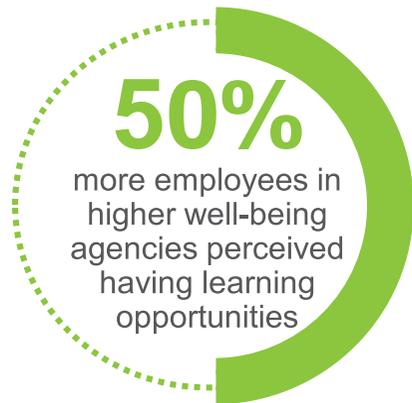
62% positive fit with organization for higher well-being agencies (compared to 54% for lower well-being)

Greater belief in organization

61% positive belief in organization among higher well-being agencies (compared to 50% for lower well-being)

What higher well-being agencies do differently from lower well-being agencies

Offer better learning and growth opportunities



Have better work-life balance



Low well-being agencies spent **\$1,094** more in OT use per employee per year

Have lower average OT hours used per eligible employee

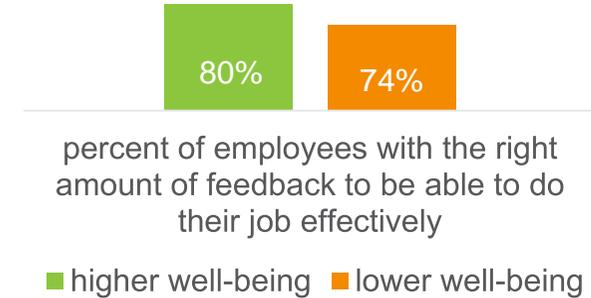
2

days/year/eligible employee in higher well-being agencies

5

days/year/eligible employee in lower well-being agencies

Provide better clarity around job expectations



Ensure that employees have the tools and the resources to do their jobs



How the agencies ranked

Limeade Agency ID	EES Response Rate	WBA Comple	Overall Wellbeing	Job Satisfaction	Resources	Overtime	Sick Leave	Turnover
36	100.00	61.19	79.46	89.70	70.73	9.40	6.14	11.80
23	93.79	54.28	79.04	75.30	58.90	21.80	6.63	7.90
13	89.44	73.53	79.86	90.60	63.33	3.00	4.33	9.50
16	87.48	71.63	77.55	77.00	57.82	8.20	6.95	8.60
7	83.70	57.37	78.60	69.90	47.26	24.60	6.55	8.80
24	82.00	68.42	79.13	71.40	51.28	8.10	5.79	6.30
19	81.82	69.57	79.35	81.20	61.81	1.10	6.09	10.20
12	75.77	74.73	78.46	81.60	57.35	4.00	5.22	8.50
22	74.92	62.44	78.13	73.10	54.53	13.20	7.31	9.30
4	74.87	55.72	79.57	77.50	62.11	14.70	6.10	15.80
29	74.25	69.09	77.91	80.20	58.55	2.20	7.27	7.80
18	73.00	54.42	81.44	83.20	73.75	0.60	5.46	5.30
33	72.00	77.32	80.79	88.30	78.67	2.80	6.17	16.20
21	69.10	55.51	78.18	71.20	58.01	17.10	7.15	8.60
11	68.85	40.64	78.48	70.90	51.44	13.90	6.79	7.80
20	68.00	49.40	80.10	70.50	58.54	NA	NA	NA
17	67.92	68.58	78.80	75.00	57.21	5.20	6.93	9.30
9	67.02	57.20	78.85	73.30	50.42	7.90	6.35	8.50
30	65.93	59.13	79.31	76.10	59.19	6.00	6.63	7.10
1	64.61	52.14	78.66	61.40	56.16	3.20	5.53	13.00
15	64.00	52.27	78.74	69.50	60.87	3.50	6.48	7.80
25	57.46	42.31	77.31	59.10	47.47	23.50	6.59	14.30
6	57.00	64.13	78.43	76.30	49.15	NA	NA	NA
28	56.83	39.66	81.04	78.50	64.79	NA	NA	NA
10	56.16	48.79	77.90	57.20	46.85	3.60	7.87	11.50
5	49.13	70.52	78.06	75.20	56.61	3.10	6.03	13.50
26	49.13	42.24	79.50	66.70	51.69	18.80	5.72	9.10
31	48.00	59.26	77.27	69.00	52.34	NA	NA	NA
14	47.92	37.61	78.89	66.60	49.02	23.50	5.07	5.70
3	47.55	52.98	79.12	84.10	62.18	1.70	6.11	9.00
35	47.00	44.18	78.72	73.60	54.31	42.80	5.53	36.20
34	46.25	37.79	78.68	64.90	50.64	46.00	6.81	7.50
32	45.29	36.16	78.46	68.30	53.91	25.50	7.11	10.00
8	38.33	36.11	77.72	61.30	45.49	36.70	6.94	7.50
27	36.30	37.19	80.16	69.90	57.03	48.30	5.72	7.90
37	33.76	31.92	77.91	72.00	56.38	43.70	6.28	12.70
2	29.74	35.38	78.63	78.40	55.93	52.60	5.87	25.00
OVERALL	52.00	27.11	79.27	69.67	55.48	28.60	6.68	9.80

When examining the agency heat map, the relationship among participation in EES and SH, overall well-being, job satisfaction, resources, use of overtime and sick leave, and turnover is noticeable

Limeade Agency ID – Proprietary naming convention
 EES – Employee Engagement Survey
 WBA – Well-being Assessment
 Job Satisfaction – measured with EES
 Resources - % positive responses to EES question, “I have the tools and resources I need to do my job effectively.”
 Over time - % of eligible employees receiving over time
 Sick leave – average sick leave hours used per capita
 Turnover – total percent turnover

Recommendations

1. Encourage employee development
2. Set clear expectations and provide timely feedback
3. Improve organizational support and leadership alignment around well-being and work-life balance
4. Focus on addressing overtime
 - Improve workforce planning to address overtime use
 - Implement well-being strategies in overtime hot spots

Thank you