John M Clymer: Next, we are privileged to hear from three experts who will illuminate the business case for hypertension control and share an example from Paychex hypertension program. First, we have Meg Guerin-Calvert, President of the Center for Healthcare Economics and Policy and Senior Managing Director at FTI Consulting. Joining Meg are Kyi-Sin Than, Senior Director at the Center for Healthcare Economics and Policy, and Bridget Hallman, Employee Wellness Manager at Paychex, Inc. Meg?

Meg Guerin-Calvert: Thank you, John, so much for that introduction and also to the leadership of the National Forum for us to be here today on this critical topic of making equitable hypertension control a new norm.

And for our panel today, I'm delighted to be working with Bridget and Kyi-Sin to really talk about the business case, the health and economic and wellbeing case, for hypertension control from two perspectives: from that of a major business and an entity that has engaged fully with its communities across the country but particularly in Rochester, to make the business case, to make the investments, to motivate the intervention, and to track results.

And then also to talk about what kinds of tools and analytics are available to make it real. And how is it that you can use these tools either as a business or an employer or a community to make a difference.

So why do we have each of these experiences to share with you today? It's really that there is the top issue, that over the pandemic and across cities in the country, there is increasing disparity but also significant increase in the impact of poor health, particularly hypertension. The numbers are off the charts. And there's an awareness that activities at the local level, and the trusted partnerships that developed in the pandemic to try to make a difference to engage and put people first, have really mattered.

But then you also do need the data and the information in order to be able to look at what are the strategies. How do you motivate it? What are the avoided costs? But most importantly, what is the gain for people? What's the reduced business risks and community risk?

So there we have seen partnerships between public and private entities form that have been successful. But let me turn it over first to you, Bridget, I think in particular where Paychex has been engaged in both of those activities. And it would be critical for all of us to learn from your experience. Bridget, over to you.

Bridget Hallman: Thank you, Meg. So, Paychex is a leading provider of human capital management solutions for payroll benefits, human resources and insurance services. So, starting many years ago, we started as a payroll company. And we actually pay one in twelve of the U.S. private sector employees. We're a top source, HR outsourcer, serving over 2.2 million employees. We have 16,000 U.S. based employees and a couple thousand internationally. We're a fairly young population, with an average age of 40.

We have 5000 employees in Rochester, New York, where we're headquartered. Where I'm sitting today. And then we have bigger hubs in Phoenix Arizona, St Pete, Greensboro North Carolina, Allentown Pennsylvania, some in Albuquerque, some in Denver, and then 40 locations kind of across the U.S. So, we have employees in most every state. So, our population is very diverse and spread out. And we at Paychex want to meet the needs of everyone.

And you know, we care about the rising cost of health care. And we're self-insured, so we pay dollar for our employees' healthcare. And hypertension tends to be a top condition that we're looking at through our health claims. And at Paychex, we want to provide the best benefit plans that are affordable for our employees and for us, while meeting the needs of our increasingly diverse workforce.

We have millions of clients who are also employees. They make up the American worker. So oftentimes we're an extension of HR for them. So, we're a bit of a stakeholder in the health and wellbeing of the worker. So Paychex historically hasn't had an objective internally in the corporate benefits space, where I work, too, that we're committed to enhancing the employees' wellbeing so that they can be the best in every area of their life. Both at work, and outside of work.

And we define wellbeing and we've adopted it from the Gallup scientists, that we have five universal elements. Those being physical, emotional financial community and career. And we offer point solutions or programs for employees to better their wellbeing in each one of those pillars. Of course hypertension being under the physical pillar. And we know from Gallup that these pillars are interrelated and interdependent. So lots of bidirectional relationships. And we've talked about the relationship between hypertension and stress, and mental health.

So Paychex started with hypertension, well, decades ago. And it

was really a broader community-wide initiative. So what we called the high blood pressure collaborative, where large employers in Rochester, us being one, Paychex. And we also have Wegmans and large healthcare systems. So we partnered with a nonprofit, Common Ground Health, and the Rochester Business Council to really tackle hypertension.

And at that time, it was really about screening and education and bringing awareness. Today we've kind of scaled back on our biometric screenings, and we're leveraging data and technology to offer those who are fighting with hypertension a really point solution that helps empower them and understand using smartphone technology. So this is through tracking, education and control. And the program also addresses comorbidity such as diabetes, high cholesterol, depression and others. We know hypertension becomes more prevalent with age and we really wanted to get ahead of it, and really have a point solution in our pocket that addresses that.

Meg Guerin-Calvert: Bridget if you could, really with this point solution and the overall initiative, could you talk a little bit more about how it is that the motivation to make these investments, what kinds of metrics for impact or data or information are you and the leadership at Paychex looking at to motivate the kind of investment, engagement, on behalf of the employees?

Bridget Hallman: Yeah, so that's a great question. And oftentimes we're skeptical when a vendor comes to us and says hey, I can give you a $2 million return on investment. And oftentimes, those numbers might be a little soft. And we really have focused on the value of investment. So, when we look at metrics, they come through health claims and pharmacy claims and through engagement, through our programs. And we feed them all into a data warehouse. And we're able to make some positive correlations when it comes to value on investment.

And we find that employees, when they feel cared about, and you know, it's not rocket science, right? When you feel cared about, you're more likely to stay with Paychex, be attracted to Paychex. And we have done a study where we're seen a decrease in our leave of absence. So those are all very compelling to our executive team, and why they do promote our wellbeing programs to our divisions.

Meg Guerin-Calvert: That really does provide a compelling story, Bridget, about people first, employees first. But also, engagement in the broader

community certainly sounds very sustained. But also, the key to understanding which metrics you're looking at ahead of time, which ones you're tracking now. Kyi-Sin, over to you.

One of the challenges that was under, that we understood as we talked with many employers and also with collaboratives is that oftentimes there isn't data available that really is focused at the city, the community, or the business and employer level that is specific enough to really make the business case as to the impact and also the gains from significant interventions. Could you walk us through the tools that have been created that really try to provide some of those solutions?

Kyi-Sin Than: Yes. That's right Meg. Let me start by emphasizing again that hypertension is a significant issue to communities and their employers as Meg and Bridget have both referred to. It is the most common health condition among U.S. adults, including the younger population of employees. Three in ten employees have hypertension. That is more than either diabetes or depression. And from our FTI consulting's survey of CEOs, employee health and wellbeing are considered to be, should be the number one priority for CEOs based on a survey of employees and their investors. So really this is a significant issue that should be on top of the minds of all employers and leaders of large communities.

And hypertension is highly prevalent, and because of that, employers face significant healthcare costs for those employees with hypertension. So, employees with hypertension have higher healthcare costs, compared to those that don't have hypertension. And that's because half the adults with hypertension actually are diagnosed with at least one other health condition or comorbidities. That can be high cholesterol, diabetes, coronary heart disease. So, when you think about hypertension, you're not thinking about hypertension in isolation. But there are all these other diseases that are associated with hypertension. And that leads to a 44% higher healthcare cost for those with hypertension for those in the employee population.

And not just healthcare costs are impacted. Employee productivity is also impacted by uncontrolled hypertension. So previous research has found that employees with uncontrolled hypertension spend 2.3 times more hours away from work compared to those with controlled hypertension. So, as you see here, the health impacts of hypertension are huge and they go beyond just hypertension.

And even looking further into specific populations, we see the prevalence of chronic conditions including hypertension are more prevalent in certain populations and communities. So there are significant differences. So as you see here, we have plotted a number of metropolitan statistical areas, or MSAs. And there is a huge variation in terms of hypertension prevalence. And that presents challenges for, and opportunities for each community. And we see that the specific populations may be more impacted by hypertension. So we've just looked at the African American population, the prevalence in that for each MSA. And that is substantially higher than the MSA average, as you see with all the green dots that are above the blue line.

And the issue is that a lot of individuals do not know that they have hypertension, or they don't have that under control. Because hypertension is treatable, and there are treatments available that are not costly, this is a target in which there would be immediate health and productivity returns for a population if hypertension control is achieved.

And to tackle this, there are various data points that can be used to assess and address the health and economic impact of hypertension in a specific population. And this includes data on prevalence, health impact, cost, and evaluating the initiatives and their impacts as Bridget had referenced. And there are a couple of tools that are available to assess a specific community or an employer's impact. And we acknowledge that not all employers have access to data warehouses and claims data as employers like Paychex might have. But these tools are really to make all employers accessible to know their own data and understand their situation.

So the first is the budget impact model. It really takes into account the various populations the employers may be dealing with. So for Bridget, you said you have different hubs of employees, and those can be really taken into account by using a simple too like this, including entering specific characteristics based on your specific population and including age and sex, race makeup as well as the number of individuals covered under a health plan. So that's really the key is you know, you can use this without access to much data, and really be able to estimate your own prevalence and plan cost and health impacts within your own population.

The tool also provides dashboard with aggregated results that you can look at in terms of the incremental costs of hypertension. So it would, it's not just, everybody has healthcare costs that they incur. But what is the incremental cost of hypertension? And this tool can

estimate that for a specific population, and various sub populations as well.

You can look at health impact, number of comorbidities. So for this example, nearly 40% of this employee population has three comorbidities. So that's very impactful health related data that you can estimate from using the model. And you can also look at different costs and categories. What's driving the total cost. There's medical cost, pharmacy cost, productivity loss which is not normally estimated in the claims data. But you can estimate that here, and look at those of hypertension and no hypertension. And really, Another key point here is that the tool can also show you trends in terms of what are the projected costs and by types. If there are no interventions for hypertension, and what is the cost of standing still on this issue.

And we know that companies like Paychex are investing and addressing hypertension among their employees. And these investments are showing measurable results. So we also see here that if we don't invest in hypertension, there will be opportunity costs. So hypertension is a treatable condition, and controlled hypertension will be associated with better health outcomes and lower costs. So that investment will result in costs that are avoided in the future as you continue to build a business.

Meg Guerin-Calvert: Thank you Kyi-Sin. And looking at this particular slide, Bridget, it reminds me what you had talked about earlier, which is that some of the focus of Paychex has been looking at those avoided costs. And this as Kyi-Sin mentioned, is really the opportunity cost of standing still. And also, the motivation for investments, which could show benefits perhaps even in the first year, given how treatable hypertension is.

I'm sure everyone participating in today's session wants to learn more from your experience as to how it is that Paychex was able on its own and also in its community to do more. Could you share a little bit more with what the other returns or the values are from making investment, either for own workforce or for the community? And then any other takeaways as to why and how employers, perhaps small, medium and large, should feel empowered and learn from your experience?

Bridget Hallman: Yeah, thanks Meg. And you guys are doing amazing work. I think the budget impact model and the claims analysis guide are amazing. We intend to use the claims analysis guide to start measuring more of our interventions. I think it's really important to

have a third party to evaluate some of your programs.

But going back to some of the returns, as I said before, one of the biggest returns we find is that value on the investment and being able to say people who are involved or engaged in our hypertension program our weight management program or our walking programs, they are more likely to stay with Paychex, right? So those positive correlations are super important for our traction and retention.

We did have the decrease in leave of absence study, where we were able to show some engagement there, and how we have employees who are less likely to go out on a leave. We also have a lot of babies, so that's oftentimes a good thing for people to go on a leave.

But specifically looking at our point solution for hypertension today, in the last ten months we've actually seen 64% of our participants reduce their blood pressure. Like you said, Meg, it's easily treatable. And if you have a solution, an awareness, and education, you can really tackle this. We had 3.6 of our participants who are in our hypertension program who had critically high readings. They were able to reduce their blood pressure back to normal ranges. So, we always think that's a really good thing.

For our executives, we do have executive dashboards where they have a number of different metrics on them around our health and wellbeing programs. We continue to iterate on those executive dashboards. Ultimately, we would love to eventually tie any health metrics of our employees back to the business, whether that be an NPS score and a promoter's score. Client retention's extremely important to us, so really being able to show those correlations is something that's very important for us.

So to talk a little bit about what employers and communities and the workforce, what they can do. I think we've mentioned that it's super important, health and wellbeing is super important to any CEO, right? And our CEO, John Gibson, actually just said that he believes having happier and healthier employees creates productive teams that serve our customers and our communities.

So I think I encourage communities to think about ways to make that happen, whether it's working with a national form, and FTI, or your local nonprofit organizations. They can definitely help you along the way. Wellbeing is very dependent on a larger culture, so

taking a look at your culture also has a big impact. Every organization's different, and Paychex has been lucky enough to have a very strong culture and a strong movement even from the bottom. So, we have wellbeing champion networks, we have employee resource groups that really influence our culture of health.

You know, I always think about that quote from Peter Drucker that says culture eats strategy for breakfast. Without culture, you can't really, even the biggest initiatives might not make *[Inaudible, garbled]*. So, the other thing I just want to mention quickly is starting small. Experiment and pilot and learn from your actions. That's how we operate at Paychex.

Oftentimes we pilot just like our hypertension program. We started in a smaller market. And to Kyi-Sin's point, take those tools and evaluate a smaller market and see what your prevalence is or what your risk might be, and try something. And then reiterate and try again. And if it's successful, expand the program or intervention. And that's really how we've gotten to where we are today.

Meg Guerin-Calvert: Thank you Bridget and Kyi-Sin and thank you again to the National Forum. And please do in the Q&A session coming up, ask us more to provide details about what you've heard.

John Clymer: Well, thanks all three of you for a very insightful discussion. Clearly initiatives like these are essential steps toward making equitable hypertension control a new norm in our communities. Employers like Paychex demonstrate that the transformative potential of business-driven interventions in promoting health equity and improving hypertension outcomes are, the value cannot be overstated.

So the insights you've just shared I think have highlighted how businesses can prioritize employee wellness and contribute to broader public health objectives while keeping their eye on their ball, which means creating value for shareholders and sustaining and growing the business. So, thank you for all those points. Now we welcome Meg, Kyi-Sin and Bridget to carry on the discussion. The floor is open for questions.

We're already getting some, which is great. And the first question that came in, Bridget, is for you. And the person who asked it is the former U.S. Surgeon General, Jerome Adams. And Dr. Adams said, your tools to quantify the business impact of hypertension align with a report I issued as Surgeon General on community

health and economic policy and our Surgeon General's call to action to control hypertension.

I'm interested in how Paychex's employee hypertension control program fits into the broader business-led initiative to reduce hypertension across the community. And certainly, Paychex has been an important part of the Rochester initiative. Can you talk a little bit about that, Bridget? And about how Paychex collaborates with other employers and institutions?

Bridget Hallman: Yeah, absolutely. So, I would say the biggest piece is our foundation. So, our foundation is also strategically aligned with the five pillars or elements of wellbeing. And with that comes the communities in which our employees live and work. And all of the community members. So, we have strategic giving in those specific regions around physical wellbeing.

So we are a huge United Way supporter, but also within this strategic initiative around the foundation, we also really focus on our community wellbeing and giving back to our communities. And that can be of monetary value, but also time and employees' involvement. So, for example, the American Heart Association, right? A huge organization that oftentimes our employees would be involved with, and doing 5K's, et cetera. So, I think that is part of the involvement. I'd love to get more involved in how we can align and make sure that our executive and leadership teams really understand what we're trying to do as the U.S. and the communities within the U.S.

John M Clymer: Thanks, Bridget. Meg, you and I've had numerous conversations offline about the Rochester initiative and how successful it's been. Do you have anything you'd want to add to Bridget's answer?

Meg Guerin-Calvert: Yes, I think it's, the Rochester initiative or the Rochester example including what Bridget spoke to is so timely right now. Particularly because small, medium and large businesses as well as community leaders are now in a way due to the pandemic sitting at the table together, having formed trust and partnerships. Who really cares about their community, their workforce, their people? So, they're looking for ways to really work.

And what I draw as I've looked back at the Rochester initiative, and we've put the common ground in, is the idea that it's a great opportunity to leverage new kinds of private and public partnerships and those trusted partnerships in small scale ways. But also, with a portfolio of options.

What I take away from the Rochester initiative was creating a registry. So, it took that awareness that Kyi-Sin talked about. Who has hypertension? Who has uncontrolled hypertension? So that you start with some core data points in a community, which is something that really can focus attention.

The other thing that happened in Rochester is a relatively straightforward target, a goal to improve control. And control and management. So, something that everyone could align around. So that I think is another idea. And then there was implementation that was really community-wide, and where no one necessarily needed to take credit. So that it had lots of different initiatives, lots of ways of going, but always putting people first.

And then I think what was done in Rochester which many communities can also do, is look at some success metrics and think about sustainability. How do you look at what your goals are? Is it to improve hypertension control? Is it to reduce the rate of hypertension, or prevalence? Is it to work on specific communities? So, I think those are all things.

And we're seeing it across the country, in different ways. One last thing I would say is a lot of energy has focused around economic resilience and food, and food security. And that again is a vehicle that can align nonprofits and business and entities together. So, I'm very optimistic that the Rochester example, which is in the chat, really can inform a number of communities. It's very replicable.

John M Clymer: Great. Thank you very much. Thanks, Kyi-Sin, for popping that into the chat. Kyi-Sin, the next question is for you. You discussed the significant economic impact of hypertension on employers. The numbers just jump off the screen, I think. They're so big. And those figures were mainly related to healthcare costs and productivity losses, as you said. Are the tools, like the budget impact model that you showed, useful for nonprofit and governmental or public sector employers as well as for-profit businesses?

Kyi-Sin Than: Yes, John. Great question, thank you. So, the budget impact model can be used by all types of employers. So, it's primarily designed for large self-funded employers who directly pay for their employees' healthcare costs. But smaller employers, you know, such as small nonprofits, can also use the model to get an insight into what the trends in hypertension related costs are for their employee population. They might not be directly paying for these

costs, but that's going to impact them on the premiums that they contribute on behalf of their employees.

So that will give you the budget impact model. Will give you an insight into the trends that you know, by standing still, you know, there is going to be an increase in healthcare costs that will also impact all businesses. The smaller businesses can certainly use the budget impact model to directly estimate productivity loss in their population due to hypertension, so that's directly estimated by the model, regardless of whether you're directly paying for their healthcare costs or not. But it's designed for all different types of employers. You can adjust the model by the industry or job functions of your employee populations, so it's highly customizable and can be used by all businesses.

John M Clymer: Thank you. Thank you, Kyi-Sin. Gosh, we have several more questions. And very limited time. So, if we can try for really quick answers here, see if we can cover a couple of questions in the next 60 seconds. Edgar Lopez asked, is there a cost to participate in the Paychex programs?

Bridget Hallman: There's no cost to the employee, or dependents of the Paychex employee. But yes, there's a cost to the employer.

John M Clymer: To the employer, but not the employee.

Bridget Hallman: Correct.

John M Clymer: All right, thank you. And you measure the value on, or return, that you get on that cost, is that right?

Bridget Hallman: Yes. And we're only 11 months into this new point solution that we have, that I mentioned earlier. That's, you know, app based or mobile based, with a cuff. So, we're still evaluating that. But we have seen some significant reduction in blood pressure.

John M Clymer: Great. Thanks, Bridget. And Hattie Reese Hanley from California asks, "do you have data and mapping on community poverty related to excess death and disability driven by preventable heart attacks and strokes?"

Kyi-Sin Than: To answer, the data does exist. But it is not directly incorporated into our model. But this is a great suggestion, and next step that we can take with looking at comorbidities. Because we know employees with hypertension have at least one comorbidity if not

two or three comorbidities. So, these are certainly things we hope to look into in the future.

John M Clymer: Thanks, Kyi-Sin. And I know we're overtime, so again, we need a quick answer. But related to Kyi-Sin's last answer, Pam Chapman asks, "have you seen employers utilize the evidence based national diabetes prevention program as a way to help improve hypertension rates?"

Bridget Hallman: So Meg, do you want to speak to that? Okay.

Meg Guerin-Calvert: Go ahead if you want it.

Bridget Hallman: I mean, yeah, as an employer, yes. Absolutely. We use the DPP guidelines whenever we can in our programming, but oftentimes we find it's a little rigorous to measure the outcomes and people don't stay engaged. So sometimes we iterate on that a little bit. But yes, those guidelines, I think employers absolutely do look at. And it's a question that oftentimes is asked of these newer diabetes vendors that are coming into the marketplace.

John M Clymer: Great. Thank you. And the final question is from Terry Williams in North Carolina, who asked, "to what extent are positive or negative financial incentives part of the approach?"

Bridget Hallman: I love the disincentive, right? We haven't experimented too much with that. We try to stay away from incentives. And we're kind of a unique employer in that space because we know that incentives, especially very high monetary incentives, do not sustain behavior change, especially when it comes to chronic disease management. So, we have very small incentives if any. For the hypertension program, we do not have any incentives. For other programs, we might use small incentives like raffles and t-shirts. They go a long way. But for this particular program, we do not have an incentive. And that really comes from our belief on sustaining behavior change and doing it in the right way.

John M Clymer: Well, thank you very much, Bridget. Bridget, Meg, Kyi-Sin, thank you so much for sharing the tools and your perspectives and insights, and we look forward to hearing more from you all in a future session. I'd call everybody's attention to comments in the chat where Bridget, Kyi-Sin, and Meg have been adding additional information.

Meg Guerin-Calvert: Thank you, John. And thank you to the National Forum.