THE EMPLOYER'S ROLE IN USING RESEARCH-BASED HEALTHCARE EVIDENCE

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THE CENTER FOR WORKFORCE HEALTH AND PERFORMANCE

Part of the series *Patient-Centered Outcomes Research (PCOR) Dissemination at Work: How Employers Use Evidence to Make Employee Health Investment Decisions*

Several Individuals were interviewed for this project

Dexter Shurney, MD, Chief Medical Director and Executive Director of Global Health Benefits and Wellness Programs, Cummins Inc.[1]

Susan Hayworth, VP of Strategic Consulting, Healthscope Benefits

Wayne Burton, MD, Chief Medical Officer, American Express[2]

Larry Becker, Director of Benefits, Xerox[3]

Steven Serra, MD, Senior Medical Director, Clinical Consulting Strategy and Analytics, Aetna

Ben Hoffman, MD, Medical Director, Waste Management Inc.[4]

Janice Grimm, Senior Director of Strategic Accounts, University of Pittsburgh Medical Center

Richard Gajdowski, MD, Senior Medical Director, Commercial Products, University of Pittsburgh Medical Center

Richard Feifer, MD, Chief Medical Director, National Accounts, Aetna[5]

Director, Health Services, Large international financial institution

Bruce Sherman, MD, Consulting Medical Director, Goodyear Inc. and Whirlpool, Inc.[6]

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INTRODUCTION

The use of research-based evidence in making health and healthcare decisions seems so logical. Yet, we find, that the journey from research setting to the provider's office takes an inordinate amount of time, and often doesn't make safe passage at all.

When we consider how to make this process more effective, employers often are left out of the discussion. Employers, however, can play a significant role — not only directly, but also in their relationship to health plans, providers and employees. In addition, the employment setting is a logical place here a whole-person approach to health and healthcare makes a good deal of sense for employee health. It is the employment setting in which employees spend the most waking hours, where health effects have the most discernible impact and where opportunities for health investments are often undervalued.

This paper is an initial exploration of the employer's role in promoting the use of research-based evidence in health and healthcare. We address these issues in **six sections:**

1. **HOW DO EMPLOYERS ACCESS AND USE BEST AVAILABLE RESEARCH EVIDENCE? WHAT FACTORS INFLUENCE EMPLOYERS IN THIS ENDEAVOR?**
2. **EMPLOYERS' ROLE WITH HEALTH PLANS**
3. **EMPLOYERS' ROLE WITH PROVIDERS**
4. **EMPLOYERS' ROLE WITH EMPLOYEES**
5. **THE IMPORTANCE OF EVIDENCE BEYOND MEDICAL TREATMENT**
6. **HOW TO SUPPORT EMPLOYERS' USE OF RESEARCH EVIDENCE IN HEALTHCARE**

PART 1

HOW DO EMPLOYERS ACCESS AND USE BEST AVAILABLE RESEARCH EVIDENCE? WHAT FACTORS INFLUENCE EMPLOYERS IN THIS ENDEAVOR?

When it comes to using best available research evidence in making clinical decisions, employers are not monolithic. The most common sources of evidence — such as peer-reviewed research literature, specialty societies, US Preventative Task Force, American College of Physicians, Choosing Wisely and Centers of Excellence — tend to be used by employers sharing two key characteristics: (1) they employ medical directors or have other internal staff with medical expertise, and (2) they are self-insured for group health benefits (Shurney, Burton). Employers that don't exhibit these characteristics tend to rely on external partners — such as health plans and consultants — to ensure that best research evidence is used in treating their employees' medical conditions. Often medical directors are focused only on occupational care issues in their organizations, but they should also be involved in plan-design issues. If they aren't involved in plan design, there is little chance they will influence the use of evidence. Researchers and funders of research evidence would like to know that the best available evidence will be used to make decisions around clinical and programmatic solutions. If we want employers to use the best research evidence in their decision-making, several additional factors must be considered:

- **Evidence in literature** must be translated to the employer's working environment. Wayne Burton of Amex states: "A good example is depression. I believe that how to treat depression is well-established in the literature but not so useful in the workplace when disability is involved.

"WHEN I WOULD EVALUATE THE IMPACT OF AN INTERVENTION, OR DECIDE ON WHAT INTERVENTION TO PURSUE, I ALWAYS WAS THINKING BEYOND THE MEDICAL SILO AND TRANSLATING EVIDENCE AND GUIDELINES INTO THE BROADER FRAMEWORK OF THE WORKPLACE."

– Wayne Burton, MD

When you look at medical claims data, depression typically is not a leading cause of medical expense, but when you look at the implications of depression using integrated data and include the HRA (health risk appraisal) data and time off, you get a very different picture."

• **The employer has** limited resources to treat the variety of health conditions in the workforce. Dr. Burton points out: "When I arrived at Amex, the company had a disease management program for diabetes. Typically, the health plan would use claims data to identify those with diabetes and then call them on the phone to engage with the program. Often the employee's first question was, 'Who are you and how do you know I have diabetes?' The measures relied upon by the company were process measures — not very effective for getting better outcomes. So, I took the program over and integrated it into our on-site clinics, which allowed us to focus on improving clinical outcomes. It allowed Amex to be more effective, to save and to re-allocate funds as well. I told the company, 'Give me half the amount of money you're spending on this disease management vendor. Let me hire a couple of nurses and do disease management internally and integrate it through our clinics and I will improve outcomes and save money as well.' In our clinics, we had dieticians, coaches, nurses, nurse practitioners, and EAP (employee assistance program) counselors because at least a third of the people with chronic conditions have behavioral health issue."

• **Plan design** can't be divorced from clinical programs. For example, the

research literature may suggest that in treating a condition, drug A is most effective. But if in the employer's pharmacy plan design, drug A is prohibitively expensive, the clinical solution will fail. Larry Becker, Xerox, points out that plan design and program structure strongly influence care delivery. He emphasizes that best research evidence is a necessary but not sufficient condition to ensure successful care. Furthermore, others note that in high-deductible plans it may be challenging to close gaps in care based on best evidence because employees are making economic, as well as health decisions.

• **Multi-comorbidities** are challenging for many employers. Typically, research evidence focuses on a single disease state. For employers, however, the situation often is far more complex. Ben Hoffman at Waste Management emphasized the importance of a person-centric — rather than a disease centric — approach to care for employees. At his organization, a relatively small proportion of the workforce represented a very large share of costs, and those employees all had multi-morbidities. Single-disease research was not particularly helpful in managing care in his setting.

• **Employers often get** push-back from employees and vendors. Larry Becker at Xerox recognized that employees must be considered in implementing new research-based guidelines. He gives the example of changes in the frequency of breast-cancer screenings. The literature said one thing, but employees didn't want to accept the less frequent screenings.

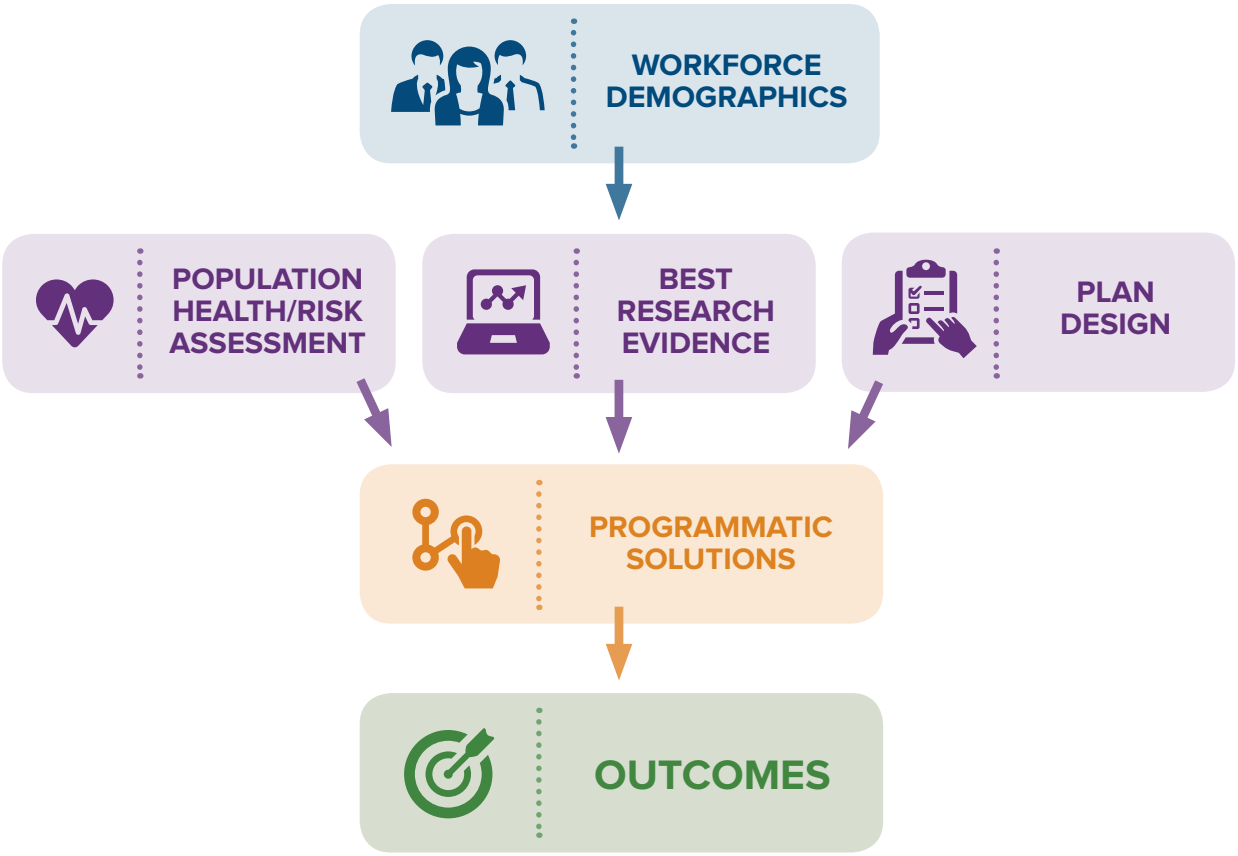
WHILE CLINICAL RESEARCH EVIDENCE IS IMPORTANT, COMPETING PRIORITIES AND LIMITED RESOURCES MEAN THAT THE BENEFITS THAT WILL FLOW TO THE BUSINESS FROM NEW CARE INTERVENTIONS MUST BE DEMONSTRATED.

He also referenced new PCORI (Patient-Centered Outcomes Research Institute) research on not using finger sticks for diabetes and recognizes that he would expect pushback from device manufacturers based on this kind of change. In addition, Becker emphasized the importance of rapidly changing technology — such as genetic testing and gene therapy — and the influence on the costs of care and employee perceptions of care they deserve.

• **A business case** often can't be made on clinical research-based information alone. Dexter Shurney of Cummins points out that in his organization he must make a business case for new care interventions. To do that, clinical research evidence is important, but competing priorities and limited resources mean he must demonstrate to the company the benefits that will flow to the business from any new intervention.

• **Costs are not** evenly distributed across the employee population. Ben Hoffman emphasizes that the company took a person-centric approach and stratified by cost, they found that close to 88% of the employees were not using the healthcare system at all. So, for this population they focused on prevention and managing health risks. About 10% of the population were in and out of the medical system, but Waste Management found that these costs were predictable. And the remaining small percent of employees represented a majority of the costs and impacted the trend. This is where integrated data across programs were particularly important because they were the chronic co-morbidities that impacted costs across the various benefit program segments. Thus, they didn't take a disease state perspective on managing cost and risk because it made no sense to them.

For these employers, their approach to using the best research evidence looks something like this:



We'll explore in the remainder of the paper how employers may work with health plans, providers and employees to help ensure that best available evidence is used in practice. In the subsequent sections of the paper, we'll expand the discussion of evidence to include strategies around better understanding the prevalence of conditions and condition outcomes important to employers. We'll end the paper with recommendations on how employers can have more influence in using outcomes and evidence in their employee health improvement efforts.

PART 2

EMPLOYERS' ROLE WITH HEALTH PLANS

Health plans represent one of the most important leverage points for employers in the use of research-based evidence. As Julie Grimm, University of Pittsburgh Medical Center, points out, "Smaller employers without medical expertise aren't particularly focused on — or interested in — research-based evidence. They expect their health-plan partners to play that role." Wayne Burton of Amex makes the point that all health plans have medical directors; in working with employers without medical expertise, it is incumbent upon the medical director to stay abreast of the latest clinical research.

Larger, self-insured employers with in-house medical expertise represent a different situation. These employers are very focused on evidence and often have internal staff monitoring the latest research. They want to make sure that the health plan is on top of the latest evidence in their relationship with their network providers.

In addition, larger employers use evidence to support their health policies. According to Dr. Steven Serra of Aetna, "Most payers that I work with have clinical policy goals relative to coverage and benefits that are evidence-based and rely on evidence in the public domain."

Relationships between employers and health plans around evidence are not without challenges, however. As one employer pointed out, there often is tension with health plans around approval of new treatments, even when, in the employer's opinion, research supports the approach.

In both cases, however, data on the employer's experience are key to focusing on using the best evidence. And those data don't exist in a vacuum.

THERE MAY BE AN OPPORTUNITY TO RE-FRAME WHAT CONDITIONS THE EMPLOYER BELIEVES ARE MOST IMPORTANT, PARTICULARLY WITH DATA THAT ARE GERMANE TO SENIOR LEADERS.

Susan Hayworth, Healthscope Benefits: "Support for employers must be data-driven to be effective. To make the best use of data, the health plan must know and understand the kinds of programs the employer has in place. The challenge for the health plan is that these data often exist in separate silos, making if challenging to get a holistic view."

The range and type of data are critical in this endeavor. It is most typical for the health plan only to use data that it collects directly — typically medical and pharmacy claims data. However, in many instances the pharmacy data are controlled by a separate vendor. This allows the health plan to identify what conditions consume the greatest resources in these domains, but tells the employer nothing about conditions that might exist in the workforce but remain untreated. Many health plans are expanding their data access to include clinical and lab data, but again those data tend to focus on conditions under care. A growing number of employers are undertaking health risk assessments and sharing that information with their health-plan partners. Oftentimes, these assessments include questions about conditions employees have for which they are not receiving care. With regard to available data, the medical director of a large multinational financial institution emphasizes that health plans should have a clinical-care engine that examines utilization data and to identify gaps in care, as well as the appropriateness of care. He sees this as an important opportunity to ensure evidence -based care is the guidepost.

How does this relate to the use of best evidence? Employers, naturally, are interested only in conditions (and relevant evidence) that are important in managing the health of their workforce. If the health plan wants to work with the employer in ensuring best evidence is used, they need to focus on the key conditions that are germane to the care of employees and their dependents. And the very definition of those key conditions depends on data available to identify them.

Employers, however, often don't approach the questions of important conditions with a blank slate. Dr. Richard Feifer: "Employers would often come to the table with a belief construct around this — around what is important, and it is often hard to change their minds into focusing on something else. They may have gotten it from their consultants, from a conversation at the last meeting they attended, personal life experience, someone in senior management, a colleague — any number of places. In some sense it is predestined when the employee gets to the table." This situation may represent the opportunity to use other sources of data to re-frame what the employer believes is most important, particularly data that are germane to senior leaders.

Feifer also points out that in his experience diabetes was universally of interest to employers because of its relationship to cardio-vascular conditions. And very few employees only have diabetes, so multi-morbidities also are a major issue as well. Dr. Feifer found that cancer also was always high on everyone's list because of its cost implications.

Employers recognize that health plans only can play a partial role in ensuring the use of best evidence. Ultimately, evidence will or will not be used at the point of care. Employers interviewed suggested several ways to ensure best evidence is used at the point of care.

For example, Larry Becker said that Xerox used financial guarantees with strict penalties to make sure health plans did what they were supposed to do. Wayne Burton of Amex suggests that employers could include in their reimbursement contract incentives and disincentives with the health plan around the use of research-based evidence in care, including removing physicians from the network for non-compliance.

"HIGH-DEDUCTIBLE HEALTH PLANS ARE OFTEN JUST RISK/COST SHIFTING TO EMPLOYEES WITH THE LIKELIHOOD THAT EMPLOYEES WILL BECOME LESS COMPLIANT WITH EVIDENCE-BASED CARE."

— Richard Feifer, MD

In addition, health plans can influence the use of evidence outside the employer and provider relationship. "Health plans often will get a call from an employer asking the plan to help point employees with specific conditions to trusted resources (Serra)." This is an additional opportunity for health plans to use evidence in support of good healthcare decision making."

An employer health plan design trend may increase challenges around the use of research-based evidence. For the past several years, a growing number of employers have adopted high-deductible health plans as a way for the employer to save money and for employees "to have skin in the game" and, ostensibly, become better consumers of care. As Dr. Feifer points out, however, "High-deductible health plans are often just risk/cost shifting to employees with the likelihood that employees will become less compliant with evidence-based care. You just can't get around the asymmetry of information in consumerism. It also assumes that an employee can take a totally rational and long-term approach to their own investments in health, which they don't or can't." If high-deductible health plans result in employees making care choices based on their short-term economic interests rather than best care, good evidence-based care may suffer.

PART 3

EMPLOYERS' ROLE WITH PROVIDERS

Employers often are ignored when it comes to influencing provider organizations on issues of using best available evidence. This influence typically is thought to be wholly the purview of health plans. However, employers can — and do — play a direct role with provider groups in a variety of ways.

Employers that work with providers tend to be those that have internal medical expertise (Hayworth) and those that have economic market leverage in a geographic area (Serra, Hoffman). Dr. Richard Gajdowski of University of Pittsburgh Medical Center suggests to employers: "Pay for what you want. If you want doctors to adhere to best available evidence, then create a construct that incents them to do that; more importantly, impose consequences if they don't."

Employers can act directly with provider groups through direct contracts, and thus influence directly through contractual language that evidence-based care be followed. Dexter Shurney points out that auditing of care can be a very effective way to help ensure evidence-based care is the standard. If audits aren't possible, quarterly case reviews can be a reasonable approach.

Absent directly working with providers, employers can partner with their health plans to influence provider behavior. Gajdowski goes on to point out that health plans typically don't impose consequences for physicians that don't use best practice. It is difficult to remove a physician from a network and the doctor doesn't believe that health plans have the appetite for it. Employers, however, can insist on such language in the contracts their health plans have with provider networks.

Susan Hayworth suggests that if employers want to work with their health plan, they should "start small" and identify a single important condition. Either directly or in conjunction with the health plan (health plans typically have evidence-based guidelines for many conditions), the employer can develop an evidence-based program in response. Larry Becker of Xerox provides an example: he developed an evidence-based design for bariatric surgery, identifying four or five things that needed to be done to ensure proper care was delivered and to protect employees who elected to have this surgery (and have Xerox pay under its plan). For example, the employee needed to work with the primary care doctor to go on a diet. Second, the employee would have to see a behavioral health specialist to deal with eating issues. Third, the company picked providers that had significant experience in this type of surgery. Becker found that through this process, they had fewer complications and lower costs.

Employers also can influence providers on what health outcomes are important. Typically, health plans focus on metrics associated with cost and care quality. Although these are important to employers, other outcomes — such as work absence and reduced performance on the job — also are outcomes of health that are critical to employers. Since under current health plan-provider arrangement, these outcomes are excluded, they have not become part of the evidence-based care discussion.

"PAY FOR WHAT YOU WANT. IF YOU WANT DOCTORS TO ADHERE TO BEST AVAILABLE EVIDENCE, THEN CREATE A CONSTRUCT THAT INCENTS THEM TO DO THAT; MORE IMPORTANTLY, IMPOSE CONSEQUENCES IF THEY DON'T."

— Richard Gajdowski, MD

PART 4

EMPLOYERS' ROLE WITH EMPLOYEES

Several of those interviewed emphasized the importance of employers supporting employees to facilitate the use of evidence-based care. This support primarily comes in two forms: supporting the employee to adopt and maintain healthy lifestyles and to learn about the proper care for their conditions.

Wayne Burton at Amex points out: "The employee can also play a role, but that requires the employer to be involved in educating employees about the best care for their conditions so that the employee knows when something is going wrong in their care patterns. Asking for a second opinion fits into this. At Amex, we would publish our research and, in that research, include comments from employees about what they did when care did not follow guidelines. Educating employees about proper care is one most important ways the employer can message employees that the employer actually cares about how the employee is treated and wants to ensure the best care possible."

At Xerox, Larry Becker used direct contact with employees as a way to help ensure evidence-based care was used. When an employee or dependent would call and report that a physician denied a certain type of care or type of drug, he would then get involved directly to consider the relevant evidence (often by calling the other health plans with which Xerox did business and asking them how they handled the issue regarding care/coverage). He could then intervene as appropriate to better ensure proper care was administered.

At Cummins, Dexter Shurney focused on improving lifestyle to help support evidence-based care.

He found that the company's onsite clinics were critical in this regard, not only to ensure that evidence-based care was used in treatment but also to provide the time to explain to employees their conditions, the care required to treat them and what role the employee should play in that care. To support this approach, the initial clinic lifestyle visit at Cummins was scheduled for 70 minutes, while follow-up visits were typically scheduled for 40 minutes. This provided sufficient time for care and education at the same time.

PART **5**

THE IMPORTANCE OF EVIDENCE BEYOND MEDICAL TREATMENT

The discussion of evidence in medical care often is focused narrowly on the efficacy of medical treatment. However, to fully support employers in their strategy around using evidence, two additional areas must be considered: evidence of prevalence of conditions (whether treated or not) and evidence about outcomes beyond cost and quality.

CONDITION PREVALENCE

Employers rarely have sufficient resources to devote to all the issues surrounding health and healthcare in their populations. Thus, it becomes critical for the employer to know condition prevalence and how those conditions may affect outcomes important to employers and employees.

Dexter Shurney of Cummins and Wayne Burton of American Express make several key points in this regard:

- **Prevalence includes** conditions that are untreated. Since employers typically have a longer planning horizon than a single year, they recognize that untreated conditions in the short term simply may become bigger (and more expensive) problems in the longer term.

In addition, employers often focus on outcomes beyond cost and quality. Both Cummins and Xerox have included self-reported health-risk assessment information in their health databases. This source of information can provide insights into untreated conditions, as well as multi-morbidities through a whole-person perspective.

• **Integrated data** across health-related programs are invaluable in understanding prevalence. Both organizations rely on a variety of data sources — medical and pharmacy claims, biometrics, clinical, health-risk assessment, disability — and their integration to understand the prevalence of conditions. Integrated data provide a person-centric view; siloed data don't. Both Burton and Shurney point out that claims data are a poor source for identifying conditions. For example, diabetes may be treated through diet and exercise, limiting the usefulness of pharmacy data; claims data are of limited use in identifying depression in the population because of the stigma still attached to care for that condition.

AS A KEY PART OF THE XEROX ENGAGEMENT STRATEGY, IF AN EMPLOYEE HAD THREE OR MORE CO-MORBIDITIES, S/HE HAD ACCESS TO A HEALTH COACH AT NO COST.

• **On-site clinics** can be an important setting in which to get broader information about the employee's health. Typically, appointment duration in onsite clinics is longer than typical in the general medical care system. This additional time allows the practitioner to learn more about the health of the patient and identify conditions that perhaps haven't been treated.

Steven Serra at Aetna found in his work with large employers that typically 15% of employees in a workforce never see a physician and, therefore, never file a claim.

He went on to say that this cannot be interpreted as these employees being healthy and emphasizes the importance of health-risk data in gaining the broadest view of employee health.

Larry Becker at Xerox also emphasized the importance of health-risk data to fully understand employee health. In its health-risk assessment, Xerox included: blood pressure, smoking prevalence, biometrics data, weight, and cholesterol metrics. This information became very important to their health coaching program. As a key part of the Xerox engagement strategy, if an employee had three or more co-morbidities, s/he had access to a health coach at no cost. One of conditions he focused on was blood pressure; he worked with several other major employers in Rochester and through their efforts they significantly increased the proportion of people whose blood pressure was under control (from about 60% to 77%). He emphasized the importance of communities in these kinds of initiatives.

Ben Hoffman at Waste Management noted that without integrated data, it was very difficult to deal with co-morbidities. A variety of data sources were critical to understand the whole person and his/her health.

HEALTH OUTCOMES

For employers, health-related outcomes that are important to the company go beyond healthcare cost and quality. Dexter Shurney had to make a compelling business case "up the organization" for approval of any new health program; for him, cost and quality were not sufficient metrics to make that case. At Cummins, metrics that were of focus included patient satisfaction, costs, lifestyle medicine index/health status, medication usage, and work accidents. The company planned to add absence and health-related job performance soon. In addition, he emphasized that Cummins is a global company and healthcare cost is not an important metric to the employer in most jurisdictions in the world.

Richard Gajdowksi made the point that employers make a variety of investments in the success of their company, such as training, new technology, and the latest materials. He believes that employee health is the next frontier for employers to connect health with business-relevant outcomes.

Business-outcome metrics vary by industry. Because he worked in transportation, Ben Hoffman at Waste Management understood that health had an impact on a very important cost center — vehicle accidents. Waste Management had 40,000 trucks on the road on any given day. When he first got there, he considered what was causing accidents and realized that much of it was associated with health issues. All of this made him realize he needed data to really diagnose the problems and he needed to integrate data to see the whole picture. He wanted data that integrated across group health, group disability, pharmacy, workers' comp, property/casualty risk and damage, including HR issues like overtime, occupation, and pay grade.

Larry Becker provided an example of the practical use of broader outcomes at Xerox. He undertook a project in partnership with Pacific Care on the total costs of health — including disability and return to work — to broaden the approach they were taking and expand outcomes. He compared outcomes across several of the health plans he was working with at Xerox, and judged which plans were doing the best job of managing "total costs" (each of the health plans had very different models of delivering care). He found significant differences across health plans in outcomes. One plan had better disability durations; another had lower medical costs but longer disability durations.

Each of the employers interviewed stressed the importance of integrating health-related data across silos and connecting those data to outcomes that matter to senior leaders. Most of these individuals emphasized the importance of on-site clinics in this regard.

PART 6

HOW TO SUPPORT EMPLOYERS' USE OF RESEARCH EVIDENCE IN HEALTHCARE

Taken as a whole the findings from these interviews suggest a range of recommendations for improving the use of research evidence in health care. As employers focus on a variety of programmatic solutions they'll benefit from a broadening of their approach to understanding the causes and consequences of worker health. The World Health Organization describes social determinants of health as the conditions in which people are born, grow, live, work and age. Likewise, the consequences of health affect an individual's ability to attend work, perform on the job and remain active in the workforce.

THE WORLD HEALTH ORGANIZATION DESCRIBES SOCIAL DETERMINANTS OF HEALTH AS THE CONDITIONS IN WHICH PEOPLE ARE BORN, GROW, LIVE, WORK AND AGE. LIKEWISE, THE CONSEQUENCES OF HEALTH AFFECT AN INDIVIDUAL'S ABILITY TO ATTEND WORK, PERFORM ON THE JOB AND REMAIN ACTIVE IN THE WORKFORCE.

These "real world" outcomes require researchers and practitioners to broaden their assessments of the consequences of health to include outcomes beyond medical and pharmacy costs with the addition of metrics focused on absence, job performance and work disability.

In partnership, employers, their solutions partners, evaluators and the larger research community can better fit solutions to problems by taking a broader perspective. This should result in better evidence and better use of that evidence. The recommendations that follow should provide a better foundation for tying the causes and consequences of worker health together and broaden the range of solutions developed to understand and improve worker health and performance.

RECOMMENDATIONS FOR EMPLOYERS & THEIR SOLUTIONS PARTNERS

• **Integrate data** to get as broad a view as possible with a whole-person perspective. Break down silos, at least from a data standpoint.

• **Look for resources** from specialty organizations (such as CDC, American Diabetes Association, American Heart Association, etc.)

• **Design programs** and data with a whole range of outcomes in mind. Use broad data to make the business case to senior leaders. Get out of the mindset that healthcare utilization is the only lens within which to examine population health. "You can't manage what you don't measure."

• **Invest money** in programs that deliver.

• **Look for gaps** in care and understand barriers to overcome.

• **For employers** with Medical Directors, expand their role beyond the occupational setting.

• **Combine clinical** and workplace expertise into solutions. Translate the science of medicine into what is practical and useful for your workplace.

• **Play a role** in facilitating communications/solutions among all stakeholders in a community around conditions and care. Create leverage for change.

• **Help employees** understand what their interest is in better condition identification and closing gaps in care.

RECOMMENDATIONS FOR RESEARCHERS, EVALUATORS & RESEARCH FUNDERS

• **Get outside** of the clinical realm and connect evidence-based research with practical solutions.

• **Broaden the outcomes** that are part of the research initiative.

• **Think broadly** about your communications strategy and audiences, including health plans, employers and employees.

• **Always remember** the things that employers can control and connect clinical research to those domains.

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