Progress, Participation and Strategic Uses for Incentives

Paul Terry, P.h.D.
HERO President & CEO

2017 American Heart Association Workplace Wellness Forum

Tuesday, February 14, 2017
Edward Jones Headquarters. 12555 Manchester Rd., Des Peres, MO
MOVING IN THE SAME DIRECTION with an altogether different perspective
Progress, Participation and Strategic Uses for Incentives

Culture, Context and the Impact of Incentives
1. Behavioral Economics Research
2. Environment and behavior change

Tailored vs. One Size Fits all Incentives
3. Work and the workplace
4. Individual differences and incentives

Intrinsic vs. Extrinsic Motivators
5. Employees, families and communities
6. What % of well-being is explained by health? (Kottke, Pronk, 2016)
Continuous Improvement in the Use of Incentives
Culture and Context for the Use of Incentives

1. Behavioral Economics Research
2. Environment and behavior change
EDITORIAL

Nudging Smokers

Cass R. Sunstein, J.D.

Why the deposit contract is less attractive but more effective.
Randomized Trial of Four Financial-Incentive Programs for Smoking Cessation

Scott D. Halpern, M.D., Ph.D., Benjamin French, Ph.D., Dylan S. Small, Ph.D., Kathryn Saulsgiver, Ph.D., Michael O. Harhay, M.P.H., Janet Audrain-McGovern, Ph.D., George Loewenstein, Ph.D., Troyen A. Brennan, M.D., J.D., David A. Asch, M.D., M.B.A., and Kevin G. Volpp, M.D., Ph.D.


- 2538 enrolled in deposit contract ($150/$650) vs. three other incentive programs (up to $800)
- 16% quit rate vs. 10% in incentives programs
- BUT 13% higher 6 month abstinence for skin in the game
Growing Ambitions
A Randomized Trial of Social Comparison Feedback and Financial Incentives to Increase Physical Activity

Mitesh S. Patel, MD, MBA, MS, Kevin G. Volpp, MD, PhD, Roy Rosin, MBA, Scarlett L. Bellamy, ScD, Dylan S. Small, PhD, Michele A. Fletcher, CPA, Rosemary Osman-Koss, BS, Jennifer L. Brady, MA, RD, LDN, Nancy Haff, MD, Samantha M. Lee, BSE, Lisa Wesby, MS, Karen Hoffer, BS, David Shuttleworth, MS, Devon H. Taylor, BS, Victoria Hilbert, MPH, RD, Jingsan Zhu, MBA, MS, Lin Yang, MS, Xingmei Wang, MS, David A. Asch, MD, MBA

• 26 weeks of weekly feedback with 286 Adults
• Comparing Social Comparisons, lottery incentives and incentives only.
• Social comparison with financial incentives most effective

AJHP, July, 2016
• $20 per week for activity achievement to self and/or to charity
• Both interventions significantly greater added walking than controls.
Weight Loss with a Low-Carbohydrate, Mediterranean, or Low-Fat Diet

Weight Loss with a Low-Carbohydrate, Mediterranean, or Low-Fat Diet

Methods In this 2-year trial, we randomly assigned 322 moderately obese subjects (mean age, 52 years; mean body-mass index [the weight in kilograms divided by the square of the height in meters], 31; male sex, 86%) to one of three diets: low-fat, restricted-calorie; Mediterranean, restricted-calorie; or low-carbohydrate, non–restricted-calorie.

The mean weight loss was 2.9 kg for the low-fat group, 4.4 kg for the Mediterranean-diet group, and 4.7 kg for the low-carbohydrate group (P<0.001 for the interaction between diet group and time); among the 272 participants who completed the intervention, the mean weight losses were 3.3 kg, 4.6 kg, and 5.5 kg, respectively.

Mediterranean and low-carbohydrate diets may be effective alternatives to low-fat diets. The more favorable effects on lipids (with the low-carbohydrate diet) and on glycemic control (with the Mediterranean diet) suggest that personal preferences and metabolic considerations might inform individualized tailoring of dietary interventions.
Finally, one might argue that the unique nature of the workplace in this study, which permitted a closely monitored dietary intervention for a period of two years, makes it difficult to generalize the results to other free-living populations. However, we believe that similar strategies to maintain adherence could be applied elsewhere.
Tailored vs. One Size Fits all Incentives

3. Work and the workplace
4. Individual differences and incentives
A Call for “Effort-Based” Incentives


From Our Webinar: In our webinar exploring international health promotion issues, we discussed the unintended consequences that can occur when expats try to contribute to other cultures. We polled our webinar participants about whether the use of financial incentives had unintended consequences and found that for the 100 plus practitioners in this audience there have been virtually no negative effects from offering incentives in their organizational cultures (go to: http://healthpromotionjournal.com and see webinar archives/Global Health Promotion).

Which Best Describes Your Experience With Incentives in Your Organization?

- Quite positive. Employees love getting stuff/discounts (27%).
- Somewhat positive. Great for most, annoying for a few (39%).
- Pretty benign. Just another tactic that seems to work as intended (29%).
- Somewhat negative. Annoying for most, liked by a few (4%).
- Quite negative. Incentives sucked the fun out of wellness (0%).

Paul E. Terry, PhD, President and CEO,
HERO: The Health Enhancement Research Organization;
Editor, The Art of Health Promotion.
Commentary

Finding Common Ground in the Use of Financial Incentives for Employee Health Management: A Call for a Progress-Based Approach

Paul E. Terry, PhD; David R. Anderson, PhD

The growing controversy over wellness incentives authorized by the Patient Protection and Affordable Care Act (PPACA) is disconcerting. Just when worksite wellness is being embraced as an effective strategy to curb the growth of chronic health conditions and related costs, recent position statements regarding Section 2705 of PPACA suggest opposing views among important wellness champions.1-3 After summarizing the arguments supporting and opposing key elements of Section 2705, this commentary proposes a perspective we believe represents common ground for advancing equitable, effective use of incentives.

Opposing Views on Financial Incentives

To encourage incentives for healthy behavior while prohibiting discrimination based on employee health status, Section 2705 allows employers to provide rewards (e.g., premium reductions) to individuals who meet a health standard, such as healthy weight, if they also offer a “reasonable alternative standard” or waiver for employees with medical conditions precluding them from achieving the health standard.4 Such outcomes-based incentives are being implemented or planned by many employers.5

The editor in chief of this journal, Michael O’Donnell, PhD, wrote that this PPACA provision “may be the most
Is the EEOC Debating the Right Question Concerning “Voluntary” Wellness Programs?

Paul E. Terry, PhD

Employers and population health management providers remained faced with a glass half empty relative to the incongruence between the Affordable Care Act (ACA) and the Americans with Disabilities Act (ADA). The Department of Health and Human Services and Department of Labor issued final regulations May 29, 2013 concerning “Incentives for Nondiscriminatory Wellness Programs in Group Health Plans.” The clarification on the ACA “health-

Testifying as “a management side employment attorney,” Leslie Silverman noted that the “Administration’s position in strong support of wellness programs within employer-sponsored health care is pretty clear.” In reference to the lack of guidance from EEOC on what the voluntary standard means in practice, Silverman testified that this “has left employers and plan sponsors in a very grey, and dare I say, frustrating area.” That the Commission articulated no ur-
JOINT CONSENSUS STATEMENT

Guidance for a Reasonably Designed, Employer-Sponsored Wellness Program
Using Outcomes-Based Incentives


Objective: To provide guidance regarding appropriate use of outcomes-based incentives as part of a reasonably designed wellness program designed to improve health and lower cost while protecting employees from discrimination and unaffordable coverage. Methods: The process included reviewing the literature, regulations, case studies, and other resources while developing consensus through numerous group discussions. Results: We offer guidance on the elements of a reasonably designed wellness program that should be in place if outcomes-based incentives are deployed and identify strategies to help ensure that effective and fair programs are put in place and evaluated. Caution—in the discussion of outcomes-based incentives used in connection with employer-sponsored wellness programs (hereafter referred to as wellness programs). Our primary goal in providing this guidance is to help employers to implement programs that engage their workforce, improve employee health, and potentially reduce health care and other related costs over time while also protecting employees from discrimination and unaffordable coverage. We believe that the fundamental goal of any wellness program should be to provide opportunities for individuals to improve their health and wellness. A wellness program of all US health care spending is for people with chronic conditions. Moreover, just four modifiable health risks (tobacco use, poor nutrition, lack of physical activity, and excessive alcohol consumption) are responsible for much of this chronic disease burden.

It makes practical sense for employers to play a positive role in influencing the health behaviors of their workforce. Improvements in employee health can reduce health care costs, disability, and absenteeism, as well as increase employee productivity. Thus, many employers have added wellness programs (also known as employee health management programs) to their health plans.
Individual vs. Organizational, Intrinsic vs. Extrinsic, Paternalistic vs. Altruistic

Intervention Intensity (# of contacts)

Incentives

- Low
- High

Great Culture
Unhealthy Culture

Terry, Seaverson, Grossmeier, Anderson, JOEM, June, 2008
FIGURE 2. COMMUNICATIONS AND CULTURE DETERMINE INCENTIVE PROGRAM SUCCESS, REGARDLESS OF INCENTIVE TYPE

HRA Participation by Incentive Design, Communication Strategy, and Worksite Culture

Source: Seaverson, E., Grossmeier, J., Miller, T., and Anderson, D. The role of Incentive design, incentive value, communications strategy, and worksite culture on health risk assessment participation. American Journal of Health Promotion. 23(5) 343-352, May/June 2009.
**Figure 3. HA Completion Rate by Incentive Value**

Building A Culture Of Workplace Health: More Complicated Than Offering Workers Money To Be Healthy
Ron Goetzel, Enid Chung Roemer, Rachel Henke, Karen Butcher Kent, Jeffrey Berko, and Kate McCleary
January 23, 2017

Editor’s note: This is part of a periodic series of Health Affairs Blog posts discussing the Culture of Health, the topic of a November Health Affairs theme issue. In 2014 the Robert Wood Johnson Foundation announced its Culture of Health initiative, which promotes health, well-being, and equity. The initiative identifies roles for individuals, communities, commercial entities, health care entities, and public policy that extend beyond the reach of medical care into sectors not traditionally associated with health. In addition, a cluster of articles in our upcoming February issue will also focus on the relationship between work and health.

Kristin Madison’s article in the Health Affairs November Culture of Health theme issue highlights many of the problems found in single-focus wellness programs that are based on the premise that paying people to improve their health is all that is needed to create a healthy workforce. However, the headline “risks of using workplace wellness” may send the wrong message to employers and policymakers. Yes, poorly designed workplace health promotion programs, founded exclusively on providing financial incentives for achieving targeted health outcomes, may result in unintended consequences. But, workplace programs founded on a strong culture of health can positively influence workers’ health and well-being, and do so in a practical, ethical, and legal manner. There is much more to wellness than the individual regulatory components discussed in Dr. Madison’s article.

As Dr. Madison’s article highlights, there is controversy over the various design elements of wellness programs and whether they, in fact, “work.” Employers are right to question which set of outcomes to accept or reject. However, as we point out in our research, a foundational difference between effective and ineffective programs is their intervention focus.
Incentives increase coaching participation

Incentives may decrease coaching impact

Intensity Effect

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<th>5</th>
<th>5</th>
<th>12</th>
<th>10</th>
<th>24-30</th>
<th>24-30</th>
<th>50</th>
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<td>30months</td>
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# of Interactions

- Modest
- Moderate
- Moderate-High
Weight Study References


Intrinsic vs. Extrinsic Motivators

5. Employees, families and communities
6. What % of well-being is explained by health?

(Kottke, Pronk, 2016)
Participation Rates in Health Assessments, Biometrics Associated with Wage Status

(From Bruce Sherman, Conduent HR Services)

RightOpt-Truven data warehouse – 2014 employee-only benefits enrollee data
Low-wage Workers are More Reactive Users of Healthcare
(From Bruce Sherman, Conduent)

<table>
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<tr>
<th>Wage Bands</th>
<th>Employee Number</th>
<th>Relative Risk Score</th>
<th>Preventive Visits / 1000</th>
<th>ED Visits / 1000</th>
<th>Ambulatory-Sensitive ER Visits / 1000</th>
<th>Avoidable Admissions / 1000</th>
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<td>≥ $20,000</td>
<td>3,243</td>
<td>1.35</td>
<td>259.6</td>
<td>628.1</td>
<td>43.2</td>
<td>9.6</td>
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<td>&gt; $20,000 - $25,000</td>
<td>6,392</td>
<td>1.28</td>
<td>250.3</td>
<td>600.7</td>
<td>35.8</td>
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<td>12,524</td>
<td>1.26</td>
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<td>462.9</td>
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<td>446.2</td>
<td>128.2</td>
<td>8.1</td>
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Job Stress

- *Neurology* Journal published results from six previous studies
- Baseline assessment of job stress then tracked employee health for 3.4 - 16.7 years

**“Passive” jobs:** low psychological demand + low control (*manual labor*)

**“Active” jobs:** high psychological demand + high control (*doctors, engineers*)

**“Low-Strain” jobs:** low psychological demand + high control (*scientists, architects*)

**“High-Strain” jobs:** high psychological demand + low control (*waitressing, nursing, service industry*)

Finding the Balance

“There will always be a “Top Ten Causes of Death.”

- Michael Osterholm
U of M, SPH
"President’s Commission on Physical Fitness, fella. Freeze!"
Would You Rather Gain 150 Pounds or Get Run Over by a Truck?

- 54.3 %...Get Run Over by a Truck
- 42.9%... Gain 150 Pounds
THE CANADIAN HIGH-FIVE
Because in Canada, stitches are free
## Effects of Risk Factors on Monthly Resource Use

(Seniors 65 and Older)

<table>
<thead>
<tr>
<th>Variable</th>
<th>At Risk</th>
<th>Not at Risk</th>
<th>Sign Level</th>
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<td>Smokers</td>
<td>$255</td>
<td>$258</td>
<td>NS</td>
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<tr>
<td>Excess Alcohol</td>
<td>$188</td>
<td>$291</td>
<td>NS</td>
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<tr>
<td>Obesity</td>
<td>$326</td>
<td>$264</td>
<td>.05</td>
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<tr>
<td>Physical Inactivity</td>
<td>$358</td>
<td>$238</td>
<td>.0001</td>
</tr>
<tr>
<td>Unhappiness</td>
<td>$424</td>
<td>$253</td>
<td>.0001</td>
</tr>
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</table>

Terry, Am J Health Promot, May 1998
Social Networks, Host Resistance, and Mortality: A 9-year Follow-up Study of Alameda County Residents

- 6928 random sample residents in Alameda County
- Examined marital status, church membership, contacts with friends, relatives, group membership
- Controlled for physical health, health practices, socioeconomic status, utilization of preventive services, etc.

Berkman, Syme. Amer J Epi 1979;109(2)
Social Networks, Host Resistance, and Mortality: A Nine-Year Follow-up Study of Alameda County Residents

• “...the more intimate ties of marriage and contact with friends and relatives were stronger predictors than were the ties of church and group membership...in each instance people with social ties had lower mortality rates than people without such ties.”

• Most isolated men had 2.3 times higher rates than most connected

• Most isolated women had 2.8 times higher rates than most connected

Berkman, Syme, Amer J Epi 1979;109(2)
The Association of Social Relationships & Activities with Mortality: Prospective Evidence from the Community Health Study

- Solitary leisure activity positively associated with mortality, $p<.05$ (watching TV, reading, listening to radio)
- For men, more involved with social relationships, activities, the less mortality, $p<.02$
- For women, church attendance significantly related, Marital status less significant for women

*House, Amer J Epi 1982;116(1)*
Obesity is Contagious

- Those who eat with one other eat 35% more than if alone
- A group of four eats 75% more
- A group of seven or more eat 96% more

“A heavy eater eats less in a light-eating group”.  
Christakis, NEJM, 2007
The Therapeutic Value of Pets

- Dogs have an anti-hypertensive effect (<.05)
- Staring at fish lowers blood pressure
- Persons walking with dogs go for longer walks
- 22% higher one year survival rate for pet owners (<.02)

HERO

**Vision:** All workplaces positively influence the health and well-being of employees, their families and communities.

**Purpose:** Advancing health, well-being and performance through employer leadership.
Appendix Slides

- HERO Scorecard
- HERO Scorecard Validation
- Activate Study
- Healthy Communities
HERO EHM Best Practices Scorecard in Collaboration with Mercer

- Online tool
- Version 4.0 launched July 2014
- Instantaneous report sent to your email
- Compare results against the national averages
- Over 1200 companies have taken the Scorecard since the inception
What We Say Versus What We Do: HERO Scorecard Analysis

<table>
<thead>
<tr>
<th>Health-Related Policies</th>
<th>% Yes</th>
<th>Physical Environment Support</th>
<th>% Yes</th>
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<tr>
<td>Tobacco-free policy</td>
<td>66%</td>
<td>Environment of safety</td>
<td>86%</td>
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<tr>
<td>Healthy eating policies</td>
<td>58%</td>
<td>Physical activity encouraged by features/resources at workplace</td>
<td>68%</td>
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<td>Work-life balance</td>
<td>57%</td>
<td>Healthy choices available</td>
<td>66%</td>
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<td>Promote use of community health resources</td>
<td>54%</td>
<td>Stress management and mental recovery areas provided</td>
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<td>Responsible alcohol use policies</td>
<td>38%</td>
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<td>Allow use of work time for stress management or rejuvenation</td>
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<tr>
<td>Allow physical activity during work time</td>
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### Supports Physical Activity

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<td>Physical Environment</td>
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### Supports Healthy Eating

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<td>Physical Environment</td>
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<td>51%</td>
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### Supports Stress Management

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<tr>
<td>Physical Environment</td>
<td>Yes</td>
<td>20%</td>
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HERO Scorecard Identified Companies

- Strategic Planning
- Organizational Support
  - Culture of health
  - Policies
  - Leadership support
- Evidence-based Programs
- Integrated Approach
- Participation Strategies
- Measurement & Evaluation

Source: HERO. 2014. Available at: www.hero-health.org/scorecard
## SCORING COMPARISON

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<td>Engagement Methods</td>
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<td>Participation Strategies</td>
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<td>Measurement and Evaluation</td>
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<td></td>
<td>Total Points</td>
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Community Preventive Services Task Force: Why Community Health Improvement Is Important

Reduce healthcare spending
  • Lower need and demand for health care

Reduce illness burden
  • Fewer cases, improved function

Make healthy choices easy choices
  • Environmental and policy changes

Maintain or improve economic vitality
  • Healthy communities complement vibrant business and industry

Increase healthy longevity
  • Today’s youth may live shorter and less healthy lives than their parents

Prepare the future workforce
  • A healthy workforce through education and skill building
Learning the Business Case

Healthy Workplaces, Healthy Communities

- A HERO initiative funded by Robert Wood Johnson Foundation (RWJF)
- Informed by an environmental scan commissioned by the IOM Population Health Improvement Roundtable
- An executive convening to learn about the business case and major barriers to engaging with community health initiatives

“Sustainable firms generate higher profits and stock returns, suggesting that developing a corporate culture of sustainability may be a source of competitive advantage for a company in the long run.”

-Eccles, et al. 2011
Call to Action

What do I do with this information?

• Join the HWHC initiative
• Use the tools on the HWHC website to get involved
• Contact Karen Moseley, karen.moseley@hero-health.org