



2011 IBI/NBCH Health and Productivity Forum

Integrated Benefits Institute &
National Business Coalition on Health

Case Studies Featuring 2011 Presentations

University of Kentucky/StayWell H&P Program Motivates Behavior Change to Reduce Health Risk

***Synopsis:** University of Kentucky (UK) used StayWell Health Management to develop and test a best practices program for changing employee health behavior to reduce health risk. The UK experience was set in the larger context of the evolution of wellness programs to increase employee engagement and activation, critical components of behavior change. When used in a comprehensive wellness program incorporating other best practices, health coaching has potential to increase employee engagement and activation, leading to behavior change and health risk reduction, as demonstrated at UK and in the Activate Study.*

Background

One of the most highly-rated sessions at the 2011 IBI/NBCH Health and Productivity Forum, “Results from the Activate Study and a Case Study from the University of Kentucky Health & Wellness Program” reported on the use of health coaching to help employees change behavior and reduce health risk.

Presenters included: Jody Ensman, MS, University of Kentucky (UK) Health & Wellness Program Manager, and Paul Terry, PhD, CEO of StayWell Health Management. Terry was the principal investigator for the Activate Study, funded by the Centers for Disease Control. He investigated a health coaching program, serving an airline and a health care organization, that was provided through the Park Nicollet Institute of Minneapolis, where Terry was working.

Reducing risk from poor health behaviors such as tobacco use or high-fat diet has always been a core activity of health and productivity management (HPM). Typically focused on higher-risk employees, health coaching is showing potential to improve employee health behavior and reduce risk when combined with other best practices in an HPM program.

“Based on StayWell’s experience, a 2% reduction in population-level risk is the threshold to begin producing return on investment,” said Terry. The Activate Study achieved a 7% risk reduction for these high-risk participants.

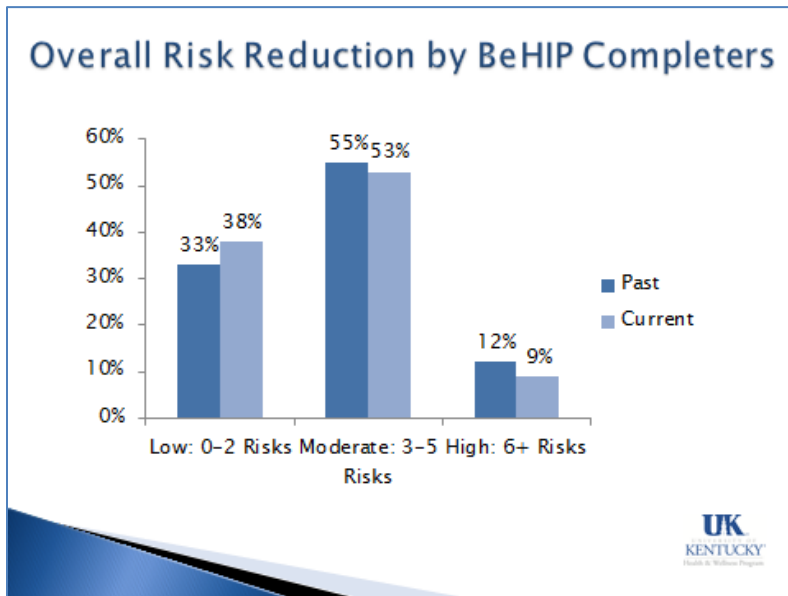
UK Outcomes

Beginning in 2003, the UK “Healthtrac Rewards” program recruited employees to participate in a population health management program requiring health assessments and use of other services to improve their health. Beginning in 2009 the subset of higher-risk participants was invited to enroll in BeHIP health coaching, in addition to taking two extra health assessments. The lower-risk subset was invited to enroll in an online Healthy Living education program. Total annual incentives for all Healthtrac activities are now at \$180 per participant, including a \$25 incentive for completing each health assessment, the program’s gateway.

Ensmann commented that their incentives may be too low to effectively drive decisions to participate in a health assessment. Response has been low, Ensmann said, with just under 25% of eligible people participating, compared to a norm above 50% for StayWell’s book of business. Nonetheless, “once people enter the program through a health assessment, statistics show they are staying in the program year-over-year,” she said.

Overall, the average number of 2.7 health risks did not change for the 3,406 people who have taken repeat health assessments from 2009 to 2010. But among the 1,188 BeHIP health coaching repeat participants, the average number of health risks decreased by 5.6%, from 3.4 to 3.2 risks. Figure 1 provides additional data about reduced risk in this group.

FIGURE 1



The UK Health & Wellness program is investigating the usefulness of two metrics self-reported by program participants: Figure 2, Days Away from Work Due to Illness or Injury; and Figure 3, Lost Productivity (“BoB” in both figures refers to StayWell’s overall book of business). Ensmann commented, “Currently, missed work days is one indicator of progress, but that could become a core goal of the program in the future.” This metric helps identify one component of return on investment.

FIGURE 2

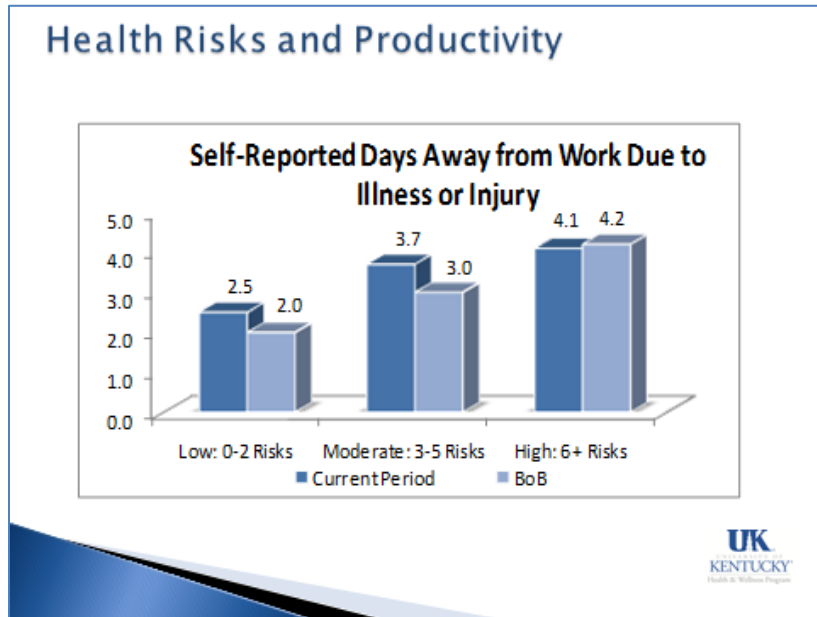
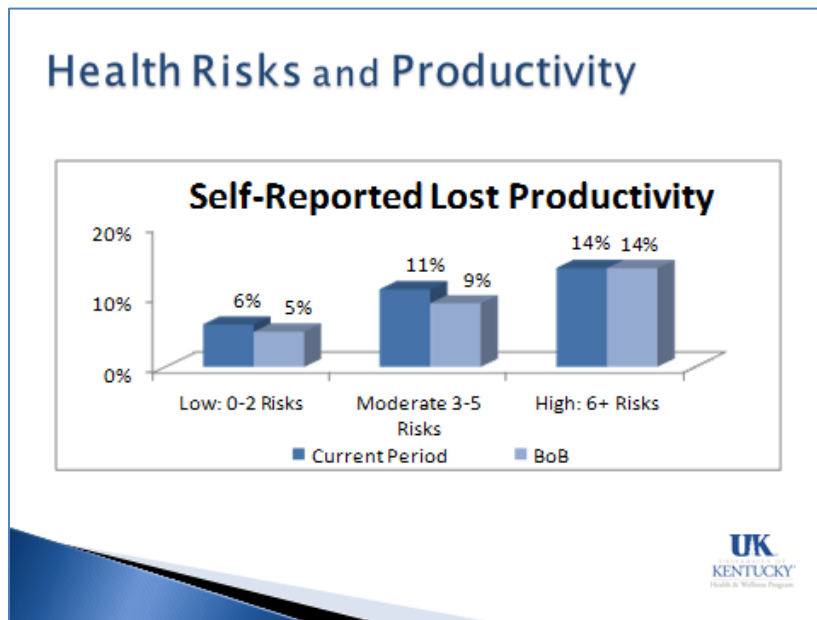


FIGURE 3



Subsequent to the 2011 Forum presentation, the UK Wellness program is continuing to mine its data. While hard numbers aren't publishable yet, Ensmann reports important trends:

- A positive ROI from the program 2006 through 2009.
- Increased saving per participant for additional years in the program.
- Program participants are higher users of preventive screenings, which could generate additional health plan savings over time.

Activate Study Outcomes

The Activate Study tested a consumer model for health coaching against a traditional motivational model. Traditional health coaching, comprising 10 to 15 phone sessions in a six-month period, focused participants on setting goals for improving health practices (quitting smoking, losing weight, etc.) and on improving management of chronic diseases. Consumer participants had up to five telephonic sessions with a coach, who focused on the skills needed to find and use resources for *self-management* of health habits and chronic conditions.

Average length and staffing costs for phone sessions were roughly equal for the two models, so fewer calls for the consumer model means substantially reduced costs. No vendor has, as yet, released a consumer activation model program for the market.

The most recent report on the Activate Study¹ suggests that combining the two models might yield the best outcomes. Participant self-reports showed that the consumer model had better work productivity results and also produced higher confidence in the ability to manage one's own health. The traditional model had greater impact on Personal Wellness Profile scores associated with reducing medical cost.

Both models had significant impact on general health status, which participants self-reported as "Excellent," "Very Good," "Good," or "Fair/Poor." In the traditional model, the most significant movements were increasing the "Excellent" group from 11.2% to 14.6% of participants, and decreasing the "Fair/Poor" group from 12.5% to 7.3%. The consumer model's most significant movement was increasing the "Very Good" group from 31.7% to 52.4%.

Incentives

Terry uses the analogy of a pipeline to describe how a program reduces health risks.

- Recruiting: did a significant percent of high-risk employees enter the pipeline by taking a health assessment? Several tools increase the number of high-risk people who enter, including: incentives, company culture, free services such as preventive screenings, and supports like health coaching.
- Engagement: do participants have sufficient readiness to change so that they stay engaged with risk-reduction activities as they move through the program pipeline? Tools like incentives and health coaching can also promote engagement—but the wellness industry has lively debates on how the tools affect each individual, and what's the right mix to keep a population of high-risk individuals engaged.
- Behavior change: by the end of the program pipeline (usually three, six or 12 months) have participants' program activities translated into changed personal behavior that reduces risk?

Research shows that recruiting employees to enter the program pipeline can be difficult. Hewitt Associates reported in September 2008 that among 248 employers in its *Employee Engagement Survey*, more than half offered smoking cessation (54%) and weight management programs (53%), but fewer than 5% of eligible employees participated.

Among these employers, 74% offered disease/condition management programs to employees, but only 10% of eligible employees participated.

The experience with participants in the Activate Study was that incentives were most effective during recruiting, and less so to promote engagement in program activities. Among U.S. corporate wellness programs, the value of incentives has crept upward; Terry cited an average of \$387 per participant in one survey prior to 2011.

“The likelihood that this will impact health behavior change is still largely untested and unknown,” said Terry. “An incentive at this level is enough to get people to show up to a health screening but not necessarily to change health-related behavior.”

Wellness plans have been shifting away from prizes or cash incentives, and into incentives such as reduced health plan premiums. The UK followed a similar evolution. The Healthtrac Rewards program initially was classified as “research” under Kentucky law, and incentives were untaxed direct cash payments to participants. Beginning July 2009, cash incentives have come through payroll and were taxed. The next program upgrades, Ensman said, will be to simplify the incentive structure and increase the incentive amount for taking the health assessment, the gateway into the program.

The Patient Protection and Affordable Care Act (PPACA) health reform contains provisions that may drive further evolution of wellness plan incentives, notes Terry. “The PPACA health reform opens the door to outcomes-based incentives,” said Terry.

Unlike incentives for participating in a program, outcome-based incentives reward only outcomes such as smoking cessation or achieving a target weight. A growing minority of employers have investigated outcome-based incentives, allowed through a worksite wellness exemption to the federal medical underwriting provisions in the group health plan market, Terry noted. PPACA provisions now formally codify this exemption.

“In this area, the science is lagging behind policy, we can’t tell exactly how this new category of incentives will affect programs,” Terry said.

Intrinsic Measures

“Extrinsic motivators like incentives lead a horse to water, but intrinsic motivators lead them to drink,” said Terry. “Outcome-based incentives could fill up a pipeline with participants who want the incentive but don’t have intrinsic reasons, so overall program success rates could actually go down.”

The Activate Study and the UK program used the Personal Wellness Profile (PWP) and Patient Activation Measures (PAM) to investigate internal motivators.

In PAM, participants respond to self-efficacy statements using a four-point Likert scale, from “disagree strongly” to “agree strongly” with 13 statements such as:

—“I know what each of my prescribed medications does.”

— “I am confident that I can maintain lifestyle changes, like diet and exercise, even during times of stress.”

Increasing PAM scores correlate with increased self-report of productivity. The PAM can also indicate readiness to change. In the Activate Study, low PAM scores at baseline correlated with greater retention rates, suggesting to Terry that “Low activation scores can be a proxy for people who know enough to know they need support.” Low scores on individual PAM statements can identify significant needs that a health coach should discuss with a participant.

The greatest predictor of engagement in the Activate Study was participation in biometric screenings to identify health status on key health measures such as blood pressure and cholesterol levels. Screenings remain popular with adult wellness program participants.

To try to achieve an effective balance between external motivators (incentives) and internal motivators, Terry advocates “progress-based incentives” that reward progress toward an appropriate goal.

“Offering a trained health coach to work with participants toward a goal that is considerate of their individual starting points and the inevitable contingencies surrounding their health habits is more likely to engage and retain the hardest to reach in a population,” said Terry. “Advancing a strict outcomes-based policy may well do the opposite, alienating and distancing those in the population we’re most interested in engaging and retaining.”

Conclusion

Employers have more motivation than ever to help high-risk employees change behavior, improve productivity and reduce medical spending, a cost category that continues to grow faster than inflation. Changing entrenched health risks like tobacco use and unhealthy diet has proven difficult. Research is showing health coaching to be a valuable addition in best-practices programs to help high-risk employees change behavior to reduce health risk. This field is continuing to evolve, driven both by employer needs and provisions in federal health reform laws.

¹ Terry, PE; Fowles, JB; Xi, M; Harvey, L. “The ACTIVATE Study: Results From a Group-Randomized Controlled Trial Comparing a Traditional Worksite Health Promotion Program with an Activated Consumer Program,” *American Journal of Health Promotion*, Nov/Dec 2011, Vol. 26 No. 2, p. e64-e73.