

Balancing Accountability and Equity: Putting Progress- Based Incentives to Work in Wellness Part 2 of 2

Our last column described the growing debate about pros and cons of “outcomes-based” vs. “participation-based” incentives and introduced our recommendations related to “progress-based” incentives. We discuss in *American Journal of Health Promotion*¹ why we think this approach represents common ground for those wanting to increase employee accountability without reducing access to needed services. Because the potential impact of such health benefit changes on employee morale and retention is so great, we believe a guiding framework is needed to support decisions about incentives, particularly if they will be integrated with health premiums. For this, we turned to the influential report from the Institute of Medicine, “Crossing the Quality Chasm,”² on the national challenge of controlling healthcare cost while also improving quality.

The following guidelines for using financial incentives adapt core tenets of the IOM reform strategy designed to identify “environmental forces that encourage or impede efforts to improve” healthcare quality. We align each IOM component — safety, participant-centered, timeliness, efficiency, equity — with evidence-based guidelines consistent with health behavior change principles. (Effectiveness is another core tenet, discussed in our last *Practitioner* column.)

Safety

Modeled on HIPAA, the health care reform law section specifying acceptable use of incentives includes this requirement: Provide a reasonable alternative standard to those for whom an outcomes-based health standard, such as achieving a target BMI, is either unreasonably difficult due to a medical condition or not medically advisable. Like a wrestler attempting to make weight, anecdotes depicting participants purging themselves to attain an incentive highlight the caution needed in designing incentive levels and reward criteria. Similarly, studies on the detrimental effects of weight recycling show the importance of adapting a target to the individual’s starting point.

In a progress-based approach, employees set goals in collaboration with a highly trained health coach, plus guidance from their physician if needed. In working with participants to set appropriate health goals, astute coaches can consider factors such as age-related metabolic changes, family environment, living in unsafe neighborhoods, working extra shifts, and dealing with other physical or environmental disadvantages beyond the participant’s control.

Participant-Centered

Creating an incentive strategy with employee input rather than imposing it goes a long way toward building a sense of shared accountability in

Lessons from Health Coaching



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the workforce. Participant-centered organizations, like patient-centered healthcare systems:

- Include employees in making decisions about program design
- Gather information from a cross-section of employees to understand how they’ll respond to proposed changes.

Provide incentives that respect and respond to employee needs and values. This involves varied and stimulating choices that give individuals autonomy in how they earn incentives. Include a mix of learning modes that respond to learner differences — such as phone, online, or face-to-face interventions.

Timeliness

Since intrinsic motivation is the main predictor of long-term behavior change, the primary role of extrinsic motivators, like financial incentives, is as a short-term catalyst for action that must be sustained by

intrinsic motivation. Aim incentives at creating the inertia to begin a program for those who have been “chronic contemplators”; offer interventions that engage participants in ways that shift their motivation to intrinsic factors. When incentives are integrated into benefit plans, for example, it is often most efficient to tie current year accomplishments to next year’s premiums. Attempts to make such incentives more timely can create complexities that are administratively inefficient and difficult to communicate. Modest rewards are effective if immediate and less of a threat to intrinsic motivation, while future rewards must be larger to make the wait seem worthwhile.

Employ a phased approach in the use of incentives:

- Begin with simple strategies such as using incentives for an event like completing a health assessment
- Incorporate additional requirements gradually over a number of years, as the workforce internalizes a shared responsibility for health
- Use tracking systems for rewards that enable and encourage participants to record their progress toward goals
- Offer regular visual cues or other monitoring systems for future incentives to make recordkeeping easy and interesting, while periodically reminding participants of the reward to come.

StayWell research suggests that larger benefit-integrated incentives are more effective than cash in catalyzing participation. Be sure to communicate about incentives early and often, focusing on shared responsibility rather than “do this, get that” (which encourages compliance rather than engagement). Keep rules and criteria for earning a reward simple, so they’re readily understood by all employees regardless of education level, which also helps participants focus on their health rather than incentive rules. Although incentives tied to health assessment completion are effective in increasing completion rates, they should be avoided since they may intentionally or unintentionally influence responses.

Equity

Not only do people have different starting lines in managing their health, but wide variations in genetics and physiology create a complex relationship between behavior and outcomes. What’s more, employee engagement strategies should take into account differences such as ethnicity, geographic location, and socioeconomic status.

Among the chief concerns in recent position statements from the American Heart Association and American College of Occupational Medicine Physicians opposing

hypertension or diabetes are less able to manage their health when their coverage costs are too high.

Aside from disputes over the economic impact of tying incentives to health status, even more basic questions concerning whether similar efforts will produce similar health improvements need to be considered. For example, one study showed that when following identical exercise regimens some participants showed significant improvements in aerobic capacity, some showed only moderate improvement, and others showed little or no improvement. Likewise, a post-menopausal woman has a much greater challenge losing weight than a young man. A single parent has a much greater challenge finding the time and energy to commit to lifestyle changes than an individual with family support.

With this in mind, consider aligning standards with the population’s overall risk level, especially in the program’s first few years. Examples include:

- Setting more lenient targets (such as BMI < 30 versus < 25)
- Providing incentives for those successfully achieving disease management goals such as staying on their medications or monitoring blood sugar as directed

Remember, incentives tied to specific interventions will increase participation even among those for whom the intervention is not appropriate.

Efficiency

One way to neutralize the costs of incentives is to integrate them into your health plan design rather than using direct “cash-equivalent” rewards.

outcomes-based incentives is the relationship between access to healthcare and the shifting of health insurance costs. These professional societies point to considerable research showing that those living with chronic conditions such as



- Requiring multiple activities throughout the year in place of achieving outcomes, while not tying a large incentive to completing a single activity.
- Offering a menu of participation options with incentives indexed to intensity, along with a strategy for triaging individuals into appropriate activities to keep incentive opportunities fair while maximizing their impact. 📄

To request our comprehensive white paper³ on the role of incentives in improving engagement and outcomes in population health management, see: www.staywellhealthmanagement.com/Contactus/IncentivesWhitePaper.aspx.

References

- ¹ Terry, PE, Anderson, DR. “Finding common ground in the use of financial incentives for employee health management: A call for a progress-based approach.” *American Journal of Health Promotion*, Sept. 2011, Vol. 26, No. 1, ev-evii.
- ² Crossing the Quality Chasm: A New Health System for the 21st Century. Institute of Medicine Consensus Report. <http://iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx>.
- ³ Terry, PE, Anderson, DR, Sept. 2011. “The Role of Incentives in Improving Engagement and Outcomes in Population Health Management: An evidence-based perspective.” www.staywellhealthmanagement.com/Contactus/IncentivesWhitePaper.aspx.

Things to in 2012



It happens every year around this time. A colleague or client will tell us of a service they’ve been providing for 12 months or more that’s not working or an activity that uses up resources but produces no real benefit. They say something like “not getting as much participation as we should” or “nothing ever seems to happen as a result of...” When we ask why they keep doing it, the answer is often “because it’s in the plan” or “that’s the way we’ve always done it” or “so-and-so wants it.”

To all of the above and more, we say: **STOP!** There’s never a good reason to waste time and resources. You know what causes this for your program, but here are a few we’ve experienced in our work with others:

- **Excessive meetings.** Some meetings are vital, but minimize, focus, and streamline them so you can actually get some work done.
- **Long reports.** If nothing ever happens as a result of creating the report, skip it. And try to get them down to a single page if you really want someone to pay attention.
- **Dormant services.** If you can’t repackage and resurrect them, bury them and start over. Why keep doing something for only the same dozen people?
- **Proving the obvious.** Healthy people cost less, are more productive, have fewer absences. It’s all in the literature. For you to prove it again for your population makes no sense. What you really should prove is that your program is effective at getting people to adopt healthy habits.
- **Overdone, inappropriate data collection.** If you find yourself saying “isn’t that interesting” when reviewing your annual data but never doing anything with it, you’re wasting everyone’s time. Don’t collect information you’re not prepared to act on, and be prepared to act on anything you collect.



Opportunity Cost

The cost of an ineffective, nonproductive activity or health promotion service goes beyond the actual dollars spent on salaries, materials, and overhead. There’s also the opportunity lost by not investing those resources in effective, productive areas — to actually help people improve health.

Take some time at the beginning of the year to see what makes sense to stop doing... then invest those resources in things you know will work or new services with greater potential. 📄