Questions and Answers with David Anderson, Ph.D.

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David Anderson, PhD, is Senior Vice President & Chief Health Officer and a co-founder of StayWell Health Management, a leading provider of health management programs and services. Since 1985 he has been the primary architect of StayWell's population health strategies, programs and tools. David also shares corporate strategic leadership and has consulted on client programs that have won nearly 50 major industry awards. David has conducted groundbreaking research of the effectiveness and cost impact of StayWell programs and coauthored several landmark studies. David is past Chairman of the Board of the Health Enhancement Research Organization (HERO) and chairs its Research Committee, serves on the Board of the Health Project, which administers the C. Everett Koop Award, and is Editor of the Population Health section of the American Journal of Health Promotion. He has also served on expert panels for CMS, CDC/P, NIOSH, NCQA, and AHRQ. A licensed psychologist, David has published numerous professional papers and speaks regularly on health management issues.

Q: What should employers know about using incentives?

Dr. Anderson: *Many employers are using financial incentives to try to increase engagement in health management program activities and to improve employee health outcomes. With this use, however, it is important for employers to know that incentives are a "double-edged sword" with potential benefits but also inherent risks. A potential benefit in the short term is that incentives may drive more participation in incented program activities, and participation has the potential to yield greater population behavior change if the incentives are thoughtfully designed and implemented in the right context. A very real risk, however, is that the incentive drives more participation and related program costs but fails to yield better behavioral or health outcomes. Employers who elicit a high rate of participation with a coercive level of incentives may experience a reduction in the success of otherwise effective interventions because they enlist many participants at low readiness to change.*

Even when incentives are offered as "carrots" as opposed to the "sticks" that erode employee goodwill, they may still backfire if employees view the incentive as an attempt by the employer to control their personal behavior. It can also be difficult to control what will be viewed as a carrot versus a stick. Employees most prepared to engage in program offerings may view a premium differential, for example, as a welcome inducement. Others less inclined to value the program offering,

even some otherwise motivated to improve their health, may view the same premium differential as punitive.

If an employer plans to use incentives in their strategy, they need to know that skillful communications and supportive culture are essential if the incentives are to achieve their desired effects.

Q: What are the dangers/drawbacks to using incentives? What can employers do to avoid these?

Dr. Anderson: *Aside from the potentially significant cost of the incentives, which need to be weighed against their potential value, the major drawback arises because incentives tend to increase compliance but decrease intrinsic motivation. Intrinsic motivation is the enjoyment or internal reward a person gets from an activity, and research has consistently shown that external incentives have a negative effect on intrinsic motivation. For example, paying me to complete a health risk assessment reduces my interest in its inherent benefits to me, so you need to keep paying me in the future – maybe even more each year – or I won't participate. This is a particularly thorny concern when it comes to tying incentives to behavior change, where intrinsic motivation is absolutely essential to long-term success.*

That said, our research and experience suggest that incentives may be effective when they are well communicated within a supportive culture of health. Generally speaking, I apply what I call the "Goldilocks principle" to designing incentives – they need to be attractive enough to get significantly more people to participate in an action without being so irresistible the individual views the incentive as the primary reason for taking the required action. It's when the incentive is the primary driver of behavior that intrinsic motivation really suffers. When the incentive is only another small factor that "nudges" employees already considering positive change, our experience and data suggest that the intrinsic factors remain the primary drivers.

Q: What role do incentives play in achieving high employee engagement?

Dr. Anderson: *You achieve high employee engagement in a program or behavior change when it is intrinsically rewarding to him or her. This is virtually the opposite of compliance with incentive program rules, where the employee is going through the motions minimally required to earn the incentive. Incentives may stimulate compliance in the short term, but they almost inevitably decrease the intrinsic motivation needed to sustain change. From this narrow perspective, you're unlikely to achieve sustained behavior change in areas like healthy eating and physical activity that have mainly long-term intrinsic payoffs without the necessary financial incentive becoming unaffordable.*

However, we need to view this situation more broadly from the perspective of our long-term goals and health management strategy. The reality is that people often become intrinsically motivated to engage in behaviors that began purely as compliance driven by the lure of reward or the threat punishment. A good example is seat belt use. A couple of decades ago most people begrudgingly began buckling up to obey the law or avoid paying a fine. Today many of those same people urge their children and grandchildren to buckle up because of strong internalized beliefs. Changes in smoking habits have followed a similar course. In both cases, public health messages and cultural and environmental changes surrounding these behaviors were key factors in the broad strategy for shifting people from begrudging compliance to active engagement.

I believe employers and our nation will be best served in the long run if we are able to dramatically increase the intrinsic value individuals place on actively managing their health and pursuing a healthy lifestyle, but that doesn't mean a bit of incentive-induced short-term compliance isn't part of the most cost-effective recipe for moving toward long-term engagement. For example, if one-third of those attempting new behaviors to win an award eventually convert to the new behavior as having merit for them independent of the reward, the incentive may still be considered cost-effective from a public health perspective despite failing to result in intrinsically sustain behavior change for the other two-thirds.

Q: What are some examples of effective incentive programs employers have used?

Dr. Anderson: *I've seen incentives used effectively by our clients and in published accounts of other programs to increase participation in health risk assessment, biometric screening, lifestyle coaching and disease management programs, use of PHRs, and population-wide informational or activity campaigns to name a few. The types of incentives that have proven effective have ranged from tokens, to merchandise or cash and cash equivalents (e.g., debit cards), to health plan incentives (e.g., preferred health plan enrollment; reduced premiums, deductibles, or co-pays; spending account contributions), to non-financial incentives with essentially no real or opportunity costs.*

Q: What are some non-financial incentives being used by employers to encourage participation in programs and behavior change?

Dr. Anderson: *Many non-financial incentives fall into the broad categories of recognition and inclusion. Most of us appreciate positive recognition from family, friends, co-workers or leaders, and this is something every employer ought to take advantage of in their program regardless of the financial incentives they may be using. A great example of the power of recognition is a program at Lincoln Industries, a company of about 400 employees based in Nebraska, where employees who achieve the "platinum level" in the wellness incentive program get to go on a 14,000 foot mountain climb in Colorado with the CEO and other senior executives – this past year more than 70 of their people made the trip, and that platinum level is pretty challenging to achieve. Other examples of recognition include sharing stories about the wellness achievements of consenting employees in company media – this is great recognition for the individual and very helpful in offering meaningful role models to others.*

Similarly, most of us have a need for inclusion and employers can use this in a variety of ways in their health management strategies. I encourage employers to make health a core business value and create a "culture of health" because employee health behaviors will gravitate over time toward alignment with that healthier environment and culture. Offering fun and collaborative group activities in the program, such as activity campaigns, is another way of tapping the need for inclusion to drive engagement.

Q: Are there important gaps in our knowledge about incentives that future research might elucidate?

Dr. Anderson: *There is an extensive body of scientific research on the impact of incentives and disincentives – or reward and punishment – on behavior. At a general level, we know a lot about how incentives and disincentives affect behavior. What's largely missing from the scientific literature and that we've only begun understanding at the worksite is the complex interplay of incentives with*

communications, organizational culture, and other factors that affect the way people perceive and respond to the incentives. Our research has shown, for example, that good communications and healthy culture can increase health assessment participation rates by 20-30 percent at a given level of incentive – that is, the average 50 percent participation rate achieved with a $100 incentive can increase to 70-80 percent or more. Another recent finding in our research is that while big incentives for completing coaching programs drives much more completion, they reduce health impact among participants just as intrinsic motivation principles would predict. It also appears that communications highlighting individual accountability and equity in presenting health plan cost differentials are significantly more effective than communications focusing on "do this and you'll get that" contingencies. The bottom line is that much more research is needed to fine-tune how the use of incentives is translated from science to practice.

Q: What works to motivate employee behavior change—both at work and at home?

Dr. Anderson: *When considering this question at the individual level I really like the way Michael O'Donnell, editor-in-chief of the American Journal of Health Promotion, discusses behavior change in a recent article in the November/December 2008 issue titled, "The Face of Wellness: Aspirational Vision of Health, Renewing Health Behavior Change Process and Balanced Portfolio Approach to Planning Change Strategies". He talks about behavior change being motivated by passion (think "readiness to change" or "activation" or intrinsic motivation) and suggests that, for most people, achieving better health is not the passion fueling their daily life.*

Much of our challenge in health management is helping people link their personal passion to improving their health. Their passion may lie in the spiritual realm, it may be physical, or it may be social, emotional or intellectual – for most of us, it's likely a combination of all of these dimensions. Great health coaching involves helping people discover how their passions and their health come together to motivate and sustain change. For example, being able to spend more quality time with their grandchildren is a source of intense passion some people tap into to drive healthy behavior changes.

Maybe even more essential to improving the health of employee populations, however, is the simple wisdom that culture always wins when it comes to health behavior change or most other behaviors for that matter. If we want to achieve high rates of sustainable health behavior change in populations, we must fundamentally change the culture – both at the worksite and in the community. Even impassioned people are challenged when the culture surrounding them fails to support their efforts to change. Employers have a role to play not just at the worksite, but also in the communities where they operate if we are to move the nation toward meaningfully better health.

Q: Are group-level or individual-level interventions more effective?

Dr. Anderson: *No one category of intervention works best for all people, so a comprehensive health management strategy includes both individual and group interventions in multiple delivery modes – onsite, telephonic, print, and online. As new modalities such as mobile technology emerge, they should also be incorporated to the extent they drive better results. What we've found over three decades of implementing and evaluating worksite health management strategies, which the science base also supports, is*

that individually tailored interventions using multiple delivery modalities that evolve with the individual's needs are most effective in maximizing change.

Since that level of individualization is challenging in practice and can also be very costly, best-practice health management providers are pursuing the most cost-effective program design and implementation strategy possible within the limitations of practicality and limited resources. In doing so, we depend on our experience, research, data, and collaboration with the participant to make decisions about the level and type of support he or she needs. A low-risk individual may proactively use online tools and seek advice from a telephonic health coach in pursuing a fitness goal such as completing a triathlon without undue risk of injury. High-risk individuals, on the other hand, typically need individualized support from a health coach over an extended time period, which may be provided face-to-face, telephonically and increasingly online, with the exact mix of each modality over time depending on the specific needs and circumstances of the individual. If they didn't need this relatively intensive support to change, they probably wouldn't have been at high risk in the first place.

High-risk individuals may get additional support from participating in group programs at the worksite or in the community while they are working with their coach. For example, an individual working with a health coach to lose weight and manage their diabetes may get support from a nurse to address clinical issues, use online tools or their mobile device to set goals and reminders and track progress, and participate in Weight Watchers and an online social networking site for social support. Regardless of an individual's risk level, the key is to offer a range of support to meet their unique mix of risk, readiness to change, self-efficacy, barriers, learning preferences, and other factors that influence what he or she needs to be successful. Additionally, the long-term program goal should always be independence, where the individual becomes capable of self-management even in the face of temptations or stress.

Q: How is information technology changing worksite wellness programs?

Dr. Anderson: *To feasibly and cost-effectively implement the highly individualized approach I just described, a flexible and robust technology platform and a comprehensive database is essential. The technology includes a personalized health portal where participants can complete their health assessment and manage their health data, learn about and enroll in programs they are eligible for, interact electronically with their health coach or other health professionals, track progress in making changes or earning incentives, and access health information personalized to their needs. It includes administrative and coaching interfaces used to set up and deliver program activities, supported by extensive and very sophisticated logic or "business rules" that determine how the program addresses each individual's needs through the participant, coach, and administrative interfaces. Finally, the database incorporates and organizes every data element on each eligible individual in ways that enable personalizing the portal, segmenting the population, monitoring and issuing invitations and outreach alerts, managing participation and program quality, reporting on results, and so on.*

Rapidly improving technology just keeps opening new doors to more cost-effectively delivering programs we could not have delivered or even imagined only a few years ago. I mentioned mobile technology as an important new direction for engaging and interacting with participants

– this is becoming a practical option for touching and communicating with a rapidly increasing portion of the population. It's important to recognize that technology is just a tool and not a solution per se – innovation requires using technology to get better results at lower cost. However, technology makes this a very exciting time to be pursuing the vision of total population health management.

Q: How can employers encourage employee participation and monitor participation in health promotion programs?

Dr. Anderson: *I believe employers can best encourage employee participation by demonstrating their commitment to health as a key long-term business strategy. This begins with engaged leadership who communicate their commitment to employees, demonstrate it through their actions, and translate it into a healthier workplace culture through policy and benefit plan design, environmental and management-practice changes.*

With this foundation of health as a core value guiding organizational actions, it's an open question whether financial incentives are still needed to stimulate high levels of employee participation. I'm aware of organizations that get very high rates of participation and the genuine engagement that yields improved health without using financial incentives. However, I think most employers just recognizing the full value of a healthy workforce feel a need to move quickly to control rising health care costs and will turn to incentives as a tool to drive high rates of participation. In this case the key is to use incentives thoughtfully to fuel long-term engagement rather than just short-term compliance and to invest concomitant resources to building a culture that will make healthy choices the easy choices for employees.

Monitoring participation requires information technology and transparency from program providers. Despite many advances in managing population health, there is still much we don't know so both employers and providers should have great interest in thoroughly tracking and understanding participation in health management interventions, as well as how true engagement versus merely compliant participation translates into health and financial outcomes.

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