Illinois
New Mexico
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Texas

April 2013
Employer Worksite Wellness Webinar

2013 Campaign Schedule

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Month	Webinar Topic	Date and Time
January	2013 Wellness – An Overview of Well onTarget	1/29 10-11 AM
February	2013 Wellness – An Overview of Well onTarget	2/26 10-11 AM
March	Thrive to Stay Alive: Happiness in the Workplace	3/19 10-11 AM
April	Wellness Incentives in Workplace Cultures: Best Practices	4/23 10-11 AM
May	BCBS Incentives Program	5/28 10-11 AM
June	2013 Wellness - Well onTarget Online Challenges	6/25 10/11 AM
July	TBD	7/23 10-11 AM
August	TBD	8/27 10-11 AM
September	TBD	9/24 10-11 AM
October	TBD	10/22 10-11 AM
November/December	TBD	12/10 10-11 AM

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April 2013

Agenda

- Introduction
- Wellness Incentives in the Workplace: Best Practices
- Questions


Our mission is to
promote the health and wellness
of our members and communities through accessible,
cost-effective, quality health care.
Experience. Wellness. Everywhere.℠

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Wellness Incentives in the Workplace: Best Practices

David K. Brennan, Instructor

University of Oklahoma, School Of Community Medicine

Human Performance Laboratory

Tulsa, Oklahoma

SCHOOL OF COMMUNITY MEDICINE

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Our Health Care System

Wage/Price Controls

Implemented during World War II

Health Benefits

Allowed in lieu of wage increases

Collective Bargaining

Embedded health care benefits into the workplace


Compromise
National health insurance
Medicaid
Federal/state funded health plan for poor persons
Must be “categorically” eligible
Medicare
Subsidized social/health insurance program
Everyone over 65 participates

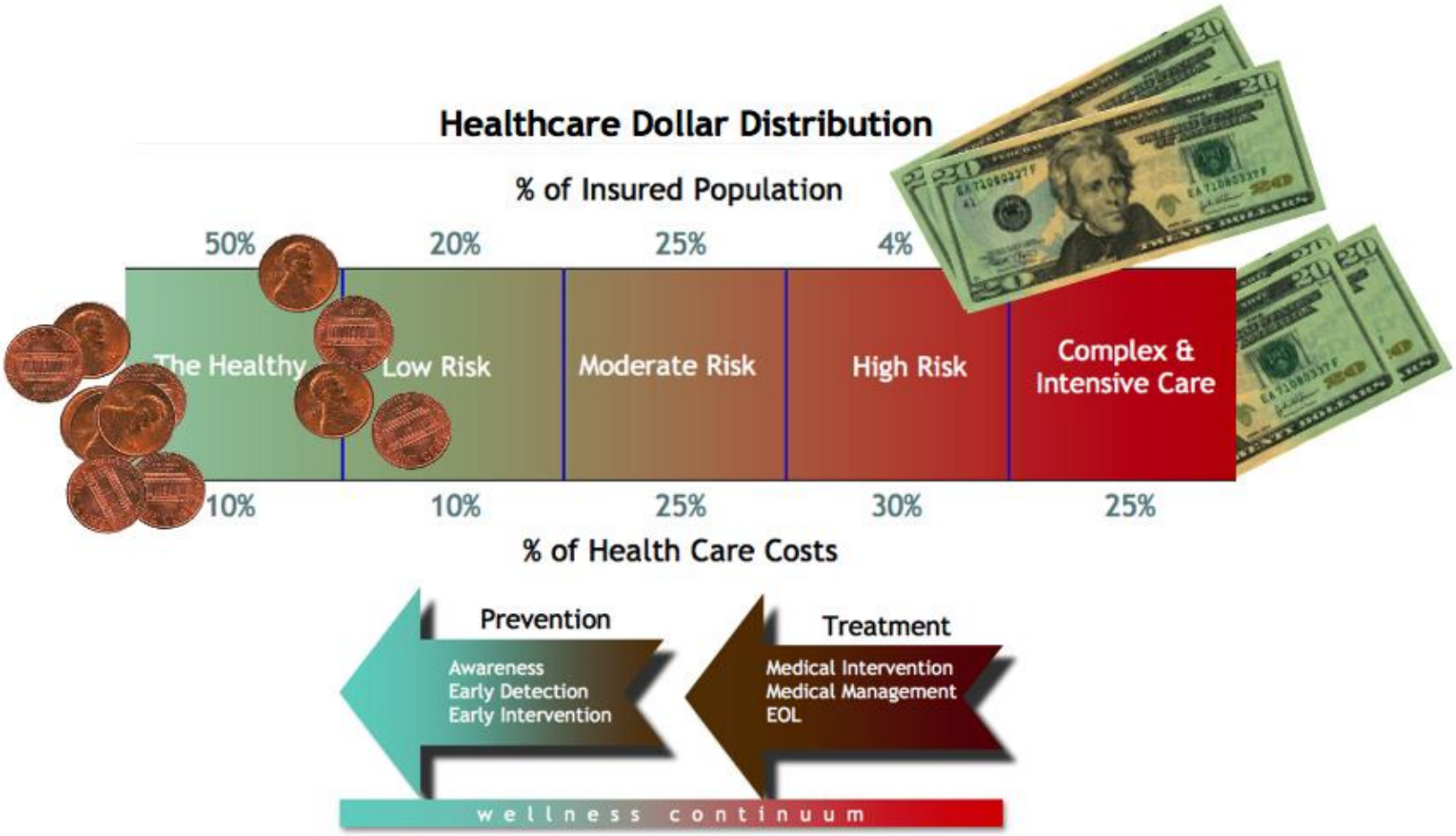
Health Systems – Where do we rank?

The World Health Organization's ranking of the world's health systems.

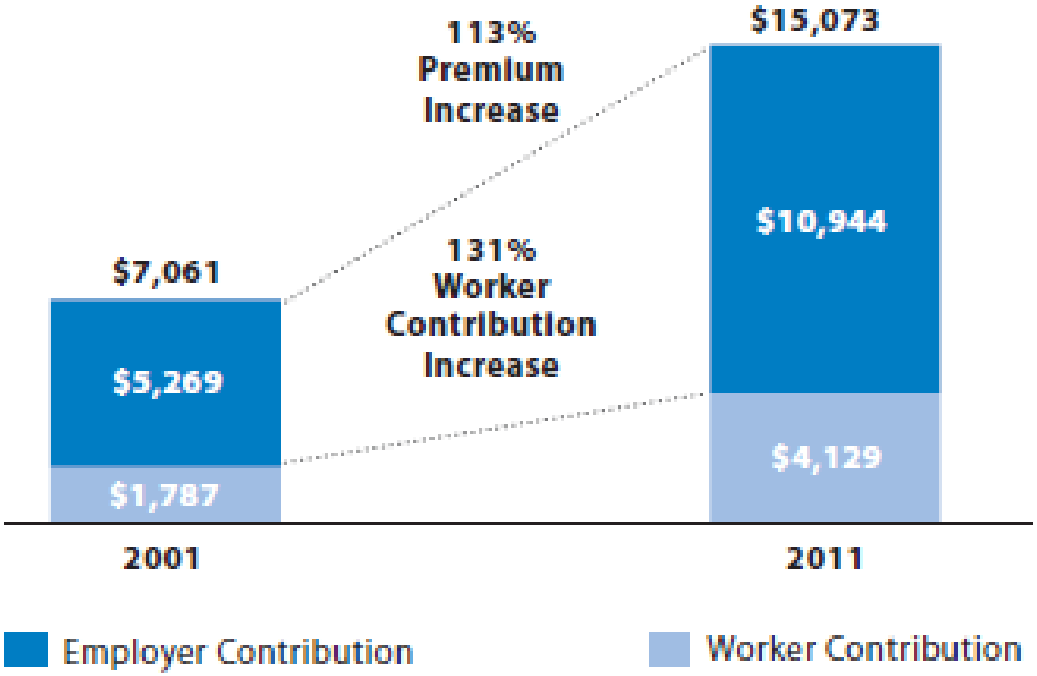
The US Spends twice as much as France !

1.	France	19.	Ireland	37.	USA
2.	Italy	20.	Switzerland	38.	Slovenia
3.	San Marino	21.	Belgium	39.	Cuba
4.	Andorra	22.	Colombia	40.	Brunei
5.	Malta	23.	Sweden	41.	New Zealand
6.	Singapore	24.	Cyprus	42.	Bahrain
7.	Spain	25.	Germany	43.	Croatia
8.	Oman	26.	Saudi Arabia	44.	Qatar
9.	Austria	27.	United Arab Emirates	45.	Kuwait
10.	Japan	28.	Israel	46.	Barbados
11.	Norway	29.	Morocco	47.	Thailand
12.	Portugal	30.	Canada	48.	Czech Republic
13.	Monaco	31.	Finland	49.	Malaysia
14.	Greece	32.	Australia	50.	Poland
15.	Iceland	33.	Chile		
16.	Luxembourg	34.	Denmark		
17.	Netherlands	35.	Dominica		
18.	UK	36.	Costa Rica		

Shift from Sickness to Wellness



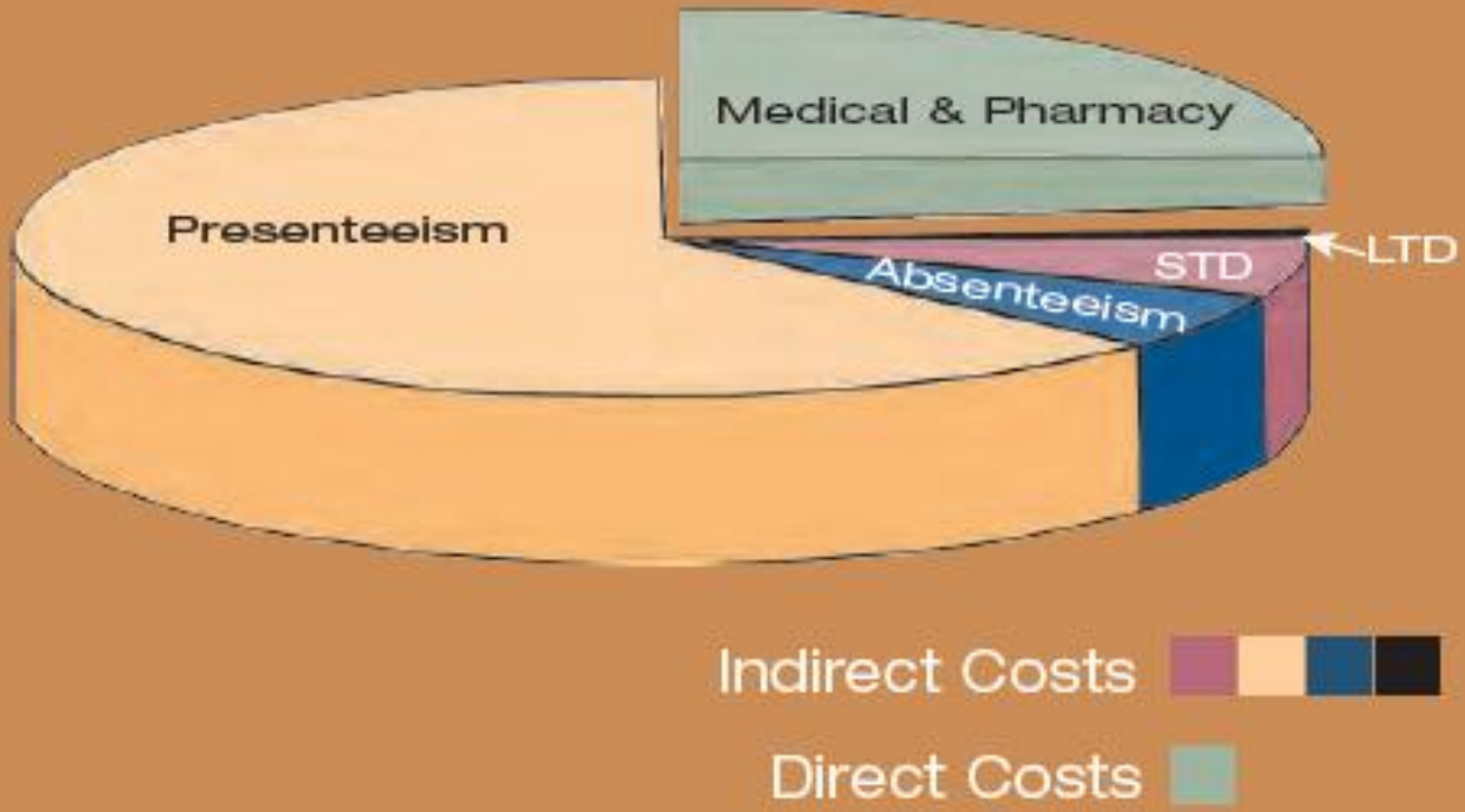
Employer/Employee Contributions



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2001–2011.

IS YOUR ORGANIZATION AWARE OF THE TOTAL COST BURDEN OF POOR EMPLOYEE HEALTH?

Relative Contribution of Direct and Indirect Costs Within a Large Financial Services Corporation



Source: Edington DW, Burton WN. Health and productivity. In: McCunney, RJ: A Practical Approach to Occupational and Environmental Medicine. Philadelphia: Lippincott Williams & Wilkins. 3rd ed. 2003:140-152[12]

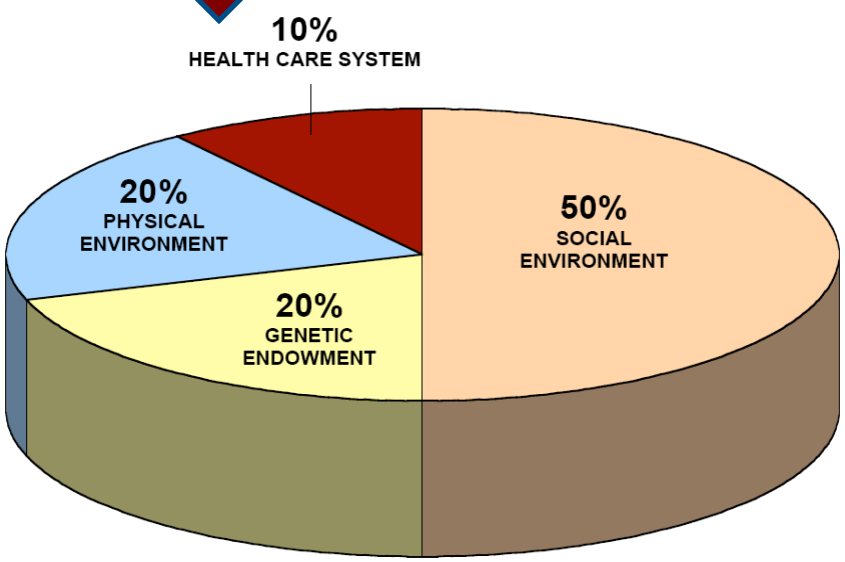
The Motivation for Incentives

Health Care Costs 2008 ► $2.3 trillion

2016 ► $4.1 trillion

DETERMINANTS OF HEALTH

WHAT IS THE ROLE OF MONEY?



The Wellness Continuum

All individuals are located somewhere between death and wellness

“a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

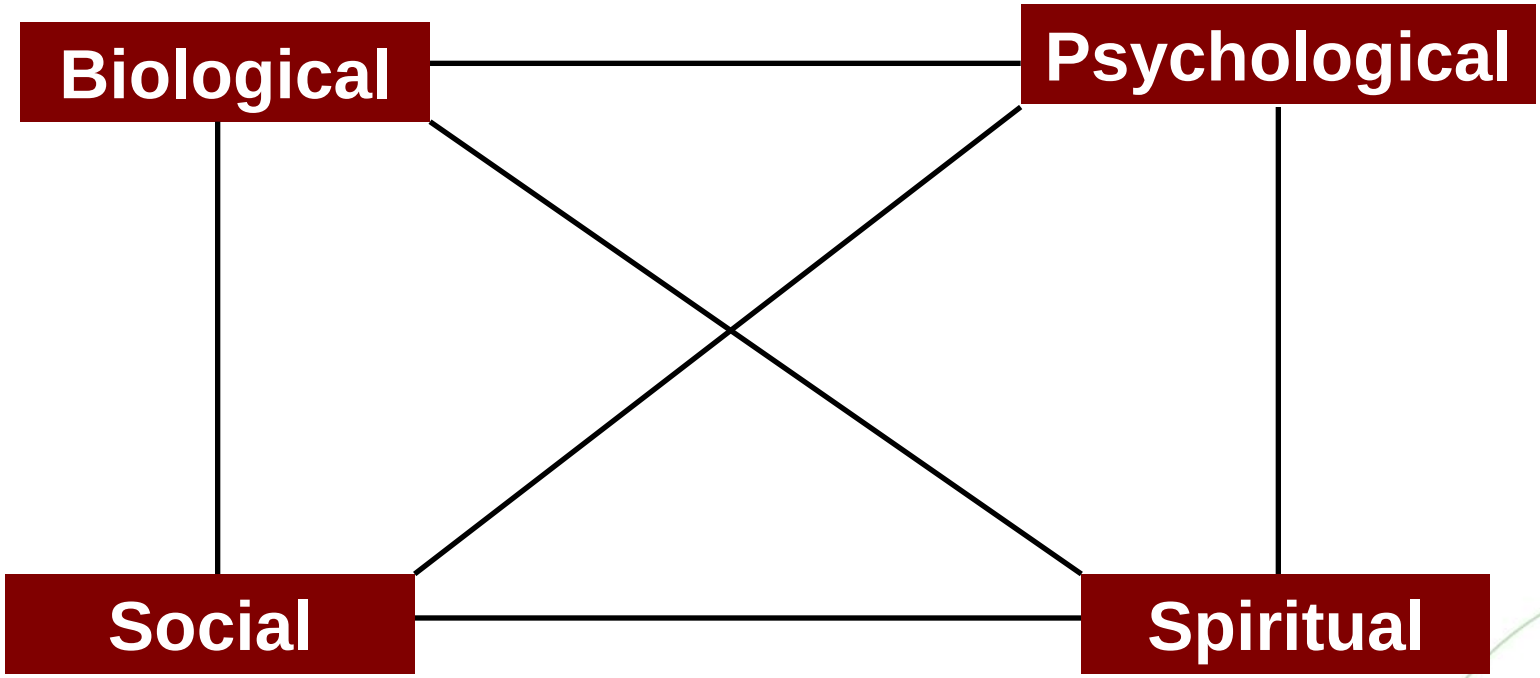
“Healthy, Happy and Wise!”



Sources : Dunn, Halbert L. (1957): Points of Attack for Raising the Levels of Wellness. In: Journal of the National Medical Association, vol. 49, no. 4, pp. 225-235, 211

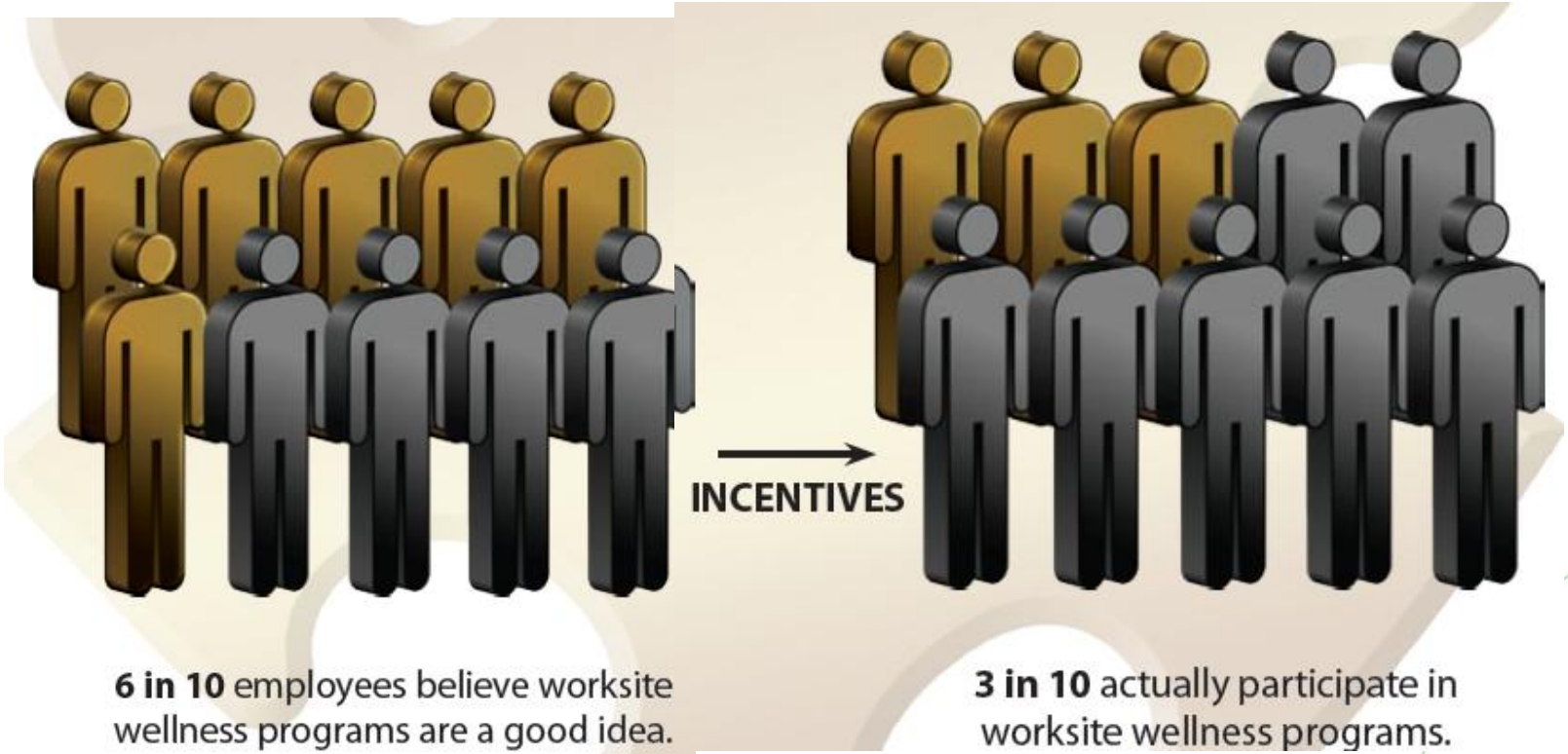
WHO. "Constitution of the World Health Organization" World Health Organization; 2006

A Holistic Model of Wellness

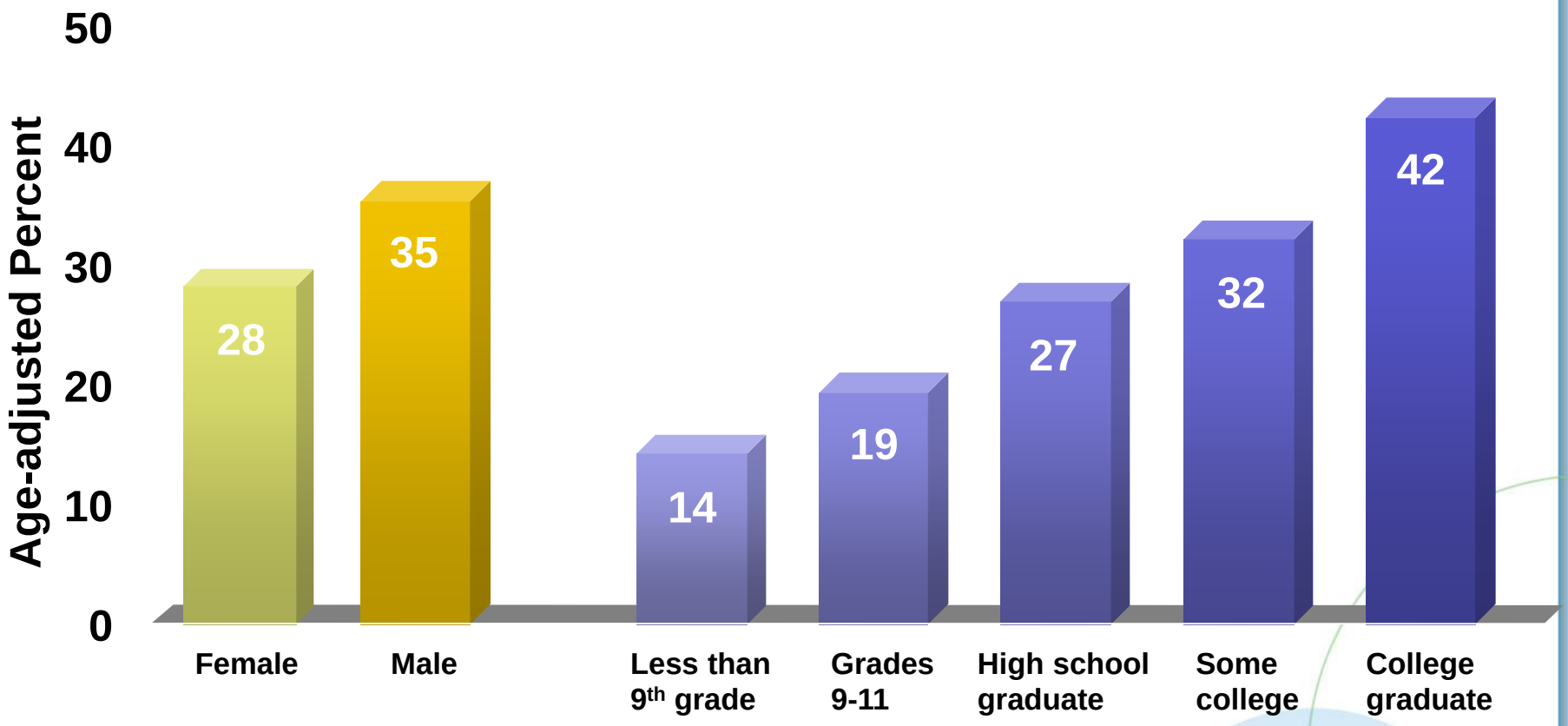


Source: Holistic Nursing: A Handbook for Practice By Barbara Montgomery Dossey, Lynn Keegan, Cathie E. Guzzetta, American Holistic Nursing Association

The Incentive Paradigm



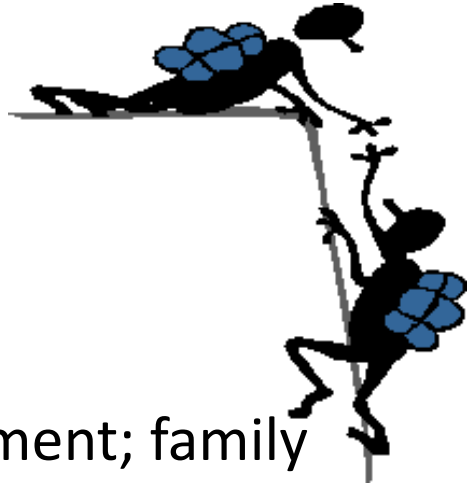
Percent of Adults Engaging in Physical Activity*



* Includes moderate activity (at least 30 minutes, 5 days per week) and/or vigorous activity (at least 20 minutes, 3 days per week).

Notes: Gender data are for persons 18 years and over. Education data are for persons 25 and over. Data are age adjusted to the 2000 standard population.Source: National Health Interview Survey (NHIS), CDC, NCHS. 2010

Wellness relationships

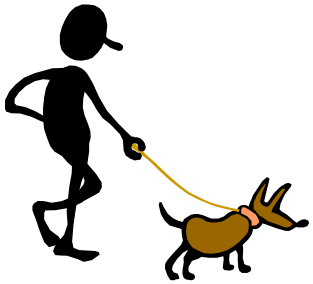


Extra-personal:

A. Relationship with physical environment

B. Relationship with interpersonal environment; family friends, communities, political order

C. Relationships with the transcendent



Source: A Biopsychosocial-Spiritual Model for the Care of Patients at the End of Life Daniel P. Sulmasy, OFM, MD, PhD The Gerontologist 42:24-33 (2002)

Wellness relationships

Intrapersonal:

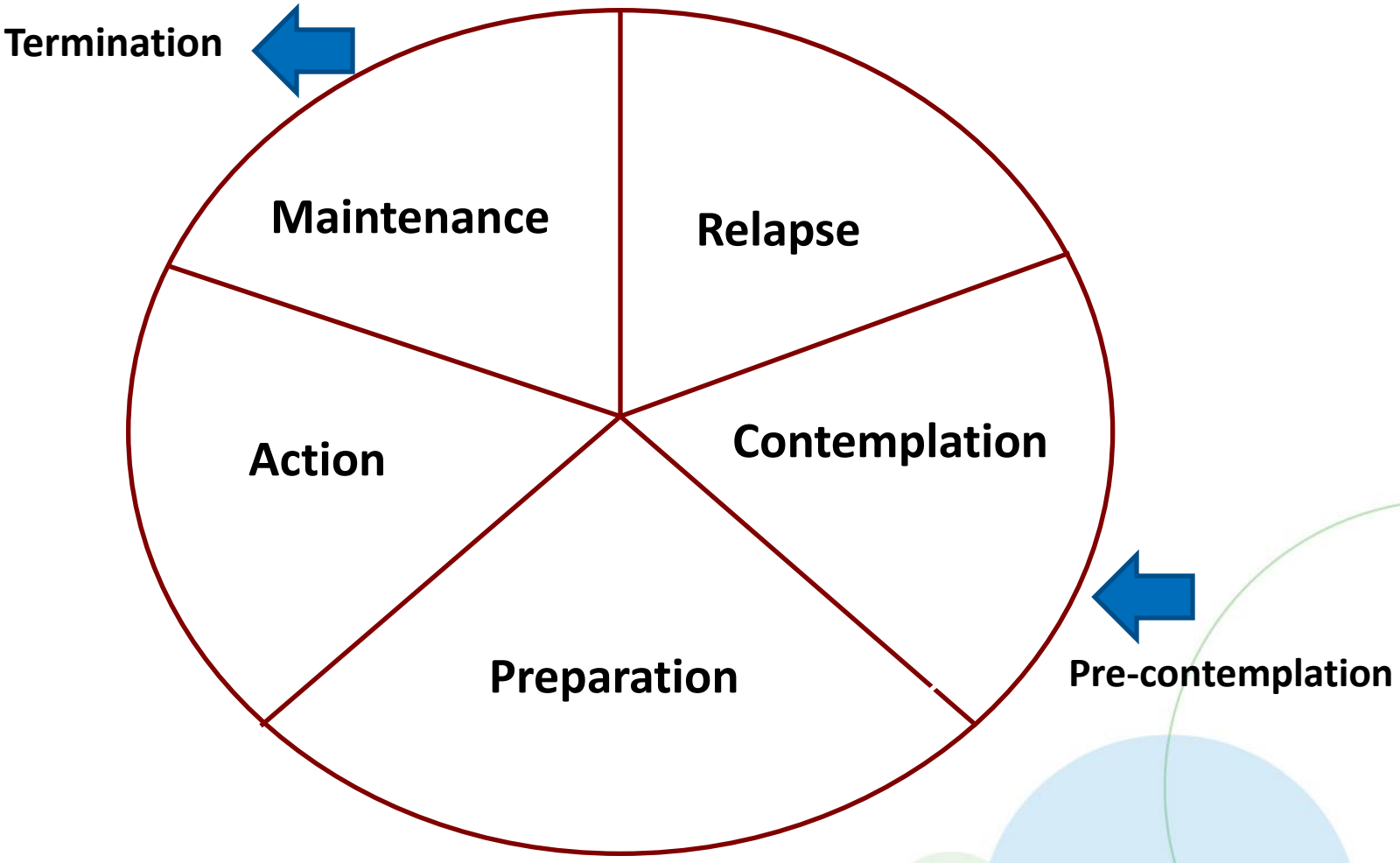
A. Physical relationships of body parts, organs, physiological and biochemical processes

B. Mind-body relationships – multiple relationships between symptoms, moods, cognitive understandings, meanings, and the person's physical state

Intrinsic Motivational Forces – more potent over time?

Source: A Biopsychosocial-Spiritual Model for the Care of Patients at the End of Life Daniel P. Sulmasy, OFM, MD, PhD The Gerontologist 42:24-33 (2002)

Stages of change cycle



Tools for Behavior change:

Precontemplation	→	**not considering change in the next 6 months**
Contemplation:	→	**seriously considering change in the next 6 months**
Preparation:	→	**planning to change in 30 days**
Action:	→	**the first 6 months of sustaining change**
Maintenance:	→	**Change for more than 6 months**
Relapse:	→	**transition to an earlier stage**

Targeted wellness incentives should consider individual SOC profiles

Sources : Prochaska, J.O., DiClemente, C.C. & Norcross, J.C. (1992). In search of how people change: Applications to addictive behaviors. American Psychologist, 47(9), 1102-1114. Prochaska, J.O., Velicer, W.F., Rossi, J.S., Goldstein, M.G., Marcus, B.H., Rakowski, W., Fiore, C., Harlow, L.L., Redding, C.A., Rosenbloom, D., & Rossi, S.R. (1994). Stages of change and decisional balance for twelve problem behaviors. Health Psychology, 13(1), 39-46.

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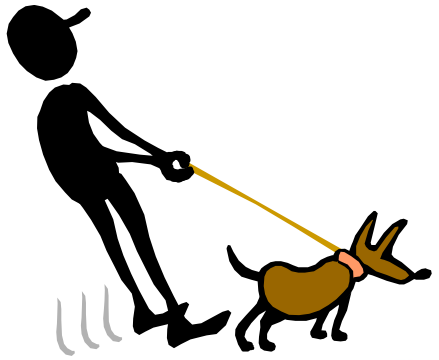
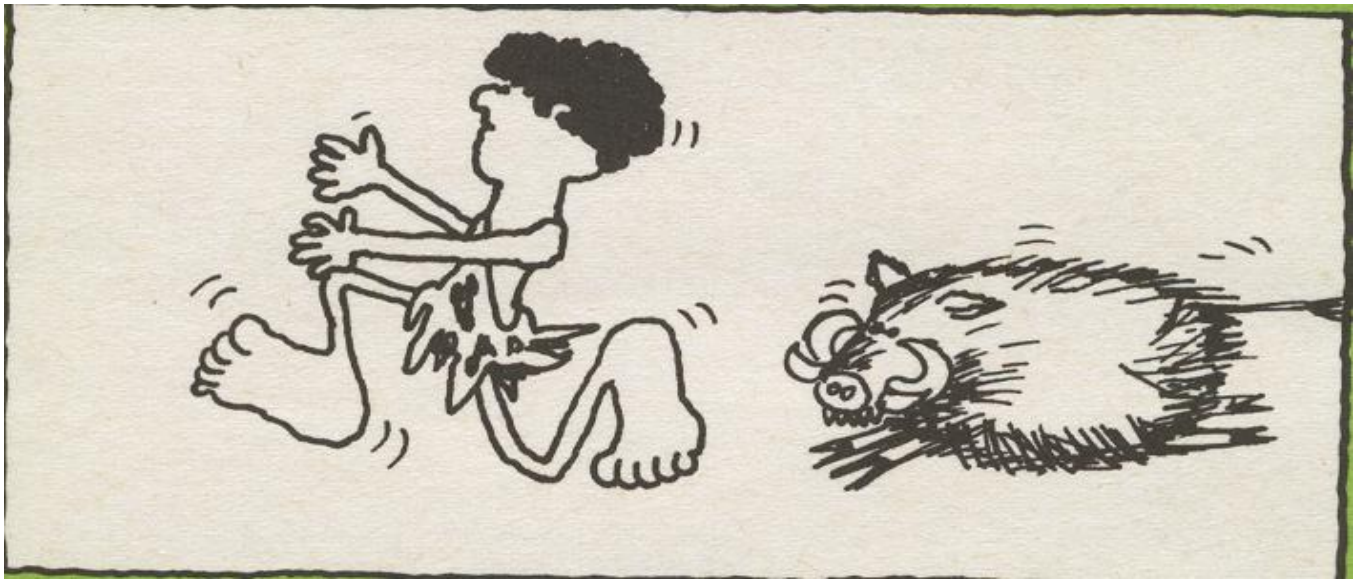
"Human behavior is a function of the consequences that follow it."

-Aubrey Daniels



Primal Motivation



Fight!, Flight! or Negotiation!

The Carrot or the Stick?

Carrot:

An anticipated positive or desirable reward designed to influence the performance of an individual of group

Stick:

An anticipated negative or undesirable consequence reward designed to influence performance of an individual of group

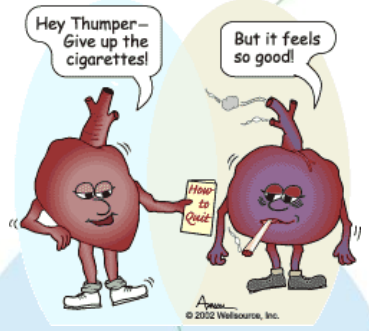
PIC's and NIC's

PIC = Positive ► Immediate ► Certain

- Motivate people to voluntary adopt health behaviors
- Can be of intrinsic and extrinsic value
- Most preferred method

NIC = Negative ► Immediate ► Certain

- Motivate people to voluntary leave behind unhealthy behaviors
- Last resort (e.g. Tobacco Cessation programs)



Source: Bringing out the best in People – Aubury Daniels

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"Wellness programs are something we do with and for employees not something we do to them"

David Hunnicutt, WELCOA,

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Incentives: How much is enough?

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"The greatest challenge to managing health care costs is employees' poor health habits and the biggest obstacle to changing employee behaviors is the lack of employee engagement."

2010 Employer Survey on Purchasing Value in Health Care Report, National Business Group on Health and Towers Watson.

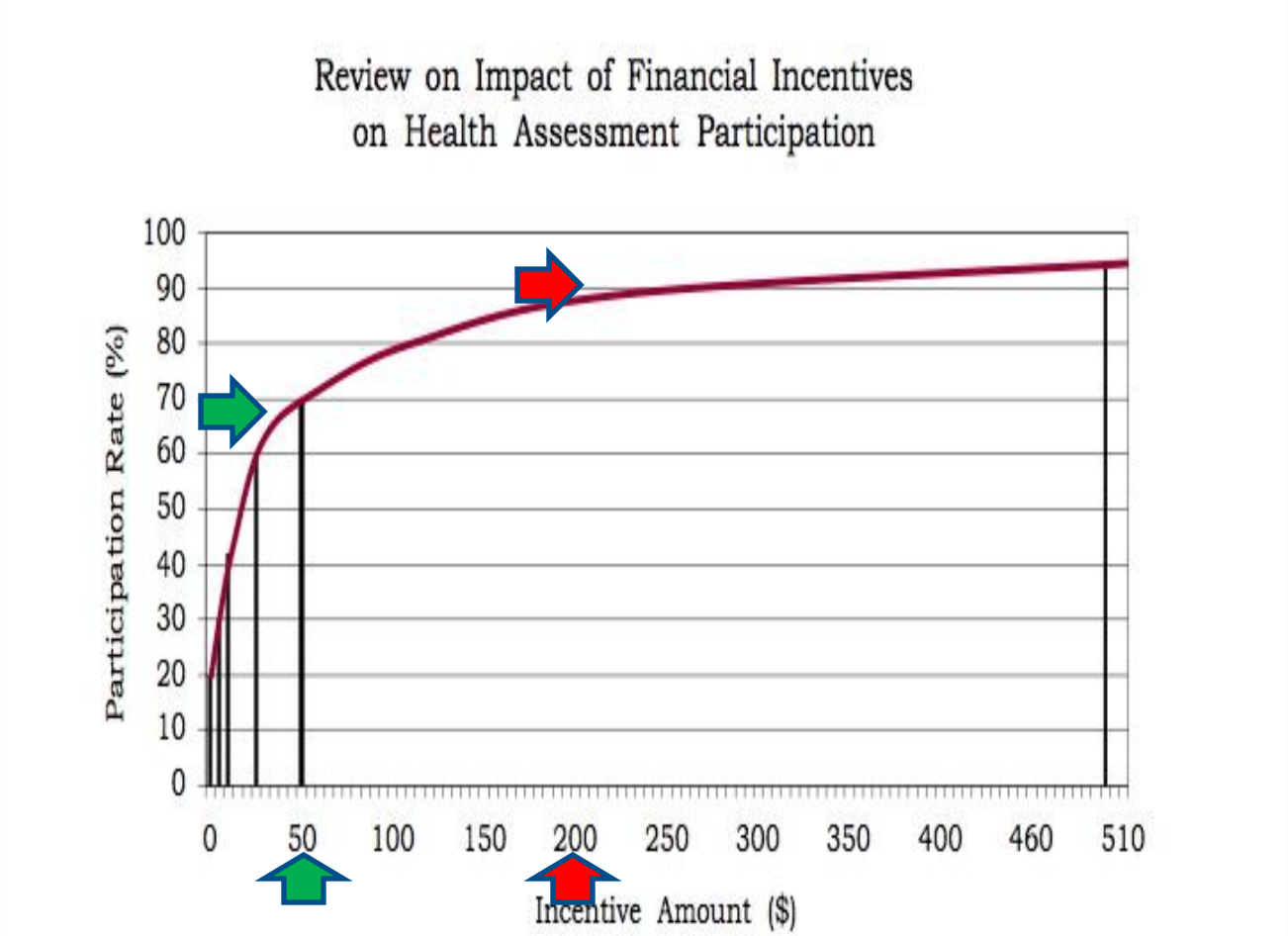
How Attitudes Affect Participation

Some will resist any new program offered to employees. Others wait and see how others fare before they try it.

Innovators	**2.5%**	**(yesterday)**
Early Adaptors	**13.%**	**(this week)**
Early Majority	**34%**	**(next week)**
Late Majority	**34%**	**(next month)**
The Laggards	**16%**	**(next year)**

Source: "Disseminating Innovations in Health Care," JAMA, April 16, 2003.

Health Risk Assessment: Incentives

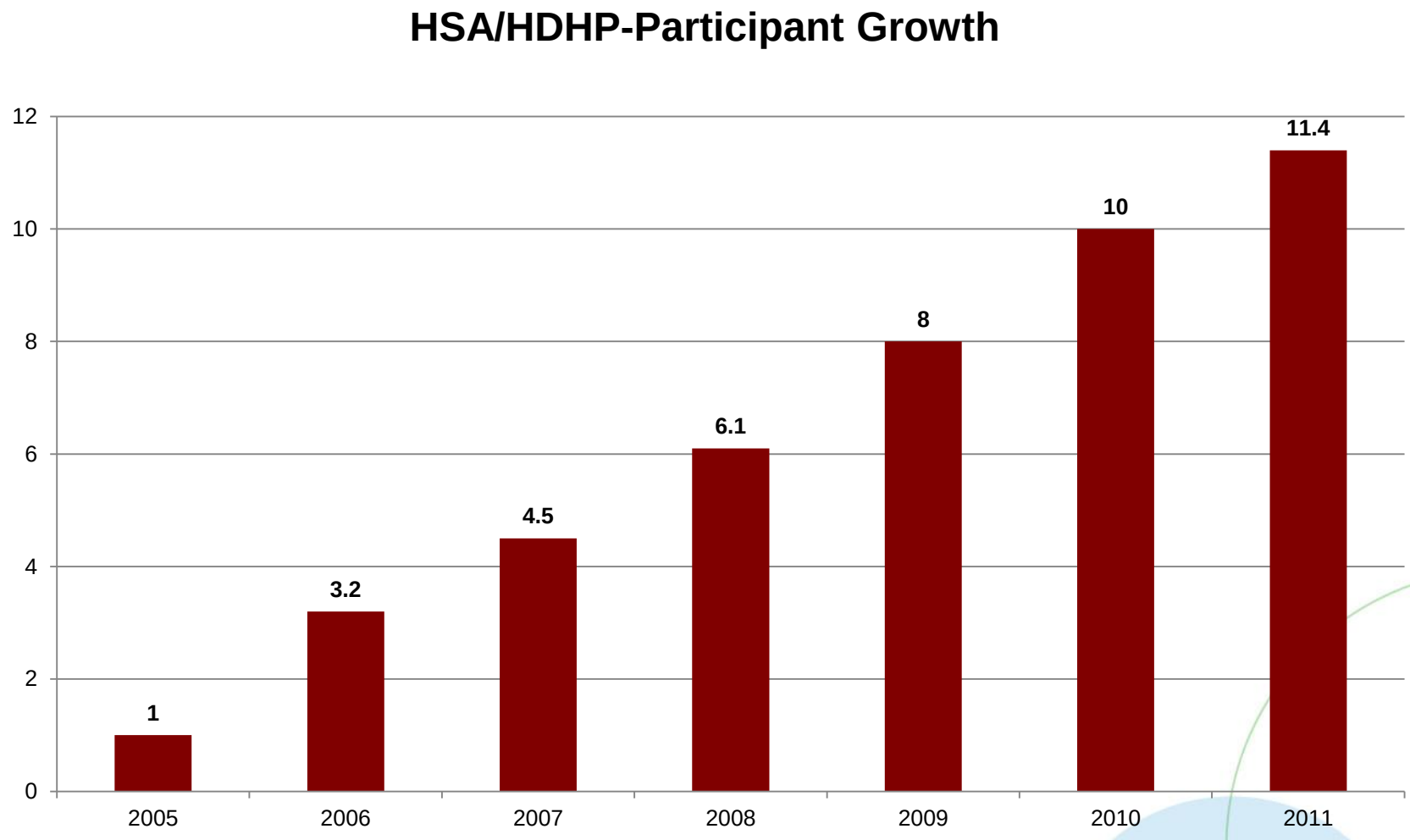


Source: Sexner, et al, The Art of Health Promotion Newsletter, 2004, March/April

Incentives and Participation Rates

Item:	**Range**
Trinkets and T-Shirts	10-15%
Merchandise	15-50%
$25-$50 cash	35-75%
Reduced Health Care Premiums	50-80%
Health Savings Accounts (HSA)	??

Health Savings Accounts Participation Rates



Sources: AHIP Center for Policy and Research, 2011 HSA/HDHP Census; US Census Bureau Current Population Survey (CPS), Annual Social and Economic (ASEC) Supplement 2010.

Legal Issues: HIPPA and Incentives (1996)

Health Insurance Portability and Accountability Act (HIPAA) - 1996 prohibits plans from pricing according to health status but allows premium discounts and other financial incentives for either "participation" or "standard" based incentives

Participation based Incentives
Examples:

- Complete a HRA, biometric screening, wellness coaching
- Waiver of co-pay or deductable for well-baby visits
- Reimbursement for gym membership
- Reimbursement for smoking cessation program despite outcome

HIPAA and Standard Based Incentives (2012)

Standard Based Incentives : Have to meet 5 additional requirements:

- Reward cannot be > than 20% of the cost of employee only coverage
- Plan must be “reasonably designed to promote health or prevent disease
- Gives employees the opportunity to qualify for the reward at 1 time/year
- Reward must be available to all employees and include a “reasonable alternative” standard where it is “medically inadvisable”
- The plan must disclose in it’s written materials the “reasonable alternative”

ADA, GINA and Incentives

Americans with Disabilities Act (ADA)

- Prohibits employers from discriminating against disabled individuals
- Limits the circumstances under which the employer can require a medical examination or responses to medical inquiries

Genetic Information Non-Discrimination Act (GINA)

- Limits the employers ability to ask employees questions about family history on risk assessments

PPACA and Incentives (2014)

Patient Protection and Affordable Care Act (PPACA)

- Significant changes to wellness program rules in areas of personal accountability and pricing!

- Expands wellness program exemption for incentives up to 30% of plan cost and could be expanded to 50% if approved by HHS, Sec of Labor and the Treasury

- Sec of Labor, HHS and the Treasury must submit a report within 3 years evaluating the effectiveness of wellness programs on:

    1. Promoting and preventing disease,
    2. Access to and the affordability of health care
    3. The impact of premium based cost-sharing (shifting!) incentives on health behavior

Incentives Axioms

- Healthy people are typically highly motivated individuals we need to focus on what motivates the less fit and more costly employees

- Keep it simple – complex reward and compliance systems will hinder program participation and outcomes

Incentives Programs that Work

- Focuses on helping employees achieve healthy behaviors day in and day out.
- All employees participate – no one is excluded, not even remote employees.
- Use of multiple “real time” technologies that are simple to use and engage the participant
- Onsite and remote kiosks and remote blood pressure monitoring devices,
- Accelerometers and HR monitors to measure physical activity levels throughout the day

Compliance vs. Commitment

If people are good only because they fear punishment and hope for a reward then we are a sorry lot in deed

-Albert Einstein

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Live Well and Thank you!

OU Physicians
HEALTH@WORK