Who's in Charge of Health?

Business and Health Institute : By Robert McCarthy

We just don't get it, we Americans. For decades we've been bombarded with warnings, dire pronouncements and unpleasant statistics, to wit: Too many of us are overweight, a sizeable proportion of us are even dangerously obese. We eat too much fat and not enough fruits and vegetables. Large numbers of us still haven't stopped smoking. Worse, large numbers are starting every day. And we don't get enough exercise. Hell, some of us have sprouted roots in the family room couch.

We've heard all the stories, studied the surveys, endured the chastisements of doctors and loved ones. Still, in our heart of hearts (the ones clogged by cholesterol) and deep in our guts (the ones that lollop over our belts) we just can't bring ourselves to BELIEVE. We just don't want responsibility for our own health.

Well it's time to see the light, my fellow Americans. We're older, fatter and less healthy than ever before. Health care costs are spiking up again, and managed care seems about out of solutions. If ever the time were ripe for wellness programs, this is it. And yet, and yet . . . say "wellness" to corporate HR departments and they reply: "We've tried it. Doesn't work." Mention the Big W to employees with health risks and you'll hear: "Boring! Sweaty! Rabbit food in the cafeteria!"

What is it with wellness? Maybe it has an image problem? Maybe a healthy lifestyle just comes across as too strenuous, too sterile, too all-or-nothing? Where's the fun in that? Yet wellness may be the only game in town.

"Interest [in wellness and in employees becoming more responsible for their own health] is greater than it has been in a long while," says Bruce Kelley, a consultant at Watson Wyatt WorldWide in Minneapolis. "Most employers we consult with are convinced managed care—at least as it has been practiced—has run out of gas. Employers are almost desperate for other solutions, and there aren't too many choices out there. Wellness/health management is known and available. So there is rapidly growing interest."

Other consultants concur. Camille Haltom, a Hewitt Associates health care consultant in Lincolnshire, Ill., points out that double-digit health care cost increases, a slower economy and legislation (such as new regulations on the nondiscrimination provisions of HIPAA) are driving employer interest in health promotion. "Employers are looking for creative and effective solutions, such as health promotion and medical management programs, that can provide cost savings, reduce absenteeism and increase productivity," Haltom says.

"But the fact remains wellness can be a tough sell to corporations that perceive wellness as fluff, or that think they've tried wellness and it hasn't worked," says Lew Holloway, executive director, Wellness Council of West Virginia in Charleston, an affiliate of Wellness Councils of America (WELCOA). "In point of fact, if these programs are not

planned and implemented correctly, the result will be fluff, and they will fail. But that's not the same thing as saying wellness doesn't work."

Two veterans in the field agree. David Hunnicutt, president of the Omaha-based WELCOA, the national nonprofit membership organization dedicated to promoting worksite wellness, and David Anderson, executive consultant at StayWell Health Management in Minneapolis, design and evaluate corporate wellness programs. Both contend that wellness can succeed, but not by accident or without investment. Wellness requires planning, research, carefully designed and targeted intervention and senior-executive-level support. Even then there are no guarantees.

"The sad reality is most corporations spend more on carpeting than they do on employee health," says Hunnicutt. "And it's far easier to get authorization to buy the carpeting."

"The biggest challenge is at the cultural level," Anderson adds. "If we had perfect control and were perfectly free to change the corporate culture and environment, we wouldn't need to do much in the way of individual motivation."

Individuals tend to be or to become products of their environment. If the environment supports wellness, fitness and health, individuals begin to adapt. Unfortunately, in large organizations, wellness mavens are rarely invited to dictate levels of management support for wellness, or corporate policies on smoking, exercise breaks or healthy options in the lunchroom. And so it comes back to motivating the individual.

FINDING THE RIGHT CARROT—OR STICK

But before we can even begin to motivate, we have to stratify, which means finding those individuals whose unhealthy lifestyle choices have already put them in jeopardy. Most wellness programs are designed for all comers. With that approach the only comers, too often, are already healthy.

"Lately, the thinking has been to target these programs," says Debra Gold, health care principal at William M. Mercer in Chicago. "First find the at-risk, using a health risk assessment (HRA) tool. Then, within that group, use Prochashka's Readiness to Change model to find out who's ready to make a change. (See "No overnight changes") Then design the intervention." She admits, though, "that still doesn't answer the motivation question, which can be a very, very hard question to answer."

Only a well-motivated smoker will be persuaded to stop puffing long enough for the behavior to become internalized. Without motivation, obese people won't be drawn into programs that will help them lose pounds and maintain a lower weight. Only through motivation will we come to grips with some of basic human frailties of procrastination, self-deception and backsliding.

Employers across the board are looking for plan designs that will encourage responsible health behavior, says Gold, and "you need all the carrots and sticks you can grab." Pocketbook pain, for example, might mitigate sweat aversion. One way is to reduce co-

pays and/or deductibles for employees who enter, say, a smoking cessation program. Get into a wellness program and get a financial reward.

"We've had discussions with employers who are saying, 'Well, we're going from a 90 percent benefit to an 80 percent benefit,' but they are also telling employees they can get back to 90 percent if...they complete the HRA, join a wellness program, reduce a risk factor," Gold says.

Still another idea is to apply the "pay for performance" concept to benefits. If someone improves health performance by, say, eliminating a risk factor, that person is compensated by a richer level of benefits or by some reduction in cost-sharing.

Defined contribution funding of employee health care—should it ever get past the pondering stage—also may help to motivate employee wellness. The fitter, healthier employees—that is, those with fewer risk factors—will undoubtedly do better in terms of lower premiums and enriched levels of benefits when they come to buy their own health insurance.

TRINKETS, PRAISE, CASH?

What kind of incentive works best? Trinkets, T-shirts, cash, paid personal holidays? "The answer is: It varies," says Stephanie Pronk, senior consultant at Watson Wyatt WorldWide in Minneapolis. "It varies from company to company, from corporate culture to corporate culture. Which means that when you are designing your incentive, it's very important that you understand what motivates your employees. Some people, in some companies, will do amazing things to win a T-shirt." But at another company that same T-shirt won't buy even a single sit-up.

Peer pressure can be an enormously powerful motivator, as can fear of consequences. Lew Holloway described the policy used by one of his wellness council members: "Should you have an offsite car accident and it's determined your injuries were worse because you failed to wear a seatbelt, you may see your deductible increase. That's one way to motivate healthy behavior. The other side of that is companies that will pay a bonus at the end of the year based on the degree of the employee's participation in wellness programs."

Another important wellness motivator is making sure each participant feels welcomed and that the programs are pertinent to his or her needs. Since the at-risk groups tend to be unfit and overweight, they shouldn't be herded into classes or groups that will make them feel embarrassed or self-conscious. "Today's more successful wellness programs have a softer approach—nonpunitive, nonembarrassing and nonjudgmental," says Haltom. "The idea is to help you do what you can do, and then help you to do a little more and then a little more."

Some see the secret to promoting wellness and responsibility in personal invitations to individually designed programs featuring one-on-one coaching. "We've been at it 14 years," says John Harris, principal of Harris Health Trends in Toledo, "and we've found

that people try harder and do better when they're 'playing' for a coach. You don't want to let your coach down."

Harris supplies individual health management to corporate clients. It's a one-on-one approach to behavior change, beginning with a personal solicitation to an at-risk employee first by letter and then by telephone. Harris claims his enrollment rate is 93 percent. Each participating employee is assigned a coach—a nurse, dietitian, exercise physiologist or other health care professional. With lots of phone contact over the course of weeks or months, the coaches function as personal trainers, mentors and enablers. In short, they become guides, philosophers and friends to individuals trying to make a difficult behavioral change.

The calls are scheduled, but their number and frequency may vary. For example, a participant in the early stages of smoking cessation may need more frequent phone support than someone planning to lose 30 pounds over the next 12 months. Calls may also be increased or decreased based on, say, the individual's personal support structure: Those living alone will get more calls than those living with families. The program lasts for one year.

"During the calls, the coaches assess the participant's progress, offer advice and encouragement, and perhaps even, with the participant's consent, make referrals to an EAP program or a disease management program," says Harris. Results are assessed not only by self-report ("I've reduced my cigarette consumption."), but also by health screenings and by claims data analysis.

The fact that the Harris program takes one year to complete is telling: The best wellness efforts don't abandon participants after a short burst of structured effort. Relapses are notoriously associated with wellness programs. Too often, the employee begins to revert to type as soon as the phone calls, classes and group activities end.

"Backsliding, yeah, it's a problem," says David Anderson. "That's why the best programs are usually those of some duration, like a year. By that time the participant usually has developed a fairly close—even very close—relationship with his health educator. And we have a toll-free phone number. Participants and former participants can call back anytime to speak to that educator. For instance, if they are having relapse problems. That's a very important thing. Preventing relapse. We're getting much better about working on what we might call the maintenance end of things, but that is still an area where many wellness programs remain weak—lack of long-term follow-up and monitoring."

Dropping out is also a problem. Wellness programs that achieve strong and continuous participation tend to use lots of reinforcement options. An individual component, perhaps something on line, will be complemented by a group component, maybe a fitness class onsite, or "lunch and learn" seminars. "To those you might add a walking group at the worksite and perhaps even community-based components such as health club discounts or fun runs sponsored by the company," Pronk suggests. "All these reinforcements help

people do a better job of sustaining behavior change."

WELLNESS EXAMPLES

Which wellness incentives work best in practice? Though trinkets and T-shirts have been tried, cash, both actual and virtual, seems to work best.

Employees and spouses fully participating in Quaker Oats' Live Well Be Well program can earn up to $600 in cash, which is deposited in the employee's flexible benefits account. Participants earn $150 for completing the HRA; $50 for taking part in the free, on-site health screenings (cholesterol; height/weight; BP; coronary risk profile) and $50 apiece for pledging to avoid tobacco, refrain from abusing or misusing alcohol or drugs and promising to exercise a minimum of 20 minutes three times a week.

Does it work? Participation levels are consistently above 80 percent and, says Joan Cantwell, manager of welfare and wellness programs: "If you look at health risk-change data and extrapolate savings from the numbers of high-risk employees moving into lower-risk categories, we are saving approximately $2 million per year in health expenses we otherwise would have incurred."

The Nebraska Health System, an Omaha-based hospital and medical center, uses "WellBucks" to encourage employees toward healthy choices and goals. By performing approved activities—exercise, healthy eating, prevention (regular physician visits), screenings, flu shots, blood pressure checks—employees accumulate WellBucks, which they can use to "buy" a number of things.

"Two hundred WellBucks buys you two passes to the zoo or the movies," explains Mike Wanheka, health promotion manager. "Twelve hundred WellBucks gets you a $20 gift certificate to a mall. And for 1,500 WellBucks, you can buy a paid day off. We've been doing this for about 10 years now, and our current participation level is 3,000 out of 4,000 employees. They're all earning some WellBucks, even though not all of them can afford a paid holiday. But I'll tell you, some people are rolling in WellBucks. They could afford to take a paid month."

Providence Everett Medical Center's Wellness Challenge pays eligible employees up to $375 in cash if they can meet four of six wellness criteria. These criteria include healthy eating (the five-a-day fruits and vegetables challenge), exercise (12 days per month, accumulating at least 30 minutes per day of some form of exercise or physical activity) and having no work loss due to pain or injury incurred on the job during the year.

"For each year of success the bonus goes up," says Ron Burt, manager of prevention services for the Everett, Wash., hospital system. "And this is cash-in-hand money. Employees can use it for anything they want. We've considered using various kinds of merchandise, etc., but the bottom line is the bottom line. Employees prefer the cash and that keeps participation high."

How high? Providence's 10-year-old Wellness Challenge averages a 65 percent

participation rate. There's payback, too, not only in healthier and more motivated employees and senior staff—55 percent of whom participate—but also in a 10-year return-on-investment of about $3.50 to the dollar. There are estimated 10 year health care cost savings exceeding $2 million, "which is absolutely wonderful," says Burt, "though I think that because of the commitment of our upper management, they would be happy if we'd done nothing more than broken even."

SIDEBAR

NO OVERNIGHT CHANGES

When it comes to engineering individual behavioral change, there are five steps in the continuum. Using smoking cessation as an example, they are:

- People in the precontemplation phase have never thought about quitting smoking.
- Those in the contemplation phase have at least thought about it.
- They make a commitment in the preparation phase.
- In the active phase, they are trying to quit or have tried to quit before but not succeeded.
- When they have quit and have stuck with it, they're in the maintenance phase.

DYING OFF THE FAT OF THE LAND

Americans are suffering from epidemics of diabetes and obesity, and during the previous decade we have done little to improve our eating habits or increase levels of physical activity, the Centers for Disease Control (CDC) announced in September of 2001.

Using data from the Behavioral Risk Factor Surveillance System, the CDC found increases in diabetes and obesity in all demographic and geographic segments of the population. More than 60 percent of Americans are overweight or obese. Fifteen million Americans over the age of 18 were diagnosed with diabetes in 2000, and 800,000 new cases are diagnosed every year.

Speaking to the Washington Business Group on Health then Surgeon General David Satcher, M.D., personalized the danger: "Type 2 diabetes, which used to be called 'adult onset diabetes,' was unheard of in people under age 30 when I was a physician in training. Today, we are seeing it in children as young as 10 years of age."

In December 2001, Satcher weighed in with his own report, "The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity." Satcher noted that "overweight and obesity may soon cause as much preventable disease and death as cigarette smoking. . . . Approximately 300,000 U.S. deaths a year currently are associated with being obese or overweight, and total direct and indirect costs attributable to these conditions amounted to $117 billion in 2000."

Obesity is, of course, a major risk factor for more than diabetes. It increases the odds for heart disease, strokes, colon cancer, breast cancer and asthma in children. That prompts former CDC Director Jeffrey P. Koplan, M.D., to warn: "If we continue on this course for the next decade, the public health implications in terms of both disease and health care costs will be staggering."

"These reports indicate that for the first time in decades the overall health of Americans is in decline," says Stephanie Pronk, senior consultant at Watson Wyatt Worldwide in Minneapolis. "At least in the past," she adds, "health care cost increases were buying improvements in overall health. Now, costs are going up but, due to poor health habits and the aging of the population, we've seen a decline in overall health status. That's of real concern to our corporate clients, and it should be a strong motivator to get them to do something to help employees become healthier, stay healthy longer."

Unfortunately, there is no sign that the upcoming generation will be any healthier. Indeed, they may be significantly worse off. Satcher has pointed out that many schools do not require physical education for grades K through 12. Further, he notes: "In a 1991 CDC survey of high school students, 43 percent said they were taking courses in physical education on a regular basis. By 1997, that figure was down to 25 percent. And, of course, many schools now contract with vendors, making available on school property very high calorie, high fat, high salt, high-sweet foods, so children are not supported in developing good habits of physical activity and good nutrition."

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