Incentives can Increase Participation in Worksite Health Promotion Programs, but at What Point are they Most Cost-Effective?

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I. Introduction and Background
   a. Recent industry surveys of financial incentive use
      i. Vast majority, ~85-90%, of employers are offering some type of financial incentive for worksite health promotion (WHP) programs
      ii. Incentives are being used more often and are being offered for more WHP program components
      iii. Requirements to earn financial incentives are becoming tougher, e.g. completing multiple program components vs. completing only one program component
      iv. The most common components for which financial incentives are offered are health risk assessments (HRAs) and biometric screenings
      v. Surveys suggest these trends will continue, with outcomes-based financial incentives becoming more common
   b. What we know about financial incentives, behavioral psychology
      i. Incentives increase compliance with simple behaviors
      ii. Complex behaviors, like long-term health behavior change, respond better to intrinsic motivation rather than extrinsic motivation
      iii. This is consistent with study findings on the relationship between financial incentives and WHP participation

II. Relationship between financial incentives and health risk assessment completion (Anderson, Grossmeier, Seaverson, & Snyder, 2008)
   a. Intent of the study
      i. Is the value of a financial incentive associated with HRA participation rates?
      ii. Is the type of financial incentive associated with HRA participation rates?
   b. Results
      i. Higher financial incentive values were associated with higher HRA participation rates, but this relationship was not a simple linear relationship
      ii. Financial incentives tied to benefits were associated with higher HRA participation rates, but were also generally higher in dollar value
      iii. Significant variability in the data suggested that other factors were contributing to HRA participation rates in some cases
   c. Implications
      i. In an effort to gather more health-related data and plan WHP programs effectively, it may be worthwhile to offer a benefits-integrated financial incentive for HRA completion
ii. These findings were consistent with other studies that support the concept that financial incentives may increase compliance with simple behaviors (Taitel, Haufle, Heck, Loepke, & Fetterolf, 2008; Wilhide, Hayes, & Farah, 2008)

iii. Benefits-integrated financial incentives have advantages over cash incentives, specifically that they can be offered at a larger perceived dollar value

III. Relationships between financial incentives, culture, communications, and health risk assessment completion (Seaverson, Grossmeier, Miller, & Anderson, 2009)

a. Intent of the study
   i. How do communication strategies and company culture influence the relationship between financial incentive dollar value and HRA participation?

b. Results
   i. Financial incentive value was associated with HRA participation, independent of the effects of other factors studied (communications and culture, primarily)
   ii. Stronger communication strategy and stronger culture of health were both positively related to HRA participation rates
   iii. True success of a financial incentive strategy appeared to be driven by cultural initiatives and communication, not just the incentive itself

c. Implications
   i. Results were consistent with other studies published around the same time (Taitel, Haufle, Heck, Loepke, & Fetterolf, 2008; Wilhide, Hayes, & Farah, 2008)
   ii. Practitioners need to be thoughtful about the incentives they use, the environment in which those incentives are applied, and how they communicate to potential participants

IV. Influence of worksite and employee variables on employee engagement in telephonic health coaching programs (Grossmeier, 2010)

a. Intent of the study
   i. Is there an association between financial incentives and the likelihood of an individual participating in a health coaching program?
   ii. How is such an association influenced by worksite factors (such as organizational support)?
   iii. How is such an association influenced by personal factors (such as age)?

b. Results
   i. Participants with more health risks were more likely to participate in coaching
   ii. Financial incentives were more strongly associated with enrollment, less strongly associated with active participation
   iii. Women and older individuals were more likely to enroll in health coaching
   iv. Communications were important for all levels of participation

c. Implications
   i. Achieving high levels of participation in health coaching may require a strong communication strategy
   ii. Differences between genders with regard to predictors of health coaching participation indicate a need for targeted communication strategies
iii. Worksite environmental factors are important in driving participation in health coaching programs
iv. Personal factors, such as age and current tobacco use, also play a large role in coaching participation

V. Relationship between financial incentives and health behavior change program participation and risk improvement (Gingerich, Anderson, & Koland, in press)
   a. Intent of the study
      i. Are financial incentives for health behavior change programs associated with program participation rates and subsequent risk change?
   b. Results
      i. Financial incentives offered for health behavior change program completion were associated with higher completion rates
      ii. Clients with financial incentives experienced slightly less risk improvement than clients without financial incentives
   c. Implications
      i. Financial incentives for coaching programs may not be cost-effective if the goal of the WHP program is risk improvement
      ii. If incentives are your only engagement strategy, improved risk reduction over the long-term is not a fair expectation

VI. Emerging trends
   a. Outcomes-based incentives
      i. Definition—A reward or penalty applied to an individual on the basis of meeting or not meeting a specific health-related measurement
      ii. Common outcomes include BMI, cholesterol, blood pressure, and tobacco use
      iii. When designing outcomes-based incentives, practitioners must consider current legislation and other legal concerns
      iv. Current research is inconclusive as to the long-term effectiveness of these strategies
   b. Progress-based incentives
      i. Reward individuals based on progress toward healthy outcomes. Also reward individuals who currently meet health outcome standards
      ii. Intended to be a middle ground approach between participation-based and outcomes-based incentive strategies
   c. Behavioral economics
      i. Use of social, cognitive, and emotional factors to understand individual economic decisions, but can also be applied to health-related decisions
      ii. “Making the healthy decision the easy decision”
      iii. Has been profiled in popular literature; “Predictably Irrational” (Ariely, 2008) “Drive” (Pink, 2009) “Nudge” (Thaler & Sunstein, 2009) and others
      iv. Much WHP-related research has been focused on the use of financial incentives for behavior change, specifically tobacco cessation and weight management (Cahill & Perera, 2008; Finkelstein, Linnan, Tate, & Birken, 2007; Kim, Kamyab, Zhu, & Volpp, 2011; Volpp et al., 2008; Volpp et al., 2009)
References


