

New Developments and Enhancements in Health Risk Assessments

ANNOUNCER: Hello. Welcome to HealthSounds, conversations with healthcare innovators. Brought to you by the Healthcare Intelligence Network.

PATRICIA DONOVAN: This is Patricia Donovan for the Healthcare Intelligence Network. Today I'm speaking with two experts in health risk assessments from Stanford University. Dr. Wes Alles, director of Stanford's Prevention Research Center, and Dr. Yann Meunier, health improvement manager for Stanford's School of Medicine Health Improvement Program. They are both presenters at HIN's webinar on "New Developments and Enhancements in Health Risk Assessments."

First of all welcome to both of you and thank you for joining me. To begin with, how much interaction occurs between your Stanford centers, for example Dr. Meunier, how does the population health research done at the Prevention Research Center influence employee HRA's and health education programs where you are?

DR. YANN MEUNIER, HEALTH IMPROVEMENT MANAGER AT STANFORD SCHOOL OF MEDICINE HEALTH IMPROVEMENT PROGRAM: Well our health risk assessment is called SHALA, which is Stanford Health Assessment and Lifestyle Assessment. It's based in science and it comes from the Stanford Prevention Research Center's research. Two of the people who designed the SHALA, Dr. Wes Alles, and he can tell you more about his background in public health and his whole population health research, and also Dr. Jack Farquhar, who did population studies, projects that were called Three

Community and Five City Projects in Silicon Valley. So those were the people who designed the health risk assessment. And also in terms of research, the reference that we used when we analyze the SHALA aggregate data, were the U.S. National Baseline and also the Healthy People 2010 targets.

PATRICIA DONOVAN: Okay, thank you very much Dr. Meunier. Dr. Alles, would you like to add anything to that about the interaction between the two centers?

DR. WES ALLES, DIRECTOR OF THE STANFORD UNIVERSITY PREVENTION RESEARCH CENTER: No, I think Yann was fine on that.

PATRICIA DONOVAN: Okay great. My next question is, Stanford's Health Improvement Program offers a general 60 question health and lifestyle assessment, several disease specific risk assessments and then a behavior change assessment. My question is why is the behavior change assessment broken out separately and how should an employer handle an extremely change-resistant worker that might be identified by the behavior change assessment?

DR. WES ALLES: Those are good questions Patricia. Thank you. First of all the SHALA, the Stanford Health and Lifestyle Assessment, currently includes what we call motivational assets, or many health educators might refer to it as elements of readiness for change. And initially we had those developed separate so that it was a briefer health risk appraisal. And then we did the readiness for change separate because not everybody wanted to enter into a health promotion program that would focus on behavior change. Ultimately, we decided that we'd still keep the option of just offering the behavior change

assessment. But we feel that our goal is to encourage people to start on a journey towards health promotion using a wellness action plan and we need information about their sense of self-efficacy, outcome expectancy, health value, and whether they have an intrinsic or extrinsic motivation for health. A sense about their motivation and commitment levels that one might collectively call readiness for change. And so within our SHALA, we include these measures because there's never been a study to demonstrate that simply taking an HRA by itself will produce long-term behavior in a population. But when you apply behavioral science to the risk factor questions that have been asked and then you can apply that behavioral science through your knowledge of their motivational assets or lack thereof, then you can help them design a plan that they can either work on by themselves, with another person, a support team or within a behavior modification group, which we've demonstrated to be effective and it can change behaviors, even when offered by a community group as opposed to being done on a university campus. So we're confident that with appropriate behavioral science applied through our curriculum in any case, for folks who want to make a change that can be done in community organizations, whether it's work side health promotion or a community based organization like the YMCA's for instance.

So the issue about what do you do about resistant employees, my response is that you take them where they are. Within any public health behavior or population based strategy that you want to implement, there will be early adopters. There will be folks who need to be convinced a little bit by seeing other people and the results it has for them. And then there will be folks who are, what you might call, slow adopters. These are the folks I would say characterize what you call the resistant

individual and I wouldn't start with them. I would start first of all by taking the low hanging fruit – those people who are the early adopters – and work with them; use them as communication vessels and begin to change the culture within an organization. And that culture could be workplace, it could be a faith-based group, it could be a neighborhood or a community group. And for people then who are resistant or slow adopters, I would take them step at a time to move them toward readiness. What I mean by that is by simply taking the health risk appraisal and getting the output report, which is very detailed, it's about a 15-18 page output report depending on the responses and they get some health education. It sensitizes them to important concepts and constructs, and from there then they are able to move a little bit along the readiness. Maybe it will encourage them to find some Web sites and find out more information. Maybe it will encourage them to talk with other people and maybe they'll attend a wellness program. It's just a commitment for a half-hour or an hour. But you work with them. You take them where they are and you move them along. The real focus is not to bombard them with information because information by itself doesn't lead to behavior change ordinarily. What we need to do is move them along this readiness continuum. And at some point in time they'll be less resistant. At some point in time they'll be neutral. At some point in time they'll be open. And at some point in time they will be ready to make a commitment to participate in their own personal wellness journey.

PATRICIA DONOVAN: Okay thank you Dr. Alles. Dr. Meunier do you have anything to add to that in your work with Stanford employees? Any success stories or examples of how the theory is applied?

DR. YANN MEUNIER: I would like to add something about the second part of the question that you gave me about the health education plans and the impact of the research on those plans. Just like the HRA, the Stanford Health Education programs are also science-based. And we have a special program, which is called a behavior change program, which was created by Deborah Balfanz who has a Ph.D. in social psychology from Princeton. She developed this program based on prior research and one was from Professor John Farquhar, which I mentioned earlier, and is called the Stanford Six-Step Method for Behavior Change. There was also the health improvement program, at Stanford, which had a change program that was created and called a MAP. And also there's another researcher at Stanford, Jane Ronstein who is a licensed psychotherapist who worked on goal setting, and the combination of all these researches resulted in a specific health program for behavior change.

PATRICIA DONOVAN: Thank you very much for that. So just getting back to the Stanford population, does Stanford incent its own employees to take its HRA?

DR. WES ALLES: Yes it does. This is recent and began this year. Employees who take the HRA receive \$150 in taxable income. The next step is that once they've taken the health risk appraisal they can, and we encourage them to, attend an interpretation session, the goal of which is to bring the information to life to help them synthesize the information and make sense of it for themselves. "What does all of this mean – not to the population or to anybody in general but to me, specifically?" And during that meeting we then invite them to participate in a two-session personal training, which is free. And to participate in a health

and fitness assessment, which is also free. And then we encourage them to bring all that information with them to a wellness coach. Obviously, they are able to share whatever they want or they don't want to share. But in the best case they would bring this information with them and then together with a wellness coach they would create a personal wellness plan. And we have a tool to help them characterize and conceptualize a plan that they go over with the wellness coach. All of the wellness coaches are very experienced people with graduate degrees in health education, exercise physiology, nutrition or a related field. And individuals who attend the interpretation session can then take any of the physical activity classes that we offer for a reduced fee of only \$20 per class per quarter. So we may offer some sort of cardio class that meets three times a week for an hour and they would only have to pay \$20 for the entire quarter. If they don't attend the interpretation session then they would have to pay the full price. So it's another incentive. It's another way of encouraging people to participate in our programs beyond just taking the HRA. And earlier I mentioned that there's never been a study that shows the HRA by itself makes a difference and sustainable behavior change. But there are plenty of studies that show that when you apply targeted programs to individuals based on their needs, they do make change and it is sustainable.

PATRICIA DONOVAN: Thank you Dr. Alles. It sounds like you have many incentives built in and I would imagine another incentive is that you have the programs on site or nearby for employees.

DR. WES ALLES: Yes and it's kind of interesting. At least one manager said something to the employee about "well you know you can't really take time off from work to attend this program."

Most people have flex time, at least here on campus. So that employee sent us an email and said "so what am I supposed to do?" Our champion, our biggest champion, for the work that we do is the provost. The provost is kind of a chief operating officer of the university and he sent an email to all managers. He didn't say I want you to give the time to these people to do this, but he said I think wellness is important. I think it's important to the individual. It's important to productivity, it's important to the university and it's important to me. And I allow my employees to take the time to go to the interpretation session. So if you have a champion at a high level, it does make a difference. And of course there are other matters that also intervene and that's union contracts for instance, that makes it a little bit more difficult, but it doesn't make it impossible. It just says you need to be creative about how you deliver interpretation programs to a population that may only get a half-hour for lunch and who tends to live further away from the university, so their commutes are further, and that makes their days longer, and they don't really want to come earlier or stay late. And we have had many people be given the time off their union employees, but they're given the time off because the university does consider this an important benefit to the university as well as to the individual.

PATRICIA DONOVAN: Well thank you. And maybe Dr. Meunier that leads into my next question as I wrote you, I noticed that you do teach several of the classes in the health improvement program. Dr. Alles kind of talked about how the classes are tied to HRA results, but maybe you could talk a little bit about how receptive employees are to these in attendance and how maybe you address the challenges of a workforce that does live further away, maybe in terms of scheduling or availability?

DR. YANN MEUNIER: Well there are two different things here. There's the classes, which are the HIP classes, about different health conditions or health improvement matters. And also the different programs that can derive from the HRA about losing weight, about controlling your blood pressure, managing your diabetes and so on. So those are two different entities. The classes themselves, the employees register voluntarily, but there is a financial incentive with the staff training incentive program and the classes that we are offering derive in part from the HRA result, the aggregate data. Also, they derive from the feedback that we get from the employees when they take the HRA's and we also have different sources of information besides the HRA. For example, we have from the Stanford University Health Welfare Benefit Plan, we can get the list of the 10 prescription drugs that were most prescribed by the doctors, so we have then a better idea of what are the main health issues of the Stanford community.

PATRICIA DONOVAN: I see, so you're looking at aggregate data, claims data and pharma data to help shape your programs in addition to the HRA. Thank you. And finally, we just had a conference on the importance of getting primary care physicians involved in health promotion and in health coaching per say and we have a lot of the methodology that you talked about, and Dr. Alles was mentioned in that program. In both of your opinions, do you think that this data, an employees primary care physician or their medical home, should receive their HRA results and should the employee be part of this decision? How should this be handled?

DR. WES ALLES: Absolutely. I think that people look to their primary care physician as a source of support and advice. I can say that most primary care physicians will respond favorable and enthusiastically to information that's given to them from an HRA, particularly if there is a kind of summary report that the physician receives. It may be a summary of the key elements; they can scan down very quickly, get a sense of the individual at risk and provide encouragement to the individual. Now most physicians, whether they're independent community based physicians or they're part of a large medical group, they're not going to do, what you might call, disease management for the individual. But if they're part of a large group they can refer to the health education department within that large group. If it's a multi-specialty practice, they typically have a health education program and they can also refer to the worksite, they can make recommendations to the individual about important classes that they should look for or they could refer them to the community. And there are many organizations and communities that offer specific programs, like heart disease prevention or heart disease management, arthritis management, cancer management, those kinds of things. And there are many organizations, I mentioned before the YMCA, there are 3,000 communities around the country that have YMCA's and they are offering a whole variety of health promotion programs with capable staff. I would see the actual role of delivering the education coming from not the primary care physician, but with the primary care physician's encouragement to the individual. They are more likely to commit and as they have subsequent visits with the physician, the physician will probably remember and say, "how are you doing?" "How is this aspect of your life change coming along?" And I think it's very important. Primary

care physicians are extremely important in the lives of individuals.

PATRICIA DONOVAN: Well thank you Dr. Alles. Dr. Meunier do you have anything to add to that?

DR. YANN MEUNIER: I would say that the physician has a key role to play. He can be an amplifier of the message that was given by the result of the HRA and he can also be an implementer of a track or a path to his recovery or prevention. And I think there's room here for increased cooperation between physicians and the people who give the HRA.

PATRICIA DONOVAN: Well thank you both very much. Those are all the questions I wanted to cover today. Thanks to you both for speaking with me, and we are looking forward to hearing more from you both during the webinar. This is Patricia Donovan for the Healthcare Intelligence Network.

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