Innovation at Charter Health

It was January 2017 and Elizabeth Quinby was preparing to lead her team’s first meeting following two weeks of field research on behalf of Charter Health (Charter), a for-profit, integrated health insurer/healthcare provider. Quinby was a partner at Hamilton Strategic Design (HSD), an innovation strategy and design consultancy that worked with clients in the health and consumer products sectors to develop and bring to market comprehensive digital and service experiences.

Caroline Hodgman, Charter’s Vice President of Member Engagement, had hired Quinby’s team to help her better understand Charter’s member base. This deep understanding would allow her to create opportunities for Charter to more effectively engage their members in their own health and well-being. Quinby and her multi-disciplinary team were now tasked with making sense of the data it had collected via various qualitative and quantitative methods so they could make recommendations.

Doubling down on prevention

Charter Health had operated in the mid-Atlantic for nearly 20 years and was recognized as an innovator in the notoriously risk-averse and highly-regulated insurance industry. It had grown from a small experiment in community-based insurance and care into a regional player. After passage of the Affordable Care Act (ACA) in 2010, Charter focused on growth, acquiring new members and expanding its provider network. Charter was now shifting its focus to achieving savings through operational excellence and increasing the overall well-being of its member base.

In its position as both payer and care provider for a large and diverse network of members, prevention had always been a natural strategic objective for Charter. However, in response to the ACA’s requirements for coverage of preventative services, Charter modified its insurance plans to eliminate co-pays for most screenings, increase reimbursements for clinicians who engaged in prevention-related coaching, and promoted adoption of a preventative mindset among both patients and providers. In the six years since, Charter had registered a significant increase in preventative screenings and treatments across its entire clinical practice.

Focusing on well-being

Charter positioned the insurance change as part of a larger effort to expand the conversation about health and to shift members’ associations of health insurance from “sickness” to “well-being.” While most people associated health with physical well-being, Charter emphasized members’ overall...
well-being. Charter’s leadership believed that by shifting members’ focus to well-being it could increase the overall health of its insured population and decrease the resources spent each year on delivering care (e.g. fewer office visits, fewer drug prescriptions, tests, etc.).

The company used the Gallup-Healthways’ Well-Being Index (WBI) as a framework for defining well-being. Built from decades of data, the index measured on a scale of zero to one hundred (0-100) “Americans’ perceptions of their lives and their daily experiences through five interrelated elements: sense of purpose, social relationships, financial security, relationship to community, and physical health.” 2 The model’s structure accounted for the full context of an individual’s well-being of which physical health was just one element. (See Figure 1 for definitions of each element of well-being.)

**Figure 1**  Gallup-Healthways’ definition of Well-Being

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**Gallup-Healthways’ definition of Well-Being**

Well-being is comprised of five elements – and all five are **interrelated** and **interdependent**.

- **Purpose:** Liking what you do each day and being motivated to achieve goals
- **Social:** Having supportive relationships and love in your life
- **Financial:** Managing your economic life to reduce stress and increase security
- **Community:** Liking where you live, feeling safe, and having pride in your community
- **Physical:** Having good health and enough energy to get things done daily

![Image](source: Gallup-Healthways)

Source:  Gallup-Healthways.

**Launching a mobile app**

As head of member engagement, Hodgman knew that increases in individual well-being (WBI) scores were associated with lower healthcare costs for those members. One study had shown that "for every 1-point increase on a 100-point scale, individuals were 2.2% less likely to have a hospital admission, 1.7% less likely to have an emergency room visit, 1% less likely to incur any healthcare costs and, if they did, incurred 1% fewer costs." 3 To increase member well-being, Hodgman launched
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a mobile app, HealthNow, in 2015. The app allowed people to chart and track well-being activities around diet, exercise, and stress reduction. It also provided basic information and tips for setting and meeting goals in each of these areas.

When it first developed the HealthNow app, Hodgman’s team looked closely at the work of Nicholas A. Christakis and James H. Fowler on social networks and the spread of obesity. Christakis’ and Fowler’s research revealed how a non-contagious condition like obesity could spread through diffuse social networks, even across indirect links (i.e. A knows B, B knows C, but A doesn’t know C), where social ties were the mechanism of “transmission.” Hodgman and her team hypothesized that Charter could leverage the power of social connections to encourage healthy behaviors among its members.

From Hodgman’s perspective, the launch was partly successful. After two years, many members had engaged with the app on a consistent basis and reported (through the app) increases in well-being. However, uptake had not been what she had hoped. She suspected that many of those who had engaged with HealthNow thus far were actually the members Charter was least concerned about from a future costs perspective.

Hodgman tasked an internal team to gather data to test this hypothesis. A survey of current HealthNow users and subsequent follow-up interviews with a subset of respondents revealed three distinct user types:

• One group of users already monitored their health closely and jumped at a free app that helped them do this.
• A second group included those who had recently decided to jump on the “healthier” bandwagon.
• The third group included those trying to get organized about their own health.

Common to all these users was some level of intrinsic motivation to monitor their health, a willingness to engage with a tool to do this, and comfort with smartphone technology. Based on these data and further review of the usage patterns of the HealthNow app, it was clear the app was attracting members who were on the extreme ends of the spectrum; at one end were the vibrantly healthy (i.e. the fit, athletic set), while at the other end were those managing chronic diseases or the more acutely sick (i.e. unwell). It captured approximately 20% of Charter’s members who could be labeled “well” and approximately 10% of members who Charter had already identified as having chronic diseases and was actively managing. Thus, the app was not addressing a wide swath of Charter’s current membership.

Engaging the “Silent Middle”

Hodgman and Charter’s leadership were especially worried about the 70% of members who were “neither sick nor well,” but who might be quietly developing conditions that would eventually progress into costly chronic diseases. This was the “silent middle.” According to recent estimates this group drove more than half of organizational healthcare costs, so engaging them was critical to Charter’s long-term viability.
The silent middle presented a number of challenges. Many of these members rarely interacted with their care providers. Furthermore, this population did not fall into a well-defined demographic bucket. Individuals in the silent middle included men and women of all races and ethnicities, aged early 20s through late 60s. They shared some physical characteristics (e.g. excess weight) or behaviors (e.g. inadequate exercise), but not necessarily others. Some had never been concerned with their health, while for others’ health had taken a backseat to other concerns, such as work or family, over time. When Quinby and her team conducted their research they would seek to identify patterns by which to segment Charter’s silent middle according to shared pain points, what they valued, and what drove their behaviors (i.e. motivators).

*Addressing modifiable behaviors to avoid chronic disease*

Hodgman’s goal was to keep those in the silent middle from developing chronic diseases such as heart disease or diabetes that accounted for over 85% of the nation’s healthcare costs. Chronic diseases were those that lasted three months or more and could neither be prevented by vaccines nor “cured” by medication.

Many of those in the silent middle were on a trajectory to develop a chronic disease if they did not make significant lifestyle changes. A growing body of research showed that chronic diseases stemmed from a set of unhealthy behaviors – including lack of exercise, poor diet, and alcohol and tobacco use – that were largely modifiable. These modifiable behaviors caused much of the illness, disability and premature death associated with chronic disease:

- More than half of adults in the U.S failed to meet minimum recommendations for aerobic physical activity with almost 40% engaging in little or no physical activity.
- Almost 40% of adults said they ate fruit less than once a day and over 20% said they ate vegetables less than once a day. At the same time, over 70% of the population exceeded recommended daily intakes of added sugars, saturated fats and sodium.
- Excessive alcohol use was also a major factor. About 38 million US adults reported binge drinking an average of 4 times a month, and had an average of 8 drinks per binge yet most binge drinkers were not alcohol dependent.
- Although far fewer Americans used tobacco than in the past, about one in five Americans (42 million) still smoked as of 2014. On average, a smoker cost an employer an additional $5,000 per year in healthcare costs and lost productivity, and nationwide, smoking was responsible for nearly 9% of healthcare costs.

Hodgman was also concerned about increases in obesity within Charter’s membership. These increases reflected national averages. The National Center for Health Statistics found that about one third of Americans meets the criteria for obesity and, as of 2010, the *Journal of the American Medical Association* reported that 16% of children aged 2 to 19 were obese. Because obesity impacted the prevalence and severity of many chronic diseases, these numbers had grave implications for the nation’s future health—and healthcare spending.

The opportunity within these grim statistics was that, to some extent, individuals could change their relationships to any of these activities.
Hiring specialists and framing the consulting engagement

While Hodgman believed she had a firm understanding of Charter’s membership, she also recognized that there was tremendous value in bringing in outside perspectives and capabilities. She had worked with Elizabeth Quinby in the past and was always impressed with her thoroughness and ability to design research that led to deep understanding of user needs and values, and in turn, to actionable insights. On that basis, she hired Quinby and her team to help her better understand the silent middle within Charter’s membership base.

Based on her work with other insurers and providers, Quinby encouraged Hodgman to broaden the scope of the research to include Charter’s providers as well. Specifically, she thought it was important to understand the differences between what clinicians understood health and well-being to be and what their patients in the silent middle might believe.

Mainstream conceptions of health traditionally focused on the absence of disease. Consequently, healthcare providers focused on a well-defined set of physical characteristics that could be measured and tracked over time, such as blood pressure, cholesterol, and weight.

Even as concepts of health became more holistic, evolving to account for mental and social health, the primary care physician’s main focus was the physical health of the patient. Tensions between doctor and patient could, therefore, be expected. A physician could believe in a patient’s right to self-determination and still feel strongly that the patient should lose fifteen pounds, improve his diet, and get his blood pressure down. Quinby wanted Hodgman to understand when and how physicians’ perspectives might deviate from the patient’s desires, needs, and values.

Hodgman agreed with Quinby that it would be helpful to better understand providers and their potential influence on the behaviors of the silent middle. She hoped that the clinicians might provide some insight into why certain members did not take advantage of the generous preventative services Charter offered. With Hodgman on board, Quinby and her team designed a research strategy that would involve first interviewing providers and then seeking to understand the silent middle through interviews and generative exercises.

Interviewing providers

Quinby’s team interviewed primary care physicians, nurse practitioners, physician assistants, and specialists treating patients with complications from their chronic diseases. Across the care spectrum, the team heard a common complaint: Why did so few patients act sooner to prevent the onset of chronic disease? (See Exhibit 1 for excerpts from provider interviews.) Doctors and nurses saw the physical, emotional, and financial toll chronic illness took on patients every day. They did not understand why patients didn’t do more to prevent these illnesses.

Quinby and her team sensed the deep frustration clinicians felt in watching patients progress into disease states that were largely preventable. Providers made it clear that this is exactly where many of Charter’s members in the silent middle might be headed if they didn’t begin attending to their own health.

To gain a clearer picture of the implications for patients of living with chronic diseases such as coronary artery disease or diabetes, Quinby and her team turned to the literature. The team quickly recognized the significant burden effective “disease management” put on both patients and providers. Many of these burdens were “functional.” People with multiple chronic conditions were
faced with managing multiple prescriptions, carefully monitoring condition indicators (e.g. blood pressure, glucose levels), and scheduling regular appointments with various providers. The complexity and relentlessness of these regimens had emotional impacts on patients as well. Many quickly felt overwhelmed and stressed. In addition to the direct personal toll, this also imposed burdens (both functional and emotional) on their relationships with families and friends. Once Quinby’s team understood these dynamics, the content of the provider interviews made much more sense.

**Seeking to understand the silent middle**

Quinby’s team was especially interested in understanding how those in the silent middle viewed and managed their own health and well-being. What motivated them to engage in healthy behaviors? What hindered them from doing so? What did well-being mean to them? To explore this broad set of questions, Quinby and her team developed a research strategy that combined interactive interviews with a series of generative exercises that challenged respondents to reflect more deeply on their current levels of well-being, their aspirations for the future and barriers they faced in making positive change.

Quinby’s team conducted in-depth, interactive interviews with over thirty silent middle Charter members. Half of the interviews took place in members’ homes enabling Quinby’s team to observe and interact with interview respondents where they lived. In addition, they video recorded each interview, which allowed them to review the interviews for subtleties they may have initially missed. They complemented the interviews with generative exercises that provided respondents the time to reflect more deeply than they might in an interview setting. In the week prior to the interviews, Quinby asked respondents to keep journals in which they made note of and reflected on day-to-day experiences that affected their well-being. Another exercise that Quinby often found quite informative was called future self in which each participant first drew images and symbols that represented his life and conception of well-being today, followed by a set of images that represented where he wanted to be five years into the future. These exercises enabled participants to express feelings and aspirations in writing and visually that often revealed latent needs and unlocked important insights regarding what motivated them and what they most valued. (See Exhibit 2 for excerpts from the interviews and journaling exercises, and see Exhibit 3 for one participant’s drawing of his future self.)

Quinby and her team pored through the hundreds of pages of interview transcripts, respondent journals and future self drawings looking for insights that would help them develop design principles and guide their ideation phase. As a first step in structuring their thinking, they clustered key quotes according to components of well-being (e.g. activity, cooking & diet, etc). During this initial review, they also sought to identify respondents who seemed to share similar pain points and to face similar challenges in maintaining healthy behaviors. Although they had yet to develop full-fledged personas, two distinct segments seemed to emerge which they labeled Segment A and Segment B. (Again, these can be found in Exhibit 2.)

**Choosing a Framework of Behavior Change**

Ultimately, Quinby’s team had to provide recommendations for how Charter could engage the silent middle. For many members, engagement would mean initiating behavior change around one
or more of the modifiable behaviors that drove chronic disease: inadequate physical activity, poor diet, tobacco use, alcohol use, and excess weight (a frequent by-product of these behaviors).

There was no shortage of models to explain and predict the process for individual behavior change and little consensus as to whether one model could even capture the process. Each model conceptualized behavior change somewhat differently. At one end of the continuum was a set of models focused narrowly on the individual's role in behavior change (e.g. Fogg Behavior Model14) while at the other were those that took a broader scope that encompassed how multiple factors (e.g. social, environmental, and technological contexts) interacted to shape individual behavior (e.g. Michie’s Behavior Change Wheel15).

Researchers and practitioners constantly grappled with the trade-off between a simpler model that might not account for the full set of significant causal factors and a more comprehensive model whose complexity made it difficult to apply. Quinby favored BJ Fogg’s Behavior Model. She had used it in the past and had found it to be simple enough to readily explain to clients and yet robust enough so as to be actionable. In addition, it seemed perfectly suited for addressing the particular challenge in front of her – that of engaging people more actively in their own health and well-being.

Fogg developed his model based on years of research he conducted at his Persuasive Technology Lab at Stanford University. He tested the efficacy of behavior change interventions derived from different models and synthesized elements from each based on outcomes to arrive at his own model. Fogg argued that three factors had to converge at the same moment for an individual to engage in a new behavior: 1) motivation, 2) ability, and 3) a trigger. In short, sufficient motivation, sufficient ability, and an effective trigger must be present to activate a behavior. If a particular intervention did not lead to a behavior change, Fogg’s Behavior Model suggested that one of these three conditions had not yet been met.16

Figure 2 provides an adapted illustration of Fogg’s Behavior Model, including several subcomponents that are critical to each factor. The model implies that motivation and ability can be viewed as trade-offs represented by the action line. While it is desirable to push the action line to the right, even if both motivation and ability are high, a behavior will not occur without an effective trigger. In addition, the subcomponents play key roles in determining the levels of motivation and ability and appropriateness of the trigger:

- Fogg identified three two-sided core motivators that were central to the human experience and played roles in determining motivation levels: sensation (pleasure/pain), anticipation (hope/fear) and belonging (social acceptance/rejection).

- Fogg often referred to ability and simplicity interchangeably and contended that ability was enhanced when a behavior was easier to do. Several simplicity factors (e.g. time, money, physical effort) played roles in making behaviors either easier or more difficult and therefore enhancing or limiting ability. A key insight was that “simplicity is a function of a person’s scarcest resource at the moment a behavior is triggered.”17 For example, if one were extremely pressed for time, taking even a 10-minute walk may become difficult. Similarly, what may seem like an easy amount of money to spend (e.g. $20) for one person may be prohibitive to another.

- Finally, triggers told an individual to perform the behavior now. Facilitators made behavior easier when ability was low but motivation was high. Sparks motivated behavior when there
was high ability but low motivation. Signals served as reminders when both ability and motivation were high.

**Figure 2** Adapted Fogg Behavior Model

**Triggers:** (1) Facilitator, (2) Spark, (3) Signal

**High Motivation**

(1) *Facilitator*

(3) *Signal*

- Triggers are effective

**Low Motivation**

(2) *Spark*

- Triggers are ineffective

**Core Motivators**

(Motivation, y-axis)

- Pleasure/Pain
- Hope/Fear
- Acceptance/Rejection

**Simplicity Factors**

(Ability, x-axis)

- Time
- Money
- Physical Effort
- Thought Required
- Social Norms
- Routinization


**Determining Next Steps**

As Quinby headed into her meeting with her team, she was confident that they had gathered a lot of valuable data. The data would help them develop recommendations that Hodgman and the Charter team could use to inform effective strategies for engaging the silent middle proactively in their health and well-being. Nonetheless, her meeting with Hodgman was only three days away and there was still a lot to do. A flurry of questions raced through her mind:

- Had they arrived at reasonable segments from the interviews and journaling exercises? Or were there alternative ways to look at the data?
- What personas did these segments represent and what were the pain points associated with each?
- What insights emerged that would help them identify design principles to guide them as they came up with ideas for possible solutions?
### Exhibit 1 Excerpts from Provider Interviews

<table>
<thead>
<tr>
<th>Primary Care Physicians, Nurse Practitioners, Physician’s Assistants, Nurses</th>
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<tbody>
<tr>
<td><strong>Why did so few patients act sooner to prevent the onset of chronic disease?</strong></td>
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<tr>
<td><strong>MD:</strong></td>
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<td><strong>PA:</strong></td>
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<td><strong>RN:</strong></td>
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<td><strong>MD:</strong></td>
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Source: Hamilton Strategic Design
**Exhibit 2**  
Excerpts from Member Interviews and Journaling Exercises

| **Segment A** | **I guess well-being is happiness, but to me, well-being is being fit and about the kinds of food you eat.**  
> My well-being deeply influences and is influenced by my kids. Money is an issue for us, which can cause tension, raise stress, pull me and my husband apart, which eventually percolates to the kids.  
> It’s not a luxury and it’s not being selfish. Your well-being benefits your family and benefits your environment. It’s a good thing for everything in your life.  
> It was a choice between a nice steady paycheck every two weeks or my overall well-being. I had saved up for nine months before I resigned. I liked the work itself, but it was the environment that was making me unhappy. I had put on almost 30 pounds in three years.  
> Nutrition, fitness, and emotional happiness – that’s my personal definition of well-being. Well-being is physical health and nutrition. Before this interview, honestly, I didn’t consider work environment, happiness and emotional state. |
|---|---|
| **What is well-being?** | **Activity**  
> There were times when I was going several times a week. Now, my responsibilities have changed.  
> Guilt is a problem. The feeling of choosing is a daily thing. A dad makes a choice in favor of his kids. My parents had a similar approach. They always focused on us. We grew up comfortably but not lavishly. I get upset if I miss one of my son’s 16 hockey games. As soon as the schedule comes out, I put it in my blackberry and schedule my life around that.  
> I finally rejoined the gym last Monday. My husband and sister already go and the kids go to the daycare. It was great to do a class with a friend.  
> It’s nice to have some social interaction while on the machines at the gym. Once I’ve decided to go, I look forward to it. The main barrier is logistics.  
> My husband goes to the gym to deal with things. I don’t have a lot of time to think about things.  
> I finally put together an exercise bike that was a present last year for Christmas. It wasn’t that hard to put together. I actually used it while I was on a conference call!  
> I used to go to Gold’s Gym, but it was expensive and the commute was too much. |
| **Cooking & Diet** | **The farmer’s market is also a resource. I’ve learned a lot there. I’m trying to perfect eggplant parmesan.**  
> I’m like the creature of best intentions. Cooking healthy is always on my list of things to do next week. Then next week comes and nothing changes. |
### Cooking & Diet (continued)

I like to think we eat pretty healthy. Pizza, processed foods, butter are not typical at our house. But beyond the most basic, I’m not sure I know what healthy cooking really looks like. I could probably do better, but it’s got to be easy! If I’ve got 15 extra minutes I don’t want to be reading a recipe.

### Stress & Sleep

My wife isn’t a pessimistic person, but she’s under a lot of stress with work and the current economy. It’s affecting us negatively.

Things have been pretty stressful lately. I don’t know proper ways to deal with stress. I should take a time out for myself. I like a glass of wine once in a while. Sitting with a friend or my sister, while the kids are running around.

It’s always been kid, kids, kids, work, work, work. I’m finally getting a couple of hours in the day now to do my own thing.

When your time gets more and more spoken for, you have less time to look after yourself, you know. You have to just allow that to happen.

Sometimes I feel really overwhelmed at work. I cut back working out in September because I didn’t have time, but not working out makes me stressed—and causes pain in my neck.

For me, the barrier to well-being is not being in control of what I would really like to be doing. Disagreements with my husband, financial obligations, and kids’ schedules are also on the list. I know I’m too busy when I’m rushing the kids.

My stress causes me stress.

The question for me is: How to stay healthy and be human without going crazy?

### Unhealthy Behaviors

My kids helped me to stop smoking. It’s pretty powerful when your 12 year old daughter says, “Dad, please quit.”

Smoking. It’s hard, it seems like you can never really quit. But I have support from friends. People are aware that you are quitting and they know that it’s a struggle. That makes me feel good that I know I have support. I need help from my whole family.

My husband and I generally don’t drink too much, but I know that the weekend beers can add up.

### Social Life

Most of my social life is built around the kids. I have two sons and I go to their hockey and lacrosse games.

My daughter still likes doing things with me, so I try to take advantage of that.

Usually the kids have some kind of sporting events on Saturdays. I like going to the sporting games and I miss watching them play in the winter.

I left my phone at home when we went to Montana. I felt disconnected, but I was glad I did it.

I love to help my fiancé because she has a lot of faith in me. It’s nice of her to have the faith in me.
<table>
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<th>Segment B</th>
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| **What is well-being?** | Well-being is low or manageable stress levels. You enjoy day-to-day activities. The good outweighs the bad. You feel healthy and optimistic. I left my job because it was impacting my well-being.  

I think I am in okay health for my age. I want to stay where I am. That may not sound so ambitious, but when the natural trajectory is decline it’s a reasonable objective. I don’t want to become a burden.  

I don’t really think of online communities as being a source of well-being. You have to spend time with real people.  

Having energy and feeling connected are the biggest pieces to well-being. Everyone gets there a little bit differently. |
| **Activity** | My problem is sticking with something. There are always obstacles along the way. I always find excuses.  

I know I have to find a way to get to the gym. I’ve tried Zumba and kickboxing and muscle conditioning. But then Christmas came and I got too busy. I have trouble being consistent. I get all fired up and then I lose steam. Whatever it is, I want to be consistent.  

If I didn’t have a dog I’d easily turn into a couch potato. I’m not really big on going to the gym.  

I’m like the creature of best intentions.  

I’ve had a routine for years and it just hasn’t included exercise.  

I have a habit, I admit, of putting things off. Especially when something really interesting comes along…and the alternative doesn’t require sweat.  

In the past I’ve found gyms overwhelming. I definitely felt out of my league. I haven’t really “worked out” since high school, so I guess it’s not that surprising.  

Some friends are much more intentionally active. They probably wouldn’t mind if I joined, but there’s no way I could keep up.  

I like doing things with people – friends. If I could find a friend who was committed and at my speed that would be amazing. |
| **Cooking & Diet** | I liked weight watchers. The people who knew I was on it would say: “So it’s a good week?” They would be encouraging without being nosy.  

My sister eats well because of high cholesterol—it’s genetic and she has to watch it. I would love some help from her. Our grandmother has diabetes and I’ve had my blood tested. Sometimes I think about it—“If I don’t start eating better, this may happen.”  

I love to cook and to entertain. My friends come over all the time. After a recent episode a friend started a very low sodium diet. I want to do right by him, but I’m struggling to adapt my cooking (which everyone loves) to his needs.  

Last time I was at my PCP he recommended a heart healthy diet and gave me some handouts, but I never really followed up. There was a lot to keep track of. |
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<table>
<thead>
<tr>
<th>Cooking &amp; Diet (cont’d)</th>
<th>For some reason, the idea of revising all my recipes to be healthier is just not exciting. I know I should, but I don’t want to change that much.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress &amp; Sleep</td>
<td>There are only a few things in life you can control; one thing is your attitude. Everything starts with how you think about things. It’s hard to get the motivation to rise above bad feelings. Getting support from people with similar issues can help. Now that my kids are out of the house my stress levels have definitely gone down. Big time. But I still try to manage them and do yoga in my living room a few times a week. That really helps.</td>
</tr>
<tr>
<td>Unhealthy Behaviors</td>
<td>My husband loves beer. Ten years ago that was not an issue. But now when we visit our nieces and nephews they bring us to local breweries. This doesn’t seem like such a big deal, but I’m uncomfortable with the role that alcohol now plays in our social life—and our diets. I know I should go to the doctor, but I just can’t quite get myself there. I don’t think there’s anything really going on with me. To us, wine signals freedom. We have a glass of wine when everything else is taken care of. I don’t think we drink too much, but I don’t know. I’ve certainly never thought to discuss it with my doctor. I smoked for ten years. It was really, really hard for me to quit. I could definitely stand to eat a little bit healthier, and to lose a few pounds, but I figure if I never smoke again then I’m ahead of the game.</td>
</tr>
<tr>
<td>Social Life</td>
<td>When I have more energy, I feel more optimistic and feel better. Seeing people and meeting people, that gives me energy. I see friends dealing with issues that are more and more serious. The last time I was at the doctor, she said my blood pressure was high – that doesn’t sound good, but I’m not ready to deal just yet and she didn’t push it. Feeling part of a community is important to me. I don’t do much online, because I don’t get much satisfaction from it. But seeing friends in real life? That feels wonderful.</td>
</tr>
</tbody>
</table>

Source: Essential Design
Exhibit 3  Example Output from Future Self Exercise

Source: Essential Design
Endnotes


8 Center for Disease Control, “Chronic Disease Overview.”


10 Centers for Disease Control and Prevention, “Chronic Disease Overview.”


16 Fogg’s Behavior Model, “What causes behavior change?”