



## Behavioral Health Awards: Employer Implementation & Best-Practices

*To recognize employers that design innovative benefits or programs, and to learn from their experience, the Business Group established a behavioral health awards program. This issue brief includes background information and employer case studies, which provide guidance to employers regarding the development, implementation, and evaluation of behavioral health programs. The award-winning programs address prevention, early intervention, treatment, disease management, return-to-work issues, and disability management.*

### 2007 Behavioral Health Award Winners

*Employer Implementation Awards:*

**Aetna**

Behavioral Healthcare Services in the General Medical Setting

**Cisco Systems**

Specialty Services for the Seriously Mentally Ill

**Delta Air Lines, Inc.**

Employee Assistance Programs

**Pitney Bowes, Inc.**

Disability Management for Behavioral Health Disorders

*Best-Practice Awards:*

**Cisco Systems**

Early Intervention

**GlaxoSmithKline (GSK)**

Healthy Work Environment

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## **Behavioral Health Background**

### **The Epidemiology of Behavioral Health Disorders in the United States**

#### *Prevalence of Mental Illness and Substance Abuse*

Mental illness and substance abuse disorders are common and costly health problems in the United States.

- An estimated 26.2% of Americans age 18 and older—about one in four adults—suffer from a diagnosable mental disorder in a given year.<sup>1</sup>
- At some point during his or her lifetime, the average American adult has a 46% chance of developing one or more mental illness or substance abuse disorders: 29% will suffer an anxiety disorder, 25% will suffer an impulse-control disorder, 21% will suffer a mood disorder (i.e., depression), and 15% will suffer a substance abuse disorder.<sup>2</sup>
- An estimated 20% of children and adolescents, similar to rates among adults, suffer from emotional and behavioral disorders. About 11% of children experience significant functional impairment; 5% of children experience extreme functional impairment, and 10-15% of children and adolescents have some symptoms of depression at any one time.<sup>3-5</sup> The diagnosis of major depression among children ages 9 to 17 has been estimated at 5%.<sup>6</sup>
- Approximately 22.2 million Americans age 12 or older are “dependent” on or “abuse” illicit drugs or alcohol.<sup>7</sup>

Contrary to popular belief, most individuals with mental illness and substance abuse disorders work. Of the 20.2 million adults who abuse or are dependent on alcohol or drugs, 15.5 million (76.7%) are employed. According to the 2005 *National Survey on Drug Use and Health*, 6.3% of full-time employed adults and 8.2% of part-time employed adults experienced a mental illness in the past year.

#### *Cost of Mental Illness and Substance Abuse*

##### **Healthcare Costs**

Medical spending for substance abuse treatment constituted an estimated \$21 billion in 2003—1.3% of all healthcare spending.<sup>8</sup> Mental health spending totaled \$100 billion in 2003, accounting for 6.2% of all United States healthcare spending. One of the fastest growing components of mental health spending are prescription drugs to treat mental disorders. Mental health prescription drug expenditures grew by 18.8% each year between 1993 and 2003. This accounted for 42% of the increased total mental health spending in those years.<sup>8</sup> Managed care was being implemented during these years as a means to control health care costs. At the same time, the use of inpatient and outpatient mental health care decreased, and rates of mental health drug prescribing increased.

### Workplace Costs

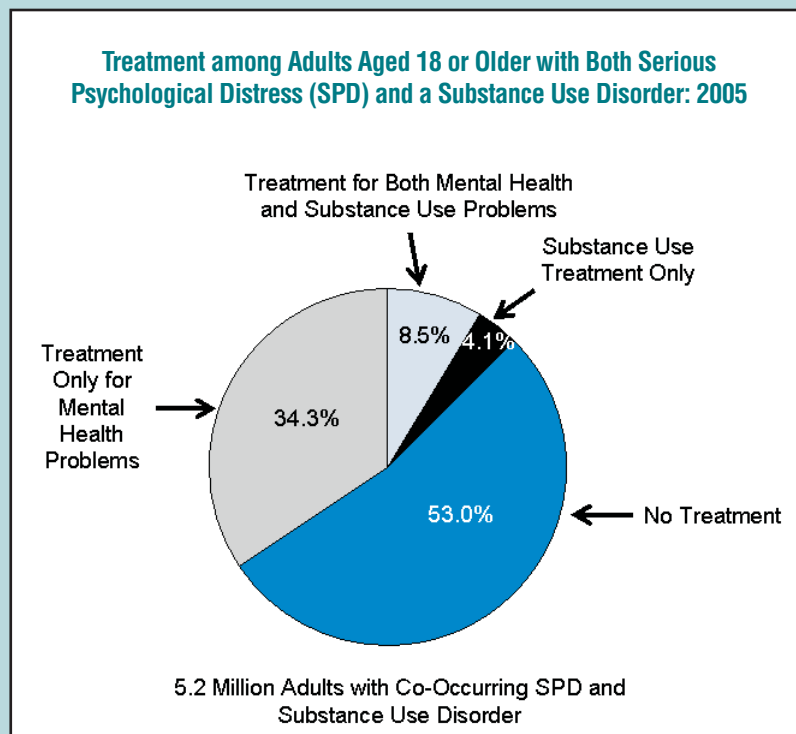
According to a study using data from two large community surveys, depression was associated with a 2.5-fold increase in the probability of missing work because of illness and a 50% increase in lost work time.<sup>9, 10</sup> Depression also affects presenteeism and is associated with limitations in time management, interpersonal/mental functioning, and overall output.<sup>11</sup>

Mental illness is associated with more days of work loss and work impairment than many other chronic conditions (i.e., diabetes, asthma, and arthritis).<sup>12</sup> Approximately 217 million days of work are lost annually due to productivity decline related to mental illness and substance abuse disorders, costing United States employers \$17 billion each year.<sup>13</sup>

Mental disorders are the leading cause of disability in the United States and Canada for people ages 15 to 44 years.<sup>14</sup> By the year 2010, depressive disorders will be the primary disorder contributing to significant years lost to disability. Furthermore, depressive disorders will become the second largest killer after heart disease.<sup>15</sup>

### Treatment

Treatment for behavioral health disorders typically includes talk therapy (psychotherapy) and psychotropic medications (i.e., antidepressants). Among adults who received treatment for a behavioral disorder between 2001-2003, 39.4% received a prescription medication, 28.5%



received outpatient treatment, and 4.6% received inpatient treatment.<sup>7</sup> The majority (22.8%) of individuals with anxiety, mood, impulse control, or substance abuse disorders who receive treatment for their condition are treated by general medical providers such

Note: Due to rounding, these percentages do not add to 100%.

Source: Substance Abuse and Mental Health Services Administration. *Results from the 2005 National Survey on Drug Use and Health: National Findings*. Rockville, MD: SAMHSA Office of Applied Studies; 2006. NSDUH Series H-30, DHHS Publication No. SMA 06-4194.

as primary care physicians; the remainder are treated by non-psychiatrist mental health providers (16.0%), psychiatrists (12.3%), and other provider types (14.9%).<sup>1,3,5</sup>

### **Unmet Treatment Needs**

Mental, emotional, and behavioral disorders are most effectively treated when they are addressed early. The efficacy of treatment for mental illness and substance abuse disorders is well documented and has improved dramatically over the past 50 years.<sup>16</sup> Most individuals with behavioral health disorders can fully recover, so long as they receive an appropriate diagnosis, effective treatment, and sufficient monitoring and support. Unfortunately, less than half of adults with behavioral health disorders get the treatment they need. Among adults with serious psychological distress who reported an unmet need for treatment, cost/insurance issues was the most frequently reported reason for not obtaining treatment (53.5%). Other reasons for not receiving treatment included not feeling a need for treatment at the time or believing that the problem could be handled without treatment (32.3%), stigma associated with treatment (26.2%), not knowing where to go for services (21.8%), and not having time (16.6%).<sup>7</sup>

### **Quality of Behavioral Health Care**

Even when individuals with behavioral health disorders seek and receive treatment, the quality of the care they receive is not always optimal. In 2006, the National Committee on Quality Assurance (NCQA) released a landmark report showing that quality improvements in behavioral healthcare were stagnating and lagged far behind improvement in the general medical setting. For example, patients on antidepressant medication are about as likely to receive appropriate care today as they were in 1999.<sup>17</sup> Quality problems are costly for employers and devastating to patients and their families. In 2005, suboptimal care for depression accounted for 8.4 million sick days and \$1.4 billion in lost productivity costs.<sup>17</sup> Given the huge economic and societal toll of untreated or inadequately treated mental illness, new approaches must be developed to bring mental healthcare quality to the level of clinical effectiveness evidence shows to be possible.<sup>17</sup>

### **State of Behavioral Health Care in the United States**

The National Business Group on Health convened the *National Committee on Employer-Sponsored Behavioral Health Services (NCESBHS)* in January 2004. The *Committee* was established to review the current state of employer-sponsored behavioral health services and to develop recommendations to improve the design, quality, structure, and integration of programs and services. The *Committee* was also charged with reviewing the recommendations of the President's New Freedom Commission on Mental Health and determining how they might apply to employer-sponsored behavioral health benefits and programs. The *Committee* consisted of 25 benefits and healthcare experts including

academic researchers, disability management professionals, employee assistance program (EAP) professionals, healthcare benefits specialists, representatives from managed care and managed behavioral health organizations, pharmacology experts, and medical directors and benefits managers from Business Group member companies. The Committee's review resulted in the following key findings<sup>18</sup>:

- A significant proportion of individuals with behavioral health problems are treated exclusively in the general medical setting, which has become the “de-facto mental healthcare system.”<sup>19</sup>
- Primary care physicians (PCPs) and other general medical providers are – and will continue to be – an integral part of behavioral healthcare in the United States.
- Psychotropic drugs have become the major treatment modality in behavioral healthcare whether prescribed by general medical physicians (i.e., primary care physicians) or by behavioral health specialists (i.e., psychiatrists).
- While employers have focused their attention on the management of high cost chronic medical conditions (i.e., heart disease and type 2 diabetes), such management efforts have not fully addressed the significant additional burden of co-morbid mental illness.
- Access to specialty behavioral healthcare services is critical to delivering effective disease management services for chronic medical problems. Therefore, limitations on behavioral healthcare benefits may limit the efficacy of disease management programs for individuals with co-morbid medical and behavioral health conditions.
- Disease management programs will not realize their full potential without fostering better coordination between the general medical healthcare system and the specialty behavioral healthcare system.
- Access to specialty mental healthcare services is constrained due to benefit design with higher co-pays, visit limits, and management of utilization. These additional financial limitations are not applied to psychotropic drug benefits or to many behavioral health interventions delivered in the general healthcare setting.
- Limited behavioral healthcare services can increase employers' non-behavioral direct and indirect healthcare costs.
- Employers have tightly managed behavioral health benefits delivered by the specialty mental healthcare system, but have not implemented comprehensive and integrated management programs to address quality and costs for psychotropic drugs and behavioral health services delivered by general medical providers.
- The lack of coordination and integration among managed care vendors of employers including; managed healthcare organizations (MCOs), managed behavioral healthcare organizations (MHBOs), employee assistance programs (EAPs), pharmacy benefit managers (PBMs), and others has created significant quality and accountability problems.

## **What Employers Can Do**

In 2005, the National Business Group on Health (Business Group) released the recommendations of the *National Committee on Employer-Sponsored Behavioral Health Services (NCESBHS)* in a publication entitled *An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing, and Implementing Behavioral Health Services (An Employer's Guide to Behavioral Health Services)*. This guide recommended that employers assist employees with mental, emotional, and behavioral disorders by providing:

- Robust mental health benefits (inpatient and outpatient care, prescription medications, and specialty services for the seriously mentally ill).
- Mental health benefits equal to physical health benefits.
- Coordination and integration among managed care vendors of employers (MCOs, MHBOs, EAPs, PBMs, and others).
- Employee assistance services.
- Disability management for behavioral health disorders.
- Information on substance abuse and mental health (health promotion, wellness, and health education programs).
- Organization of work assessments to evaluate the effects of stress related to work organization on employee health status, productivity, and job satisfaction.

Research and experience has shown that proactive programs that address prevention and early intervention may help reduce presenteeism, absenteeism, and disability claims associated with behavioral health disorders. Quality improvement initiatives in the general medical setting and the specialty behavioral health setting are also important.

## **Purpose of the Behavioral Health Awards**

Mental illness and substance abuse disorders are common and costly health problems. United States employers lose \$17 billion annually due to productivity decline related to mental illness and substance abuse disorders.<sup>13</sup> Mental disorders are the leading cause of disability in the United States.<sup>14</sup> Less than half of adults with behavioral health disorders get the treatment they need. Even when individuals with behavioral health disorders seek and receive treatment, the quality of the care they receive is not always optimal. Given the huge economic and societal toll of behavioral health disorders, behavioral health needs to be a top priority for employers. Employers need to implement quality comprehensive behavioral health benefits, policies, and innovative programs to improve an employer's business operations and the health of beneficiaries.

Starting this year, the National Business Group on Health will honor employers who have recognized quality behavioral health benefits, programs and policies as essential for employees. The Center for Mental Health Services, a division of the Substance Abuse and Mental Health Services Administration (SAMHSA), sponsored the 2007 behavioral health awards program.

Employers have put into effect a wide range of benefits, programs, and policies tailored to their own populations that help prevent, treat, and manage behavioral health disorders. Since the release of *An Employer's Guide to Behavioral Health Services*, a number of large employers have implemented one or more of the recommendations. The Business Group established the behavioral health awards program to:

- Recognize employers who have implemented comprehensive methodologies, programs, benefits, or policies as presented in the recommendations of *An Employer's Guide to Behavioral Health Services*.
- Recognize employers who have designed an innovative methodology, program, benefit, or policy to measurably improve an employer's business operations and the health of beneficiaries.
- Allow others to learn from exemplary employers' experiences regarding the development, implementation, and evaluation of behavioral health programs.

The Business Group honored five companies and six programs at the October 2007 Joint Forum on Employee Health and Productivity. Award categories included: Behavioral Healthcare Services in the General Medical Setting, Specialty Services for the Seriously Mentally Ill, Employee Assistance Programs, Disability Management for Behavioral Health Disorders, Early Intervention, and Healthy Work Environment.

#### ***National Business Group on Health's Behavioral Health Award Winner Program Summaries***

- Aetna improved the health of its employees by implementing a program that encouraged primary care providers to screen for depression and monitor improvements in depressed patients' symptoms.
- Cisco used evidence-based benefit design techniques to address the needs of individuals diagnosed with autism.
- Cisco used health risk assessments to help identify behavioral health issues among employees, develop programs tailored to specific populations or disorders, and assist with program evaluation.
- Delta was able to reduce costs and improve access by restructuring its employee assistance program to be more responsive to the unique needs of its employees.
- GSK's preventive program teaches employees and managers interpersonal skills to manage stress, improve communication, and stay mentally healthy.
- Pitney Bowes developed a personalized, employee-centered program that was able to get employees disabled by a behavioral health problem back to work as promptly and efficiently as possible.

## EMPLOYER CASE STUDIES

### Employer Implementation Award: “Behavioral Healthcare Services in the General Medical Setting”

#### *Aetna*

*Headquarters: Hartford, Connecticut*

A significant proportion of individuals with behavioral health problems are treated exclusively in the general medical setting. Primary care physicians (PCPs) and other general medical providers are – and will continue to be – an integral part of behavioral healthcare in the United States. *An Employer’s Guide to Behavioral Health Services* recommends that providers screen for depression and other common behavioral health conditions among

#### **Aetna**

Headquarters: Hartford, Connecticut  
 Industry: Healthcare  
 Sector: Healthcare Plans  
 Employees: 31,130 in the United States

individuals with chronic medical problems, and that employers provide coverage for screening and monitoring. Additionally, employers need to prompt better coordination between the general medical healthcare system and the specialty behavioral healthcare system for individuals with co-occurring chronic health problems and behavioral health conditions.<sup>18</sup>

Aetna improved the health of its employees by implementing a program that encouraged primary care providers to screen for depression, manage co-occurring depression among individuals with chronic medical problems, and monitor improvements in depressed patients’ symptoms.

Over the past decade, Aetna has noticed a rise in depression either as a primary or secondary diagnosis in its book of business member population. Aetna’s managed behavioral healthcare unit, Aetna Behavioral Health (ABH), found that close to 12% of all Aetna medical claimants used antidepressants, with a female to male ratio of 3 to 1. Of the total claimants who used antidepressants, 44% also had a behavioral health claim pointing to the co-occurrence of medical/behavioral health issues and the need for intervention. ABH also found that members with depression had higher average healthcare costs than members without depression. The hospital admission rate among members with depression was twice as high as the population average. Of the total number of members diagnosed with depression, nearly 2% were disabled due to a major depressive disorder with an average cost of \$18,168. Furthermore, indirect costs related to a rise in absenteeism and decreased productivity accounted for significant expenditures.

In addition to this review of claims information, Aetna conducted literature searches on the impact of depression and an antidepressant study. In this study, Aetna compared members with new cases of major depression on antidepressant therapy who received follow-up care with a prescribing psychiatrist or who adhered to an antidepressant medication regimen for 6 months, to those who did not. The results showed that those who adhered to the regimen and/or received follow-up had lower overall medical costs than those who did not.

Aetna believes that pro-active assessment and early intervention combined with structured care coordination services enables optimal treatment outcomes. According to Dr. Hyong Un, the National Medical Director for Aetna Behavioral Health, Aetna wants to “. . . have more productive and healthy members by facilitating access to good behavioral health care.” ABH concluded that it needed to develop and implement a fully integrated program that proactively addressed the needs of members and provided a comprehensive treatment approach.

### Program Features

Aetna worked with colleagues across Aetna to define the program. It reviewed the depression cost analysis with senior management, which eventually led to support from the chief executive officer and the chief medical officer of Aetna, who became executive sponsors for the programs. This sponsorship facilitated further institutional support and the alignment required for integration. Aetna defined integration as a major corporate strategy and integrated behavioral and physical health data in one platform.

### Aetna Approach to Depression

#### Pro-active assessment

- Primary Care Provider (PCP) Initiative

#### Disease management programs

- Medical Psychiatric High Risk Case Management (Med-Psych)
- Depression Disease Management (DDM)

As a result of these efforts, ABH developed and implemented three programs to assist Aetna members suffering from depression.

### PCP Initiative

The PCP Initiative is a nationwide program, open to all Primary Care Physicians (PCPs). PCPs are reimbursed for screening using the Patient Health Questionnaire (PHQ-9<sup>®</sup>) assessment. The PHQ-9<sup>®</sup> is an industry standard used to assess symptoms and functional impairment, diagnose depression, determine severity, and monitor treatment response. A Care Planner (CP) follows up with members referred to the program by the PCP, repeats the PHQ-9<sup>®</sup> at set intervals, and supports the member. As appropriate, members are referred to behavioral health providers for treatment.

ABH recognized that financial reimbursement to PCPs was feasible from a financial and processing perspective and should be given for positive depression screenings (i.e., positive response on one of the first two PHQ-9<sup>®</sup> questions). Reimbursement for the depression screenings, through the use of the standardized PHQ-9<sup>®</sup> would make the initiative distinctive and promote provider implementation. ABH contacted the National Committee for Quality Assurance (NCQA) regarding potential collaboration for identifying and field testing depression pay-for-performance measures.

### **Medical Psychiatric High Risk Case Management Program**

The Medical Psychiatric High Risk Case Management Program (Med-Psych) helps members who have simultaneous medical and behavioral health conditions, where coordination of care between the two disciplines is of importance. Members are referred to the program if they have a positive screen for depression using the SF-12<sup>®</sup> Health Survey. The SF-12<sup>®</sup> Health Survey is a brief, industry-standard health status assessment questionnaire that collects data

#### **Communication Strategies**

- Provider Welcome Kit, which includes an overview and operational details related to the program.
- Dedicated public website used for information and training purposes.
- Physician Continuing Medical Education, which offers 2 free CEUs.
- Two-sided flyer for providers with an overview of the program and a summary sheet.
- Post card mailing to participating PCPs.
- Presentations to providers and plan sponsors at seminars, meetings, and in-office rounds or bag-lunches.
- Informational brochures on the treatment of depression mailed to members enrolled in the care management program.

on people's perceptions of their mental and physical health. Mental Component Summary (MCS) and Physical Component Summary (PCS) sub-scores are calculated within the SF-12<sup>®</sup>.

Enrollees in the Med-Psych Program are referred to a care manager who assesses the member's needs and identifies opportunities for intervention before conditions become more severe. The case manager helps to develop a recovery plan best suited to the individual's needs, assists the member in arranging treatment services by behavioral health providers, and ensures that a coordinated behavioral health and medical care approach is implemented.

SF-12<sup>®</sup> results for 2006 showed an average increase of 45% in a member's Physical Component Summary (PCS) and an 8% increase in the Mental Component Summary (MCS). These members saved an average of 3.5 days missed from work while enrolled in the program. Evidence based data indicates a 13% savings per member per month for members enrolled in the Med-Psych High Risk Case Management Program with a 3 to 1 return on investment.

In addition, Aetna evaluated the impact of the Med-Psych Program on medical, pharmacy costs and utilization of services. Members with evidence of major depression who enrolled in the Med-Psych Program had lower medical costs and utilization of services compared to members with a severe health condition who were not managed in the program.

### **Depression Disease Management**

The Depression Disease Management (DDM) program is based upon referrals of individuals that are already utilizing behavioral health services for depression. The program is designed to help members understand and better manage depression. DDM uses appropriate assessment, treatment planning and goal setting, and care management services to address the needs of members with chronic depression.

SF-12<sup>®</sup> results for 2006 showed an average increase of 30% for the member's Physical Component Summary. The members saved an average of 2.5 days missed from work while enrolled in the Depression Disease Management Program. In addition, ABH conducted an anti-depressant utilization study that demonstrated a \$57.00 per member per month savings for members who remained on anti-depressants for a 6 month period.

### **Future Directions**

Aetna continues to expand their programs. Future programs will address behavioral health disorders that frequently co-exist with depression such as alcohol abuse, anxiety disorder, and bipolar disorder.

### **Critical Success Factors**

- **Member enrollment**  
Members who screened positive for depression became enrolled in the program in a timely manner and had all needed assessments completed.
- **Completion rate**  
A high percentage of enrollees, if not all, completed the program and had demonstrated results. This included completion of the PHQ-9<sup>®</sup>, completing case management parameters, and completing the treatment program and discharge planning.
- **SF-12<sup>®</sup> Completion**  
Members completed the assessment form prior to and following treatment.
- **Symptom severity**  
Review the severity of member symptoms at time of admission, during treatment (if appropriate), and at the end of the treatment process.
- **Member satisfaction survey**  
Members complete and submit a satisfaction survey and allowing for the survey to be analyzed and used for program enhancement purposes.

## Employer Implementation Award: “Specialty Services for the Seriously Mentally Ill”

*Cisco Systems, Inc.*

*Headquarters: San Jose, California*

*An Employer’s Guide to Behavioral Health Services* recommends that employers implement coverage for evidence-based treatment modalities for seriously mentally ill adults and children, and:

### **Cisco Systems, Inc.**

Headquarters: San Jose, California

Industry: Networking &  
Communication Devices

Sector: Technology

Employees: 61,535 Globally  
16,835 in the United States

- Direct MCOs and MBHOs to add providers that can deliver evidence-based treatment modalities to their networks.
- Direct MCOs and/or MBHOs to annually review behavioral health treatment modalities and make recommendations about whether new treatment modalities need to be added to employers’ benefit structures.<sup>18</sup>

Cisco used evidence-based benefit design techniques to address the needs of individuals diagnosed with autism.

Autism Spectrum Disorders (ASD), also known as Pervasive Developmental Disorders (PDDs), cause severe and pervasive impairment in thinking, feeling, language, and the ability to relate to others. These disorders are usually first diagnosed in early childhood and cause varying levels of functional impairment. The illness in its most severe form is called “autistic disorder.” A milder form of the disorder is termed “Asperger syndrome.” The thinking and learning abilities of people with ASD can vary – from gifted to severely challenged. All children with ASD demonstrate deficits in social interaction, verbal and nonverbal communication, and repetitive behaviors or interests.

ASD begins before the age of 3 and lasts throughout a person’s life. A 2007 report from the Centers for Disease Control and Prevention’s Autism and Developmental Disabilities Monitoring Network, found about 1 in 150 8-year-old children in the United States had an ASD. It affects an estimated 1.5 million Americans and is increasing at a rate of 10% to 17% each year. ASD is four times more common in boys than in girls.

Direct medical costs are highest for a child with ASD during the first 5 years of life (average of around \$35,000 per year).<sup>20</sup> According to a Northern California Kaiser Permanente Medical Care program, children with autism incurred 2.5 times more outpatient costs, 2.9 times more inpatient costs, and 7.6 times more medication costs as randomly selected

children without autism.<sup>21</sup> In 2000, total healthcare expenditures for children age 17 and younger with autism averaged \$5,316 per patient; only patients with bipolar disorder (\$5,766), psychosis (\$6,787), or mental retardation (\$11,662) had higher average expenditures.<sup>22</sup> It can cost about \$3.2 million to take care of an autistic person over his or her lifetime. Caring for all people with autism over their lifetimes costs an estimated \$35 billion per year.<sup>20</sup>

The exact cause of autism is not known and there is currently no cure for the disorder. There is also no recognized best treatment for all children with ASD. However, early intervention is important and most individuals with ASD respond well to highly structured, specialized programs. Due to the individualized needs of children with autism, comprehensive benefits for autism coverage are difficult to design. Common standards for autism coverage include:

- A comprehensive evaluation for diagnostic purposes (frequently limited to one per person).
- Medical and behavioral health services. Within behavioral services, "medically necessary" interventions that are "evidenced-based" around specific symptoms and that can be delivered by credentialed therapists, psychiatrists, psychologists, or social workers.
- Speech and occupational/physical therapy services (subject to annual and life-time maximums).

### **Program Features**

Cisco employees with autistic children requested more comprehensive benefits for autism. To address this need, Cisco teamed with United Behavioral Health (UBH), CIGNA Behavioral Health, and Towers Perrin to create a comprehensive supplemental benefit for autism. Cisco assessed the current economic impact of services used by families with autism, and the prevalence and incidence of the disorder. Based on claims analysis, Towers Perrin estimated the prevalence rate in the population was .00187%.

Some autism interventions rely on intensive behavioral techniques delivered by certified behavioral therapists but who are almost always outside the network. These therapists are also not traditionally credentialed and as a result, are frequently considered ineligible clinicians

### **Cisco's use of Evidence-Based Benefit Design**

- Interview families affected to better comprehend the problems they face and to identify what they believe would be greater equity in autism coverage.
- Review clinically evaluated best-practices as reported in the literature.
- Evaluate multiple current treatment guidelines from a variety of countries.
- Review recommendations of consensus and expert panels.
- Evaluate centers of excellence approaches based on government and state support for major research centers and regional centers of excellence.

and not included in plan networks. Likewise, in traditional benefits programs, ongoing comprehensive evaluations and reevaluations are frequently denied. The situation is further confounded by the inability to delineate and determine what constitutes education versus what constitutes therapy. Ever-changing special education funding allocations or voids created by different state and local commitments further complicate the situation. Likewise, regional variations in best-practice approaches create difficulties in standardizing benefit design. The impact of all this confusion is seen in the economic and psychological strain on families, coupled with frustration and isolation affecting presenteeism, absenteeism and company loyalty in employees.

Cisco, United Behavioral Health (UBH), and CIGNA Behavioral Health decided to monitor the latest research in order to:

1. Find proven treatments (those based on the highest standard of evidence) that should be adopted.
2. Identify treatment modalities that show promising results and deserve tracking to make decisions about possible inclusion in the future.
3. Determine which treatment approaches are purely experimental, highly controversial, unproven, potentially harmful, or completely spurious.

#### **Cisco Autism Benefit Changes**

- Supplemental in nature.
- Expanded scope of interventions.
- Independent of the plan's out-of-pocket maximum and available at 80% of negotiated rates (\$30,000 annual maximum and a \$90,000 lifetime maximum).
- Right to appeal for further services on a case-by-case basis.
- Expanded scope of eligible providers with a focus on supervision and treatment planning by the most qualified individuals.

In order to make decisions on limits - annual and lifetime and whether to base those on units of service or dollar amounts - Towers Perrin, and UBH conducted an analysis of the economic and clinical impact by state and region. Additionally, in order to ensure that specific benefit descriptions did not further compound problems, Cisco included families affected by autism to understand types of services used.

Towers Perrin calculated the financial viability of the supplemental benefit in regards to benefit design, resolution of limits, nature of

dollar maxims, definitions of exclusions, and the definition of the benefit as “supplemental.” The proposed benefit changes resulted from consensus discussions, with both CIGNA and UBH. These took into account:

- **Family Support**
  - Greater development of self help tools for families.
  - Improvement of internet interactive support.
- **Defining Services and Qualifications**
  - Challenges of required care management expertise.
  - Definition of a “qualified” provider.
  - Definition of what therapies would or would not be included.
  - Importance of distinguishing educational from therapeutic services, wherever possible (in order to maximize the benefit).
- **Monitoring**
  - Need for a special appeals board.
  - Utilization of specific CPT codes.
  - Reevaluation and development of network capabilities that highlighted centers of excellence for evaluation and on-going monitoring.

### **Future Directions**

Cisco’s comprehensive supplemental benefit for autism will continue to be driven by its ability to demonstrate the value that the program provides to individuals and their families, and its impact on employee wellness, productivity, retention, benefits and competitiveness. Cisco continues to monitor and evaluate their supplemental autism benefit. Evaluations include:

- **Individual Benefit**
  - Case specific outcomes based on the individualized behavioral plans filed for each child and ratings by families on the child’s quality of life and functional improvement.
  - Family focus groups and a satisfaction survey to assess the impact on families and evaluate the extent to which the changes have provided viable solutions.
- **Costs**
  - Comparison of comprehensive claims costs against Towers Perrin cost predictions.
  - Family medical utilization rates. The supplemental autism benefit may decrease stress and result in better health for other family members.
  - Pre-post analysis to assess productivity data detailed in the annual Health and Work Performance Questionnaire, health risk assessment, and reported absences of employees who have a child with autism.
  - Comparisons between employees who avail themselves of the benefit as compared to those who do not.
- **Administrative Impact**
  - Follow-up interviews with the care management staff, claims staff, and network development staff.

## Best-Practice Award: “Early Intervention”

**Cisco Systems, Inc.**

**Headquarters: San Jose, California**

*An Employer's Guide to Behavioral Health Services* recommends that employers evaluate and address productivity and absenteeism issues that may be caused by psychosocial problems. Structured programs need to be designed and developed to deliver health promotion and

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healthcare education tools that significantly affect employee and beneficiary health and productivity. These programs need to be coordinated with other health services including health plan and disability management programs. Furthermore, periodic organizational assessments need to be conducted to evaluate the effects of work organization on employee health status, productivity, and job satisfaction.<sup>18</sup>

Cisco used health risk assessments to help identify behavioral health issues among employees, develop programs tailored to specific populations or disorders, and assist with program evaluation.

Each Fall Cisco employees complete an online health assessment. This assessment measures employee absenteeism, presenteeism, chronic health and mental health conditions. Analysis of Cisco's 2005 health assessment data identified that approximately 9% of Cisco's workforce reported problems with anxiety and/or depression. These workers, many of whom suffer co-occurring sleep problems, accounted for 40% of Cisco's total lost productivity due to chronic health conditions. Cisco teamed with United Behavioral Health (UBH), Harvard Medical School (HMS), and WebMD to develop a program

### **Program Participants**

#### **Outreach Group**

99 employees assigned to the Outreach Group.  
92 employees consented to participate in the program.  
60% identified as at risk for depression.  
40% identified as at risk for bipolar disorder.

#### **Standard Group**

111 employees assigned to the Standard Group.  
106 employees consented to participate in the program.  
58% identified as at risk for depression.  
42% identified as at risk for bipolar disorder.

to identify, assess and reach-out to employees suffering from negative impacts to their productivity and wellness due to stress, anxiety, depression or sleeplessness.

In 2006, Cisco designed a pilot outreach program to address the problems identified in the 2005 health assessment. The revised health assessment, administered in the fall of 2006, included the questions used in 2005 as well as additional questions on bipolar disorder. The 2006 health assessment included the Health and Work Performance Questionnaire (HPQ), an instrument developed by HMS and the World Health Organization, with questions about absenteeism, productivity, and chronic and mental health conditions.

The Cisco pilot outreach program is a randomized study that compares the outreach program to standard UBH care. HMS and UBH screened people into the study based on answers to 2006 health assessment questions about depression, anxiety, sleeplessness and bipolar disorder. These broader symptoms are examined because depression is sometimes masked by these other conditions.

HMS and UBH identified 210 individuals as having some degree of risk for depression and/or bipolar disorder, of those employees with UBH coverage who completed the health assessment, and agreed to be contacted further as part of a health outreach program. All information was handled in a secure and confidential manner with only UBH having information on potential participants. Employees were randomly assigned to either the new outreach program (“Outreach Group”) or to receive standard UBH care (“Standard Group”).

### **Program Features**

Development of the outreach program took approximately 6 months. Costs of developing the program primarily involved the staff time of those at Cisco, UBH, and HMS who met for 1 hour bi-weekly during the development period. Additional costs included the initial analysis of the 2005 health assessment data, costs involved in adding and editing the questions included in the WebMD-administered 2006 health assessment, and the costs of obtaining the approval of the study design by an Independent Review Board.

The pilot outreach program began early in 2007 and consists of a UBH Care Advocate (a Masters-level therapist) making outreach calls to Cisco employees enrolled in the outreach group. During outreach, the Care Advocate establishes a collaborative relationship with the Cisco employee, conducts initial assessments of depression and bipolar symptoms, and facilitates in-person behavioral health services as needed. In addition, the Care Advocate assists the employee in overcoming personal and social barriers to care, provides the employee with various resources by mail, including answers to common questions about

depression, and tips to recognizing and treating depression. For employees who enter in-person treatment, the Care Advocate assesses response to treatment, coordinates care, and helps the employee adhere to treatment. For employees who do not enter treatment, the Care Advocate uses motivational interviewing techniques to engage with the employee, and to encourage improvement of their symptoms.

An additional component to the outreach program is an online toolkit created by The Brain Resource Company, Ltd. This toolkit, called WebNeuro, consists of a set of on-line interactions that test memory, motor functions, concentration, emotions, and other brain functions. The results are reviewed by the Care Advocate and discussed with the employee. If the results suggest the need for further evaluation, the Care Advocate facilitates appropriate services.

The response from employees participating in the outreach program has been extremely positive. They appreciate the outreach calls even if their symptoms decreased or dissipated since they first took the health assessment. Opt-out rates to the study are low: only 12 of the original 210 participants refused to participate or left the study. This suggests that employees are ready and willing to receive help.

### **Future Directions**

Cisco continues to collect employee data; therefore, the pilot outreach program has not been evaluated yet. In the fall of 2007, Cisco employees will take the health assessment again. This will allow HMS to measure the effect of the outreach program by comparing the results against those of employees using standard UBH services and assessing differences to employee responses between the 2007 and 2006 health assessments. Changes to depression, anxiety, chronic sleep problems, bipolar disorder, absenteeism and productivity between 2006 and 2007 will be assessed. In addition to the health assessment data, HMS researchers will have data on which employees used behavioral, medical, and pharmacy services in 2006, allowing an analysis of the differences between the groups in terms of utilization and costs incurred. It is expected that employees who participated in the outreach program will have fewer depression and/or bipolar symptoms, have greater workplace productivity and will have lower health care utilization costs than those who received standard UBH services. While the current outreach program has focused on depression and bipolar symptoms, there is potential to expand this outreach program in the future to address other behavioral health problems that may be identified within the Cisco population.

## Implementation Award: “Employee Assistance Programs”

*Delta Air Lines, Inc.*

*Headquarters: Atlanta, Georgia*

*An Employer’s Guide to Behavioral Health Services* recommends that redundancies between EAPs and health plans be reduced by re-structuring EAPs. Essential EAP services need to be retained amidst other benefit changes. Periodically, organizational assessments need to be conducted to evaluate the effects of work organization on employee health status, productivity, and job satisfaction.<sup>18</sup> Furthermore, EAPs need to encourage coordination with other health services including health plans, disability management, and health promotion.

### **Delta Air Lines, Inc.**

Headquarters: Atlanta, Georgia

Services 461 destinations in 96 countries

Industry: Major airline

Sector: Service

Employees: 46,000

Delta was able to reduce costs and improve access by restructuring its employee assistance program to become coordinated with other health services and, as a result, became more responsive to the unique needs of its employees.

Delta Air Lines’ commitment to service extends far beyond the customers they serve; Delta places high importance on the services it offers employees. In 2005 and 2006, Delta, while in bankruptcy, had many hard decisions to make. In a top to bottom review of all costs, a multifaceted effort was initiated to remove transactional HR functions, administrative overhead, and duplicated tasks, while maintaining safety, and improving benefit offerings. To reduce waste, lower medical expenditures, and realign health-related benefits with strategy, Delta decided to rearrange many facets of their compensation and benefits program. This case study describes the changes Delta made to improve the quality and comprehensiveness of their employee assistance program (EAP).

Delta had an internal EAP in place for 15 years. In an effort to reduce costs, and better align resources with the geographic distribution of their employees, Delta redesigned their EAP. They selected an external EAP to expand upon their services and become integrated with Delta’s health plan and management consultation services. Delta chose to partner with United Behavioral Health (UBH) to provide EAP services. In a planned and disciplined effort to transition to the EAP, Delta moved from an internal to an external model in a matter of a few months. This was an extraordinary effort given Delta’s culture and the high value that the internal EAP had within the company. Delta retained one

### Communication Strategies:

- Article in company magazine with traveling consultants pictures.
- Customized brochures and posters.
- Member introduction letters.
- Health specific content in newsletters.
- Company health and safety fairs.
- Meet and greets with consultants who work directly with employees.
- Memos and meeting with senior leaders and steering committees.

internal EAP manager to help facilitate the changes within the company, manage the contract, and provide strategic oversight to the new model.

Organizational transitions are often stressful for employees. As Delta underwent its organizational transition, the management made it a priority to put as much of a human face on the new external EAP as possible. In addition to reducing employee resistance to the new EAP program, it also aided employees during the transition. Delta values its employee-centered corporate culture so it made the shift to using an external provider

cautiously. Fiscal requirements, cultural inferences, structure, implementation, and strategies of the move from a well-established internal EAP to an external program were all taken into account when Delta retooled their program. In an effort to reduce the amount of employee apprehensiveness about the new UBH program, Delta convened workgroups with the pilot's union and heavy EAP users such as flight attendants. These workshops helped to address employee concerns about the new program and how services would be administered.

The UBH consultants traveled across the country to meet with supervisors and establish relationships in Delta's five major U.S. hubs in Atlanta, Salt Lake City, Cincinnati, Boston and Los Angeles. Delta wanted the consultants to have an in-depth understanding of its organizational culture and employees. Delta trained UBH consultants in Delta's lingo, demographics, and employee expectations so they could provide an external service but with a familiar orientation other Delta in-house programs possess.

One of Delta's goals is to create a seamless integration between EAP and behavioral health services. This integration expands the services offered to members, as well as simplifies the process of obtaining services. Delta hopes that both changes will increase utilization.

The re-designed EAP includes the following enhancements:

- Telephonic support for domestic and international participants 24 hours a day, 7 days a week.
- Three free face-to-face visits for any Delta employee and any household member.
- No payment for EAP services.

- No need to switch clinicians when a beneficiary moves from using the EAP to his/her behavioral health benefits because providers in both programs are in-network.

Delta anticipates that these enhancements will increase the continuity of care employees receive and also to encourage employees to seek services sooner.

Delta effectively integrated the EAP program enhancements with other existing programs and services. For example:

- UBH and management consultants expanded services to supervisors and managers while maintaining the Trigger Diagnosis and Substance Abuse Recovery Programs already established within the company prior to bankruptcy.
- UBH's services are particularly effective at addressing accidents or incidents with their Critical Incident Response Service, which includes mental health professionals and Delta peer volunteers.
- Delta's disability provider is also connected to the EAP program so that all behavioral health disability claims are referred to UBH for additional management and depression screening. This relationship between disability, EAP, and behavioral health benefits is important to promote Delta's smoking cessation, health advocate, and disease management programs.

Another challenge Delta faced was the short 3-month time frame to execute their new EAP. Their bankruptcy situation drove them to create a more cost-effective program by tailoring services to employee need and by reducing the number of internal EAP staff.

The first "test" of the re-designed program was successful. Five days shy of the official launch of the new EAP, the crisis team at UBH faced a major disaster (Flight 5191 crashed in Lexington, KY) and was required to provide emergency service sooner than expected. UBH's was able to provide services to the families of the crew and passengers affected by the accident immediately.

Flexibility, clear communication, and constant quality improvement are the foundation of Delta's retooled EAP program:

- Flexibility ensures that service gaps are addressed in a timely manner to minimize problems.
- Delta makes it a priority to support clear and open communication among UBH and other Delta benefit providers.
- Delta and UBH are always looking for ways to improve the program. Small adjustments in program content and structure have been made in response to problems or challenges identified during the mid-course review.

Employee satisfaction with the new EAP service is extremely important to Delta, so UBH conducts follow-up reviews for all consenting participants through phone calls and emails. Results from the first 4 months of the program's implementation are promising:

- 95% overall EAP satisfaction.
- 97.7% satisfaction with timeliness of call answer.
- 97.7% satisfaction with EAP staff helpfulness.
- 97% satisfaction with clinician appointment wait time.

UBH also asks participants fill out a one-page wellness assessment periodically during their treatment, which helps UBH monitor and report on clinical outcomes. Data from the 2006 assessment indicates that Delta employees who used the behavioral health program demonstrated a 26% reduction on global distress. The data collected from the EAP and behavioral health programs will be compiled to provide a better view of the outcomes associated with this type of care, including productivity for Delta employees.

#### **Success of Delta's new program facts:**

- 8.4% utilization of the new program.
- 15.7% reduction in behavioral health cost claims.
- 95% member satisfaction with the EAP program overall.
- 15.7% reduction in average monthly cost per participant for behavioral health.

Reducing costs and maintaining quality are important goals after bankruptcy. Prior to the re-design of their EAP program, Delta spent over \$1.2 million per year on EAP services. Shifting to an external program, and adding the enhancements described above, reduced program costs by 30% (to \$875,000 per year). Most notably, Delta was able to reduce their costs while enhancing access, expanding their service offerings, and improving employee satisfaction.

## Best-Practice Award: “Healthy Work Environment”

### GlaxoSmithKline (GSK)

Headquarters: United Kingdom

*An Employer’s Guide to Behavioral Health Services* recommends that employers need to proactively identify and address psychosocial problems that may lead to issues of reduced productivity and increased absenteeism. Structured programs need to be designed and developed to deliver health promotion and healthcare education tools that significantly affect employee health and productivity. Stress-related problems that may be the result of work organization can be addressed by periodic organizational assessments conducted to evaluate the effects of work organization on employee health status, productivity, and job satisfaction.<sup>18</sup> GSK’s preventive program teaches employees and managers interpersonal skills to manage stress, improve communication, and stay mentally healthy.

### GlaxoSmithKline (GSK)

Headquarters: United Kingdom  
 Located in 116 countries  
 Industry: Pharmaceuticals  
 Sector: Health  
 Employees: Over 100,000 Globally  
 24,000 in the United States

GSK is committed to “improving the quality of human life by enabling people to do more, feel better and live longer.” This value statement guides the programs and services that GSK provides to its own employees, including a range of programs to support and enhance employee well-being within:

- The health plan, including comprehensive smoking cessation benefits.
- Health promotion, including onsite health and fitness centers, musculoskeletal and ergonomic improvement programs, walking programs, weight management programs, screening programs including blood pressure.
- Occupational health/support, including flexible working arrangements.
- Employee assistance programs (EAP), including family support services.

GSK offers employees the opportunity to complete a confidential lifestyle and work/life balance health risk appraisal (HRA) to assess current health risks and the risk of future ill health. This enables employees to review their lifestyle behaviors and make appropriate changes if desired. GSK uses aggregate HRA data to target specific areas for program intervention.

### Program Features

GSK built a program to address the emotional pressures related to working conditions, competing priorities, demanding schedules, management or team practices, standards of quality, and work/life balance. When pressures are too great, employees can experience stress. Stress is associated with variety of illnesses, both mental and physical.

## Program Chronology

### 2001

- Employee Health Management decides to focus on behavioral health.
- Personal Resilience program launched.

### 2003

- Team Resilience program launched in the UK and US.
- Team Resilience program on-line team assessment introduced.

### 2005

- Team Resilience program launched worldwide.

### 2006

- Personal Resilience UK Pre- and post-training evaluation of effectiveness and benefits.
- Team Resilience assessment tool and reporting available in 13 languages.

### 2007

- Leadership Resilience program launched including Energy4Performance.
- Redesigned Personal Resilience program.

According to Annette Byrd, manager of GSK's U.S. Worklife Solutions, the company wanted to provide employees and managers with tools that can help them build the skills they need to resist the negative impact of stress both at home and at work. "Although we've always offered a stress-management program, we realized that once the course was over, employees soon felt intense pressures creep back once they returned to work. That's why we wanted to take a team approach to assessing where pressures come from and work together to eliminate them."<sup>23</sup>

The GSK stress prevention strategy represents a company-wide commitment to improving the resilience of managers and employees. According to GSK, resilience is used by GSK to refocus staff towards workplace health and

well-being. Resilience is defined by GSK as "the ability to be successful, personally and professionally, in a highly-pressured, fast-paced and continuously changing environment." According to GSK, resilience emphasizes organizational initiatives aimed at improving performance in a competitive business environment while promoting the importance of taking personal responsibility for maintaining good health.

GSK has developed programs to support resilience on three different levels:

- Personal Resilience
- Team Resilience
- Leadership Resilience

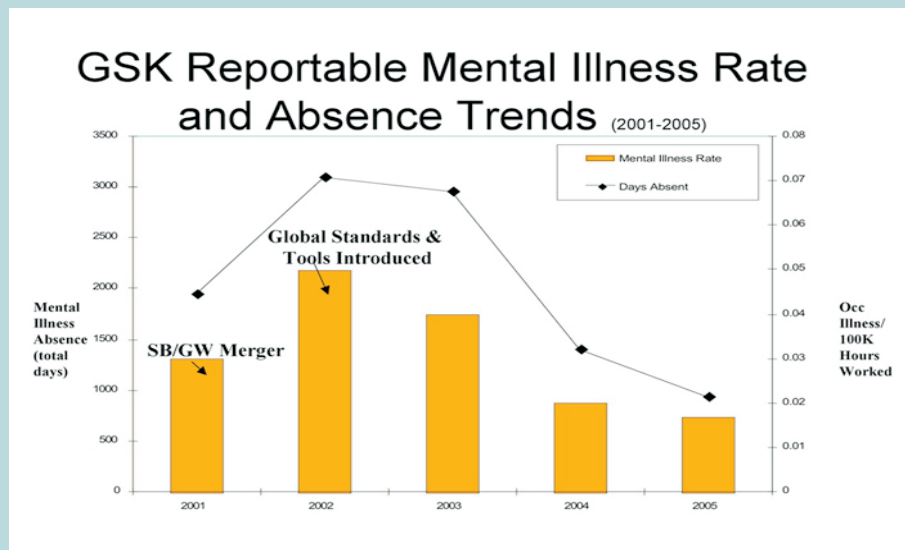
## Personal Resilience

The Personal Resilience program was launched in 2001. From 2001 to 2006 GSK taught approximately 2,300 Personal Resilience sessions. Personal resilience is the "demonstration of physical, psychological and emotional competencies that enable one to manage pressure." GSK's program teaches employees how to become more adaptable, energetic, focused, organized, confident and proactive.

A 2006-2007 pre- and post-evaluation of the personal resilience program indicated a:

- 10% reduction in fatigue.
- 16% reduction in frustration.
- 12% increase in the sense of feeling relaxed.
- 7% increase in mental clarity.
- 14% increase in self esteem.
- 15% increase in satisfaction.

Furthermore, employees reported a significant reduction in stress. Prior to the resilience program 54% of participants reported that they were “not stressed”; and after completion of the program 72% of respondents reported that they were “not stressed.”



Skills employees develop as a result of the program are relevant to the work environment; they are also adaptable to home and personal life. Resilience results from 2001-2005 show that employees are achieving transferable skills: 72% of employees thought they could manage their work/life balance more effectively and 25% of employees experienced a reduction in work/life conflict. Additionally, from 2001-2005 GSK reported a 60% global reduction in work-related mental health, a 66% reduction in newly reported cases, and a 29% reduction in lost work days due to work-related mental health problems. Mental health problems also dropped from the third leading cause of occupational illness in 2002 to the fifth leading cause of illness in 2004.

### Communication Strategies

- Database with all marketing, presentation and facilitation materials.
- Website with success stories.
- Component of GSK health website.
- Human Resources Department marketing support.
- Affiliation with Health Risk Appraisal and educational programs.
- Network of over 200 global facilitators to share experiences and mutual support.
- Articles about resilience published in GSK internal magazine 'GSK Spirit'.
- Corporate Social Responsibility report contains information on Resilience annually.

### Team Resilience

The Team Resilience program was launched in 2003 in the United Kingdom and United States. GSK introduced the program to all global units in 2005. In February 2004, Chief Executive Officer, Jean -Pierre Garnier spoke about the company's team resilience program. "With the participation of GSK's passionate, 'can do' employees, our company will succeed. . . Passion, Resilience, Innovative Solutions, Sense of Urgency are all critical." In 2006, he embedded the concept of Resilience in the operational objectives of his team. Almost 18,000 employees worldwide (17% of the GSK

population) have participated in Team Resilience. GSK's goal is to have all employees to engage in the program by the end of 2009.

One component of the Team Resilience program is an on-line assessment. This assessment looks at issues that can cause pressure and affect performance such as work demands, team relationships, management practices, career and development concerns, and work culture. The on-line assessment provides standardized reporting to managers and employees about the sources and impact of job-related stress. Managers and their teams are able to review and discuss causes of pressure and identify solutions. Lastly, teams are able to develop specific action plans together.

### Critical Success Factors

- **Train the trainer:** Employee Health Specialists train HR colleagues and safety professionals to support managers in leading their teams through the team resilience process.
- **Peer-led approach:** Employee Health Management, team leaders, health and safety, and HR professionals deliver resilience across sites globally.
- **Cross-Cultural Application:** Team Resilience Program is available in 13 languages and very few cultural adjustments have been necessary.

GSK measures the impact of resilience on productivity by assessing the performance, commitment and engagement of employees. Analysis of team resilience in 2006 found that 50% of employees were committed or highly committed and 75% of employees never or only occasionally considered leaving the company. Data also showed a 7% increase of employees being proud to be part of GSK (a proxy for engagement), a 9% increase in employees who would recommend GSK as an employer (a proxy for commitment), a 21% increase in staff satisfaction with the company, and a 14% increase in willingness among staff to

experiment with new work practices. Additionally, GSK reports a 60% decrease in work-related mental ill-health and a 25% decrease in pressure due to work/life conflicts.

### **Leadership Resilience**

In 2007, GSK chose to utilize its resilience program among the organization's leadership. Leadership Resilience is "the human resources model for the sustainability of the GSK business and its people." GSK's new leadership framework emphasizes the importance of leaders developing self mastery skills (Personal Resilience) as well as skills of leading others (Team Resilience assessment and intervention tools). Dr. JP Garnier, Chief Executive Officer, explains in the GSK 2005 Year End Broadcast, "Sometimes it is all about resilience . . . Resilience is an important part of culture. We want to be known as a resilient company." Leaders who are committed to continuous development of their physical and psychological well being are able to call upon their best strengths, stamina, judgment and personal effectiveness. An integral component of leadership resilience training addresses the importance of leaders becoming good role models.

### **Future Directions**

GSK continues to expand their resilience programs. Future evaluation areas include the sustainability of Personal Resilience program with healthy lifestyles and preliminary outcomes of the new Leadership Resilience program.

## Employer Implementation Award: “Disability Management for Behavioral Health Disorders”

*Pitney Bowes, Inc.*

*Headquarters: Stamford, Connecticut*

### **Pitney Bowes, Inc.**

Headquarters: Stamford, Connecticut

Industry: Mailstream Technology and Services

Sector: Mailstream software, hardware, services and solutions

Employees: 23,000 in the United States

*An Employer’s Guide to Behavioral Health Services* recommends that employers

review disability management programs and instruct vendors to actively manage all behavioral health disability claims.

Employees on disability for a psychiatric condition need to be referred to EAP for return-to-work assistance. A behavioral health specialist needs to be involved in the certification of all psychiatric

disabilities and in the review of the treatment plan.<sup>18</sup> Pitney Bowes developed a personalized, employee-centered program that was able to get employees disabled by a behavioral health problem back to work as promptly and efficiently as possible.

Pitney Bowes has an in-house disability department that manages short-term disability, long-term disability, Family and Medical Leave Act (FMLA), and workers’ compensation supplement for the company’s 23,000 US employees. Pitney Bowes, a leading worldwide mailstream solutions company, is working with ValueOptions to implement an active management model for short-term behavioral health disability.

### **Program Features**

The initial goal of the program was to implement an efficient model that would reduce the duration of short-term disability claims. The program manages psychiatric disability using a coherent, clinically-based approach. The program’s philosophy is based on the beliefs that:

1. Work has inherent therapeutic value.
2. An individual must suffer a significant amount of distress to come to the point where they cannot function adequately at work.
3. Absence from work longer than necessary is not beneficial and may be potentially harmful.

Key program components include a designated team of disability care managers who provide specialized care management in an integrated team setting. Additionally, psychiatrists oversee the program. Each disability claim begins with an initial comprehensive behavioral

health disability assessment. These assessments are more intensive than a general behavioral diagnostic evaluation. The initial assessment is a critical part of the active management process to assist in the validation of the claimant's eligibility, assess contributing factors, and determine functional capacity. The assessment allows the disability care team to

determine the most effective course of treatment that will result in a timely return to work for the disabled employee. Returning to work is considered part of the recovery process and return-to-work goals are integrated into treatment. Family and social support are also expected and considered an important part of the treatment process.

Referral to the employee assistance program (EAP) for return-to-work support is considered for each employee. The EAP assists the employee in anticipating potential return-to-work issues and conducts a return to work meeting with the employee's manager. In addition, the EAP supports the manager in the return-to-work process through consultation with the workplace advisory services team using an on-line resource.

Employees on short-term disability receive a comprehensive continuum of care. Reviews with providers are frequent and in-depth and structured in a collaborative coaching and consultative manner. The individualized return-to-work criteria are reviewed based on an agreed upon timeline for follow-up with the employee and therapist. Treatment is coordinated with providers by the behavioral health disability care manager through the establishment of review dates and expectations as well as both short-term and long-term goals. Cognitive-behavioral strategies are employed along with close coordination with medical providers as appropriate.

The behavioral health disability care manager acts as liaison between members of the treatment team and disability management team with the disabled employee being considered an integral member of the team. Constant communication is maintained between the behavioral health disability clinical care manager and the Pitney Bowes disability nurse. It is this coordination that prompts a smooth transition back to work for each employee. Employee contact with the workplace is encouraged throughout the disability process. Reviews are conducted with the provider and employee at scheduled intervals. All team members are kept up-to-date on the stated goals and progress. Barriers to returning to work are addressed throughout the process. Transition plans are

#### **Members of the Treatment and Disability Management Team**

- Behavioral health disability clinical care managers.
- Treatment providers.
- Medical Director (Psychiatrist).
- Employee assistance program (EAP).
- Pitney Bowes disability nurse.
- Employee.

individualized and Pitney Bowes plays a key role in workplace preparation for the employee's return to work. Temporary restrictions and accommodations are provided as a part of the return-to-work process as needed.

This active model of behavioral disability management demonstrated cost-effectiveness within the first 6 months of implementation. The program led to a 40% reduction in the duration of short-term disability claims. Since employees return to work earlier, individual and team productivity are restored; this factor also leads to cost-savings.

### Future Directions

Pitney Bowes continues to review and evaluate their short-term disability management program. The disability department will be conducting a pilot in which depression screening questions will be part of the initial comprehensive disability assessment. Those with positive answers will be assessed further and referred into the employee assistance program or behavioral health benefit plan.

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## ISSUE Brief

October 2007

### Behavioral Health Awards: Employer Implementation & Best-Practices



#### Acknowledgment

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This issue brief was written by Wendy I. Slavit, MPH, CHES, Program Analyst and Georgette Flood, BS, Program Assistant in the Center for Prevention and Health Services at the National Business Group on Health.

#### About the Center for Prevention and Health Services

The Center houses Business Group projects related to the delivery of prevention and health services through employer-sponsored health plans and worksite programs. Employers should look to the Center for:

- Current information and practical recommendations from both federal agencies and professional associations;
- Analyses of model programs from other employers, and
- Findings from recent clinical and health service research.

For more information, visit <http://www.businessgrouphealth.org/prevention/index.cfm> or email [healthservices@businessgrouphealth.org](mailto:healthservices@businessgrouphealth.org).

#### About the National Business Group on Health

The National Business Group on Health, formerly the Washington Business Group on Health, is the national voice of large employers dedicated to finding innovative and forward-thinking solutions to the nation's most important health care issues. The Business Group represents over 250 members, primarily Fortune 500 companies and large public sector employers, who provide health coverage for approximately 50 million U.S. workers, retirees, and their families. The Business Group fosters the development of a quality health care delivery system and treatments based on scientific evidence of effectiveness. The Business Group works with other organizations to promote patient safety and expand the use of technology assessment to ensure access to superior new technology and the elimination of ineffective technology.

Helen Darling, President.

National Business Group on Health  
50 F Street NW, Suite 600 • Washington DC 20001  
Phone (202) 628-8320 • Fax (202) 628-9244 • [www.businessgrouphealth.org](http://www.businessgrouphealth.org)