



Department of
Mental Health

THE LUVU PROJECT^{INC.}

In Memory of Carolyn C. Mattingly



Mental Health in the Workplace: A Call to Action

Second International Symposium to Advance Total Worker Health

May 11, 2018



JOHNS HOPKINS

BLOOMBERG SCHOOL
of PUBLIC HEALTH

Mental Health in the Workplace: A Public Health Summit

Sectors

- Academia
- Industry
- Government

Professional Disciplines

- Mental and occupational health
- Corporate medicine
- Workplace wellness
- Human resources
- Health promotion
- Clinical practice
- Journalism
- Community health
- Insurance
- Policy making



Mental Health in the Workplace: A Public Health Summit

Goals

- Examine state-of-the-art and -science for workplace mental health initiatives – from individual and organizational perspectives
- Brainstorm on what we now know – and what we need to know to put in place evidence-based, practical, and cost-effective solutions
- Inspire a “call to action” directed at the business community and its partners



OPEN

Mental Health in the Workplace: A Call to Action Proceedings From the Mental Health in the Workplace—Public Health Summit

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Objective: The aim of the study was to declare a call to action to improve mental health in the workplace. **Methods:** We convened a public health summit and assembled an Advisory Council consisting of experts in the field of occupational health and safety, workplace wellness, and public policy to offer recommendations for action steps to improve health and well-being of workers. **Results:** The Advisory Council narrowed the list of ideas to four priority projects. **Conclusions:** The recommendations for action include developing a mental health in the workplace (1) “how to” guide, (2) scorecard, (3) recognition program, and (4) executive training.

Keywords: culture of health, mental health, well-being, workplace health promotion, workplace mental health, workplace wellness

On September 30, 2014, an employee of the Cystic Fibrosis Foundation based in Bethesda, Maryland, brutally murdered Carolyn Mattingly at her home in Potomac, Maryland, after being confronted by organization officials regarding his theft of Foundation property. The Foundation’s Executive Vice President and Chief Operating Officer, C. Richard Mattingly, was Carolyn’s husband. Instead of descending into lifelong grief and despair, Mattingly and his daughter Christin and her husband Alex formed The Luv u Project, named after Carolyn’s iconic signature “luv u,” which she regularly included on her notes to family members and friends.

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THE LUVU PROJECT

In Memory of Carolyn C. Mattingly

The mission of The Luv u Project is to turn an unacceptable tragedy into a quantifiable agenda and responsible actions that advance the understanding of, and treatments for, mental health issues.

C. Richard Mattingly

Founder & President

The Luv u Project



Business Case

Cost Burden of Mental Illness to Employers

- Mental health disorders are costly for business, totaling \$186 billion in 2014¹
- Often comorbid with physical health conditions^{2,3,4,5}
- Projected savings of \$38-68 billion/year by integrating medical and behavioral health services⁶



Business Case

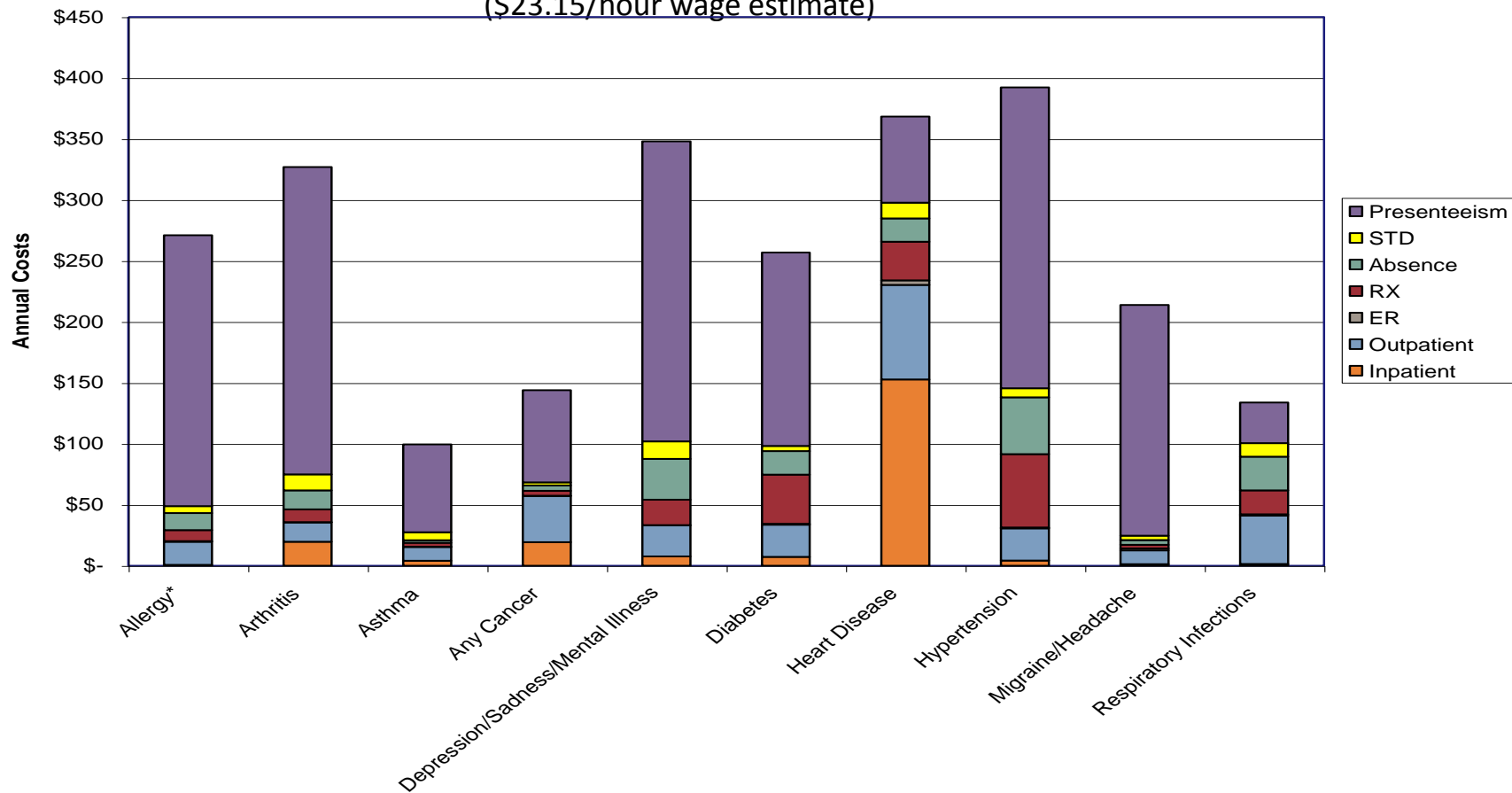
The Health and Productivity Burden of Mental Illness

- Poor mental health, stress at work associated with^{7,8}
 - Reduced job performance
 - Reduced engagement in work
 - Disrupted communication with co-workers
 - Impaired day-to-day functioning
 - Higher rates of disability, unemployment
- Major depression associated with ~11% decrease in productivity⁹



The Big Picture: Overall Burden of Illness by Condition

Using Average Impairment and Prevalence Rates for Presenteeism
(\$23.15/hour wage estimate)



Source: Goetzel, Long, Ozminkowski, et al. JOEM 46:4, April, 2004)

HERO II Study – Published Nov. 2012

COSTS & QUALITY

By Ron Z. Goetzel, Xiaofei Pei, Maryam J. Tabrizi, Rachel M. Henke, Niranjana Kowlessar, Craig F. Nelson, and R. Douglas Metz

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Ten Modifiable Health Risk Factors Are Linked To More Than One-Fifth Of Employer-Employee Health Care Spending

ABSTRACT An underlying premise of the Affordable Care Act provisions that encourage employers to adopt health promotion programs is an association between workers' modifiable health risks and increased health care costs. Employers, consultants, and vendors have cited risk-cost estimates developed in the 1990s and wondered whether they still hold true. Examining ten of these common health risk factors in a working population, we found that similar relationships between such risks and total medical costs documented in a widely cited study published in 1998 still hold. Based on our sample of 92,486 employees at seven organizations over an average of three years, \$82,072,456, or 22.4 percent, of the \$366,373,301 spent annually by the seven employers and their employees in the study was attributed to the ten risk factors studied. This amount was similar to almost a quarter of spending linked to risk factors (24.9 percent) in the 1998 study. High risk for depression remained most strongly associated with increased per capita annual medical spending (48 percent, or \$2,184, higher). High blood glucose, high blood pressure, and obesity were strongly related to increased health care costs (31.8 percent, 31.6 percent, and 27.4 percent higher, respectively), as were tobacco use, physical inactivity, and high stress. These findings indicate ongoing opportunities for well-designed and properly targeted employer-sponsored health promotion programs to produce substantial savings.

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Section 4303 of the Affordable Care Act of 2010 and section 2705 of the Public Health Service Act of 1944, which was amended by the Affordable Care Act, contain provisions that encourage employers to adopt health promotion and risk reduction programs, also known as employee wellness programs. An underlying premise of these provisions is that modifiable health risks, such as obesity and high blood pressure, are associated with increased health care costs in the employed population. Therefore, employers that undertake risk-reduc-

tion programs may save on health care expenditures.

The largest employer-based study that supported the association between higher health risks and higher costs used data that are now seventeen years old. Also, both personal health behavior and health care services have changed over time. We therefore revisited this pivotal assumption using more current data. In doing so, we demonstrated that the relationships shown more than a decade ago between employee health risks and subsequent total health care costs still hold today. These enduring rela-

HERO II Study: Risk-Cost Impacts

EXHIBIT 1 Average Unadjusted And Adjusted Medical Expenditures, In 2009 Dollars, By Risk Levels

Risk measure	Risk level	Unadjusted means (\$)	Adjusted means (\$)	Unadjusted difference (%)	Adjusted difference (%)
Depression	High	6,207	6,738	59.1	48.0
	Lower	3,902	4,553		
Blood glucose	High	6,532	6,849	70.0	31.8
	Lower	3,842	5,196		
Blood pressure	High	5,264	5,734	27.4	31.6
	Lower	4,132	4,356		
Body weight	High	4,956	5,078	41.7	27.4
	Lower	3,498	3,988		
Tobacco use	High	4,192	4,184	10.8	16.3
	Lower	3,784	3,597		
Physical inactivity	High	4,477	4,582	26.6	15.3
	Lower	3,537	3,976		
Stress	High	5,024	5,249	13.0	8.6
	Lower	4,444	4,836		
Cholesterol	High	4,780	4,913	2.0	-2.5
	Lower	4,688	5,037		
Nutrition and eating habits	High	3,245	3,261	-23.2	-5.2
	Lower	4,226	3,440		
Alcohol consumption	High	3,857	3,843	-3.94	-9.48
	Lower	4,015	4,246		



Prudential Financial: A Case Study

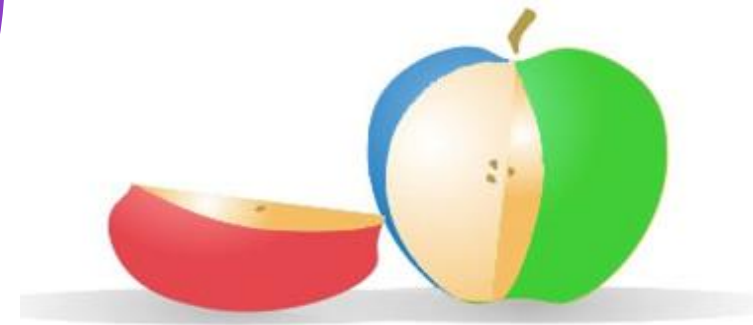
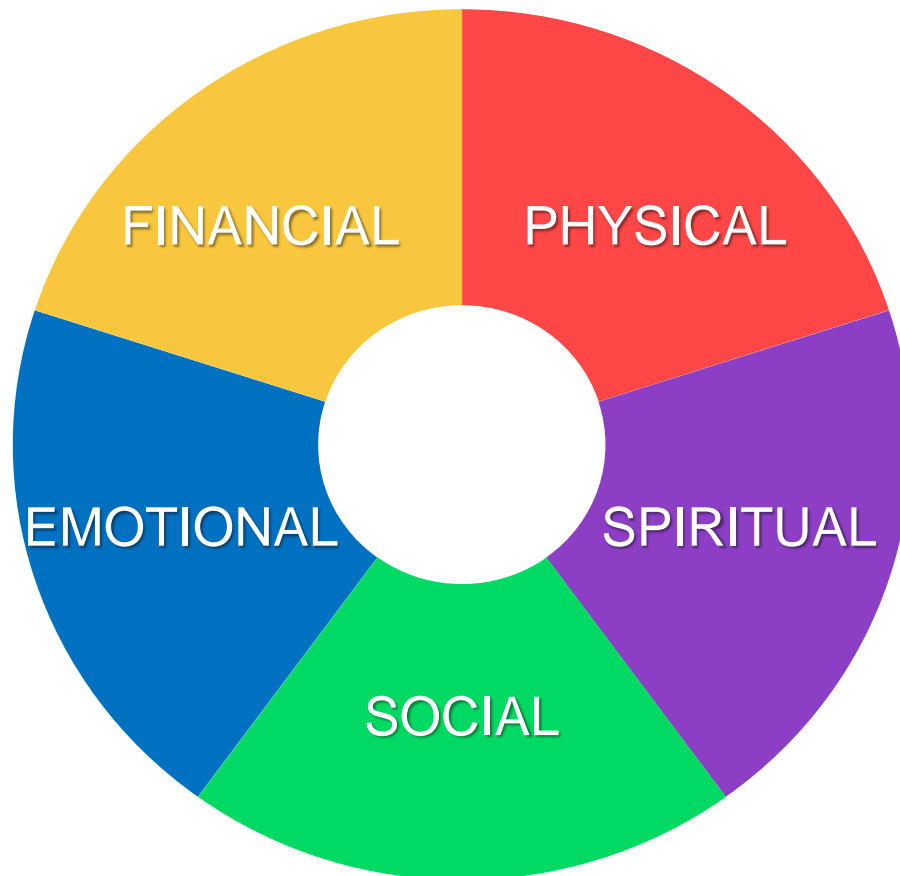
K. Andrew Crighton, M.D.

VP Global Health Organization/Chief Medical Officer

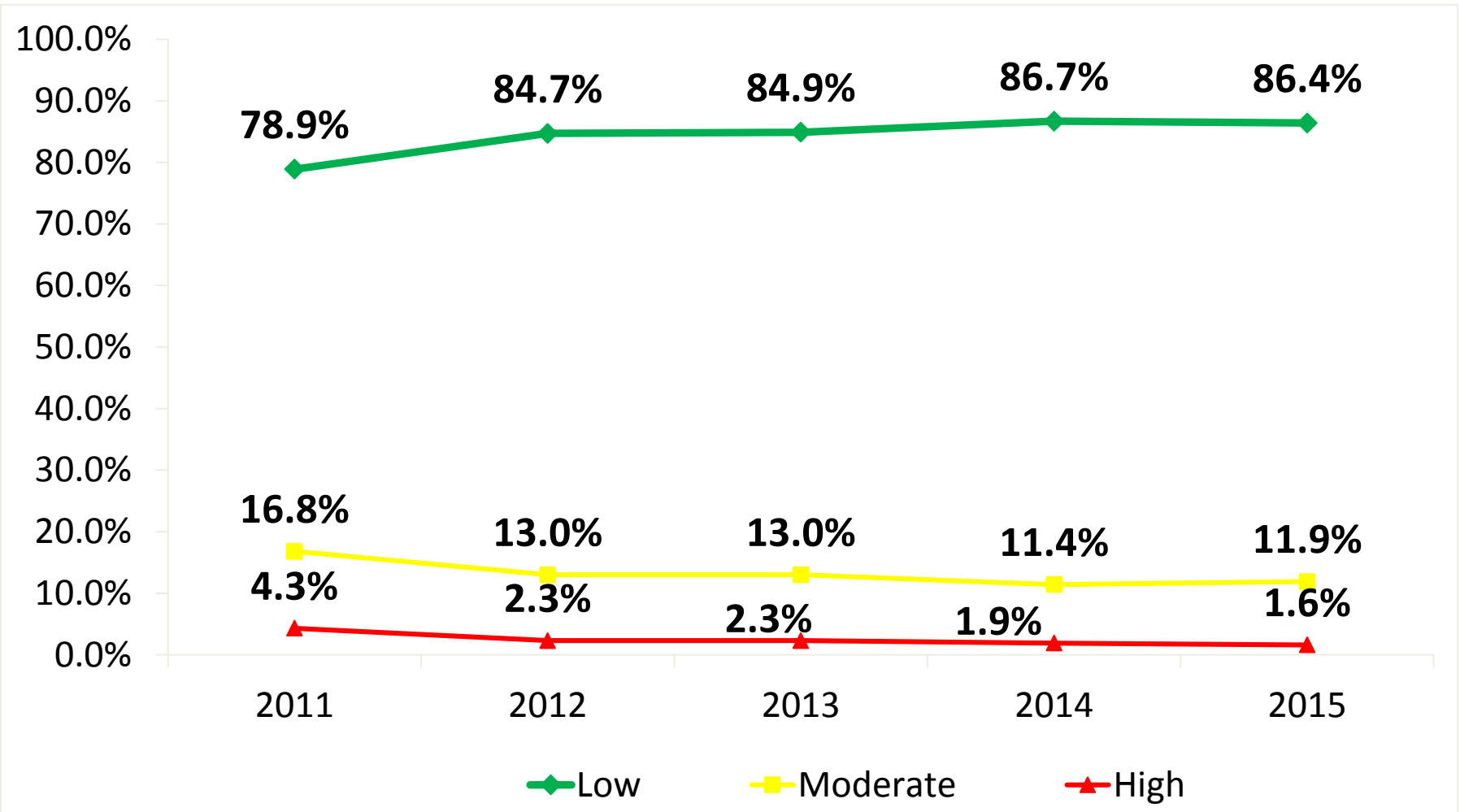
Prudential Financial



Moving to a Holistic Model of Health



Health Risk



Call to Action: Three Levels of Intervention

- Individual
- Organizational
- Policy / Societal



Individual

- Provide access to evidence-based medical and psychotherapeutic treatments
- Offer cognitive behavioral therapy -- computerized, telephonic, face-to-face
- Facilitate access to multicomponent programs that integrate mental and physical health interventions



Organizational

- Provide free/subsidized/insurance-covered depression care, lifestyle coaching/counseling, self-management
- Distribute educational materials that address depression and stress management
- Offer training to managers to improve ability to recognize depression and signs of stress
- Create opportunities for employees to participate in organizational decisions that affect job stress



Policy / Societal

- Fund national organizations, community centers, facilities that deliver mental health and stress management services
- Collect HIPAA protected, confidential data on workers' well-being for research and guide public health innovations
- Promote policies that address people in underserved communities, e.g. supporting community health workers



Summit Recommendations

- Develop mental health in the **workplace ‘how to’ guide**
- Create a mental health in the workplace **scorecard**
- Develop a workplace mental health **recognition program**
- Establish **executive leadership training programs** focused on building healthy company cultures



Our Vision: An Academic Center for Excellence (COE) in Workplace Mental Health

1. Academic research
2. Development of implementation tools and resources
3. Dissemination of best practices, through public health and business schools, social media, public relations firms, and journalists
4. Consulting on best practices related to “real world” measurement and evaluation of workplace mental health programs



References

1. National Center for Health Statistics. Health, United States, 2016: with Chartbook on Long-term trends in Health. Hyattsville, MD. 2017. <https://www.cdc.gov/nchs/data/hus/hus16.pdf>. Accessed March 6, 2018.
2. Merikangas KR, Ames M, Cui L, et al. The impact of comorbidity of mental and physical conditions on role disability in the US adult household population. *Arch. Gen. Psychiatry* 2007;64(10):1180-1188.
3. Scott KM, Lim C, Al-Hamzawi et al. Association of mental disorders with subsequent chronic physical conditions: Work mental health surveys from 17 countries. *JAMA Psychiatry*. 2016; 73(2):150-158.
4. Glassman AH. Depression and cardiovascular comorbidity. *Dialogues Clin. Neurosci.* 2007;9(1):9.
5. Luppino FS, de Wit LM, Bouvy PF, et al. Overweight, obesity, and depression: a systematic review and meta-analysis of longitudinal studies. *Arch. Gen. Psychiatry* 2010;67(3):220-229.
6. Melek SP, Norris DT, Paulus J, et al. Potential economic impact of integrated medical-behavioral healthcare. Updated Projections for 2017. Milliman Research Report, January 2018. <http://www.milliman.com/uploadedFiles/insight/2018/Potential-Economic-Impact-Integrated-Healthcare.pdf>. Accessed March 1, 2018.
7. Wang J, Adair CE, Patten SB. Mental health and related disability among workers: a population-based study. *Am J Ind Med.* 2006;49(7):514–522.
8. Greenberg PE, Kessler R, Birnbaum HG, et al. The economic burden of depression in the United States: how did it change between 1990 and 2000? *J Clin Psychiatry.* 2003;64(12):1465–1475.
9. Lerner D, Adler DA, Chang H, et al. The clinical and occupational correlates of work productivity loss among employed patients with depression. *J Occup Environ Med.* 2004;46(6 Suppl):S46–S55.

