Mental Health Works

Fourth Quarter 2012

South Shore Hospital Studies Self-Care in Health Care

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Partnership for Workplace Mental Health™

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Dear Reader:

Our last *Mental Health Works* issue focused on research efforts that intersected with workplace mental health. This issue features another approach to research that we hope will help you take action to implement new ideas and changes at your workplace.

Our employer feature story describes a program at South Shore Hospital, a regional medical center in suburban Boston. Like many medical settings, South Shore was concerned that its healthcare workers were caring compassionately for their patients while neglecting their own emotional and physical health. Learn how the hospital piloted — and measured the effects of — Self-Care in Health Care, a stress management program for staff, and achieved successful results.

Neglecting one's health, while caring for others, is not a problem unique to healthcare workers. There are a growing number of workers who are also caregivers, and many leading employers have instituted practices to support these employees. We're pleased to highlight a study that examines best practices by 17 employers in workplace eldercare to give you practical ideas that can be applied to your workplace.

The American Psychiatric Association has a number of free practical informational tools you can use to bolster employee education efforts. A DVD and companion guidebook *Mental Health: A Guide for African Americans and their Families* is now available to tailor health education messages specifically to African-American employees and their families. This article gives strategies to help you use this resource at your workplace.

And, finally, in response to employer questions about implementation of the Mental Health Parity and Addiction Equity Act, we've included an article to help you make sense of a few of the more complex elements of the law's regulatory requirements.

Please be in touch with us. Share your ideas, from information on a successful practice that's making a difference at your company, to something that's giving you a headache and that you want help with — we want to hear from you! Please contact us at **mhw@psych.org** or 703-907-8586.

Sincerely,

Alan A. Axelson, MD
Co-Chair, Partnership for Workplace Mental Health Advisory Council

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Mental Health Works

Partnership for Workplace Mental Health™

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Caring for Working Caregivers

BY KATE A. BURKE

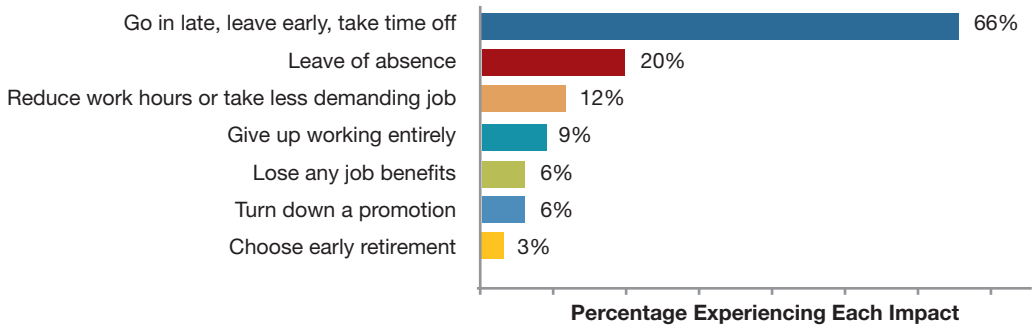
"Demographics" is not a word that tends to excite large numbers of people. Demographics are however foundational to many trends that will impact your business and hopefully your business strategy. This is the first time in American history that we have had four different generations working side-by-side in the workplace (Hammill, 2005). Moreover, the number of workers who are also caregivers is growing. A recent study jointly sponsored by the National Alliance for Caregiving (NAC), ReACT, and the Alzheimer's Immunotherapy Program (AIP) – ***Best Practices in Workplace Eldercare*** (Workplace Eldercare Study) (2012) – focused specifically on this aspect of the changing demographics of the United States, namely caregiving and its implications for the workplace. While caregiving is required by a range of populations, including injured veterans, children with special needs, and individuals with chronic medical needs, 72% of caregivers currently take care of someone age 50 years or older (National Alliance for Caregiving & AARP, 2009). The Workplace Eldercare Study was conducted to identify current trends and innovations in workplace policies and practices that support employees with eldercare responsibilities. Much of the learning can be applied to the broader range of caregiving needs. This article shares the study findings as well as connects complementary views of mental health in the workplace.

The Challenge and Connection to Mental Health

Millions of Americans provide care for family members at home who are aging or chronically ill, and that number is expected to grow as the number of older Americans is likely to double by the year 2030, according to the U.S. Department of Health and Human Services (2010). A typical profile of the caregiver population shows that 57% have worked and managed caregiving responsibilities at the same time. More than six in ten of these working caregivers (66%) report their caregiving responsibilities have affected their work (see Figure 1).

Figure 1: Work Accommodations Due to Caregiving

Q34. In your experience as both a worker and a caregiver, did you ever...?



Base: 2009 Caregivers who worked while caregiving (n=1,033)
(National Alliance for Caregiving & AARP, 2009)

The Workplace Eldercare Study also notes that working caregivers reported absenteeism, stress, and distraction at work. These realities have both indirect and direct costs for employers and when left unaddressed increase turnover costs. NAC has an online calculator for employers to estimate the cost of caregiving in terms of lost productivity: **www.eldercarecalculator.org.** The Partnership for Workplace Mental Health also has links to cost calculators that can assist employers to make the business case for programs that support the whole health of their employees (See the box at left).

In the **second quarter 2012 issue of *Mental Health Works*,** we highlighted information from the American Psychological Association's report ***Stress in America™: Our Health at Risk* (2012).** Findings from this survey show that caregivers report higher levels of stress, poorer health, and a greater tendency to engage in unhealthy behaviors to alleviate their stress, compared with the general public. Alternatively, the survey also reported that caregivers who feel adequately supported have, on average, significantly lower levels of stress than those who do not (American Psychological Association, 2012). "The caregiver group seems to do much better when they are plugged in to some sort of a support system," said Dr. Katherine Nordal, executive director for professional practice at the American Psychological Association. Dr. Nordal pointed out that caregivers demonstrate less isolation, less loneliness, better coping strategies, less depression, less irritability, and less risk of chronic disease when they have the support of family and friends and are connected to a variety of community-based support systems.

Visit the Partnership's **Business Case webpage.**

The Good News — Best Practices

Your organization can put in place any number of the best practice models that were revealed in the Workplace Eldercare Study and can become, or facilitate, the supportive network that your employees need.

The best practices from this study were collected from the 17 participant employers representing the following industries: professional and nonprofit associations, financial industry, healthcare providers, higher education, insurance, manufacturing, media, pharmaceutical, and information technology. There was also a wide range in size of organizations and in the type of workforce. The participants were:

1. Aetna
2. American Psychological Association
3. Caring.com
4. CBS Corporation
5. Duke University
6. Emblem Health
7. Emory University
8. Fannie Mae

9. Gundersen Lutheran Health System
10. Intel
11. Johnson & Johnson
12. Johns Hopkins University
13. Kimberly-Clark
14. MWV (MeadWestvaco)
15. Suncoast Hospice
16. UnitedHealth Group
17. U. S. Chamber of Commerce

"Key benefits to employers […] include worker retention, improved productivity, lower stress and improved health among workers, and is a plus for attracting new employees — all factors that take on special importance in a down economy." *(Workplace Eldercare Study)*

You can view additional details in the study. Participants companies were found through their membership or affiliation with ReACT, which works to highlight employers who have already identified the need for assistance in the area of employee caregiver needs.

The following synopsis summarizes the Workplace Eldercare Study best practice findings:

Paid Time Off and Flexibility in Scheduling: The ability to shift working hours, with notice from the employee, often is sufficient to meet most caregiver needs. When more time is required, there are a range of means for additional paid/unpaid time off to address caregiving needs, dependent on the size of the organization.

Geriatric Care Manager Service and Consultations: Providing access to independent and trained care managers allows employees to ask questions as they create a care plan. Having care managers who are independent consultants reduces employees' perceptions of conflict of interest on the part of the care manager or employer.

Planning for the Workplace Program: Taking the time to plan will make an important contribution to the success of your program. The planning process should include stakeholders such as trained professionals in geriatrics, elder law, work-life professionals, representative(s) from a peer institution who has managed a similar program, and recipients of the services. Having clear goals such as *increase employee engagement, reduce absenteeism rates, increase retention rates, and reduce the healthcare costs of employee caregivers,* along with the use of recurring surveys to measure success and/or need for adjustments will help keep you on focus and keep the program relevant.

Offering Employees Benefits Based upon Core Business Elements: Although many of the programs noted in the study are focused on services directly to the elderly patients or caregivers, including other employees in the offerings, for example a webcast on blood pressure management or yoga sessions, allows for *crossover benefit* to other employees.

Best Practices in Workplace Eldercare

The National Alliance for Caregiving (NAC) represents family caregivers and provides research and related resources, while ReACT is dedicated to addressing the challenges faced by employees who are caregivers for elderly persons and to reducing the impact on the companies that employ caregivers. The Alzheimer's Immunotherapy Program, of Janssen and Pfizer Inc., focuses on research and products to reduce the burden of neurodegenerative conditions (Workplace Eldercare Study).

Evidence-Based Programming: Highlight and use tools and materials that apply the most up-to-date research in order to enhance service outcomes. There are many organizations, such as the **National Alliance for Caregiving** (NAC) and **ReACT** that provide these tools at no cost.

Volunteer Programs: When funds are particularly tight, employee-organized volunteer groups have provided grassroots efforts to build a supportive community and share ideas. These networks are often important in reducing the sense of isolation, even when other more formal benefits are available.

The Corporate Culture: Modeling of support by the leaders of the organization, whether the C-suite or managers and supervisors, is crucial for employees to make use of the services developed for their benefit.

Looking Ahead to the Future

Utilization of services is an overarching need that was noted in the Workplace Eldercare Study that could impact your potential programming. High utilization increases corporate goals of increased recruitment and retention, and reduction of workplace accommodations and adverse outcomes, such as staff leaving the workplace altogether as a consequence of caregiving. The study indicated that a good strategy for achieving high utilization includes the following components:

"At work, generational differences can affect everything, including recruiting, building teams, dealing with change, motivating, managing, and maintaining and increasing productivity. Think of how generational differences, relative to how people communicate, might affect misunderstandings, high employee turnover, difficulty in attracting employees and gaining employee commitment." *(Hammill, 2005)*

- An understanding of your workforce and their needs;
- A program or policy that is available to all employees and not just one category of employee;
- Training of supervisors and managers about eldercare;
- Education for employees about the caregiving process and ways in which the program can support their goal of continuing to be a family caregiver and a productive worker; and
- Programs to help employees plan ahead for their caregiving responsibilities.

Communication and Trust

We come full circle to demographics. Key elements to the success of any of these programs include communication and trust. An added twist is that age not only impacts the study's caregiving recipients but also the way people communicate with one another and how much trust exists. Cross-cultural communication gaps are in play. One gap is between employers and employees. Another gap is related to generational preferences and sensibilities. For instance, Generation X, who currently are or are on the cusp of being caregivers to the elderly, are typically skeptical of authority figures in the workplace (Hammill, 2005). These differences impact a person's comfort level and underlying trust, which in turn impacts help-seeking behavior.

In a workplace characterized by fear and lack of communication, the costs are high to both employees and employers because of the tendency to wait to address caregiving issues until they are at crisis level. Now consider the hoped for future state of the workplace, where open dialogue about what is needed and potential consequences from both the employee and employer perspective allows early intervention and planning which mitigates risk for all involved.

Remember: As you start discussing needs and plans, keeping generational and communication style differences in mind will help to begin the discussion from a place of trust. Remember that trust is a two-way street.

Continual Review of Generational Impact

While much is said and written about the aging of the Baby Boomer generation, the need for employee caregiving of the elderly will not end. The Workplace Eldercare Study notes that the increase in the number of old-old elders (age 85 years and older) is compounded by fewer employees taking retirement by the expected age of 65 years. An aging workforce, as well as the next generation of caregivers, who will likely have different views and expectations, should influence employers to keep this issue on the radar for the future.

Remember: Schedule periodic reviews and/or surveys to help the workplace leadership keep informed about the changing dynamics of your workforce and ensure the relevance, adaptability, and success of your program.

Conclusion

The best practices and considerations for the future outlined in this article provide a number of building blocks for your response to your employees' needs. Gail Hunt, the President and CEO of the National Alliance for Caregiving, noted one more item that everyone should know. Whether you are an employer, human resources professional, employee assistance professional, or employee, Ms. Hunt urges the use of the Eldercare Locator **(www.eldercare.gov),** a public service of the U. S. Administration on Aging that provides a connection to a range of services for older adults and their families. You can also access the Eldercare Locator by calling 1-800-677-1116.

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South Shore Hospital Studies Self-Care in Health Care:

Using a Toolbox for Managing Stress

BY MAUREEN DEMENNA, RN, BSN; ANNA MICCI, MSW, LICSW, ACSW; AND MARGUERITE WOOD, MSW, LICSW

The previous issue of *Mental Health Works* featured an employer, **State Government of Maine,** that participated in a large research project with the University of Massachusetts. Participating in major research projects may not be possible for all workplaces. Many employers, however, are able to conduct small pilot studies that, combined with other evidence, may help to advance the knowledge base for workplace mental health. Here is an example of a pilot study in a hospital setting.

Healthcare workers are notorious for caring compassionately for their patients while neglecting their own emotional and physical health. At South Shore Hospital, a busy regional medical center in the suburban Boston area, clinicians in the hospital's Employee Assistance and Wellness Program (EAP) have struggled with traditional approaches to dealing with the stress associated with providing healthcare. A few years ago, they found they were stuck in a repeating loop of providing Critical Incident Stress Debriefing (CISD) sessions with little positive impact.

The EAP clinicians decided to take a proactive approach to meeting the needs of the healthcare workers they serve. They developed and launched the "Self-Care in Health Care" program and pilot study to explore more effective ways to help employees manage stress.

What Makes South Shore Hospital Distinctive?

South Shore Hospital's administration is highly incentivized to provide excellent health and wellness care because the hospital self-insures its employees. The hospital is unusual in having chosen to take an evidence-based approach to caring for the workforce, much like the approach it takes in delivering excellent medical care. Instead of "just trying something else," the clinical social workers in the EAP dug into their clinical experience and went to the literature to explore more effective approaches.

South Shore Hospital is a 318-bed, not-for-profit, tax-exempt, charitable provider of acute, emergency, outpatient, home health, and hospice care to the people of Southeastern Massachusetts. The hospital's 900-member medical staff represents all leading medical specialties. South Shore Hospital employs 3,800 people, supported by a team of 600 volunteers. The hospital is licensed to provide level II trauma care and level III maternal/newborn care. South Shore Hosptal has been ranked among the top three hospitals in Massachusetts, according to the 2012 *U.S. News & World Report Best Hospitals* report, and named a Top Place to Work by *The Boston Globe.* South Shore Hospital exists to benefit the people of the region by promoting good health and by healing, caring, and comforting.

South Shore Hospital Wellness programs include:

- yoga,
- neuromuscular integrative action (NIA) — a non-impact exercise routine,
- non-diet workshops addressing emotional overeating,
- smoking cessation clinics,
- blood pressure screenings,
- health questionnaires,
- sun damage screenings, and
- walking programs.

The EAP clinicians came up with several well-validated stress management interventions and combined them into a staff education program. They thought that if they could help key leaders develop a personal toolbox of coping skills to manage stress, it might have a positive ripple effect that would end up being felt across the entire organization. As the pieces began to crystallize, they decided they needed to create a research protocol to test their hunch. They also knew they needed backing for their efforts.

Employer Support

The EAP clinicians first sought administrative approval by approaching their leader, Bob Wheeler, Vice President of Human Resources, with the idea of the Self-Care in Health Care toolbox. He recognized that self-care in healthcare was problematic. Mr. Wheeler had recently launched an employee wellness campaign in partnership with Harvard Pilgrim Healthcare called "Choices for Healthy Living and Four Seasons for Health" to assist staff in moving toward self-care. The idea of a self-care program for managing stress also fit in nicely with the hospital's strategic plan to improve nurse satisfaction by addressing the stress that is epidemic in the healthcare environment.

Evidence

Chronic stress is blamed for healthcare worker burnout and is responsible for costly, high staff turnover rates. Multiple studies correlate various measures of stress with medical error rates and other negative patient outcomes, such as increased mortality, failure to rescue, and patient dissatisfaction (Jennings, 2008). Healthcare executives seek creative strategies for mitigating stress and preventing burnout. Creating a positive workplace culture in the healthcare environment requires acceptance of stress as a fact of life. Researchers recommend focusing attention on creating emotional resilience, rather than trying to avoid stress (Sergeant & Laws-Chapman, 2012).

Evidence-based Practice: the practice of health care in which the practitioner systematically finds, appraises, and uses the most current and valid research findings as the basis for clinical decisions.

Mosby's Medical Dictionary, 8th edition (2009, Elsevier)

Nurses are reluctant to care for themselves and rarely take breaks (Stephancyk, 2009). One study compared nurses' *perceived stress* to job-related *nursing stress scale scores* and found that even when the nursing stress indicators are lower, perceived stress may remain high. The implication is that the *perception* of stress among nurses may be related to negative patient outcomes (Purcell, Kutash, & Cobb, 2011). A better understanding of how to reduce perceived stress and increase resilience is needed to craft effective solutions.

The success or failure of efforts to reduce stress is reflected in work satisfaction scores, patient satisfaction scores, and ultimately patient safety scores. These scores will have a greater impact on hospital reimbursement as healthcare reform moves toward rewarding institutions with positive patient health outcomes and penalizing those with poor quality indicators.

Critical Incident Stress Debriefing

The idea for the pilot project first presented itself when the EAP clinicians at South Shore Hospital became aware of the increasing number of requests from nurse managers for critical incident stress debriefing (CISD). CISD is requested when there is a trauma and staff members are called together to discuss the incident. The theory is that this type of processing of the trauma makes it easier for the survivors to work through their emotions.

The EAP clinicians found that they and hospital clergy would prepare for a debriefing, but employees would rarely participate. When later questioned, employees would report feeling that talking in a group did not relieve their stress and often made things worse. CISD attendance was low, and effectiveness seemed minimal, despite robust utilization of other EAP services. The hospital's experience was consistent with the research literature. A meta-analysis of CISD confirmed that this approach did not actually improve natural recovery from psychological trauma and could even exacerbate trauma (Van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002).

EAP clinicians then reviewed previous stress reduction efforts, such as team building, assertiveness training, professional coaching, and stress management workshops. Although hospital staff reported that these seminars were helpful, they shared that the skills were not readily utilized during traumas and other stressful situations. The EAP clinicians knew from their experience that there were other stress management tools that were effective. They came up with the idea of teaching employees how to use a stress management toolbox, with the goal that this would be an ongoing and sustainable way of managing stress.

Stress Management Toolbox

The toolbox consists of well-validated stress management techniques that healthcare workers can use as needed.

The toolbox components are based on:

- Cognitive Behavior Therapy — an approach used to assist people in changing their negative thoughts, thereby positively changing their emotional state (Butler, Chapman, Forman, & Beck, 2006). A study of nurses hypothesized that burnout is related to irrational thinking and found that by disarming irrational beliefs, nurses could foster professional growth and decrease workplace stress (Balevre, 2001).
- Positive Psychology — a relatively new field of psychology that teaches learned optimism (Emmons & McCullough, 2003). The idea is that a capacity for happiness and well-being can be cultivated through gratitude journaling (Seligman, Steen, Park, & Peterson, 2005).

- Mindfulness Based Stress Reduction (MBSR) — an approach that promotes a nonjudgmental awareness of moment-to-moment sensations, experiences, and reactions. MBSR employs meditation techniques that promote relaxation and stress reduction (Kabat-Zinn, 1994). This technique has been documented "as an effective tool to support nurses psychologically and to improve work satisfaction" (Penque, 2009).
- The Relaxation Response — another highly effective tool closely related to MBSR that reduces stress. The relaxation response is a state of deep rest that changes the physical and emotional response to stress, e.g., decreases heart rate, blood pressure, rate of breathing, and muscle tension (Benson & Klipper, 2000).

Intervention sessions were held in a converted residence, which houses EAP and wellness services, across the street from the hospital.

Designing the Pilot

The EAP clinicians envisioned a program where healthcare workers would learn to help themselves by using the tools in the toolbox to manage stress. Before such a program could be put in place on a large scale, the effectiveness of a stress management toolbox had to be measured.

The EAP clinicians wanted access to the nurse managers as a starting point to test their hypothesis. They sought approval from the hospital's Vice President and Chief Nursing Officer, Tim Quigley, who recognized that nurse managers particularly endure tremendous stress on a day-to-day basis. He responded enthusiastically by sharing literature and arranged for EAP clinicians to pitch the idea to the nursing directors. More important, Mr. Quigley and his nursing directors granted release time for nurse managers to participate in an on-site program.

EAP clinicians contacted the research department for help designing a pilot study. The manager of the clinical research department and Susan Duty, ScD, the nurse scientist at the hospital, helped the EAP clinicians craft their ideas into a researchable question with a measurable outcome that could withstand the scrutiny of the hospital's institutional review board (IRB). This was no easy task since the target population was nurse managers and the sample size would be small, even if 100% of the nurse managers agreed to participate. Finally, the ideas were designed into a randomized, prospective, quasi-experimental study to evaluate the effectiveness of a proactive approach to reduce perceived stress in nurse managers. The study was approved by the IRB.

Intervention Format:
- Half-day workshop
- 90 minute meetings every other week for three months

Materials:
- Guided imagery CD
- Workbook
- Gratitude journal

The Pilot

The research team, which consisted of two clinical social workers affiliated with the EAP and a research nurse, recruited and organized a small group of nurse managers to meet in a quiet setting, away from telephones and pagers. The nurses began the intervention with a half-day workshop based on the stress management theories and the stress

management toolbox described above. Each participant received a guided imagery relaxation CD to promote the relaxation response, a workbook to log the amount of time spent in a state of mindfulness training, and a gratitude journal. Over a three-month period, the nurses met with the team every other week for 90-minute sessions to elaborate on and reinforce the stress management toolbox techniques. (Sample materials are available by request to the authors.)

To measure the effectiveness of the program, the study used a well-validated, 14-item questionnaire called the **Perceived Stress Scale (PSS)** (Cohen, Kamarck, & Mermelstein, 1983). This scale is available for nonprofit academic research or nonprofit educational purposes. A 10-item version of the scale is shown in the inset box. Differences in PSS scores of significant magnitude have been observed in previous studies with numbers of participants similar to that in the hospital's pilot study (Shapiro, Astin, Bishop, & Cordova, 2005). To reduce self-selection bias, researchers insisted that the participants be randomly assigned to receive the stress management intervention. Seventeen nurse managers volunteered for the study. Twelve participated in the intervention, and the others served as the control group. The control group was offered the intervention after the three-month period. This required two programs to run consecutively. All participants were surveyed before random assignment to study groups, after the intervention period, and/or again after a follow-up period.

Perceived Stress Scale — 10 Item

(Cohen, Kamarck, & Marmelstein, 1983)

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, please indicate with a check how often you felt or thought a certain way.

Responses: 0=never, 1=almost never, 2=sometimes, 3=fairly often, 4=very often

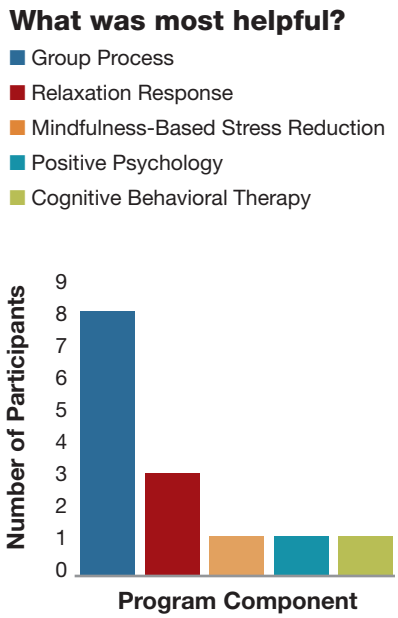
1. In the last month, how often have you been upset because of something that happened unexpectedly? ① ② ③ ④
2. In the last month, how often have you felt that you were unable to control the important things in your life? ① ② ③ ④
3. In the last month, how often have you felt nervous and "stressed"? ① ② ③ ④
4. In the last month, how often have you felt confident about your ability to handle your personal problems? ① ② ③ ④
5. In the last month, how often have you felt that things were going your way? ① ② ③ ④
6. In the last month, how often have you found that you could not cope with all the things that you had to do? ① ② ③ ④
7. In the last month, how often have you been able to control irritations in your life? ① ② ③ ④
8. In the last month, how often have you felt that you were on top of things? ① ② ③ ④
9. In the last month, how often have you been angered because of things that were outside of your control? ① ② ③ ④
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? ① ② ③ ④

Pilot Study Results

The study resulted in some interesting findings:

High level of perceived stress — The baseline PSS scores of the nurse manager participants were double what would be expected for the general population (Cohen & Williamson, 1988).

Reduced perceived stress in the intervention group — The team saw a modest downward trend in perceived stress scores for the intervention group, while the control group's PSS scores continued to rise. Though all participants' stress levels remained comparatively high, relative to the general population, the comparative analysis of scores between the intervention and control groups showed a reduction in PSS in the intervention group. Those in the intervention group who most actively applied the stress



management tools did better in the short term. However, once the group disbanded, their perceived stress rose again. Without group support, the participants found sustained use of the tools difficult.

Low self-compassion noted — Anecdotally, the research team noticed a low level of self-compassion among the participants. Self-compassion is the ability to view oneself with care, concern, and acceptance. **The Self-Compassion Scale** was introduced to help participants recognize this concept (Neff, 2003). The team also observed that when a high level of trust was achieved within the group, there was greater satisfaction and adherence to the program.

Group process valued — Program evaluation surveys revealed the group process to be the most helpful aspect of the program. The second most helpful aspect was learning the relaxation response. Subjects commented that time pressures prevented them from completing the gratitude journal, which was the positive psychology tool.

Almost all subjects said they planned to employ the tools they learned in the program. Several expressed desire for continued sessions to maintain these skills. One participant wrote, "I am very appreciative; I fear I will fall back into my old ways without some way to force myself to recall what we have learned." In general, participants were very positive about the program. For example, one participant provided the following comment on the program evaluation: "Thanks for the time and opportunity. I feel I react to stress better now and am more direct in my conversations with my supervisor." Another wrote, "Overall, I believe the program gave me some good insight into understanding and managing my stress load professionally and personally."

Summary

The pilot study confirmed that healthcare workers are challenged with extremely high levels of perceived stress and reluctant to engage in self-care. The high level of perceived stress in this population warrants additional research to enhance understanding of this finding, as well as ongoing efforts to develop effective, sustainable interventions.

Just as one's own oxygen mask is required before assisting other passengers on an airplane, caring for oneself is a prerequisite for effectively caring for others.

Based on previous studies, reducing perceived stress in the workforce should ultimately have a positive impact on patient care (Jennings, 2008). Just as one's own oxygen mask is required before assisting other passengers on an airplane, caring for oneself is a prerequisite for effectively caring for others. This pilot study suggests that building a self-care toolbox through an on-site, proactive, multipronged group program is effective in reducing perceived stress.

Healthcare employers who are successful in creating a positive workplace culture with lower perceived stress may have a competitive edge in terms of healthcare premium savings and improved quality indicators. South Shore Hospital continues to support its employees with a wide range of wellness services.

For more information, contact Marguerite Wood, MSW, LICSW, Director of Employee Assistance and Wellness, South Shore Hospital, at Marguerite_Wood@sshosp.org

Supporting healthcare workers to build and use a self-care toolbox shows great promise for reducing perceived stress, improving employee satisfaction, and ultimately improving the delivery of patient care.

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Parity Law Compliance: Standards for Financial Requirements and Treatment Limitations

BY MARILYN VADON, JD, LLM

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its implementing regulations, called the Interim Final Rules (IFR) (U. S. Department of the Treasury, U. S. Department of Labor, & U. S. Department of Health and Human Services, 2010), contain many concepts and details that can be confusing to plan sponsors. Despite these complex requirements, employers should be mindful that as plan sponsors, they are responsible for compliance with the law and any financial penalties associated with noncompliance, which can be substantial. See the article **"Parity Compliance Problems and What Employers Can Do to Protect Themselves"** in the Fourth quarter 2011 issue of *Mental Health Works* for a discussion of specific areas of concern.

MHPAEA applies to health plans that cover more than 50 employees and offer mental health and/or substance use disorder coverage. It prohibits these health plans from imposing financial requirements and treatment limitations on mental health and substance use disorder benefits that are not comparable to or are more stringent than requirements or limitations imposed on medical/surgical benefits. But how do you know whether your company health plan's or plans' financial requirements and treatment limitations are comparable, and therefore, in compliance with MHPAEA and its IFR?

Key Concepts for Parity Compliance

The parity law's IFR includes and defines key concepts fundamental to compliance: financial requirements and two types of treatment limitations, quantitative and nonquantitative.

Financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. Essentially, these are the aspects of plan design that outline the cost-sharing between the plan and the enrollee.

Treatment limitations, the other key mechanism that defines the parameters of benefit coverage, can be quantitative and nonquantitative. Quantitative treatment limitations include treatment limitations that are expressed numerically, such as annual outpatient visits and hospital days. Nonquantitative treatment limitations, on the other hand, are treatment limitations that are not necessarily expressed numerically, but otherwise affect the scope and duration of the benefit. Examples of nonquantitative treatment limitations include medical management standards, standards for provider network admission (such as provider reimbursement rates), fail-first policies, and exclusions based on failure to complete a course of treatment.

Mental Health Parity and Addiction Equity Act of 2008

The law requires that any group health plan that covers more than 50 employees and offers mental health and/or substance use disorders coverage must provide coverage with no greater financial requirements or treatment limitations than the predominant requirements that it applies to substantially all medical/surgical benefits.

Previous federal legislation in 1996 provided limited parity on lifetime and annual dollar limits and did not extend to substance use disorders.

Visit the Partnership for Workplace Mental Health's **parity webpage** for more information.

Standards for Measuring Compliance

The IFR provides the same standard for financial requirements and quantitative treatment limitations. Stated briefly, a group health plan cannot apply any financial requirement or treatment limitation to mental health and substance use disorder benefits that is more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits. The implementation of the standard for financial requirements and quantitative treatment limitations has been quite successful, due to the fact that the standard is a straightforward, arithmetic calculation.

In contrast to the test for financial requirements and quantitative treatment limitations, due to the non-arithmetic nature of nonquantitative treatment limitations, implementation of the standards with respect to nonquantitative treatment limitations has been more difficult to ascertain. As the IFR explains, the parity standards for nonquantitative treatment limitations (the "NQTL rule") require a slightly different analysis.

To be in compliance with the NQTL rule, health plans must satisfy a three-prong test when comparing the provision of medical/surgical benefits and mental health and substance use disorder benefits within the same plan. The NQTL rule says that a covered health plan cannot impose a limitation with respect to mental health and substance use disorder benefits in any classification unless:

(1) the nonquantitative treatment limitation is comparable to a nonquantitative limitation for medical/surgical benefits; **AND**

(2) the nonquantitative treatment limitation is applied no more stringently to mental health and substance use disorder benefits than to medical/surgical benefits; **OR**

(3) there is no recognized clinically appropriate standard of care that would permit an exception to the NQTL rule and allow disparate handling of the limit between mental health and substance use disorder benefits and medical/surgical benefits.

The first two prongs are interdependent; therefore, if *either* of the prongs of the NQTL rule is not met, the parity standard for nonquantitative treatment limitation is not satisfied and there is a violation of MHPAEA. The third prong constitutes a limited exception to the NQTL rule; therefore, the plan must demonstrate that this exception is met if either one or both of the first two requirements are not satisfied.

So, for example, if a health plan imposes a preauthorization requirement on the use of mental health and substance use disorder services, it must either have a comparable preauthorization requirement on the use of medical/surgical services that is applied no less stringently than the preauthorization requirement on the use of mental health and substance use disorder services or have a recognized clinically appropriate standard of care that permits a difference.

Recently, URAC (formerly known as the Utilization Review Accreditation Commission) issued guidelines related to MHPAEA. These guidelines require that health plans accredited by URAC must be able to substantiate that there is a written basis for compliance with the NQTL rule. To receive URAC accreditation, among other things, a health plan must document that it has provided parity between mental health and substance use disorder services and medical/surgical services and has a detailed internal audit and analysis of each medical management intervention applied to behavioral health treatments.

To ensure compliance with MHPAEA and the IFR and satisfy URAC's new requirements, check to see if your company's health plan(s) has an analysis of its basis for compliance with MHPAEA and the IFR and check whether the analysis is consistent with the three-prong test described above.

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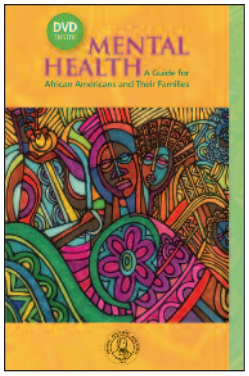
See the article **"URAC Health Plan Accreditation Requires Parity Compliance Programs"** in the third quarter 2012 issue of *Mental Health Works* to learn more.

SOURCE

U. S. Department of the Treasury, U. S. Department of Labor, and U. S. Department of Health and Human Services. (February 2, 2010). *Interim final rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.* Retrieved from http://workplacementalhealth.org/Business-Case/Mental-Health-Parity/Text-of-the-Interim-Final-Rule.aspx?FT=.pdf

DVD and Guidebook Available for African American Employee Education

BY ANNELLE PRIMM, MD, MPH AND MARY CLAIRE KRAFT



The American Psychiatric Association (APA) has developed an educational resource that is now available to employers to raise awareness about mental health at the workplace. **Mental Health: A Guide for African Americans and their Families,** a DVD and companion guidebook, was created to inform the general public about mental health, to dispel common misperceptions, and to reduce the stigma of mental illness among African Americans.

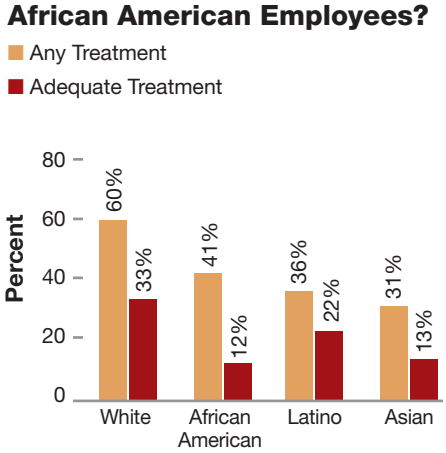
Developed by APA in collaboration with the African Methodist Episcopal Church, the DVD features former US Surgeon General David Satcher, MD, PhD, and discussions with people in treatment who talk about their experiences with mental illness. Leading psychiatric experts Tracee Burroughs, MD, and Michael A. Torres, MD, discuss common mental illnesses, their symptoms and treatments, and issues of special relevance to African Americans.

The 30-minute DVD and guidebook explores:

- Different types of mental illnesses
- Ways to treat mental illness
- How the traditional resilience and strength of the African American community can help people recover from mental illness and achieve their goals and dreams.

A downloadable version of **Mental Health: A Guide for African Americans and their Families** is available free online. Free copies of the DVD and the guidebook may be requested by sending an email to **apa@psych.org.**

Why Tailor Health Education to African American Employees?



Adapted from "Disparity in Depression Treatment Among Racial and Ethnic Minority Populations in the United States," by M. Alegria, P. Chatterji, K. Wells, Z. Cao, C. Chen, D. Takeuchi, J. Jackson, and X.-L. Meng, 2008, *Psychiatric Services, 59,* p. 1268. Copyright 2008 by the American Psychiatric Association.

Why Tailor Health Education to African American Employees?

African American communities are underserved by the nation's mental health system. For example, one out of three African Americans who need mental health care receives care (Young, Klap, Sherbourne, & Wells, 2001). Compared to the general population, African Americans are more likely to stop treatment early and are less likely to receive follow-up care.

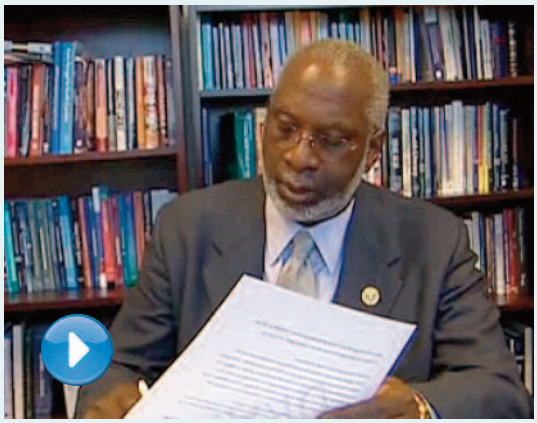
Rates of mental illnesses among African Americans are similar to those in the general population. However, there are differences in the nature of some specific disorders and disparities in mental healthcare. For example, depression in African Americans tends to be more chronic and disabling than Caucasians. African Americans receive less care and poorer quality treatment, and they often lack access to culturally competent care (Primm & Lawson, 2010). Historically, mental health research has been focused on Caucasian- and European-based populations and did not incorporate understanding of other racial and ethnic groups and their beliefs, traditions,

and value systems. Culturally competent care is crucial to improving utilization of services and effectiveness of treatment for these communities.

One recent study of African American mental health consumers found a number of common barriers to treatment, including:

- The importance of family privacy (not letting anyone outside of the family know about the illness)
- Lack of knowledge regarding available treatments; denial of mental health problems
- Concerns about stigma, medications, and treatment
- Not receiving appropriate information about services
- Receiving inadequate or dehumanizing services (Ayalon & Alvidrez, 2007).

The researchers concluded that it is important to educate the general public, not just mental health consumers, about the nature of mental illness and available services.



Former US Surgeon General David Satcher, MD, PhD, explains why mental health is an important cause to him in his career. Click to play

According to Sandra Walker, MD, chairperson of the APA Council on Minority Mental Health and Health Disparities, "This DVD and guide provide a great opportunity for employers to reach out to their employees with information that is greatly needed. Employers are uniquely positioned to help their employees by simply making resources like this available. Providing education helps reduce stigma surrounding these illnesses and encourages employees who need care to feel comfortable accessing the treatment they need."

Strategies for Using the Educational Materials

The DVD and guidebook available from the APA can be used by employers to tailor health education messages specifically to African American employees and their families. Making health messages culturally relevant to African Americans and drawing on African Americans' strengths are crucial. "Throughout history, African Americans have overcome great adversity. Informed by accessible information, this strength can be used today to help manage a leading cause of suffering in the African American community," said Walker.

Employers are encouraged to consider the following strategies for using the DVD and guidebook to educate employees about mental illness and mental health:

- Create links to the DVD and guidebook on your company intranet, benefits portals, and anywhere employees access health and benefits information.
- Incorporate the educational content into your company's wellness and health education offerings.

- Integrate messages to help normalize mental health problems and combat stigma.
- Encourage benefits managers to contact their EAP and worklife vendors to ensure they have the guidebook available.
- Promote the DVD and guidebook in locations where African American employees are likely to see the information.
- Use the DVD and guidebook to train managers and supervisors about African American mental health and about appropriate steps managers can take to help employees in need.
- Bring employees together for a lunch-and-learn session. Use the guidebook to help facilitate a conversation about mental health. Be sensitive to the fact that due to stigma, some employees will feel more comfortable than others.
- Play the DVD on televisions placed in common areas, such as employee break rooms. Provide collateral material about how to access employee health benefits and services, including the employee assistance program (EAP).
- Promote the availability of the DVD and guidebook at employee health fairs and in occupational health settings.
- Celebrate National Minority Health Month (April), Black History Month (February), and Bebe Moore Campbell National Minority Mental Health Month (July) and shine a spotlight on African American mental health through activities and educational offerings.
- Connect educational information with reminders about the benefits and services available to employees and their family members. In particular, promote the company's EAP and other services for employees and family members, independent of whether they receive health coverage through corporate health benefits.

Additional information about African American mental health is available at **APA website: Healthy Minds. Healthy Lives.**

For more on mental health disparities in the African American population, check out the APA Fact Sheet, **Mental Health Disparities: African Americans.**

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Save the Dates

2013 IBI/NBCH Health & Productivity Forum

February 25–27, 2013, The Fairmont Dallas, Texas

Two nationally-recognized non-profit organizations (**Integrated Benefits Institute** and the **National Business Coalition on Health**) focused on workforce health and its broad impact on worker productivity and quality of life are partnering to host the **2013 IBI/NBCH Health and Productivity Forum.** The program will provide employers, their supplier-partners and other health and productivity stakeholders a unique learning environment. The goal is to foster objective discussion and evaluation of the latest practical approaches to investing in and promoting workforce health and productivity.

For more information, visit the **Forum website.**

7th Annual National Conference for Caregiving Coalitions

March 13, 2013 in Chicago, Illinois

For employers interested in corporate eldercare, attendance will provide the opportunity to: discover the latest family caregiving research, technologies and developments; discuss current legislative updates and advocacy planning; build caregiving coalition strategies; and review new resources for family caregivers.

For more information, visit the **Conference website.**

2013 Annual EASNA Institute

May 1–3, 2013, The Sax Hotel Chicago, Illinois

The goal of the Institute is to bring together exemplary employer representatives, industry-leading employee assistance providers and other human capitol experts to engage in informative discussions for the benefit of employers, employees/workers, unions, human resource professionals, and benefits consultants in successfully addressing the new dynamics of today's global workforce.

For more information, visit the **EASNA website.**

2013 American Psychiatric Association Annual Meeting

May 18–22, 2013, San Francisco, California

The theme for the 166th Annual Meeting of the American Psychiatric Association is "Pursuing Wellness Across the Lifespan." Save the date and look for more information about events specifically of relevance to psychiatrists and employers in interested in workplace mental health.

For more information, visit the **APA website.**

Resources for Employee Education

The American Psychiatric Association *Let's Talk Facts* brochures provide factual information based on scientific research about psychiatric disorders and their treatments.

Bulk purchasing and customization options are available (minimum quantity of 5,000 for customization). To learn more, email *mhw@psych.org*. Mention "Mental Health Works" for special pricing!

***Let's Talk Facts* brochures are available on a wide variety of topics including:**

- Anxiety
- Bipolar Disorder
- Common Childhood Disorders
- Domestic Violence
- Eating Disorders
- Obsessive-Compulsive Disorder (OCD)
- Panic Disorder
- Posttraumatic Stress Disorder
- Psychotherapy
- Schizophrenia
- Seasonal Affective Disorder (SAD)
- Sexual Orientation
- Teen Suicide
- Warning Signs of Major Mental Illness

Check out the entire line of available *Let's Talk Facts* brochures.

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- Business case for action
- Employer case studies
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