Presentation

Slide1

One of the biggest opportunities you have as an employer is to purchase health benefits that improve your employee's clinical outcomes AND your own bottom line. Depression care is a health benefit that does both.

Slide 2

As an overview we are going to cover three major points today:

1. Depression in the workplace so you can get a handle on how big a problem depression is to your organization.
2. Depression's burden both to your employees and your organization with the care you currently purchase.
3. Lastly and most excitingly, we will look at the ways you can reduce that burden by purchasing value, value that accrues to both the employee and the organization.

Slide 3

Benefits managers are becoming more alarmed as they learn more about depression in the workplace. According to the latest national studies, 7.2% of American employees experience a serious depressive episode every year. That means that you can walk down an aisle in the building you work at and go past fourteen cubicles and realize that one out of those fourteen individuals will have serious problems with depression this year.

Slide 4

It is important that we all understand what we mean by the term depression. It is used in a variety of different ways depending on who you talk to. Depression is more than just a bad day. The clinical criteria for depression requires two weeks or more of an employee being consistently sad or blue or reporting they have lost interest in things they usually care about. , These employees will also experience other serious problems including major changes in their sleeping patterns or their eating patterns, trouble with fatigue, self-doubt or inappropriate guilt, major problems concentrating, either be really hyper or really lethargic , and have thoughts of self harm.

However, depression doesn't always appear in the workplace the way that it appears when a patient is seeking treatment for it. The sad or blue employee person does not burst out into tears at the least provocation of the workplace. Oftentimes the sad or blue employee will be continually negative or very, very irritable. The employee who has lost interest used to feel part of the team and now acts very withdrawn. Depressed employees often have problems with deadlines. The self doubt and guilt emerges as excessive apologizing or what you might think of as shirking responsibility simply because they do not have the confidence to undertake tasks that they used to. Concentration problems will show up as increased mistakes.. Thoughts of self harm oftentimes appear as morbid or dark humor.

Slide 5

It is important to understand that depression like diabetes is a disease. So it burdens an individual biologically as well as psychologically and socially. The impairment from depression is so severe that depressed individuals cut back on their usual activity. That means they stay in bed for the day or they reduce their usual activities by half a day or more 66.4 days per year. That's two months out of their lives.

Slide 6

Major depression also increases absenteeism - depressed workers will report an extra 1.6 days of absenteeism each month that can be attributed solely to the depression and it will reduce their productivity on days that they are at work. Depressed workers report 70% of peak productivity during their episodes.

Slide 7

The bottom line? Depression treatment costs American employers $27 billion a year. However, employers pay an additional $36 billion a year because the depression treatment you currently purchase has little if any effect on absenteeism and reduced productivity at work. It's like buying $27,000 worth of computers for a project and having to pay an extra $36,000 for repairs the same year in order to complete the project.

Slide 8

This left all of us scratching our heads and asking what is wrong with this picture…..

Slide 9

Even though antidepressant medication costs are among the top drugs that most employers pay for and they are rising. Most of the increasing costs appear to be for off label use. . 5 out of 10 depressed employees who visit their primary care provider during their episode fail to start any treatment at all. And 4 in 10 who start treatment discontinue medication before they can realize any clinical benefit. So even the dollars we are spending are not dollars that are going to do anybody any good.

Slide 10

What direction do we need to going? We need to be working with employers like the ones in this room who want value when they purchase a product. Employers who understand that they can design health benefits to ensure that their depressed employees receive the treatment shown by multiple research studies to improve clinical and work outcomes.

Slide 11

So what does that treatment look like? We call it depression management in the workplace or DMW care.

DMW care confidentially provides

1. Systematic identification of your depressed employees
2. Education and monitoring of depressed employees over 24 months.
3. Oversight by a licensed mental health professional.

4. Feedback to doctor if employee fails to improve or relapses.

The take home message here is that depression is a treatable disease if we identify it and stay on it.

Slide 12

So let's look at how the treatment you are currently purchasing impacts the number of days your employees either stay in bed or do half of what they usually do. The care that you are currently paying for is that dark blue line. The number of impairment days improve, but not much. The care you could be purchasing is the pink line. With DMW care you start at the same place you get a substantial drop by month six which continues to month 12 and sustains over the second year after treatment has begun. If you look at the difference between those curves - the difference between what you are purchasing now and what you could be purchasing- each of your depressed employees will suffer 31 fewer impairment days each year.- an extra month of feeling alive.

Slide 13: Effects on Absenteeism

OK Great, but what's in it for me as the employer? The dark blue line represents absenteeism with the depression care you are currently paying for. Depressed employees lose about 20 hours of work a month at the beginning. Absenteeism improves a bit but within two years, heads right back up to levels that are very expensive for your organization. The pink line represents absenteeism with the care you could be purchasing. With DMW care, absenteeism starts at the same place. However, absenteeism not only improves faster but stays improved. In fact at the end of two years, a depressed employee is no more likely to miss work than any other employee in your organization. If you look at the difference between those two curves, economists tell us that DMW care reduces absenteeism by 6.1 days for each participant each year, at an annual economic value of $619 per depressed employee. Scientists not salemen calculate that with DMW care, your organization gets at an annual return of $619 per depressed participant in improved absenteeism.

Slide 14: Effects on Productivity

However DMW care is even more successful in improving presenteeism, or productivity on days that employees are at work. The dark blue line represents presenteeism with the care you're currently paying for. You see that depressed employees are on average report 72% of maximum productivity when we identify them. But over time, their productivity at work actually diminishes, and we're very concerned that this represents side effects from antidepressant medications which aren't adjusted appropriately. The pink line represents presenteeism with the care you could be purchasing. With DMW care, productivity immediately starts going up until it hits almost 80% of maximum productivity, the level non-depressed employees report . So that again if we look at the difference between the two curves, DMW care improved productivity at work by 8.2% which is an additional 18 days of work you're getting per participant each year. Again, scientists not salemen calculate that with DMW care, your organization gets at an additional annual return of $1,982 per depressed participant in improved productivity at work.

Slide 15: Effects on Workplace Conflict

How many days have you or other managers in your organization developed pounding headaches from trying to resolve employee conflicts which defy rational resolution?

With the care you're currently purchasing, about 19% of your depressed employees will report one or more serious conflicts at work during the year. With DMW care, it's 8%. DMW care benefits more than just the depressed employee.

Slide 16 ROI: Organization

Most organizations want to do the right thing by their employees, but they also have to manage the bottom line. So scientists analyzed whether DMW care provided a return on investment (or ROI) for an organization. So we're all on the same page, let's define ROI. Organization ABC pays an additional dollar to purchase a new product, and receives additional value for that dollar. In the case of DMW care, Organization ABC pays a dollar to purchase DMW care, and realizes 3 dollars of additional work, both through improved absenteeism and improved productivity at work.

Slide 17 ROI: Organization

So let's look at the ROI from DMW care to a transportation firm who employees 10,000 workers. The annual savings to the company in improved absenteeism and productivity is estimated to be $423,112. The annual cost to the company for DMW care is estimated to be $58,500. So their Return on Investment or ROI is 3.6:1. Or $3.60 in savings for every dollar that they spent on DMW care.

Slide 18 Results potentially vary by……

You can lose your ROI unless you pay attention to three considerations.

1. Make sure your organizational policies and practices regarding missed work indicate you should expect an ROI. Our team did these calculations for you from the information you told us in your first interview, and we'll visit them shortly.
2. Employee Selection – Vendors offer DMW Care for all your depressed employees. Vendors also offer DMW care for a selected group of your depressed employees. If you're interested in ROI, pay attention to employee coverage.
3. Vendor Selection Choose a vendor who sells DMW care. There's a lot of products out there on the market right now, some of them are gonna give you value, and some of them are just going to be additional dollar drains.

Slide 19 Organizational Policies and Practices

If your calculator results indicate you are not going to get a return on investment given your organizational policies and practices, don't expect one. Don't believe vendors who tell you that depression care management programs will lower your health premiums. There's no scientific evidence that your health care costs will go down. If the dollar argument doesn't pan out for your organization, you may still be interested in depression disease management for its clinical value, or you may want to invest in another benefit with clinical and work outcomes.

Slide 20 Employee Selection

Many vendors have capitalized on employer interest in depression disease management by adding it on to their chronic disease management programs. The problem with this approach is that the vast majority of your depressed employees do not participate in chronic disease management programs because they are on average 40 years old. Not surprisingly to the scientists, these add-ons have no demonstrated ROI whether they cost a lot or a little. Purchase a program that covers all your depressed employees.

Slide 21 Vendor Selection

Vendors can get it right, or they can get it wrong. And vendors who get it wrong will cost you money without delivering your ROI. You need to buy a product with 4 components:

1. systematic and confidential identification of your depressed employees.
2. education and monitoring over two full years (e.g., not until the employee 'feels better').
3. Program Supervision by a mental health professional .
4. Feedback to the treating provider when the patient fails to improve or relapses.

Slide 22 Vendor Choices

When you move forward, you will learn that your organization can purchase depression disease management from 5 different vendor types

Disease management firm that includes many of the firms you're already purchasing dDisease management programs from.

Managed behavioral health organizations that are particularly good if you're carving out your mental health care.

Employee assistance programs, if that's a benefit that you offer to all your employees in your organization.

Pharmaceutical Benefit management companies, if you're dealing with those vendors to supply pharmaceuticals at reduced costs.

Health plans. Some health plans offer depression disease management for all covered lives, usually for an add-on premium. This is a good solution for organizations that offer only one health plan and only a partial solution to organizations that offer multiple health plans.

Slide 23 Technical Assistance

Lots of information to consider in taking your next step. We're offering free technical assistance to every participant to support you to proceed from here. So what is technical assistance? It's an unbiased and experienced health benefits consultant who's willing to consult with you and your organization over the next 24 months if you're interested in improving the care your depressed employees are getting. For some organizations, the next step will be selling the idea of DMW care to the skeptics in their company. For other organizations who are ready to purchase, it will be help finding the right vendor. And for some organizations, it will be help developing contract language to assure the product delivers the components of care that assure your ROI.

The goal of technical assistance is to aid you and your company to ensure that your employees get high quality depression care. And its absolutely free to you as part of the study.

Slide 24 – Contact Information

The contact information on this slide is also on a page in your notebook. I'm here to tell you that I'm looking forward to talk to each and every one of you when you call or email me.

Slide 25 – Ending Slide

Value-based purchasing will not arise from any legislative mandate. Its going to be people in groups just like the group that we have convened here. Who are gonna look at each other and say " if we want to get something in return for the dollars we lay out every year, , we can"

Questions?

Q: ***Why do you say that depressed employees have 66 impairment days a year when the graph shows that they have 6.6 days/month (6.6*12 = 79 days/year) at baseline?***

A: We used calculus to estimate how many impairment days employees reported the first month, the second month, the third month…out to 24 months. We summed those days and divided by 2 (24 months = 2 years) to get impairment days per year.

Q: ***Why is there a slippage in DMW impact on impairment days and absenteeism at 18 months?***

A: In the second year, DMW provides depressed employees less intensive monitoring in the second year than the first year. When we monitor depressed individuals during the second year, some have slipped back into depression, but haven't gotten themselves together to do anything about it so their impairment days are increasing.

Q: ***Isn't that an argument to not switch from monthly to quarterly?***

A: When you call them every month, you get, "oh here's that depression lady again" .Those that need it like it. But the majority don't need it and they don't like it because it reminds them of an awful time in their lives. We need to keep that balance. If we call them every quarter, they still want to hear from us. If we call them every month, then you take a risk that some individuals are going to drop out of the program.

Q: ***Should DMW care be provided on an ongoing basis after 24 months?***

A: We suspect DMW care needs to be provided on an ongoing basis just like diabetes care, but we don't have the studies to document it.

Q: ***Is there an economy of scale on ROI? Is there some economy of scale where the more employees you have, the better your return is going to be?***

A: There is no economy of scale in ROI for most employers. Employers have to choose smartly to realize an ROI. Review Slide 18.

Q: ***Should Donna be accepting questions from the audience during the presentation or save them to the end?***

A: How we usually do it is to take questions for clarification during the presentation its self. And save questions for discussion until the end of the presentation. There's no way that the presentations are going to stimulate the same questions in each group, and we want to encourage discussion in presentations, but I think we should keep the process standardized. Which is, present every thing on every bullet the same way, take clarifying questions as they arrive and then have kind of the same amount of time for discussion. The solution is not perfect, but it's better to do that than to cut discussion off. So you could see it as the intervention is the presentation and everything that stimulates afterwards. Part of what it stimulates afterwards is a public discussion. Part of what stimulates after is a private discussion that the employers are going to have amongst themselves. And we can't control the public or private discussion that they have.

Q: ***When you say supervision by a mental health professional, you mean a mental health professional who is supervising the care managers?***

A: Right, Care managers are often times nurses or other health professionals that have very good telephone skills. They are not necessarily psychiatric nurses or nurse practitioners, they are mostly generalists. But the mental health professional could be a psych nurse, or a psychiatrist, a psychologist, or a pharmacist that has special expertise in psycho-tropic meds. Generally what the supervisor does is they review the caseload. They look at their PHQ9 scores and they say "oh these 10 patients are all improving, they are on the trajectory we expect and they're getting better. But oh my god there's these two patients and they're not improving at all." The nurse care manager doesn't know exactly what to do with that information, if they know that they need a change in their regiment, but she has to go to the mental health pro, and the mental health pro says "You've got these guys on Lexopro, maybe you should try them on Wellbutrin" or that person has only been on the medication for 3 weeks, you want to give them another week before we really get worried about them. Then the nurse care manager takes that information and sees it back to the PCP.

Q: ***So with DMW, care managers are completing the PHQ9 once a month and talking to the employees?.***

A: Care managers first interprets the PHQ9 score (Your depression is mild, moderate, or severe, and your depression is improving or getting worse). Then, she problem-solves how to ensure the patient receives the treatment they need. Like "Tell me about taking your anti-depressant meds last week", and the patient will say, "I know I'm supposed to be taking them, but I'm having a really hard time because they are making me throw up." Then the nurse care manager goes and problem solves around that. Or "I'm taking them exactly as I should be taking them, but I'm getting real tired of this because I don't feel any better than I felt 4 weeks ago," and then the Depression Care manager tells them, "Well it sounds like you really been great in trying to stick with it, even though you didn't see any immediate improvement, so now we need to try the next step. Do you mind if I call your doctor and think about getting you started on a second or different anti-depressant, because only 53% of patients respond to the first anti-depressant." That kind of patient education stuff - largely around treatment change, and treatment compliance.

Q: ***When employers start saying "How come I got this ROI, and the guy next to me got a completely different ROI?" I will need to explain the reasons why these vary.***

A: We've made standard assumptions about the product providing DMW care, about participation rates and about per-capita program costs. We incorporated company-specific data about average salaries and organizational policies and practices on missed work

Q: ***And from talking to some of our members with school districts, you're gonna have higher numbers for ROI, for replacement costs,***

A: Organizations with paid time off and no replacement costs have no sick leave expenses. If I have paid time off, every time I take a sick day, it essentially just subtracts one day from my vacation pool. But many employers, like that school district and airline companies, have negotiated actual sick leave and hire a temporary person when a person is absent.

Q: ***Why is the estimate for impairment days larger than the estimate for absenteeism days?***

A: Impairment days average 66.4 days per year, but absenteeism averages only 19.2 days per year. Depressed individuals are spending lots of weekend down time . And when they come to work, they

accomplish 50% or less of what they normally do. If you want to throw this little anecdote in, you can. Researchers did a study where we identified employees with depression and we gave them a pager. And they paged them at randomly selected times during the day and asked them what they were doing the 15 seconds before the pager went off. In 35% of the cases the answer was “absolutely nothing.” So many times, even though they are at work, they have severely cut back on activity and are not doing much of anything at all.