Insights and Actions to Help Minnesota Employers Advance Mental Health in the Workplace

WORKING WELL IN MINNESOTA

Minnesota Health Action Group™
Innovating, Leading, Engaging

Mental Health Parity—It's Time to Fulfill the Promise!

Deb Krause, Minnesota Health Action Group Vice President

Recently, I asked a small group of benefits managers and directors at leading Minnesota organizations a relatively straightforward question: Is your health plan in compliance with the Mental Health Parity and Addiction Equity Act? The answer was unanimous: YES! They were quick to answer for two reasons: (1) they believed it, and (2) even if they didn't, they were smart enough not to admit that their plan was not in compliance!

Indeed, following the passage of the 2008 law, they, like their peers nationwide, promptly removed the obvious disparities in benefits between physical and mental health. Limits on number of visits and maximum benefits were eliminated, and plans were deemed to provide parity and be in compliance. But, that's not the full story.

Action Group members who have participated in the 2017 Mental Health Learning Network heard from regional and national subject matter experts and key informants. It became shockingly clear that even after nearly a decade since the law passed, we don't have true parity. Addressing the benefit design aspect of parity took us only so far. Work remains to be done to fulfill the promise of real parity, including:

Stigma

An employee diagnosed with breast cancer willingly shares their diagnosis. Managers accommodate flexible scheduling needed for treatment regimens. Coworkers volunteer to join them in raising awareness and funds, and friends express support through cards, flowers and meals. Research shows that a robust support network at work and in the community is important to recovery. However, mental health is different. Stigma still exists. The employee may be reluctant to share a mental health diagnosis and, if they do, those around them may greet it with silence. Many employers are beginning to tackle the issue of stigma, and the most successful ones engage leaders and employees throughout the organization in emphasizing that "it's O.K." to discuss this illness, and sharing will be met with understanding and support. Successful efforts to bring parity involve communications, training, and cultural change.

Network/ Access

If an employee experiences a heart attack, they quickly have access to a robust network of cardiologists. However, with the shortage of mental health providers and beds, an employee or dependent with an acute mental health condition may wait weeks or months for care! The emergency room often becomes the point of entry. In terms of network and access, parity does not exist. Progressive employers are tackling this by working with their health plans to add standing appointments, broaden the network through supplemental providers, and offer telemental health as an option.

Payment

Lower reimbursements also reflect the lack of parity. Reimbursement schedules for mental health providers lag other specialties, and this news has recently received significant attention in Minnesota. Inadequate reimbursement has workforce implications (fewer physicians drawn to the field) and network implications (mental health specialists may refuse to participate in networks) that impact the patient. In addition, physicians who provide care coordination services may not be reimbursed by health plans for their services. Much work remains to be done in terms of payment parity.

Outcomes

Over the past dozen years, Minnesota Bridges to Excellence, a purchaser-led pay for performance program, has rewarded clinics for providing optimal care for patients with diabetes, vascular disease, and depression. The average statewide performance has increased to 62 percent and 45 percent for vascular disease and diabetes, respectively. Yet, despite attention and effort, the statewide average for depression remission at 6 months remains at only 8 percent. If parity is measured by health outcomes, parity does not exist.

Perhaps the correct answer to the question "is your health plan in compliance with the Mental Health Parity and Addiction Equity Act" is—no, not to the extent it should be. The easy step of removing arbitrary limits has been taken. The harder steps outlined here remain. Employers working together can accomplish more than anyone can alone. It will require a strong, firm voice of those who write the checks for health care. It's time to fulfill the promise of parity, and The Action Group's Mental Health Learning Network will continue moving this important work forward.

Contents

- Advancing Mental Health in the Workplace 3
- Basics of Mental Health Economics 5
- Insights on Mental Health Today 6
- Purchaser Value Statement 7
- Driving Value: A Checklist for Employers 8
- Special Topics:
  - Benefits Design Best Practices 11
  - Collaborative Care 11
  - Employee Assistance Programs 12
  - Maternal Mental Health 13
  - Measurement 14
  - Mental Illness Medications 15
  - Tobacco Cessation 17
- Looking to The Future 18
- Mental Health Resources 19
- Mental Health Glossary 21
- Acknowledgements 23

"Participation in this Network with my fellow Action Group members has given me optimism that we can accelerate the drive toward ensuring mental health parity for our employees and their family members."

Deidre Serum, Senior Director of Benefits, Best Buy

On the cover

Balancing rocks—and life—requires focus and intention. Minnesota artist, Peter Juhl, whose Zigzag Zen II is featured on the cover, says, "We all have a craving for balance, and it creates a sense of wonder when we achieve it." To learn more about the beauty of Peter's Balanced Stone Art, please visit:

temporarysculpture.squarespace.com/

Advancing Mental Health in the Workplace

"Today, for mental health, it is the best of times, and it is the worst of times. The barriers to achieving the mental health system we need are not just a chasm of a poorly organized system of care but a mountain range of issues that stop us from bringing mental health and well-being into the 21st century on par with the rest of health care. We have been starting to move these mountains, but it is a heavy lift and will require unprecedented dialogue, engagement of diverse stakeholders, and actions on many fronts to get us to the other side."

Michael Thompson, President and CEO, National Alliance of Healthcare Purchaser Coalitions

Indeed, for mental health, it is:

- **The best of times:**

  The law requires parity in mental health care, brain science and evidence-based treatments are advancing, and there is a growing acceptance that mental illness is a "real, common, and treatable" condition.

- **The worst of times:**

  Stigma and prejudice are still rampant, stress and isolation in the workplace are increasing, and access, quality and outcomes often fall short of expectations.

Mental Health Parity

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

Amid this challenging landscape, 11 leading Minnesota employers united in the 2017 Mental Health Learning Network ("the Network"). The collaboration relied on a process used to tackle other complex conditions with variation in price and quality, including back and spine, total joint replacement, maternity and infertility, and specialty pharmacy.

Market Assessment	Key Informant Meetings	Purchaser's Guide
Subject matter expert advisor What's wrong What's right Who's doing what	Health plans Care systems Consultants Other stakeholders	Current state of the industry Individual employer action Collective employer action Engaging consumers

While the process was similar, the Network motivation was unique. For this condition, the quest for knowledge and desire to drive action was not rooted in high cost, overuse or abuse, and the mission was not purely professional. Without exception, the Network participants all knew someone affected by mental illness—a family member, a friend, or a co-worker. Firsthand knowledge of the pain, sadness and tragedy of mental illness provided a greater sense of meaning to this work.

The scope of mental health is very broad. For purposes of the 2017 Network, employers focused on depression and anxiety, the two most common conditions in the workplace. However, many of the learnings can be applied across the continuum of mental health concerns.

Because it was important for those in the Network to determine areas of interest to study, The Action Group started its mental health learning journey in 2017 with a participant survey. The information gathered indicated these key themes and needs:

Key Challenges

Cost, Utilization, Prevalence, Array of Programs, Opportunity for Impact

- A significant number of employees are undiagnosed and not receiving proper treatment
- Depression is the highest disease prevalence
- Use of the employee assistance program (EAP) is low
- A high number of short-term disability claims are due to mental health
- Use of prescription drugs for mental health is within the top 10 of pharmacy claims
- Total spend on mental health claims is 8 percent, up 41 percent over the previous period

Current Situation

Readiness, Diverse Array of Vendors, Benefit Design Limitations

- More than 50 percent indicated that mental health was an important issue for their organization and that leadership was engaged
- Fewer than 50 percent had a strategic, integrated approach to address mental health issues in the workplace or had implemented any recent changes. In addition, less than half felt well informed about the issue
- Those that had or had not communicated with employees, managers and leaders about mental health were evenly split
- Most offer standard benefits under a co-pay or high deductible plan with a 3–5 visit EAP model
- Other benefits and interventions include online Cognitive Behavioral Therapy, on-site meditation room, courses in resiliency and well-being, and specific program offerings (Beating the Blues, Make It OK)

Primary Goals

Understanding the Market, Learning from Other Employers

- What can we expect from providers, and which are best for the conditions being treated?
- What innovations are being developed?
- Are prescription drugs effective, and who is best to provide them?
- Is mindfulness and resiliency training effective?
- Are there enough mental health providers, and are the services provided adequate?
- Which legislative and regulatory issues affect mental health services?
- Which employer practices are best in class?
- How can claims be analyzed to identify issues and opportunities for improvement in utilization and outcomes?

More than half of survey participants identify mental health as an important issue, yet fewer than 50% have adopted a strategic, integrated approach to address the challenge.

Basics of Mental Health Economics

Dr. Ezra Golberstein, Assistant Professor of Health Policy & Management at the University of Minnesota, served as an expert advisor to the Network, and he provided employers with an overview of mental health economics as a foundation for learning. He emphasized that things that are tough in health care delivery and finance (generally) are even tougher for mental health care.

- The "moral hazard" is greater. Consumers are more responsive to prices for mental health than for other conditions, and managed care organizations also respond to prices.
- There are significant comorbidities, and "adverse selection" is more of a concern for mental health.
- Quality measurement is difficult, and mental health lags behind other conditions with regard to meaningful measures.
- Coordination of care is complicated.

Seeking Better Outcomes

From an economics perspective, the goal of improving mental health care is NOT to save money. Rather, the goal of improving mental health care is to deliver higher-value care. Sometimes, this could save money elsewhere (hospitalizations, emergency department use, productivity), but that is not the primary goal.

"The economic costs of mental illness will be more than cancer, diabetes and respiratory ailments put together."

Thomas Insel, M.D., Former Director, U.S. National Institute of Mental Health, at the World Economic Forum, January 2015

Mental illnesses are diseases that affect the working-age population, so the impact on employee productivity can be significant. In addition, under the Affordable Care Act, employers are now "front-line" in financing of mental health care for dependents up to age 26.

Value-based benefits design has been used successfully in chronic disease settings (such as with diabetes), but it has not yet been widely applied to mental health. Financing effective mental health services and getting the incentives right can be challenging. However, new codes for reimbursement of collaborative care, health care home-type financing models, more assertive use of performance measurement, and creative blends of financing incentives hold promise for the future.

"First-episode psychosis often happens between the ages of 18-25, which is meaningful because a child can now stay on a parent's health plan until age 26. There is a big — and too-often-missed — opportunity to change the trajectory of a person's lifelong health through proper intervention at a first major mental health event."

Ezra Golberstein, Ph.D., Assistant Professor, Division of Health Policy and Management, University of Minnesota

Insights on Mental Health Today

Sue Abderholden, Executive Director of the National Alliance on Mental Illness (NAMI) Minnesota, also served as an expert advisor to the Network. She shared this eye-opening perspective: The mental health system is not broken—it was *never built.* The system we have today reflects decades of discrimination, misunderstanding and misspending, coupled with lack of research, funding cuts, and failed efforts. With passage of the Mental Health Parity law and the Affordable Care Act, more people than ever before have mental health benefits coverage and are seeking treatment.

In Minnesota, we lack sufficient providers and facilities. Indeed, the needs for both health care and community services outpace the current system capacity. The lack of urgent care options frequently results in hospital emergency departments being an entry-point to the mental health care system. The list of things that are wrong is longer than the list of things that are right.

Yet, the mountains are beginning to move in Minnesota.

- ***Care systems in Minnesota are restructuring delivery to provide more integrated, collaborative care—even when that is in conflict with their self-interests. (If the problems of high emergency department utilization and inappropriate inpatient care are resolved, their revenues will decline.)***
- ***Health plans and medical groups are beginning to focus on helping providers "practice at the top of their license" to create leverage and address capacity.***
- ***Innovative point solutions for services such online Cognitive Behavior Therapy (CBT), second opinion services, telemental health, and pharmacogenomics are emerging to address known gaps in care.***
- ***We have a foundation of measurement and reporting for mental health outcomes, as well as nonprofits to provide resources and support quality improvement.***

So, while there is a long way to go, there is reason for optimism. This guide summarizes the Network's journey during 2017, with a focus on recapping the learnings, synthesizing the insights, and translating ideas to actions to help Minnesota employers advance mental health in the workplace.

Cutface Creek Lean, *Peter Juhl*

A Huge Mental Health Care Gap

In 2012, there were 3,669 Mental Health Professional Shortage Areas (HPSAs) in the U.S., containing almost 91 million people. At least 1,846 psychiatrists and 5,931 other practitioners would be needed to fill the gap.

(Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, 2013)

Purchaser Value Statement

Purchasers expect high-value health care. Given the complexity and sensitivity, this is especially critical for mental health conditions.

High-value mental health care should include:

- Access to primary and specialist care that is in full compliance with the Mental Health Parity and Addiction Equity Act, including parity in:
  - Breadth and quality of network (number and types of providers, locations and credentials)
  - Ability to access care (timeliness, distance)
  - Provider reimbursement levels
- Delivery of compassionate, personalized and collaborative care for adults and children:
  - Without stigma
  - With seamless integration of physical and mental health care
  - Across primary care and specialist care
  - Including comorbid conditions
  - Recognizing the impact of the patient's condition on family and caregivers
- Care models that are appropriate for the patient's condition, evidence-based, and cost effective, across the continuum of acute and chronic care for mental health conditions
- Aligned incentives through benefit plan designs and payment models to improve quality outcomes, including:
  - Reduction of unnecessary or ineffective medication
  - Reduction in emergency room use as a gateway to mental health care
- Development and implementation of new or enhanced quality measures that focus on outcomes across the spectrum of mental health conditions
- Collection and public reporting of quality by facilities and providers, including:
  - Clinical outcomes
  - Patient-reported outcomes
- Public reporting and improvement in the quality of mental health care over time

Putting the Value Statement to Work

This Value Statement may be used by employers to guide conversations with vendors, health plans, and providers to express their goals, compare current practices, and identify gaps.

Working together, purchasers and other stakeholders can remove barriers to care and advance this vision of high-quality mental health care for employees, their families, and all Minnesotans.

"Because of the challenges our employees and their family members face when it comes to getting the mental health care they need, we knew it was imperative that we participate in this Learning Network. We will be making our collective expectations known in the marketplace in a way that is a powerful force for change."

Ken Horstman, Senior Director of Total Compensation, University of Minnesota

Driving Value: A Checklist for Employers

Based on the input of expert advisors and key informants, the Network developed a checklist to help employers improve the value of mental health care and build a culture of total well-being. The best actions for an individual employer depend on their current practices, vendor partner capabilities and, importantly, organization strategy and culture.

The leading employers participating in the Network indicated that they are doing some of these things today and actively considering many others.

For the convenience of benefits professionals and to enable action, the checklist is organized by vendor/partner/ stakeholder.

Health Plan

- ☐ Understand current spend for mental health conditions, including co-morbidities
- ☐ Review covered services vs. best practices and enhance as appropriate (crisis residential services, partial hospitalization, tobacco cessation, etc.)
- ☐ Be sure your plan complies with the Mental Health Parity and Addiction Equity Act
- ☐ Broaden network to address gaps/needs (contract with supplemental providers)
- ☐ Require health plan to have standing/on-demand appointments for urgent care
- ☐ Implement virtual/telemental health to improve access overall and access to specialists, as well as address stigma and offer a wider array of options
- ☐ Require health plan to turn on collaborative care codes
- ☐ Identify and implement value-based mental health benefits (also known as value-based insurance design or VBID)
- ☐ Understand/expand health plan capabilities/services for maternal mental health
- ☐ Require greater measurement and reporting on mental health conditions and costs

Prescription Drug Benefits *(with health plan or PBM, depending on approach)*

- ☐ Understand current pharmacy spend (conditions, drugs, adherence, etc.)
- ☐ Add pharmacogenomics benefit (as part of covered services or as part of Rx prior authorization process)
- ☐ Review/manage formulary issues related to mental health drugs
- ☐ Monitor drug pipeline for new/emerging mental health drugs and therapies

Employee Assistance Plan

- ☐ Offer EAP to employees, family and household members (not only employees)
- ☐ Understand EAP utilization (by division, location) and what is driving (depression, anxiety, etc.)
- ☐ Rebrand EAP to reduce stigma/increase utilization
- ☐ Require EAP referrals for employees in disease management programs
- ☐ Implement performance guarantees for EAP. Focus on meaningful measures, including clinical PGs
- ☐ Integrate EAP and health plan (note: even when the same organization is the health plan and the EAP, they may not be integrated)

Disability Carrier

- ☐ Understand current spend on mental health cases, including number, cost, screening protocols, treatment intensity, and return to work
- ☐ Ensure case managers are trained on mental health screening
- ☐ Provide disease management program to employees on mental health disability

Other Vendors

- [ ] Contract with expert resources/advisors (including a psychiatrist) to advise the employer, as needed
- [ ] Consider other innovative vendors for cognitive behavioral therapy (CBT), pharmacogenomics, telemedicine, brain health/training, etc.
- [ ] Add mental health providers to onsite clinics, if offered
- [ ] Host mental health vendor summit, including health plan, PBM, EAP, disability carrier, etc.

Strategic/Culture/Training

- [ ] Consistently and regularly communicate organizational commitment to mental health and well-being
- [ ] Educate executives to "walk the talk" (e.g. model work/life balance, be welcoming of the need for accommodations, be sensitive to language, consider mental health in business decisions, etc.)
- [ ] Educate managers to identify emotional distress, respond promptly and constructively, refer to EAP, support employees, promote return to work, etc.
- [ ] Educate all employees to reduce stigma and increase understanding of how to access benefits/navigate system
- [ ] Engage internal wellness champions network
- [ ] Include strategic mental health metrics on board and executive management dashboards

Workplace Practices

- [ ] Review/update return-to-work process (return-to-work conference, graduated return, accommodations, psychological safety net, etc.)
- [ ] Add mental health questions to health risk appraisals, including proactive outreach to at-risk individuals
- [ ] Include mental health as part of wellness incentives (e.g., brain training to earn points/rewards)
- [ ] Have a special budget set aside to offer other treatments outside of the plan, as warranted
- [ ] Provide adequate vacation time

Community/Market

- [ ] Identify meaningful published metrics for mental health—use those currently in place (e.g., MN Community Measurement's (MNCM) depression remission at 6 months) and promote adoption of additional, new metrics (e.g., MNCM's peds/adolescent mental health/depression screening) to hold providers and care systems accountable and drive quality improvement
- [ ] Articulate what is valuable and attempt to shift the mindset of vendors/providers
- [ ] Define and pilot a new model for mental health care delivery
- [ ] Conduct randomized research trial related to mental health VBID, communication campaign, or other
- [ ] Contract with EAP for bank of consulting/education hours, and use EAP for onsite training related to mental health and well-being
- [ ] Have quarterly call/meeting and annual meeting with EAP to ensure effective strategy, execution, communication
- [ ] Use EAP as centralizing function for disability manager, physician, employee, manager, and HR

Benefits Design Best Practices

While best practices for benefits and evidence-based treatment guidelines are commonplace and kept current for major disease states such as heart disease, cancer and diabetes, this is not necessarily the case for mental health conditions.

The most current review of the evidence for the efficacy of well-documented treatments is from 1996 and suggests that covered services should include the following:

- Hospital and other 24-hour services (e.g., crisis residential services)
- Intensive community services (e.g., partial hospitalization)
- Ambulatory or outpatient services (e.g., focused forms of psychotherapy)
- Medical management (e.g., monitoring psychotropic medications)
- Case management
- Intensive psychosocial rehabilitation services

Based on more recent evidence and innovations, key informants to the Network also suggested that the following services should be covered:

- Collaborative care
- Telemental health (including online CBT)
- Tobacco cessation (evidence-based coverage components: Rx, counseling, no barriers)

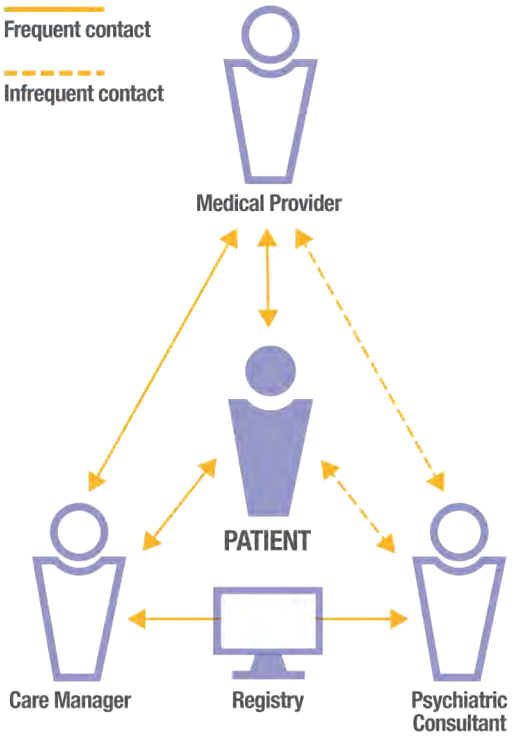
Additional review of the literature and collaborative discussions between employers and other stakeholders are essential to defining current best practices for benefits design. In the meantime, the list above should guide assessments and enhancements of employer benefit coverage.

Collaborative Care

Integrating mental health care with primary or specialist care is now widely considered an effective strategy for improving outcomes for the millions of Americans with mental health conditions. While it may go by different names and there are some variations in how the model may be designed and deployed, the basic premise of collaboration is consistent.

The public sector has taken a lead in advancing collaborative care. Beginning January 1, 2017, Medicare initiated separate payments to physicians and non-physician practitioners for behavioral health integration services they furnish to beneficiaries. This is likely to spur similar payment reform in the commercial sector, beginning in 2018.

Experts regionally and nationally have underscored that adoption of these codes by employers will be an important component of enhanced service delivery.



SOURCE: University of Washington, 2017

Four Essential Elements of Collaborative Care

1. Team-driven
2. Population-focused
3. Measurement-guided
4. Evidence-based

What is the Psychiatric Collaborative Care Model (CoCM)?

A model of behavioral health integration that has been shown to improve outcomes in multiple studies. CoCM enhances "usual" primary care by adding two key services:

- Care management support for patients receiving behavioral health treatment; *and*
- Regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose conditions are not improving.

Why should employers be interested in collaborative care?

In general, benefits of collaborative care may include improvements in depression screening and diagnosis, delivery of care, and adherence to treatment, as well as improvements in symptoms, response, remission, and recovery.

Interestingly, collaborative care has been shown to also result in greater patient and physician satisfaction. However, the CoCM requires provider investments in physical space, as well as people, processes and technology. If providers are not fairly compensated for the investment required, the model will not be sustainable.

What are the codes?

Effective January 1, 2017, the Centers for Medicare & Medicaid Services (CMS) defined a series of codes to bill for services furnished using the CoCM: G0502, G0503, and G0504. These codes were temporary until the American Medical Association (AMA) CPT codes were approved for January 1, 2018. The new codes are:

99492	99493	99494

The definitions are the same as G0502-G0504 and cover both initial and subsequent care. More information about collaborative care and the billing codes is available at ama-assn.org.

Benefits of Collaborative Care

- *Improved depression screening/diagnosis*
- *Better care delivery*
- *Adherence to treatment*
- *Improved symptoms, response, remission, and recovery*
- *Greater patient and physician satisfaction*

What should purchasers ask about collaborative care?

Generally, purchasers should request information from their health plan about:

- Adoption of codes – including whether the health plan is:
  - Currently reimbursing
  - Planning to reimburse within the next six months
  - Actively promoting codes by means of plan-sponsored training, CMEs, CEUs or other recognition
  - Other (explain)
  - None of the above
- Utilization of codes—including periodic results related to:
  - Number and dollar volume of billed claims
  - Number and dollar volume of paid claims

Ultimately, purchasers will want to know if collaborative care is resulting in improved outcomes for patients.

Employee Assistance Programs

Employee assistance programs (EAPs) are commonplace among large employers (90%+ offer them). On one hand, they offer timely access to a mental health system that can be difficult to understand and navigate. On the other hand, there is significant and widespread employer disappointment in the value they provide. In a marketplace where abuse and overuse of health care services is rampant, conversely, EAPs are dramatically underused.

Key informants to the Network offered insights into the EAP vendor landscape and shared suggestions to improve the value of services.

Landscape

In Minnesota, there is downward price pressure on EAPs. This is attributed, in part, to the number of wellness vendors offering similar services. Generally, if employers go out to bid for their EAP, they can expect to get a lower cost. This competitive landscape and the low margins it creates ultimately impacts the quality and quantity of services delivered.

"No-barrier access" to services is core to the EAP model—including a specified number of free visits and access via phone. Even so, utilization of EAPs is typically less than five percent of employees, which represents a significant gap relative to the potential need for services. This is attributed to both awareness and stigma. Some leading employers nationally have begun to tackle this challenge through communications and anti-stigma campaigns. They have demonstrated results, potentially doubling utilization of EAP services (or more).

Sky Tower, *Peter Juhl*

Lack of Integration

Across the board, there is a lack of integration of EAPs with the delivery system—even when they are the same organization. Lack of integration is a source of frustration for patients with medical needs, but for patients with mental health conditions, needing to "begin fresh" and recount medical history is a source of genuine pain and may discourage patients from seeking treatment.

Beyond integration between the EAP and medical care, there are gaps in integration of EAPs with short- and long-term disability programs and the Family and Medical Leave Act (FMLA). Leading employers are beginning to shine a light on these gaps and work to close them. However, benefits design solutions have limitations, and product and delivery system reform are also required.

On the positive side, most EAPs now have more modalities for increasing access, including tele-video, telephonic, and chat (for appointments). Face-to-face is still the most utilized modality, even with millennials. EAPs are also broadening their range services to address work/life needs of employees. This trend reflects the reality that employees may be more willing to access services to address the stress of parenting, moving, finances, and other life challenges. An initial positive experience with the EAP may increase the likelihood that the EAP is contacted for mental health conditions such as depression or anxiety. Also, technology is exploding in this space. All EAPs have apps, but they are typically a "buy-up" option. Key informants predicted that, in five years, these apps will likely be included in core pricing.

EAP vendor accountability should focus on meaningful measures and outcomes realized, including results for both the employee and the workplace.

Yet, vendor accountability is too often limited to basic process metrics—such as number of calls, number of referrals, or call abandonment rate. Comparisons are frequently to "book of business." Accountability should focus on meaningful measures and outcomes realized, including whether, and how, the employee was helped (both clinical and patient-reported outcomes), over what length of time, and with what impact on the workplace.

At the end of the day, most benefits departments have scarce time and resources. This reality, combined with the market dynamics and low expectations, has allowed many EAPs to exist, versus be optimized, as a benefit offering.

Best Practices

Employers should expect more, and hold EAP vendors accountable for providing high-quality, integrated services. EAP best practices recommended by Aon, a key informant to the Network, include:

- Solid integration across all health and welfare benefits and vendor relationships to support employee health initiatives including referral protocols, data sharing, tracking, and measurement
- Short-term five to eight visits per issue per year
- Assessment and referral conducted by licensed behavioral health clinicians
- Access alternatives via phone, web, and mobile applications for counseling/coaching services
- Bank of service hours available for topic-specific training/education and critical incident stress debriefing (CISD)
- CISD highly aligned with your organization's safety, occupational health, and risk management teams
- On-site and field EAP services including assessments, counseling, education, training, and manager consultation
- Robust communication and promotion plan aligned with your organization's preventive health and well-being strategy
- Relevant program measurement components that demonstrate your specific program outcomes

In exchange for high-value services, employers should compensate EAP vendors fairly and demonstrate true partnership. Specific actions are included in the "Driving Value" checklist included in this guide.

Maternal Mental Health

Maternal depression is the most underdiagnosed obstetric complication.

Given that women with children are the fastest growing segment of the U.S. workforce and almost 60 percent of women who have an infant younger than one year of age are employed outside of the home, maternal mental health is a business issue. According to 2020 Mom:

- Women in their childbearing years account for the largest group of Americans with depression.
- Postpartum depression is the most common complication of childbirth.
- There are more new cases of mothers suffering from maternal depression each year than women diagnosed with breast cancer.
- The American Academy of Pediatrics has noted that maternal depression is the most underdiagnosed obstetric complication in America.

The "baby blues" may affect 75 percent to 80 percent of postpartum women. This includes "mild depression interspersed with happier feelings," and may be described as "an emotional roller-coaster." However, this is not considered a disorder, should not require professional treatment, and should subside within two weeks after delivery.

In contrast, pregnancy and postpartum depression affects 10 percent of pregnant and 15 percent of postpartum women. Pregnancy and postpartum generalized anxiety affects 6 percent of pregnant and 10 percent of postpartum women. Less common conditions include: Postpartum panic disorder (up to 10 percent of women), pregnancy/postpartum obsessive-compulsive disorder (OCD, 3 percent to 5 percent of women), postpartum posttraumatic stress disorder (PTSD, 1 percent to 6 percent of women), and postpartum psychosis (less than 1 percent of women).

During 2017, The Action Group used a survey instrument developed by 2020 Mom to gather information from Minnesota health plans regarding their maternal mental health capabilities, including identification of trained providers, network adequacy, training and education, OB/GYN capacity, measurement, and contracts and payment. Three of the four Minnesota health plans responded, and the health plan responses were shared with Network participants, along with recommended actions.

Overall, the responding health plans are taking some actions to address maternal mental health. However, actions fall far short of the expectations set for identifying treatment and screening for all by 2020, as outlined by 2020 Mom.

The information above was provided by the National Alliance of Healthcare Purchaser Coalitions and 2020 Mom, an initiative of The Ben and Ana Lucy Walton Fund of the Walton Family Foundation, that is closing gaps in maternal mental health care through education, advocacy and collaboration. More information is available at: 2020mom.org.

There is a general consensus that maternal mental health disorders are caused by a combination of physiological factors, psychosocial factors, and preexisting vulnerability. Professional treatment may be required, and employers should work with their health plan to ensure that women receive appropriate care.

Measurement

There is widespread consensus that metrics for mental health conditions and their adoption by providers lag other health conditions.

Reporting and transparency are necessary, but not sufficient. The 2016 Minnesota statewide average for depression remission at six months remains stalled at 8 percent, and there is broad consensus that the quality of care must be improved.

"Measurement-based care optimizes the accuracy and efficiency of symptom assessment, improves the detection of non-response (prompting revisions to the treatment plan), and maximizes the likelihood that patients receive the most effective treatment."

The Kennedy Forum

Experts note that there remains a need to develop and adopt meaningful metrics to address anxiety and other prevalent and high-risk mental health conditions. Where measures exist, they are largely less-sophisticated process measures such as screening, assessment rates, or monitoring rates, rather than outcomes. For example, there is tracking of patient survival rates for cardiac and cancer care, but not for mental health conditions. Yet, the current focus of national and regional conversations about measurement and reporting is frequently about aligning measures and reducing reporting burden on providers.

In this environment, there is a unique opportunity for employers, as purchasers, to build market demand for accountability in mental health care, including consistent reporting of performance against current measures, development of an expanded set of meaningful, outcomes-based measures for mental health conditions, and demonstrated improvement in results.

Key Depression Measures

In Minnesota, under the stewardship of MNCM, there are solid process and outcome measures addressing depression, with public reporting on mnhealthscores.org.

Key depression measures currently include:

- *Depression Utilization of the PHQ-9 Depression*
- *Remission at 6 months Depression Response at 6 months – Progress Towards Remission*
- *Depression Remission at 12 months*
- *Depression Response at 12 months – Progress Towards Remission*
- *Screening for Clinical Depression & Follow Up*
- *Antidepressant Medication Management*

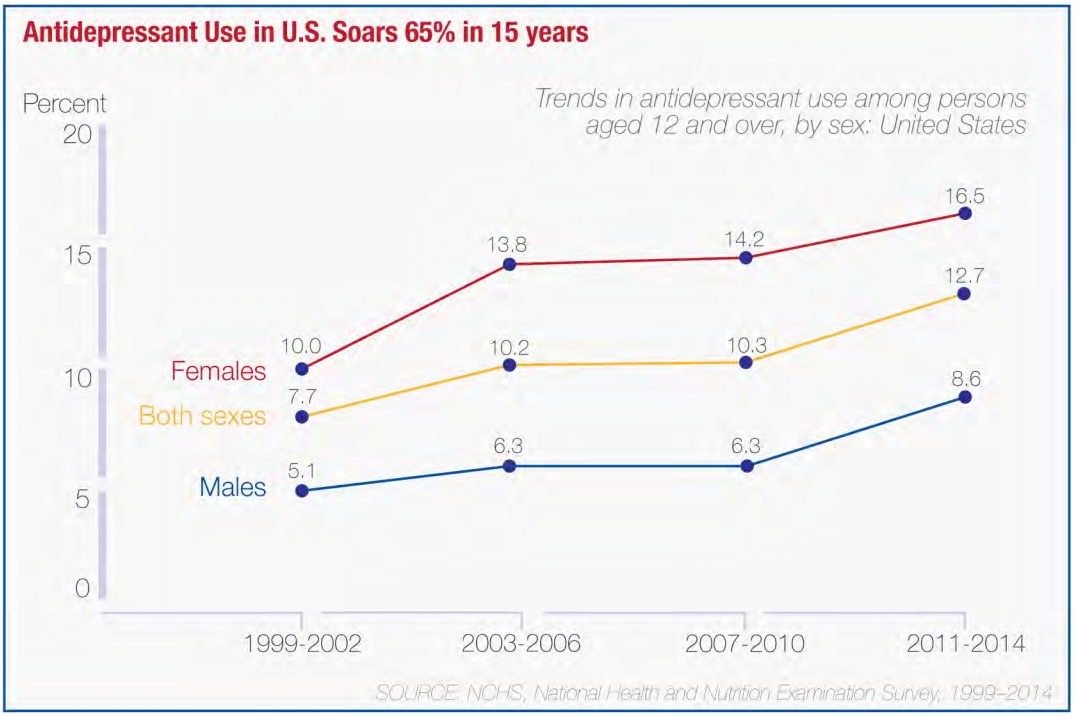
Mental Illness Medications

Medications can play a role in treating several mental disorders and conditions. Treatment may also include psychotherapy (also called "talk therapy"). In some cases, psychotherapy alone may be the best treatment option. Choosing the right treatment plan should be based on a person's individual needs and medical situation, and under a mental health professional's care.

Antidepressants

Antidepressants are medications commonly used to treat depression. Antidepressants are also used for other health conditions, such as anxiety, pain and insomnia. Although antidepressants are not FDA-approved specifically to treat ADHD, antidepressants are sometimes used to treat ADHD in adults.

While the increasing use of antidepressants could be a hopeful sign of decreasing mental health stigma, it is also likely a worrisome sign that people are increasingly stressed and depressed in our society, and that these drugs are being used as a first line of treatment.



The most popular types of antidepressants are called selective serotonin reuptake inhibitors (SSRIs). Examples of SSRIs include: Fluoxetine, Citalopram, Sertraline, Paroxetine, and Escitalopram.

"I would say at least half the folks who are being treated with antidepressants aren't benefiting from the active pharmacological effects of the drugs themselves but from a placebo effect. If people knew more, I think they would be a little less likely to go down the medication path than the psychosocial treatment path."

Steven Hollon, Ph.D, Gertrude Conaway Vanderbilt Professor of Psychology, Vanderbilt University

Other types of antidepressants are serotonin and norepinephrine reuptake inhibitors (SNRIs). SNRIs are similar to SSRIs and include venlafaxine and duloxetine.

Another antidepressant that is commonly used is bupropion. Bupropion is a third type of antidepressant that works differently than either SSRIs or SNRIs. Bupropion is also used to treat seasonal affective disorder and to help people stop smoking.

Anti-Anxiety Medications

Anti-anxiety medications help reduce the symptoms of anxiety, such as panic attacks, or extreme fear and worry. The most common anti-anxiety medications are called benzodiazepines. Benzodiazepines can treat generalized anxiety disorder. In the case of panic disorder or social phobia (social anxiety disorder), benzodiazepines are usually second-line treatments, behind SSRIs or other antidepressants.

Benzodiazepines used to treat anxiety disorders include: Clonazepam, Alprazolam and Lorazepam.

Short half-life (or short-acting) benzodiazepines (such as Lorazepam) and beta-blockers are used to treat the short-term symptoms of anxiety. Beta-blockers help manage physical symptoms of anxiety, such as trembling, rapid heartbeat, and sweating that people with phobias experience in difficult situations. Taking these medications for a short period of time can help the person keep physical symptoms under control and can be used "as needed" to reduce acute anxiety.

Buspirone (which is unrelated to the benzodiazepines) is sometimes used for the long-term treatment of chronic anxiety. In contrast to the benzodiazepines, buspirone must be taken every day for a few weeks to reach its full effect. It is not useful on an "as-needed" basis.

Special attention must be paid to pharmacy benefit management when dealing with drugs for mental illness.

Other Drugs for Mental Illness

In addition to anti-depressants and anti-anxiety medications, other drugs for mental illness include stimulants, antipsychotics, and mood stabilizers.

The condition-specific information above is from the National Institute of Mental Health. For further information, please see:

nimh.nih.gov/health/topics/mental-health-medications/index.shtml

Special Issues for Employers

Pharmacy benefit management is always important for benefits professionals. In the case of drugs for mental illness, special attention is needed.

- A holistic approach to mental health conditions is extremely important. CBT is a first-line treatment for anxiety and depression, and it can be complementary to drug therapy. Yoga, meditation and exercise are also helpful and may be underappreciated.
- Adherence varies by definition and population, as well as condition. Adherence improves outcomes. Barriers to adherence include: (1) recognition of the need for ongoing treatment, (2) availability of tools to take medications the right way, (3) tolerance (side effects), and (4) cost.
- According to experts, some beneficial psychiatric pharmaceuticals are not covered by commercial insurance today. Advocates are working with policy makers to get this changed in Minnesota.
- Transitions in the formulary for psychiatric drugs can have a significant impact on the patient and should be carefully considered. Requiring a patient who is responding to a treatment to change drugs can be extremely disruptive to care.
- There are new specialty psychiatric drugs that can be infused. Monitoring the pipeline of new/emerging drugs and therapies is recommended.
- Finally, because of the nature of psychiatric medications, employers should be aware of the potential for misuse or abuse.

Only half of patients respond to the first drug prescribed, and one in six experience intolerance.

Emerging Practice: Pharmacogenomics

Pharmacogenomics (PGx) is pharmacology (study of drugs) + genomics (study of genes and their functions). People metabolize drugs differently, and this impacts the best drug regimen for each patient.

Typically, providers use general information to decide which drug is most likely to work, and the current standard of practice is to try drugs in succession until one is identified that works. A psychiatric drug may take 6-12 weeks to get the intended benefit. If it doesn't work, the patient cycles off that drug and onto another one. According to STAR*D project results, only about half of patients respond to the first drug, and one in six have intolerance with a first drug. Response rate to drugs falls with each new drug tried, and the intolerance rate increases.

PGx is an easy, non-invasive test (current cost of around $300) that allows providers to make better decisions regarding the selection and dosing of medication for mental illness or other health conditions.

Employers may contract for this benefit directly with a vendor or through their health plan. PGx can be offered in several ways: As a covered benefit (may be condition focused), as part of an employee wellness program, as part of a prior authorization requirement, or through clinical management/medication therapy management. At this time, a cautious approach would be to cover PGx only when the initial therapy fails.

"Because each person responds differently to specific drugs, many people have to endure trial and error to find what works. But when we couple genetic information with what we know about the drugs, we can often to get to the right drug faster."

Paul Owen, CEO, OneOme

What many employers may not realize is that individuals with mental illness are more likely to smoke. In fact, according to the National Survey on Drug Use and Health (NSDUH-2015), the nationwide rate of current cigarette smoking among adults (18 or older) with past year any mental illness (AMI) is 31.6 percent vs. 18.7 percent without AMI.

Tobacco Cessation

It is well known that tobacco use is a key risk factor for heart disease, stroke, cancer, and diabetes, and smokers cost more in terms of medical costs, lost productivity, and workers' compensation.

Most Minnesota employers have taken action to reduce tobacco use among employees. Examples include coverage of tobacco cessation under the benefits plan, incentives in wellness programs, and culture initiatives such as the introduction of smoke-free campuses.

In addition, nonprofit collaboratives have sponsored public awareness campaigns, policy makers have increased statewide tobacco taxes, and leading cities have recently adopted "T21" laws to increase the legal age to purchase tobacco products.

The Minnesota statewide smoking rate continues to decline and compares favorably to other states.

Tobacco use may be negatively affecting employer efforts to address depression and mental health issues. Employers may want to review and potentially enhance tobacco cessation benefits, especially for employees with a mental health condition.

- Smoking cessation is associated with reduced anxiety, depression, stress, and improved quality of life compared to smoking.
- The effect size has even been found to be equivalent to or greater than the use of anti-depressants.

According to the Centers for Disease Control, for tobacco cessation coverage to be effective, it is important that it be comprehensive in scope. Comprehensive coverage includes:

- All evidence-based cessation treatments, including individual, group and telephone counseling.
- All seven FDA-approved cessation medications, including both prescription and over-the-counter medications (bupropion, varenicline, and five forms of nicotine replacement therapy (NRT), including the patch, gum, lozenge, inhaler, and nasal spray).
- Minimal or no barriers to access, including no copays, coinsurance or deductibles, and no annual or lifetime limits.

Employer collaboration with health plans, EAPs, and wellness vendors can emphasize that employees have options and support to quit smoking. In addition to the well-documented benefits of reducing heart disease, stroke, cancer, and diabetes, smoking cessation improves mental health.

Looking to the Future

All of the actions outlined in this guide are responsive to the themes and needs indicated at the project outset, and many can be accomplished by individual employers working within their own organizations. Still, the systemic needs regarding stigma, parity, care delivery and outcomes, performance measurement, and payment will be best addressed through collaboration and shared accountability.

Network participants indicated that there is work yet to be done in the community to identify and publish meaningful mental health metrics and to promote the adoption of new metrics to drive quality improvement and hold providers accountable for outcomes. Employers also believe they can more clearly articulate what is valuable to purchasers and attempt to shift the mindset of vendors and service providers. In addition, there is an appetite to create and test an alternative model for mental health care delivery and payment. Some of the models to be explored could include value-based collaborative care, transitional care bundled payments, and coordinated specialty care for first-episode psychosis.

Minnesota is in a unique position to leverage community assets and multi-payers to move toward a shared vision of optimal mental health.

"Four in 10 living in the U.S. will face mental illness or substance abuse in their lives, many during the prime of their working years. Whether fearing the perceived negative attitudes of self-identifying a problem, or simply unaware of how to seek help, more than half will suffer in silence, and 40 percent will simply stay home from work. Although there's no 'magic wand' for this troubling problem, employers—and employees—can play a meaningful role in moving toward lasting solutions."

Sue Abderholden, Executive Director, NAMI Minnesota

Mental Health Resources

There are many resources available to employers. The list below is not an endorsement of these specific programs and is offered to help employers understand the breadth and range of available resources. In addition, there are various commercial programs available to employers. As you consider them, inquire about the program's evidence base and connect with employers using them to learn more about how they are working and how results are being measured.

Mental Health Programs for the Workplace

ICU Program (workplacementalhealth.org)

An anti-stigma campaign designed to foster a workplace culture that supports emotional health. Developed by DuPont for its global workforce and donated to the Partnership for Workplace Mental Health for other employers to use at no cost.

#IWILLLISTEN (naminyc.iwilllisten.org)

Award-winning social media-based public service campaign designed to create awareness of the prevalence of mental illnesses and reduce the stigma associated with them. Used by major employers including American Express, Deutsche Bank, and PricewaterhouseCoopers.

Make It OK (makeitok.org)

A campaign to reduce the stigma of mental illnesses by encouraging open conversations and education on the topic, provided by HealthPartners.

Right Direction (rightdirectionforme.com)

A creative educational initiative designed to reduce stigma, motivate employees and their families to seek help when needed, and provide employers with appropriate support tools and resources.

Stamp Out Stigma (stampoutstigma.com/support.html)

An initiative spearheaded by the Association for Behavioral Health and Wellness (ABHW) to reduce the stigma surrounding mental illness and substance use disorders.

Other Programs

In Our Own Voice (nami.org/Find-Support/NAMI-Programs?NAMI-In-Our-OwnVoice)

A program that involves a 90-minute group interaction led by two group facilitators who are in recovery from serious mental illness.

Live Your Life Well Campaign (mentalhealthamerica.net/living-well)

A campaign to promote mental health, including tools to achieve wellness and other resources, from Mental Health America.

NAMI Stigma Free (nami.org)

A campaign that promotes acceptance and challenges social stereotypes.

Working Minds (sprc.org/resources-programs/working-minds-suicide-prevention-workplace)

Offers culturally responsive, comprehensive and sustained strategies to help workplaces make mental health promotion and suicide prevention health and safety priorities.

Non-U.S. Programs

Beyondblue (beyondblue.org.au)

A national initiative of the Australian government to raise awareness and reduce the stigma associated with depression and anxiety. Offers workplace programs. Also available in the U.K. under the name Impact on Depression.

Elephant in the Room (mooddisorderscanada.ca/page/elephant-in-the-room-campaign)

An anti-stigma campaign in Canada that works to decrease stigma and promote awareness in the workplace.

Opening Minds (mentalhealthcommission.ca)

A program established by The Mental Health Commission of Canada to reduce the stigma facing people living with mental illness.

R U OK? (ruok.org.au)

A not-for-profit organization dedicated to encouraging all Australians to regularly and meaningfully ask anyone struggling with life, "Are you O.K.?" Includes strategies and resources for the workplace.

Time to Change (time-to-change.org.uk/)

An anti-stigma campaign in England for people suffering from mental illness.

Leading National Nonprofit/Government Organizations

Center for Workplace Mental Health (workplacementalhealth.org)

Nonprofit organization with a mission to help workers with mental illness by inspiring companies to increase awareness of mental health issues and provide better support for employees. The website includes tools to make the business case, mental health calculators, and employer case studies.

Kennedy Forum (thekennedyforum.org)

Nonprofit organization focused on advancing the current ideas, policies and programming in behavioral health known to be effective, while shining a light on the solutions of the future. The website includes toolkits, policy briefs, videos, and more.

National Alliance on Mental Illness (NAMI) (nami.org)

The nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. The website has extensive information, data, research, and programs.

National Council for Behavioral Health (thenationalcouncil.org)

Nonprofit organization that serves as the unifying voice of America's health care organizations that deliver mental health and addiction treatment and services. Website includes best practices, policy information, events, and training.

National Institute of Mental Health (nimh.nih.gov)

The lead federal agency for research on mental disorders, one of the 27 Institutes and Centers that make up the National Institutes of Health, which is part of the U.S. Department of Health and Human Services. The website includes data, research and legislative information.

SAVE (Suicide Awareness Voices of Education) (save.org)

Minnesota nonprofit organization dedicated to the prevention of suicide. Their work is based on the foundation and belief that suicide is preventable and everyone has a role to play in preventing suicide.

Mental Health Glossary

Antisocial personality disorder
People with this disorder characteristically disregard the feelings, property, authority, and respect of others for their own personal gain. This may include violent or aggressive acts toward others without a sense of remorse or guilt.

Attention deficit hyperactivity disorder (ADHD)
A developmental disorder where there are significant problems with attention, hyperactivity or acting impulsively.

Anxiety disorder (also called generalized anxiety disorder or GAD)
Anxiety that becomes overwhelming and repeatedly affects a person's life. Excessive worry about health, money, family, or work, and continual anticipation of disaster.

Autism
A group of developmental disorders, autism spectrum disorder (ASD) makes it difficult to socialize and communicate with others.

Behavioral therapy
Therapy that focuses on recognition of certain harmful or maladaptive behaviors that may be operating subconsciously and serve as the substitute for more helpful behaviors. Elements may include stress management, biofeedback, and relaxation training to change thinking patterns and behavior.

Bipolar disorder
Causes dramatic highs and lows in a person's mood, energy and ability to think clearly.

Borderline personality disorder (BPD)
Characterized by severe, unstable mood swings, impulsivity and instability, poor self-image, and stormy relationships.

Cognitive behavioral therapy (CBT)
A combination of cognitive and behavioral therapy that focuses on thinking patterns and the harmful or self-destructive behaviors that might accompany them. It combines changing thinking patterns, along with changing the behavior. Often the preferred treatment for mild to moderate depression, phobias, panic disorder, obsessive-compulsive disorder, anxiety, and bulimia.

Cognitive therapy
Seeks to identify and correct thinking patterns that can lead to troublesome feelings and behavior.

Collaborative care
A collaborative care team is led by a primary care provider (PCP) and includes care managers, psychiatrists, and other mental health professionals. The essential elements of collaborative care are as follows:

Team-Driven: A multidisciplinary group of health care professionals providing care in a coordinated fashion and empowered to work at the top of their professional training.

Population-Focused: The collaborative care team is responsible for the provision of care and health outcomes of a defined population of patients.

Measurement-Guided: The team uses systematic, disease-specific, patient-reported outcome measures (e.g., symptom rating scales) to drive clinical decision-making.

Evidence-Based: The team adapts scientifically proven treatments within an individual clinical context to achieve improved health outcomes.

Critical incident stress debriefing (CISD)
A specific, seven-phase, small-group, supportive crisis intervention process. One of many crisis intervention techniques included under the umbrella of Critical Incident Stress Management (CISM) program.

Critical incident stress management (CISM)
An adaptive, short-term psychological helping process that focuses solely on an immediate and identifiable problem. It can include pre-incident preparedness, to acute crisis management, to post-crisis follow up.

Day treatment
Includes special education, counseling, parent training, vocational training, skill building, crisis intervention, and recreational therapy, lasting at least four hours per day.

Dependent personality disorder
People with this disorder rely heavily on others for validation and fulfillment of basic needs. Often unable to properly care for themselves and typically lack self-confidence and security and are deficient in making decisions.

Depression
More than just feeling sad or going through a hard period of life, depression is a serious mental health condition causing severe despondency and dejection that requires treatment.

Dissociative disorders
A spectrum of disorders that involve disruptions or breakdowns in a person's memory, awareness, identity, or self-perception.

DSM-IV
A manual published by the American Psychiatric Association that includes all currently recognized mental health disorders.

Dual diagnosis
A person with an alcohol or a drug problem and an emotional or psychiatric illness has a dual diagnosis. The term is also used to describe a person with an intellectual disability and an emotional or psychiatric illness.

Early psychosis (also called first-episode psychosis)
When a person is experiencing psychosis for the first time. Psychotic episodes are periods of time when symptoms of psychosis are strong and interfere with daily life.

Eating disorders
A range of serious but treatable psychological disorders (e.g., anorexia, bulimia) that cause a person to become so preoccupied with food and weight issues they find it hard to focus on other aspects of life.

Evidence-based practices or programs
Based on systematic, empirical research relying on measurements or observational methods that provide reliable and valid data across evaluators and observers, and across studies by investigators, and rigorous data analyses, adequate to test the stated hypotheses and to justify general conclusions drawn.

Group therapy
Includes a small group of people who, with the guidance of a trained therapist, discuss individual issues and help each other with problems.

Histrionic personality disorder
People with this disorder are overly conscious of their appearance, are constantly seeking attention, and often behave dramatically in situations that do not warrant this reaction. Emotional expressions are often judged as superficial and exaggerated.

Inpatient residential treatment
Either a mental health facility or a drug and/or alcohol or process addiction treatment program that is provided to patients in a residential setting.

Mental illness
Collectively refers to all mental disorders, defined as health conditions associated with distress or impaired functioning and characterized by abnormalities in thinking, emotion, mood, behavior, human interaction, or some combination thereof.

Narcissistic personality disorder
Characterized by severely over-inflated feelings of self-worth, grandiosity, and superiority over others. People with this disorder often exploit others who fail to admire them, and are overly sensitive to criticism, judgment and defeat.

Obsessive-compulsive disorder (OCD)
Causes repetitive, unwanted, intrusive thoughts (obsessions) and irrational, excessive urges to do certain actions (compulsions). People with OCD are inflexible to change, experience anxiety, and have trouble completing tasks and making decisions.

Panic disorder
Characterized by chronic, repeated and unexpected panic attacks, which are bouts of overwhelming fear of being in danger without specific cause. Between panic attacks, sufferers worry excessively about when and where the next attack may occur.

Paranoid personality disorder
People with this disorder are often cold, distant and unable to form close relationships. Often overly, yet unjustifiably, suspicious of their surroundings, they cannot see their role in conflict situations and often project their feelings of paranoia as anger.

Partial hospitalization
A time-limited, structured program of multiple and intensive psychotherapy and other therapeutic services provided by a multidisciplinary team, as defined by Medicare, and provided in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization programs and services. The goal is to resolve or stabilize an acute episode of mental illness.

Person-centered care
Refers to a document that is developed through a process focused on and directed by the individual and his or her family or advocate. It identifies desired outcomes and determines supports and services needed to reach them.

Phantom networks
A listing of providers purported to participate in a managed care plan, but who do not, in fact, do so.

Pharmacogenomics
The study of how genes affect a person's response to drugs. This relatively new field combines pharmacology (the science of drugs) and genomics (the study of genes and their functions) to develop effective, safe medications and doses that will be tailored to a person's genetic makeup.

Phobia
An overwhelming and unreasonable fear of an object or situation, such as public speaking.

PHQ-9
A multipurpose instrument for screening, diagnosing, monitoring, and measuring the severity of depression. It incorporates DSM-IV depression diagnostic criteria with other leading major depressive symptoms into a brief self-report tool.

Post-traumatic stress disorder (PTSD)
A result of traumatic events such as military combat, assault, abuse, an accident or a natural disaster, symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event.

Psychiatrist (M.D. or D.O.)
A professional who completed medical school and training in psychiatry, and is a specialist in diagnosing and treating mental illness. May prescribe medications.

Psychoanalysis
A long-term therapy meant to uncover unconscious motivations and early patterns to resolve issues and to become aware of how those motivations influence present actions and feelings.

Psychologist
A professional with a doctoral degree in psychology and whose training is in the assessment and treatment of psychological conditions. Generally may not prescribe medications.

Psychosis
Characterized as disruptions to a person's thoughts and perceptions that make it difficult for them to recognize what is real and what isn't; a loss of contact with reality.

Residential treatment
A live-in care facility providing therapy for substance abuse, mental illness, or other behavioral problems.

Schizoaffective disorder
Characterized by symptoms of schizophrenia, such as a mood disorder or manic episodes.

Schizophrenia
A long-term mental disorder that involves a breakdown in the relationship between thought, emotion and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion, and a sense of mental fragmentation.

Seasonal affective disorder (SAD)
A mood disorder characterized by depression related to a certain season of the year, especially winter.

Social phobia
An anxiety disorder that causes severe anxiety and discomfort related to a fear of being embarrassed, humiliated or scorned by others in social or performance situations.

STAR*D
The National Institute of Mental Health-funded Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study was conducted to determine the effectiveness of different treatments for people with major depression who have not responded to initial treatment with an antidepressant.

Acknowledgements

The Action Group is grateful to:

Participating Employers

The following Minnesota employers demonstrated their commitment to improving mental health in Minnesota through their participation in the 2017 Mental Health Learning Network:

- Best Buy
- Blue Cross Blue Shield of Minnesota
- City of Saint Paul
- Emerson Rosemount
- HealthPartners
- Medica
- State Employee Group Insurance Program (SEGIP)
- SUPERVALU
- Target
- University of Minnesota
- University of Minnesota Physicians

Expert Advisors and Key Informants

The following organizations and individuals supported the work of the 2017 Mental Health Learning Network by providing valuable information and insights:

- Allina Health – Dr. Paul Goering
- Aon – Bridget Neurer and Kathleen White
- Best Doctors – Eric Glazer and Ryan Schoenecker
- Blue Cross Blue Shield of Minnesota – Dr. Dan Holland, Brendan Shane, and other expert resources
- CentraCare Health – David Hartford and Dr. John Schmitz
- Essentia Health – Dr. Steven Sutherland
- HealthPartners – Dr. Karen Lloyd and Dr. Mike Trangle
- Learn to Live – Dr. Russell Morfitt
- NAMI Minnesota – Sue Abderholden
- National Alliance of Healthcare Purchaser Coalitions – Mike Thompson and Foong-Khwan Siew
- National Council for Behavioral Health – Donna DeWan
- Nationwide Insurance – Kathleen Herath
- Northeast Business Group on Health – Laurel Pickering and colleagues
- OneOme – Paul Owen and Mark Billmayer
- PreferredOne – Darcee Weber
- University of Minnesota – Dr. Jeffrey Bishop, Dr. Ezra Golberstein, and Dr. Mark Schneiderhan
- University of Washington – Dr. Henry Harbin

In addition, the work of the Mental Health Learning Network was informed by countless conversations with experts and advocates locally and nationally, including 2020 Mom, Minnesota Community Measurement, the Minnesota Bridges to Excellence Guiding Coalition, the Pacific Business Group on Health, and the Kennedy Forum. Their perspectives have enhanced our work and inspired our commitment.

Notes

Notes

For nearly 30 years, the Minnesota Health Action Group has been singularly focused on health care, uniting employers around common issues, amplifying the voice of those who write the checks for health care, and improving patient experience and outcomes for Minnesotans. Our members are helping make health care better.

www.mnhealthactiongroup.org

Minnesota Health Action Group©
7900 International Drive, Suite 1080
Bloomington, MN 55425
952-896-5186