WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Commission Teleconference Meeting
March 25, 2021
PowerPoint Presentations and Handouts

Agenda Item 1:	•	**PowerPoint:**	**Workplace Mental Health - Carolyn S. Dewa, MH, Phd**
	•	**PowerPoint:**	**The Role of Employers in Driving Solutions for Workplace Mental Health**
	•	**PowerPoint**	**Workplace Mental Health – Darcy Gruttadaro, J.D.**
	•	**Handout:**	**Infographic – Mental Health Parity**
	•	**Handout:**	**Infographic – The Collaborative Care Model**
Agenda Item 3:	•	**PowerPoint:**	**San Francisco - Innovations Learning Project Proposal**
Agenda Item 4:	•	**Handout:**	**Legislation Tracking Chart**

Mental Health Services Oversight and Accountability Commission Public Hearing on Workplace Mental Health

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UC DAVIS
UNIVERSITY OF CALIFORNIA

Discussion Topics

- Workplace mental health as a strategic environment for prevention and early intervention
- Findings about best practices to build resiliency and reduce risk for mental health needs in the workplace
- Strategies and models to address challenges around workplace mental health

Topic 1: Workplace mental health as a strategic environment for prevention and early intervention

Work Environment's Strategic Position

- Large labor force participation
- Key relationship between work and mental health
- Relationship between work stress and mental health

Labor Force Participation

The majority of the US participates in the labor force

- In Feb 2021, labor force participation rate: 61.4%
- The employment-population ratio: 57.6%
- Average weekly hours: 34.6 hours

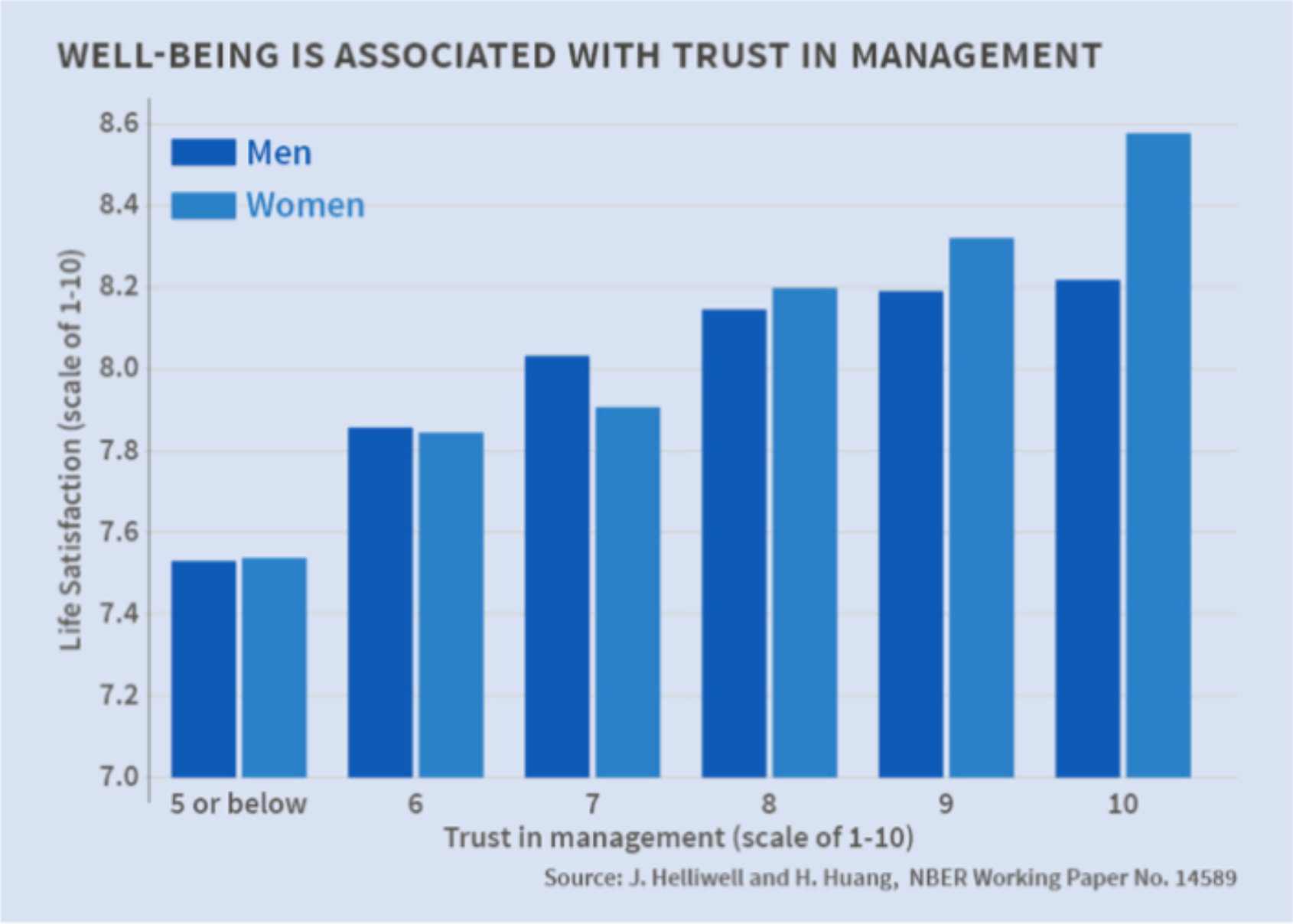
Source: US Bureau of Labor Statistics

In What Ways Does Work Promote Well-being?

What Is Well-Being?

The World Health Organization (WHO) defines **well-being** as:

A state in which every individual **realizes his/her own potential**, can **cope with normal stresses** of life, can **work productively and fruitfully**, and is able to **make a contribution to his/her community**.

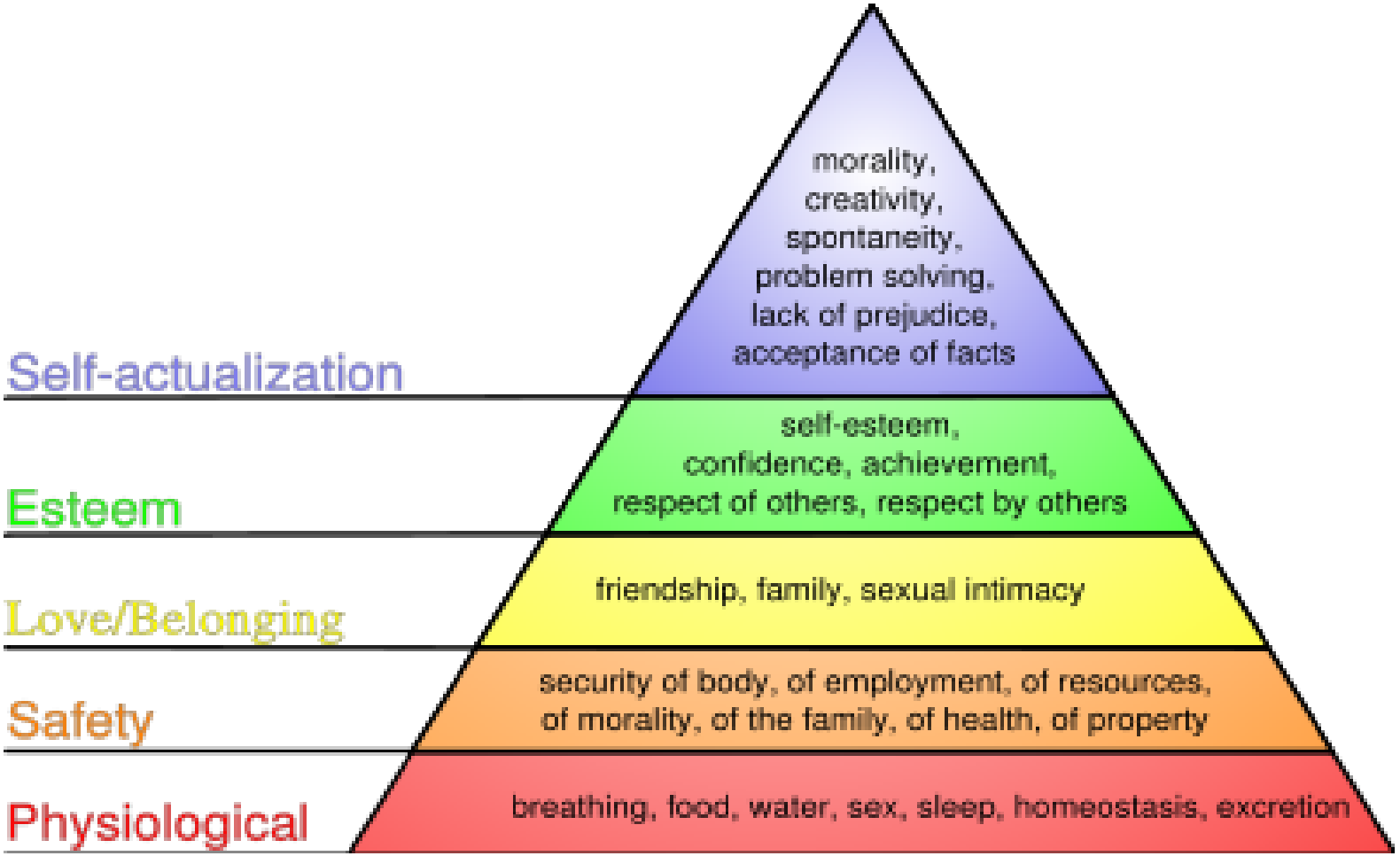

WELL-BEING IS ASSOCIATED WITH TRUST IN MANAGEMENT
Men
Women
Life Satisfaction (scale of 1-10)
8.6
8.4
8.2
8.0
7.8
7.6
7.4
7.2
7.0
5 or below
6
7
8
9
10
Trust in management (scale of 1-10)
Source: J. Helliwell and H. Huang, NBER Working Paper No. 14589

What is Occupational Well-Being?
Van Horn et al. (2004)

It has at least 5 dimensions:

- Affective well-being (satisfaction & commitment)
- Professional well-being (autonomy & competence)
- Social well-being (social functioning at work)
- Cognitive well-being (concentration & new info)
- Psychosomatic well-being

Maslow's Hierarchy of Needs



Source: Maslow, A.H. A Theory of Human Motivation. *Psychological Review* 50: 370-396, 1943.

A musician must make music, an artist must paint, a poet must write, if he is to be ultimately happy. What a man can be, he must be. This need we may call self-actualization.

Source: Maslow, A.H. A Theory of Human Motivation. *Psychological Review* 50: 370-396, 1943.

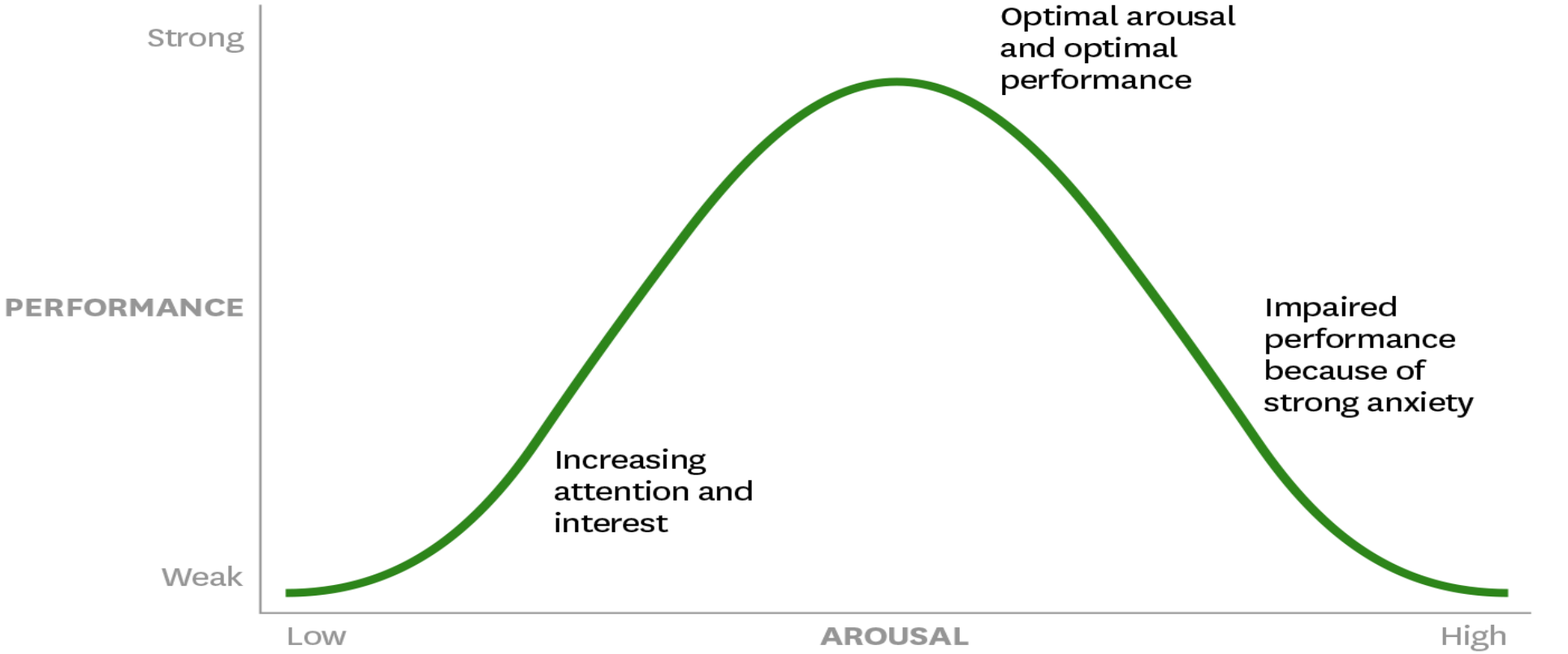
No Country, however rich, can afford the waste of its human resources. Demoralization caused by vast unemployment is our greatest extravagance. Morally, it is the greatest menace to our social order.

Franklin D. Roosevelt, Second Fireside Chat on Government and Modern Capitalism, Washington, D.C., September 30, 1934

In What Ways Can Work be Detrimental to Well-being?

The Yerkes-Dodson Law

How anxiety affects performance.



SOURCE ROBERT M. YERKES AND JOHN D. DODSON

Karasek's Demand-Control Model

- Higher autonomy than psychological demand
- Skill discretion
- Job insecurity
- Physical exertion
- Social support

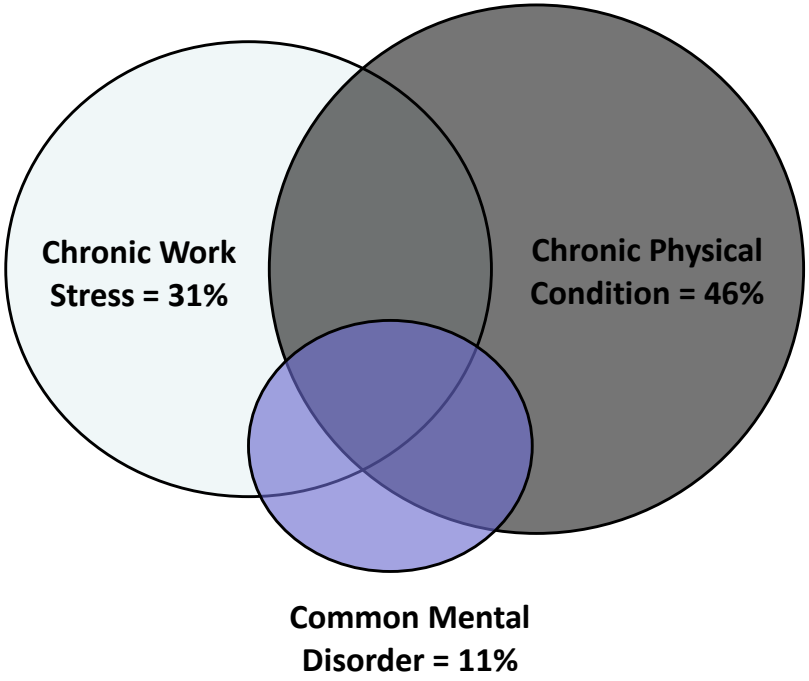
Table 3: Logistic regression results: Outcome = "High Stress" work

Variable	Odds ratios	95% Confidence Interval
Male	0.585	0.452–0.758
Age	1.009	0.997–1.020
Non-white	0.795	0.534–1.186
Marital status (Reference group: single)		
Married	1.225	0.844–1.778
Disrupted marriage	1.980	1.248–3.140
Did not finish high school	0.867	0.441–1.703
Currently not working	0.738	0.414–1.313
Job versus career	0.692	0.515–0.930
Satisfied with work	0.485	0.375–0.626
Risk of liability	2.169	1.647–2.857
Extra hours	1.461	1.137–1.878
Variability in work hours	1.997	1.526–2.614
Work is boring	1.254	0.980–1.603
Occupation (Reference group: clerical/office worker)		
Manager/Professional	2.193	1.380–3.485
Proprietor	1.287	0.697–2.376
Sales	1.048	0.532–2.065
Services	1.233	0.733–2.074
Farmer	0.808	0.367–1.776
Manufacturing/Trades	0.900	0.468–1.730
Other	2.008	0.776–5.197
Employed in a small business	0.693	0.533–0.900

Source: Dewa, C.S.; Thompson, A.H.; Jacobs, P. Relationships Between Job Stress and Worker Perceived Responsibilities and Job Characteristics. *International Journal of Occupational and Environmental Medicine*. 2(1):37-46, 2011.

Percent of Workers with Chronic Work Stress, Mental Disorders & Chronic Physical Disorders in a 30-day Period

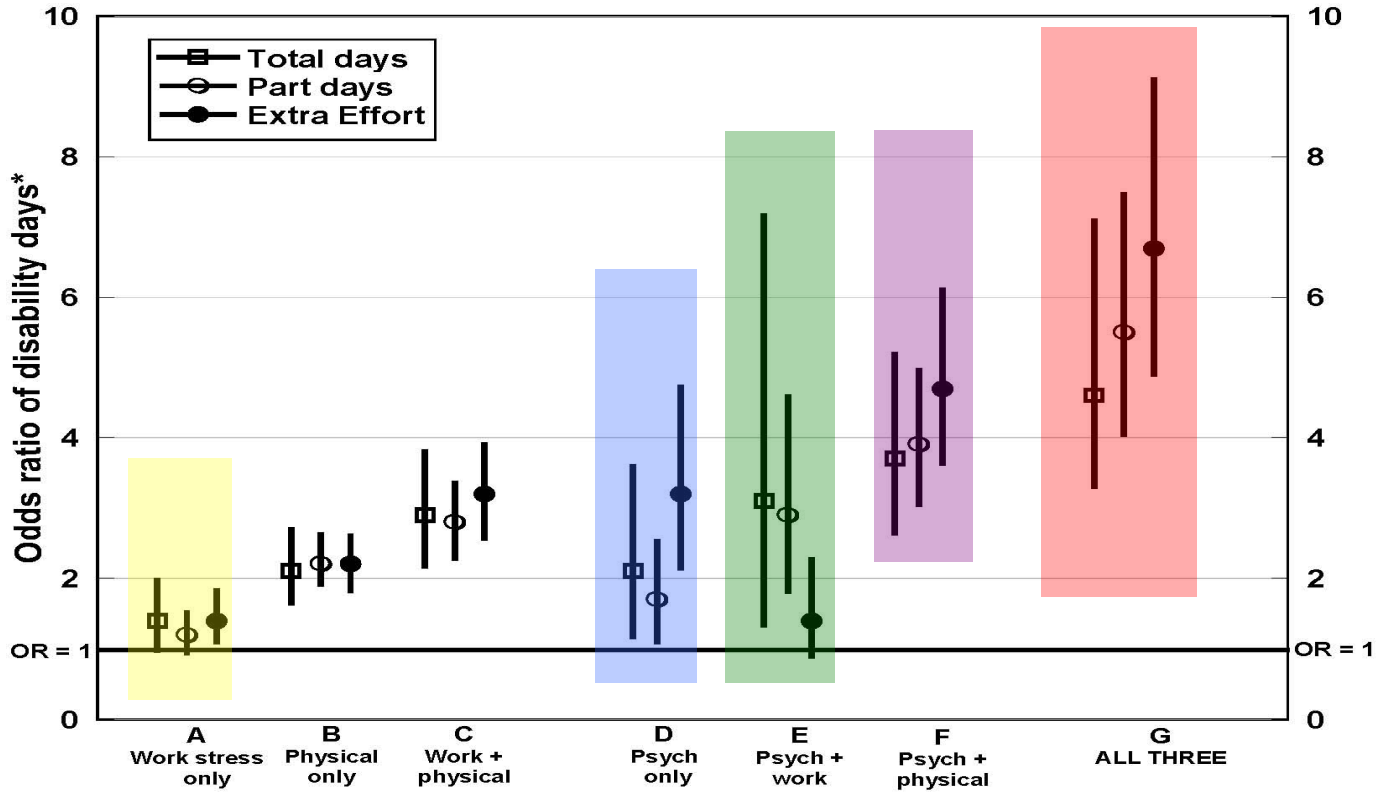
- Only a third of workers did not report having chronic work stress, a chronic physical condition, or a common mental disorder
- Almost a third of workers report experiencing chronic work stress
- About 1 in 10 workers have a mental disorder
- Disorders/conditions come in combinations



Source: Dewa, C.S.; Lin, E.;. Koehoorn, M.; Goldner, E. Psychiatric Disorders, Chronic Physical Conditions, Workplace Stress and Disability in the Canadian Working Population. *Psychiatric Services* 58(5): 652-658, 2007.

Odds Ratios for Disability Days & Disorders/Conditions

Figure 1. The relationship between different levels of disability days and chronic work stress, chronic physical problems, and psychiatric disorders among workers.



* Comparison group = no chronic work stress or chronic physical illness or psychiatric disorder

Source: Dewa, C.S.; Lin, E.;. Koehoorn, M.; Goldner, E. Psychiatric Disorders, Chronic Physical Conditions, Workplace Stress and Disability in the Canadian Working Population. *Psychiatric Services* 58(5): 652-658, 2007.

Topic 2: Findings about best practices to build resiliency and reduce risk for mental health needs in the workplace

Fig. 1. The arena in work disability prevention (figure adapted from Loisel *et al.* (87)).

Source: Loisel, P., R. Buchbinder, et al. "Prevention of work disability due to musculoskeletal disorders: the challenge of implementing evidence." *J Occup Rehabil* 15(4): 507-24, 2005.

Work Environment and Personal System

- Self-care
- Coping
- Need for Recovery

Mental Health Promotion
Kobau et al. (2011)

A public health approach to mental health promotion **fosters individual competencies, resources, and psychological strengths** and to **strengthen community assets** to prevent mental disorders and **enhance quality of life for people and communities**.

Role of Self-Care

The World Health Organization (2013) definition:

> The ability of individuals, families and communities to **promote health**, **prevent disease**, **maintain health**, and to **cope with illness and disability** with or without the support of a health-care provider.

What is Coping?

Coping = cognitive and behavioral efforts to master, reduce, or tolerate internal or external demands created by stressors

Major Types of Coping

- Emotion-focused coping: Regulations of emotions or distress
- Problem-focused coping: Management of problem causing distress

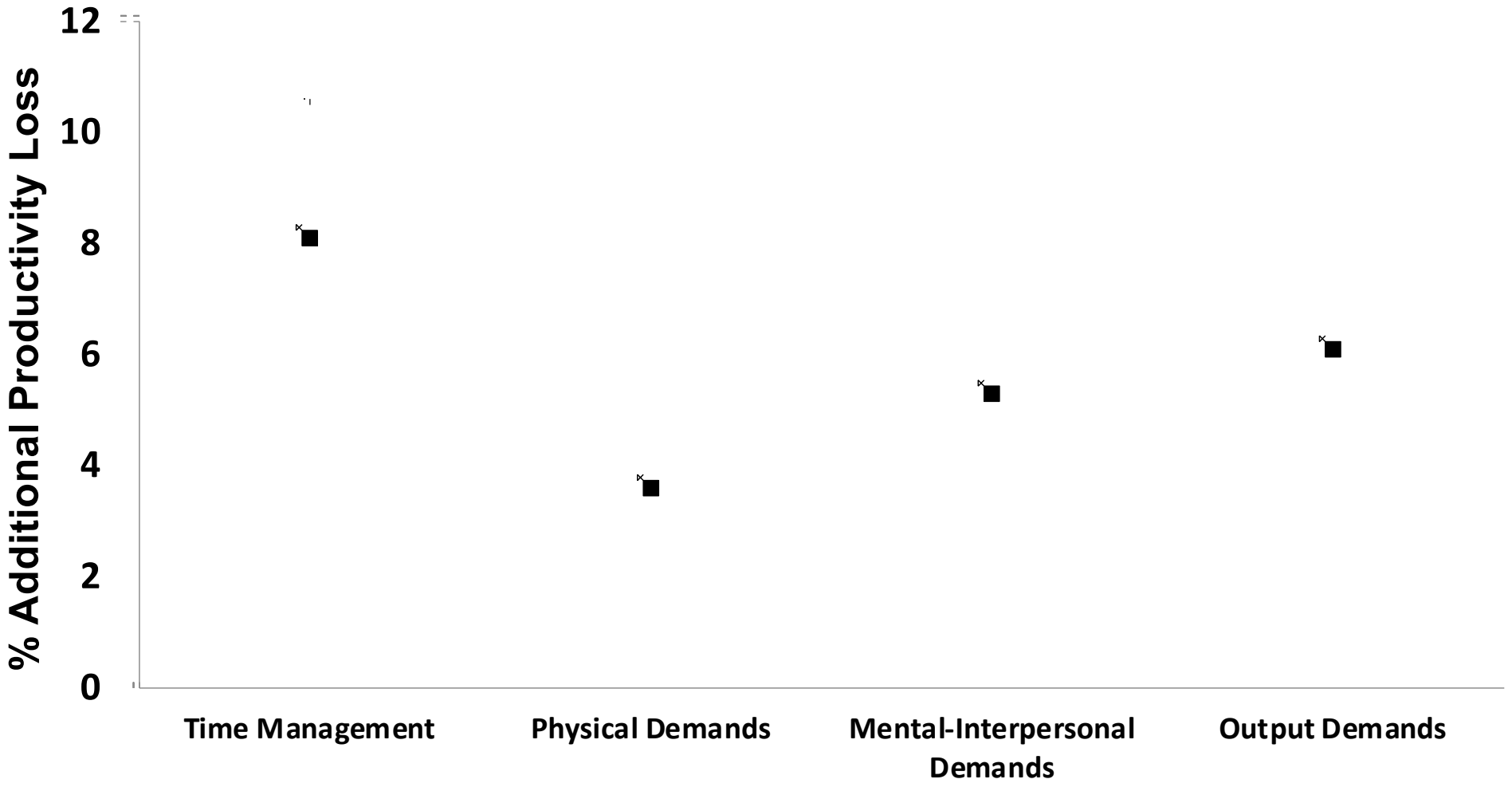
What is Recovery?

A process of psychophysiological unwinding that is the opposite of activation of psychophysiological systems during effort expenditure particularly under stressful situations (Geurts and Sonnentag 2006)

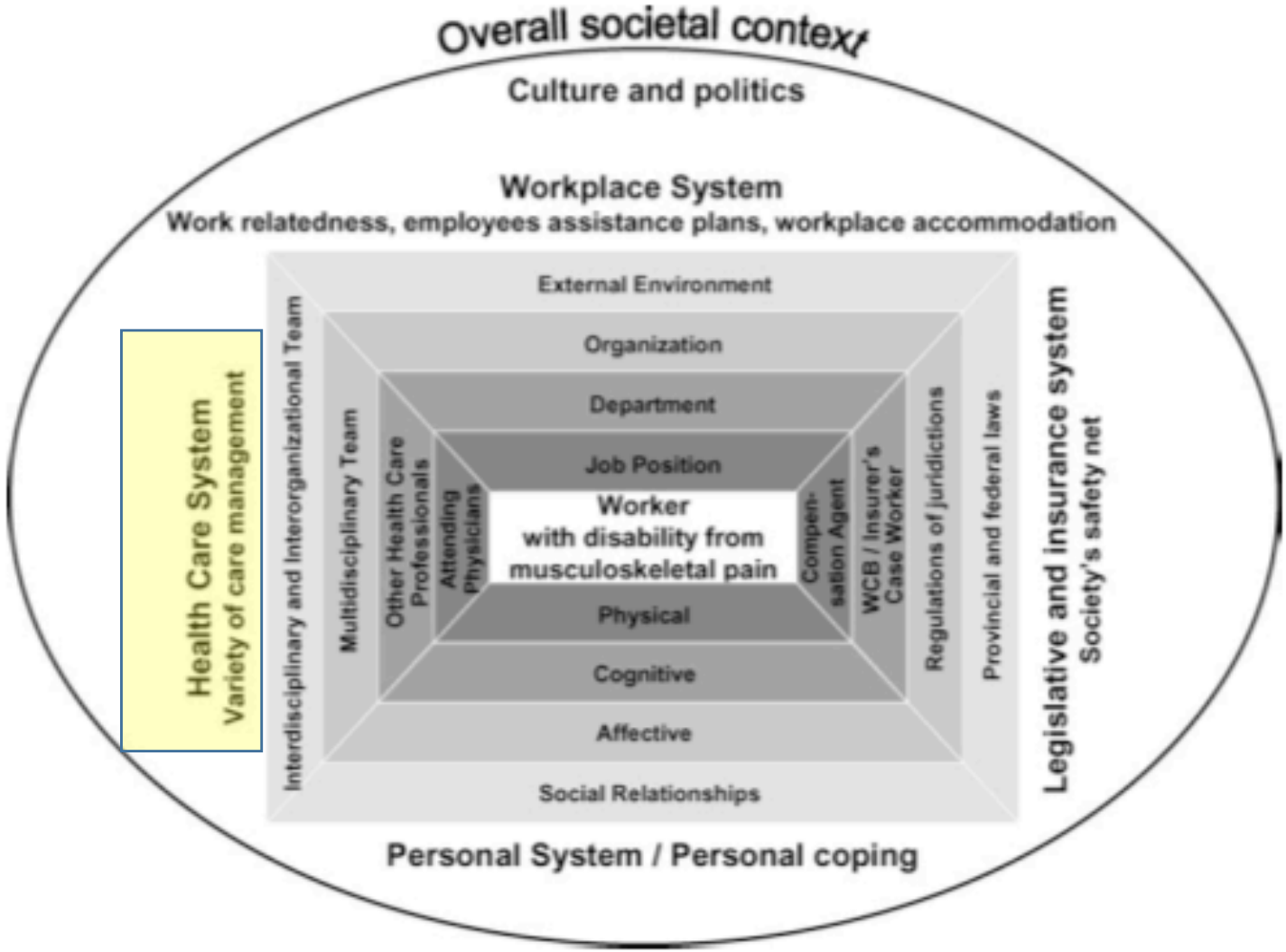
Need for Recovery

Occurs when there is persistent exposure to stressful situations and there is insufficient time to recover

% Additional Productivity Losses with High Need for Recovery



Source: Dewa, C.S.; Nieuwenhuijsen, K.; Parikh, S.; Sluiter, J. (2019). How Does the Presence of High Need for Recovery Affect the Association Between Perceived High Chronic Exposure to Stressful Work Demands and Work Productivity Loss? *JOEM*. 61(1): 75-80.



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Work Environment and the Healthcare System

- Treatment can help workers to continue working
- Early intervention decreases disability related to mental disorders
- Adequate care reduces the risk of future disability

Treatment Protects Work Productivity

- OR for productivity with moderate depressive episode tx vs no tx = 2.44
- OR for productivity with severe depressive episode tx vs no tx = 6.92

Source: Dewa, C.S.; Thompson, A.H.; Jacobs, P. The Association of Treatment for Major Depressive Episodes and Work Productivity. *Canadian Journal of Psychiatry*. 56(12):743-50, 2011.

Probability of Returning to Work

Variables	Odds ratio	95% Confidence Interval
Demographic Variables		
Female	1.44	(0.924, 2.257)
Manager position	1.16	(0.797, 1.683)
Age (in years)	0.98	(0.964, 0.999)
Severity & Complexity Variables		
Number of symptoms	0.83	(0.779,0.884)
Depression only	0.92	(0.680, 1.255)
One antidepressant fill only	0.43	(0.165, 1.133)
One antidepressant exclusively	0.30	(0.131, 0.696)
Switched antidepressants	0.16	(0.069, 0.376)
Augmented antidepressants	0.16	(0.069, 0.389)
Guideline Recommended Use Variables		
% Used recommended 1st line agent	1.69	(0.861, 3.311)
% Used recommended dose	1.54	(0.947, 2.494)
% Used within 30 days of SDIS start	1.06	(0.677, 1.655)
Company Fixed Effects		
Company 1	1.73	(0.852, 3.499)
Company 2	1.20	(0.850, 1.683)

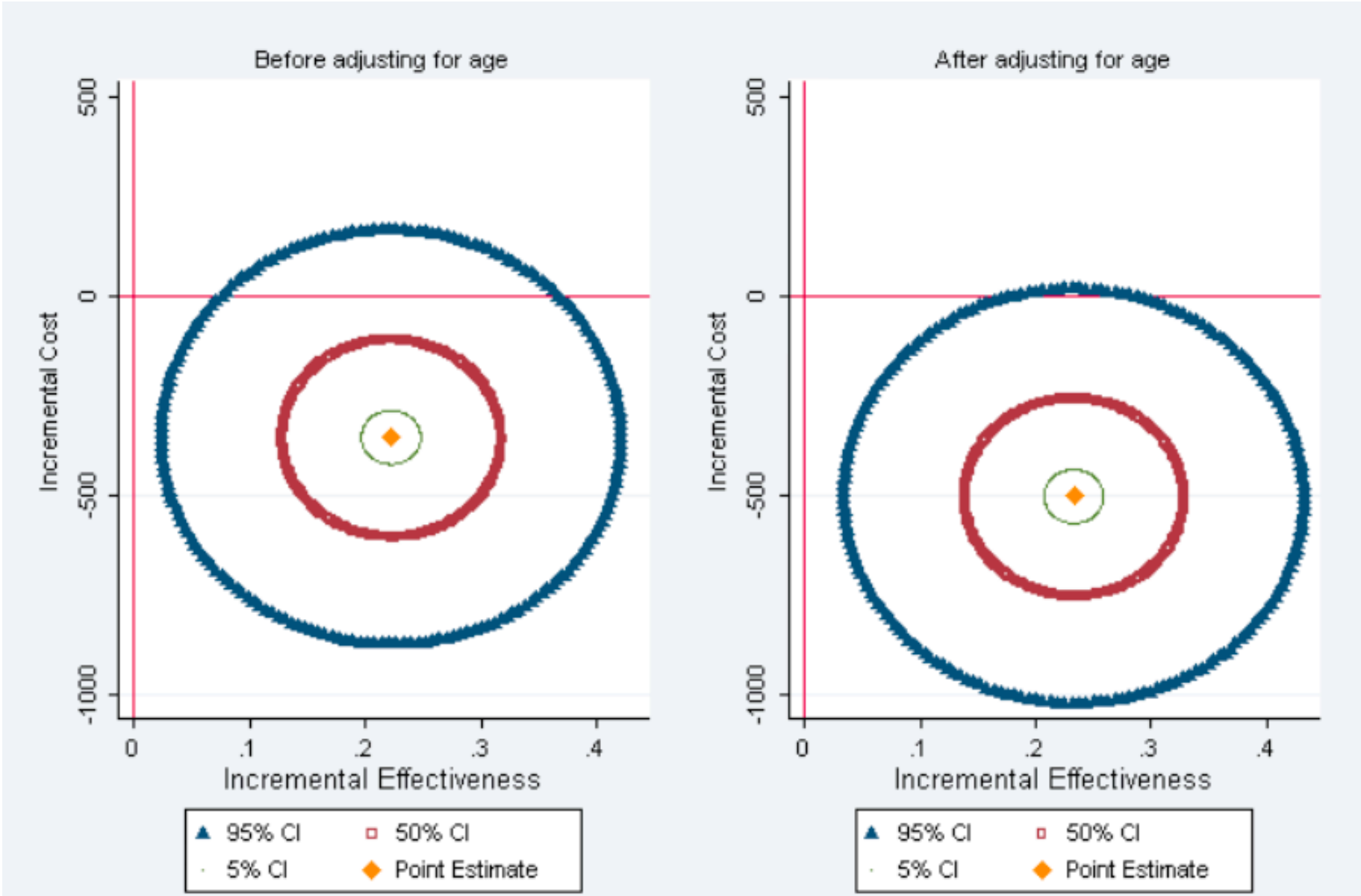
Source: Dewa, C.S.; Hoch, J.S.; Lin, E.; Paterson, M.; Goering, P. The Relationship Between Guideline Concordant Treatment of Depression and Short-Term Disability. *British Journal of Psychiatry*. 183:507-513, 2003.

Length of Episode for Those Who Returned to Work

Variables	B	95% Confidence Interval
Demographic Variables		
Female	-1.63	(-11.429, 8.177)
Manager position	10.15	(2.637, 17.664)
Age (in years)	0.010	(-0.348, 0.368)
Severity & Complexity Variables		
Number of symptoms	7.52	(6.225, 8.813)
Depression only	-5.28	(-11.453, 0.888)
One antidepressant fill only	29.88	(6.494, 53.269)
One antidepressant exclusively	41.70	(18.122, 65.281)
Switched antidepressants	60.24	(36.689, 83.781)
Augmented antidepressants	62.13	(35.458, 88.797)
Guideline Recommended Use Variables		
% Used recommended 1st line agent	-8.48	(-30.000, 13.046)
% Used recommended dose	-4.87	(-17.355, 7.614)
% Used within 30 days of SDIS start	-24.18	(-34.952, -13.417)
Company Fixed Effects		
Company 1	-38.58	(-55.051, -22.107)
Company 2	-21.59	(-28.381, -14.797)
Constant	47.19	(31.111, 63.065)

Source: Dewa, C.S.; Hoch, J.S.; Lin, E.; Paterson, M.; Goering, P. The Relationship Between Guideline Concordant Treatment of Depression and Short-Term Disability. *British Journal of Psychiatry*. 183:507-513, 2003.

Effectiveness of Adequate Treatment

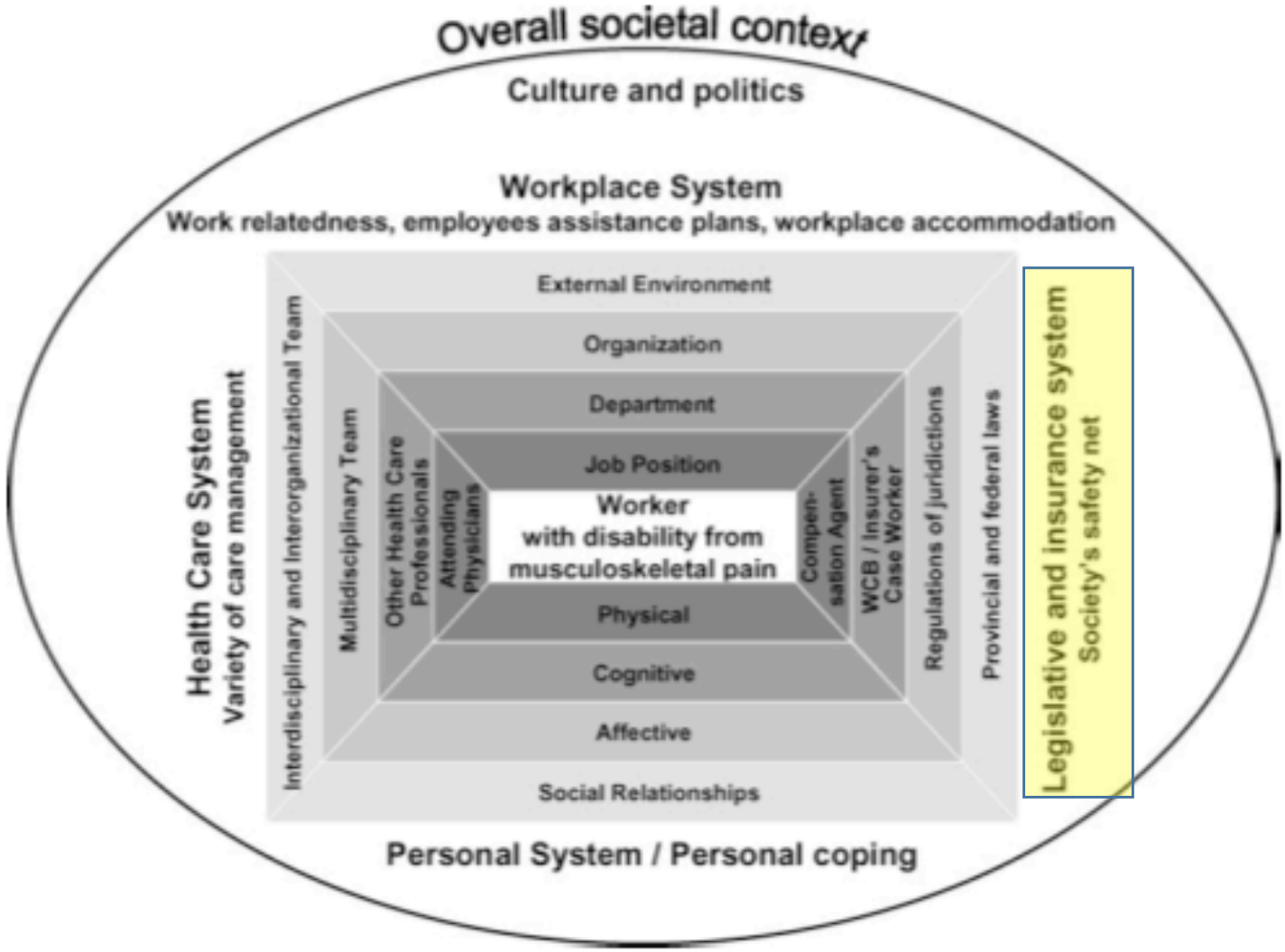


Source: Dewa, C.S.; Hoch, J.S.; Carmen, G.; Guscott, R.; Anderson, C. An Economic Evaluation of a Collaborative Care Program for Workers Receiving Short-Term Disability Benefits for Psychiatric Disorders. *Canadian Journal of Psychiatry*. 54(6):379-388, 2009.

Reducing the Risk of Future Disability

- Workers adherent to antidepressant or psychotherapy treatment in the acute phase of depression had a 16% reduced risk of a future work leave compared to those who were non-adherent.

Source: Gaspar, F.W.; Wizner; Morrison, J.; Dewa, C.S. The Influence of Antidepressant and Psychotherapy Treatment Adherence on Future Work Leaves for Patients with Major Depressive Disorder. *BMC Psychiatry*. 20(1):320



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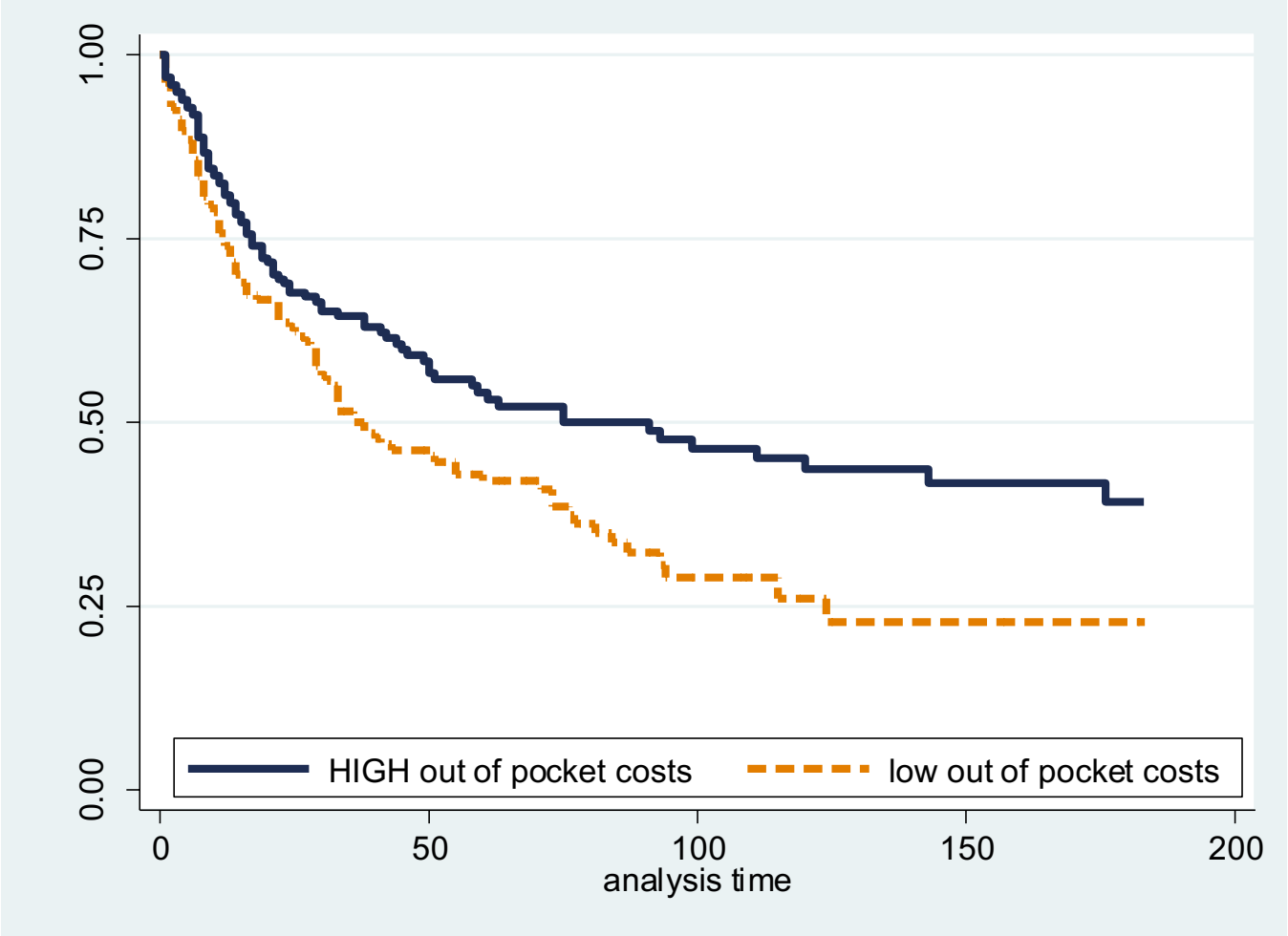
Work Environment and Insurance System

- Insurance benefit structure can be a barrier to care

Probability of no antidepressant claim as a function of time by level of out of pocket costs (e.g., High vs. low out of pocket costs)

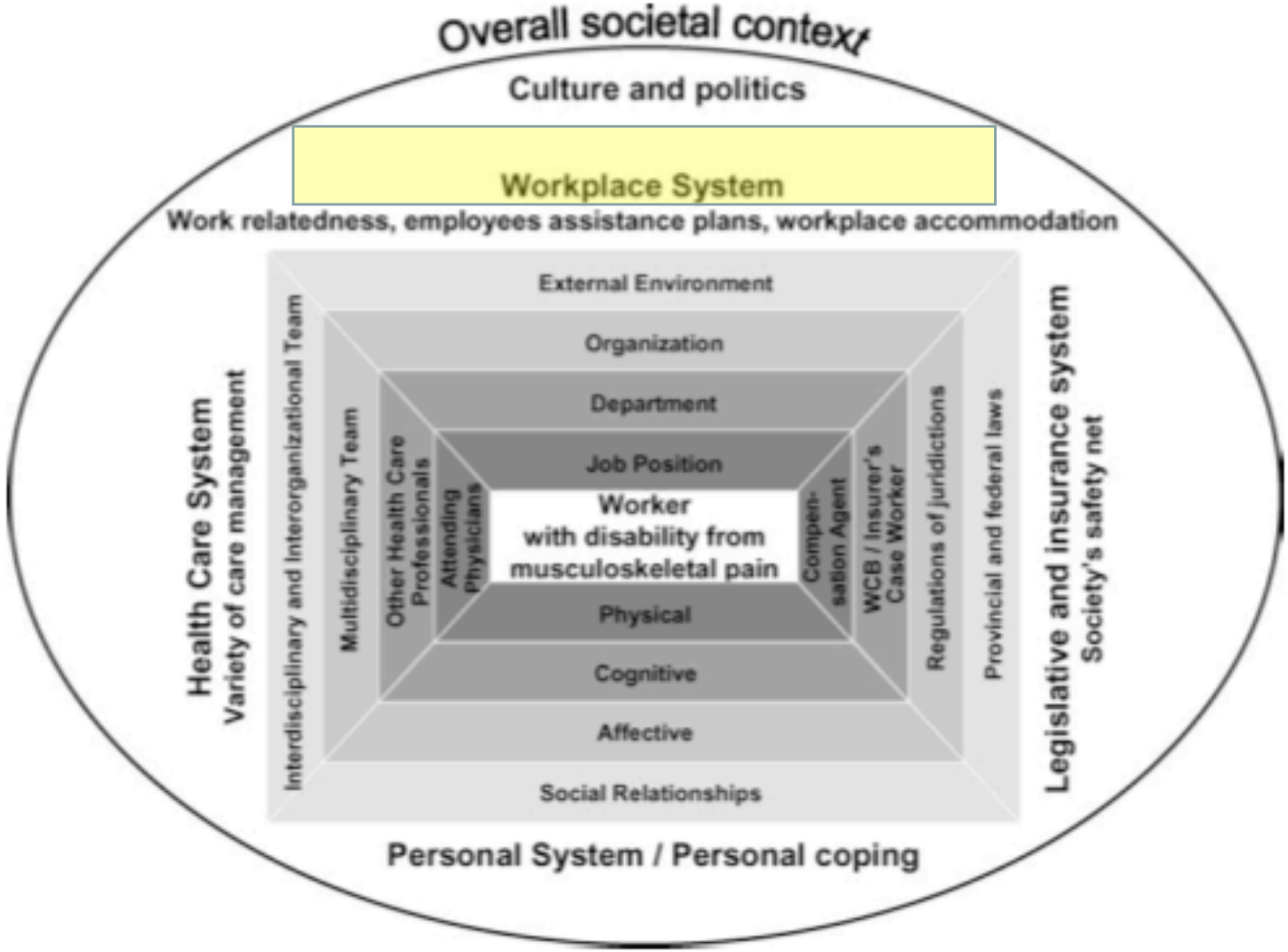


Source: Dewa, C.S.; Hoch, J.S.; Goering, P. Previous Out-Of-Pocket Expenditures and Patterns of Antidepressant Use Among Workers Receiving Depression-Related Disability Benefits. *Healthcare Policy*. 4(2):.e149-e166, 2008.

Impact of Co-payments

- Higher out-of-pocket costs for antidepressant prior to the beginning of a disability episode was significantly associated with higher probability of using an antidepressant during the episode
- Higher out-of-pocket costs for other prescription drugs prior to the beginning of the episode was significantly associated with lower probability of using an antidepressant during the episode

Source: Dewa, C.S.; Hoch, J.S.; Goering, P. Previous Out-Of-Pocket Expenditures and Patterns of Antidepressant Use Among Workers Receiving Depression-Related Disability Benefits. *Healthcare Policy*. 4(2):.e149-e166, 2008.



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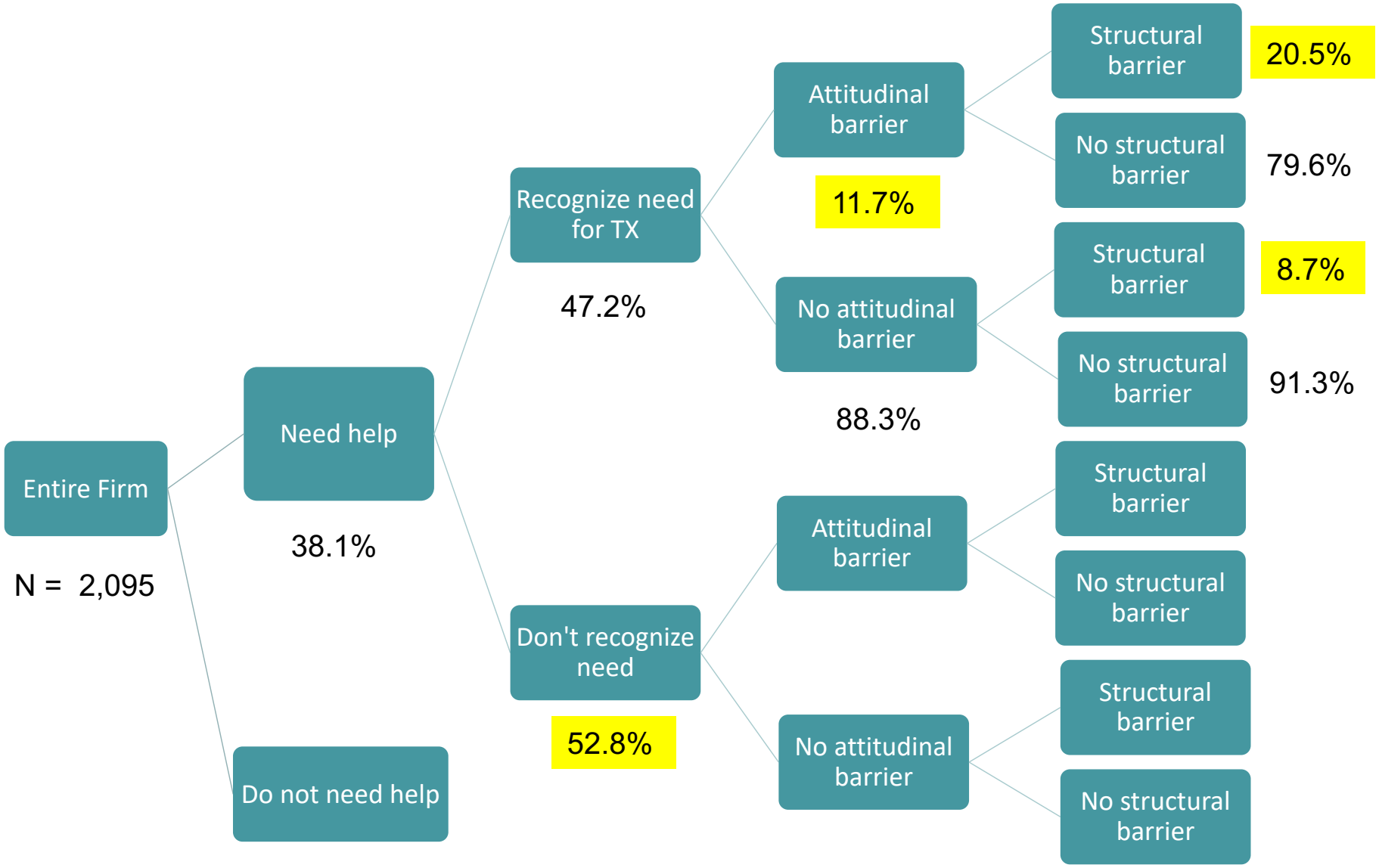
Work Environment and Workplace System

- Stigma can be a barrier to accessing help

Barriers to Help with Depressive Symptoms



Source: Dewa et al. (2015). Barriers to Mental Health Service Use Among Workers with Depression and Work Productivity. *Journal of Occupational and Environmental Medicine*. 57(7):726-31

Topic 3: Strategies and models to address challenges around workplace mental health

The National Standard of Canada for Psychological Health and Safety in the Workplace

Objective: specify "requirements for a documented and systematic approach to develop and sustain a **psychologically healthy and safe workplace**... This Standard provides a framework to create and continually improve a psychologically healthy and safe workplace."

Psychological Safety = the absence of harm and/or threat of harm to mental well-being

Findings About the Standard

- Between February 2015 and January 2017 of 1,010 companies, 17% indicated they were aware of the *Standard*.
- Awareness more likely among companies employing > 500 people and in the government and public administration sector
- Adopted identified greatest benefit as increased job satisfaction and employee retention
- Adoption barriers: inadequate resources, not relevant to their enterprise, insufficient knowledge to implement it, getting requisite buy-in and culture change
- Might be difficult for small organizations or those that hire staff on short-term contracts.

Sources: Sheikh MS, Smail-Crevier R, Wang J. A Cross-Sectional Study of the Awareness and Implementation of the National Standard of Canada for Psychological Health and Safety in the Workplace in Canadian Employers. *Can J Psychiatry* 2018:706743718772524.
Kalef L, Rubin C, Malachowski C, Kirsh B. Employers' Perspectives on the Canadian National Standard for Psychological Health and Safety in the Workplace. *Employee Responsibilities and Rights Journal* 2016;28:101-12.
Kunyk D, Craig-Broadwith M, Morris H, Diaz R, Reisdorfer E, Wang J. Employers' perceptions and attitudes toward the Canadian national standard on psychological health and safety in the workplace: A qualitative study. *Int J Law Psychiatry* 2016;44:41-7.

Summary

- Workplace mental health is a strategic environment for prevention and early intervention
- Resiliency and risk reduction for mental health needs in the workplace must be addressed in the personal, healthcare, policy/insurance, and workplace systems
- The *National Standard of Canada for Psychological Health and Safety in the Workplace* offers important lessons in implementing large scale and voluntary workplace standards

The Role of Employers in Driving Solutions for Workplace Mental Heatlh

MHSOAC Public Meeting
March 2021

It is impossible to build a successful workforce without prioritizing employee mental health.

1 in 3	Ratio of working-age adults in the US **experiencing a mental disorder**, regardless of gender, age, race/ethnicity, or occupation.[1]
13% - 29%	The percentage of time at work in which depressed employees have **impaired performance**.[2]
$24 billion	Amount spent annually in the US on **lost work productivity** due to depression alone.[3]
$89 billion	Amount spent annually in the US on health care for **mental health conditions**.[4]
8.4 million	People in the U.S. who **provide unpaid care for a loved one with a mental illness.**[5]

[1] National Comorbidity Survey Replication." 2007. Available at: https://www.hcp.med.harvard.edu/ncs/ftpdir/table_ncsr_12monthprevgenderxage.pdf
[2] Online screening initiative as part of the Work and Health Initiative Study, a randomized clinical trial testing a work-focused intervention for depression, which was sponsored by the National Institute on Aging. Available at: https://link.springer.com/chapter/10.1007/978-1-4419-0428-7_6
[3] Stewart et al. "Cost of lost productive work time among US workers with depression." 2003. Available at: https://jamanetwork.com/journals/jama/fullarticle/196767
[4] Peterson Kaiser Health Tracker (2016) Available at: https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/#item-u-s-hospitals-13-mental-health-discharges-10-substance-use-discharges-readmitted-within-30-days
[5] On Pins and Needles. National Alliance for Caregiving. https://www.caregiving.org/wp-content/uploads/2016/02/NAC_Mental_Illness_Study_2016_FINAL_WEB.pdf

Insights from Employers about the Role of Employers

Solutions must meet employees where they are at any given point in time.

Do not underestimate the impact of leadership from the top down.

Empower managers and equip them with the right knowledge and resources.

Engage to understand and eliminate stigma, social prejudice and discrimination.

Embed continuous evaluation to grow the body of evidence-based best practices.

AMERICAN PSYCHIATRIC ASSOCIATION FOUNDATION

CENTER FOR WORKPLACE MENTAL HEALTH

Mental Health Services Oversight & Accountability Commission

Public Hearing on Workplace Mental Health 3.25.2021

Presented by: Darcy Gruttadaro, J.D.
Director, Center for Workplace Mental Health

Mental Health Concerns are High

The Pandemic's *Second Wave*

AMERICAN PSYCHIATRIC ASSOCIATION FOUNDATION | CENTER FOR WORKPLACE MENTAL HEALTH

Indicators of Anxiety or Depression Based on Reported Frequency of Symptoms During Last 7 Days

Select Indicator

Symptoms of Anxiety Disorder or Depressive Disorder

Symptoms of Anxiety Disorder or Depressive Disorder

Phase Label	Phase 3 (Oct 28 – Dec 21)					Break 2		Phase 3 (Jan 6 – Mar 1)							
Time Period Label	Nov 11 -	Nov 25 - Dec 7		Dec 9 - Dec 21		Dec 22 - Jan 5		Jan 6 - Jan 18		Jan 20 - Feb 1		Feb 3 - Feb 15		Feb 17 - Mar 1	
Group	95% CI	Percent	95% CI	Percent	95% CI	Percent	95% CI	Percent	95% CI	Percent	95% CI	Percent	95% CI	Percent	95% CI
National Estimate															
United States	1.8 - 43.4	41.4	40.7 - 42.2	42.4	41.5 - 43.3			41.1	40.2 - 41.9	41.5	40.7 - 42.2	39.2	38.5 - 39.8	38.9	38.0 - 39.7
By Age															
18 - 29 years	5.4 - 60.7	56.5	54.3 - 58.7	56.2	53.5 - 58.9			53.2	50.4 - 56.1	57.0	54.2 - 59.8	55.7	53.0 - 58.3	55.4	53.0 - 57.8
30 - 39 years	6.4 - 50.5	47.6	46.1 - 49.2	49.1	47.4 - 50.9			45.5	43.7 - 47.4	45.9	44.5 - 47.3	43.4	41.7 - 45.2	45.2	43.4 - 46.9
40 - 49 years	3.8 - 47.4	45.3	43.3 - 47.3	45.1	43.2 - 47.0			43.0	41.1 - 44.8	41.1	38.9 - 43.2	39.9	37.9 - 41.8	39.2	37.7 - 40.9
50 - 59 years	8.7 - 41.7	40.0	38.3 - 41.7	41.1	39.5 - 42.7			40.4	38.5 - 42.3	41.2	39.8 - 42.6	36.3	34.5 - 38.1	36.8	34.7 - 38.8
60 - 69 years	2.4 - 36.0	32.3	30.6 - 34.1	33.6	31.9 - 35.3			33.1	31.4 - 34.9	33.4	31.6 - 35.4	32.0	30.6 - 33.5	28.9	27.4 - 30.5
70 - 79 years	6.3 - 31.0	26.4	24.0 - 28.8	27.1	25.2 - 29.1			28.4	25.9 - 31.0	26.3	24.6 - 28.0	24.5	22.6 - 26.4	24.5	22.9 - 26.2
80 years and above	9.4 - 29.3	19.4	15.4 - 23.9	28.3	22.2 - 35.0			26.6	21.7 - 32.0	22.5	18.5 - 27.0	24.1	19.8 - 28.8	22.6	18.5 - 27.2
By Gender															
Female	6.5 - 48.6	45.7	44.8 - 46.5	46.5	45.4 - 47.6			45.4	44.5 - 46.3	44.8	43.8 - 45.8	43.0	42.1 - 43.9	42.0	40.9 - 43.2
Male	6.0 - 38.5	36.8	35.7 - 38.0	37.9	36.7 - 39.1			36.4	35.1 - 37.7	38.0	36.9 - 39.1	35.5	34.4 - 36.6	35.5	34.2 - 36.7
By Race/Hispanic ethnicity															
Hispanic or Latino	5.6 - 50.8	48.0	45.1 - 50.9	46.3	44.0 - 48.5			42.1	39.9 - 44.3	47.1	44.7 - 49.4	43.8	41.3 - 46.3	42.9	40.6 - 45.2
Non-Hispanic Asian, single race	9.4 - 36.3	35.0	31.8 - 38.2	33.1	29.5 - 36.8			34.0	31.4 - 36.6	37.4	33.4 - 41.5	36.2	33.4 - 39.2	33.8	30.6 - 37.1
Non-Hispanic black, single race	0.4 - 46.8	42.5	40.2 - 44.9	48.0	45.3 - 50.7			42.2	39.1 - 45.4	44.5	41.6 - 47.5	41.9	39.7 - 44.1	41.5	39.2 - 43.8

While nation's struggle to manage the initial waves of the death and disruption associated with the pandemic, accumulating evidence indicates another "second wave" is building: rising rates of mental health and substance use disorders. - JAMA, October 12, 2020

Three Areas of Focus in WMH

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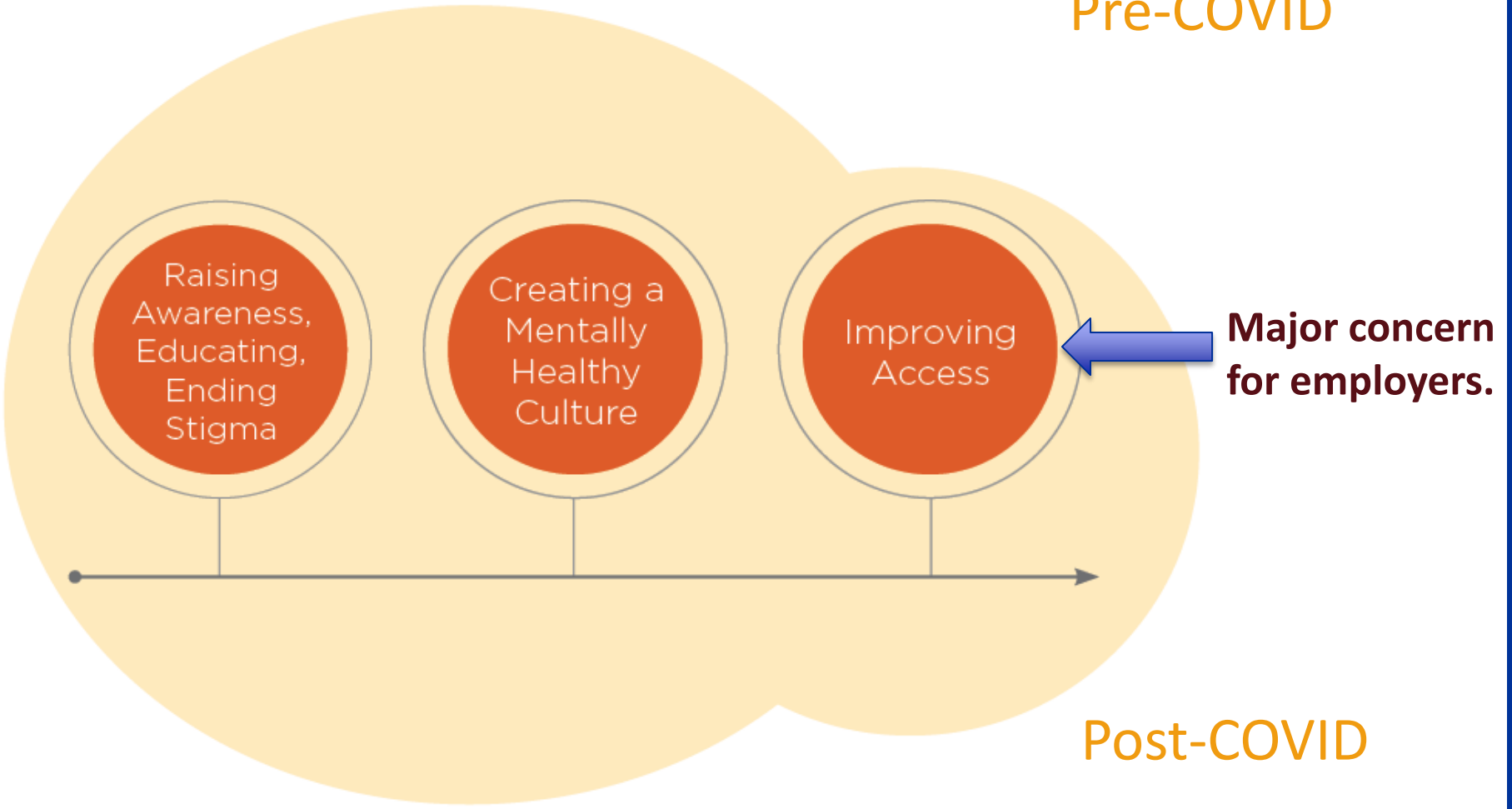

Improving Access to timely, effective & affordable MH & SUD Care is a high priority for employers.

Improving access to care is a ***HIGH*** priority for the employer community.

Why? Because employers care about employees & their families & BH conditions are common and costly:

- Employees inform HR & benefit leads that they cannot access care
- Productivity costs: absenteeism and presenteeism
- Disability rates: globally depression is #1 in disability
- Retention concerns: keeping high performing employees
- Treating underlying health conditions is 2 to 3x higher

Opportunity to engage key stakeholders like employers, providers, business coalitions, benefit consultants, health plans, state & federal officials & others in improving access to care.

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Improving Access & Quality in 5 Key Areas

- Increase access to in-network MH/SUD providers (2-tiered inequitable system)
- Expand implementation of the Collaborative Care Model (CoCM)
- Expand screening for & monitoring of MH/SUD conditions through Measurement Based Care (MBC)
- Sustain expanded access to tele-behavioral health services
- Ensure Mental Health Parity Compliance

The Path Forward for mental health and substance use
Driving market-based improvement in access and care for all Americans

AMERICAN PSYCHIATRIC ASSOCIATION FOUNDATION

CENTER FOR WORKPLACE MENTAL HEALTH

Increase Access to In-network MH/SUD Providers

Opportunities to address network issues:

- Securing timely appointments & effective care (reduce search & wait times)
- Disparate reimbursement rates (MH vs. Med-Surg) despite supply & demand realities
- Administrative, credentialing and financial burdens
- Need for partnerships between provider organizations & health plans to expand network participation

The Path Forward for mental health and substance use
Driving market-based improvement in access and care for all Americans

American Psychiatric Association Foundation

Center for Workplace Mental Health

Expand Implementation of the CoCM

Opportunities to address integrated care:

- Behavioral health care is often delivered in PC with mixed results
- CoCM is the only evidence-based integrated care model with more than 70 RCTs showing improved treatment and cost outcomes
- Promotion, provider outreach, training and support are needed for PCP to expand the model
- Creates a triage system for limited BH specialty care and referrals

The Path Forward for mental health and substance use
Driving market-based improvement in access and care for all Americans

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Expand Measurement Based Care (MBC)

Opportunities to address MBC:

- Improve quality outcomes measurement & accountability
- Promote use of standardized MH/SUD symptom measurement tools like the PHQ-9, GAD-7 and reporting
- Routine screening for depression, treatment plan development and measuring remission at 12 months

The Path Forward for mental health and substance use
Driving market-based improvement in access and care for all Americans

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Sustain expanded access to tele-behavioral health services

Opportunities to address tele-BH:

- Access is improved with “no show” rates down
- People appreciate choice in treatment modality (audio, audio-video, in-person)
- Sustain reimbursement practices for audio & audio-video treatment at same rates as in-person care

The Path Forward for mental health and substance use
Driving market-based improvement in access and care for all Americans

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Ensure MH Parity Compliance

Opportunities to address parity:

- Non-compliance remains a concern with national reports, stepped up state and federal regulatory actions, and lawsuits showing disparities
- Non-quantifiable treatment limits (NQTLs) remain barriers to care
- US DOL new authority to enforce parity provisions in federal law

The Path Forward for mental health and substance use
Driving market-based improvement in access and care for all Americans

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National Trends in Advancing MH Parity

New Federal MH Parity Provisions (Consolidated Appropriations Act signed 12.27.20) provides the US DOL with new enforcement authority:

- Requires employer health plans & insurers to perform and document comparative analysis of the design & application of NQTLs for MH and SUD and med/surg benefits
- Plans & insurers must provide analysis and related information to federal and state authorities upon request, and it must include the following:
  - Terms of each NQTL
  - Factors used to determine whether NQTLs apply to MHSUD benefits or med/surg benefits and the evidentiary standards used to design & apply NQTLs to specific benefits
- If compliance is not met, provide DOL with corrective action plan, if compliance is still not met, plan enrollees must be notified of failure to comply

New State Laws, Lawsuits & Regulatory Action

- New state laws broadening MH parity provisions
- CA SB 855
- Stepped up state enforcement of MH parity laws
- Lawsuits filed to enforce MH parity laws
- Interest in MH parity enforcement continues to grow with strong advocacy for compliance

Contact Information

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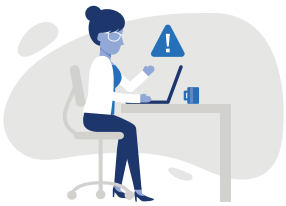
MENTAL HEALTH PARITY

A SMART INVESTMENT WITH HIGH ROI

MAKING THE BUSINESS CASE

Treatment works for common conditions like **depression, anxiety and opiate addiction.**

Unlike coverage for other medical conditions, **people experience barriers to full insurance coverage** due to denials and medical management limits on mental health and substance use care.



Access to timely and effective care **impacts employer costs, retention, disability rates, performance and productivity.**

MENTAL HEALTH PARITY

WHAT IS IT?

Federal and state laws requiring that coverage offered for mental health and substance use conditions is **no more restrictive than coverage for other medical conditions.**

Parity laws apply in two areas:

Quantitative Treatment Limits (QTLs): numerical limits on the scope or duration of treatment, like...

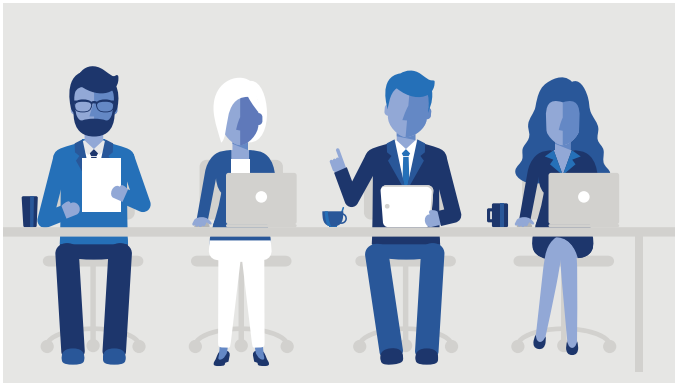
- ✓ Co-payments and deductibles
- ✓ Annual or lifetime visits and hospital days allowed
- ✓ Maximum out-of-pocket limits

Non-Quantitative Treatment Limits (NQTLs): practices that limit the scope of care, duration of treatment and the medical management processes used to determine coverage, like...

- ✓ Preauthorization of treatment facilities, procedures, and prescription drugs
- ✓ Review of medical necessity
- ✓ Design of prescription drug formularies
- ✓ Standards for provider admission to health plan networks
- ✓ Reimbursement rates for providers
- ✓ Fail-first policies or step therapy protocols
- ✓ Written treatment plan requirements

WHO DOES IT APPLY TO?

- ✓ In general, health plans for employers with **51 or more employees**
- ✓ **Self-insured** employers and **third-party** administrators
- ✓ **Federal Employee Health Benefit** (FEHB) plan
- ✓ **State and local government health plans** unless they "opt out"
- ✓ Health plans purchased through the **Health Insurance Marketplaces**



BENEFITS OF PARITY

Ends discriminatory insurance practices, stigma and the implication that treatment for mental health conditions is less important than treatment for other medical conditions.

Ensures employers get what they paid for from their health plans or TPAs while ensuring employees receive timely, affordable and medically necessary care.

Avoids disruptions, delays and denials of care so people can get better and improve their overall health.

Avoids self-insured employers risking significant financial penalty for noncompliance with parity laws.

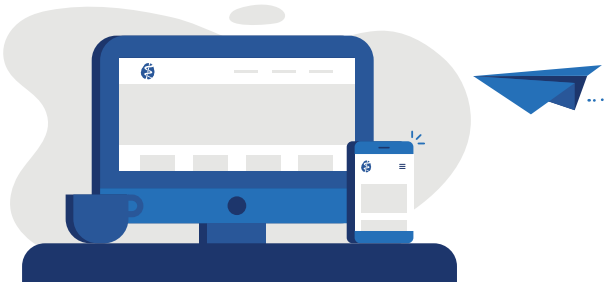
Supports an end to discriminatory insurance practices while showing an organizational commitment to the overall health and well-being of employees.

WHAT CAN EMPLOYERS DO TO SUPPORT EMPLOYEES AND ACCESS TO CARE?*

- ☑ **Use the Department of Labor's Self Compliance Tool** to determine whether your group health plan or health insurance issuer complies with parity laws and to create best practices for demonstrating your compliance.
- ☑ Assess your health plan or third-party administrator's (TPA) compliance with parity laws by using a **Model Data Request Form (MDRF)** developed to evaluate parity compliance.
- ☑ Examine the data collected in the MDRF and request an explanation of disparities, corrective action and a timeline for action from your health plan or TPA.
- ☑ Learn more about parity compliance from resources issued by the U.S. Department of Labor in the form of **FAQs** and **warning signs for NQTL violations.**

*To access the resources listed above, visit **www.workplacementalhealth.org/parity**

FOR MORE INFORMATION



To learn more, visit
www.workplacementalhealth.org/parity

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CENTER FOR WORKPLACE MENTAL HEALTH

Citations available upon request.

janssen PHARMACEUTICAL COMPANIES OF Johnson & Johnson

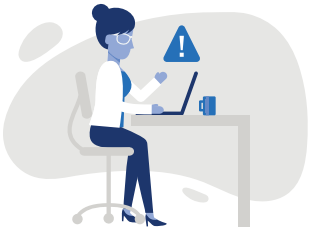
The American Psychiatric Association Foundation is grateful to Johnson & Johnson for providing support to the Center for Workplace Mental Health to develop this infographic.

The Collaborative Care Model

A SMART INVESTMENT WITH HIGH ROI

MAKING THE BUSINESS CASE

Mental health conditions are common impacting **1 in 5 adults** in the US.



These conditions **impact performance, productivity, retention and more.**

Global rates of depression and anxiety are **rising at a rate of 15 to 20%** over the last decade.

Mental health conditions are costly, take depression, **costing the US economy $210 billion annually.**

THE COLLABORATIVE CARE MODEL (CoCM)

Quality mental health treatment can be **difficult to access.**

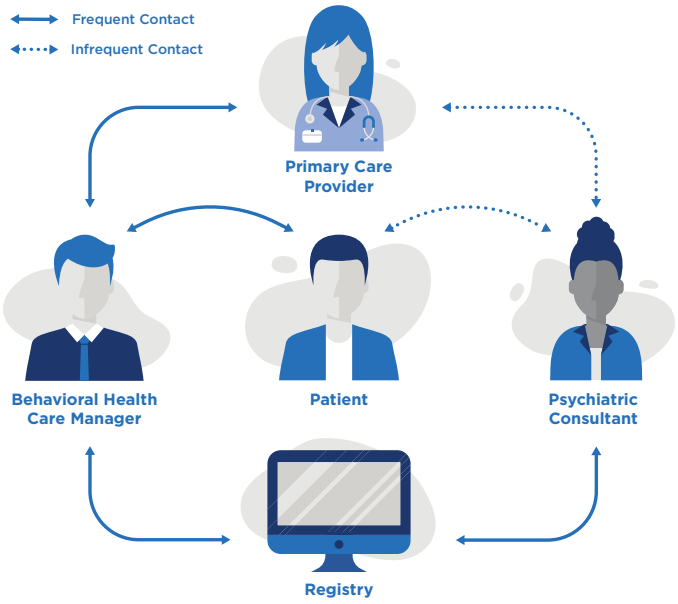
When accessible and done right, mental health treatment **works.**

Yet, **1/2 of people** with depression go untreated.

Many people start with their PCP and do not connect to effective care for multiple reasons:

- PCP inadequate **knowledge** and **resources**
- **Shortage** of mental health providers or long wait lists
- Inadequate mental health provider **networks**
- **Stigma**
- Lack of **engagement** in treatment

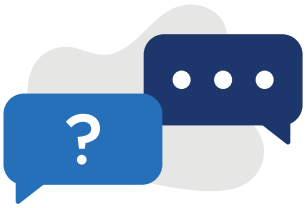
The CoCM delivers effective mental health care in primary care with a care team led by the primary care provider (PCP), and including a behavioral health care manager and consulting psychiatrist.



BENEFITS OF CoCM

Provides access to mental health care that is **timely, effective, less costly and less stigmatizing.**

Engages people in their treatment so they can get back on track.



Effective, supported by over 80 randomized clinical trials.

For every $1 spent on care delivered in the CoCM, there is a **$6.50 ROI** in improved health and productivity.

Receiving care in CoCM, employers can see a **combined cost savings of $1815 per employee per year** in health care spend and improved productivity.

Results in **knowledge transfer** from psychiatrists to PCPs and leaves PCPs feeling more comfortable delivering behavioral health care, increasing access to care.

WHAT CAN EMPLOYERS DO TO SUPPORT EMPLOYEES AND ACCESS TO CARE?

- ☑ Confirm that your health plan has turned on the CoCM CPT billing codes (99492, 99493, 99494).
- ☑ Request data from your health plans on use of the CoCM CPT billing codes.
- ☑ Request that health plans provide ongoing support for provider technical assistance and training in implementing the CoCM.

FOR MORE INFORMATION

To learn more, visit
workplacementalhealth.org/collaborate

AMERICAN PSYCHIATRIC ASSOCIATION FOUNDATION

CENTER FOR WORKPLACE MENTAL HEALTH

Citations available upon request.

San Francisco - Innovations Learning Project Proposal

March 25, 2021

Culturally Congruent and Innovative Practices for Black/African American Communities

Problem we are trying to solve for San Francisco

Black/African Americans have the highest rate of hospitalization for depression in San Francisco. Also, our County Behavioral Health Services system shows a high penetration rate of Black/African Americans in our Child, Youth and Families System of Care. Black/African Americans have the highest penetration of any group for 5 or more visits.

Overall, our mental/behavioral health system statistics continue to show that Black/African Americans in San Francisco are receiving services at a disproportionate rate compared to the Black/African American population in San Francisco. **As of November 2020, Black/African Americans account for about 20% of the population served across San Francisco's behavioral health system while Black/African Americans make up only 6% of the city's population.**

What is not working and how this INN project will address the problem

After years of trying to better engage with Black/African American San Francisco residents, we realized our engagement and intervention strategies were not working.

We identified the need to evaluate robust outreach efforts to determine how to best engage this community and the need to evaluate culturally-adaptive interventions. We identified the need to innovate.

<u>Innovative Component</u>

This project is unique to San Francisco since **we will test and utilize innovative and culturally congruent interventions that have not previously been offered to San Francisco's Black/African American communities.** This project will include four (4) primary learning goals.

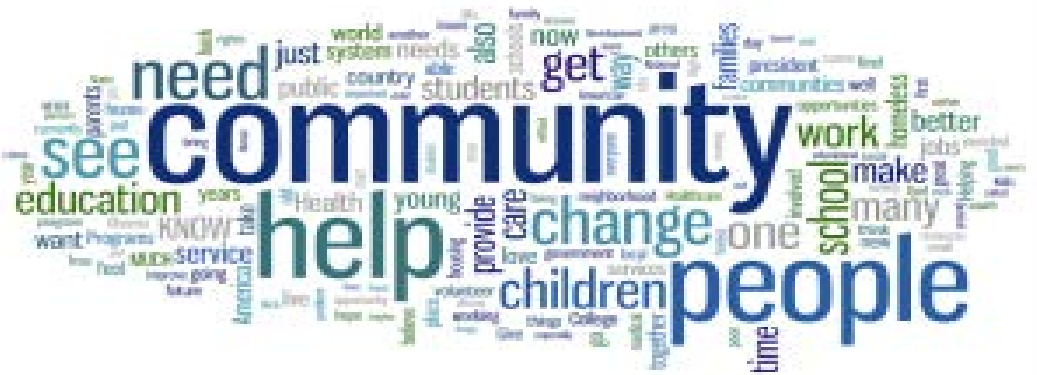
1. Implement and evaluate **new outreach and engagement practices for Black/African American clients** including those who are currently underserved by the County mental health plan.
2. Implement and evaluate **culturally adaptive interventions and practices** that increase consumer satisfaction, efficacy and retention.
3. Implement and evaluate the efficacy of using **peers with lived experience** who represent the Black/African American communities and have specialized expertise working with this population.
4. Develop a **wellness-oriented manualized curriculum that emphasizes elements of the Sankofa framework.**

How the San Francisco community contributed to the creation of this project

The San Francisco Mental Health Services Act (SF-MHSA) team hosted nineteen (19) community engagement meetings to better understand the needs of the community. Community stakeholders requested the following:

- Community healing practices and non-traditional methods of interventions and engagement should be offered to the Black/African American community.
- We need better ways to incorporate a person's cultural values into the services being provided.
- The County should integrate art, socialization, life-skills and family-based groups when working with this population.
- We need to explore alternate ways of engaging with Black/African American community members.
- Maybe engage this community by using Black/African American peers to go out to community spaces and local places including churches, barbershops and other places where this community may congregate.

The community is advocating for this project along with invested stakeholders working with the San Francisco Racial Equity Ordinance - No 188-19.



What we are hoping to learn and how we will measure it

Culturally Adaptative Interventions and Practices

This project will implement and evaluate the following culturally congruent interventions/practices:

- Better **link consumers with someone who is representative of intersecting identities** such as race, gender, sexual identity and age.
- Implement **African Centered story-telling, expressive arts, community rituals and/or spirituality practices** based on the interest of the participants.
- Hold **trauma-informed community healing circles** at community programs, churches, faith-based programs, barbershops or other community settings.

Key Learning Questions

1. What components of the culturally relevant program improves overall wellness for Black/African American clients?
2. What engagement strategies work best to engage Black/African American individuals into mental/behavioral health services?
3. What peer interventions are most helpful for Black/African American clients?
4. What culturally congruent practices are reported to result in improvement in the mental health and wellness of Black/African American consumers?
5. What activities lead to a positive experience for Black/African American clients throughout the continuum of care?

Data collection may include, but not limited to:

- Consumer application, acceptance and enrollment logs
- Attendance logs
- Self-confidence measures
- Measures of social and community connectedness
- Consumer feedback tools
- Consumer mental health recovery scale
- PDSA (Plan-Do-Study-Act)
- Client interviews and focus groups

Description of the Budget

San Francisco County is requesting $600,000 in Innovation funding for the first year, and $1,200,000 annually for the four subsequent years, for a total INN budget of $5,400,000 over five (5) years.

BUDGET	Year One	Year Two	Year Three	Year Four	Year Five	Total
Peer Specialist Budget	$ 250,000	$ 532,500	$ 532,500	$ 532,500	$ 532,500	$ 2,380,000
Behavioral Health Staff (to support peers)	$ 150,000	$ 372,500	$ 372,500	$ 372,500	$ 372,500	$ 1,640,000
Evaluation Budget	$ 50,000	$ 90,000	$ 90,000	$ 90,000	$ 90,000	$ 410,000
Cultural Liaisons (cultural interventions)	$ 130,000	$ 170,000	$ 170,000	$ 170,000	$ 170,000	$ 810,000
Operating Budget (Client engagement)	$ 20,000	$ 35,000	$ 35,000	$ 35,000	$ 35,000	$ 160,000
TOTAL INNOVATION BUDGET	**$ 600,000**	**$ 1,200,000**	**$ 1,200,000**	**$ 1,200,000**	**$ 1,200,000**	**$ 5,400,000**
Leveraged Funding	$ 62,313	$ 62,313	$ 62,313	$ 62,313	$ 62,313	$ 311,565
TOTAL OPERATIONAL BUDGET	**$ 662,313**	**$ 1,262,313**	**$ 1,262,313**	**$ 1,262,313**	**$ 1,262,313**	**$ 5,711,565**

Questions?

Jessica Brown, MPH

Director of MHSA

Behavioral Health Services

San Francisco Department of Public Health

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PROPOSED MOTION

The Commission approves San Francisco's Innovation Plan as follows:

Name:	Culturally Congruent and Innovative Practices for Black/African American Communities
Amount:	Up to $5,400,000 in MHSA INN funds
Project Length:	Five (5) Years

Mental Health Services
Oversight & Accountability Commission

I. Commission Positions on 2021 Legislation

Commission Sponsored Legislation

Assembly Bill 573, Assemblywoman Carrillo: Youth Mental Health Boards

AB 573 establishes the California Youth Mental Health Board (state board) within the California Health and Human Services Agency to advise the Governor and Legislature on the challenges facing youth with mental health needs and determine opportunities for improvement. The state board would be comprised of 15 members who are between 15 and 23 years of age, and at least half of whom are youth mental health consumers who are receiving, or have received, mental health services, or siblings or immediate family members of mental health consumers. The bill would specify the powers and duties of the state board, including reviewing program performance in the delivery of mental health and substance use disorder services for youth.

This bill will also require each community mental health service to establish a local youth mental health board (board) consisting of eight or more members, as determined by the governing body, and appointed by the governing body.

The Commission voted to sponsor this bill at its February 17, 2021 meeting.

Commission Supported Legislation

Senate Bill 14, Senator Portantino: Pupil Health – School Employee and Pupil Training – Excused Absences – Youth

Current law, requires a pupil to be excused from school for specified types of absences, including, among others, if the absence was due to the pupil's illness. AB 14 would include as another type of required excused absence an absence that is for the benefit of the behavioral health of the pupil.

The Commission voted to support this bill at its February 17, 2021 meeting.

Commission Co-Sponsored Legislation

Senate Bill 224, Senator Portantino: Pupil Instruction – Mental Health Education

SB 224 requires each school district to ensure that all pupils in grades 1 to 12, inclusive, receive medically accurate, age-appropriate mental health education from instructors trained in the appropriate courses at least once in elementary school, at least once in junior high school or

middle school, as applicable, and at least once in high school. The bill would require that instruction to include, among other things, reasonably designed instruction on the overarching themes and core principles of mental health. The bill would require that instruction and related materials to be appropriate for use with pupils of all races, genders, sexual orientations, and ethnic and cultural backgrounds, pupils with disabilities, and English learners.

The Commission voted to co-sponsor this bill at its February 17, 2021 meeting.

II. MHSOAC 2021 Legislative Tracking

Suicide Prevention

Assembly Bill 234, Assemblymember Ramos: Office of Suicide Prevention Clean-Up

AB 234 is a clean-up bill for 2020's AB 2112 (Ramos), which created the framework for a statewide Office of Suicide Prevention. The Commission sponsored AB 2112 last year and the recommendations in the bill are consistent with our *Stiving for Zero*, report. This bill removes the requirement that the Department of Public Health fund the Office of Suicide Prevention using existing resources, opening the door for the development of a statewide suicide prevention strategy.

Mental Health and Substance Use Disorders

Senate Bill 465, Senator Eggman: Mental Health

SB 465 amends the eligibility criteria for full-service partnerships with an emphasis on serving those at risk of experiencing homelessness, hospitalization, or criminalization.

SB 465 also requires the Commission to report to the Senate and Assembly Committees on Health, Senate Budget Subcommittee on Health and Human Services, and Assembly Budget Subcommittee on Health and Human Services the outcomes for people receiving community mental health services under a full service partnership model, including any barriers to receiving the data and recommendations to strengthen California's use of full service partnerships to reduce incarceration, hospitalization, and homelessness.

Mental Health Services
Oversight & Accountability Commission

Schools and Mental Health

Senate Bill 508, Senator Stern: Student Mental Health Services

SB 508 will require health plans to provide mental health services to students. It would also make children's mental health services more accessible by expanding the network of school-based mental health practitioners and use of telehealth. This bill:

- Ensures health plans are meeting the requirement to provide mental health services to students who are referred by the school.
- Makes it easier to access children's mental health experts by permanently adopting telehealth options established during the pandemic.
- Ensures that commercial health plans are meeting mental health parity standards by requiring them to collaborate with local education agencies.

Assembly Bill 586, Assemblymember O'Donnell: School Health Demonstration Projects: Building and Sustaining K-12 School-Based Services

AB 586 establishes the *School Health Demonstration Project* to expand comprehensive health and mental health services to students by providing intensive assistance and support to selected local educational agencies to build the capacity for long-term sustainability through leveraging multiple funding streams and partnering with county Mental Health Plans, Managed Care Organizations, and community-based providers. Lessons learned through the pilot project will be used as a basis to scale up robust and sustainable school-based health and mental health services throughout the state.

Research and Evaluation

Senate Bill 525, Senator Grove: Mental Health Effects of School Closures

SB 525 requires the State Department of Public Health, in consultation with the State Department of Education, to establish a policy no later than 6 months after the effective date of the bill, to address the mental health effects of school closures on pupils in years when a state or local emergency declaration results in school closures. The bill would require local educational agencies to adopt the policy subject to an appropriation in the annual Budget Act for that purpose.

Assembly Bill 638, Assemblymember Quirk-Silva: Mental Health and Substance Use Disorders

AB 638 authorizes prevention and early intervention strategies that address mental health needs, substance use or misuse needs, or needs relating to co-occurring mental health and substance use services under the Mental Health Services Act.

Last year, the Commission supported Assembly Bill 2265, authored by Assemblymember Quirk-Silva, that clarified the Mental Health Services Act funds can include substance use disorder treatment for co-occurring mental health and substance use disorders, for individuals who are eligible to receive mental health services. The Governor signed into law AB 2265, Ch. 144, Statutes of 2020.

AB 638 amends the MHSA by including a provision to authorize prevention and early intervention services for prevention and early intervention strategies that address mental health needs, substance use or abuse needs, or needs relating to cooccurring mental health and substance use services.

Assembly Bill 686, Arambula: California Community-Based Behavioral Health Outcomes and Accountability Review

AB 686 requires the California Health and Human Services Agency to establish, by July 1, 2022, the California Community-Based Behavioral Health Outcomes and Accountability Review to facilitate a local accountability system that fosters continuous quality improvement in county behavioral health programs and in the collection and dissemination by the agency of best practices in service delivery. The bill would require the agency to convene a workgroup, by October 1, 2022, composed of representatives, as follows:

- County behavioral health agencies
- Legislative staff
- Behavioral health provider organizations
- Interested behavioral health advocacy and academic research organizations
- Current and former county behavioral health services recipients and their family members
- Organizations that represent county behavioral health agencies and county boards of supervisors
- California External Quality Review Organizations
- State Department of Health Care Services
- State Department of Social Services

- State Department of Public Health
- California Behavioral Health Planning Council
- Mental Health Services Oversight and Accountability Commission

The purpose of the workgroup is to develop an updated methodology, that can measure and evaluate behavioral health services.

Senate Bill 749, Senator Glazer: Mental Health Program Oversight and County Reporting

SB 749 will require the Commission, in consultation with state and local mental health authorities, to create a comprehensive tracking program for county spending on mental and behavioral health programs and services. This bill will require counties to report funding source, funding utilization, and outcome data at the program, service, and statewide levels. The Commission will be required to submit a report of the to the Governor and the Legislature each year.