

North Carolina Institute of Medicine

Task Force on Prevention

May 29, 2009

Meeting Minutes

Poor Mental Health, Worksite Wellness, and Recommendations Review



Chairs: Jeff Engel, MD, and Bob Seligson, MBA

Task Force Members/Steering Committee Members: Paula Collins, Calvin Ellison, John Frank, William Lawrence, Peter Lehmuller, Michael Lewis, Meg Molloy, Peg O'Connell, Barbara Pullen-Smith, Kelly Ransdell, George Reed, Vandana Shah, William Smith, Charles Wilson, Joyce Young, Steve Cline, Ruth Petersen, Marcus Plescia, Meka Sales

Interested Persons and Speakers: Lexie Nykamp, Willona Akingbade, Whitney Davis, John Dervin, Peter Leone, Laura Linnan, Samara Nielsen, Debi Nelson, Jessica Schorr Saxe, John Tote, Walker Wilson

NCIOM Staff and Interns: Pam Silberman, Mark Holmes, Jennifer Hastings, Berkeley Yorkery, Kimberly Alexander-Bratcher, Thalia Shirley-Fuller, Heidi Carter, Catherine Liao

Worksite Wellness: Connecting the Dots in NC to Maximize Employee Health and Well-being

Ruth Petersen, MD, MPH, North Carolina Division of Public Health.

Dr. Petersen's presentation aimed to explain how to move North Carolina forward in maximizing employee well-being and health. Several reasons explain the rationale for investment in worksite wellness. Fifty percent of chronic disease results from preventable causes related to lifestyle. Common health risks including depression, stress, obesity, physical inactivity, and high glucose levels account for 15-35% of annual medical costs. Evidence-based strategies exist that can effectively reduce risk.

The University of Michigan (Dee Edington) analyzed nearly four million health risk assessments (HRAs) over the last decade to estimate health risks among employees. Their findings showed that 41.8% of employees are at high risk for a body mass index (BMI) greater than 27.5; 31.8% are at high risk for stress; and another 23.3% are at high risk for physical inactivity. Although a majority of employees (55.3%) are at low health risk, 17% fall into the high health risk category.

Edington went on to divide people into risk categories: low, medium, and high. The health costs related to health risks increase as the risk level rises. From a base cost of \$2,199 (including medical and pharmaceutical costs) for low risk, to an additional \$3,321 for high risk, employees with excessive health risks can account for 23% of an employer's expenses. Presenteeism, or being present but unproductive at work, is a big problem among employers. Emory University and Wake Forest University are working to promote complete health to reduce health care costs and to increase worker productivity.

Effective worksite interventions include policy and individual behavior change strategies (e.g. smoking cessation programs, flex-time to accommodate exercise, healthy changes to a cafeteria menu) and employer follow-up on employee-completed HRAs. Because evidence-based interventions exist for tobacco cessation, physical activity, and nutrition issues in the workplace, the return on investment (ROI) can be significant. The average annual cost reduction associated with the reduced number of health claims ranges from 2-4% of total claims. Generally, ROIs range from 1:1.5 to 1:3.0; in other words, for every \$1 invested in worksite wellness, an employer can expect to receive \$1.50 to \$3.00 back.

Five elements of a comprehensive worksite wellness program include health education with lifestyle behavior change; a supportive social and physical environment; integration of program into organizational structure; linkages to related programs (e.g. EAP); and worksite screening and education as needed (combined with referrals to providers). While one of the objectives of Healthy People 2010 was that 75% of worksites offer a comprehensive wellness program, only 6.9% of worksites nationwide (n=730) actually did. It is important to determine a way for small businesses to share resources since 42 percent of people in NC work for business with less than 100 employees, and 30 percent work for companies with less than 25.

Improving employee health can be accomplished in six steps: define a strategy and work from a plan; spend wisely; choose interventions that will work; communicate the concept of health in the workplace; measure progress and outcomes; and work with experts.

Senator Tom Harkin has reintroduced legislation, the Healthy Workplace Act of 2009 (S. 803/H.R. 1987), which would create a tax credit for businesses that have comprehensive employee wellness programs. Concerns have been raised; however, that financial rewards and penalties may result in “lifestyle discrimination.”

Dr. Petersen provided the following recommendations to the Task Force:

- 1) Establish a North Carolina Worksite Wellness Collaborative, which would maximize worksite wellness strategies with a statewide approach using a “Healthy Workplace Assessment” at the organizational level; individual employee assessment through HRAs; technical assistance; and a data collection system to ensure data is being stored in a central location so we can have common measurements at the state level to support evaluation efforts.
- 2) Enact state tax credits for businesses offering comprehensive employee wellness programs (in the absence of federal legislation).

A Healthy Workplace = Healthier Employees (And Saves Money): *Meg Molloy, DrPH, MPH, RD
President and CEO, NC Prevention Partners*

North Carolina spends at least \$26 billion annually – or \$5,711 per employee per year – on health problems that result from tobacco use, poor diet, and physical inactivity. Nine out of 10 North Carolina adults have at least one of these risk factors that increase their risk of cancer, diabetes, heart disease, and other preventable illnesses.

A 2007 study involving Duke Health and university employees showed a clear linear relationship between BMI and rate of claims. Specifically, very overweight employees had twice as many workers’ comp claims, seven times the medical costs, and 13 times more workdays lost than employees at a healthy weight. Maintaining healthy weight is not only important to workers, but should also be a high priority for their employers given the strong effect of BMI on workers' injuries.

NC Prevention Partners (NCP) has developed the Healthy Workplace Assessment, which involves a 68-question, three-part online survey that takes 30 to 40 minutes to complete. The assessment examines nutrition, physical activity, and tobacco use policies, environments, and benefits; and it allows employers to become aware of the benefits of instituting wellness policies. A demonstration of the NCP Healthy Workplace Assessment illustrated how an employer would log-in, begin the assessment, and compare its progress to a similarly-sized organization within its sector. Sixty-two workplaces, including hospitals and government, have completed the assessment since 2008.

Because it has become too easy to become unhealthy in the workplace, given the difficulty in making a good choice in the cafeteria or break room, it is critical that employers make it more convenient for an employee to make the healthy choice. Employees know they want to get started in making the healthy choice, but may not have the tools to do so.

Lessons learned regarding the need for capacity and outreach ranged from “high-dose” to “moderate-dose” to “low-dose” interventions. Tobacco-free hospitals, characterized as high-dose, have been three years in the making. By the summer of 2009, all 130 North Carolina acute-care hospitals will have passed 100% tobacco-free policies. NCPP has taken a moderate-dose approach by hosting regional Prevention Institutes, which entail two-day intensive worksite wellness workshops. A low-dose intervention provides a collaborative opportunity with natural networks where NCPP speaks at annual meetings and seminars for health underwriters, chambers of commerce, health departments, and other interested partners.

Dr. Molloy noted that state funds should first focus on state and local government worksites, and then small businesses. In addition, data from NCPP’s NC Employer Prevention Database should be made public through State Center for Health Statistics and as part of the NC-CATCH data system. With more data, there will be the ability to run queries by county, region, and sector to examine trend data; and identify differences in policies, environments, and capacity for prevention to target outreach for training and technical assistance.

Stress and Depression: An Overview of Prevention and Early Intervention Concepts: *John Tote, Executive Director, Mental Health Association in NC, Inc.*

Stress is a normal part of life that is an automatic physical reaction and is different for everyone. Defined as a psychological and physiological response to events that upset our personal balance in some way, the body’s defenses kick into high gear when faced with stress, resulting in the “fight or flight” response.

Although the lifetime prevalence of an individual having any anxiety disorder is 25%, positive stress adds anticipation and excitement to life and provides the dynamic tension we need to keep us moving in a positive direction. Despite the benefits of good stress, including a job change, marriage, or the birth of a baby, issues out of our control can send our stress in a downward spiral. Recent studies have examined the role stress plays in the development of chronic disease, such as the prevalence of depression in cancer patients.

Risk factors for stress include the economy, one’s job situation, money, time, illness, school, and family. Like any major health issue, mental health has the same issues as other illnesses, and a basic understanding of the role of stress and its risk factors is critical in prevention. Stress devolving to true depression, and not just the “blues,” is real and treatable, despite the stigma often associated with the disease. Risk factors for depression can be genetic or environmental; every individual differs in his or her chemical makeup, brain functioning, and stress management. Early identification, and worksite wellness and school-based initiatives can be used to recognize factors and behaviors that lead to mental illness. Individuals tend to “shy away” from early intervention with stress believing that it is something they can work through. It is important to understand the role of stress in our lives and work with families to de-stress. Faith communities can play an important role in early intervention. Sometimes depression is not preventable making early intervention even more important.

We have made significant advancements in understanding depression; much of what we know, we have learned in the last two decades. However, stigma is still a major issue. Risk factors for major depression include genetics and the environment. Prevention and early intervention are reliant upon early identification, worksite wellness programs, reducing stress, and school-based initiatives where teachers and counselors are trained to recognize risk factors. Although the typical onset of major depression occurs in mid- to late-20 year-olds, we are beginning to see signs and symptoms of major depression in the pre-teen years. Often, we hesitate to label youth as “depressed,” which leads to treatment not occurring soon enough. Depression in the elderly is also a chronic issue.

In the US, 9.5 percent of people annually are depressed. The cost of depression in the US is approximately \$2 billion annually. Of that amount, \$900 million is spent on treatment, while the rest is due to loss of wages and

productivity. Generally, we are not seeing a big change in prevalence across the U.S. In North Carolina, 400,000 people (or approximately 4.0 to 5.0% of the population) have moderate to significant depressive issues in any given year. North Carolina is slightly ahead of national rates for significant depression.

There is not much data to provide evidence-based strategies. However, the United States Preventive Services Task Force has screening recommendations for depression. I-CARE, Community Care of North Carolina (CCNC), patient-centered planning, and wrap-around model of system of care are key concepts in North Carolina for prevention and early intervention.

Mr. Tote provided the following recommendations to the Task Force:

- 1) Expand school-based initiatives to identify depression. This is most effective at the middle-school level (grades 6-9, ages 11-14). It is also important to get early identification tools in place for elementary schools
- 2) Broaden implementation of I-Care and the System of Care model
- 3) Provide training for clergy members to enable them to identify risk factors in an individual and make referrals to appropriate services