



DISABILITY MANAGEMENT EMPLOYER COALITION

DMEC 2014 Behavioral Risk Survey



DMEC White Paper Series



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Abstract

This report provides a summary and an analysis of the 2014 Disability Management Employer Coalition's biennial survey, which tracks employer strategies, advancements, prevalence, and effectiveness in the area of Behavioral Risk Management. These findings build on the results from 2006, 2008, 2010, and 2012 studies, providing an opportunity to identify changes in employer trends. The data indicates employers' continued recognition of the subject matter and the emergence of processes to address mental and behavioral conditions in the workplace. As evidenced by the survey results, employers continue to enhance these offerings for their employees and recognize the value they provide in improving the overall employee experience, as well as in containing the high costs that can be incurred as a result of behavioral risk conditions.

Background

The Disability Management Employer Coalition (DMEC) coined the term "Behavioral Risk Management" in 2006 and established a stage for open discussions related to behavioral absence and productivity initiatives through its annual behavioral risk conference and related programs. DMEC defines Behavioral Risk Management as a core philosophy to assess behavioral risk in a unique way in order to decrease claim and productivity loss, increase corporate profitability, and increase the quality of life for employees.

Mental health conditions continue to be among the top noncommunicable diseases and are associated with high treatment costs and lost wages. These conditions are often "under the radar," so their impact may not be captured in claims data for employees who are not specifically diagnosed. Given that employees are spending more than half of their day at work, inadequate staffing, low increases in pay, and high job expectations are having a significant impact on stress-related physical and psychological illnesses.¹ Thus, the compounded impact of mental/behavioral health conditions on businesses, both from cost and workforce perspectives, is important. One survey respondent said that "depression/mental health continues to be a high cost in our plan," and another said that some employees are "bitter, sick, and frustrated, which affects our bottom line."

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Compelling Research and Statistics

- Every year, mental illness and substance abuse cost employers an estimated \$80 to \$100 billion in indirect costs.²
- In 2013, an estimated 43.8 million adults aged 18 or older in the United States had any mental illness (AMI) in the past year, which translates to 18.5% of all adults or nearly one in five. An estimated 10.0 million U.S. adults aged 18 or older had serious mental illness (SMI) in the past year, representing 4.2% of all adults.³

¹ Tower's Watson, *Staying @ Work Survey Report 2013/2014*. The Business Value of a Healthy Workforce.

² SHRM, *Accommodating Mental Illness*, September 15, 2014.

³ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (September 4, 2014). *The NSDUH Report: Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

- Overall, 11.4 million U.S. adults aged 18 or older had a disorder that greatly impaired their ability to function in daily life.⁴
- Employees rank inadequate staffing (lack of support, uneven workload or performance in group), low pay or low increases in pay, and unclear or conflicting job expectations as the top sources of stress.⁵
- Stress is listed as the top workforce risk factor by 78% of U.S. employers, yet only 15% said improving the emotional/mental health of employees was a top priority for their health and productivity programs.⁶

Challenges to Overcome

As was found in the 2012 environment, strides are being made to increase the application of behavioral health management at the workplace. At the same time, the environment within which we are working is becoming increasingly complex.

- Stigma is still an issue and is increasing for some employers.
- Screening is being applied more broadly and through better tools, but not by enough employers.
- Return to Work efforts are becoming more formalized and interactive, with reliance on the physician community still remaining an issue.
- Although training is increasing, there is still not enough of it, and methods used to identify “at risk” employees need to be improved.

Survey Design and Methods

DMEC’s 2014 Behavioral Risk Survey is similar to surveys conducted every two years since 2006. The 2014 survey contains 42 questions, three more than in 2012; however, the content is comparable. The primary goal of the study remains: to determine what progress is being made as it relates to Behavioral Risk Management.

The survey sample has differed in each survey time period, and the intent is to take an overall pulse of the market rather than detail tactical changes at specific organizations. As such, the survey was primarily closed-ended but allowed for further explanation where appropriate.

Survey Statistics

The survey was released during the period of July 21 through August 20, 2014. An online survey tool was used to collect information, which resulted in 314 completed responses compared to 141 responses in 2012.

⁴ Substance Abuse and Mental Health Services Administration. (2012). Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-42, HHS Publication No. (SMA) 11-4667. Rockville, MD: Substance Abuse and Mental Health Services Administration.

⁵ Tower’s Watson, Staying @ Work Survey Report 2013/2014. The Business Value of a Healthy Workforce.

⁶ Ibid.

Participant Profile

Participants were recruited from an expanded population over 2012 with mid-sized employers (1,000 to 10,000 employees) making up a larger percentage in 2014, increasing from 41% in 2012 to 50%, and small employers (fewer than 1,000 employees) representing a smaller percentage.

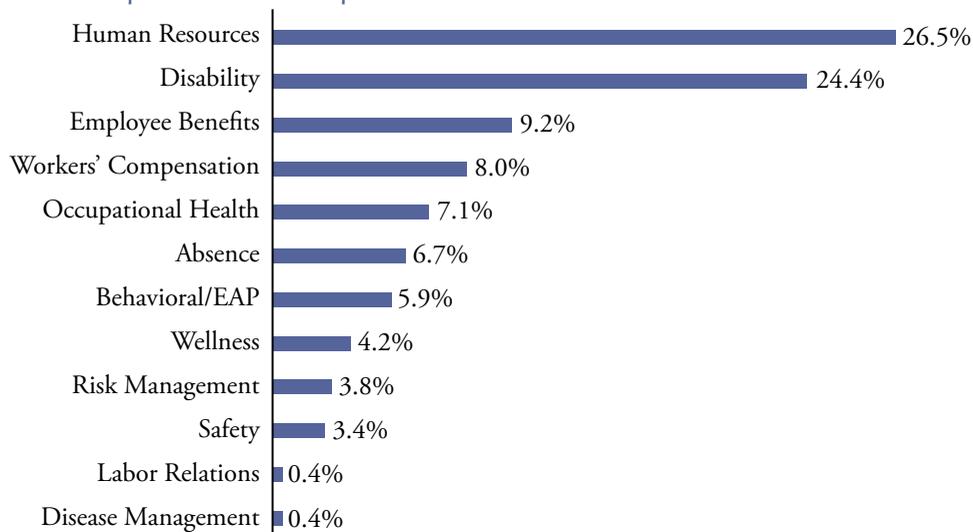
Table 1: Participant Employer Size

Size	2012	2014
Small (fewer than 1,000)	20.6%	13.0%
Mid-size (1,000-10,000)	41.0%	50.0%
Large (more than 10,000)	38.2%	35.7%

In terms of location, the West has the most significant concentration of respondents in 2014 (36.9%), whereas the Midwest had the highest concentration in both 2010 and 2012. For the past two surveys, the South has had the smallest representation, at 10.8% in 2014. Similar to 2010 and 2012 survey respondents, 2014 employers are primarily engaged in healthcare and social assistance (25.6% versus 17.6% in 2012), manufacturing (19.7% versus 27.2% in 2012), and education services (8.8% versus 6.4% in 2012).

When asked their field of specialty, participants were able to select any and all applicable responses. Similar to 2012 survey results, the areas of Human Resources and Disability were the primary answers, regardless of employer size. Table 2 below summarizes all responses:

Table 2: Participants' Areas of Specialization



Overall, survey participants are open to learning more about this important topic of behavioral risk and health; just under 60% indicate they would be interested in attending a one-day employer focus group exploring best practices in Behavioral Risk Management. Forty-three respondents indicate they would be willing to share successful strategies with other members through participation in a special interest group, and 21 respondents say they would be willing to present at a future conference.

Survey Results and Discussion

The 2014 survey results continue to support DMEC's theory, with about 87% of survey respondents indicating that behavioral risk management is an important and continually emerging area of concern. The 2014 data indicates that employers of all sizes are interested in the associated risks that behavioral health has on the workplace, with small employers (fewer than 1,000 employees) less likely (44%) to have a behavioral component in their program compared to mid-sized employers (1,000 to 10,000 employees) and large employers (more than 10,000 employees). This may be due to the fact that smaller employers have lower incidence rates and fewer resources available to manage behavioral risk. It may also be due to healthcare reform and the fact that employers of all sizes are still unsure of what actions they will take in the coming years.

Approximately 60% of respondents indicate that they include a behavioral component in their integrated or coordinated disability/absence management program.

In 2014, approximately 60% of respondents indicate that they include a behavioral component in their integrated or coordinated disability/absence management program, a significant increase from 2012 and 2010 (40% and 47.3%, respectively). Mid-sized and large employers are more likely to have a behavioral component (66.1% and 64.7%, respectively) than small employers (43.8%).

Providing Behavioral Health and Related Programs

The majority of employers surveyed in 2014 provide health coverage for mental healthcare, with a high percentage (78.9%) carving it within their medical plan compared to 12% that have a separate "carve-out" behavioral health plan. The utilization of a separate behavioral plan decreased from 17.4% in 2012 and 20.5% in 2010, continuing the trend of traditional health plans growing their abilities to provide strong behavioral health programs and validating the extended reach of mental health parity through the Patient Protection and Affordable Care Act. The survey documents 86.9% of respondents having substance abuse coverage (down from 97.8% in 2012), 59.0% providing disease management or case management for chronic pain conditions (remaining steady since 2012 at 60.3%), and 63.7% offering disease management or case management for depression (up from 51.5% in 2012). Over half (53.5%) of respondents have a disability plan that requires employees to receive treatment with an appropriate care provider for behavioral health disability claims.

The prevalence of employee assistance programs (EAP) continues to be strong, with 93.3% of 2014 survey respondents providing them (similar to 97.2% in 2012 and 97.2% in 2010 and 2008). Large employers (more than 10,000 employees) are the most likely to offer them, at 100%, whereas small employers (fewer than 1,000 employees) are less likely to offer an EAP, at 65%. Although it is still most common for EAP services to be provided by external resources (62.7% in 2014, down slightly from 71.2% in 2012), 20% of large employers and an increasing number of mid-sized firms (30% in 2014 compared to 17% in 2012) use internal resources.

As shown in Table 3, the services most often provided by the 2014 respondents are similar to those reported in 2012 but with financial, legal, and employee treatment being higher than consultation/coaching and training.

Table 3. Most Common EAP Services Offered



This year's survey asked how many EAP visits are offered, both per year and/or per issue. Similar to 2012 results, the most common number of visits is three to six, with "other" indicating an unlimited number of visits on an as-needed basis. Also new this year, the survey asked who can receive EAP benefits and found that 89% of respondents offer benefits to all employees and half (50.5%) offer benefits to family members. Only about a third of respondents limit EAP benefits to full time employees working more than 30 hours or other household members (36.3% and 34.6%, respectively).

Table 4. EAP Visits

Number of EAP Visits Provided	2012	2014
1 – 3 visits per year	22.3%	7.3%
1 – 3 visits per issue	N/A	10.8%
3 – 6 visits per year	49.2%	22.5%
3 – 6 visits per issue	N/A	22.9%
7 – 20 visits per year	18.4%	14.2%
7 – 20 visits per issue	N/A	4.7%
Other	10.0%	17.3%

Similar to 2012 and 2010 results, employers rank use of EAPs as the most influential program element for Return to Work efforts (66.8%). Following EAP services, employers feel that engaging in the interactive process and communicating with employees and supervisors (48.7% and 45.3%, respectively) are the next most influential elements in producing positive behavioral/mental health return to work results. This shows that keeping the communication channels open from the very beginning and through the applicable event or condition is effective in returning employees to work.

Screening and Behavioral Health Triggers

The use of screening for underlying psychological or psychosocial issues increased slightly, from 29.6% in 2012 to 32.8% in 2014. Stress or anxiety (35.9%) is the most common issue screened for, closely followed by substance abuse (34.7%) and depression (31.6%). Unlike in 2012 survey results, workers' compensation (at 43.7%) is the most common area employers screen in 2014, closely followed by Family and Medical Leave Act (41.4%), then short-term disability (STD) (39.4%) and long-term disability (LTD) (38.6%). In 2012, performance (50.9%) and STD (47.0%) were the most common areas. Overall, the screening is most often conducted by EAP (32.8%), followed by Human Resources (19.9%) and occupational health nurses (14.0%).

The type of tools leveraged for screening remain similar to those cited in prior years, with red flags climbing higher on the list, likely due to increasing technology capabilities with case management systems and the ability to define and automate triggers.

- Red flags: 49.2%
- Supervisor communication: 46.8%
- Case management review or judgment: 45.3%
- Review by other case management professionals: 35.9%
- Review by mental health professional: 21.4%
- Other screening tools (e.g., EAP, health risk assessments): 10.9%

There seems to be a movement toward a more formalized process rather than leaving RTW assessment and the decision whether to accommodate to the direct supervisor.

Somewhat concerning is that more than half (54.6%) of respondents indicate they do not screen at all for stress, anxiety, substance abuse, depression, or child/spousal/senior abuse. Instead, and similar to 2012 and 2010 results, the most prevalent method companies use to identify "at risk" employees experiencing a work absence due to a psychiatric disability is employee self-report or claim (64%).

Return to Work

When asked what Return to Work (RTW) activities are in place to assist employees with mental/behavioral health disabilities, 2014 respondents still strongly indicate referrals to EAP and other programs (63.1%) but report a stronger focus on engagement in the interactive process (57.3%) and the development of transitional job modifications (46.4%) compared to 2012.

Activities thought by respondents to produce the best behavioral/mental health RTW results are:

- Use of EAP: 66.8%
- Engaging in the interactive process: 48.7%
- Communication to employees and supervisors: 45.3%
- Early intervention and identification: 41.1%

Conversely, programs that respondents considered the least influential in producing positive RTW results are Independent Medical Exams with RTW mindset (16.8%), RTW committees (18.4%), and vendor integration or coordination (21%).

As shown in Table 5, employees returning to work after psychiatric care should expect discussions and sign-off on RTW plans between employees and supervisors, fitness for duty tests, interim “touch base” meetings, and training. Other requirements noted by respondents are regular contact with EAP during the employee’s absence and prior to return to work, and a note from the doctor specifying that the employee can perform the job duties listed in the job description. Similar to 2012 results, there seems to be a movement toward a more formalized process rather than leaving RTW assessment and the decision whether to accommodate to the direct supervisor.

Table 5: Special Requirements for Return to Work

	2012	2014
Discuss and sign off on RTW program between employee and the supervisor	19.3%	35.9%
Any fitness for duty test to determine their ability to perform the job	33.3%	33.0%
Interim “touch base” meetings with the employee to determine if the RTW program is successful	23.3%	30.9%
Training on any change to their job since they have been absent	18.6%	28.8%
None	34.8%	25.9%
Not sure	7.7%	11.3%
Other	16.2%	6.6%

The most significant barriers to RTW initiatives for behavioral health conditions are 1) employees relying on their primary care physician rather than seeking treatment with a mental health professional (65.1% in 2014, compared to 57.6% in 2012); 2) doctors enabling or overprotecting patients (64.2% in 2014, compared to 60% in 2012); and 3) doctors providing unclear RTW full-capacity timeframes (63% in 2014, compared to 60% in 2012) for their patients.

Use of a Mental Health Professional (MHP)

In 2014 the use of a Mental Health Professional (MHP) was indicated by 31% of surveyed firms that included an EAP representative or other MHP on their Disability Management team, similar to the 27% who responded in 2012. This occurs more often for mid-sized and larger organizations than for smaller organizations (22%).

Fewer than half (40%) of respondents use an MHP to perform or oversee case management (with their reasons for doing so remaining comparable to those expressed in 2012). Other uses of MHPs, such as for web-based chats, gained ground in 2014 (see Table 6).

Training and Communications

The 2014 survey shows that more companies are providing training to identify “at risk” employees, as fewer respondents reported providing no mental health awareness training (35%, compared to 43.5% in 2012). The most common types of training continue to be supervisor feedback to Human Resources, “warm transfers” from STD/LTD/WC claims personnel to EAP, and integration or coordination of plans that allows cross referrals. As shown in Table 7, other means of identification are holding steady, and there is an upward trend of employers using predictive modeling to help.

As shown in Table 8, additional types of training and education programs are focused on wellness/ health promotion and safety, with management training, conflict resolution, and stress management/ resilience training continuing to be important.

Table 6: Comparison of the Use of Mental Health Professionals

	2008	2010	2012	2014
Psychiatric and psychological claims	25.4%	62.9%	64.0%	76.1%
Telephonic consultation	23.9%	35.5%	60.0%	48.6%
Physical claims with potential underlying psychosocial or psychiatric issues	21.1%	35.5%	42.0%	38.5%
Disciplinary or performance problems	16.9%	27.4%	28.0%	33.0%
Face-to-face consultation	N/A	37.1%	34.0%	32.1%
Referral source to identify areas of concern	N/A	35.5%	24.0%	27.5%
Safety reports	N/A	11.3%	18.0%	19.27%
Web-based chat	N/A	N/A	N/A	13.7%

Note: Respondents were asked to check all that apply, which yields percentages of greater than 100.

Table 7: Methods Used to Identify “At Risk” Employees

	2010	2012	2014
Supervisor feedback to Human Resources	N/A	N/A	55.4%
“Warm transfer” from STD/LTD/WC claims personnel to EAP	37.9%	26.9%	27.7%
Integration/coordination of plans that allows cross referrals or “warm transfers” to behavioral health providers	25.2%	20.8%	17.1%
Data obtained from a health risk assessment tool	18.4%	16.2%	15.2%
Depression screening at intake point	8.7%	13.8%	11.3%
Predictive modeling from claims data	2.9%	4.6%	10.5%

Note: Respondents were asked to check all that apply, which yields percentages of greater than 100.

Table 8: Training and Education Offered

	2010	2012	2014
Wellness/health promotion (exercise, nutrition, relaxation)	91.1%	85.4%	77.3%
Safety	85.1%	72.4%	70.0%
Management Training	N/A	N/A	66.8%
Conflict resolution	67.3%	60.2%	66.4%
Stress management/resilience training	76.2%	70.7%	64.3%
Communication skills	72.3%	63.4%	64.3%
Diversity	70.3%	57.7%	60.7%
Work-life balance	60.4%	56.1%	57.8%
(Awareness of) Depression, anxiety, bipolar disorders	38.6%	30.9%	26.7%
Substance abuse (disorder)	53.5%	40.7%	17.8%

Note: Respondents were asked to check all that apply, which yields percentages of greater than 100.

Stigma

Often behavioral health conditions can go unrecognized or untreated, in part because they are difficult to diagnose and in part because of social stigma. Regardless, they have major implications for the employees suffering from illnesses as well as for the employers and health providers trying to treat them. Employers are continually trying to do more with less in an increasingly regulatory and financially constricted environment. The pressure on employees to be productive is higher than ever,⁷ and employees are experiencing greater stress⁸ and more complex personal issues than in the past.

It is therefore not surprising that although the percent of respondents who believe stigma exists has stayed relatively the same between 2014 and 2012, the percentage saying stigma increased was considerably higher compared to 2012. Depending on the area of perception (see Table 9), 20.5% to 25.6% believe the stigma has increased over the past two years, compared to only 3.0% to 7.6% in 2012. The data shows that stigma associated with having a psychological/psychiatric problem and receiving various forms of treatment has dramatically increased over the past two years. This is especially pronounced for EAP services and taking psychotropic/mental health prescriptions, in which there is a distinct shrinkage in the percentage of respondents who feel the stigma has decreased.

The pressure on employees to be productive is higher than ever, and employees are experiencing greater stress and more complex personal issues than in the past.

Table 9: Perception of Stigma

Area of Perception	Stigma Increased		Stigma Decreased		Stigma Stayed the Same		No Stigma	
	2012	2014	2012	2014	2012	2014	2012	2014
Having a psychological/psychiatric problem	7.6%	24.2%	25.0%	25.1%	59.8%	41.4%	7.6%	9.2%
Seeing a MHP	3.0%	20.59%	35.6%	26.0%	50.8%	42.0%	10.6%	11.3%
Taking psychotropic/mental health prescriptions	3.1%	23.4%	38.9%	25.1%	45.8%	42.6%	12.2%	8.7%
Utilizing EAP services	3.0%	25.6%	40.2%	24.7%	39.4%	33.1%	17.4%	16.3%

The perception of stigma varies somewhat by employer size, with mid-sized employers more often perceiving an increase and large employers more often seeing a decrease or status quo. Small employers feel stigma has remained the same.

The perception of stigma also varies by program design. Respondents who have an integrated/coordinated disability and absence program that includes a behavioral health component more often report an increase in stigma than those who don't, especially with respect to seeing an MHP or utilizing EAP services. This may be because they are more aware of mental health issues, the support available, and the impact of employee absence on their bottom line.

⁷ 2010 MetLife Study on Employee Benefits.

⁸ American Psychological Association, Stress in America™ Survey, August 2013.

Table 10: Perception of Stigma: By Employer Size

Area of Perception	Stigma Increased			Stigma Decreased			Stigma Stayed the Same			No Stigma		
	Small	Mid-sized	Large	Small	Mid-sized	Large	Small	Mid-sized	Large	Small	Mid-sized	Large
Having a psychological/psychiatric problem	18.8%	30.6%	17.6%	18.8%	22.3%	31.8%	59.4%	38.8%	38.8%	3.1%	8.3%	11.8%
Seeing a MHP	9.4%	29.2%	12.9%	25.0%	20.0%	35.3%	56.3%	39.2%	41.2%	9.4%	11.7%	10.6%
Taking psychotropic/mental health prescriptions	25.0%	28.9%	15.3%	21.9%	24.0%	28.2%	46.9%	38.8%	47.1%	6.3%	8.3%	9.4%
Utilizing EAP services	15.6%	35.5%	15.5%	15.6%	16.5%	40.5%	46.9%	29.8%	33.3%	21.9%	18.2%	10.7%

Note: n = 32 for small (fewer than 1,000 employees); n = 121 for mid-sized (1,000 to 10,000 employees); n = 85 for large (more than 10,000 employees).

Table 11. Perception of Stigma Increased: Integrated/Coordinated Program and a Behavioral Health Component

Area of Perception	Stigma Increased			
	Disability/Absence Management Program		Behavioral Health Component in Integrated or Coordinated Disability/Absence Management Program	
	Integrated or Coordinated	Not Integrated or Coordinated	Included	Not Included
Having a psychological/psychiatric problem	26.2%	19.4%	28.7%	16.1%
Seeing a MHP	24.2%	6.5%	24.8%	11.3%
Taking psychotropic/mental health prescriptions	25.1%	25.8%	26.7%	16.1%
Utilizing EAP services	29.4%	9.7%	32.9%	11.3%

Note: n=187 for those that include a behavioral health component; n=90 for those that do not include a behavioral health component.

Management Awareness and Acceptance

When asked how their upper management's opinion regarding the need to review behavioral health issues has changed over the last two years, an increased percentage of respondents report that "Yes, it has become more open" (36.8%, up from 25.0% in 2012). This is a positive shift since 2012, when more employers (53.8%) felt it had not changed, and an encouraging signal as the workplace becomes more challenging.

Conclusion

Behavioral Risk Management is a topic that is increasingly recognized by employers for its importance and its impact on employee health and productivity. Positive trends from 2012 have continued in 2014, and employers are increasingly applying it as part of their overall approach.

More formalized processes, particularly surrounding RTW efforts, have continued, and the use of technology to identify critical cases and apply analytics is increasing. Speaking to these points, one respondent said, "EAP professionals will conduct and/or coordinate RTW conferences with the employee and appropriate parties (with employee's permission) for all cases that they are managing where an employee has had any period of time out of work for a behavioral or mental health or addiction issue." Another said, "If accommodations are identified in the interactive process, we work with the employee and the department HR staff to identify ways to reasonably accommodate the employee and make sure that the accommodations allow the employee to be safe and productive in the job assignment."

Lastly, the need for strategies to combat the perceived stigma associated with behavioral health is more pronounced in 2014 than in recent years, particularly as the workplace becomes more stressful and employers do more to manage productivity. Perhaps the biggest challenge for companies will be to strike a balance between providing support to people that need it while also rewarding people who show up to do the work when others are unable.

More formalized processes, particularly surrounding RTW efforts, have continued, and the use of technology to identify critical cases and apply analytics is increasing.

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Appendix A: Survey Questions

1. Does your company have an integrated/coordinated disability and absence management program?
 - a. Yes, fully integrated/coordinated
 - b. Yes, partially integrated/coordinated
 - c. No
 - d. Considering
 - e. Not sure

2. Does your company currently include a behavioral component (EAP referral or depression screening) to your integrated or coordinated disability/absence management program?
 - a. Yes (please explain in comments area)
 - b. No
 - c. Considering (please explain in comments area)
 - d. Not sure
 - e. Comments

3. Does your company provide health insurance coverage for behavioral healthcare?
 - a. Yes
 - b. No

4. If yes, who provides behavioral health benefits?
 - a. Carve In (included as part of a medical plan)
 - b. Carve out (managed by a behavioral health plan)
 - c. Other
 - d. Not sure

5. Does your company offer behavioral health plan?
 - a. Yes
 - b. No

6. Does your company provide disease management or case management for depression?
 - a. Yes
 - b. No
 - c. Considering
 - d. Not sure

7. Does your company provide disease management or case management for chronic pain conditions (arthritis, back pain, fibromyalgia, or other)?
 - a. Yes
 - b. No
 - c. Considering
 - d. Not sure

8. Does your company offer an Employee Assistance Program (EAP)?
 - a. Yes
 - b. No
 - c. Not sure

9. Does your EAP program offer benefits to any of the following? (Check all that apply.)
- All employees
 - Full time working more than 30 hours
 - Family members
 - Household members
10. If yes, are services provided by:
- Internal EAP
 - External EAP
 - Combination
 - Other (please describe)
11. How many visits does your EAP provide?
- 1-3 visits per year
 - 1-3 visits per issue
 - 3-6 visits per year
 - 3-6 visits per issue
 - 7-20 visits per year
 - 7-20 visits per year
 - Other (please describe):
12. Does your EAP offer any of the following programs? Check all that apply.
- Management training
 - Management consultation/coaching
 - Employee training
 - Employee consultation/coaching
 - Referral only
 - Employee treatment
 - Automatic disability claim referral
 - Safety department review of accident records
 - Other (please describe)
13. Does your company identify or screen claims for possible underlying psychological or psychosocial issues?
- Yes
 - No
 - Considering
 - Not sure
14. Do you screen for any of the following – check all that apply:
- Stress or anxiety
 - Substance use disorder
 - Depression
 - Child/Spousal/Senior abuse
 - None

15. Is the person responsible for identification or screening in the following role?
- EAP
 - Human Resources
 - Occupational Health Nurse
 - Disability carrier
 - LOA administrator
 - Other
16. If yes, what areas do you screen? (Check all that apply.)
- LTD
 - STD
 - FMLA
 - Workers' Compensation
 - Performance
 - Safety
 - Health and Wellness coaching
 - Disease Management
 - Health Risk Appraisals
 - Other (please describe)
17. If yes, how do you screen? (Check all that apply.)
- Red flags
 - Supervisor communication
 - Case management review or judgment
 - Screening tool (describe in the comments section)
 - Review by Mental Health Professional (MHP)
 - Review by other case management professional (e.g., Occupational Health; claims adjuster, etc.)
 - Other (please describe)
18. How does your company identify an employee who is experiencing a work absence due to a psychiatric impairment? (Check all that apply.)
- Predictive modeling from claims data
 - Employees self-report or claim
 - Depression screening (such as PHQ9) at intake point
 - Data obtained from a health risk assessment (HRA) tool
 - Integration/coordination of plans that allows cross referrals
 - No screening for this risk
 - Other (please describe)
19. Does your disability plan require an employee receive treatment with an appropriate care provider for behavioral health disability claims?
- Yes
 - No
 - I do not know

20. Does your company utilize a MHP to perform or oversee case management on potential psychological or psychiatric claims?
- Yes, always
 - Yes, occasionally
 - No , occasionally utilize a MHP to perform
 - No , occasionally utilize a MHP
 - Considering
 - Not sure
21. If yes, in what ways do you utilize the MHP to do case management? (Check all that apply.)
- Psychiatric or psychological claims
 - Physical claims with potential underlying psychosocial or psychiatric issues
 - Disciplinary or performance problems
 - Safety reports
 - Face-to-face consultation
 - Telephonic consultation
 - Web-based chat
 - Referral source to identify areas of concern
 - Other (please describe)
22. Do you use guidelines (MDA, ODG) for management of behavioral health conditions?
- Yes (please describe in the comments section)
 - No
 - Considering
 - Not sure
 - Comments
23. Do you currently include an EAP representative or other MHP on your Disability Management Team?
- Yes, always
 - Yes, occasionally
 - Considering
 - No
 - Not sure
24. Does anyone in your company receive training to recognize and support employees who may be “at risk” for a behavioral health absence? (Check all that apply.)
- Employees themselves
 - Corporate and field HR professionals
 - Benefits service center teams
 - Managers who directly supervise employees
 - Senior management
 - No one receives mental health awareness training.
 - Not sure

25. Does your company offer any of the following training programs? (Check all that apply.)

- a. Stress management/resilience
- b. Awareness of depression, anxiety, bipolar disorders
- c. Conflict resolution
- d. Management training
- e. Communication skills
- f. Work-Life balance
- g. Diversity
- h. Wellness/health promotion (exercise, nutrition, relaxation)
- i. Safety
- j. Substance use disorder
- k. None

26. Has upper management's opinion regarding the need to review behavioral issues changed in the last two (2) years?

- a. Yes, become more open
- b. Yes, become more closed
- c. Not changed
- d. Don't know

27. Please rate the level of emphasis your upper management places on the following organizational, cultural, or management practices:

	High Emphasis	Somewhat High	Moderate	Somewhat Low	Low Emphasis
Respect, civility, and cooperative work relationships	<input type="checkbox"/>				
Safe work environments	<input type="checkbox"/>				
Open and regular communication at all levels	<input type="checkbox"/>				
Ethics, values, and mission alignment	<input type="checkbox"/>				
Learning and career development	<input type="checkbox"/>				
Flexible work schedules	<input type="checkbox"/>				
Modeling healthy lifestyle behaviors	<input type="checkbox"/>				

28. Do you think behavioral risk management is an important emerging area of concern for employers?

- a. Very important
- b. Somewhat important
- c. Moderately important
- d. Less important
- e. Not important

29. What level of or change in stigma associated with the following have you witnessed in the last two (2) years?

	Increased	Decreased	Same	No Stigma
Having a psychological/psychiatric problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing a MHP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking psychotropic/mental health prescriptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Utilizing EAP services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. What Return to Work (RTW) activities does your company have in place to help employees with mental/ behavioral health disabilities return to work? (Check all that apply.)

- Analysis to determine the cognitive demands of the job in order to determine the potential stressors that may prevent RTW
- Development of any transitional job modification possibilities
- Consultation with a vocational rehabilitation counselor from either WC or disability provider
- Referral to EAP or depression disease management programs
- Communications between you, your disability provider or EAP to develop job accommodations to enable the employee to RTW gradually
- Job coach (before or during RTW process)
- Engage in the interactive process
- None
- Other (please explain)

31. Do you have any special requirements for an employee who returns to work from a psychiatric disability? (Check all that apply.)

- Discussion and sign off on RTW program between employee and the supervisor
- Any fitness for duty test to determine their ability to perform their job
- Training on any changes to their job since they have been absent
- Interim “touch base” meetings with the employee to determine if the RTW program is successful
- None
- Not sure
- Other (please explain)

32. Which RTW barriers do you most often encounter with employees out of work due to a psychiatric/ behavioral illness? (Check all that apply.)

- Doctors enabling or overprotecting patients
- Doctors enabling RTW planning
- Doctor’s unclear RTW full-capacity timeframe
- Difficulty developing transitional duty options
- Employees depending on their primary care physician and not seeking treatment with a MHP
- Workplace issues (e.g., supervisor or co-worker conflict, resistance to accommodations)
- Poor communication between supervisor and employee
- Personal stressors
- Other (please describe)

33. Which of the following program elements or solutions do you feel have produced the best behavioral/mental health RTW results in your company? (Check all that apply or explain your unique program.)
- a. Use of EAP
 - b. Use of MHP or behavioral case manager
 - c. Mandatory referral to EAP
 - d. RTW committee
 - e. RTW coach or advocate
 - f. Parity of benefits (mental and physical)
 - g. Early intervention and identification
 - h. Vendor integration or coordination
 - i. Communication to employees/supervisors
 - j. Transitional duty options
 - k. Independent Medical Examiner (IME) with RTW mindset
 - l. Engaging in the interactive process
34. What is the primary business of your company or organization?
- a. Accommodation and food services
 - b. Administrative/Support/Waste Management/Remediation Services
 - c. Agriculture, Forestry, Fishing, Hunting, and Mining
 - d. Arts, Entertainment, and Recreation
 - e. Construction
 - f. Educational Services
 - g. Finance and Insurance
 - h. Healthcare and Social Assistance
 - i. Information
 - j. Management of Companies and Enterprises
 - k. Manufacturing
 - l. Non-Profit
 - m. Other Services (except Public Administration)
 - n. Professional, Scientific, and Technical Services
 - o. Public Administration
 - p. Real Estate, Rental and Leasing
 - q. Retail Trade
 - r. Transportation and Warehousing
 - s. Utilities
 - t. Wholesale Trade
35. Please indicate the total number of employees in your company.
- a. < 500
 - b. 500 – 999
 - c. 1,000 – 2,499
 - d. 2,500 – 4,999
 - e. 5,000 – 7,499
 - f. 7,500 – 10,000
 - g. 10,001 – 24,999
 - h. > 25,000

36. Please identify your field of specialty. (Check all that apply.)
- Human Resources
 - Disability
 - Absence
 - Workers' Compensation
 - Risk Management
 - Employee Benefits
 - Wellness
 - Behavioral/EAP
 - Safety
 - Disease Management
 - Occupational Health
 - Labor Relations
37. Would you be interested in attending a one-day employer focus group exploring best practices in BRM?
- Yes
 - No
38. In what part of the country would be most convenient to attend a conference?
- East
 - West
 - Midwest
 - South
39. Do you have a successful Behavioral Risk program that you would be willing to share with other members? (Check all that apply.)
- Present at a future conference
 - Present at a chapter meeting
 - Add to the DMEC Speaker's Bureau
 - Share information about your workplace program in a written case study
 - Participate in a special interest group
40. Are you interested in receiving a copy of the survey results?
- Yes
 - No
41. Are you interested in a Starbucks gift card as our thank-you for your time and valuable input?
- Yes
 - No
42. If you responded to questions 36, 37, or 38, please provide your name, email, and telephone number so that we may contact you.
- Name
 - Mailing address
 - City/Town
 - State
 - ZIP/Postal code
 - Title
 - Email

The Disability Management Employer Coalition (DMEC) is the only association dedicated to **knowledge, education, and professional networking** in **integrated disability, absence management, and Return to Work solutions**. DMEC and its network of local chapters provide companies with **trusted information, strategies, tools, and management resources** to minimize lost work time and improve workforce productivity.

For more information on DMEC, including upcoming conferences, seminars, virtual education webinars, chapter activities, and member news and resources visit www.dmec.org or call 800.789.3632.