

Reducing Workplace Absenteeism Caused by Work Stress in a Health Maintenance Organization Department of Psychiatry

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ABSTRACT

Introduction: It is well established that work stress is a major economic burden not only in lost work productivity but also in increased health care utilization and costs. However, there is little research into effective treatment models for work stress.

Objective: To retrospectively examine the effectiveness of a psychiatric pilot quality improvement program in improving the return-to-work rate in patients in a health maintenance organization who had work stress and took medical leave from work.

Methods: A health maintenance organization's Department of Psychiatry developed a pilot quality improvement program that reviewed a new program of group psychotherapy and specialty mental health treatment targeting patients who self-identified as having work stress and who requested medical leave from work. The retrospective data were collected from the electronic medical record.

Results: Of the 166 patients who participated in the Work Recovery Group program, 141 (85%) returned to work and did not have any days off after the Work Recovery Group within the 11-month analysis. Involvement in the group also was associated with improvement in self-reported symptom severity, with a 4.5-point decrease in the average score on the Adult Outcomes Questionnaire about depression and anxiety.

Discussion: This is the first known treatment program from a health maintenance organization to provide data on return-to-work outcomes. By providing specialty mental health treatment and getting patients back to work more quickly, this program has potential to reduce mental health service utilization. These results show promise for program expansion and have broader implications for health care organizations and employers.

INTRODUCTION

Absenteeism from work owing to mental health symptoms is a multifaceted and complex public health issue with many stakeholders: The employee, employer, health care practitioners, health care insurance company, and public and private disability insurance carriers. If the mental health injury occurred at work or if there are allegations of discrimination, additional stakeholders include occupational medicine clinicians, workers' compensation insurance, and federal and state regulatory agencies (US Equal Employment Opportunity Commission and the Department of Fair Employment and Housing) as well as other labor and employment law organizations.

Work stress is a known risk factor for negative health outcomes such as elevated risk of coronary artery disease¹ and metabolic syndrome.² Conversely, workplace wellness interventions may reduce health care utilization.³ In 2019, the World Health

Organization⁴ included burnout as a diagnosis in the International Classification of Diseases, Eleventh Revision, with the following description: *Burn-out is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy.*⁴

Predictors of absenteeism include work stress, low occupational status, subjective lower work ability, mental health symptoms, history of mental health disorders, higher symptom severity, previous absenteeism, high job demands, female sex, lower educational level, smoking, and low perceived general health; on the other hand, an employee's belief or expectancy of future work success is associated with positive health outcomes and reduced absenteeism.⁵⁻⁷ According to the Centers for Disease Control and Prevention: *Work-related stress is the leading workplace health problem and a major occupational health risk, ranking above physical inactivity and obesity. Productivity losses from missed work cost employers \$225.8 billion, or \$1685 per employee, each year.*⁸

Despite the high cost of work absenteeism and the known relationship between mental health and absenteeism, there is little research into effective treatment models. Depression treatment in a primary care setting has been shown to improve work productivity.⁹ Returning to work on a modified or graduated schedule reduces the risk of permanent work disability.¹⁰ Treatment is effective in enhancing successful work participation in people with common mental disorders.^{11,12} A deeper evidence base is needed to clarify how to provide interventions effective at reducing the time to return to work (RTW). This study was conducted to examine the effectiveness of a pilot quality improvement program in improving the RTW rate in patients with work stress who took medical leave from work.

METHODS

Setting and Background

This pilot program took place in the adult psychiatric clinic of a large health maintenance organization. In this clinic, mental health treatment is directed by a patient's presenting symptoms

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and his/her responses on a self-report measure called the Adult Outcomes Questionnaire (AOQ). This measure is routinely used in the Kaiser Permanente (KP) Northern California Region's East Bay Market, in the Department of Psychiatry and in primary care clinics, to evaluate severity of depression and anxiety symptoms. Although there are no empirically validated, peer-reviewed studies on the AOQ, there are KP regional published guidelines for symptom severity. Higher scores on the AOQ indicate that a patient reports more severe psychiatric symptoms.

Patients with self-reported more severe symptoms (AOQ score > 20) are typically referred to the department's Intensive Outpatient Program. This program provides intensive outpatient treatment for patients with risk factors, including recent hospitalizations and suicidality, with the goals of preventing hospitalization and of stabilizing the patient so s/he can transition to routine outpatient care.

Most patients treated in the Department of Psychiatry do not require this intensive level of care and receive routine outpatient treatment, or treatment as usual. Treatment as usual entails having patients scheduled for an initial intake appointment (by phone, video, or in person) followed by an appointment with a therapist, often 4 to 6 weeks later. At the intake, the patients may be referred to a mental health group treatment (depression stabilization, coping skills, etc). After the patients see their individual therapist, some patients are placed off work (put on medical leave) until they are scheduled with their therapist again, sometimes weeks away. During

treatment, some patients would be taken off work until they can be seen again by their therapist, sometimes 3 to 6 weeks later.

Medical leave, as operationally defined by the Department of Psychiatry, is when a patient has a diagnosis of a psychiatric condition and has functional impairments and problems managing activities of daily living, including working. Medical leave is applied for the purpose of participating in treatment.

Initial data (unpublished) collected in the Intensive Outpatient Program and other group treatments showed that 30% to 50% of patients in these groups were off work primarily because of work stress issues. Additionally, individual practitioners in the clinic had widely variable practices in providing time off work. Decisions about granting time off work are complicated by the possibility of symptom exaggeration and malingering. In consultation with behavioral health managers and disability resource experts, this pilot project was designed to assess the effectiveness of a structured approach to patients with mental health symptoms and time off work with the goals of reducing time to RTW and standardizing the authorization of time off.

A written treatment program was developed for the pilot program, called the Work Recovery Group (WRG). Written consent was obtained for the patients to participate in the treatment program. This retrospective study was regarded as exempt from the institutional review board.

Patient Selection

The WRG received referrals of employed adults from the organization's primary care and psychiatry practitioners. The study inclusion criteria were as follows:

- A licensed mental health practitioner completed an initial psychiatric assessment
- A psychiatric condition such as depression, anxiety, adjustment disorder, and/or an occupational stress disorder was diagnosed
- Symptoms caused impairments in activities of daily living
- Time away from work was requested or indicated for the patient to participate in mental health treatment
- Work stress was regarded as one of the primary stressors.

If the inclusion criteria were met, a time off request for sick leave (work slip) was provided until the date that the patient could begin the WRG, typically in a few days from the initial assessment.

Program Description

The pilot program started on June 4, 2018. The WRG treatment program was an open enrollment group with a census of 6 to 12 patients entering and graduating at various times. There was no set length of treatment for any individual patient. The WRG met twice a week for 90 minutes each session. If a participant requested a work slip, s/he also completed a self-assessment form of activities of daily living (adapted from the Social Security Administration's Function Report-Adult) and was scheduled for an individual meeting with a psychologist. During the individual meeting, patients were oriented to the program. Time off work was given in small increments of a few days while patients participated in treatment. Time off work

Session Format

1. Group rules (verbal/written rules reviewed before each session):

- purpose of the group—"work stress and life stresses are discussed and how to be more successful in [coping with] both"
- confidentiality
- attendance and tardiness
- Adult Outcomes Questionnaire
- work slip request procedure

2. Check in (all patients answer the following questions):

- What is your name?
- What is your primary challenge in the workplace?
 - depression/anxiety
 - boss/coworkers
 - quantity or quality of work expectations
 - value conflict with the company or the work
 - work-life balance issues (ie, long commute)
 - something else
- What would have to change for you to feel more successful in the workplace?
 - your attitude
 - quantity/quality of work expectations
 - relationship with boss/colleagues
 - something else

3. Didactic discussion of personal challenges, with group support and problem solving. Didactic topics included conflict management; problem solving; self-care; mindfulness; improving effective communication; improving coping skills, sleep hygiene, resilience, and identifying cognitive distortions.

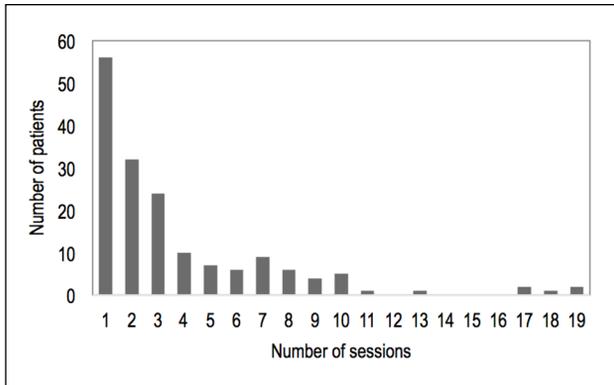


Figure 1. How many Work Recovery Group sessions each patient attended (N = 166).

could be provided by either a physician or a psychologist. To set expectations, patients were instructed that they would likely graduate to modified duty (RTW but may still be able to attend treatment) and then return to full duty within days to weeks.

A licensed clinical psychologist facilitated the group. Each session's format is described in the Sidebar: Session Format.

Data Analysis

The retrospective data were collected from the KP Health-Connect electronic health record. All data were compiled and collected by the primary author (TT) into a secure database. Data were collected from the pilot program from June 4, 2018, through April 29, 2019. Patients included in the analyses attended at least 1 group session and 1 individual meeting with the group facilitator.

The primary variable considered was how many days off work the patient was provided for mental health purposes before and after each patient participated in the WRG, as documented in the Work Activity Status Form of the electronic health record. The Work Activity Status Form was reviewed for the 3 months before and after each patient completed participation in the WRG. Only time off work for psychiatric illness was included in the analyses. Patients who had any days off because of psychiatric issues were included in the analyses.

A secondary measure considered was the mean AOQ scores for patients who attended at least 2 WRG sessions.

RESULTS

One-third of the patient referrals to the WRG came from the Psychiatry Department's crisis services, and the remainder of the referrals came from clinicians throughout the department. Of the 204 patients referred to the WRG, 31 patients were "no-shows"; 7 other patients attended only 1 group but did not receive an individual assessment and were excluded from analysis. The 166 remaining patients were included in analysis. These patients attended, on average, 4 group sessions, with a range of 1 to 19 group sessions (Figure 1).

The patients who attended the group were racially and ethnically diverse: 55% African American, 22% white, 12% Latino/Hispanic, 7% Asian American, and 4% other (mixed race/ethnicity). Seventy-three percent of the patients who participated were female. There was a wide variety of occupations represented, with the highest proportion of patients coming from business and administrative jobs (Figure 2). The average age of the participants was 46 years.

The primary variable considered was how many days off work the patient was provided for mental health purposes before and after each patient participated in the WRG. Days off work before program participation ranged from 0 to 126 days (average = 12 days; Table 1). Days off after the WRG ranged from 1 to 162 days (average = 10 days). Of all patients, 85%

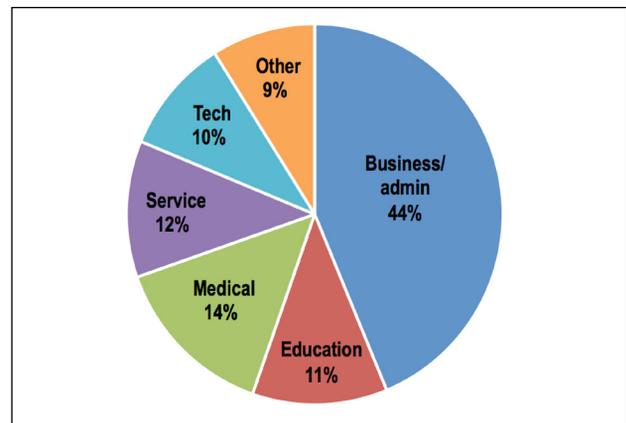


Figure 2. Occupation of group participants (N = 166).^a

^a Other: Agriculture, arts and communications, construction, finance, and manufacturing. Admin = administration; tech = technology.

Measure	All patients (N = 166)	Patients with workers' compensation or litigation (n = 18)
AOQ score before WRG treatment	26.2 (9.0)	28.8 (6.6)
AOQ score after WRG treatment	21.7 (10.0)	27.8 (7.6)
Number of WRG treatment sessions	3.7 (3.7)	6.6 (5.2)
Psychiatric days off before WRG	12.0 (19)	13.1 (20.0)
Psychiatric days off during WRG	9.9 (14.2)	25.7 (24.5)
Psychiatric days off after WRG	8.0 (27.7)	31.4 (55.2)
Returned to work with no days off after WRG, no. (%)	141 (85)	11 (62)

^a Data are mean (standard deviation) unless otherwise indicated (ie, last row). AOQ = Adult Outcomes Questionnaire; WRG = Work Recovery Group.

(141/166) returned to work after the WRG with no days off in the study period.

A secondary measure considered was the AOQ scores for patients who attended at least 2 WRG sessions, 110 patients. Compared with the initial score before the WRG, the average AOQ score after the WRG decreased by 4.5 points (from 26.2 to 21.7; Table 1). Sixty-six percent of patients did not require additional mental health treatment after the WRG treatment and could be discharged from care.

DISCUSSION

There is scant literature on structured mental health interventions for people with work stress. Often, patients involved in occupational medicine are integrated into traditional mental health pathways. Access to mental health services is limited to individual treatment and/or groups for either diagnosis-specific treatment (ie, bipolar group or depression stabilization) or more broad and general coping skill interventions (ie, mindfulness-based stress reduction, coping skills groups, trauma grounding skills for coping with trauma).

Overall, the WRG appeared to be effective at returning patients to work (85% of all participating patients were RTW). Unfortunately, there was no treatment-as-usual comparison group, but that could be an area of future research. Involvement in the WRG also led to improvement in self-reported symptom severity, with a decrease in the average AOQ score of 4.5 points, a modestly clinically relevant decrease in symptom severity.¹³ Involvement in the WRG predicted low utilization of future mental health services, but this study is not able to demonstrate causality because there was no treatment-as-usual comparison group.

Some patients made it known that they were involved in either litigation or workers' compensation claims, although this topic was not formally assessed or measured. This smaller percentage of WRG participants who were involved in either litigation or workers' compensation (10% of patients) were included in the WRG analyses. When these patients were analyzed separately, they were involved in more treatment sessions and did not seem to have notable improvements in their subjective psychiatric symptoms (Table 1). The role such claims played was not explored. It may be worthwhile to formally assess involvement in litigation or workers' compensation claims in future similar studies.

Although there are many work stress treatment programs, this is the first known treatment program from a health maintenance organization to provide data looking at RTW outcomes. Limitations of this quality improvement pilot program include a post hoc analysis, no control group, potential for selection bias, and limited sample size. Future research directions can consider analyzing the treatment-as-usual model with the WRG program for RTW rates.

CONCLUSION

This quality improvement pilot program on work stress treatment and absenteeism reduction was believed to be successful in meeting the unique needs of this patient population. Additionally, the program perhaps lowered utilization of both mental health and primary care services, with associated systemic cost savings. There are hopes of program expansion at the regional level in the future. ❖

Disclosure Statement

The author(s) have no conflicts of interest to disclose.

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