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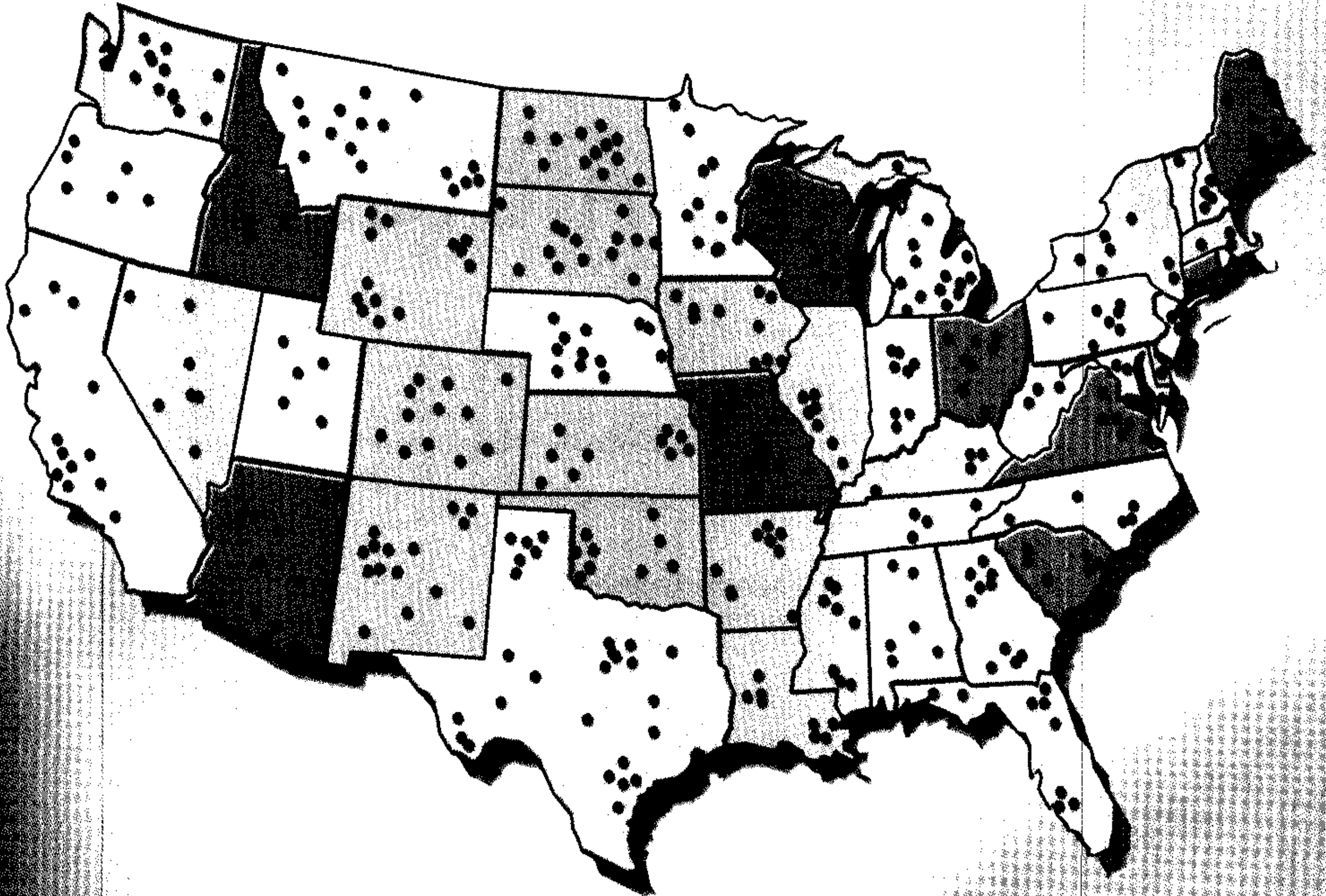
EAP Digest™

Bring It on Home

A call for a return to localized EAP services



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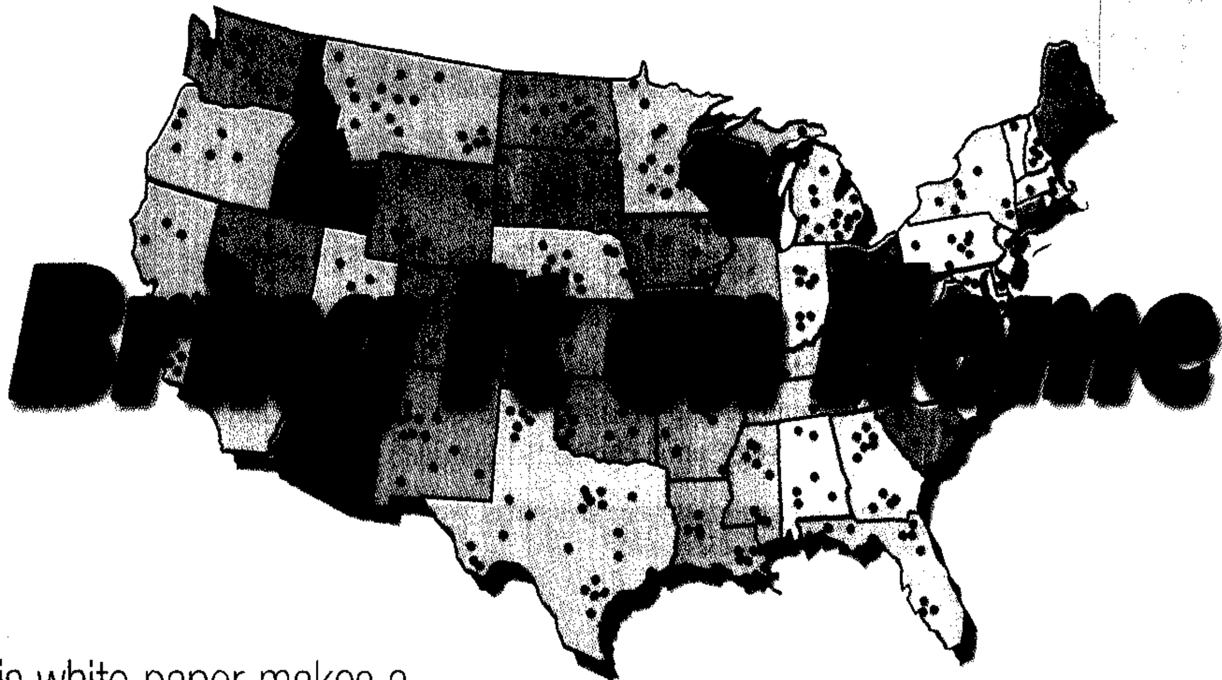

This white paper makes a strong case for returning to localized EA services.

By Tom Bjornson and Dave Sharar

It is commonly understood and accepted that health care, like politics is practiced locally. This "localness" allows for the understanding of regional practice differences and quality of care issues, which personalizes the service and, in theory, creates better outcomes. Although the value may seem self-evident to the purchaser, the bulk of current employee assistance (EA) services fail to integrate local EA providers with key local workplace stakeholders.

Both internal and regional employee assistance program (EAP) operations are in a better position than large, national firms to integrate with workplace stakeholders and identify and impact workplace issues. However, these regional EAP firms also are perceived by benefits brokers and purchasers as being geographically constrained as well as limited by not having sufficient technology and appropriate infrastructure to support national service delivery. In many cases, these perceived shortcomings no longer exist. But, as a result of this lingering perception, national managed behavioral health/EAP firms have cornered the vast majority of national EAP contracts. Prior to this, contracted EAP services were primarily delivered through multiple service agreements between regional human resources (HR) departments and local EA providers.

Historically, regional EAP firms were perceived as routinely delivering quality workplace services, and the overall utilization results were outstanding. However, as national firms became more involved, there was a push to functionally integrate behavioral health benefits administration/ management and EA assessment services. In addition, EAPs were standardized into a single-source benefit plan.

This centralized approach was frequently implemented over the objections of regional HR departments and managers, who preferred local EAP counseling and consulting services. However, to corporate benefits purchasers, these national firms appeared to offer clinical infrastructure, geographic coverage, appealing new benefits, low prices and logical role integration. During this process, many valuable internal EAP roles and functions also were outsourced. The dominance of national firms has, in large part, forced an evolution of EAPs into a commodity benefit plan.

The outcome of this 15-year managed-care-benefits EAP evolution is now in. If purchasers took the time to analyze these results, they would see that actual counseling utilization is very low, and management consultations are essentially non-existent. These results constitute substantial missed opportunities for the employer stakeholders who are truly motivated to use an EAP as a tool to proactively address emerging performance problems that affect workplace productivity and safety.

At best, EAP is currently a half-hearted and low dose extension of the behavioral-health-benefits management function with mixed motives. EAP has become increasingly irrelevant to internal HR and day-to-day organizational operations. In fact, EAP is frequently an elusive tool for managers dealing with employee per-

sonal problems that overlap with job and safety issues. It's time for a change and renaissance in the EAP field. There is a need to return to core values, and reinstate fidelity to the service technology that originally made EAP an effective organizational tool.

The benefits approach is not working

Overall, program promotional efforts by national managed care/EAP firms have become passive by design. The motives and financial focus are generally misguided and self-serving, particularly from a purchaser's perspective.

This is because capitated contractual arrangements, by structure, involve the vendor taking the financial risk against program use. This pricing approach and financial incentive makes no sense if the goal is to identify and surface employee problems — which often involve denial and rationalization — that lead to productivity and safety issues in the workplace.

Seeing more at-risk people on behalf of employers should be an outcome the EAP strives to achieve. This should be done in close collaboration with stakeholders in the organization such as HR, workers' compensation, front-line supervisors, EEO, occupational medicine, etc. However, a distant, commodity-style service implementation has now become the norm, and it's yielding fewer and fewer counseling cases with a qualified, local face-to-face provider.

Razzle-dazzle features, benefits and "who knows what you're getting" capitated pricing creates market confusion. Sophisticated marketing puff and spin, the appearance of comprehensiveness, and false promises easily influence employers and their brokers.

The national managed-care EAP approach is to drive people to lower levels of service. However, this low level may not be easy to decipher in a typical utilization report that is intended to be misleading, confusing, inflated, and full of creative numbers crunching.

The primary counseling medium is rapidly becoming either Web or telephone based, rather than face-to-face. Most utilization reports do not separate the simple Web hit from the more intense and expensive use of face-to-face local providers. Face-to-face counseling has been managed down to a minimum in an effort to maximize profits. This is a result of low-ball bids.

Current samples of actual reports from several national firms indicate, across entire books of these firms' business, face-to-face counseling utilization is less than 1%. These national EAP plans may be the best-kept secret in an organization's plan. While this fact has become the norm, it is commonly hidden from the benefits or HR purchasers who are responsible for monitoring the performance of their EAP, or at least ignored in the face of more pressing HR and benefits matters.

Poor results, useless data and misleading reporting

Misleading reporting, touting such things as telephone contacts for information, Web hits and other routine client activities as "cases," is commonly used to cover up poor performance and a lack of results. These "utilization" reports are purposefully difficult to decipher when it comes to actual program outcomes. They also are not helpful in determining the appropriate action management should take in response to these results. EAP account management has tended to become more about smoke-and-mirrors reporting and manufacturing the appearance of activity in order to maintain accounts and contracts.

Centralized account management between an EAP vendor and a corporate office also has isolated local work sites from local EA providers, reducing the potential impact of the "localness" value and opportunity. Another critical element is whether or not the local manager has a personal relationship with an accessible EAP account manager who lives and works near the local manager's community. This type of relationship increases the likelihood that potentially difficult cases are being identified and treated.

Little regard for core technology management services

Beyond this basic lack of easy access and the lost early intervention impact opportunities, work-performance-based management referrals have become not just minimal but almost non-existent. The primary workplace-oriented response provided by national firms is to react to critical incidents, following workplace disasters or a critical event. They also offer some occasional training, usually voluntary and online, although it is frequently not effective in raising management awareness of the role of EAP in solving performance issues.

Delivering only these relatively small program elements as the principal interventions of an EAP misses the heart of the value of EAP to employers. What used to be a set of services that improves productivity has been devalued and placed on the back shelf or is passively available as an online training feature.

"It's all about price"

Currently, brokers, consultants and employee benefits' purchasers are hard pressed to distinguish one commodity managed-care EAP from another. Therefore, it logically tends to become "all about price."

However, let's look at price on a slightly different basis: one that measures the value and outcomes derived by what is being spent. For example, $1 per employee per month (PEPM) may be expensive; $3 PEPM could be a bargain. Let's review the facts:

- **If EAP services are not used, they are irrelevant.** This is a fact regardless of claims of effectiveness made during a sales process and appear-

ances that are designed for an inflated utilization report.

- **Too often, programs have become nothing more than a glorified Web site, with passively available work-life telephone referral services.** This approach has actually become relatively expensive given the low number of employee problem situations actually surfaced and managed and for what is being delivered for the price.
- **When serving in the dual role of managing behavioral health care and EAP by the same national vendor, games have been played between how counseling visits are actually deployed and paid for under the capitated assess-and-refer aspect of EAP and the employer's self-insured managed behavioral health benefit.** A simple audit of actual utilization can easily reveal the way these games are played. One "game" is to receive a capitated rate for a six-session EAP, and then routinely refer to the employer's self-funded behavioral health benefit plan after a single session or a focused telephone screening. This leads to increased profits for the EAP product and shifts the financial risk to the employer for ongoing benefits utilization beyond the EAP screening.
- **This benefits-management focus for EAP also has led to confusion regarding its function as a proactive workplace problem solver.** It increasingly has become an underutilized service that provides relatively little value. In fact, few employees and managers can distinguish the role of an EAP from a typical or marginal outpatient mental health benefit. In some cases, EAP has become a cheap replacement for a mental health benefit rather than a tool to prevent, mitigate or correct workplace problems.

Some enlightened HR and risk control managers are beginning to express understandable misgivings about EAP's ability to impact issues of concern to them (e.g., violence avoidance and threat management, controlling workers' comp costs, reducing employment law and other legal liabilities, improving labor relations, handling work performance issues, facilitating best HR practices, managing the high cost of co-morbidity, etc.).

Key issues and metrics for determining EAP success

Fundamentally, it needs to be understood and accepted that to achieve EAP performance goals, face-to-face counseling utilization is a good thing. For example, discussing performance-based pricing approaches helps customers become more aware that their self-interest is served when EAP services are used extensively and to understand how the effort can be organizationally integrated and become more targeted to achieve employer goals.

The omnipresent question needs to be, "What are the actual outcomes being achieved?" For example, is there a correlation between the percent of drug and alcohol cases seen and followed with a subsequent reduction in absenteeism or workers' compensation? We suspect a look at the history of managed care EAP will reveal an undeniable track record established of poor results if or when outcomes are objectively analyzed.

EAP utilization doesn't happen when services are available primarily through passive resources. Unlike any other employee benefit — perhaps with the exception of routine dental and physical exams — its value is actualized when employees know about and use it. The objective is to constructively intervene to help prevent individual employee/family-member personal issues, as well as organizational problems, from occurring and to stop them from progressing when they do occur. Increased awareness can help facilitate a "low threshold" access to needed help. Otherwise, unaddressed personal situations tend to persist. This can negatively impact work, relationships and productivity, which is costly to all concerned.

The goal is to proactively assist employees and family members through telephone consultations, training and education, self-help Web tools and face-to-face counseling.

Marital and family issues, substance abuse problems and other personal/emotional matters generally require face-to-face counseling. This is a critical medium that is often overlooked and avoided by many national vendors. Although the provision of locally based, face-to-face counseling is more expensive to the EAP vendor under a capitated funding model, it is essential when intervening with more difficult, complex or severe personal problems. Most medical physicians will not diagnose or evaluate new patients over the phone or an e-mail, instead requiring direct personal communication and examination. What makes an EAP assessment different? Employers should be certain EAP vendors segregate the reporting of face-to-face counseling cases from telephone or online cases.

Counseling utilization levels, in face-to-face settings, should be in the 4%-9% range of the total employee population. In some cases, it should be even higher. For example, hospital and public safety employees might range between 10% and 15%, and more. In addition, the telephone counseling, work-life, legal and dependent care services components should also be utilized in the 4%-9% range. These outcomes are achieved through effective account management, proactive program promotion and perceived value by employees and family members.

There also should be at least a 1% level of management consultations that result in an actual referral for EAP assessment and counseling. This level indicates the HR risk-management part of the process is sufficiently available. The goal and intention is to sup-

port and assist supervisors in dealing with employee performance issues that routinely occur in the workplace.

Perhaps, understandably, the management-services aspect of EAP has not been a priority for benefits administrators and consultants. This aspect has gotten lost in the benefits-reporting translation. However, not making this program component a priority is a huge mistake and a substantial missed opportunity to actualize savings on those employees who are at risk for high-cost claims that increase an employer's liability.

A new way of thinking

The issues for EAP purchasers should be:

- How many people were actually seen? For what? To what outcome?
- Does it create an improved ROI? How can this be measured? What qualitative outcomes are produced?
- How does this tie to current organizational goals and plans? Is the EAP integrated into day-to-day operations and readily available as needed?
- Do people know how and when to appropriately use services?
- Does management consider employees an asset, expense, or some combination thereof?

In support of a new way of thinking, the key metrics for evaluating overall EAP impact and effectiveness should be:

1. Number of work-life telephone consultations provided
2. Number of counseling cases seen
3. Total number of visits provided
4. Number of performance-based management consultations provided

If these areas are being measured with satisfactory results, it means the rest of the EAP service efforts are working properly. A positive experience with one plan aspect leads to more overall use of available services to solve problems.

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Much more is possible, but low employer expectation is a problem

The universally poor results of managed care EAPs have led to lower overall employer expectations for EAP services. This has made employers increasingly less inclined to look at changing service providers. Four or five years ago, about 38% were changing EAP providers at renewal time based on low rates or some dissatisfaction with the results achieved. But then it became clear. Why bother? It's just going to be more of the same or worse, regardless of the national vendor whose networks, call centers, and account management processes are about the same. Without a viable alternative, the field has tended to stagnate.

A consistent approach: a partnership model

Although national vendors tend to tout various assumptions about the economic efficiencies of their size and number of covered employee lives, on a practical basis, there is no correlation between corporate gigantism and superior outcomes in EAPs (or health care services in general). Given the very nature of an EAP service, we contend that many smaller, mid-sized EA providers have differentiated themselves as "high touch" vendors, stressing flexibility, local knowledge and responsiveness, personalized service and the ability to achieve unique performance characteristics. Some of these vendors already have national accounts with multi-location employers headquartered in their service delivery area but have relied upon the same out-of-area network provider model employed by the big nationals.

The key is to build a model that brings the best regional EA providers together to deliver a national solution with the critical benefit of understanding what an EAP is supposed to do along with the specific local needs of employers, employees and their families.

A multi-location employer can still have the convenience of a single-source contract but install a locally responsive program that operates seamlessly within the same quality standards and information systems. This new model, referred to as a "partners" model, is a confederation or coalition of regionally based EA vendors that have longstanding professional roots in all metropolitan areas. Each provider, or partner, has a keen understanding of the local resources, culture and business climate, allowing for the delivery of a national solution with the benefit of understanding the specific local needs of employees and families. This local factor is critical, because many of today's most progressive employers want to involve the parties closest to workplace problems in the design and delivery of solutions.

The maxim for this new model is that like politics, all health and social service delivery is ultimately local, and there is no substitute for geographic proximity, local decision-making and working alongside customers, clients and the community resources who serve them.

Local/regional providers have a stronger sense of loyalty toward their communities and customers, and their ability to integrate with the local work site is actual, not virtual. The true integration of an EAP with a local work site is simply not possible with a national vendor and account manager that attempts to oversee services from a distance.

The partners model shares these characteristics:

- **Interlinked systems.** All regional partners are interlinked via an Internet-based system in order to share a common infrastructure around data collection, performance measurement and quality management activities.
- **Practitioner-driven.** Local EA practitioners comprised of both clinicians and business managers develop and adhere to an agreed upon set of protocols, procedures and quality assurance activities, rather than have these imposed upon them.
- **Local promotion and visibility.** Each regional partner promotes the EA service and provides training and account management in highly collaborative ways with the local work site, becoming integrated with companies' human-resource and risk-management practices.
- **Financial incentives.** The partnership model ensures that regional partners have the financial motivation to build a close and consultative relationship with the local employer, either through partial capitation or performance-based pricing.
- **Self-regulating.** Although partners share common systems, each partner regulates the utilization and quality of their own regional program instead of having an out-of-area vendor pretending to oversee responsibility of these critical functions.
- **Partnership synergy.** Companies benefit when regional vendors are linked under one contractual umbrella with agreed upon values to share information, act flexibly and work harmoniously in a cooperative but strategic fashion.
- **Interdependency.** For regional providers to compete effectively with national vendors, they should collaborate with like-minded partners rather than act as a single agent. This creates a healthy interdependency in that solutions to the problems with national EAP delivery go beyond what single vendors can accomplish alone, particularly around common data collection and quality assurance procedures.

The raw material for this partnership model are the "best-of-breed" local/regional vendors whose heterogeneous traits, abilities and philosophy of care can bring about a renaissance in the EA field. This critical mass of partners would eliminate the current model where a single, large vendor imposes bureaucratic control over a loose network of providers, requiring them to be subordinates rather than partners.

The partners model is the only initiative in the EA field with the potential to better coordinate and integrate services over time and across geographic areas while allowing for a necessary degree of local autonomy and flexibility. It's also the only model that recognizes professional help works best when there is a direct relationship between those asking for help and those providing the helping service. ■

Tom Bjornson is an early pioneer in the EA field, starting the program at Pacific Gas & Electric more than 30 years ago. He also created one of the nation's first external EAPs. He is chairman of Claremont Partners, a company that links the best regional EAPs throughout the US and abroad into a seamless and local delivery system with a focus on proactive intervention. He can be reached at 510-451-1430 or at tbjornson@claremonteap.com.

Dave Sharar is the managing director of Chestnut Global Partners, the international employee assistance division of Chestnut Health Systems based in Bloomington, Ill. He is a doctoral candidate at the University of Illinois at Urbana-Champaign and the author of more than 25 articles on employee assistance, managed behavioral health care and integrated delivery systems in behavioral health and human services. He can be reached at 309-820-3570 or at dsharar@chestnut.org.