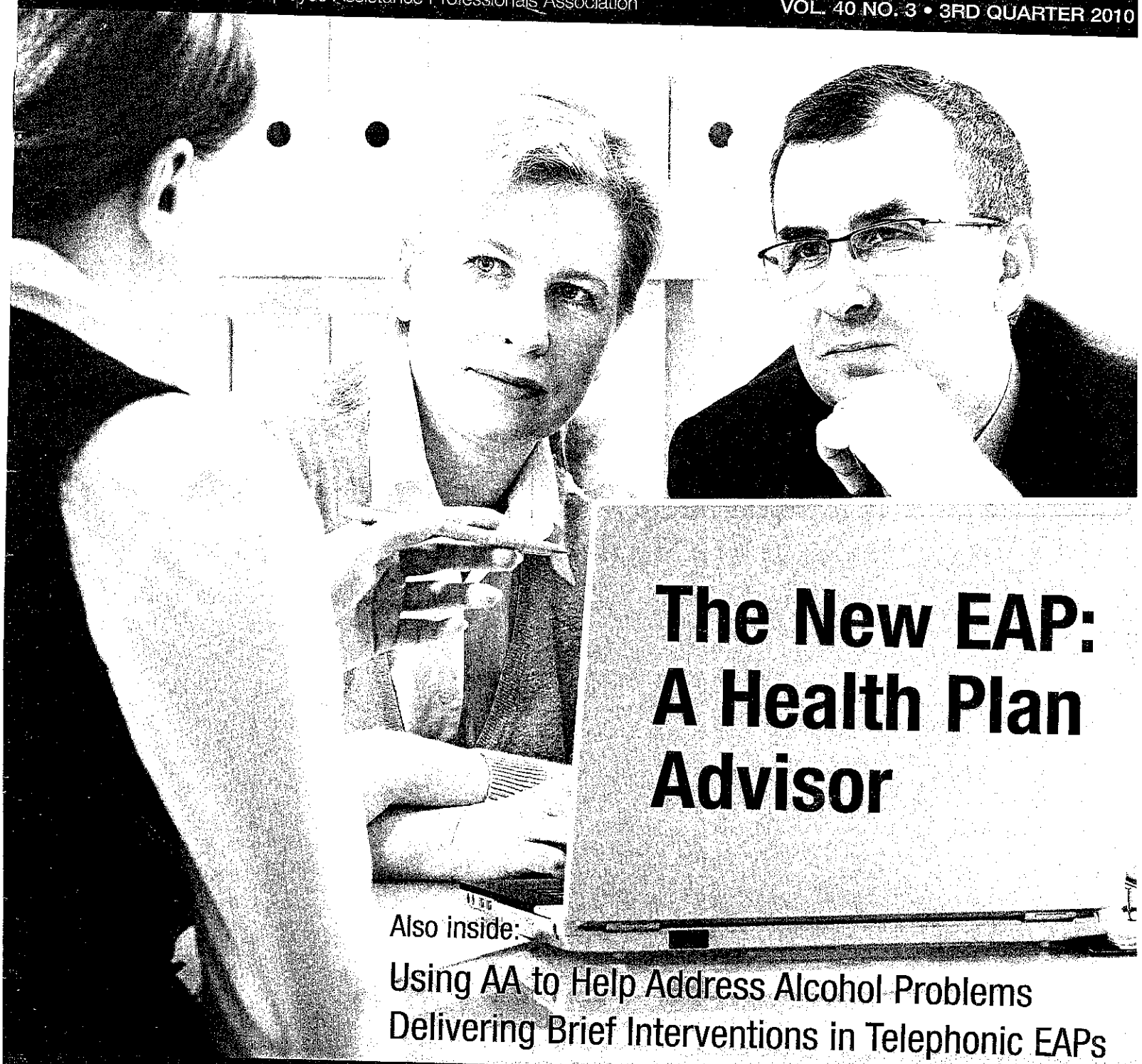
Journal of
Employee Assistance

The magazine of the Employee Assistance Professionals Association

VOL. 40 NO. 3 • 3RD QUARTER 2010



The New EAP: A Health Plan Advisor

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Using AA to Help Address Alcohol Problems

Delivering Brief Interventions in Telephonic EAPs

Employee Assistance Professionals Association

Delivering Brief Alcohol-Related Interventions in Telephonic EAPs

A pilot program showed that EAP call centers using tested protocols can better identify unhealthy drinking behaviors and deliver interventions tailored to risk levels.

by Gregory L. Greenwood, Ph.D., M.P.H.; Eric Goplerud, Ph.D.; Tracy L. McPherson, Ph.D.; Francisca Azocar, Ph.D.; Eugene M. Baker, Ph.D.; and Sherri Dybdahl, M.A.

Businesses increasingly are relying on employee assistance programs (EAPs) to assist workers and their families who have substance use and mental health problems. The proportion of businesses with EAPs has more than doubled in the past 15 years, from about 33 percent in 1995 to 75 percent in 2008 (Society for Human Resource Management 2008). More than 100 million American workers are now estimated to have access to an EAP (Masi 2004).

EAPs were developed to address substance use issues in the workplace. But despite the widespread availability of EAPs and the high prevalence of alcohol use disorders among working people, only about 160,000 EAP cases explicitly identify alcohol use as a primary problem (Tom Amaral, personal communication, 2010).

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Studies show that about 20-25 percent of the U.S. population drinks at a hazardous level, but it is often undetected (SAMHSA 2002). The estimated health care and workplace costs associated with this risky alcohol use are enormous. For example, alcohol costs U.S. businesses an estimated $134 billion in losses, mostly due to higher health care costs, missed work, low productivity, and job turnover (SAMHSA 2002).

Alcohol misuse also increases the risks for or exacerbates well-known medical conditions (Babor et al. 2005) and common co-occurring mental health problems (Kessler et al. 2005). People with alcohol problems are 3.9 times more likely to have major depressive disorder, 6.3 times more likely to have bipolar disorder, 4.6 times more likely to have generalized anxiety disorder, and 2.2 times more likely to have post-traumatic stress disorder. When alcohol abuse and other problems co-occur, they result in more frequent hospitalizations, longer hospital stays and poorer outcomes (Goplerud et al. 2008). A recent report by Polen and colleagues at Kaiser Permanente (2010) found that risky alcohol use is associated with negative health attitudes and behaviors.

These research findings underscore the need for a low-cost, effective treatment method that is widely available. Miller and Wilbourne (2002) found that alcohol screening combined with brief intervention (SBI) was the single most effective method of more than 40 treatments examined. Return on investment for alcohol SBI typically exceeds 2:1, consistent with the savings associated with diabetes or depression management programs (Fleming et al. 2002).

SBI is a systematic, focused process of rapid assessment, quick engagement and immediate implementation of change strategies (Babor and Higgins-Biddle 2001; Babor et al. 2001). The overall goals of SBI are to screen for hazardous and harmful drinking and provide tailored brief interventions and referrals.

DEVELOPING AN SBIRT PILOT

Alcohol SBIRT (screening, brief intervention and referral to treatment) protocols have been rigorously tested in medical settings and, recently, in a managed behavioral health organization (MBHO) setting. A unique public-private partnership was formed to translate an evidenced-based alcohol SBIRT protocol for delivery in a telephonic EAP. The partnership involved Medica, a large health plan; OptumHealth Behavioral Solutions (OptumHealth by United Behavioral Health); UnitedHealth Group Information Technology (IT); and Eric Goplerud and Tracy McPherson, researchers at the Center for Integrated Behavioral Health Policy and Ensuring Solutions to Alcohol Problems at George Washington University.

The partnership agreed to target Medica health plan members calling into one of the three designated EAP call centers. UnitedHealth Group IT built out a Web-based alcohol screening tool that ensured fidelity to screening protocol (Babor et al. 2001) and allowed for efficient measurement and evaluation. Using a train-the-trainer model, OptumHealth Behavioral Health Sciences developed a training program

		Alcohol Education (Risk 1: Low Risk)	Simple Advice (Risk 2: Hazardous)	Advice + Brief Counseling (Risk 3: Harmful)	Referral (Risk 4: Abuse or Dependence)
F	Feedback	x	x	x	x
R	Responsibility	x	x	x	x
A	Advise	x	x	x	x
A	Assess			x	x
A	Assist	x	x	x	x
M	Menu (Options)	x	x	x	x
E	Empathy	x	x	x	x
S	Strengths	x	x	x	x

Figure 1: **The "FRAAAMES" Brief Intervention Model**

and delivered it to EAP site supervisors, who in turn delivered it to their teams. The pilot was successfully launched with a quality assurance program to provide follow-up support and supervision.

The pilot's SBIRT protocol, which is based on a World Health Organization protocol (WHO 2003; Babor et al. 2001, 2005), includes systematic alcohol screening using the Alcohol Use Disorders Identification Test (AUDIT) during clinical intake as well as brief alcohol education/risk reduction counseling and referral tailored to risk level. The AUDIT is a 10-item screening tool that has been extensively tested and validated both nationally and internationally and is available in many languages (Babor et al. 2001, 2005).

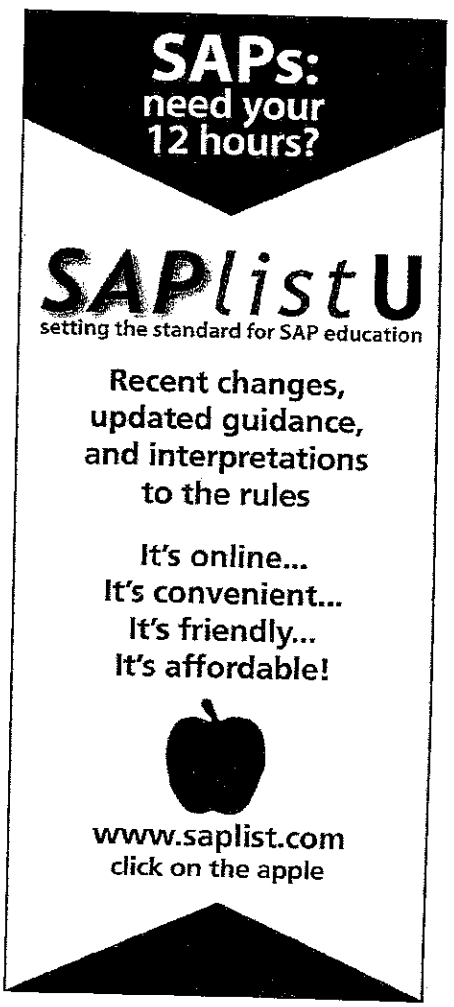
The partnership relied on a variety of sources (Babor and Higgins-Biddle 2001; Babor et al. 2001; McPherson and Goplerud 2008; Miller and Rollnick 2002; WHO 2003) to develop a brief intervention model designed specifically for the EAP call centers. The partnership added two "A" components to the World Health Organization's "FRAMES" model, yielding a "FRAAAMES" approach: feedback, responsibility, advise, assess, assist, menu (options), empathy and strengths.

IDENTIFYING RISKY BEHAVIORS

SBIRT typically starts by providing tailored feedback about clients' AUDIT scores and risk levels. A central component of brief interventions is advising about low- and high-risk drinking limits, though the protocol also emphasized that callers are responsible for their own drinking and decision making. To assess and assist clients in the top two risk categories (see Figure 1), it was essential to understand their views of their drinking behaviors and negotiate change plans with them.

Menu options identified strategies, resources and referrals available to clients. Throughout the process, EAP specialists maintained a warm, reflective, empathetic and understanding approach when delivering the BI and also noted clients' strengths to promote confidence in their behavior change plans.

The primary aims of the pilot were to examine whether alcohol SBI in a telephonic EAP resulted in increased rates of (a) identification of risky alcohol use and



(b) delivery of telephonic alcohol brief interventions. A pre-/post-intervention design was used to test the primary aims. EAP data recorded six months prior to the start of the alcohol SBI pilot ("Pre-SBI Time Period") were compared to data recorded six months after the pilot launch ("Post-SBI Time Period"). The sample was limited to "clinical callers" only.

Alcohol SBI delivered telephonically through an EAP represents an effective strategy for improving quality of care.

Not only was the pilot program associated with higher identification rates of risky alcohol use, it also yielded higher telephonic delivery rates of alcohol education and risk reduction. Callers who reported drinking at a hazardous (or even riskier) level received immediate telephonic brief interventions tailored to their risk level. The post-SBI time period was associated with a 37 percent increase in such telephonic interventions. Thus, alcohol SBI delivered telephonically through an EAP represents an effective strategy for improving quality of care.

While more research is needed to validate and assess the findings, this study has important implications for quality improvement efforts within EAPs. For example, OptumHealth recently approved a modification to its EAP substance abuse policy to include alcohol SBI as a standard of practice for its entire EAP book of business. Such efforts are also reportedly under way at other national and local EAPs. These changes will allow EAPs to more effectively identify and assist those with non-dependent alcohol use prior to the need for more extensive or specialized treatment.

MAKING SBIRT ROUTINE

George Washington University is working with the EAP industry to support SBI programs. Through a cooperative agreement with the National Highway Traffic Safety Administration and support from the Center for Substance Abuse Treatment, GWU is facilitating a learning collaborative, the Brief Intervention Group ("BIG") Initiative, to bring together all of the major EAP leaders and associations and representatives from federal and state agencies (Goplerud et al. 2010). The aim of the BIG Initiative is to make screening, brief intervention, and referral to treatment for alcohol problems routine practice across the EAP industry.

In addition to OptumHealth, other active partners in the BIG Initiative include Aetna, ValueOptions, Chestnut Health System, Federal Occupational Health, the Association of Flight Attendants, First Sun, CIGNA, Magellan, MHN, and Ceridian. Through these and other partners, BIG has the potential to reach more than 100 million covered lives in the United States.

The initiative has assigned committees to focus on specific aspects of delivering SBIRT, including changing EAP call center practices, providing training to and supporting change among EAP network providers, and identifying measurement tools and common metrics to assess program impact on health and business outcomes. Together, these committees aim to advance the adoption of SBIRT protocols wherever possible.

Persons interested in learning more about the BIG Initiative should contact Eric Goplerud at goplerud@gwu.edu. ■

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