EAP ASSOCIATION

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Twin Pearls

EAPA readies to release a pair of monographs on EAP Standards and Managed Behavioral Health Care

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EDITOR'S COMMENT

Twin Pearls

MAY 1, 1990 may be a day that EAP professionals, 10 years from now, proudly look back on. On that day EAPA's Board of Directors, cloistered in Arlington, Virginia's Holiday Inn, approved two documents which indelibly mark the parameters of the EAP practice: EAPA's new *EAP Program Standards*, and a managed care paper entitled "Maximizing Behavioral Health Benefit Value through EAP Integration." The documents followed similar paths in their development and, as depicted on this month's cover, they are like two pearls harvested together.

THE STANDARDS replaces the current set, which has been in use for over a decade. The new standards clearly identify the elements of an EAP and resonates the message, "If you have these elements, you are an EAP. If not, then you are *not* an EAP." Why is this important? An EAP professional recently commented that she received a survey questionnaire in May from a university which sought information on knowledges and skills for EAP work. "It didn't even once ask anything about dealing with work organizations: not with supervisors, not with management, not with organizational development, not on the development of consulting skills. The questions were all clinical in nature," she said.

The university researchers apparently had a lack of understanding about the elements of a comprehensive EAP. The *Standards*, upon publication by the EAP profession's most authoritative membership organization, will help to quell the spread of misinformation. EAPA's job will be to get the *Standards* monograph in the hands of people like the university researchers who prepared the survey.

THE MANAGED CARE MONOGRAPH is the first release of a three-part sequence on the relationship between EAP and managed behavioral health care. One could say that it takes EAP practice standards and applies them to an oftentimes awkward circumstance in which EAP and managed-care functions are entwined. Appropriately, the monograph specifies those aspects of EAP practice which are, in and of themselves, forms of managed care.

In sum, this pair of monographs sets the record straight about what EAPs do well and have been doing well for years. We hope they will be of value to EAP professionals in their work on behalf of business and labor.

Rudy M. Yandrick

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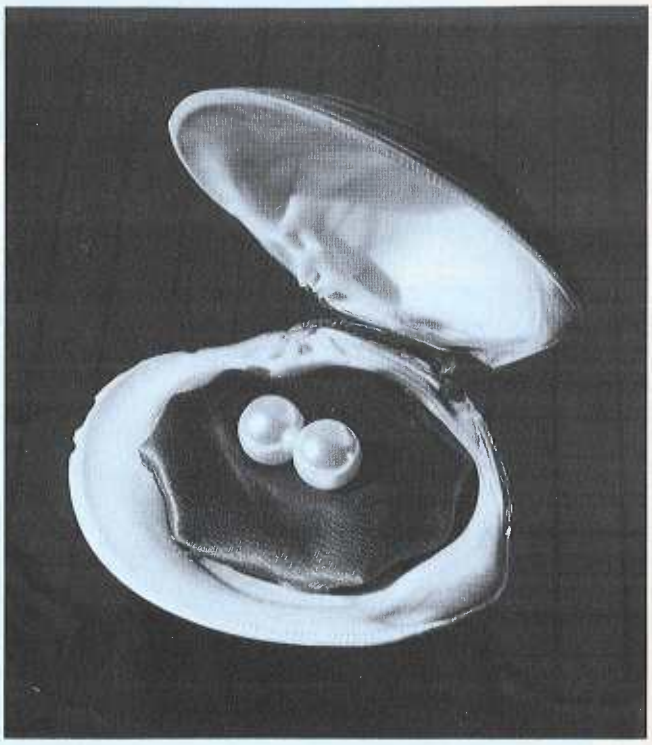

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OF SPECIAL INTEREST

FROM THE EXECUTIVE DIRECTOR

Thomas J. Delaney Jr.

During its 1990 spring meeting on May 1, EAPA's Board of Directors approved the monograph about EAPs and managed care. It is the result of 1½ years of work by a special committee composed of Board members who were appointed by President Tom Pasco. It is headed by Benefits Committee chair Sally Lipscomb. In considering the manuscript, many Board members noted that it is especially important to have clear information for companies on the role of managed health care.

This need was also stressed by a paragraph in a *Boston Globe* editorial on May 7 about proposals for a national health care plan. It stated:

"...the [health care] system is increasingly snarled in red tape that is viciously expensive. The costs of recording, reviewing, processing, auditing and justifying medical charges, along with promoting competitive insurance plans, are among the fastest-rising components of health-care costs..."

As EAPs have had to spend increasing amounts of time helping employees and management to understand these additional levels of red tape, we have also seen that they can easily become a barrier to a healthy work force. That, of course, is not what management had in mind when it committed to employee health insurance.

The *Globe* editorial was about the national debate and what a future national health care plan should look like. This debate is now moving to the forefront in companies, unions, the health care providers, insurance companies, the press and in government. During a discussion at the University of Maryland EAP school, a representative of one of these barriers to care—in this case, an HMO—said that all elements of the health care field were going to have to cut costs, and he specifically mentioned EAPs. I quickly corrected him by pointing out that EAPs are not part of the health care field, but are part of industrial human resource management. As the Board-approved managed care document points out, EAPs are primarily designed to reduce the costs of illness to employers and unions by intervening early with problem employees and returning them to health and productivity.

I am afraid that that speaker is not the only person who thinks that EAPs are part of the health care system. The key element of the EAP has always been the identification of employees with a problem and assisting the worker and his or her colleagues in resolving the problem. But, EAPs are part of that internal world of work and not the external health care system, which employers and unions make available to workers and their families through benefit plans.

Some of this confusion is due to the fact that some EAP providers also provide counseling. It is certainly understandable when employers ask their EAP vendors to provide counseling beyond the EAP specialty. After all, they have a major responsibility of sustaining their business. However, it is important to distinguish between EAP and the provision of health care. As I mentioned at the University of Maryland, the opinions of the California Supreme Court in the *Grace Church* case seem to be helpful in distinguishing between therapeutic and non-therapeutic counseling.

Just as it is a misuse of talent and trained personnel to have health care professionals spending large portions of their time on managed care and other cost-control projects, it is also frustrating for EAP personnel to be spending their time providing health care or fighting with the benefit gatekeepers. EAPA has a Board-level, standing committee called the Benefits Committee (until recently, known as the Insurance Committee) because EAPA recognized that in order for EAPs to be most effective, its clients had to have access to care and that employee insurance plans often lacked coverage for the types of services needed to serve our most prevalent clients—those with problems related to alcohol or drug abuse. The Benefits Committee dealt with these issues systematically. The challenge was to convince the benefits administrators that the old annuity health insurance programs needed to include alcohol and drug treatment coverages. The challenge with managed health care and other new health insurance schemes is also to influence the benefits policy makers.

The techniques for influencing the new health insurance models seem to be similar to those used with the old annuity plans. We have to collect data and know how the benefits plans are impacting the organizational goals. We have to develop good working relationships with our colleagues in benefits. Gene Gaeta of AT&T gave a fascinating talk at the Southern Region Conference about how that process evolved at AT&T. At the chapter level, we have to support each other and confront managed care providers with collective information, just as some chapters have done with the Blues and HMOs. Chapters also have to let community opinion leaders, such as the press, know what is happening. The managed care position paper which the Board approved represents a similar strategy as the publication of papers a dozen years ago about the

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need for annuity plans to cover alcoholism treatment.

Learning from that experience, there has to be continuing efforts. EAPA's Board, for instance, has approved the publication of two future managed care publications. [For details, see the lead feature article, which begins on page 14.]

On the public policy front, there needs to be efforts at the state and national levels. Last fall, I spoke at a legislative breakfast in Roanoke, Virginia and suggested that the legislators might want to go back to Richmond and hold information-gathering hearings on the impact that managed care is having on access to care. I think this would be worthwhile in every state. On the national level, I continue to think that national health insurance is our most important public policy issue. The chair of the Public Policy and Legislative Committee, Barbara Feuer, has made this a priority. Many large corporations are starting to focus their lobbying efforts on the content of a national health insurance plan. EAP practitioners should influence those efforts, and Barbara Feuer and I would like to hear from members who think we can work with their companies' government relations staff on national health insurance.

In the press discussions about national health insurance, we often hear the suggestion that health care costs need to be cut back. Paradoxically, these same outlets talk about all the unmet health needs. Undoubtedly, there can be a better distribution of resources, as the *Boston Globe* suggests when it points out all that goes into red tape. However, as anyone with any budgeting experience knows, the balancing of income with expenses is only one critical debate (excepting the federal government, it seems). Another is about how you go about allocating resources. If the advocates of health care accept an arbitrary limit on the percentage of national resources to go to health care without a debate on the allocation of all public and private resources, then we will be agreeing that health care is not a priority.

EAPs have a unique contribution to this debate because we are in a position to see where investments in certain types of health care can pay a dividend in increased national productivity. □