UNIVERSITY OF MICHIGAN

Worker Health Program and Labor Studies Center, Institute for Research on Labor, Employment and the Economy

# *Longitudinal Lens to Examine Service Delivery Models for the Future*

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# Current Trends of Each Industry

## Introduction

As a supplement to this workshop we thought it was important to give participants insight into the current trends and issues facing all three industries. These are dynamic industries with parallel histories, "cultures," issues and pressures. Purchasers must sort through a myriad of factors in order to make sound decisions. There are many key issues driving purchaser decisions; specifically around these three benefit services in the wellness field the connection between health and productivity is propelling the spread of these programs. Many studies are showing the poor worker health is directly correlated to lower productivity and visa versa. In the work/life field, there is tremendous competition for top talent and studies have shown that companies with effective work/life programs are able to recruit and retain talented employees. In the EAP field, there are also a growing number of studies that substance abuse and mental health conditions such as depression have an adverse impact on workplace and employee productivity. Understanding these trends and issues will help participants consider the pros and cons of program integration.

## EAP Trends/Issues

*Courtesy of Dave Sharar, Chestnut Global Partners*

1. There is a shift to centralized telephone/internet counseling as a replacement (not supplement) to face-to-face. This is primarily being done as way to reduce expenses. The telephonic approach is a low dose model being used and is the most popular method of cost reduction. Some EAP's are promoting the use of internet counseling but it is not clear how it is being used or whether there is any triaging of individuals who may benefit from it. There are many claims as to the effectiveness of these newer approaches but there is no evidence base for it use.

2. Significant overlap between EAP networks and general practice counselors/therapists are occurring in a way which encourages largely duplicate existing mental health benefits. The use of EAP core technology is being diminished and there is an increase in the blurring of the lines between EAP practice and clinical practice. This is resulting in the loss of true assessment and referrals to appropriate services. In some cases mental health clinicians are simply using the "EAP label" as a funding source for their clinical work.

3. Lack of focus and attention on scientific study using rigorous methodologies to demonstrate business value and outcomes. EAP vendors are the most "guilty" of this by consistently taking experience from one group i.e., time saved, and applying the result across the board to all members using the service. There is a huge need to be on the same page with data definitions so that the outcome measures accurately report and guide what is practiced in the field

4. EAPs have become "consumed" or "buried" into larger health plan benefits and "wellness initiatives" to the point where the workplace focus is diluted or absent. As an industry we are not able to articulate the differences between EAP and other types of employee benefit programs that resonate with purchasers. The current major debate in the EA field amongst both practitioners and researchers is whether there is a "benign neglect" of EAPs proper place in the employee benefit portfolio. Some argue that the industry should press forward into the health arena whereas others view that as a loss of focus on the workplace. Others submit that both are appropriate areas of focus.

5. Quality is largely invisible to the employer/purchaser and the field has no agreed upon performance standards/operational definitions. Due to the capitation rate funding environment as well as the "being buried" issue, there is a loss of focus on important performance metrics and a shift toward more marketing metrics such basic penetration rates. Key measurements such as management and supervisory consultations, referral rates by different constituents, and so on are getting lost. But hope is on the way because a new EAPA Research Foundation is in the works to encourage some serious research on the whole issue of metrics in the EAP field.

## Work/Life Trends/Issues

*Courtesy of Mary Ellen Gornick, Workplace Options*

1. Utilization - demand for high utilization is at an all time high. Lots of different ways of looking at utilization - no real definition in place that is agreed upon as an industry - as financial resources are squeezed more pressure is on use it or lose it. Companies want the benefit to be used especially the telephone consultation piece - not looking for just web visits, looking for more substantial examples of how the service is helping. The real push on utilization is coming from companies that have stand along programs with high utilization respectively for EAP and WL and are now moving to integrated programs. With integration there is the expectation that the combining will add to the overall utilization i.e. 1+1 = 3. This is putting more pressure on the EAP to promote and track utilization for "telephone consultations regarding WL."

2. Focus on broadening basic core WL i.e., dependent care (adult and child) and daily living with legal and financial. This includes specific "add ons" like enhanced elder care services such as geriatric care management, coaching or back up care. The broadening is also to focus on wellness resources as well as education (career planning - advancement etc.).

3. Interest in the "crossover" of referrals between EAP and WL - this is a level of integration that requires more cross-functional learning, procedures, etc. Historically, we have found that both W/L and EAPs occasionally refer clients to the other department. When we asked why so few referrals, respondents reported; differences in historical development of programs, needing different skill sets etc. But when we asked in a more qualitative fashion, most respondents said it was a "Turf" problem.

4. The pursuit of "equity benefits" is a global challenge. In our typical American centric view of all things - the thinking is how to duplicate what we do with WL in the US - globally. The challenge globally is: what is the best way to provide services based upon the local nuances, delivery systems, cultures, laws and customs.

5. Along with utilization there continues to be a real emphasis on the value that the end user places on the services - interest in outcomes are at an all time high. Not necessarily using the info to do outcome studies or ROI - at this point it is important to have the data to support the program and resources.

## Wellness Trends/Issues

*Courtesy of Michael Mulvihill, Behavioral Wellness Consultant*

1. There is a shift to a population health focus. In the beginning wellness programs started out as corporate based fitness centers, which for the most part tended to be used by relatively healthy employees. Then programs were developed for "high risk conditions" such as smoking, obesity, high blood pressure, high cholesterol, and stress. During this same time, disease management programs were rapidly expanding to assist in the management of chronic conditions such as heart disease, diabetes, asthma, and COPD. Now programs are being developed for all risk and disease conditions along with programs to keep healthy individuals healthy, thus a population approach.

2. There is a growing concern and focus on increased participation in programs and program engagement. As program offerings expand there is a need to increase the number of participants in order to justify the cost of the programs. Many employers groups are offering incentives including cash and increased benefits to entice employees to participate. There is controversy regarding the use of incentives and potential "discrimination" against individuals with various health conditions. Related to this issue is that there is a need to better understand "the consumer" and provide better "messaging" to reach them and help them understand the value of various programs. There is also a need to expand programs globally in order to include ex-pats and the employees of internationally based companies. Programs need to be culturally appropriate and relevant to different groups of people. The issue of program participation raises a larger issue, that being, are wellness programs sustainable in the future if the program participation issue is not successfully resolved?

3. As programs expand, there is also continued debate over which programs are most effective: high touch or high tech? High touch companies frequently use telephonic health coaching and on a more limited based one of one face to face. High tech companies use sophisticated Internet based "tailoring engines" to "mimic" health coaching. High tech companies claim that they reach larger audiences at lower cost and, in the aggregate, create better outcomes. High touch companies refute these claims indicating that technology cannot replace the human interaction and that high touch interventions create longer term or sustained behavior changes. Some argue that both approaches are appropriate for different audiences based on sophisticated triage methodologies, but there are no good studies on which groups benefit from which type of intervention.

4. There is tremendous consolidation in the wellness/disease prevention industry. Large insurers, health plans, behavioral health companies and well established corporate wellness companies are purchasing smaller niche focused wellness firms. This is having two very different impacts. On the one hand this is helping to disseminate wellness programs to much larger audiences at lower costs. On the other hand, some programs are being "watered down" and diluted thereby losing their quality and effectiveness. This growing tension is creating consternation in the industry and will receive a lot of future "airplay."

5. There is a growing acceptance by purchasers (HR managers, Benefits and Financial Officers) that comprehensive wellness programs that are well designed produce a positive ROI with a number of studies showing returns in the range of $3 for every $1 invested. However, because there are a large variety of programs in the marketplace, purchasers are demanding to know which programs work the best and which ones have the best outcomes. There are no widely accepted standards for how to measure the success of programs and wellness vendors show results in a myriad of different analytical formats. There is not one agreed-upon industry standard for calculating ROI. Differences in calculation methodologies and variables used create an environment in which companies can produce a large range of returns and no one way for organizations to compare programs. Related to this issue are growing concerns over which programs can ***sustain*** lifestyle related behavior changes beyond 6 and 12 months. There is also growing concerns that unless wellness programs become "integrated" with other employee benefit programs, the "whole person" will get lost and the ROI and sustained behavior change will not be achieved.

## A Brief History of EAP, Work-Life and Wellness

### Employee Assistance Programs

Early EAP services initially arose out of a need for a stable and skilled workforce during WWII. The severe shortage of male workers in New York City prompted some corporations to recruit workers from the Bowery district, resulting in the hiring of numerous alcoholics. Corporate medical directors postulated that it might be more cost effective to rehabilitate problem drinkers than to have a revolving door employment policy (Trice, Harrison & Schronbrunn, 1981). This corporate approach led to the emergence of Occupational Alcoholism Programs (OAPs). These workplace-based programs grew in acceptance and number throughout the 1950s and 1960s. The U.S. federal government promoted OAPs through legislation such as the Hughes Act of 1970, which required all federal agencies and military installations to have an OAP and it's amendment in 1972 to include drug abuse. In the early 1970s, the U.S. government established the National

Institute on Alcohol Abuse and Alcoholism (NIAAA) with the mission of promoting the growth and diffusion of EAPs throughout the United States. Also emerging at this time was the Association for Labor—Management Administrator and Consultants on Alcoholism (ALMACA). During the mid 1970s, private EAP consulting firms such as Human Affairs International and Personnel Performance Consultants began to offer an alternative option for the delivery of EAP services from an internal model to an external model.

During the 1980s, EAPs became more popular in North America. At this point in time, the mix of services offered by EAPs expanded to feature more comprehensive elements. The drug-free workplace legislation was passed in 1988 in the U.S. This event spurred further growth of EAPs as they offered expertise and guidance to employers regarding the management of employees with substance abuse problems. In 1985, it was reported that approximately 68% of EAPs were provided through internal programs. By 1988, this number of internal EAPs had decreased to 58% (Blum & Roman, 1988). Data from 1994, estimates the number of internal EAP programs in the U.S. to be less than 20% (French et al., 1997). Unfortunately, there is no more recent empirical data that has addressed the question of the prevalence of different models of EAPs. Another trend that began in the late 1980s was the expansion of EAP services to family members (Burden, 1987; Jankorski, 1988).

In the 1990s, EAPs became a standard component of employee benefits at the majority of large companies. EAPs responded to this growth by broadening their services to address issues such as work-life balance, elder care, workplace violence, and supporting company-wide changes, such as mergers and downsizing. In the early 1990s managed mental health care also made its entrance into the health care arena, with EAP being a source of referral into these counselor networks.

The EAP field has been nurtured over the years by the support of its two major professional organizations, the *Employee Assistance Professionals Association* (EAPA; which evolved from ALMACA) and the *Employee Assistance Society of North America* (EASNA; which has a strong Canadian influence). Today, the number of members in these two associations exceeds 5,000 people and is growing worldwide. For a more detailed history of EAPs refer to Davidson and Herlihy (1999).

## Work-Life Programs

Although there are reports of On-Site Child Care Programs during the Civil War and over 3,000 Child Care Centers during World War II (Friedman, 1990), Work/Family Programs themselves trace their development to the Great Society policies of President Lyndon Johnson. During the 1960s, the U.S. Federal Government sponsored the formation of county-based "child care coordinating councils" (4-Cs). These programs were specifically designed to coordinate childcare resources for preschool children so that Head Start Centers would be in close physical proximity to targeted children. The 4-Cs spawned the formation of childcare resource and referral programs that emerged in the corporate sector during the early 1980s. The creation of these employer sponsored child-care resource and referral services is credited with the beginnings of the Work/Family and later the Work-life industry (Burud, 1984). By 1985, several private companies began administering referral networks for large multi-site employers. This field grew throughout the early 1990s and eventually evolved into offering services focusing on helping today's workers deal with the multiple demands of careers, care of their children, and care of their aging parents.

Today, the Work-life Field continues to evolve in two main areas: First, programmatic focus on supporting workers to balance the demands of both their work and personal life; and second, consultation to corporations on how to provide a family friendly supportive environment aimed at increasing creativity and productivity in the workplace (Gornick, 2002). For a more detailed history of Work/Family refer to Rose (2000).

## Wellness

Wellness programs began in the 1970s as worksite-based offerings that focused on physical fitness centers and related health activities. One of the first fitness-oriented books, Kenneth Cooper's *Aerobics* (1968), had a major influence on this movement. The healthy living focus led to the spread of corporate fitness centers and then to modern, state-of-the-art corporate fitness facilities. Many of these now offer a range of occupational, physical therapy, rehabilitative, and alternative medical services. Another major development occurred when Erfurt, Foote and Heirich (1990) began conducting cardiovascular-oriented blood pressure screenings of employees in the auto industry. They were among the first to promote annual health screenings and to coordinate linkages between wellness programs and EAPs. The U.S. government, through the Department of Health and Human Services, has also played a major role in the spread of wellness and health promotion programs

through it series of "Healthy People" reports. Together, these developments and influences set the stage for today's portfolio of comprehensive health management services, including fitness centers, health screenings, health risk appraisals, educational activities, behavior change programs, and high-risk interventions. The focus of health and wellness programs is expanding toward a total population approach including high-risk individuals, low-risk individuals and the chronically ill. Increasingly, health and wellness programs disease management, demand management (self-care), disability management, EAPs, work-life will become integrated with a variety of health and productivity programs including initiatives, health care coverage and other key employee benefit programs. Health and productivity initiatives are becoming a major corporate strategy to improve employee health and to engage employees at a high level of workplace functioning. For a more detailed history of the Wellness field refer to Mulvihill (2003).

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