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EAP ASSOCIATION

Exchange

The Magazine of the Employee Assistance Professionals Association

EAPs AND MANAGED CARE

organization productivity issues and "employee client" personal concerns affecting job performance and ability to perform on the job. The EAP Core Technology is as follows: (1) consultation with, training of, and assistance to work organization leadership (managers, supervisors, and union stewards) seeking to manage the troubled employee, enhance the work environment, and improve employee job performance; and outreach to and education of employees and their family members about the availability of EAP services; (2) confidential and timely problem identification/assessment services for employee clients with personal concerns that may affect job performance; (3) use of constructive confrontation, motivation, and short-term intervention with employee clients to address problems that affect job performance; (4) referral of employee clients for diagnosis, treatment, and assistance, plus case monitoring and follow-up services; (5) consultation to work organizations in establishing and maintaining effective relations with treatment and other service providers, and in managing provider contracts; (6) consultation to work organizations to encourage availability of, and employee access to, health benefits covering medical and behavioral problems, including but not limited to alcoholism, drug abuse, and mental and emotional disorders; and (7) identification of the effects of EAP services on the work organization and individual job performance.

TRADITIONAL INDIVIDUAL PSYCHOTHERAPY ALONE IS NOT CONSIDERED AN APPROPRIATE PRIMARY TREATMENT MODALITY FOR SUBSTANCE ABUSE TREATMENT. THE TREATMENT PLAN MUST INCLUDE PARTICIPATION IN ORGANIZED SUPPORT GROUPS. FOR CONTINUED STAY IN INPATIENT DETOXIFICATION, PHYSICAL SIGNS AND SYMPTOMS OF ACUTE WITHDRAWAL MUST BE DOCUMENTED THREE TIMES DAILY. THE CARE MANAGER SHOULD DETERMINE IF A PATIENT'S CONDITION PROHIBITS HIM/HER FROM MAKING USE OF THIS SERVICE AND WHETHER TRANSFER TO A MORE APPROPRIATE LOCATION IS WARRANTED. PARTIAL HOSPITALIZATION IS A LEVEL OF CARE TANTAMOUNT TO THE ACUTE LEVEL OF CARE, WITH THE SINGULAR EXCEPTION THAT THE PATIENT DOES NOT REQUIRE 24-HOUR MEDICAL AND NURSING CARE. IT IS INTENDED TO BE PROVIDED UP TO EIGHT HOURS PER DAY, UP TO SEVEN TIMES PER WEEK. THERE MUST BE DOCUMENTATION FOR EACH DAY OF TREATMENT THAT ATTEMPTS TO TRANSITION THE PATIENT TO A LOWER LEVEL OF CARE THAT IT WOULD RESULT IN RE-EMERGENCE OF SYMPTOMS SUFFICIENT TO MEET PARTIAL HOSPITALIZATION PROGRAM ADMISSION CRITERIA. CONSUMER RECORDS ARE THE PROPERTY OF THE HEALTH PLAN AND ARE GOVERNED BY THE PLAN'S POLICIES. THE PLAN MAINTAINS THE RIGHT TO ACCESS THE FULL MEDICAL RECORD (INCLUDING DETAILED PSYCHOTHERAPY NOTES) OF ANY CONSUMER COVERED UNDER ITS BENEFIT PLAN AT ANY TIME.

INSIDE: EMPLOYEE ASSISTANCE RESEARCH SUPPLEMENT

Quality is Its Own Reward... Until November 21st!

Last year, EAPA joined with the EAP Digest to sponsor a new award recognizing excellence in EAP services. The award, the EAP Digest/EAPA Quality Award for EAP Excellence, was presented to Bayer Corporation at the 1999 EAPA Annual Conference in Orlando, Fla.

On Nov. 21, at the 2000 EAPA Annual Conference in New York, the award will be presented a second time to an employer organization that best meets the criteria below. If the employer's EAP is managed by an external vendor, the vendor also will receive formal recognition.

The nominations process for the EAP Digest/EAPA Quality Award for EAP Excellence is under way and will continue until Aug. 31, 2000. To request an application form or for more information, call the EAP Digest at 1-800-453-7733 or call EAPA at (703) 387-1000.

Entries will be judged by members of a joint EAP Digest/EAPA Awards Panel. Applications will be "blinded" to avoid the possibility of a conflict of interest.

All nominees must, at a minimum, adhere to the basic EAPA standards of practice. Nominees will be asked to provide answers to the following questions:

Program Design

- Does the organization have a written EAP policy statement?
- Have organizational and employee needs assessments been completed?
- Is the program served by an advisory function made up of key members of the work force?

Management and Administration

- Does the organization have written procedures to operationalize its policies?
- Are there adequate staffing levels of qualified professionals?
- Is there an ongoing professional staff development effort?
- Are there formal client records?
- Does the organization carry liability insurance for the EAP?
- Do all EAP staff adhere to a professional code of ethics?

Direct Service

Does the EAP provide the following direct services?

- Problem identification/assessment and referral
- Crisis intervention
- Short-term problem resolution
- Monitoring and follow-up
- Training
- Consultation with organization's leadership
- Program promotion and education

Confidentiality and Regulatory Rights

- Does the program have written policies and procedures on all limits of confidentiality?

Drug-Free Workplace

- Does the EAP support and receive referrals from the organization's drug-free initiative?

Strategic Partnerships

- Does the EAP evaluate and utilize behavioral healthcare resources?
- Is the EAP positioned at an effective organizational level?

Evaluation

Does the program evaluate measurable process and outcome objectives?

- The program must show that it has moved beyond the EAPA standards of practice with innovative elements that serve to enhance the quality of the EAP.

Each nomination also must include answers to the following questions:

1. How do you determine where to make program improvements?
2. How do you make continuous improvements, i.e., what is your CQI plan/implementation?
3. What are you doing to creatively and innovatively meet your customers' needs?

Important Dates

August 31: Deadline to submit nominations
October 15: Date on which winner will be notified
November 21: Award presentation at 2000 EAPA Annual Conference

For more information or to request an application form, contact the EAP Digest at 1-800-453-7733 or EAPA Headquarters at (703) 387-1000, ext. 315.

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The Lessons of Managed Care

by **John Maynard, Ph.D., CEAP**

For the past several months, the U.S. Congress has been debating a so-called "patients' bill of rights" that its supporters say would help protect people covered by managed health care programs. President Clinton has pledged to do whatever is necessary to get a bill passed and signed into law before Congress adjourns for the November elections, but the health care industry isn't waiting for Washington—indeed, market- and employer-driven changes in health care may soon render the bill moot.

Already, some employers are abandoning their historic role as health insurance middleman and letting their employees take control of the health insurance reins. By providing employees with a specified amount of money and allowing them to pick and choose the coverage they want, employers think they can better control their health care costs and allow employees to tailor their benefits to their needs.

The reasons for this shift in the relationship between employers, employees, and health insurers are many, including the fear that employers could be held liable if insurers decide improperly to withhold or deny treatment. But perhaps the most significant reason is a growing feeling that the health care market won't be fully accountable to consumers until and unless they hold the purse strings.

What will this mean for EAPs, especially those that function as part of an integrated EAP/managed care system? We all know that EAPs are far more than a health care benefit; they are a proven organizational tool to improve employee retention and productivity and reduce accidents and mistakes. Management training, organizational consultation, supervisory referrals—all are functions of an effective EAP. But what would the EAP look like under a voucher-based system? For more thoughts on this, see the article on page 19.

In the meantime, managed care plans will continue to dominate the U.S. health care market, and EAPs must determine how best to serve employers and employees within managed care environments. One example worth considering—described in more detail in the "News Briefs" department on page 27—is that of an employer that established its own substance abuse provider network under the direction of its EAP. Although the company limits employees to one lifetime substance abuse treatment episode, its program enjoys an exceptional success rate (70 percent to 80 percent), in large part because the EAP closely supervises treatment and maintains high quality standards for network providers.

As these and other articles in this issue demonstrate, managed care continues to offer both opportunities and challenges for EAPs. And though managed care still is limited largely to the United States, the experiences of U.S.-based employee assistance professionals in dealing with managed care vendors and programs offer useful lessons for their peers in other countries and cultures.

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Employee Assistance at Chevron

In the January/February 2000 issue of the *EAPA Exchange*, Ken Collins' comments on his personal career journey ("A Different Workplace and a Different Workforce," p. 42) included references to the employee assistance program at Chevron. I was left with the impression from his comments that the program at Chevron had faltered and that, faced with competition for dwindling resources, had faded into the shadows.

I want to report that, to the contrary, Chevron continues to sponsor a first-class internal EAP that is valued highly by employees, family members, and Chevron's management team. Our staff includes eight internal advisors and several external contractor EAP counselors, all of whom are licensed clinicians of the highest caliber with many years of experience in the EAP field. We serve both domestic and international employees and families, are located around the United States where the largest numbers of our employees live and work, and have recently taken over responsibility for Chevron's work/life services.

Since Ken Collins' departure, we have actually undergone a few more rounds of scrutiny. We have continued to compete for resources and have continued to thrive as a respected and highly valued part of what contributes to Chevron's success as a company. As we begin our 32nd year at Chevron, we are glad to report that one of the oldest EAPs in the United States continues to be one of the finest as well.

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EAPA Staff Opening

The Employee Assistance Professionals Association (EAPA), an international professional association of nearly 7,000 members who administer employee assistance programs (EAPs), is seeking a chief executive officer for its headquarters in Arlington, Va.

The successful candidate will be a strong team leader with demonstrated competence in organizing marketing, human resources, and financial management skills. Excellent interpersonal, communications, and planning skills are a must, as is a proven record of leading staff in maximizing the use of information technology to provide member services. Experience in building membership, initiating successful marketing and promotional plans, and creating and developing education, training, and information programs is highly desirable. Must be willing to take the association to a higher level by implementing a new strategic plan, using measurable goals and results.

Success in raising money and winning grants is highly desirable. Experience with, or knowledge of, employee health policy issues and 501(c)(3) association guidelines is an asset. The Certified Employee Assistance Professional (CEAP) credential is preferred but not required.

The deadline to submit applications is June 30. All replies must include a cover letter, resume, and references. Mail materials to Kenton Pattie, President, Executive Search Services, 8421 Frost Way, Annandale, VA 22003.

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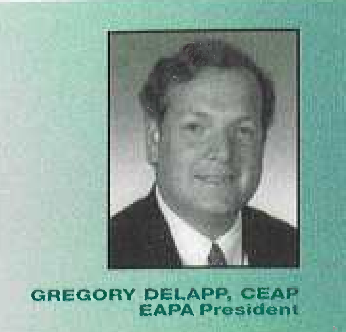
GREGORY DELAPP, CEAP
EAPA President

Ancestors to the Future

by **Gregory P. DeLapp, CEAP**

The short version of this column is that we have a strategic plan to guide us for the next several years, a budget for fiscal year 2001, and an abundance of dedicated, talented, and energetic professionals in EAPA. But on the way to the plan and the budget, I had many, many opportunities to interact with EAPA members and related professionals—enough to fill a long version, too.

As president of EAPA, I receive a constant stream of requests—far more than time and budgets allow me to accept—to attend chapter gatherings, conferences, meetings, and much more (reminder: I still work at Carpenter Technology Corporation!). In the months of April, May, and June, I have traveled more than during any three-month period in my career. So far, the tickets have read Hawaii, Vancouver, Gulf Shores (Ala.), Indianapolis, Washington, D.C., and Milwaukee. Actual airtime: 53 hours.

In between those 53 hours were many discussions with EAPA chapter presidents: Patricia Anderson (Hawaii), Karen Carlberg (Western Canada), and Shirley Culp (Alabama). All three are excellent representatives of what EAPA chapter leadership is all about. I was impressed.

Then there were the presentations and discussions at the Fourth Annual Asia-Pacific Conference on EAPs. The good folks at IPS Employee Assistance, organizer of the conference, asked that I participate and sponsored my attendance in Honolulu. It proved to be the perfect place for a truly international gathering, with nearly 75 people from 14 countries. It was clear that I wasn't in Reading, Pa., anymore!

The attendees demonstrated an impressive level of interest and expertise in employee assistance as they discussed EAP growth around the globe; credentialing; challenges to U.S. models of EA service delivery (for example, intervention as practiced in the United States would cause shame and show disrespect in Shanghai and Hong Kong); the work by and for indigenous peoples (Aborigines in Australia, Maori in New Zealand); the struggle for EA acceptance in the Cayman Islands, Brazil, Hong Kong, and other nations; and other issues. William Rezentes, Ph.D., talked of blending native Hawaiian culture, language, teachings, and imagery with traditional psychology.

And if I had not yet gotten the message about the global links between us, the diversity we talk about in the United States but that is genuinely being lived elsewhere, and the need to help our members make the changes necessary to practice in an evolving global marketplace, there was Ken Hunt. Ken is a Navaho Indian from New Mexico, living and working in Hawaii, who cautioned us that we are " … ancestors to the future."

Which brings me to my trek to Vancouver, British Columbia, Canada. The entire EAPA Board of Directors made the trip, much of which was paid for by the Greater Vancouver Convention & Visitors Bureau to help promote the EAPA Annual Conference in Vancouver in November 2001.

If we are to be ancestors to the future, we need a plan. To develop a plan, the board worked very diligently for many months, solicited the thoughts and suggestions of chapters, committees, and members, and heard from consultants and EAPA staff members. The result of our work is a strategic plan that lays the groundwork for membership development, professional growth, and change. The plan focuses on—

- Helping members worldwide be more effective in their jobs;
- Demonstrating the value and utility of employee assistance;
- Strengthening the voice of EAPA through increased memberships and affiliations; and
- Increasing organizational effectiveness.

The strategic plan supports EAPA's time-honored mission of promoting the highest standards of EA practice and the continuing development of EA professionals and programs. While that mission has not changed over time, the profile of the average EAPA member, the tools and technologies s/he uses, the environments where s/he works, and the range of workplace issues s/he faces have changed dramatically.

To support the strategic plan, several short- and long-term financial issues, staffing questions, and board structure concerns must be faced. The EAPA fiscal 2001 budget was passed in Vancouver, and it is very lean. But thanks to the resolve of EAPA members, we have built up a reserve fund

of $1 million (U.S.), and the board has authorized spending up to $300,000 of it to fund the key staffing and program initiatives called for in the strategic plan. My compliments to the board for their efforts to develop and promote the strategic plan.

The good folks in Alabama were the first to hear the details of the strategic plan, as I attended their statewide gathering just two days after the board meeting in Vancouver. There were questions, as there should be, and responses in kind. What I sensed was a chapter looking for their association to set a course and take the actions needed to get there. The reception was good in Indianapolis, too. Both visits demonstrated that there is a need to communicate the particulars of the plan and the strategic intent behind each segment of the plan. We will do so through every means possible within EAPA.

I have been immensely impressed with the people I have met in my travels during the past few months. There is a significant amount of EA expertise and professionalism in every location I visited. There is also a real sense of urgency to move ahead, further develop the EA profession, and provide the tools members need to do their jobs. We will get there with your support. We're on the way!

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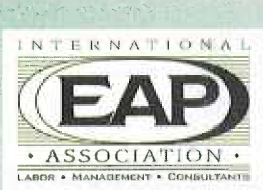

EAPA Mission Statement

To promote the highest standards of practice and the continuing development of employee assistance professionals and programs.

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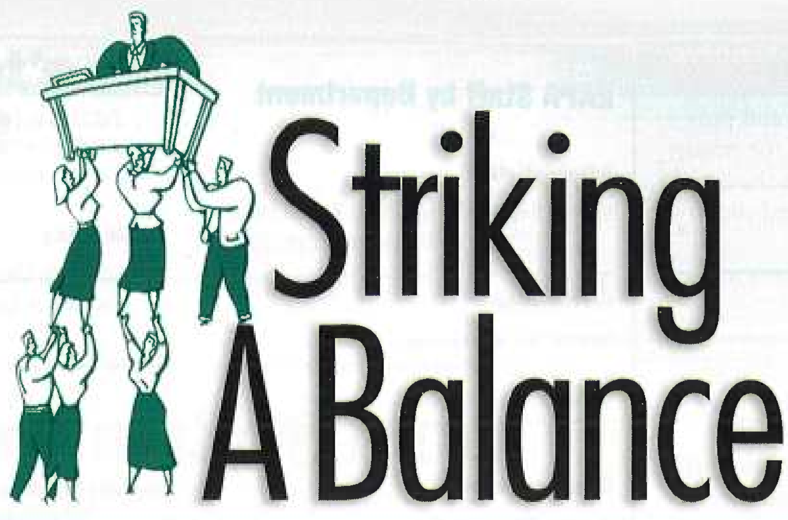

Striking A Balance

EAPA Makes Plans for Its 29th Annual Conference

by Bernard Beidel, CEAP, and Helene King, CEAP

Millions of immigrants who left their homelands and traveled to the United States to begin a new life greeted their arrival in New York with a mixture of excitement and uncertainty. As EAPA prepares to hold its 29th Annual Conference in New York this fall, many of us view the current environment in the employee assistance field in similar terms.

Clearly, our profession has witnessed striking changes over the past few decades: the defining and solidifying of the Core Technology; the rise of labor-management EA partnerships; the emergence of drug testing and other regulatory requirements; the certification and licensure of employee assistance professionals; the creation and enhancement of professional standards; the blending of new and traditional models of employee assistance service delivery; the development of managed behavioral health care and corporate risk management programs; the diversification of the workforce; the development and delivery of EA services on an international and global level; and the enhancement of addiction and mental health treatment approaches—to name just a few.

Equally clear is the fact that the employee assistance profession will continue to change in the years ahead. Consider some of the challenges to our profession that are looming on the horizon: defining the role of technology and electronic communications in employee assistance service delivery; identifying new markets in the global economy; managing the integration of the world's workforces; anticipating the workplace effects of mergers and acquisitions; valuing diversity and harnessing the contributions of a diverse workforce; delivering services to various types of employees (part-time, contract, "permatemps," telecommuters, etc.) in various workplace settings (home offices, satellite offices, and so on); and balancing the demands and stresses of the workplace with the pressures and pleasures of one's personal life.

These and other challenges demand our attention and present a singular, major challenge to our field: How do we meet the demands of the future without compromising the values and foundation of our EAP Core Technology?

As the EAPA Conference Program Planning Committee began looking forward to and planning for the 29th Annual Conference, the theme for the convention seemed to emerge on its own—"Striking a Balance." This theme refers not only to the need to balance the challenges of a changing workplace and workforce with the core functions of EA service delivery, but also to balancing the foundation and practices of our profession with the delivery of EA services to new audiences in new worksites.

Over the years, EAPA has attempted to provide the tools to help us strike this balance, not only as a profession but as individual professionals as well. EAPA's mission, vision, and standards play a critical role in achieving that balance.

In a similar way, we as a Program Planning Committee are faced with the challenge of "striking a balance" for conference attendees. This means we must address a variety of programmatic, demographic, international, and service delivery issues in an informative and attention-grabbing way by providing workshops that—

- Are forward-looking but also remind us of the value of providing core services that meet or exceed the standards of our profession;
- Challenge us to think "outside the box" yet also impart practical skills that translate into immediate use in the workplace;
- Provide information for those who are on the leading edge of the profession as well as for those who are looking for the basics of good EA service delivery;
- Offer innovative approaches to the traditional practice of our profession; and

- Appeal to seasoned conference participants as well as first-time attendees.

It's quite a challenge, but one that has been and continues to be our aim as we move through the conference planning process.

When we sent out the call for papers, we said our goal was to "bring the best to the best." When we met as a committee on April 14 to evaluate and select the abstracts for the conference, we had that goal foremost in our minds.

Our intention in leaving the conference and the call for papers open-ended this year was to refrain from limiting submissions to "theme days" or "content tracks." While EAPA has had success with these approaches in the past, we felt that the challenges confronting our profession warrant a conference that will provide an opportunity to present diverse ideas, issues, innovations, and approaches that meet the multiple demands of the changing workplace, our changing profession, and our conference participants.

We have learned from evaluations returned by past conference attendees that you want presenters who will give you the opportunity to "stretch" your knowledge and enhance your skills while maintaining a commitment to the EAP Core Technology. We are committed to doing the same.

Over the next several issues of the *EAPA Exchange*, we will provide you with regular updates on the planning for the conference. Be on the lookout for the pre-conference brochure as well.

Following are the EA professionals serving as your Conference Program Planning Committee:

- Bob Anderson, Blue Point, N.Y. (EAPA Long Island Chapter)
- Bern Beidel, Washington, D.C.
- Dotty Blum, Clifton, Va.
- Jon Christensen, Racine, Wis.
- Sally Davis, Las Vegas, Nev.
- Jack Hennessy, New York, N.Y. (EAPA New York City Chapter)
- Richard Hopkins, London, United Kingdom
- Helene King, Washington, D.C.
- Ellyn Kravette, Brodheadsville, Pa. (EAPA New York City Chapter)
- Gary Maltbia, Kansas City, Mo. (EAPA Diversity Committee liaison)
- Doug McKibbon, Edmonton, Alberta, Canada
- Joe Murray, New York, N.Y. (EAPA New York City Chapter)
- Jim Nestor, Trenton, N.J.
- Linda Sturdivant, Pittsburgh, Pa. (EAPA president-elect)

We hope you are as excited about attending the EAPA 2000 Annual Conference as we are about planning it. See you in New York!

Bern Beidel and Helene King are co-chairs of the Conference Program Planning Committee for EAPA's 29th Annual Conference, to be held Nov. 18-21 in New York.

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The Legacy of the Exxon Valdez

Will Recovering Employees Be Excluded?

by Tamara Cagney, CEA

More than 11 years have passed since the supertanker *Exxon Valdez* ran aground on Bligh Reef off the coast of Alaska, spilling 10.8 million gallons of crude oil—roughly the amount needed to fill 125 Olympic-sized swimming pools—into Prince William Sound. Much of the evidence of the spill has been cleaned up or washed away by waves, but the impact of the disaster still is being felt in the workplace, as illustrated by an unsettling court decision issued earlier this year.

On Feb. 11, a federal appeals court ruled that Exxon's policy of excluding all employees with a record of past substance abuse from certain safety-sensitive positions does not violate Title I of the Americans With Disabilities Act. The court's decision stems from a lawsuit filed against Exxon in 1995 by the U.S. Equal Employment Opportunity Commission (EEOC). The EEOC filed the lawsuit after Exxon demoted two employees from the position of aircraft flight engineer, a "designated" safety position, to mechanic, a "nondesignated" position. One of the employees had undergone treatment for drug abuse prior to being hired by Exxon; the other had attended an outpatient treatment program for alcoholism, also before being hired.

Exxon had adopted the policy in the aftermath of the *Exxon Valdez* grounding, which the National Transportation Safety Board attributed partly to the failure of the ship's captain to provide a proper navigation watch, possibly due to impairment from alcohol (tests conducted on the captain nine hours after the ship ran aground showed a blood alcohol count of 0.061 and a urine reading of 0.09, both in excess of the maximum 0.04 percentage allowable under Coast Guard regulations). Exxon justifies the policy—which applies to roughly 10 percent of its positions—as a means of promoting safety in jobs in which it is unable to oversee employees to ensure they are not relapsing into substance abuse. The company also maintains that the policy furthers environmental protection, helps prevent future tort liability, and demonstrates good corporate citizenship.

When the EEOC filed suit against Exxon in 1995, the agency moved for partial summary judgment, arguing that the ADA does not permit an employer to impose a safety qualification standard unless the employer can prove that the individual employee poses a "direct threat" to the health or safety of other individuals in the workplace. Exxon disagreed, arguing that the ADA does not explicitly require the direct threat test to be applied in every instance in which a safety-based qualification standard is at issue. Exxon also contended that under the ADA, a qualification standard that tends to screen out or deny jobs or benefits to individuals with disabilities can be defended if it can be shown to be "job-related and consistent with business necessity."

The U.S. District Court for the Northern District of Texas granted the EEOC's motion, but on Feb. 11 the U.S. Court of Appeals for the Fifth Circuit reversed the ruling. The appeals court held that the ADA does not state, nor does the act's legislative history or case law suggest, that the direct threat provision applies to safety-based qualification standards in cases where an employer develops a standard that is applicable to all employees of a given class.

"Direct threat focuses on the individual employee, examining the specific risk posed by the individual's disability," the court stated. "We find that applying direct threat only in cases in which the employer imposes a special safety standard in an individual case offers a more coherent meaning of the statute and of the role of safety under it."

The appeals court also held that Exxon could defend its policy on the grounds that it is job-related and consistent with business necessity.

"Business necessity addresses whether the qualification standard can be justified as an across-the-board requirement," the court stated. "In evaluating whether the risks addressed by a safety-based qualification standard constitute a business necessity, the court should take into account the magnitude of possible harm as well as the probability of occurrence. The acceptable probability of an incident will vary with the potential hazard posed by the particular position: a probability that might be tolerable in an ordinary job might be intolerable for a position involving atomic reactors, for example. In Exxon's case, the court should thus consider the magnitude of a failure in assessing whether the rate of recidivism among recovering substance abuse users constitutes a safety risk sufficient for business necessity."

The court's findings have far-reaching implications for the employee assistance field. In particular, the decision raises the following questions:

Following are provisions of the Americans With Disabilities Act (ADA) relevant to *Equal Employment Opportunity Commission v. Exxon Corporation:*

Discrimination (Section 102)

(a) General rule. No covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment.

(b) Construction. As used in subsection (a) of this section, the term "discriminate" includes—

(6) using qualification standards, employment tests or other selection criteria that screen out or tend to screen out an individual with a disability or a class of individuals with disabilities unless the standard, test or other selection criteria, as used by the covered entity, is shown to be job-related for the position in question and is consistent with business necessity;

Defenses (Section 103)

(a) In general. It may be a defense to a charge of discrimination under this chapter that an alleged application of qualification standards, tests, or selection criteria that screen out or tend to screen out or otherwise deny a job or benefit to an individual with a disability has been shown to be job-related and consistent with business necessity, and such performance cannot be accomplished by reasonable accommodation, as required under this subchapter.

(b) Qualification standards. The term "qualification standards" may include a requirement that an individual shall not pose a direct threat to the health or safety of other individuals in the workplace.

- Will all recovering substance abusers be banned from safety-sensitive positions?
- How do we assess the risk of recidivism, and can it be shown empirically?
- Is the risk of relapse affected by the length of recovery?
- What is the obligation when the EAP and the Medical Department or Benefits Department know that a safety-sensitive employee has entered treatment on his or her own?
- How will this type of exclusion affect our efforts to encourage employees to self-identify and seek assistance?
- What protection can we offer employees who seek help through their EAP?

This case is far from reaching its conclusion, and it is important for EA professionals to continue to follow its twists and turns. The next chapter may be "recidivism on trial."

Tamara Cagney has managed both internal and external EAPs during her 25 years in the employee assistance field. She chairs EAPA's Professional Education Committee and served on the EAPA Board of Directors for 12 years.

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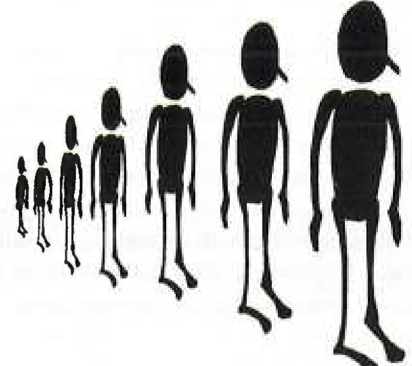

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Welfare to **Work:** A 'Modified EAP' Approach

by James Baker

In January 1996, the state of Connecticut imposed a 21-month limit on cash payments to most families receiving welfare benefits (in some instances, clients can receive six-month extensions). Adults in families that are subject to the 21-month limit are referred for participation in the Employment Success Program (ESP), a statewide welfare-to-work program managed by the Connecticut Council of Family Service Agencies (CCFSA).[1]

ESP is designed to help welfare recipients achieve self-sufficiency through an intensive, solution-focused process of case management and care coordination that identifies and eliminates barriers to sustained employment. Self-sufficiency, in practice, often means finding and keeping a job that pays wages above the payment standard,[2] but for some families it may mean taking intermediate steps to employment, such as attaining a general equivalency degree (GED), attending English as a second language (ESL) classes,[3] obtaining treatment for medical/psychiatric problems, securing child care, and arranging transportation.

Referrals to ESP come from the Department of Social Services and the Department of Labor and typically are people whom both agencies might consider their hardest to serve. Families who are referred to ESP either (1) cannot be located, (2) have not responded to multiple inquiries, (3) use public services but show some cause for concern (e.g., they appear confused or disoriented or are unable to stay awake in classes), or (4) reveal issues of significant dysfunction, such as untreated mental illness.

To best meet the needs of these families, we at CCFSA decided to model ESP after employee assistance programs because we see our role in assisting welfare-to-work clients as paralleling the role of EAPs in providing assessment, referral, case monitoring, follow-up, and other services to employees. We even refer to ESP as "a modified EAP for welfare-to-work families" because it is based on some of the core components of EAPs.[4]

Our familiarity with EAPs stems from the fact that several CCFSA agencies have been providing employee assistance services for years to help their clients balance work and family commitments. Our longtime attention to work/family issues naturally influenced the design of ESP as we planned how we could best help families make the transition from welfare to the workforce.[5]

ESP Operations

ESP is a family support and case management system with centralized administration and regional and local service delivery. ESP staff are hired by the 20 member agencies of CCFSA, which are located in every major city in the state. Management and oversight are provided through CCFSA's central office and United Way of Connecticut/Infoline, a partner in the project, to ensure standardized protocols, comprehensive data collection and analysis, quality assurance, staff support and development, and contractual reporting and accountability to the Connecticut Department of Social Services and the Connecticut Department of Labor, which fund the program.

ESP's 60 case managers, located at family service agencies in the CCFSA network, usually serve clients in their homes. Case managers employ various strategies to locate referred clients, including working during non-traditional hours—early mornings, late evenings, and on Saturdays. These tactics are necessary because some clients move frequently and live under different family names so as to survive economic challenges.

Once a case manager locates and engages a family (usually on a home-visit basis), he or she conducts an assessment. The primary assessment tool is the Situational Assessment Scale (SAS), which provides a comprehensive evaluation of the barriers to self-sufficiency. The SAS is a detailed, 57-question assessment developed by ESP that evaluates a wide range of barriers to employment, from housing to child care to substance abuse.

In the process of engaging a client and/or as a consequence of certain scores on the SAS, the case manager may call in a child and family consultant (CFC) to conduct a more thorough assessment of ongoing family issues. The assessment process generally is comparable to a one- to eight-session EAP model and often concludes with the development of a service plan that includes referrals with which the client concurs.

ESP and EAPs

The services that ESP provides to welfare recipients greatly resemble the services EAPs provide to employees. Following are comparisons of the core components of EAPs and those of ESP:

Consultation, training, and assistance. EAPs offer consultation, training, and assistance to employers to help them manage troubled workers, enhance the work environment, and improve employees' job performance. They also conduct outreach and education activities to inform employees and their family members about the availability and types of employee assistance services.

ESP provides consultation, training, and assistance to the Department of Social Services and the Department of Labor, with all efforts geared toward helping clients become or remain employed. In some instances, ESP directly addresses how the employee may improve his or her job performance; in every instance, we address barriers that interfere with becoming or remaining employed. Our outreach efforts are designed to locate clients and make them aware of how ESP can help them improve their lives.

Constructive confrontation, motivation, and short-term intervention. EAPs use constructive confrontation, motivation, and short-term intervention with employee clients to address problems that affect job performance. ESP uses various strategies, including constructive confrontation and short-term intervention, to address job performance and/or work-related issues. Our assessments incorporate the motivational interviewing model,[6] which matches interventions to the level of motivational readiness.

Referral, case monitoring, and follow-up services. EAPs refer employee clients for diagnosis, treatment, and assistance and provide case monitoring and follow-up services. ESP referrals generally fit into one of two categories: (1) treatment referrals, such as medical referrals, alcohol and drug treatment referrals, and psychotherapeutic referrals; and (2) resource referrals, which include referrals for affordable/emergency housing, education (GED or ESL classes), and skills training. We work with the referral sources and follow up with clients to increase the probability of success. In addition, we encourage family support for referrals so that behavioral change can be maintained within the family context.

Organizational consultation, provider relations, and contract management. EAPs offer consultation to employers in establishing and maintaining effective relations with treatment and other service providers and in managing provider contracts. At ESP, senior leaders of CCFSA manage our contracts with both the Department of Social Services and the Department of Labor.

One of the major strengths of ESP is that we are a statewide network of 29[7] family service agencies (Catholic, Jewish, and non-sectarian agencies) with a presence in every major city in Connecticut. This network allows us to provide a wide range of services to a diverse client base, including Latinos, Eastern Europeans, and the deaf. It also links us to local referral sources when we do not directly provide the appropriate service to meet a specific client's needs (e.g., methadone maintenance).

Consultation to work organizations related to employee health benefits. EAPs provide consultation to employers to encourage the availability of, and access to, employee health benefits covering both medical and behavioral problems, including alcoholism, drug abuse, and mental and emotional disorders. ESP provides consultation, education, and training to regional workforce boards, the departments of Labor and Social Services, our own network of family service agencies, and any other organizations or groups that could affect the employment of our clients.

Identification and evaluation of program effectiveness. EAPs identify and evaluate the effects of their services on the entire work organization and on the job performance of individual employees. ESP continually collects data on its clients and communicates the information through various channels. This process serves multiple purposes, from alerting us to specific needs of the population we serve—which, in turn, prompts us to focus more attention and resources on certain areas—to informing legislative bodies of welfare-to-work issues, which has the potential consequence of shaping public policy. It also serves to identify administrative functions that could be modified to improve our ability to serve our clients.

Adding Value

In addition to incorporating many of the core components of EAPs into its repertoire, ESP practices case discovery by identifying barriers to self-sufficiency. These barriers include, but are not limited to, mental health problems, alcohol and drug use, domestic violence, and child welfare issues. As long as these barriers exist and a family remains on welfare, we may return to assist the family on an as-needed basis. This ongoing involvement enables us to revise our assessments and service plans as needed and encourage clients to follow through on services to which they have been referred.

For example, one client who was referred to ESP was a Hispanic head of household who had agreed to an outpatient counselor's recommendation that his son be seen by a school psychologist. He had no idea why the recommendation had been made, nor how to go about making such an appointment. The counselor assumed that the appointment had been scheduled and even heard a verifying "yes" when making a follow-up phone call. Unfortunately, the son had not received the help he needed.

ESP implemented the EAP technique of "working the assessment" by closing the loop between the family and the referral source so that the reason for the referral was understood, the family supported it, and the referral was not only made but monitored for success. Such early identification of the issues facing a client/family and coordination of the community service providers involved can both improve the odds that a client will become self-sufficient and increase the cost savings for all involved.

James Baker is coordinator of clinical services at ESP/CCFSA. *The author wishes to thank Bob Gagnon, Carol Huckaby, Judith Jordan, Art Krzyzanowski, Eunjung Lee, Heidi Levitz-Landino, Stephen Ristau, and Adina Rivera for their assistance in preparing this article.*

[1] Inquiries about CCFSA should be directed to Judith Jordan, vice president, Connecticut Council of Family Service Agencies, 1310 Silas Deane Highway, Suite 219, Wethersfield, CT 06109.

[2] The standard varies according to the number of dependent children.

[3] Almost one-fifth of clients earning less than the payment spoke a primary language other than English.

[4] See Cagney, Tamara, "Defining the EA Profession," *EAPA Exchange*, March/April 1998, p. 10.

[5] The most significant difference between our modified EAP model and traditional EAP models is that our service follows the client and thus tracks his or her history with multiple employers. Thus, ESP might better be described as a worker-based program than a worksite-based program. In essence, ESP offers clients a portable EAP.

[6] See Miller, William R. and Stephen Rollnick, "Motivational Interviewing: Preparing People to Change Addictive Behavior," New York, Guilford Press, 1991, p. 18.

[7] Twenty of the 29 CCFSA family service agencies participate directly in ESP.

The Integration of EAPs And Managed Care

"Access and quality problems [in mental health care] and the failure to treat those most in need predate managed care."

Mental Health: A Report of the Surgeon General
U.S. Department of Health and Human Services, 1999

In their pursuit of lower health care costs and greater workplace productivity, U.S. employers have made extensive use of employee assistance programs and managed health care plans. More than 80 percent of Fortune 500 firms have EAPs, which help workers address personal concerns that may affect their job performance. Managed care plans, which feature preferred networks of treatment providers, utilization review and financial accountability processes, and referral mechanisms (also called "gatekeepers") to connect employees with proper health care services, represent at least one-half and as many as 70 percent of working Americans.

On paper, EAPs and managed care plans share a similar goal—to help employers make efficient use of their health care dollars by identifying problems early, referring employees to appropriate treatment, and returning them to work as quickly as possible. But in practice, employee assistance professionals often find that their views about necessary levels of treatment and appropriate treatment settings are at odds with those of managed care organizations.

Partly because managed care has helped hold down employers' health care costs—the average rise in employers' premiums was only about 1 percent in 1996, and costs actually dropped in 1997—EAPs have been unable to exercise much influence over the design and administration of employee health benefits. But changes in the health care field and the workplace may gradually alter the relationship between EAPs and managed care organizations. For example, employers' health insurance premiums are rising and probably will continue to do so in the next several years. The demand for workers, especially skilled workers, is expected to remain strong and even increase. And large numbers of so-called baby boomers will begin retiring in the next few years.

These and other developments may well prompt employers to take a fresh look at employee assistance programs and consider new ways to make use of their services. Until then, there are steps that EAPs can take to improve the quality and accessibility of health care in a managed environment. The following articles offer a look at how EAPs can make the most of the current health care situation while preparing for new opportunities that may arise in the near future.

EAPs Can Improve the Quality and Accessibility Of Managed Care

by Mary Graham

In May 1999, the National Mental Health Association (NMHA) released the first in a series of reports on best and worst practices in private sector managed mental health care. The first report addresses level-of-care criteria—the policy documents whereby managed care vendors make decisions about whether to approve or deny authorization of, and payment for, services. The second report, published two months later, focuses on confidentiality issues, while the most recent report, issued in February 2000, analyzes written benefit materials distributed by managed care organizations (MCOs) to consumers. A fourth and final report, due later this year, will address pharmaceutical benefits management organizations and how they restrict access to medications.

These reports are designed to encourage reform by appealing to the competitive nature of MCOs. NMHA has been working on managed care reform for years, both in the public and private sectors, by encouraging passage of legislation, urging adoption of regulations, and meeting with key decision makers and leaders. We've been working on just about every possible issue you can imagine: What's included in benefits? How does utilization review occur? How are managed care decisions appealed? Who gets included in the provider network? What are the rights of consumers? Do consumers have their choice of providers? What kinds of forms have to be completed? Another issue we've been addressing is parity for mental health benefits—that's one of our highest policy priorities.

Over time it occurred to us that one of the arguments we were always hearing from the managed care industry was that the reforms we were urging weren't feasible for the amount of dollars they were being paid. So we decided that if we could show MCOs some of the things their competitors were doing, we would have more success getting our reforms adopted.

So far, the response from the managed care industry to these reports has been very positive. After the first report was released, several MCOs actually asked us to provide consultation when they revise their documents. That's a real positive, because level-of-care policies and documents have a tremendous impact on millions of people in this country.

One of the indirect conclusions to be drawn from these reports is that managed care cannot be viewed as a single entity. Managed care is really just a set of tools that, if used well and professionally and responsibly, can maximize the efficient use of mental health dollars. But sometimes the dollars are so few that access to care becomes overly restricted, rights get compromised, and providers get shortchanged. So managed care is all over the spectrum—there is good managed care, and there is bad managed care.

To be fair, managed care has resulted in a few very positive outcomes. One is an expansion of the settings in which people receive treatment. There used to be just an inpatient benefit and an outpatient benefit. Managed care got people out of the hospital and into less restrictive settings—maybe a little too aggressively, but at least it gave people the opportunity to receive more treatment in their community.

Positives and Negatives

I had hoped that another positive result of managed care would be database management, because that's an area where managed care has the capacity to contribute a lot of good information about the efficacy of different treatments and other issues. But this hasn't come to fruition as much as I had anticipated, although there has been a little bit of progress. In the public sector in particular, managed care has failed in terms of managing data: There have been a lot of problems with claims not getting paid, and it isn't possible to get good encounter data out of many states.

One of the negative outcomes of managed care is that it has become overly restrictive—the administrative hoops have become abominably obstructive to accessing care. I think many MCOs, though certainly not all, have accepted contracts for too low a fee. They've gotten into bidding wars, and they've agreed to accept a workload that isn't feasible for the amount of money they're being paid. As a result, people are being denied access to services. Another negative is that the managed care industry hasn't always preserved the rights of consumers, although there are exceptions to this as well.

These problems are especially acute in the area of mental health care. Much of the trouble stems from the misperception that mental health care is not particularly scientific or evidence-based, when in fact the efficacy rates for many treatment interventions for mental illnesses are higher than for a lot of physical problems. There are a lot of good data and diagnostic criteria in mental health, and some promising

Following are highlights from the first three NMHA reports on best and worst practices in private sector managed mental health care. Copies of the reports, which address level-of-care criteria, confidentiality, and benefit materials (a fourth report, on pharmaceutical benefits management organizations and how they restrict access to medications, will be released later this year), can be ordered from NMHA by calling (703) 684-7722.

Level-of-Care Criteria

Best Practices

- Base criteria on the American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual* IV and practice guidelines developed by the APA and the American Academy of Child and Adolescent Psychiatry
- Include extensive involvement from consumers, families, and advocacy organizations in the development process
- Ensure that criteria cover the full range of treatment settings, including EAPs
- Include detailed criteria for substance abuse versus mental health, as well as protocols for persons with co-occurring disorders
- Embrace the concept of treatment in the least restrictive environment appropriate to meeting the consumer's needs
- Support individualized treatment planning, including attention to psychosocial, occupational, and cultural factors
- Use realistic definitions of "treatment settings" that are comparable to the programs in the marketplace
- Encourage development of a written agreement with the consumer when compliance is a challenge
- Include a withdrawal scale for inpatient detoxification
- Demonstrate an understanding that relapse during the beginning stages of treatment is common and is not indicative of treatment failure
- Have an appropriate level of provider autonomy, without care managers excessively directing care
- Offer a recommendation of an alternative treatment plan when the proposed one is denied authorization

Confidentiality

Worst Practices

- Require access to the full medical record and psychotherapy session notes, not just the diagnosis, objectives, and treatment plan
- Fail to provide up-front information about confidentiality protocols to consumers when they join a new health plan or request such information later
- Fail to provide release forms that include a statement indicating that consent may be withdrawn at any time, as well as the date or condition upon which consent will expire if it is not withdrawn
- Fail to maintain and monitor explicit written policies for paper files, including storage, internal documents, off-site storage, and disposal of records (e.g., marking them "confidential," avoiding use of consumer identifiers, locking files with limited access, noting releases, etc.)
- Fail to implement special protections for electronic, audio, and video files containing sensitive medical information
- Fail to comply with strict policies concerning the transfer of information between providers and MCOs through mail, phone, e-mail, and facsimile
- Fail to require MCO staff privacy training or to implement appropriate disciplinary responses to breaches, including termination and legal repercussions
- Fail to require providers and their staff to undergo privacy training
- Fail to ensure that minors 12 years of age or older are responsible for consent and that parents and other legal guardians are appointed to make decisions concerning the release of information for consumers who are under 12 years old or are legally incompetent
- Fail to ensure that family members of adult consumers cannot access information without the consumer's consent

Benefit Materials

Best Practices

- Supply the MCO's definition of "medical necessity"
- Provide a list of treatment settings and provider types that are covered and not covered
- Provide information on preventive care
- Embrace consumer participation in treatment decisions
- Describe confidentiality policies
- Provide a comprehensive explanation of appeal and grievance procedures
- Provide toll-free and TDD numbers with 24-hour access to live customer service representatives
- Use readability tests to evaluate materials

advances have been made in technology and treatment. But oftentimes there's still a stigma associated with mental health—especially among employers, who often are the payers for mental health benefits—that it's a "soft" science, when in fact it isn't.

The irony is that some companies are growing more reluctant to pay for mental health benefits at a time when work/life and work/family programs and even so-called concierge services are becoming more popular as a means of keeping employees productive and working at their jobs. A lot of employers still see substance abuse as bad behavior or a character issue, with the result that substance abuse benefits in the private sector are ridiculously low. And an employee with co-occurring mental illnesses and substance abuse problems is really caught in a bind, because most businesses don't pay for integrated care—you have to get the substance abuse under control first, but the employer doesn't offer benefits for substance abuse care, so you don't get sufficient treatment for the substance abuse or the mental health problem.

An employee assistance program usually doesn't have much control over the level of substance abuse or mental health benefits. The employer tells the MCO, "Here's the benefit, now tell me what I have to pay you to administer it." But there are a lot of things that EAPs can do to improve the quality and accessibility of the care that is provided. For example, in terms of benefit materials, EAPs can and often do play a lead role in designing the materials that tell employees how to access care. In terms of contracting with managed care companies, NMHA offers consultation on developing requests for proposals (RFPs) and evaluating contracts, and EAPs can take advantage of our expertise. In fact, NMHA conducts advocacy training programs to build health care reform coalitions in the states—we've done almost a hundred of them—and we're interested in getting EAPA chapters involved in these programs.

Results of Reform

Where will our efforts to reform the managed care industry lead? My guess is that over the next few years, much of the responsibility for care will be transferred to the providers. It's already happening in the public sector, where health care providers are organizing to set up their own managed care entities. I think we'll also see less intensive management and more capitation—the managed care entity will pay the health care provider a certain amount of money per covered person, and the provider will manage the care. And I think the for-profit MCOs will perform less and less public sector work. A lot of them are losing money in this area.

The Internet certainly will continue to play a major role in health care, but it's unclear what result that will have. The Internet is like managed care in that it can be used well or used poorly. The biggest concern with the Internet is confidentiality, especially for those with mental health needs. It's certainly an advantage to be able to get on your computer and perform a mental health screening and access a lot of good information, but even if there are laws and regulations to protect confidentiality, you can't always guarantee your privacy.

For example, I've received calls from mental health consumers who have not been able to qualify for life insurance because the life insurance company found out they were being treated for depression, even though it was being managed by a different vendor. Obviously, there are data floating around that shouldn't be accessible; for example, employers shouldn't know who's in treatment. With most illnesses, the MCO needs to know the diagnosis and the treatment plan and goals, but they don't need psychotherapy session notes that reveal personal details of your life. So there's still a lot of work that needs to be done in this area to establish new protections and enforce the ones that already exist, and I encourage employee assistance professionals to work with NMHA to help MCOs improve their operations and procedures in this area.

Mary Graham is vice president of healthcare reform for the National Mental Health Association, where she directs training and other policy activities related to private and public sector managed care. Prior to joining NMHA, she served as director of economic affairs for the American Psychiatric Association, director of clinical affairs for the American Academy of Child and Adolescent Psychiatry, and manager of proposal development for Value Behavioral Health.

Developing an Integrated EAP/Behavioral Health Carveout in a Large Academic Health Center

A Preliminary Evaluation

by Markus Dietrich, M.H.S., CRC, CAAP

Shands Healthcare is a large, nonprofit health care system associated with the University of Florida in Gainesville, Fla. A 564-bed teaching hospital anchors the system, which in the last five years has added four community hospitals—some of them in rural areas—as well as a rehabilitation hospital and a psychiatric/substance abuse facility. A network of clinics and a home health care service complete the delivery network and position Shands as a major health care player in Northern Florida.

In 1999, Shands Healthcare implemented a mental health "carveout," integrating employee assistance and behavioral health services for its employees and their dependents. The total number of employees is close to 5,000, and more than 10,000 enrollees are covered under the plan.

The teaching hospital never had an EAP, although some employee assistance functions were provided informally through the Occupational Health Department. Some of the acquired facilities did have EAPs through external providers, but all existing agreements were terminated after the acquisitions occurred to allow for a unified, system-wide plan.

The first step toward this goal was taken in 1997, when Shands Human Resources approached the Shands Behavioral Health Network (SBHN) to propose an EAP. The SBHN consists of the Department of Clinical and Health Psychology and the Department of Psychiatry at the University of Florida as well as Shands at Vista, a full-service psychiatric and substance abuse facility. The proposed goals for the EAP were as follows:

- Easy access to counseling and referral services for employees and their dependents
- An improved system of referral to occupational health resources
- Significant cost reductions in behavioral health benefit expenses for the self-insured plan

Shands Human Resources hoped to save $300,000 in behavioral health expenses in the first year, but it quickly became apparent that this goal could not be realized through the addition of an EAP alone. SBHN therefore proposed to carve out behavioral health services from the medical benefit and create an integrated EAP/mental health plan. The program would be a capitated managed care plan, and SBHN would administer the program as needed to achieve the desired cost savings. The proposal was accepted, and the EAP was launched on January 1, 1999. The behavioral health carveout was rolled out three months later, on April 1, 1999.

Developing the Carveout

The following assumptions were made in developing the integrated EAP/behavioral health carveout:

- EAP services will be provided only by licensed/faculty providers (no students/trainees) within the Shands system.
- Employees' transitions from the EAP to behavioral health services, if required, will be seamless.
- The transition from a point-of-service plan to a managed carveout will be gradual for employees and providers.
- The quality of service will be high.
- The health plan will realize the targeted savings in the first year.
- For behavioral health services under the insurance plan, Shands Healthcare behavioral health personnel and University of Florida faculty will serve as the carveout's core providers, supplemented by community providers.
- Out-of-network care will be available if the need arises.
- Triage of employees and referral to appropriate services will be performed from a central location.
- Operations will be based on a capitated managed care model.

The plan has a generous behavioral health benefit by today's standards: The outpatient benefit covers a maximum of 26 visits annually with a copay of $20 per visit, and inpatient treatment is covered for up to 30 days annually for psychiatric and substance abuse treatment, with a copay of $200 for substance abuse admissions and a lifetime limit of two inpatient substance abuse admissions. This was the existing benefit, and the desire was not to reduce it but rather to reduce costs by managing it. A new benefit of up to four free visits with an EAP-referred counselor/therapist was added to the package.

Care Delivery

The new EAP is an internal program staffed by a core team of providers in the SBHN. When putting this team together, care was taken to include providers with experience in meeting a wide range of needs, including substance abuse, child and adolescent treatment, and marital counseling.

Free EAP visits are available only through team providers. The behavioral health carveout uses the team as a preferred provider group. For behavioral health services, the team is complemented by two psychiatrists at 0.5 FTE (full-time equivalent) for access to medication evaluation and management.

At the request of the customer, Shands Human Resources, access to an existing network of University of Florida clinics and community providers is still available. Employees and dependents have their choice of providers within this network, but management plays a gatekeeper function through pre-authorization and continued utilization management.

The program has offices in three locations to maximize convenience and confidentiality. A dedicated telephone number is answered at Shands at Vista, and the call center is staffed 24 hours per day. Call center staff can schedule care team members directly through IDX, a network computer system used throughout Shands Healthcare (access to this scheduling location is protected).

SBHN created an entity called FloridaPsychCare, which has contracted with Shands Human Resources for a two-year period. Reimbursement is based on historic utilization rates and takes into consideration the desired cost reduction. The agreement stipulates that all EAP and behavioral health services for the covered population will be provided at a capitated amount based on a per-employee, per-month (PEPM) rate.

FloridaPsychCare contracts with SBHN provider departments for provider time by assuming the FTE of the provider's salary and benefits. These providers (care team) are the equivalent of a staff model HMO and do not generate claims. Facilities and community networks are reimbursed according to a fee schedule.

Initial Challenges

The immediate challenge facing SBHN in launching FloridaPsychCare was to establish the infrastructure of a managed care plan, including an authorization process, utilization management criteria, and a utilization management plan. SBHN contracted with a third-party administrator (TPA) to process claims by non-team providers and established a transition plan to address the continued use of non-network providers for an existing episode of care.

Communication with employees about the upcoming changes was coordinated closely with the Shands Human Resources Department. A provider handbook was developed and sent to network participants. A mechanism to transfer funds from the trust account to FloridaPsychCare and the TPA was established, and a risk fund was set up through the TPA.

A key concern during the development of the integrated EAP/behavioral health carveout was whether Shands Healthcare employees would trust and use an internal EAP. While the EAP and the carveout are financially and administratively linked, great care is being taken to promote the two programs separately to prevent the "mental illness" stigma from becoming associated with the EAP.

The confidential nature of employee assistance was emphasized to employees before and after the launch of the EAP, and efforts to spread this message continue. Nonetheless, it soon became apparent that many employees were worried about the possibility of generating medical records as a result of using the EAP. Since EAP records are not medical records, they are not linked with the medical records system of Shands Healthcare.

Evaluation Results

In its first year of operation, the EAP has been received well and has earned high satisfaction marks from Shands employees. The utilization rate was 3 percent for the first year and is rising. Supervisors and management are making increased use of the EAP as a resource for education programs and to coordinate interventions with drug-free workplace policies, occupational health guidelines, and so on. At this time, the goal for the EAP is an increase in utilization rates to between 4 percent and 5 percent in the second year.

Administering the behavioral health carveout has turned out to be a difficult proposition for a management team whose background is mostly with service provider organizations rather than insurance plans. The following lessons have been learned during the first year:

1. Changes cannot be communicated too often or too early. Efforts to communicate the upcoming changes in the benefit plan started six months before the changes took place, and several different means of communication were employed, including newsletters and mailings to employees' homes. Still, a substantial number of employees claimed they knew nothing about the changes. This resulted in problems with employees accessing non-network providers and not obtaining initial authorization, and ultimately led to denials of claims.

2. Simple delivery models work best. The design of FloridaPsychCare, using a "prepaid" care team as well as a fee-for-service network, made clinical sense and met the

strategic goal of increasing market share for the SBHN. Operationally, however, this design depended on clinic staff, clerical support staff, and financial services staff understanding the model and using correct procedures. Given the many locations and individuals involved, as well as staff turnover and lack of training for new staff, many billing errors occurred. Sometimes bills were generated for team providers, although their services were prepaid through an FTE arrangement; other times, no claims were generated for providers that should have been billed. The TPA and the plan required a substantial amount of time to resolve these problems during the first year.

3. Evaluate the network. As stated earlier, SBHN already had a provider network in place when FloridaPsychCare accepted this contract. By agreeing to allow Shands employees to continue using this network. FloridaPsychCare missed an opportunity to evaluate and potentially redesign the network in terms of size, available provider specialty, and practice patterns of providers. The experience of the first year has demonstrated that the network is too extensive and that providers have a wide range of practice patterns in regard to brief, goal-oriented interventions. The provider network probably will be reduced in size during the second year, but it would have been better to implement the reduction when the whole plan changed.

4. A change from a non-managed plan to a moderately managed plan is acceptable to employees. The majority of employees accepted the change to a moderately managed plan, thanks partly to effective communication by the Human Resources Department in explaining that the change would help preserve an excellent benefit that otherwise might have to be reduced. But it was apparent from inquiries by employees that a drastic change from an unmanaged plan to a tightly managed plan would have met with disapproval.

5. Managing the money and the care through the same entity may benefit employee care. Unlike traditional managed care organizations run by business executives, FloridaPsychCare is a group of behavioral health professionals with management experience. Provided that the capitation has been negotiated at a sufficiently high rate, a group like this can focus on quality of care for employees. Having to manage the money as well as the care has led FloridaPsychCare to seek opportunities to improve the delivery of care, including developing programs for special needs groups, increasing the number of therapy and psycho-educational groups, and working closely with hospital professionals to arrange appropriate follow-up care.

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The Future of Managed Care: Implications for EAPs

by Nancy Alfred Persily, M.P.H.

Although prepaid health care in the United States began in the late 1700s, health insurance was largely unknown in this country until 1929, when Blue Cross began operating in Texas as an experimental program to protect schoolteachers in Dallas from the financial burdens of hospital care. Physician care later was provided through a parallel plan, Blue Shield. Other Blue Cross/Blue Shield plans were developed on a regional basis throughout the country, and commercial indemnity plans soon followed.

Indemnity plans were developed not to reduce the costs to the insurer, but rather to help the insured—the employee—cover his or her health care costs better and reduce the risk of depleting resources because of a health crisis. Under indemnity plans, insurers were extremely passive: they received the bill, and they paid it. But they only paid for care when people were sick; they rarely paid for preventive care. For example, an insurer rarely would pay for a checkup unless the diagnosis noted a problem such as a lump in the breast, a high cholesterol level, or elevated blood pressure.

The early managed care plans were different than indemnity plans—they integrated the financing and delivery of health care into one system, which was tightly controlled by the plan. The physicians normally practiced together in multispecialty groups. For this reason, managed care plans were first called "prepaid group practice medical care." Although there were areas of the country where these organizations became popular, for the most part they did not catch on nationally.

The first type of managed care designed to control costs was called managed indemnity, which in many ways resembles old-fashioned indemnity coverage. Managed indemnity pays for a semi-private room in a hospital (with a deductible) and a doctor (also with a deductible); the employee usually pays a co-insurance of 20 percent of the bill and the doctor gets 80 percent from the insurer. The insurer usually requires pre-admission screening, meaning that if a doctor wants to admit a patient for a gallbladder problem that is not an emergency, he or she has to call the insurer and get pre-approval.

For high-cost illnesses or injuries under managed indemnity, there is case management—the insurance company manages the patient's care to try to get him or her to the lowest level of care as soon as possible while being responsive to the patient's needs. Case management focuses on helping the patient function at the highest level possible with his or her disability or illness.

The next development in the continuum of health insurance offerings was the preferred provider organization (PPO), in which an insurance company recruits certain doctors and hospitals to participate in its provider network. Doctors that join PPOs receive reduced payments for their services—typically 70 or 80 percent of what they usually charge for a given service—in exchange for being listed in the insurer's network directory and thus enjoying a greater volume of patients. Usually there are no restrictions within PPOs in terms of gatekeepers; if a patient with a stomachache wants to visit a gastroenterologist, he or she simply finds a gastroenterologist in the provider directory. The patient rarely pays a deductible and does not pay co-insurance. If an enrollee wishes to see a doctor outside the network, the insurer pays a deductible and co-insurance.

One of the ways that insurers with PPOs manage their costs is by evaluating their providers on a yearly basis. For example, if a gastroenterologist performs an inordinate number of invasive procedures that the PPO believes are unnecessary, he or she might be "deselected" from the PPO the following year. The same thing can happen to a hospital—if its average length of stay is too long or if many patients develop post-operative infections, it can be deselected by the insurer and dropped from the provider network.

Health maintenance organizations (HMOs) are much like PPOs except that HMOs integrate cost control and care delivery in a much more aggressive fashion. Modern HMOs developed from the prepaid group practice plans of the 1930s and 1940s, which usually were operated by nonprofits like the Kaiser Foundation and Group Health of Puget Sound and Harvard Community Health Plan. For example, the Kaiser health plans were developed in the late 1930s by the Kaiser Construction Company to provide health coverage for the company's shipyard workers in California. Kaiser

later provided health care for its workers in Washington who were helping build the Grand Coulee Dam.

HMOs usually require patients to select a primary care physician who manages the care of the patient and serves as a gatekeeper for referrals to specialists. HMOs come in three forms: a staff model, a group model, and a network model (or a mixed model that incorporates two or more of these forms). In a staff model, the insurance company owns the health care facilities and essentially puts the doctors on salary. In a group model, a close group of health care providers works intimately with the HMO, as in the case of Kaiser Permanente—the Permanente Medical Group provides care for the Kaiser Health Foundation. Kaiser pays Permanente a certain amount of money to manage its patients' care, and Kaiser provides the insurance or financing mechanism and either owns the hospitals or pays the institutional costs.

In the network model, which is the most popular managed care product today, the insurer contracts directly with hospitals and doctors to form a network of providers. The patient chooses a primary care physician, who then makes referrals to specialists within the network. In most instances, the primary care physician is paid on a capitation basis—he or she receives a certain amount of money per patient, per month, depending on age and gender, to manage the enrollees' health care. In many instances, the primary care physician—often called a gatekeeper—is given financial incentives to manage the utilization of services for those patients for whom he or she is responsible.

The newest managed care product is the point-of-service (POS) plan, which is like a mixture of an HMO and a PPO in that it features a primary care physician who manages costs by acting as a gatekeeper, but the patient has the option of going outside the network for care. If the patient stays inside the network, the only cost is the usual copayment; going outside the network requires paying the coinsurance and a deductible.

Most of the managed care products on the market today are really managing cost rather than care. They pay providers on a capitation basis, but set aside some of the money and use it to pay unanticipated costs. For example, if a doctor is paid $10 per member, per month, the doctor may get only $8, and the remaining $2 is put into a pool. If there are more emergency room visits or hospitalizations than expected, the doctor may receive only a portion of the $2, or even none at all. Alternatively, there are a few HMOs that offer incentive programs—they may pay the doctor $9 per member, per month, then give him or her 25 cents more to keep extended office hours so patients don't visit emergency rooms as often and additional money if they take continuing education courses, keep utilization low, or perform certain procedures in their offices that often are performed by specialists.

Moving Toward Vouchers?

Managed care has proven enormously popular—many more than half of all insured Americans are covered by managed care plans. How popular managed care will be in the future remains to be seen. Health care costs are beginning to rise again, perhaps by as much as 12 percent this year. One reason is that health care costs are cyclical, and the cycle is trending up again. Another reason is that some providers withheld care for a long time to help keep costs down, and now their patients are in need of care and can't wait any longer. A third factor is that employers want to offer more health care choices to attract and retain employees, and these kinds of programs increase costs.

So far, employers are accepting the increases in health care costs because the economy is strong. If the economy starts to falter a little, employers probably aren't going to be so flexible. But regardless of what the economy does, there's no question that cost management is here to stay.

A look at the history of behavioral health care explains why. Behavioral health care has become one of the most restrictive benefits within managed care, but in the days of commercial indemnity plans it was the least restrictive. If patients were allowed 30 days of inpatient care through their indemnity policy, the doctor would keep them in the hospital for 30 days. If the benefit was 60 days, they would stay in the hospital for 60 days. There was very little control of mental health care: Insurers were very passive about controls like pre-certification. Over time, there was so much abuse that the pendulum swung back in the other direction.

What eventually happened with behavioral health care was that it became one of the first carveouts, meaning that companies are paid a capitated amount to manage the behavioral health care benefits of a certain population. Health care services that are carved out tend to be the kinds of specialties in which physician "extenders" can be used to change the way care is delivered. For example, eye care often is carved out because many routine services can be delivered by people without medical degrees, such as optometrists. In the case of mental health care, a social worker or counselor or employee assistance professional frequently will conduct an initial screening. The patient will be referred to a psychiatrist if medications need to be administered, but otherwise, mental health care within managed care generally is not psychiatrist-driven.

Recently, a trend has begun to develop in which employers give their employees a specified amount of money each year and let them buy the benefits they want. This represents the second iteration of cafeteria benefits, and the attractions for both employers and employees are obvious. More employees are having to balance their work lives with child care and elder care responsibilities, so employers that offer these benefits can keep their workers on the job and make them more productive, without increasing their costs.

This trend is very worrying because people who think they are healthy may not value insurance to cover health care, especially mental health care, so they may take the money and put it into child care or elder care or some other

benefit. There already are roughly 44 million people in the United States without health insurance, and the preponderance of them—90 percent or more—are employed. Letting workers pick and choose their benefits risks exacerbating this problem.

This approach also is short-sighted because the labor market is so tight that employers need to keep their existing workers healthy and productive. Under a voucher system, if an employee doesn't purchase mental health benefits but develops a need for them, the options for care are limited. Most community mental health centers are not equipped to handle an increase in patients—in fact, they have trouble caring for the case load they already have.

New Markets for EAPs

If the United States moves toward a voucher system for health benefits, federal regulations may need to be put in place that require employees to purchase some form of health insurance and insurers to provide a minimum benefit structure. The insurance industry probably would back such action. Insurance companies generally don't want regulations, but they don't want a system that's entirely freewheeling, either.

In the short term, the managed behavioral health care companies probably will try to make better use of employee assistance programs to manage health care and costs. This would be in keeping with their overall strategy of using the least educated and specialized providers to deliver care, such as by sending alcohol abusers to Alcoholics Anonymous and other support groups. As a result, there will be more referrals *to* EAPS—not just referrals from EAPs to mental health care providers, but referrals back to EAPs to manage substance abuse care and other types of services. These sorts of arrangements probably are going to become more and more popular.

EAPs also may well become more involved in managing care for retired workers. Many large employers offer supplemental Medicare insurance to their retirees, and these companies may start asking their EAPs to provide information about health care to retirees and even make referrals for them so the retirees won't use their "Medigap" insurance as often. With the aging of the workforce and the anticipated explosion in the number of retirees, this could provide a huge market for employee assistance professionals.

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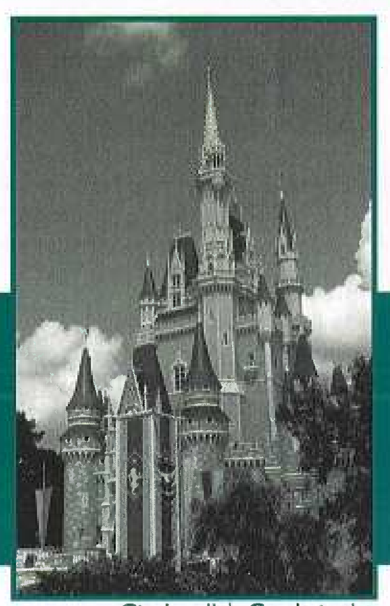
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Managed Care and EAPs in Latin America

by Celina Pagani-Tousignant

Employee assistance programs and managed care are U.S.-based concepts that are relatively new phenomena in Latin America. Both were unknown in the region until the 1990s.

To the extent managed care exists in Latin America today, it is being exported through multinational firms at the request of the client in the United States. A typical request for managed care services may sound like this: "We have 300 employees in Chile. How can you help us?" At that point, managed care firms contact providers in other countries and create the service locally.

EAPs in Latin America share a similar genesis—they were exported through multinational companies. Now things are beginning to shift. In the last few years I've met many people in countries like Chile, Argentina, Brazil, and Mexico who've run across information on EAPA's Web site, and they want to get something started in their workplaces. These people—usually psychologists or psychiatrists—typically work in the field of chemical dependency and/or study the effects of personal problems on employee productivity and quality of life. Social workers also are interested in EAPs, particularly the ones who are addressing what I would call "survival issues"—helping employees obtain housing, resolve financial problems, and so on.

But EAPs still are unknown in much of Latin America. Businesspeople in that area are more interested in incorporating the latest technology and management systems into their companies than trying to motivate their personnel. They have a very conservative view of their human resources: They believe that giving employees a job and fair compensation is enough to keep them motivated.

The first barrier to overcome in establishing an employee assistance program in Latin America is to convince company officials that EAPs have value, that you can invest a dollar in them and get more back. This is more difficult than you might think, because all of the studies and data are from the United States, and many business executives in Latin America want proof that EAPs will work in their countries and cultures. But until EAPs are established, data can't be collected to prove the business case.

A second barrier is that most companies in Latin America don't offer mental health benefits. People do get coverage for medical benefits—in Chile, for example, a percentage of each employee's salary is taken out automatically every year and put into a pool of money to support private and public services—but mental health care typically is not provided unless employees buy complementary insurance. In general, if you have a mental health problem, you go to the doctor or the public health service.

When I worked for Levi-Strauss from 1993 to 1997 as manager of work/family initiatives, I had the opportunity to travel to Latin America. One of my trips was to the Levi's plant in São Paulo, Brazil, after receiving a request to set up an EAP. Plant officials had just re-engineered the business and they wanted to create a structure to deal with employees' "social issues."

There was a doctor at the plant, because the law says you must have a doctor on site if you have a certain number of employees. So people would visit the doctor and he would tend to their physical problems, but then the employees would open up and tell the doctor about other problems, and usually they would be mental health issues.

Did the company offer mental health services? No, it didn't—and the local community didn't have mental health agencies to which the company could refer its employees. In the United States we have an infrastructure to address issues like aging and domestic violence and depression. There are some agencies in Latin America to handle these problems, but not to the extent we have them here.

Another barrier to establishing EAPs is the stigma associated with counseling, prevention, and mental health issues. Frankly, it's not part of the culture in Latin America to visit a therapist. If you get referred to one, you'll probably wonder, "What will people think?" Class status is important in Latin America, so you dress accordingly and you behave accordingly, and the next thing you know people are saying you're crazy because you're seeing a counselor. So people don't talk about mental health problems, and if they do it's just inside the family.

A fourth barrier is management's mentality. In countries with high unemployment, management may think that people are expendable—they can hire someone today, and if that employee doesn't work out, they can just fire him and get someone else. In addition, managers typically think that any benefit that betters the quality of life of workers is an act of generosity, not an investment that supports the business and the people.

How can these barriers be overcome? To sell an EAP, it's important to make the business case using whatever data are available about the effects of substance abuse, family, emotional, and/or financial problems on productivity, accidents, and leaves of absence. This information can be gathered from local mental health agencies, governments, and universities in each country.

Another step is to convince the company to provide mental health benefits so that employees can be supported. One way companies might resolve this is by having the EAP provide some of the mental health sessions, so instead of seeing people for just one or two sessions and offering a quick diagnosis and referral, the EAP could see people for more sessions. If longer treatment is needed (more than 5-10 sessions), the person can be transferred to the public sector.

Celina Pagani-Tousignant is president and founder of Normisur International, a human resources consulting firm.

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