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Employee Assistance Program (EAP) Networks: New Partnership Model Combines Strength of National Network with Localized Delivery

Employee assistance programs (EAPs) are clearly a "first entry point" for millions of American workers and their families seeking professional help and referrals for personal, family, and behavioral health concerns. Approximately 62.8 million employees are enrolled in stand-alone EAPs and another 17.4 million are enrolled in integrated EAP/managed care models, according to the *OPEN MINDS Yearbook of Managed Behavioral Health & Employee Assistance Program Market Share in the United States, 2002 – 2003*.

Today's EAP marketplace is dominated by large external vendors that are insurance-based or investor-owned companies. These national EAP vendors, which account for approximately 75 percent of the market share, contract with a network of local EAP providers to serve client needs. These vendors provide clinical assessment/counseling via a telephone call center or face-to-face at off-site, private office locations with professional subcontractors (i.e. network affiliates).

The historic mission of helping workers receive proper treatment and return to full workplace functioning has been largely replaced by using EAP as a supplemental outpatient mental health benefit. As employers have attempted to mainstream and integrate health plan benefits, the EAP has inadvertently become a marginal extension of the benefit plan. In addition, intense price competition among vendors has led to several years of underpricing EAP services in order to gain market share. Since the EAP has become an inexpensive service, buyers do not usually place the same importance on it as they do on benefits such as health, dental, and retirement. Consequently, they tend to select the vendor with the lowest bid.

One of biggest challenges is finding avenues to help already burdened human resources (HR) and benefits purchasers understand and appreciate the true potential of an effective EAP and overcome low expectations about what an EAP can accomplish. An EAP can be overpriced at $1 per-employee-per-month (PEPM), or a tremendous value at $4 PEPM, depending on the outcomes it achieves. In the current market environment where "its all about price," there are vendors who quietly push clients to lower levels of face-to-face counseling utilization and rely on cheaper forms of Web-based and telephone utilization to drive pricing down. This commoditization of the market has made it difficult for vendors to differentiate their services based on quality rather than price.

Critiquing the Network Model

To market benefits successfully, it's necessary to review and understand three central issues that severely affect the quality and effectiveness of today's EAP delivered through the affiliate network model.

1. Criteria for affiliate selection. Beyond having a license, vendors seem content with affiliates in their network who fill out forms correctly and return phone calls, reducing the EAP to little more than an automated directory of licensed practitioners. A recent study (Sharar, White, and Funk, 2002) cited several shortcomings among subcontractors, including:

- Failing to understand the mechanics of a formal, company supervisory referral
- Lack of knowledge of available community resources
- Reluctance to refer clients when indicated
- Failing to adequately assess chemical dependency
- Confusing the passing along of a phone number with the complete referral of a client
- Failing to conduct follow-up activities with the referral resource or client

• Failing to understand the relationship between personal problems/issues and workplace productivity

Employee assistance (EA) practitioners need to be competent is addressing substance abuse, emotional disorders, family problems, as well as knowledgeable about issues related to HR management, policy, and workplace interventions. The way some networks are currently structured is a declaration that all licensed therapists can provide EA services. As opposed to being an early intervention, workplace productivity enhancement tool, assessing employee problems in the context of his or her job, EAP affiliate networks have largely become another reactive benefit for clinical detection and intervention.

2. Degree of local worksite connections. Subcontract affiliates rarely have any real connection to the local worksite and are frequently unknown to the local employer, HR manager, or union representatives. In many cases, the local affiliate is restricted by the national vendor from making contact with the customer because of non-compete clauses in the vendor/subcontractor agreement.

The lack of integration between the local employer and the local provider may explain the decline in formal management referrals to EAP and, in particular, the drop in referrals due to substance abuse. This decline is occurring at a time when the percent of employees who are problem drinkers and substance abusers has changed very little over the past 10 years. In addition, studies have shown that supervisors show a strong preference for contacting an EA practitioner whose name and face they know from repeat worksite visits and training sessions, as opposed to contacting someone at an out-of-state 800 number they have never interacted with.

As a result, national vendors have created an EAP model that is commonly removed from the job performance management process and is not routinely viewed as a tool for management and labor to address the “human factor” issues.

3. Dissatisfaction among subcontract affiliates. Although anecdotal, subcontract affiliates enrolled in national vendor networks have expressed much dissatisfaction to the range of administrative practices imposed upon them. Examples include failure to pay claims, long delays in getting paid, heavy handed oversight regarding numbers of visits, sharp cuts in hourly rates, lack of involvement with the worksite, poorly trained call center staff, excessive paperwork requirements, and other criticisms. Affiliate dissatisfaction is significant because it leads to fractious relationships between vendors and affiliates that result in an unstable EAP delivery network.

The affiliates’ attitude toward the vendor will also affect their personal and professional commitment to the client, ultimately impeding an effective EAP intervention. These ill feelings inevitably are passed along to clients, who then become less satisfied with their employer-sponsored EAP. Due to the stigma surrounding seeking help for personal problems, clients rarely pass along complaints to an employer HR or benefits representative.

Despite this conventional knowledge, most national vendors report high levels of affiliate network provider satisfaction with their processes and interactions. Marketing materials and proposals routinely discuss highly collaborative and collegial relationships between the vendor and its affiliates, resulting in an effective program and “client-centered” care. Many vendors base these claims on the results of satisfaction surveys among affiliates. However, the survey information volunteered by the national vendor is not audited or monitored by any independent authority, calling into question both the objectivity and veracity of any claims.

Toward a New Model of Partnership

Given the very nature of an EAP service, many smaller, mid-sized providers have differentiated themselves as “high touch” vendors, stressing flexibility, local knowledge and responsiveness,

personalized service, and the ability to achieve unique performance characteristics. Some of these vendors already have national accounts with multi-location employers headquartered in their service delivery area, but have relied upon the same out-of-area network provider model employed by the national vendors.

The key is having a model that brings the best regional EA providers together to deliver a national solution with the critical benefit of understanding what an EAP is supposed to do along with the specific local needs of employers, employees, and their families. A multi-location employer can still have the convenience of a single-source contract but install a locally responsive program that operates "seamlessly" within the same quality standards and information systems. This new "partnership" model represents a confederation or coalition of regionally based EA vendors that have long-standing professional roots in all metropolitan areas. Each provider, or partner, has a keen understanding of the local resources, culture, and business climate, allowing for the delivery of a national solution with the benefit of understanding the specific local needs of employees and families. This local positioning is critical since many of today's most progressive employers are seeking to involve the parties closest to workplace problems in the design and delivery of solutions.

The partnership model shares the following essential characteristics:

- **Interlinked systems.** All regional partners are interlinked via an Internet-based system in order to share a common infrastructure around data collection, performance measurement, and quality management activities.

- **Practitioner driven.** Local EA practitioners, comprised of both clinicians and business managers, develop and adhere to an agreed upon set of protocols, procedures, and quality assurance activities.

- **Local promotion and visibility.** Each regional partner promotes the EA service and provides training and account management in highly collaborative ways with the local worksite, becoming integrated with companies' HR and risk management practices.

- **Financial incentives.** The partnership model ensures that regional partners have the financial motivation to build a close and consultative relationship with the local employer, either through partial capitation or performance-based pricing.

- **Self-regulating.** Although partners share common systems, each partner regulates the utilization and quality of its own regional program.

- **Partnership synergy.** Companies benefit when regional vendors are linked under one contractual umbrella with agreed upon values to share information, act flexibly, and work harmoniously in a cooperative but strategic fashion.

- **Interdependency.** In order for regional providers to compete with the national vendors, there is recognition that collaboration with "like minded" partners is better than acting as a single agent. This has created a healthy interdependency in that solutions to the problems with national EAP delivery go beyond what single vendors can accomplish alone, particularly around common data collection and quality assurance procedures.

The raw material for the partnership model is best-of-breed local/regional vendors whose heterogeneous traits, abilities, and philosophy of care bring complementary strengths to the practice of EA. This critical mass of partners eliminates the current model where a single, large vendor imposes bureaucratic control to a loose network of providers, requiring them to be subordinates rather than partners. The partnership model is the only initiative in the EA field that has the potential to better coordinate and integrate services over time and across geographies

while allowing for a necessary degree of local autonomy and flexibility. It's also the only model that recognizes that professional help works best when there is a direct relationship between those asking for help and those actually providing the service.

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