External Employee Assistance Program Vendors: A Study of RFI Data from 2009-2010

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ABSTRACT. *Today "external" EAP vendors supply the bulk of the services offered in American workplaces. This paper will offer a partial summary of the results from a survey of 24 of the largest "external" EAP vendors in the United States. The paper examines trends in the field and offers a partial picture of the external EAP industry circa early 2011. The paper concludes with recommendations for quality improvement among vendors and suggests parameters that EAP purchasers should consider when selecting new services or when contemplating a switch in vendors.*

Introduction

Each year, the health benefits consulting firm Aon Hewitt distributes its Behavioral Health Request for Information (RFI) to collect data on Employee Assistance (EA), Work/Life, and managed Mental Health/Chemical Dependency (MH/CD) programs in the U.S. The data is used to support Aon Hewitt consultants in evaluating vendor capabilities. The information consists of vendor self-reports gathered through contacts with key informants. Vendors would typically be aware that this data would be used to review their programs for possible opportunities to supply services to Aon Hewitt customers. In 2009, 36 vendors were selected as targets and 26 vendors responded (a 68% return rate). In 2010, 47 vendors were targeted with 26 returning data (a 56% return rate). This RFI survey data was collected from large, medium and smaller sized Employee Assistance Program (EAP) vendors. These include the largest vendors in the United States, as well as some local "boutique" vendors. The largest 11 organizations were responsible for over a million or more lives each. The 12 mid-sized programs were responsible for anywhere from 100,000 to just under a million lives. The three smaller programs were responsible for 25,000 to 100,000 lives.

Twenty five vendors chose to respond to the RFI inquiries for both 2009 and 2010. Not all vendors responded to each question. One vendor provided data only addressing performance from 2009 and one provided data for only 2010. Thus, 24 EAPs provided data for both the 2009 and 2010.

The survey was electronic as vendors were invited to participate via e-mails sent to key informants within the organizations. The survey was administered in the fall of 2010 and 2011. Respondents were asked to provide data from the previous year.

The vendors were categorized into three groups defined by the type of organization and services they provided. These groups included:

(1) those which only provided EAP and in some cases Work/Life or other Human Resources services – called **Free-standing EAPs** (*n* = 13);

(2) those which were part of large comprehensive health insurance plans – called **Health Plan EAPs** (*n* = 5); and

(3) those which were a component of a larger behavioral health organization which also delivered other Mental Health Managed Care (MHMC) services but was not affiliated with a comprehensive health plan – called **MHMC EAPs** (*n* = 7).

Results

This section describes the organizations surveyed and offers the major findings. The survey examined the number of covered employee lives; issues related to the intake process of each vendor, program accreditation status, having the designation of the Certified Employee Assistance Professional (CEAP) among both intake staff and affiliate clinicians, the use of Screening, Brief Intervention and Referral to Treatment (SBIRT) during the intake process, the composition of the affiliate workforce, the option of self-referral among affiliate clinicians; clinical utilization rate, the types of presenting problems most commonly seen, evaluation tools, and issues related to innovation in service delivery. Some data also was compared from year 2009 to 2010 and between the three types of EAP organizations.

Size of Covered Employee Population

A total of 24 EAP organizations provided data on their number of covered total employee lives in their book of business for both 2009 and 2010. As shown in Figure 1, the aggregate count of covered employees across all vendors in the study sample was over 46 million in 2009 and over 56 million in 2010. When converted to the average count per each individual EAP organization, there were differences between the three types of EAPs. The carve-out MHMC type was the largest of the three, with an average book of business of over three million covered employees in both years. The Free-standing EAP type averaged approximately 1.5 million covered employees in each year. The Health Plan EAP was closer to the Free-standing EAP in 2009 but closer to the MHMC EAP type in 2010.

Comparison of the data by each year revealed an overall increase in the size of covered employee populations of +17% for total sample. However, this result varied by type of EAP. The Health Plan EAP group experienced significant growth in covered employees (+58%). Organizations that offered both EAP and carve-out MHMC programs had an increase in covered employees of +11%. In contrast, Free-standing EAPs had almost no change over time (a small decrease of less than 1%).

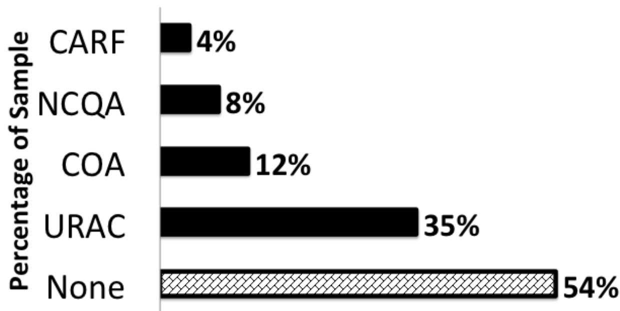
Figure 1. Total Covered Employee Lives

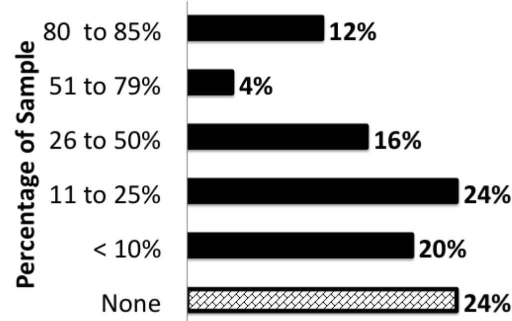
Total Covered Employee Lives for Group			
Type of EAP	*Count*	*Year 2009*	*Year 2010*
Free-standing EAP	13	19,446,701	19,265,092
MHMC & EAP	7	21,958,427	24,611,576
Health Plan EAP	4	5,078,178	12,338,408
Total	**24**	46,483,306	56,215,076

Aveage Total Covered Employees Lives Per EAP			
Type of EAP	*Count*	*Year 2009*	*Year 2010*
Free-standing EAP	13	1,495,900	1,481,930
MHMC & EAP	7	3,136,918	3,515,939
Health Plan EAP	4	1,269,545	3,084,602
Total	**24**	1,936,804	2,342,295

Program Accreditation

Some vendors can become accredited by various external organizations as a demonstration of following industry best practices and quality standards for EAP and other related services. Accreditation is voluntary in the EAP field. Figure 2 shows the results for this area. Just over half of these venders (54%) were *not* accredited in year 2010. Among the vendors that were accredited, four different accreditation-granting organizations were represented. Three vendors were accredited with two organizations. These organizations included the Utilization Review Accreditation Commission (URAC) – at 35% of the total sample, the Council on Accreditation (COA) – at 12%, the National Committee on Quality Assurance (NCQA) – at 8% and the Commission on Accreditation of Rehabilitation Facilities (CARF) – at 4%. However, only the COA offers an EAP-specific accreditation with the others focusing more broadly on behavioral health. See Figure 2 on next page. These findings indicate that for these U.S.-based vendors, accreditation is not a dominant feature of their business model.





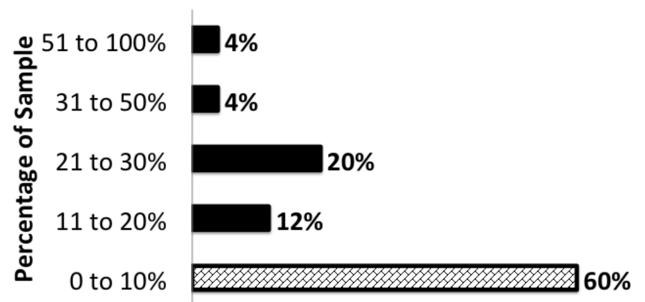
Intake Process

Some EAPs staff an intake telephone line with customer service representatives (CSRs). The staff obtains basic demographic data, information about the caller's reason for contacting the EAP and most service requests. Other EAPs staff the intake line with master's level clinicians who are responsible for collecting appropriate information, assisting the caller while on the phone, and referring to necessary services. This latter approach ensures the caller engages with a single contact, rather than being transferred during the intake process. The majority of vendors (55%) offer purchasers the choice of who is the initial respondent for an intake call: either a CSR or a mental health professional (MHP). A third of vendors only offer MHPs (33%) and another 12% of vendors only offer CSRs to respond to initial EAP phone contacts.

Intake Staff Holding the CEAP Certification

The CEAP designation is a national credential administered by the Employee Assistance Certification Commission.[1] The RFI inquired about CEAP certification for both intake clinicians and affiliates. Figure 3 indicates there is a great deal of variation among vendors in regards to the level of CEAP among their intake staff. One in four vendors (24%) had no CEAPs among their intake staff, while another 20% of vendors had less than 10% of their intake staff with the CEAP. Forty-percent of vendors had between 11% and 50% of their intake staff with a CEAP. Only 16% of vendors had call centers staffed primarily by CEAPs (51% to 85% of staff).

Figure 4 examines the number of CEAPs among the EAP affiliate network part-time staff. The majority of vendors (60%) reported that, of the degreed affiliates within their networks, less than 10% were CEAPs. About a third of the vendors had between 11% and 30% of their network affiliates with the CEAP. Only 8% of vendors had a majority of their network affiliates with the CEAP. By comparison with Figure 3, this data also indicates fewer affiliate counselors who are CEAP certified than EAP intake staff who are CEAP certified.

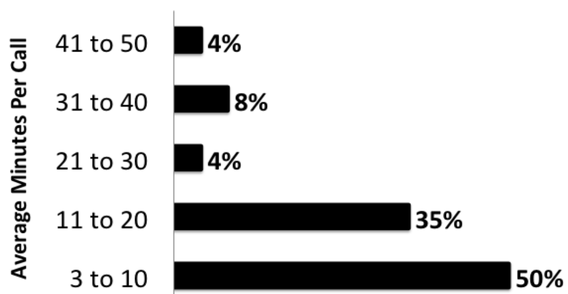


Average Intake Call Time

The average length of an intake call across vendors in 2010 was 14.79 minutes; however, a few outliers positively skew this average. Figure 5 displays the distribution of the average call times across the sample. Although length of call ranged from a low of 3-10 minutes to a high of 41-50 minutes, the majority of vendors reported having an intake call time lasting

only 3-10 minutes. The manner in which the data was collected made it impossible to separately examine the call times of CSRs compared to MHPs.

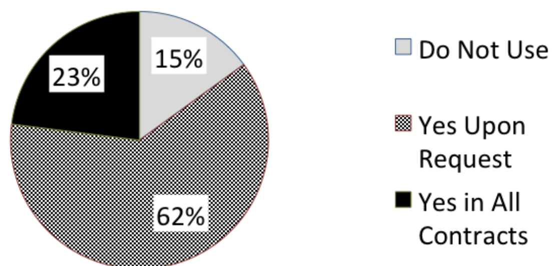
FIGURE 5
Intake Call Times
Year 2010 (*n* = 26)



SBIRT

SBIRT stands for Screening, Brief Intervention and Referral to Treatment. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing the disorders.[2] Our data (see Figure 6) indicates that by late 2010, about 1 in 4 EAP vendors (23%) had incorporated SBIRT as a standard component of the intake process for all contracts. But more typical was for vendors to apply SBIRT protocols only if specifically requested by the purchaser (62%). The remaining 15% of vendors did not use SBIRT at all. Thus, 7 of 8 vendors use SBIRT to some degree when conducting assessments.

FIGURE 6
SBIRT Use at Intake
Year 2010 (*n* = 26)



Affiliate Networks

Typically, the affiliate networks for EAPs consist of a mix of licensed clinical professional counselors, clinical social workers, or psychologists. Across the entire sample of vendors about 80% of their affiliates held master's degrees and 20% held doctorates.

Affiliate Self-Referral Option for Continuation of Counseling from the Same EAP Counselor

Self-referrals occur when the EAP counselor is allowed to continue providing additional services to the same client after the contractually-specified number of clinical sessions has been reached (e.g., a limit of up to 5 sessions allowed per case). The survey showed that most vendors permit affiliate self-referrals, some in all cases, but most take situational or customer preference into consideration (between 24% and76%). In this sample of larger providers, only two vendors made a policy of restricting self-referrals.

Annual Utilization Rate for EAP Face-to-Face Counseling Cases

The vendors were also asked to respond to questions about utilization using a consistent definition as follows: "Percent of members who received at least one face-to-face counseling service through the EAP." The results revealed an average case-level clinical utilization rate of:

- 2009 = 5.7%
- 2010 = 6.0%

There was no appreciable difference between the utilization rates in 2009 and 2010. But, once again, there was wide variation between EAPs. For example, in 2010, the utilization levels varied widely across vendors, ranging from a low of 1.3% to a high of 13.0%.

Rates of utilization may differ widely within a vendor's book of business due to differences in organizational culture among the purchasers, level of stress present in the purchaser's workplace[3]and other services, which may be paired with the EAP (e.g., Work/Life or carve-out MH/CD).

Reasons for Contacting EAP

Vendors were asked to indicate the three most common presenting problems noted across their employer book-of-business. Both for 2009 and 2010, the top 3 most common primary presenting issues were:

1. Marital/family
2. Stress
3. Depression

Given the historical emphasis on alcohol from EAPs, it is interesting that chemical dependency issues were listed among the top three problems by only one of these 25 vendors. Thus, addiction issues are not among the most commonly presented issues at EAPs today.

Evaluation of Assessment, Referral, and Clinical Services

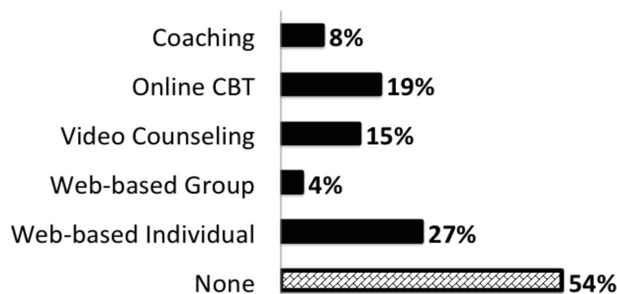
In 2010, 60% of the vendors engaged in a formal evaluation process using at least one validated psychometric instrument. Among these vendors the most popular scale was the Patient Health Questionnaire 9-item scale (PHQ-9), followed by the Social Functioning 12-item scale (SF-12), and the Life Status Questionnaire and Youth Life Status Questionnaire (LSQ/YLSQ).[5, 6,7] Most of the vendors who used rating scales had employed more than one instrument. For example, some used their own internally developed proprietary instrument along with other standardized scales, such as the Hamilton Depression Inventory.[8] Other instruments mentioned were the Global Assessment of Functioning (GAF)and work-related problems scales including the Work Limitations Questionnaire (WLQ) and the Stanford Presenteeism Scale (SPS-6).[9, 10, 11]

In 2010, 60% of vendors who collected evaluation data did not share it with their purchasers. Nor did all the vendors who had an infrastructure to collect data actually implement evaluations for customers.

Innovation

New and innovative approaches included telephonic counseling, online lifestyle coaching, online live-chat focused on selected issues, and coaching services. In 2010, among the 24 vendors responding to this question, experimentation with new services remained low (see Figure 7) as just over half had none of the innovations examined in the study.

FIGURE 7
EAP Innovation
Year 2010 (*n* = 26)



The results found that 4% of vendors had implemented web-based groups and 15% implemented video counseling. More vendors were offering online cognitive behavioral therapy (CBT) at 19% and also web-based individual counseling at 27%. This data indicates that although these EAPs are investigating these kinds of service innovations, it does not mean that these new approaches are widely available to their customers.

Discussion

This paper describes the features of EAP vendor operations and services which may be useful for other vendors when comparing their products with similar EAPs and for purchasers to consider when selecting new programs. The information presented here also points to the need for further research into the, as of yet, unknown effects resulting from variations among these parameters.

The information from this RFI indicates a trend toward increasing covered employee populations among select types of EAPs. Those EAPs integrated within comprehensive health plans or MBHC carve-outs, appear to be slowly gaining greater market share.

Some form of program accreditation was evident among 46% of these vendors. EAP-specific program accreditation by COA was present for only 12% of vendors. Quality assurance and consistent performance of operational best practices could be

an issue for the field of EAP with this low level of accreditation.

There is also a relatively low level of certification at the individual level of CEAP certification among degreed clinical intake staff and even less among network clinical affiliates. Vendors should encourage their staff to pursue the CEAP, and purchasers should investigate the number of intake and affiliate staff holding the credential. Vendors reporting that staff is "CEAP eligible" may not be a comparable indicator of therapist qualification since the CEAP test validates knowledge, which time working in the field alone may not guarantee. Higher levels of CEAP credentialing in each of these groups might insure that counselors have a greater knowledge of workplace issues. Staff knowledge about the workplace is an important differentiator between an EAP counseling service and a purchaser's Mental Health/Chemical Dependency benefit program.

To demonstrate value to purchasers, most EAPs also appear to be responding to calls for greater evidence-based practice. Today, an increased number of vendors report that they are including SBIRT interventions for callers with possible alcohol problems. Further, and also in the interest of a greater evidence base for program effectiveness, 60% of vendors reported implementing or at least creating an infrastructure for a formal evaluation of their own services using research-validated tools.

One of the more surprising findings of this data is the brief duration of most call times conducted by EAP intake staff. This data suggests that intake staff is only collecting demographic data, providing the member with a list of referrals, and are probably failing to offer meaningful support to callers. With many calls of less than 10 minutes it also suggests that intake workers are rarely conducting meaningful screening and assessment. To what extent the clinicians are doing this important step in risk-management instead of after the intake call was not assessed on the RFI.

Admittedly, it remains unclear as to how long the optimal time for a phone intake call actually should be. Nevertheless, call times of 10 minutes or less would make any probing or consultation beyond the client's initial problem description unlikely. Although having more in-depth evaluations conducted later by affiliates may mitigate this concern, typically EAP vendors have much less control over these contractors and the clinical decisions they might make. Purchasers may wish to examine the assessment and referral patterns of a vendor's affiliates to insure that some form of triage is in fact occurring and that appropriate referrals are indeed being implemented.

The availability of SBIRT and other outcome data may help facilitate the evaluation and adequacy of the EAP's triage processes. Purchasers may wish to require that the aggregate data acquired from SBIRT screening be regularly reported. Being aware of the number of callers with high risk drinking profiles and then examining the appropriateness of the referrals made for these individuals may provide an important performance measure for EAP vendors.

Throughout the history of EA there has been a continuing call for more research and evaluation. To address this need, there have been a series of studies relying on pre versus post research designs.[4] Of course, research designs of this nature that lack a comparison or control group are fraught with methodological issues. However, although they may be imperfect, pre/post designs can help a vendor and purchaser determine which components of a program are functioning well or failing to function. Consequently, a formal process of evaluation is an essential component of an effective program. This should not be confused with a patient satisfaction survey, as these inquiries do not measure clinical outcomes or issues related to worker productivity. Many of the vendors surveyed do claim to have an infrastructure for collecting outcome data however even when data is collected it is typically not reported back to the purchaser.

Recent attempts have been made by one vendor to develop a standardized outcome measurement tool to be used across EAP providers. The Chestnut Global Partners Workplace Outcomes Suite (WOS) is one such instrument. The 25-item scale is in the public domain and is available for use at no charge: www.chestnutglobalpartners.org/ResearchTools.[12]

Lastly, almost half of these EAP programs are attempting to innovate to increase the scope and availability of the services they deliver. Of these

technological innovations, web-based counseling for individuals is what is being offered most often.

Opportunities

Opportunities exist to enhance the delivery of EAP services within employer purchased programs. Vendors should consider--and purchasers should request--more useful data reporting. Statistics should be collected reflecting program outcomes rather than mere utilization rates or satisfaction surveys. More complete intake and triage processes should be considered to maximize the value and quality of the employee's first contact with the EAP. Suggestions for evaluation and data collection should be established in performance guarantees that focus on meaningful outcomes for the purchaser's organization.

Limitations

The data was from vendor self-reports to RFIs. The data was not collected from a random sample of vendors and is not intended to be representative of the entire population of EAP vendors. Rather the data was collected from only those vendors having some previous relationship with Aon Hewitt Consulting. The survey response data was not confirmed or verified for accuracy by staff at Aon Hewitt nor was it collected in a systematic process such as via a data warehouse. Another limitation is that the data was not initially collected with a research project or publication in mind, which made it difficult to interpret some of the findings.

Note: This review is a summary of a more detailed report that was presented at the 2012 Annual EASNA Institute and currently submitted to a peer-reviewed journal.

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