Needs Assessment and Implementation of an Employee Assistance Program

PROMOTING A HEALTHIER WORK FORCE

by Mary K. Monfils, RN

Employee Assistance is a system to restore, maintain and/or improve the functioning of people with personal problems that can and do affect their jobs. The benefits most companies expect to achieve by implementing this service are in the areas of improved employee health, increased productivity, increased effectiveness of supervisors, increased stress management skills for employees, increased employee morale, decreased accidents, decreased absenteeism, decreased turnover, and improved utilization of the behavioral health benefit.

Employee Assistance Programs (EAPs) are now being used by 90% of Fortune 500 companies (Burke, 1988) and 71% of businesses employing greater than 1,000 employees (Bureau of Labor Statistics, 1988). However, like any new program, they can present an implementation challenge to the occupational health professional.

To varying degrees, every management initiative reflects the corporate culture within an organization. With an EAP, this phenomenon is especially evident since the program deals with the most personal aspect of an organization—the behavioral health of the people who comprise the organization. For this reason, the personalities of the management team and the work force at large need to be considered in implementing an EAP. Education may be needed to overcome stereotypes or misconceptions. If these considerations are accommodated and the EAP is planned and implemented around an adequate needs assessment, it can become an indispensable management tool.

A needs assessment is part of the planning quadrant of the Shewhart or PDCA (plan, do, check, act) Cycle used by Dr. W. Edwards Deming (Figure 1). Dr. Deming was an American statistician who began to work with Japanese companies after World War II. These companies were interested in breaking into foreign markets but had a reputation for poor quality. Dr. Deming convinced them they could have the best quality in the world if they used his methods. The rest is history. Dr. Deming became an internationally renown consultant, credited by many for the "Continuous Quality Improvement" movement in the United States.

Deming introduced the PDCA cycle in his teaching in 1950, referring to it as the Shewhart Cycle (Scherkenbach, 1988). The four quadrants of the PDCA tool comprise a cycle of activity which promotes continuous improvement of quality.

The first quadrant, Plan or P, refers to the collection of data about a specific process and the establishment of a process improvement plan based on that data. The next step, Do or D, is the execution of the plan followed by Check or C, which is again gathering data to determine if the plan is effective. The last step, Act or A, is the process of deciding what changes should be made, based on data gathered.

At this point the cycle returns to Plan and the process begins again (Gitlow, 1987). Using this tool, a process is continually being examined and improved. These activities also can be applied to the implementation and ongoing management of an EAP within a company.

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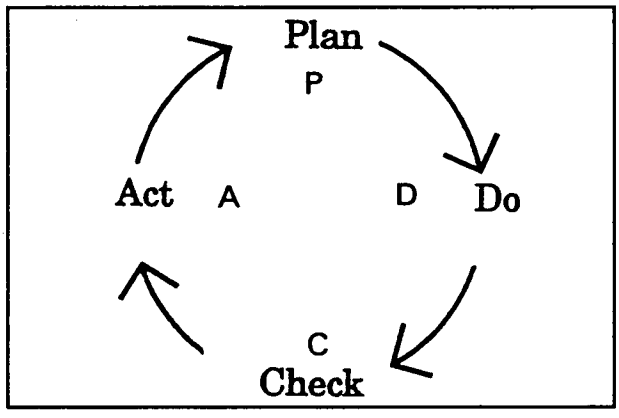

Figure 1: The Shewhart Cycle.

This assessment process is very familiar to occupational health nurses. It is essentially the same process the nurse uses to assess an individual, but applied to an organization. The nurse will be measuring critical indicators of a company's behavioral health, comparing it against norms, determining overall status, identifying root causes, and planning prevention strategies (Herman, 1987).

PLAN

A good place to start is by gathering data to support the nurse's observed need for an EAP or by determining the source of the company's desire for EAP services. Does the nurse believe an EAP would be advantageous to better meet the needs of the employee population? If so, why? If management is requesting the nurse to research EAPs, what is its reason? Are the employees asking for an EAP? If so, why?

Frequently occupational health nurses see employees who would benefit from referral to a behavioral health professional and are frustrated if no system is in place to accomplish these referrals. Implementation of such a system can be accomplished in several ways, ranging from an informal referral arrangement to a full EAP. Therefore, data should be gathered to determine the necessary level of intervention.

An EAP is the answer only if the data supports a need for the program beyond providing an easier referral process for the occupational health nurse. If the nurse's interest in EAP comes from employees needing referral, data can be collected about the volume of employees seen, time to accomplish referrals, employees left with unmet needs, and any estimates of the financial impact, for example.

If a nurse is seeing employees who could benefit from a referral to an EAP, it is fair to assume there are employees not seeking service from the health service who could also benefit from an EAP. Data could be obtained directly from this population by several means. A survey tool could be developed to explain EAPs and measure interest/need among employees. Small focus group discussions with a number of groups representing a cross section of the population is another method for assessing need.

Indirect measures of the need for an EAP could be obtained by surveying supervisors to determine how many times they could have used an EAP over a given period of time for counseling employees with performance problems. Other indirect ways to determine need in this population, such as absenteeism and productivity, are discussed later.

An assessment is not complete without considering financial issues. In the past few years there has been widespread discussion of the crisis in health care and health care costs. Some economic forecasters predict by the year 2000, national health care expenditures will comprise more than 15% of the gross national product (Polzer, 1990). A 1992 benefit survey shows the rise in mental health costs outstripping the rise in total health care costs for the years from 1986 to 1991 (Health care, 1992). The same study provides estimates, by employer, of mental health and substance abuse as a percent of total health care costs. These percentages range from 8% to 30% with the average being 8.8%. The average behavioral health care cost per employee per year is estimated at $318 (Health care, 1992).

In states where mental-mental claims are recognized as potentially compensable by workers' compensation, stress related issues take on increased importance since employees can be compensated for mental conditions caused by job stress (U.S. Chamber of Commerce, 1994). Information should be gathered on the stress related claims for the company being assessed. Regardless of workers' compensation law, if a management team actively seeks to identify and effectively treat substance abuse, depression, and the other behavioral health issues in the work force, that effort will have a positive effect in reducing workers' compensation costs, accidents, and disability cases.

Begin by collecting the following types of information on the company being assessed. What has been happening to the health care costs of the company being assessed? Can the third party administrator or insurance carrier separate insurance costs to reflect only substance abuse and mental health costs? How do these compare against costs in similar companies? What has happened to these costs over time? How much training does front line management staff have in identifying personnel with personal problems and intervening before these problems begin to affect their work? What is the company's safety record? Percent absenteeism? Turnover? Cost for replacing a worker? Workers' compensation record?

All these are areas in which an EAP can have a positive effect. These figures should be compared with the records of comparable industries. Also, assess whether management is comfortable with the company's performance in these areas or recognizes a need to improve.

One will need to quantify the assessment data as much as possible to gain the support of upper management and to determine valid baseline measures to adequately evaluate the program, if implemented. The officers of most companies are familiar with the concept of managing capital risk. Initial and ongoing support for an EAP will likely be stronger if presented in terms of managing human risk and

discussed in financial language. The more involvement company decision makers have in the process, the greater the likelihood of an end result that will support the overall business strategy of the organization and be successful. Management involvement should be promoted as soon as the need for EAP is evident.

Another important consideration to research in this assessment phase is managed care. Managed care is a health care system that arranges with selected health care providers to furnish benefits to its members, sets standards for selecting providers, establishes formal programs that encompass quality assurance and utilization review, and offers financial incentives for members to use the services of the plan. The objective of managed care is to control costs and/or quality (Alter, 1993).

Many employee assistance and managed care products are blending. An EAP, because it encourages clients to enter the program early in the development of a problem and because of the confidentiality that it provides, makes an excellent gateway for employees to access their behavioral health benefit. A 5 to 10 counseling sessions model can provide much of the care within the EAP without the need to use other benefits. If referral to a benefit eligible resource is necessary, the EAP can assist the client in accessing care at the most appropriate level. This can decrease cost and increase effectiveness of treatment. The decision to have the EAP stand alone or combine with managed care should be made before potential EAP providers are approached.

Once the need for an EAP is demonstrated, the choice of a model that best satisfies the identified needs and fits within budget expectations should be the next planning issue. Probably the most basic model decision is whether the EAP will be an internal model, delivered by an employee or employees of the company, or an external model, delivered by an external provider.

The majority of companies use external programs. Of the Fortune 1000 companies with EAPs, 18% have internally run programs, 6% have an internally run program supplemented by vendor contracts, and 80% have an externally contracted program (Smith, 1992). Companies that choose to deliver an EAP through their own staff are generally large because of the depth of resources necessary to employ and support such staff.

Internal staff can be integrated more totally into the corporate culture and are a good source for training and ongoing coaching. An external program, on the other hand, comes "ready made" and can be easier to implement. The provider takes responsibility for licensure and ongoing training of their personnel, and employee confidence in confidentiality may be higher. The pros and cons of each model need to be weighed carefully. Some large companies combine both models by hiring an EAP manager who is responsible for managing a variety of external providers around the country.

According to industry standard, models also vary in the number of sessions provided, falling in the range of 1 to 10 counseling sessions and grouped into two categories. The first category is assessment and referral. Assessment and referral models generally offer 1 to 3 sessions. The purpose is to triage clients and get them to the most appropriate treatment source.

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The second category provides short term problem resolution. These models tend to cluster around 5 to 6 or 8 to 10 sessions. Models that offer 5 to 10 sessions claim to be able to provide goal directed problem resolution to a sizable percentage of clients they see. This feature means that these people will have their problem resolved within the EAP and will not have to use their insurance benefit. An EAP should be asked to provide recommendations and data to support the model they believe will be most effective for a specific company. How many sessions are provided and how many clients are seen within the EAP as opposed to being referred out? Obviously, prices are higher as more sessions are delivered. The company's overall health care strategy should be taken into account in making this selection.

Consulting firms are frequently used at this stage for companies that are large or have complex needs and have decided to purchase an external program. Effective consultants will listen carefully to a company's current and projected needs and develop a Request for Proposal (RFP) based on those needs. Frequently, the RFP asks for information in a specific format so it can be entered on a grid to allow for consistent comparisons among the various programs being considered.

Because of the complexity of the service being evaluated, a grid comparison process can be helpful and is recommended, with two caveats, whether or not a consultant is being used. The first caution; there is no substitute for a long term, professional working relationship with a provider. It is easy to get lost in the data and lose sight of such qualities as the personality, flexibility, and motivation of the various bidders. Those qualities can be vital to the success of the program. Secondly, remember the grid is only a tool. It should not be so narrowly interpreted that a provider who does not fit in the grid is summarily dismissed. Perhaps they have a better mouse trap.

Some program comparisons that may be helpful are:

- Provider's average EAP utilization percentage, including formula for calculating.
- Staff credentials and qualifications.
- Education provided to EAP staff.
- Service components provided.
- Internal promotional support.
- Supervisory training program.

- Quality assurance program in place.
- System to assure confidentiality.
- Multi-language capability.
- Accessibility—24 hours/day, 7 days/week.
- Reporting capabilities—sample of standard report.
- Outcome measurements provided.
- Percentage of clients handled within the EAP.
- Training available to company.
- Management consultation.
- Special services, i.e., critical incident debriefing, downsizing support, elder care assistance, child care assistance.
- Waiting time for appointment.
- Flexibility/commitment to respond to specific needs.

These service capabilities will begin to define the quality of the providers being considered, allowing for comparison. This information should be asked for in a standardized format to simplify comparison. A site visit to an external EAP under consideration also can provide a great deal of information, such as ease of access, professional atmosphere, and responsiveness of staff.

Industry standards are helpful in designing appropriate questions about a program's standards and evaluating responses. Two national organizations for EAP professionals publish standards for Employee Assistance Programs. Such standards are valuable tools during program selection and evaluation, especially if the occupational health professional is working without the help of a consultant. The two organizations are: Employee Assistance Professionals Association, Inc (EAPA), Arlington, Virginia, and Employee Assistance Society of North America (EASNA), Oak Park, Illinois.

DO

Once needs are assessed, and a model and provider(s) are selected, implementation begins. A well selected provider, or manager if an internal model is chosen, is invaluable in this phase. The EAP provider should begin by meeting with upper management to gain its support, understand its goals for the program, and begin developing a working relationship. Supervisory training is a critical component of implementation as well as policy and procedure development, selection of a liaison at each organization, development of an initial promotional campaign, and employee orientation.

Ongoing promotion should also be planned at this time to keep the program highly visible in the company. Most external model EAPs invoice a set fee per employee per year regardless of the number of employees or family members who use the service; therefore, the more the EAP is promoted and used, the better the return on investment for the company.

CHECK

Adequacy of promotion can be evaluated by monitoring the utilization rate reported by the EAP. Utilization rate is defined as the number of cases treated divided by the number of eligible cases (Spicer, 1983). For instance, if Company X has 100 eligible employees and 8 of them use the EAP within a year's time, the utilization for the year is 8% (8/100). During the first year of program start up, the utilization rate could be checked more frequently than quarterly or semi-annually, the usual report interval. Knowing that the rate is on target is a good indicator that orientation and promotion activities are effective and the employees are accepting the program.

The standard acceptable utilization rate set by the EAPA is 5% to 10% annually (A. Harris, personal communications, 1995). This standard measure for EAP utilization is based on cases, not clients. For instance, if a married couple is seen together by the EAP for marital problems only, they are counted as one utilization measure, one case. A word of caution—some EAPs will inflate utilization by counting individual clients or sometimes even people who have been to training sessions.

The formula for calculating utilization rate and defining a utilization measure should be shared and discussed. This allows the occupational health professional to make meaningful comparisons against other programs and against industry standards.

The Table is a sample partial utilization report provided by an external model EAP in the Midwestern United States. In the interest of space, only part of this report is shown. Many EAPs offering computerized formats such as this one can customize reports based on customer need and will have different report formats based on the EAP product being delivered. Also, an EAP should provide a contact person to help analyze the data in their report. However, through careful study of the data, much useful information can be determined by the nurse.

As an example, the report partially shown in the Table was generated based on an employee population of 800 and shows 50 cases opened for four quarters. The nurse should know this EAP's definition of a "case." Fifty cases divided by 800 eligible associates (employees) is a 6.25% utilization. This utilization is within the target of 5% to 10%. Utilization peaked at 9.5% the second quarter and dropped the third quarter and again in the fourth quarter. The nurse and EAP representative should discuss the significance of this drop. It may be just a temporary drop, there may be something happening within the organization, or the promotion of the program may need to be increased.

Other questions that may be asked by the nurse are:

- Why are there so few household members using the program compared to associates? Does more promotion need to be sent to homes?
- There are only two referrals by supervisors for performance issues. Is this an acceptable level? Are there so few referrals because there are few performance issues at this company, or could supervisors benefit by more training in the use of the program?
- Are the associate demographics representative of the associate population or is there a group that seems underserved? If there appears to be an underserved

TABLE

Sample Utilization Report

	1st Quarter Jan. 93-March 93		2nd Quarter Apr. 93-June 93		3rd Quarter July 93-Sept. 93		4th Quarter Oct. 93-Dec. 93		Total Report	
Activity										
A. Cases Opened	14	7.00%	19	9.50%	11	5.50%	6	3.00%	50	6.25%
B. Management Consultations	0		0		0		0		0	
C. Inquiries	0		0		0		0		0	
Type of Referral										
A. Associate Self	13	92.86%	16	84.21%	10	90.91%	4	66.67%	43	86.00%
B. Household Self	1	7.14%	2	10.53%	1	9.09%	1	16.67%	5	10.00%
Supervisory Referral										
C. Informal Referral	0	0.00%	1	5.26%	0	0.00%	1	16.67%	2	4.00%
D. Performance Referral	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Total	14	100.00%	19	100.00%	11	100.00%	6	100.00%	50	100.00%
Associate Demographics										
A. Job Level										
1. Executive/ Management	1	7.14%	0	0.00%	0	0.00%	0	0.00%	1	2.00%
2. Supervisor	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
3. Professional	1	7.14%	0	0.00%	0	0.00%	2	33.33%	3	6.00%
4. Plant	8	57.14%	10	52.63%	6	54.55%	2	33.33%	26	52.00%
5. Service/ Maintenance	2	14.29%	7	36.84%	5	45.45%	2	33.33%	16	32.00%
6. Office	1	7.14%	2	10.53%	0	0.00%	0	0.00%	3	6.00%
7. Other	1	7.14%	0	0.00%	0	0.00%	0	0.00%	1	2.00%
8. Not Known	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Total	14	100.00%	19	100.00%	11	100.00%	6	100.00%	50	100.00%
B. Length of Employment										
1. Less than 1 year	0	0.00%	0	0.00%	0	0.00%	1	16.67%	1	2.00%
2. 1 to 5 years	4	28.57%	3	15.79%	2	18.18%	2	33.33%	11	22.00%
3. 6 to 10 years	2	14.29%	1	5.26%	2	18.18%	0	0.00%	5	10.00%
4. 11 to 15 years	5	35.71%	7	36.84%	2	18.18%	2	33.33%	16	32.00%
5. 16 to 20 years	3	21.43%	8	42.11%	4	36.36%	0	0.00%	15	30.00%
6. Over 20 years	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
7. Refused	0	0.00%	0	0.00%	1	9.09%	1	16.67%	2	4.00%
Total	14	100.00%	19	100.00%	11	100.00%	6	100.00%	50	100.00%
C. Sex										
1. Male	6	42.86%	8	42.11%	6	54.55%	2	33.33%	22	44.00%
2. Female	8	57.14%	11	57.89%	5	45.45%	4	66.67%	28	56.00%
Total	14	100.00%	19	100.00%	11	100.00%	6	100.00%	50	100.00%

Adapted from: Concern EAP (1993).

group, how could this group be reached though promotion?

These questions should all be discussed with the EAP contact to continue to maintain and improve the program.

In organizations where intervention and treatment of behavioral health problems are viewed negatively, the EAP can become more reactive and less proactive. More time is spent with performance problems and poorly performing work groups than in early intervention and prevention. An EAP is no substitute for healthy leader-

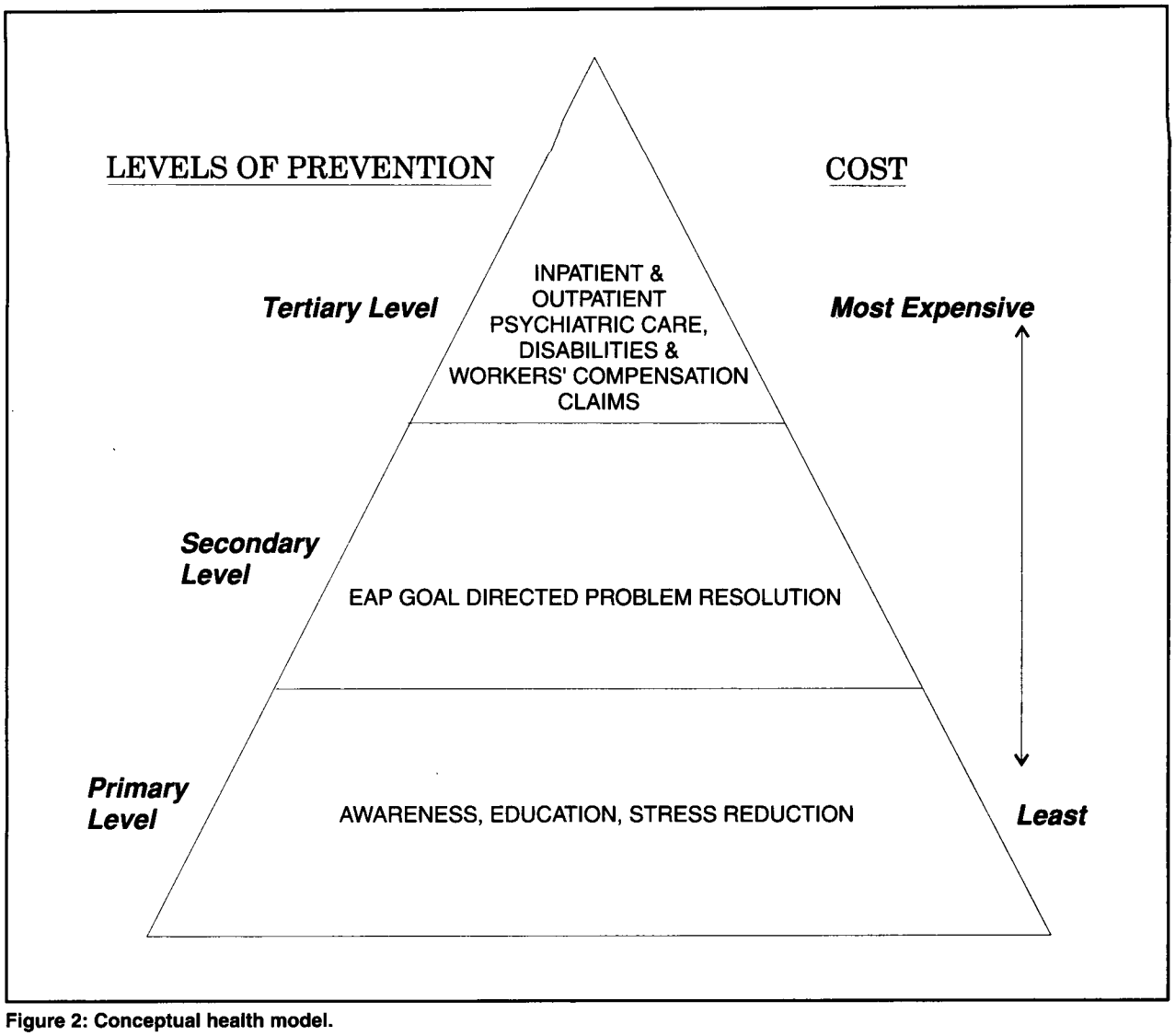

Figure 2: Conceptual health model.

ship and effective work groups. Although an EAP can help identify problems in these areas, the management problems need to be addressed for an EAP to be most successful.

Following implementation, ongoing evaluation should be the next consideration. The critical elements of the program identified during the initial assessment and selection process should be reidentified here, along with the initial goals set by management and the hypothesis upon which the program was based. A comprehensive assessment and planning phase will make evaluation a much easier and more accurate task. The financial data that initially pointed to a need for an EAP should be reviewed and the same data elements should be collected again for comparison after the first full year of the program.

Here again, a well selected provider or manager will be of great assistance. What evaluation tools can they provide? Many behavioral health programs are beginning to measure treatment outcomes for reporting purposes. This is an important tool to measure value. What other information can be provided by the EAP based on its standard report? Were its utilization projections met? If not, why?

If the EAP does not routinely survey clients at completion of their EAP sessions, they should be asked to develop a survey tool to accomplish that task. This should be done in conjunction with the company to ensure that the feedback is useful to the company in evaluating the program's progress toward meeting expected goals.

An inherent strength of an EAP is its design as a prevention tool. Intervention can be accomplished anywhere in the prevention continuum, from primary to tertiary. However, the focus of an EAP is on primary and secondary prevention, the least expensive and most effective types of intervention. Figure 2 depicts the different

levels of EAP prevention.

The principal focus of the EAP is mental health promotion and education. This serves not only as a vehicle to raise awareness of the client population, but to increase coping skills and encourage early entry into an EAP, before problems begin affecting the workplace or an individual's health.

While early intervention makes the EAP very attractive, it can complicate the evaluation of its effectiveness. It is difficult to demonstrate or measure the prevention of a negative event. The company and EAP should agree on indictors to be used to measure the EAP prevention efforts. These could include absenteeism, productivity measures, accidents, and disability, for example.

Corroborating data from multiple sources throughout the organization are helpful in more accurately evaluating the impact of the program. In addition to financial data and employee surveys, a third area to evaluate is management/supervision satisfaction. A survey tool could be developed to determine the value of the program to front line managers. Providing effective support and improving the skills of supervisors is a critical measure of the success of the EAP. Supervisors deal with the effects of personal problems in the work force on a day by day basis. Adequate and productive intervention on their part will make a significant difference to the efficiency and effectiveness of an organization.

ACT

Throughout the evaluation process, the EAP and the company should work collaboratively and creatively. All data, except that which is confidential, should be shared between company and EAP. The goal is not to "grade the EAP," but to join the best resources of customer and supplier in analyzing the collected data to allow for continuous program improvement as the end product. This sets the stage for a true joint venture and encourages a long term relationship.

As data point to areas of variation or deficit, these are discussed with the employee assistance provider. Together, the company and EAP should then work on developing strategies to improve, and the planning phase of the PDCA cycle begins again. When analyzing program performance, one should assume that improvement is always possible and that responsibility for that improvement belongs to both the EAP and customer company. Using this continuous cycle of activity can produce program quality and better results than anticipated by either party during the initial design.

IN SUMMARY

Needs Assessment and Implementation of an Employee Assistance Program

Promoting a Healthier Work Force.

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1. The functions of a continuous quality improvement tool used by Deming—the Plan, Do, Check, Act Cycle—can be applied to the assessment, implementation, and ongoing evaluation of an Employee Assistance Program (EAP).

2. Various methods are available to assess the need for an EAP. As much data as possible should be collected to qualify and quantify the need so that management can make an informed decision and develop measures to determine program effectiveness.

3. Once an EAP is implemented, it should be monitored continually against the effectiveness measures initially developed. Using a continuous quality improvement process, the occupational health nurse and the EAP provider can establish a dynamic relationship that allows for growth beyond the original design and increased effectiveness of service to employees.

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