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THE ETHICS OF REFERRALS AND OWNERSHIP STRUCTURES IN EMPLOYEE ASSISTANCE: ISSUES, CONFLICTS, AND THE NEED FOR A REVISED ETHIC

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A recent study examined how a nation-wide random sample of EA professionals perceived the state of ethical conduct related to the business practices within the EA/managed behavioral healthcare field (Sharar, White, and Funk, 2001). Ten percent of a diverse mix of EA professionals, comprised of EAPA and EASNA members, were randomly surveyed in the fall of 2000 and 43% responded, a return rate well within rates normally seen in health care ethics surveys. Data analysis included the use of descriptive statistics for those variables that could be quantified and qualitative analysis for open-ended questions. This article will highlight some findings related to the ethics of referrals and ownership structures along with some interpretation of issues and practical judgments. Specifically, two primary concerns will be addressed: (1) Biased referral patterns among local/regional EA providers, and (2) Concerns of competence and value among large-scale, national EA vendors.

Twenty-two percent of respondents identified the ethics of EA referrals and ownership structures as one of the most important or critical business ethical issues facing the field. It is important to emphasize that the following discussion is based on EA professionals' perceptions of ethical problems, not the actual prevalence of ethical breaches in the EA field.

Biased Referrals to Vested Programs/Practitioners in Local/Regional EAPs

Survey data suggests that over 60% of EAPs are owned and operated by behavioral health agencies, hospitals, or private clinics (e.g. parent organizations). These local and regionally based players tend to be not-for-profit organizations or proprietor owned practices or treatment facilities. Even though these types of EAPs are prevalent, they likely comprise less than 25% of total EAP enrollment in the U.S.

A commonly cited ethical concern was that parent organizations that own and operate EA programs engage in biased referral practices, meaning the parent expects its EAP to generate treatment revenue via a pattern of preferential referral beyond the EAP to vested programs or practitioners. In effect, the parent (implicitly

or explicitly) utilizes its EAP division or department as a business development strategy for the expansion of "feeder" systems and increased market security. Given that an "objective" or "neutral" EA referral is a "cornerstone of an ethical EAP" (EASNA Code of Ethics), the concern is that EA professionals (who work for parent organizations) could base referrals on factors that are not related to connecting the client with the most appropriate helping resource available. Instead, referrals could be based on financial interests that conflict with "neutral" or "objective" assessments of where a client's treatment needs could best be met. This situation creates potential conflicting loyalties for the EA clinician, potentially undermining the clinician's fundamental obligation to serve as a client advocate. An incentive exists for the EA clinician to increase the number of referrals to an affiliated program and yet there is a simultaneous obligation to present the best "independent" treatment options available to the client.

The perception that this biased referral practice of "self-feeding" is pervasive and unethical among EAPs owned by parent organizations was strongly challenged by a sub-set of respondents. This group of respondents called the prohibition against self-feeding "outdated", "impractical", and "overstated", citing the following reasons:

1. Many EAPs, with short-term counseling models, have become inadequate replacements for marginalized (or non-existent) outpatient behavioral health benefits, making referrals more obsolete.
2. Claims denials, delayed payments, reduced fees, and payment hassles have made third party, commercially insured referrals increasingly undesirable, particularly among not-for-profits who are forced to add expensive overhead to their billing/collections departments.
3. Managed care plans, not EAP clinicians, usually determine if and where clients receive on-going treatment beyond the EAP.
4. Managed care plans frequently do not include community-based not-for-profit providers/programs on preferred panels, and even when inpatient/residential referrals are recommended by EAP and authorized by managed care, the service dosage is sharply reduced and tightly monitored.

Are there ways for EA professionals to "ethically" refer clients to other practitioners or programs within their own organizations? Respondents offered the following suggested procedures to mitigate any appearance or accusation of unethical conduct:

- full disclosure is made (to both employer and client) regarding any affiliations with proposed referral options,
- the EA clinician "objectively" presents more than one referral option to the client,
- the referral is clinically justifiable (in the best interests of the client),
- the referring EA clinician does not receive any direct gain or financial remuneration for referring clients to particular programs or practitioners,
- the EAP should institute a peer review approach to monitor and evaluate the quality and appropriateness of referrals, and
- the employer's utilization/service summary report should contain detailed information on patterns/sources of referrals beyond the EAP for continuing care and treatment.

Concerns of Competence and Value in National EAPs

Historically, local/regional EA vendors dominated the EAP industry; this is in marked contrast to present times where a

few nationally based vendors hold about 75% of total EAP enrollment in the U.S. These national players tend to be for-profit, insurance-based and investor-owned companies that offer EAPs to large employers along with other core products, such as managed behavioral healthcare and work-life benefits.

One key ethical concern respondents alluded to is the competence and use of EA subcontractors (a.k.a. “affiliates” or “network providers”) by national vendors when referrals are indicated (national vendors routinely subcontract with practitioners in locations where the vendor does not have a staff office). Respondents suggested that many subcontractors utilized by national vendors, while licensed in their respective behavioral health disciplines, lack a rudimentary understanding of the anatomy of a referral in the EA context. Common mistakes by subcontractors (who are allegedly inexperienced in the distinguishing aspects of EA practice) include: (a) lacking knowledge in available community resources, (b) being reluctant to refer clients, except occasionally to themselves, (c) failing to assess when a referral is in order, particularly with chemical dependency cases, (d) failing to understand the mechanics of a company supervisory referral, (e) confusing the simple task of handing over a phone number with the complete referral of a client, (f) failing to conduct any follow-up with the referral resource or client.

Another ethical concern noted by respondents, which is decidedly more broad and qualitative in nature, is that the quality of EA programming is withering in the face of massive consolidation and large-scale national mergers as the predominant ownership structure in the field. This restructuring of EA providers could compromise the best interests of individuals served by EAPs as well as the long-term interests of companies and overall commitment to the EA field. It is interesting to note that 71% of respondents employed by national vendors cited this concern in addition to 82% of respondents employed by local/regional firms. What is not entirely clear from the survey data is whether or not this could be viewed as a case of national EA vendors indicting themselves.

At the heart of this issue is the perception that national vendors lack, as a core value, a collaborative, community-based ethos based on geographic proximity, personal communication, community benefit, and outcome over cost. In other words, EAPs, employers, employee families, and service providers, under national plans, are “a group only united by a contract, brochure, and rare telephone calls", according to one respondent. This lack of ethos in national vendor models manifests itself in ways that minimizes and dilutes some of the potential “strengths” of local/regional EA firms:

- community knowledge that allows for a local understanding of helping resources and linkages,
- a connection (or even integration) between the local EA vendor and the local work site,
- the retention of dollars and assets within the community itself,
- a commitment to finding innovative ways to solve the local employer’s workplace issues,
- the ability to react responsively to local employer concerns and crises,
- the ability to quickly custom tailor programs and procedures to meet the employer’s unique circumstances.

Local/regional players generally believe they are in better positions to truly form collaborative relationships with area employers and referral resources which leads to more integrated, innovative, and customized programs, as opposed to “off the shelf” programs. One respondent commented that “close, collaborative relations between EAPs, employers, and referral resources can only occur at the local level and are simply not possible with a national vendor who manages services from a distance”.

Local/regional players also tout the fact that they are either not-for-profits or small business entities who do not have "an obligation to a third party stockholder who is not the employer/purchaser or the employee client". That financial obligation requires that a portion of the premium dollar gets shuffled to investors and debt facilities. The perceived implication is that a larger percentage of the premium dollar with the local/regional EAP is utilized to provide direct client care and employer services (e.g. assessment, counseling, follow-up, training, supervisor consultation, account management, etc.). Although all vendors want to ultimately "be in the black", allocation of profits to shareholders is not a fundamental criterion for success among local/regional firms.

Despite these criticisms, national EA vendors claim to offer many program features and infrastructure capabilities that are especially attractive to large employers with multiple locations, as evidenced by their undisputed dominance in the market place. A few of these features include:

- superior access to capital in order to offer program innovations and improvements, such as on-line platforms for employees or supervisors seeking EA services,
- the ability to afford and implement established or emerging accreditation requirements, such as the National Committee for Quality Assurance managed behavioral healthcare standards,
- more sophisticated management information systems and databases which allow for the management of financial risk and the delivery of complex reports,
- expansive, nationwide networks of affiliates which enables all locations to be serviced through a single contract between the national vendor and the employer,
- the ability to provide products that can be integrated with an EAP, such as a work-life program or managed behavioral healthcare service,
- economies of scale that are unattainable in local/regional models which ultimately produce more competitive pricing.

Sub-sets of national vendors also challenge the claim that their services are not locally focused and community-based. Some national vendors have "regionally-based" account management and service center sites which emphasize the same type of local integration, coordination, and responsiveness that the local/regional vendors claim is their unique advantage. This supportive regional management structure, when in place, has the potential to produce the kind of collaborative, community-based ethos that many respondents perceive as missing in national EA vendor models.

Does it make a difference in the quality of the program if the vendor is local/regional or national? It probably does, according to the perceptions and opinions of respondents in this survey, but the quality is not automatically better in one than the other. The reality is that work organizations, as purchasers and decision-makers, not EA professionals, bear the ultimate responsibility for determining what constitutes a quality program in their vendor of choice. Whether an EA provider is local or national, for-profit or not-for-profit, or owned by a parent organization or managed care company is likely a combined response to employer preferences, marketing prowess of the vendor, and perceived relative value and consumer satisfaction.

Conflicts of Interest in Ownership Structure in the EA field

In theory, the predominant ownership structures among EAPs are set up to either (1) encourage referrals for treatment to affiliated programs to generate revenue (e.g. EAPs owned by parent organizations), or (2) discourage referrals for treatment to minimize costs (e.g. EAPs owned by

national insurance or managed care companies). Regardless of one's perspective on the competing ethical virtues and demerits surrounding referral practices and ownership structures, this scenario requires an appreciation for irony, particularly given our "duty" to avoid even the appearance of conflicts of financial interest.

Any financial incentives which are organizationally structured to induce EA professionals to either limit necessary care or encourage unnecessary care has the potential to coincide with the welfare of the client or the interests of the client organization. Ethical problems are more likely when owners encourage certain decisions or referrals by financially rewarding or penalizing EA clinicians or gatekeepers on the basis of their patterns of practice. One of the most notable financial incentive programs employed by owners is to attach a bonus, usually from a pool of withheld funds from a capitated EA payment, to specific utilization goals. Consider, as an example, the case where an EA gatekeeper receives an end-of-year bonus that is tied to reducing admissions and service dosage for intensive and costly treatment services. This type of program could force the gatekeeper to choose between receiving a monetary bonus or providing more care to a client.

Financial incentive programs are not in and of themselves unethical and have the potential to eliminate inefficiency and encourage only optimal and necessary care. Consider another case where an EA clinician receives an end-of-year bonus for achieving high levels of client satisfaction and acceptable clinical outcomes when providing appropriate brief intervention within an eight-session EAP model.

A general rule of thumb, as suggested by the American Medical Association's Council on Ethical Affairs (1998), is to find ways to base incentive programs on indicators associated with quality rather than quantity of services or referrals and avoid linking financial incentives to individual treatment decisions. One problem with this suggestion is that measurements of quality in EAP and behavioral health are rudimentary at best. Our field, and the work organizations we serve, cannot seem to reach consensus on what constitutes a "quality" program. Some examples of quality performance indicators employed by various owners as a financial incentive program include: (a) length of time to schedule routine or urgent appointments, (b) resolution of problems within a short-term counseling model, and (c) client satisfaction with their EA clinician.

What would an EAP look like were it organized and structured to neutralize the incentives to under-serve or over-refer clients and maximize the incentives to provide an ethical program of high quality? Enumerating these organizational features is beyond the scope of this article, although we must, as a field, encourage employers to select EA vendors and models that foster the principled practice of EA programming.

Reflections on the Need for a New Professional Ethic

These are challenging times for the EA field. We perceive a growing disconnect between the historic concept of EA ethics and the changing circumstances and emerging environment in the provision of EAP. The current climate of intense competition for increased market share, operating losses, "merger mania", referral incentives masked as integrated delivery systems, and blurring of boundaries between EA entities and ancillary products is unlikely to foster an atmosphere that nurtures high standards in referral and business practices. It seems the field is being pulled in one direction by members of the traditional guard, who rail against programs that have drifted away from the original mission of employee assistance, and in another by programs and entrepreneurs that are diverse, expansive, and market or profit driven. The latter calls for a new professional ethic, one that is not yet developed or institutionalized, and takes into account a broader, more complex set of business related ethical guidelines and responsibilities. Because of this growing

misfit between traditional concepts of EA ethics and professionalism and dominant ownership structures and referral practices, we argue the field needs a new professional ethic that incorporates these emerging complexities and the ways EAP actually operate.

Two areas addressed in this article that substantiate the need for a new professional ethic are the challenges presented by: (1) the advent of large scale, national models of service delivery, and (2) EAPs owned by parent organizations that need to, at a minimum, confront the appearance of a conflict of financial interest. This article is not proclaiming a type of modern day "David" (righteous local/regionals) versus "Goliath" (money hungry national vendors). Each type of ownership structure, as discussed, has its own version of ethical vulnerabilities derived out of its respective historical context and institutionally driven interests.

One place to start is with this new ethic is to revise our codes of ethics and conduct. Current codes of ethics and conduct (EAPA and EASNA) lay an ethical foundation but hardly build the whole house. They are minimalist codes that are restricted in scope and unable to provide much guidance to the complex and ambiguous predicaments related to the business practices of EAPs, such as the ethics of referral and ownership. Our vision is that the leadership of the EA field engage in ethics related advocacy by organizing and supporting an "Ethics Summit", comprised of a diverse mix and cross section of EA leaders, practitioners, constituents (e.g. employee/employer consumers), and appropriate representatives from allied fields (e.g. human resources, benefits, labor, managed care, treatment, etc.). This Summit would not be a conference but rather a working meeting with sub-groups entering into a dialogue on how to revise segments of the field's Code to be more relevant and informative in the area of business ethics. Another goal of this Summit could be to explore ways to develop an independent audit function for all external EAPs.

In closing, we are reminded of a quote in the Hastings Center Report (1990) by Leon Kass who was commenting on the state of ethics in health care: "Though originally intended to improve our deeds, the reigning practice in ethics, if truth be told, has, at best, improved our speech." Our hope is that some of the survey findings and interpretation of issues in this article will stimulate interest and discussion in a way that ultimately affects referral practices and ownership structures in the EA field and is not just exercise in "ethics talk".

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Declaration of Institutional Interest: Chestnut Health Systems, a private not-for-profit community-based provider, owns and operates a division that provides regionally based EA services. In addition to employee assistance, Chestnut also provides a wide variety of behavioral health care programs, prevention activities, and research, program evaluation, and training services. Both authors are employed by Chestnut Health Systems.