



# **Addressing Substance Use Problems: Workplace–Based Programs and Resources**

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# Today's Presentation

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- Workplace-based programs: the landscape
- Employee Assistance Programs
- Disease management
- Wellness/health promotion
- Issues to consider for future



# Why the Workplace?

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- Most people with substance use disorders are employed
- Time and connections in the workplace
- Incentives for employers
- Key role of employers in providing health benefits



# “Workplace”

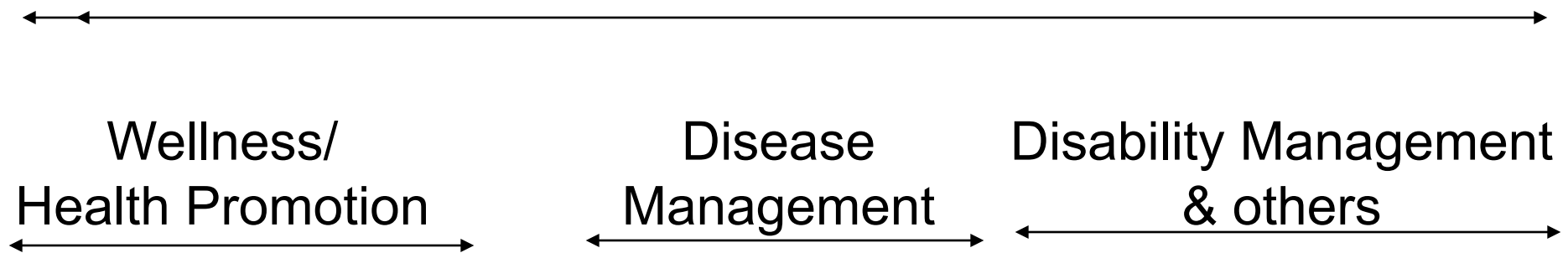
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- May mean interventions actually take place on site
- Or workplace is route to reaching people
- Or workplace connection is simply that employers pay for the program or resource



# Program Targets

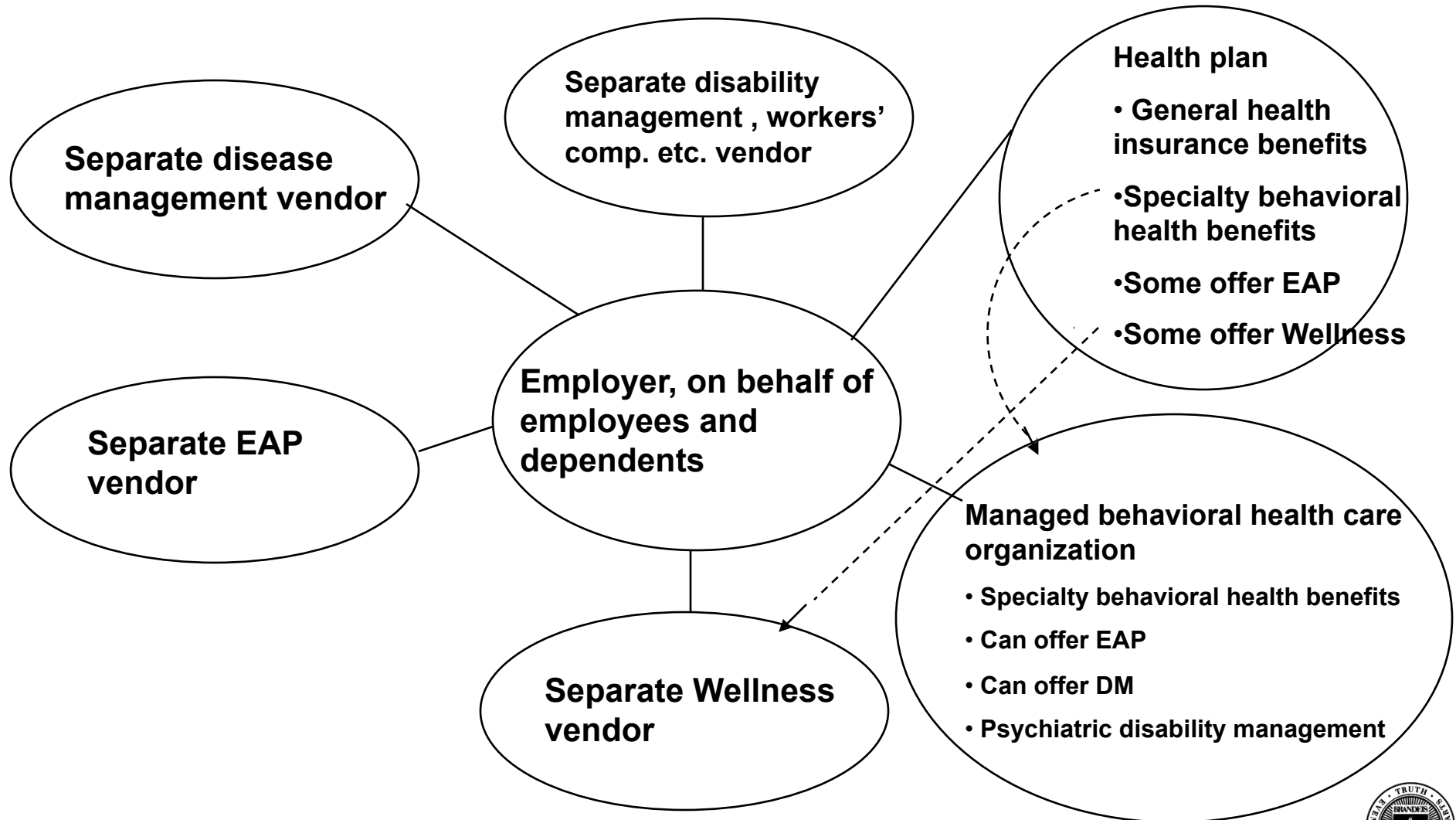
Employee Assistance Program\*



<b>Prevention</b>	<b>Addressing Risky Use</b>	<b>Enhancing Treatment/ Managing Disorders</b>	<b>Addressing Consequences of Disorders</b>
		<b>*[EAP: Assess/ refer/support]</b>	<b>*[EAP: Coordinate, assist with RTW]</b>
<b>No risk factors or risk factors but no disorder</b>		<b>Has formal disorder</b>	<b>Has formal disorder with specific consequences, disability</b>



# Employer/Workplace as Locus of Programs and Resources



# Employee Assistance Programs (EAPs)

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Workplace-based programs designed to address substance use and other problems that negatively effect employees' well-being or job performance

Blum, TC, Roman PM: Cost-Effectiveness and Preventive Implications of Employee Assistance Programs, in, Vol. No. DHHS RP-0907. Edited by Substance Abuse and Mental Health Services Administration CfSAP. Rockville, MD, DHHS, 1995.



# Scope and Prevalence of EAPs

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- Today's EAPs evolved from occupational alcohol programs
- Most contemporary EAPs are “broad-brush” programs addressing wide range of issues
  - Substance use problems
  - Mental health
  - Work-life including resource assistance, e.g. referral/consultation on childcare, eldercare, legal, financial issues
  - Organizational component
- 66% of worksites with 100 or more employees have EAP (2005 Bureau of Labor Statistics)
- More common in larger employers



# EAP Models & Benefits

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## Models

- Internal – original, less common
- External – contracted out, network model, private office location
- Can have hybrid model
- Face-to-face, telephonic, web-based resources

## Benefits

- Often 3-8 visits for assessment +/- or short-term counseling
- Also 3-session or fewer model for information and referral
- NO COPAYMENT
- Often includes family members of employee
- Can be a separate benefit or integrated with behavioral health benefits



# EAP Evidence Base

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- **Reviews of EAP research (only some specific to SUD), most studies have found improved clinical and work outcomes; also evidence of SBIRT effectiveness specifically within EAP.**
- **Cost effect complex: utilization and direct health care costs may increase utilization temporarily (e.g. due to facilitation of needed services) but productivity improvements and longer-term health impact may reduce costs in longer term; more research needed.**
- **Most large companies find it worthwhile to offer, many findings of positive ROI**
- **In general, need for additional EAP research:**
  - **Methodological issues (single case studies, lack of appropriate control or comparison groups, selection bias, etc.)**
  - **Older studies based on EAP models that are now rare**
  - **Need to learn more about contemporary EAP programs and “active ingredients” (black box/heterogeneity issues)**

*(See references last slide)*

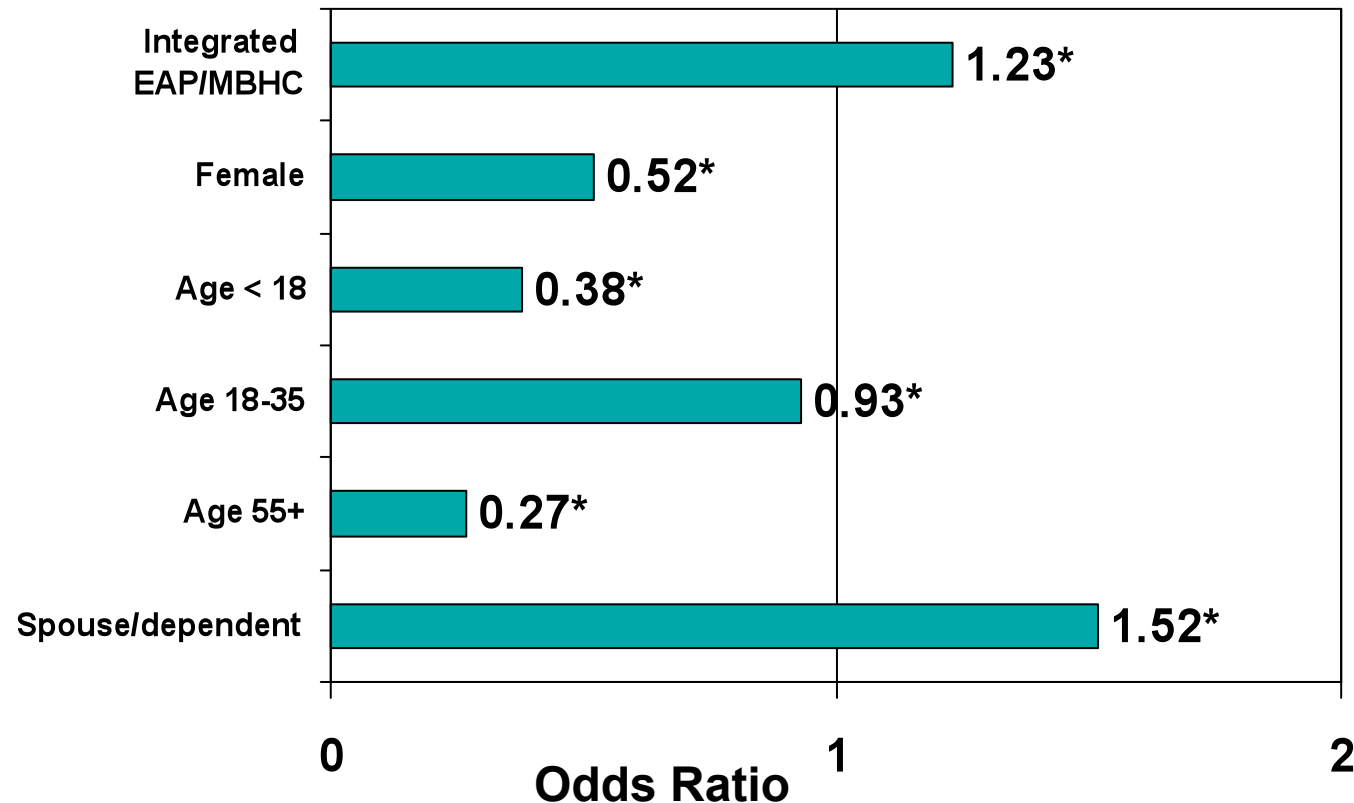


# Utilization challenges

- Even when programs and practices may be effective, need to engage in them to derive benefit
- Reported EAP utilization varies widely, partly due to differing ways of calculating
- Also, how does EAP affect BH utilization?
- Example from current “Pathways to SA Treatment” study in the NIDA-funded Brandeis/Harvard Research Center



# “Pathways to Substance Abuse Treatment” Study Access Findings: Factors Affecting Likelihood of Any SUD Claim, in Large MBHO, 2004



N = 286,750 enrollees (weighted) in integrated and MBHC only plans

Model also controlled for employer size state parity laws (NS), and region (lower in Midwest and South vs. West)

Merrick, ESL, Hodgkin, D, Horgan, CM, Hiatt, D, McCann, B, Azzone, V, et al. Integrated Employee Assistance Program/Managed Behavioral Health Care Benefits: Relationship with Access and Client Characteristics. *Adm Policy Ment Health* (2009) 36:416-423.



# Predictors of any EAP Clinical Service Use

Organizational Factor	Odds Ratio (95% CI)
<b>Higher level of employer promotion of EAP/integrated product</b> (Reference = Low to moderate promotion)	1.14* (1.10-1.18)
<b>Any worksite EAP activities conducted</b> (Reference = No worksite EAP activities)	1.09** (1.03-1.15)
<b>High employer focus on wellness and prevention programs</b> (Reference = Low to moderate level of focus)	0.96** (0.92-1.00)
<b>Experienced unusual/significant workplace stress in past year</b>	0.86* (0.83-0.90)

\* p<.01, \*\* p<.05      N=853,317 enrollees, 2005

Azzone V, McCann B, Merrick EL, Hiatt D, Hodgkin D, Horgan CM. Workplace stress, organizational factors and EAP utilization. *Journal of Workplace Behavioral Health* 2009; 24(3):344-356.



# How do EAP benefits affect behavioral health treatment utilization?

- Examining 26,464 service users (EAP and/or MBHC), 2005
- Having one additional EAP visit allowance is associated with a rate of 11% fewer behavioral outpatient sessions.
- For each (actual) EAP visit, annual costs for regular behavioral outpatient care were reduced by 16%.
- Having an EAP benefit of 4-5 sessions/incident predicts a lower use of regular outpatient sessions, compared with an EAP benefit of 3 sessions/year
- Partial offset in utilization

(Hodgkin D et al. manuscript under review)



# Disease Management Programs

- DM has been defined as “a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant” (DMAA)
- Key components:
  - Population-identification processes
  - Evidence-based practice guidelines
  - Collaborative practice models
  - Patient self-management education
  - Process and outcomes measurement, evaluation and management
  - Routine reporting and feedback



# Disease Management Approaches

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- Commercial DM programs generally telephonic
- Patient-focused activities including visit and medication adherence reminders and support, self-management tools and coaching, care coordination, outcomes measurement
- Provider-focused activities include feedback on patients' medication adherence, other process of care measures, outcomes feedback, guideline
- Other disease management more based in provider settings – enhanced chronic care management a la Wagner CCM through practice transformation



# Prevalence and Focus of Disease Management Programs

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- Targeted to persons with chronic disease
- National survey of health plans found over 90% had a disease management program (Brandeis Health Plan Survey)
- Medical disease management programs adopted widely first
- Depression disease management programs = 37% of health plans in 2003; virtually no substance abuse programs
- Now, signs of increased interest in substance abuse disease management



# Disease Management Evidence Base

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- Reviews and meta-analyses have found support for effectiveness of (non-substance abuse) disease management—improved care processes, some clinical outcomes *(see references last slide)*
- Some disappointing results, however, and cost savings/ROI results – varies by disease focus
- For depression, including productivity impacts and a longer time frame suggests significant net benefit to employers - unlike short- term health care cost results

(LoSasso et al., *Medical Care* 2006; Wang et al. *Arch Gen Psych* 2006, *JAMA* 2007)



# Disease Management and Substance Use Disorders

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- Alcohol and drug dependence are very appropriate targets for disease management
- Little published data so far
- A RTC of disease management for substance dependence has been conducted, results to be published soon (R. Saitz, JGIM abstracts, Spring 2010)



# Wellness/Health Promotion

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- Focus on prevention
- Often based on health risk appraisal/assessment (HRA)
  - Survey on health status, history, lifestyle
  - Typically voluntary, sometimes with financial incentives
  - Usually broad in focus, not specific to substance use
  - However, alcohol use in particular is typically captured (screening, risk stratification)
- Feedback on HRA results provided to individuals
- Wellness programs often include health coaching, self-management tools, other supports; classes, fitness/exercise



# Findings on Wellness/Health Promotion

- Most not focused on substance use, SUD
- Heterogeneous programs out there, but most recent studies and reviews indicate at least moderate effectiveness and positive ROI (see reference list)
- Need more research focused specifically on substance use as an outcome
- Some indications that programs targeted at other conditions (e.g. cardiovascular) may reduce risky drinking



# Issues to Consider

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- Multiplicity of programs – working together
- Participation rates, program promotion
- Additional research on wellness programs with both direct and indirect focus on alcohol, other substances
- Implications of parity and health reform



## Additional References

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