Referrals and Ownership Structures

The first of two articles on the need for a revised ethic in employee assistance considers whether ownership structures can improperly influence EAP professionals.

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A recent study examined how a random sample of employee assistance professionals perceive the state of ethical conduct related to business practices within the EA/managed behavioral health care field (Sharar, White, and Funk, 2001). The survey, conducted in the fall of 2000, was distributed to a diverse mix of members of the Employee Assistance Professionals Association and the Employee Assistance Society of North America.

Forty-three percent of survey recipients responded, a return rate well within rates normally seen in health care ethics surveys. Data analysis included the use of descriptive statistics for variables that could be quantified and qualitative analysis for open-ended questions.

Twenty-two percent of survey respondents identified the ethics of EA referrals and ownership structures as among the most important or critical business ethical issues facing the industry. This article will address concerns about possible bias in referral patterns among local/regional EA providers.

Note: 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.

Preferential Referrals

Survey data suggest that more than 60 percent of EAPs are owned and operated by behavioral health agencies, hospitals, or private clinics (i.e., parent organizations). These entities tend to be nonprofit organizations, proprietor-owned practices, or treatment facilities. Although these types of EAPs are prevalent, they likely comprise less than one-quarter of total EAP enrollment in the United States.

Many survey respondents expressed concern that parent organizations that own and operate EAPs expect them to generate treatment revenue via a pattern of preferential referral to vested programs or practitioners. According to these respondents, the parent implicitly or explicitly uses 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), an expectation of preferential referrals would create conflicting loyalties for the EA professional, potentially undermining his/her fundamental obligation to serve as a client advocate. An incentive would exist for the EA professional to base referrals on financial interests that conflict with "neutral" or "objective" assessments of how and/or where a client's treatment needs can best be met.

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

- Fully disclosing (to both employer and client) any affiliations with proposed referral options;
- Offering an "objective" presentation of more than one referral option to the client;
- Providing clinical justification that the referral is in the best interests of the client;
- Refusing to accept any direct gain or financial remuneration for referring clients;
- Instituting a peer review program to monitor and evaluate the quality and appropriateness of referrals; and
- Developing a utilization/service summary report for employers containing detailed information on patterns of referral for continuing care and treatment.

Ownership Structure Conflicts

In theory, the predominant ownership structures among EAPs are set up to encourage referrals for treatment to affiliated pro-

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grams to generate revenue (e.g., EAPs owned by parent organizations) or to discourage referrals for treatment to minimize costs (e.g., EAPs owned by national insurance or managed care companies). Organizational financial strategies that induce EA professionals to either limit necessary care or encourage unnecessary care have the potential to conflict with the welfare of the individual 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 professionals or gatekeepers on the basis of their patterns of practice. One of the most notable financial incentive programs employed by EAP 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 professional 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 EA professional to choose between receiving a monetary bonus or providing more care to a client.

Financial incentive programs are not, in and of themselves, unethical; properly structured, they have the potential to eliminate inefficiency and encourage only optimal and necessary care. For example, 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 interventions within an eight-session EAP model.

A general rule, as suggested by the American Medical Association's Council on Ethical Affairs, 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 employee assistance and behavioral health are rudimentary at best. Our profession, and the client organizations we serve, cannot seem to agree on what constitutes a "quality" program. Some examples of quality performance indicators employed by various owners as part of a financial incentive program include—

- Length of time to schedule appointments;
- Resolution of problems within a short-term counseling model; and
- Client satisfaction with the EA professional.

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

A New Professional Ethic?

These are challenging times for the EA field. We perceive a growing disconnect between the historic concept of employee assistance ethics and the changing circumstances and emerging environment in the provision of employee assistance services. The current climate of intense competition for increased market share, operating losses, "merger mania," referral incentives masked as integrated delivery systems, and the 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 EA field is being pulled in one direction by members of the traditional guard, who rail against programs they feel 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 are calling for a new professional ethic that takes into account a broader, more complex set of business-related ethical guidelines and responsibilities.

One place to start is to revise our codes of ethics and conduct. Current codes of ethics and conduct (those of 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 for the leadership of the employee assistance field to engage in ethics-related advocacy by organizing and supporting an "ethics summit" composed of a cross-section of EA leaders, professionals, constituents (employee/employer clients), and representatives from allied fields (e.g., human resources, benefits, labor, managed care, treatment, and so on). This summit would be a working meeting, with subgroups entering into a dialogue on how to revise the field's ethics codes to be more relevant and informative in the area of business ethics. Another goal of the 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," Kass said, "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 interpretations of issues in this article will stimulate interest and discussion (not just "ethics talk") in a way that ultimately affects referral practices and ownership structures in the EA field. E

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Declaration of Institutional Interest: Chestnut Health Systems, a private, nonprofit community-based provider, owns and operates a division that provides regional EA services. In addition to employee assistance, Chestnut also provides a wide variety of behavioral health care programs, prevention activities, and research as well as program evaluation and training services. Both authors are employed by Chestnut Health Systems.