BEST CARE
EMPLOYEE ASSISTANCE PROGRAM

9239 W. Center Road, Suite 201
Omaha, NE 68124-1900
402.354.8000 or 800.801.4182
Fax: 402.354.8046
www.BestCareEAP.org

AFFILIATE PROVIDER PACKET

Reimbursement Requirements

In order to fulfill our reporting responsibilities to our customer companies, and for you to be reimbursed for the services that you will provide for us, all the following forms (Alcohol/Drug Assessment only when applicable) must be completed and returned to Best Care EAP:

Forms for affiliate counselor to complete:

Authorization of Service. This two-page form must be completed for all service billings.

WHEN APPLICABLE: Alcohol/Drug Assessment. This form is used with alcohol/drug-related referrals when an alcohol/drug assessment has been arranged. Please complete this form in its entirety, including the provision of a diagnostic impression and suggested education, counseling or treatment recommendations. **Please do not discuss final treatment recommendations with the client prior to consulting with a Best Care EAP counselor.** If counseling or treatment will likely be recommended by Best Care EAP, please include the name of a qualified provider who could provide the counseling or treatment. **Please complete the form and fax it to Best Care EAP within forty-eight hours after the assessment has been completed.**

Forms for client to complete:

Privacy Notice Written Acknowledgement. Please provide each client a copy of our *Privacy Notice* and have them complete the *Written Acknowledgement* indicating they have been provided our privacy notice. If a client declines to sign, please note this on the form and sign and date it.

Statement of Understanding. This form provides a brief overview of Best Care EAP's counseling services, including communications between Best Care EAP and you, their affiliate provider. Please have the client read and sign this form. If a client declines to sign, please note this on the form and sign and date it.

Client Screening Questions. These screenings provide guidance for the counseling by identifying potential problem areas. They are not diagnostic tools. Please have the client complete these screenings as part of their intake paperwork.

These forms can be accessed on our web site at http://www.bestcareeap.org/uploads/WEBSITE-ONLY---Alcohol-Drug-Affiliate-Provider-Packet.pdf. Feel free to duplicate the forms for use with future Best Care EAP referrals.

IMPORTANT REMINDER! In order for reimbursement to be made, Best Care EAP must have your completed *Affiliate Provider Agreement* on file.

<u>ATTENTION ALCOHOL/DRUG ASSESSMENT PROVIDER:</u> PLEASE DO NOT DISCUSS FINAL TREATMENT RECOMMENDATIONS WITH THE CLIENT PRIOR TO CONSULTING WITH A BEST CARE EAP NATIONAL COUNSELOR.

BEST CARE EMPLOYEE ASSISTANCE PROGRAM

ALCOHOL/DRUG ASSESSMENT

CLIENT NAME: _____

LAST 4 DIGITS OF CLIENT'S SS#: _____

TYPES OF ALCOHOL/DRUGS USED:

1. Type: _____
   Age of first use: _____
   Frequency: _____
   Quantity: _____
   Date of last use: _____
2. Type: _____
   Age of first use: _____
   Frequency: _____
   Quantity: _____
   Date of last use: _____
3. Type: _____
   Age of first use: _____
   Frequency: _____
   Quantity: _____
   Date of last use: _____
4. Type: _____
   Age of first use: _____
   Frequency: _____
   Quantity: _____
   Date of last use: _____

PERIOD OF HEAVIEST USE (ex.: age 20 – 22): _____

DURING PERIOD OF HEAVIEST USE:

Type of drug used: _____

Age of first use: _____

Frequency of use: _____

Quantity of use: _____

FAMILY HISTORY OF DRUG USE: _____

_____

SYMPTOMS EXPERIENCED (IF CHECKED, PLEASE EXPLAIN):

☐ loss of control _____ ☐ black outs _____
☐ preoccupation _____ ☐ tolerance _____
☐ withdrawal _____ ☐ attempts to "cut back"_____
☐ other _____
_____

CONSEQUENCES OF USE (IF CHECKED, PLEASE EXPLAIN):

☐ marital_____ ☐ family _____
☐ physical health _____ ☐ social _____
☐ work _____ ☐ legal/DUI _____
☐ financial _____ ☐ other _____
_____

HISTORY OF TREATMENT: ☐ Yes ☐ No
If yes, where, when, type: _____
_____

12-STEP PROGRAM ATTENDANCE: ☐ Yes ☐ No
If yes, name of program and when: _____
_____

COLLATERAL SOURCE(S) CONSULTED? ☐ Yes ☐ No
If yes, please provide pertinent collateral information: _____
_____
_____
_____

TESTING TOOLS ADMINISTERED? ☐ Yes ☐ No
If yes, please list type of tool and provide interpretive summary: _____
_____

DIAGNOSIS AND/OR DIAGNOSTIC IMPRESSION: _____
_____
_____

TREATMENT RECOMMENDATIONS (TO BE REVIEWED/APPROVED BY BEST CARE EAP)

Individual Alcohol/Drug Counseling Sessions ☐ Yes ☐ No If yes, # of sessions: _____

Alcohol/Drug Treatment ☐ Yes ☐ No

☐ Level I Outpatient Days/Time/# of Sessions: _____

☐ IOP Days/Time/# of Sessions: _____

☐ Residential Days/Time/# of Sessions: _____

☐ Inpatient Days/Time/# of Sessions: _____

Education or 12-Step Program Meeting Attendance (ex: A/D Ed. and AA/NA) ☐ Yes ☐ No
If yes, education, name/location of Program: _____

If yes, AA/NA, name of Program: _____ # Meetings per week: _____

Aftercare/Continuing Care ☐ Yes ☐ No
If yes, type/frequency of aftercare/continuing care: _____ Duration: _____

If a counseling or treatment recommendation is made by Best Care EAP, can you, or your agency, provide this?
☐ Yes ☐ No

If no, please suggest an appropriate counseling or treatment provider (name, address and phone #):

_____

Please complete and fax to _____ at (402) 354-8046 within 48 hours after assessment has been completed.

NOTE: This form must be submitted along with Best Care EAP's *Privacy Notice Written Acknowledgement, Statement of Understanding, Client Screening Questions and two-page Authorization of Service* form in order for your services to be reimbursed.

_____ _____
Signature Date

_____ _____
Printed Name Phone Number

BEST CARE EMPLOYEE ASSISTANCE PROGRAMS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice applies to the following programs or services that are affiliated as part of Methodist Health System, Best Care Employee Assistance Program (Best Care EAP), and share similar information practices:

►Methodist Health System ● (402) 354-6863
►Best Care Employee Assistance Program ● (402) 354-8000 / (800) 801-4182

►Substance Abuse Expert Services ● (402) 354-8000 / (800) 801-4182

►Nebraska Licensee Assistance Program ● (402) 354-8055 / (800) 851-2336

►Community Counseling Program ● (402) 354-6891

Privacy Contact (402) 354-8096

The programs and services listed above will share your clinical information with each other, as necessary, to carry out counseling, payment and clinical services operations.

Understanding Your Record/Clinical Information
Every time you visit a Best Care Employee Assistance Program clinical service, a record of your visit is made. This record may include your presenting problems, background information, assessments, treatment, and plans for future clinical services. This information - your client record – is used to plan your clinical services.

Your Rights
Although your client record belongs to the program or service that compiled it, you do have certain rights with regard to your clinical information.

- You have the right to expect that your clinical information will be kept secure and used only for legitimate purposes.
- You have the right to receive this privacy notice that tells you how your clinical information may be used or disclosed.
- You have the right to know who has seen your clinical information during the previous six years, and for what purpose. If you make additional requests for such an accounting during any 12-month period, we may charge you a reasonable, cost-based fee.
- You have the right to view, and receive a copy or summary of, all of your clinical records in the format you request (electronic and/or paper), except for psychotherapy notes. Your request for a copy of your record must be in writing. We may charge you a reasonable, cost-based copying or labor fee for such copy.
- You have the right to ask for correction or amendment of anything in your records that you feel is in error. If we are unable to comply with your request we will notify you why in writing within 60 days. You also have the right to request that a statement of disagreement be included in your record. Your request must be in writing and include supporting documentation.
- You have the right to request we not use or share certain clinical information you consider especially sensitive for counseling, payment or our clinical services operations. You also have a right to request we not share information with your health insurer if you pay for a service or item out-of-pocket in full. However, we are not required to accommodate your request except as provided below.
- You have the right to be notified of a breach of your unsecured protected clinical information.
- You have the right to request confidential communications by asking us to contact you in a specific way or to send mail to a different address. We will honor all reasonable requests.
- You have the right to choose someone to act for you. If you give someone medical power of attorney or if someone is your legal guardian, we will confirm the person has the authority and can act for you before we take any action.

Your Choices
You have the right and choice to tell us to:

- Share information with your family, friends or others involved in your care;
- Share information in a disaster relief situation;
- Contact you for fundraising efforts.

Our Responsibilities
We also have certain responsibilities. These include:

- Maintaining the privacy and security of your clinical record;
- Providing you with a copy of this Notice;
- Abiding by the terms of this Notice;
- Notifying you if a breach occurs that may compromise your information;
- Not using or sharing your information other than as described in this Notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time; let us know in writing if you change your mind.

We may revise this Notice as our information practices change. Any revision will be effective for all information in the record, regardless of whether it was gathered before or after the change took effect. However, before we change our practices, a copy of our new Notice will be posted at all Best Care EAP offices and on our web site. The effective date of our Notice will always appear at the end of the Notice.

Our Uses & Disclosures for Clinical Services, Payment and Program Operations
When state law requires us to obtain your written permission to use or disclose your information for your clinical services, payment or program operations, we will do so. However, there are also situations where we may use or disclose your information for clinical services, payment and program operations without your permission.

We may use or disclose your information for clinical purposes.

For example: Information obtained by members of your clinical team will be documented in your record and used to determine the course of your clinical care. Your clinician, his/her clinical supervisor, and Best Care EAP management may communicate with one another personally and through your client record to coordinate your care. These exchanges may be done through electronic information networks.

We may use or disclose your information for payment purposes.

For example: We may provide your physician or other service provider with copies of reports that may help determine your future treatment. We may also disclose your information to another service provider for its payment purposes or its health care operations. We may send your bill to you or your insurance company. Your bill may contain information that identifies you, as well as your diagnosis, procedures and supplies used. However, if you pay for a clinical service out-of-pocket in full and request in writing that we not provide information to your health insurer, we will comply with your request unless a law requires us to share that information with them.

We may use or disclose your clinical information for program operations purposes and internal business practices.

This information is used in our ongoing efforts to improve the quality and effectiveness of the clinical services we provide.

Other Disclosures That May be Made Without Your Authorization
Unless we are otherwise restricted from doing so, we may also use or disclose your information for the following purposes without your authorization:

Affiliate Providers: Some services of our program are provided through contractual arrangements with affiliate providers. These include assessments, counseling, training, consultation, coaching, and other related services. When services are provided by an affiliate, we may exchange your information with each other so that we can provide the services that we have been asked to provide and they can bill us for those services. Our affiliate providers must use appropriate safeguards to protect your clinical information.

Business Associates: Some services of our organization are provided through contractual arrangements with business associates. When services are provided by a business associate, we may disclose your clinical information to our business associate so that they can perform the job we have asked them to do. In addition, we may disclose your clinical information to accrediting agencies and certain outside consultants. Our business associates must use appropriate safeguards to protect your clinical information.

Public Health: When required or permitted by law, we may disclose your clinical information to public health or legal authorities responsible for preventing or controlling disease, injury, or disability or performing other public health functions. In addition, we may disclose your clinical information in order to avert a serious threat to health or safety.

Specialized governmental functions: We may disclose your clinical information for military and veterans activities, national security and intelligence activities, and similar special governmental functions as required or permitted by law.

Law enforcement: We may disclose your clinical information for law enforcement purposes as required or permitted by law or in response to a valid subpoena, court order or other binding authority.

Disclosures required by law: We may use or disclose your clinical information as required by law provided such use or disclosure complies with and is limited to the relevant requirements of such law.

Health Oversight Agencies: We may disclose your health information to an appropriate health oversight agency, public health authority or attorney involved in health oversight activities.

Judicial and Administrative Proceedings: We may disclose your clinical information for judicial or administrative proceedings as required or permitted by law or in response to a valid subpoena, court order or other binding authority.

For More Information or to Report a Problem
If you have questions or would like additional information, you may contact Best Care EAP's Privacy Contact at the phone number listed at the beginning of this Notice or the Methodist Health System (MHS) Privacy Officer at (402) 354-6863. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Contact, with the MHS Privacy Officer, or with the Office of Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Effective Date: October 1, 2016

BEST CARE EMPLOYEE ASSISTANCE PROGRAMS

PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT

☐ I have received the Best Care Employee Assistance Programs Notice of Privacy Practices. (Note: My signature does not indicate that I have read, understood or agree with the Notice, only that it has been provided to me.)

_____ _____

Signature of Client (or Parent/Legal Guardian if client is a minor) Date

_____

(Relationship to client)

For Affiliate Provider use only

Documentation of Good Faith Effort

☐ Attempted to distribute the Notice of Privacy Practices to the client/parent/legal guardian, but the client/parent/legal guardian declined to acknowledge the receipt of the Notice of Privacy Practices.

☐ Client/parent/legal guardian directed to Best Care EAP website to view the Notice of Privacy Practices.

☐ The Notice of Privacy Practices was mailed to the client/parent/legal guardian on _____.
(Date)

☐ Other _____

_____

_____

_____ _____

Affiliate Provider Date

BEST CARE EMPLOYEE ASSISTANCE PROGRAM

STATEMENT OF UNDERSTANDING

Welcome to Best Care Employee Assistance Program. We provide assessment, short-term counseling, and referral services to employees and eligible family members of our customer companies and organizations. These EAP services are provided at no cost to the employee or family member. It is the responsibility of the client to pay for any services outside of the EAP counseling benefit.

EAP counseling services are strictly confidential and your counseling information cannot be disclosed without your permission. There are a few exceptions. In order for Best Care EAP to provide your EAP counseling, it is necessary for Best Care EAP and your affiliate provider to exchange counseling and billing information. Certain reports to authorities are required by law, such as suicidal intent or threats of imminent physical violence toward others. In addition, suspected abuse of children, the elderly, and incompetent or disabled persons must also be reported. For a more complete description of counseling confidentiality, please see our *Privacy Notice* that we have included with your intake forms.

We strive to provide you excellent professional counseling services. In order to achieve this, you are expected to be a full participant in the counseling process. This includes arriving at mutually agreed upon counseling goals and a plan to achieve those goals with your affiliate counselor. After completing your counseling with Best Care EAP, we solicit your feedback on that experience as an essential part of our ongoing effort to provide excellent counseling services.

It is the policy of Best Care EAP to use its best efforts to avoid participation in adversarial actions against customer companies or organizations, or in any client legal actions, such as child custody suits, divorce proceedings or personal injury lawsuits. If you are considering or are involved in such actions, your EAP counselor can refer you to an independent health care professional for assistance. Since such services are outside your EAP benefits, costs for these services would be your responsibility.

If you have any questions or concerns about your counseling services, please contact Best Care EAP's Clinical Services Manager, Terry Coleman, at (402) 354-8000 or (800) 801-4182. He will do his best to answer your questions or address your concerns. If you are not satisfied after speaking with Terry, please contact our Corporate Director, Jean Faber. You may also contact Jeff Prochazka, our Vice President, at Nebraska Methodist Health System, (402) 354-6078, or the Nebraska Department of Health and Human Services, Division of Public Health, Licensure Unit, at (402) 471-2115, regarding your concerns.

By signing below, you acknowledge that you have read and understand this information and you give your consent for Best Care EAP to provide counseling services for you and any of your minor children who participate in the counseling.

Date: _____ Signature: _____

Date: _____ Spouse/Significant Other: _____

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CLIENT SCREENING QUESTIONS

Client Name _____ Last 4 of SS #_____ DOB _____

Employee's Name _____ Last 4 of SS #_____ DOB _____

Please circle your rating at this time for the following issues that apply in your situation to the counseling client. We will ask your ratings on these issues again after counseling has been completed to determine if counseling has led to improvement.

Self-esteem:	Poor	Fair	Good	Very Good	Excellent
Job/Employer satisfaction:	Poor	Fair	Good	Very Good	Excellent
Spouse/significant other relationships:	Poor	Fair	Good	Very Good	Excellent
Family relationships:	Poor	Fair	Good	Very Good	Excellent
Overall stress level:	Poor	Fair	Good	Very Good	Excellent
Overall attitude/happiness:	Poor	Fair	Good	Very Good	Excellent

Are your counseling issues related to worry, fears or possible anxiety?_____Yes_____No
If yes, please circle your answers to the following *Generalized Anxiety Disorder* (GAD-7) questions.

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T_____=_____+_____+_____)

Are your counseling issues related to discouragement, sadness or possible depression?_____Yes_____No
If yes, please circle your answers to the following *Patient Health Questionnaire* (PHQ-9) questions.

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - - being so fidgety or restless that you have been moving around a lot more that usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

(For office coding: 0___+_____+_____+_____= Total Score:_____)

If you circled <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

---

Are your counseling issues related to use of alcohol?_____Yes_____No
If yes, please circle your answers to the following *Short Michigan Alcohol Screening Test* (SMAST) questions.

1. Do you feel you are a normal drinker?	Yes	**No**
2. Do your spouse or parents worry or complain about your drinking?	**Yes**	No
3. Do you ever feel bad about your drinking?	**Yes**	No
4. Do friends or relatives think you are a normal drinker?	Yes	**No**
5. Are you always able to stop drinking when you want to?	Yes	**No**
6. Have you ever attended a meeting of Alcoholics Anonymous?	**Yes**	No
7. Has drinking ever created problems between you and your spouse?	**Yes**	No
8. Have you ever gotten into trouble at work because of drinking?	**Yes**	No
9. Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?	**Yes**	No
10. Have you ever gone to anyone for help about your drinking?	**Yes**	No
11. Have you ever been in the hospital because of drinking?	**Yes**	No
12. Have you ever been arrested even for a few hours because of drinking?	**Yes**	No
13. Have you ever been arrested for drunk driving or driving after drinking?	**Yes**	No

(For office coding: 1 point for each answer in bold
2 points = possible problem _____
3 points = probable problem_____)

Are your counseling issues related to use of drugs?_____Yes_____No
If yes, please circle your answers to the following *Drug Abuse Screening Test* (DAST-10) questions.

The questions below are about your possible involvement with drugs during the past 12 months.
"Drug use" means -
(1) Using your medications in excess of the directions, or
(2) Using your medications to get high
"Drug use" does not include alcohol beverages

1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Do you abuse more than one drug at a time?	Yes	No
3. Are you always able to stop using drugs when you want to?	Yes	No
4. Have you had "blackouts" or "flashbacks" as a result of your drug use?	Yes	No
5. Do you ever feel bad or guilty about your drug use?	Yes	No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7. Have you neglected your family because of your use of drugs?	Yes	No
8. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No

(For office coding: 1 point for each "Yes" response
0 No problem reported _____
1-2 Low level _____
3-5 Moderate level_____
6-8 Substantial level_____)

Are your counseling issues related to gambling?_____Yes_____No
If yes, please check your answers to the following *Gambling Screening* questions.

1. In the past 12 months have you gambled more than you intended to?
   _____No _____Once Only _____More Than Once
2. In the past 12 months have you claimed to be winning money when you were not?
   _____No _____Yes
3. In the past 12 months have you felt guilty about the way you gamble or about what happens when you gamble?
   _____No _____Yes
4. In the past 12 months have people criticized your gambling?
   _____No _____Yes
5. In the past 12 months have you had money arguments that centered on gambling?
   _____No _____Once Only _____More Than Once
6. In the past 12 months when you were gambling, did you feel that you had to persist until you won?
   _____No _____Yes
7. If you answered yes to 2 or more of these questions, how often has it happened?
   _____No _____Once Only _____More Than Once

(For office coding:
Yes to one_____
Yes to two or more but Once Only_____
Yes to two or more or More Than Once or more than three_____)

SCORING KEY FOR INTAKE SCREENINGS

GAD-7

GAD-7 Anxiety Severity.

This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. GAD-7 total score for the seven items ranges from 0 to 21.

Scores represent: **0-5 mild 6-10 moderate 11-15 moderately severe anxiety 15-21 severe anxiety.**

PHQ9

for healthcare professional use only

Scoring—add up all checked boxes on PHQ-9

For every 3: Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score Depression Severity

1-4 Minimal depression
5-9 Mild depression
10-14 Moderate depression
15-19 Moderately severe depression
20-27 Severe depression

SMAST

SMAST Degree of Problem Suggested	Score Alcohol Involvement Action
0-2 No problems reported	None at this time
3 Borderline alcohol problem reported	Further investigation is required
4 or more Potential Alcohol Abuse reported	A full assessment is required

DAST-10

Question #3 is to be scored 1 point if it is answered "No"

Score 0-2 Score is in the low-risk range	Client would be advised to stay within the recommended prescription limits
Score 3-5 Score is in the at-risk or high risk range	Client would be advised to reduce use of opiate medications to within the recommended prescription limits
Score 6 or more Score is in the severe risk range	Use of opiate medications could result in significant harm or even death. Recommend client consultation with doctor immediately.

GAMBLING SCREEN

If a person answers no to all questions, you can be very confident that he or she does not have a gambling problem. A score of 2 may indicate that he or she is developing a problem, but currently does not have a problem. If the person scores 3 or more you can be very confident that he or she does have a problem; over 97% of people who do not have a problem score less than 2 on these items. A score of 2 is a judgment call; the majority of people who do not have a problem score less than 2, but the majority of people who do have a problem score more than 2. This score may indicate a person that is in transition. Question 7 is used to adjust a person's score. If a person scored 3 or above, but responded once only to question 7, then he or she may be at risk or in transition, but probably does not currently have a gambling problem.