# Provider Guideline
# Assessment & Treatment of Focus on Success Management Referrals

**Purpose:** This guide describes the standards and procedures for New Avenues Focus on Success Management Referrals. These individuals have been referred by their employer for concerns related to work performance. Assessment, treatment, treatment recommendations and decisions are strictly within the scope of the provider(s) professional judgment. New Avenues acts as a neutral, objective third party to arrange professional services appropriate to the nature of the referral, to serve as an intermediary between the provider, employee, and employer, to coordinate treatment, to communicate information and reports subject to the scope of the authorization for release of information.

**Focus on Success Management Referral clients are either**:

- **Disciplinary** Related to an employer's corrective action – often at the final stage of discipline or pre-termination or
- **Non-disciplinary** Related to work performance concerns but may not be part of the employer's disciplinary process.

The reporting requirements and procedures remain the same for the provider for both disciplinary and non-disciplinary employer referrals.

**Important Points:**

- **Treatment is expected to be intensive, brief, and goal directed.** Set expectations with the client that sessions will be weekly, or alternate schedule if more intensive, in order to resolve these concerns within a reasonable timeframe.

- **The focus of treatment goals should be on work performance/work relationship issues.** Because this referral is related to an employee's work, the treatment plan should focus on the issues in the employee's life, condition, attitude, behavior, or circumstances that are impacting work performance.

- **Please call New Avenues Care Manager if other services are indicated** in order to discuss referral options, modifications in treatment plan, reimbursement questions, and assistance with coordination of services.

- **Do NOT communicate with the employer, union agents, supervisors, or anyone outside of the EAP** unless directed to do so by New Avenues Care Manager and with an appropriate Release of Information. New Avenues is responsible for communicating progress and compliance reports to the employer subject to the scope of the New Avenues Consent for Release of Information form that accompanies this referral. If you have questions regarding the scope of the information that New Avenues is able to share with the employer, please refer to this Release of Information form. Be aware that the employee may request you to communicate with their employer for a variety of reasons; please contact the referring New Avenues Care Manager first. Your provider contract prohibits being involved in an employee's grievance, dispute, conflict, or in any actions, implied or direct, against an employer.

- **Retain your objectivity** with regard to understanding the employer's action and the employee's perception. These referrals often occur under challenging circumstances at work; our experience is that employers make these referrals based on significant rationale that has warranted action. However, the employee may not perceive of the situation the same as the employer. The goal is to provide the employee with the opportunity to obtain professional help that will result in work performance improvement. **It is imperative that you remain neutral and not make any statements, directly or indirectly, that could be construed as critical of the employer or the**

**employer's actions.** If you have serious concerns about the congruency of information you receive or the employment environment, please discuss with the Care Manager.

- **Potential leaves of absence:** If in your judgment, it appears that the employee may benefit from a leave of absence, please refer the employee to a medical provider for evaluation. It is not the role of you, as a New Avenues provider, to make this determination. With regard to leaves of absence in all documentations, please refrain from using the term "FMLA." Instead, use the term "medical leave." FMLA is a legal term and it is the employer's determination as to whether the FMLA applies to the particular situation.

- **Reimbursement for EAP services:** Most employees have an EAP benefit available for the initial session and for subsequent short-term number of outpatient sessions which are at no charge to them. **Bill New Avenues for EAP services using the Focus on Success Management Referral Codes. Do not bill the employee for EAP services.** Please review your authorization form that accompanies this referral in order to determine how many EAP visits are available.

- **Reimbursement for non –EAP services:** In the majority of instances, employees are responsible for the cost of treatment beyond the EAP benefit or for services not covered by the EAP benefit such as IOP, classes, inpatient, and psychological testing. Most employees use their insurance benefits and are responsible for co-payments and/or deductibles. For insurance benefit information, please refer to the intake form call sheet in order to determine if insurance benefits are available and if New Avenues manages the behavioral health benefit or if the employee is covered by an insurance plan that requires any pre-authorization. The payment arrangements and claims information should be discussed with the employee or New Avenues as part of managing ongoing treatment.

- **Provider reports:** Your assessment and reports on the employee's attendance, compliance, and progress are critical to enabling New Avenues to fulfill its obligation to the employer to delivering timely compliance reporting. The employee's job may rest on the employer seeing evidence of the employee's attendance and compliance.

- **Involvement in the Focus on Success Management Referral Program is not intended to substitute or replace the employer's normal policy and procedure.** An employee is expected to meet all job performance standards while involved in the Focus on Success Management Referral program.

## Procedures for Focus on Success Management Referral Cases

1. **Review New Avenues referral intake form and the documentation provided by the employer prior to meeting with the client** in order to fully understand the employment concerns.

2. **Contact the client after receiving the EAP referral/authorization within two (2) days** unless the appointment is made ahead of the authorized fax. Please note whether the preferred contact is home or work.
   a. Notify New Avenues as soon as the appointment is made or if there is difficulty making the appointment within two days.
   b. Appointments should be scheduled outside the employee's work hours unless special permission is given by the employer to attend the first evaluation during work hours. On rare occasion, an employee may need time off from work. If time off from work is required for treatment, the employee may utilize medical leave, short term disability, long term disability, or worker's compensation benefit depending on the approval from his/her company, the length of time needed and the employer's policy. It is the employee's responsibility to understand the company policy and to arrange for time off from work.

3. **Initial Clinical Assessment (Level II EAP): Fax to New Avenues the ICA after the first visit.** Any recommendations such as testing, psychiatric evaluation, etc. that require another provider needs to be addressed through New Avenues first. The treatment plan should be focused on improvement of work performance or work-related concerns.

4. **An Outpatient Treatment Report (OTR) must be completed when an employee transfers from EAP to insurance** if New Avenues manages the insurance benefit and authorization of benefits is required.

5. **Therapist Monthly Progress Report: Fax this form to New Avenues at the end of the third (3rd) week of each month.** Include details regarding attendance dates, compliance with treatment recommendations, and progress towards treatment goals. Please describe in language that can be shared with the employer when New Avenues is required to report monthly to the employer on the employee's compliance and progress. Compliance means meeting all of the following conditions:
   - Employee is participating and attending regularly the recommended sessions.
   - Employee is completing treatment recommendations.
   - Employee is remaining sober/abstinent if applicable. Failure or refusal of a provider mandated drug testing is considered noncompliance. Call the Care Manager.
   - Employee is meeting financial responsibility for any co payments, deductibles, or charges beyond the EAP visits.

6. **Notify New Avenues promptly in cases of missed appointments, cancellations, or interruption in treatment.** Employers are very concerned regarding compliance and request that New Avenues notify them immediately of any interruption in service including the employee withdrawing from service.

7. **Contact New Avenues Care Manager when you anticipate that the case is nearing closure. Case closing is a joint decision between the provider and Care Manager.** If indicated, the Care Manager will confer with the employer to determine if the employer perceives performance improvement to point of closure. If both parties agree, fax a Closing Summary Form when treatment goals have been completed or immediately if the employee drops out of the treatment or therapy ends for whatever reason. Please complete this form in its entirety.

8. **It is the responsibility of this office to inform the provider of any changes in the status of their client regarding benefits, employment, etc.**

*As we all know, these disciplinary referrals are very labor intensive. A strong partnership approach can help to dramatically improve the employee's chance for success and avoid any controversy about the process and procedures that were utilized. We appreciate your collaboration as we try to help these employees be successful in their jobs.*

**Please call New Avenues Case Management Team for any assistance or consultation.**
**Provider line: 866-925-5730**

MR

# MONTHLY EMPLOYEE PROGRESS REPORT FROM THERAPIST

**NOTE: PLEASE FOCUS YOUR REPORT TO THOSE ISSUES THAT AFFECT WORK PERFORMANCE AND USE LANGUAGE THAT MAY BE QUOTED IN THE REPORT BY NEW AVENUES TO THE EMPLOYER. EMPLOYEE WILL RECEIVE A COPY OF THIS REPORT.**

**Client**: ____________________________________________ **Month**: ___________________________

**Agency**: _____________________________________ **Therapist**: ______________________________

**Treatment plan recommendation:** ☐ Individual ☐ Group ☐ IOP ☐ Self Help ☐ Other

1. **Attendance**: *Please specify all dates for this month for kept and failed appointments.*

_______________________________________________________________________________

_______________________________________________________________________________

2. **Attitude**: ☐ Positive ☐ Resistant ☐ Compliant ☐ Motivated

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

3. ☐ **Compliant** with recommended treatment plan.

4. ☐ **Non compliant** with recommended treatment plan.

*(Please note in what area of treatment plan is member non compliant.)*

_______________________________________________________________________________

5. **Progress**: ☐ Excellent ☐ Satisfactory ☐ Minimal ☐ None ☐ Condition Worse

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

6. **Have you or are you recommending further evaluation related to this condition?**

   ☐ Primary Care ☐ Psychiatrist ☐ Psychologist ☐ Psychological Testing ☐ Other

7. **Estimated date of completion**: _________________________________________________________

8. **To your knowledge what is the member's current employment status?**

   ☐ Working regular schedule ☐ Working reduced schedule

   ☐ On leave ☐ Recommendation for leave

9. **Additional comments**: ______________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

___________________________________ ___________________________

**Agency/Therapist's Signature** **Date**

**<u>PLEASE FAX this form to New Avenues 574-271-5980</u>**

# MANAGEMENT REFERRAL

# FAX COVER LETTER

**New Avenues, Inc.**
**New Avenues EAP    Midwest Behavioral Health Network**
**P.O. Box 360    South Bend, IN  46624**
**Toll Free:  EAP 800-731-6501  574-232-2131**
**MBHN  800-223-6246  574-271-5177**
**Fax  EAP/MBHN  574-271-5980**

**Date:** ______________________________

**Company:** **New Avenues EAP**    **Fax #** **574-271-5980**

**To:** **Case Management Team**    **From:** ______________________________

**Regarding:** ______________________________________________________________

**Total Pages Including Cover Sheet:** ______________________________________

**Comments:**__________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

You can access forms, policies and our Provider Manual on our web site at www.NewAvenuesOnline.com

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New Avenues
Midwest Behavioral Health Network

# NEW AVENUES / MBHN: Initial Clinical Assessment

❒ ICA - MBHN
❒ Level II - EAP

**MR**

Employee Assistance Program · P.O. Box 360, South Bend, IN 46624 · Phone: (866) 925 - 5730 · Fax: (574) 271 – 5980
Midwest Behavioral Health Network · P.O. Box 360, South Bend, IN 46624 · Phone: (866) 925 - 5730 · Fax: (574) 271 – 5980

**When to submit this form:**
**MBHN** ⇨ After First Session; **EAP** ⇨ For Referral Into Behavioral Health Benefit

**I. Demographics:** Assessment Date: ______________________
Client Name: ________________________________
SSN/Case #: ______________ Birth Date: ______________
People Present: ________________________________

**II. Client (or employer) Presented the Following Concerns**:
________________________________________
________________________________________
________________________________________
________________________________________
Client's Level of Subjective Distress: ❒ Low ❒ Moderate ❒ Significant ❒ Severe

**III. Type of Initial Referral:**
- ❒ MBHN Self Referral
- ❒ EAP Level II
  - ❒ Self Referral (EAP to Insurance)
  - ❒ Management Referral
  - ❒ Fitness For Duty
  - ❒ DOT ❒ Other

**IV. This client is being assessed for:**
- ❒ Fitness For Duty
- ❒ Job Jeopardy
- ❒ Treatment beyond EAP – must meet criteria of medical necessity.
- ❒ Specialized service not covered by EAP
- ❒ Other_______________________

**V. Chemical Abuse/Dependency:** ❒ None user/abstainer ❒ Experimental ❒ Social/Recreational ❒ Self-Medicating ❒ Loss of Control
❒ Self/Others concerned about usage ❒ Compulsive use ❒ Continued use (despite adverse consequences)
❒ Other: ________________________________________
Family History of Abuse/Dependence: ❒ Father ❒ Mother ❒ Grandfather ❒ Grandmother ❒ Sibling ❒ Spouse ❒ Child
Prior History of Abuse/Dependency: ❒ Yes ❒ No ❒ Recovering (describe recovery program in Section XI.) Date of last use? ______________
Currently using? ❒ Yes ❒ No What?________________________________
Amount: ______________________ Frequency: ______________________ Length of Use______________________
Length of Most Recent Period of Sobriety: ______________________ Comments:(use Section XI for additional comments)

**VI. Signs & Symptoms/Functioning:** (**Check** all applicable items & **Circle** the degree of impact - items unmarked are considered **"Not Applicable"**)

**Legend:**
1 = MILD -- **impacts** quality of life, but no significant effect upon day-to-day functioning
2 = MODERATE -- **significant impact** on quality of life and/or day-to-day functioning
3 = SEVERE -- **marked impact** on quality of life and day-to-day functioning

| | | | | |
|---|---|---|---|---|
| ❒ Family Conflict | 1 2 3 | ❒ Depression | 1 2 3 | Anorexia Nervosa |
| ❒ Marital/Couple Conflict | 1 2 3 | ❒ Sleep Disturbance | 1 2 3 | ❒Yes ❒No |
| ❒ Unresolved Grief | 1 2 3 | ❒ Appetite Change | 1 2 3 | |
| ❒ Parenting Difficulties | 1 2 3 | ❒ Lethargic | 1 2 3 | Binging/Purging |
| ❒ Child Behavioral Problems | 1 2 3 | ❒ Hopeless | 1 2 3 | ❒Yes ❒No |
| ❒ Aggressive Behavior | 1 2 3 | ❒ Guilt | 1 2 3 | |
| ❒ School Performance | 1 2 3 | ❒ Anxiousness | 1 2 3 | Trauma Victim |
| ❒ Attention Problems | 1 2 3 | ❒ Panic Attacks | 1 2 3 | ❒Yes ❒No |
| ❒ Hyperactivity | 1 2 3 | ❒ Phobias | 1 2 3 | |
| ❒ Developmental Delays | 1 2 3 | ❒ Obsessive/Compulsive | 1 2 3 | Trauma Perpetrator |
| ❒ Eating Disorder | 1 2 3 | ❒ Gambling | 1 2 3 | ❒Yes ❒No |
| ❒ Health Concerns | 1 2 3 | ❒ Psychotic Symptoms | 1 2 3 | |
| ❒ Somatic Complaints | 1 2 3 | ❒ Paranoid Thinking | 1 2 3 | Abuse Victim |
| ❒ Sexual Dysfunction | 1 2 3 | ❒ Thought Disorders | 1 2 3 | ❒Yes ❒No |
| ❒ Low Self-Esteem | 1 2 3 | ❒ Impaired Memory | 1 2 3 | |
| ❒ Anger/Temper problem | 1 2 3 | ❒ Self-Care impaired | 1 2 3 | Other_____________ |

**Symptoms have been present for:**
❒ less than 1 month ❒ 1-6 months ❒ 7-12 months ❒ more than 12 months

**VII. Organic Indicators:**
Not Assessed [ ]

| | Yes | No |
|---|---|---|
| Oriented x 3 | ❒ | ❒ |
| Impaired Memory | ❒ | ❒ |
| Tangential | ❒ | ❒ |
| Below Average Intelligence | ❒ | ❒ |
| Overly Preoccupied with Detail | ❒ | ❒ |
| Impaired Level of Consciousness | ❒ | ❒ |
| Decrease Attention Span | ❒ | ❒ |
| Other Cognitive Impairment | ❒ | ❒ |

Explain: ______________________________
______________________________

**Other:**
- ❒ Medical Concern:______________________________1 2 3
- ❒ Psychological Concern: ______________________________1 2 3
- ❒ Other: ______________________________1 2 3

________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

# New Avenues / MBHN Initial Clinical Assessment (ICA)

Client Name: ____________________

**VIII. Medication:** (List all psychotropic & other medications) Not Assessed **[ ]**

Has the patient been evaluated for medication? ❒ Yes ❒ No Prescribing Physician: ____________________

Current Medication: ❒ None ❒ Psychotropic ❒ Medical ❒ Other: ____________________

| **Medication** | **Dosage/Frequency** | **Start Date** | **Medication** | **Dosage/Frequency** | **Start Date** |
|---|---|---|---|---|---|
| ① | | | ③ | | |
| ② | | | ④ | | |

**Overall Health Issues if any**: ____________________

**II. Prior Treatment:** (Check all that apply) Not Assessed **[ ]**

| | Psychiatric | Chemical Dependency |
|---|---|---|
| Traditional Outpatient (Individual/Group) | ❒ | ❒ |
| Partial Hospitalization/IOP | ❒ | ❒ |
| Inpatient | ❒ | ❒ |

(❒ Past Year ❒ Past 5 Years ❒ 10+ Years)

**IX. Risk Assessment:** Not Assessed **[ ]**

(Check all that apply)

| | Suicidality | Homicidality |
|---|---|---|
| Not Present | ❒ | ❒ |
| Ideation | ❒ | ❒ |
| Plan | ❒ | ❒ |
| Means | ❒ | ❒ |
| Prior Attempt | ❒ | ❒ |

Any issues of violence in client or client's family history or current situation at home or work?

❒ Yes ❒ No If yes, please explain:

____________________

____________________

**X. DSM-IV Diagnosis:**

AXIS I: Primary: __________ Secondary: __________

AXIS II: Primary: __________ Secondary: __________

AXIS III: ____________________

AXIS IV: ____________________

AXIS V: (current GAF): __________

AXIS V: (past year GAF): __________

**Global Assessment of Functioning (GAF) Scale**

91-100 Superior Functioning
81-90 Minimal Symptoms
71-80 Mild/Transient Symptoms
61-70 Mild Symptoms
51-60 Moderate Symptoms/Moderate Living Impairment
41-50 Serious Symptoms/Serious Living Impairment
31-40 Impaired Reality Testing/Major Living Impairment
21-30 Inability to Function in Almost All Areas of Life
11-20 Some danger to self/others
01-10 Serious danger to self/others

**XI. Clinical Overview:** Briefly summarize any factors, which may impact the treatment process (e.g., pertinent history, concomitant issues, family dynamics, and support systems):

____________________

____________________

____________________

____________________

____________________

____________________

**XII. Treatment Plan Summary:** Focus of Treatment: - Objectives for treatment

#1: ____________________

#2: ____________________

**Outcomes**: Be specific about behavioral & functional improvements anticipated:

____________________

____________________

**XIII. Provider Coordination of Care with PCP:**

❒ Patient has signed consent form

❒ Patient declined to sign consent form

❒ Provider has not discussed consent form with Patient

Communicated with PCP by: ❒ Verbal ❒ Written

Date of communication with PCP: __________

**XIV. Access to care:**

First appointment offered within 10 days of patients call?

❒ Yes ❒ No If No, Why?

❒ Patient declined initial appointment offered
❒ Appointment within 10 days was not available
❒ Other ____________________

____________________

**Frequency of Sessions:** ❒ **Weekly** ❒ **Every Two Weeks** ❒ **Monthly** ❒ **Other (explain):** __________

**Modalities**: ❒ Individual ❒ Family ❒ Couple ❒ Group ❒ Other ❒ Self- Help/Community

**CD Treatment Recommended**: ❒ Individual ❒ IOP ❒ Detox ❒ Classes ❒ AA ❒ Relapse/Aftercare

**XV. Expected Treatment Outcomes:** (check all that apply)

| | **Goal #1** | **Goal #2** |
|---|---|---|
| • Problem resolution & discharge. | ❒ | ❒ |
| • Transfer to self-help group or other community support services. | ❒ | ❒ |
| • Provide ongoing treatment through insurance benefit or self-pay. | ❒ | ❒ |
| • Refer for Psych Evaluation, Med Evaluation or other services. | ❒ | ❒ |

**This plan has been discussed with patient and/or guardian**
❒ **Yes** ❒ **No**

**NUMBER of SESSIONS REQUESTING NOW:** ________ **DATE AUTHORIZATION SHOULD BEGIN:** __________

**EXPECTED DATE of COMPLETION (Month/Year):** __________ **Date Signed:** __________

**Provider's Name (Print):** __________ **Provider's Signature:** __________

# NEW AVENUES EMPLOYEE ASSISTANCE PROGRAM

**P.O. Box 360 South Bend, IN 46624 Phone: 866-925-5730 Fax: 574-271-5980**
eap_referral@newavenuesonline.com

## EAP Case Closing Summary

***Fax or (secure) email after final EAP session***

MR

| **Member Name:** | **Employee Name:** |
|---|---|
| **Date of Birth:** | **Employer:** |
| **Member ID/Policy #** | Routine EAP Referral Management Referral |

Assessment Date: Date Closed:

Number of Sessions Held: Number of Cancellations: Number of No Shows:

**Disposition of Case at Closing:**

Goals Met: Yes No Improved

Client discontinued EAP services.

Recommended continued treatment beyond EAP. Yes No Member Declined

Client was terminated from employment.

Client quit their job and was no longer eligible for services.

**Presentation of the Concerns:**

| | | | |
|---|---|---|---|
| Alcohol Use | Depression | Financial | Marital/Relationship |
| Anxiety/Stress | Domestic Violence | Grief or Loss | Trauma |
| Child/Adolescent | Drug Use | Health | Work Stress/Occupational |
| COVID-19 | Family | Legal | Other |

**Additional Resources Recommended:**

| | |
|---|---|
| Ongoing Behavioral Health Services | Primary Care Physician |
| Psychiatric Evaluation | Support Group |
| Psychological or Neuropsychological Testing | Community Referral |
| Substance Use Treatment | AA or NA |
| Higher Level of Care i.e., Inpatient, PHP, IOP | Social Service Agency |
| Other | |

**Comments:**

**Provider Signature:** **Date**:

**Print Name:**